Report To:	Group Board		
Date of Meeting:	N/A		
Report Title:	University Hospitals Bristol and Weston (UHBW) Maternity Incentive Scheme Year Seven Assurance Report		
Report Author:	Sarah Windfeld, Director of Midwifery and Nursing Martin Gargan, Clinical Director, Women and Children's Division Jo Mockler, Quality and Patient Safety Manager		
Report Sponsor:	Prof. Steve Hams, Group Chief Nursing and Improvement Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	✓		
	The purpose of this report is to provide assurance that UHBW's Perinatal Services are compliant with each of the ten safety actions within the NHS Resolution Maternity Incentive Scheme Year 7.		

Key Points to Note *(Including any previous decisions taken)*

The scheme financially rewards Trusts that meet ten safety actions designed to improve the delivery of best practice in maternity and neonatal services.
UHBW has been able to demonstrate 100% compliance against the standards for CNST in previous six years and received the full rebate.

UHBW is submitting a position of compliance, with supporting evidence against each of the ten safety actions outlined within the NHS Resolution Maternity Incentive Scheme (MIS) Year 7.

An independent audit of UHBW's evidence was undertaken by ASW Assurance between the 9th and 18th of December 2025, a copy of their audit findings is provided in Appendix 1.

In addition, a review of UHBW's evidence took place on 18th December 2025 which was inclusive of Executive and Non-Executive Directors. The position of compliance against each safety action and supporting evidence was approved noting that the February 2026 Trust Board minutes would complete the remaining MIS evidence requirements.

The Trust Board are asked to consider and approve the following outstanding requirements:

Safety Action 1: The ASW Assurance auditors identified that the reporting oversight for UHBW's Quarterly PMRT Report did not meet MIS technical guidance as the oversight of UHBW's Quarterly PMRT data was provided by two subcommittees of Board and not reviewed by the Trust Board directly. A mapping exercise for assurance was undertaken and shared at the evidence review on the 18th of December with the Executive and Non-Executive Directors.

The Executive and Non-Executive Directors were of the collective opinion that there had been sufficient oversight of the PMRT Report by members of the Trust Board during the reporting period. For additional assurance, the three PMRT reports covering the period January – September 2025 have been uploaded to Convene and shared with all Board Members.

The Board are asked to agree that members have had sufficient sight of PMRT information during MIS Year 7 and that compliance with Safety Action 1 has been achieved.

Safety Action 4: Overall compliance with Safety Action 4 has been met.

During their review of the evidence for Safety Action 4 the ASW Assurance auditors noted that UHBW's action plan relating to our Neonatal Nursing Workforce has been in place for several years. They propose that the Trust Board should assess the safety implications of not meeting BAPM neonatal staffing standards and determine an appropriate timeframe for maintaining an action plan to achieve compliance with the BAPM nursing staffing standards.

Safety Action 6: UHBW ask the Trust Board to note that a review of UHBW's compliance with Saving Babies Lives was completed by the LMNS/ICB at the beginning of December 2025. This verified that an overall compliance of 87% had been fully implemented as of the end of Quarter two, 2025 to 2026. This is an increase from the percentage of interventions achieved by Quarter two in the previous year.

Progress has also been demonstrated through improving robustness of audit programmes (all notes now audited), in addition several stretch targets have being achieved.

Compliance for Safety Action 6 has been achieved.

Safety Action 7: The ASW Assurance auditors identified that four of the Terms of Reference for Trust safety and governance meetings did not specify the MNVP Lead a quorate member, this related to the Women's Governance Group, Clinical Effectiveness Group, Maternity Safety Champions Group and the Women's Services Experience Group. UHBW can confirm that following the ASW review all four groups have revised their Terms of Reference to ensure that the MNVP is reflected as a quorate member

Compliance for Safety Action 7 has been achieved.

Safety Action 10: It has been recommended by the ASW Assurance auditors that additional evidence in the form of screen shots demonstrating completion of the early notification (EN) reporting system be submitted for MIS Year 8.

Compliance for Safety Action 10 has been achieved.

Strategic and Group Model Alignment

This report forms part of the divisional reporting requirement which supports the delivery of safer maternity care. This reflects the Trusts priority of Patient Safety within the Patient First True North Strategy.

The NHS Resolution Maternity Incentive Scheme is part of the Clinical Negligence Scheme for Trusts (CNST) and now in Year 7 of publication. The scheme incentivises ten maternity safety actions, Trusts that can demonstrate they have achieved all ten of the safety actions will recover the element of their contribution to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

University Hospitals Bristol and Weston and North Bristol NHS Trust are reviewing reporting and governance processes within the Maternity Incentive Scheme to ensure alignment across both Trusts.
Risks and Opportunities
The risks associated with this report include: 33 / 3553 / 4628
Recommendation
This report is for **Approval** • This report is for **Approval.** • Attached CNST MIS Board Declaration Form **for Board Sign Off**
History of the paper (details of where paper has <u>previously</u> been received)
N/A

Appendices:	1. ASW Assurance Report 2. CNST MIS Board Declaration Form

University Hospitals Bristol and Weston (UHBW) Maternity Incentive Scheme Year Seven Assurance Report

1. Purpose

1.1 The purpose of this paper is to share the requirements of the Maternity Incentive Scheme Year 7 with the Trust and ICB Governance Processes inclusive of Trust Board, Trust Chief Executive Officer and ICB Accountable Officer sign off.

1.2 This paper will inform Trust Board of the Declaration of Compliance against each of the safety actions and their sub requirements, access to the supporting evidence folder is available on request.

2. Background

2.1 The Maternity Incentive Scheme is part of the Clinical Negligence Scheme for Trusts (CNST) that is now in Year 7. The scheme incentivises ten maternity safety actions, Trusts that can demonstrate they have achieved all ten of the safety actions will recover the element of their contribution to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

2.2 Trusts that do not achieve compliance for all ten safety actions will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help make progress against actions they have not achieved.

2.3 The scheme uses a self-assessment declaration form that must be signed off by the Chief Executive Officer to confirm the Trust Board are satisfied with the evidence provided to demonstrate achievement of meeting each safety action.

2.4 The Trust is also responsible for ensuring the Accountable Officer for the ICB is appraised of the MIS safety action evidence.

2.5 The relevant reporting period or MIS Year 7 is 1st December 2024 to 30th November 2025. The board declaration form must be sent to NHS Resolution before 12 noon on 3rd March 2026.

2.6 UHBW has been able to demonstrate 100% compliance against the standards for CNST in previous six years and received the full rebate.

3. Declaration of Compliance

3.1 UHBW is declaring compliance with each of the ten safety actions.

3.2 This position is supported following an in-depth review of the evidence through:

- An independent audit of UHBW's evidence by ASW Assurance conducted between the 9th and 18th of December 2025.
- An in-depth review of UHBW's evidence by the Executive and Non-Executive Directors on the 18th of December 2025.

4. Safety Action 1: Are you using the Perinatal Mortality Review Tool (PMRT) to review deaths that occurred between 1 December 2024 to 30 November 2025 to the required standard?

4.1 UHBW are declaring compliance with Safety Action 1, all deadlines with the PMRT have been achieved and this will be externally verified via MBRRACE-UK.

