Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 11 November 2020

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Title:	**Maternity Incentive Scheme Update Report**

Status:	**For Discussion**
History:	**Maternity Clinical Governance Committee 26 October 2020**

Board Lead:	**Chief Nursing Officer**
Author:	**Kelly Davis, Quality Assurance & Improvement Midwife**
Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This paper is to give an early brief update on the ten maternity safety actions included in the NHS Resolution Maternity Incentive Scheme Year 3 (published 23rd December 2019, updated 6th February 2020 and again 1st October 2020) and on the current status of the scheme.
2. It will also provide an overview of the continuity of carer (CoC) provision across maternity services at Oxford University Hospital (OUH) FT.

Recommendations

3. The Trust Board is asked to:
    - note the contents of the update report,
    - consider the benefits of such pathways and acknowledge how the pathways have thrived across the pandemic, which is contrary to the national picture,
    - consider that the Maternity Incentive Scheme (MIS) standard of 35% of 'women placed onto a CoC pathway' for 2020/21 will be surpassed with our current average being 82%. However, next steps are being addressed and implemented to ensure that we continue to drive forward with the secondary target of 51% 'achieved CoC' by March 2022. This secondary target is not within this annual MIS standards, however, the momentum regarding this work is maintained and with a variety of pathways yet to be implemented. Our current overall achieved CoC stands at 15% which falls short of the March 2022 target,
    - support the expansion of the Lotus service to meet the heightened need across the Country and to prioritise BAME and all vulnerable groups across Oxfordshire,
    - discuss how the Trust could support the Maternity and Neonatal units with overcoming the challenges that have been identified.

Contents

1. Purpose

1.1. This paper is to give an early brief update on the ten maternity safety actions included in the NHS Resolution Maternity Incentive Scheme Year 3 (published 23rd December 2019, updated 6th February 2020 and again 1st October 2020) and on the current status of the scheme.

1.2. It is also to draw the attention of the Board to areas of risk and to generate discussion as to how the Trust could support the Maternity and Neonatal units.

2. Background

2.1. NHS Resolution (NHSR) runs the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to support the delivery of safer maternity care. As in previous years, as a member of the CNST Oxford University Hospitals NHS Foundation Trust (OUH FT) will contribute an additional 10% of the CNST maternity premium to the scheme.

2.2. If OUH FT can demonstrate full compliance with all of the ten safety actions then the Trust will recover the 10% contributed **and** will also receive a share of any unallocated funds.

2.3. If OUH FT cannot demonstrate full compliance with all ten of the safety actions then the Trust will not recover the 10% contributed but may be eligible for a small discretionary payment from the scheme to help make progress towards meeting the requirements of the actions that were not achieved. This discretionary payment would be at a much lower level than the 10% contributed.

2.4. The deadline for the Board declaration to reach NHSR is now 12 noon on Thursday 20 May 2021 (see section 4 below).The declaration must state that the Board is satisfied that the evidence provided to demonstrate achievement of the ten safety actions meets the required standards as set out in the 'Ten maternity safety actions with technical guidance' document. The content of the declaration form must be discussed with the commissioner of the Trust's maternity services, and then it must be signed by the Trust Chief Executive.

2.5. There will be a number of external verification points by which NHSR can cross check whether the declaration form represents an accurate picture of the Trust status with regard to the safety actions, and will be sense checked with the Care Quality Commission (CQC).

2.6. The ten safety actions for year 3 of the scheme were first published by NHS Resolution on 23 December 2019 (see section 5 below).

2.7. This paper outlines the required standards for each of the ten safety actions along with the initial evaluation of the current status and level of risk for each standard (see section 6 below).

3. March Update from NHS Resolution: Scheme on hold during Covid-19 period

3.1. On 23rd March 2020 NHS Resolution announced that with immediate effect the majority of reporting requirements relating to demonstrating achievement of the Maternity Incentive Scheme 10 safety actions were paused. Therefore no Trust Board papers have been submitted regarding the Maternity Incentive Scheme during this period.

3.2. The expected date for re-launch of the scheme as announced in March was Monday 31st August 2020, but this was to be kept under review. The reporting period was then expected to run from Tuesday 1st September 2020 until Friday 30th April 2021.

3.3. Due to the pause in the scheme, the 10% uplift to the CNST for the Maternity Incentive Fund was not collected from Trusts in April 2020 for the year 2020/2021.

3.4. Trusts were asked to continue to apply the principles of the 10 safety actions with the aim of supporting the delivery of safer maternity care. Furthermore, it was emphasised that reporting of perinatal deaths to MBRRACE-UK should remain a priority, and every reasonable effort should be made to make a monthly Maternity Services Data Set submission to NHS Digital. These work streams have continued at OUH FT throughout the Covid-19 period, and this paper marks the re-commencement of MIS reporting to the Trust Board despite the scheme having not yet re-launched formal reporting requirements.

4. August Update from NHS Resolution

4.1. On 12th August 2020 NHS Resolution issued an update for Trusts, outlining that the current plan is to relaunch the scheme in line with Maternity Transformation Programme (MTP) planning for programme recovery by working closely with the MTP policy team.

4.2. The MIS safety actions are currently being reviewed by members of the NHS Collaborative Advisory Group – the implication here is that it is unlikely the scheme will be ready to be re-launched as previously planned on 31st August.

4.3. The planned reporting period from re-launch to the submission deadline for the Board declaration will now be six months – two months less than previously announced.

4.4. There will be additional elements within some safety actions to ensure that learning from important emerging Covid-19 themes is rapidly implemented by maternity services. Full details of the additional elements have not been announced.

4.5. The financial arrangements will continue on the same basis as before, with the 10% uplift contribution to the Maternity Incentive Fund to be collected in April 2021.

4.6. In this interim update, information is provided on changes to be made to three of the ten safety actions: 2, 6 and 8. These updates and the Maternity Directorate initial response are outlined in section 5 below.

4.7. The senior teams for the Maternity and Neonatal Directorates will be reviewing the strategy for compliance with the scheme as a priority to maximise the chance that OUH will achieve compliance with all ten safety actions before the deadline.

5. October Re-launch and Revised Guidance from NHS Resolution

5.1. On 1st October 2020 NHS Resolution wrote to Trusts announcing the relaunch of the scheme.

5.2. In this launch letter to Trusts some reference was made to the addition of elements aiming to ensure key learning from important emerging Covid-19 themes were considered and implemented.

5.3. The launch letter highlights the importance of all ten safety actions but places particular emphasis on safety action 2 and submitting data to the NHS Digital Maternity Services Data Set (MSDS).

5.4. NHS Resolution make no further reference to safety actions 6 and 8 in this launch which differs to the August update. The letter does draw attention to revisions and additions to Safety Action 10: (reporting 100% of qualifying cases to the Health Safety Investigation Branch (HSIB).

5.5. The new guidance has been extensively reviewed and it has been flagged to the senior teams for the Maternity and Neonatal Directorates that there have been significant iterations, additions and revisions to a number of safety actions. A Summary of Changes document has been produced and disseminated. Section 6 of this document has been comprehensively updated to this end.

6. Year 3 Safety Actions: Brief Overview

6.1. **Safety Action 1**: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? **Moderate RISK of non-compliance (upgraded from low risk since last update in view of new guidance)**

6.1.1. October re-launch from NHS Resolution: several additions to standards a) and b). See section 6.1 for details of changes and compliance with each standard of this safety action.

Financial implications: No further financial implications currently expected for this safety action.

6.2. **Safety Action 2**: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? **Low RISK of non-compliance (downgraded from moderate to low)**

6.2.1. See section 6.2 for details of compliance with each standard in this safety action.

6.2.2. August 2020 Update from NHS Resolution: Item 14 on the Maternity Record Standard has been removed from action two and will be progressed separately by NHSX. NHS Digital announced on 1 April 2020 that the Digital Maternity Record Standard (DMRS) compliance date had been delayed from Monday 30 November 2020 to Sunday 28 February 2021.

6.2.3. The work on the Maternity Digital Record Standard will need to continue but its removal from the Maternity Incentive Scheme does reduce our risk of non-compliance with this safety action. It is anticipated that this will remain on the agenda at CNST and as it has not been included in the October re-launch it is expected to be included in the Year 4 scheme.

6.2.4. Work is still ongoing to ensure that all the required MSDS information can be submitted on a monthly basis to NHS Digital. We have had successful submissions every month so far. However, the information team has been unable to submit some of the information that will need to be submitted before the end of the scheme to be compliant as the current EPR build does not support gathering the required information. The build work is expected to be completed in order to submit the data on time. Therefore the risk status has been downgraded to low.

6.2.5. **Financial implications:** No further financial implications currently expected for this safety action, above the work that is already ongoing.

6.3. **Safety Action 3**: Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? **High risk on non-compliance**

6.3.1. See section 6.3 for details of compliance with each standard in this safety action.

6.3.2. This safety action is a key area of concern for the Maternity and Neonatal Directorates. The Transitional Care Service was launched on the postnatal ward at the beginning of 2020 but current staffing levels, skills mix and capacity mean that the admission criteria cannot yet meet the minimum standards required by the Maternity Incentive Scheme.

6.3.3. **Financial implications:** It is expected that work is needed to become compliant and this will require financial support.

6.4. **Safety Action 4**: Can you demonstrate an effective system of clinical workforce planning to the required standard? **High risk of non-compliance (Neonatal Nursing workforce not currently compliant – risk status upgraded from moderate risk at last update)**

6.4.1. See section 6.4 for details of compliance with each standard in this safety action.

6.4.2. **Financial implications:** It is expected that the work needed to become compliant will have a significant financial implication due to the need to extend the neonatal medical and nursing workforces. To be compliant the MIS asks for action plans to be approved at Board level to address any deficiencies. An action plan for the neonatal medical workforce is currently being developed alongside a business case and the plan is to submit the action plan as an appendix to the next MIS Update Paper. However, a realistic action plan for bringing the neonatal nursing workforce up to the required standard will be more complicated and require significant resources to achieve. This has been costed and a paper submitted by the Divisional Director of Nursing outlining the shortfall and what is need in order to achieve compliance. There is no further update as the review of this document has been significantly delayed due to the Covid-19 pandemic.

6.5. **Safety Action 5**: Can you demonstrate an effective system of midwifery workforce planning to the required standard? **Low risk of non-compliance**

6.5.1. See section 6.5 for details of compliance with each standard in this safety action.

6.5.2. **Financial implications:** No further implications currently expected for this safety action as recruited to establishment.

6.6. **Safety Action 6**: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? **Moderate RISK of non-compliance**

6.6.1. See section 8.0 for details of compliance with each standard in this safety action.

6.6.2. August 2020 Update from NHS Resolution: During the Covid-19 pandemic it has been difficult to implement some elements of SBLCB and in particular element one as carbon monoxide testing has been suspended. Compliance with element 1 will therefore require an audit

based on the percentage of women asked whether they smoke at booking and at 36 weeks gestation.

6.6.3. See Appendix 2 for the most recent survey submitted to NHS England.

6.6.4. **Financial implications:** No further financial implications currently expected for this safety action, above the work that is already ongoing.

6.7. **Safety Action 7**: 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 to coproduce local maternity services? **Low risk of non-compliance**

6.7.1. See section 6.7 for details of compliance with each standard in this safety action.

6.7.2. **Financial implications:** No further financial implications currently expected for this safety action, above the work that is already ongoing.

