Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD MEETING - PUBLIC (REDUCED AGENDA)

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19 December 2023

09:30 GMT Europe/London

Virtual -TEAMS

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AGENDA

- 2312 - A Meeting Business 1
  - 00 Public Board Agenda - 19 December 2023 v2.pdf 2
  - 2312 - A1 Welcome, apologies for absence and declarations of interest (09:30) 5
    - Register of Interests & FPP (13.12.23).pdf 6
  - 2312 - A2 Actions from previous meeting 9
- 2312 - B True North SA1 - QUALITY AND EFFECTIVENESS 10
  - 2312 - B1 Chair's Assurance Log - Quality & Effectiveness Committee (09:35) 11
    - B1 - Chair's Assurance Log - Quality & Effectiveness Committee.pdf 12
  - 2312 - B2 Clinical Negligence Scheme for Trusts (CNST) Year 5 Board Declaration (09:40) 14
    - B2 - Clinical Negligence Scheme for Trusts Year 5 Board Declaration.pdf 15
    - B2 - CNST Presentation.pdf 17
    - B2 - Training Action Plan (embedded in presentation).pdf 32
  - 2312 - B3 Maternity & Neonatal Update (10:00) 33
    - B3 - Maternity & Neonatal Update.pdf 34
    - B3 - Appendix 1 Training Action Plan Safety Action 8.pdf 44
    - B3 - Appendix 2.pdf 45
- 2312 - C True North SA4 - FINANCE AND PERFORMANCE 80
  - 2312 - C1 Operational Performance Update (10:10) 81
  - 2312 - C2 Finance Update (10:20) 82
    - C2 - Finance Update - Month 8.pdf 83
- 2312 - D GOVERNANCE, ASSURANCE & STRATEGY 90
  - 2312 - D1 Chair's Assurance Log - Charitable Funds Committee (10:30) 91
    - D1 - Chair's Assurance Log - Charitable Funds Committee.pdf 92
  - 2312 - D2 Use of Trust Seal (10:30) 94
    - D2 - Use of Trust Seal.pdf 95
- 2312 - E OTHER ITEMS 97
  - 2312 - E1 - Any other business (to be agreed with the Chair prior to the meeting) (10:40) 98
  - 2312 - E2 Governor Questions regarding the business of the meeting * (10:45) 99
  - 2312 - E3 Minutes of the Meeting held on 28 November 2023 (10:55) 100
    - E3 - Draft Public Board Minutes 28 November 2023 v3.pdf 101
  - 2312 - E4 Date and Time of Next Meeting (11:00) 117
- MEETING CLOSE (11:00) 118

2312 - A MEETING BUSINESS

Suzy Brain England OBE, Chair

REFERENCES

Only PDFs are attached

00 Public Board Agenda - 19 December 2023 v2.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Board of Directors Meeting Held in Public
To be held on Tuesday 19 December 2023 at 09:30
Via MS Teams

Enc		Purpose	Time
A	**MEETING BUSINESS**		**09:30**
A1	Welcome, apologies for absence and declarations of interest *Suzy Brain England OBE, Chair* *Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known* *Members of the public and governor observers will have both their camera and microphone disabled for the duration of the meeting*		5
A2	Actions from previous meeting (no active actions) *Suzy Brain England OBE, Chair*	*Review*	
B	**True North SA1 - QUALITY AND EFFECTIVENESS**		**09:35**
B1	Chair's Assurance Log – Quality & Effectiveness Committee *Jo Gander, Non-executive Director*	*Assurance*	5
B2	Clinical Negligence Scheme for Trusts (CNST) Year 5 Board Declaration *Lois Mellor, Director of Midwifery*	*Approve*	20
B3	Maternity & Neonatal Update *Lois Mellor, Director of Midwifery*	*Assurance*	10
C	**True North SA4 – FINANCE & PERFORMANCE**		**10:10**
C1	Operational Performance Update (verbal) *Denise Smith, Chief Operating Officer*	*Assurance*	10
C2	Finance Update *Alex Crickmar, Deputy Director of Finance*	*Note*	10
D	**GOVERNANCE, ASSURANCE & STRATEGY**		**10:30**
D1	Chair's Assurance Log – Charitable Funds Committee *Hazel Brand, Non-executive Director*	*Assurance*	5
D2	Use of Trust Seal *Fiona Dunn, Director Corporate Affairs / Company Secretary*	*Note*	5

E	**OTHER ITEMS**		**10:40**
E1	Any other business (to be agreed with the Chair prior to the meeting) *Suzy Brain England OBE, Chair*	*Discussion*	5
E2	Governor questions regarding the business of the meeting (10 minutes)* *Suzy Brain England OBE, Chair*	*Discussion*	10
E3	Minutes of the meeting held on 28 November 2023 *Suzy Brain England OBE, Chair*	*Approval*	5
E4	**Date and time of next meeting:** **Date:** Tuesday 30 January 2024 **Time:** 09:30 **Venue:** MS Teams	*Information*	
F	**MEETING CLOSE**		**11:00**

***Governor Questions**

The Board of Directors meetings are held in public but they are not 'public meetings' and, as such the meetings, will be conducted strictly in line with the above agenda.

For Governors in attendance, the agenda provides the opportunity for questions to be received at an appointed time. Due to the anticipated number of governors attending the virtual meeting, Lynne Schuller, Lead Governor will be able to make a point or ask a question on governors' behalf. If any governor wants Lynne to raise a matter at the Board meeting relating to the papers being presented on the day, they should contact Lynne by 5pm the day before the meeting to express this. All other queries from governors arising from the papers or other matters should be emailed to Fiona Dunn for a written response.

In respect of this agenda item, the following guidance is provided:

- Questions at the meeting must relate to papers being presented on the day.
- Questions must be submitted in advance to Lynne Schuller, Lead Governor.
- Questions will be asked by Lynne Schuller, Lead Governor at the meeting.
- If questions are not answered at the meeting Fiona Dunn will coordinate a response to all Governors.
- Members of the public and Governors are welcome to raise questions at any other time, on any other matter, either verbally or in writing through the Trust Board Office, or through any other Trust contact point.

Suzy Brain England OBE
Chair of the Board

2312 - A1 WELCOME, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Suzy Brain England OBE, Chair 09:30

Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known

Members of the public and governor observers will have both their camera and microphone disabled for the duration of the meeting

REFERENCES

Only PDFs are attached

Register of Interests & FPP (13.12.23).pdf

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
Register of Directors' Interests

Register of Interests

Suzy Brain England OBE, Chair of the Board

Chair at Keep Britain Tidy
Lead Examiner for Chartered Director by the Institute of Directors
Founder and Chair of Cloud Talking, Aspirational Mentoring
Co-opted Board member Doncaster Chamber of Commerce
Advisory Committee on Clinical Impact Awards (ACCIA)
Facilitate/Chair NHS Providers training & development session as required

Kath Smart, Non-Executive Director

Chair – Acis Group, Gainsborough (Housing provider)
Court Secretary – Foresters Friendly Society, Sheffield (Mutual Society)
Senior Trust Associate Manager (TAM – or 'Hospital Manager' under the Mental Health Act) – Rotherham, Doncaster & South Humber NHS FT

Mark Bailey, Non-Executive Director

Non-Executive Chair, Doncaster and Bassetlaw Healthcare Services Ltd
Non-Executive Director – Derbyshire Community Health Services Foundation Trust
Executive Coach – NHS Leadership Academy (voluntary)
Non-Executive Director for MEDQP Ltd (Voluntary)

Jo Gander, Non-Executive Director

Managing Director Gander Healthcare Solutions (Dormant business)
Membership of Advisory Committee on Clinical Impact Awards (ACCIA) Yorkshire and Humber Sub-Committee

Mark Day , Non-Executive Director

Health Development Director, Equity Solutions Group - (Investment and development organisation that specialises in partnerships with the public sector and the Design, Build, Finance and Operation (DBFO) of bespoke buildings)
Non-Executive Chair, Summerhill Service Limited (SSL)- SSL is a wholly owned subsidiary of Birmingham and Solihull Mental Health NHS Foundation Trust providing a range of support services to the Trust and other customers
Director of Corporate Services, Money Advice Trust, aregistered charity providing debt advice to the public, influencing public policy, and collaborating with a range of partners to improve practice

Hazel Brand , Non-Executive Director

Councillor, Bassetlaw District Council (independent) In this role, member of the Council's Appointments and Planning Committees
Parish Councillor, Misterton

(as at 13 December 2023)

Lucy Nickson , Non-Executive Director
Chief Executive for Day One Trauma Support, national charity

Richard Parker OBE, Chief Executive Officer
Member of the South Yorkshire Integrated Care Board
Spouse is a senior Nurse at Sheffield Health and Social Care Trust

Dr Tim Noble, Executive Medical Director
Spouse is a Consultant Physician at DBTH

Jon Sargeant, Interim Director of Recovery, Innovation & Transformation
Director, Doncaster and Bassetlaw Healthcare Services Ltd

Zoe Lintin, Chief People Officer
Trustee on the Board of Sheffied Academy Trust
Spouse works in NHS (STH)

Denise Smith, Chief Operating Officer
Various family members work in NHS. None working in SYB network

Karen Jessop , Chief Nurse
Husband VSM at Hull University Hospital (Chief Nurse Information Officer)

Emma Shaheen, Director Communication & Engagement
Sister is Deputy Director of Involvement, South Yorkshire ICB

Fiona Dunn, Director Corporate Affairs/Company Secretary
Animal Ranger, Yorkshire Wildlife Park

The following have no relevant interests to declare:

Emyr Jones	Non-Executive Director
Zara Jones	Deputy Chief Executive
Nick Mallaband	Acting Executive Medical Director

(as at 13 December 2023)

Fit and Proper Person Declarations

The Trust can confirm that every director currently in post has declared that they:

(i) am not an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;

(ii) am not the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

(iii) am not a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

(iv) have not made a composition or arrangement with, or granted a trust deed for, my creditors and not been discharged in respect of it;

(v) have not within the preceding five years been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on me;

(vi) am not subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986;

(vii) have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which I am employed;

(viii) am able by reason of my health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which I am appointed or to the work for which I am employed;

(ix) have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity;

(x) am not included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland; and

(xi) am not prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

Directors are requested to note the above and to declare any changes to their position as appropriate in order to keep their declaration up to date.

(as at 13 December 2023)

2312 - A2 ACTIONS FROM PREVIOUS MEETING

Decision Item

Suzy Brain England OBE, Chair

No active actions

2312 - B TRUE NORTH SA1 - QUALITY AND EFFECTIVENESS

2312 - B1 CHAIR'S ASSURANCE LOG - QUALITY & EFFECTIVENESS COMMITTEE

Discussion Item | Jo Gander, Non-Executive Director | 09:35

5 minutes

REFERENCES

Only PDFs are attached

B1 - Chair's Assurance Log - Quality & Effectiveness Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Quality & Effectiveness Committee - Chair's Highlight Report to Trust Board

Subject:	**Quality & Effectiveness Committee Meeting**	**Board Date: December 2023**
Prepared By:	Jo Gander, Committee Chair & Non-executive Director	
Approved By:	Quality & Effectiveness Committee Members	
Presented By:	Jo Gander, Committee Chair & Non-executive Director	
Purpose	The paper summaries the key highlights from the Quality & Effectiveness Committee meeting held on 05 December 2023	

Matters of Concern (Moderate, Partial or No Assurance)	**Work Underway / Major actions commissions**
Clinical Audit update following deep dive, good progress but further improvements still required. Sufficient action taken to close the limited assurance high risk actions from Internal Audit report, but further work and embedding of described processes to follow. **Partial Assurance** QEC acknowledged the draft DRI Post-mortem inspection report and the Trust's response to the recommendations of Sir Jonathan Michael's report into David Fuller/Maidstone and Tunbridge Wells. **Partial Assurance** Nutrition Steering Group Annual Report highlighted the need for a Food & Drink strategy refresh in 2024 and areas of non-compliance requiring improvement. **Partial Assurance** Executive Medical Director Report recognising the need for a more streamlined approach and the balance between clinical commitments and evidencing good governance through attendance and active contribution at clinical governance meetings **Partial Assurance** Mortality Data Assurance Group Report noted along with acknowledgement that further improvement work in senior clinical/medical engagement in the SJR process is needed plus clinical coding work **Partial Assurance** Radiation Safety/IRMER Standards Compliance Update Report – still developments that need to be made and supported so that the trust is able to fully evidence compliance with regulatory demands, including software solution to monitor documents, versions, amendments required in addition to staff equipment training **Partial Assurance**	Assurance and monitoring of Sir Jonathan Michael's report (Independent Inquiry re. David Fuller case) to be added to the QEC workplan Alison Hall/Howard Timms plus Executive Medical Director to bring a report to the next QEC (February 2024). Board Assurance Framework reviewed recognising the Board development session to determine risk appetite and actions required to close the gap required. Committee assured of current position as set out in the BAF but agreed that a view on what it would take to reduce the current risk score to the target score needs to be understood and discussed at future meetings. Also, key issues descriptions will be updated to ensure the narrative reflects the potential risk associated with the descriptions, as opposed to the descriptions being a risk themselves.

Significant or Full Assurances to Provide	Decisions Made
Chief Nurse Report – Patient Safety serious incident action plan compliance against timeframe for closure and information regarding each divisional team's compliance, Compliance per division against Duty of Candour requirements and progress made. DBTH now live with the national requirement The Learn from Patient Safety Events (LFPSE) service launched to replace previous national reporting systems. **Significant Assurance** Chief Nurse report - Quality - Reduction in Hospital Acquired Pressure Ulcer category two on track to meet trajectory. Tendable audit results across falls demonstrates sustained improvement. DBTH within agreed thresholds for infection prevention and control (IPC). **Significant Assurance** Maternity & Neonatal Transformation Report – following approval of key reporting requirements at board update on progress against CNST currently on track to meet target for December 2023 **Significant Assurance**	Revisit Board Assurance Framework overview post Board Development session to confirm risk appetite and actions required to achieve ambition.

Assurance Levels	
Internal - Second Line of Defence	
Full Assurance	The system design and existing controls are working well. Potential innovations being considered all relate to achieving recognised best practice
Significant Assurance - with minor improvement opportunities	The system design and existing controls are working well. Some minor improvements have been identified. Identified manangement actions are not considered vital to achievemnet of strategic aims & objectives - although if unaddressed may increase likelihood of risk
Partial Assurance - with improvements required	The system design and existing controls require strengthening in areas. A few operational weaknesses have been recognised. Existing performance presents some areas of concern regarding exposure to reputational or other strategic risks. Weaknesses identified present an unacceptable level of risk to achieving strategic aims & objectives. A small number of priority actions havae been accepted as urgently required.
No Assurance	The system design & existing controls are ineffective. Several fundamental operqational weaknesses have been recognise. Existing performance presents an unaccpetable exposure to reputational or other strategic risks. Weaknesses identified are directly impacting upon the prevention to achieving strategic aims & objectives. Several priority management actions have been accpeted as urgently required.
External - Third Line of Defence	
Substantial	IA - That the framework of governance, risk management and control has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed.
Significant	IA - That there is generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
Moderate	IA - That there is generally sound framework of governance, risk management and control, however, inconsistent application of controls puts the achievement of the organisation's objectives at risk.
Limited	IA - That there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the organisation's objectives.
Weak	IA - That there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that will result in failure to achieve the organisation's objectives.

2312 - B2 CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) YEAR 5 BOARD DECLARATION

Decision Item | Lois Mellor, Director of Midwifery | 09:40

20 minutes

REFERENCES

Only PDFs are attached

- B2 - Clinical Negligence Scheme for Trusts Year 5 Board Declaration.pdf
- B2 - CNST Presentation.pdf
- B2 - Training Action Plan (embedded in presentation).pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	19 December 2023	**Agenda Reference:**	**B2**
Report Title:	**Clinical Negliegence Scheme for Trusts (CNST) Board Declaration Presentation**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Lois Mellor, Director of Midwifery Tomas Barani, Clinical Director (Apologies sent due to annual leave)		
Appendices:			

Report Summary

Executive Summary

This presentation gives an overview of the progress against the Year 5 Clinical Negligence Scheme for Trusts (CNST) Safety actions.

The presentation shows the current position of the collated evidence and the predicted final submission.

Currently Safety actions 6 & 8 have outstanding evidence requirements. These should be met following today's meeting and production of the minutes.

The service is predicting to be able to declare full compliance with the 10 safety actions by 1st February 2024.

The Board is asked to consider the evidence provided, and give the CEO authority to sign the Board declaration for submission on 1st February 2024.

Recommendation:	The Board is asked to consider the evidence provided, and give the CEO authority to sign the Board declaration for submission on 1st February 2024.			
Action Require:	**Approval**	~~Review~~	**Take assurance**	~~Information only~~
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care and improve patient experience	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire & Bassetlaw ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		Yes	

Implications	
Board assurance framework:	BAF risk 1 - No Changes
Risk register:	ID 16 - Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs
Regulation:	CQC - Regulation 12 Potential high impact

Legal:		Clinical Negligence Scheme for trusts - High impact
Resources:		
Assurance Route		
Previously considered by:		Governance Meeting in Children's & Families Division Children & Families Board
Date:	6th October 2023	
Any outcomes/next steps		Support to continue improvements in maternity & neonatal service, and achieve year 5 CNST standards
Previously circulated reports to supplement this paper:		

CNST Board Declaration Presentation

Lois Mellor, DOM & Tomas Barani, CD (*apologies as on AL*)

Strategic objectives

www.dbth.nhs.uk

To be the safest trust in England, outstanding in all that we do.

www.dbth.nhs.uk

Board Declaration Overview (Current position)

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	9	0	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	6	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	7	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	14	0	0	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	5	0	0	0	0
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	No	3	1	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	8	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	No	26	1	1	0	0
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?	Yes	12	0	0	0	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Yes	8	0	0	0	0

LMNS Overview from assurance visits 16th October

CNST Safety Actions	DBTH
Safety Action 1 (PMRT)	
Safety Action 2 (MSDS)	
Safety Action 3 (ATAIN)	
Safety Action 4 (Clinical Workforce Planning)	
Safety Action 5 (Midwifery Workforce)	
Safety Action 6 (SBLv3)	
Safety Action 7 (MNVP)	
Safety Action 8 (CCF - Training)	
Safety Action 9 (Trust Board Oversight)	
Safety Action 10 (HSIB & ENS)	

RAG	
G - fully compliant	
A/G - currently amber but projected to be green	
A - on track	
A/R - currently amber - risk to acheiveing	

Safety Actions

Milestone	Milestone deadline	(RAG RATING)	Expected date of completion / Comments
SA1 – PMRT	7th December 2023	9/9	Need Trust Board minutes November & December & spreadsheet for evidence
SA2 – MSDS	7th December 2023	6/6	Need Trust Board November TB minutes due in December for evidence re sustained engagement
SA3 – Transitional Care / ATAIN	7th December 2023	7/7	Need Trust Board November minutes due in December for evidence

Safety Actions

Milestone	Milestone deadline	(RAG RATING)	Expected date of completion / Comments
SA4 Clinical Workforce	7th December 2023	14/14	Need November & December Trust Board minutes / December's paper for evidence
SA5 – Midwifery Workforce	7th December 2023	5/5	Need November & December Trust Board minutes / December's paper for evidence

Safety Actions

Milestone	Milestone deadline	(RAG RATING)	Expected date of completion / Comments
SA6 – Saving Babies Lives	1st February 2024	3/4	Continue to input into implementation tool via NH Futures and work towards full implementation by March 2024. Share SBL toolkit with Trust Board.
SA7 – Listening / Co production	7th December 2023	8/8	Need November & December Trust Board minutes / December's paper for evidence for service user updates

Safety Actions

Milestone	Milestone deadline	(RAG RATING)	Expected date of completion / Comments
SA8 – Training	1st December 2023	26/27	Action plan to achieve 90% for all staff groups by 23/02/23 to be approved at Trust Board December then will need minutes for evidence
SA9 – Board Safety	7th December 2023	12/12	Need Trust Board minutes November due in December for evidence and Decembers due January Need Decembers C&F & CG minutes December
SA10 – HSIB	7th December 2023	8/8	Need Trust Board minutes November due in December for evidence and December's paper / minutes due January

Risks & Issues

Risk			
Description	**Owner**	**Comments/Actions**	**Rating**
SBLV3 - not achieving full implementation by 31 March 24	Emma Merkuschev	Working towards increasing the percentage compliance for each element with the leads	*10*

Training – Staff not being able to attend training due to staffing issues	Lois Mellor / Eki Emovon	Escalation emails being escalated though clinical governance by the training leads

Current Outstanding Evidence

- Need Minutes from formal Trust Board meetings for November and December 2023
- Safety Action 6 – Confirmation to the trust board that the service is on track to fully implement all 6 elements of Saving Babies Lives version 3 by March 2024.
- Awaiting final confirmation from LMNS re CoC Plan if plan is acceptable then the service is on track to fully implement all 6 elements of Saving Babies Lives version 3 by March 2024.

Current Outstanding Evidence

- Safety Action 8 - Confirmation that all groups staff have achieved > 80% and if 90% not achieved an action plan is in place approved by Trust Board
- *80% has been achieved in all staff groups and an action plan developed to achieve 90% for those staff groups not achieving 90% by 01/12/23. Below is the action plan for approval :-*

Microsoft Word Document

Board Declaration Overview

(expected submission on 1st February 2024)

That the service will be fully compliant with all 10 safety actions providing all the training requirements meet > 90% by 23rd February 2024 (this expected to be completed by the submission on 1st February 2023 & further evidence will not need to be submitted) AND saving babies lives submission remains on track until 1st February 2024.

Next Steps

- The Trust Board to confirm they are satisfied with the evidence provided to achieve the ten maternity safety actions
- The trust board to give their permission for the CEO to sign the Board Declaration form prior to submission to NHS Resolution on 1st February 2024
- The CEO to ensure that the Accountable Officer for their integrated Care system is appraised of the MIS safety actions (Cathy Winfield, ICB Chief Nurse who attends the LMNS Collaborative Board)

Thank you, any questions?

Training Action Plan

Action plan to achieve 90% compliance for all staff groups if not achieved by 01/12/23 by 23/02/24

Action	Lead	Support Required	Timescale
Ensure that all remaining members of staff who are not booked are booked on	SR/ES/LC	Support from staffs supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	ASAP
Continue to monitor compliance weekly/monthly and escalate as appropriate.	SR/ES/LC	Support from staffs supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	Ongoing
90% achieved for Fetal Monitoring study day – Consultants	SR/ES	Support from staffs supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	06/02/24
90% achieved for Fetal Monitoring study day – Doctors	SR/ES	Support from staffs supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	05/12/23
90% achieved for Fetal Monitoring study day – Midwives (Inc B&A)	SR/ES	Support from staffs supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	06/02/24
90% achieved for Prompt study day – Doctors	LC	Support from staffs supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	12/01/24
90% achieved for Prompt study day – Midwives (inc B&A)	LC	Support from staffs supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	26/01/24
90% achieved for Prompt study day – Maternity Support Workers	LC	Support from staffs supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	26/01/24
90% achieved for Prompt study day – Anaesthetic Consultants	LC	Support from staffs supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	14/12/24
All leads to send an email 1 month prior to expiration date of the individual's competency. This will serve as an early reminder before the member of staff becomes non-compliant to keep the 90% up	SR/ES /LC	Support from staffs supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	Ongoing monthly

Updates will be provided to Trust Board as the 90% is achieved.

01/12/2023
Author – Angela Lister, Project Manager - Maternity
Contributor – Danielle Bhanvra, HOM

2312 - B3 MATERNITY & NEONATAL UPDATE

Discussion Item | Lois Mellor, Director of Midwifery | 10:00

10 minutes

REFERENCES

Only PDFs are attached

- B3 - Maternity & Neonatal Update.pdf
- B3 - Appendix 1 Training Action Plan Safety Action 8.pdf
- B3 - Appendix 2.pdf
- B3 - Appendix 2.xlsx

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	19 December 2023	**Agenda Reference:**	**B3**
Report Title:	**Maternity & Neonatal Report**		
Sponsor:	Karen Jessop, Chief Nurse		
Author:	Lois Mellor, Director of Midwifery Laura Churm, Divisional Nurse, Paediatrics		
Appendices:	Appendix 1 - Action plan to achieve 90% training Appendix 2 - Saving Babies lives Toolkit		

Report Summary

Executive Summary

This report gives an overview on the progress within the maternity and neonatal services against the national standards. The report details the outcomes for mothers and babies in the service together with a number of initiatives to improve quality and safety.

Work against the current year 5 clinical negligence scheme for trusts (CNST) is ongoing, and progress is steady. Safety action 6 has be externally assessed by the LMNS and is on track to be fully compliant by 31st March 2024. Included in the report is:

- The Saving Babies Lives toolkit which needs to be shared with the trust board (current position) - Appendix 2
- The action plan to achieve 90% training within 12 weeks is included in this paper, and needs formally approving by the Trust Board of Directors - Appendix 1

The service is non-compliant with British Association of Perinatal Medicine (BAPM) nursing requirements but has an action plan in place to meet these requirements. Work is ongoing to improve transitional care for eligible babies, and their families.

Midwifery staffing is stable, and the service is continuing to recruit to midwifery posts.

Medical staffing remains stable, and consultants have attended in person when required. The service is non-compliant with compensatory rest for medical staff but has an action plan in place to address this.

The service is continuing to make progress with all the national guidance, and where it is non-compliant has action plans in place to meet the recommendations.

Please also note that the Maternity and Newborn Safety Investigations (MNNSI) programme has now come into effect, hosted by the CQC and replacing Health Services Investigation Bureau for maternity/neonates.

Recommendation:	For the Trust Board of Directors to take assurance from the detail provided within this Maternity and neonatal report and approve the training action plan.			
Action Require:	**Approval**	~~Review~~	**Take assurance**	~~Information only~~

Link to True North Objectives:	TN SA1:	TN SA2:	TN SA3:	TN SA4:
	To provide outstanding care and improve patient experience	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire & Bassetlaw ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications	
Board assurance framework:	BAF risk 1 - No Changes
Risk register:	ID 16 - Inability to recruit a sufficient workforce and to ensure colleagues have the right skills to meet operational needs
Regulation:	CQC - Regulation 12 Potential high impact
Legal:	Clinical Negligence Scheme for trusts - High impact
Resources:	

Assurance Route	
Previously considered by:	Governance Meeting in Children's & Families Division Children & Families Board
Date:	6th October 2023
Any outcomes/next steps	Support to continue improvements in maternity & neonatal service, and achieve year 5 CNST standards
Previously circulated reports to supplement this paper:	

Monthly Board Report

December 2023

Additional information in support of this report is provided in conjunction with the Board Surveillance PowerPoint Presentation.

1. Findings of review of all perinatal deaths

1.1 Stillbirths and late fetal loss > 22 weeks

There were four stillbirths in November at 24+6, 24+5, 30+3 and 29+1 week gestations. Antenatal rapid reviews have been undertaken, with no initial immediate learning identified.

1.2 Neonatal Deaths

There were no neonatal deaths in November.

1.3 Actions/ Learning from Perinatal Mortality Review Tool (PMRT)

One case was closed in November 2023 with no actions.

2. Neonatal Services

Neonatal staffing is 87% recruited with 83% of establishment at work, with 6% maternity leave. The Qualified in Speciality ratio is below the 70% standards at 64% on the Neonatal Unit (NNU). During October we had 90% of shifts resourced within British Association of Perinatal Medicine (BAPM) standards compared to a quarter 2 average of 75% at DRI and 59% at Bassetlaw. Half of these shifts had the number of registered nurses for clinical care but were missing a supernumerary co-ordinator. A workforce review and 3 year plan to meet BAPM and CNST standards was discussed in the Trust Executive Group in September 2023, the gaps were acknowledged and it was agreed to support the development of a phased business plan to be submitted to Trust Capital Investment Group and included in the divisions business planning requirements for 2024/25. This was reported to Trust Board in October.

The Local Maternity and Neonatal Service (LMNS) and Operational Delivery Network (ODN) have been updated on the gaps and action plan.

Proposed investment for Meeting BAPM standards

Year	Investment	Total funding
2023-2023	increase clinical roles to 25% uplift at SCBU and NNU	67,865.76
2024-2025	Quality roles on SCBU and coordinator at night NNU	217,133.97
2025-2026	24 hour coordinator for SCBU at night	310,252.37
2027-2027	AHP at recommendations	201,056.73
total investment		796,308.84

No new serious incidents or Maternity and Newborn Safety Investigation Programme (MNNSI) eligible cases.

The Getting It Right First Time (GIRFT) action plan for Neonatal service remains open while we establish transitional care, a joint Quality Improvement (QI) programme commenced in June to develop a transitional care plan for neonates on both sites. Work to review neonatal consultant cover including planned absences is ongoing in relation to a historic Serious Incident (SI) with a paper going to the Capital Investment Group in December.

2.1 Avoiding Term Admissions into Neonatal Units (ATAIN)

Due to sickness and a change of staff the ATAIN reviews have been delayed. Multidisciplinary reviews are recommencing and the reviews for October and November will be reported in the January 2024 Board.

3. Findings of review of all cases eligible for referral MNNSI

Executive summary

Table 1 MSNI cases

	Cases to date
Total referrals	27
Referrals / cases rejected	8
Total investigations to date	19
Total investigations completed	18
Current active cases	1
Exception reporting	0

3.1 Reports Received since last report

The service is expecting the final report of the one outstanding investigation, this is currently with the family for factual accuracy checking.

3.2 Current investigations

One case.

3.3 Maternity and Newborns Safety Investigations (MNNSI) / NHS resolutions (NHSR) / Care quality Commission (CQC) or other investigation with a concern or request for action made directly to the Trust

None.