4.2 The quarterly PMRT reports have been discussed with the Board Level Safety Champion and received by the Trust Executive Committee. In addition, PMRT data is shared quarterly within the Maternity and Neonatal Safety Report shared with the Quality Outcomes Committee.

4.3 The ASW Assurance auditors identified that the reporting oversight for UHBW's Quarterly PMRT Report did not meet MIS technical guidance as the oversight of UHBW's Quarterly PMRT data was provided by two subcommittees of Board and not reviewed by the Trust Board directly. A mapping exercise for assurance was undertaken and shared at the evidence review on the 18th of December with the Executive and Non-Executive Directors

On review of this mapping exercise the Executive and Non-Executive Directors were of the collective opinion that there had been sufficient oversight of the PMRT Report by members of the Trust Board during the reporting period.

For additional assurance, the three PMRT reports covering the period January – September 2025 have been uploaded to Convene and shared with all Board Members.

4.4 The ASW Assurance team highlighted the contents of the Trust's PMRT as an example of best practice and plan to share this as part of a notable practice guide for other trusts.

4.5 The Board are asked to agree that members have had sufficient sight of PMRT information during MIS Year 7 and that compliance with Safety Action 1 has been achieved.

5. Safety Action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

5.1 UHBW has received confirmation from NHS Digital that safety action 2 has been achieved using the July 2025 data submission.

6. Safety Action 3: Can you demonstrate that you have Transitional Care (TC) services are in place and you are undertaking a quality improvement to minimise separation of parents and their babies?

6.1 UHBW are declaring compliance with safety action 3, the neonatal unit is compliant with the British Association of Perinatal Medicine, Transition Care Framework for practice (babies born 34+0 to 36+6).

6.2 UHBW opted to continue and expand with the Transitional Care quality improvement project (QI) which was established in MIS Year 6 with the aim to reduce admission to NICU for Hyperbilirubinemia. Updates have been shared on a regular basis with both the Local Maternity and Neonatal System and Board Safety Champions. The project was registered as a QI project with the Trust during MIS Year 6.

7. Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

7.1 UHBW are declaring compliance with all clinical workforce requirements within Safety Action 4 for obstetric, anaesthetic, neonatal medical and neonatal nursing workforce.

7.2 An audit of short-term locums was undertaken from February to August 2025 to ensure that all short-term locums employed by the unit met the Royal College of Obstetricians

and Gynaecologist (RCOG) criteria (middle grade employed and 2 weeks or less), the audit demonstrated that all short-term locums met at least one of three criteria.

7.3 An audit of long-term locums was conducted during the same period to ensure that all long-term locums employed by the unit fully met the RGOC criteria for engagement of long-term locums, the audit demonstrated that all long-term locums met the necessary requirements.

7.4 Trusts are required to meet at least 80% compliance for consultant attendance in person to the clinical situations listed in the RCOG workforce document for a minimum of 80% of applicable situations. Trusts are required to demonstrate a minimum of 80% compliance through audit of any 3-month period between February and November 2025. UHBW completed a full audit between April and June 2025, this demonstrated compliance in excess of 97% during each of these months.

In addition to this detailed audit UHBW monitor compliance via exception reporting on the Perinatal Quality Surveillance Matrix, there is a SOP in place should any episodes of non-attendance occur.

7.5 The Anaesthetic Medical workforce meets the required Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1.

7.6 The Neonatal Medical Staffing is in line with the British Association of Perinatal Medicine (BAPM) standards.

7.7 The Neonatal Nursing Workforce is not in line with the British Association of Perinatal Medicine (BAPM) standards. The unit remains compliant with the safety action through the associated action plan, demonstrating progress from MIS Year 6 in working towards a position of compliance.

7.8 The ASW Assurance auditors noted: The Trust is currently not compliant with BAPM nursing workforce standards, an action plan has been in place for several years to address this non-compliance, specifically focusing on the Neonatal Nursing workforce and the need for additional staff who are Qualified in Speciality (QIS) trained. Additionally, a risk relating to the Neonatal Nursing workforce has been recorded on the Trust's risk register for the past 11 years.

The ASW Assurance auditors acknowledged that there is a national shortage of QIS trained nurses and recognised that to address this the Southwest Neonatal Network has introduced a regional QIS programme, which takes approximately 2 to 2.5 years to complete. Whilst the Trust currently has nurses enrolled in this program this alone will not resolve workforce challenges due to ongoing staff turnover.

Considering recent developments in other local units, The ASW Assurance auditors recommend that the Trust Board should assess the safety implications of not meeting BAPM neonatal staffing standards and determine an appropriate timeframe for maintaining an action plan to achieve compliance with the BAPM nursing staffing standards.

8. Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

8.1 UHBW are declaring compliance with Safety Action 5, the funded establishment is in line with the most recent Birthrate Plus recommended establishment (Birthrate Plus Report July 2022). UHBW have recently received a new Birthrate Plus report and work to meet the updated requirements is now in progress.

8.2 Supernumerary status of the labour ward co-ordinator and the provision of one-to-one care of all women in labour have both been maintained at 100% throughout the MIS relevant reporting period.

8.3 The six-monthly midwifery staffing oversight report covering staffing and safety issues was shared with Trust Board (Quality and Outcomes Committee) in line with MIS requirements.

9. Safety Action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies Lives Care Bundle Version 3?

9.1 UHBW are declaring compliance with Safety Action 6, this is evidenced through the Saving Babies Lives Implementation Tool and quarterly improvement discussions with the ICB.

9.2 The Maternity Incentive Scheme Year 7 required the ICB to confirm it is assured that all best endeavours and sufficient progress have been made towards full implementation in line with the locally agreed improvement trajectory.

9.3 A review of UHBW's compliance with Saving Babies Lives was completed by the LMNS/ICB at the beginning of December 2025. This verified that an overall compliance of 87% had been fully implemented as of the end of Quarter two, 2025 to 2026. This is an increase from the percentage of interventions achieved by Quarter two in the previous year.

9.4 Progress has also been demonstrated through improving robustness of audit programmes (all notes now audited), in addition a number of stretch targets have being achieved.

10. Safety Action 7: Listen to women, parents and families using maternity and neonatal services and co-produce services with users.

10.1 UHBW are declaring compliance with Safety Action 7, a funded, user led Maternity and Neonatal Voices Partnership (MNVP) is in place in line with the Three-Year Delivery Plan and MNVP Guidance.

10.2 There is an action plan which has been co-produced (inclusive of a joint review of the free text) with the MNVP in response to the annual CQC Maternity Survey, progress with the action plan has been monitored via the Safety Champions and Local Maternity and Neonatal System.

10.3 The ASW Assurance auditors identified that four of the Terms of Reference for Trust safety and governance meetings did not specify the MNVP Lead a quorate member, this related to the Women's Governance Group, Clinical Effectiveness Group, Maternity Safety Champions Group and the Women's Services Experience Group. UHBW can confirm that following the ASW review all four groups have revised their Terms of Reference to ensure that the MNVP is reflected as a quorate member.

11. Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

11.1 UHBW is declaring compliance with Safety Action 8, all staff groups as outlined within the Maternity Incentive Scheme have achieved at least 90% compliance for Fetal Monitoring

and Surveillance, Maternity Emergencies and Multi-professional training and Neonatal Basic Life Support.