6.8. **Safety Action 8**: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year? **Moderate RISK of non-compliance (neonatal resuscitation not currently compliant)**

6.8.1. See section 6.8 for details of compliance with each standard in this safety action.

6.8.2. August 2020 Update from NHS Resolution: NHS Resolution appreciates that local face-to-face, multi-professional training has not been possible during the emergency response due to Covid-19. When it is possible to resume training, social distancing/Covid-19 precautions will still affect the ability of units to provide face-to-face training. As an interim arrangement, we are planning to amend the requirements of safety action eight, as we recognise that traditional ‘hands-on’ drills and skills/in situ simulations may not be possible or practical for the immediate future. The interim arrangements will include local multidisciplinary training being provided as a local, half-day virtual/on-line training package as an alternative option for local MIS training requirements. If any ‘hands-on’ training is undertaken, or training is held in one room, as with clinical work, teams should follow the current guidance in relation to infection prevention control procedures, social distancing and personal protective equipment requirements, to ensure staff safety.

6.8.3. All training requirements of the Maternity Incentive Scheme have restarted with adherence to Infection Prevention and Control guidance regarding social distancing. Before the MIS was paused work was being done to review the percentage of each staff group that meet the neonatal resuscitation training requirement, and in some cases this was found to be below 50%. The training is going to be re-launched as e-learning and it felt that this will make it more likely that the 90% requirement may be reached. A Neonatal Resuscitation Officer involved in this training has contacted the scheme to ensure clarity on

the minimum requirement for training in person. We are awaiting a response from the MIS team.

6.8.4. The October re-launch from NHS Resolution includes multiple changes to the technical guidance of the MIS. It also details half-day virtual/on-line training package as an alternative option See section 6.8.

6.8.5. **Financial implications:** No further financial implications currently expected for this safety action, above the work that is already ongoing.

6.9. **Safety Action 9**: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues? **Low risk of non-compliance**

6.9.1. See section 6.9 for details of compliance with each standard in this safety action.

6.9.2. **Financial implications:** The action plan to be compliant with the Continuity of Carer aspect of this safety action is outlined in section … and an action plan can be found in Appendix 1.

6.10. **Safety Action 10**: Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme? **Low risk of non-compliance**

6.10.1. See section 6.10 for details of compliance with each standard in this safety action. There have been multiple additions to this action in the September re-launch.

6.10.2. On 20th April 2020 it was announced that Trusts were no longer required to report cases to NHS Resolution as part of the Early Notification (EN) Scheme. Instead, all cases meeting EN criteria would continue to be reported to the Healthcare Safety Investigation Branch (HSIB) who would triage cases and share information directly with NHS Resolution.

6.10.3. The October re-launch draws attend to the revisions and additions made to this safety action.

6.10.4. Financial implications: No further financial implications currently expected for this safety action, above the work that is already ongoing.

7. Overview on Compliance with Continuity of Carer

7.1. This section will provide an overview of the continuity of carer (CoC) provision across maternity services at Oxford University Hospital (OUH) FT. It will also demonstrate the '**overall achieved CoC'** across the service, as well as **'women placed onto a CoC pathway'.** These two standards are set by NHS England and outlined within the Maternity Incentive Scheme (MIS).

7.2. The definitions that we are benchmarking against are as follows:

Placed onto CoC Pathway

7.2.1. 'Each LMS should ensure that by March 2021, 35% of women booked for maternity care are placed on to continuity of carer pathways, and that "the proportion of Black and Asian women and those from the most deprived neighbourhoods on continuity of carer pathways should meet or exceed the proportion in the population as a whole. Being 'placed' on a continuity of carer pathway means that a woman has received care from a midwife/team who aims to provide all her antenatal, intrapartum and postnatal care, as set out above. A woman should be 'placed' on a continuity of carer pathway as early as possible – to give the woman maximum opportunity to build a trusting relationship with their midwife, and realise the benefits set out in evidence – and certainly by the 28 weeks antenatal appointment at the very latest, to be counted nationally.' (NHS Long Term Plan, 2020).

Achieved CoC Pathway

7.2.2. *Achieved CoC is defined as the full care pathway across the pregnancy continuum, which includes antenatal, intrapartum & postnatal care delivered by no more than 8 midwives. Each woman will be assigned a named lead midwife & associated midwifery team. The matrix for achieved CoC by March 2022 will stand at 51%.*

7.3. The CoC pathways implemented within the Trust have supported improved outcomes and overall experience for women and their families. All of which helps to address the national ambition of decreasing the perinatal mortality risk by 50% (Saving Babies Lives Care Bundle – see Appendix 2 for evidence).

7.4. The lotus team (full caseloading team model for vulnerable families) was launched in January 2020 and since implementation, overall **achieved CoC** of completed care provision was 88.8% (96/108).

7.5. Across the wider service, **achieved CoC** has seen an increase from 6-7% of all births to 15% over the last 6 months (March-July 2020). This increase of over 50% system wide has occurred throughout the pandemic and with further steps being made to introduce CoC specialist pathways.

7.6. The current average of **placed onto a CoC pathway** across OUH standards at 82%.

7.7. **The Lotus Caseloading Team**

7.7.1. The Lotus Caseloading Team was commenced in January 2020 in line with the Better Births Continuity of Carer (CoC) Agenda. The team consists of 6.4 WTE midwives delivering a full CoC model throughout the pregnancy continuum and across Oxford County. The provision was implemented after a successful bid through the 2019/2020 transformation funding. Each 1.0 WTE caseloads approximately 30-32 women and per month the team will have a maximum of 18 women across the team caseloads booked for birth. By having a set quota of 18 women due each month provides a degree of flexibility if some births occur before or after the monthly EDD. This ensures the model is protected from destabilisation.

7.7.2. The team criteria are aligned with a variety of key deliverables and inclusive of a multitude of complex vulnerabilities. It has been well evidenced that CoC case loading teams can have a profound positive impact, not only for women and their wider families, but from the perspective of improved birth outcomes. This includes a decrease in pre-term birth, repeat fetal loss and also a reduction in the long-term generational impact when supporting women whom may be subjected to complex vulnerabilities. This is evidenced through the Adverse Childhood Experiences (ACE's) and first 1000 days work, as well as aligning with the NHS Long Term Plan (LTP), MBRRACE & PMRT.

7.7.3. Some of the complex vulnerabilities that the team have provided a full CoC provision for is listed below:

- Care for women with a previous late fetal loss
- Non-English speaking and asylum seeking or destitute women
- Safeguarding concerns, such as a Child Protection Plan or S47 enquiries
- Domestic Abuse
- Moderate to Severe Mental Health
- Teenage Pregnancy if not under Family Nurse Partnership
- Birth Trauma and Tocophobia

7.7.4. Further details regarding the received/declined referrals are situated within Appendix 3.

7.7.5. In comparison to the wider national picture and to the significant reconfiguration of maternity services that have occurred during the Covid-19 pandemic, it is notable that the Lotus team has not only thrived, but is one of the few case loading teams still functioning during this pandemic. OUH has also been able to continue with the wider service provision and provide all four options for birth.

7.7.6. The team provides the provision across the County, which is a large geographical area spanning the North, City and South of Oxford; 2.0 WTE are allocated to each area.

7.7.7. The data outcomes highlighted through this paper are split into three quarters and will highlight the measures achieved since implementation.

7.7.8. The quarter data will be split as follows:

Quarter 1: January – March 2020
Quarter 2: April – June 2020
Quarter 3: July – September 2020

Referrals – 2020

2020 Quarters	**Q1**	**Q2**	**Q3**
Dates:	January - March	April - June	July - September
No of Referrals:	158	75	65
No of Referrals accepted:	127 (80.3%)	51 (68%)	41 (63%)

Running Total Accepted:	127	178	219

7.7.9. It is not surprising to note that the first quarter (implementation phase) saw a high number of new referrals to the team. The following quarters saw new referral numbers in line with the team's capacity and at no point were the team under anticipated caseload numbers. The referral flow remains steady and all Lotus midwives are fully embedded into all clinical areas, with visibility across the system.

7.7.10. Since the commencement of Lotus, 108 discharges since January 2020 (completed Lotus care) have been achieved. Quarter 1 had smaller numbers in comparison to Q2 and Q3, as the team had just been implemented and therefore the majority of women would have still been pregnant.

	Quarter 1	Quarter 2	Quarter 3
No. of discharges	19	38	51

7.8. **CoC Achieved**

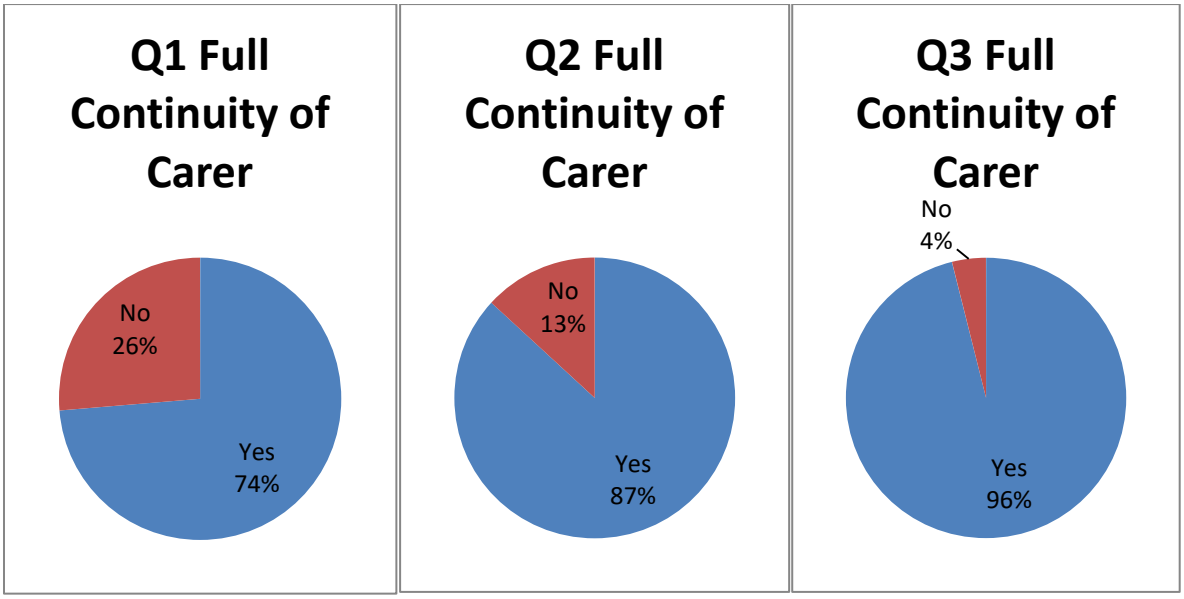
7.8.1. To demonstrate the overall CoC achieved across the team and in line with the Maternity Incentive Scheme standards, each quarter will report on CoC at the end of a woman's care provision. This decreases the risk of duplication of data and also the potential of missed data points. Therefore, the data outlined within this paper has been based on the CoC at the point of discharge from OUH maternity services.

7.8.2. To help provide context for each component of care, the CoC data will be presented as 'overall CoC achieved' and subsequently split into antenatal, intrapartum and postnatal CoC.

7.9. **Overall CoC Achieved**

7.10. Taking into account the full continuum of CoC data for each pregnancy, the team have successfully achieved the following overall CoC figures since implementation. This means achieved CoC throughout the pregnancy continuum i.e. antenatal, intrapartum and postnatal care.

