Extraordinary Trust Board Meeting ('Part 1') - Formal meeting, which is open to members of the public (to observe)

Maidstone and Tunbridge Wells NHS Trust

Thu 08 July 2021, 10:00 - 10:30

Virtual Meeting, via webconference

Agenda

Please note that members of the public will be able to observe the meeting, as it will be broadcast live on the internet, via the Trust's YouTube channel (www.youtube.com/channel/UCBV9L-3FLrluzYSc29211EQ).

07-1
To receive apologies for absence

David Highton

07-2
To declare interests relevant to agenda items

David Highton

Quality items

07-3
To approve the NHS Resolution maternity incentive scheme submission

Gemma Craig and Sarah Blanchard-Stow

NHS Resolution maternity incentive scheme submission.pdf (46 pages)

07-4
To consider any other business

David Highton

To approve the NHS Resolution maternity incentive scheme submission	**Acting Chief Nurse / Div. Director of Midwifery, Nursing and Quality / Head of Midwifery**

NHS Resolution operates a Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. This is the third year of the scheme. To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on 15/07/21.

The enclosed report provides details on the Trust's compliance for the NHS Resolution maternity incentive scheme submission. Please note that the embedded documents are not accessible from within the meeting book, but any of the documents are available on request from the Trust Secretary.

The Trust Board is asked to:

1. Approve the declaration of compliance (Appendix 1), and give permission to the Chief Executive to sign the Board declaration form prior to submission to NHS Resolution. The active reporting declaration form will be published on NHS Resolution's website in the forthcoming months.
2. Note that the Anaesthetic Medical and Neonatal Junior Medical Staffing standards have been met (see Appendix 2), and that an action plan is in place to comply with the Neonatal Nursing standards (see Appendix 3) (for Safety Action 4)
3. Note the contents the Quarterly Saving Babies Lives Care Bundle Surveys (see Appendices 4 to 8) (for Safety Action 6). Quarterly surveys have not previously been submitted to the Trust Board but these will be submitted in the future, to assure the Trust Board of progress against full implementation.
4. Confirm the Trust Board's commitment to facilitate local, in-person, fetal monitoring training when this is permitted (for Safety Action 6).
5. Confirm the Trust Board's commitment to facilitate local, in-person, MDT training when this is permitted (for Safety Action 8).

Which Committees have reviewed the information prior to Board submission?

- Maternity Board, 21/06/21 (progress with the CNST submission preparation and discussion of specific items)
- Women's Directorate Board, 23/06/21 (progress with the CNST submission preparation and discussion of specific items)

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

1. To approve the declaration of compliance (Appendix 1), and give permission to the Chief Executive to sign the Board declaration form prior to submission to NHS Resolution.
2. To note that the Anaesthetic Medical and Neonatal Junior Medical Staffing standards have been met (see Appendix 2), and that an action plan is in place to comply with the Neonatal Nursing standards (see Appendix 3).
3. To note the contents the Quarterly Saving Babies Lives Care Bundle Surveys (see Appendices 4 to 8).
4. To confirm the Trust Board's commitment to facilitate local, in-person, fetal monitoring training when this is permitted.
5. To confirm the Trust Board's commitment to facilitate local, in-person, MDT training when this is permitted.

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

1/46

Report on the Compliance for Maternity CNST Scheme 19/20

The Maternity Incentive Scheme was launched three years ago and detailed 10 safety actions. The purpose of the scheme is to support the delivery of safer maternity care across the United Kingdom, and applies to all acute trusts that deliver maternity services and are members of the CNST scheme. The ten safety actions are incentivised and announced each year in Autumn. Trusts must demonstrate that they have achieved all elements of the scheme in order to receive the payment. This scheme must be supported by the Trust Board and signed off by such each year.

Due to the COVID19 outbreak in March 2020 it was announced that the incentive scheme was placed on hold with no expectation for organisations to demonstrate their compliance with the safety actions. We were advised that we would not be monitored against our submission of items, and that each trust could take their own stance on how they proceeded. At Maidstone Tunbridge Wells NHS Trust we took the decision that, if we could continue, we would.

In March 2021, NHS Resolution published revised safety actions, reflecting challenges caused by Covid-19. The table below shows the 10 safety actions and the position of MTW maternity services.

In conclusion, we are confident that, subject to completion of the few additional actions or evidence listed, the safety actions have been achieved and that the evidence required to support compliance is available within the trust and/or via external scrutiny.

Maternity Incentive Scheme condition available at https://resolution.nhs.uk

June 2021

2/46

NHS
Maidstone and Tunbridge Wells NHS Trust

Board report stating Maidstone and Tunbridge Wells NHS Trust progress against the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme – Year three

Section A: Evidence of Trust's progress against 10 Safety Actions:

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?					
	a) i. All perinatal deaths eligible to be notified to MBRRACEUK from Monday 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death. ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to 15 March 2021 will have been started before 15 July 2021.	Notifications must be made and surveillance forms completed using the MBRRACE-UK reporting website. The perinatal mortality review tool must be used to review the care and draft reports should be generated via the PMRT. A report has been received by the Trust Board each quarter from Thursday 1 October 2020 onwards that includes details of the deaths reviewed and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met.	CNST - PMRT Compliance Database	Achieved	
	b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15 March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021.		CNST - PMRT Compliance Database	Achieved	
	c) For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby		PMRT Flow Chart - Updated February 20	Achieved	

3/46

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
	have been sought. This includes any home births where care was provided by your Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trust should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and these actions.		PMRT leaflet - MTW.docx PMRT TOR.docx		
	d) i. Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.		02. Board minutes, 25.02.21 (Part 1 - final 05. Board minutes, 27.05.21 (Part 1 - final Q2 PMRT Report October 2020.doc Q3 PMRT Report May 2021.docx	Achieved	
Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?					

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.	NHS Digital will issue a monthly scorecard to data submitters (Trusts) that can be presented to the Board. It will help Trusts understand the improvements needed in advance of the assessment. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met All 13 criteria are mandatory. Items 1, 2, 4-13 will be assessed by NHS Digital and included in the scorecard. Item 3 will be reported to NHS Resolution. Item 14 related to the Maternity Record Standard has been removed from the MIS safety action two.	 CNSTSCORECARDDEC20 Final.xlsx  CNST Standard 2 - LMS compliance .msg  DCB3066 Digital Maternity Record St  Wellbeing Maternity Clinical U	Achieved	
Safety action 3: Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?					
	D) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC. **Covid-19 Revision**	• As and when requested, commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are shared with the Local Maternity System (LMS), ODN or commissioner.	BadgerNet data submitted monthly to NCCMDSv2 and available to LMS and ODN	Achieved	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
	Commissioner returns on request – as per ODN request but there should be no expectation that Trusts are returning data on admissions between Sunday March 1 2020 and Monday August 31 2020. This should be taken from existing BadgerNet data directly for the intervening period.				
	E) A review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) is undertaken to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.	• An audit trail is available which provides evidence that a review of term admissions during the period Sunday 1 March 2020 – Monday 31 August 2020 has been undertaken • Evidence that the review specifically considered the impact of changes to parental access; staff redeployment, closure or reduced TC capacity and changes to postnatal visits on admission rates including those for jaundice, weight loss and poor feeding.	ATAIN compliance & action plan repor	Achieved	
	F) An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19 period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion. **Covid-19 Revision** Progress on Covid-19 related requirements are monitored monthly by the neonatal and board safety champions from January 2021.	• An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from ATAIN reviews. • Evidence of an action plan to address identified and modifiable factors for admission to transitional care.	ATAIN action plan MTW 2021-22 (2).xls FW_ ATAIN.msg	Achieved	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
		• Evidence that the action plan has been revised in the light of learning from term admissions during Covid-19. Where no changes have been made, the rationale should be clearly stated. • Evidence that the action plan has been shared and agreed with the neonatal, maternity safety champion and Board level champion.			
	G) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.	• Evidence that progress with the revised ATAIN action plan has been shared with the neonatal, maternity safety champion and Board level champion.	FW_ ATAIN.msg ATAIN action plan MTW 2021-22 (2).xls: Structure of meetings 2021.pptx	Achieved	
Safety Action 4: Can you demonstrate an effective system of clinical* workforce planning to the required standard?					
	Anaesthetic medical workforce An action plan is in place and agreed at Trust Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.7.2.5, 1.7.2.1 and 1.7.2.6	Trust Board minutes formally recording the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met.	ACSA-STDSFULL-2019 .pdf	Achieved	CNST Standard 4 Summary for Board Ju

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
		Where Trusts did not meet these standards, they must produce an action plan (ratified by the Trust Board) stating how they are working to meet the standards.	CNST Anaesthetic update response.msg		N.B. The Trust Board should note that a) the Anaesthetic Medical and Neonatal Junior Medical Staffing standards have been met (see Appendix 2) b) an action plan is in place to comply with the Neonatal Nursing standards (see Appendix 3)
	Neonatal medical workforce The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level	The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce training action. If the requirements are not met, an action plan should be developed to meet the recommendations and should be signed off by the Trust Board.	LNU_doc_Nov_2018.pdf RE BAPM medical staffing standards p	Achieved	
	Neonatal nursing workforce The neonatal unit meets the service specification for neonatal nursing standards. If these are not met, an action plan is in place and agreed at board level to meet these recommendations	The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, an action plan should be developed to meet the standards and should be signed off by the Trust board and a copy submitted to the Royal College of Nursing (Fiona.smith@rcn.org.uk) and Neonatal Operational Delivery Network (ODN).	Safe Staffing NNU September 2020.doc Recommendations and action plan from	Achieved	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?					
	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated • Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing • An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified • Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover shortfalls • The midwife to birth ratio • The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not	Staffing Review Maternity acute 11.1 Section 2 Q45 BR+ Summary Report.do Midwifery Staffing Shortfall Action Plan.d Huddle Terms of reference.docx JD Care Pathway Coordinator.doc Continuity of Carer MTWs next steps June	Achieved	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
		included in clinical numbers. This includes those in management positions and specialist midwives. • Did Covid-19 cause impact on staffing levels? - Was the staffing level affected by the changes to the organisation to deal with Covid-19? - How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability			
	b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service	• Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. **Must include plan for mitigation/escalation to cover any shortfalls**. Revised safety actions - updated March 2021 35	NEW Maternity Staffing Daily Sheets.x	Achieved	There is no audit data demonstrating compliance with this standard. However, the department is confident that a visit to labour ward on any given day will demonstrate that the co-ordinator will have supernumerary status. The Care Pathway Coordinator role is an additional supernumerary presence in the unit 24/7.