4. Serious Incident Investigations (Internal)

There is one internal investigation reported last month that is under review.

5. Training Compliance

The service has achieved 80% compliance with all training requirements by 1st December 2023. For all areas that are <90% there is an action plan in place to achieve 90% compliance within 12 weeks.

These areas are:

- All staff groups for attendance at the fetal monitoring study day
- PROMPT training for all staff groups except Consultant Obstetricians

All other areas of training achieved 90% or more.

The training position on 1st December 2023 was:

K2 E learning package and Cardiotocograph (CTG) Study Day

Table 2 - K2 & CTG figures

Staff Group	K2 CTG Compliance	Study Day Compliance
90% of Obstetric Consultants	**93.3 % ↑**	**80% ↓**
90% of All other Obstetric Doctors including trainees	**90 % ↑**	**80%↑**
90% of Midwives including Bank & NHSP	**90.9% ↑**	**86.3% ↑**

Practical Obstetric Multi Professional Training (PROMPT) Training (Obstetric Emergencies)

Table 3 - PROMPT figures

Staff Group	Prompt Compliance
90% of Obstetric Consultants	**100% ↑**
90% of All other Obstetric Doctors including trainees	**89.5% ↑**
90% of Midwives including NHSP & agency	**85.9% ↑**
90% of Maternity Support Workers	**86.7% ↑**
90% of Obstetric Anaesthetic Consultants	**87.5% ↑**

Newborn Life Support (NLS) Training

Table 4 - NLS figures

Staff Group	NLS Compliance
90% of neonatal consultants or paediatric consultants covering neonatal units	**100% ↑**
90% of neonatal junior doctors	**92% →**
90% of neonatal nurses (Band 5 7 above)	**100% ↑**
90% of advances neonatal practitioner (ANNP's)	**100% →**
90% of Midwives	**92.77 % ↓**

6. Service User Feedback

The Maternity and Neonatal Voices partnership meeting was held on 23rd November 2023. The Labour ward lead obstetrician attended the meeting and was extremely well received by the participants.

The chairs of the meeting asked many questions that had been submitted by the maternity services neonatal voices partnership members. There was plenty of discussion about work that is ongoing and could be considered including:

- Increasing early pregnancy services from 6 days a week to 7 days
- Support for women miscarrying in A & E departments
- Mental health support for trauma
- Support for parents with pre term infants on neonatal units.

Many local partners and charities were present to share what is on offer for Doncaster and Bassetlaw women.

The 15 steps challenge has been completed in neonatal services and will be commencing in maternity in the near future.

7. Coroner Prevention of Future deaths (Reg 28) made directly to Trust

None.

8. Progress in achievement of Clinical Negligence Scheme for Trusts (CNST)

Work is continuing of the Year 5 CNST standards, with operational oversight from the CNST and Ockenden Oversight Committee. The service continues to collect evidence to support compliance with the safety actions. The latest update was presented to the Trust's Quality and Effectiveness Committee in December 2023.

The LMNS are holding regular "confirm and challenge" meetings with trusts in relation to progress against achieving CNST year 5, the report from the November visit is awaited.

For safety action 6 (saving babies lives care bundle version 3) the service has been assessed by the LMNS as compliant at 70% implementation with the tool which needs to be shared with the trust board (please see appendix 2). The service is currently on track to be fully compliant with saving babies Lives care bundle version 3 by 31st March 2024.

As reported above the service has achieved >80% in all areas of training and has action plans in place to achieve 90% within 12 weeks. The action plan for achieving 90% training has been included in appendix 1 for approval by the Trust Board of Directors.

8.1 Board Level Safety Champion

The maternity and neonatal safety champion clinical visit and meeting took place on 23rd November 2023. The board level safety champions, two non-executive directors and the chair of the maternity and neonatal voices partnership visited the clinical areas. They met with the Quadrumvirate after their clinical visit.

New concerns raised were:

- The outdated décor on Special care Baby Unit and the poor standard of resident family accommodation
- Concerns re: a newly qualified midwife supervising a student midwife – this addressed immediately with the Head of Midwifery

Concerns addressed since last meeting:

- Worries about supporting the newly qualified midwives – a meeting was held to discuss the concerns, and ongoing support provided by the recruitment and retention team / Professional Midwife Advocates

There has been support from safety champions by reviewing progress against the CNST standards, and the reporting to the board.

Looking to the future there was also discussion about the implementation of Patient safety incident response Framework which will commence on 1st December 2023. The need for inclusion of families' testimonies, and the planned family liaison officers.

8.2 Culture, Leadership & SCORE survey

The service is working with an external facilitator to undertake 'culture conversations'. These sessions are confidential and encourage all staff to talk about what it is like to work in the maternity and neonatal service. There have been four sessions so far, and the vacillator will collect feedback and identify themes from the conversations.

This information together with the identified themes from the SCORE survey will be used to make changes in the service with an aim to improve the working environment.

9. Perinatal Surveillance dashboard

Due to the timings of the December meeting and data availability, the perinatal surveillance dashboard data will be reported in the January board paper.

10. Midwifery staffing

The newly qualified midwives have completed their induction and supernumerary time. The service now has the highest number of midwives working since January 2019. The service continues to recruit midwives and are interviewing current year 3 students who qualify January to March 2024. The NHSP incentive ceased on 13th November 2023, shifts that are required to maintain safe services are continuing to be offered on NHSP. If there are safety critical shifts required, these are released to the agencies 3 days before. In November the attrition rate for midwives was 0%.

Planning has commenced for the recruitment of newly qualified midwives who finish in September 2024.

One to one care in labour remains stable, and for the month of November is:

Doncaster - 100%
Bassetlaw - 100 %

The labour ward coordinator has remained supernumerary 100% on both sites.

On the live birthrate+® app midwives can record any red flag incidents. The data is inputted every four hours and the following episodes of red flags were recorded in October 2023.

Table 5 Doncaster BR+ © data

Red Flag	Number of times
Delayed or cancelled critical time activity	1
Delay between presentation and triage	1
Delay between admission and commencing induction	2
Management Actions taken	
Redeploy staff internally	18
Redeploy staff from community	2
Staff sourced from bank / agency	6
Unit on divert	9
Escalate to Manager on call	3

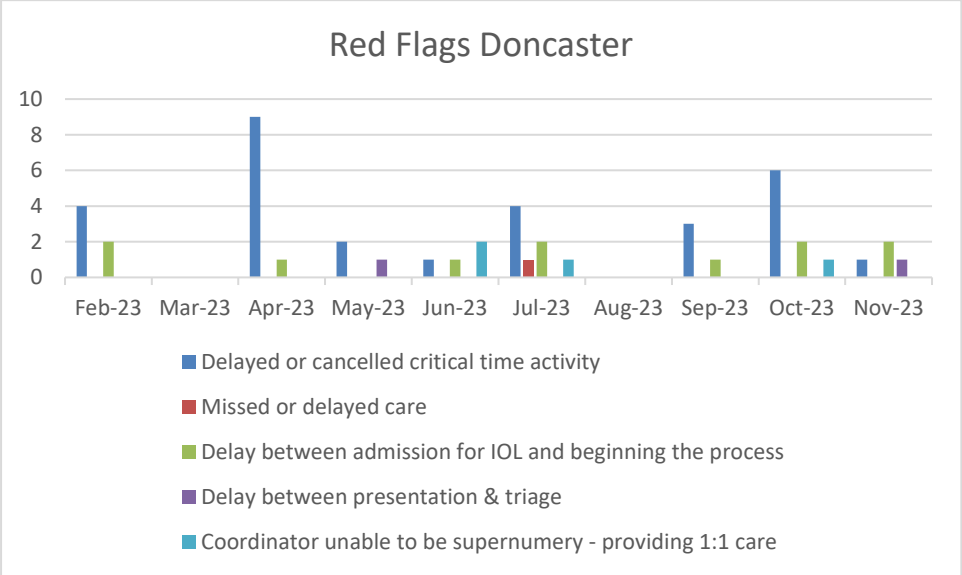
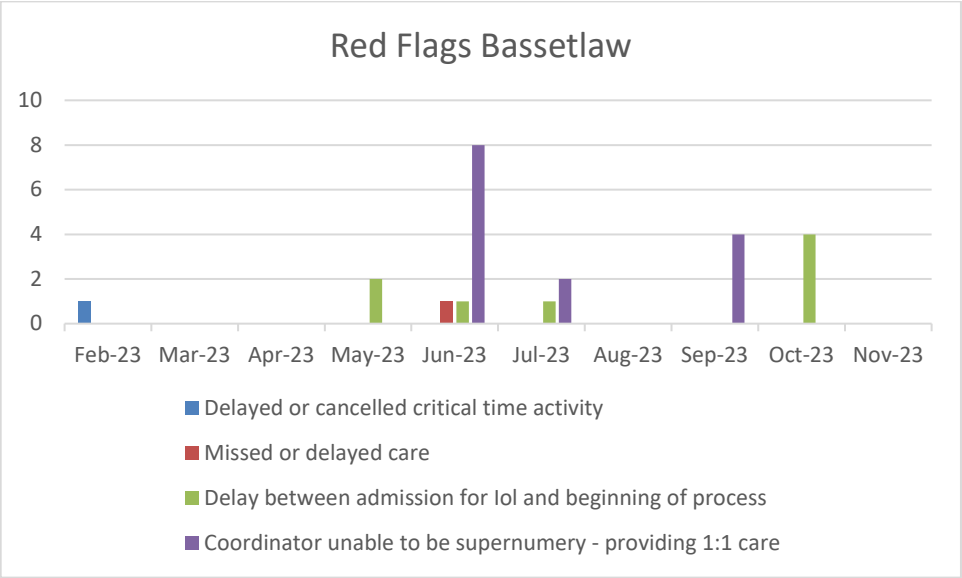


Table 10 Bassetlaw BR+ © data

Red Flag	Number of times
None	
Management Actions taken	
Redeploy staff internally	9
Redeploy staff from community	1
Unit of divert	11
Escalate to Manager on call	5



The Triage Service

Due to the short time frame for this board report the performance for November is not available and will be reported together with December in the January paper.

11. Medical Workforce

Medical staffing in obstetrics and neonates remains stable.

There has been no recorded incidents of consultant non-attendance in an emergency in this month.

The SOP for compensatory rest has been added to the intranet, the service remains non-compliant and as reported in the November paper has an action plan to meet compliance.

12. Conclusion

This report contains the details of the Trust performance against local and nationally agreed measures to monitor maternity services, the risks in relation to training compliance are highlighted and the Trust assessment of compliance with meeting the CNST standards is detailed, the Trust Board of Directors are asked to consider the assurance provided in this report and approve the action plan contained in Appendix 1.

Appendix 1

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Training Action Plan

Action plan to achieve 90% compliance for all staff groups if not achieved by 01/12/23 by 23/02/24

Action	Lead	Support Required	Timescale
Ensure that all remaining members of staff who are not booked are booked on	SR/ES/LC	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	ASAP
Continue to monitor compliance weekly/monthly and escalate as appropriate.	SR/ES/LC	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	Ongoing
90% achieved for Fetal Monitoring study day – Consultants	SR/ES	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	06/02/24
90% achieved for Fetal Monitoring study day – Doctors	SR/ES	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	05/12/23
90% achieved for Fetal Monitoring study day – Midwives (Inc B&A)	SR/ES	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	06/02/24
90% achieved for Prompt study day – Doctors	LC	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	12/01/24
90% achieved for Prompt study day – Midwives (inc B&A)	LC	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	26/01/24
90% achieved for Prompt study day – Maternity Support Workers	LC	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	26/01/24
90% achieved for Prompt study day – Anaesthetic Consultants	LC	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	14/12/24
All leads to send an email 1 month prior to expiration date of the individual's competency. This will serve as an early reminder before the member of staff becomes non-compliant to keep the 90% up	SR/ES /LC	Support from staff supervisors, Clinical Director, HOM, Director of Midwifery, managers, NHSP management and Agency management to facilitate attendance.	Ongoing monthly

Updates will be provided to Trust Board as the 90% is achieved.

01/12/2023
Author – Angela Lister, Project Manager - Maternity
Contributor – Danielle Bhanvra, HOM

Saving Babies Lives Care Bundle (Version 3)

Implementing Version 3 of the Care Bundle

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

Organisational roles and responsibilities

As part of the Three Year Delivery Plan for Maternity and Neonatal Services, NHS Trusts are responsible for implementing SBLCBv3 by March 2024 and Integrated Care Boards (ICBs) are responsible for agreeing a local improvement trajectory with providers, along with overseeing, supporting, and challenging local delivery. Successful implementation of SBLCBv3 requires providers, commissioners, and networks to collaborate successfully:

→ **Providers** are responsible for implementing SBLCBv3, including baselining current compliance, developing an improvement trajectory, and reporting on implementation with their ICB as agreed locally. They are also responsible for submitting data nationally relating to key process and outcome measures for each element.

→ **ICB's** are responsible for agreeing a local improvement trajectory with providers, along with overseeing, supporting and challenging local delivery. Where there is unresolved clinical debate about a pathway, providers may wish to agree a variation to an element of the care bundle with their integrated care board. An integral part of ICSs, **LMNSs** are accountable to ICBs and have the system's maternity and neonatal expertise to support planning and provide leadership for improvement, facilitating peer support, and ensuring that learning from implementation and ongoing provision of SBLCBv3 is shared across the System footprint.

→ **Clinical Networks and Regional Maternity teams** are responsible for providing support to providers, ICBs and LMNSs to enable delivery and achieve expected outcomes. It is important that specific variations from the pathways described within SBLCBv3 are agreed as acceptable clinical practice by their Clinical Network.

Implementation tool user guide

The Futures NHS Collaboration Platform includes a user guide for use alongside this implementation tool. This user guide is intended for all LMNS and Trust colleagues who are responsible for implementing SBLCB v3. The user guide includes a variety of resources, videos, testimonials, presentations and freqently asked questions to support the use of the implementation tool. To view the resources or request access to the user guide use the link below:

Implementation Tool - Saving Babies' Lives Implementation Tool - FutureNHS Collaboration Platform

Contents

Element 1 – Reducing smoking in pregnancy

Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction

Element 3 – Raising awareness of reduced fetal movement

Element 4 – Effective fetal monitoring during labour (N.B. information not capturable in MSDS v2.0)

Element 5 – Reducing preterm birth

Element 6 – Management of Diabetes in Pregnancy

Contact Us

Queries or questions in relation to the functionality or use of the implementation tool: england.maternitytransformation@nhs.net

Queries or questions in relation to the NHS Resolutions CNST guidance: nhsr.mis@nhs.net

Queries or questions in relation to the Saving Babies Lives Care Bundle Version 3 guidance: england.maternitytransformation@nhs.net

Further Support/Information

Saving babies' lives version three: a care bundle for reducing perinatal mortality - published 31 May 2023

NHS Resolutions Maternity Incentive Scheme – year five - published May 2023

Core competency framework version two - published 31 May 2023

Saving babies' lives implementation tool user guide (NHS Fututes) - published July 2023

Standard Operating Procedure

Developed by: Jo Hadley - Midlands Regional Digital Midwife
Jenny Brown - Midlands Senior Quality Improvement Manager
Tony Kelly - National Clinical Advisor for National Maternity and Neonatal Safety Improvement programme and Leadership and Culture Programme
Karen Thirsk - Senior Project Manager
Charlie Podschies - Senior Programme Manager
Rachel Vollans - Project Coordinator

Quality assured by: NHS England

Saving Babies Lives Care Bundle (Version 3)

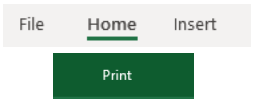
Document version history

Version	Date Issued	Brief Summary of Change
V0.1	26/05/2023	Draft version of newly designed SBLCB v3.0 Implementation Tool
V0.2	09/06/2023	Beta version for testing
V1.0	03/07/2023	Final version for publishing
V1.1	13/07/2023	Updated for technical issue on Element 5 with assessment drop-down fields
V1.2	18/07/2023	Logo and acknowledgement updated
V1.3	15/11/2023	Various changes - see 'Implementation Tool Version 1.3 Change Log' for further details.

Saving Babies Lives Care Bundle (Version 3)

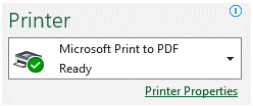
How to Print the Implementation Tool

The implementation tool can be printed by following the instructions below:

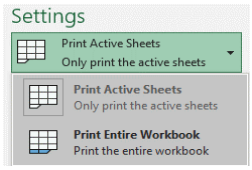


Select File from the Menu Bar or Alt and F (simultaneously) on the keyboard

Select Print from the Menu List or Alt and P (simultaneously) on the keyboard to open the Print Option



Select the Printer option. You can either print to a PDF document which can be saved and then emailed or shared. Or you can select an available printer from the drop down list and print to paper.



Change the printer settings to either:
Print only the selected worksheet you are currently viewing; OR

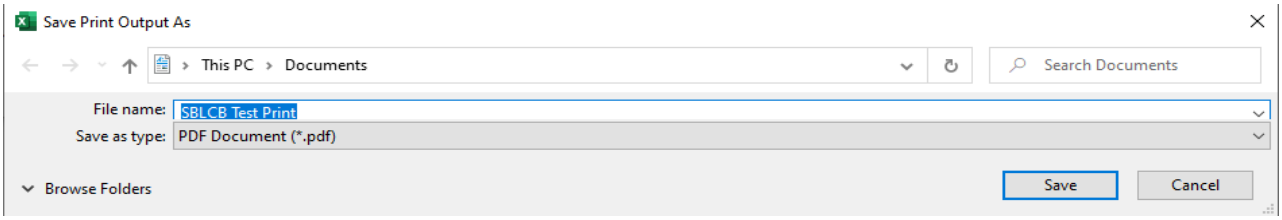
Print all worksheets within the implementation tool.

The page orientation, margins and scaling have been set within the tool and do not need to be changed in the printer settings.

The paper size can be adjusted to suit preference and printer functionality when choosing to print to paper.

Select the required number of copies and select Print.

If you choose to print to a PDF document, you will be prompted to select the save location and file name for your PDF:



Saving Babies Lives Care Bundle (Version 3)

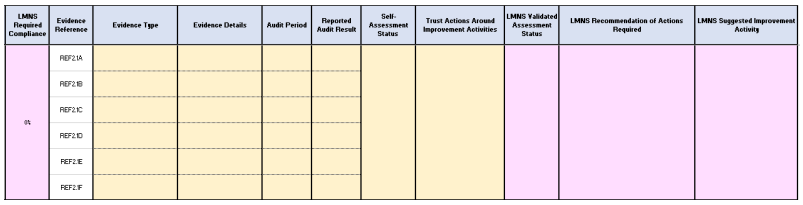
How to Use the Implementation Tool

This implementation tool is designed to gather information on progress towards full implementation of the Saving Babies' Lives Care Bundle Version 3, published 31 May 2023. This tool will support providers to baseline current practice against SBLCBv3, agree a local improvement trajectory with their ICB, and track progress locally in accordance with that trajectory. The results of this survey will enable NHS maternity providers to self-assess their compliance against the interventions and their alignment to Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). Please base your responses on your assessment of how much of your current activities match the requirements of the care bundle. Links to both guidance documents are included below under 'Further Support/Information'.

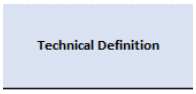
Provider Guidance

NHS maternity providers are required to complete the yellow boxes only on each of the following worksheets (the pink boxes are for completion only by the LMNS as part of their assurance process):

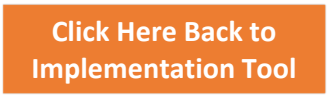
Implementation tool E1
Implementation tool E2
Implementation tool E3
Implementation tool E4
Implementation tool E5
Implementation tool E6



The relevant data items for the process and outcome indicators related to SBLCBv3 should be recorded where possible on the provider's Maternity Information System and included in the MSDS submissions to NHS England in an MSDSv2 (Information Standard Notice compatible format, including SNOMED-CT coding). Each of the above worksheets include, where available, technical guidance related to measuring and collecting evidence within the Maternity Services Data Set (MSDS) or another data collection tool. Where available, you can click on the relevant process or outcome indicator link to take you to the technical reporting guidance:



For ease at the top of each of the technical definition worksheets, there is a button that when clicked will take you directly back to the implementation tool worksheet that you were working on:



Each intervention within each element enables up to six pieces of evidence to be submitted for review and verification by the LMNS. Each piece of evidence submitted should be named using the reference number listed on the implementation tool in line with the intervention it relates to. You should also ensure your Trust name is specified in the evidence description/title. E.g. when saving evidence for Element 1, Intervention 1 use 'REF1.1A TRUST NAME Evidence description' as the document/evidence name.

If a piece of evidence relates to multiple interventions you only need to save and submit the evidence once. In this case include all reference numbers listed in the implementation tool in line with the interventions the evidence relates to. E.g. 'REF1.1A REF2.2B REF3.2C TRUST NAME Evidence description'.

The Futures NHS Collaboration Platform has restricted folders for every maternity provider which has been set up by NHS England to store evidence to demonstrate implementation and hold a live copy of the implementation tool for each provider. Please follow the link below to access the tool for your system and provider.

Implementation Tool - Saving Babies' Lives Implementation Tool - FutureNHS Collaboration Platform

Permissions have been granted based on the contacts authorised by LMNSs, alongside relevant NHS England regional and national programme leads. If you require access for other colleagues please email:

england.maternitytransformation@nhs.net

Please see LMNS SBLCB SOP for further information.

Completed tools will be analysed for the purpose of understanding national and regional implementation challenges and areas where further support may be required to help support full implementation. NHS England will aim to collate overall implementation progress of SBLCB v3 to allow organisations to gain insights and provide useful benchmarking. This will not form part of the assurance process but will aid understanding of the degree of implementation at a national level. By using this tool, you are granting NHS England access to your submitted data. If you do not wish for your data to be collated, please email england.maternitytransformation@nhs.net.

england.maternitytransformation@nhs.net

Saving Babies Lives Care Bundle (Version 3)

How to Assure with the Implementation Tool

LMNS Guidance

Following a system first approach, Local Maternity and Neonatal Systems (LMNS) should be assuring themselves that maternity providers within their systems are fully implementing the care bundle and meeting the CNST maternity incentive scheme in relation to the Saving Babies Lives Care Bundle Version 3. LMNS's should review the evidence through their system level governance frameworks at least quarterly and validate compliance against each of the standards. This will enable the ICSs and providers of services to identify common problems and barriers to implementation and develop and share effective solutions.

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

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

2. Holding quarterly quality improvement discussions with the ICB.

Developing the standards for local compliance:

There is variation in clinical care across England and as a result setting an arbitrary single national ambition or aim is unrealistic. However, there needs to be robust local provider-commissioner discussions regarding the level of local ambition in relation to previous improvements and related benchmarking. Within each intervention, where available, we have included a stretch ambition and a minimum level of expected achievement (see Column G). The level of ambition is to be set following discussions between the LMNS and the Trust and should appropriately challenge realistic improvements within organisations.

For each intervention, Column I on the following worksheets, should be completed by the LMNS with the agreed required compliance level prior to the provider completing the worksheets to demonstrate their evidence to meet the defined local ambition target.

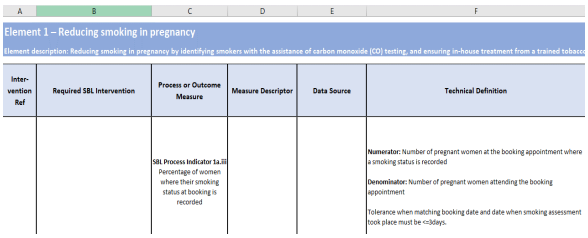
Implementation tool E1
Implementation tool E2
Implementation tool E3
Implementation tool E4
Implementation tool E5
Implementation tool E6

When assessing if the agreed compliance threshold is met for each intervention, compliance should be measured over an appropriate timeframe that demonstrates sustained and embedded improvements. LMNSs should consider provider's progress, and systems and procedures in place to monitor compliance, when setting appropriate monitoring timeframes. For example, a provider that has regular audit mechanisms in place and can consistently demonstrate achieving the ambitions set may be suitable to submit six monthly audits to monitor continued achievement of the ambitions set. Whereas a provider that demonstrates audits that inconsistently meet the ambitions set, would require closer monitoring and more frequent audit timeframes. The LMNS should be assured quarterly that providers are meeting or are on track to meet the required interventions and elements.

Measuring improvements and data sources:

Official Statistics about NHS-funded maternity services in England, from the Maternity Services Data Set (MSDS), including activity at booking and pregnancy outcomes, can be found at https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics. NHS England has moved to a provisional and final processing submission model for the Maternity Services Data Set (MSDS). MSDS data will be published on NHS Digital's website earlier than before as 'provisional' data. A finalised version of the data will also be published later as normal. This will enable data to be available more quickly for operational decision making and planning purposes.

Where there are no defined MSDS measure descriptors in column D of the implementation tool elements, providers may use local data to drive real-time quality improvement. Where it is not possible to source this data through their maternity information system (MIS), this may be measured through snapshot audits of consecutive records as agreed with their local maternity and neonatal system (LMNS). Guidance has been provided within the technical definition (column F) for these interventions on the data to be collected and analysed to measure improvements.



A	B	C	D	E	F
Element 1 – Reducing smoking in pregnancy					
Element description: Reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing, and ensuring in-house treatment from a trained tobacco					
Inter-vention Ref	Required SBL Intervention	Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition
		SBL Process Indicator 1a.iii Percentage of women where their smoking status at booking is recorded			Numerator: Number of pregnant women at the booking appointment where a smoking status is recorded Denominator: Number of pregnant women attending the booking appointment Tolerance when matching booking date and date when smoking assessment took place must be <=3days.

System peer assessment and validation:

Through an appropriately agreed governance framework (for example the LMNS SBLCB SOP), the ICB/LMNS should review the evidence submitted and complete the pink boxes (columns O, P and Q) on each of the 'Implementation Tool Element' worksheets to validate compliance and identify improvement actions.

LMNS SBLCB Quarterly Assurance meeting:

Providers and their LMNS partners need to meet at the end of each quarter to discuss progress against this version of the Saving Babies Lives Care Bundle. The dates of these meetings should be logged within the tool on the:

Progress and LMNS review record

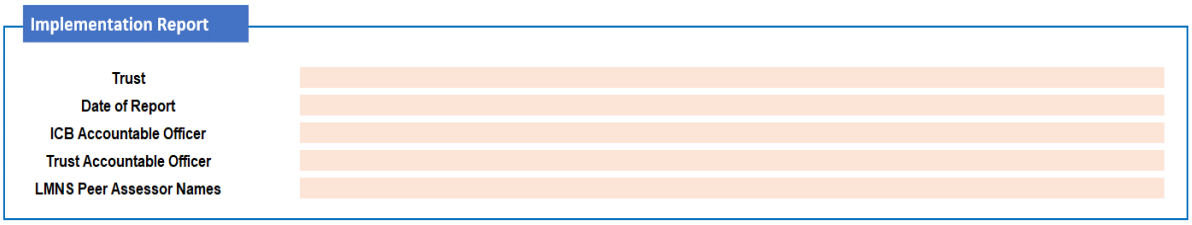
When validating the implementation status of each intervention within each element the following criteria should be used:

Element Progress	Progress Measure
Fully implemented	All minimum evidence requirements (column G) and where applicable the LMNS required compliance (column H) are met
Partially implemented	1 or more, but less than all, minimum evidence requirements (column G) and where applicable the LMNS required compliance (column H) are met
Not implemented	None of the minimum evidence requirements (column G) and where applicable the LMNS required compliance (column H) are met

There should be a minimum of two Quarterly Assurance meetings prior to the final Clinical Negligence Scheme for Trusts (CNST) submission date. Following each meeting the Trust should submit a summary report to their organisation and system board demonstrating progress to date. The Board report template developed within the tool can be used:

Board report and action plan

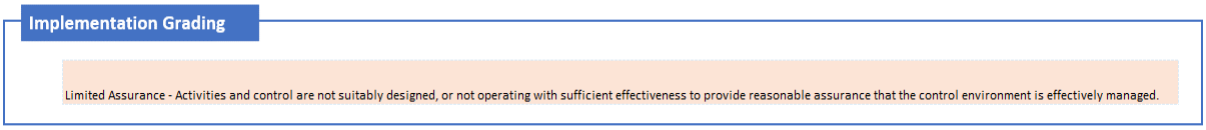
Complete the Trust details, date of assessment and assessors names in the pink boxes on the 'Board report and action plan' worksheet:



The Board Report and Action Plan show an aggregate of the intervention implementation across each of the six elements and also across all elements combined. This also maps to the current year's NHS Resolution Maternity Incentive Scheme compliance requirements for Safety Action 6 (correct at time of publishing the tool). When aggregating the interventions the Board Report table uses the LMNS validated assessment scores only and applies the following criteria:

Element Progress	Progress Measure
Fully implemented	All interventions in an element are fully implemented
Partially implemented	More than 1, but less than all interventions in an element are fully implemented
Not implemented	All interventions in an element are partially implemented, not implemented, or a mixtures of both

Following validation of the implementation of the care bundle evidence, apply an appropriate assurance grading on the confidence of full implementation.



Recommended content of LMNS SBLCB quarterly meetings should include the following areas:

1. Review of areas within the implementation tool that are not implemented or partially implemented for each element and specific improvement work being undertaken.
2. Review of SBLCB Process and Outcome Indicators for each element by trust, and review trust SBLCB improvement plans and progress made between quarterly review meetings.
3. Review SBLCB audit plans developed by trusts to ensure they are appropriate to meet the interventions.
4. Review trends and themes identified by trusts following their examination of outcomes in relation to the interventions.
5. Review all population groups and identify any health inequalities across all six elements.
6. Review evidence of continuous learning by individual trusts and sharing of learning within their local ICB and neighbouring trusts.
7.Review of engagement work with bereaved families through the Maternity and Neonatal Voice Partnerships (MNVP) to ensure all voices are heard and ensure lessons are learnt from every baby's death so continual improvement can be made.

