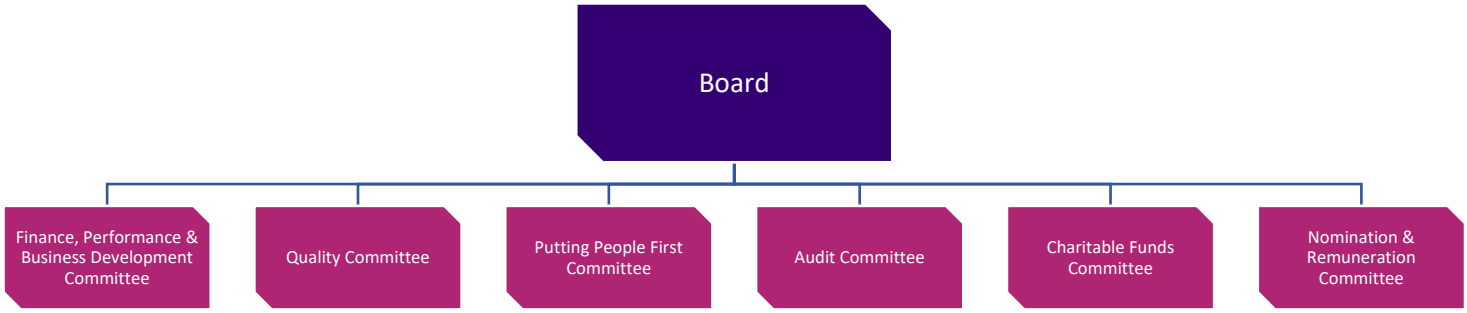
Liverpool Women's NHS Foundation Trust

Trust Board

12 January 2023, 09.30am
Boardroom, LWH & Virtual, via Teams



NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

Location	Boardroom and Virtual (via Teams)
Date	12 January 2023
Time	9.30am

AGENDA					
Item no. 22/23/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
172	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	09.30 (5 mins)
173	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
174	Minutes of the previous meeting held on 1 December 2022	Confirm as an accurate record the minutes of the previous meeting(s)	Written	Chair	
175	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
176	Chair & CEO announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	09.35 (5 mins)
MATERNITY					
177	Maternity Incentive Scheme (CNST) Year 4 – Sign off	To approve	Written	Chief Operating Officer	09.40 (20 mins)
Board Thank you					
CONCLUDING BUSINESS					
178	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	10.05 (5 mins)
179	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
180	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
181	Jargon Buster	For reference	Written	Chair	
Finish Time: 10.10					

Date of Next Meeting: 2 February 2023

10.10 – 10.20	*Questions raised by members of the public*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

The Board of Directors is invited to adopt the following resolution:

'That the Board hereby resolves that the remainder of the meeting to be held in private, because publicity would be prejudicial to the public interest, by reason of the confidential nature of the business to be transacted'. [Section (2) of the Public Bodies (Admission to Meetings) Act 1960]

Liverpool Women's
NHS Foundation Trust

Meeting attendees' guidance

Under the direction and guidance of the Chair, all members are responsible for ensuring that the meeting achieves its duties and runs effectively and smoothly.

Before the meeting

- Consider the most appropriate format for your meeting i.e. physical, virtual or hybrid. There are advantages and disadvantages to each format, and some lend themselves to particular meetings better than others. Please seek guidance from the Corporate Governance Team if you are unsure.

General considerations:

- Submit any reports scheduled for consideration at least 8 days before the meeting to the meeting administrator. Remember to try and answer the 'so what' question and avoid unnecessary description. It is also important to ensure that items/papers being taken to the meeting are clear and provide a proposal/recommendation to reduce unnecessary discussion time at the meeting.
- Ensure your apologies are sent if you are unable to attend and *arrange for a suitable deputy to attend in your absence
- Prepare for the meeting in good time by reviewing all reports
- Notify the Chair in advance of the meeting if you wish to raise a matter of any other business

*some members may send a nominated representative who is sufficiently senior and has the authority to make decisions. Refer to the terms of reference for the committee/subcommittee to check whether this is permitted.

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

- For the Chair / Administrators:
  - Ensure that there is a clear agenda with breaks scheduled if necessary
  - Make sure you have a list of all those due to attend the meeting and when they will arrive and leave.
  - Have a paper copy of the agenda to hand, particularly if you are having to host/control the call and refer to the rest of the meeting pack online.
  - If you are the host or leader for the call, open the call 10-15 minutes before the start time to allow everyone to join in an orderly way, in case there are any issues.
  - At the start of the call, welcome everyone and run a roll call/introduction - or ask the meeting administrator to do this. This allows everyone to be aware of who is present.
  - Be clear at the beginning about how long you expect the meeting to last and how you would like participants to communicate with you if they need to leave the meeting at any point before the end.

- General Participants
  - Arrive in good time to set up your laptop/tablet for the virtual meeting
  - Switch mobile phone to silent
  - Mute your screen unless you need to speak to prevent background noise
  - Only the Chair and the person(s) presenting the paper should be unmuted
  - Remember to unmute when you wish to speak

- Use headphones if preferred
- Use multi electronic devices to support teams.
- You might find using both mobile and laptops is useful. One for Microsoft teams and one for viewing papers

At the meeting

General Considerations:

- For the Chair:
  - The chair will assume that all members come prepared to discuss agenda items having read through supporting papers, this obviates the need for leads to take up valuable time presenting their papers.
  - The chair will allow a free ranging debate and steer discussions to keep members on track whilst at the same time not being seen to overly influence the outcome of the debate.
  - The chair will provide a brief summary following presentation and discussion of the paper, confirming any key risks and / or assurances identified and whether there are any matters for the Chair's log.
  - The chair will question leads when reports have not been submitted within the Trust's standard template or within the required timeframe.
  - Ensure that correct people are in the room to 'form the meeting' with other attendees invited to attend only when presenting their item.

- General Participants:
  - Focus on the meeting at hand and not the next activity
  - Actively and constructively participate in the discussion
  - Think about what you want to say before you speak; explain your ideas clearly and concisely and summarise if necessary
  - Make sure your contributions are relevant and appropriate
  - Respect the contributions of other members of the group and do not speak across others
  - Ensure you understand the decisions, actions, ideas and issues agreed and to whom responsibility for them is allocated
  - Do not use the meeting to highlight issues that are not on the agenda that you have not briefed the chair as AoB prior to the meeting
  - Re-group promptly after any breaks
  - Take account of the Chair's health, safety and fire announcements (fire exits, fire alarm testing, etc)
  - Consent agenda items, taken as read by members and the minutes will reflect recommendations from the paper. Comments can still be made on the papers if required but should be flagged to the Chair at the beginning of the meeting.

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

- For the Chair:
  - Make sure everyone has had a chance to speak, by checking at the end of each item if anyone has any final points. If someone has not said anything you might ask them by name, to ensure they have not dropped off the call or assist them if they have not had a chance to speak. In hybrid meetings, it can be useful to ask the 'virtual' participants to speak first.

  - Remember to thank anyone who has presented to the meeting and indicate that they can leave the meeting. It can be easy to forget this if you can't see them.

- General Participants:
  - Show conversation: open this at start of the meeting.
    - This function should be used to communicate with the Chair and flag if you wish to make comment
  - Screen sharing
    - If you wish to share a live document from your desktop click on share and identify which open document you would like others to view

Attendance

Members are expected to attend at least 75% of all meetings held each year

After the meeting

- Follow up on actions as soon as practicably possible
- Inform colleagues appropriately of the issues discussed

Standards & Obligations

1. All documentation will be prepared using the standard Trust templates. A named person will oversee the administrative arrangements for each meeting
2. Agenda and reports will be issued 7 days before the meeting
3. An action schedule will be prepared and circulated to all members 5 days after the meeting
4. The draft minutes will be available at the next meeting
5. Chair and members are also responsible for the committee/ subcommittee's compliance with relevant legislation and Trust policies
6. It is essential that meetings are chaired with an open and engaging ethos, where challenge is respectful but welcomed
7. Where consensus on key decisions and actions cannot be reached this should be noted in the minutes, indicating clearly the positions of members agreeing and disagreeing – the minute should be sufficiently recorded for audit purposes should there need to be a requirement to review the minutes at any point in the future, thereby safeguarding organisational memory of key decisions
8. Committee members have a collective duty of candour to be open and honest both in their discussions and contributions and in proactively at the start of any meeting declaring any known or perceived conflicts of interest to the chair of the committee
9. Where a member of the committee perceives another member of the committee to have a conflict of interest, this should be discussed with the chair prior to the meeting
10. Where a member of the committee perceives that the chair of the committee has a conflict of interest this should be discussed with the Trust Secretary
11. Where a member(s) of a committee has repeatedly raised a concern via AoB and subsequently as an agenda item, but without their concerns being adequately addressed the member(s) should give consideration to employing the Whistle Blowing Policy
12. Where a member(s) of a committee has exhausted all possible routes to resolve their concerns consideration should be given (which is included in the Whistle Blowing Policy) to contact the Senior Independent Director to discuss any high-level residual concerns. Given the authority of the SID it would be inappropriate to escalate a non-risk assessed issue or a risk assessed issue with a score of less than 15

13. Towards the end of the meeting, agendas should carry a standing item that requires members to collectively identify new risks to the organisation – it is the responsibility of the chair of the committee to ensure, follow agreement from the committee members, these risks are documented on the relevant risk register and scored appropriately

Speak well of NHS services and the organisation you work for and speak up when you have Concerns

Page 129 Handbook to the NHS Constitution 26th March 2013

Liverpool Women's
NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held in the Boardroom and Virtually via Teams at 09.30am on 1 December 2022

PRESENT

Robert Clarke	Chair
Kathryn Thomson	Chief Executive
Eva Horgan	Chief Finance Officer
Louise Martin	Non-Executive Director
Zia Chaudhry MBE	Non-Executive Director
Dr Lynn Greenhalgh	Medical Director (until item 166c)
Dianne Brown	Interim Chief Nurse
Michelle Turner	Chief People Officer / Deputy Chief Executive
Gloria Hyatt MBE	Non-Executive Director
Tracy Ellery	Non-Executive Director / Vice-Chair
Sarah Walker	Non-Executive Director
Jackie Bird MBE	Non-Executive Director

IN ATTENDANCE

Matt Connor	Chief Information Officer
Jenny Hannon	Assoc. Director – System Partnerships
Joe Downie	Deputy Chief Operating Officer
Gillian Walker	Patient Experience Matron (item 160 only)
Catherine Haughton	Lead Consultant Genetic Counsellor (item 160 only)
Vicky Clarke	Family Health Divisional Manager (until item 163b)
Heledd Jones	Head of Midwifery (items 161 – 163b only)
Yana Richens	Director of Midwifery (until item 163b)
Lesley Mahmood	Member of the public
Felicity Dowling	Member of the public
Jackie Sudworth	Public Governor
Annie Gorski	Public Governor
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Prof. Louise Kenny CBE	Non-Executive Director / SID
Gary Price	Chief Operating Officer

Core members	**Dec 21**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Sep**	**Oct**	**Nov**	**Dec 22**
Robert Clarke - Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Kathryn Thomson - Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Dr Susan Milner - Non-Executive Director / SID	✓	✓	✓	✓	✓	✓	NM					
Tracy Ellery - Non-Executive Director / Vice-Chair	✓	✓	✓	✓	✓	✓	✓	✓	A		✓	✓
Louise Martin - Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓

Tony Okotie - Non-Executive Director	A	✓	✓	✓	✓	✓	A	Non-member				
Prof Louise Kenny - Non-Executive Director	A	✓	A	A	A	✓	✓	A	✓		A	A
Eva Horgan – Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Marie Forshaw – Chief Nurse & Midwife	✓	✓	✓	✓	✓	A	✓	✓	Non-member			
Dianne Brown – Interim Chief Nurse	Non-member								✓		✓	✓
Gary Price - Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	A
Michelle Turner - Chief People Officer	✓	A	✓	✓	✓	A	✓	✓	✓		✓	✓
Dr Lynn Greenhalgh - Medical Director	✓	✓	✓	A	A	✓	✓	✓	✓		✓	✓
Zia Chaudhry – Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Gloria Hyatt – Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	A		✓	✓
Sarah Walker – Non-Executive Director	✓	✓	✓	✓	✓	A	✓	A	A		A	✓
Jackie Bird – Non-Executive Director	Non-member				✓	A	✓	✓	✓		A	✓

22/23/	
155	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. Apologies were noted as above and there were no declarations of interest. No items had been included on the consent agenda.
156	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
157	**Minutes of the previous meeting held on 3 November 2022** The minutes of the Board of Directors meeting held on 3 November 2022 were agreed as a true and accurate record.
158	**Action Log and matters arising** Updates against the following actions were noted as follows: 22/23/097e – Women's Health Strategy for England – It was agreed to close the action on the tracker as the Trust's strategic objectives would be reviewed to ensure alignment with the Women's Health Strategy.
159	**Service Outline - Family Health Divisional Update** The Deputy Chief Operating Officer reported that the representatives from the Trust's three Divisions would be attending Board over the next few meetings to present on their key developments and challenges. The aim of this was to help demonstrate that effective leadership and grip on significant risks was in place throughout the organisation. The Family Health Divisional Manager provided an outline of the Division noting that it consisted of a broad spectrum of services. Progress on key objectives was reported and priorities for the next six months were described. The following were identified as key work programmes for the Division: • Family Health Workforce Investment

	• Maternity Transformation The Chief People Officer queried if the experience pf patients and staff from marginalised groups had been included within the transformation programme. The Director of Midwifery confirmed that this was being overseen within the 'cultural assessment' heading within the programme. The Interim Chief Nurse added that equality, diversity, and inclusion was embedded as 'business as usual' in several workstreams. Non-Executive Director, Louise Martin, asked for further information on how community services were being included within the maternity transformation programme. The Family Health Divisional Manager noted that the Community Midwife Team Leader was a key part of the programme. Time had also been spent with the teams to understand their priority areas of improvement e.g., IT infrastructure. Non-Executive Director, Jackie Bird, congratulated the Division on the 100% retention rate for the recent midwifery preceptorship cohort. The fact that the Division had acknowledged the challenges in this achievement was noted as good practice, particularly for learning lessons for future years. It was asked if a similar model was to be utilised for neonatal nurses. The Interim Chief Nurse noted that there were several preceptorship schemes across the Trust and the aim was to integrate these to support the sharing of learning and strengthen oversight. The Chief People Officer added that the Trust was also sharing its experience with the wider system via the Local Maternity & Neonatal System and the CMAST midwifery workforce group. The Trust had also been invited to present at the Royal College of Midwives. The Chair highlighted that sickness rates within the Division remained a challenge and asked what actions were in place to improve this. The Chief People Officer explained that work was underway to understand the underpinning drivers of high midwifery sickness rates nationally. It was noted that high sickness rates in this staffing group pre-dated Covid-19 and staffing shortages. The Director of Midwifery remarked that the Trust was developing its midwifery staffing model, and this included exploring opportunities to strengthen links with other staffing areas and increasing options for flexible working. The Chair asserted that strong assurance had been received from the presentation and that there was evidence that the investment to strengthen the leadership capacity in the Division was delivering the expected benefits. The service outline was noted. *Gillian Walker, Patient Experience Matron and Catherine Haughton, Lead Consultant Genetic Counsellor joined the meeting.*
160	Patient Story The Lead Consultant Genetic Counsellor reported that the Liverpool Centre for Genomic Medicine had been based on the Crown Street site since 2015 and had three designated clinic rooms in the Antenatal Outpatient Department. Patient's attending the Genomic Medicine clinic shared the waiting area 'A' with all other patients attending the Antenatal Outpatients Department. Over the past several years multiple patients had expressed their distress and discomfort at sharing this waiting area. These patient experiences had led the Trust to develop an area within waiting area 'A' that was designated for Genomic Medicine patients with the aim of improving the experience of patients. It was noted that the service wanted to not only meet but to exceed expectations of patient experience. Several suggestions for future improvements to the waiting and clinic areas were described.

	Non-Executive Director, Louise Martin, queried whether there was a need for the genetics service to be co-located next to acute services. The Lead Consultant Genetic Counsellor explained that the service was becoming increasingly involved in multi-disciplinary teams and was changing from being an outpatient service to a place of treatment in the moment. For this reason, adjacency with other acute services was important and would continue to be so. The Medical Director queried if there was a need for the service to re-locate within the Crown Street site. The Lead Consultant Genetic Counsellor noted that despite the improvements made, patients were still required to pass through antenatal outpatients waiting areas which could be distressing. For this reason, it was suggested that space utilisation within the Trust could be re-visited. The Chief People Officer asserted the importance of securing an appropriate changing space for young people and adults. The Chief Executive noted that the Executive Team were looking to learn lessons to ensure that solutions for issues such as the one described in the story were identified through the annual business planning cycle. *Gillian Walker and Catherine Haughton left the meeting.* *Heledd Jones, Head of Midwifery joined the meeting*
161	Chair's announcements The Chair reported that along with Non-Executive Director Jackie Bird, he had attended a recent ICB/CMAST event. Together with updates on key challenges facing the whole system (finance and waiting time performance), the event provided an opportunity to consider what collaboration between trusts would start to look like in practice. The definition of an organisation being 'well-led' was evolving to include effective system and 'place' working as well as ensuring effective internal controls. It was stated that it would be important for the Board to develop its approach to demonstrating how decision-making was taking into consideration the systemic and socio-economic context. Action: To consider how the Board could effectively consider its impact and contribution to system aims in its decision-making processes. Other issues noted included: • The Council of Governors meeting held on 17 November 2022 had approved Grant Thornton as the Trust's external auditors. • A successful charity event had taken place on the 26 November 2022. Thanks and congratulations were extended to all staff who had volunteered to participate in the strictly come dancing style event and to those involved in its organisation. The Board noted the Chair's update.
162	Chief Executive's report The Chief Executive presented the report which detailed local, regional, and national developments. Attention was drawn to the Crown Street Enhancements Programme update which provided a useful overview of several projects that are designed to improve patient safety and experience. The Chief Executive noted that an issue regarding the quality of the Trust's food offer had been raised at a patient story in September 2022. The Interim Chief Nurse circulated a presentation which provided assurance that the food offer had improved. This would be evaluated formally and reported through to the Patient Involvement and Experience Sub-Committee.