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
	c) All women in active labour receive one-to-one midwifery care		MTW Maternity Dashboard 2020-21.xl	Achieved	
	d) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board at least once a year, during the maternity incentive scheme year three reporting period (December 2019 – July 2021).		Board Report Nursing and Midwifer Appendix 1 - Board Report Non ward ar		
Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?					
	1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2019/20 standard contract.	Evidence of the completed quarterly care bundle surveys for 2020/21 should be submitted to the Trust board.	Maternity Board minutes 17Feb20.do Maternity Board minutes 19April21.doc	Partially achieved Quarterly surveys have not previously been submitted to trust board, but are now attached and will be submitted to assure the board of progress against full implementation in future	For Trust Board to note the contents (see Appendices 4 to 8) South East Coast Maidstone & Tunbrid South East Coast Maidstone & Tunbrid South East Coast Maidstone & Tunbrid

11/46

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
					South East Coast Maidstone & Tunbrid South East Coast Maidstone & Tunbrid
		Element one: A. Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital B. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. C. Percentage of women where CO measurement at 36 weeks is recorded The Trust board should receive data from the organisation's MIS evidencing 80% compliance. **A threshold score of 80% compliance should be used to confirm successful implementation.**	CNSTSCORECARDDEC20 Final.xlsx Saving Babies Lives Dashboard - Evidence Action Plan CO monitoring June 2021	Achieved	CNST Safety Action 6 additional informatior

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
		If the process metric scores are less than 95% Trusts must also have an action plan for achieving >95%.			
		Element two: A. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking. **A threshold score of 80% compliance should be used to confirm successful implementation.** **If the process metric scores are less than 95% Trusts must also have an action plan for achieving >95%.** In addition, the Trust board should specifically confirm that within their organisation: 1) women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards 2) in pregnancies identified as high risk at booking, uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 3) There is a quarterly audit of the percentage of babies born 37+6 weeks' gestation	100% compliance - mandatory question on maternity information system Maternity - Growth Assessment Programr Maternity - antenatal booking a	Achieved	Verbal agreement with CCG and CN that the Growth surveillance protocol is acceptable in absence of uterine artery dopplers – 29 June 2021.

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
		If this is not the case the Trust board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice.			Written confirmation pending
		Element three: A. Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy B. Percentage of women who attend with RFM who have a computerised CTG **A threshold score of 80% compliance should be used to confirm successful implementation.** **If the process metric scores are less than 95% Trusts must also have an action plan for achieving >95%.**	Saving Babies Lives Dashboard - Evidence	Achieved	
		Element four: A. Percentage of staff who have received training on intrapartum fetal monitoring in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness.	6. Ed & Training Report June 2021.dc Saving Babies Lives Dashboard - Evidence	Achieved	N.B. The Trust Board should its commitment to facilitate local, in-person, fetal monitoring training when this is permitted.

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
		B. Percentage of staff who have successfully completed mandatory annual competency assessment. Note: An in-house audit should have been undertaken to assess compliance with these indicators. Each of the following groups should be attending the training: • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres			To improve compliance with saving babies lives version 2 there is a long-term plan to provide 8 hours of paid CTG training for all midwives and obstetricians (See highlighted section) Saving-Babies-Lives -Care-Bundle-Versio (See also Action 8)
	2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network	**Element 5:** A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.	May 2021 SBLCB Quarterly Report for	Achieved	CNST Safety Action 6 additional informatior

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
		B. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. C. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance) **If the process indicator scores are less than 85% Trusts must also have an action plan for achieving >85%** In addition, the Trust board should specifically confirm that within their organisation: • women at high risk of pre-term birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • an audit has been completed to measure the percentage of singleton	 Saving Babies Lives Dashboard - Evidence  Maternity - antenatal booking a  SOP for Referral to MTW Condition-Led A		

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
		live births occurring more than seven days after completion of their first course of antenatal corticosteroids. **Further guidance regarding element 5 of the SBL care bundle V2** The Board's assessment of the percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance) should be based on all deliveries from December 2020, January and February 2021. This data is captured on BadgerNet	Extract from Saving Babies Lives Care Bun		
	3. The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBv2 including the data submission requirements. The corroborating evidence is the SBLCBv2 survey and MSDS data, availability of this depends on the COVID-19 status.		See Section 1 above – for Trust Board to review	Achieved	
Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?					
	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	• Terms of Reference for your MVP	west-kent-mvp-tor-april-2018.pdf	Achieved	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
		• A minimum of one set of minutes of MVP meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback	MTW MVP Minutes 24th April 2019.pdf MVP and HoM meeting 4.3.21.msg MTW MVP Minutes 11 October 2019.pd		
		• Evidence of service developments resulting from coproduction with service users	Project Charter DadPad.docx Project Charter - Active Birth Tool.docx Project Charter - Impact of Vaginal Ass		
		• Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses	MVP CNST Remuneration Lette		

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
		• Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of UKOSS 2020 coronavirus data.	Re Diversity data for MVP.msg MTW Maternity Voices Update for C		
Safety action 8: Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?					
	a) Covid-19 specific e-learning training has been made available to the multi-professional team members?		PROMPT Course Programme.docx Attendance list 2mar21.docx	Achieved	
	b) Team required to be involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since the launch of MIS year three in December 2019?		6. Ed & Training Report June 2021.dc	Achieved	
	c) There is a commitment by the trust board to facilitate multi-professional training sessions, including fetal monitoring training once when this is permitted.	Trust Board should minute in their meeting records a written commitment to facilitate local, in-person, MDT training when this is permitted		Not yet achieved – Trust Board commitment to MDT training required	N.B. The Trust Board should its commitment to facilitate local, in-person, MDT training when this is permitted.

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
Safety action 9: Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?					
	a) A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks.	a) Evidence of a written pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) the LMS and d) Patient Safety Networks.	 Supporting Evidence for Safety /  Safety Champions Pathway for Sharing N	Achieved	
	b) Board level safety champions are undertaking feedback sessions every other month, for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to Covid-19 service changes and service user feedback and can demonstrate that progress with actioning named concerns are visible to staff.	b) Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff.	 safety champions (1).pdf  Safety Champions Pathway for Sharing N	Achieved	
	c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. Taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas, a revised action plan describes how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve.	c) Evidence that discussions regarding safety intelligence, concerns raised by staff and service users in relation to, but not exclusively, the impact of Covid-19 on maternity and neonatal services; progress and actions relating to the local improvement plan(s) and QI activity are reflected in the minutes of Board, LMS and Patient Safety Network meetings. Minutes should also include discussions on where	 MSC Terms of reference 5.2.21.doc  Staff Experience Report.docx  FW Maternity and Neonatal Safety Cha	Achieved	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
		efforts should be positively recognised.	Safety Champion Minutes 28.10.20.do Terms of Reference Dec 2019 Quality Impı poster template.pub		
		d) Evidence of a safety dashboard or equivalent, visible to both maternity and neonatal staff which reflects action and progress made on identified concerns raised by staff and service users. This should include concerns relating to the Covid-19 pandemic.	Q & S A update March 2021 -.pub Maternity Dashboard for Repc		
		e) Evidence that Board level safety champions have reviewed their continuity of carer action plan in light of Covid-19. Plans should reflect how the Trust will continue or resume continuity of carer models so that at least 35% of women booking for maternity care are being placed onto continuity of	Action Plan - C of C GANTT 21.01.2020 F Continuity of Carer MTWs next steps Jul		

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
		carer pathways. In light of the increased risk facing, women from Black, Asian and minority ethnic backgrounds and women from the Revised safety actions - updated March 2021 57 most deprived areas, local systems should consider bringing forward enhanced continuity of carer models primarily targeting these groups			
		f) Evidence of Board level oversight and discussion of progress in meeting the revised continuity of carer action plan.	 Continuity of Carer MTWs next steps June  Maternity Board minutes 21June21.doc	Achieved	
	d) Together with their frontline safety champions, the Board safety champion has reviewed local outcomes in relation to: I. Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of Covid-19, drawing on resources and guidance to understand and address factors which led to these outcomes. II. The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK.	g) Evidence that the frontline and Board safety champions have reviewed local outcomes as set out in standard d) above and are addressing relevant learning, drawing on insights and recommendations from the two named reports and undertaking the requirements within the letter targeting perinatal support for Black, Asian and Minority Ethnic groups.	 MBRRACE 2020 Covid Gap analysis -  SE maternity services assessment	Achieved	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
	III. The MBRRACE-UK SARS-Covid-19 https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACEUK_Maternal_Report_2020_v10_FINAL.pdf IV. The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups				
	e) The Board Level Safety Champion is actively supporting capacity (and capability) building for all staff to be actively involved in the following areas: • Maternity and neonatal quality and safety improvement activity within the Trust, including that determined in response to Covid-19 safety concerns • Specific national improvement work and testing lead by MatNeoSIP that the Trust is directly involved with	h) Evidence of how the Board has supported staff involved in the four key areas outlined in part e) of the required standard and specifically to: • Work with Patient Safety Networks, local maternity systems, clinical networks, commissioners and others on Covid-19 and non Covid-19 related challenges and safety concerns, ensuring learning and intelligence is actively shared across systems • Utilise SCORE safety culture survey results to inform the Trust quality improvement plan • Undertaking of improvement work aligned to the MatNeoSIP national driver diagram and key enablers	10th June 2021.docx Womens 2020-21 staff survey action pla Score survey.docx	Achieved	

Safety Action	Required Standard	Evidential Requirement	Evidence	Achieved ?	Other comments
Safety action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme?					
	a) Reporting of all outstanding qualifying cases for the year 2019/20 to NHS Resolution's EN scheme. b) Reporting of all qualifying cases to the Healthcare Safety Investigation Branch (HSIB) for 2020/21. c) For qualifying cases which have occurred during the period 1 October 2020 to 31 March 2021 the Trust Board are assured that: 1. the family have received information on the role of HSIB and the EN scheme; and 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to HSIB and the NHS Resolution Early Notification team. **Trust Board** sight of evidence that the families have received information on the role of HSIB and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.	HSIB & ENS database 2019-20.xlsx HSIB Maternity Referral Family Card F HSIB_Maternity_Family_Information_Summa New HSIB NHS R DOC template 2021.d DatixWebReport for DOC compliance Oct	Achieved	