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

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

Implementation Report

Trust	**Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust**
Date of Report	**13-Dec-23**
ICB Accountable Officer	**Cathy Winfield, Executive Chief Nurse**
Trust Accountable Officer	
LMNS Peer Assessor Names	**LMNS PMO Team - Programme Director, Obstetric Clinical Lead, Neonatal Clinical Lead,**

Background

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

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

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

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

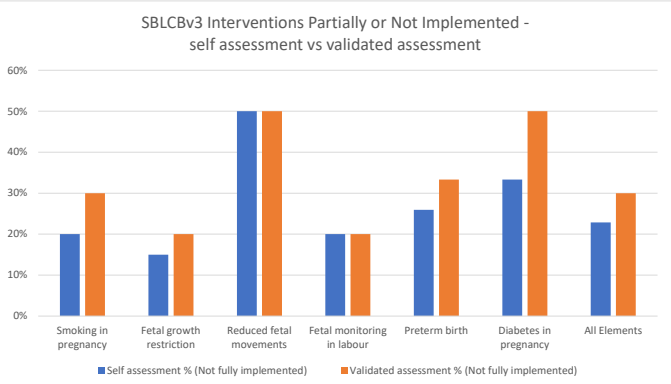
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

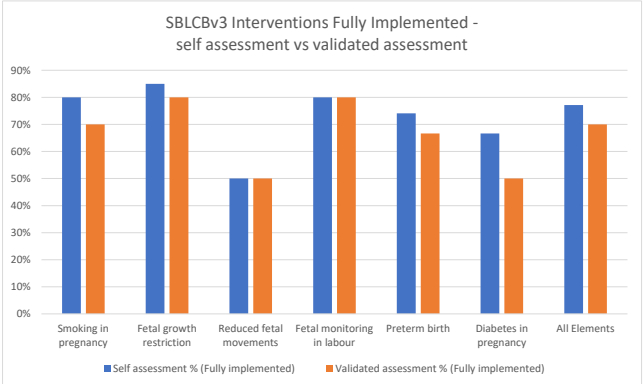
Implementation Grading

Significant Assurance - Except for specific weaknesses identified the activities and controls are suitably designed and operating with sufficient effectiveness to provide reasonable assurance that the control environment is effectively managed.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	70%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	85%	Partially implemented	80%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	74%	Partially implemented	67%	CNST Met
Element 6	Diabetes	Partially implemented	67%	Partially implemented	50%	CNST Met
All Elements	TOTAL	Partially implemented	77%	Partially implemented	70%	CNST Met





Action Plan

Element 1

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
1.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Small smaple audit of CO2 at every contact (to discuss - why small
1.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
1.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Recommend that guideline flow chart includes smoking status at all appointments - not clear in flow chart or main body of guideline that
1.4	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data included and 83.9% referred. Require minimum of 90% referrals for SBL (with plan to 100% to deliver the national tobacco model)
1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Recommend that the smoking in pregnancy guideline also refers to the RDASH policy - ie guideline says women could be referred to the GP for NRT (in community) whereas the RDASH guideline (and
1.6	Fully implemented	Fully implemented	0	Reported audit results (in tool) indicate compliance based on RDASH data - however, the evidence uploaded (RDASH smoke free pregnancy activity) does not match these figures (for 1c and 1d).
1.7	Fully implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Discussed at meeting. Minor update to guideline to reflect regualr audit.
1.8	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Evidence included (in the tool) shows <90% training compliance - not clear where these %s have been derrived from. Continued roll out of training plan.
1.9	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Training provided as part of mandatory training. Evidence of compliance required.
1.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Email included from RDASH confirming staff are trained to NCSCT standards. There is no data or evidence accompanying this. Information accepted in good faith.

Element 2

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
2.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Post assessment note - K2 audit added demonstrating compliance.
2.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Post assessment note - K2 audit added demonstrating compliance.
2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.5	Fully implemented	Fully implemented	0	Discussed at the meeting. Fully implemented - approach and evidence explained.
2.6	Partially implemented	Partially implemented	Evidence not in place - improvement required.	Plan included as evidence. Timeline indicates review of guideline aligned to SBLv3 deadline (March 2023)
2.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit evidence added post meeting demonstrating compliance.
2.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.11	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	TNA included as evidence. Training compliance is evidenced (30%) ongoing training plan included, although timescales for this are not clear.
2.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.14	Partially implemented	Partially implemented	0	Ensure reference to assessment of fetal and maternal condition in guidance, or reference to PIGF. To implement digital BP monitors.
2.15	Fully implemented	Fully implemented	0	0
2.16	Fully implemented	Fully implemented	0	0
2.17	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Clarify core specialist MDT team and ensure there is a specific clinic available - to be uploaded. Audit evidence included with actions to be completed by January 24 and so remains partially implemented
2.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline indicates delivery should occur at 37 weeks. Should include that this should be no later than 37+6 weeks.
2.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Ensure ongoing audit.
2.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Element 3

INTERVENTIONS				
3.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
3.2	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Audit evidence included, however, unclear if 72 hours is always next working day. Additional audit / analysis required to demonstrate current position.

Element 4

INTERVENTIONS				
4.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
4.2	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Final version guideline reviewed at meeting. Audit evidence required.
4.3	Fully implemented	Fully implemented	0	Final version guideline reviewed at meeting - to be uploaded to evidence portal.
4.4	Fully implemented	Fully implemented	0	0
4.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Element 5

INTERVENTIONS				
5.1	Partially implemented	Partially implemented	0	JD for Obstetric and neonatal leads required. Confirmation required on the maternal medicine JD that is included as evidence - this does not appear to be an explicit pre-term role.
5.2	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Patially implemented due to national ambition - work is underway and rate is improving due to QI work. With continued improvement and QI work, local trajectory to be agreed with a stretch to the
5.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.6	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit evidence included with actions to be completed by January 24 and so remains partially implemented until actions are implemented and re-audit demonstrates improvement in practice.
5.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit discussed and clarified.
5.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Discussed. Additional guideline reviewed which articulates referral pathway from DBTH. Possibly clarity required regionally to ensure consistency but clear from DBTH perspective. Section 7 of guideline
5.14	Fully implemented	Fully implemented	0	CoC plan included which includes realistic timelines based on MCoC guidance - to establish teams when building blocks allow. To note this does not indicate compliance with MCoC - but that there is a
5.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Additonal guideline reviewewd at the meeting which states information to be shared and information leaflet reviewed. Comms published version to be added as evidence.
5.16	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit evidence included, currently below required compliance. To complete actions relating to review of local practice.
5.17	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Additional evidence included. Still requires ODN data to be compiled. To ensure all elements are included within the guideline including thermal care at birth, early EBM.
5.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Small number of off-pathway births occuring per quarter. To include evidence to demonstrate review (avoidable or non-avoidable) and any learning.
5.20	Fully implemented	fully implemented	0	Audit data discussed. Variation due to manual data cleanse which is not reflected in the ODN data until the following quarter.
5.21	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data included demonstrating <90%. Action plan included identifying actions. Include data for outcome 5j(brain injury)
5.22	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data included, however there is variation between local and ODN published. To discuss. Both data sets indicate <90%. Action plan included but this is not specific to antibiotics.
5.23	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Progress made. Ensure action plan focusses on DCC.
5.24	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data indicates <target. Action plan included.

5.25	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	To review updates to Q2 data when ODN Q3 data is published to ensure improved DQ.
5.26	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.27	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Element 6

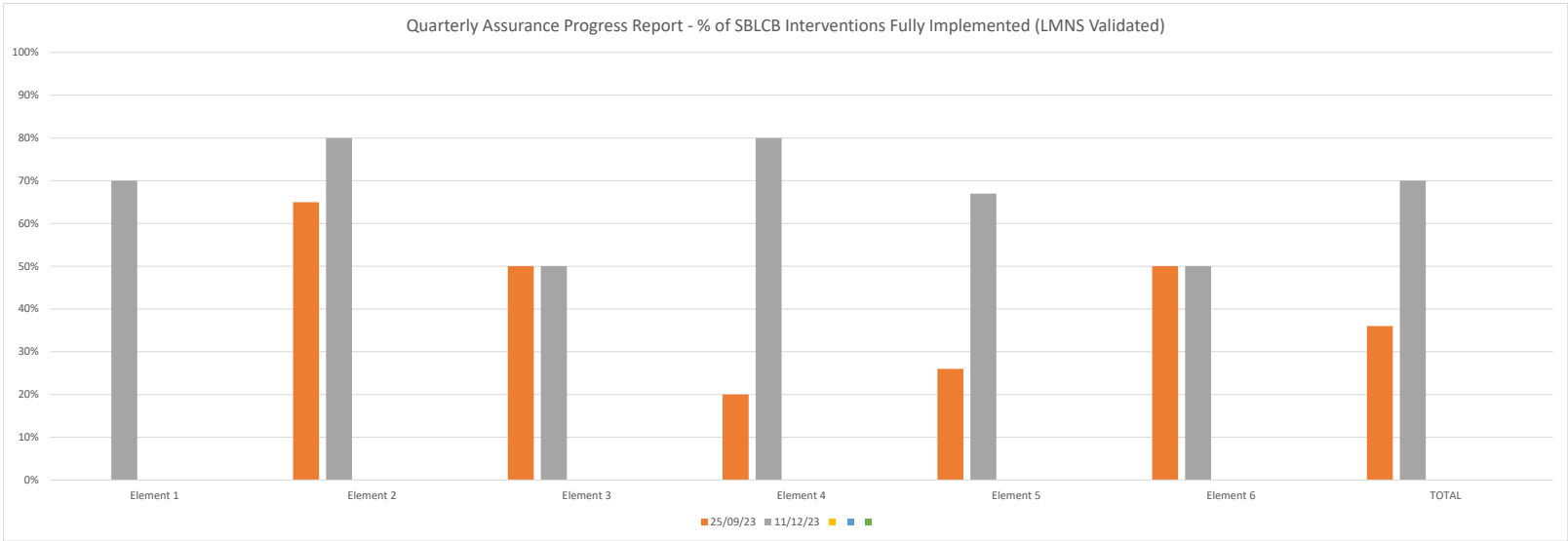
INTERVENTIONS				
6.1	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Trust confirm that model is in place as set out in evidence (JDC RR) however, post meeting it appears that the pilot of 2 separate clinics has ceased - to be reinstated. Confirmation there is a dietician
6.2	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Training evidence required. Audit of at least 25 sets of ntoes (or 10% whichever is highest) is required to demonstrate embedded practice.
6.3	Fully implemented	Fully implemented	0	0
6.4	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Training evidence required. Audit of at least 25 sets of ntoes (or 10% whichever is highest) is required to demonstrate embedded practice.
6.5	Fully implemented	Fully implemented	0	To include criteria for referral to MMN as evidence - not in the guideline
6.6	Fully implemented	Fully implemented	0	0

LMNS Quarterly Assurance Meeting Record on Implementation of the Saving Babies Lives Care Bundle (Version 3)

Trust: **Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust**

ICB: **North East and Yorkshire**

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5	Assessment 6	Assessment 7	Assessment 8	Assessment 9	Assessment 10	Assessment 11
Review Quarter	**Q3 23/24**	**Q4 23/24**										
Assurance Review Date	**25/09/23**	**11/12/23**										
Element 1	0%	70%										
Element 2	65%	80%										
Element 3	50%	50%										
Element 4	20%	80%										
Element 5	26%	67%										
Element 6	50%	50%										
TOTAL	36%	70%										



Element 1 – Reducing smoking in pregnancy

Element description: Reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing, and ensuring in-house treatment from a trained tobacco dependence adviser[1] is offered to all pregnant women who smoke, using an opt-out referral process.

Inter-vention Ref	Required SBL Intervention	Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
1.1	CO testing offered to **all** pregnant women at the **antenatal booking** and **36 week** antenatal appointment.	**SBL Process Indicator 1a.i** Percentage of women where there is a recorded CO measurement at booking appointment	SBL_Element1_ProcessIndicator1 SBL_Element1_ProcessIndicator2	Recording of CO measurement for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & Tobacco Dependence Treatment data collection.	Pass DQ checks on MSDS Dashboard Clinical Quality Improvement Metrics **Numerator:** Number of pregnant women attending booking appointment where a CO value (ppm) is recorded **Denominator:** Number of pregnant women attending booking appointment Tolerance when matching booking date and date when CO testing took place must be <=3days.	Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric for the most recent published data. If the data quality is not met there should be a plan in place and agreed by the LMNS to improve data quality. Guideline evidencing surveillance pathway of routine CO testing at booking and 36 weeks. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. An ambition of 95% for high performing organisations with minimum ambition of 90%, with a clear action plan to achieve 95% reliability (within locally agreed timeframes). Regular audit of testing rate and declines is recommended to consider interventions to maintain adequate compliance.	90%	REF1.1A	Dashboard	DBTH Maternity Dashboard	Sep-23		Fully implemented	Compliant Public Health Midwife (PHM) in post. Audit complaince - lack of availble equipment meaning no CO @ booking recorded for 4.03%. Work ongoing to ensure equipment availble. PHM actioning	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Small smaple audit of CO2 at every contact (to discuss - why small sample when K2 available?) In order to deliver against the national tobacco model: Recommend that there is continued review of smoking status & CO2 at all contacts - action plan included.
								REF1.1B									
								REF1.1C									
								REF1.1D									
								REF1.1E	Guideline/policy	Smoking in pregnancy guideline							
								REF 1.1F	Audit	CO @ booking - data quality checked and ratified	Q2 23/24	93%					
								REF1.1G	Guideline/policy	Antenatal Risk Assessment and ongoing care (ANRA)	previously uploaded						
								REF1.1H	Other	CO levels and smoking status numerator and denominator not data quality checked for CO reading	Q2 23/24						
								REF1.1I	Other	Action plan							
		SBL Process Indicator 1a.ii Percentage of women where there is a recorded CO measurement at 36-week appointment	SBL_Element1_ProcessIndicator3	Recording of CO measurement for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & Tobacco Dependence Treatment data collection.	**Numerator:** Number of pregnant women at the 36 week appointment where a CO value (ppm) is recorded **Denominator:** Number of pregnant women attending the 36 week appointment Tolerance around gestational age contact date for the 36 week appointment must be within 245 days (35+0 weeks) and 258 days (36+6 weeks).	Guideline evidencing surveillance pathway of routine CO testing at booking and 36 weeks. Details of the stop smoking strategy and any plans for improvement. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. An ambition of 95% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 95% reliability (within locally agreed timeframes). Regular audit of testing rate and declines is recommended to consider interventions to maintain adequate compliance.	80%	REF1.1J	Guideline/policy	ANRA	previously uploaded					
								REF1.1K	Guideline/policy	Smoking in pregnancy guideline and trust QUIT smoking information along with trust strategy							
								REF1.1L	Audit	36/40 CO Testing data quality checked and ratified	Q2 23/24	91.10%		Compliant			
								REF1.1M	Other	Action Plan							
								REF1.1N	Audit	declines							
1.2	CO testing offered at all other antenatal appointments to groups identified within: NICE Guidance NG209	Percentage of smokers* where CO measurement is recorded at all antenatal appointments	N/A	Recording of CO measurement for each pregnant woman in line with NG209 on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** The number of pregnant smokers* who have a recorded CO measurement at each antenatal appointment during pregnancy **Denominator:** Number of pregnant smokers* who have come to the end of their pregnancy*** Tolerance when matching antenatal contact date and date when CO testing took place must be <=3days. * In line with NICE guidance a "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). ***End of pregnancy is the trigger point which includes a) transfer of care to another provider, b) miscarriage, c) ectopic pregnancy d) termination of pregnancy e) following birth (live or stillborn).	Guideline evidencing surveillance pathway of routine CO testing at all antenatal appointments for pregnant smokers* as per NICE Guidance NG209. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'. Regular audit of testing rate and declines is recommended to consider interventions to maintain adequate compliance. There is an expectation that data is reported to the MSDS and audited using the Measure Descriptor processes. However, as there is no defined MSDS measure descriptor, providers may use local data to drive real-time quality improvement. Where it is not possible to source this data through MIS, this may be through Snapshot Audit of consecutive records as agreed with the local system.	50%	REF1.2A	Guideline/policy	Smoking in pregnancy guideline			Fully implemented	compliant	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF1.2B	Audit	K2 Audit report consultations vs co reading	Q2 23/24	74.9%					
								REF1.2C	Dashboard	DBTH Maternity Dashboard - numerator and denominator for smokers who have delivered in Q2	Sep-23						
								REF1.2D	Other	CO levels and smoking status numerator and denominator not data quality checked for CO reading	Q2 23/24	64.0%					
								REF1.2E			7						
								REF1.2F									
1.3	Whenever CO testing is offered, it should be followed up by an enquiry about smoking status with the CO result and smoking status recorded.	**SBL Process Indicator 1a.iii** Percentage of women where their smoking status at booking is recorded	N/A	Recording of smoking status for each pregnant woman in line with NG209 on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of pregnant women at the booking appointment where a smoking status is recorded **Denominator:** Number of pregnant women attending the booking appointment Tolerance when matching booking date and date when smoking assessment took place must be <=3days.	Guideline evidencing surveillance pathway of routine CO testing and smoking assessment as per NICE Guidance NG209, followed by delivery of Very Brief Advice (VBA) about smoking, making an opt-out referral and the processes within their maternity pathway (e.g. referral, feedback, data collection). Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 95% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 95% reliability (within locally agreed timeframes). Regular audit of testing rate and declines is recommended to maintain adequate reliability with meeting the intervention.	80%	REF1.3A	Guideline/policy	Smoking in pregnancy guideline			Fully implemented	Compliant	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Recommend that guideline flow chart includes smoking status at all appointments - not clear in flow chart or main body of guideline that smoking status must be obtained alongside CO reading (although evidence is included that this is happening)
								REF1.3B	Audit	VBA evidence	Q2 23/24	99.2%					
								REF1.3C	Audit	Smoking status recorded @ booking	Q2 23/24	100.0%					
								REF1.3D	Other	CO levels and smoking status numerator and denominator not data quality checked for CO reading	Q2 23/24						
								REF1.3E									
								REF1.3F									
		SBL Process Indicator 1a.iv Percentage of women where their smoking status at 36 weeks is recorded			**Numerator:** Number of pregnant women at the 36 week appointment where a smoking status is recorded **Denominator:** Number of pregnant women attending the 36 week appointment Tolerance around gestational age contact date for the 36 week appointment must be within 245 days (35+0 weeks) and 258 days (36+6 weeks).	Guideline evidencing surveillance pathway of enquiry about smoking status at 36 weeks as per NICE Guidance NG209. Details of the stop smoking strategy and any plans for improvement. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. An ambition of 95% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 95% reliability (within locally agreed timeframes). Regular audit of testing rate and declines is recommended to maintain adequate reliability with meeting the intervention.	80%	REF1.3G	Guideline/policy	Smoking in pregnancy guideline							
								REF1.3H	Standard operating procedure	cessation SOP							
								REF1.3I	Audit	K2 data quality checked and ratified	Q2 23/24	100.0%					
								REF1.3J									
								REF1.3K									
								REF1.3L									
		Percentage of smokers* where smoking status is recorded at all antenatal appointments			**Numerator:** The number of pregnant smokers* who have a recorded smoking status at each antenatal appointment during pregnancy **Denominator:** Number of pregnant smokers* who have come to the end of their pregnancy*** Tolerance when matching antenatal contact date and date when smoking assessment took place must be <=3days. * In line with NICE guidance a "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). ***End of pregnancy is the trigger point which includes a) transfer of care to another provider, b) miscarriage, c) ectopic pregnancy d) termination of pregnancy e) following birth (live or stillborn).	Guideline evidencing surveillance pathway of enquiry about smoking status at all antenatal appointments for pregnant smokers* as per NICE Guidance NG209. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'. There is an expectation that data is reported to the MSDS and audited using the Measure Descriptor processes. However, as there is no defined MSDS measure descriptor, providers may use local data to drive real-time quality improvement. Where it is not possible to source this data through MIS, this may be through Snapshot Audit of consecutive records as agreed with the LMNS.	50% (ensuring booking and 36 week targets met)	REF1.3M	Guideline/policy	Smoking in pregnancy guideline				Compliant			
								REF1.3N	Audit	K2 data	Q2 23/24	74.9%					
								REF1.3O									
								REF 1.3P									
								REF1.3Q									
								REF1.3R									

Element 1 – Reducing smoking in pregnancy

Element description: Reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing, and ensuring in-house treatment from a trained tobacco dependence adviser[1] is offered to all pregnant women who smoke, using an opt-out referral process.

Inter-vention Ref	Required SBL Intervention	Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
1.4	Instigate an opt-out referral for all women who have an elevated CO level (4ppm or above), who identify themselves as smokers, or have quit in the last 2 weeks, for treatment by a trained tobacco dependence treatment adviser (TDA) within an in-house tobacco dependence treatment service.	**SBL Process Indicator 1b** Percentage of smokers* that have an opt-out referral at booking to an in-house tobacco dependence treatment service	N/A	Recording of opt out referral for each pregnant woman who is a smoker* on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator**: Number of pregnant smokers who have an opt out referral to an in-house/in-reach tobacco dependence treatment service recorded **Denominator:** Number of pregnant smokers* * A "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). In-house service is where clinical leadership, delivery and oversight of the service and its outcomes remains with maternity. Services are considered as in-house when the woman's care for treating their tobacco dependence remains within the maternity service i.e. is not referred out to another provider like a local authority stop smoking service. In-reach services, where a third party, such as the local authority stop smoking service, provide services as part of the maternity team with the patient staying under the care and management of the maternity service would count as in-house.	Guideline evidencing referral pathway in place as per NICE Guidance NG209. Service specification from Tobacco Dependence Treatment service. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 95% for high performing organisations with minimum ambition of 90%, with a clear action plan to achieve 95% reliability (within locally agreed timeframes). An additional quality improvement check would be for providers to look at referrals that are made after 15 weeks gestation/trimester 1 to understand why late referrals are being made and what if any improvements can be made.	90% for SBL - plan to 100% (based on tobacco model)	REF1.4A	Guideline/policy	Smoking in pregnancy guideline			Fully implemented		Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data included and 83.9% referred. Require minimum of 90% referrals for SBL (with plan to 100% to deliver the national tobacco model)
								REF1.4B	Audit	RDaSH Data	Q4 & Q1						
								REF1.4C	Audit	opt out referal complaince	Q2 23/24	83.9%					
								REF1.4D	Standard operating procedure	cessation SOP							
								REF1.4E	Other	action plan and QI plan							
								REF1.4F	Service specification	Service Spec RDASH							
1.5	Nicotine replacement therapy (NRT) should be offered to all smokers and provision ensured as soon as possible.	N/A	N/A	N/A	N/A	Guideline evidencing NRT treatment offered to all smokers in place as per NICE Guidance NG209. Service specification from Tobacco Dependence Treatment service.	N/A	REF1.5A	Guideline/policy	Smoking in pregnancy guideline			Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Recommend that the smoking in pregnancy guideline also refers to the RDASH policy - ie guideline says women could be referred to the GP for NRT (in community) whereas the RDASH guideline (and practice) indicates direct supply / e-voucher for NRT.
								REF1.5B	Guideline/policy	trust NRT guidance the word Midwife is being added							
								REF1.5C	Service specification	Service Spec RDASH							
								REF1.5D									
								REF1.5E									
								REF1.5F									
1.6	The tobacco dependence treatment includes behavioural support and NRT, initially 4 weekly sessions following the setting of the quit date then regularly (as required, however as a minimum monthly) throughout pregnancy to support the woman to remain smokefree. Successful implementation of this standard could be measured by audit of recorded treatments at specific appointments, however, implementation should result in improved overall outcomes in relation to reducing smoking in pregnancy; which is the focus of the subsequent process/outcome measures.	**SBL Process Indicator 1c** Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date	N/A	Recording of quit dates and CO verified smoking status in Maternity Information System (MIS) and submitted to Tobacco Dependence Treatment data collection.	**Numerator:** Number of pregnant smokers* with an opt out referral recorded who have set a quit date **Denominator:** Number of pregnant smokers* with an opt out referral recorded * A "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days).	Guideline evidencing NRT treatment pathway for all smokers in place as per NICE Guidance NG209. Service specification from Tobacco Dependence Treatment service. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition based on current system performance and improvement trajectory to reach stretch ambition of 60%. Clear action plan to be in place to meet to achieve 60% reliability (within locally agreed timeframes). See 'How to assure with the tool'.	30% (to increase to 50, then 60 with incentives)	REF1.6A	Guideline/policy	Smoking in pregnancy guideline			Fully implemented		Fully implemented		Reported audit results (in tool) indicate compliance based on RDASH data - however, the evidence uploaded (RDASH smoke free pregnancy activity) does not match these figures (for 1c and 1d). Discussed at meeting - no data provided by ABL (at the time - now available) - so Trust have reviewed data across all providers and arrived at the percentages. Fully implemented - but requires additional evidence upload to show % across both providers.
								REF1.6B	Guideline/policy	NRT							
								REF1.6C	Other	RDaSH Data	Q4 & Q1	94.0%					
								REF1.6D	Service specification	Service Spec RDASH							
								REF1.6E									
		SBL Outcome Indicator 1e Percentage of smokers* that set a quit date and are identified as CO verified non smokers at 4 weeks			**Numerator:** Number of pregnant women in the denominator who are recorded as a CO verified non-smokers at 4 weeks (28 day) **Denominator:** All pregnant women who have a 4 week (28 day) smoking status outcome recorded in a given month The tolerance for recording the 4 week (28 day) quit is in line with the NCSCT recommendations at -5 to +14 days. If no outcome is recorded within 45 days of the quit date a default outcome of "smoker" should be used. * A "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days).	Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 60% of smokers who set a quit date are CO verified non-smokers at 4 weeks for high performing organisations with minimum ambition of 50%, with a clear action plan to achieve 60% reliability (within locally agreed timeframes). Of these, 85% have should have CO verification. An additional quality improvement check would be a sample audit of women who opt-out or fail to engage to understand why and what can be done to address this.	30% (to increase to 50, then 60 with incentives)	REF1.6F	Other	RDaSH Data	Q4 & Q1	60.0%					
								REF1.6G	Other	ACTION PLAN STRETCH TARGETS AND QI							
								REF1.6H	Service specification	ABL							
								REF1.6I									
								REF1.6J									
		SBL Outcome Indicator 1d Percentage of smokers* at antenatal booking who are identified as CO verified non smokers at 36 weeks			**Numerator:** Number of denominator with a CO reading at =<4ppm and self-identified as a non-smoker at the 36 week appointment (within the tolerance) **Denominator:** Number of women who were identified as a smokers* at booking who birthed at or after 37+0 weeks The tolerance of gestational age contact date for the 36 week appointment is within 245 days (35+0 weeks) and 258 days (36+6 weeks). * A "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days).	Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'. Additional quality improvement checks would be for providers to look at: a) women who had a CO level =>4ppm / identified as a smoker at booking but had an end of pregnancy before 36 weeks to identify smoking status at the most recent appointment and any associated learning points / trends. b) women who do not have 36 week CO test or smoking status reported within the relevant tolerance, but do have one reported after 37 weeks for learning points/ trends.	10% (with stretch to 20%)	REF1.6K	Other	RDaSH Data	Q4 & Q1	66.7%					
								REF1.6L	Other	QI PLAN							
								REF1.6M									
								REF1.6N									
								REF1.6O									
1.7	Feedback is provided to the pregnant woman's named maternity health care professional regarding the treatment plan and progress with their quit attempt (including relapse). Where a woman does not book or attend appointments there should immediate notification back to the named maternity health care professional.	Percentage of women who have documented evidence of immediate feedback to the named maternity health care professional when a woman does not book or attend appointments with the in-house tobacco dependence treatment service.	N/A	N/A	**Numerator:** Number of women who have documented evidence of immediate feedback to the named maternity health care professional when a woman does not book or attend appointments with the in-house/in-reach tobacco dependence treatment service **Denominator:** Number of woman who do not book or attend appointments with the in-house/in-reach tobacco dependence treatment service In-house service is where clinical leadership, delivery and oversight of the service and its outcomes remains with maternity. Services are considered as in-house when the woman's care for treating their tobacco dependence remains within the maternity service i.e. is not referred out to another provider like a local authority stop smoking service. In-reach services, where a third party, such as the local authority stop smoking service, provide services as part of the maternity team with the patient staying under the care and management of the maternity service would count as in-house.	Guideline evidencing follow up and feedback processes to the pregnant woman's named maternity healthcare professional in place. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	Embed feedback loop within practice - with action plan to improve. Must be included within guidance and audited to demonstrate continua improvement	REF1.7A	Guideline/policy	Smoking in pregnancy guideline			Fully implemented	SIP Guideline updated. Feredback currently providedwd via email however new template just launched. This will ensure that moving forward the feedback is more robust	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Discussed at meeting. Minor update to guideline to reflect regualr audit.
								REF1.7B	Other	Feedback proforma							
								REF1.7C	Audit	Audit of feedback	Sept-Nov 23	13.4%					
								REF1.7D									
								REF1.7E									
								REF1.7F									
1.8	Any staff member using a CO monitor, should have appropriate training on its use and discussion of the result. See Core Competency Framework Version 2	Percentage of staff with in date training compliance on the use of a CO testing and discussion of results	N/A	Local training records.	**Numerator:** Number of denominator with in-date annual training compliance on the use of a CO monitor and interpretation/discussion of results **Denominator:** Number of staff delivering front line care who use CO monitors in accordance with local pathways Training requirements are outlined in the Core Competency Framework Version 2. For quality improvement purposes training should be analysed by all grades/bands and disciplines who are required to use a CO monitor e.g. medical staff; midwives; support workers; nurses.	A training plan should be in place to cover all six core modules of the Core Competency Framework. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A minimum ambition of 80% attendance with a annual update (provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period) and a stretch ambition of >95% attendance, with a clear action plan to achieve >95% for those organisations on an improvement journey as outlined in the Core Competency Framework.	90%	REF1.8A	Training plan/TNA	Uploaded			Partially implemented	percentage is a combination of tea trolly and rest complaince	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Evidence included (in the tool) shows <90% training compliance - not clear where these %s have been derrived from. Continued roll out of training plan.
								REF1.8B									
								REF1.8C	Training compliance	Tea Trolley evidence uploaded - 80 staff members	Q2 23/24	%					
								REF1.8D	Training compliance	REST study day for CO and VBA 45 staff members	Q2 23/24	46.8%					
								REF1.8E	Other	Action plan							

Element 1 – Reducing smoking in pregnancy

Element description: Reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing, and ensuring in-house treatment from a trained tobacco dependence adviser[1] is offered to all pregnant women who smoke, using an opt-out referral process.