12. Safety Action 9: Can you demonstrate that here is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

12.1 UHBW are declaring compliance with Safety Action 9, the Perinatal Quality Surveillance Model (PQSM) is embedded and presented at Quality and Outcomes Committee at least on a quarterly basis by the Director of Midwifery and Nursing. The Trust has a Patient Safety Incident Response Plan (PSIRP) in place. The Maternity and Neonatal Board Safety Champions work closely with and support the perinatal quadrumvirate. The ASW Assurance team highlighted the Trust's use of the national PQSM/PQOM which is considered best practice.

12.2 There is evidence of collaboration with the Local Maternity and Neonatal System including shared learning and trust level intelligence, via LMNS forums.

12.3 The Trusts Claims Scorecard is reviewed alongside incident and complaint data and discussed with Board Level Safety Champions on a quarterly basis. The ASW Assurance team highlighted the Trust's Triangulation Report as an example of best practice and plan to share this as part of a notable practice guide for other trusts.

12.4 A progress update on the Perinatal Culture and Leadership Programme was shared with Trust Board in October 2025.

13. Safety Action 10

13.1 UHBW are declaring compliance with Safety Action 10, all qualifying cases have been reported to Maternity and Newborn Safety Investigations (MNSI) programme and the NHSR Early Notification Scheme from 1 December 2024 to 30 November 2025. Duty of Candour letters have been sent to families covering required information and no accessible information requests have been received. Trust Board have oversight of MNSI and EN incidents and sight of compliance with the statutory duty of candour.

13.2 It has been recommended by the ASW Assurance auditors that additional evidence in the form of screen shots demonstrating completion of the early notification (EN) reporting system be submitted for MIS Year 8.

14. Summary

14.1 UHBW are declaring compliance with the Maternity Incentive Scheme Year 7, the proposed position follows monthly divisional scrutiny and an in-depth review of the evidence by both ASW Assurance and the divisional management team, the Group Chief Nursing and Improvement Officer and the Non-Executive Director for North Bristol Trust (NBT) plus Board Level Safety Champions.

15. Recommendations

This report is for **Approval.**
Attached CNST MIS Board Declaration Form **for Board Sign Off**

The Board is recommended to sign off the CNST MIS Board Declaration Form based on the above evidence.

ASW Assurance
Sharing excellence in governance

NHS

University Hospitals Bristol and Western NHS Foundation Trust
Final Internal Audit Report: CNST Year 7 - Maternity Evidence Review

Report Reference: UHBW20/26
January 2026

Distribution List (for action):

- Sarah Dodds, Director of Nursing
- Sarah Windfeld, Director of Nursing and Midwifery
- Jo Mockler, Quality & Patient Safety Manager

Additional Copies (final report, for information):

- Sue Balcombe, Chair of the Quality and Outcomes Committee
- Trust Secretariat
- Shane Devlin, Chief Executive, BNSSG Integrated Care Board
- Layla Green, Deputy Director Safety & Quality (Maternity & Neonatology) BNSSG Integrated Care Board

Executive Summary

AUDIT BACKGROUND, SCOPE AND OBJECTIVES

Background

As part of the 2025/26 Audit and Assurance Plan, we have reviewed the evidence being collated within the perinatal services to support the submission against the criteria set out in the NHS Resolution's guidance for the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) – year seven; to provide an independent assessment of the quality of the evidence being presented, prior to the Board's review and the planned submission to NHS Resolution by 3 March 2026.

MIS continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

The original ten Safety Actions were developed in 2017 and have been updated annually by a Collaborative Advisory Group (CAG) including NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC), the Maternity and Newborn Safety Investigation Programme (MNSI) and service user representatives.

Trusts that can demonstrate they have achieved all ten of the Safety Actions in full will recover their element of the contribution relating to the CNST MIS fund and this will be returned to the source of the initial CNST payment. They will also receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a smaller discretionary payment from the scheme to help to make progress against actions they have not achieved.

The Local Maternity and Neonatal System (LMNS) plays a key role in supporting and providing assurance to organisations across an Integrated Care System (ICS). The LMNS ensures that a Trust is able to demonstrate required safety and quality standards, support development of evidence and oversight through system meetings, and sharing of learning that supports the Trust's overall declaration of compliance with CNST MIS Year 7.

LMNS leads receive and validate the Trusts' progress on Safety Action 6, implementation of the Saving Babies' Lives Care Bundle (SBLCBv3) through structured quarterly meetings and assesses whether the organisation is anticipated to achieve the locally agreed improvement trajectory. Similarly, for Safety Action 7, the LMNS has a responsibility for commissioning System Maternity Neonatal Voices Partnership with formal job descriptions, remuneration, and governance structures.

To strengthen rigor to ensure appropriate levels of assurance, representatives from the LMNS have attended all feedback sessions for each Safety Action as part of this audit. This has enabled a higher level of candour and transparency between the System and Trust, which will support the Integrated Care Board (ICB) sign off of the Trusts declaration of compliance.

The Trust is due to submit the self-assessment to the Board in February 2026 prior to submission to NHS Resolutions by 12 noon on the 3 March 2026.

Objectives and Scope of the Audit

We reviewed evidence collated within the perinatal services to support the submission against the criteria set out in the NHS Resolution's guidance for the MIS – year seven; to provide an independent assessment of the quality of the evidence being presented, prior to the Board's review and the planned submission to NHS Resolution by 12 noon on the 3 March 2026.

The review was conducted, as a desktop exercise, in conjunction with reviews for Torbay & South Devon Healthcare NHS Foundation Trust, University Hospitals Plymouth NHS Trust and Royal Devon University Healthcare NHS Foundation Trust. The review was undertaken during the period 8 – 19 December 2025 for all Trusts involved. Following the review of each Safety Action we met with the Safety Action Lead/ Senior Responsible Officer to go through our queries and any additional information that will need to be collated by the Trust before the declaration. Following each of these meetings we provided by email, a summary of the outcome and a list of additional evidence required.

OVERALL CONCLUSION

Based on the evidence provided in support of the Trust's CNST MIS self–assessment, it is our opinion that at the time of undertaking this review, there is adequate evidence to support 'full compliance' with seven of the ten Safety Actions. We have provided a rating of 'non-compliant' for one of the Safety Actions (SA) as follows:

- **Safety Action 1 -** *Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?*

Our review of evidence to support SA1 found that current reporting on PMRT does not meet evidential and technical guidance requirements. While PMRT data is regularly reported to the Executive Committee, MIS guidance requires quarterly reporting to the Trust Board, which cannot be delegated to a subcommittee. Board papers currently include PMRT numbers within the IPR but lack confirmation that all eligible cases were reviewed, compliance with required standards, and details of learning and action plans. This means the Board has not received sufficient assurance in line with the guidance.

Going forward, the Trust should ensure all required PMRT data is explicitly reported to the Board quarterly. If using the NHSE PQOM template, missing PMRT elements must be added. The report currently provided to the Executive Committee is considered sufficient and should be submitted to the Board.

For CNST declaration, we recommend mapping where PMRT information has been reported, its frequency, and which Board members attended. This mapping should accompany the audit report. Ultimately, it is for the Board to determine whether they are adequately assured that this requirement has been met, and therefore determine whether the Trust is compliant with this Safety Action and overall CNST requirements.