Appendix 1

NHS Resolution

Maternity incentive scheme - Board declaration Form

Trust name Please choose your trust in the Guidance tab
Trust code

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	No		-	You have not entered an action plan for this unmet safety action, please check
Q2 MSDS	No		-	You have not entered an action plan for this unmet safety action, please check
Q3 Transitional care	No		-	You have not entered an action plan for this unmet safety action, please check
Q4 Clinical workforce planning	No		-	You have not entered an action plan for this unmet safety action, please check
Q5 Midwifery workforce planning	No		-	You have not entered an action plan for this unmet safety action, please check
Q6 SBL care bundle	No		-	You have not entered an action plan for this unmet safety action, please check
Q7 Patient feedback	No		-	You have not entered an action plan for this unmet safety action, please check
Q8 In-house training	No		-	You have not entered an action plan for this unmet safety action, please check
Q9 Safety Champions	No		-	You have not entered an action plan for this unmet safety action, please check
Q10 EN scheme	No		-	You have not entered an action plan for this unmet safety action, please check
Total safety actions	-	-		
Total sum requested			-	

Sign-off process:

Electronic signature

For and on behalf of the board of Please choose your trust in the Guidance tab

Confirming that:
The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

Electronic signature

For and on behalf of the board of Please choose your trust in the Guidance tab

Confirming that:
The content of this form has been discussed with the commissioner(s) of the trust's maternity services

Electronic signature

For and on behalf of the board of Please choose your trust in the Guidance tab

Confirming that:
There are no reports covering either **this year (2020/21) or the previous financial year (2019/20)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.

Electronic signature

For and on behalf of the board of Please choose your trust in the Guidance tab

Confirming that:
If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which

Name:
Position:
Date:

25/46

Appendix 2

CNST Standard 4

Anaesthetic medical workforce

An action plan is in place and agreed at Trust Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.7.2.5, 1.7.2.1 and 1.7.2.6

From ACSC accreditation standards:

STANDARD 1.7.2.5 Where there are elective caesarean section lists, there are dedicated obstetric, anaesthesia, theatre and midwifery staff

STANDARD 1.7.1.2 An obstetric anaesthetist takes part in regular multidisciplinary 'labour ward forum' or equivalent meetings

STANDARD 1.7.2.6 The duty anaesthetist for obstetrics should participate in delivery suite ward rounds including multidisciplinary handovers

These standards are met – no action plan required

Confirmation evidence provided by Dr O Blightman, but could also be evidenced by rotas, theatre lists, forum minutes & TOR and observational audit of attendance at MDT handovers

Neonatal medical workforce
The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level

From BAPM national standards:

3.2 Medical staffing of LNUs and SCUs

3.2.1 Tier One

3.2.1a Local Neonatal Units

• Units designated as LNUs should have immediately available at least one resident Tier 1 practitioner dedicated to providing emergency care for the neonatal service 24/7; the provision of newborn infant physical examination should not be the sole responsibility of this individual and midwives should be trained to deliver this aspect of care [37, 38]

• In large LNUs (>7000 births) there should be two dedicated Tier 1 practitioners 24/7 to support emergency care, in keeping with the NICU framework [1]

3.2.2 Tier Two

3.2.2a Local Neonatal Units

• LNUs should provide an immediately available resident Tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00-22.00, seven days a week

26/46

• LNUs undertaking either >1500 RCDs or >600 IC days annually should have immediately available a dedicated resident Tier 2 practitioner separate from paediatrics 24/7

• LNUs undertaking either >1000 RCDs or >400 IC days annually should strongly consider providing a 24/7 resident Tier 2 dedicated to the neonatal unit and entirely separate from paediatrics; a risk analysis should be performed to demonstrate the safety, timeliness and quality of care delivery to both paediatrics, delivery suite, maternity unit and neonatal services if the Tier 2 is shared at any point 24/7 in these units. Considerations should include the level of activity of ©BAPM2018 8 any Paediatric Unit including peak activity times and the geography of the site including the location of A&E and the Paediatric wards.

• The Tier 2 should be immediately available at all times to the neonatal unit and the labour ward. If the site of the paediatric unit makes this immediate response impossible separate Tier 2 rotas are required.

These standards are met – no action plan required

Confirmation evidence provided by Dr R Gupta, but could also be evidenced by rotas or audit of response times to neonatal emergencies

Neonatal nursing workforce
The neonatal unit meets the service specification for neonatal nursing standards. If these are not met, an action plan is in place and agreed at board level to meet these recommendations

3.1 Nursing staffing

Standards for defining neonatal nurse to patient ratio determined by illness severity were defined by BAPM giving one-to-one nursing for intensive care, one-to-two nursing for patients in high dependency care and one-to-four nursing for neonates in special or transitional care.

The Toolkit also defined a standard for the proportion of the nursing establishment qualified in specialty. We believe these remain key standards across all levels of units.

These standards are not met – action plan in place

The shortfall in neonatal nursing workforce was identified in the Board Report, Safe Staffing Reviews – September 2020

An action plan is in place to increase nursing establishment and mitigate the current shortfall.

Appendix 3: Safe, sustainable and productive staffing - An improvement resource for neonatal care

	Recommendations	Information	RAG
1	Boards must ensure there is a strategic multi professional staffing review at least annually (or more frequently if service changes are planned or quality or workforce concerns are identified), which is aligned to the operational planning process. In addition a mid-year review should provide assurance that neonatal services are safe and sustainable. This should assess whether current staffing levels meet the recommended levels and are likely to do so in future	• Annual review with HR, Deputy Chief Nurse and NICU leads / Paediatric leads in place – last completed November 2020 • Ongoing issues with band 6 recruitment – action plan in place for this and in house training provision. Agency line and increase in qualified bank staff • Business case to be submitted and reviewed – delayed due to covid-19 to ensure compliance with future workforce plans , currently using bank to support staffing levels • New pathways in place for staff development –. Advanced clinical nurse specialist in place and pathway from band 7-8a. Band 6 link roles in place • 21% uplift in place for nursing staffing to cover leave, study leave etc • Designated lead consultant in place who is responsible for clinical and professional leadership, and management of the service along with the Matron and General Manager are in place • Clinical Educator in place • AHPs- physio , dietician, paediatric pharmacist in place	
2	All neonatal units should work collaboratively within an operational delivery network (ODN), sharing their workforce plans and strategies for recruitment and retention across the ODN	• Operational delivery network in place • Allocated staff attend and feedback to unit • Neonatal Transfer pathways in place and sharing of best practice • Effective networking within the designated ODN and co-operation with staff in other units and the transport service are in place • ODN action plan in place	
3		• Skill mix reviewed regularly and adapted	

Appendix 3: Safe, sustainable and productive staffing - An improvement resource for neonatal care

	Recommendations	Information	RAG
	Skill mix should be regularly reviewed to ensure that the most suitable staff are in undertaking the correct roles and are available in sufficient numbers.	• Rotation with paediatric in patient in ward to maintain skill set of staff • Medical rota split – neonatal specific consultant rota in place now compliant • Business case underway for neonatal outreach plan – new service gap due to transition of CCNT to KCHFT	
4	Professional judgement should be used together with appropriate workforce and acuity tools	• Professional judgement method utilised at yearly safe staffing review • Safe care module being launched on NICU August 2021 – currently under development specifically for NICU standards. Trust lead and NICU lead in place	
5	Data collected using Badgernet and the neonatal nurse staffing tool (Dinning) should be used to calculate the required establishment according to the level of activity shared with the neonatal ODN .	• Safe care module being launched on NICU August 2021 – currently under development. Trust lead and NICU lead in place • Trust does not use Dinning , however data collected using Badgernet	
6	Training and development must be linked to annual individual appraisals and development plans, and must be provided within the resources available to the team	• Annual appraisal system in place with clear development processes for staff • Clinical educator band 7 in post (maternity leave) however replaced by university lecturer practitioner doing post on bank) • Staff training in place specific to needs – parent support, bereavement, infant feeding • Access to multidisciplinary education and training including neonatal simulation • Bliss accreditation achieved • Baby Friendly level 2 achieved • Peer review completed – no actions regarding staff training or development	
7	Organisations should recognise the increasing need for flexible working patterns to meet the fluctuating needs in neonatal services.	• Flexible working policy in place for trust and implemented on NICU • Retire and return pathway in place • Working from home for some staff in key positions implemented during covid	

Appendix 3: Safe, sustainable and productive staffing - An improvement resource for neonatal care

	Recommendations	Information	RAG
8	All neonatal units should adhere to the pathways agreed with the ODN and specialised commissioning teams to ensure efficient working across the network.	• Clear pathways in place with ODN and specialist commissioning teams. • HDU and SCBU funding adapted and awaiting ITU contracts and funding • Transfer to tertiary centres pathways in place	
9	All neonatal units should input data into BadgerNet to enable national benchmarking.	• Badgernet in place and updated daily / as required. • Staff trained in use	
10	Areas of concern highlighted by parents/families or staff using workforce planning and analysis methods must be carefully scrutinised and appropriate actions taken to address them.	• Weekly complaints meeting • Complaints and incidents pathway for review in place - Monthly risk meeting with Bimonthly Neonatal specific overview • Monthly PALS report • Monthly Neonatal Management Meeting in place • Monthly Neonatal and Paediatric Directorate meeting in place • Bimonthly Divisional Quality • Risk leads for NICU in place – Lou Mair and Dr Raj Gupta • FFT – have Neonatal feedback – currently being transferred to trust FFT system awaiting confirmation of layout of parent forms as will then be available on line • Parent group in place to involve in service development • BLISS feedback and reports	

Action plan May 2021

	Issues identified	Leads	Due for completion	Further information

Appendix 3: Safe, sustainable and productive staffing - An improvement resource for neonatal care

1	Business case to review current staffing levels in line with BABPM Standards - delayed due to covid-19	Lou Mair / Nicola Cooper	Sept 2021	• Agency line for band 6 staff (QIS trained to support service) in place currently • Staff hours amended – increased to ensure appropriate cover utilising bank and short term Change of contract • Paediatric rotation in place to support retention and recruitment
3	Business case underway for neonatal outreach plan – new service gap due to transition of CCNT to KCHFT	Lou Mair / Nicola Cooper/ Jackie Tyler	July 2021	• Service currently provided by CCNT service which is moving to KCHFT from August 2021 – gap for infants on oxygen currently being picked up by Paediatric respiratory team
4	Safecare module to be implemented as part of trust roll out - Care hours per patient day - Quality Dashboard	Lou Mair Mollie Hills– Trust lead Janice Anderson	Sept 2021	• Being launched on NICU August 2021 • Currently under development specifically for NICU standards. • Trust lead and NICU lead in place

Appendix 4

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

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

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

Please note:

The calculation setting for this workbook should be set to 'Automatic' in order for all of the functions to work correctly. In order to check this setting, please click:

-> 'Formulas' in the top ribbon

-> 'Calculation Options' to the right

-> 'Automatic' from the dropdown menu.