Inter-vention Ref	Required SBL Intervention	Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
								REF1.8F									
1.9	All staff providing maternity care to pregnant women should receive training in the delivery of Very Brief Advice (VBA) about smoking, making an opt-out referral and the processes within their maternity pathway (e.g. referral, feedback, data collection). See Core Competency Framework Version 2	Percentage of staff providing maternity care with annual in date training compliance on the delivery of VBA, making an opt-out referral and maternity pathway processes	N/A	Local training records.	**Numerator:** Number of staff providing frontline maternity care with in date annual training compliance on the delivery of VBA, making an opt-out referral and maternity pathway processes **Denominator:** Number of staff providing frontline maternity care Training requirements are outlined in the Core Competency Framework Version 2. For quality improvement purposes training should be analysed by all grades/bands and disciplines who are required to use a CO monitor.	A training plan should be in place to cover all six core modules of the Core Competency Framework. Very Brief Advice on smoking in pregnancy can be accessed via NCSCT e-learning or HEE eLearning for Health Hub. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 95% for high performing organisations with minimum ambition of 80% (provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period), and a clear action plan to maintain 90% reliability, for those organisations on an improvement journey as outlined in the Core Competency Framework.	90%	REF1.9A	Training plan/TNA	Uploaded			Partially implemented	VBA training is a mandatroy request for all staff on e-learning. Provided via e-lfh. Difficulty in pulling complaince data from e-lfh. Education lead to investigate.	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Training provided as part of mandatory training. Evidence of compliance required.
								REF1.9B	Audit								
								REF1.9C	Other	Action plan							
								REF1.9D									
								REF1.9E									
								REF1.9F									
1.10	Individuals delivering tobacco dependence treatment interventions should be fully trained to NCSCT standards.	Percentage of individuals delivering tobacco dependence treatment interventions who are fully trained to NCSCT standards	N/A	Local training records.	**Numerator:** Number of staff delivering tobacco dependence treatment interventions with in date annual refresher training compliance to NCSCT standards **Denominator:** Number of staff delivering tobacco dependence treatment interventions	A training plan should be in place to cover all six core modules of the Core Competency Framework. NCSCT derived competency frameworks are also available on NHS Futures. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Minimum 90% reliability of staff delivering tobacco dependence treatment are trained to NCSCT standards.	90%	REF1.10A	Training plan/TNA	Uploaded			Fully implemented	Received confirmation via email and individual certificates from all staff being complaint as per the standard	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Email included from RDASH confirming staff are trained to NCSCT standards. There is no data or evidence accompanying this. Information accepted in good faith.
								REF1.10B	email	RDASH complaince with training confirmation		100.0%					
								REF1.10C									
								REF1.10D									
								REF1.10E									
								REF1.10F									

Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction

Element description: Risk assessment and management of babies at risk of or with fetal growth restriction (FGR).

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
2.1	Assess all women at booking to determine if prescription of Aspirin is needed using an appropriate algorithm (for example Appendix C) agreed with the local ICS and regional maternity team.	Percentage of women booked who had a risk assessment for Aspirin at booking	N/A	N/A	**Numerator:** Number of women booked who have had a completed risk assessment undertaken for Aspirin at booking **Denominator:** Number of women booked The pathways in Appendix C have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed by the local ICS following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care.	Guideline evidencing assessment at booking to determine if prescription of Aspirin is needed using an appropriate algorithm. Agreement of use of an appropriate algorithm for assessment by the local ICS and regional maternity team. If using Appendix C of the SBLCBv3 then no agreement is necessary. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	100% (of women had risk assessment)	REF2.1A	Guideline/policy	ANRA	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Post assessment note - K2 audit added demonstrating compliance.
								REF2.1B	Audit	Audit of aspirin prescription	Q4 22/23	97.7%					
								REF2.1C	Audit	Documentation audit - Risk assessment	Q2 23/24	100.0%					
								REF2.1D									
								REF2.1E									
								REF2.1F									
2.2	Recommend vitamin D supplementation to all pregnant women.	Percentage of women booked who are recommended Vitamin D at booking	N/A	N/A	**Numerator**: Number of women booked who are recommended vitamin D supplementation at booking **Denominator**: Number of women booked	Guideline evidencing recommendation of Vitamin D supplementation to all pregnant women. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	100%	REF2.2A	Guideline/policy	ANRA	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Post assessment note - K2 audit added demonstrating compliance.
								REF2.2B	Audit	Documentation audit - Risk assessment	Q2 23/24	100%					
								REF2.2C	Audit	K2 Audit	Q2 22/23	98.1					
								REF2.2D									
								REF2.2E									
								REF2.2F									
2.3	Assess smoking status and manage findings as per Element 1.	N/A	N/A	N/A	N/A	Guideline evidencing smoking status is assessed and managed as outlined in Element 1 for women identified as at risk of fetal growth restriction. .	N/A	REF2.3A	Guideline/policy	Smoking in pregnancy	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.3B									
								REF2.3C									
								REF2.3D									
								REF2.3E									
								REF2.3F									
2.4	Perform a risk assessment for FGR by 14 weeks gestation using an agreed pathway (for example, Appendix D). In multiparous women risk assessment should include the calculation of previous birthweight centiles. The pathway and centile calculator used must be agreed by both the local ICS and the regional maternity team.	**SBL Process Indicator 2a** Percentage of pregnancies where a risk status for FGR is identified and recorded at booking	N/A	Recording of FGR risk status for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of pregnancies where a risk assessment for FGR is completed by 14 weeks **Denominator:** Total number of pregnancies submitted to MSDS The pathways in Appendix D have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed with local ICSs following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care. Trusts submitting data to the MSDS will be able to view the percentage of <3rd centile births in each gestational week of the third trimester in their unit annually.	Guideline evidencing risk assessment to be performed for FGR prior to 14 weeks gestation using an agreed pathway. Agreement of use of an appropriate algorithm for assessment by the local ICS and the regional maternity team. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 90% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 90% reliability, for those organisations on an improvement journey.	80%	REF2.4A	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.4B	Audit	FGR risk assessment @ booking	Q2 23/24	97%					
								REF2.4C									
								REF2.4D									
								REF2.4E									
								REF2.4F									
2.5	During risk assessment trusts are encouraged to use information technology platforms to facilitate accurate recording and correct classification of risk by staff. No single provider is recommended, but technology platforms should not prevent compliance with Element 2 guidance and should follow national recommendations on the use of fundal height and fetal growth charts.	N/A	N/A	N/A	Electronic ultrasound database and MIS suppliers should provide EFW centile charts and birthweight centile charts with reference curves for the 3rd and 10th centiles. Providers using paper EFW centile charts and birthweight centile charts should ensure that the charts have reference curves for the 3rd and 10th centiles. Actual birthweight of the baby should be assessed using the same methodology used antenatally i.e., based on EFW reference, not a birthweight reference scale to ensure consistency.	Evidence from system supplier that latest software in use by the organisation complies fully with all requirements of element 2 of SBLCBv3. Evidence that EFW centile charts and birthweight centile charts in use (whether paper or electronic) include reference curves for the 3rd and 10th centiles. Evidence that actual birthweight of the baby should be assessed using the same methodology used antenatally i.e., based on EFW reference, not a birthweight reference scale to ensure consistency.	N/A	REF2.5A	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded		Fully implemented	Implementing GROW2.0. Not yet gone 'live'	Fully implemented		Discussed at the meeting. Fully implemented - approach and evidence explained.
								REF2.5B	Audit	birth centile AN and PN evidence							
								REF2.5C									
								REF2.5D									
								REF2.5E									
								REF2.5F									
2.6	As part of the risk assessment for FGR, blood pressure should be recorded using a digital monitor that has been validated for use in pregnancy for all pregnant women: Recommendations for digital blood pressure monitoring in maternity services	N/A	N/A	N/A	Agree a plan for the replacement of blood pressure monitors in use with pregnant women as necessary, so that all are compliant with Guidance from the Chief Scientific Officer. Plans and timescales must be in view of local resources, with priority given to the replacement of analogue/aneroid blood pressure monitors. In the meantime, the use of non-compliant devices should be raised in the service risk register.	Evidence of a plan to roll out the use of digital monitors. Guideline evidencing that as part of the risk assessment for FGR, blood pressure should be recorded using a digital monitor that has been validated. Trust equipment procurement plans if using non-compliant devices.	N/A	REF2.6A	Other	Action plan to roll out digital monitors and equipment procurment plan			Partially implemented	On risk register. Awaiting to see whoich are validiated for use in clincal area and not home use	Partially implemented	Evidence not in place - improvement required.	Plan included as evidence. Timeline indicates review of guideline aligned to SBLv3 deadline (March 2023)
								REF2.6B									
								REF2.6C									
								REF2.6D									
								REF2.6E									

Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction

Element description: Risk assessment and management of babies at risk of or with fetal growth restriction (FGR).

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
								REF2.6F									
2.7	Women who are designated as high risk for FGR (for example see Appendix D) should undergo uterine artery Doppler assessment between 18+0 to 23+6 weeks gestation.	Percentage of women booked that are identified as high risk for FGR who have had a uterine artery doppler assessment between 18+0 and 23+6 weeks gestation	N/A	N/A	**Numerator**: Number of women booked that are identified as high risk for FGR who have had a uterine artery doppler assessment between 18+0 and 23+6 weeks gestation **Denominator**: Number of women booked that are identified as high risk for FGR The pathways in Appendix D have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed with local ICSs following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care.	Guideline evidencing women identified high risk for FGR, using an appropriate algorithm, undergo uterine artery doppler assessment between 18+0 and 23+6 weeks gestation. Agreement of use of an appropriate algorithm for assessment by the local ICS and regional maternity team. If using Appendix D of the SBLCBv3 then no agreement is necessary. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	90%	REF2.7A	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit evidence added post meeting demonstrating compliance.
								REF2.7B	Audit	Growth assessment audit	previously uploaded	64					
								REF2.7C									
								REF2.7D									
								REF2.7E									
								REF2.7F									
2.8	The risk of FGR should be reviewed throughout pregnancy and maternity providers should ensure that processes are in place to enable the movement of women between risk pathways dependent on current risk.	**SBL Process Indicator 2c** Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT).	N/A	Perinatal Mortality Review Tool (PMRT).	Use the PMRT to calculate the percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue. Trusts should review their annual MBRRACE perinatal mortality report and report to their ICS on actions taken to address any deficiencies identified.	Guideline evidencing risk of FGR should be reviewed throughout pregnancy and that processes are in place to enable the movement of women between risk pathways dependent on current risk. Report demonstrating % of stillbirths which had issues associated with FGR management identified using PMRT and the actions taken and learning shared to make improvements.	N/A	REF2.8A	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded		Fully implemented	Audit needed	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.8B	Audit	Audit - low percentage is good	Q2 23-24	0%					
								REF2.8C									
								REF2.8D									
								REF2.8E									
								REF2.8F									
2.9	When an ultrasound-based assessment of fetal growth is performed Trusts should ensure that robust processes are in place to review which risk pathway a woman is on and agree a plan of ongoing care.	N/A	N/A	N/A	N/A	Guideline evidencing robust processes are in place to review which risk pathway a woman is on and agree a plan of ongoing care following an ultrasound-based assessment of fetal growth.	N/A	REF2.9A	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.9B									
								REF2.9C									
								REF2.9D									
								REF2.9E									
								REF2.9F									
2.10	Women who are at low risk of FGR following risk assessment should have surveillance using antenatal fundal height (FH) measurement before 28+6 weeks gestation. Measurements should be plotted or recorded on charts by clinicians trained in their use. NICE Guidance NG201	N/A	N/A	N/A	Offer symphysis fundal height measurement at each antenatal appointment after 24+0 weeks (but no more frequently than every 2 weeks) for women with a singleton pregnancy unless the woman is having regular growth scans [NICE guideline (NG201), August 2021]	Guideline evidencing women identified low risk for FGR, using an appropriate algorithm, undergo FH measurement before 28+6 weeks gestation. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	90%	REF2.10A	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.10B	Audit	Audit SFH done before 28+2	Q2 23-24	87%					
								REF2.10C									
								REF2.10D									
								REF2.10E									
								REF2.10F									
2.11	Staff who perform FH measurement should be competent in measuring, plotting (or recording), interpreting appropriately and referring when indicated. Only staff who perform FH measurement need to undergo training in FH measurement. See Core Competency Framework Version 2	Percentage of staff with in date training on FH measurement	All staff providing antenatal care should have competence in measuring fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated.	Local training records.	**Numerator:** Number of staff* with in date annual training compliance on the measurement of FH and recording and interpretation of results **Denominator:** Number of staff* to be trained *A list of staff in and out of scope for inclusion in training numbers is outlined in the technical guidance for Safety Action 8 of CNST MIS. Training requirements are outlined in the Core Competency Framework Version 2. For quality improvement purposes training should be analysed by all grades/bands and disciplines who are required to undertake FH measurements e.g. medical staff; midwives.	A training plan should be in place to cover all six core modules of the Core Competency Framework. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 95% for high performing organisations with minimum ambition of 80% (provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period), and a clear action plan to achieve 95% reliability, for those organisations on an improvement journey, as outlined in the Core Competency Framework.	95%	REF2.11A	Training plan/TNA	Uploaded			Partially implemented		Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	TNA included as evidence. Training compliance is evidenced (30%) ongoing training plan included, although timescales for this are not clear.
								REF2.11B	Other	GAP training raw data available - password protected document	previously uploaded						
								REF2.11C	Audit	GAP training annual rolling data	GAP complaince training	30.6					
								REF2.11D	Other	Action plan	UPLOADED						
								REF2.11E									
								REF2.11F									
2.12	Women who are undergoing planned serial scan surveillance should cease FH measurement after serial surveillance begins. FH measurement should also cease if women are moved onto a scan surveillance pathway in later pregnancy for a developing pregnancy risk (e.g., recurrent reduced fetal movements)	N/A	N/A	N/A	N/A	Guideline evidencing FH measurement is not undertaken for those women who are on a serial scan surveillance pathway and are receiving regular scans to monitor fetal growth.	N/A	REF2.12A	Guideline/policy	ANRA		previoulsy uploaded	Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.12B									
								REF2.12C									
								REF2.12D									

Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction

Element description: Risk assessment and management of babies at risk of or with fetal growth restriction (FGR).

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
	reduced fetal movements).							REF2.12E									
								REF2.12F									
2.13	Women who are at increased risk of FGR should have ultrasound surveillance of fetal growth at 3-4 weekly intervals until delivery (see RCOG guidance and Appendix D).	N/A	N/A	N/A	The pathways in Appendix D have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed by the local ICS following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care.	Guideline evidencing women identified at increased risk for FGR, using an appropriate algorithm, have ultrasound surveillance of fetal growth at 3-4 weekly intervals until delivery. Agreement of use of an appropriate algorithm for assessment by the local ICS and regional maternity team. If using Appendix D of the SBLCBv3 then no agreement is necessary.	N/A	REF2.13A	Guideline/policy	Fetal Growth Assessment guideline		previoulsy uploaded	Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.13B									
								REF2.13C									
								REF2.13D									
								REF2.13E									
								REF2.13F									
2.14	When FGR is suspected an assessment of fetal wellbeing should be made including a discussion regarding fetal movements (see Element 3) and if required computerised CTG (cCTG). A maternal assessment should be performed at each contact this should include blood pressure measurement using a digital monitor that has been validated for use in pregnancy (hyperlink as above to follow) and a urine dipstick assessment for proteinuria. In the presence of hypertension NICE guidance on the use of PlGF/sflt1 testing should be followed.	N/A	N/A	N/A	N/A	Guideline evidencing assessment of fetal and maternal wellbeing as outlined at each contact.	N/A	REF2.14A	Guideline/policy	ANRA		previoulsy uploaded	Partially implemented	Not using digital BP monitors	Partially implemented		Ensure reference to assessment of fetal and maternal condition in guidance, or reference to PlGF. To implement digital BP monitors.
								REF2.14B									
								REF2.14C									
								REF2.14D									
								REF2.14E									
								REF2.14F									
2.15	Umbilical artery Doppler is the primary surveillance tool for FGR identified prior to 34+0 weeks and should be performed as a minimum every 2 weeks. Maternity care providers caring for women with early FGR identified prior to 34+0 weeks should have an agreed pathway for management which includes fetal medicine network input (for example, through referral or case discussion by phone). Further information is provided in Appendix D.	N/A	N/A	N/A	The pathways in Appendix D have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed by the local ICS following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care.	Guideline evidencing that umbilical artery doppler is the primary surveillance tool for FGR identified prior to 34+0 weeks and should be performed as a minimum every 2 weeks (as per Appendix D), along with pathway for referral.	N/A	REF2.15A	Guideline/policy	Fetal Growth Assessment guideline		previoulsy uploaded	Fully implemented		Fully implemented		
								REF2.15B									
								REF2.15C									
								REF2.15D									
								REF2.15E									
								REF2.15F									
2.16	When FGR is suspected, the frequency of review of estimated fetal weight (EFW) should follow the guidance in Appendix D or an alternative which has been agreed by the local ICS following advice from the provider's Clinical Network and/or regional team.	N/A	N/A	N/A	The pathways in Appendix D have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed by the local ICS following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care.	Guideline evidencing that the frequency of review of EFW follows Appendix D, or an alternative, when FGR suspected.	N/A	REF2.16A	Guideline/policy	Fetal Growth Assessment guideline		previoulsy uploaded	Fully implemented		Fully implemented		
								REF2.16B									
								REF2.16C									
								REF2.16D									
								REF2.16E									
								REF2.16F									
2.17	Risk assessment and management of growth disorders in multiple pregnancy should comply with NICE guidance or a variant that must be agreed by both the local ICS and the regional maternity team.	N/A	N/A	N/A	N/A	Guideline evidencing alignment to NICE guidance on risk assessment and management of growth disorders in multiple pregnancy. Audit reviewing implementation of guideline and standards.	N/A	REF2.17A	Guideline/policy	Multiple Pregnancy Guideline		previoulsy uploaded	Fully implemented	NICE Baseline Audit to be completed	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Clarify core specialist MDT team and ensure there is a specific clinic available - to be uploaded. Audit evidence included with actions to be completed by January 24 and so remains partially implemented until actions are implemented and re-audit demonstrates improvement in practice.
								REF2.17B	Audit	MULTIPLE PREGNANCY AUDIT UPLOADED							
								REF2.17C									
								REF2.17D									
								REF2.17E									
								REF2.17F									
2.18	All management decisions regarding the timing of FGR infants and the relative risks and benefits of iatrogenic delivery should be discussed and agreed with the mother. When the estimated fetal weight (EFW) is	**SBL Outcome Indicator 2d** Percentage of babies <3rd birthweight centile born >37+6 weeks (this is a	N/A	Recording of FGR risk status for each pregnant woman on Maternity Information System (MIS) and inclusion of this data	**Numerator:** Number of babies <3rd birthweight centile born >37+6 weeks	Guideline evidencing initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation when there are no other risk factors for babies <3rd centile.	0% Review current	REF2.18A	Guideline/policy			previoulsy uploaded					
								REF2.18B	Audit	IOL audit	previously uploaded		Fully implemented	Q2 not available as IOL MW off sick. Data being compiled - will be uploaded	Fully implemented	Fully meets standard - continue with regular monitoring of	Guideline indicates delivery should occur at 37 weeks. Should include that this should be no
								REF2.18C									

Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction

Element description: Risk assessment and management of babies at risk of or with fetal growth restriction (FGR).

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
[illegible]	[illegible] <3rd centile and there are no other risk factors (see 2.20), initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation.	[illegible] measure of the effective detection and management of FGR).	N/A	in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Denominator:** Total number of babies <3rd centile	Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	data / poisition	REF2.18D					[illegible]	[illegible] being completed - will be updated after 15th November	[illegible]	implementation.	[illegible] weeks. Should include that this should be no later than 37+6 weeks.
								REF2.18E									
								REF2.18F									
2.19	In fetuses with an EFW between the 3rd and <10th centile, delivery should be considered at 39+0 weeks. Birth should be achieved by 39+6 weeks. Other risk factors should be present for birth to be recommended prior to 39 weeks (see 2.20) .	**SBL Process Indicator 2b** Percentage of pregnancies where an SGA fetus (between 3rd & <10th centiles) is antenatally detected	SBL_Element2_ProcessIndicator2	Recording of SGA risk status for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of pregnancies where an SGA fetus is detected during the antenatal period **Denominator:** Total number of pregnancies submitted to MSDS	Trusts submitting data to the MSDS will be able to view the percentage of <10th centile births in each gestational week of the third trimester in their unit annually. If MSDS data quality low a snapshot audit of 10% of denominator or 25 records, whichever is lowest. Data required via audit for compliance with intervention, however there is no recommended ambition to be achieved.	0%	REF2.19A	Audit	K2 data	Q2 23/24	86.4	Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Ensure ongoing audit.
								REF2.19B	Audit	Undetecetd SGA Audit presentation	previously uploaded	46					
								REF2.19C									
								REF2.19D									
								REF2.19E									
								REF2.19F									
		SBL Outcome Indicator 2e Percentage of babies >3rd birthweight centile born <39+0 weeks gestation, where growth restriction was suspected	N/A		**Numerator:** Number of babies >3rd birthweight centile born <39+0 weeks, where growth restriction was suspected **Denominator:** Total number of babies >3rd centile The aim of this indicator is to pick up babies who are suspected of being small, but who are not small and have been induced earlier than is necessary. This can be assessed through a representative audit but will rely on effective recording of indications for induction. Babies can be identified by birthweight and gestation initially, and then by indication for induction or delivery of suspected growth restriction .	Guideline evidencing appropriate timing of delivery in fetuses with an EFW between >3rd and <10th centile. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	0%	REF2.19G	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded					
								REF2.19H									
								REF2.19I									
								REF2.19J									
								REF2.19K									
								REF2.19L									
2.20	Opinion on timing of birth for fetuses with declining growth velocity and EFW >10th centile, where risk factors are present, should be made in consultation with specialist fetal growth services or fetal medicine services depending on Trust availability. In infants where declining growth velocity meets criteria (see Appendix D), with no other risk factors present, delivery should be planned from 37+0 weeks.	N/A	N/A	N/A	The pathways in Appendix D have been widely implemented but are not mandated. If an alternative pathway is chosen it should be agreed by the local ICS following advice from the provider's Clinical Network and/or regional team as to whether the pathway is acceptable to prevent idiosyncratic care.	Guideline evidencing consultation with specialist fetal growth services or fetal medicine services in infants where declining growth velocity meets criteria (see Appendix D), with no other risk factors present, and that delivery should be planned from 37+0 weeks.	N/A	REF2.20A	Guideline/policy	Fetal Growth Assessment guideline	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF2.20B									
								REF2.20C									
								REF2.20D									
								REF2.20E									
								REF2.20F									

Element 3 – Raising awareness of reduced fetal movement

Element description: Raising awareness amongst pregnant women of the importance of reporting reduced fetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
3.1	Information from practitioners, accompanied by an advice leaflet on RFM, should be based on current evidence, best practice and clinical guidelines, and be available to all pregnant women by 28+0 weeks of pregnancy and FM discussed at every subsequent contact. For example: RCOG; or Tommy's leaflet available in multiple languages)	N/A	N/A	N/A	N/A	Guideline evidencing that women are provided with information from practitioners, accompanied by an advice leaflet on RFM by 28+) weeks of pregnancy and that RMF are discussed at every subsequent contact. Advice leaflet on RFM based on current evidence, best practice and clinical guidelines, this needs to be in different languages for local populations.	N/A	REF3.1A	Guideline/policy	Reduced Fetal movements guideline	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF3.1B	Other	Tommys leafelt, available in muiltiple languages and audio	previously uploaded						
								REF3.1C	Audit		Q2 23/24	95%					
								REF3.1D									
								REF3.1E									
								REF3.1F									
3.2	Use provided checklist (on page 40 of SBLCBv3) to manage care of pregnant women who report RFM, in line with national evidence-based guidance: RCOG Green-Top Guideline 57	**SBL Process Indicator 3a** Percentage of women who attend with RFM who have a computerised CTG	SBL_Element3_ProcessIndicator2	Recording of episodes of RFM for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of women with reduced fetal movement identified at a care contact who have a computerised cardiotocogram (CTG) **Denominator:** Number of women with reduced fetal movement identified at a care contact	Guideline evidencing use of the provided RFM checklist within SBLCBv3 demonstrating that women who report RFM are offered computerised CTGs. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	100% (of women within inclusion criteria) Scan performed if no CTG	REF3.2A	Guideline/policy	Reduced Fetal movements guideline	previously uploaded		Partially implemented	need to audit if USS undertaken next working day.	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Audit evidence included, however, unclear if 72 hours is always next working day. Additional audit / analysis required to demonstrate current position.
								REF3.2B	Audit	Admsission for RFM audit	Q4 23/24	98%					
								REF3.2C									
								REF3.2D									
								REF3.2E									
								REF3.2F									
		SBL Process Indicator 3b Proportion of women who attend with recurrent* RFM who had an ultrasound scan by the next working day to assess fetal growth.	N/A	Recording of episodes of RFM and USS for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of women with reduced fetal movement identified at a care contact who have an ultrasound scan by the next working day to assess fetal growth **Denominator:** Number of women with reduced fetal movement identified at a care contact *There is no accepted definition of what recurrent RFM means; one region of the UK has successfully adopted a consensus definition of two or more episodes of RFM occurring within a 21-day period after 26 weeks' gestation. Ultrasound scan for fetal growth, liquor volume and umbilical artery Doppler should be offered to women presenting with recurrent RFM after 28+0 weeks' gestation. Scans are not required if there has been a growth scan in the previous two weeks.	Guideline evidencing that women who report recurrent RFM are offered an ultrasound scan by the next working day to assess fetal growth and risk stratification to determine ongoing care for women presenting with RFM . Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	80%	REF3.2G	Guideline/policy	Reduced Fetal movements guideline	previously uploaded						
								REF3.2H	Audit	Audit of scans date and reson delayed	Q2 23-24	86%					
								REF3.2I									
								REF3.2J									
								REF3.2K									
								REF3.2L									
		SBL Outcome Indicator 3c Percentage of stillbirths which had issues associated with RFM management identified using PMRT.	N/A	Perinatal Mortality Review Tool (PMRT).	N/A	Report demonstrating % of stillbirths which had issues associated with RFM management identified using PMRT and the actions taken and learning shared to make improvements.	N/A	REF3.2M	Report	PMRT uploaded							
								REF3.2N									
								REF3.2O									
								REF3.2P									
								REF3.2Q									
								REF3.2R									
		SBL Outcome Indicator 3d Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation.	N/A	Recording of IOL on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of inductions before 39+0 weeks where reason for induction of labour identified as RFM **Denominator:** Number of inductions before 39+0 weeks	Guideline evidencing appropriate use of induction of labour when RFM is the only indication (for example, induction of labour for RFM alone is not recommended prior to 39+0 weeks). Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	*to discuss with fetal monitoring group and understand baseline information? Ensure following recommendation re RFM IOL <39wks%	REF3.2S	Guideline/policy	Reduced Fetal movements guideline	previously uploaded			Compliant			
								REF3.2T	Audit	IOL audits	previously uploaded						
								REF3.2U	Guideline/policy	IOL guideline	previously uploaded						
								REF3.2V									
								REF3.2W									
								REF3.2X									

