NHS Resolution

Maternity (Perinatal) Incentive Scheme Year 8 v1.0

Supplementary guidance

Roles and Responsibilities: ‘What good might look like’
Technical guidance, Abbreviations, References

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Contents

Supplementary Guidance - What Good Might Look Like

The following sections provide supplementary guidance to the core Maternity (Perinatal) Incentive Scheme (MIS) document. They offer examples of 'what good might look like' and illustrate how a high-functioning Trust might deliver and assure each requirement. These explicit steps are not mandated; this is intended to support local application and strengthen consistency.

This is structured around the following sections:

Who – Roles and Responsibilities

The roles and teams that should be involved in delivering, monitoring and assuring the standards.

This section reinforces the multidisciplinary nature of MIS: responsibility does not sit with one individual, but with the whole perinatal leadership team, including midwifery, obstetrics, neonatology (nursing and medical), anaesthetics, service user representation, governance, data, and executive leadership.

It also reflects established good governance practices, including effective use of quality governance committees (or equivalent delegated committees) and timely and appropriate escalation to the Executive Board.

How

Evidence examples for each Safety Action. Processes that may be in place in a Trust that meets the requirements. This will vary depending on local context.

Many elements will align with routine governance activity already embedded within safe, effective services. This content responds directly to Trusts' requests for clearer interpretation, practical examples of *what good looks like*, improved guidance on evidence and Board assurance. It also supports the broader shift toward demonstrating change and improvement, rather than meeting processes in isolation.

References

Key evidence sources, national reports and frameworks underpinning the Safety Action.

The enhanced structure directly reflects what Trusts have asked for:

- Support for flexibility to allow for local prioritisation and processes.
- Support interpreting standards.
- More explicit evidence examples.
- Stronger articulation of purpose and outcomes.
- Support to provide greater consistency in governance and assurance.

Much of this aligns with business-as-usual governance in effective Trusts. By setting it out clearly, the Year 8 supplementary document aims to support trusts to strengthen consistency, reduce avoidable ambiguity, but also enable teams local flexibility to focus on delivering meaningful and sustained improvement.

Who - Roles and responsibilities

Delivering the MIS safety actions requires a coordinated, multidisciplinary approach. Responsibility does not sit with any single individual or staff group. Instead, it relies on shared leadership across midwifery, obstetrics, neonatology, anaesthetics, governance, data, service user voice and executive oversight. High performing Trusts demonstrate collective ownership, clear role boundaries, and regular cross-professional communication to ensure timely action, triangulated assurance and sustained improvement. Some key roles (recognising there may be local variation in naming conventions) involved in delivering the scheme include:

Head / Director of Midwifery

Provides strategic and operational leadership for maternity services, overseeing governance, workforce, training, safety actions and improvement plans. Ensures accurate reporting, effective escalation and Board level assurance.

Clinical Director for Obstetrics

Provides senior medical leadership for obstetric services, ensuring clinical oversight of investigations, care bundles, training, workforce compliance and escalation of risk through governance structures.

Clinical Director / Lead for Neonatology

Leads neonatal medical governance, ensuring compliance with national standards, oversight of neonatal elements of investigations and care bundles, and contribution to joint maternity–neonatal safety and improvement work.

Lead Nurse for Neonatal Services

Oversees the neonatal nursing workforce, training, compliance with British Association of Perinatal Medicine (BAPM) standards and supports pathway development, data quality and neonatal input into investigations and quality improvement.

Lead Anaesthetist for Obstetrics

Ensures obstetric anaesthetic staffing, rota oversight, compliance with standards and anaesthetic contribution to emergency training, escalation pathways and governance.

Governance and Risk Lead (Maternity & Neonatal)

Coordinates all maternity and neonatal governance processes, maintains trackers and logs, triangulates data and produces reports for governance committees and the Board. Ensures risks and learning are escalated and monitored.

Education & Training Leads / Practice Development Teams

Coordinate delivery, monitoring and recording of all mandatory and multidisciplinary team training (MDT) training. Support competency assessment, programme development and reporting of training compliance to governance forums.

Digital Leads

Support accurate data capture, data entry processes, digital workflows and assurance on data quality for required reporting, including neonatal screening and pulse oximetry.

Departmental Managers / HR Leads

Oversee rota management, workforce records, locum verification, induction, and workforce related compliance logs. Support escalation where staffing pressures impact safety or capacity.

Board Maternity and Neonatal Safety Champions (Executive & Non-Executive)

Provide visible leadership, challenge and advocacy for maternity and neonatal safety. Ensure risks, themes and learning are escalated and that actions are delivered, monitored and resourced appropriately. Provides a link from the ‘Board to Ward’ and back up again.