In addition, please ensure that you select 'enable content' when prompted by the security dialog box at the top.

NHS England

Survey Number	1st
Survey Date	Oct-19

Reducing Stillbirths Care Bundle Elements

Element 1: Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) and referring to stop smoking service/specialist as appropriate

1a. Are you meeting all requirements of Element 1 of the care bundle? *If "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	No
1b. Are you carrying out any improvement activity designed to reduce smoking in pregnancy? *If "yes", please go to question 1c, If "no", please go to question 1j.*	No
1c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. CO monitoring at booking and additional CO testing throughout pregnancy including the 36 week antenatal appointment, with the outcome recorded?	Yes
ii. Referring expectant mothers, with elevated CO levels (4ppm or above), to a trained stop smoking specialist, based on an opt out system with a pathway that includes feedback and follow up processes?	Yes
1d. Do the improvement activities include training all maternity staff on the use of the CO monitor and having a brief and meaningful conversation with women about smoking?	Yes
1e. Have all recorded outcomes of CO testing in pregnancy relating to element 1 activities been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	Yes
1f. If you answered "no" to question **1b**, are you planning on introducing this type of intervention / improvement activity?	Yes

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

Currently without a Smoking in Pregnancy Midwife in post. Recruitment in progress.

Element 2: Identification and surveillance of pregnancies with fetal growth restriction

2a. Are you meeting all requirements of Element 2 of the care bundle? *If "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	No
2b. Are you carrying out any improvement activity designed to risk assess and manage babies at risk of Fetal Growth Restriction (FGR)? *If "yes", go to question 2c. If "no", please go to question 2j.*	Yes
2c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C of the care bundle or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	Yes
ii. Risk assessment and surveillance of women at increased risk of FGR, with triage of women at increased risk of FGR into an appropriate clinical pathway?	Yes
iii. Risk assessment and management of growth disorders in multiple pregnancy in compliance with NICE guidance or a variant agreed locally following advice from the provider's Clinical Network?	Yes
2d. Regarding women not undergoing serial ultrasound scan surveillance of fetal growth does your standard operating procedure (e.g. guidelines) include assessment performed using antenatal symphysis fundal height (SFH) charts by clinicians trained in their use?	Yes
2e. Does your standard operating procedure (guidelines) include differentiation between the management of the SGA and growth restricted fetus in accordance with the pathways and guidance outlined in version 2 of the Saving Babies Lives Care Bundle?	Yes
2f. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Following recommended guidance on the frequency of ultrasound review of estimated fetal weight (EFW) when SGA is detected, in accordance with appendix D of SBLCBv2 or a variant agreed locally following advice from the provider's Clinical Network?,	Yes
ii. Maternity care providers caring for women with FGR identified prior to 34+0 weeks having an agreed pathway for management which includes network fetal medicine input (for example, through referral or case discussion by phone)?	No
2g. Accepting the proviso that all management decisions should be agreed with the mother in the cases of fetuses <3rd centile and with no other concerning features does your standard operating procedure (e.g. guidelines) include the following principles: • Initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation. • Delivery <37+0 weeks can be considered if there are additional concerning features, but these risks must be balanced against the increased risk to the baby of birth at earlier gestations.	Yes
2h. Does your standard operating procedure (e.g. guidelines) include individualised care of fetuses between 3rd – 10th centile using a risk assessment including Doppler investigations, assessment for the presence of any other high risk features such as recurrent reduced fetal movements, and the mother's wishes ; and in the absence of any high risk features the offer of delivery or the initiation of induction of labour at 39+0 weeks?	Yes
2i. Have all findings of small for gestational age fetuses been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	Yes
2j. If you answered "no" to **2b**, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Risk assessment currently performed using GAP programme in addition to MIS data

Current guideline for women with FGR identified prior to 34 weeks does not have a pathway which includes network fetal medicine input

Element 3: Raising awareness amongst pregnant women of the importance of detecting and reporting reduced fetal movement (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM

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

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

Anticipated update to MIS expected to ensure that all fields required to monitor SBLCBv2 will be captured and therefore submitted to MSDS

Element 4: Effective fetal monitoring during labour

4a. Are you meeting all requirements of Element 4 of the care bundle? *If "yes", the questions below (with exception to question 4d) will be automatically populated on dropdown selection. Please also complete question 4d. If "no", please complete all questions below.*	Yes
4b. Are you carrying out any improvement activities designed around effective fetal monitoring during labour? *If "yes", go to question 4c. If "no", please go to question 4h.*	Yes
4c. Do your improvement activities include annual multidisciplinary training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation for staff who care for women in labour? *If "yes", go to question 4d. If "no", please go to question 4e.*	Yes
4d. What is the percentage of staff who care for women in labour that have undertaken this training in the last 12 months?	50-75%
4e. Do you have a system that, irrespective of place of birth, assesses risk at the onset of labour to determine the most appropriate fetal monitoring method, as described in SBLCBv2?	Yes
4f. Do your improvement activities include a review at least every hour of fetal well-being incorporating the following:	
i. CTG or Intermittent Auscultation;	Yes
ii. reassessment of fetal risk factors	Yes
iii. a fresh eyes/buddy system	Yes
iv. clear guideline for escalation if concerns are raised through the use of a structured process?	Yes
4g. Do your improvement activities include identifying a Fetal Monitoring Lead for a minimum of 0.4WTE per consultant led unit during which time it is their responsibility to improve the standard of intrapartum risk assessment and fetal monitoring?	Yes
4h. If you answered "no" to **4b**, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Fetal Wellbeing Midwife appointed, but delay in releasing from previous role has delayed start date

Anticipated update to MIS expected to ensure that all fields required to monitor SBLCB v2 will be captured and therefore submitted to MSDS

32/46

Element 5: Reducing preterm births	
5a. Are you meeting all requirements of Element 5 of the care bundle? *If "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	Yes
5b. Are you carrying out any improvement activity designed around reducing the number of preterm births and optimising care when preterm delivery cannot be prevented? *If "yes", go to question 5c. If "no", please go to question 5g.*	Yes
5c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing all women at booking for the risk of preterm birth and stratifying to low, intermediate and high-risk pathways as per the criteria in Appendix F of the SBLCB v2 of the care bundle document; or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	Yes
ii. Assessing women with a history of preterm birth to determine whether this was associated with placental disease and a discussion about prescribing aspirin with the woman based upon her personalised risk assessment?	Yes
iii. All women being offered screening for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking, and a repeat MSU to confirm clearance following any positive culture?	Yes
iv. Having access to transvaginal cervix scanning (TVCS) and a clinician with an interest in preterm birth prevention with a clinical pathway for women at risk of preterm birth that is agreed with local commissioners (CCGs) following advice from the provider's clinical network (for example, UK Preterm Clinical Network guidance or NICE guidance)?	Yes
5d. Does your standard operating procedure (e.g. guidelines) include risk assessment and management in multiple pregnancy compliant with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network?	Yes
5e. Does your standard operating procedure (e.g. guidelines) include the following:	
i. every provider having referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories including access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage?	Yes
ii. women at imminent risk of preterm birth being offered transfer to a unit with appropriate and available neonatal cot facilities when safe to do so and as agreed by the relevant neonatal Operational Delivery Network (ODN)?	Yes
iii. offering Antenatal corticosteroids to women between 24+0 and 33+6 weeks, optimally at 48 hours before a planned birth?	Yes
iv. offering Antenatal corticosteroids to women between 24+0 and 33+6 weeks, optimally at 48 hours before a planned birth? If so to what extent have you implemented this improvement activity?	Yes
v. offering Magnesium Sulphate to women between 24+0 and 29+6 weeks of pregnancy; and considering offering Magnesium Sulphate for women between 30+0 and 33+6 weeks of pregnancy, who are in established labour or are having a planned preterm birth within 24 hours? If so to what extent have you implemented this improvement activity?	Yes
vi. ensuring the neonatal team are involved when a preterm birth is anticipated, so that they have time to discuss options with parents prior to birth and to be present at the delivery?	Yes
vii. holding a multidisciplinary discussion before birth between the neonatologist, obstetrician and the parents about the decision to resuscitate the baby for women between 23 and 24 weeks of gestation? If so to what extent have you implemented this improvement activity?	Yes
5f. Have all instances of maternal antenatal administration of corticosteroids for fetal lung maturation been recorded on your MIS enabling its submission as in MSDS v2.0 monthly submissions?	Yes
5g. If you answered "no" to **5b**, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Fetal Wellbeing Midwife appointed, but delay in releasing from previous role has delayed start date

Anticipated update to MIS expected to ensure that all fields required to monitor SBLCB v2 will be captured and therefore submitted to MSDS

Please fill in the following details	
Name of person completing the form	Susan Powley
Job Title	Matron for Governance, IT & Projects
Hospital Name	TWH/MBC/CBC
Trust Name	MAIDSTONE AND TUNBRIDGE
Trust Code	RWF
SCN Area	South East Coast
Please provide information here if the drop-down boxes do not include the correct information for your trust	Free Text Box

33/46

Saving Babies Lives - Updates & Action Planning

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

Action Plan

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

Recommendation Number	Recommendation	Action plan to address recommendation	Action progress against plan	Action priority 1 = Critical (Under 1 Month) 2 = Essential (1-3 Months) 3 = Recommended (over 3 months)	Action owner	Baseline date	Forecast date	Closure date	Current status
1	Smoking in Pregnancy Midwife to support Element 1	Recruit Smoking in Pregnancy Midwife	Recruitment in progress	2	Alison Mendes		Jan-20		G
2	MIS (Euroking E3) to capture all elements of SBLCB v2	Implement update to MIS when available	E3 updates in development	3	Susan Powley		Jan-20		G
3	All staff caring for women in birth setting are up to date with CTG training	Fetal Wellbeing Midwife to improve rate of compliance with CTG training for all staff who care for women in the birth setting	Fetal Wellbeing Midwife appojnted, but unable to take up post until current position filled	2	Susan Powley		Jan-20		G
4	Fetal Wellbeing Midwife to support all elements of SBLCB v2	Recruit Fetal Wellbeing Midwife	Fetal Wellbeing Midwife appojnted, but unable to take up post until current position filled	2	Susan Powley		Jan-20		G
5	Determine compliance of each element of SBLCB v2	Audit compliance for each element to identify any further actions required	Audit to be conducted when Fetal Wellbeing midwife in post	3	Susan Powley		Mar-20		G
6									
7									
8									
9									
10									
11									
12									

34/46

Appendix 5

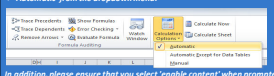
The purpose of this survey is to gather information on how much of current standard practice aligns with the interventions that make up the Saving Babies' Lives Care Bundle v2. Each intervention is made up of improvement activities. Improvement activities are the actions that make up the elements of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

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

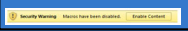
PLEASE CLICK THE ARROW TO USE THE DROP DOWN MENU TO SELECT YOUR ANSWERS.