Element 4 – Effective fetal monitoring during labour

Element description: Effective fetal monitoring during labour

Inter-vention Ref	Required SBL Intervention	Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
4.1	All staff who care for women in labour are required to undertake annual training and competency assessment on knowledge and skills required for effective fetal monitoring via Intermittent auscultation (IA) [Midwives] and electronic fetal monitoring [Midwives and Obstetricians]. See Core Competency Framework Version 2	**SBL Process indicator 4a** Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors and situational awareness **SBL Process Indicator 4b** Percentage of staff who have successfully completed mandatory annual competency assessment	N/A	Local training records.	**Numerator**: Number of staff* with in date annual training compliance on fetal monitoring **Denominator:** Number of staff* to be trained Principles for training packages are included in Appendix E. It is recommended that all trusts mandate annual human factor training for all staff working in a maternity setting; this should include principles of psychological safety, upholding civility in the workplace, and escalating clinical concerns. The content of training must be agreed within the LMNS, Ockenden, 2022. All staff should pass an annual competency assessment that has been agreed by the local commissioner (ICB) based on the advice of the Clinical Network. Trusts should agree a procedure with their ICB for how to manage staff who fail this assessment. *A list of staff in and out of scope for inclusion in training numbers is outlined in the technical guidance for Safety Action 8 of CNST MIS. Training requirements are outlined in the Core Competency Framework Version 2.	A training plan should be in place to cover all six core modules of the Core Competency Framework. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A minimum of 80% reliability of staff caring for women in labour trained annually on effective fetal monitoring and that have completed competency assessment, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period. No member of staff should care for women in a birth setting without evidence of training and assessment within the last year. Evidence to monitor and ensure that all medical and midwifery staff working in a birth setting are compliant with training requirements (pass mark 85%).	90% 85%	REF4.1A	Training plan/TNA	Uploded			Fully implemented	Training requiremment now down to 80% as per CNST chnages. Awaitign Action Plan from FM Midwives,	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF4.1B	Training compliance	K2 assessment compliance	YTD Sept 2023	90%					
								REF4.1C									
								REF4.1D	Training compliance	One day study day	YTD Sept 2023	86.31%					
								REF4.1E									
								REF4.1F									
4.2	At the onset of every labour, there is a structured risk assessment undertaken which informs the clinicians recommendation of the most appropriate fetal monitoring method at the start of labour. This risk assessment should be revisited throughout labour as part of a holistic review.	Percentage of women that had a risk assessment at onset of labour to determine most appropriate fetal monitoring method	N/A	N/A	**Numerator:** Number of audited records that had risk assessment completed at the onset of labour **Denominator:** Number of women who have given birth in the period of review that were included within the audit Risk assessment should include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. This assessment should be agreed with local commissioners (ICBs) based on the advice of the Clinical Network and reflect fetal monitoring guidelines.	Guideline evidencing completion of a structured risk assessment at the onset of labour outlining the most appropriate fetal monitoring method and the freqency of review of the risk assessment throughout labour. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 95% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 95% reliability, for those organisations on an improvement journey.	95%	REF4.2A	Guideline/policy	Fetal Surveillance in labour guideline	new version uploaded		Partially implemented	Risk assessments being added to guideine. Paper assesemnts ot be completed whilst awating K2. NO audit as yet. K2 does have a risk assessment function but doesn't meet all requirement paper copy now live will be able to audit	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Final version guideline reviewed at meeting. Audit evidence required.
								REF4.2B									
								REF4.2C									
								REF4.2D									
								REF4.2E									
								REF4.2F									
4.3	Regular (at least hourly) systematic review of maternal and fetal wellbeing should be agreed and implemented. This should be accompanied by a clear guideline for escalation if concerns are raised using this structured process. All staff to be trained in the review system and escalation protocol.	**SBL Outcome Indicator 4d** The percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor. Percentage of women birthed that had an hourly systematic review of maternal and fetal wellbeing	N/A Fetal wellbeing to be assessed regularly (at least hourly) during labour and documented using a structured proforma.	Perinatal Mortality Review Tool (PMRT). N/A	N/A **Numerator:** Number of audited records that had hourly documented review of maternal and fetal wellbeing and evidence of concerns being appropriately escalated in line with clinical guidance **Denominator:** Number of women who have given birth in the period of review that were included within the audit This review should be more than recording the fetal heart rate via IA or categorisation of the CTG.	Report demonstrating % of stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monioring identified as a contributory factor using PMRT and the actions taken and learning shared to make improvements. Guideline evidencing regular (at least hourly) review of maternal and fetal wellbeing and escalation of concerns using a structured process. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 95% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 95% reliability, for those organisations on an improvement journey.	N/A 95%	REF4.3A	Report	PMRT extract of issues and actions	Q2 23/24	0%	Fully implemented	0% low percentage is good outcome indicator	Fully implemented		Final version guideline reviewed at meeting - to be uploaded to evidence portal.
								REF4.3B	Report	Audit of CTG issues with HIE incidents	Q2 23/24	0%					
								REF4.3C	Report	report of all babies where CTG mx was an issue	Q2 23/24	0%					
								REF4.3D									
								REF4.3E	Guideline/policy	Fetal Surveillance in labour guideline	previsouly uploaded						
								REF4.3F	Audit	Fresh Eyes	Q2 23/24	96.20%					
								REF4.3G									
								REF4.3H									
4.4	A buddy system should be used to help provide an objective holistic review for example 'Fresh Eyes' – this should be undertaken at least hourly when CTG monitoring is used and at least four hourly when IA is utilised, unless there is a trigger to provide a holistic review earlier.	Percentage of women birthed that had an hourly fresh eyes on all intrapartum CTGs or 4 hourly fresh eye review when IA is utilised	Introduce a Buddy system to pair up more and less experienced midwives during shifts to provide accessible senior advice with protocol for escalation of any concerns.	N/A	**Numerator:** Number of audited records that had a documented fresh eye review within required timeframe of fetal heart rate or categorisation of CTG and risk factors and any required escalation in line with clinical guidance **Denominator:** Number of women who have given birth in the period of review that were included within the audit A discussion between the midwife caring for the woman and another midwife or doctor should include the FHR (IA or CTG), review of antenatal risk factors such as concurrent reduced fetal movements, fetal growth restriction, previous caesarean birth; and intrapartum risk factors such as meconium, suspected infection, vaginal bleeding or prolonged labour and should lead to escalation if indicated (Appendix E).	Guideline evidencing 'fresh eye' review and required frequency. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 95% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 95% reliability, for those organisations on an improvement journey.	95%	REF4.4A	Guideline/policy	Fetal Surveillance in labour guideline	previsouly uploaded		Fully implemented	Fresh cares recently added to guidline for IA.	Fully implemented		
								REF4.4B	Audit	Fresh Eyes	July-Sep 23	95.60%					
								REF4.4C									
								REF4.4D									
								REF4.4E									
								REF4.4F									
4.5	Identify a dedicated lead midwife (minimum of 0.4 WTE) and lead obstetrician (minimum 0.1WTE) with demonstrated fetal monitoring expertise to focus on and champion best practice in fetal monitoring.	**SBL Process Indicator 4c** Fetal monitoring lead roles appointed	N/A	N/A	Some Trusts may choose to extend the remit of the Practice Development Midwife to fulfil the role of Fetal Monitoring Lead, whereas others may wish to appoint a separate clinician. The critical principle is that the Fetal Monitoring Leads have dedicated time within their remit to support staff working in intrapartum care to provide high quality intrapartum risk assessments and accurate fetal heart rate interpretation using either IA or CTG. The role should contribute to building and sustaining a safety culture in intrapartum care with all staff committed to continuous improvement.	The Trust board should specifically confirm to the system that within their organisation a dedicated Lead Midwife (0.4 WTE) and Lead Obstetrician (0.1 WTE) per consultant led unit have been appointed and is in post. Job desciption of role and responsibilities.	N/A	REF4.5A	Job description/job plan	Midwife JD/PS	previsouly uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF4.5B	Job description/job plan	Obs Lead JD/PA	previsouly uploaded						
								REF4.5C									
								REF4.5D									
								REF4.5E									
								REF4.5F									

Element 5 – Reducing preterm birth

Element description: Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
5.1	Each provider trust should have: a) An Obstetric Consultant lead for preterm birth, delivering care through a specific preterm birth clinic, or within an existing fetal medicine service. b) An identified local preterm birth/perinatal optimisation Midwife Lead c) A Neonatal Consultant lead for preterm perinatal optimisation d) An identified Neonatal Nursing lead for preterm perinatal optimisation	N/A	N/A	N/A	The Preterm Birth Lead Team should provide leadership and oversight of the implementation of Element 5 of SBLCBv3.	The Trust board should specifically confirm to the system that within their organisation they have appointed and have in post the leads specified. Job desciption of role and responsibilities.	N/A	REF5.1A	Job description/job plan	Maternal Medicine Midwife JD			Partially implemented	Awating JDs from Obs & NN	Partially implemented		JD for Obstetric and neonatal leads required. Confirmation required on the maternal medicine JD that is included as evidence - this does not appear to be an explicit pre-term role.
								REF5.1B	Other	email re the MM MW JD							
								REF5.1C	Job description/job plan								
								REF5.1D									
								REF5.1E									
								REF5.1F									
5.2	Each Preterm Birth Lead team should have clear audit and QI pathways for preterm birth prevention, prediction and perinatal optimisation, and should engage in shared learning and QI with local preterm birth clinical networks, LMNSs and neonatal ODNs.	**SBL Outcome Indicator 5I** The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: a) in the late second trimester (from 16+0 to 23+6 weeks). b) preterm (from 24+0 to 36+6 weeks).	N/A	Recording of birth outcome for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of women who give birth to a singleton (liveborn or stillborn) between 16+0 and 23+6 weeks **Denominator:** Total number of singleton births (liveborn or stillborn)	Guideline evidencing preterm pathway for prevention, prediction and perinatal optimisation. Report demonstrating % of late second trimester singleton births and preterm births (using PMRT for analysis) where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue and the actions taken and learning shared to make improvements. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	To be disucssed	REF5.2A	Guideline/policy	Preterm pregnancy, labour & birth guideline	previously uploaded		Fully implemented	QI project to be registered	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Partially implemented due to national ambition - work is underway and rate is improving due to QI work. With continued improvement and QI work, local trajectory to be agreed with a stretch to the national ambition.
								REF5.2B	Report	report highlighting no issues with optimisation for the babies where SB or NND have occurred in Q2	Q2 23-24	0%					
								REF5.2C									
								REF5.2D									
					Numerator: Number of women who give birth preterm to a singleton (liveborn or stillborn) between 24+0 and 36+6 weeks **Denominator:** Total number of singleton births (liveborn or stillborn)		6% *as per the national ambition	REF5.2E	Dashboard	Dashboard for Q2 highlighting preterm data	Q2 23-24	7.52%					
								REF5.2F									
								REF5.2G									
								REF5.2H									
		SBL Outcome Indicator 5k Percentage of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	N/A	Perinatal Mortality Review Tool (PMRT).	N/A	Report demonstrating % of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue and the actions taken and learning shared to make improvements.	N/A	REF5.2I	Report	report highlighting no issues with optimisation for the babies where SB or NND have occurred in Q2	Q2 23-24	0%					
								REF5.2J									
								REF5.2K									
								REF5.2L									
								REF5.2M									
								REF5.2N									
		SBL Outcome Indicator 5i Mortality to discharge in very preterm babies (NNAP definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner)	N/A	Local data as submitted to National Neonatal Audit Programme	**Denominator:** Number of babies admitted to a neonatal unit whose birth gestation was 24+0 to 31+6 weeks inclusive (22+0 and 23+6 weeks for additional reporting) **Numerator:** Deaths of babies 24+0 to 31+6 weeks gestation inclusive (22+0 and 23+6 weeks for additional reporting), before discharge from hospital to home, or discharge for palliative care with agreed non-intervention plan in place followed by death prior to 44 weeks post-menstrual age Note: Babies discharged to a hospice for palliative care (such as for compassionate extubation) and who die prior to 44 weeks postmenstral age are counted in the numerator. In hospital, deaths in units not submitting data to the NNAP will be included. Change to the audit measure for 2023 data year: The NNAP will additionally report mortality at 22 and 23 weeks gestational age, however this group will not be included in reporting against the improvement goal.	Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	to be set locally based on current performance (to review NNAP data) %	REF5.2O								
								REF5.2P									
								REF5.2Q									
								REF5.2R									
								REF5.2S									
								REF5.2T									
5.3	Assessment of all women at booking for their risk of preterm birth and stratification to low, intermediate and high-risk pathways using the criteria in Appendix F.	Percentage of women at booking who had a completed risk assessment for preterm birth as outlined in Appendix F.	N/A	Recording of preterm birth risk assessment for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator**: Number of women with a completed risk assessment for preterm birth as outlined in Appendix F at booking **Denominator**: Number of women booked This assessment should take place at the booking appointment with referral by 12 weeks. Appendix F includes a suggested risk assessment and management algorithm that providers may wish to adopt. It is recognised that there are imperfections in the predictability of preterm birth on the basis of history; the use of digital algorithms & tools (for example the Tommy's app) may also be useful to support assessment.	Guideline evidencing the risk assessment at booking as outlined in Appendix F. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 90% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 90% reliability, for those organisations on an improvement journey.	90%	REF5.3A	Guideline/policy	ANRA	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.3B	Audit	Documentation Audit	Q2 23-24	100%					
								REF5.3C									
								REF5.3D									
								REF5.3E									
								REF5.3F									
5.4	In the assessment of women presenting in suspected preterm labour, evaluated digital tools are now available (QUIDS, QUPP) to improve predictive accuracy of triage and enable collaborative decision making.	N/A	N/A	N/A	N/A	Guideline evidencing use of evaluated prediction tools for women presenting in suspected preterm labour.	N/A	REF5.4A	Guideline/policy	Preterm pregnancy, labour & birth guideline	previously uploaded		Fully implemented	Audit is not a requirement.	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.4B									
								REF5.4C									
								REF5.4D									
								REF5.4E									
								REF5.4F									
5.5	Networked Trusts should agree on the use of these tools	N/A	N/A	N/A	There should be evidence that the trust has developed and agreed at LMNS level local transfer pathways for women predicted in preterm labour using the evaluated	Evidence of the tool that has been agreed for use and approved through the ICS/LMNS	N/A	REF5.5A							Fully meets standard - continue with regular monitoring of		
								REF5.5B									
								REF5.5C									

Element 5 – Reducing preterm birth

Element description: Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
	within their ICS/LMNS.				digital tools.	Board.		REF5.5D								implementation.	
								REF5.5E									
								REF5.5F									
5.6	Risk assessment and management in multiple pregnancy should comply with NICE guidance or a variant that has been agreed with the local network or ICS following advice from the provider's clinical network.	N/A	N/A	N/A	N/A	Guideline evidencing alignment to NICE guidance on risk assessment and the management of growth disorders in multiple pregnancy. Audit reviewing implementation of guideline and standards. The risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (ICBs) following advice from the provider's clinical network.	N/A	REF5.6A	Guideline/policy	Multiple pregnancy guidleline	previously uploaded		Fully implemented		Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit evidence included with actions to be completed by January 24 and so remains partially implemented until actions are implemented and re-audit demonstrates improvement in practice.
								REF5.6B	Audit	NICE Baseline audit uploaded							
								REF5.6C									
								REF5.6D									
								REF5.6E									
								REF5.6F									
5.7	Assess smoking status (see Element 1) and implement appropriate intervention to ensure the pregnancy is smoke free before 15 weeks.	N/A	N/A	N/A	N/A	Guideline evidencing smoking status is assessed and managed as outlined in Element 1 (intervention 1.1) for women identified as at risk of pre-term birth.	N/A	REF5.7A	Guideline/policy	Smoking in pregnancy	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.7B									
								REF5.7C									
								REF5.7D									
								REF5.7E									
								REF5.7F									
5.8	Assess all women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C or an alternative which has been agreed with the local network or ICS following advice from the provider's clinical network.	N/A	N/A	N/A	N/A	Guideline evidencing assessment at booking as outlined in Element 2 (intervention 2.1) to determine if prescription of Aspirin is needed using an appropriate algorithm.	N/A	REF5.8A	Guideline/policy	ANRA	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.8B									
								REF5.8C									
								REF5.8D									
								REF5.8E									
								REF5.8F									
5.9	Symptomatic women require assessment using quantitative fetal fibronectin (qfFN) measurements (and use of decision-assist tools such as the QUIPP and QUIDS apps). The use of TVCS may also be used with or without qfFN.	Percentage of symptomatic women for preterm birth that are assessed using quantitative fetal fibronectin (qfFN) measurement	N/A	Local case notes or electronic patient records.	**Numerator:** Number of symptomatic women for preterm birth assessed using quantitative fetal fibronectin (qfFN) measurement (or other prediction test if qfFN not available) **Denominator:** Number of symptomatic women for preterm birth Further advice may be sought from UK Preterm Clinical Network, BAPM, or NICE guidance55).	Guideline evidencing the assessment of quantitative fetal fibronectin (qfFN) measurements (or other prediction test if qfFN not available) and use of decision-assist tools such as the QUIPP and QUIDS apps for symptomatic women. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	% To be discussed	REF5.9A	Guideline/policy	Preterm pregnancy, labour & birth guideline	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.9B	Standard operating procedure	Actim Partus SOP	previously uploaded						
								REF5.9C	Audit	QUIPP	1/12/20-28/2/21	previously uploaded					
								REF5.9D									
								REF5.9E									
								REF5.9F									
5.10	Assess each woman with a history of preterm birth to determine whether this was associated with placental disease and discuss prescribing aspirin with her.	N/A	N/A	N/A	N/A	Guideline evidencing that each woman with a history of preterm birth is reviewed to determine whether this was associated with placental disease and prescribing aspirin discussion takes place.	N/A	REF5.10A	Guideline/policy	PTSC	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.10B	Guideline/policy	ANRA	previously uploaded						
								REF5.10C									
								REF5.10D									
								REF5.10E									
								REF5.10F									
5.11	Test for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking. Following any positive culture and treatment, a repeat MSU to confirm clearance is recommended.	Percentage of women assessed as intermediate or high risk at booking who have a completed MSU for culture and senstivity.	N/A	Recording of MSU for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England.	**Numerator:** Number of women booked and assessed as intermediate or high risk who had a MSU completed at booking **Denominator:** Number of women booked assessed as intermediate or high risk	Guideline evidencing MSU is required at booking for women assesed as intermediate or high risk and repeat MSU required following positive culture and treatement. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	% To be discussed (to confirm - intermittent and high-risk for PTB, not for ALL antenatal women)	REF5.11A	Guideline/policy	Bacteruria in pregnancy	previously uploaded		Fully implemented	10% notes audited as currently not built into K2 audits therefore requiring manual pull. 10% = 136 sets notes for Q2.	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit discussed and clarified.
								REF5.11B	Audit	MSU @ booking	Q2 23-24	100%					
								REF5.11C	Audit	repeat MSU	Q2 23-24	96.3					
								REF5.11D									
								REF5.11E									
								REF5.11F									
								REF5.12A	Guideline/policy	PTSC	previously uploaded						
								REF5.12B									

Element 5 – Reducing preterm birth

Element description: Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
5.12	Asymptomatic women should have access to transvaginal cervix scanning (TVCS) to assess the need for further interventions such as cervical cerclage and progesterone supplementation (Appendix F).	N/A	N/A	N/A	All high risk pregnant women to be offered transvaginal cervix scanning every 2-4 weeks between 16 and 24 weeks as a secondary test to more accurately quantify the risk of preterm birth. For pregnant women defined as intermediate risk single transvaginal cervix scan between 18-22 weeks as a minimum is required.	Guideline evidencing asymptomatic women have access to transvaginal cervix scanning (TVCS) as outlined in Appendix F.	N/A	REF5.12C					Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.12D									
								REF5.12E									
								REF5.12F									
5.13	Every provider should have referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories. This should include access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage. These procedures are performed relatively infrequently and therefore are best provided on a supra-regional basis in order to maintain expertise.	N/A	N/A	N/A	Where preterm birth prevention clinics are not available providers should ensure that women are able to access care that guarantees that they are given evidence-based information, access to risk assessment tests and interventions as appropriate and can actively participate in decisions regarding their management. Providers should have access to supra-regional prevention services within their care pathways and networks, which include access to high vaginal and transabdominal cerclage.	Guideline referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories.	N/A	REF5.13A	Guideline/policy	PTSC	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Discussed. Additional guideline reviewed which articulates referral pathway from DBTH. Possibly clarity required regionally to ensure consistency but clear from DBTH perspective. Section 7 of guideline needs to be reviewed to ensure that IUT matches regional IUT guideline and please upload additional guideline as evidence. To consider amalgamating to one guideline to ensure consistency.
								REF5.13B									
								REF5.13C									
								REF5.13D									
								REF5.13E									
								REF5.13F									
5.14	Local implementation plans for midwifery CoC models should ensure prioritisation of women from the most deprived groups in line with Core20+5.	N/A	N/A	N/A	Midwifery Continuity of Carer (CoC) models, with a focus on individualised risk assessment and care pathways, may prevent preterm birth and save babies' lives: Delivering midwifery continuity of carer at full scale - published Midwifery CoC must be supported by safe staffing levels to preserve the safety of all pregnant women and families: Final Report of the Ockenden Review - published March 2022	Evidence of local implemenation plan for midwiferyy CoC and priortisation of women from most deprived groups in line with Core 20+5.	N/A	REF5.14A	Other	CoC Plan			Fully implemented		Fully implemented		CoC plan included which includes realistic timelines based on MCoC guidance - to establish teams when building blocks allow. To note this does not indicate compliance with MCoC - but that there is a realistic plan (as per the SBL timelines) to implement.
								REF5.14B									
								REF5.14C									
								REF5.14D									
								REF5.14E									
								REF5.14F									
5.15	Women identified to be at increased risk of preterm birth should be made aware of the signs/symptoms of preterm labour and encouraged to attend their local maternity unit early if these occur.	N/A	N/A	N/A	N/A	Guideline evidencing that those women at risk of preterm birth are made aware of signs/symptons and actions to take. Patient information leaflet outlining the signs and symptoms of preterm birth and what to do.	N/A	REF5.15A	Guideline/policy	PTSC	previously uploaded		Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Additonal guideline reviewewd at the meeting which states information to be shared and information leaflet reviewed. Comms published version to be added as evidence.
								REF5.15B	Other	PIL	previously uploaded						
								REF5.15C									
								REF5.15D									
								REF5.15E									
								REF5.15F									
5.16	Ensure the neonatal team are involved when a preterm birth is anticipated, so that there is time to meet as a perinatal team to discuss care options with parents prior to birth. This is especially important at earlier gestational ages.	Percentage of women who deliver preterm where the neonatal team have a discussion with the parents regarding care options.	N/A	N/A	**Numerator:** Number of women who deliver preterm that have a discussion with the neonatal team regarding care options **Denominator:** Number of women who deliver preterm In the case of extreme prematurity where complex decision making is required (active survival focused care or comfort care), management should be as outlined in: 2019 BAPM Framework for Practice regarding Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation: "Conversations with parents should be clearly documented and care taken to ensure that the agreed management plan is communicated between perinatal professionals and staff shifts. Decisions and management should be regularly reviewed before and after birth in conjunction with the parents; plans may be reconsidered if the risk for the fetus/baby changes, or if parental wishes change."	Guideline evidencing the neonatal team are involved when a preterm birth is anticipated. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	90%	REF5.16A	Guideline/policy	Preterm pregnancy, labour & birth guideline	previously uploaded		Partially implemented	Audit of only 10% for Q2 = 91 pre term deliveries. Included 22+0-36+6. Actions to review local practice and guideline and documentation of staff at delivery	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit evidence included, currently below required compliance. To complete actions relating to review of local practice.
								REF5.16B	Audit	Neonatal Attendance at preterm delivery audit	Q2 23-24	77.02					
								REF5.16C									
								REF5.16D									
								REF5.16E									
								REF5.16F									
5.17	Women identified to be potentially at increased risk of imminent preterm birth, where active survival focused care is planned, should be made aware of optimisation interventions that may be offered. Families should also be offered information and support for families from charities such as Bliss	**SBL Process Indicator 5h** Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (5.19 to 5.25) achieved.	N/A	Recording of perinatal optimisation for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting system for PRECEPT National Patient Safety Programme.	**Numerator:** Number of the relevant optimisation interventions 5.19 to 5.25 achieved **Denominator:** Total number of optimisation interventions [calculated from total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation)] Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Unit level BadgerNet perinatal optimisation audit report demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	70%	REF5.17A	Guideline/policy	Preterm pregnancy, labour & birth guideline	previously uploaded		Partially implemented	ODN data to be compiled	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Additional evidence included. Still requires ODN data to be compiled. To ensure all elements are included within the guideline including thermal care at birth, early EBM.
								REF5.17B	Guideline/policy	Y&H IUT Guideline							
								REF5.17C	Dashboard	Preterm audit	ongoing continuous data						
								REF5.17D									
								REF5.17E									
								REF5.17F									
5.18	Acute tocolysis may be used when short term delay is desirable i.e. in utero transfer, and probably to ensure adequate antenatal exposure to corticosteroid/magnesium sulphate (i.e. no longer than 48 hours).	N/A	N/A	N/A	N/A	Guideline evidencing that tocolytics are used for short term delay of preterm birth in specific circumstances.	N/A	REF5.18A	Guideline/policy	Preterm pregnancy, labour & birth guideline	previously uploaded		Fully implemented	ODN data to be compiled. There is clear refercnt ot use of tocolysis in ourt PT guidelinen	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.18B									
								REF5.18C									
								REF5.18D									
								REF5.18E									
								REF5.18F									
								REF5.19A	Guideline/policy	Y&H IUT Guideline							

Element 5 – Reducing preterm birth

Element description: Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
5.19	Women who have symptoms suggestive of preterm labour or who are having a planned preterm birth: a) less than 27 weeks gestational age (in a singleton pregnancy) b) less than 28 weeks gestational age (in a multiple pregnancy) c) any gestation with an estimated fetal weight of less than 800g should be managed in a maternity service on the same site as a neonatal intensive care unit (NICU).	**SBL Process Indicator 5a** Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU)	N/A	Recording of birth location for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting system for PRECEPT National Patient Safety Programme.	**Numerator:** 1st episode of baby born <27 weeks (singleton), <28 weeks (multiples) and <800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU) **Denominator:** Total number 1st episode of baby born <27 weels (singleton), <28 weeks (multiples) and <800g Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Unit level BadgerNet perinatal optimisation audit report demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 85% (in line with the Neonatal Critical Care Review) for high performing organisations with minimum ambition of 70%, with a clear action plan to achieve 85% reliability, for those organisations on an improvement journey.	85%	REF5.19B REF5.19C REF5.19D REF5.19E REF5.19F	Audit 	To be uploaded precept data 			Fully implemented	ODN data to be compiled	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Small number of off-pathway births occuring per quarter. To include evidence to demonstrate review (avoidable or non-avoidable) and any learning.
5.20	Antenatal corticosteroids should be offered to women between 22+0 (where active management is agreed) and 33+6 weeks of pregnancy, optimally at 48 hours prior to birth. A steroid-to-birth interval of greater than seven days should be avoided if possible, and repeat courses of steroids should be avoided where possible.	**SBL Process Indicator 5b** Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth Percentage of babies born (less than 34+0 weeks) where birth is more than seven days after completion of their first course of antenatal corticosteroids	N/A N/A	Recording of AN corticosteriod administration for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting system for PRECEPT National Patient Safety Programme.	**Numerator:** Number of live births born before 34+0 weeks gestation who received a full course of antenatal corticosteroids within seven days of birth **Denominator:** Total number of live births born before 34+0 weeks gestation Note, live births should include singletons and multiples. Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement. **Numerator:** Number of live births born before 34+0 weeks gestation and more than 7 days after completion of their first course of antenatal corticosteroids **Denominator:** Total number of live births born before 34+0 weeks gestation Note, live births should include singletons and multiples. Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Unit level BadgerNet perinatal optimisation audit report demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 55% for high performing organisations with minimum ambition of 40%, with a clear action plan to achieve 55% reliability, for those organisations on an improvement journey. Guideline evidencing optimisation interventions and perinatal optimisation passport. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	55% N/A	REF5.20A REF5.20B REF5.20C REF5.20D REF5.20E REF5.20F REF5.20G REF5.20H	Report Audit Guideline/policy 	ODN data Precept lcoal data Preterm pregnancy, labour & birth guideline 	Q2 23-24 Q2 23-24 	23.5 61% 	Fully implemented	discrepnecy between local and ODN data	Fully implemented		Audit data discussed. Variation due to manual data cleanse which is not reflected in the ODN data until the following quarter.
5.21	Magnesium sulphate to be offered to women between 22+0 (where active management is agreed) and 29+6 weeks of pregnancy - and considered for women between 30+0 and 33+6 weeks of pregnancy - who are in established labour or are having a planned preterm birth within 24 hours.	**SBL Process Indicator 5c** Percentage of babies being born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth **SBL Outcome Indicator 5j** Percentage of babies born below 32 weeks gestational age with brain injury as defined in the technical guidance	N/A N/A	Recording of magnesium sulphate administration for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting system for PRECEPT National Patient Safety Programme.	**Numerator:** Number of babies born before 30+0 weeks receiving magnesium sulphate within the 24 hours prior to birth **Denominator:** Total number of babies born before 30+0 weeks gestation Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement. **Numerator:** Number of denominator with brain injury (NNAP definition) **Denominator:** Number of babies born <32 weeks gestational age who are admitted to a neonatal unit and experience their final neonatal discharge in the calendar year of analysis Preterm Brain Injury (NNAP definition) - include only the following forms of brain injury: a) Germinal matrix/ intraventricular haemorrhage b) Post haemorrhagic ventricular dilatation c) Cystic periventricular leukomalacia	Guideline evidencing optimisation interventions and perinatal optimisation passport. Unit level BadgerNet perinatal optimisation audit report demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 90% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 90% reliability, for those organisations on an improvement journey. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	90% % To be discussed	REF5.21A REF5.21B REF5.21C REF5.21D REF5.21E REF5.21F REF5.21G REF5.21H	Guideline/policy Report Guideline/policy Audit Audit Other 	Preterm pregnancy, labour & birth guideline ODN data Y&H IUT Guideline Precept local audit Precept local audit preterm action plan 	previously uploaded Q2 23-24 Q2 23-24 Q2 23-24 	 50 50 	Partially implemented		Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data included demonstrating <90%. Action plan included identifying actions. Include data for outcome 5j(brain injury)
5.22	All women in preterm labour at less than 37 weeks of gestation should receive intravenous intrapartum antibiotic prophylaxis (Benzylpenicillin, where not contraindicated) to prevent early onset neonatal Group B Streptococcal (GBS) infection irrespective of whether they have ruptured amniotic membranes.	**SBL Process Indicator 5d** Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection	N/A	Recording of IV antibiotic prophylaxis for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting system for PRECEPT National Patient Safety Programme.	**Numerator:** Number of women who give birth (exc caesarean) <34 weeks and up to 36+6 weeks who receive IV intrapartum antibiotic prophylaxis **Denominator:** Number of women who give birth (exc caesarean) <34 weeks and up to 36+6 weeks This excludes planned caesarean births without labour. NB – this intervention should be considered up to 36+6 weeks. Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Unit level BadgerNet perinatal optimisation audit report demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	90%	REF5.22A REF5.22B REF5.22C REF5.22D REF5.22E REF5.22F	Guideline/policy Report Audit Other 	Preterm pregnancy, labour & birth guideline ODN data Precept local audit preterm action plan 	previously uploaded Q2 23-24 Q2 23-24 	 21 62 	Partially implemented	discrepnecy between local and ODN data	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data included, however there is variation between local and ODN published. To discuss. Both data sets indicate <90%. Action plan included but this is not specific to antibiotics.
5.23	Babies born at less than 37 weeks gestational age should have their umbilical cord clamped at or after one minute after birth – this can have benefits for all babies. Perinatal multidisciplinary teams should work together to ensure this can reliably be delivered at all births.	**SBL Process Indicator 5e** Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth	N/A	Recording of umbilical cord clamping for woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting system for PRECEPT National Patient Safety Programme.	**Numerator**: Babies born at less than 34 weeks who have their umbilical cord clamped at or after one minute after birth **Denominator**: Babies born at less than 34 weeks Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Unit level BadgerNet perinatal optimisation audit report for babies born below 34 weeks who have their umbilical cord clamped at or after one minute after birth demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 75% of babies born below 34 weeks have their umbilical cord clamped at or after one minute after birth for high performing organisations with minimum ambition of 50%, with a clear action plan to achieve 75% reliability, for those organisations on an improvement journey.	75%	REF5.23A REF5.23B REF5.23C REF5.23D REF5.23E REF5.23F	Guideline/policy Report Audit Other 	Preterm pregnancy, labour & birth guideline ODN data Precept local audit preterm action plan 	 Q2 23-24 Q2 23-24 	 68 68 	Partially implemented		Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Progress made. Ensure action plan focusses on DCC.
5.24	Babies born at less than 37 weeks gestational age should have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. Neonatal normothermia can have benefits for all babies.	**SBL Process Indicator 5f** Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth	N/A	Recording of temperature for babies on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting system for PRECEPT National Patient Safety Programme.	**Numerator**: Babies born at less than 34 weeks who have their first temperature which is both between 36.5–37.5°C and measured within one hour of birth **Denominator**: Babies born at less than 34 weeks Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Unit level BadgerNet perinatal optimisation audit report for babies born below 34 weeks who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 80% for high performing organisations with minimum ambition of 65%, with a clear action plan to achieve 80% reliability, for those organisations on an improvement journey.	80% NB (NNAP 90%)	REF5.24A REF5.24B REF5.24C REF5.24D REF5.24E REF5.24F	Guideline/policy Report Guideline/policy Audit 	Preterm pregnancy, labour & birth guideline ODN data Y&H IUT Guideline Precept local audit 	previously uploaded Q2 23-24 Q2 23-24 	 68 68 	Partially implemented		Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit data indicates <target. Action plan included.
	Early maternal breast milk (MBM) - Babies born below			Recording of MBM on Maternity Information System (MIS) and	**Numerator**: Babies born at less than 34 weeks who receive their own mother's	Guideline evidencing optimisation interventions and perinatal optimisation passport.		REF5.25A REF5.25B	Guideline/policy Report	Preterm pregnancy, labour & birth guideline ODN data	 Q2 23-24	 67					