	Non-Executive Director, Sarah Walker, noted that when recently attending a corporate induction event, anxiety regarding security on the Crown Street site had been expressed by staff. The Chief People Officer stated that there was a recognition that regular communications relating to on-going security improvements would need to continue. Non-Executive Director, Zia Chaudhry, noted that a positive aspect from the major incident was the cohesive approach taken with community partners and it was asked if the Trust had taken action to maintain and develop these relationships. The Chief People Officer confirmed that events with community groups had and would continue to take place. Non-Executive Director, Gloria Hyatt, queried if the UK Covid-19 Public Inquiry would be taking into consideration health inequalities. The Trust Secretary explained that the Inquiry terms of reference were wide ranging and that it was likely that the experiences of ethnic and socio-economic groups would form part of the findings. The Interim Chief Nurse stated that there were lessons for the Trust to learn from the pandemic but particularly relating to preparedness from a EPRR (Emergency Preparedness Resilience and Response) perspective. The Board of Directors noted the Chief Executive update.
163a	Maternity and neonatal services in East Kent: 'Reading the signals' report – LWH Response The Board received an outline of the key findings from the recently published report into maternity failings at East Kent Hospitals Trust. The Interim Chief Nurse noted that the report had assessed that if the problems in the units had been addressed 45 of the 65 baby deaths assessed by the Panel could have been avoided and 97 of the 202 cases of injury/harm. Other key findings included: • a repeated lack of kindness and compassion both when care was given and afterwards following injuries or death • a failure to recognise the scale and nature of the problems, because most births in the Trusts did not result in damage to either mother or baby • failures of teamworking • failures of professionalism including issues of bullying and divisive behaviour amongst midwifery and obstetric staff (known but not addressed) • lack of learning after safety incidents • the Board attributing failure to individuals rather than looking more closely at systemic failure • missed opportunities by a range of regulators. NHS England had communicated an expectation that trusts should not wait for the publication of the delivery plan and instead continue with their own response plans. The Interim Chief Nurse noted that the Trust was working to avoid a 'tick box' action plan approach. Rather, key themes had been identified and work undertaken to benchmark the Trust's current position with additional steps being developed. The key themes included: • Effectively monitoring safety performance – 'reading signals among the noise' • Improving standards of clinical behaviour – recognising that technical care was not enough • Ensuring that effective teamwork was in place – all areas pulling in the same direction • Ensuring that an accurate picture of maternity performance was reported through the Trust's governance structure – avoiding a 'looking good while doing badly' scenario The Chair remarked that the actions from the East Kent report should not be viewed as separate from those developed in response to earlier maternity reports e.g., Ockenden. The Director of Midwifery agreed and stated that the report would be factored into the continuous improvement process via the Maternity Transformation Programme. The Director of Midwifery continued to provide an update of the progress the Trust had made to date against the identified action points from the Ockenden report. It was noted that a key priority throughout December would be to focus resource on the safe staffing essential actions. The Chief Finance Officer noted that the Trust had to date not received additional funding to support the investments made to meet the Ockenden recommendations. It was agreed that this issue should be escalated at a system, regional and national level.

	The Chief People Officer asserted that a significant theme from most recent maternity reports identified dysfunctional cultures as a major contributing factor to poor patient outcomes. Work was underway to develop a method of incident reporting for cultural reasons in addition to safety reasons. The Chief Executive reiterated the maternity safety concerns at the Trust resulting from being on an isolated site. The Chair noted that it was encouraging to receive evidence of a co-ordinated and continuous improvement approach to the issues highlighted in the East Kent and other maternity reports. The Board of Directors noted the presentation.
163b	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update The Deputy Chief Operating Officer outlined the scheme requirements for compliance required to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year 4 and the Trust's status against this. It was noted that specific information was required to be noted by the Board. This related to the following: • Safety Action 3 – ATAIN & Transitional Care Audit Q2 Report • Safety Action 9 - Perinatal Surveillance Dashboard Update • Safety Action 2 - extract from the NHSD Monthly CNST scorecard confirming all 6 Data Quality metrics were met for July's submission for Liverpool Women's It was reported that the Trust was now reporting compliance against the requirement to ensure that 90% of each maternity staff group attended multi-professional education and training (MPET). This had been identified as a key risk at previous Board meetings. The Chief Executive noted that it was encouraging that the Trust had been proactive in seeking the involvement of the LMNS and ICB in the year 4 sign off process. The Chair suggested that the MVP Chair be invited to undertake a development session with the Board regarding patient involvement and engagement. Action: For the MVP Chair to be invited to undertake a development session with the Board regarding patient involvement and engagement (March 2023). The Board of Directors: • Received the current position in relation to CNST Year 4 • Noted the specific updates in relation to: o Perinatal Surveillance Dashboard Update o ATAIN & Transitional Care Audit Q2 Report o Extract from the NHSD Monthly CNST scorecard *Heledd Jones, Vicky Clarke and Yana Richens left the meeting*
164a	Chair's Report from the Quality Committee The Board considered the Chair's Reports from the Quality Committee meeting held on 21 November 2022. The Committee Chair, Non-Executive Director Sarah Walker, noted that the Committee had expressed disappointment that a detailed action plan in relation to blood sampling errors had been deferred. The CSS Division had been requested to provide an update to the December 2022 meeting. The Committee had also noted a deterioration against the 52-week position confirming that the Trust had become an outlier within the region against this metric. The Committee Chair and Interim Chief Nurse had participated in a discussion with the Chair of the Putting People First Committee, Chief People Officer, and Chief Finance Officer to consider an option to outsource activity to support an improved position. This discussion had taken into consideration the financial, quality and workforce

	implications. An outcome from the meeting was a recognition of a need to improve report writing to provide a more holistic perspective on key decisions at the respective Board level Committees. The Committee had noted the detailed work undertaken to review clinical incidents attributable to the isolation of LWH services from other specialist services. The report identified additional work to consider the impact of the perinatal mental health team for Trust patients. A Committee meeting was scheduled for December, and this would be focused on blood sampling errors and assurance for the Year 4 CNST sign off. A workshop session was also planned that would consider how best to improve reporting into the Committee. The Board of Directors received and noted the Chair's Reports from the Quality Committee meeting held on 21 November 2022.
164b	Quality & Operational Performance Report The Board considered the Quality and Operational Performance Report. The Deputy Chief Operating Officer noted that there continued to be work undertaken to improve the formatting of the data and an update would be available in the New Year. The Deputy Chief Operating Officer noted that September 2022 had seen an increase in maternity activity. There had been a 40% C/Section rate which was increasing pressure on theatres and staffing. The Trust's neonatal services had also been overperforming in terms of delivery for the year to date. Performance against the 52-week wait target had deteriorated. In addition to the outsourcing option, the Trust was reviewing job planning and service models to provide a sustainable series of actions for improvement. The Medical Director informed the Board that there had been a maternal death following a referral into the Trust. This was being reviewed through the established governance processes and an update would be provided to the Board when it was possible to do so. The Chair stated that the Trust's thoughts were with the women's family and that it would be vital to identify the lessons to be learned. Non-Executive Director, Louise Martin, asked if the Trust had kept the Maternity Led Unit (MLU) open during the reporting period. The Deputy Chief Operating Officer stated that the MLU had remained open for most of the time and that this had been supported by the increase in new maternity staff. Louise Martin continued to note that the six-week diagnostic performance showed signs of deterioration and asked how this was being addressed. The Deputy Chief Operating Officer reported that trajectory plans were in place and there had been improvements in several diagnostic areas. Non-obstetric ultrasound remained a challenge and recruitment efforts continued. Plans to explore transformation for the imaging service were underway to achieve long-term and sustainable improvements. Non-Executive Director, Gloria Hyatt, drew attention to the cancer two week wait performance and queried if the drivers of deteriorating performance were understood and what actions were in place to make improvements. The Deputy Chief Operating Officer explained that there had been a 30-40% increase in referrals over the past year. The 6% conversion rate from referrals to cancer diagnoses had remained constant during this time. In response to this, the Trust was working with the ICB and Cancer Alliance to develop and improve cancer pathways. The Board of Directors: • Received and noted the Quality & Operational Performance Report.
164c	Integrated Governance Report – Q2 2022/23 The Board received the report which outlined the oversight and assurance monitoring arrangements of Integrated Governance across the Trust.

	The main points highlighted included: • Incident reporting within the Ulysses system continued to increase across all Divisions reflecting staff awareness of what constitutes an incident supported by ongoing training within the system from the Corporate Team. • Incident trends were well known but further work was required to improve outcomes for induction of labour delays and blood sampling errors • Good administration and reporting systems had now been established for the management of face fit mask testing across all divisions • A detailed legal services report was in development, and this would report to the Quality Committee. This would be aligned with Getting it Right First Time (GIRFT) data. The Quality Committee had received the report in November 2022 and commended the strengthened process with the divisions and advised further work on strengthening evidence on outcomes within the report. The Chair remarked that the developing triangulation of key risks facilitated by the report was encouraging. It was requested that future reports expand on the proposed resolutions to the increase in complaints and PALs incidents. Non-Executive Director, Louise Martin, sought confirmation that OCS staff were able to access and input into the Trust's incident management system. The Interim Chief Nurse confirmed that this was in place and there had been good examples on incident reporting from this source. The Board of Directors noted the assurances received in the report.
164d	Guardian for Safe Working Hours Quarterly Report – Q1 & Q2 2022/23 The Board received the report noting that in the period there had been a significant increase in gaps for the Obstetrics and Gynaecology rota. This had been managed utilising agency doctors and consultants 'acting down'. The Putting People First Committee had received the report in November 2022 and had undertaken to explore how best to ensure that the Trust remained an attractive place for medics to practice. Work was also in place to develop the physician associate role. It was noted that there had been no increase in exception reporting during the period. A review of job planning was underway, and progress was being made with the work to create a new junior doctor mess space. The Board of Directors noted the assurances received in the report.
164e	Analysis of clinical incidents attributable to the Isolation of LWH services from other specialist Services The Medical Director stated that it was well recognised that the Trust provided services for patients at a site (Crown Street) which was isolated from other medical specialisms. This isolation caused significant clinical risk for patients, which would increase over time with increasing complexity of health care and specific specialism medical training. A review had been performed of all clinical incidents reported from September 2021 to the end of September 2022 logged on the LWH clinical incident system in which the isolation of services at Crown Street was thought to have contributed. From the review, 41 relevant incidents were identified, although there was a significant and unknowable under-ascertainment of the true number. The findings, therefore, only provided a qualitative assessment of the situation. The commonest risk category was "Lack of access to other adult acute specialties at Crown Street". Three of the incidents related to the lack of a facility to provide emergency psychiatric assessment on site for LWH patients.

	The Deputy Chief Operating Officer noted that work was underway with Merseycare to explore the offer available for mental health practitioner and clinical psychiatrist support. Training of other members of staff for the management of such incidents was also planned. Throughout the report, there was evidence that staff were trying to mitigate these risks by ad hoc 'work arounds' outside of current pathways. Recent work had included collaborative working between LWH and LUHFT. A draft shared risk register was being developed as part of this collaboration. The Quality Committee had requested to review the joint risk register in six months and it was noted that future reports to the Committee would include complaints received (that had the isolated site as a contributing factor) for enhanced triangulation. The Board of Directors noted the report.
	Board Thank you The Chief People Officer presented a thank you to Rachel London, Rachel Cowley, Kate Davis and Pam Dobie in recognition of their work in establishing the staff pantry. The Medical Director presented a thank you to Andrew Sefton and Helen McNamara in recognition of their work in providing guidance to the Trust through the recent blood shortage. The Interim Chief Nurse presented a thank you to Sarah McGrath, Ade Akeredolu, Joanne Wilson in recognition of their work in supporting the development of Healthcare Support Workers.
165a	Chair's Report from the Putting People First Committee The Board considered the Chair's Report from the Putting People First Committee meeting held on 14 November 2022, presented by the Committee Chair and Non-Executive Director, Gloria Hyatt. The Committee had been informed that planning for industrial action was ongoing both internally through Business Continuity Plans and across the Cheshire & Merseyside system. The Trust was working closely with union colleagues to manage the impact of potential strike action. Issues in relation to a negative culture experienced by several candidates on the Midwifery Preceptorship programme had been reported. Significant work had been undertaken to support the preceptees during that time. The Committee remitted an action to the Family Health Divisional Board to review the feedback from midwifery preceptees on culture within the division and related freedom to speak up feedback to provide a response. The Committee had noted that a full review of car parking capacity arrangements was underway to address a shortage of capacity at Crown Street. It was confirmed that security and quality of the carparks were also being considered as part of the review. Positive assurance was received in relation to the Trust being shortlisted for the top 50 inclusive organisations. The Trust's final position within the top 50 would be revealed later in the week. Non-Executive Director, Sarah Walker, noted a key finding from the East Kent report was that there had been long standing non-compliance with mandatory training. It was stated that it would be important for the Trust to plan effectively to provide the headroom for staff to complete their mandatory training. The Board of Directors: • Received and noted the Chair's Report from the Putting People First Committee meeting held on 14 November 2022.
165b	Workforce Performance Report The Board received the Workforce Performance Report.

	The Chief People Officer remarked that several issues in the report had been discussed in other items on the agenda. It was asserted that this demonstrated that people and staffing were significant themes for the organisation. The Board of Directors: • Noted the Workforce Report.
166a	Chair's Report from the Finance, Performance and Business Development Committee The Board considered the Chair's Reports from the Finance, Performance and Business Development Committee meeting held on 21 November 2022. The Chair of Committee, Non-Executive Director Louise Martin, reported that the Committee had been appraised of the financial position and the on-going status of the recovery plan. The potential non-achievement of Elective Recovery Funding had been identified as a significant risk to the financial position. Whilst there had been a slight improvement in month, the cash balance was highlighted as a matter of concern as the balance was below minimum levels set out in the Treasury Management policy. Regarding the outsourcing proposal to help recover the 52-week position, the Committee had advised that the Trust should be certain of its own productivity and pathways ahead of progressing with the option. The positive movement of agency spend within Maternity services noting a zero spend during the last few weeks had been acknowledged by the Committee. Non-Executive Director, Tracy Ellery, noted that the Committee had agreed the sharing of the Financial Recovery Plan with the ICB following suggested amendments. The Board of Directors: • Received and noted the Chair's Report from the Finance, Performance and Business Development Committee meeting held on 21 November 2022.
166b	Finance Performance Review Month 7 2022/23 The Chief Finance Officer presented the Month 7 2022/23 finance performance report which detailed the Trust's financial position as of 31 October 2022. It was noted that at Month 7, the Trust was reporting a £257k surplus year to date (YTD). This was £487k off plan and was supported by £8.4m of non-recurrent items. The forecast out-turn (FOT) before further recovery actions was a £2.4m deficit, £3m worse than plan, after inclusion of £1.9m of additional recovery actions. Whilst there had been an improvement in the monthly run-rate from Month 6 to Month 7, a financial gap remained. This position had been reported to the ICB and had prompted an additional level of scrutiny. The Trust was achieving its total Cost Improvement Programme (CIP) target YTD and was forecast to exceed this for the full year, albeit with more non-recurrent measures than initially planned. Any further CIPs would remain subject to a Quality Impact Assessment. The cash balance at the end of Month 7 was £5.5m, an increase from £3.3m at Month 6. This balance remained below minimum levels set out in the Treasury Management policy (15 days expenditure or c£5.9m minimum cash level). The cashflow forecast assumed cash support via the ICB (which had not yet been agreed). Should cash support not be forthcoming from the system, revenue PDC support would be required which would come at a cost. Capital spend was behind trajectory (£4.2m behind plan). However, most of the plan was now committed with orders placed.

	The Chief Finance Officer continued to outline the key risks to financial recovery. As activity had been lower than expected, and due to a change in the funding model, there was a risk to the funding of the Community Diagnostic Centre (CDC). The Trust was making the case that it should not be in financial detriment for hosting a service on behalf of the system. The Trust was also behind plan in relation to the Elective Recovery Fund. The Associate Director – System Partnerships queried if there were actions available to the Trust in terms of creditors and debtors to support the cash position. The Chief Finance Officer noted that the Trust owed LUHFT £4m and work was on-going to discuss the timing of payment. Actions were underway to attempt to clear aged debtors wherever possible. Non-Executive Director, Sarah Walker, queried if there was action the Trust could take in terms of the commercial liabilities for the delay in installing the permanent CT scanner in the CDC. It was confirmed that this was being reviewed. The Board of Directors: • Noted and received the Month 7 2022/23 Finance Performance Review
166c	Recovery Plan The Board received the financial recovery plan which had been developed in response to the Trust reporting an off plan FOT. It was noted that the plan had been developed with good engagement from the Divisions and there was a total identified opportunity of £5.3m of which £1.9m was included in the Month 7 forecast. However, many of the opportunities would require further work up or decision including Quality Impact Assessment. The Trust also faced several risks which had not yet materialised and so had not been included in the FOT. It was noted that the reliance on non-recurrent items to meet the 2022/23 financial plan would have an impact on the 2023/24 position. Attention was drawn to section 6 of the report which outlined the key themes of the recovery plan. The approach taken to recovery was to have individual divisional Recovery Plans aggregated up to a trust wide plan, overlaid with trust wide and corporate potential savings. A discussion was held regarding the timing of the decision to request PDC revenue support. There was acknowledgement that the decision could not be taken close to the year-end point and therefore the Finance, Performance and Business Development (FPBD) Committee and Trust Board would require regular updates to ensure that a timely decision was made. The Chair queried if the Trust had identified and begun to put into action those items that would generate the most significant outcomes in terms of recovering the FOT. The Chief Finance Officer confirmed that work was underway to identify the items that would provide the greatest return and were deliverable within the required timeframe. The Board of Directors: • Received the report • Noted that the financial position remained an on-going challenge and regular updates on the efficacy of recovery actions would be required at the FPBD Committee and Board. *Lynn Greenhalgh left the meeting*
167a	Approval of the Liverpool Women's NHS Foundation Charitable Trust Annual Report and Accounts 2021/22 The Chief Finance Officer reported that the Charity Annual Report and Accounts for the 2021/22 financial year were reviewed by the Charitable Funds Committee on the 17 October 2022. The Charitable Funds Committee had recommended their approval by the Trust Board in its role as Corporate Trustee of the charity.

	Key headlines for the 2021/22 year were noted as follows: • There had been a slight increase in the Investments value compared to the prior year of £7k, which was largely due to the realised gain on investments. • The creditor balance was lower than the prior year due to the charity repaying the Trust £175k in 2021/22. Of the £361k creditors figure only £96k of it related to the interdebtedness with the Trust. • At the 31 March, the charity was in a position of net current liabilities which meant that it could not have repaid the balance owed to the Trust of £96k without liquidating some investments. • The net movement in funds in 2021/22 was an increase of £58k, with the closing fund balance £562k. The Board of Directors: • Approved the 2021/22 Charitable Funds Annual Report and Accounts in its role as the Corporate Trustee of the Charity • Noted that the Charitable Funds Annual Report and Accounts would be filed with the Charity Commission for England and Wales before the deadline of the 31 January 2023.
167b	Corporate Objectives 2022/23: Six Month Review The Trust Secretary reported that the outputs against the Trust's corporate objectives had been considered in detail during the strategy update at the November 2022 Board meeting. The Board noted the performance / progress to date against the 2022/23 Corporate Objectives.
167c	Board Assurance Framework The Board of Directors received the Board Assurance Framework. The Trust Secretary explained that the BAF risks had been discussed at the aligned Committees during November 2022. The report outlined proposed scores for Quarter 3 2022/23 for each respective BAF risk. There had also been several housekeeping amendments and updates made to actions. There was a recommendation at the November 2022 FPBD Committee to separate the financial sustainability threat from the 'in-year' threat to provide greater visibility to the latter. This would be undertaken for the December 2022 Committee and reported back to the Board. It was also agreed that the narrative for this new risk needed to include recovery planning work. The Board of Directors: • Reviewed the BAF Risks • Agreed the proposed BAF scores for Q3 2022/23
168	Review of risk impacts of items discussed The Chair identified the following risk items: • Ensuring that the Trust could effectively view the 'signals through the noise' for maternity services • The impact of potential industrial action • On-going challenges with waiting times and trajectories • The Trust's financial position and long-term sustainability • Risks to the year-end financial position including not achieving ERF and CDC funding, the cash position and not securing additional income for overactivity.
169	Chair's Log No Chair's Logs noted.