Please note:

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



In addition, please ensure that you select 'enable content' when prompted by the security dialog box at the top.



NHS England

Survey Number	2nd
Survey Date	Dec-19

Reducing Stillbirths Care Bundle Elements

Element 1: Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) and referring to stop smoking service/specialist as appropriate

Have any of your responses to the below questions in Element 1 changed since the last survey? *If "yes", make your changes below. If "no", go to Element 2.*	Yes
1a. Are you meeting all requirements of Element 1 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	Yes
1b. Are you carrying out any improvement activity designed to reduce smoking in pregnancy? *If "yes", please go to question 1c, if "no", please go to question 1f.*	Yes
1c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. CO monitoring at booking and additional CO testing throughout pregnancy including the 36 week antenatal appointment, with the outcome recorded?	Yes
ii. Referring expectant mothers, with elevated CO levels (4ppm or above), to a trained stop smoking specialist, based on an opt out system with a pathway that includes feedback and follow up processes?	Yes
1d. Do the improvement activities include training all maternity staff on the use of the CO monitor and having a brief and meaningful conversation with women about smoking?	Yes
1e. Have all recorded outcomes of CO testing in pregnancy relating to element 1 activities been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	Yes
1f. If you answered "no" to question **1b**, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Vacant Smoking Cessation Midwife in recruitment process.

Element 2: Identification and surveillance of pregnancies with fetal growth restriction

Have any of your responses to the below questions in Element 2 changed since the last survey? *If "yes", make your changes below. If "no", go to Element 3.*	Click to Select
2a. Are you meeting all requirements of Element 2 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	No
2b. Are you carrying out any improvement activity designed to risk assess and manage babies at risk of Fetal Growth Restriction (FGR)? *If "yes", go to question 2c. If "no", please go to question 2j.*	Yes
2c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C of the care bundle or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	Yes
ii. Risk assessment and surveillance of women at increased risk of FGR, with triage of women at increased risk of FGR into an appropriate clinical pathway?	Yes
iii. Risk assessment and management of growth disorders in multiple pregnancy in compliance with NICE guidance or a variant agreed locally following advice from the provider's Clinical Network?	Yes
2d. Regarding women not undergoing serial ultrasound scan surveillance of fetal growth does your standard operating procedure (e.g. guidelines) include assessment performed using antenatal symphysis fundal height (SFH) charts by clinicians trained in their use?	Yes
2e. Does your standard operating procedure (guidelines) include differentiation between the management of the SGA and growth restricted fetus in accordance with the pathways and guidance outlined in version 2 of the Saving Babies Lives Care Bundle?	Yes
2f. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Following recommended guidance on the frequency of ultrasound review of estimated fetal weight (EFW) when SGA is detected, in accordance with appendix D of SBLCBv2 or a variant agreed locally following advice from the provider's Clinical Network?,	Yes
ii. Maternity care providers caring for women with FGR identified prior to 34+0 weeks having an agreed pathway for management which includes network fetal medicine input (for example, through referral or case discussion by phone)?	No
2g. Accepting the proviso that all management decisions should be agreed with the mother in the cases of fetuses <3rd centile and with no other concerning features does your standard operating procedure (e.g. guidelines) include the following principles: • Initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation. • Delivery <37+0 weeks can be considered if there are additional concerning features, but these risks must be balanced against the increased risk to the baby of birth at earlier gestations.	Yes
2h. Does your standard operating procedure (e.g. guidelines) include individualised care of fetuses between 3rd – 10th centile using a risk assessment including Doppler investigations, assessment for the presence of any other high risk features such as recurrent reduced fetal movements, and the mother's wishes ; and in the absence of any high risk features the offer of delivery or the initiation of induction of labour at 39+0 weeks?	Yes
2i. Have all findings of small for gestational age fetuses been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	Yes
2j. If you answered "no" to **2b**, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Birth weight centile recorded on MIS and available for MSDS v2.0 submission when functionality allows

Element 3: Raising awareness amongst pregnant women of the importance of detecting and reporting reduced fetal movement (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM

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

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

RFM recorded on MIS and available for MSDS v2.0 submission when functionality allows

Element 4: Effective fetal monitoring during labour

Have any of your responses to the below questions in Element 4 changed since the last survey? *If "yes", make your changes below. If "no", go to Element 5.*	Yes
4a. Are you meeting all requirements of Element 4 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below. Please take extra care to ensure your percentage of trained staff in question 4d is up to date.*	No
4b. Are you carrying out any improvement activities designed around effective fetal monitoring during labour? *If "yes", go to question 4c. If "no", please go to question 4h.*	Yes
4c. Do your improvement activities include annual multidisciplinary training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation for staff who care for women in labour? *If "yes", go to question 4d. If "no", please go to question 4e.*	Yes
4d. What is the percentage of staff who care for women in labour that have undertaken this training in the last 12 months?	50-75%
4e. Do you have a system that, irrespective of place of birth, assesses risk at the onset of labour to determine the most appropriate fetal monitoring method, as described in SBLCBv2?	Yes
4f. Do your improvement activities include a review at least every hour of fetal well-being incorporating the following:	
i. CTG or Intermittent Auscultation;	Yes

35/46

ii. reassessment of fetal risk factors	Yes
iii. a fresh eyes/buddy system	Yes
iv. clear guideline for escalation if concerns are raised through the use of a structured process?	Yes
4g. Do your improvement activities include identifying a Fetal Monitoring Lead for a minimum of 0.4WTE per consultant led unit during which time it is their responsibility to improve the standard of intrapartum risk assessment and fetal monitoring?	Yes
4h. If you answered "no" to **4b**, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Fetal Monitoring Lead not yet appointed. SBL Midwife role appointed to, but not yet in post.
Current guideline for training does not include requirement for competency assessment

Element 5: Reducing preterm births

Have any of your responses to the below questions in Element 2 changed since the last survey? *If "yes", make your changes below. If "no", go to the final part of the survey below.*	Click to Select
5a. Are you meeting all requirements of Element 5 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	Yes
5b. Are you carrying out any improvement activity designed around reducing the number of preterm births and optimising care when preterm delivery cannot be prevented? *If "yes", go to question 5c. If "no", please go to question 5g.*	Yes
5c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing all women at booking for the risk of preterm birth and stratifying to low, intermediate and high-risk pathways as per the criteria in Appendix F of the SBLCB v2 of the care bundle document; or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	No
ii. Assessing women with a history of preterm birth to determine whether this was associated with placental disease and a discussion about prescribing aspirin with the woman based upon her personalised risk assessment?	Yes
iii. All women being offered screening for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking, and a repeat MSU to confirm clearance following any positive culture?	Yes
iv. Having access to transvaginal cervix scanning (TVCS) and a clinician with an interest in preterm birth prevention with a clinical pathway for women at risk of preterm birth that is agreed with local commissioners (CCGs) following advice from the provider's clinical network (for example, UK Preterm Clinical Network guidance or NICE guidance)?	Yes
5d. Does your standard operating procedure (e.g. guidelines) include risk assessment and management in multiple pregnancy compliant with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network?	Yes
5e. Does your standard operating procedure (e.g. guidelines) include the following:	
i. every provider having referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories including access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage?	Yes
ii. women at imminent risk of preterm birth being offered transfer to a unit with appropriate and available neonatal cot facilities when safe to do so and as agreed by the relevant neonatal Operational Delivery Network (ODN)?	Yes
iii. offering Antenatal corticosteroids to women between 24+0 and 33+6 weeks, optimally at 48 hours before a planned birth?	Yes
iv. offering Magnesium Sulphate to women between 24+0 and 29+6 weeks of pregnancy; and considering offering Magnesium Sulphate for women between 30+0 and 33+6 weeks of pregnancy, who are in established labour or are having a planned preterm birth within 24 hours?	Yes
v. ensuring the neonatal team are involved when a preterm birth is anticipated, so that they have time to discuss options with parents prior to birth and to be present at the delivery?	Yes
vi. holding a multidisciplinary discussion before birth between the neonatologist, obstetrician and the parents about the decision to resuscitate the baby for women between 23 and 24 weeks of gestation?	No
5f. Have all instances of maternal antenatal administration of corticosteroids for fetal lung maturation been recorded on your MIS enabling its submission as in MSDS v2.0 monthly submissions?	Yes
5g. If you answered "no" to **5b**, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Current guideline for preterm birth does not explicitly include requirement for MDT discussion about the decision to resuscitate baby for women between 23 and 24 weeks
Current guideline for antenatal booking does not include formal risk assessment for preterm labour
AN corticosteroids recorded on MIS and available for MSDS v2.0 submission when functionality allows

Please fill in the following details	
Name of person completing the form	Susan Powley
Job Title	Matron for Governance
Hospital Name	Maidstone & Tunbridge Wells
Trust Name	MAIDSTONE AND TUNBRIDGE
Trust Code	RWF
SCN Area	South East Coast
Please provide information here if the drop-down boxes do not include the correct information for your trust	Free Text Box