Quarter 1 = 74% (n:19)
Quarter 2 = 87% (n:38)
Quarter 3 = 96% (n:51) **Total (across 3 Quarters): 88.8%**



7.11. Further details regarding the Lotus achievements are presented within appendix 1, the Trust board are recommended to acknowledge the finer detail outlining the CoC achieved. This includes clinical/behavioural outcomes, as well as the overall feedback from women and their families.

7.12. To celebrate the achievements, the team have been nominated for the 2021 RCM Team of the Year.

7.13. **OUH Wider CoC Pathways**

7.13.1. This section of the paper presents the data on the wider OUH CoC pathways from March to July 2020 (a period challenged by COVID-19).

7.13.2. The KPI for CoC is no more than 8 midwives through the duration of a woman's maternity care (antenatal/intrapartum and postnatal).

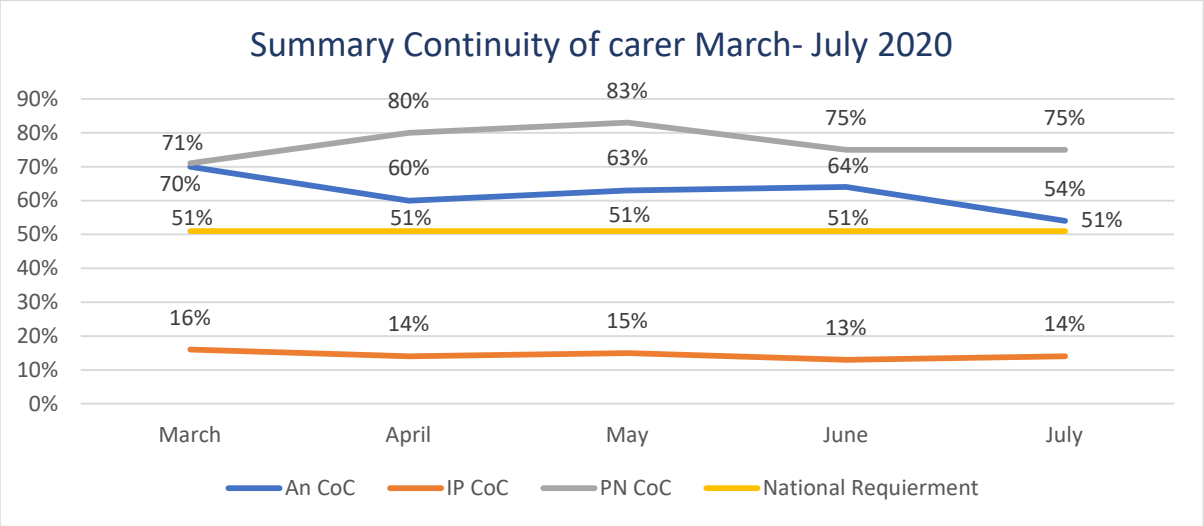
7.13.3. Data has been compiled from EPR, as well as a postnatal survey which was reported by women prior to discharge to capture the user feedback.

7.14. OUH maternity does not currently meet the CoC requirements of **achieved CoC** of 51% across the pregnancy continuum. However, there are signs of CoC increasing. Pre COVID-19, the CoC data stood at 6% in comparison to the current average of 15% achieved. This is a two-fold increase in comparison to the previous collated data. The 51% target is to be achieved by March 2022.

7.15. Despite a challenging time with Covid-19 an increase in home births/births at MLUs were noted and we anticipate this trend will continue throughout the year.

7.16. Across the county, antenatal and postnatal CoC decreased slightly over the past five months in comparison to January/ February data. This trend was not unexpected due to COVID-19 and the impact of reducing overall number of face to face appointments in line with national recommendations to reduce virus transmission.

7.17. The following graph and table demonstrates a summary of CoC over the last 5 months with antenatal CoC between 54-70%, intrapartum between 13-16% and postnatal 71-83%. When reviewing the full CoC achieved, this overall would stand at an average of 15%.



	AN COC (1-2 MW during pregnancy) (Audit/ survey)	IP COC (Labour care from known Midwife) (Denominator total births/ COC)	PN COC (<3 MW during postnatal period) (Denominator total births/ COC)	NHSE National Recommendations COC
March	70% (19 data sheet)	17% (605/ 102)	71% (579/ 411)	51%
April	60% (14 data sheet)	14% (562/ 77)	80% (585/ 470)	51%
May	63% (38)	15% (616/ 90)	83% (581/ 484)	51%
June	64% (40)	13% (582/ 74)	75% (614/ 461)	51%
July	54% (31)	14% (601/ 85)	75% (601/ 454)	51%

7.18. **Placed onto a CoC Pathway**

7.18.1. Most women booking at OUH Maternity are eligible to be placed onto a CoC pathway, which is in line with the national ambition of 35% of women by March 2021.

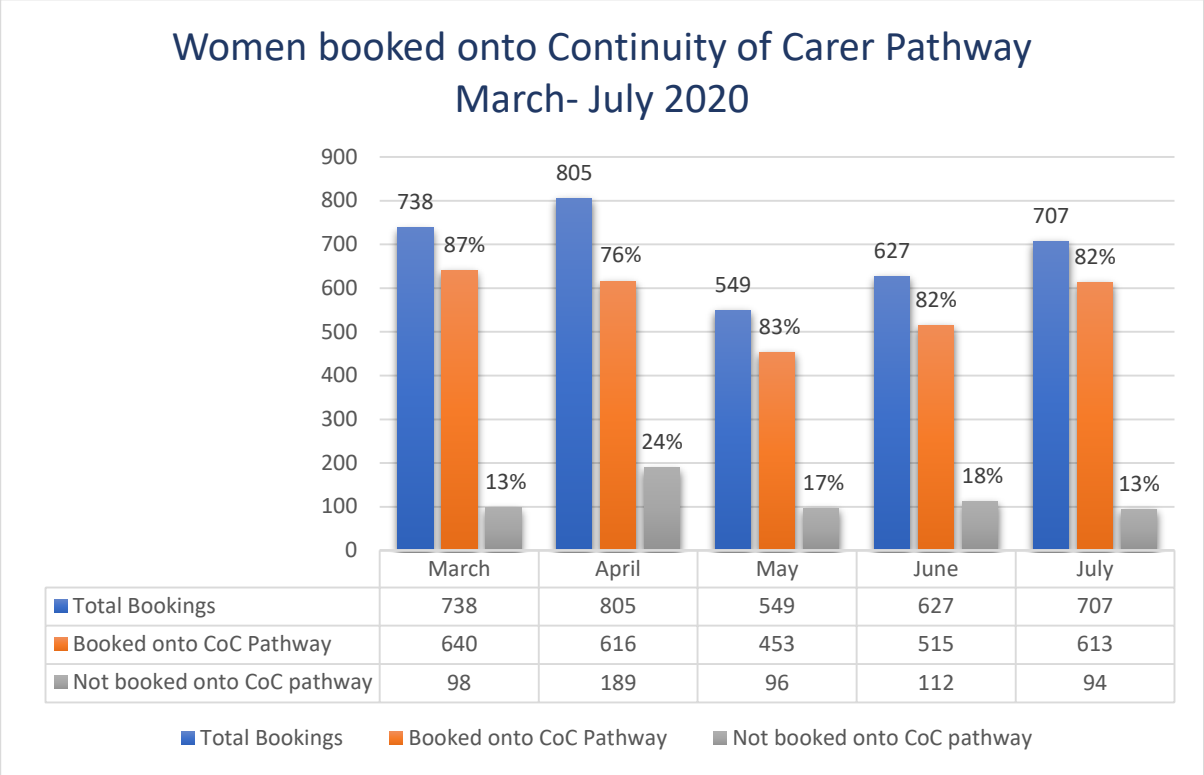
7.18.2. The community CoC pathway refers to women having a named midwife and booked onto a smaller team case-loading model which consists of 3-4 midwives/ MSWs.

7.18.3. Women booked at OUH may have their pathways altered later in their pregnancy due to specialised needs or developing obstetric issues during pregnancy; however, women are still booked onto a CoC pathway at the point of booking their pregnancy with an OUH Community team.

7.18.4. Women identified as out of area or late bookers after 28 weeks cannot be on a continuity pathway as they will not be able to achieve the full continuum of CoC.

7.18.5. To date we have 76-87% of women placed onto a CoC pathway and on average 82% (March-July 2020). This surpasses the Maternity Incentive Scheme standard of 35%.

7.18.6. Wider wraparound pathways are in the process of implementation and include a Rainbow service (care of pregnant women after previous fetal/neonatal loss), Diabetes, elective caesarean section, induction of labour, perinatal mental health, hybrid midwifery led unit model; this will be integrated with the community teams.



7.18.7. Further detail surrounding the postnatal CoC, personalised care plans and user feedback is presented within Appendix 4.

8. Year 3 Safety Actions: Detail of current status and risk level

Safety Action 1: Perinatal Mortality Review Tool (PMRT)

Required Standards following re-launch of MIS	October update on current status and R.A.G. rating for risk of non-compliance	Expected Evidence
a) i. All perinatal deaths eligible to be notified to MBRRACE-UK from Thursday 1 October 2020 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.	**Expecting to be compliant** Newly appointed 0.6 WTE bereavement midwife will support this process and the others outlined in this safety action Newly appointed Child Mortality Team will support this process and take ownership of reporting all neonatal deaths within 24 hours (as per the revised technical guidance in the October 2020 re-launch).	Paper submitted to Confidential Trust Board November 11th 2020 Paper submitted to Confidential Trust Board January 11th 2021 CNST will check our PMRT data.
a) ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to Wednesday 30 September 2020 will have been started by Thursday 31 December 2020. This includes deaths after home births where care was provided by your Trust staff and the baby died.	**Compliance already achieved for all deaths in this time period**	Paper submitted to Confidential Trust Board November 11th 2020 Paper submitted to Confidential Trust Board January 11th 2021 CNST will check our PMRT data.

a) iii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Thursday 1 October 2020 will have been started within four months of each death. This includes deaths after home births where care was provided by your Trust staff and the baby died.	**Expecting to be compliant**	Paper submitted to Confidential Trust Board November 11th 2020 CNST will check our PMRT data.
b) i. At least 75% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Friday 31 July 2020 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 by Thursday 31 December 2020.	**Expecting to be compliant** During the Covid-19 period three midwives who were redeployed from patient-facing roles supported the Perinatal Mortality Review process, helping the timely review and completion of PMRT draft reports. This meant that the status of this standard has been downgraded from moderate risk of non-compliance to low risk of non-compliance. However, as these members of staff are no longer participating in this work, those still involved will need to continue to put in significant amounts of work to ensure that the risk of non-compliance does not rise. There are currently (updated October 2020) • 29 cases that meet eligibility criteria for standard b)i. • 18 (62%) have already met standard b(i) • The remaining cases have been allocated to PMR members to draft a report by the deadline of 31st December 2020.	Paper submitted to Confidential Trust Board January 11th 2021

	Other Trusts in our region have approximately 10-15 cases to review each year, whereas there are approximately 50-60 cases per year in OUH FT.	
b) ii. At least 40% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Saturday 1 August 2020 to Thursday 31 December 2020 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.	**Expecting to be compliant** 11 cases within this reporting period which will be reviewed within the aforementioned scheduled PMR meetings which is predicted to achieve over 40% of cases having a review and draft report created	Paper submitted to Confidential Trust Board January 11th 2021
c) For 95% of all deaths of babies who were born and died in your trust from Friday 20 December 2019, the parents were told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.	**Expecting to be compliant**	Paper submitted to Confidential Trust Board November 11th 2020 Evidence in first section of the PMR tool. Data collected in bereavement checklists used in both maternity and the neonatal unit respectively. At time of submission CNST pulled data from PMRT will be subsequent Trust Board Papers.