170	Any other business & Review of meeting The Chair noted the cost-of-living crisis that would be impacting several Trust staff. It was requested that the respective Committees start to consider this through their respective agendas. The Chief People Officer undertook to circulate a briefing on the actions the Trust were taking to support staff. Action: To circulate a briefing to the Board on the actions being taken to support staff through potential hardship. Review of meeting No comments noted.
171	Jargon Buster Noted.

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Action Log

Trust Board - Public
12 January 2023

Key	Complete	On track	Risks identified but on track	Off Track

Meeting Date	Ref	Agenda Item	Action Point	Owner	Action Deadline	RAG Open/Closed	Comments / Update
1 December 2022	22/23/170	Any other business & Review of meeting	To circulate a briefing to the Board on the actions being taken to support staff through potential hardship	Chief People Officer	Jan 23	Completed	Circulated with January 2023 Board workshop pack
1 December 2022	22/23/163b	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	For the MVP Chair to be invited to undertake a development session with the Board regarding patient involvement and engagement.	Trust Secretary	Mar 23	On track	
1 December 2022	22/23/161	Chair's announcements	To consider how the Board could effectively consider its impact and contribution to system aims in its decision-making processes.	Trust Secretary	Jan 23	Completed	Scheduled as an agenda item for the January 2023 Board workshop.
3 November 2022	22/23/138e	Our Strategy – Review of Delivery	To review what would be possible in terms of identifying commercial opportunities for the Trust.	Chief Finance Officer	Jan 23	Completed	High level commercial opportunities will be reviewed and included as part of the 23/24 planning process during Q4 22/23 with a view to developing these as part of the Trust's longer term sustainability plans
3 November 2022	22/23/136e	Bi-annual staffing paper update, January 2022-June 2022 (Q4 21/22 & Q1 22/23)	To outline the factors (quantified) that result in the Trust not operating to its funded midwifery establishment.	Chief Nurse	Feb 23	On track	

3 November 2022	22/23/136e	Bi-annual staffing paper update, January 2022-June 2022 (Q4 21/22 & Q1 22/23)	To provide a breakdown of the midwifery establishment against the investments made by the Trust over the previous three years.	Chief Nurse	Feb 23	On track	
1 September 2022	22/23/097f	Safeguarding Annual Report	To receive a safeguarding case study and actions taken by the Trust at a future Board development session	Chief Nurse	March 23	On track	
7 July 2022	22/23/076	Chief Executive's report	To provide an overview of the C-GULL study to a future Board meeting	Medical Director	~~Nov 22~~ Feb 2023	On track	To be reported under the 'Service Line' item at a future Board meeting.

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	03.11.2022	To explore how effectively the Trust retains contact with students and school leavers following career engagement events. Executive Lead: Chief People Officer	PPF	January 2023	On track	
Delegated	03.11.2022	To understand the drivers behind the increase in neonatal activity during 2022/23. Executive Lead: Chief Operations Officer	Quality	January 2023	On track	
Delegated	01.09.2022	To explore the reasons behind a notably greater number of in utero transfers in LWH compared to SMH (noted from Neonatal External Review). Executive Lead: Medical Director	Quality	January 2023	On track	

Delegated	07.07.2022	To receive a profile of agency usage against agreed establishment levels. Lead Officer: CFO	FPBD	January 2023	On track	

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Trust Board

COVER SHEET

Agenda Item (Ref)	22/23/177	Date 12.01.2023
Report Title	Maternity Incentive Scheme (CNST) Year 4 – Sign off	
Prepared by	Angela Winstanley – Maternity Quality & Safety Matron Heledd Jones- Head of Midwifery Gary Price – Chief Operating Officer	
Presented by	Alice Bird – Clinical Director Yana Richens – Director of Midwifery Heledd Jones- Head of Midwifery	
Key Issues / Messages	This report outlines the scheme requirements for compliance required to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year 4 and the Trust's current status against this. The paper outlines the final compliance position and requests approval for CEO sign off.	
Action required	Approve ☒	Receive ☐ / Note ☐ / Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it* / *For the intelligence of the Board / Committee without in-depth discussion required* / *To assure the Board / Committee that effective systems of control are in place*
	For Decisions - in line with Risk Appetite Statement – Y	
	The Trust Board is asked to take assurance that to date all requirements have been met, evidence is available to demonstrate our compliance position and instruct the CEO to sign the Board Declaration Form.	
Supporting Executive:	Gary Price, Chief Operating Officer	

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

To develop a well led, capable, motivated and entrepreneurial ***workforce***	☐	To participate in high quality research and to deliver the most ***effective*** Outcomes	☒
To be ambitious and ***efficient*** and make the best use of available resource	☒	To deliver the best possible ***experience*** for patients and staff	☒
To deliver ***safe*** services	☒		

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 3.1 Failure to deliver an excellent patient and family experience to all our service users	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	Monthly	Chief Nurse	Monthly updates to be provides to the Committee and where required, issues will be escalated to the Board for formal noting and assurance. This final position report was received and accepted by the Committee in December 2022.
Divisional CNST Oversight Committee	Twice Monthly	COO	Twice monthly progress updates from scheme safety action leads.
Family Health Divisional Board	Monthly	Clinical Director for Family Health	Monthly updates provided to the FHDB to escalate any issues of non-compliance and identify actions to resolve.

EXECUTIVE SUMMARY

This paper provides Liverpool Women's Hospital Maternity Services compliance position for the 10 Safety Actions and their associated standards, of the CNST Maternity Incentive Scheme Year 4.

In October 2022, a further revision of the Maternity Incentive Scheme was published and along with some safety action updates, a new Trust Board sign off date was announced. Areas highlighted in BLUE denote any updates or extra requirements announced in the October 2022 MIS publication.

The Trust's Quality Committee received the compliance position and a detailed presentation in December 2022. Safety Action 10 requires that the Trust Board receives assurance that 100% of qualifying cases to HSIB and to NHS Resolutions' Early Notification scheme have been completed, with full compliance against duty of candour regulations as described in the MIS scheme guidance. The period in question for this is from 1 April 2022 until 5 December 2022. Due to timing, this was not included in the December 2022 Quality Committee report but has been included as an appendix to this report (appendix 5).

MAIN REPORT

Introduction.

NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST.

As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. As in year three, the scheme incentivises ten maternity safety actions.

Trusts that can demonstrate they have achieved all ten safety actions and will recover the element of their contribution relating to the CNST maternity incentive fund and will receive a share of any unallocated funds.

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

December 2021.

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on 30 June 2022. However, it should be noted there was an imposed submission deferral issued on the 23rd of December 2021. The Family Health Senior Leadership team agreed to continue and maintain progress as a means of preparedness and the Trust Executive Team supported this approach.

May 2022.

In May 2022, NHS Resolution introduced a re-launch of the scheme, after the scheme pause, with the publication of full up to date guidance, with a new submission date of the Board Declaration form by Thursday 5th January 2023.

October 2022

On 11th October 2022, NHS Resolution, in response to the recognition of ongoing pressure within the national maternity system, published a further updated to the scheme guidance (Appendix 1). A new revised Board Declaration date was issued and sign off of the scheme now stands on **February 2nd 2023.**

Conditions of the scheme.

The Quality Committee and ultimately, the Trust Board must also be aware of the conditions of the scheme, some have been added and are detailed in the October 2022 update. These are as follows:

- Trusts must achieve all ten maternity safety actions

- The declaration form must be submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Head of Midwifery, Director of Midwifery and Clinical Director for Maternity Services (May and October 2022)
- The Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:

  - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document.

  - There are no reports covering either this year (2021/22) or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to our declaration (e.g., Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before **2nd February 2023.**

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

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

Note: CCG functions will be subsumed into integrated care systems, with CCGs ceasing to exist as statutory organisations by July 2022.

- Trust submissions will be subject to a range of external validation points, these include cross checking with: ---
  - MBRRACE-UK data (safety action 1 standard a, b and c),
  - NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, standard 2 to 7 inclusive),
  - National Neonatal Research Database (NNRD)
  - HSIB for the number of qualifying incidents reportable (safety action 10, standard a).
  - Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

- The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' update at Local Maternity System (LMS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.

- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions, then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-

declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.

• NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

Scheme Safety Actions

The table below outlines the ten safety actions for Year four of the scheme.

- **Safety action 1**: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
- **Safety action 2**: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
- **Safety action 3**: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?
- **Safety action 4**: Can you demonstrate an effective system of clinical workforce planning to the required standard?
- **Safety action 5**: Can you demonstrate an effective system of midwifery workforce planning to the required standard?
- **Safety action 6**: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?
- **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 (MVP) to coproduce local maternity services?
- **Safety action 8**: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance, and newborn life support, starting from the launch of MIS year 4?
- **Safety action 9**: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?
- **Safety action 10**: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?

Family Health Division Scheme Management and Leadership.

- In the interests of the ability to share and collate evidence for scheme stakeholders, the Information Team have developed a Microsoft Teams Channel. This consists of each Safety action spreadsheet being held centrally with action owners given the ability to update and upload actions and evidence as the scheme progresses throughout the coming year. This allows oversight by the FHD Division Management Team and CNST Oversight Group.

- Every action has been nominated a lead, with associated actions being given to action owners. Action Leads and owners who are responsible for ensuring their progress, challenges and completions are presented and overseen by the FHD CNST Oversight Group. This meeting, now twice monthly, is chaired by the Chief Operating Officer will provide assurance to the FHD Board, with assurance to Quality Committee and Trust Board from the associated assurance paper.

Current Position for Year 4 against the updated October 2022 scheme update

RAG Rating Guidance	Description.
	All workstreams/safety actions on target. Evidence collated to demonstrate compliance.
	Workstreams ongoing, forecasted compliance expected with some evidence collated.
	Risk of Non-Compliance/Safety Action requiring escalation/No evidence to support compliance.

Safety Action Point	Description	Issue / Update for consideration	Status RAG
SA.1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Leads: Ae Wei Tang – Consultant Obstetrician Rebecca Kettle – Consultant Neonatologist Sarah Howard – Quality & Safety Matron	All eligible births and deaths, from 6th May 2022 must meet the following conditions: A. i) **100%** all deaths have been reported to MBRRACE within the seven working day timeframe with 100% of deaths having surveillance completed within one month to date from 6th May 2022 – 100% Compliance. *15.11.2022 - There are 33 cases eligible for reporting to MBRRACE for this standard. Of these cases 12 are exempt from this standard as the surveillance case is assigned to an external trust.* ii) **95%** of all deaths of babies, suitable for PMRT Review, will have had their case started within TWO MONTHS of the deaths from 6th May 2022 - 100% Compliance. *15.11.2022 - There are 32 cases eligible for this standard, one case less than standard Ai. The 33rd case (84430) does not qualify as the standard deadline is after the qualifying date for CNST.* B. **50%** of deaths of all babies who are born and die within the Trust, from 6th May 2022. All reports are either in: - Draft format within four months - On track for completion – 80% - Fully published within six months - On track for completion – 100%. C. **95%** of families have been informed and offered involvement in the review of their care and that of their baby. 100% Compliance D. Quarterly reports submitted to Trust Board from 6th May 2022. 100% Compliant **Q3** 21/22 Learning from Deaths Report. - Submitted to QC Feb 21 - Submitted to Board May 2022 **Q4** 21/22 Learning from Deaths Report - Submitted to QC May 2022 - Submitted to Board July 2022 ***Thematic Review of Stillbirths 21/22 -Submitted to QC 26th Sept 2022*** **Q1** 22/23 Learning from Deaths Report - Submitted to QC 26th Sept 22	
SA.2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	New requirement for a digital maternity to align with Trust Digital strategy - the Maternity Digital Strategy has been developed and was presented and approved at Trust Board in September 2022 by the CIO. MSDS data for July 2022 data has been submitted in September 2022. Data quality reports from NHDS Digital relating to the CNST standards are reviewed monthly and the Trust is current compliant against all requirements based on May 2022 data.	

	Leads: Head and Deputy of Information Richard Strover & Hayley McCabe	Confirmed with LMNS on 14.10.2022 that Digital Strategy has been received.	
SA.3	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? Leads: Anna Paweletz– Consultant Neonatologist Sarah Brownrigg – ANNP Paula Nelson – ANNP Sarah Howard – Quality & Safety Matron	A) Pathways of care into TC jointly agreed – Completed B) Pathways of care into TC are audited quarterly and shared with Neonatal Safety Champion, LMNS, Commissioner and ICS Quality Surveillance – Ongoing C) Data recording process (electronic/paper based) capturing all term babies admitted to NICU – Completed using Badger Net. D) Data recording process for capturing all TC activity has been embedded – Completed - using Badger Net E) Commissioner returns are available to be shared on request from LMNS/ODN and ICS – Returnable on request. F) Quarterly review of all babies admitted to NICU and shared with BLSC, LMNS and ICS Quality Surveillance Meeting – Ongoing - LWH hold weekly reviews with quarterly reporting. G) Action Plan from TC and ATAIN audit agreed with Mat, Neo and Board Level Safety Champion – Completed and Ongoing. H) Progress with ATAIN action plan shared with Mat, Neo, Board Level Safety Champion and the LMNS and ICS Quality Surveillance Meeting – Completed January 2022. All workstreams completed or on track for completion. All Transitional Care and ATAIN audits are on track, Q4 21-22 Audits and Q1 22-23 have been submitted to the FHD Safety Champions. The combined ATAIN & Transitional Care Audit Q2 report can be found in the appendix to this update.	
SA.4	Can demonstrate an effective system of clinical workforce planning to the required standard? Leads: Alice Bird – Obstetrics Christopher Dewhurst – Neonates Neonatal Nursing – Jen Deeney Anaesthetic Workforce – Rakesh Parikh	Obstetric Workforce – Paper submitted to Trust Board in December 2020, outlining the current obstetric position as outlined in the RCOG Workforce document. Update paper required as per May 2022 requirements was submitted to Trust Board in July 2022 and outlined the ongoing obstetric workforce review and associated action plan. Anaesthetic Medical Workforce – Complete. Workforce review submitted to Quality Committee April 2022. Neonatal Nursing Workforce – Complete – Workforce review submitted to Trust Board April 2022. Board Mins to reflect requirements within scheme guidance. Neonatal Medical Workforce – Complete – Workforce review submitted to Trust Board April 2022. Board Mins reflect requirements within scheme guidance.	

SA.5	Can demonstrate an effective system of midwifery workforce planning to the required standard? Leads: Heledd Jones – Head of Midwifery Alison Murray – Deputy Head of Midwifery	Full Birth-rate Plus and Maternity Staffing paper received at Trust Board in February 2022. Trust Board paper covered all aspects of the evidential requirements. • 100% Supernumerary Labour Ward Co-ordinator • Provision of 1:1 Care in Labour A further detailed midwifery staffing analysis was tabled at Trust Board in September 2022, with detailed Trust Board Minutes being made available to the MIS scheme leads and Head of Midwifery, that confirm the following: -Trust Boards must provide evidence of funded establishment being compliant with the outcomes of Birth Rate+… and/if (MIS, 2022) -Trust Boards are not compliant with a funded establishment based on Birth Rate+, Trust Board minutes must show the agreed plan, including timescales for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	
SA.6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version 2? Leads: Clinical Director Alice Bird – Obstetrics Angela Winstanley – Quality & Safety Matron	Trust Board level consideration of how the organisation is complying with the SBLCBV2 and evidence that the quarterly care bundle surveys have been submitted to Trust Board. - SBLCBV2 Survey 6 submitted to Trust Board in June 2022. - SBLCBV2 Survey 7 in the Appendix to this Update - October 2022 A brief synopsis of the audit results of each safety element as follows Full audit to be tabled at Quality Improvement Group – December 2022 **Element 1 Smoking in Pregnancy – COMPLIANT.** • CO Screening compliances of >95% at Booking and >80% at 36 Weeks, over a four-month period. Action plan formulated to address compliance rates at 36 weeks. • Proportion of women with CO >4ppm (*audit sample requirement was 20 cases, LWH sample 47)* – 57.5% accepted referral, 38.3% declined referral. **Element 2 FGR Screening & Management - COMPLIANT** • 100% of cases identified as high risk and 100% of cases identified as moderate risk of FGR compliant with the relevant risk assessment at 20wks. • 85.7% of sample compliant with the complete high-risk pathway. 90% compliance with complete moderate risk pathway. **Element 3 Managing Reduced Fetal Movements – COMPLIANT** 100% Compliance of women receiving information on RFM. 100% Compliance of women attending with RFM having a computerised CTG **Element 4 MDT Training & Fetal Surveillance Training – COMPLIANT** • This element centres on MDT training and Fetal Surveillance Training (Full update on compliance and trajectory as per Safety Action 8) **Element 5 Preterm Labour Prediction, Prevention and Management – COMPLIANT** *(No compliance targets in this element, only requirement is action plan developed for those < 80%. Audit sample required 20 cases presenting with threatened preterm birth, LWH Sample 48)* • 77% of cases of threatened preterm labour (TPTL) had complete course of corticosteroids within 7 days of birth. • 8.3% gave birth >7 days after completion of corticosteroids (should be as low as possible and reported as the proportion) • 87% of cases of women in threatened preterm labour received magnesium sulphate • 100% of women give birth in a setting appropriate to gestation (Level 3-4 NICU at LWH supports births of all gestations)	

SA.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 (MVP) to coproduce local maternity services? Lead: Heledd Jones Head of Midwifery .	A new MVP Chair has been recruited and started in her role in September 2022. HOM has plan with the FHDB that is being aligned to ensure that all MIS requirements are achieved. Agreement by Executive Committee to fund a Deputy Chair to strengthen MVP representation. Invites extended to newly appointed MVP Chair to attend Maternity Risk & Governance Meeting and Divisional Safety Champion meeting. MVP Chair is a member of the Maternity Service Improvement Action Plan Task and Finish Group, latest meeting held October 13th, 2022 which MVP Chair attended. MVP Chair meeting weekly with DoM, HoM and Matrons for feedback from service users, to identify improvements with potential for rapid resolution, safety concerns identified by service users escalated to MVP etc. Updated ToR received from MVP – sighted by Safety Champions, to be reviewed by FHDB. MVP Meeting scheduled 30th November 2022.	
SA.8	Can you evidence that at least 90% of each maternity unit staff group attendance an 'in-house' multi-professional maternity emergencies training session within the last year. Leads: Alison Murray – Midwifery Jonathon Hurst – Neonatal	There is a formal maternity training plan which incorporates all the requirements of the Core Competency Framework in accordance with this safety action. This has been tabled and approved by the FHDB and acknowledgment given to recognise the staffing shortages during COVID have disrupted progress. We are endeavouring to meet full compliance prior to the original submission date of 5th December 2022 with the acknowledgment that staffing, and sickness absence are risk to the 90% compliance target. Full further detail and analysis of current compliance data can be found in the Perinatal Quality Surveillance Dashboard Paper. A full and detailed analysis of current training compliance rates and trajectories is available in Appendix 4.	
SA.9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on Maternity and neonatal safety and quality issues? Leads: Rachel McFarland – Obstetric Safety Champion Angela Winstanley – Midwifery Safety Champion Fauzia Paize – Neonatal Safety Champion.	There are robust processes in place feeding perinatal safety information to Trust Board and Quality Committee on a monthly basis via the Perinatal Clinical Quality Dashboard. Trust Boards must have reviewed current staffing in the context of the letters to systems on 1st April 2022 and 21st September regarding roll out of Midwifery COC. Maternity Continuity of Carer and its implementation plan, specifically prioritising those service users most likely to experience poor outcomes, 75% BAME, and 10% of deprived neighbourhoods. The Board received a full paper in June 2022, this followed on from the Non-Executive Board Level Safety Champion meeting on 31st May 2022 with the DONM, Dep HOM and COC Leads where specific details of the CoC plan were discussed in-depth. Letter received from NHSE in September 2022 by the Senior Leadership Team and position statement released to all staff that reflects that the Maternity Service will continue with the four CoC teams which were previously rolled out, with a pause on any further trajectory. The LMNS have also acknowledged the current CoC status at a touchpoint meeting on 14th October 2022.	