Element 5 – Reducing preterm birth

Element description: Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented

Inter-vention Ref	Required SBL Intervention	SBL Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
5.25	37 weeks gestational age should receive their own mother's milk, ideally within 6 hours, but aiming always within 24 hours of birth (except in rare situations where there are contraindications to MBM). Perinatal teams should work together to ensure consistent delivery of antenatal advice about MBM, with support (equipment, education, help) for mothers to express within two hours of birth.	**SBL Process Indicator 5g** Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth	N/A	[redacted] inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS England & via BadgerNet Neonatal Reporting system for PRECEPT National Patient Safety Programme.	milk within 24 hours of birth **Denominator**: Babies born at less than 34 weeks Unit level BadgerNet perinatal optimisation audit reports are accessed via 'National Reports' section of BadgerNet National Neonatal Patient Data Management Care Record System. If trusts are not reporting into the PRECEPT National Safety Programme providers may use local data to drive real-time quality improvement.	Unit level BadgerNet perinatal optimisation audit report for babies born below 34 weeks who have early maternal breast milk demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	60%	REF5.25C	Guideline/policy	Y&H IUT Guideline			Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	To review updates to Q2 data when ODN Q3 data is published to ensure improved DQ.
								REF5.25D									
								REF5.25E									
								REF5.25F									
5.26	For babies born below 34 weeks' gestation who need invasive ventilation, use volume-targeted ventilation (VTV) in combination with synchronised ventilation as the primary mode of respiratory support.	Percentage of babies born <34 weeks who receive volume-targeted ventilation (VTV) in combination with synchronised ventilation as the primary mode of respiratory support, if invasive ventilation is required	N/A	N/A	**Numerator**: Babies born at less than 34 weeks who receive volume-targeted ventilation (VTV) in combination with synchronised ventilation as the primary mode of respiratory support, if invasive ventilation is required **Denominator**: Babies born at less than 34 weeks NB – For preterm babies who do not need invasive ventilation, consider nasal CPAP or nasal high-flow therapy as the primary mode of respiratory support. Guidance in line with: Quality Standard QS193 The use of volume targeted ventilation is recommended but this data is not currently recorded or presented with national datasets.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	90%	REF5.26A	Guideline/policy	Preterm pregnancy, labour & birth guideline			Fully implemented	Audit to be completed	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.26B	Guideline/policy	Neonatal RDS							
								REF5.26C	Audit	uploaded		95%					
								REF5.26D									
								REF5.26E									
								REF5.26F									
5.27	For babies born below 30 weeks' gestation, caffeine reduces the chance of death or disability. Caffeine should be started within 24 hours of birth.	Percentage of babies born <30 weeks who are started on caffeine within 24 hours of birth	N/A	N/A	**Numerator**: Babies born at less than 30 weeks who are started on caffeine within 24 hours of birth **Denominator**: Babies born at less than 30 weeks Guidance in line with: Quality Standard QS193 Getting It Right First Time (GIRFT) recommendations The use of caffeine is recommended but this data is not currently recorded or presented with national datasets.	Guideline evidencing optimisation interventions and perinatal optimisation passport. Data required via audit to monitor reliability with intervention. LMNS to agree local ambition and improvement trajectory based on current system performance. Clear action plan to be in place to meet improvement trajectories and timeframes agreed. See 'How to assure with the tool'.	90%	REF5.27A	Guideline/policy	Preterm pregnancy, labour & birth guideline			Fully implemented		Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	
								REF5.27B	Guideline/policy	Neonatal RDS							
								REF5.27C	Audit	uploaded		100%					
								REF5.27D									
								REF5.27E									
								REF5.27F									

Element 6 – Management of Diabetes in Pregnancy

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

Inter-vention Ref	Required SBL Intervention	Process or Outcome Measure	Measure Descriptor	Data Source	Technical Definition	Recommended Minimum Evidence Requirements (variations to be agreed by LMNS Board)	LMNS Required Compliance	Evidence Reference	Evidence Type	Evidence Details	Audit Period	Reported Audit Result	Self-Assessment Status	Trust Actions Around Improvement Activities	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
6.1	Women with a diagnosis of pre-existing diabetes in pregnancy should be offered care in a one stop clinic, providing care to pre-existing diabetes only, which routinely offers multidisciplinary review and has the resource and skill set to address all antenatal care requirements.	**SBL Process Indicator 6a** Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only	N/A	N/A	The multidisciplinary team should consist, as a minimum, of: Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse (DSN), Diabetes Dietitian, Diabetes Specialist Midwife (DSM).	Guideline evidencing an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc).	N/A	REF6.1A	Meeting minutes	Service review minutes	previously uploaded		Fully implemented		Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Trust confirm that model is in place as set out in evidence (JDC RR) however, post meeting it appears that the pilot of 2 separate clinics has ceased - to be reinstated. Confirmation there is a dietician available for each clinic. Maternal medicine midwife in post.
								REF6.1B	Meeting minutes	Service review minutes	previously uploaded						
								REF6.1C	Meeting minutes	Service review minutes	previously uploaded						
								REF6.1D	Meeting minutes	Service review minutes	previously uploaded						
								REF6.1E	Guideline/policy	Management of diabetes in pregnancy	previously uploaded						
								REF6.1F		Janines data							
6.2	Women with type 1 diabetes should be offered real time continuous glucose monitoring (CGM) ...	**SBL Outcome Indicator 6f** Percentage of women with type 1 diabetes that have used CGM during pregnancy.	N/A	Local data as submitted for the NPID dashboard (2021/22 data planned to be released October 2023)	**Numerator:** Number of pregnant women who have type 1 diabetes that used CGM during pregnancy **Denominator:** Number of pregnant women who have type 1 diabetes Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.	Guideline evidencing the trust pathway for CGM and trust to share education package in place for women to support the use of CGM. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of >95% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve >95% reliability, for those organisations on an improvement journey.	95%	REF6.2A	Guideline/policy	Management of diabetes in pregnancy	previously uploaded		Partially implemented	need to work with Diabetes team and Obs team to pull data/manual audit. Need trainig evidence	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Training evidence required. Audit of at least 25 sets of ntoes (or 10% whichever is highest) is required to demonstrate embedded practice.
								REF6.2B	Audit	in progress to be uploaded							
								REF6.2C									
								REF6.2D									
	and be provided with appropriate education and support to use this.	**SBL Process Indicator 6d** Demonstrate compliance with CGM training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes.	N/A		**Numerator:** Number of MDT diabetes team members who have a responsibility to interpret CGM that have completed annual CGM training **Denominator:** Number of MDT diabetes team members who have a responsibility to interpret CGM For quality improvement purposes this should be analysed by staff group e.g. DSMs, DSNs, Dieticians.	Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. A stretch ambition of 90% for high performing organisations with minimum ambition of 80%, with a clear action plan to achieve 90% reliability, for those organisations on an improvement journey.	90%	REF6.2E								
								REF6.2F									
								REF6.2G									
								REF6.2H									
6.3	Women with type 2 diabetes should have an objective record of their blood glucose recorded in their hospital records/EPR and be offered alternatives (e.g. intermittently scanned CGM) to blood glucose monitoring if glycaemic targets are not achieved.	**SBL Process Indicator 6c** Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets.	N/A	N/A	N/A	Guideline evidencing the agreed method of objectively recording blood glucose levels and pathway if glycaemic targets are not achieved.	N/A	REF6.3A	Guideline/policy	Management of diabetes in pregnancy	previously uploaded		Fully implemented		Fully implemented		
								REF6.3B									
								REF6.3C									
								REF6.3D									
								REF6.3E									
								REF6.3F									
6.4	Women with diabetes should have an HbA1C measured at the start of the third trimester and those with an HbA1C above 48mmol/mmol should be offered increased surveillance including additional diabetes nurse/dietetic support, more frequent face to face review and input from their named, specialist Consultant to plan ongoing care and timing of birth decisions.	**SBL Outcome Indicator 6g** Percentage of women with type 1 and type 2 diabetes that have an HbA1C measured at the start of the third trimester.	N/A	Local data as submitted for the NPID dashboard (2021/22 data planned to be released October 2023)	**Numerator:** Number of pregnant women with type 1 and type 2 diabetes that have had a HbA1C measured between 24+0 and 30+0 weeks. **Denominator:** Number of pregnant women who have type 1 and type 2 diabetes Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.	Guideline evidencing this standard. Audit demonstrating achievement and meeting LMNS required compliance over agreed compliance timeframe. See 'How to assure with the tool'. Stretch ambition would indicate a level of full implementation of >95% and minimum ambition of 80% with a clear action plan to achieve >95% reliability, for those organisations on an improvement journey.	80%	REF6.4A	Guideline/policy	Management of diabetes in pregnancy	previously uploaded		Partially implemented	Audit being requested from Digital Midwife. Consider use of NPID data	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Training evidence required. Audit of at least 25 sets of ntoes (or 10% whichever is highest) is required to demonstrate embedded practice. Guideline doesn't state HbA1c in third trimester
								REF6.4B									
								REF6.4C									
								REF6.4D									
								REF6.4E									
								REF6.4F									
6.5	Women with diabetes and retinopathy requiring treatment during pregnancy and/or kidney impairment (CKD 2 with significant proteinuria i.e PCR>30; or CKD 3 or more) should be managed in a regional maternal medicine centre where care can be delivered in a single MDT clinic.	**SBL Process Indicator 6b** Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes.	N/A	N/A	In circumstances where regular travel to a tertiary clinic is not possible, ongoing care should be planned via regular (4-6 weekly) MDT discussion with the MMC centre throughout the pregnancy.	Guideline evidencing an agreed pathway for referral to the regional maternal medicine for women with complex diabetes.	N/A	REF6.5A	Guideline/policy	Management of diabetes in pregnancy	previously uploaded		Fully implemented		Fully implemented		To include criteria for referral to MMN as evidence - not in the guideline
								REF6.5B									
								REF6.5C									
								REF6.5D									
								REF6.5E									
								REF6.5F									
6.6	Recognising the very high risk of fetal death (stillbirth rate 160 per 1,000 births) associated with diabetic ketoacidosis (DKA), all pregnant women presenting to secondary care with DKA should have ongoing multidisciplinary Consultant input and be cared for in line with the jointly agreed trust policy.	**SBL Process Indicator 6e** Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with DKA during pregnancy.	N/A	N/A	N/A	Guideline evidencing an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with DKA during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities and availability of expertise.	N/A	REF6.6A	Guideline/policy	Guidelines for Enhanced Maternity Care	previously uploaded		Fully implemented		Fully implemented		
								REF6.6B	Guideline/policy	Non Obs care guideline	previously uploaded						
								REF6.6C									
								REF6.6D									
								REF6.6E									
								REF6.6F									

Maternity Services Data Set (MSDS) v2.0 Technical Glossary
Version 2.24 Metadata File

Contents

Element 1 – Reducing smoking in pregnancy
Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction
Element 3 – Raising awareness of reduced fetal movement
Element 4 – Effective fetal monitoring during labour *(N.B. information not capturable in MSDS v2.0)*
Element 5 – Reducing preterm birth
Element 6 – Management of Diabetes in Pregnancy

Document version history

Version	Date Issued	Brief Summary of Change
1.0	30/09/2019	First published version, developed following feedback from NHS Digital clinical terminologists and NHS England and Improvement.
1.1	16/10/2019	Minor changes to add new SNOMED CT code for computerised CTGs, and amend minor typos.
1.2	21/11/2019	Minor changes to align with the March 2019 published SBLCBv2. Publication for NHS Digital Website.
1.3	04/02/2020	Minor updates throughout to formatting to use standard SNOMED CT notation. Additions to the following process outcome indicators, to provide alternative methods of submitting the required data: Element 1 (Process indicator i) Element 2 (Process indicator i, including Risk Factor Mapping), (Outcome indicator i) Element 3 (Outcome indicator ii) Element 5 (Process indicator i), (Process indicator iii) & (Outcome indicator i)
1.4	23/04/2021	Minor amendment to process outcome indicators, Element 5 (Process indicator i), to reflect that antenatal corticosteroids are administered to the mother before birth and recorded in the MSD202 or MSD302 table, and not the baby in the MSD405 table.
1.5	22/10/2021	Minor amendment to process outcome indicators, Element 3 (Process indicator i), to reflect the new SNOMED concept: 1361991000000102 |Provision of information leaflet about fetal movement (procedure)| being live. To be used for SBL E3 P1: Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy.
1.6	22/06/2022	Minor amendment to the 'Notes' column in process outcome indicators, Element 1 (Process indicator ii), to reflect the following change in the Tolerance from Tolerance when matching booking date and date when CO monitoring took place **may be** considered when conducting analysis **(e.g. +/-3 days)** to read: Tolerance when matching booking date and date when CO monitoring took place **is** considered when conducting analysis **(+3 days)**

Saving Babies Lives Care Bundle Version 2

Maternity Services Data Set (MSDS) v2.0 Technical Glossary

The Saving Lives Care Bundle Version Two (SBLCBv2) has been developed to help reduce perinatal mortality across England. It sets out a series of measures based on five elements of care that are widely recognised as evidence-based and/or best practice. Data for many of these measures can be obtained from the Maternity Services Data Set (MSDS). MSDS v2.0 is a patient-level data set that captures information about activity carried out by NHS-funded maternity services relating to mothers and babies.

This technical glossary is designed to assist MSDS v2.0 data submitters in collecting and submitting data which will support the various process and outcome indicators specified in SBLCBv2. Each tab relates to a separate element of SBLCBv2, and details the relevant data items, values and (where relevant) SNOMED CT terms and codes that can be included in MSDS v2.0 submissions.

Please see the website links below for further information about SBLCBv2, MSDS v2.0 & SNOMED CT (syntax described in section 5.1):

https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/

digital.nhs.uk/MSDS

https://confluence.ihtsdotools.org/display/DOCECL/Expression+Constraint+Language+-+Specification+and+Guide

Element 1 – Reducing smoking in pregnancy

Element description: Reducing smoking in pregnancy by assessing exposure to carbon monoxide (CO) as appropriate to assist in identifying smokers (or those exposed to CO through other sources) and refer them for support from a trained stop smoking advisor.

Process/outcome indicator description	Numerator	Fields required	Denominator	Fields required	Notes
Recording of CO reading for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS Digital.	Number of case records submitted to MSDS where the CO reading field is complete	Count of distinct UniqPregID from MSD101PREGNANCYBOOKING inner join MSD202CareActivityPreg on UniqPregID and Person_ID_Mother where MSD101.RPStartDate is in the reporting period and MSD101.AntenatalAppDateis in the reporting period and MSD202.RPStartDate is less than or equal to reporting period and (MSD202.ProcedureCode = '226571000000100' or MSD202.COMonReading >= 0)	Number of pregnancies with booking appointments in the reporting month submitted to MSDS	Count of distinct UniqPregID from MSD101PREGNANCYBOOKING where RPStartDate is in the reporting period and AntenatalAppDate is in the reporting period	
Percentage of women where CO measurement at booking is recorded.	Number of pregnant women where a value (ppm) is recorded	Count of distinct UniqPregID from MSD101PREGNANCYBOOKING inner join MSD201CareContactPreg on UniqPregID and Person_ID_Mother inner join MSD202CareActivityPreg on UniqPregID and Person_ID_Mother where MSD101.RPStartDate is in the reporting period and MSD101.AntenatalAppDateis in the reporting period and MSD201.RPStartDate is less than or equal to reporting period and MSD202.COMonReading >= 0 and datediff(MSD201.CContactDate, MSD101.AntenatalAppDate) <= 3 days (StartDate: MSD101.AntenatalAppDate, EndDate: MSD201.CContactDate)	Number of pregnant women attending booking appointment	Count of distinct UniqPregID from MSD101PREGNANCYBOOKING where RPStartDate is in the reporting period and AntenatalAppDate is in the reporting period	Tolerance when matching booking date and date when CO monitoring took place must be <=3days. Recommend using UCUM Unit of Measurement 'ppm'. Note: Each woman will only be counted once in the denominator.
Percentage of women where CO measurement at 36 weeks is recorded.	Number of pregnant women at the 36 week appointment where a CO value is recorded	Count of distinct UniqPregID from MSD201CareContactPreg inner join MSD202CareActivityPreg on UniqPregID and Person_ID_Mother and CareConID where MSD201.RPStartDate is in the reporting period and MSD201.CContactDate is in the reporting period and MSD202.RPStartDate is in the reporting period and (GestAgeCContactDate between 245 and 258) and MSD202.COMonReading >= 0	Number of pregnant women attending the 36 week appointment	Count of distinct UniqPregID from MSD201CareContactPreg where RPStartDate is in the reporting period and CContactDate is in the reporting period and (GestAgeCContactDate between 245 and 258)	To determine 36 week appointment, the 'Care Contact Date' in the MSD201 table is compared with the derived 'Gestational Age (Care Contact Date)' field in the MSD201 table. Tolerance around gestational age contact date for the 36 week appointment must be within 245 days (35+0 weeks) and 258 days (36+6 weeks). Recommend using UCUM Unit of Measurement 'ppm'. Note: Each woman will only be counted once in the denominator.
Percentage of women with a CO measurement ≥4ppm at booking.	Number of pregnant women at booking with CO measurement of 4ppm or above is recorded	Count of distinct UniqPregID from MSD201CareContactPreg inner join MSD202CareActivityPreg on UniqPregID and Person_ID_Mother and CareConID where MSD201.RPStartDate is in the reporting period and MSD201.CContactDate is in the reporting period and MSD202.RPStartDate is in the reporting period and (GestAgeCContactDate between 245 and 258) and MSD202.COMonReading >= 0	Number of pregnant women attending booking appointment	Count of distinct UniqPregID from MSD101PREGNANCYBOOKING where RPStartDate is in the reporting period and AntenatalAppDate is in the reporting period	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element. Tolerance when matching booking date and date when CO monitoring took place must be <=3days. Note: Each woman will only be counted once in the denominator.
Percentage of women with a CO measurement ≥4ppm at 36 weeks.	Number of pregnant women at the 36 week appointment with a CO reading of 4ppm or above	Count of distinct UniqPregID from MSD201CareContactPreg inner join MSD202CareActivityPreg on UniqPregID and Person_ID_Mother and CareConID where MSD201.RPStartDate is in the reporting period and MSD201.CContactDate is in the reporting period and (GestAgeCContactDate between 245 and 258) and MSD202.RPStartDate is in the reporting period and MSD202.COMonReading >= 4	Number of pregnant women attending the 36 week appointment	Count of distinct UniqPregID from MSD201CareContactPreg where RPStartDate is in the reporting period and CContactDate is in the reporting period and (GestAgeCContactDate between 245 and 258)	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element. To determine 36 week appointment, the 'Care Contact Date' in the MSD201 table is compared with the derived 'Gestational Age (Care Contact Date)' field in the MSD201 table. Tolerance around gestational age contact date for the 36 week appointment must be within 245 days (35+0 weeks) and 258 days (36+6 weeks). Note: Each woman will only be counted once in the denominator.
Percentage of women who have a CO level ≥4ppm at booking and <4ppm at the 36 week appointment.	Number of pregnant women with CO reading of 4ppm or above at booking appointment and less than 4ppm at the 36 week appointment.	Count of distinct UniqPregID from MSD201CareContactPreg inner join MSD202CareActivityPreg as ca on cc.UniqPregID = ca.UniqPregID and cc.Person_ID_Mother = ca.Person_ID_Mother and cc.CareConID = ca.CareConID where cc.RPStartDate is in the reporting period and cc.CContactDate is in the reporting period and (GestAgeCContactDate between 245 and 258) and ca.RPStartDate is in the reporting period and ca.COMonReading < 4) inner join MSD101PREGNANCYBOOKING as bk on a.UniqPregID = bk.UniqPregID and a.Person_ID_Mother = bk.Person_ID_Mother inner join msd201carecontactpreg as cc1 on bk.UniqPregID = cc1.UniqPregID and bk.Person_ID_Mother = cc1.Person_ID_Mother inner join msd202careactivitypreg as ca1 on cc1.UniqPregID = ca1.UniqPregID and cc1.Person_ID_Mother = ca1.Person_ID_Mother and cc1.CareConID = ca1.CareConID where bk.RPStartDate <= reporting period start date and datediff(bk.AntenatalAppDate,cc1.CContactDate) between -3 and 3 and a.CContactDate > cc1.CContactDate and ca.COMonReading >= 4	Number of pregnant women with CO reading of 4ppm or above at booking appointment	Count of distinct UniqPregID from msd201carecontactpreg as cc inner join msd202careactivitypreg as ca on cc.UniqPregID = ca.UniqPregID and cc.Person_ID_Mother = ca.Person_ID_Mother and cc.CareConID = ca.CareConID where cc.RPStartDate is in the reporting period and cc.CContactDate is in the reporting period and (GestAgeCContactDate between 245 and 258) and ca.RPStartDate is in the reporting period and ca.COMonReading >= 0 inner join MSD101PREGNANCYBOOKING as bk on a.UniqPregID = bk.UniqPregID and a.Person_ID_Mother = bk.Person_ID_Mother inner join msd201carecontactpreg as cc1 on bk.UniqPregID = cc1.UniqPregID and bk.Person_ID_Mother = cc1.Person_ID_Mother inner join msd202careactivitypreg as ca1 on cc1.UniqPregID = ca1.UniqPregID and cc1.CareConID = ca1.CareConID and cc1.Person_ID_Mother = ca1.Person_ID_Mother where bk.RPStartDate <= reporting period start date and datediff(cc1.CContactDate, bk.AntenatalAppDate) between -3 and 3 and a.CContactDate > cc1.CContactDate and ca1.COMonReading >= 4	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element. For this measure we look at the cohort of women who had a 36 week appointment in the reporting period where CO reading was taken. i.e. a woman should have a CO reading taken at both booking and 36 week appointment to be considered for this measure To determine 36 week appointment, the 'Care Contact Date' in the MSD201 table is compared with the derived 'Gestational Age (Care Contact Date)' field in the MSD201 table. Tolerance around gestational age contact date for the 36 week appointment must be within 245 days (35+0 weeks) and 258 days (36+6 weeks). Tolerance when matching booking date and date when CO monitoring took place must be <=3days. May also consider the most recent appointment, in event of pre-term birth (i.e. no 36 week appointment takes place). Note: Each woman will only be counted once in the denominator.

Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction

Element description: Risk assessment and management of babies at risk of fetal growth restriction (FGR).

Process/outcome indicator description	Numerator	Fields required	Denominator	Fields required	Notes
Percentage of pregnancies where an SGA fetus is antenatally detected and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital	Number of pregnancies where an SGA fetus is detected during the antenatal period	Count of distinct UniqPregID from MSD401.BabyDemographics left join MSD106DiagnosisPreg on UniqPregID where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD401.RPStartDate >= MSD106.RPStartDate and MSD106.Diag = 267258002) union (MSD401.BabyDemographics left join MSD109FindingObsMother on UniqPregID where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD401.RpStartDate >= MSD109.RPStartDate and MSD109.FindingCode = 267258002) union (MSD401.BabyDemographics left join MSD201CareContactPreg on UniqPregID left join MSD202CareActivityPreg on UniqPregID and CareConID where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD401.RpStartDate >= MSD201.RPStartDate and MSD202.FindingCode = 267258002)	Total number of pregnancies submitted to MSDS	Count of distinct UniqPregID from MSD401.BabyDemographics where RPStartDate is in the reporting period and PersonBirthDateBaby is in the reporting period	Derived data item 'Unique Pregnancy Identifier' will be used when conducting analysis to ensure that pregnancies are not double counted where a mother may have her antenatal care with more than one provider.

Element 3 – Raising awareness of reduced fetal movement

Element description: Raising awareness amongst pregnant women of the importance of reporting reduced fetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.