We have assessed the remaining two Safety Actions as *'requiring further explanation' (*including provision of additional detail and/or adjustment prior to submission). Where additional evidence is made available prior to submission of the assessment to NHS Resolution, it is possible that these Safety Actions could be re-assessed to demonstrate full compliance with the Safety Action element.

It is important to note that NHS Resolution has indicated significant changes for the Year 8 assessment. Until the new guidance is issued (expected in April 2026), the Trust should continue to follow the Year 7 MIS guidance.

Our assessment of each Safety Action is summarised in the table below:

	Criteria for the Maternity Safety Strategy CNST	Trust Assessment	Our Assessment
1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?	✓	✗
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	✓	✓
3	Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?	✓	✓
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	✓	✓
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	✓	✓
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version 3?	✓	−
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	✓	−
8	Can you evidence the following three elements of local training plans and 'in-house', one day multi-professional training?	✓	✓
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	✓	✓
10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?	✓	✓

Key for the Assessment Table above and throughout the report

Rating	Description
✓	Evidence provided is appropriate or requires minimal additional evidence. Any issues that were identified are not significant.
−	Evidence provided is appropriate, however in our opinion requires further explanation/detail/adjustment prior to submission.
✗	Evidence provided does not demonstrate compliance with the Element of the Safety Action.

We would like to acknowledge the help and assistance given by the Director of Nursing, Director of Nursing and Midwifery and the Quality & Patient Safety Manager and the individual Safety Action Leads, during the course of this review.

Rating of Recommendations

Recommendations raised in this report have been rated in accordance with the organisation's risk matrix.

Report Data

Date of Work Undertaken	8-19 December 2025
Date of Issue of Draft Report	8 January 2026
Date of Return of Draft Report	16 January 2026
Date of Approval of Final Report	19 January 2026
Lead Auditor	Hanna Somerwill, Audit and Assurance Manager – Specialist Services Gill Travers, Registered Midwife, Audit and Assurance Manager – Specialist Services
Client Lead Manager(s)	Sarah Windfeld, Director of Nursing and Midwifery
Client Lead Director	Sarah Dodds, Director of Nursing
Governance/Regulatory Links	CNST Maternity Standards Year 7

Action Plan

Unique ID	Recommendation	Risk rating	Agree/ disagree	Management action (SMART)	Evidence required to close action	Action lead/ manager responsible	Action date
1676	**For SA1 - Year 7 Board Declaration** The Trust should map where Perinatal Mortality Review Tool (PMRT) data has been reported, including frequency of reporting and which Board Members (Executive and Non-Executive Directors) attended these meetings. A copy of this mapping exercise should be provided alongside our audit report as part of the Trusts declaration of compliance for CNST. The Board can then decide whether the Trust is compliant with this evidential requirement and whether the Board is assured that they have had sight of sufficient information relating to PMRT in line with this requirement for their assurance needs in order to meet compliance.	**Very High (15)**	Agree	The mapping exercise has been completed and presented at the internal CNST review meeting. Following this, PMRT data has retrospectively been shared with all Board members for oversight. Alongside the Board declaration, a statement will confirm that the mapping has been carried out and that the Trust Board can be assured it has received sufficient assurance regarding PMRT. The Board will ultimately decide on compliance with this safety action. For Year 8, the plan is for the Trust to review perinatal reporting across both Trusts, ensuring alignment with MIS requirements.	Mapping Exercise, Minutes of the Board confirming discussion on whether the Board are adequately assured that members have had sufficient sight of PMRT information in line with the requirements for MIS.	Sarah Windfeld, Director of Nursing and Midwifery	18/02/2026

Unique ID	Recommendation	Risk rating	Agree/ disagree	Management action (SMART)	Evidence required to close action	Action lead/ manager responsible	Action date
1679	**For SA4 - Year 8** In light of recent developments in other local units, the Trust Board should review the safety implications of not meeting the British Association of Perinatal Medicine neonatal workforce standards, consider the proposed staffing uplift suggested from the Operational Delivery Network, and agree on a clear, time-bound action plan to achieve full compliance with these national standards.	Moderate (6)	Agree	A formal statement on the BAPM Action Plan will be included within the MIS declaration. The Board paper will highlight that than regional approach will be required and seek the boards views on an appropriate timeframe for maintaining an action plan to achieve compliance with the BAPM standard and the ODNs suggested uplift.	MIS year 7 Paper to the Board and Mins of the February Board Meeting noting that a regional decision solution will be required and that the Trust Board have discussed an appropriate timeframe for maintaining an action plan.	Sarah Windfeld, Director of Nursing and Midwifery	18/02/2026
1680	**For SA4 - Year 8** In light of recent developments in other local units, the Trust Board should review the safety implications of not meeting the British Association of Perinatal Medicine neonatal workforce standards, consider the proposed staffing uplift suggested from the Operational Delivery Network, and agree on a clear, time-bound action plan to achieve full compliance with these national standards.	Moderate (6)	Agree	The Director of Midwifery will have a separate strategic conversation with the ODN regarding the uplift and Qualified in Specialty (QIS) trained staff.	Evidence that meeting has taken place and summary of any agreed outcomes in a follow up email or meeting notes.	Sarah Windfeld, Director of Nursing and Midwifery	31/03/2026
1681	**For SA6 - Year 7 Declaration** The Trust should report its compliance % for Saving Babies Lives verified by the ICB alongside its CNST Declaration in February 2025.	Moderate (6)	Agree	The overall compliance % will be reported alongside the Declaration and is included within the PQOM report.	MIS year 7 Paper to the Board and Mins of the February Board Meeting noting Trusts compliance %.	Jo Mockler, Quality & Patient Safety Manager	18/02/2026

Unique ID	Recommendation	Risk rating	Agree/ disagree	Management action (SMART)	Evidence required to close action	Action lead/ manager responsible	Action date
1682	**For SA7 - Before Year 7 Declaration** To ensure compliance with the requirements ahead of the Board Declaration, the following Terms of References should be updated to explicitly state that the Maternity and Neonatal Voices Partnership (MNVP) Lead is a quorate member of the following groups: • Women's Governance Group • Clinical Effectiveness Group • Maternity Safety Champions Group • Women's Services Experience Group	**Very High (15)**	Agree	Three of the Terms of References have been updated and approved the final Terms of Reference for the Women's Governance will be approved on 8 January 2026.	Copies of the approved Terms of Reference for the: • Women's Governance Group • Clinical Effectiveness Group • Maternity Safety Champions Group • Women's Services Experience Group	Jo Mockler, Quality & Patient Safety Manager	31/01/2026
1683	**For SA7 - Year 7 Declaration** At the February Board Declaration assurance should be provided that the following Terms of References have been updated and reflect the required changes: • Women's Governance Group • Clinical Effectiveness Group • Maternity Safety Champions Group • Women's Services Experience Group	**High (12)**	Agree	Assurance will be provided at the Board Declaration in February 2026 that the Terms of References have been updated.	MIS year 7 Paper to the Board and Mins of the February Board Meeting noting that Terms of References have been updated.	Sarah Windfeld, Director of Nursing and Midwifery	18/02/2026
1684	**For SA10 - Year 8 - Best Practice** The Trust should provide examples of screen shots demonstrating the Trust has completed the field showing whether families have been informed of NHS Resolution's involvement on the Early Notifying (EN) Reporting system as evidence.	**High (12)**	Agree	For year 8 the Trust will provide examples of screen shots demonstrating the Trust has completed the field showing whether families have been informed of NHS Resolution's involvement on the Early Notifying (EN) Reporting system as evidence.	Evidence for year 8 declaration - examples of screen shots from EN.	Jo Mockler, Quality & Patient Safety Manager	30/11/2026

* Recommendation Unique ID is generated by our K10 Vision Audit Management System so these may not appear in consecutive order.