		All Board Level and Frontline Safety Champion exercises continued throughout the scheme pause.	
SA.10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme? Leads: Incoming Maternity and Neonatal Governance Managers. Interim Lead: Angela Winstanley	• All eligible HSIB cases have been reported to HSIB. This has been audited and cross checked against available Badger Net data with regards to inborn cooled babies and early neonatal deaths. • All families, referred to HSIB, have had information on HSIB and Early Notification/NHSR Scheme in the form of a letter and DOC documented discussion. • All Duty of Candour duties have been undertaken. • Information pertaining to HSIB reporting is included in the Perinatal Quality Surveillance Paper as well as the Trust Board Performance Report. • A full breakdown of all activity pertaining to HSIB, Duty of Candour will be presented to Trust Board in January 2022. • MIAA are intending an audit of this standard for further assurance of compliance.	

Conclusion

The Trust Board are requested to note the positive position in relation to the Maternity Incentive Scheme (CNST) Year 4. Compliance is demonstrated against the 10 Safety Actions of which evidence is available to support.

Recommendation

The Trust Board is asked to take assurance that to date all requirements have been met, evidence is available to demonstrate our compliance position and instruct the CEO to sign the Board Declaration Form.

Appendices:

Number	Title
1.	New Maternity Incentive Scheme Guidance - October 2022 https://resolution.nhs.uk/wp-content/uploads/2022/10/MIS-year-4-relaunch-October-2022-v5-Final-HV-approved-1.docx
2.	Regional Chief Midwifery SBL Survey October 2022 (Survey 7).
3.	ATAIN & TC Audit Q2 Report.
4.	MPMET, Fetal Surveillance and NLS training compliance.
5.	Legal and maternity clinical governance reports of qualifying HSIB and EN scheme incident numbers reported

Access to SBLCB v2 Survey

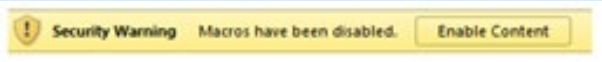
In order to reduce the burden that this survey has on the submitter's time, we have pre-populated this survey with your provider's responses from the last survey.

In the case that the status of your provider has not changed since completion of the last survey, the first question of each element will still need updating.

Please tick the box below to confirm that you understand the pre-population process and that the survey responses will need to be updated to reflect the current status of your organisation.

☑ I understand that the survey has been pre-populated with the responses from the last SBLCB v2 survey and needs to be updated with the current status of my organisation.

NB: Please ensure that you select 'enable content' when prompted by the security dialog box at the top. Without enabling macros, you will not be able to access the survey.



NEW: Saving Babies Lives Care bundle Version 2 - A care bundle for reducing perinatal mortality

This brief assurance survey is designed to gather information on progress towards full implementation of the Saving Babies' Lives Care Bundle Version 2, published March 2019. The results of this semi-qualitative self-assessment will enable NHS England, commissioners and providers to identify common problems and barriers to implementation and share effective solutions. Please base your responses on your assessment of how much of your current activities match the requirements of the care bundle.

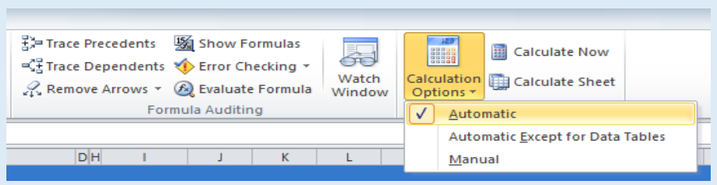
Full implementation of the care bundle and completion of the quarterly care bundle implementation survey will be included in the revised 2022/23 CNST incentive scheme, although the final details are yet to be agreed. We expect compliance with the CNST maternity incentive scheme standard to be primarily assessed using objective data submitted as part of a provider's MSDS submission, however this survey will also provide supporting information in relation to some aspects of implementation.

The technical specification available in the appendix provides guidance to help providers submit the data that will be used to assess compliance with the CNST maternity incentive scheme standard.

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 if carbon monoxide testing has not been reinstated.

The action planning template is designed to complement the survey and is optional to complete.

Please note:
The calculation setting for this workbook should be set to 'Automatic' in order for all of the functions to work correctly. In order to check this setting, please click:
-> 'Formulas' in the top ribbon
-> 'Calculation Options' to the right
-> 'Automatic' from the dropdown menu.



Saving babies Lives Version 2 - A care bundle for reducing perinatal mortality

Survey Collection Schedule

Survey 1 Collection Round: October 2019
Circulate: 4th October 2019
Collect: 5th November 2019

Survey 2 Collection Round: December 2019
Circulate: 19th December 2019
Collect: 28th January 2020

Survey 3 Collection Round: September 2020
Circulate: 22nd September 2020
Collect: 20th October 2020

Survey 4 Collection Round: January 2021
Ciculate: 20th January
Collect: 17th February

Survey 5 Collection Round: April 2021
Ciculate: 30th April
Collect: 28th May

Survey 6 Collection Round: April 2022
Circulate: week commencing 18th April
Collect: week commencing 16th May

Survey 7 Collection Round: October 2022
Circulate: week commencing 3rd October
Collect: week commencing 7th November

Update Report

Communications:	Thank you for your ongoing support to reduce the tragedy of stillbirth for families in England. This questionnaire has been designed to reflect version 2 of the Saving Babies Lives Care Bundle (SBLCB v2) published in March 2019. The main purpose of the questionnaire will be as a tool to identify areas most in need of support as maternity services work to deliver full implementation on SBLCB v2 in accordance with the associated planning guidance deliverable and condition in the standard contract. Update September 2020: The survey questions for elements 1, 2 and 5 have been amended to reflect the additional SBLCBv2 gudiance which was issued in response to the COVID-19 pandemic as described here: https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-covid-19-information/ The optional additional 'Case Study' and 'Action Planning' sections in the questionnaire for version 1 of the care bundle were well received and have therefore been retained in the questionnaire.
Programme Developments:	The Saving Babies' Lives Project Impact and Results Evaluation (SPiRE) was commissioned by NHS England and delivered by the Tommy's Centre for Stillbirth Research within the Faculty of Biology, Medicine and Health Sciences at the University of Manchester. The evaluation report, published in July 2018, confirmed the challenges and successes of implementation, the impact on maternity services and perinatal outcomes and the key factors that might affect implementation. The full report is available to download from The University of Manchester University website via the following link: https://www.manchester.ac.uk/discover/news/download/573936/evaluationoftheimplementationofthesavingbabieslivescarebundleinearlyadopternhstrustsinenglandjuly2018-2.pdf

Version two of the Saving Babies' Lives Care Bundle (SBLCBv2), was developed to build on the achievements of version one and to address the learnings identified in the SPiRE evaluation. It aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy

This element provides a practical approach to reducing smoking in pregnancy by following NICE guidance. Reducing smoking in pregnancy will be achieved by offering carbon monoxide (CO) testing for all women at the antenatal booking appointment and as appropriate throughout pregnancy, to identify smokers (or those exposed to tobacco smoke) and offer them a referral for support from a trained stop smoking advisor.

2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)

The previous version of this element has made a measurable difference to antenatal detection of small for gestational age (SGA) babies across England. It is however possible that by seeking to capture all babies at risk, interventions may have increased in women who are only marginally at increased risk of FGR related stillbirth. This updated element seeks to address this possible increase by focussing more attention on pregnancies at highest risk of FGR, including assessing women at booking to determine if a prescription of aspirin is appropriate. The importance of proper training of staff who carry out symphysis fundal height (SFH) measurements, publication of detection rates and review of missed cases remain significant features of this element.

3. Raising awareness of reduced fetal movement (RFM)

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

4. Effective fetal monitoring during labour

Trusts must be able to demonstrate that all qualified staff who care for women in labour are competent to interpret cardiotocographs (CTGs), always use the buddy system and escalate accordingly when concerns arise or risks develop. This element now includes use of a standardised risk assessment tool at the onset of labour and the appointment of a Fetal Monitoring Lead with the responsibility of improving the standard of fetal monitoring.

5. Reducing preterm birth

This is an additional element to the care bundle developed in response to The Department of Health's 'Safer Maternity Care' report which extended the 'Maternity
Safety Ambition' to include reducing preterm births from 8% to 6%. This new element focuses on three intervention areas to improve outcomes which are prediction and prevention of preterm birth and better preparation when preterm birth is unavoidable.

From the care bundle team.

Key Dates:	**Survey 5 Collection Round: <u>April 2021</u>** Circulate: 30th April Collect: 28th May **Survey 6 Collection Round: <u>April 2022</u>** Circulate: week commencing 18th April Collect: week commencing 16th May Survey 7 Collection Round: October 2022 Circulate: week commencing 3rd October Collect: week commencing 7th November

The purpose of this survey is to gather information on how much of current standard practice aligns with the interventions that make up the Saving Babies' Lives Care Bundle v2. Each intervention is made up of improvement activities. Improvement activities are the actions that make up the elements of the care bundle.

Collecting this survey allows monitoring of progress towards full implementation of the Care Bundle elements as standard practice and more importantly the identification of areas most in need of additional support with implementation. Please base your responses on your assessment of how much of your current activities match the requirements of the care bundle.

PLEASE CLICK THE ARROW TO USE THE DROP DOWN MENU TO SELECT YOUR ANSWERS.

IF THE CELL IS HIGHLIGHTED IN RED IT MEANS THE CELL IS LOCKED. PLEASE CHANGE YOUR ANSWERS TO THE QUESTIONS ASKING IF ANYTHING HAS CHANGED SINCE LAST SURVEY OR IF YOU HAVE MET ALL REQUIREMENTS OF THE ELEMENT AND THE CELLS SHOULD UNLOCK.

Please note:
The calculation setting for this workbook should be set to 'Automatic' in order for all of the functions to work correctly. In order to check this setting, please click:
-> 'Formulas' in the top ribbon
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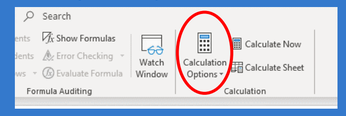

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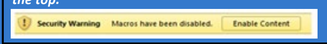

Survey Number	7th
Survey Date	Oct-22

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.*	No
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.*	Yes
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.*	**Yes**
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?	Yes
1f. If you answered "no" to question 1b, are you planning on introducing this type of intervention / improvement activity?	**Not Applicable**

Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element 1 of SBLCBv2 or submitting the required data to MSDSv2; and to provide details of any learning developed as a result of the implementation.

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.*	Yes
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.*	**Yes**
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?	Yes
2i. Have all findings of small for gestational age fetuses been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	Yes
2j. If you answered "no" to 2b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element 2 of SBLCBv2 or submitting the required data to MSDSv2; and to provide details of any learning developed as a result of the implementation.

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.***	No
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.***	Yes
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?	Yes
3h. If you answered "no" to 3b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element 3 of SBLCBv2; and to provide details of any learning developed as a result of the implementation.

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.**	No
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 80% to 89%
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**

Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element 4 of SBLCBv2; and to provide details of any learning developed as a result of the implementation.

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.***	No
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

Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element 5 of SBLCBv2 or submitting the required data to MSDSv2; and to provide details of any learning developed as a result of the implementation.

Please fill in the following details	
Name of person completing the form	Angela Winstanley
Job Title	Qulaity & Safety Matron
Hospital Name	
Trust Name	Click to Select
Trust Code	Automatic
SCN Area	North West Coast
Please provide information here if the drop-down boxes do not include the correct information for your trust	Free Text Box

Saving Babies Lives - Updates & Action Planning

The implementation survey gives a good insight into implementation trends but does not in itself increase levels of implementation of the care bundle. This action planning section is designed to complement the survey and support an increase in the levels of implementation by encouraging the development of explicit actions that outline how progress will be made and address the specific barriers faced by a particular trust.

Action Plan

R	Red: Immediate remedial action required to progress this activity
A	Amber: Action required for successful delivery of this activity
G	Green: Activity on target
B	Black: Completed activity

Recommendation Number	Recommendation	Action plan to address recommendation	Action progress against plan	Action priority 1 = Critical (Under 1 Month) 2 = Essential (1-3 Months) 3 = Recommended (over 3 months)	Action owner	Baseline date	Forecast date	Closure date	Current status
1									
2									
3									
4									
5									
6									

7									
8									
9									
10									
11									
12									

Appendix: Technical Specification

The technical specification attached provides guidance to help providers submit the data that will be used to assess compliance with the CNST Incentive scheme standard.

SBLCBv2 MSDS v2.0
Technical Glossary
(for publication)

APPENDIX 3

Liverpool Women's NHS Foundation Trust

Combined report for

Review of Term and Late Preterm Admissions to the Neonatal Unit

ATAIN 2022-23

and

Transitional Care admissions audit

TC audit 2022-23

Quarter 2 July – September 2022

ANNP Paula Nelson

ANNP Sarah Brownrigg

Dr Helen Sacre

Dr Mahalakshmi Neerukonda

Dr Anna Paweletz

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Overview

1. Review of Term and Late Preterm Admissions to the Neonatal Unit ATAIN
   1.1. Term admission
   1.2. Late Preterm admissions
   1.3. Conclusions
2. Transitional Care admissions Audit
   2.1. Background
   2.2. Aims & Objectives
   2.3. Methodology
   2.4. Audit standards and criteria
   2.5. Results
   2.6. Conclusion
3. Summary
4. Actions

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1. Review of Term and Late Preterm Admissions to the Neonatal Unit ATAIN

Purpose

This report summarises the findings of weekly MDT meetings undertaken jointly by the obstetric and neonatal teams which review all babies delivered at ≥ 34+0 weeks gestation who were admitted to the neonatal intensive care unit (NICU).

Categorisation and Review

The review team classifies each admission to NICU as follows:

- **Appropriate** – admission to NICU was unavoidable. This may include expected admissions such as congenital abnormality or unexpected admissions where all care pathways and guidance have been followed but the baby still required NICU support.
- **Appropriate but avoidable** – issues in care or practice were identified which may have reduced the risk of admission to NICU, for example compliance with care pathways and guidance.
- **Inappropriate** – identified issues in care that have impacted on the admission to NICU or where the admission could have been avoided by appropriate use of transitional care.

1.1. TERM ADMISSIONS

(Previous quarter shown for comparison)

	Total term livebirths	Term admissions	Appropriate but avoidable (of Term admissions)	Inappropriate (of Term admissions)	Total potentially avoidable (of Term admissions)
Q1 2022-23	1666	89 (5.3%)	6 (6.7%)	2 (2.2%)	8 (9.0%)
Q2 2022-23	1759	71 (4 %)	10 (14%)	2 (2.8%)	12 (16.9%)

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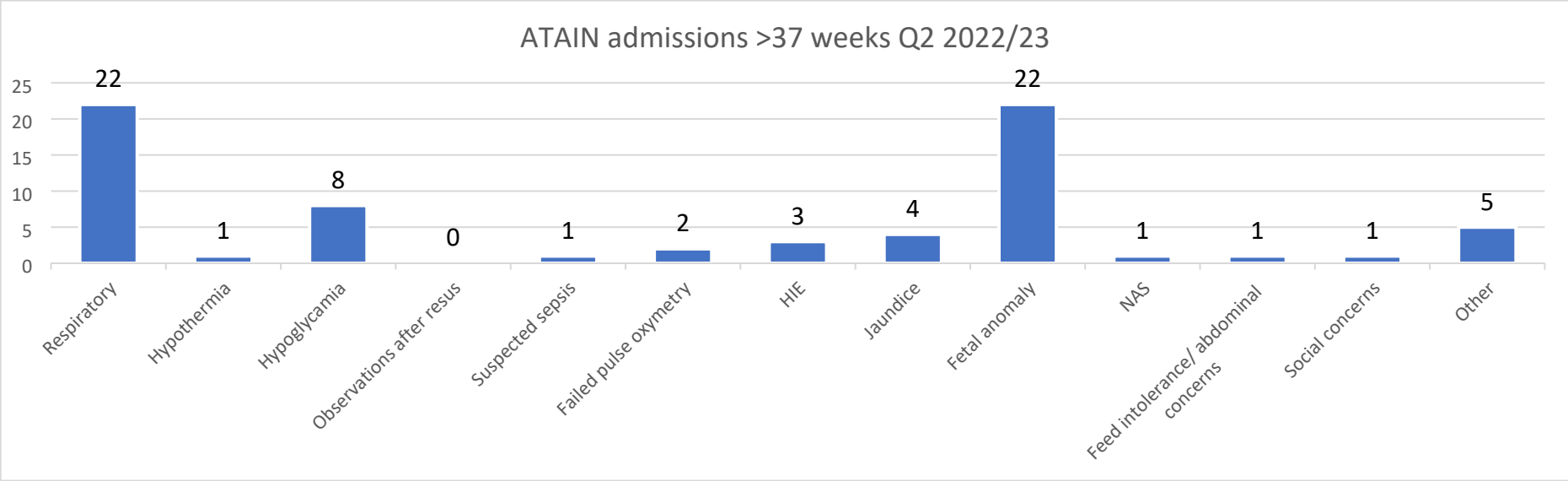
A total of 71 infants > 37 week gestation were admitted to NICU, which is a marked decrease compared to Q1 2022/23. The most common reason for Term admissions to NICU were Respiratory distress (n=22) and Fetal anomaly (n=22). The proportion of infants with Fetal anomaly increased in this quarter from 15.7% to 35.2%. Other reasons for admission included Hypoglycaemia, Failed pulse oximetry, Feeding problems, HIE/seizures, Jaundice, Neonatal abstinence syndrome, Social concerns, Hypothermia and Suspected sepsis.



There were 10 Term admissions to the NICU that were deemed appropriate but avoidable:

- Respiratory symptoms (n=3). One infant required intubation and ventilation (consented to SurfON trial). This baby was born via elective Caesarean Section and did not receive antenatal steroids prior to delivery. Further admissions included a baby with an initial oxygen requirement which settled shortly after admission to NICU and a baby with a dusky episode at almost 3 hours of age who was hypothermic on admission.