Process/outcome indicator description	Numerator	Fields required	Denominator	Fields required	Notes
Percentage of women who attend with RFM who have a computerised CTG	Number of women with reduced fetal movement identified at a care contact who have a computerised cardiotocogram (CTG)	Count of distinct Person_ID_Mother from Records from MSD202□ where MSD202.RPStartDate is in the reporting period□ and MSD202.FindingCode is in (276369006, 289432001, 249038009) #Reduced Fetal Movement□ □ APPENDED TO□ □ Records from MSD106 where□ MSD106.RPStartDate is in the reporting period□ and MSD106.DiagDate is in the reporting period□ and MSD106.Diag is in (276369006, 289432001, 249038009)) a Join to MSD202 on UniqPregID, Person_ID_Mother and RPStartDate where MSD202.FindingCode = 245761000000108 □	Number of women with reduced fetal movement identified at a care contact	Count of distinct Person_ID_Mother from (Records from MSD202□ where□ MSD202.RPStartDate is in the reporting period□ and MSD202.FindingCode is in (276369006, 289432001, 249038009) #Reduced Fetal Movement□ □ APPENDED TO□ □ Records from MSD106 where□ MSD106.RPStartDate is in the reporting period□ and MSD106.DiagDate is in the reporting period□ and MSD106.Diag is in (276369006, 289432001, 249038009) #Reduced Fetal Movement)□	

Element 4 – Effective fetal monitoring during labour (N.B. information not capturable in MSDS v2.0)

Element descritpion: Effective fetal monitoring during labour

Process/outcome indicator description	Numerator	Fields required	Denominator	Fields required	Notes

Element 5 – Reducing preterm birth

Element description: Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented

Process/outcome indicator description	Numerator	Fields required	Denominator	Fields required	Notes
Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth	Number of singleton live births born before 34+0 weeks gestation who received a full course of antenatal corticosteroids within seven days of birth	Count of distinct Person_ID_Baby from MSD401.BabyDemographics Inner join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother, RPStartDate Inner join to MSD302CareActivityLabDel on UniqPregID and Person_ID_Mother inner join MSD201CareContactPreg on UniqPregID, Person_ID_Mother, RPStartDate inner join MSD202CareActivityPreg on UniqPregID and Person_ID_Mother and CareConID where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth < 238 and ((MSD302.ProcedureCode = '434611000124106') and (Difference between MSD401.PersonBirthDate and MSD302.ClinInterDateMother is between 0 and 7)) or ((MSD202.ProcedureCode = '434611000124106') and (Difference between MSD401.PersonBirthDate and MSD201.CContactDate is between 0 and 7))	Total number of singleton live births born before 34+0 weeks gestation	Count of distinct Person_ID_Baby from MSD401.BabyDemographics Inner join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother, RPStartDate where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth < 238	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element.
Percentage of singleton live births (less than 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids	Number of singleton live births born before 34+0 weeks gestation and more than 7 days after completion of their first course of antenatal corticosteroids	Count of distinct Person_ID_Baby from MSD401.BabyDemographics Inner join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother, RPStartDate Inner join to MSD302CareActivityLabDel on UniqPregID and Person_ID_Mother inner join MSD201CareContactPreg on UniqPregID, Person_ID_Mother, RPStartDate inner join MSD202CareActivityPreg on UniqPregID and Person_ID_Mother and CareConID where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth < 238 and ((MSD302.ProcedureCode = '434611000124106') and (Difference between MSD401.PersonBirthDate and MSD302.ClinInterDateMother is > 7)) or ((MSD202.ProcedureCode = '434611000124106') and (Difference between MSD401.PersonBirthDate and MSD201.CContactDate is > 7))	Identical to Element 5 Process Indicator 1 Denominator Total number of singleton live births born before 34+0 weeks gestation	Count of distinct Person_ID_Baby from MSD401.BabyDemographics Inner join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother, RPStartDate where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth < 238	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element.
Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth	Number of singleton live births born before 30+0 weeks receiving magnesium sulphate within 24 hours prior to birth	Count of distinct Peson_ID_Baby from MSD401.BabyDemographics Inner Join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother and RPStartDate Inner join to MSD302CareActivityLabDel on UniqPregID and Person_ID_Mother where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth < 210 and MSD302.ProcedureCode = '144351000000105' and MSD302.ClinInterDateMother is between the MSD401.PersonBirthDateBaby and 24h prior.	Total number of singleton live births born before 30+0 weeks gestation	Count of distinct Peson_ID_Baby from MSD401.BabyDemographics Inner Join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother and RPStartDate where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth < 210	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element.
The incidence of women with a singleton pregnancy giving birth (liveborn) as a % of all singleton live births in the late second trimester (from 22+1 to 23+6 weeks)	Number of women who give birth to a singleton between (22weeks +1) and 23+6 weeks (only include singleton live birth)	Count of distinct Peson_ID_Mother from MSD401.BabyDemographics Inner Join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother and RecordNumber where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth between 155 and 167	Total number of singleton live births (This should include singleton live birth > 22 weeks)	Count of distinct Peson_ID_Mother from MSD401.BabyDemographics Inner Join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother and RecordNumber where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth >154	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element.
The incidence of women with a singleton pregnancy giving birth (liveborn) as a % of all singleton live births preterm (from 24+0 to 36+6 weeks)	Number of women who give birth to a singleton between 24+0 and 36+6 weeks (only include singleton live birth)	Count of distinct Peson_ID_Mother from MSD401.BabyDemographics Inner Join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother and RecordNumber where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth between 168 and 258	Identical to Element 5 Outcome Indicator 1a Total number of singleton live births (This should include singleton live birth > 22 weeks)	Count of distinct Peson_ID_Mother from MSD401.BabyDemographics Inner Join to MSD301LabourDelivery on UniqPregID, Person_ID_Mother and RecordNumber where MSD401.RPStartDate is in the reporting period and MSD401.PersonBirthDateBaby is in the reporting period and MSD301.BirthsPerLabAndDel = 1 and MSD401.PregOutcome = '01' and MSD401.GestationLengthBirth >154	MSDS indicator no longer aligns to SBL intervention and needs to be reviewed. Please refer to technical definition within the implementation tool element.

Element 6 – Management of diabetes in pregnancy (N.B. information not capturable in MSDS v2.0)

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

Process/outcome indicator description	Numerator	Fields required	Denominator	Fields required	Notes

2312 - C TRUE NORTH SA4 - FINANCE AND PERFORMANCE

2312 - C1 OPERATIONAL PERFORMANCE UPDATE

Discussion Item | Denise Smith, Chief Operating Officer | 10:10

verbal
10 minutes

2312 - C2 FINANCE UPDATE

Discussion Item | Alex Crickmar, Deputy Director of Finance | 10:20

10 minutes

REFERENCES

Only PDFs are attached

C2 - Finance Update - Month 8.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	19 December 2023	**Agenda Reference:**	**C2**
Report Title:	**Finance Update – Month 8 (November) 2023**		
Sponsor:	Jon Sargeant, Chief Financial Officer		
Author:	Alex Crickmar, Deputy Director of Finance & Finance Team		
Appendices:	None		

Executive Summary	
Purpose of report:	To provide the Board an update with regards to the Trust's financial position at Month 8.
Summary of key issues:	The Trust's reported surplus for month 8 (November 2023) was £1.2m, which was £1.7m favourable to plan and £1.1m favourable to forecast. Year to Date (YTD) the Trust's reported deficit at month 8 was £23.6m, which was £0.4m favourable to plan and £0.1m favourable to forecast. The surplus in month is driven mainly by non-recurrent income items including £1.7m improvement in Elective Recovery Fund (ERF) performance for month 1 to month 8 mainly as a result of the national reduction in the ERF target (£1.2m of the £1.7m), year to date catch up in other clinical income of £0.5m following agreement to contracts with some local authorities and ICBs. As at month 8 the Trust's ERF performance was in line with the NHS England target value, giving a breakeven financial position, the target value includes both the original 2% target reduction for industrial action (applied across the year) and the further 1.2% reduction agreed recently following subsequent industrial action. Pay spend is favourable to plan by c.£0.1m YTD (£1.2m adverse to plan in month), however within this medical staff are overspent by £6.1m, which includes junior doctor strike costs of £1.6m. Pay costs increased in month by £0.65m which was across nursing, medics and admin staff groups and across most Divisions. This includes £0.15m of winter costs due to the early opening of extra beds. Excluding recharges, pay spend is £0.3m adverse to forecast YTD. Non-pay spend is £3.1m adverse to plan YTD (£1.4m favourable to plan in month), driven by continued overspends related to the phasing of the independent sector usage (£1.0m – where independent sector usage has been front loaded by the Division) and drugs (£2.9m). Excluding reserves and recharges, non-pay spend is £0.5m adverse to forecast YTD, mainly driven by drug expenditure (£1.1m adverse). A deep dive with escalation meetings with the CFO and Divisions on drug spend is currently being undertaken. In month the Trust saw a £0.1m increase in spend versus month 7 with favourable movements in drugs (£0.2m) and outsourcing (£0.4m), offset with a number of other areas including clinical supplies where there was increased spend for loan kits due to the additional activity undertaken in month. There are a number of key risks to the year end financial position, most notably: • Delivery of the cost improvement programme • Delivery of activity targets and thereby the impact on the Trust's income position. This includes the impact of winter and further industrial action. • Agreement on HCA banding review • Finalisation of income positions with the ICB.

	Capital Capital spend in month 8 was £7m against a plan of £4.3m giving an in-month over-performance of £2.7m. The YTD position is £22.6m against a plan of £29.2m showing an under-performance of £6.6m. The main underspends are against Community Diagnostic Centre (CDC) of £1.1m and Bassetlaw Emergency Village (BEV) of £4.3m. A revised plan for both CDC and BEV shows current spend is in line with year-end expectations. The Trust is forecasting to deliver its year end capital plan. **Cash** The cash balance at the end of November was £20.9m (October: £15.4m), meaning cash has increased by £5.5m in the month. This is as a result of the Trust receiving £7.2m in cash via Public Dividend Capital (PDC) in the month from NHS England/Department of Health. This is partially offset by cash spent on capital expenditure of £3.7m. The Trust has submitted a cash drawdown request of £5.6m for Quarter 4 from NHS England/Department of Health. This is in line with the Trust's deficit position and in line with what has been formally agreed at Board previously. Work is beginning to take place to look at liquidity for Q1 in 24/25 as this is when a high level of capital payments are likely to be due, alongside a significant underlying deficit position. This is likely to require the Trust to draw down either deficit or working capital support. For the month of November, the Better Payment Practice Code (BPPC) has remained stable to 79% for invoice value (October: 78%) Year to date, for invoice value the metric is 78%. If the financial plan is not achieved including ERF this would impact on the amount of funding needed from NHS England/Department of Health. We will keep this position under review and will continue to keep the Board updated on this throughout the year. **CIPs (Cost Improvement Programme)** In month, the Trust has delivered £1.7m of savings versus the plan submitted to NHSE of £2.6m and therefore is £0.9m adverse to plan. YTD the Trust has delivered £12.9m of savings versus the plan submitted to NHSE of £11.8m and is therefore favourable to plan by £1.1m. Whilst the Trust is ahead of plan YTD at this point, the phasing of the CIP programme has started to increase as shown by the in month adverse variance.
Recommendation:	The Board is asked to note: • The Trust's deficit YTD at month 8 (November 2023) was £23.6m, which was £0.4m favourable to plan and £0.1m favourable to forecast.

Action Require:	~~Approval~~	**Information**	**Discussion**	~~Assurance~~	~~Review~~

Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care for our patients	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*

Implications	
Board assurance framework:	This report relates to strategic aims 2 and 4 and the revised BAF risk F&P1.
Corporate risk register:	See above
Regulation:	No issues
Legal:	No issues
Resources:	No issues

Assurance Route	
Previously considered by:	N/A

Date:		**Decision:**	
Next Steps:			
Previously circulated reports to supplement this paper:			

FINANCIAL PERFORMANCE

Month 8 – November 2023

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

M8 November 2023

1. Income and Expenditure vs. Budget

Performance Indicator	Monthly Performance					YTD Performance				
	Actual £'000	Variance to budget £'000		Variance to forecast £'000		Actual £'000	Variance to budget £'000		Variance to forecast £'000	
Income	(48,224)	(2,006)	F	(3,704)	F	(362,105)	(3,367)	F	(3,809)	F
Pay	30,500	1,180	A	933	A	245,189	(87)	F	1,058	A
Non Pay	15,476	(1,351)	F	1,444	A	136,125	3,086	A	2,789	A
Financing Costs	1,048	465	A	242	A	4,675	10	A	(123)	F
(Profit)/Loss on Asset Disposals	0	0	A	0	A	0	0	A	0	A
(Surplus)/Deficit for the period	**(1,199)**	**(1,711)**	**F**	**(1,085)**	**F**	**23,884**	**(358)**	**F**	**(85)**	**F**
Adj. for donated assets	(41)	(7)	F	0	A	(329)	(56)	F	0	A
Adjusted (Surplus)/Deficit for the purposes of system achievement	**(1,240)**	**(1,718)**	**F**	**(1,085)**	**F**	**23,555**	**(414)**	**F**	**(85)**	**F**

Income: Over-achieved F | Under-achieved A

Key F = Favourable A = Adve

Expenditure: Underspent F | Overspent A

3. Statement of Financial Position

	Opening balance £'000	Closing balance £'000	Movement £'000
Non Current Assets	**295,075**	**301,108**	**6,033**
Current Assets	79,601	**53,604**	**-25,997**
Current Liabilities	-112,917	**-92,352**	**20,565**
Non Current liabilities	-16,014	**-16,373**	**-359**
Total Assets Employed	**245,745**	**245,987**	**242**
Total Tax Payers Equity	**-245,745**	**-245,987**	**-242**

2. CIPs

Performance Indicator	Monthly Performance			YTD Performance			Annual Plan £'000
	Plan £'000	Actual £'000		Plan £'000	Actual £'000		
Local / Unidentified	954	772	A	5,163	8,665	F	9,130
Cross Cutting - Pay - Job Plans / Agency	867	294	A	3,033	2,887	A	6,500
Cross Cutting - Elective - Theatres/OP/Diagnostics/LOS	365	28	A	1,838	419	A	3,250
Cross Cutting - Procurement	72	54	A	401	218	A	720
Cross Cutting - Major Contracts	121	339	F	590	411	A	1,000
Cross Cutting - RPA	56	0	A	278	0	A	500
Cross Cutting - Corp Pay/Benefits from PLACE	125	258	F	500	264	A	1,000
Total CIP	**2,559**	**1,744**	**A**	**11,802**	**12,864**	**F**	**22,100**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual Plan £'000
	Plan £'000	Actual £'000	Plan £'000	Actual £'000	
Cash Balance		15,366		15,366	1,900
Capital Expenditure	4,281	6,959	29,249	22,631	65,051

5. Workforce

	Funded WTE	Substantive WTE	Bank WTE	Agency WTE	Total worked WTE
Current Month	6,872.14	6,237.82	387.35	153.12	6,778.29
Previous Month	6,860.33	5,963.41	388.09	146.70	6,498.20
Movement	11.81	274.41	-0.74	6.42	280.09

1. Month 8 Financial Position Highlights

Income and Expenditure

The Trust's reported surplus for month 8 (November 2023) was £1.2m, which was £1.7m favourable to plan and £1.1m favourable to forecast. Year to Date (YTD) the Trust's reported deficit at month 8 was £23.6m, which was £0.4m favourable to plan and £0.1m favourable to forecast.

The surplus in month is driven mainly by non-recurrent income items including £1.7m improvement in Elective Recovery Fund (ERF) performance for month 1 to month 8 mainly as a result of the national reduction in the ERF target (£1.2m of the £1.7m), year to date catch up in other clinical income of £0.5m following agreement to contracts with some local authorities and ICBs. As at month 8 the Trust's ERF performance was in line with the NHS England target value, giving a breakeven financial position, the target value includes both the original 2% target reduction for industrial action (applied across the year) and the further 1.2% reduction agreed recently following subsequent industrial action.

Pay spend is favourable to plan by c.£0.1m YTD (£1.2m adverse to plan in month), however within this medical staff are overspent by £6.1m, which includes junior doctor strike costs of £1.6m. Pay costs increased in month by £0.65m which was across nursing, medics and admin staff groups and across most Divisions. This includes £0.15m of winter costs due to the early opening of extra beds. Excluding recharges, pay spend is £0.3m adverse to forecast YTD.

Non-pay spend is £3.1m adverse to plan YTD (£1.4m favourable to plan in month), driven by continued overspends related to the phasing of the independent sector usage (£1.0m – where independent sector usage has been front loaded by the Division) and drugs (£2.9m). Excluding reserves and recharges, non-pay spend is £0.5m adverse to forecast YTD, mainly driven by drug expenditure (£1.1m adverse). A deep dive with escalation meetings with the CFO and Divisions on drug spend is currently being undertaken. In month the Trust saw a £0.1m increase in spend versus month 7 with favourable movements in drugs (£0.2m) and outsourcing (£0.4m), offset with a number of other areas including clinical supplies where there was increased spend for loan kits due to the additional activity undertaken in month.

There are a number of key risks to the year end financial position, most notably:

- Delivery of the cost improvement programme
- Delivery of activity targets and thereby the impact on the Trust's income position. This includes the impact of winter and further industrial action.
- Agreement on HCA banding review
- Finalisation of income positions with the ICB.

Capital

Capital spend in month 8 was £7m against a plan of £4.3m giving an in-month over-performance of £2.7m. The YTD position is £22.6m against a plan of £29.2m showing an under-performance of £6.6m. The main underspends are against Community Diagnostic Centre (CDC) of £1.1m and Bassetlaw Emergency Village (BEV) of £4.3m. A revised plan for both CDC and BEV shows current spend is in line with year-end expectations. The Trust is forecasting to deliver its year end capital plan.

Cash

The cash balance at the end of November was £20.9m (October: £15.4m), meaning cash has increased by £5.5m in the month. This is as a result of the Trust receiving £7.2m in cash via Public

Dividend Capital (PDC) in the month from NHS England/Department of Health. This is partially offset by cash spent on capital expenditure of £3.7m.

The Trust has submitted a cash drawdown request of £5.6m for Quarter 4 from NHS England/Department of Health. This is in line with the Trust's deficit position and in line with what has been formally agreed at Board previously. Work is beginning to take place to look at liquidity for Q1 in 24/25 as this is when a high level of capital payments are likely to be due, alongside a significant underlying deficit position. This is likely to require the Trust to draw down either deficit or working capital support.

For the month of November, the Better Payment Practice Code (BPPC) has remained stable to 79% for invoice value (October: 78%) Year to date, for invoice value the metric is 78%.

If the financial plan is not achieved including ERF this would impact on the amount of funding needed from NHS England/Department of Health. We will keep this position under review and will continue to keep the Board updated on this throughout the year.

CIPs (Cost Improvement Programme)
In month, the Trust has delivered £1.7m of savings versus the plan submitted to NHSE of £2.6m and therefore is £0.9m adverse to plan. YTD the Trust has delivered £12.9m of savings versus the plan submitted to NHSE of £11.8m and is therefore favourable to plan by £1.1m. Whilst the Trust is ahead of plan YTD at this point, the phasing of the CIP programme has started to increase as shown by the in month adverse variance.

2. Recommendation

The Board is asked to note:

The Trust's deficit YTD at month 8 (November 2023) was £23.6m, which was £0.4m favourable to plan and £0.1m favourable to forecast.

2312 - D GOVERNANCE, ASSURANCE & STRATEGY

2312 - D1 CHAIR'S ASSURANCE LOG - CHARITABLE FUNDS COMMITTEE

Discussion Item | Hazel Brand, Non-executive Director | 10:30

5 minutes

REFERENCES

Only PDFs are attached

D1 - Chair's Assurance Log - Charitable Funds Committee.pdf

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Charitable Funds Committee - Chair's Highlight Report to Trust Board

Subject:	**Charitable Funds Committee Meeting**	**Board Date: December 2023**
Prepared By:	Hazel Brand, Committee Chair & Non-executive Director	
Approved By:	Charitable Funds Committee Members	
Presented By:	Hazel Brand, Committee Chair & Non-executive Director	
Purpose	The paper summaries the key highlights from the Charitable Funds Committee meeting held on 7 December 2023	

Matters of Concern (Moderate, Partial or No Assurance)	**Work Underway / Major actions commissioned**
• Task & Finish group to be formed to further actions relating to the Charity Support proposal. This to focus on next steps, including transition to management by Healthcare Services Ltd, recruitment to Head of Charity Operations (working title), and service level agreements, with particular reference to financial oversight. **Partial Assurance** • Ability to meet previously committed initiatives once the Fred & Ann Green Legacy has been spent, and during transition period (above). **Partial Assurance**	• Update of the Dormant Funds policy. A paper to the Committee showed 124 named funds: those that are inactive, fundholders will be contacted with a view to rationalisation • Re-tender for investment advisers: working group to be convened so that options can be presented to the March meeting • Audit by Ernst & Young in progress
Significant or Full Assurances to Provide	**Decisions Made**
• Annual Report 2022/23 approved for submission by 31 January 2024. Full assurance	• To support the business cases for a rehab robot at Montagu Hospital, and for a surgical robot at DRI, funded from the Fred & Ann Green (FAG) Legacy. The full business case for the latter will be circulated to trustees. A third case for a hydrotherapy pool at Montagu Hospital was not supported due to insufficient funds in the FAG Legacy. Also need to establish if this meets the 'additionality' criteria. May be the subject of a future fund-raising appeal • 2-year pilot project for a music therapist had been agreed prior to the meeting • Support the Charity Support proposal with some further actions (see above) • Support the launch of a new appeal to provide equipment for the paediatric area of the new Bassetlaw Emergency Village. To be launched in the new year

Assurance Levels	
Internal - Second Line of Defence	
Full Assurance	The system design and existing controls are working well. Potential innovations being considered all relate to achieving recognised best practice
Significant Assurance - with minor improvement opportunities	The system design and existing controls are working well. Some minor improvements have been identified. Identified manangement actions are not considered vital to achievemnet of strategic aims & objectives - although if unaddressed may increase likelihood of risk
Partial Assurance - with improvements required	The system design and existing controls require strengthening in areas. A few operational weaknesses have been recognised. Existing performance presents some areas of concern regarding exposure to reputational or other strategic risks. Weaknesses identified present an unacceptable level of risk to achieving strategic aims & objectives. A small number of priority actions havae been accepted as urgently required.
No Assurance	The system design & existing controls are ineffective. Several fundamental operqational weaknesses have been recognise. Existing performance presents an unaccpetable exposure to reputational or other strategic risks. Weaknesses identified are directly impacting upon the prevention to achieving strategic aims & objectives. Several priority management actions have been accpeted as urgently required.
External - Third Line of Defence	
Substantial	IA - That the framework of governance, risk management and control has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed.
Significant	IA - That there is generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
Moderate	IA - That there is generally sound framework of governance, risk management and control, however, inconsistent application of controls puts the achievement of the organisation's objectives at risk.
Limited	IA - That there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the organisation's objectives.
Weak	IA - That there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and control that will result in failure to achieve the organisation's objectives.

2312 - D2 USE OF TRUST SEAL

Information Item | Fiona Dunn, Director Corporate Affairs / Company Secretary | 10:30

5 minutes

REFERENCES

Only PDFs are attached

D2 - Use of Trust Seal.pdf

Report Cover Page			
Meeting Title:	**Board of Directors**		
Meeting Date:	19 December 2023	**Agenda Reference:**	**D2**
Report Title:	**Use of Trust Seal**		
Sponsor:	Fiona Dunn, Director Corporate Affairs / Company Secretary		
Author:	Fiona Dunn, Director Corporate Affairs / Company Secretary		
Appendices:	None		
Report Summary			
Purpose of report:	The purpose of this report is to confirm use of the Trust Seal, in accordance with Section 14 of the Trust's Standing Orders.		

Executive Summary

Seal No	Description	Signed	Date of sealing
134	Contract documents. East Ward Block – Fire improvement works. Project between Bermer Building Company Ltd (edge Property solutions) & DBTH	Richard Parker OBE Chief Executive Fiona Dunn Company Secretary	21 November 2023
135	Contract documents. W7C Ward M1– Fire improvement works. Project between Bermer Building Company Ltd (edge Property solutions) & DBTH	Richard Parker OBE Chief Executive Fiona Dunn Company Secretary	21 November 2023
136	Supplemental Lease – WH Smiths Main Foyer DRI. East Ward. Contract between WH Smiths hospitals Ltd & DBTH	Zara Jones Deputy Chief Executive Jon Sargeant Chief Financial Officer	6 December 2023
137	Deed of Variation of contract-sexual health services. Extension to term of the contract by 6 months & variation of payment provisions for 22/23 &2024. Contract between Notts County Council & DBTH	Richard Parker OBE Chief Executive Jon Sargeant Chief Financial Officer	13 December 2023

The contracts have been scrutinised by the Head of Contracts and Chief Financial Officer before signing.

Recommendation:	The Board is requested to note and take assurance of appropriate use of the Trust Seal			
Action Required:	Approval	Discussion	**Take assurance**	Information only
Link to True North Objectives:	**TN SA1:**	**TN SA2:**	**TN SA3:**	**TN SA4:**
	To provide outstanding care and improve patient experience	*Everybody knows their role in achieving the vision*	*Feedback from staff and learners is in the top 10% in the UK*	*The Trust is in recurrent surplus to invest in improving patient care*
We believe this paper is aligned to the strategic direction of:	**South Yorkshire ICS**		**NHS Nottingham & Nottinghamshire ICS**	
	Yes		**Yes**	

Implications	
Board assurance framework:	*N/A*
Risk register:	*N/A*
Regulation:	Board of Directors Standing Orders
Legal:	*N/A*
Resources:	*N/A*

Assurance Route	
Previously considered by:	Executive Directors
Date:	27/9/2023
Any outcomes/next steps	Approved
Previously circulated reports to supplement this paper:	Contract

2312 - E OTHER ITEMS

2312 - E1 - ANY OTHER BUSINESS (TO BE AGREED WITH THE CHAIR PRIOR TO THE MEETING)

Discussion Item | Suzy Brain England OBE, Chair | 10:40

5 minutes

2312 - E2 GOVERNOR QUESTIONS REGARDING THE BUSINESS OF THE MEETING *

Discussion Item | Suzy Brain England OBE, Chair | 10:45

10 minutes

2312 - E3 MINUTES OF THE MEETING HELD ON 28 NOVEMBER 2023

Decision Item | Suzy Brain England OBE, Chair | 10:55

5 minutes

REFERENCES

Only PDFs are attached

E3 - Draft Public Board Minutes 28 November 2023 v3.pdf

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING

Minutes of the meeting of the Trust's Board of Directors held in Public on Tuesday 28 November 2023 at 09:30 via MS Teams

Present:
Mark Bailey - Non-executive Director
Suzy Brain England OBE - Chair of the Board (Chair)
Hazel Brand - Non-executive Director
Mark Day - Non-executive Director
Jo Gander - Non-executive Director
Karen Jessop - Chief Nurse
Dr Emyr Jones - Non-executive Director
Zoe Lintin - Chief People Officer
Dr Nick Mallaband - Acting Executive Medical Director
Lucy Nickson - Non-executive Director
Richard Parker OBE - Chief Executive
Jon Sargeant - Chief Financial Officer
Kath Smart - Non-executive Director / Deputy Chair
Denise Smith - Chief Operating Officer

In attendance:
Fiona Dunn - Director of Corporate Affairs / Company Secretary
Dr Kirsty Edmondson – Jones, Director of Innovation & Infrastructure (agenda item F1)
Dr Kelly Mackenzie-Smith – Public Health Consultant (agenda item F1)
Jo McQuade - Therapy Assistant Practitioner - Falls (agenda item B1)
Lois Mellor - Director of Midwifery
Dr Anna Pryce - Guardian of Safe Working (agenda item D3)
Emma Shaheen - Director of Communications & Engagement

Public in attendance:
Kim Anderson - Board Delegate Programme
Denise Carr - Public Governor
David Gregory - Public Governor
Annette Johnson – Public Governor
Paula Marchetti– Board Delegate Programme
Andrew Middleton - Public Governor (Deputy Lead Governor)
Joseph Money - Staff Governor
Gavin Portier - Staff Governor
Mandy Tyrrell - Staff Observer
Sheila Walsh - Public Governor

Apologies: Lynne Schuller – Lead Governor

P23/11/A1 **Welcome, apologies for absence and declaration of interest (Verbal)**

The Chair welcomed everyone to the virtual Board of Directors meeting, including governors and observers. The above apology for absence was noted and no declarations were made.

P23/11/A2 **Actions from Previous Meetings**

There were no active actions.

P23/11/B1 **Get Up, Get Dressed, Get Moving – Falls Prevention (Enclosure B1)**

The Therapy Assistant Practitioner for Falls was welcomed to the meeting to share with the Board the award winning project, Get Up, Get Dressed and Get Moving to prevent deconditioning and improve patient mobility. A series of goals had been identified to meet a minimum standard of mobility, reduce the length of stay of patients, reduce physiotherapy and occupational therapy referrals and reduce the number of falls. In order to work towards these goals a number of changes to practice were introduced, colleagues were educated on the effect of deconditioning, on the job training was provided and the Therapy Assistant supported colleagues to proactively engage with and address patient's mobility. The changes brought with them success, as the Trust was awarded a gold medal in NHSE's Reconditioning the Nation, the only Trust in the North-east region to be awarded silver and gold and the team was awarded Change Champion of the Year at 2023's Star Awards. Improvements were seen against the identified targets, colleagues felt empowered and patients had an improved experience with positive friends and families feedback received. In terms of next steps, consideration would be given as to how to roll out of the project across the Trust.

Having recently visited Ward 17, Non-executive Director, Jo Gander recognised the positive improvements and had witnessed the enthusiasm of colleagues involved in the project. In respect of the reduction in physiotherapy and occupational referrals, rather than spare capacity being created on the ward, this supported delivery across the Trust as part of a peripatetic model.

The Deputy Chief Executive reflected on the opportunity to share the learning beyond the acute sector as patients were discharged, with support, into the community, which had the potential to reduce readmission and support partnership working. The Therapy Assistant Practitioner recognised the gap in education and the opportunity to influence the public's perception of a hospital stay, including the benefits of mobility in recovery. The Chair of the Board encouraged community partners to extend this work.

Non-executive Director, Kath Smart acknowledged the positive outcomes of the project, and enquired which areas had been considered for roll out, giving thought to those areas where the greatest impact could be seen. The Chief Nurse recognised the need to better capture the harm associated with deconditioning and use this to inform the decision.

Non-executive Director, Emyr Jones, shared his congratulations and recognised the success of the project, the commitment and professionalism of the Therapy Assistant Practitioner and enquired how this could be replicated across the organisation, utilising a train the trainer model. The Therapy Assistant Practitioner confirmed this was work in progress, opportunities were being explored as to how best to offer the support to upskill nurses and therapists to work differently.

In response to a question from Non-executive Director, Hazel Brand, with regards to engaging patients in other purposeful activities as part of their preparation for discharge, earlier mobility was encouraged, with nurses nurturing and assisting patients to be out of bed, encouraging movement around the ward and visits to the day room.

The Chair thanked the Therapy Assistant Practitioner for her work and for sharing the success of the project with the Board of Directors.

The Board:

- ***Noted the Get Up, Get Dressed, Get Moving presentation***

P23/11/C1 **Executive Medical Director Update (Enclosure C1)**

The Acting Executive Medical Director brought the Board's attention to the key highlights of the current programmes of work across his portfolio.

Guidance in respect of Martha's Rule was awaited from NHSE, the Trust had undertaken significant work related to the identification of sepsis which had included learning from sepsis related incidents.

Progress was noted in respect of the number of outstanding job plans in Orthopaedics and the distribution of the national Clinical Excellence Awards in December 2023 would be partly reliant upon a signed off job plan. An increase in the utilisation of virtual wards was reported, with additional pathways introduced to provide increased capacity.