Maternity and Neonatal Voices Partnership (MNVP) Lead and Service User Representatives

Provide independent insight into family experience, equity, communication and service design. Contribute to co-production of information and challenge governance discussions, ensuring service-user voice informs improvement.

Maternity and Neonatal Governance Forum

The operational forum for monthly triangulation of incidents, investigations, service user insight, workforce, training and improvement data. Prepares verified summaries for Quality Governance Committee (QGC) and flags risks requiring escalation.

Quality Governance Committee

Formally delegated committee of the Trust Board. Scrutinises quarterly maternity and neonatal quality and safety information, including training, workforce, incidents, investigations, care bundles and service user themes. Escalates risks and unmet actions to the Trust Board / Executive Board.

Executive Board

Holds ultimate accountability for maternity and neonatal safety. Receives escalations and quarterly summaries, approves plans, allocates resources and assures delivery of improvement through the perinatal quality oversight model (PQOM) aligned oversight. Formally provides agreement and consent for the Chief Executive Officer (CEO) to undertake the organisation's final MIS sign-off.

Perinatal Leadership Team

Cross specialty leadership group responsible for coordinating delivery across all Safety Actions, overseeing culture improvement, triangulating insight and maintaining a coherent improvement plan. It typically includes (but is not restricted to) the Director of Midwifery, Clinical Directors for Obstetrics and Neonatology, the Lead Nurse for Neonatal Services, the Lead Anaesthetist for Obstetrics, and the MNVP Lead, who represents the wider service user voice.

How - Evidence examples

Safety Action A – Workforce and capacity

Safe staffing levels - Trusts must demonstrate that funded establishments for obstetric, midwifery, neonatal, anaesthetic, and perioperative teams meet nationally recognised workforce standards.

1. Consultant attendance (obstetric workforce)

Compliance with the Royal College of Obstetricians and Gynaecologists (RCOG) "Roles and Responsibilities of the Consultant providing acute care" standard: ≥80% consultant presence in defined acute care situations.

What good might look like:

- A local summary or guideline that clearly sets out the RCOG consultant attendance and "inform" criteria.
- Consultant rotas and job plans that show how labour ward responsibilities are covered.
- Up to date documentation confirming competence sign off for senior trainees or specialty, associate specialist and specialist (SAS) doctors, where this affects attendance requirements.
- Clinical records that note when the consultant was informed or attended, with reasons documented where they did not.
- Short audit reports showing consultant attendance against RCOG scenarios, with any exceptions explained.
- Examples of case reviews or debriefs that highlight consultant involvement and learning.
- Relevant risk register entries or workforce updates where recurring gaps or challenges have been recognised and managed.
- Evidence of Board oversight of compliance with this sub-action (linking to sub-action A7 and Safety Action F governance and reporting).

2. Short-term locum certification (obstetric workforce)

Trusts must ensure locum certification and maintain a local (Trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas. Eligibility must be verified before first engagement and reviewed annually for all locums on the register.

What good might look like:

- A current, Trust specific locum register showing all short-term locums and the dates their eligibility was verified and last reviewed.
- Confirmation that each locum has a valid NHS Certificate of Eligibility for Locums (CEL) or, where applicable, documented checks of specialist registration and recent NHS experience.
- Records showing that key pre-employment checks (such as GMC status, references, training) were verified before the locum undertook any clinical work.
- A brief induction record for each locum, including access to local systems, guidelines, escalation routes, and identification of their named consultant support.
- Periodic checks or audits showing all locums on the register remain compliant and that ineligible locums are not being booked.
- Notes from governance or workforce meetings showing oversight of locum use and any issues identified with agency supplied locums.
- Evidence of Board oversight of compliance with this sub-action (linking to sub-action A7 and Safety Action F governance and reporting).

3. Neonatal workforce establishment (nursing & medical)

Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation (NICU, LNU, SCU) and the neonatal nursing workforce calculator output (2020).

What good might look like:

- A recent neonatal workforce review that clearly shows how the funded posts compare with what BAPM standards, and the neonatal nursing calculator say is needed.
- Identification of any gaps, along with a realistic (SMART) plan for how the Trust intends to move toward full compliance.
- Routine monitoring of workforce pressures (for example, cot closures, staffing related transfers, red flags, or mismatch between dependency levels and available staff) with evidence of escalation and mitigations.
- A neonatal workforce dashboard or report that is regularly discussed in neonatal and maternity governance meetings.
- Clear evidence that neonatal staffing is considered alongside maternity staffing pressures, rather than in isolation.
- Evidence of Board oversight of compliance with this sub-action (linking to sub-action A7 and Safety Action F governance and reporting).