Opportunities for System Improvement

As this year's CNST audit was conducted in conjunction with three other NHS Trusts, we identified several areas for improvement relating to the Saving Babies' Lives Care Bundle (Year 8) for the Trust's consideration.

These improvement opportunities have been shared with all four organisations participating in this year's CNST MIS Evidence Review. As these are general recommendations intended to support system-wide improvement, some may already have been implemented by the Trust.

However, given the current financial constraints and recruitment challenges across organisations, while these improvements would be beneficial, implementation may not be feasible at this time. The identified opportunities improvement are as follows:

Area	Description
Data Quality	The Trust should ensure that regular data quality audits are conducted on the source data used within the Saving Babies' Lives audit, so that the information entered into the system can be relied upon.
Continuation of Removed Audits	The Trust should continue conducting any audits that were removed from Saving Babies' Lives this year, as these were originally identified as key interventions to reduce harm.
Single System Wide Saving Babies' Lives Dashboard	The LMNS should consider developing a system-wide Saving Babies' Lives dashboard. This dashboard should be used by each Trust to monitor and demonstrate progress on each intervention on a monthly basis.
Using Latest Ratified Versions of Guidelines	A review should be conducted of all guidelines published on the BNSSG LMNS Saving Babies' Lives NHS Futures page to confirm that the most current, ratified versions are being used as evidence and that these versions are readily accessible to staff.

Safety Action One - Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?

What We Checked

The evidence provided to demonstrate compliance with Safety Action (SA) 1 was reviewed. Following our review, we provided feedback at a meeting with Safety Action Leads and provided a breakdown of additional evidence that was required to demonstrate compliance.

What We Found

The Trust is currently not compliant with this Safety Action. Our assessment is below.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days?	✓	No issues identified.	No additional evidence required.
For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	✓	No issues identified.	No additional evidence required.
Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	✓	No issues identified.	No additional evidence required.
Were 75% of all reports completed and published within 6 months of death? MIOS verification period: Dec 2024 to April 2025 60% of Cases. 2 April 2025 to 30 Nov 2025 75% of cases.	✓	No issues identified.	No additional evidence required.
For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025.	✓	No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans. A report should be received by the Trust Executive Board each quarter that includes details of the deaths reviewed, any themes identified 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. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.	✖	The evidence provided does not meet the required evidential requirements and technical guidance, which may result in the Trust being non-compliant with this Safety Action and consequently ineligible for the CNST financial rebate. Although PMRT is regularly reported to the Executive Committee, the MIS Guidance clearly states that these reports must be submitted to the Trust Board on a quarterly basis, this cannot be delegated to a Sub Committee. This requirement was recently reiterated during an NHS Resolution webinar attended in the autumn. Our review of the Trust Board papers indicates that, while PMRT numbers are included in the IPR, the Board papers do not include: • Confirmation that PMRT has been used to review all eligible perinatal deaths or that the required standards (a), (b), and (c) have been met. • Details of the learning and associated action plans. As a result, the Board reports do not provide the level of detail necessary to comply with this requirement. Going forward, the Trust should ensure that all data required to meet this evidential requirement is explicitly reported to the Trust Board on a quarterly basis. Please note that the NHSE PQOM template does not include all data expected for PMRT under this requirement; therefore, any missing elements will need to be incorporated if the Trust chooses to use this report. The report currently presented to the Executive Committee is considered sufficient to meet this requirement and should be submitted to the Trust Board. We wish to highlight the content of this PMRT report as an example of best practice. We have requested permission from the Trust to share this evidence as part of a notable practice guide for other Trusts undertaking this audit.	

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
		For the declaration: We suggest the Trust maps where this information has been reported, including frequency of reporting and which Board Members (Executive and Non-Executive Directors) attended these meetings. A copy of this mapping exercise should be provided alongside our audit report as part of the Trusts declaration of compliance for CNST. The Board can then decide whether the Trust is compliant with this evidential requirement and whether the Board is assured that they have had sight of sufficient information relating to PMRT in line with this requirement for their assurance needs.	
Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?		No issues identified, we are satisfied that the data has been shared with Safety Champions.	No additional evidence required.

Safety Action 2 - Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

What We Checked

The evidence provided to demonstrate compliance with SA2 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of additional evidence required to demonstrate compliance.

What We Found

The required evidence has been provided by the Trust, and our review suggests compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/Issues to Address
Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)		No issues identified.	No additional evidence required
Did July's 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)		No issues identified.	No additional evidence required.

Safety Action 3 - Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

What We Checked

The evidence provided to demonstrate compliance with SA3 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of the additional evidence required to demonstrate compliance.

What We Found

The required evidence has been provided, and our review therefore suggests compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?	✓	No issues identified.	No additional evidence required.
Or Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards.	**N/A – Transitional Care Pathway in place.**		
For units commencing a new QI project			
By 2 September 2025, register the QI project with local Trust quality/service improvement team.	**N/A – Continuing with a QI project**		
By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress.			
Or - For units continuing a QI project from the previous year			
Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions	✓	No issues identified.	No additional evidence required.
By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period.	✓	No issues identified.	No additional evidence required.

Safety Action 4 - Can you demonstrate an effective system of clinical workforce planning to the required standard?

What We Checked

The evidence provided to demonstrate compliance with SA4 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of the additional evidence required to demonstrate compliance.

What We Found

The required evidence has been provided, and our review therefore suggests compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
Obstetric medical workforce			
Locum currently works in their unit on the tier 2 or 3 rota? **Or** They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progression (ARCP) **Or** They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	✓	No issues identified.	No additional evidence required.
Has the Trust Implemented the RCOG guidance on engagement of long-term locums in full? Trusts should demonstrate full compliance through audit of any 6-month period from February 2025 to 30 November 2025.	✓	No issues identified.	No additional evidence required.
Is the Trust compliant with Consultant attendance in person to the clinical situations listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	✓	No issues identified.	No additional evidence required.
Do you have evidence that the Trust position with the above has been shared with Trust Board?	✓	No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	✓	No issues identified.	No additional evidence required.
Do you have evidence that the Trust position with the above has been shared with the LMNS?	✓	No issues identified.	No additional evidence required.
Anaesthetic medical workforce			
Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) Representative month rota acceptable for evidence.	✓	No issues identified.	No additional evidence required.
Neonatal medical workforce			
Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	✓	No issues identified.	No additional evidence required.
Is this formally recorded in Trust Board minutes?	✓	No issues identified.	No additional evidence required.
If the requirements are not met, Trust Board should agree an action plan with updates on progress against any previously developed action plans. This should be monitored via a risk register.	✓	No issues identified.	No additional evidence required.
Was the above action plan shared with the LMNS?	✓	No issues identified.	No additional evidence required.
Was the above action plan shared with the Neonatal ODN?	✓	No issues identified.	No additional evidence required.
Neonatal nursing workforce			
Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	✓	The Trust is currently not compliant with BAPM nursing workforce standards. An action plan has been in place for several years to address this non-compliance, specifically focusing on the Neonatal Nursing workforce and the need for additional staff who are Qualified in Specialty (QIS) trained. Additionally, a risk relating to the Neonatal Nursing workforce has been recorded on the Trust's risk register for the past 11 years.	