d) i. Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.	**Currently compliant** Quarterly reports were put on hold during the Covid-19 period. The last report that was submitted to Confidential Trust Board was in January 2020, covering Quarter 3 of 2019/20. The current plan is to submit for Confidential Trust Board meetings in: • November 2020: Quarter 4 of 2019/20 and Quarters 1 and 2 of 2020/21 • March 2021: Quarter 3 of 2020/21 • May 2021: Quarter 4 of 2020/21 All reports will be discussed with the Trust maternity safety champion prior to being reviewed at the Board meeting.	All quarterly papers submitted to Confidential Trust Boards Evidence of date that paper was discussed with Maternity Safety Champion

Safety Action 2: Maternity Services Data Set (MSDS)

Required Standards following re-launch of MIS	October update on current status and R.A.G. rating for risk of non-compliance*	Expected 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. **All 13 criteria (shown below) are mandatory**. Criteria 1-13 will be assessed by NHS Digital and included in the scorecard.	See below for details of 13 mandatory criteria.	Scorecards which are to be presented to the boar d in the update papers each quarter
1. At least two people registered to submit MSDS data to SDCS Cloud and still working in the Trust on Saturday 31 October 2020.	**Compliant**	Email confirming that Trust has 7 listed people - completed
2. MSDSv2 webinar attended by at least one colleague from each trust in January/February 2020	**Compliant**	Email to confirm attendance
3. Trust Boards to confirm to NHS Resolution that they have fully conformed with the MSDSv2 Information Standards Notice, DCB1513 And 10/2018, which was expected for April 2019 data, by Sunday 28 February 2021, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS.	**Compliant – awaiting evidence**	Email to/from Director of Midwifery (DOM) showing that the plan is agreed with her or proof we're meeting this is provided and accepted Minutes from LMS meeting

		where DOM will take the plan and their minutes must show it was discussed and agreed. Or proof we meet this as above.
4. Made a submission relating to August 2020 - December 2020 data, submitted to deadlines October 2020 - February 2021.	**Compliant**	Evidence pulled from NHS Digital May need confirmation from the Information Team of submission
5. December 2020 data included all following tables MSD000 MSDS Header MSD001 Mother's Demographics MSD002 GP Practice Registration MSD101 Pregnancy and Booking Details MSD102 Maternity Care Plan MSD201 Care Contact (Pregnancy) MSD202 Care Activity (Pregnancy) MSD301 Labour and Delivery MSD302 Care Activity (Labour and Delivery) MSD401 Baby's Demographics and Birth Details MSD405 Care Activity (Baby) MSD901 Staff Details	**Partially compliant** Confirmed compliance with: MSD000; MSD001; MSD002; MSD101; MSD102; MSD201; MSD301; MSD302; MSD401; MSD405;MSD901 Expecting compliance with MSD202 - work underway including building of changes into EPR. Operations Service Manager has been in contact with MIS team to gain clarity on requirements.	Evidence pulled from NHS Digital May need confirmation from the Information Team of submission
6. December 2020 data contained at least 90% of the deliveries recorded in Hospital Episode Statistics (unless reason understood). (MSD401)	**Already compliant**	Evidence pulled from NHS Digital May need confirmation from the Information Team of submission

7. December 2020 data contained at least as many women booked in the month as the number of deliveries submitted in the month (unless reason understood). (MSD101)	**Already compliant**	Evidence pulled from NHS Digital May need confirmation from the Information Team of submission
8. December 2020 data contained Estimated Date of Delivery for 95% of women booked in the month. (MSD101)	**Already compliant**	Evidence pulled from NHS Digital May need confirmation from the Information Team of submission
9. December 2020 data contained valid postcode for mother at booking in 95% of women booked in the month. (MSD001)	**Already compliant**	Evidence pulled from NHS Digital May need confirmation from the Information Team of submission
10. December 2020 data contained valid ethnic category (Mother) for at least 80% 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)	**Expecting to be compliant**	Evidence pulled from NHS Digital May need confirmation from the Information Team of submission
11. December 2020 data contained antenatal continuity of carer plan fields completed for 90% of women booked in the month. (MSD101/2)	**Expecting to be compliant** EPR changes now live so this has changed from amber to green	Evidence pulled from NHS Digital May need confirmation from the Information Team of submission

12. December 2020 data contained antenatal personalised care plan fields completed for 90% of women booked in the month. (MSD101/2)	**Expecting to be compliant**	Evidence pulled from NHS Digital May need confirmation from the Information Team of submission
13. December 2020 data contained valid presentation at onset of delivery codes for 90% of births where this is applicable. (MSD401)	**Expecting to be compliant**	Evidence pulled from NHS Digital May need confirmation from the Information Team of submission

Safety Action 3: Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Required Standards following re-launch of MIS	October update on current status and R.A.G. 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 neonatal involvement in decision making and planning care for all babies in transitional care.	**Non-compliant** The pathway into transitional care has been jointly approved by 31 Jan 2020, however the admission criteria must meet a minimum of HRG XA04 (see gap analysis in section 6.3.1 below). The Maternity Assurance Team has identified that the pathway does not meet the required standard and therefore we will not be compliant (and the deadline has already passed). The Trust Assurance Team has been informed, and the Maternity and Neonatal Teams are currently in discussions for how to move forward with this safety action. The Chief Nurse (board level safety champion) will be updated, via the maternity and neonatal safety champions, on progress with this action.	
b) The pathway of care into transitional care has been fully implemented and is audited monthly. Audit findings are shared with the neonatal safety champion.	**Non-compliant** No evidence of auditing taking place and auditing of pathway that does not meet BAPM standards	Audits

c) A data recording process for capturing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded.	**Compliant**	
d) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.	**Expecting to be compliant**	Evidence requested from ODN minutes
e) A review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) is undertaken to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.	**Expecting to be compliant**	Audit data
f) An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19 period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion.	**Expecting to be compliant** Ongoing ATAIN reviews require a significant amount of investment of time, currently undertaken by a Band 7 midwife and Obstetric Consultant. A strategy is currently being discussed as to how to modify the	Action plan on minutes of Safety Champions Meeting

	review process to be able to formulate and progress appropriate actions in a more sustainable way.	
G) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.	**Expecting to be compliant**	Evidence of discussion re action plan (minutes/email) Discussion about progress needs to be reflected in Safety Champions Meeting minutes

Gap analysis: Transitional Care (TC) requirements according to the Maternity Incentive Scheme

MIS Requirements of TC (prior to re-launch of MIS)	Current status of TC at OUH FT
A multidisciplinary approach between maternity and neonatal teams	**Compliant**
An appropriately skilled and trained workforce	**Compliant** Staffing for TC at OUH FT includes Midwives, Maternity Support Workers, Advanced Neonatal Nurse Practitioners and Paediatricians/ Neonatologists. All babies receiving TC have a named neonatal consultant and are reviewed regularly by the ANNP team.
Data collection with regards to activity	**Awaiting confirmation of compliance status**
A link to community services.	**Compliant**
Appropriate admissions as per HRGXA04 criteria (Neonatal Critical Care, Special Care, Carer resident at cot-side and caring for baby)*: *The following list pertain to an otherwise well baby who therefore does not require intensive or high dependency care	**Partially compliant (see list below for details)**
• Presence of an indwelling urethral or suprapubic catheter	**Compliant** Babies with catheters or stomas who no longer require

• Care of a Stoma	intensive/high dependency care have a 'Transitioning to Home' period on the Neonatal Unit. In these circumstances the parent/carer 'rooms in' and is supported by the neonatal team to learn how to care for their baby's needs prior to discharge home.
• Birth weight ≤2kg for first 48 hours after birth	**Compliant**
• Gestation at birth 35 weeks for first 48 hours after birth	**Compliant**
• Gestation at birth 34 weeks for first 7 days (168 hours) after birth	**Compliant**
• Gestation at birth <34 weeks until discharge from hospital	**Compliant**
• Intravenous medication not otherwise specified elsewhere	**Compliant**
• Feeding by orogastric, nasogastric, jejunal tube or gastrostomy • Oxygen by low flow nasal cannula • Receiving Intravenous Sugar +/- electrolyte solutions • Receiving drug treatment for neonatal abstinence AND on an observations scoring regimen 4 hourly or more frequently	**Not currently compliant** Strategy being developed for how to develop the current service.

Safety Action 4: Clinical work force planning

Required Standards following re-launch of MIS	October update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
Obstetric medical workforce All boards should formally record in their minutes the proportion of obstetrics and gynaecology trainees in their trust who responded 'Disagreed or /Strongly disagreed' to the 2019 General Medical Council (GMC) National Trainees Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' Furthermore, there should be an agreed strategy and an action plan with deadlines produced by the Trust to address these lost educational opportunities due to rota gaps. The Royal College of Obstetricians and Gynaecologists (RCOG) has examples of trust level innovations that have successfully addressed rota gaps available to view at www.rcog.org.uk/workforce The action plan should be signed off by the trust Board and a copy (with evidence of Board approval) submitted to the RCOG at workforce@rcog.org.uk	**Expecting to be compliant**	Evidence of GMC outcomes in Board Meeting minutes Action plan signed by board Email evidence of email and receipt of email to RCOG Strategy and action plan written
Anaesthetic medical workforce An action plan is in place and agreed at Trust Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.7.2.5, 1.7.2.1 and 1.7.2.6	**Expecting to be compliant**	Action plan & Trust Board formal minutes

Neonatal medical workforce The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level	**Expecting to be compliant** An action plan is being developed to address deficiencies and will be presented to the Trust Board as an appendix to a future MIS Update paper.	Action plan & Trust Board formal minutes
Neonatal nursing workforce The neonatal unit meets the service specification for neonatal nursing standards. If these are not met, an action plan is in place and agreed at board level to meet these recommendations	**Work ongoing – not currently compliant – awaiting confirmation of whether we will be compliant by the deadline.**	Action plan & Trust Board formal minutes Copy of costings and paper submitted by Divisional Director of Nursing

Safety Action 5: midwifery workforce planning

Required Standards following re-launch of MIS	October update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	**Compliant**	Bi-annual papers submitted to Trust Board
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	**Compliant**	Bi-annual papers submitted to Trust Board
c) All women in active labour receive one-to-one midwifery care	**Compliant**	Bi-annual papers submitted to Trust Board
d) Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board.	**Compliant**	May Trust Board would be 6 months but needs to submitted to March Board due to end of MIS year.