4. Midwifery workforce establishment

Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline. In addition, further adjustments based on professional judgement of the Director / Head of Midwifery should be added where appropriate. Regional Chief Midwives are able to support this process if required.

What good might look like:

- A recent BR+ report (within three years) demonstrating how the funded midwifery establishment compares with the BR+ recommendations.
- Evidence of explanation where professional judgement has been used to adjust BR+ numbers (for example, reflecting local case mix, service configuration, acuity trends, development roles and headroom uplifts).
- A clear explanation for any differences between funded and required numbers, and an agreed plan for how the Trust intends to address these gaps over time (n.b. aligned midwifery establishment must be funded for MIS compliance).
- Routine monitoring of key safety indicators such as one-to-one care in labour, red flags, missed breaks, or high acuity periods, with actions taken in response.
- A monthly or quarterly update to governance groups showing workforce trends, pressures, and progress against recruitment or retention plans.
- Examples of joint conversations across maternity and neonatal teams to ensure midwifery staffing is seen as part of wider perinatal workforce planning.
- Evidence of Board oversight of compliance with this sub-action (linking to sub-action A7 and Safety Action F governance and reporting).

5. Anaesthetic workforce

Trusts must ensure that obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained Anaesthetic Assistant available 24/7 in line with ACSA standards 1.3.1.2.

What good might look like:

- Rotas that clearly show 24/7 obstetric anaesthetic cover, with arrangements for planned and unplanned leave to maintain safe staffing.
- Evidence that a trained Anaesthetic Assistant is always available, including escalation plans when cover is at risk.
- A regular review of obstetric theatre delays or incidents where anaesthetic staffing was a factor, with actions recorded where needed (linking to sub-action A6).

- Evidence of job plans showing named anaesthetic lead for obstetrics, with protected time to support service delivery, governance, and workforce planning.
- Meeting notes or workforce reports showing that anaesthetic staffing pressures are monitored and discussed alongside maternity and neonatal activity.
- Examples of collaborative working between anaesthetic, midwifery, obstetric, and theatre teams to ensure the service runs safely during busy or complex periods (also linking to sub-action A6).
- Evidence of Board oversight of compliance with this sub-action (linking to sub-action A7 and Safety Action F governance and reporting).

Capacity to deliver planned and emergency care

Trusts must demonstrate that capacity is sufficient to deliver timely elective and emergency maternity/neonatal care. **Trusts do not need to prove that delays never occur. They must demonstrate that delays are detected, analysed, reported and that persistent issues are escalated.**

6. Planned Caesarean birth capacity mapping

Trusts must undertake annual demand–capacity mapping for planned Caesarean birth lists, covering the full pathway (pre-operative assessment → theatre → recovery → post-natal ward). Trusts should use existing data reported through NHS England regional maternity SitRep requirements wherever possible to avoid duplication.

What good might look like:

- An annual demand–capacity review showing how planned Caesarean activity compares with available theatre time, staffing, recovery and post-natal ward capacity.
- Use of regional maternity SitRep data to understand pressure trends and seasonal variation, reducing the need for local data duplication.
- A summary of recurring delays, including cases where planned procedures were carried out on emergency lists, outlining the reasons, the impact on services and service users, and any mitigations.
- Evidence that outputs from capacity mapping inform service planning, such as increased protected elective lists, improved scheduling, or increased anaesthetic or theatre support.
- Evidence of routine monitoring of same day delays, with clear escalation when capacity issues begin to affect emergency or urgent workload.

- Regular discussion of Caesarean birth capacity at maternity and theatre governance meetings, ensuring the whole pathway is understood and managed jointly.

Governance, escalation, and forward planning

Trusts must have robust governance processes to monitor workforce risks, escalate issues, and plan for future workforce needs.

7. Board and governance oversight (as detailed in Safety Action F)

Trusts must have a governance system that ensures workforce and capacity risks are monitored, scrutinised and escalated appropriately. This should include a six-monthly integrated workforce report covering maternity and neonatal staffing levels and rota gaps across medical, midwifery, neonatal, anaesthetic and perioperative teams.