- Hypoglycaemia (n=1). This admission was deemed appropriate but potentially avoidable as the baby only received a small milk volume prior to admission. Baby was also hypothermic on arrival in NICU (36.9C).
- HIE (n=2). Two term infants born in poor condition and requiring cooling treatment were deemed appropriate but potentially due to obstetric reasons (delay in ARM and delivery).
- Jaundice (n=1). A term infant was admitted aged 36 hours with a Bilirubin level above exchange line. The infant had not received phototherapy treatment for 16 hours prior to admission, despite high Bilirubin levels.
- Social concerns (n=1). Baby was admitted to NICU as mother self discharged and baby was awaiting Foster care placement.
- Other (n=2). Two term infants were admitted to NICU for a period of observation after falls from maternal beds.

There were 2 Term admissions to the NICU that were deemed to be inappropriate:

- Baby admitted with hypothermia (n=1). A baby on the Small Baby Pathway was admitted to NICU at the age of 4 hours with a Temperature of 34.9C and a low heart rate of 80 bpm. The infant had been in an incubator on the PNW for 2 hours, which was set at 32C. Baby had not been reviewed on PNW at 2 hours of age as the medical team had not been made aware of baby.
- Baby admitted for examination and echocardiography as per FMU plan. This was deemed inappropriate as baby could have remained with parents on postnatal ward.

There were no term admissions in this quarter due to lack of transitional care (TC) capacity or staffing problems.

1.2. LATE PRE-TERM ADMISSIONS (34+0 to 36+6 week gestation)

(Previous quarter shown for comparison)

	Total late preterm livebirths	Late preterm admissions	Appropriate but avoidable	Inappropriate	Total potentially avoidable
Q1 2022-23	112	45 (40.2%)	5 (8.9%)	0	5 (11.1%)
Q2 2022-23	125	29 (23.2%)	3 (10.3%)	1 (3.4%)	4 (13.7%)

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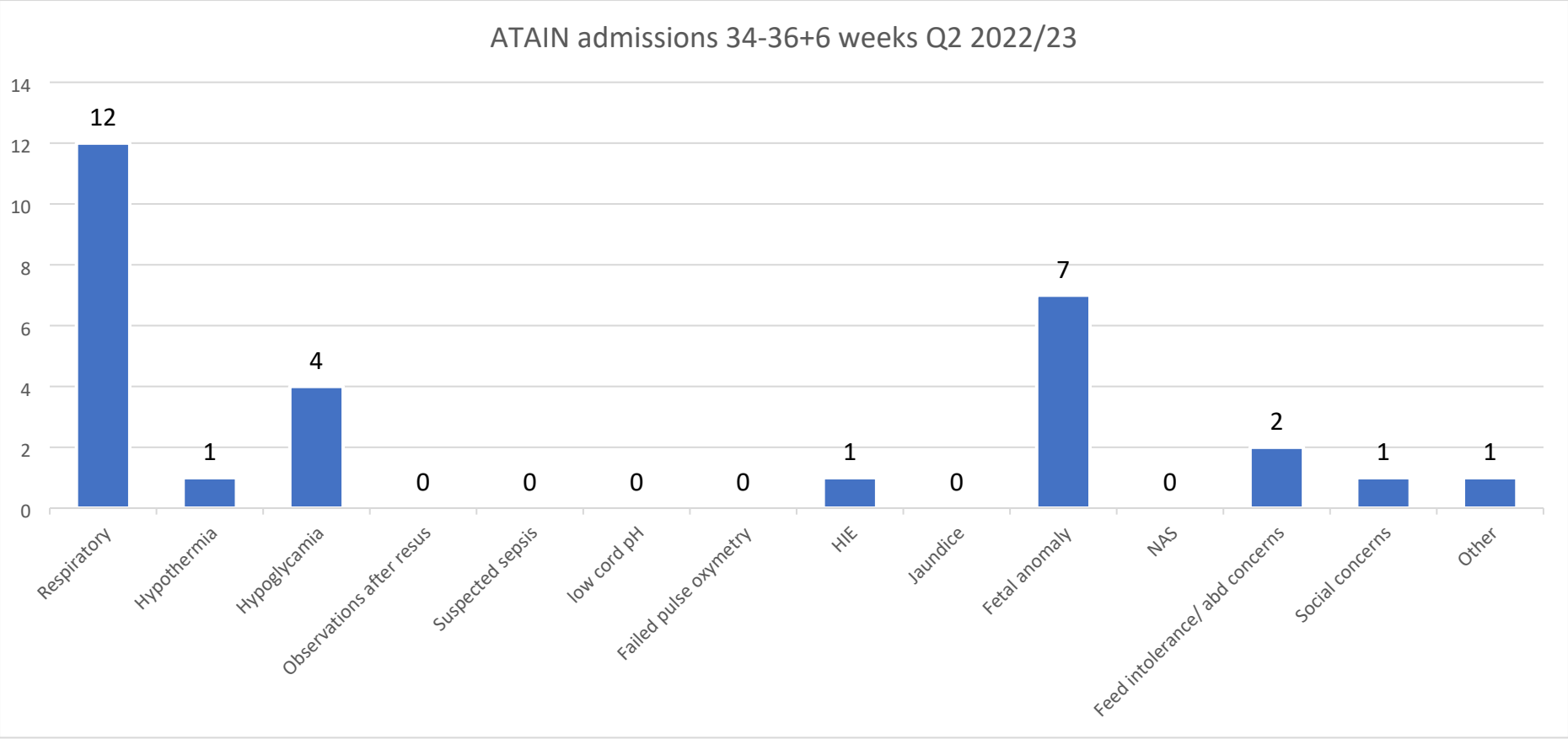

The most common reason for late preterm admission to NICU remains Respiratory distress (n=12), followed by Fetal anomaly (n= 7) and Hypoglycaemia (n=4). Other reasons included Social issues, Hypothermia, HIE/ Seizures, Feed intolerance and other.

APPENDIX 3

There were 3 Late-preterm admissions to the NICU that were deemed appropriate but avoidable:

- Baby born at 36+1 weeks with hypoglycaemia which required treatment. Baby did not receive appropriate 10ml/kg feed volume prior to admission.
- Baby born at 36+2 weeks gestation admitted for social reasons. Baby required phototherapy treatment for jaundice, Mum was discharged home as caring for other children.
- Baby born at 36+1 weeks was admitted at the age of 10 minutes with unrecordable temperature and a dusky episode (temperature on admission 35.9C). Baby required high flow oxygen for > 24 hours and received a course of antibiotics for raised CrP.

There was 1 Late-preterm admissions to the NICU that were deemed inappropriate:

- Baby born at 35+6 weeks, admitted to NICU with respiratory distress and hypothermia. There was no oxygen requirement on admission. The admission was deemed avoidable as baby could have been monitored and received thermoregulatory support prior to admission.

There were no Late-preterm admissions in this quarter due to lack of transitional care (TC) capacity or staffing problems.

1.3. CONCLUSIONS

Despite an increase in total live births for term infants, the proportion of term babies admitted to the neonatal unit in this quarter was 4%, which is a small decrease from 5.3% compared to Q1. There is a sustained low level of inappropriate term admissions, however a relative increase in potentially avoidable term admissions (14% compared to 6.7% in Q1). There was an increase in the total late preterm live birth rate compared to Q1, however a decrease in total late preterm admissions in Q2 compared to Q1, with a steady and sustained decrease in the proportion avoidable late preterm admissions. One late preterm admission was deemed inappropriate. There were no term or late- preterm admissions in this quarter due to lack of transitional care (TC) capacity or staffing problems.

APPENDIX 3

Appropriate but avoidable admissions:

1. Term admissions (n=10 (14%))

   The total live births increased in Q2 compared to Q1 (1759 versus 1666). Despite this, the proportion of term babies admitted to the neonatal unit in this quarter was 4%, which is a small decrease from 5.3% compared to Q1.

   Within the term population, there was an increase in potentially avoidable admissions to 14%. The most identified problems leading to potentially avoidable admissions in Q2 2022/23 were admissions related to Respiratory distress (n=3). HIE (n=2), Hypoglycaemia (n=1), Social concerns (n=1), Sustained falls (n=2) and Jaundice (n=1) were further reasons for potentially avoidable admissions. Whilst the infant admitted with low blood sugars did not receive adequate milk volumes prior to NICU admission, the baby with jaundice was admitted with a jaundice level near exchange line and had not received phototherapy. This was perceived as a near miss.
   Two babies were admitted with HIE for cooling treatment following neonatal resuscitation. In both cases it was felt that obstetric management potentially contributed (delay in ARM and delivery).
   Similar to Q1 there were two admissions of babies after a fall. Both babies sustained a fall from mother's hospital beds. There were no term admissions in this quarter due to lack of transitional care (TC) capacity or staffing problems.

2. Late Preterm admissions (n=3(10.3%))

- There were a total of 3 appropriate but avoidable late preterm admissions to NICU. One baby was admitted for social reasons awaiting a Foster placement. A further infant was admitted with hypoglycaemia requiring treatment. It was felt that the infant had not received sufficient milk volumes prior to admission. The third a Baby was admitted with unrecordable temperature and a dusky episode.

APPENDIX 3

Inappropriate admissions

1. Term admissions (n=2 (2.8%))

   The number of inappropriate term admission remained unchanged (n=2).

   - Baby was placed on the Small Baby Pathway, however, was not reviewed, as the medical team was not informed. Was placed in incubator set at 32C. Admitted at the age of 4 hours with hypothermia of 34.9C and bradycardia (heart rate 80). Baby's observations normalised (although continued to have an oxygen requirement). Septic screen was negative.
   - Baby admitted for examination and echocardiography as per FMU plan. This was deemed inappropriate as baby could have remained with parents on postnatal ward.
   -

2. Late Preterm admissions
   - One late preterm baby was admitted to NICU inappropriately in this quarter. The baby born at 35+6 weeks gestation initially presented with respiratory distress and hypothermia. On admission to NICU oxygen therapy was no longer needed. The admission was felt to be inappropriate as baby could have received thermoregulatory support and monitoring on the postnatal ward.
   -

APPENDIX 3

2. Transitional Care Admissions Audit

2.1 BACKGROUND / RATIONALE

The transitional care unit prevents unnecessary separation of mother and baby and reduces admission to the neonatal unit. It is an area for mothers who are well following delivery to care for their weight baby with the additional support and encouragement from the transitional care team who provide care that exceeds normal routine care.

CNST Maternity Safety Action 3 relates to transitional care activity, specifically asking trusts to demonstrate that they have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme. This audit serves to look at compliance with this action, specifically looking at the use of transitional care in line with unit guidelines (Transitional Care Admission Criteria 2021 (version 11-NICU 34) guideline).

Currently a separate audit report on Avoiding Term Admissions into Neonatal Units (ATAIN) is produced. From Q1 2022 these reports will be merged and continue to be produced on a quarterly basis.

2.2 AIMS & OBJECTIVES

The aim of this audit is to assess compliance with the Transitional Care (TC) Admission Criteria of LWH (2021 – version 11– NICU 34) between 01.07.2022 and 30.09.2022.

2.3 METHODOLOGY

All admissions to the Transitional care unit between 01.07.22 and 30.09.22 were assessed. A BadgerNet search was performed to identify these babies.

Inclusion and exclusion criteria:

Babies that have received at least one day of transitional care, in line with BAPM 2011, HRG definitions, and LWH Transitional Care Guideline. Babies who were still an inpatient on TC on 30/9/22 were excluded from this audit.

APPENDIX 3

Details regarding the date of birth, gestation, gestation at admission, birth weight, gender, date of admission to TC, reason for admission to TC (In line with TC guideline on Badger). Where the baby was admitted from, if the baby was admitted from NICU if this was due to no TC availability and whether they were referred to the community team at discharge.

2.4 STANDARDS / CRITERIA THAT WILL BE AUDITED

100% of the admissions to transitional care should be in accordance with the admission criteria (as outlined in Transitional Care Admission Criteria 2021 (version 11-NICU 34) guideline

- Babies 34- 35 weeks gestation as per current TC guideline. To comply with CNST requirements (safety section 3), babies born between 34 and 36+6 weeks gestation who neither had surgery nor were transferred during any admission were included
- Birth weight below 1.8kg
- Admission following joint review from 'Small Babies Pathway (2020)' for TC admission (Babies < 2.5kg and < 35 weeks gestation at birth)
- Admission for nasogastric tube feeding
- Babies >33 weeks gestation who have been stable for 72 hours from Neonatal Unit and using

  apnoea mattress or stable for at least 24 hours off any form of respiratory support
- Other – Specify (Consultant decision, maternal input needed)
- Other topics reviewed (no pre-audit standards set - Benchmarking):
  - Number of special care or normal care days where supplemental oxygen was not delivered in babies between 34 and 36+6 weeks gestation (CNST requirement, safety section 3). This was evaluated for infants initially admitted to NICU.
  - Place admitted from (including TC bed unavailability)
  - Referral to Liverpool Women's Hospital Neonatal Community Outreach team.

2.5 RESULTS

Between 01.07.2022 and 30.09.2022, there were 49 babies who met the inclusion criteria.

- Average occupancy of the TC unit during this period was 66.9% compared to 51.2% in Q1
- Average weight 2397g (range 1540g -3800g)
- Gestation range (at admission) 33+4 to 41 +2
- 31 male infants, 18 female infants
- Length of stay on TC ranged from 36hrs to 17 days. The average stay was 6.8 days. This was slightly longer than in the previous quarter (5.9 days).
- The average age at TC admission was 2.6 days with a range from 1-14days which was similar to Q1

All babies met TC criteria for admission to TC – 100% complaint.

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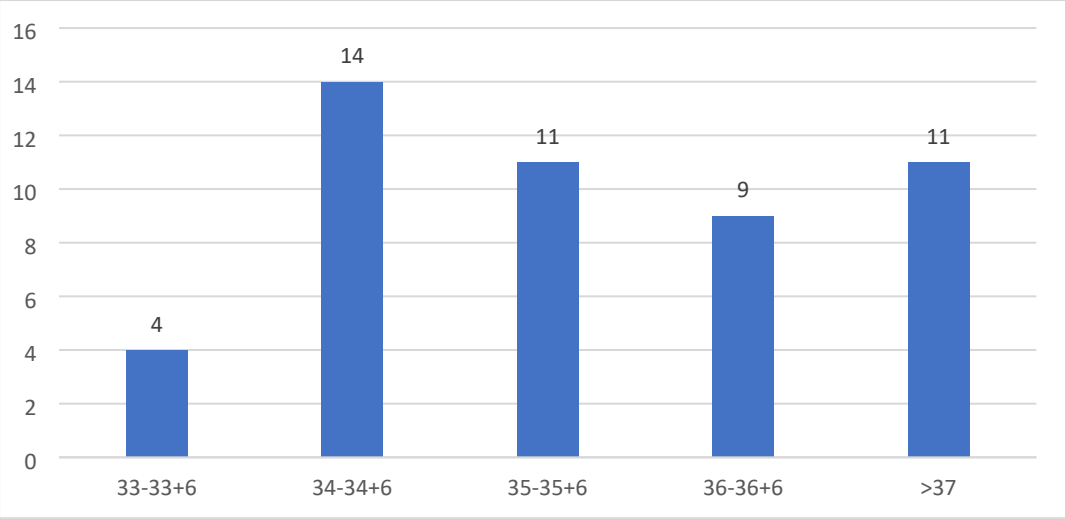
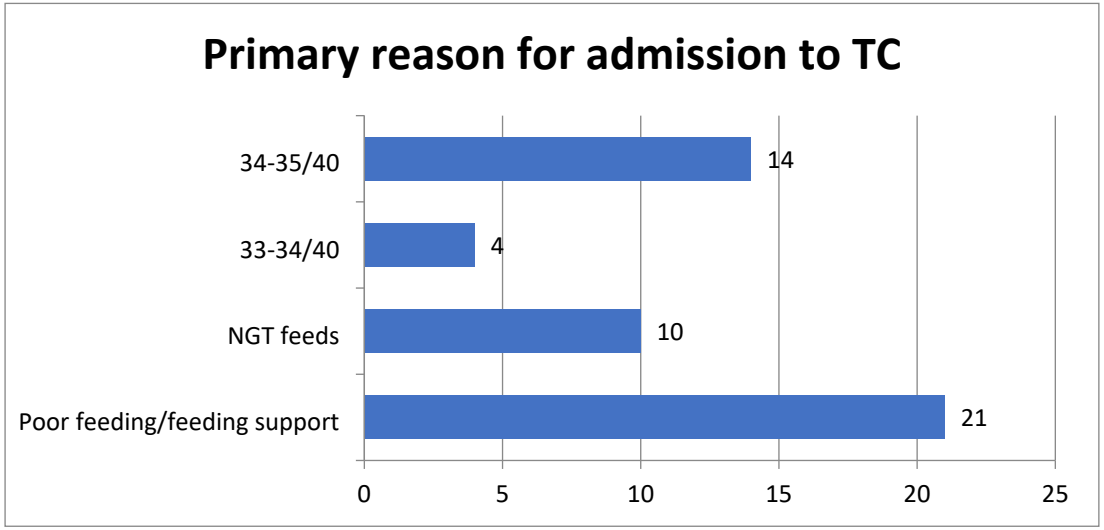


Details of gestations of babies admitted to TC



Primary reason for TC admission

APPENDIX 3

Details per gestation:

33-33+6 = 4

- All admitted via NICU (None admitted to NICU due to lack of TC bed)
- All admitted due to gestational age for Nasogastric tube feeding and thermoregulation
- 1 was <1.8kg

34-34+6 = 14

- 4 admitted from NICU (None admitted to NICU due to lack of TC bed)
- 10 admitted from theatre/ward due to gestational age for feeding support
- 2 of these babies also had a birthweight of <1.8kg

35-35+5 = 11

- 5 admitted for NGT feeding
- 6 admitted with poor feeding and feeding support

36-36+6 =9

- 3 admitted for NGT feeds
- 6 admitted with poor feeding and feeding support
- 1 of whom was <1.8kg, and 1 was hypoglycaemic

>37 = 11

- All admitted due to poor feeding/feeding support one of whom had a cleft palate

In this Quarter there was no admissions to TC with Hypothermia.

APPENDIX 3

Benchmarking:

No babies this quarter were identified to have been admitted to NICU for special care or normal care days who could have been cared for in TC setting (34-36+6/40). All babies this gestation admitted to NICU were either receiving respiratory support or IV fluids.

Place babies were admitted from:

A large proportion of babies were admitted via NICU (17 babies), all for valid reasons (not focused on in this audit), none due to no TC availability. All remaining admissions were from Delivery Suite (15 babies) and Postnatal Ward (17 babies).

TC bed unavailability

No babies this quarter were documented as being admitted to NICU due to no TC beds.

Babies referred to neonatal community outreach team-Benchmarking

46 babies were referred for local community follow up either due to meeting eligibility or deemed to require some additional support. 2 babies were out of the community outreach catchment area. 1 did not require support.

2.6 CONCLUSIONS

This audit demonstrates that transitional care is a busy and active part of the neonatal care provided at Liverpool Women's Hospital. It prevents unnecessary separation of mother and baby and reduces admission to the neonatal unit. It can be seen from the data above that the transitional

care service supports the recommendations outlined in the CNST action plan (standard 3), and its use is in line with the unit guidelines on the whole.