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
		No additional evidence required for year 7. **To note** - There is a national shortage of QIS-trained nurses. To address this, the South West Neonatal Network has introduced a regional QIS programme, which takes approximately 2–2.5 years to complete. While the Trust currently has nurses enrolled in this programme, this alone will not resolve workforce challenges due to ongoing staff turnover. Best practice would involve the region implementing a recruitment incentive scheme for neonatal nursing, alongside collaboration with education providers to promote the role and encourage newly qualified nurses to remain within the region. **For Year 8** In light of recent developments in other local units, the Trust Board should assess the safety implications of not meeting BAPM neonatal staffing standards and determine an appropriate timeframe for maintaining an action plan to achieve compliance with the British Association of Perinatal Medicine national nursing staffing standards	
Is this formally recorded in Trust Board minutes?	✓	No issues identified.	No additional evidence required.
Was the above action plan shared with the LMNS?	✓	No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
Was the above action plan shared with the Neonatal ODN?	✔	No issues identified, no additional evidence required. **To note** - The ODN have suggested that, given the acuity of the unit, that the Trust move to a staffing model based on commissioned cot base to ensure long-term sustainability through the development of a 5-year workforce plan. **For Year 8** As the Trust is currently unable to meet the BAPM standards for Neonatal Workforce, the proposed additional staffing uplift from the ODN should be considered when the Board reviews the safety implications of this non-compliance and determines an appropriate timeframe for maintaining an action plan to achieve full compliance.	

Safety Action 5 - Can you demonstrate an effective system of midwifery workforce planning to the required standard?

What We Checked

The evidence provided to demonstrate compliance with SA5 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of the additional evidence required to demonstrate compliance.

What We Found

The required evidence has been provided, and our review therefore suggests compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.)	✓	No issues identified.	No additional evidence required.
Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. Every report should include an update on all of the points below: • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. • The midwife to birth ratio. • 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 on duty at the start of every shift. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour. • Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?	✓	No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
FOR INFORMATION ONLY We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated, This includes: • Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour.	✓	No issues identified.	No additional evidence required.
Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: • Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	✓	No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	✓	No issues identified.	No additional evidence required.
Where deficits in staffing levels have been identified must be shared with the local commissioners.	✓	No issues identified.	No additional evidence required.
Evidence from an acuity tool (may be locally developed) that the Midwifery Coordinator in charge of labour ward must supernumerary status: (defined as having a rostered planned supernumerary co-ordinator at the start of every shift) to ensure that there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator at the start of a shift.	✓	No issues identified.	No additional evidence required.
FOR INFORMATION ONLY A workforce action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward co-ordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. Development of the workforce action plan will NOT enable the trust to declare compliance with this sub-requirement	✓	No issues identified.	No additional evidence required.
Evidence from an acuity tool (may be locally developed), local audit and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour.	✓	No issues identified.	No additional evidence required.
A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. Development of the improvement plan will enable the Trust to declare compliance with this sub-requirement. This improvement plan does not need to be submitted to NHS Resolution.	✓	No issues identified.	No additional evidence required.

Safety Action 6 - Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

What We Checked

The evidence provided to demonstrate compliance with SA6 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of the additional evidence required to demonstrate compliance.

What We Found

The LMNS has confirmed that the Trust's latest position for Saving Babies Lives V3, is 87% compliant. In addition to reviewing the three evidential requirements for SA6 we have also undertaken a deep dive into 20 interventions across the six elements of Saving Babies Lives V3. For all 20 interventions reviewed, we can confirm the guidelines covered the requirements listed and where appropriate we were able to review suitable audit evidence and action plans.

The Trust has a number of additional pieces of evidence to locate before it can declare compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment?		The evidence reviewed suggests compliance, however, the Trust Board has not yet been informed of the results of the Saving Babies' Lives Version 3 verification by the LMNS.	**For the Year 7 Declaration** The Trust should report its compliance % for Saving Babies Lives verified by the ICB alongside its CNST Declaration in February 2025.
Where full implementation is not in place, has the ICB been assured that all best endeavours and sufficient progress has been made towards full implementation, in line with locally agreed improvement trajectory?		No issues identified.	No additional evidence required.
Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle?		No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
These meetings must include: • Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory. • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.			
Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?	✓	No issues identified.	No additional evidence required.
If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.	**N/A – Implementation Tool is being utilised.**		

As the CNST audit was conducted with three other NHS Trusts, we identified several areas for improvement related to the Saving Babies' Lives Care Bundle (Year 8) for the Trust's consideration, detailed in the Opportunities for System Improvement section on Page 11. These are general system-wide observations, so some may not apply to the Trust. The identified areas of weakness are as follows:

Area	Control Weakness
Data Quality	Data quality audits were not consistently carried out to confirm the accuracy of source data used in the Saving Babies' Lives audits, creating a risk of inaccurate reporting and false assurance.
Continuation of Removed Audits	Due to limited resources, some Trusts have stopped undertaking audits from the Saving Babies' Lives programme that were removed nationally because improvement targets were not being met. These audits were originally key interventions to reduce harm, so continuing them would be best practice, especially as they may support future improvement work.

Area	Control Weakness
Single System Wide Saving Babies' Lives Dashboard	Compliance with Saving Babies' Lives audits was monitored inconsistently across organisations, with some tracking improvement trajectories more effectively than others. There is an opportunity to develop a system-wide Saving Babies' Lives dashboard. This dashboard should enable each Trust to monitor and demonstrate progress on interventions monthly, helping to identify trends and track performance over time.
Using Latest Ratified Versions of Guidelines	The latest ratified guidelines were not always shared with the LMNS, or, when shared, were not accessible to staff, creating a risk of inconsistent clinical practice and delayed implementation of evidence-based care, which may compromise patient safety and reduce assurance.

Safety Action 7 - Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

What We Checked

The evidence provided to demonstrate compliance with SA7 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of additional evidence required to demonstrate compliance.