36/46

Saving Babies Lives - Updates & Action Planning

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

Action Plan

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

Recommendation Number	Recommendation	Action plan to address recommendation	Action progress against plan	Action priority 1 = Critical (Under 1 Month) 2 = Essential (1-3 Months) 3 = Recommended (over 3 months)	Action owner	Baseline date	Forecast date	Closure date	Current status
1	Appoint Smoking Cessation Midwife	Complete recruitment process	Recruitment in progress	1	Alison Mendes / Rachel Thomas	20/01/2020	20/02/2020		G
2	Ensure compliance with CO monitoring and smoking cessation referrals	Audit compliance	Awaiting appointment of Smoking cessation and fetal Wellbeing Midwives (FWB)	2	Smoking Cessation Midwife	20/01/2020	20/03/2020		A
3	All maternity staff to have training on CO and VBA	GAP analysis of training among al maternity staff	Awaiting appointment of Smoking cessation and FWB midwives	2	Smoking Cessation Midwife	20/01/2020	20/03/2020		A
4	Appoint Fetal Monitoring Lead	Complete recruitment process	Recruitment process to commence	2	Susan Powley / Sarah Blanchard-Stow	20/01/2020	20/03/2020		A
5	Maternity care providers caring for women with FGR identified prior to 34+0 weeks having an agreed pathway for management which includes network fetal medicine	Review guideline to explicitly require network fetal medicine input	Amendment request to be made via appropriate pathway	2	Shazia Nazir	20/01/2020	20/03/2020		A
6	All findings of small for gestational age fetuses are recorded on your MIS	Monitor MIS to ensure that all birth weight centiles are recorded	Add to regular MIS quality assurance checks	2	Susan Powley	20/01/2020	20/03/2020		A
7	Assess all women at booking for the risk of preterm birth and stratify to low, intermediate and high-risk pathways as per the criteria in Appendix F of the SBLCB v2 of the	Amend antenatal booking guideline to include formal assessment of the risk of preterm birth	Guideline update request to be made via appropriate pathway	2	Alison Mendes	20/01/2020	20/03/2020		A
8	Hold a multidisciplinary discussion before birth between the neonatologist, obstetrician and the parents about the decision to resuscitate the baby for women	Amend preterm birth guideline to include explicit recommendation for MDT discussion	Guideline update request to be made via appropriate pathway	2	Fetal Wellbeing Midwives	20/01/2020	20/03/2020		A
9									
10									
11									
12									

37/46

Appendix 6

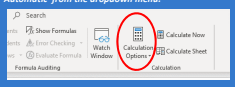
The purpose of this survey is to gather information on how much of current standard practice aligns with the interventions that make up the Saving Babies' Lives Care Bundle v2. Each intervention is made up of improvement activities. Improvement activities are the actions that make up the elements of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

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

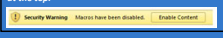
PLEASE CLICK THE ARROW TO USE THE DROP DOWN MENU TO SELECT YOUR ANSWERS.

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

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



In addition, please ensure that you select 'enable content' when prompted by the security dialog box at the top.



Survey Number	3rd
Survey Date	Sep-20

Reducing Stillbirths Care Bundle Elements

Element 1: Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) and referring to stop smoking service/specialist as appropriate

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

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

Element 2: Identification and surveillance of pregnancies with fetal growth restriction

Have any of your responses to questions 2aii to 2j below changed since the last survey? *If "yes", answer question 2ai and make your changes below. If "no" answer question 2ai and then go to Element 3.*	No
2ai. Are you meeting all requirements of the modified version Element 2 of the care bundle, which was changed due to the COVID-19 pandemic? NB The modified version of element 2 should only be implemented in the case of significant COVID-19 related staff shortages. *Irrespective of your answer please ensure section 2 is completed on the basis of your Standard Operating Procedure i.e. once recovery from COVID has been instigated.*	No
2aii. In the case of you having no significant COVID related staff shortages, do you meet all requirements of Element 2 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	No
2b. Are you carrying out any improvement activity designed to risk assess and manage babies at risk of Fetal Growth Restriction (FGR)? *If "yes", go to question 2c. If "no", please go to question 2j.*	Yes
2c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C of the care bundle or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	Yes
ii. Risk assessment and surveillance of women at increased risk of FGR, with triage of women at increased risk of FGR into an appropriate clinical pathway?	Yes
iii. Risk assessment and management of growth disorders in multiple pregnancy in compliance with NICE guidance or a variant agreed locally following advice from the provider's Clinical Network?	Yes
2d. Regarding women not undergoing serial ultrasound scan surveillance of fetal growth does your standard operating procedure (e.g. guidelines) include assessment performed using antenatal symphysis fundal height (SFH) charts by clinicians trained in their use?	Yes
2e. Does your standard operating procedure (guidelines) include differentiation between the management of the SGA and growth restricted fetus in accordance with the pathways and guidance outlined in version 2 of the Saving Babies Lives Care Bundle?	Yes
2f. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Following recommended guidance on the frequency of ultrasound review of estimated fetal weight (EFW) when SGA is detected, in accordance with appendix D of SBLCBv2 or a variant agreed locally following advice from the provider's Clinical Network?,	Yes
ii. Maternity care providers caring for women with FGR identified prior to 34+0 weeks having an agreed pathway for management which includes network fetal medicine input (for example, through referral or case discussion by phone)?	No
2g. Accepting the proviso that all management decisions should be agreed with the mother in the cases of fetuses <3rd centile and with no other concerning features does your standard operating procedure (e.g. guidelines) include the following principles: • Initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation. • Delivery <37+0 weeks can be considered if there are additional concerning features, but these risks must be balanced against the increased risk to the baby of birth at earlier gestations.	Yes
2h. Does your standard operating procedure (e.g. guidelines) include individualised care of fetuses between 3rd – 10th centile using a risk assessment including Doppler investigations, assessment for the presence of any other high risk features such as recurrent reduced fetal movements, and the mother's wishes ; and in the absence of any high risk features the offer of delivery or the initiation of induction of labour at 39+0 weeks?	Yes
2i. Have all findings of small for gestational age fetuses been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	Yes
2j. If you answered "no" to 2b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Element 3: Raising awareness amongst pregnant women of the importance of detecting and reporting reduced fetal movement (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM

Have any of your responses to the below questions in Element 3 changed since the last survey? *If "yes", make your changes below. If "no", go to Element 4.*	No
3a. Are you meeting all requirements of Element 3 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	Yes
3b. Are you carrying out any improvement activity designed to raise awareness among pregnant women of the importance of Reduced Fetal Movement (RFM)? *If "yes", please go to question 3c. If "no", please go to question 3h.*	Yes
3c. Do the improvement activities include providing pregnant mothers with information and an advice leaflet on reduced fetal movement based on current evidence, best practice and clinical guidelines,?	Yes
3d. Do the improvement activities include giving pregnant mothers this information by 28 weeks of pregnancy at the latest?	Yes
3e. Do the improvement activities include discussing RFM with pregnant mothers at every subsequent contact?	Yes
3f. Do the improvement activities include making use of an approved checklist to manage the care of pregnant woman who report reduced fetal movement, in line with national evidence-based guidance?	Yes

38/46

3g. Have all findings of reduced fetal movement been recorded on your MIS enabling their submission as Coded Clinical Entry in MSDS v2.0 monthly submissions?	Yes
3h. If you answered "no" to 3b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Element 4: Effective fetal monitoring during labour

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

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

Element 5: Reducing preterm births

Have any of your responses to questions 5aii to 5g changed since the last survey? *If "yes", answer question 5ai and make your changes below. If "no" answer question 5ai and then complete the final section.*	Yes
5ai. If you are using the modified version of element 5 of the care bundle, are you meeting all of the requirements? *Irrespective of your answer please complete the rest of section 5 on the basis of your SOP once recovery from COVID has been instigated.*	Not Applicable
5aii. Are you meeting all requirements of Element 5 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	Yes
5b. Are you carrying out any improvement activity designed around reducing the number of preterm births and optimising care when preterm delivery cannot be prevented? *If "yes", go to question 5c. If "no", please go to question 5g.*	Yes
5c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing all women at booking for the risk of preterm birth and stratifying to low, intermediate and high-risk pathways as per the criteria in Appendix F of the SBLCB v2 of the care bundle document; or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	Yes
ii. Assessing women with a history of preterm birth to determine whether this was associated with placental disease and a discussion about prescribing aspirin with the woman based upon her personalised risk assessment?	Yes
iii. All women being offered testing for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking, and a repeat MSU to confirm clearance following any positive culture?	Yes
iv. Having access to transvaginal cervix scanning (TVCS) and a clinician with an interest in preterm birth prevention with a clinical pathway for women at risk of preterm birth that is agreed with local commissioners (CCGs) following advice from the provider's clinical network (for example, UK Preterm Clinical Network guidance or NICE guidance)?	Yes
5d. Does your standard operating procedure (e.g. guidelines) include risk assessment and management in multiple pregnancy compliant with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network?	Yes
5e. Does your standard operating procedure (e.g. guidelines) include the following:	
i. every provider having referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories including access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage?	Yes
ii. women at imminent risk of preterm birth being offered transfer to a unit with appropriate and available neonatal cot facilities when safe to do so and as agreed by the relevant neonatal Operational Delivery Network (ODN)?	Yes
iii. offering Antenatal corticosteroids to women between 24+0 and 33+6 weeks, optimally at 48 hours before a planned birth?	Yes
iv. offering Magnesium Sulphate to women between 24+0 and 29+6 weeks of pregnancy; and considering offering Magnesium Sulphate for women between 30+0 and 33+6 weeks of pregnancy, who are in established labour or are having a planned preterm birth within 24 hours?	Yes
v. ensuring the neonatal team are involved when a preterm birth is anticipated, so that they have time to discuss options with parents prior to birth and to be present at the delivery?	Yes
vi. holding a multidisciplinary discussion before birth between the neonatologist, obstetrician and the parents about the decision to resuscitate the baby for women between 23 and 24 weeks of gestation?	Yes
5f. Have all instances of maternal antenatal administration of corticosteroids for fetal lung maturation been recorded on your MIS enabling its submission as in MSDS v2.0 monthly submissions?	Yes
5g. If you answered "no" to 5b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

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

39/46

Saving Babies Lives - Updates & Action Planning

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

Action Plan

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

Recommendation Number	Recommendation	Action plan to address recommendation	Action progress against plan	Action priority 1 = Critical (Under 1 Month) 2 = Essential (1-3 Months) 3 = Recommended (over 3 months)	Action owner	Baseline date	Forecast date	Closure date	Current status
1	Meeting requirement of modified version of Element 2	Continued review of scanning staffing situation and modification of pathway as required	Ongoing	2	R Thomas / A Teasdale				Green
2	All staff who care for women in labour are trained in use of CTG annually	Plan in place to catch up with backlog of training compliance caused by cessation of training due to COVID	Plan for additional sessions and on-line options in place	2	Fetal Wellbeing Midwives				Green
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

40/46

Appendix 7

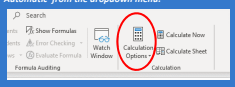
The purpose of this survey is to gather information on how much of current standard practice aligns with the interventions that make up the Saving Babies' Lives Care Bundle v2. Each intervention is made up of improvement activities. Improvement activities are the actions that make up the elements of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

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

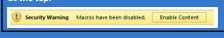
PLEASE CLICK THE ARROW TO USE THE DROP DOWN MENU TO SELECT YOUR ANSWERS.