It is important to note that there may be some overlap between the reasons for admission to TC, e.g. 'babies 34 - 35 weeks gestation' and 'babies below 1.8Kg', though for the purpose of this audit, the primary reason documented on Badger was used.

The number of babies admitted to TC each Quarter is increasing. Jan-March 2022 saw 26 babies. April-June 41 babies, and July to sept 49.

Occupancy has been adjusted this quarter to take into account the extra 2 cots providing capacity for twins only, as there are 6 maternal beds with 8 cots. Taking this into account the occupancy for quarter 1 has been recalculated at 38%, with an increase in quarter 2 to 51%

There were more boys than girls in this time period (31 boys and 18 girls). The length of stay averaged at 6.8days in Q 2 (compared to 5.9 days in Q 1 and 8.9 days in the previous Q4 2021/22). All admissions met TC criteria. A large proportion of babies were admitted via NICU (17 babies), all other admissions came from DS and PNW.

All babies meeting TC criteria were cared for in the TC setting. All babies admitted to NICU were receiving some degree of acute support such as respiratory support or IV fluids or Jaundice at exchange level.

The primary reason for admission was documented. 18 babies were admitted on gestation criteria (33-35/40), 10 babies for NGT feeding, 21 were admitted due to poor feeding/feeding support, all of whom were over 35/40. The 3 babies who were <1.8kg were either 33 or 34/40 so would have been admitted on gestation alone. No babies were admitted due to hypothermia compared to 3 in the previous Quarter.

As a part of the Transitional care service, staff oversee babies on the small baby pathway. This service prevents admission to NICU due to the support they provide and identifies early, babies that require escalation of care and therefore admission. The pathway is currently a paper document and is not clearly documented on Badger, therefore is not currently included in this audit.

46 out of 49 babies were referred for community neonatal outreach support in the Liverpool area, all were reviewed regularly at home after discharge. 19 Of these babies were out of the standard NCOT referral criteria (<35/40 at birth and/or <2.3kg at discharge) but were deemed to require additional support for various reasons such as weight monitoring, feeding support or parental support. This demonstrates that a robust referral process to the community team is in place, ensuring adequate support for all families post discharge. 2 babies lived out of catchment area, 1 did not require additional support.

APPENDIX 3

Documentation as to whether an eligible baby remained on NICU due to lack of TC beds was not evident this quarter. No admissions were identified as inappropriate through the ATAIN process. The primary reason for TC admission was not consistently documented.

ACTIONS

1. Dissemination of these audit findings to the wider neonatal team – Neonatal MDT and presenting in Neonatal Clinical Governance Day as well as Maternity, Neonatal and Board level safety champions, LMNS and ICS quality surveillance.
2. The TC documentation audit has completed data collection- and is currently in the process of writing the report. The findings will be presented in Neonatal Clinical Governance when available (Emily Hoyle/ Sonya Devine/Holly Evans)
3. A designated Consultant (Anna Paweletz) and Lead ANNP (Paula Nelson) will complete quarterly audit and reports as per CNST requirements.
4. Improved/expanded facilities are required to enable LWH to offer equivalent facilities to TC parents as NICU parents currently receive. The TC ward has been moved to a more suitable area within the postnatal ward and there are plans in place to renovate the area and bring it in line with NICU standards for parents- renovations still awaited.
5. Aim to move towards electronic Small baby pathway documentation (Badger or K2) to enable better information gathering and inclusion into the TC audit.

APPENDIX 3

3. SUMMARY

ATAIN

The ATAIN report demonstrates a small decrease in the overall number of term and late preterm admissions in Q2 2022/23, despite an increase in total term and preterm live births. The number of avoidable term admission as slightly increased, while avoidable term admissions have remained stable low. The number of avoidable late preterm admissions remains low. There was one inappropriate late preterm admission to NICU in Q2 2022/23. In this quarter, the most commonly identified reason for admission in both term and late preterm infants was Respiratory distress and Fetal anomaly. A total of 24 term infants were admitted to NICU with Respiratory distress. Three of these admissions were deemed appropriate but avoidable. In the late preterm group, a total of 12 infants were admitted for respiratory distress, one of which was considered an avoidable admission. All respiratory admissions had been delivered by C/S or EMCS. Apart from one infant, who was intubated for SurfON trial, all other infants required a small amount of oxygen and had negative septic screens. In admission, two babies admitted with Respiratory distress also were hypothermic. We should consider a respiratory pathway for babies born via C/S with no other risk factors for sepsis. This would set out acceptable saturations and management of temperature in the recovery room, to allow infants to stay with parents where possible. There is an ongoing education program regarding management of hypothermia and hypoglycaemia and numbers of infants admitted for those reasons remain stable. Over the coming weeks we will be trialling mOm incubators and Kanmed twin cots. These portable and space saving units could be used on postnatal ward and TC to manage babies at risk of hypothermia. In addition, a QI should be considered to reduce admissions with hypothermia. Two infants have been admitted to NICU in Q2 following falls from maternal beds. In Q1 three infants were admitted for similar reasons.
Currently, septic screens for infants from DS or the PNW are performed in the treatment room on NICU, where the first dose of antibiotics is administered. Whilst we welcome parents to be present, to be fully compliant with CNST requirements, septic screens and administration of antibiotics should be performed on the postnatal ward to minimise separation. This will require a wide-reaching educational program. An initial meeting to develop this is planned for November 2022.

There was an increase in babies with Fetal anomalies both in the term and late preterm group in Q2. There were no term or late preterm admissions in this quarter due to lack of transitional care (TC) capacity or staffing problems.

TC audit

The number of babies admitted to TC each Quarter is increasing. Jan-March 2022 saw 26 babies. April-June 41 babies, and July to sept 49 and capacity has increased. TC is now providing a total of 8 cots for six maternal beds, allowing accommodations of twins. The length of stay averaged at 6.8days in Q 2 (compared to 5.9 days in Q 1 and 8.9 days in the previous Q4 2021/22). All admissions met TC criteria.

Primary reasons for admission to TC included babies admitted on gestation criteria (33-35/40) NGT feeding or feeding support. No babies were admitted due to hypothermia compared to 3 in the previous Quarter.

As a part of the Transitional care service, staff oversee babies on the small baby pathway. This service prevents admission to NICU due to the support they provide and identifies early, babies that require escalation of care and therefore admission. The pathway is currently a paper document and is not clearly documented on Badger, therefore is not currently included in this audit.

46 out of 49 babies were referred for community neonatal outreach support in the Liverpool area, all were reviewed regularly at home after discharge. This demonstrates that a robust referral process to the community team is in place, ensuring adequate support for all families post discharge. 2 babies lived out of catchment area, 1 did not require additional support.

TC bed availability

Documentation as to whether an eligible baby remained on NICU due to lack of TC beds was not always clearly evident from Badger documentation. Cross referencing with ATAIN data it appears, that in this Quarter no babies remained on NICU due to TC bed unavailability. The primary reason for TC admission was not consistently documented.

APPENDIX 3

TC audit ACTIONS

1. Dissemination of these audit findings to the wider neonatal team – Neonatal MDT and presenting in Neonatal Clinical Governance Day as well as Maternity, Neonatal and Board level safety champions, LMNS and ICS quality surveillance.
2. The TC documentation audit has completed data collection- and is currently in the process of writing the report. The findings will be presented in Neonatal Clinical Governance when available (Emily Hoyle/ Sonya Devine/Holly Evans)
3. A designated Consultant (Anna Paweletz) and Lead ANNP (Paula Nelson) will complete quarterly audit and reports as per CNST requirements.
4. Improved/expanded facilities are required to enable LWH to offer equivalent facilities to TC parents as NICU parents currently receive. The TC ward has been moved to a more suitable area within the postnatal ward and there are plans in place to renovate the area and bring it in line with NICU standards for parents- renovations still awaited.
5. Aim to move towards electronic Small baby pathway documentation (Badger or K2) to enable better information gathering and inclusion into the TC audit.
6. Trial of mOm incubators and Kanmed twin cots planned to improve management of hypothermia on TC.

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ATAIN

ATAIN Action	Narrative	Owner	Target date	Evidence required	Status
Education and training around prevention and management of hypothermia/hypoglycaemia	Include a presentation (monthly) delivered by ANNP at regular Fetal Surveillance sessions	Fiona Chandler/ Sarah Brownrigg/ Sarah Howard	December 2022	1. Presentation 2. Records of sessions/attendance 3. Set up QI to reduce hypothermia 4. Trial mOm incubators and Kanmed twin cots	Regular education session delivered by ANNP initiated as part of fetal surveillance study days. Teaching session delivered and planned. Attendance not provided. - 12/7/22 - 27/7/22 - 21/9/22 ATAIN 2022 Mat 2 presentation Q2_.pptx
Start midwives undertaking eLFH ATAIN module	One-off, nationally approved online training	Emma Pimblett	September 2022	Download of numbers of midwives completing online module	eLFH ATAIN module as per 16.09.22 is 73.54% eLFH compliance Q2 2022.23.png
Education/training (around CTG interpretation, risk assessment, escalation process when signs of concern)	To be included in Fetal Surveillance sessions	Ange Winstanley/ Fiona Chandler/ Kate Alldred	June 2023	1. Presentation 2. Records of sessions/attendance	Local risk assessment and esc Fetal Surveillance Day introduction an Fetal Surveillance & SVBLCBv2 Study Fetal surveillance Q2 2022.23.png

APPENDIX 3

Education around recognition and management of respiratory distress	Lesson of the week (LOTW) reminder	Sarah Brownrigg	September 2022	LOTW shared week commencing 29/8/22	ATTAIN Lesson of the week Sept 2022.docx
Management of mothers delivering in a standing position	Ongoing incident review	Laura Thorpe	September 2022	Incident review completed and findings shared Birthing mats to be used	Lessons learned: Preparations for birth when standing to include the use of a birth mat and maintained close observation. Actions: Birthing mats ordered for both intrapartum areas DS and MLU for use when delivery in standing position Feedback provided to staff involved
Infants sustaining falls from maternal beds on postnatal ward	1. Falls linked to C/S deliveries 2.Multi agency safe sleep policy to be updated (escalated to local safeguarding board and Corporate risk aware)	Joan McDonald /Alison Murray	September 2022	To update Safe Sleeping policy	1.Plan to purchase "over the bed cots" for mothers who delivered by C/S. Further update awaited (Joan McDonald) 2.Multi-agency Safe Sleeping policy expired. Current policy extended as per corporate risk. Once revised needs to be adopted at LWH. Further update awaited (Alison Murray)
Develop respiratory and thermoregulation pathway for babies born by C/S	Saturation and Temperature guidance to reduce admissions with respiratory	Sarah Brownrigg/ Anna Paweletz/ Laura Thorpe	September 2023	1. Pathway development 2. Teaching sessions	First meeting planned 11/22

	distress following CS				
Development of postnatal antibiotic pathway	Minimise separation by performing septic screens and administering first dose of antibiotics on PNW/ DS	Alex Cleator/ Anna Paweletz/ Sally Ogden/ Sarah Brownrigg	September 2023	Initial meeting planned for November 2022 to discuss development of pathway.	First meeting planned 11/22

APPENDIX 3

CNST May 2022

Safety action 3 Standards

- a- Jointly approved pathway of care TC pathway - ***In place***.
- b- pathway fully implemented and audited on quarterly basis. - ***Quarterly combined TC and ATAIN findings are shared appropriately.***
- c- a electronic data recording process for all babies admitted to NICU- ***In place (BadgerNet).***
- d – data recording process in place to monitor existing TC capacity and captures babies between 34+0 and 36+6 weeks gestation who neither had surgery, nor were transferred during any admission, t monitor the number of special care and normal care days where supplemental oxygen was not delivered. – ***In place (TC audit)***
- e- Commissioner return for HRG activity are available to be shared with ODN, LMNS and commissioners.
- f- reviews of babies admitted to NICU continue on a quarterly basis and are shared with the Board Level Safety Champion. Reviews should include all neonatal unit transfers and admissions regardless of their length of stay and /or admission to BadgerNet- ***all admissions to NICU, regardless of length of stay, are recorded on BadgerNet. TC bed availability and infants requiring nasogastric tube feeding recorded in TC audit. Findings shared appropriately.***
- g- Action plan agreed
- h- progress with revised ATAIN action plan- ***shared.***

APPENDIX 4

CNST SA8	Staff Group	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	
SA 8b. MPMET	Midwives	13%	19%	22%	38%	61%	76%	78%	78%	80%	78%	93%	
	Maternity HCA	10%	19%	21%	30%	49%	69%	75%	75%	71%	74%	91%	
	Cons Obstetrician	6%	10%	46%	62%	71%	71%	71%	71%	84%	85%	90%	
	Trainee Obstetrician	9%	20%	51%	64%	91%	97%	97%	97%	29%	53%	91%	New rotation in August
	Cons Anaesthetist	6%	13%	26%	26%	26%	37%	37%	37%	50%	69%	94%	
	Trainee Anaesthetist	11%	44%	44%	11%	33%	55%	55%	55%	12%	16%	100%	New rotation in November
SA 8c. Fetal Surveillance	Midwives	2%	7%	19%	28%	53%	72%	78%	78%	85%	88%	98%	
	Cons Obstetrician	2%	10%	20%	35%	60%	63%	74%	74%	74%	84%	96%	
	Trainee Obstetrician	0%	13%	39%	63%	67%	80%	83%	83%	24%	73%	93%	New rotation in August
SA 8d. NLS	Midwives	13%	19%	22%	39%	62%	76%	78%	78%	80%	83%	95%	Delivered on MPMET day
	Cons Neonatologist	94%	94%	94%	94%	100%	100%	100%	100%	100%	100%	100%	
	Trainee Neonatologist	95%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	New rotation March & September
	ANNPs	62%	85%	88%	88%	88%	86%	93%	93%	96%	100%	100%	
	Neonatal Nurses	80%	84%	89%	89%	89%	89%	96%	99%	99%	100%	100%	

Appendix 5

MAIN REPORT

The National Maternity Safety Strategy in 2015 set out the NHSE Department of Health and Social Care's ambition to reward Maternity Trusts who have taken action to improve maternity safety, with the introduction of the Maternity Incentive Scheme (MIS). The Trust have been operating Year 4 of the scheme since its release in August 2021.

Safety Action Ten of the MIS Scheme sets out a mandate that Trust Boards are sighted and assured of three reporting standards.

These standards include:

a) Reporting all qualifying cases to Healthcare Safety Investigation Branch (HSIB) from 1st April 2021 to 5th December 2022.

b) Reporting of all qualifying Early Notification cases to NHS Resolutions (NHSr) Early Notification (EN) Scheme from 1st April 2022 until 5th December 2022.

c) All qualifying cases which have occurred during the period 1st April 2021 to 5th December 2022, the Trust Board are assured of the following:

i. The family have received information on the role of HSIB and NHSR EN Scheme, and

ii. There has been compliance, where required, with regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

Evidential standards Required for Trust Board

Safety action 10, in the MIS scheme lays out the minimum evidential standards required for Trust board, these are:

- Trust Board sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution.

- Trust Board sight of evidence that the families have received information on the role of HSIB and the EN scheme.

- Trust Board sight of evidence of compliance with the statutory duty of candour.

Cases that qualify for HSIB Referral fall into the following categories:

There are set criteria that clinical cases must meet to necessitate a referral by the Trust to HSIB. The criteria are as follows:

- All births must be of ≥37+0 completed weeks of gestation, following labour, that resulted in severe brain injury diagnosed in the first seven days of life, born in the Trust. These are any babies that fall into the following categories:

    o Was diagnosed with Grade III Hypoxic Ischaemic Encephalopathy (HIE)

    [OR]

    o Was Therapeutically Cooled (active cooling only)

    [OR]

    o Had decreased central tone AND was comatose AND had seizures of any kind.

- Any Intrapartum Stillbirth – where the baby was thought to be alive at the start of labour but was born with no signs of life (as per Each baby Counts definition of labour).

- Any early neonatal death within 7 days of birth (≥37+0, excluding congenital abnormalities)

- Direct or Indirect Maternal Deaths up to and within 42 days of the end of pregnancy (excluding suicide and homicide)

The full standard operating procedure for referral to HSIB can be found the Trust intranet.

Reporting to NHSR requirements

NHS Resolution is a Special Health Authority, which operates in a similar way to an insurer by providing protection for clinical negligence to NHS hospitals. NHSR work to ensure that patients who are eligible to receive financial compensation do so as quickly as possible.

NHS Resolution's Early Notification (EN) scheme aims to provide a more rapid, caring response to families whose baby may have suffered severe harm. On completion of the HSIB safety investigation, where a case has progressed following referral for a potential severe brain injury.

In order to reflect the significant impact of the COVID 19 pandemic on Trusts, reporting to NHS Resolution by the Trust, was paused from the 1st April 2020. There remained an ongoing requirement that Trusts continue to report all cases that meet the criteria to the Healthcare Safety Investigation Branch (HSIB) for investigations to take be undertaken.

In order to ensure cases were reported to the EN scheme, HSIB took on the responsibility for reporting potential eligible Early Notification cases to NHS Resolution for further consideration from a legal perspective. In April 2021, the Trust received communication from NHSr that this pause in reporting would continue until further notice.

In May 2022, the Trust received an updated and amended MIS scheme guidance outlined requirements that with effect from 1 April 2022, Trusts will be required to continue to report their qualifying cases to HSIB via the electronic portal and that in addition, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once HSIB have confirmed they are progressing an investigation due to clinical or MRI evidence of neurological injury.

Governance Records pertaining to required Standard A

Reporting of all qualifying cases to HSIB from **1 April 2021 to 5 December 2022**

Grade 3 - HIE Diagnosis and Therapeutic Hypothermia Treatment (Active Cooling).

All eligible cases of babies diagnosed with Grade III Hypoxic Ischaemic Encephalopathy have been reported to HSIB in accordance with the records found in Table 1.

The table below (table 1) is taken from the locally held maternity governance records of all qualifying cases (patient identifiable details redacted) or reporting to the Healthcare Safety Investigation Branch (HSIB) from 1st April 2021 to 5th December 2022.

Name	Baby W	Mum W Number	DOB	Eligibility	Location & Gestation	Location of Birth	HSIB Reported	HSIB Referral Number
[redacted]			09.05.2021	Cooled	40 wks	MLU	Yes	MI-003609
			13.05.2021	Cooled	40 wks	Theatre	Yes	MI-004061
			27.07.2021	Cooled	38 wks	DS	Yes	MI-003937
			02.09.2021	Cooled	41 wks	DS	Yes	MI-004101
			18.09.2021	Cooled	39 wks	Theatre	Yes - Rejected	MI-004231 - Not in labour.
			23.09.2021	Cooled	40 wks	Theatre	Yes - Rejected	MI-004247 - Normal MRI
			30.09.2021	Cooled	39 wks	MLU	Yes	MI-004410
			08.11.2021	Cooled	39 wks	Theatre	Yes	MI-004944
			15.11.2021	Cooled	40 wks	DS	Yes - Rejected	MI- 004977 - Normal MRI
			16.11.2021	Cooled	42 wks	Theatre	Yes	MI-004979
			19.11.2021	Cooled	41 wks	Theatre	Yes	MI-005186
			22.11.2021	Cooled	37 wks	Theatre	Yes - Rejected	Not Eligible - Not in labour.
			09.12.2021	Cooled	37 wks	DS	Yes	MI-005402
			26.12.2021	Intrapartum SB	39 wks	DS	Yes	MI 006094
			31.01.2022	Cooled	38wks	DS	Yes	MI 006456
			01.02.2022	Cooled	40 wks	Theatre	Yes - Rejected	MI 006457 - Normal MRI
			13.03.2022	Cooled	39 wks	Theatre	Yes	MI-007512
			13.03.2022	SUDI 3 days	40 wks	MLU	Yes	MI 007611
			24.03.2022	Cooled	40 wks	DS	Yes	MI-007978
			08.05.2022	Cooled	41 wks	DS	Yes	MI 009247
			12.06.2022	Cooled	39 wks	Theatre	Yes	MI 010288
			24.07.2022	Cooled	39 wks	Theatre	Yes - Rejected	MI 012298 - Normal MRI
			05.09.2022	Cooled	40 wks	Theatre	Yes	MI 014312
			11.09.2022	Cooled	39 wks	Theatre	Yes - Rejected	MI 014838 - Normal MRI

Table 1: Maternity Governance records: All, in born births, meeting reporting requirements to HSIB.