Safety Action 6: Saving Babies' Lives care bundle Version 2

Required Standards following re-launch of MIS	October update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
a) Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives Care Bundle Version 2 (SBLCBv2), published in April 2019.	See below	Referenced in Overarching Papers to Public Trust Board meetings in November, January, March & May
b) 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. The process metrics described in SBLCBv2 should be used by the Board to assess implementation with a threshold score of 80% compliance used to confirm successful implementation. If the process metric scores are less than 95% Trusts must also have an action plan for achieving >95%.	**Not currently compliant but expecting to be compliant by the deadline** EPR changes have been requested to enable compliance	Scorecards SBL dashboard Action plan or exemption report
c) The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBv2 including the data submission requirements. The corroborating evidence is the SBLCBv2 survey and MSDS data, availability of this depends on the COVID-19 status.	**Compliant**	All survey submission emails (Survey 2 completed this month – see Appendix 2)

The following rows outline the assurance required to assess compliance with each element of the care bundle		
Element 1: • Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital* • Percentage of women where CO measurement at booking is recorded* • Percentage of women where CO measurement at 36 weeks is recorded* Recording that the test was offered and declined can be included in the numerator of the element 1 compliance metrics* The relevant data items for these indicators should be recorded on the provider's Maternity Information System (MIS) and included in the April 2020 MSDS submission to NHS Digital. 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 using locally available data or case records should have been undertaken to assess compliance with this indicator. A threshold score of 80% compliance should be used to confirm successful implementation. If the process metric scores are less than 95% Trusts must also have an action plan for achieving >95%. *Interim August update from NHSR announced that this	**Not currently compliant but expecting to be compliant by the deadline** EPR changes are now live and are currently being implemented across the community midwifery teams.	Scorecards SBL dashboard Action plan or exemption report

would be changed to: • Percentage of women where **smoking status** at booking is recorded • Percentage of women where **smoking status** at 36 weeks is recorded. If CO monitoring is suspended due to Covid 19 the audit described above will be based on the percentage of women asked whether they smoke at booking and at 36 weeks.		
Element 2: • Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking. Note: The relevant data items for these metrics should be recorded on the provider's Maternity Information System (MIS) and included in the April MSDS submission to NHS Digital. 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 using locally available data or case records should have been undertaken to assess compliance with this indicator. A threshold score of 80% compliance should be used to confirm successful implementation. 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:	**Not currently compliant but expecting to be compliant by the deadline** EPR changes are being requested to enable compliance An exception report will be submitted for an alternative to offering ultrasound assessment from 32 weeks' gestation for women with BMI>35kg/m^2	Statements in Paper for 11th November Trust Board Trust board specifically confirms 1, 2 & 3 of this element.

1. women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards 2. in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 3. There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation. If this is not the case the trust board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice.		
Element 3: • Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy. • Percentage of women who attend with RFM who have a computerised CTG. Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of 2 weeks' worth of cases or 20 cases whichever is the smaller to assess compliance with the element 3 indicators. A threshold score of 80% compliance should be used to confirm successful implementation. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.	**Expecting to be compliant** The Tommy's Reduced Fetal Movement leaflet has been added to the Maternity Handheld Notes so that 100% will receive it.	Reduced fetal movement audit
Element 4: • Percentage of staff who have received training on	**Expecting to be compliant**	

fetal monitoring in labour, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness. • Percentage of staff who have successfully completed mandatory annual competency assessment. Note: An in-house audit should have been undertaken to assess compliance with these indicators. The compliance required is the same as safety action 8 i.e. 90% of maternity staff which includes 90% of each of the following groups: • 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 theatre midwives who also work outside of theatres.		
Element 5: • Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. • Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.	**Expecting to be compliant**	

• Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System (MIS) and included in the April 2020 MSDS submission to NHS Digital. 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 a minimum of 4 weeks' worth of consecutive cases up to a maximum of 20 cases to assess compliance with the element 5 indicators. Completion of the audits should be used to confirm successful implementation. If the process indicator scores are less than 85% Trusts must also have an action plan for achieving >85%. In addition, the trust board should specifically confirm that within their organisation: • women at high risk of pre-term 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 (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • an audit has been completed to measure the percentage of singleton live births (less than 34+0		

	weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids		

Safety Action 7: Service user feeding and coproducing maternity services with Maternity Voices Partnership (MVP)

Required Standards following re-launch of MIS	October update on current status and R.A.G. rating for risk of non-compliance*	Expected 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 to coproduce local maternity services?	See below for details of evidence required.	
Terms of Reference for your Maternity Voices Partnership	**Expecting to be compliant**	Terms of Reference
Minutes of regular Maternity Voices Partnership meetings demonstrating explicitly how a range of feedback is obtained and consistent involvement of trust staff in coproducing service developments based on this feedback	**Expecting to be compliant**	Minutes of Meetings
Evidence of service developments resulting from coproduction with service users	**Expecting to be compliant**	Emails evidencing input in PILs
Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses	**Expecting to be compliant**	Statement from OMVP Chair
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, as a result of UKOSS 2020 coronavirus data.	**Expecting to be compliant**	Statement from OMVP Chair ?Anonymised survey of MVP members ethnicity

Safety Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Required Standards following re-launch of MIS	October update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
a) Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training day since the launch of MIS year three in December 2019?	**Expecting to be compliant** Note that the technical guidance document also states: • Training should include integrated team working with relevant simulated emergencies and or hands on workshops • Training should include **fetal monitoring** in labour (for relevant staff groups) as a session on their multi-professional maternity emergencies day until a separate local fetal monitoring training day has been set up to meet the requirements of the Saving Babies Lives fetal monitoring recommendations (see Safety Action 6). • If a separate fetal monitoring day has not yet been implemented, then there	Data from eLMS

	should be an action plan, with Trust board sign off, to release of staff and a date for commencement of the training to meet the requirements of the Saving Babies Lives fetal monitoring recommendations (see Safety Action 6). The RCM and RCOG are introducing a national intrapartum fetal surveillance training package in 2020 that can be used locally and will comply with the requirements for training listed in Element 4 of the SBLCB v2. • In addition, units should ensure that there are multi-professional case history discussions that demonstrate the use of local fetal monitoring tools and resources for risk assessment, classification and escalation.	
b) Can you evidence that multiprofessional training occurs at least twice a year with anaesthetic/maternity/neonatal teams in the clinical area, and that risks/issues identified are addressed.	**Expecting to be compliant**	Data from eLMS will be gathered in April 2021 ready for submission in Trust Board Paper in May 2021.

c) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since the launch of MIS year three in December 2019.	**Status in March 2020 (not expected to have improved): Not currently compliant** At last data check (March 2020) 19.5% of midwives and 52% of the neonatal team had already completed the training. Training was then cancelled due to Covid-19, so it is therefore not expected to have changed significantly since then. Note also: There is a discrepancy between what OUH FT asks employees to complete and what the MIS requires. The Trust requirement for resuscitation training is once every 15 months, and the target for each directorate is 80%. The MIS requirement for neonatal resuscitation training is once every 12 months and to have 90% trained within this period. The risk of non-compliance by the deadline may now be lower than previously thought, in that the interim update announced this training could be done virtually/online. If the assessment of clinical competence can also be done online then this will	Data from eLMS

	take significantly fewer resources to achieve than getting 200+ staff members through small-group training with very few appropriately trained assessors. Once the detail of the scheme is announced at the re-launch, the risk status for this safety action will be reviewed. October 2020 data being reviewed and as mentioned above a Neonatal Resuscitation Officer has asked the MIS team for clarity on this.	

Safety Action 9: Can you demonstrate that the Trust safety champions (obstetrician, midwife and neonatologist) are meeting bi-monthly with Board level champions to escalate locally identified issues?

Required Standards following re-launch of MIS	October update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
a) A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks.	**Expecting to be compliant**	Pathway Minutes of Safety Champions Meeting showing the pathway works Minutes of LMS showing the pathway works Minutes of MatNeoSIP etc. showing it works.
b) Board level safety champions are undertaking monthly feedback sessions for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to Covid-19 service changes and service user feedback and can demonstrate that progress with actioning named concerns are visible to staff.	**Expecting to be compliant**	Monthly Staff Safety Meeting newsletter Poster for Staff Listening Event October 2020
c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. Taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas, a revised action plan describes how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer	**Compliant** Action plan received and approved by Board level safety champion	Minutes from Trust Board

pathway, prioritising women from the most vulnerable groups they serve.		
d) Together with their frontline safety champions, the Board safety champion and MatNeoSIP Patient Safety Networks has reviewed local outcomes in relation to: I. Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of Covid-19, drawing on resources and guidance to understand and address factors which led to these outcomes. II. The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK. III. The MBRRACE-UK SARS-Covid-19 https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACEUK Maternal_Report_2020_v10_FINAL.pdf IV. The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups And considered the recommendations and requirements of II, III and IV on I.	**Expecting to be compliant** as long as the following work is undertaken (details from the technical guidance document): "the Board should support staff to: • identify key trust-level safety improvement priorities, including areas identified via the SCORE culture survey • develop a trust-level improvement plan • implement the plan and engage in relevant improvement/capability building initiatives nationally, regionally or via the local learning systems • maintain oversight of improvement outcomes and learning" Maternity now has an Obstetric Consultant Lead for Quality Improvement, and a Maternity Quality Improvement plan is currently being developed.	Minutes of these meetings clearly showing the points met (Safety Champions Meetings and PSN) Newsletter related to Black, Asian and ethnic minorities (BAME) approved.

e) The Board Level Safety Champion is actively supporting capacity (and capability) building for all staff to be actively involved in the following areas: - Maternity and neonatal quality and safety improvement activity within the Trust, including that determined in response to Covid-19 safety concerns - The Patient Safety Networks of which each Trust will be a member - Specific national improvement work and testing lead by MatNeoSIP that the Trust is directly involved with - The Patient Safety Network clinical leaders group where Trust staff are members	**Expecting to be compliant**	Minutes from meeting referred to above.

Safety Action 10: NHSR Early Notification Scheme

Required Standards following re-launch of MIS	October update on current status and R.A.G. rating for risk of non-compliance*	Expected Evidence
a) Reporting of all outstanding qualifying cases for the year 2019/20 to NHS Resolution's EN scheme.	**Expecting to be compliant** Note that Trusts are currently not required to report incidents to the Early Notification Scheme, as all these cases are reported to HSIB who are triaging them and forwarding to ENS. NHS Resolution is planning to review this process in September 2020.	Ulysses incident reporting system data HSIB tracker spreadsheet
b) Reporting of all qualifying cases to the Healthcare Safety Investigation Branch (HSIB) for 2020/21.	**Expecting to be compliant**	Ulysses incident reporting system data HSIB tracker spreadsheet
c) For qualifying cases which have occurred during the period 1 October 2020 to 31 March 2021 the Trust Board are assured that: 1. 1. the family have received information on the role of HSIB and the EN scheme; and 2. 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**	Copy of a letter Statement in overarching paper to Public Trust Board in May

9. Conclusion

9.1. This paper outlines the Trust's current level of compliance with the re-launched Maternity Incentive Scheme requirements.

9.2. 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.

10. Recommendations

10.1. The Trust Board is asked to:

- note the contents of the update report,
- consider the benefits of such pathways and acknowledge how the pathways have thrived across the pandemic, which is contrary to the national picture,
- consider that the Maternity Incentive Scheme (MIS) standard of 35% of 'women placed onto a CoC pathway' for 2020/21 will be surpassed with our current average being 82%. However, next steps are being addressed and implemented to ensure that we continue to drive forward with the secondary target of 51% 'achieved CoC' by March 2022. This secondary target is not within this annual MIS standards, however, the momentum regarding this work is maintained and with a variety of pathways yet to be implemented. Our current overall achieved CoC stands at 15% which falls short of the March 2022 target,
- support the expansion of the Lotus service to meet the heightened need across the Country and to prioritise BAME and all vulnerable groups across Oxfordshire.
- discuss how the Trust could support the Maternity and Neonatal units with overcoming the challenges that have been identified.