What We Found

The Trust has a number of additional pieces of evidence to locate before it can declare compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
Evidence of an action plan coproduced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge.	✓	No issues identified.	No additional evidence required.
Has progress on the coproduced action above been shared with Safety Champions?	✓	No issues identified.	No additional evidence required.
Has progress on the coproduced action above been shared with the LMNS?	✓	No issues identified.	No additional evidence required.
Evidence of Maternity Neonatal Voices Partnership (MNVP) infrastructure being in place from your LMNS/ICB, including all of the following: • Job description for MNVP Lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost.	✓	We reviewed the MNVP infrastructure budget and noted that there is no dedicated budget line for IT, communications, engagement, training, or administrative support. While we understand that funding for these elements has been provided to the provider, it is not reflected as a separate budget line. Additionally, the current Volunteer Agreement states: "*Travel expenses will be reimbursed. Any other expenses need to be agreed in advance.*"	

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
		The LMNS confirmed that the contract, budget, and Volunteer Agreement were established three years ago, prior to these requirements being mandated by NHS Resolution. During the SA feedback meeting, LMNS, as commissioners of the MNVP contract, confirmed that the contract is currently being retendered, and the following actions will be implemented for the next year: • The budget will explicitly include all elements, with allocated funds for IT, communications, engagement, training, and administrative support. • The Volunteer Agreement will be updated to clearly define "out-of-pocket expenses" and presented in a formal policy format **Please note:** This action falls outside the Trust's direct control.	
If the MNVP infrastructure is not in place and evidence of an MNVP, commissioned and functioning in full as per the national guidance, is unobtainable (and you have answered No, go to Q4) Has this been escalated via the Perinatal Quality Oversight Model (PQOM) at trust, ICB and regional level? In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below to meet compliance for MIS for this safety action.	**N/A - as per technical guidance as MNVP infrastructure is in place.**		

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: • Safety champion meetings • Maternity business and governance • Neonatal business and governance • PMRT review meeting • Patient safety meeting • Guideline committee		**Evidence provided does not cover the evidential requirements and the technical guidance –** Four of the Terms of Reference do not specify the MNVP Lead as a quorate member. **For Year 7 -** To ensure compliance with the requirements ahead of the Board Declaration, the following ToRs should be updated to explicitly state that the MNVP Lead is a quorate member of the following groups: • Women's Governance Group • Clinical Effectiveness Group • Maternity Safety Champions Group • Women's Services Experience Group **For the Declaration** At the February Board Declaration, assurance should be provided that the above Terms of Reference have been updated and reflect the required changes.	
Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.		No issues identified.	No additional evidence required.

Safety Action 8 - Can you evidence the following three elements of local training plans and 'in-house', one day multi-professional training?

What We Checked

The evidence provided to demonstrate compliance with SA8 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of additional evidence required to demonstrate compliance.

What We Found

The required evidence has been provided, and our review therefore suggests compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
Fetal monitoring and surveillance (in the antenatal and intrapartum period) training			
90% of obstetric consultants.	✓	No issues identified.	No additional evidence required.
90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor).	✓	No issues identified.	No additional evidence required.
For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	✓	No issues identified.	No additional evidence required.
90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres.	✓	No issues identified.	No additional evidence required.
Maternity emergencies and multi-professional training			
90% of obstetric consultants.	✓	No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota	✓	No issues identified.	No additional evidence required.
For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	✓	No issues identified.	No additional evidence required.
90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives.	✓	No issues identified.	No additional evidence required.
90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).	✓	No issues identified.	No additional evidence required.
90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors.	✓	No issues identified.	No additional evidence required.
90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA.	✓	No issues identified.	No additional evidence required
For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	✓	No issues identified.	No additional evidence required
Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.	✓	No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
Neonatal basic life support (NBLS) training			
90% of neonatal Consultants or Paediatric consultants covering neonatal units	✓	No issues identified.	No additional evidence required.
90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births.	✓	No issues identified.	No additional evidence required.
For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	✓	No issues identified.	No additional evidence required.
90% of neonatal nurses (Band 5 and above).	✓	No issues identified.	No additional evidence required.
90% of advanced Neonatal Nurse Practitioner (ANNP)	✓	No issues identified.	No additional evidence required.
For Information only: 90% of maternity support workers, health care assistants and nursery nurses *dependant on their roles within the service - for local policy to determine.	✓	No issues identified.	No additional evidence required.
90% of 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 and bank midwives employed by the Trust	✓	No issues identified.	No additional evidence required.
In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance. **Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance**	✓	No issues identified.	No additional evidence required.

Safety Action 9 - Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

What We Checked

The evidence provided to demonstrate compliance with SA9 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of additional evidence required to demonstrate compliance.

What We Found

The required evidence has been provided, and our review therefore suggests compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the revised Perinatal Quality Oversight Model (PQOM) when published in 2025? (including the following)	✓	No issues identified, however, we would like to highlight the Trust use of the national PQSM/PQOM which is considered best practice.	No additional evidence required.
Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?	✓	No issues identified.	No additional evidence required.
Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context.	✓	No issues were identified; however, we wish to highlight the Trust's Triangulation Report as an example of best practice. We have requested permission from the Trust to share this evidence as part of a notable practice guide for other Trusts undertaking this audit.	No additional evidence required.
Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?	✓	No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	✓	No issues identified.	No additional evidence required.
Ongoing engagement sessions with staff as per previous years of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025.	✓	No issues identified.	No additional evidence required.
Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)? 2 April - 30 November.	✓	No issues identified.	No additional evidence required.
Evidence in the Trust Board minutes that Board Safety Champion(s) and the MNVP lead (where infrastructure is in place as per SA7) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented. Where the infrastructure is in place, this should also include the MNVP as per SA7.	✓	No issues identified.	No additional evidence required.
Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	✓	No issues identified.	No additional evidence required.

Safety Action 10 - Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?

What We Checked

The evidence provided to demonstrate compliance with SA10 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of additional evidence required to demonstrate compliance.

What We Found

The required evidence has been provided, and our review therefore suggests compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025.	✓	No issues identified.	No additional evidence required.
Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025?	✓	No issues identified.	No additional evidence required.
Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	✓	No issues identified.	No additional evidence required.
Has there been compliance, for all eligible cases, with regulation 20 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014 in respect of the duty of candour?	✓	No issues identified.	No additional evidence required.
For any occasions where it has not been possible to provide a format that is accessible for eligible families, has a SMART plan been developed to address this for the future.	✓	No issues identified.	No additional evidence required.
Has 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?	✓	No issues identified.	No additional evidence required.
Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	✓	No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this.	✓	No issues identified.	No additional evidence required.
Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	✓	No issues identified.	No additional evidence required.
When reporting EN cases, have you completed the field showing whether families have been informed of NHS Resolution's involvement? Completion of this will also be monitored, and externally validated.	✓	No issues identified.	No additional evidence required. **For Year 8 – Best Practice** The Trust should provide examples of screen shots demonstrating the Trust has completed the field showing whether families have been informed of NHS Resolution's involvement on the EN Reporting system as evidence.

ASW Assurance – About Us

ASW Assurance is the largest provider of internal audit, counter fraud and consultancy services in the South West. We maintain a local presence and close engagement within each health community, with audit teams based in Bristol, Exeter, North Devon, Plymouth, Torquay and Cornwall, linked by shared networks and systems. More information about us, including the services we offer, our client base, our office locations and key people can be found on our website at www.aswassurance.co.uk.

ASW Assurance is a member of TIAN; a group of NHS internal audit and counter fraud providers from across England and Wales. Its purpose is to facilitate collaboration, share best practice information, knowledge and resources in order to support the success and quality of our client's services.

All audit and assurance assignments are conducted in conformance with the International Standards for the Professional Practice of Internal Auditing.

Confidentiality

This report is issued under strict confidentiality and, whilst it is accepted that issues raised may need to be discussed with officers not shown on the distribution list, the report itself must not be copied/circulated/disclosed to anyone outside of the organisation without prior approval from the Director of Audit and Assurance Services.