Further assurance can be given below (table 2) after a secondary review of in-born admissions to LWH NICU was performed using the Trust BadgerNet System, in order to ensure all eligible cases of inborn therapeutic cooling and HIE diagnosis have reported to HSIB. All of the cases listed in table 2 are NICU admissions for cooling and/or HIE, correspond with those in table 1 (exception is the one case of intrapartum stillbirth and SUDI).

Babies who have been cooled - Wed 21 Dec 2022 at 14:05 (Units: All allowed)								
National ID	Hospital ID	Name	DOB	Admitted	Gest	BW	Episode	Cooling Type
[redacted]			09/05/2021 08:13	09/05/2021 08:55	40	3060	Admitted 09 May 21 at 08:55 from Midwifery led unit. Discharge	Active
			13/05/2021 15:00	13/05/2021 15:25	40	3905	Admitted 13 May 21 at 15:25 from Theatre. Discharged home 19	Active
			27/07/2021 09:18	27/07/2021 09:50	38	3850	Admitted 27 Jul 21 at 09:50 from Labour ward. Discharged hom	Active
			02/09/2021 05:38	02/09/2021 06:45	41	3938	Admitted 02 Sep 21 at 06:45 from Labour ward. Discharged hon	Active
			18/09/2021 04:57	18/09/2021 05:40	39	3710	Admitted 18 Sep 21 at 05:40 from Theatre. Discharged to Alder	Active
			23/09/2021 20:56	23/09/2021 21:15	40	3135	Admitted 23 Sep 21 at 21:15 from Theatre. Discharged home 16	Active
			30/09/2021 23:37	01/10/2021 01:50	39	2820	Admitted 01 Oct 21 at 01:50 from Midwifery led unit. Discharge	Active
			08/11/2021 05:18	08/11/2021 06:20	39	4005	Admitted 08 Nov 21 at 06:20 from Theatre. Discharged to Postn	Active
			15/11/2021 05:49	15/11/2021 11:00	40	3735	Admitted 15 Nov 21 at 11:00 from Labour ward. Discharged hon	Active
			16/11/2021 19:52	16/11/2021 20:40	42	3480	Admitted 16 Nov 21 at 20:40 from Labour ward. Discharged hon	Active
			19/11/2021 16:51	19/11/2021 17:30	41	3170	Admitted 19 Nov 21 at 17:30 from Theatre. Discharged home 27	Active
			22/11/2021 19:56	22/11/2021 20:15	37	3210	Admitted 22 Nov 21 at 20:15 from Theatre. Discharged home 02	Active
			09/12/2021 17:30	09/12/2021 17:55	37	2490	Admitted 09 Dec 21 at 17:55 from Labour ward. Discharged hon	Active
			31/01/2022 00:41	31/01/2022 04:45	38	2350	Admitted 31 Jan 22 at 04:45 from Postnatal ward. Discharged ho	Active
			01/02/2022 03:42	01/02/2022 04:10	40	3690	Admitted 01 Feb 22 at 04:10 from Theatre. Discharged home 06	Active
			13/03/2022 06:12	13/03/2022 06:40	39	3405	Admitted 13 Mar 22 at 06:40 from Theatre. Discharged to Postn	Active
			24/03/2022 14:15	24/03/2022 14:30	40	3100	Admitted 24 Mar 22 at 14:30 from Labour ward. Discharged to A	Active
			08/05/2022 23:05	08/05/2022 23:40	41	3360	Admitted 08 May 22 at 23:40 from Labour ward. Discharged hon	Active
			12/06/2022 14:09	12/06/2022 14:35	39	4070	Admitted 12 Jun 22 at 14:35 from Theatre. Discharged to Alder H	Active
			24/07/2022 11:17	24/07/2022 12:10	39	5220	Admitted 24 Jul 22 at 12:10 from Theatre. Discharged home 18 A	Active
			05/09/2022 13:30	05/09/2022 13:50	40	3770	Admitted 05 Sep 22 at 13:50 from Theatre. Discharged home 21	Active
			11/09/2022 04:08	11/09/2022 04:40	39	3550	Admitted 11 Sep 22 at 04:40 from Labour ward. Discharged hon	Active

Table 2. BadgetNet records of babies admitted for HIE and /or hypothermic treatment 01.04.2021 - 05.12.2022

Intrapartum Stillbirth (>37wks)

Liverpool Women's Hospital NHS Foundation Trust reported one case of intrapartum stillbirth to HSIB – which has been investigated and is concluded.

- All data pertaining to intrapartum stillbirths has been cross referenced and reviewed, using the MBRRACE/PMRT data base by the Maternity Governance Lead and Lead Midwife for Perinatal Mortality and is accurate.

Maternal Death

Liverpool Women's Hospital NHS Foundation Trust did not refer any cases of maternal death to HSIB.

- A sad case of a maternal death at home, some 45 days post birth, was discussed with HSIB for potential referral – but was rejected as the timescale did not meet the 42-day criteria. This case was subject to a Trust led serious incident investigation and is now in the final stages of completion.

Neonatal Death

Liverpool Women's Hospital NHS Foundation Trust referred one case that met the criteria of neonatal death to HSIB.

- A case of sudden infant death in the Community which has been subject to a full HSIB investigation and is now concluded.

Governance Records pertaining to required Standard B

Reporting of all qualifying Early Notification cases to NHSr EN Scheme from **1st April 2022 until 5th December 2022**.

Liverpool Women's Hospital NHS Foundation Trust, since 01.04.2022, has referred five cases to NHSr EN scheme as detailed below, these have been referred in accordance with the criteria.

This data has been cross referenced against LWH Legal service records, locally held records, BadgerNet and MBRRACE/PMRT.

Name	Baby W Mum W Number	DOB	Eligibility	Location & Gestation	Location of Birth	HSIB Reported	HSIB Referral Number	DOC/HSIB/EN INFO	NHSR/ EN Reference Number
[redacted]		08.05.2022	Cooled	41 wks	DS	Yes	MI 009247	11.05.2022	Temp Number 147560 - Reported October 2022 - Rejected. Re-reported & Accepted 22.12.2022
		12.06.2022	Cooled	39 wks	Theatre	Yes	MI 010288	14.06.2022	Temp Number 147558 - Reported November 2022 - Rejected. Re-reported & Accepted 22.12.2022
		24.07.2022	Cooled	39 wks	Theatre	Yes - Rejected	MI 012298 - Normal MRI	25.07.2022	NA - Rejected by HSIB
		05.09.2022	Cooled	40 wks	Theatre	Yes	MI 014312	07.09.2022	Temp 147576 - Reported November 2022- Rejected Re-reported & Accpeted 22.12.2022
		11.09.2022	Cooled	39 wks	Theatre	Yes - Rejected	MI 014838 - Normal MRI	12.09.2022	NA - Rejected by HSIB

Table 3: Maternity governance records detailing NHSr/EN Scheme referral details.

Governance Records pertaining to Required Standard C

All qualifying cases which have occurred during the period 1st April 2021 to 5th December 2022, the Trust Board are assured of the following:

i. The family have received information on the role of HSIB and NHSR EN Scheme, and

ii. There has been compliance, where required, with regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

The table below details the dates and duty of candour leads for each case referred to HSIB.

Ulysess	Name	Baby W	Mum W Number	DOB	Eligibility	Location & Gestation	Location of Birth	HSIB Reported	HSIB Referral Number	DOC/HSIB/EN INFO	NHSR/ EN Reference Number
79207	[redacted]			09.05.2021	Cooled	40 wks	MLU	Yes	MI-003609	10.05.2021 - MCJ	NA - COVID 19 arrangement - HSIB reported to NHSR
79372				13.05.2021	Cooled	40 wks	Theatre	Yes	MI-004061	15.05.2021 - MCJ	NA - COVID 19 arrangement - HSIB reported to NHSR
81257				27.07.2021	Cooled	38 wks	DS	Yes	MI-003937	29.07.2021 - MCJ	NA - COVID 19 arrangement - HSIB reported to NHSR
82033				02.09.2021	Cooled	41 wks	DS	Yes	MI-004101	07.09.2021 - RMc	NA - COVID 19 arrangement - HSIB reported to NHSR
82623				18.09.2021	Cooled	39 wks	Theatre	Yes - Rejected	MI-004231 - Not in labour.	21.09.2021 - MCJ	NA - COVID 19 arrangement - HSIB reported to NHSR
82858				23.09.2021	Cooled	40 wks	Theatre	Yes - Rejected	MI-004247 - Normal MRI	27.09.2021 - LTho	NA - COVID 19 arrangement - HSIB reported to NHSR
83048				30.09.2021	Cooled	39 wks	MLU	Yes	MI-004410	04.10.2021 - AWin	NA - COVID 19 arrangement - HSIB reported to NHSR
84099				08.11.2021	Cooled	39 wks	Theatre	Yes - Rejected	MI-004944 - Normal MRI	09.11.2021 - RMc	NA - COVID 19 arrangement - HSIB reported to NHSR
84316				15.11.2021	Cooled	40 wks	DS	Yes - Rejected	MI- 004977 - Normal MRI	18.11.2021 - AWT	NA - COVID 19 arrangement - HSIB reported to NHSR
84402				16.11.2021	Cooled	42 wks	Theatre	Yes	MI-004979	18.11.2021 - AWT	NA - COVID 19 arrangement - HSIB reported to NHSR
84572				19.11.2021	Cooled	41 wks	Theatre	Yes	MI-005186	23.11.2021 - RMc	NA - COVID 19 arrangement - HSIB reported to NHSR
84555				22.11.2021	Cooled	37 wks	Theatre	Yes - Rejected	Not Eligible - Not in labour.	23.11.2021 - RMc	NA - COVID 19 arrangement - HSIB reported to NHSR
85211				09.12.2021	Cooled	37 wks	DS	Yes	MI-005402	10.12.2021 - LTho	NA - COVID 19 arrangement - HSIB reported to NHSR
85921				26.12.2021	Intrapartum SB	39 wks	DS	Yes	MI 006094	25.01.2022 - KALL	NA - COVID 19 arrangement - HSIB reported to NHSR
86451				31.01.2022	Cooled	38wks	DS	Yes	MI 006456	01.02.2022 - Ltho	NA - COVID 19 arrangement - HSIB reported to NHSR
86452				01.02.2022	Cooled	40 wks	Theatre	Yes - Rejected	MI 006457 - Normal MRI	01.02.2022 - Ltho	NA - COVID 19 arrangement - HSIB reported to NHSR
87574				13.03.2022	Cooled	39 wks	Theatre	Yes	MI-007512	25.04.2022 - Abird	NA - COVID 19 arrangement - HSIB reported to NHSR
87631				13.03.2022	SUDI 3 days	40 wks	MLU	Yes	MI 007611	16.03.2022 - RMc	NA - COVID 19 arrangement - HSIB reported to NHSR
87871				24.03.2022	Cooled	40 wks	DS	Yes	MI-007978	28.03.2022 - MCJ	NA - COVID 19 arrangement - HSIB reported to NHSR
89230				08.05.2022	Cooled	41 wks	DS	Yes	MI 009247	11.05.2022 - RHain	Temp Number 147560 - Reported October 2022 - Rejected. Re-reported & Accepted 22.12.2022
90127				12.06.2022	Cooled	39 wks	Theatre	Yes	MI 010288	14.06.2022 - RMc	Temp Number 147558 - Reported November 2022 - Rejected. Re-reported & Accepted 22.12.2022
91382				24.07.2022	Cooled	39 wks	Theatre	Yes - Rejected	MI 012298 - Normal MRI	25.07.2022 - LWat	NA - Rejected by HSIB
92641				05.09.2022	Cooled	40 wks	Theatre	Yes	MI 014312	07.09.2022 - RMc	Temp 147576 - Reported November 2022- Rejected Re-reported & Accpeted 22.12.2022
92706				11.09.2022	Cooled	39 wks	Theatre	Yes - Rejected	MI 014838 - Normal MRI	12.09.2022 - LTho	NA - Rejected by HSIB

Table 4: Maternity Governance Record of Duty of Candour.

Information has been provided to all parents in all cases relating to and requiring reporting to NHSR and HSIB and all Ulysses duty of candour details have been updated and completed.

Parents/Families are provided with a Duty of Candour letter that describes the role of HSIB and NHSr/EN scheme. This letter is supplied to the parents along with a full and in-depth duty of candour conversation with a Consultant Obstetrician/Duty of Candour Lead, prior to discharge from the hospital (where possible) with full explanation as to the review and referral process An example of the DOC letter provided can be found in Appendix B.

HSIB have also produced patient information leaflets that are provided to all parents where a referral has been necessary.

ANALYSIS

The Trust Board should take assurance from the evidence and information provided in this paper that the required standards to confirm compliance with safety action 10 of the maternity incentive scheme have been fulfilled.

Appendix A.

Safety action 10: **Safety action 10**: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?

Required standard	A) Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022 B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022 C) For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that: 1. the family have received information on the role of HSIB and NHS Resolution's EN scheme; and 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.
Minimum evidential requirement for Trust Board	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of HSIB and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Validation process	Self-certification to NHS Resolution using Board declaration form. Trusts' reporting will be cross-referenced against the HSIB database and the National Neonatal Research Database (NNRD), and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard a) and b) have been met in the relevant reporting period. In addition, for standard C1 there is a requirement to complete field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.
What is the relevant time period?	Reporting to HSIB – from Wednesday 1 April 2021 to 5 December 2022 Reporting period to HSIB **and** to NHS Resolution - from 1 April 2022 to 5 December 2022
What is the deadline for reporting to NHS Resolution?	By 5 January 2023 at 12 noon

Technical guidance for Safety action 10

Technical guidance

Where can I find information on HSIB?	Information about HSIB and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website • EN main page • Trusts page • Families page
What are qualifying incidents that need to be reported to HSIB?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [0r] • Was therapeutically cooled (active cooling only) [Or] • Had decreased central tone AND was comatose AND had seizures of any kind Once HSIB have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury.
Changes in the EN reporting requirements for Trust from 1 April 2021 to 31 March 2022	Between 1 April 2021 to 31 March 2022, all qualifying cases should still be reported to HSIB. HSIB will then inform NHS Resolution of the case. Should you wish to discuss further, please contact HSIB at maternity@hsib.org.uk
Changes in the EN reporting requirements for Trust from 1 April 2022 going forward	With effect from 1 April 2022, Trusts will be required to continue to report their qualifying cases to HSIB via the electronic portal. In addition, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once HSIB have confirmed they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must share the HSIB report with the EN team within 30 days of receipt of the final report by uploading the HSIB report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading HSIB reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the HSIB report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation.
Changes in the Outstanding 2021/22 cases to be reported	If there are any outstanding cases which occurred from 1 April 2021 to 31 March 2022, Trust should report them as soon as possible to HSIB, following the process outlined above.
What qualifying EN cases need to be	• Trusts are required to report cases to NHS Resolution where HSIB are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury.

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

Will we be penalised for late reporting?	Trusts are strongly encouraged to report all incidents to HSIB as soon as they occur and to NHS Resolution as soon as HSIB have confirmed that they are taking forward an investigation. Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to HSIB and where applicable to NHS Resolution and this is confirmed with data held by NNRD and HSIB and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme.

Appendix B

The following page contains an example of the Trust Duty of Candour letter to families whose cases meet the criteria for referral to HSIB. This letter would be signed by the Clinical Director and/or Head of Midwifery.

Find us on

NHS
Liverpool Women's
NHS Foundation Trust

Family Health Division
Crown Street
Liverpool
L8 7SS

Tel: 0151 708 9988
Fax: 0151 702 4028
www.liverpoolwomens.nhs.uk

PRIVATE AND CONFIDENTIAL

[redacted]

14 June 2022

Dear N[redacted] and K[redacted],

As Clinical Director for Maternity, I am writing to you to express my regret that your baby boy F[redacted] has required therapeutic cooling after birth. This was an unexpected event in the hospital, we will perform an immediate review of the care both you and your baby have received.

The full review of your care throughout pregnancy, delivery and immediate post-delivery care of your baby will also be examined in detail by an independent NHS organisation known as HSIB (Healthcare Safety Investigation Branch). Investigating cases like these is part of a national initiative to provide Safer Maternity Care, and we have given you further information about it today in the family information leaflet. A member of the HSIB team will be in contact with you directly, for you to participate and contribute to the review process. This is in addition to any discussions you will have with clinical teams whilst in hospital regarding ongoing clinical care for you and your baby.

Your case will automatically be referred to NHS Resolution under the early notification scheme, who provide expertise to the NHS on resolving concerns and disputes fairly, sharing learning for improvement and preserving resources for patient care. NHS Resolution will undertake their own independent review including clinical experts. This will be available to the trust once completed but this can take several years to be finalised. This information will be made available to you at the earliest opportunity.

Our usual practice is to invite you back to meet a Consultant Obstetrician and Consultant Neonatologist to keep you updated about the process of the ongoing review by HSIB and discuss results of tests arranged for you and your baby. This appointment is also an opportunity to answer any further questions that you may have, and for us to make a plan for any future pregnancies. You should expect to receive an appointment about 8-10 weeks after your discharge from hospital. In the meantime, the neonatal team will continue to regularly review your baby in the outpatient department.

Liverpool Women's
NHS Foundation Trust

Jargon Buster

We know that the language used in healthcare can sometimes be quite confusing, especially when acronyms are concerned. To make life a little easier, we will try to ensure that we spell out acronyms in full at first mention and then put the abbreviation in brackets, for example, Strategic Clinical Network (SCN) in our reports and minutes.

We've also put together a list of acronyms that you might see throughout our documentation. If you spot a gap, please email our Trust Secretary on mark.grimshaw@lwh.nhs.uk.