11. Appendix 1: Continuity of Carer Action Plan

Recommendation	Action	Pathways	RAG	Measure Achieved	Measure Predicted	Timeline	MIS Compliance
Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions	***No more than 8 midwives/MSW's to deliver team CoC through pregnancy continuum (AN/IP & PN)***	***Combination of Caseloading model/ community sub-team/hybrid & wrap around CoC pathways (Models listed below)***	***Green - Embedded Pathway Amber - Implementation Phase Red - Development Stage***	***As of 1/10/2020***	***Annual Predictor***	***Implementation Date***	***Placed onto CoC - compliance (20/21 MIS standard)***
		Lotus Team - Caseloading Full Model: vulnerable Groups & in line with wider national deliverables		Overall achieved 88.8% of caseload (Jan- Sept 2020) = equates to **1.44%** of overall birth rate	2.5-3%	Embedded as of Jan 2020	
		Rainbow Clinic - Wrap around pathway for previous fetal/neonatal loss			2%	Launch 4/11/2020	
		Diabetes - Wrap around pathway for Type 1 diabetes			2%	Launch 5/1/2021	
		Elective CS - All planned ERCS (AN/IP & PN) - inclusive of BAC/Breech			10%	Embedded Sept 2020	
		IOL		38-43% (June-Aug 2020) = equates to of overall birth rate **2.1%**	8%	Embedded July 2020	
		Community Hybrid - A cohort of women at Spires (20-30% of spires births)			4%	Launch Nov 2020	
		General CoC Pathways (all clincial areas) - inclusive of freestanding hybrid/home birth/ community sub-teams & IP care in Spires/DS		Achieved **15%** of all care (March - July 2020) - inclusive of IOL & Lotus			
		Total Achieved		**Total achieved to date: 15%**	**Predictor Total: 29%**		
	All Women placed onto a CoC Pathway - 35% Target March 2021	Placed on a CoC pathway by 29/40 & not OOA (Named midwife/buddy midwife & small sub-team)		Achieved average: **82% Total** (March - July 2020)	>90%	Launched Dec 19/Jan 2020 (captured on EPR)	

12. Appendix 2: Saving Babies Lives Care Bundle v2 Survey 3

Reducing Stillbirths Care Bundle Elements	
Element 1: Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) and referring to stop smoking service/specialist as appropriate	
Have any of your responses to the below questions 1aii. to 1f. changed since the last survey? *If "yes", answer question 1ai and make your changes below. If "no" answer question 1ai and then go to Element 2.*	Yes
1ai. Are you meeting all requirements of the modified version Element 1 of the care bundle, which was changed due to the COVID-19 pandemic? *Irrespective of your answer please ensure section 1 is completed on the basis of your Standard Operating Procedure once recovery from COVID has been instigated.*	No
1aii Once CO testing is re-introduced, will your trust meet all the requirements of Element 1 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	No
1b. Are you carrying out any improvement activity designed to reduce smoking in pregnancy? *If "yes", please go to question 1c, If "no", please go to question 1f.*	Yes
1c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. CO monitoring at booking and additional CO testing throughout pregnancy including the 36 week antenatal appointment, with the outcome recorded?	Yes
ii. Referring expectant mothers, with elevated CO levels (4ppm or above), to a trained stop smoking specialist, based on an opt out system with a pathway that includes feedback and follow up processes?	Yes
1d. Do the improvement activities include training all maternity staff on the use of the CO monitor and having a brief and meaningful conversation with women about smoking?	Yes
1e. Have all recorded outcomes of CO testing in pregnancy relating to element 1 activities been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	No
1f. If you answered "no" to question 1b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

Element 2: Identification and surveillance of pregnancies with fetal growth restriction	
Have any of your responses to questions 2aii to 2j below changed since the last survey? *If "yes", answer question 2ai and make your changes below. If "no" answer question 2ai and then go to Element 3.*	No
2ai. Are you meeting all requirements of the modified version Element 2 of the care bundle, which was changed due to the COVID-19 pandemic? NB The modified version of element 2 should only be implemented in the case of significant COVID-19 related staff shortages. *Irrespective of your answer please ensure section 2 is completed on the basis of your Standard Operating Procedure i.e. once recovery from COVID has been instigated.*	No
2aii. In the case of you having no significant COVID related staff shortages, do you meet all requirements of Element 2 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	No
2b. Are you carrying out any improvement activity designed to risk assess and manage babies at risk of Fetal Growth Restriction (FGR)? *If "yes", go to question 2c. If "no", please go to question 2j.*	Yes
2c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C of the care bundle or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	Yes
ii. Risk assessment and surveillance of women at increased risk of FGR, with triage of women at increased risk of FGR into an appropriate clinical pathway?	Yes
iii. Risk assessment and management of growth disorders in multiple pregnancy in compliance with NICE guidance or a variant agreed locally following advice from the provider's Clinical Network?	Yes
2d. Regarding women not undergoing serial ultrasound scan surveillance of fetal growth does your standard operating procedure (e.g. guidelines) include assessment performed using antenatal symphysis fundal height (SFH) charts by clinicians trained in their use?	Yes
2e. Does your standard operating procedure (guidelines) include differentiation between the management of the SGA and growth restricted fetus in accordance with the pathways and guidance outlined in version 2 of the Saving Babies Lives Care Bundle?	Yes
2f. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Following recommended guidance on the frequency of ultrasound review of estimated fetal weight (EFW) when SGA is detected, in accordance with appendix D of SBLCBv2 or a variant agreed locally following advice from the provider's Clinical Network?,	Yes
ii. Maternity care providers caring for women with FGR identified prior to 34+0 weeks having an agreed pathway for management which includes network fetal medicine input (for example, through referral or case discussion by phone)?	Yes

2g. Accepting the proviso that all management decisions should be agreed with the mother in the cases of fetuses <3rd centile and with no other concerning features does your standard operating procedure (e.g. guidelines) include the following principles: • Initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation. • Delivery <37+0 weeks can be considered if there are additional concerning features, but these risks must be balanced against the increased risk to the baby of birth at earlier gestations.	Yes
2h. Does your standard operating procedure (e.g. guidelines) include individualised care of fetuses between 3rd – 10th centile using a risk assessment including Doppler investigations, assessment for the presence of any other high risk features such as recurrent reduced fetal movements, and the mother's wishes ; and in the absence of any high risk features the offer of delivery or the initiation of induction of labour at 39+0 weeks?	No
2i. Have all findings of small for gestational age fetuses been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	No
2j. If you answered "no" to 2b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

Element 3: Raising awareness amongst pregnant women of the importance of detecting and reporting reduced fetal movement (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM	
Have any of your responses to the below questions in Element 3 changed since the last survey? *If "yes", make your changes below. If "no", go to Element 4.*	Yes
3a. Are you meeting all requirements of Element 3 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	No
3b. Are you carrying out any improvement activity designed to raise awareness among pregnant women of the importance of Reduced Fetal Movement (RFM)? *If "yes", please go to question 3c. If "no", please go to question 3h.*	Yes
3c. Do the improvement activities include providing pregnant mothers with information and an advice leaflet on reduced fetal movement based on current evidence, best practice and clinical guidelines,?	Yes
3d. Do the improvement activities include giving pregnant mothers this information by 28 weeks of pregnancy at the latest?	Yes
3e. Do the improvement activities include discussing RFM with pregnant mothers at every subsequent contact?	Yes
3f. Do the improvement activities include making use of an approved checklist to manage the care of pregnant woman who report reduced fetal movement, in line with national evidence-based guidance?	Yes
3g. Have all findings of reduced fetal movement been recorded on your MIS enabling their submission as Coded Clinical Entry in MSDS v2.0 monthly submissions?	No
3h. If you answered "no" to 3b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

Element 4: Effective fetal monitoring during labour	
Have any of your responses to the below questions in Element 4 changed since the last survey? If "yes", make your changes below. If "no", go to Element 5.	Yes
4a. Are you meeting all requirements of Element 4 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below. Please take extra care to ensure your percentage of trained staff in question 4d is up to date.*	Yes
4b. Are you carrying out any improvement activities designed around effective fetal monitoring during labour? *If "yes", go to question 4c. If "no", please go to question 4h.*	Yes
4c. Do your improvement activities include annual multidisciplinary training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation for staff who care for women in labour? *If "yes", go to question 4d. If "no", please go to question 4e.*	Yes
4d. What is the percentage of staff who care for women in labour that have undertaken this training in the last 12 months?	Yes below 60%
4e. Do you have a system that, irrespective of place of birth, assesses risk at the onset of labour to determine the most appropriate fetal monitoring method, as described in SBLCBv2?	Yes
4f. Do your improvement activities include a review at least every hour of fetal well-being incorporating the following:	
i. CTG or Intermittent Auscultation;	Yes
ii. reassessment of fetal risk factors	Yes
iii. a fresh eyes/buddy system	Yes
iv. clear guideline for escalation if concerns are raised through the use of a structured process?	Yes
4g. Do your improvement activities include identifying a Fetal Monitoring Lead for a minimum of 0.4WTE per consultant led unit during which time it is their responsibility to improve the standard of intrapartum risk assessment and fetal monitoring?	Yes
4h. If you answered "no" to 4b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

Element 5: Reducing preterm births	
Have any of your responses to questions 5aii to 5g changed since the last survey? *If "yes", answer question 5ai and make your changes below. If "no" answer question 5ai and then complete the final section.*	Yes
5ai. If you are using the modified version of element 5 of the care bundle, are you meeting all of the requirements? *Irrespective of your answer please complete the rest of section 5 on the basis of your SOP once recovery from COVID has been instigated.*	Yes
5aii. Are you meeting all requirements of Element 5 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	Yes
5b. Are you carrying out any improvement activity designed around reducing the number of preterm births and optimising care when preterm delivery cannot be prevented? *If "yes", go to question 5c. If "no", please go to question 5g.*	Yes
5c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing all women at booking for the risk of preterm birth and stratifying to low, intermediate and high-risk pathways as per the criteria in Appendix F of the SBLCB v2 of the care bundle document; or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	Yes
ii. Assessing women with a history of preterm birth to determine whether this was associated with placental disease and a discussion about prescribing aspirin with the woman based upon her personalised risk assessment?	Yes
iii. All women being offered testing for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking, and a repeat MSU to confirm clearance following any positive culture?	Yes
iv. Having access to transvaginal cervix scanning (TVCS) and a clinician with an interest in preterm birth prevention with a clinical pathway for women at risk of preterm birth that is agreed with local commissioners (CCGs) following advice from the provider's clinical network (for example, UK Preterm Clinical Network guidance or NICE guidance)?	Yes
5d. Does your standard operating procedure (e.g. guidelines) include risk assessment and management in multiple pregnancy compliant with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network?	Yes

5e. Does your standard operating procedure (e.g. guidelines) include the following:	
i. every provider having referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories including access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage?	Yes
ii. women at imminent risk of preterm birth being offered transfer to a unit with appropriate and available neonatal cot facilities when safe to do so and as agreed by the relevant neonatal Operational Delivery Network (ODN)?	Yes
iii. offering Antenatal corticosteroids to women between 24+0 and 33+6 weeks, optimally at 48 hours before a planned birth?	Yes
iv. offering Magnesium Sulphate to women between 24+0 and 29+6 weeks of pregnancy; and considering offering Magnesium Sulphate 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?	Yes
v. ensuring the neonatal team are involved when a preterm birth is anticipated, so that they have time to discuss options with parents prior to birth and to be present at the delivery?	Yes
vi. holding a multidisciplinary discussion before birth between the neonatologist, obstetrician and the parents about the decision to resuscitate the baby for women between 23 and 24 weeks of gestation?	Yes
5f. Have all instances of maternal antenatal administration of corticosteroids for fetal lung maturation been recorded on your MIS enabling its submission as in MSDS v2.0 monthly submissions?	Yes
5g. If you answered "no" to 5b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

13. Appendix 3: Lotus Caseloading Team

During the implementation phase and in order to support safe, successful and sustainable provision, all clinical areas were visited and time spent with all clinicians to encourage uptake of referrals.