Inherent Limitations of the Audit

There are inherent limitations as to what can be achieved by systems of internal control and consequently limitations to the conclusions that can be drawn from this review. These limitations include the possibility of faulty judgment in decision-making, of breakdowns because of human error, of control activities being circumvented by the collusion of two or more people and of management overriding controls. Also there is no certainty that controls will continue to operate effectively in future periods or that the controls will mitigate all significant risks which may arise in future. Accordingly, unless specifically stated, we express no opinion about the adequacy of the systems of internal control to mitigate unidentified future risk.

Rating of Audit Recommendations

The recommendations in this report are rated according to the organisation's risk-scoring matrix and have been arrived at by assessing the risk in relation to the organisation as a whole.

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Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 1 December 2024 to 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose N/A)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 75% of all reports completed and published within 6 months of death? MIS verification period: Dec 2024 to April 2025 60% of cases. 2 April 2025 to 30 Nov 2025 75% of cases	Yes
5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025	Yes
6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.	Yes
7	Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Yes

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Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No)
1	Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month? This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)	Yes
2	Did July 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

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Safety action No. 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?	Yes
2	**Or** Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards?	
Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation.		
For units commencing a new QI project		
3	By 2 September 2025, register the QI project with local Trust quality/service improvement team.	
4	By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress.	
Or **For units continuing a QI project from the previous year**		
5	Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions.	Yes
6	By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period	Yes

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Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing all short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 and before submission to Trust Board (select N/A if no short-term locum doctors were employed in this period): Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust ensured that the RCOG guidance on engagement of long-term locums has been implemented in full for employing long-term locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 to 30 November 2025 (select N/A if no long-term locum doctors were employed in this period)	Yes
3	**For information only:** RCOG compensatory rest (not reportable in MIS year 7) Have you met, or are working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.	Yes
4	Is the Trust compliant with the Consultant attendance in person to the clinical situations guidance, listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	Yes
5	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Yes
6	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	Yes
7	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) Representative month rota acceptable for evidence.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	Yes
10	Is this formally recorded in Trust Board minutes?	Yes
11	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	
12	Was the above action plan shared with the LMNS?	
13	Was the above action plan shared with the Neonatal ODN?	
d) Neonatal nursing workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	No
15	Is this formally recorded in Trust Board minutes?	Yes
16	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	Yes
17	Was the above action plan shared with the LMNS?	Yes
18	Was the above action plan shared with the Neonatal ODN?	Yes

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Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, you can declare compliance but evidence of communication with the BirthRate+ organisation (or equivalent) MUST demonstrate this.)	Yes
2	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. This must include at least one report in the MIS period 2 April - 30 November. Every report must include an update on all of the points below: ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● 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 on duty at the start of every shift. ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour ● Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?	Yes
3	**For Information Only:** We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated, This includes: •Redeployment of staff to other services/sites/wards based on acuity. •Delayed or cancelled time critical activity. •Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). •Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). •Delay of more than 30 minutes in providing pain relief. •Delay of 30 minutes or more between presentation and triage. •Full clinical examination not carried out when presenting in labour. •Delay of two hours or more between admission for induction and beginning of process. •Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). •Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally.	Yes
4	Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
5	Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	
6	Where deficits in staffing levels have been identified must be shared with the local commissioners.	
7	Evidence from an acuity tool (may be locally developed) that the Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
8	**For Information Only:** A workforce action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the workforce action plan will NOT enable the trust to declare compliance with this sub-requirement.**	
9	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
10	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the improvement plan will enable the Trust to declare compliance with this sub-requirement. This improvement plan does not need to be submitted to NHS Resolution**	

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Safety action No. 6

Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3.2 is fully in place, and can you evidence that the Trust Board have oversight of this assessment?	No
2	Where full implementation is not in place, has the ICB been assured that all best endeavours and sufficient progress has been made towards full implementation, in line with the locally agreed improvement trajectory?	Yes
3	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? These meetings must include: ● Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory. ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Yes
4	Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?	Yes
5	If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB	N/A

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Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of an action plan co-produced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge	Yes
2	● Has progress on the co-produced action above been shared with Safety Champions?	Yes
3	● Has progress on the co-produced action above been shared with the LMNS?	Yes
4	**Do you have evidence of MNVP infrastructure being in place from your LMNS/ICB, in full as per national guidance, and including all of the following:** • Job description for MNVP lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Yes
5	**If MNVP infrastructure is not in place and evidence of an MNVP, commissioned and functioning in full as per national guidance, is unobtainable (and you have answered N to Q4):** Has this has been escalated via the Perinatal Quality Oversight Model (PQOM) at trust, ICB and regional level? In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below to meet compliance for MIS for this safety action.	N/A
6	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Terms of Reference for Trust safety and governance meetings, showing the MNVP lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	Yes
7	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Yes

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Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2025? Rotational medical staff in posts shorter than 12 months can provide evidence of applicable training from a previous trust within the 12 month period using a training certificate or correspondence from the previous maternity unit.		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota? (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank midwives employed by Trust and maternity theatre midwives who also work outside of theatres)?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants?	Yes
6	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota?	Yes
7	For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust?	Yes
9	90% of maternity support workers and health care assistants? (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors?	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA?	Yes
12	For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
13	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.	Yes
	Neonatal resuscitation training	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births?	Yes
16	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
17	90% of neonatal nurses? (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
19	**For Information Only:** 90% of maternity support workers, health care assistants and nursery nurses? (dependant on their roles within the service - for local policy to determine)	Yes
20	90% of midwives? (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust)	Yes
21	In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance? Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.	Yes

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Safety action No. 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the Perinatal Quality Oversight Model (PQOM)?	Yes
2	Has a non-executive director (NED) been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM/PQOM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context?	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM/PQOM?	Yes
6	Ongoing engagement sessions should be being held with staff as per previous years of the scheme. Is progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025?	Yes
7	Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period 2 April - 30 November)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period 2 April - 30 November) and that any support required of the Trust Board has been identified and is being implemented? **Where the infrastructure is in place, this should also include the MNVP lead as per SA7.**	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented?	Yes

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Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025?	Yes
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025?	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	Yes
4	For any occasions where it has not been possible to provide a format that is accesible for eligible families, has a SMART plan been developed to address this for the future?	N/A
5	Has 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?	Yes
6	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	Yes
7	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this?	Yes
8	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
9	When reporting EN cases, have you completed the field showing whether families have been informed of NHS Resolution's involvement? Completion of this will also be monitored, and externally validated.	Yes

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NHS Resolution

Section A : Maternity safety actions - University Hospitals Bristol NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	7	0	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	2	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	3	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	13	0	1	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	5	0	1	0	0
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	4	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	6	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	20	0	1	0	0
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes	9	0	0	0	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes	8	0	0	0	0

Maternity Incentive Scheme - Year 7 Board declaration form

Trust name	**University Hospitals Bristol NHS Foundation Trust**
Trust code	**T076**

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	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	-		
Total sum requested			**-**	

Sign-off process confrming 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.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2025/26) or the previous financial year (2024/25)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding 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 will be escalated to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	University Hospitals Bristol NHS Foundation Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	University Hospitals Bristol NHS Foundation Trust
Name:	
Position:	
Date:	