The following webpage might also be useful - https://www.england.nhs.uk/participation/nhs/

A		
A&E	Accident & Emergency	hospital department specialising in the acute care of patients who arrive without a prior appointment with urgent or emergency trauma
AC	Audit Committee	a committee of the board – helps the board assure itself on issues of finance, governance and probity
AGM	Annual General Meeting	a meeting to present and agree the trust annual report and accounts
AGS	Annual Governance Statement	a document which identifies the internal controls in place and their effectiveness in delivering effective governance
AHP	Allied Health Professionals	health care professions distinct from dentistry, optometry, nursing, medicine and pharmacy e.g. physiotherapists, radiographers, speech therapists and podiatrists
AHSC	Academic Health Science Centre	a partnership between a healthcare provider and one or more universities
AHSN	Academic Health Science Network	locally owned and run partnership organisations to lead and support innovation and improvement in healthcare
ALOS	Average Length of Stay	the average amount of time patients stay in hospital
AMM	Annual Members Meeting	a meeting that is held every year to give members the opportunity to hear about what the trust has done in the past year; could be part of the AGM
AO	Accountable Officer	senior person responsible and accountable for funds entrusted to their trust; for NHS provider organisations this person will be the chief executive
ALB(s)	Arms Length Bodies	an organisation that delivers a public service but is not a ministerial government department; these include HEE, HSCIC, HRA, HTA, NHSE, NICE, Monitor, NHSBSA, NHSBT, NHSI, NHSLA, MHPRA, CQC, PHE (See individual entries)
	Agenda for Change	the NHS-wide grading and pay system for NHS staff, with the exception of medical and dental staff and some senior managers; each relevant job role in the NHS is matched to a band on the Agenda for Change pay scale

B		
BAF	Board Assurance Framework	the key document used to record and report an organisation's key strategic objectives, risks, controls and assurances to the board
BCF	Better Care Fund	this fund creates a local single pooled budget to incentivise the NHS and local government to work more closely together in local areas
BMA	British Medical Association	trade union and professional body for doctors
BAME	Black Asian Minority Ethnic	terminology normally used in the UK to describe people of non-white descent
BoD	Board of Directors	executive directors and non-executive directors who have collective responsibility for leading and directing the trust
	Benchmarking	method of gauging performance by comparison with other organisations

C		
CAMHS	Child and Adolescent Mental Health Services	specialise in providing help and treatment for children and young people with emotional, behavioural and mental health difficulties
CapEx	Capital Expenditure	an amount spent to acquire or improve a long-term asset such as equipment or buildings. Typically, capital is raised via a loan, but it can come from reserves and is paid back/written off over a number of years from revenue income. This is a contrast with revenue spend which is always from in-year income
CBA	Cost Benefit Analysis	a process for calculating and comparing the costs and benefits of a project
CBT	Cognitive Behavioural Therapy	a form of psychological therapy used mostly in depression but increasingly shown to be a useful part of the treatment for schizophrenia
CCG	Clinical Commissioning Group	groups of GPs, clinicians and managers who are responsible for commissioning local health services in England (all GP practices must belong to a CCG)
CDiff	Clostridium difficile	a bacterial infection that most commonly affects people staying in hospital
CE / CEO	Chief Executive Officer	leads the day-to-day management of a foundation trust, is a board member and the accountable officer for the trust.
CF	Cash Flow	the money moving in and out of an organisation
CFR	Community First Responders	a volunteer who is trained by the ambulance service to attend emergency calls in the area where they live or work
CHC	Continuing Healthcare	Whereby those with long-term or complex healthcare needs qualify for social care arranged for and funded by the NHS
CIP	Cost Improvement Plan	an internal business planning tool outlining the Trust's efficiency strategy
CMHT	Community Mental Health Team	A team of mental health professionals such as psychiatrists,

		psychologists, social workers, community psychiatric nurses and occupational therapists, who work together to help people manage and recover from mental illness.
CoG	Council of Governors	the governing body that holds the non-executive directors on the board to account for the performance of the board in managing the trust, and represents the interests of members and of the public
COO	Chief Operating Officer	a senior manager who is responsible for managing a trust's day-to-day operations and reports to the CEO
CPD	Continuing Professional Development	continued learning to help professionals maintain their skills, knowledge and professional registration
CPN	Community Psychiatric Nurse	a registered nurse with specialist training in mental health working outside a hospital in the community
CQC	Care Quality Commission	The independent regulator of all health and social care services in England
CQUIN	Commissioning for Quality and Innovation	a sum of money that is given to providers by commissioners on the achievement of locally and nationally agreed quality and improvement goals
CSR	Corporate Social Responsibility	A business practice which incorporates sustainable goals, usually positive impacts on environmental, economic and social factors, into a business model
CT	Computed Tomography	A medical imaging technique
CFO	Chief Finance Officer	the executive director leading on finance issues in the trust
CNST	Clinical Negligence Scheme for Trusts	The Clinical Negligence Scheme for Trusts (CNST) handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) in England currently belong to the scheme.
	Caldicott Guardian	A board level executive director responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian

D		
DBS	Disclosure and barring service	conducts criminal record and background checks for employers
DBT	Dialectical behavioural therapy	A type of psycho-therapy, or talk therapy, which has been developed from CBT to help those experiencing borderline personality disorder
DGH	District General Hospital	major secondary care facility which provides an array of treatment, diagnostic and therapeutic services, including A&E
DHSC	Department of Health and Social Care	the ministerial department which leads, shapes and funds health and care in England
DN	Director of Nursing	The executive director who has professional responsibility for services provided by nursing personnel in a trust

DNA	Did Not Attend	a patient who missed an appointment
DNAR	Do Not Attempt Resuscitation	A form issued and signed by a doctor, which tells a medical team not to attempt CPR
DPA	Data Protection Act	the law controlling how personal data is collected and used
DPH	Director of Public Health	a senior leadership role responsible for the oversight and care of matters relating to public health
DTOCs	Delayed Transfers of Care	this refers to patients who are medically fit but waiting for care arrangements to be put in place so therefore cannot be discharged
	Duty of Candour	a legal duty on hospital, community, ambulance and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm

E		
E&D	Equality and Diversity	The current term used for 'equal opportunities' whereby members of the workforce should not be discriminated against because of their characteristics. This is promoted by valuing diverse characteristics in a workplace.
ED(s)	Executive Directors *or* Emergency Department	senior management employees who sit on the trust board *or* alternative name for Accident & Emergency department
EHR	Electronic Health Record	health information about a patient collected in digital format which can theoretically be shared across different healthcare settings
EOLC	End of Life Care	support for patients reaching the end of their life
EPR	Electronic Patient Record	a collation of patient data stored using computer software
ESR	Electronic staff record	A collation of personal data about staff stored using computer software

F		
FFT	Friends and Family Test	a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care
FOI	Freedom of Information	the right to ask any public sector organisation for the recorded information they have on any subject
FT	Foundation Trust	a public benefit corporation, which is a legal body established to deliver healthcare to patients / service users and has earned a degree of operational and financial independence
FTE	Full Time Equivalent	a measurement of an employees workload against that of someone employed full time e.g. 0.5 FTE would be someone who worked half the full time hours
FTSU	Freedom to speak up	An initiative developed by NHS Improvement to

		encourage NHS workers to speak up about any issues to patient care, quality or safety
	Francis Report	the final report, published in 2013, of the public inquiry into care provided by Mid Staffordshire NHS FT chaired by Sir Robert Francis QC

G

GMC	General Medical Council	the independent regulator for doctors in the UK
GDP	Gross Domestic Product	the value of a country's overall output of goods and services
GDPR	General Data Protection Regulations	The legal framework which sets the guidelines for collecting and processing personal information from individuals living in the European Union

H

HCAI	Healthcare Associated Infection	these are infections that are acquired in hospitals or as a result of healthcare interventions; MRSA and Clostridium difficile can be classed as HCAIs if caught whilst in a healthcare setting
HCA	Health Care Assistant	staff working within a hospital or community setting under the guidance of a qualified healthcare professional
HDU	High Dependency Unit	an area in a hospital, usually located close to the ICU, where patients can be cared for more extensively than on a normal ward, but not to the point of intensive care, e.g. patients who have had major surgery
HEE	Health Education England	the body responsible for the education, training and personal development of NHS staff
HR	Human Resources	the department which focusses on the workforce of an organisation including pay, recruitment and conduct
HRA	Health Research Authority	protects and promotes the interests of patients and the public in health research
HSCA 2012	Health & Social Care Act 2012	an Act of Parliament providing the most extensive reorganisation of the NHS since it was established, including extending the roles and responsibilities of governors
HSCIC	Health and Social Care Information Centre	the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care
HTA	Human Tissue Authority	regulates the removal, storage, use and disposal of human bodies, organs and tissue for a number of scheduled purposes such as research, transplantation, and education and training
HWB / HWBB	Health& Wellbeing Board	a local forum to bring together partners from across the NHS, local government, the third sector and the independent sector, led by local authorities
	Health Watch	A body created under the Health and Social Care Act 2012

		which aims to understand the needs and experiences of NHS service users and speak on their behalf.

I		
IAPT	Improved Access to Psychological Therapies	an NHS programme rolling out services across England offering interventions approved by the National Institute of Health and Care Excellence for treating people with depression and anxiety disorders
IG	Information Governance	ensures necessary safeguards for, and appropriate use of, patient and personal information. Key areas are information policy for health and social care, IG standards for systems and development of guidance for NHS and partner organisations
ICP	Integrated Care Pathway	a multidisciplinary outline of care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through diagnosis and treatment to positive outcomes
ICS	Integrated Care system	Groups of NHS providers, commissioners and local authorities working together to improve health and care in the local area
ICT	Information Communications Technology	an umbrella term that includes any communication device or application, encompassing: radio, television, cellular phones, computer and network hardware and software, satellite systems, as well as the various services and applications associated with them
ICU *or* ITU	Intensive Care Unit Intensive therapy unit	specialist unit for patients with severe and life threatening illnesses
IP	Inpatient	a patient who is hospitalised for more than 24 hours
IT	Information Technology	systems (especially computers and telecommunications) for storing, retrieving, and sending information
IV	Intravenous	treatment which is administered by injection into a vein

K		
KLOE(s)	Key Line of Enquiries	detailed questions asked by CQC inspectors which help to answer the five key questions to assess services: are they safe, effective, caring, responsive and well-led?
KPIs	Key Performance Indicators	indicators that help an organisation define and measure progress towards a goal
	King's Fund	independent charity working to improve health and health care in England

L		
LD	Learning Disability	a disability which affects the way a person understands information and how they communicate
LGA	Local Government Association	the national voice of local government in England and Wales. It seeks to promote better local government and maintains communication between officers in different local authorities to develop best practice
LOS	Length of Stay	a term commonly used to measure the duration of a single episode of hospitalisation

M		
M&A	Mergers & Acquisitions	mergers bring together two or more bodies to form a new legal entity and disband the merging bodies. acquisitions are take-overs of one body by another
MD	Medical Director	a member of the board who has a clinical background and has professional responsibilities for doctors and dentists in the trust
MHPRA	Medicines and Healthcare Products Regulatory Agency	an executive agency of DHSC which is responsible for ensuring that medicines and medical devices work and are acceptably safe
MIU	Minor Injuries Unit	A unit which treats injuries or health conditions which are less serious and do not require the A&E service
MoU	Memorandum of Understanding	describes an agreement between two or more parties
MRI	Magnetic Resonance Imaging	a medical imaging technique
MRSA	Methicillin-Resistant Staphylococcus Aureus	a bacterium responsible for several difficult-to-treat infections in humans
MSA	Mixed Sex Accommodation	wards with beds for both male and female patients

N

NAO	National Audit Office	an independent Parliamentary body in the United Kingdom which is responsible for auditing central government departments, government agencies and non-departmental public bodies. The NAO also carries out Value for Money audits into the administration of public policy
NED	Non Executive Director	directors who are appointed, but not employed by the trust; they have no executive responsibilities and are responsible for vetting strategy, providing challenge in the boardroom and holding the executive directors to account
NHSBSA	NHS Business Services Authority	a Special Health Authority of DHSC which provides a range of services to NHS organisations including: NHS Prescription Services, NHS Pensions, Help With Health Costs, Student Services, NHS Dental Services, European Health Insurance Card, Supplier Management (including NHS Supply Chain) and NHS Protect
NHSBT	NHS Blood and Transplant	a Special Health Authority of DHSC responsible for providing a reliable, efficient supply of blood, organs and associated services to the NHS
NHSE	NHS England	an executive non-departmental public body with a mandate from the Secretary of State to improve health outcomes for people within England
NHSI	NHS Improvement	The Independent regulator of NHS Foundation Trusts
NHSLA	NHS Leadership Academy	national body supporting leadership development in health and NHS funded services
NHSP	NHS Professionals	provides bank (locum) healthcare staff to NHS organisations
NHSX		A unit designed to drive the transformation of digital technology in the NHS
NICE	National Institute for Health and Care Excellence	provides national evidence-based guidance and advice to improve health and social care
NIHR	National Institution for Health Research	The largest funder of health and social care research in the UK, primarily funded by the Department of Health and Social Care
NMC	Nursing and Midwifery Council	nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
	Never Event	serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. NHS England defines the list of never events every year

	NHS Digital	The information and technology partner to the NHS which aims to introduce new technology into services
	NHS Providers	NHS Providers is the membership organisation for NHS public provider trusts. We represent every variety of trust, from large acute and specialist hospitals through to community, ambulance and mental health trusts.
	Nolan Principles	key principles of how individuals and organisations in the public sector should conduct themselves comprising of: selflessness, integrity, objectivity, accountability, openness, honesty, leadership. Set by the Committee for Standards in Public Life, an independent advisory non-departmental public body set up to advise the prime minister on ethical standards
	NHS Resolution	not-for-profit part of the NHS which manages negligence and other claims against the NHS in England on behalf of their member organisations. Also, an insurer for NHS bodies
	Nuffield Trust	independent source of evidence-based research and policy analysis for improving health care in the UK, also a charity

O

OD	Organisational Development *or* Outpatients Department	a systematic approach to improving organisational effectiveness *or* a hospital department where healthcare professionals see outpatients (patients which do not occupy a bed)
OOH	Out of Hours	services which operate outside of normal working hours
OP	Outpatients	a patient who is not hospitalized for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment
OPMH	Older People's Mental Health	mental health services for people over 65 years of age
OSCs	Overview and Scrutiny Committees	established in local authorities by the Local Government Act 2000 to review and scrutinise the performance of public services including health services
OT	Occupational Therapy	assessment and treatment of physical and psychiatric conditions using specific activity to prevent disability and promote independent function in all aspects of daily life

P		
PALS	Patient Advice & Liaison Service	offers confidential advice, support and information on health-related matters to patients, their families, and their carers within trusts
PAS	Patient Administration System	the automation of administrative paperwork in healthcare organisations, particularly hospitals. It records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient
PbR	Payment by Results or 'tariff'	a way of paying for health services that gives a unit price to a procedure
PCN	Primary care network	A key part of the NHS long term plan, whereby general practices are brought together to work at scale
PDSA	Plan, do, study, act	A model of improvement which develops, tests and implements changes based on the scientific method
PFI	Private Finance Initiative	a scheme where private finance is sought to supply public sector services over a period of up to 60 years
PHE	Public Health England	a body with the mission to protect and improve the nation's health and wellbeing and reduce health inequalities
PHSO	Parliamentary and Health Service Ombudsman	an organisation which investigates complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England
PICU	Psychiatric Intensive Care Unit *or* Paediatric Intensive Care Unit	a type of psychiatric in-patient ward with higher staff to patient ratios than on a normal acute admission ward *or* an inpatient unit specialising in the care of critically ill infants, children, and teenagers
PLACE	Patient-Led	Surveys inviting local people going into hospitals as
	Assessments of the Care Environment	part of a team to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance
PPI	Patient and Public Involvement	mechanisms that ensure that members of the community --- whether they are service users, patients or those who live nearby – are at the centre of the delivery of health and social care services
PTS	Patient Transport Services	free transport to and from hospital for non-emergency patients who have a medical need

	Primary Care	the first point of contact with the NHS for most people and is delivered by a wide range of independent contractors, including GPs, dentists, pharmacists and optometrists, it also includes NHS walk-in centres and the NHS 111 telephone service

Q

QA	Quality assurance	monitoring and checking outputs to make sure they meet certain standards
QI	Quality improvement	A continuous improvement process focusing on processes and systems
QIA	Quality Impact Assessment	A process within NHS trusts which ensures the quality of service is systematically considered in decision- making on service changes
QUI	Qualities and Outcomes Framework	The system for performance management and payment of GP's in the NHS

R

R&D	Research & Development	work directed towards the innovation, introduction, and improvement of products and processes
RAG	Red, Amber, Green classifications	a system of performance measurement indicating whether something is on or better than target (green), below target but within an acceptable tolerance level (amber), or below target and below an acceptable tolerance level (red)
RGN	Registered General Nurse	a nurse who is fully qualified and is registered with the Nursing and Midwifery Council as fit to practise
RoI	Return on Investment	the benefit to the investor resulting from an investment of some resource. A high RoI means the investment gains compare favourably to investment cost. As a performance measure, RoI is used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments.
RTT	Referral to Treatment Time	the waiting time between a patient being referred by a GP and receiving treatment

S		
SALT	Speech and Language Therapist	assesses and treats speech, language and communication problems in people of all ages to help them better communicate
SFI	Standing Financial Instructions	Policy used for the regulation of the conduct of an NHS trust in relation to all financial matters
SHMI	Summary Hospital Level Mortality Indicator	reports mortality at trust level across the NHS in England using standard and transparent methodology
SID	Senior independent Director	a non-executive director who sits on the board and plays a key role in supporting the chair; the SID carries out the annual appraisal of the chair, and is available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair
SIRO	Senior Information Risk Officer	a senior manager who will take overall ownership of the organisation's information risk policy
SITREP	Situation Report	a report compiled to describe the details surrounding a situation, event, or incident
SLA	Service Level Agreement	an agreement of services between service providers and users or commissioners
SoS	Secretary of State	the minister who is accountable to Parliament for delivery of health policy within England, and for the performance of the NHS
SRO	Senior Responsible officer	A leadership role which is accountable for the delivery and outcome of a specific project
STP	Sustainability and Transformation Partnership	Partnerships formed between local councils and NHS services to help plan and run services, and agree system-wide priorities
SUI	Series Untoward Incident / Serious Incident	A serious incident which resulted in one or more of the following: unexpected or avoidable death, a never event, a prevention of organisation's ability to continue to deliver healthcare services, abuse, or loss of confidence in a service
SWOT	Strengths, Weaknesses, Opportunities, Threats	a structured planning method used to evaluate the strengths, weaknesses, opportunities and threats involved in a project or in a business venture
	Secondary Care	NHS health service provided through hospitals and in the community

T		
TTO	To Take Out	medicines to be taken away by patients on discharge

	Tertiary Care	healthcare provided in specialist centres, usually on referral from primary or secondary care professionals

V

VTE	Venous Thromboembolism	a condition where a blood clot forms in a vein. This is most common in a leg vein, where it's known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE)
VfM	Value for Money	used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it both acquires and provides, within the resources available to it

W

WLF	Well Led Framework	a set of indicators that seek to identify how well led an organisation is, also used as a framework for board governance reviews
WRES	Workforce Race Equality Standard	a metric to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of black and minority ethnic (BME) board representation
WTE	Whole-time equivalent	See FTE

Y

YTD	Year to Date	a period, starting from the beginning of the current year, and continuing up to the present day. The year usually starts on 1st April for financial performance indicators