Reason for Declined Referrals:

	Quarter 1		Quarter 2		Quarter 3	
Reason for declined Referrals	**No**	**%**	**No**	**%**	**No**	**%**
Capacity	**8**	**26**	**14**	**58**	**13**	**54**
Miscarriage	3	10	0	0	2	8
>28/40	3	10	1	4	0	0
Out of area	4	13	1	4	2	8
Does not meet criteria	2	6	5	21	1	4
Declined by woman	5	16	2	8	1	4
Under FNP	6	19	1	4	5	21
Other	0		0	0	0	0
Total Declined Referrals	**31**		**24**		**24**	

The primary reason for declined referrals across all three quarters came down to maximum capacity, 35 women in total did in fact meet the criteria, but unfortunately the team had no capacity. Family Nurse Partnership (FNP), out of area and 'did not meet the criteria' were also other common indicators for declined referrals.

Reason for Referrals:

It is not unusual for teams supporting seldom heard groups and women requiring additional needs to have a multitude of vulnerabilities and therefore, the reasons for referrals were often multifaceted. The primary reasons for referral, which were evidenced across all three quarters, were mental health, social services involvement, no English and Domestic Abuse. This is highlighted within the following table and graphs. 30/219 of the referrals spoke no English and 4 were asylum seekers or identified as being destitute.

	Quarter 1		Quarter 2		Quarter 3	
Main Reason for Referral	**No**	**%**	**No**	**%**	**No**	**%**
Social services involvement	**35**	**22**	**31**	**41**	**24**	**37**
Previous bereavement >24/40	7	4	4	5	4	6
Teenage pregnancy	12	8	6	8	7	11
Severe mental health	**83**	**53**	**42**	**56**	**42**	**65**
No English (BAME)	15	9	11	15	4	6
Current domestic abuse	16	10	8	11	4	6

Homeless/traveller	8	5	6	8	6	9
Asylum seeker/destitution (BAME)	1	1	3	4	0	0
Learning difficulties	7	4	5	7	3	5
Physical disabilities	1	1	0	0	1	2
Substance misuse	6	4	3	4	11	17
Other	7	4	7	9	13	20

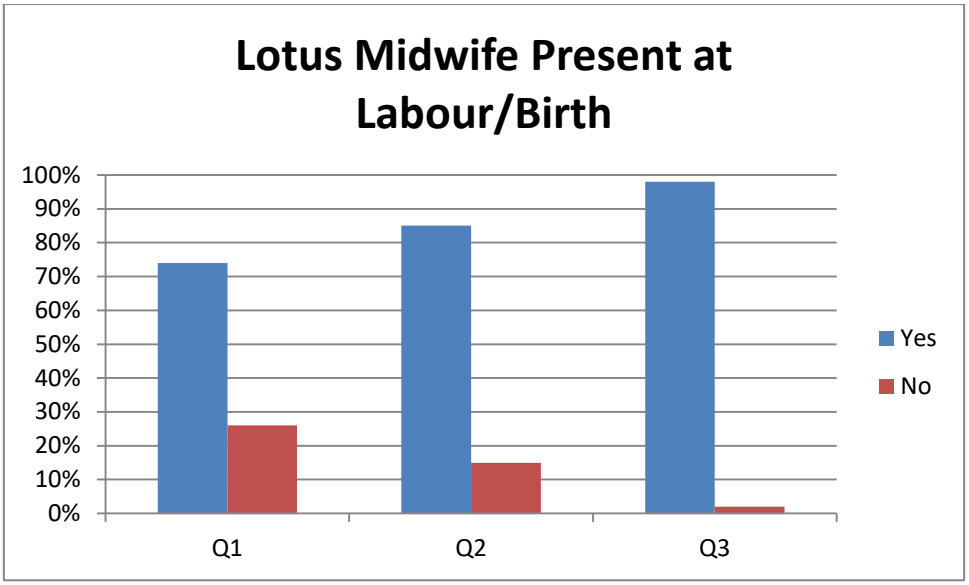
During all three quarters women predominantly saw no more than 2 midwives through the pregnancy and between 74-84% of their care were facilitated by their named Lotus midwife. During Q3, one woman saw 3 midwives from the team; this was due to acute sickness and the caseload requiring re-allocation. As per the local KPI, this would still meet the CoC indicators as care was delivered via the team.

Antenatal Number of midwives	**Quarter 1 Number seen**	**%**	**Quarter 2 Number seen**	**%**	**Quarter 3 Number seen**	**%**
1	16	**84%**	32	**84%**	39	**76.4%**
2	3	16%	6	16%	11	21.5%
3	0		0		1	1.9%
>3	0		0			

Intrapartum CoC

The table below highlights the number of labour/births facilitated by the team across all three quarters. The numbers within Quarter 1 and 2 were impacted by teething issues during the implementation phase. This included three incidences whereby the hospital did not contact Lotus in time as well as a number of unforeseen BBA's. Quarter 2 was impacted by an extremely busy 24 hours whereby 6 babies were born and due to capacity/acuity a set of twins and singleton were therefore not cared for by the team.

Lotus MW at Labour/Birth	**Q1**	**%**	**Q2**	**%**	**Q3**	**%**
Yes	14	**73.6%**	33	**84.6%**	49	**96%**
No	5		6		2	



Quarter 1: 50% were cared for by their named or buddy midwife during labour/birth
Quarter 2: 79% were cared for by their named or buddy midwife during labour/birth, with the busiest day being the 3rd April 2020 - 6 Lotus babies were born within 24 hours. One woman had a successful VBAC after 3 C-sections
Quarter 3: 73% were cared for by their named or buddy midwife during labour/birth. One woman had a successful VBAC after 2 C-sections and several women who had anxiety surrounding birth/tocophobia were supported to have a positive birth experience

Postnatal CoC

During all three quarters women predominantly saw no more than 2 midwives through the postnatal period and between 41-63% solely their named midwife. Quarter 3 saw three mother and baby placements out of area, postnatal care was facilitated on the ward prior to discharge.

Postnatal Number of midwives	Quarter 1 Number seen	%	Quarter 2 Number seen	%	Quarter 3 Number seen	%
1	11	**57.8%**	24	**63.1%**	23	**45.0%**
2	5	26.3%	9	23.6%	24	47%
3	3	15.7%	5	13.1%	4	7.8%
>3	0		0			

Birth Outcomes:

The following data regarding birth outcomes includes the women who received CoC through the intrapartum period. There have been a total of 13 births that Lotus were unfortunately not able to reach across all three quarters during labour/birth – the reasons behind this have been highlighted above. For the purpose of presenting the

data the 13 women who did not receive Lotus care during the three quarters have been excluded from this section.

Onset of Labour	Quarter 1	%	Quarter 2	%	Quarter 3	%
Spontaneous	10	71.4%	20	60.6%	28	57.1%
Induction of Labour (IOL)	2	14.2%	9	27.2%	11	22.4%

Planned elective C-section is not included in the onset of labour numbers

The 2 scheduled IOL within Quarter 1 were for postdates and obstetric cholestasis

Quarter 2 & 3 consisted of the following reasons for IOL:

- Pre-eclampsia
- IUGR
- Previous stillbirth
- Postdates
- Previous traumatic delivery
- Previous 3rd/4th degree tear
- Obstetric cholestasis
- APH
- Maternal medical conditions

Gestation and Weight of births

Quarter 1 and 2 saw two preterm births (33/40 & 36+6) and quarter 3, four. The reasons within Quarter 3 included:

- Emergency CS (EMCS) at 35+4 due to fetal abnormalities requiring multiple in utero transfusions
- Spontaneous labour at 35+3
- EMCS at 36+6 due to spontaneous labour prior to elective
- Elective at 36+5 due to rising Anti-C antibodies and previous CS

Across all 3 quarters, the team have had 1 IUD (28/40) and 6 SCBU admissions. Admissions were predominantly down to prematurity or associated fetal anaemia, 1 baby (term) with meconium aspiration and 3 respiratory distress at birth (2 at term).

Birth Weight

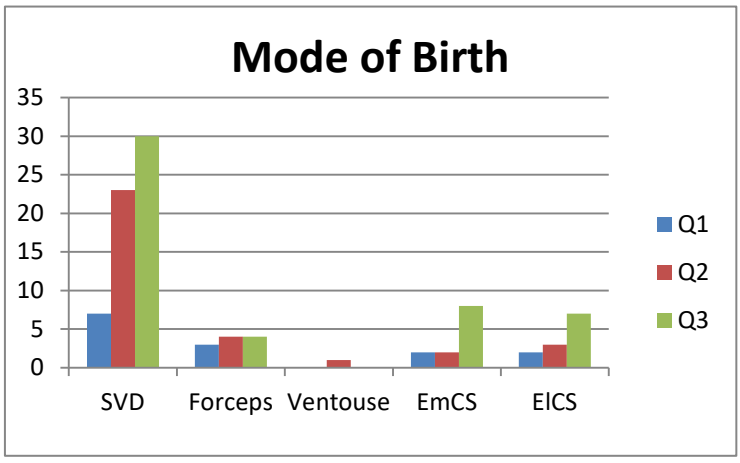
Across all three quarters 4 of the neonates out of 96 births, were under <2500g and 1 baby under 2000g parameter.

Place of Birth

Taking into account the increased medical/pharmacological complexities that are often associated with women who require additional needs, it was not surprising to note that the chosen birth place for the caseload of women was predominantly

Delivery Suite. However, it was positive to see that despite Delivery Suite being associated with increased medical intervention, 50-70% of the overall births were unassisted vaginal births across all three quarters.