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

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



In addition, please ensure that you select 'enable content' when prompted by the security dialog box at the top.



Survey Number	4th
Survey Date	Jan-21

Reducing Stillbirths Care Bundle Elements

Element 1: Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) and referring to stop smoking service/specialist as appropriate

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

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

Element 2: Identification and surveillance of pregnancies with fetal growth restriction

Have any of your responses to questions 2aii to 2j below changed since the last survey? *If "yes", answer question 2ai and make your changes below. If "no" answer question 2ai and then go to Element 3.*	No
2ai. Are you meeting all requirements of the modified version Element 2 of the care bundle, which was changed due to the COVID-19 pandemic? NB The modified version of element 2 should only be implemented in the case of significant COVID-19 related staff shortages. *Irrespective of your answer please ensure section 2 is completed on the basis of your Standard Operating Procedure i.e. once recovery from COVID has been instigated.*	No
2aii. In the case of you having no significant COVID related staff shortages, do you meet all requirements of Element 2 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	No
2b. Are you carrying out any improvement activity designed to risk assess and manage babies at risk of Fetal Growth Restriction (FGR)? *If "yes", go to question 2c. If "no", please go to question 2j.*	Yes
2c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C of the care bundle or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	Yes
ii. Risk assessment and surveillance of women at increased risk of FGR, with triage of women at increased risk of FGR into an appropriate clinical pathway?	Yes
iii. Risk assessment and management of growth disorders in multiple pregnancy in compliance with NICE guidance or a variant agreed locally following advice from the provider's Clinical Network?	Yes
2d. Regarding women not undergoing serial ultrasound scan surveillance of fetal growth does your standard operating procedure (e.g. guidelines) include assessment performed using antenatal symphysis fundal height (SFH) charts by clinicians trained in their use?	Yes
2e. Does your standard operating procedure (guidelines) include differentiation between the management of the SGA and growth restricted fetus in accordance with the pathways and guidance outlined in version 2 of the Saving Babies Lives Care Bundle?	Yes
2f. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Following recommended guidance on the frequency of ultrasound review of estimated fetal weight (EFW) when SGA is detected, in accordance with appendix D of SBLCBv2 or a variant agreed locally following advice from the provider's Clinical Network?,	Yes
ii. Maternity care providers caring for women with FGR identified prior to 34+0 weeks having an agreed pathway for management which includes network fetal medicine input (for example, through referral or case discussion by phone)?	No
2g. Accepting the proviso that all management decisions should be agreed with the mother in the cases of fetuses <3rd centile and with no other concerning features does your standard operating procedure (e.g. guidelines) include the following principles: • Initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation. • Delivery <37+0 weeks can be considered if there are additional concerning features, but these risks must be balanced against the increased risk to the baby of birth at earlier gestations.	Yes
2h. Does your standard operating procedure (e.g. guidelines) include individualised care of fetuses between 3rd – 10th centile using a risk assessment including Doppler investigations, assessment for the presence of any other high risk features such as recurrent reduced fetal movements, and the mother's wishes ; and in the absence of any high risk features the offer of delivery or the initiation of induction of labour at 39+0 weeks?	Yes
2i. Have all findings of small for gestational age fetuses been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	Yes
2j. If you answered "no" to 2b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Element 3: Raising awareness amongst pregnant women of the importance of detecting and reporting reduced fetal movement (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM

Have any of your responses to the below questions in Element 3 changed since the last survey? *If "yes", make your changes below. If "no", go to Element 4.*	No
3a. Are you meeting all requirements of Element 3 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	Yes
3b. Are you carrying out any improvement activity designed to raise awareness among pregnant women of the importance of Reduced Fetal Movement (RFM)? *If "yes", please go to question 3c. If "no", please go to question 3h.*	Yes
3c. Do the improvement activities include providing pregnant mothers with information and an advice leaflet on reduced fetal movement based on current evidence, best practice and clinical guidelines,?	Yes
3d. Do the improvement activities include giving pregnant mothers this information by 28 weeks of pregnancy at the latest?	Yes
3e. Do the improvement activities include discussing RFM with pregnant mothers at every subsequent contact?	Yes
3f. Do the improvement activities include making use of an approved checklist to manage the care of pregnant woman who report reduced fetal movement, in line with national evidence-based guidance?	Yes

41/46

3g. Have all findings of reduced fetal movement been recorded on your MIS enabling their submission as Coded Clinical Entry in MSDS v2.0 monthly submissions?	Yes
3h. If you answered "no" to 3b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Element 4: Effective fetal monitoring during labour

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

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

Challenge is conducting training in Covid climate, virtual sessions being facilitated for this and E Learning

Element 5: Reducing preterm births

Have any of your responses to questions 5aii to 5g changed since the last survey? *If "yes", answer question 5ai and make your changes below. If "no" answer question 5ai and then complete the final section.*	Click to Select
5ai. If you are using the modified version of element 5 of the care bundle, are you meeting all of the requirements? *Irrespective of your answer please complete the rest of section 5 on the basis of your SOP once recovery from COVID has been instigated.*	Not Applicable
5aii. Are you meeting all requirements of Element 5 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	Yes
5b. Are you carrying out any improvement activity designed around reducing the number of preterm births and optimising care when preterm delivery cannot be prevented? *If "yes", go to question 5c. If "no", please go to question 5g.*	Yes
5c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing all women at booking for the risk of preterm birth and stratifying to low, intermediate and high-risk pathways as per the criteria in Appendix F of the SBLCB v2 of the care bundle document; or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	Yes
ii. Assessing women with a history of preterm birth to determine whether this was associated with placental disease and a discussion about prescribing aspirin with the woman based upon her personalised risk assessment?	Yes
iii. All women being offered testing for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking, and a repeat MSU to confirm clearance following any positive culture?	Yes
iv. Having access to transvaginal cervix scanning (TVCS) and a clinician with an interest in preterm birth prevention with a clinical pathway for women at risk of preterm birth that is agreed with local commissioners (CCGs) following advice from the provider's clinical network (for example, UK Preterm Clinical Network guidance or NICE guidance)?	Yes
5d. Does your standard operating procedure (e.g. guidelines) include risk assessment and management in multiple pregnancy compliant with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network?	Yes
5e. Does your standard operating procedure (e.g. guidelines) include the following:	
i. every provider having referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories including access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage?	Yes
ii. women at imminent risk of preterm birth being offered transfer to a unit with appropriate and available neonatal cot facilities when safe to do so and as agreed by the relevant neonatal Operational Delivery Network (ODN)?	Yes
iii. offering Antenatal corticosteroids to women between 24+0 and 33+6 weeks, optimally at 48 hours before a planned birth?	Yes
iv. offering Magnesium Sulphate to women between 24+0 and 29+6 weeks of pregnancy; and considering offering Magnesium Sulphate for women between 30+0 and 33+6 weeks of pregnancy, who are in established labour or are having a planned preterm birth within 24 hours?	Yes
v. ensuring the neonatal team are involved when a preterm birth is anticipated, so that they have time to discuss options with parents prior to birth and to be present at the delivery?	Yes
vi. holding a multidisciplinary discussion before birth between the neonatologist, obstetrician and the parents about the decision to resuscitate the baby for women between 23 and 24 weeks of gestation?	Yes
5f. Have all instances of maternal antenatal administration of corticosteroids for fetal lung maturation been recorded on your MIS enabling its submission as in MSDS v2.0 monthly submissions?	Yes
5g. If you answered "no" to 5b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Please fill in the following details	
Name of person completing the form	Alison Costello
Job Title	Fetal Well-being Midwife
Hospital Name	MTW NHS Trust
Trust Name	MAIDSTONE AND TUNBRIDGE
Trust Code	RWF
SCN Area	South East Coast
Please provide information here if the drop-down boxes do not include the correct information for your trust	Free Text Box

42/46

Saving Babies Lives - Updates & Action Planning

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

Action Plan

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

Recommendation Number	Recommendation	Action plan to address recommendation	Action progress against plan	Action priority 1 = Critical (Under 1 Month) 2 = Essential (1-3 Months) 3 = Recommended (over 3 months)	Action owner	Baseline date	Forecast date	Closure date	Current status
1	Meeting requirement of modified version of Element 2	Continued review of scanning staffing situation and modification of pathway as required	Ongoing	2	R Thomas / A Teasdale				Green
2	All staff who care for women in labour are trained in use of CTG annually	Plan in place to catch up with backlog of training compliance caused by cessation of training due to COVID	Plan for additional sessions and on-line options in place	2	Fetal Wellbeing Midwives				Green
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

43/46

Appendix 8

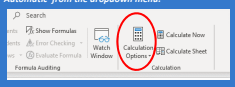
The purpose of this survey is to gather information on how much of current standard practice aligns with the interventions that make up the Saving Babies' Lives Care Bundle v2. Each intervention is made up of improvement activities. Improvement activities are the actions that make up the elements of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

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

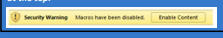
PLEASE CLICK THE ARROW TO USE THE DROP DOWN MENU TO SELECT YOUR ANSWERS.