Since the paper had been written a 20% reduction in demand for obstetric ultrasound had been seen.

Non-executive Director, Jo Gander, sought feedback on the current virtual ward numbers and the quality and efficiency of provision, in line with Getting it Right First Time (GIRFT) standards, as compared to peers. The Acting Executive Medical Director confirmed that meaningful comparisons were difficult to be drawn in view of the recent introduction of virtual wards, the variance in operating models and metrics used. In terms of usage the Trust was currently in the third quartile and further work was ongoing to improve this position. With regards to GIRFT, the quality aspect would be considered by the Clinical Governance Committee.

In view of the ongoing work to manage CT demand, Non-executive Director, Emyr Jones, sought clarity on the requirement for all emergency surgical pathway admissions to require a CT scan. The Acting Executive Medical Director confirmed that whilst this was not mandated, the limited Senior House Officer resource meant they were not always available to make the assessment within the Emergency Department. A paper to address the limited workforce capacity had recently been considered and supported by the Corporate Investment Group; the impact of this change would be considered against the rate of admission from the Emergency Department. In respect of the significant demand for obstetric ultrasound, the Acting Executive Medical Director confirmed that following actions to reinforce the pathway a 20% reduction in demand had been seen in the last month.

In response to a question from Non-executive Director, Hazel Brand regarding the difference between the number of referrals to virtual wards and patients accepted. The Acting Executive Medical Director confirmed he did not see this as a negative, recognising ongoing learning, improved knowledge of referral criteria and maximising referral opportunities, a Virtual Ward First Thought pathway was being developed to support improved usage.

In respect of outcomes, local data was not available, however, there had been no concerns/incidents raised, the impact nationally on bed capacity and length of stay was limited, although from a quality and patient experience there was evidence of the benefits of the service in supporting transition back into the community following a hospital stay.

At a system level, the Chief Executive confirmed that, unlike the Trust, neighbouring acute providers had seen a reduction in their use of their virtual ward capacity, in view of the challenges highlighted. Doccla, an IT solution purchased by the Integrated Care Board may support transparent patient reporting and included an interface to the call stack, where calls to the ambulance service were listed. This would mean that virtual ward teams had the ability to respond to calls into the ambulance service, enabling care to be provided by the right person, in the right place and at the right time. The national Paediatric Innovator Programme would also provide virtual ward provision for respiratory illnesses, providing support to families at home.

In terms of step up care, discussions with General Practice and at Place were ongoing, the challenge in identifying responsible consultants was recognised in the care of the elderly team.

Non-executive Director, Kath Smart, reflected on the job plans in discussion, where no previously agreed e-Job Plan was in place, the Acting Executive Medical Director acknowledged this was his greatest concern in job planning and which he would be held to account for the delivery of, with an intention to reduce to ten by April 2024.

In respect of job plans which contained high levels of Programmed Activities (PAs) and following discussion at the Trust Executive Group, the Acting Executive Medical Director would propose a multi-year approach to address this, commencing with those where PAs exceeded 15. In some specialties, such as Gastrointestinal Surgery and Obstetrics and Gynaecology, a reduction could only be made through consultant recruitment.

The Chief Executive highlighted that as each PA equalled four hours, a 15 PA contract equated to a 60 hour working week, so the value of limiting total PAs to achieve an improved work life balance was critical from a health and wellbeing perspective.

The Chair recognised the positive commitment from the Board in relation to looking after its workforce and providing patient care.

In her capacity as Chair of the Audit & Risk Committee, Kath Smart reminded members of the recent audit report which provided a low level of assurance on the clinical prioritisation of waiting lists and noting the development of the clinical harm review policy enquired where harm would be reported to from a governance perspective. The Chief Operating Officer confirmed that the policy would be taken to the Trust Executive Group for approval in December and reporting would be considered as part of the trust wide governance review.

The Board:

- ***Noted and took assurance from the Executive Medical Director Update***

P23/11/C2 **Chief Nurse Update (Enclosure C2)**

The Chief Nurse Update provided information, outcomes, and assurance on the key deliverables for patient safety and experience.

The Board's attention was drawn to the current Clostridium difficile numbers, whilst they were within the current variance it was now anticipated that achievement of the year-end target would not be met. The Trust's performance was in line with the national position and following attendance at a recent webinar assurance was taken on the Trust's current actions, agreed by the Trust Executive Group.

Two MRSA bacteraemia cases had been reported, linked to non-compliance with screening protocols; gaps in admission processes had been addressed and no patient harm had occurred.

Non-executive Director, Emyr Jones acknowledged and welcomed the focus on serious incidents and the implementation of the Patient Safety Incident Reporting Framework (PSIRF) within the Chief Nurse report.

In response to a question from Non-executive Director, Kath Smart with regards to the downward trajectory for falls, the Chief Nurse confirmed there was a need to reset the threshold, the focus continued to be on falls prevention and the reduction of related harm. Regional and national benchmarking of falls would be welcomed within the report.

Following her attendance at a recent Health & Safety Committee, where the Trust's Health & Safety strategy was being refreshed, Non-executive Director, Kath Smart highlighted common themes in learning between this and PSIRF and suggested it may be beneficial for the teams to consider those links. The Chief Nurse confirmed she was happy to support this and would check if it was already being progressed by the Associate Chief Nurse for Patient Safety and Quality.

In response to a question from Non-executive Director, Jo Gander regarding the inclusion of patient and carer's testimonies in the resolution on incidents, the Chief Nurse confirmed that this practice was currently in place. A business case for recruitment of Family Liaison Officers had recently been approved at the Corporate Investment Group and would be a key part of the process.

Non-executive Director, Mark Bailey welcomed the reporting of the serious incidents and enquired of the mechanism to ensure organisational memory of learning was retained. The Chief Nurse confirmed that with the introduction of PSIRF the approach to reporting would change. As part of the development of the Patient Safety Incident Response Plan a thematic analysis had been completed of the Trust's existing incident profile to ensure learning and improvement linked to themes was identified and organisational memory captured.

The Board:

- ***Noted and took assurance from the Chief Nurse Update***

P23/11/C3 **Maternity & Neonatal Update (Enclosure C3)**

The Board received the Maternity & Neonatal Update, which provided an overview of progress against the national standards and compliance against Year 5 Clinical Negligence Scheme for Trusts Standards (CNST).

The Chief Nurse recognised the wealth of information provided, which had been shared with the non-executive maternity safety champions and been subject to a check and challenge review by the Local Maternity & Neonatal System.

The Director of Midwifery brought the Board's attention to the non-compliance with the British Association of Perinatal Medicine (BAPM) standards in respect of the neonatal nursing workforce, and that an action plan was in place to address the deficit, which required approval by the Board following review at the Trust Executive Group.

Term admissions to the Neonatal Unit remained below regional and national thresholds, an overarching action plan was in place, shared with the Board for oversight and approval.

In respect of CNST safety action eight, initial training compliance had been reduced to 80%, with a view to achieving 90% within a twelve week period. Should all booked training go ahead as planned the Trust was expected to declare compliance.

Safety action six was proving to be a challenge nationally, in view of the need to fully implement version three of Saving Babies' lives by 31 March 2024, this had been raised locally and escalated as the Trust would declare non-compliance.

An action plan to support transitional care for babies was provided for Board oversight and approval.

Non-executive Director, Jo Gander recognised the considerable efforts of colleagues across the service. With regards to clarification of the impact of non-compliance with BAPM, the Chief Nurse confirmed from a Trust perspective the aspect which was not delivered consistently was that of a supernumerary co-ordinator, particularly at times of peak activity, and or acuity. Appropriate escalation routes were identified and on occasions, in order to maintain a safe service, the unit may be closed to admissions. Whilst the BAPM standards were guidance, rather than mandated requirements, a neonatal workforce plan had been taken to Trust Executive Group and would be included in future business planning.

The Chief Executive confirmed that the Trust's position relating to meeting the high standards of BAPM was replicated across the country, achievement of the aspirational standards was recognised as a positive but would take place over time, the key being to ensure appropriate risk management was in place. In order to strengthen self-assessments and provide additional external assurance to Trust Boards, peer reviews were undertaken by the Local Maternity & Neonatal System.

In response to a question from Non-executive Director, Kath Smart regarding concerns relating to the support of the newly qualified midwives, the Director of Midwifery confirmed the pastoral team, educators and senior management team were actively supporting the newly appointed Band 6 midwives to act as mentors to the newly qualified midwives. The Chief People Officer acknowledged the package of support offered to the

newly qualified midwives, which included health and wellbeing, alongside educational development but recognised the volume of new recruits created a challenge.

In view of the various and extensive action plans in place across Maternity and Neonatal Services, Non-executive Director, Kath Smart sought confirmation that the Director of Midwifery had access to the various tools, techniques and support required for delivery. The Director of Midwifery confirmed that the process was carefully managed by the Project Manager.

The Board:

- ***Noted and took assurance from the Maternity & Neonatal Update and approved the transitional care action plan (Safety Action 3), the Q1 & Q2 action plans related to ATAIN (safety action 3), the action plan for the use of short term locums (safety action 4), the action plan for the engagement of long term locums (safety action 4) , the action plan to meet the BAPM standards for neonatal nursing workforce (safety action 4) and the local training need analysis (safety Action 8)***

P23/11/D1 **Chair's Assurance Log – People Committee (Enclosure D1)**

Non-executive Director, Mark Bailey shared the key highlights from the People Committee's Chair's Assurance log, including positive assurance, ongoing major programmes of work, areas of concern and decisions taken.

Non-executive Director, Kath Smart confirmed she had recently presented at an event for NHS Cadets as part of the widening participation programme, details of which would be shared with the Board, who may be invited to speak at future events.

Non-executive Director, Jo Gander recognised the progress made with regards to the digital staff passport and its cross organisational support of training.

The Board

- ***Noted and took assurance from the Chair's Assurance Log***

P23/11/D2 **People Update (Enclosure D2)**

The Chief People Officer provided an overview of work to improve colleague experience, including staff survey, flexible working and the Trust's involvement in wave one of the digital staff passport roll out.

The national staff survey had recently closed and the latest known response rate compared favourably with that of last year. The Trust's 2022 results had been commended in a letter recently received by NHSE's National Director for People. Future reports would include identified staff survey measures, aligned to the People Strategy, with previous year's performance and national acute provider comparator data. This would sit alongside the existing People metrics provided in the Integrated Quality and Performance Report.

The Chief Executive acknowledged NHSE's recognition of the Trust's positive movement in all seven elements of the People Promise, with a response rate of 65% assurance could be

taken that the actions addressed those areas of concern and work continued to further improve colleague experience.

Non-executive Director, Emyr Jones, confirmed as part of his role of maternity safety champion that flexible working was supported in practice, assisting the recruitment and retention of colleagues.

The Chair welcomed the progress made and the effective scrutiny and oversight of the People Committee.

The Board:

- ***Noted and took assurance from the People Update***

P23/11/D3 **Guardian of Safe Working Quarterly Report (Enclosure D3)**

The Chair of the Board welcomed the Guardian of Safe Working to the meeting, who reported an improvement in rota gaps from August, when compared to previous years, resulting in reduced locum costs. The number of overall exception reports remained low, a slight increase had been seen since August, linked to junior doctors commencing in post. No themes were identified across specialities, historical peaks seen in general medicine and surgery had not been seen this year due to an improved staffing position.

The majority of reports related to additional hours worked, reflecting the workload of junior doctors, there had been very few exception repots related to missed education opportunities. Feedback from the junior doctors' forum signalled an apparent reluctance for locum cover due to historical concerns related to high workload; the Guardian of Safe Working felt this was not an ongoing issue and suggested work was required to influence a shift in perception. Additional funding for ten middle grade doctors in emergency medicine also supported the position going forwards.

The Chair sought the Guardian of Safe Working's view on how best to improve the reputational perception, which was acknowledged to be difficult in view of a lack of affiliation to the Trust. The Acting Executive Medical Director recognised the reduced demand for cover and the positive impact this had in attracting locum's interest.

In response to a question from the Chief Executive regarding any other issues raised in the Junior Doctor Forum, the Guardian of Safe Working noted the benefit of qualitative feedback, which had included access to parking for twilight shifts. Any themes outside of exception reporting would be escalated by the Guardian through the appropriate channels.

The Chief Operating Officer expressed an interest in attending the Junior Doctor Forum to share with colleagues the Trust's winter plans.

In respect of the qualitative data provided within the report, Non-executive Director Kath Smart enquired of the mechanism to ensure that junior doctors were aware concerns had been heard, including those not able to attend the Forum. The Guardian of Safe Working confirmed that the invitation was extended to all junior doctors, however, the majority of attendees were management trainee representatives, who were utilised as a valuable resource to disseminate information. Requests for feedback via email has been

encouraged where colleagues were unable to attend. In addition, senior colleagues such as the Chief People Office, Acting Executive Medical Director and Associate Director of Education were in attendance to hear and respond to feedback.

Reflecting on the impact of the industrial action throughout the year, and in view of recent press coverage Non-executive Director, Kath Smart sought an update from the Chief People Officer. Following negotiations between the British Medical Association and the Government, views of consultant BMA members were currently being sought on a pay offer, during which time industrial action was paused. The Chief Executive reflected on the response from other trade unions and recognised the potential for the BMA discussion to reignite industrial action across the non-medical workforce.

The Board:

- ***Noted and took assurance from the Guardian of Safe Working Quarterly Report***

P23/11/E1 Chair's Assurance Log – Finance & Performance Committee (Enclosure E1)

Non-executive Director, Mark Day shared the key highlights from the Finance & Performance Committee's Chair's Assurance log, including positive assurance, ongoing major programmes of work, areas of concern and decisions taken.

Reflecting on yesterday's Committee meeting Mark acknowledged the positive and calm approach taken by the executive directors which provided a great deal of confidence, the Executive Place Director for Doncaster also attended as senior responsible office (SRO) for the Urgent & Emergency Care Improvement Programme. The challenging system and national financial positions were acknowledged, which impacted upon the Trust, with risks mitigated where able. The significant work undertaken to prepare for potential funding of the Doncaster Royal Infirmary estate was commended. Getting It Right First Time, Virtual Wards and diagnostic performance would be a focus in the coming months.

The Deputy Chief Executive recognised the breadth of the Committee's business, worthy of consideration as part of the trust wide governance review.

The Board:

- ***Noted and took assurance from the Chair's Assurance Log***

P23/11/E2 <u>Finance Update (Enclosure E2)</u>

The Chief Financial Officer reported a month seven deficit of £0.9m, £24.8m deficit year to date, which was £1.3m adverse to plan and £1m adverse to forecast.

Capital expenditure in month seven was £5.3m against a plan of £4.3m, the year to date position was £15.7m against a plan of £25m.

The cash balance at the end of October was £15.4m. The Trust had an approved cash drawdown request of £14.9m for Quarter 3, £7.2m of which would be received in November. This was in line with the Trust's deficit position and as previously agreed; the Board confirmed its support of the cash drawdown.

The Trust had delivered £3.3m of savings in month, £0.6m favourable to plan, £11.1m year to date and £1.9m favourable to plan.

Non-executive Director, Lucy Nickson noted the significant increase in phasing of the Cost Improvement Programme from Quarter 3 and enquired what the impact of this was. The Chief Financial Officer confirmed there had been an expectation that schemes would be designed in year, in addition not all schemes had delivered as planned and escalation meetings with the SRO, Chief Financial Officer and Chief Executive had taken place and recovery plans agreed. Additional savings through theatre efficiency, outpatients and job planning were being explored, and where identified changes had been implemented, but the benefit not realised, schemes would be revisited.

Following the recent national announcement of largely repurposed funds to support the cost of industrial action and the impact on the ability to earn Elective Recovery Funding, an amount of £800m had been confirmed, £23m of which was assigned to the South Yorkshire Integrated Care Board (ICB). In view of the system's current unidentified financial gap the funds would be retained by the ICB, in addition a revised year end forecast was submitted to the national team of £55m. As a result, providers had been asked to improve their year-end positions, the ask of the Trust was an improvement of £4m and whilst there was no plan to support this, the Trust had committed to explore opportunities.

Since the ICB submission a further ask to close the gap to £30-35m had been made, with a focus on temporary staffing and discretionary spend, scrutiny of the Trust's position was expected in view of its current deficit plan. An external assessment across the system was anticipated.

The Chief Executive noted that it was reported that any year-end system deficit would be removed before allocations, and would be in addition to any further efficiencies, and that this would result in an increasingly challenging financial ask. Due to a change in approach, the Chief Financial Officer confirmed this deduction would be made in 2025/26. The work undertaken by Deloitte to understand the Trust's drivers of deficit confirmed the Trust's view of an historical underfunding, which had been escalated to the ICB for review. As the Trust approached winter the increased challenges were recognised, which required effective partnership working to deliver the required level of care to patients.

Non-executive Director, Mark Bailey enquired what improvement could be made against current service lines, the Chief Financial Officer confirmed good analysis was available. During the pandemic a number of services had become less efficient and programmes of work to consider this, in areas such as theatres and outpatients had taken place, with ongoing work to ensure that the change translated to a benefit, the limitations of the estate were recognised.

Non-executive Director, Emyr Jones acknowledged the financial challenges faced by the Trust and reinforced the need to maintain the quality of care and services provided, the Chief Financial Officer noted a patient first priority approach, with assurance provided that any efficiencies did not negatively impact quality, assessed by the Chief Nurse and Executive Medical Director as part of the Quality Performance Impact Assessment. The national directive was also clear on patient care and the continued support over Winter as part of the urgent and emergency care pathways. The Chief Executive confirmed the need to engage with the public with regards to the way services would be delivered in

the future, ensuring efficient and effective service provision, in a timely, safe and sustainable manner at Place and across the system.

The Board:

- ***Noted the Finance Update and confirmed its support of the cash drawdown***

P23/11/E3 **Directorate of Recovery, Innovation & Transformation Update (Enclosure E3)**

The Director of Recovery, Innovation & Transformation provided an overview of the Directorate's work. Changes made earlier this year to the way in which the Quality Improvement & Innovation Team worked had significantly increased the level of support across the organisation and a summary of the various projects was included within the report.

A significant amount of work to develop a suite of programmes and processes had taken place should funding become available to improve the Doncaster Royal Infirmary site, likely be focused on the East Ward Block, where the majority of patients were located.

A decision to open the Mexborough Elective Orthopaedic Centre on 8 January 2024 had been taken by the ICB and partner Trusts, with the support of an insourced staffing model.

The Board:

- ***Noted and took assurance from the Directorate of Recovery, Innovation & Transformation Update***

P23/11/E4 **Operational Performance Update (Enclosure E4)**

The Chief Operating Officer's report highlighted the Trust's performance against September's access standards and elective activity plan and cancer waiting times for August 2023.

The Board's Finance & Performance Committee had scrutinised reporting at yesterday's meeting. The Board's attention was drawn to minor improvements across the urgent and emergency care pathways, although the service continued to face considerable challenges for patient access. There continued to be a significant number of patients who were medically fit for discharge occupying beds, which impacted upon bed capacity; an improvement in CT and MRI scan performance was confirmed, due to additional capacity.

In respect of cancer standards, the Trust had achieved 94.5% against the 96% standard for 31 day diagnosis to treatment, this was due to an increased in dermatology referrals.

The Board:

- ***Noted and took assurance from the Operational Performance Update***

P23/11/E5 **Same Day Emergency Care Business Case (Enclosure E5)**

The Chief Operating Officer confirmed that the business case supported delivery of a twelve hour a day, seven day a week same day emergency care for medical patients, in line with the national standard. The majority of funding for this year had been identified, with a gap of £96k remaining and the case had been presented to the Board's Finance & Performance Committee for consideration.

The Chair of the Finance & Performance Committee confirmed the Committee's support to increase the service in line with national standards and in view of recurrent funding. This year's funding gap had been included within the Trust's financial plans.

The potential to extend the opening hours further had been discussed, however, as this would present a further financial and recruitment pressure the suggestion was to proceed in line with the minimum national standard, with the potential for this to be reviewed in the future.

The Board:

- ***Approved the Same Day Emergency Care Business Case***

P23/11/E6 **Winter Plans (Enclosure E6)**

The Chief Operating Officer confirmed the report and sought final approval for investment towards 2023/24 winter plans. Significant investment had taken place to date to support patient flow and maintain patient safety. Following divisional and corporate workshops and subsequent check and challenge processes a series of schemes had been worked up, with deliverable priority schemes identified which were expected to have the greatest impact. The total, worst case scenario, cost was identified at £671k, which assumed additional nursing costs at agency rates and a 100% fill rate.

Non-executive Director, Hazel Brand sought clarification on the reference to overnight transport costs, which the Chief Operating Officer confirmed related to the discharge of patients from either the Emergency Department or assessment areas, rather than a ward. The Chief Executive highlighted the importance of a system response to winter, with bed occupancy at DRI running above the recommended 92% for the last three years, the importance of timely discharge was critical to support flow through the department, with no additional beds available to open over the winter months. The recent revision to budgets had included the indicative winter plan costs. Non-executive Director, Hazel Brand acknowledged the span of partners and associated plans, which the Chief Operating Officer confirmed had been subject to regional and national submission.

In response to a question from Non-executive Director, Kath Smart regarding the effectiveness of the recently refurbished and relocated discharge lounges, the Chief Operating Officer confirmed the capacity and opening hours had been increased, with use of the discharge lounge promoted as the default, unless a clinical reason prevented this. The Chief Nurse acknowledged the proactive support offered in the movement of patients by the discharge lounge.

In response to a question from Non-executive Director, Lucy Nickson, with regards to additional workforce requirements, the Chief Operating Officer confirmed that the financial assumption for planning for nursing assumed agency costs, although additional

hours may be taken up by substantive colleagues. Additional medical and non-nursing requirements would likely be covered by additional hours, although agency rate costs had been factored in.

The Board:

- ***Approved the Winter Plans***

P23/11/F1 **Health Inequalities Strategy (Enclosure F1)**

The Chair of the Board welcomed the Director of Innovation & Infrastructure and the Public Health Consultant to the meeting.

The detail of the strategy had been considered by the Board earlier in the year, with a final draft reviewed by the Board's Finance & Performance Committee in October. The strategy was supported by a three tier adapted framework and delivery plan, six key priority areas were identified, aligned to Place, ICB and NHSE priorities:

- Prevention
- Elective Care Pathways
- Urgent and Emergency Care Pathways
- Children and Young People
- Maternity / best start in life
- Research and Innovation

Significant engagement had taken place internally, at Place and across the system. In terms of next steps, and subject to approval by the Board of Directors, the strategy would be formally branded and launched, with a celebration event planned to raise awareness.

In response to a question from Non-executive Director, Jo Gander regarding how the impact of the strategy would be measured, the Public Health Consultant recognised this was difficult at such an early stage of the strategy's development. A clear priority to embed health inequalities into business as usual was noted. The Chief Executive confirmed that health inequalities was a key strand of the ICB's work, with improvement measured at a system level, with the support of Place organisations to support delivery of more equitable services.

The Chief People Officer welcomed the links with local, regional and national strategies and the holistic approach to its development and the value of positive internal and external connections. Whilst the ongoing monitoring of the strategy would be via the Board's Finance & Performance Committee, the Chief People Officer enquired if there was an opportunity for the Board to receive periodic updates given its scope and importance, in a similar vein to the Research & Innovation Strategy which would report bi-annually to the Board. The Consultant in Public Health agreed to consider this suggestion.

The Deputy Chief Executive recognised the need to be mindful of the consequence of decisions from a health inequalities perspective and suggested it may be helpful to identify a metric to monitor progress as a system, in order to demonstrate progress.

Non-executive Director, Lucy Nickson suggested it may be helpful to identify the transactional activities required to achieve the agreed strategic outcomes, in order that progress could be evidenced.

In response to a question from Non-executive Director, Hazel Brand, regarding the wider determinants of health, the Consultant in Public Health confirmed a toolkit had been developed to assist in signposting patients. In respect of training packages, there was currently very little material already developed, this was the subject of discussion with counterparts and opportunities for working collaboratively would be explored. The Chair of the Board noted the ambitious target for 90% of staff, governors, and volunteers to be trained by March 2024 and sought clarification on how this would be achieved, the Consultant in Public Health confirmed 90% was in line with the requirement for statutory and essential training, with an expectation that governors and volunteers would be updated as part of briefing and development sessions.

The Chief Nurse suggested the Consultant in Public Health may wish to connect with the recently appointed youth worker in Paediatrics and the SRO of strategic theme five of the Quality Framework, for the care of vulnerable patients.

The Board:

- ***Approved the Health Inequalities Strategy***

P23/11/G1 **Annual Emergency Preparedness, Resilience & Response (EPRR) Core Standards Compliance (Enclosure G1)**

The Chief Operating Officer brought the Board's attention to the increased level of evidence required for 2023/24 core standards. The Trust's final return had been submitted on 21 November, and whilst feedback to the Trust was outstanding no further change was expected to the 31% compliance rate. Across South Yorkshire, compliance ranged between 10-45% and a programme of work would be developed to address the shortfalls, monthly reports would be taken to the Trust Executive Group, with compliance and programmes of work reported to the Audit & Risk Committee.

In response to a question from the Chair of the Audit & Risk Committee, the Chief Operating Officer acknowledged the learning in respect of the increased evidence would be used to support the next annual submission. As EPRR featured in the internal audit strategy it was suggested that thought be given as how to utilise the skills to prepare for the external assessment.

The Board:

- ***Noted and took assurance from Annual Emergency Preparedness, Resilience & Response Core Standards Compliance***

P23/11/G2 **Quality & Effectiveness Committee Terms of Reference (Enclosure G2)**

The Company Secretary confirmed the terms of reference had been agreed by the Committee and were received for approval.

The Chief Executive suggested that the Chairs of the Quality & Effectiveness and Audit & Risk Committees consider the addition of the Deputy Chief Executive as a member and

attendee, respectively. Both Chairs confirmed their support of the proposal and subject to the following amendment the terms of reference was approved.

The Board:

- ***Approved the Quality & Effectiveness Committee Terms of Reference***

P23/11/G3 **People Committee Terms of Reference (Enclosure G3)**

The Company Secretary confirmed the terms of reference had been agreed by the People Committee and were received for approval by the Board.

The Board:

- ***Approved the People Committee Terms of Reference***

P23/11/H **Information Items (Enclosure G1 – G7)**

The Board noted:

- H1 Chair and NEDs Report
- H2 Chief Executives Report
- H3 Integrated Quality & Performance Report
- H4 Minutes of the Finance and Performance Committee 24 July & 21 September 2023
- H5 Minutes of the People Committee 5 September 2023
- H6 Minutes of the Quality & Effectiveness Committee 1 August 2023
- H7 Minutes of the Charitable Funds Committee 15 June 2023
- H8 Minutes of the Audit & Risk Committee 20 July 2023
- H8 Minutes of the Trust Executive Group 11 September & 9 October 2023

P23/11/I1 **Minutes of the meeting held on 31 October 2023 (Enclosure I1)**

The Board:

- ***Approved the minutes of the meeting held on 31 October 2023.***

P23/11/I2 **Any other business (to be agreed with the Chair prior to the meeting)**

No items of other business were received.

P23/11/I3 **Governor Questions regarding the business of the meeting (10 minutes) ***

On behalf of the Council of Governors, the Duty Lead Governor asked the following question:

How confident can the Trust be that the identified target of 90% of staff, volunteers and governors to be trained/educated in health inequality matters by 31 March 2023 can be met?

The Consultant in Public Health confirmed the 90% standard was aligned to the statutory and essential training compliance, governor and volunteer training would be addressed as part of a briefing and development session.

The Deputy Lead Governor would share further questions with the Company Secretary for a response outside of the meeting.

In relation to concerns related to the standard of staff accommodation, whilst the matter had been discussed at last month's Board, the Chief Executive had been included in recent correspondence and a further response had been provided. The Chief Executive had ensured, via the Chief Nurse, that the pastoral team for international recruits were sighted on the escalation route, and medical colleagues via their divisional teams. All colleagues were encouraged to raise concerns through the established routes to ensure a timely response. In addition, guidance and relevant contact details would be provided to users of the accommodation to support the reporting of concerns.

The Board:

- ***Noted the governor questions***

P23/11/I4 **Date and time of next meeting (Verbal)**

Date: Tuesday 19 December 2023
Time: 09:30am
Venue: MS Teams

P23/11/J **Close of meeting (Verbal)**

The meeting closed at 13:05

2312 - E4 DATE AND TIME OF NEXT MEETING

Information Item | Suzy Brain England OBE, Chair | 11:00

Date: Tuesday 30 January 2024
Time: 09:30
Venue: MS Teams

MEETING CLOSE

11:00

*Governor Questions

The Board of Directors meetings are held in public but they are not ?public meetings' and, as such the meetings, will be conducted strictly in line with the above agenda.

For Governors in attendance, the agenda provides the opportunity for questions to be received at an appointed time. Due to the anticipated number of governors attending the virtual meeting, Lynne Schuller, Lead Governor will be able to make a point or ask a question on governors' behalf. If any governor wants Lynne to raise a matter at the Board meeting relating to the papers being presented on the day, they should contact Lynne by 4pm the day before the meeting to express this. All other queries from governors arising from the papers or other matters should be emailed to Fiona Dunn for a written response.

In respect of this agenda item, the following guidance is provided:
• Questions at the meeting must relate to papers being presented on the day.
• Questions must be submitted in advance to Lynne Schuller, Lead Governor.
• Questions will be asked by Lynne Schuller, Lead Governor at the meeting.
• If questions are not answered at the meeting Fiona Dunn will coordinate a response to all Governors.
• Members of the public and Governors are welcome to raise questions at any other time, on any other matter, either verbally or in writing through the Trust Board Office, or through any other Trust contact point.

Suzy Brain England OBE
Chair of the Board