Place of Birth	Quarter 1	%	Quarter 2	%	Quarter 3	%
Home	0		1	3.0%	3	6.1%
BBA	1	7.1%	0			
Freestanding MLU	1	7.1%	2	6.0%	1	2.0%
Spires Alongside MLU	2	14.2%	6	18.1%	4	8.1%
Delivery Suite	10	71.4%	24	72.7%	41	83.6%



Mode of Birth

MOB	Q1	Q2	Q3
SVD	50.0%	69.7%	61.2%
Forceps	21.4%	12.1%	8.2%
Ventouse	0.0%	3.0%	0.0%
Emmis	14.3%	6.1%	16.3%
Elk's	14.3%	9.1%	14.3%

Quarter 3 saw an increase in both elective and emergency caesarean sections due to the following reasons:

Elective

- X5 previous CS
- X1 previous traumatic delivery/4th degree tear
- X1 tocophobia

Emergency

- X2 fetal concerns in labour (spontaneous onset)
- X1 fetal concerns, non-labouring
- X2 fetal concerns in labour following IOL
- X2 planned ELCS but laboured spontaneously before
- X1 from ECV clinic

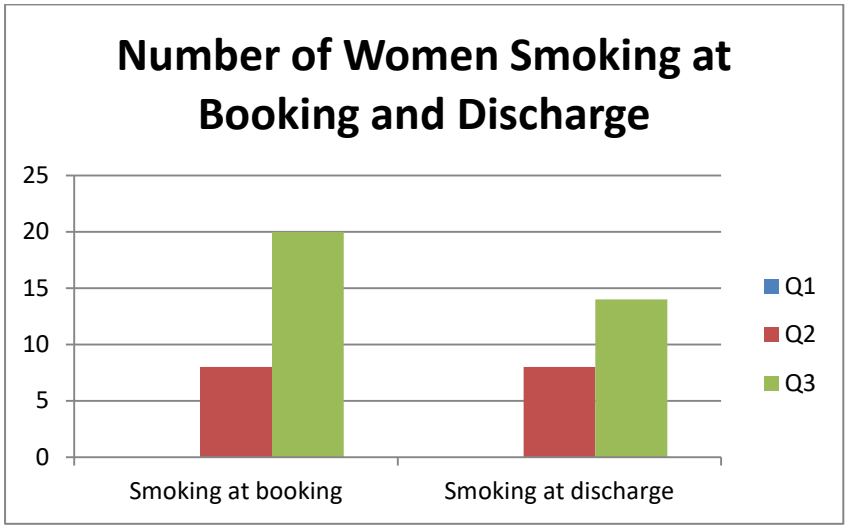
Safeguarding and Public Health Outcomes

Quarter 1 of the completed CoC pathway saw no concerns specifically associated to child protection, substance misuse or smoking concerns. This picture changed across Quarter 2 and 3 and in total, the team have supported;

- 7/96 women and their babies were discharged to mother and baby residential foster placements
- 2/96 women were discharged home with their babies having had previous children removed from their care
- 1/96 mother and her baby were discharged home together but the baby and her other children were removed from her care at 1 week postnatally

Smoking

In line with Saving Babies Lives and the national ask of reducing fetal/neonatal loss by 50%, a huge amount of work has been focused around the cessation of smoking, referring to stop smoking services and behavioural change in collaboration with the CO screening. During Covid-19 and since March 2020, CO screening has been temporary paused. However, the team has remained and sustained the discussions with all women around smoking and carbon monoxide.



- **Quarter 2:** 8/96 smokers at booking, 8 maintained smoking at point of discharge, with 5 engaged with Solutions for Health
- **Quarter 3:** 20/96 smokers at booking, 14 maintained smoking at point of discharge, 6 ceased altogether. 11/20 engaged with Solutions for Heath

Substance Misuse

- 15/96 disclosed a history of substance misuse, 9 ceased at point of pregnancy or just prior
- 4 referred to Turning Point
- 1 supported on a methadone programme
- At point of discharge this situation had not changed and abstinence had been maintained

Feeding

Quarter 2 and 3 saw an increase in the uptake of breastfeeding compared to intended plans and over 50% who commenced breastfeeding at birth remained to exclusively breastfeed at the point of discharge (28 days).

Feedback

The feedback received since the implementation of Lotus team has been nothing, but outstandingly positive with some very emotive and emotional personal stories. To evidence and demonstrate the significant impact that the team have achieved, a variety of vignettes are enclosed within this report.

“They were, kind, caring and completely supportive of what I wanted from my care and helped with my birth plan and it was the first time I got to have the birth experience I had always wanted...if I could turn back time and pick my care team for all of my previous babies I would definitely choose Lotus team without a second thought no questions asked. THE LOTUS TEAM ROCK!!”

“The care given by our lotus team midwife throughout my pregnancy was beyond amazing. We were referred to the team because of a previous traumatic pregnancy loss and our midwife supported us every step of the way with reassurance, knowledge and sympathy. The fact that she was able to visit us in our own home made such a difference and allowed us to build such a trusting and strong relationship. It allowed my husband to be more involved with the pregnancy which reassured him and in turn, allowed him to support me more effectively. The consistency of seeing the same midwife was invaluable given our previous experience. The fact that we didn’t need to keep explaining our history to lots of different medical professionals made for a less upsetting pregnancy experience and allowed us to focus on the positives of this new pregnancy.”

“We first came into contact with our Lotus Midwife at 4 weeks gestation after 3 losses. I was really anxious and scared so rang the doctors asking for advice on how to avoid another loss, on the back of this phone call my midwife called and spent at least an hour on the phone to me discussing my anxiety surrounding the pregnancy, acknowledging my previous experience and helping with mindfulness, it was at this point our journey with Lotus started and a trusting and caring relationship was formed with our midwife. This first contact set the tone for the rest of our journey with yourselves. Your care, compassion, understanding and empowering attitude towards not just myself but my family enabled me to not only have the birth and labour I wanted (by having a successful VBAC), but also completely changed my whole view on myself, my confidence , my self-belief and general well-being, which has changed dramatically thanks to the support from the whole team. The team took the time to meet me during hospital stays and get to know me which made us feel reassured

and cared for. Not only did my midwife and Lotus Team as a whole give us confidence throughout the pregnancy and delivery but empowered me to continue with the same mind-set after being discharged."

14. Appendix 4: Postnatal Continuity of Carer

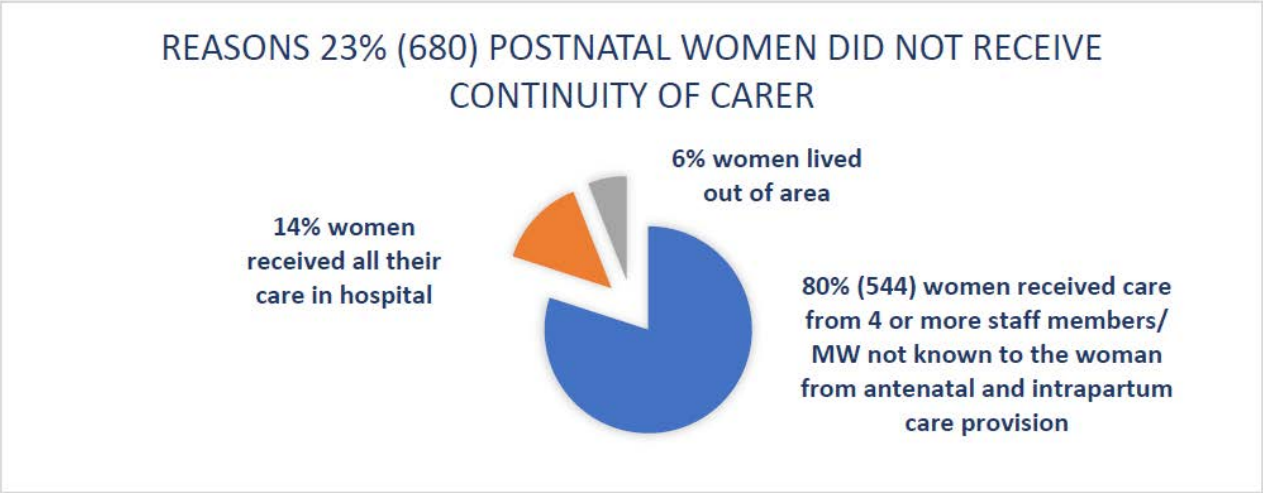
The following graphs present the postnatal CoC within OUH Community Midwifery Teams and the reasons behind why CoC was not always met.

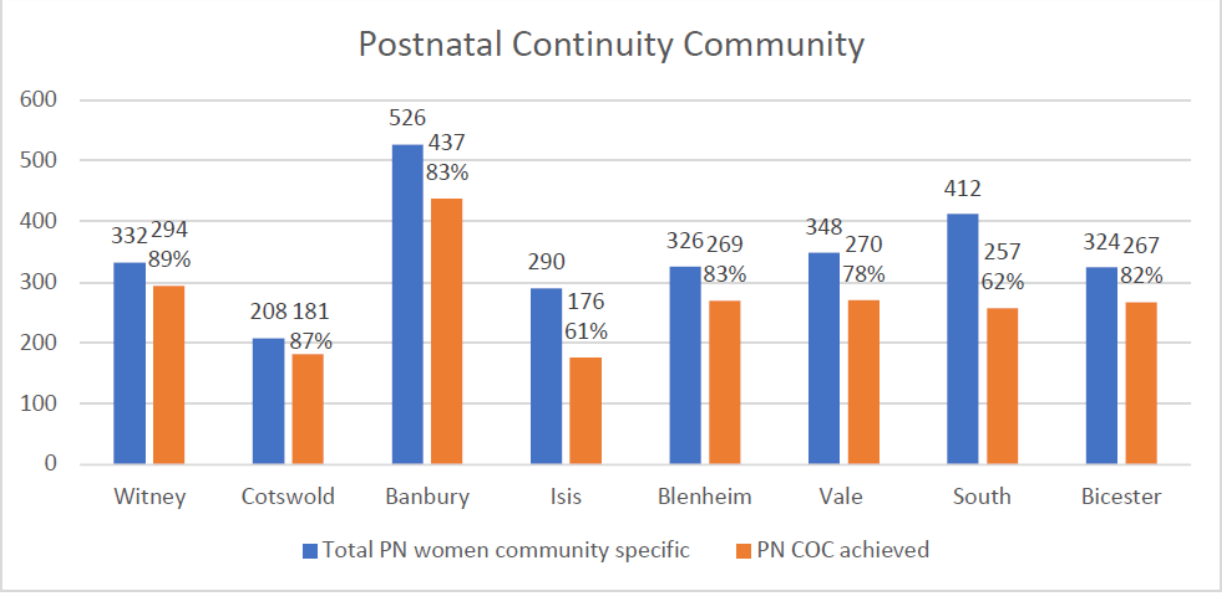
Buddy systems for each Community Team were reviewed in September 2020 and it was identified that the main focus was to ensure consistency in the small sub-teams ('named midwife/ buddy system')

The community sub-team equates to the following:

- A named lead Midwife coordinating the woman's care
- A buddy Midwife supporting the lead Midwife when he/she is unable to provide care
- A team Midwife/ MSW to support both Lead and buddy Midwife

Each Community Team has a Better Births Champion who oversees and supports these ongoing processes.





User Feedback

98 women responded to the postnatal survey from May- July 2020 of which 6% of women identified themselves as from a BAME background

60% of women identified themselves as receiving CoC throughout the antenatal period from 1-2 community midwives. This is an aspect of care most mothers viewed as important to them

90% of mothers felt the midwife understood their needs and the needs of their families

88% of women felt able to ask questions and felt involved in their own care

89% of mothers felt safe/ listened to by their midwife during pregnancy

Personalised Care Plans (PCP)

In line with the ambition of ensuring all women have access to personalised care plans (PCP), a mum and baby app was launched in January 2020. All women booking at OUHFT are offered opportunities to develop personalised care plans via this app. Current data suggests that 90% of the women booked were offered the app and therefore, access to a PCP.

PCPs are tools to frame conversations around individual choices and preferences for care in pregnancy, labour and the postnatal period focusing on choices around wider health needs. Personalised care planning sets out to encourage individualised connection to care with equal opportunities to access and choose local maternity offers. Personalised care planning conversations centre on listening to women, identifying what matters to them and how to best support the family as a unity.

PCPs are key components in the Better Births Agenda and NHS Long Term Plan. At OUH, PCPs are regularly audited and feedback through to the wider BOB Local Maternity Systems. Furthermore the LMS provides OUH with data on PCP downloads from each community team