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

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



In addition, please ensure that you select 'enable content' when prompted by the security dialog box at the top.



Survey Number	5th
Survey Date	Apr-21

Reducing Stillbirths Care Bundle Elements

Element 1: Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) and referring to stop smoking service/specialist as appropriate

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

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

Element 2: Identification and surveillance of pregnancies with fetal growth restriction

Have any of your responses to questions 2aii to 2j below changed since the last survey? *If "yes", answer question 2ai and make your changes below. If "no" answer question 2ai and then go to Element 3.*	No
2ai. Are you meeting all requirements of the modified version Element 2 of the care bundle, which was changed due to the COVID-19 pandemic? NB The modified version of element 2 should only be implemented in the case of significant COVID-19 related staff shortages. *Irrespective of your answer please ensure section 2 is completed on the basis of your Standard Operating Procedure i.e. once recovery from COVID has been instigated.*	Not Applicable
2aii. In the case of you having no significant COVID related staff shortages, do you meet all requirements of Element 2 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	No
2b. Are you carrying out any improvement activity designed to risk assess and manage babies at risk of Fetal Growth Restriction (FGR)? *If "yes", go to question 2c. If "no", please go to question 2j.*	Yes
2c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C of the care bundle or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	Yes
ii. Risk assessment and surveillance of women at increased risk of FGR, with triage of women at increased risk of FGR into an appropriate clinical pathway?	Yes
iii. Risk assessment and management of growth disorders in multiple pregnancy in compliance with NICE guidance or a variant agreed locally following advice from the provider's Clinical Network?	Yes
2d. Regarding women not undergoing serial ultrasound scan surveillance of fetal growth does your standard operating procedure (e.g. guidelines) include assessment performed using antenatal symphysis fundal height (SFH) charts by clinicians trained in their use?	Yes
2e. Does your standard operating procedure (guidelines) include differentiation between the management of the SGA and growth restricted fetus in accordance with the pathways and guidance outlined in version 2 of the Saving Babies Lives Care Bundle?	Yes
2f. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Following recommended guidance on the frequency of ultrasound review of estimated fetal weight (EFW) when SGA is detected, in accordance with appendix D of SBLCBv2 or a variant agreed locally following advice from the provider's Clinical Network?,	Yes
ii. Maternity care providers caring for women with FGR identified prior to 34+0 weeks having an agreed pathway for management which includes network fetal medicine input (for example, through referral or case discussion by phone)?	No
2g. Accepting the proviso that all management decisions should be agreed with the mother in the cases of fetuses <3rd centile and with no other concerning features does your standard operating procedure (e.g. guidelines) include the following principles: • Initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation. • Delivery <37+0 weeks can be considered if there are additional concerning features, but these risks must be balanced against the increased risk to the baby of birth at earlier gestations.	Yes
2h. Does your standard operating procedure (e.g. guidelines) include individualised care of fetuses between 3rd – 10th centile using a risk assessment including Doppler investigations, assessment for the presence of any other high risk features such as recurrent reduced fetal movements, and the mother's wishes ; and in the absence of any high risk features the offer of delivery or the initiation of induction of labour at 39+0 weeks?	Yes
2i. Have all findings of small for gestational age fetuses been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	Yes
2j. If you answered "no" to 2b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Element 3: Raising awareness amongst pregnant women of the importance of detecting and reporting reduced fetal movement (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM

Have any of your responses to the below questions in Element 3 changed since the last survey? *If "yes", make your changes below. If "no", go to Element 4.*	No
3a. Are you meeting all requirements of Element 3 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	Yes
3b. Are you carrying out any improvement activity designed to raise awareness among pregnant women of the importance of Reduced Fetal Movement (RFM)? *If "yes", please go to question 3c. If "no", please go to question 3h.*	Yes
3c. Do the improvement activities include providing pregnant mothers with information and an advice leaflet on reduced fetal movement based on current evidence, best practice and clinical guidelines,?	Yes
3d. Do the improvement activities include giving pregnant mothers this information by 28 weeks of pregnancy at the latest?	Yes
3e. Do the improvement activities include discussing RFM with pregnant mothers at every subsequent contact?	Yes
3f. Do the improvement activities include making use of an approved checklist to manage the care of pregnant woman who report reduced fetal movement, in line with national evidence-based guidance?	Yes

44/46

3g. Have all findings of reduced fetal movement been recorded on your MIS enabling their submission as Coded Clinical Entry in MSDS v2.0 monthly submissions?	Yes
3h. If you answered "no" to 3b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Element 4: Effective fetal monitoring during labour

Have any of your responses to the below questions in Element 4 changed since the last survey? *If "yes", make your changes below. If "no", go to Element 5.*	Yes
4a. Are you meeting all requirements of Element 4 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below. Please take extra care to ensure your percentage of trained staff in question 4d is up to date.*	No
4b. Are you carrying out any improvement activities designed around effective fetal monitoring during labour? *If "yes", go to question 4c. If "no", please go to question 4h.*	Yes
4c. Do your improvement activities include annual multidisciplinary training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation for staff who care for women in labour? *If "yes", go to question 4d. If "no", please go to question 4e.*	Yes
4d. What is the percentage of staff who care for women in labour that have undertaken this training in the last 12 months?	Yes 70% to 79%
4e. Do you have a system that, irrespective of place of birth, assesses risk at the onset of labour to determine the most appropriate fetal monitoring method, as described in SBLCBv2?	Yes
4f. Do your improvement activities include a review at least every hour of fetal well-being incorporating the following:	
i. CTG or Intermittent Auscultation;	Yes
ii. reassessment of fetal risk factors	Yes
iii. a fresh eyes/buddy system	Yes
iv. clear guideline for escalation if concerns are raised through the use of a structured process?	Yes
4g. Do your improvement activities include identifying a Fetal Monitoring Lead for a minimum of 0.4WTE per consultant led unit during which time it is their responsibility to improve the standard of intrapartum risk assessment and fetal monitoring?	Yes
4h. If you answered "no" to 4b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Element 5: Reducing preterm births

Have any of your responses to questions 5aii to 5g changed since the last survey? *If "yes", answer question 5ai and make your changes below. If "no" answer question 5ai and then complete the final section.*	No
5ai. If you are using the modified version of element 5 of the care bundle, are you meeting all of the requirements? *Irrespective of your answer please complete the rest of section 5 on the basis of your SOP once recovery from COVID has been instigated.*	Not Applicable
5aii. Are you meeting all requirements of Element 5 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	Yes
5b. Are you carrying out any improvement activity designed around reducing the number of preterm births and optimising care when preterm delivery cannot be prevented? *If "yes", go to question 5c. If "no", please go to question 5g.*	Yes
5c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing all women at booking for the risk of preterm birth and stratifying to low, intermediate and high-risk pathways as per the criteria in Appendix F of the SBLCB v2 of the care bundle document; or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	Yes
ii. Assessing women with a history of preterm birth to determine whether this was associated with placental disease and a discussion about prescribing aspirin with the woman based upon her personalised risk assessment?	Yes
iii. All women being offered testing for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking, and a repeat MSU to confirm clearance following any positive culture?	Yes
iv. Having access to transvaginal cervix scanning (TVCS) and a clinician with an interest in preterm birth prevention with a clinical pathway for women at risk of preterm birth that is agreed with local commissioners (CCGs) following advice from the provider's clinical network (for example, UK Preterm Clinical Network guidance or NICE guidance)?	Yes
5d. Does your standard operating procedure (e.g. guidelines) include risk assessment and management in multiple pregnancy compliant with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network?	Yes
5e. Does your standard operating procedure (e.g. guidelines) include the following:	
i. every provider having referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories including access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage?	Yes
ii. women at imminent risk of preterm birth being offered transfer to a unit with appropriate and available neonatal cot facilities when safe to do so and as agreed by the relevant neonatal Operational Delivery Network (ODN)?	Yes
iii. offering Antenatal corticosteroids to women between 24+0 and 33+6 weeks, optimally at 48 hours before a planned birth?	Yes
iv. offering Magnesium Sulphate to women between 24+0 and 29+6 weeks of pregnancy; and considering offering Magnesium Sulphate for women between 30+0 and 33+6 weeks of pregnancy, who are in established labour or are having a planned preterm birth within 24 hours?	Yes
v. ensuring the neonatal team are involved when a preterm birth is anticipated, so that they have time to discuss options with parents prior to birth and to be present at the delivery?	Yes
vi. holding a multidisciplinary discussion before birth between the neonatologist, obstetrician and the parents about the decision to resuscitate the baby for women between 23 and 24 weeks of gestation?	Yes
5f. Have all instances of maternal antenatal administration of corticosteroids for fetal lung maturation been recorded on your MIS enabling its submission as in MSDS v2.0 monthly submissions?	Yes
5g. If you answered "no" to 5b, are you planning on introducing this type of intervention / improvement activity?	Not Applicable

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

Please fill in the following details	
Name of person completing the form	Alison Costello
Job Title	Fetal Well-being Midwife Band 7
Hospital Name	Tunbridge Wells Hospital at Pembury
Trust Name	MAIDSTONE AND TUNBRIDGE
Trust Code	RWF
SCN Area	South East Coast
Please provide information here if the drop-down boxes do not include the correct information for your trust	Free Text Box

45/46

Saving Babies Lives - Updates & Action Planning

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

Action Plan

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

Recommendation Number	Recommendation	Action plan to address recommendation	Action progress against plan	Action priority 1 = Critical (Under 1 Month) 2 = Essential (1-3 Months) 3 = Recommended (over 3 months)	Action owner	Baseline date	Forecast date	Closure date	Current status
1	Meeting requirement of modified version of Element 2	Continued review of scanning staffing situation and modification of pathway as required	Ongoing	2	R Thomas		Oct-21		Green
2	All staff who care for women in labour are trained in use of CTG annually	Plan in place to catch up with backlog of training compliance caused by cessation of training due to COVID	Plan for additional sessions and on-line options in place	2	Fetal Wellbeing Midwives		Oct-21		Green
3	Meeting requirement of modified version of element 1 regarding CO monitoring	Recommencing CO monitoring to full pre-covid level	CO monitoring at booking appoitments already in place for 4 months, recommencing at other antenatal contacts by the end of May	1	SIP Midwife Merja Hart		Jul-21		Green
4									
5									
6									
7									
8									
9									
10									
11									
12									

46/46