What good might look like:

- A regular, integrated workforce report to the Board (at least six-monthly) presenting a clear picture of staffing levels, vacancies, sickness, rota gaps, and reliance on temporary staffing across all maternity and neonatal professions.
- A Statistical Process Control (SPC) based workforce dashboard showing key trends and early warning signs such as red flags, one-to-one care in labour, neonatal dependency levels, and indicators of capacity pressure.
- Clear routes for escalating persistent workforce or capacity issues through governance structures, with evidence that these issues are discussed and actions tracked.
- Governance meeting minutes showing routine triangulation of workforce data with incidents, complaints, outcomes, and staff and service user feedback.
- A Trust risk register entry (or equivalent) reflecting any significant workforce risks, with up-to-date mitigation plans and progress updates.
- Examples of Board and senior leadership discussions demonstrating understanding of the current workforce position, challenges, and improvement plans across obstetric, midwifery, neonatal, anaesthetic and perioperative teams.

Safety Action B – Training

Trusts should aim to ensure all staff have attended the required annual training listed below. A minimum of ≥90% compliance must be achieved for every required staff group at two points during the MIS year (April 26-November 26): 30 November (mandatory MIS checkpoint), and one other Trust selected checkpoint, declared in advance through Quality Governance Committee (QGC). Please see the technical guidance for further details of training, and identification of staff that may be excluded from this calculation, including new and rotational staff in their first three months, and staff on maternity and long-term sick leave.

1. Obstetric emergency training

Trusts must ensure that maternity staff attend annual multidisciplinary obstetric emergency training that incorporates local learning, human factors, communication, teamwork, escalation pathways and situational awareness.

Anaesthetists working in maternity are required to attend at least half of the MDT training day as a minimum, during which obstetric emergencies requiring anaesthetic input (e.g. post-partum haemorrhage (PPH)), escalation pathways, call chains, teamwork, communication and human factors are rehearsed.

Trusts must ensure that an impacted fetal head (IFH) scenario is incorporated into obstetric emergency training by the end of MIS Year 8 (November 2026) as a preparatory step for Avoiding Brain Injury in Childbirth (ABC) implementation, aligning to the proposed ABC methodology. There is not an expectation that all staff will have received training.

What good might look like:

- An annual MDT training plan that covers the required emergencies and integrates local learning, communication and teamwork principles, escalation routes and human factors.
- A local training needs analysis used to identify priorities, ensure training content reflects local risks, and tailor the programme to emerging themes.
- A training trajectory or forward plan outlining how the service will maintain high attendance and meet future training needs, including scheduling, workforce release planning and projected compliance.
- Attendance records showing participation from maternity, neonatal, anaesthetic and theatre staff, with anaesthetists attending the required portion of the programme.
- Scenario outlines demonstrating that key obstetric emergencies including PPH, maternal collapse, shoulder dystocia and cord prolapse are regularly practised, and from this year incorporating IFH.
- Evidence that learning from incidents, claims, complaints and governance reviews is fed into training design.

- Evidence of service user input. For example, involving MNVP representatives in shaping scenario design, highlighting communication challenges, or identifying areas where service users felt emergencies were poorly understood or explained.
- Feedback summaries or debrief notes indicating that training is relevant, realistic and supports effective MDT working.
- Examples of collaborative delivery involving obstetrics, anaesthetics, midwifery, neonatology and theatre teams.

2. Neonatal resuscitation

As a minimum, Trusts must ensure that all staff who may act as an unsupervised first attender or primary resuscitator at any birth (including all midwives) complete annual neonatal resuscitation training and are assessed as meeting at least basic capability, as defined in the BAPM Neonatal Airway Safety Standard. Where further enhanced training is in place for additional staff groups, this should continue (e.g. NLS or equivalent).

What good might look like:

- A local training register showing annual neonatal resuscitation training and capability sign-off for all relevant staff, supported by completed assessment records.
- Assessments clearly mapped to the BAPM standard, demonstrating that staff meet basic capability before undertaking unsupervised primary resuscitator roles.
- Scenario-based training plans reflecting local environments and escalation pathways, with updates informed by recent incidents or debriefs and service user feedback about communication during neonatal emergencies. Scenarios include community births.
- A training needs analysis used to shape the annual programme and identifying any areas requiring additional support.
- Evidence of neonatal resuscitation compliance and capability included in routine maternity/neonatal training reports to the Board, ensuring ongoing oversight of any gaps or risks.

3. Fetal monitoring training

Trusts must ensure that all staff who provide care in antenatal or intrapartum settings, whether substantively or when responding in escalation, complete annual fetal surveillance training.

What good might look like:

- A local training register showing annual fetal monitoring training and assessment for all relevant staff, including those who may ever cover shifts in escalation.
- Evidence that training content aligns with national guidance and local learning, with session plans, eLearning records or competency sign-offs available.
- Scenario or case-based training reflecting local risks and recent incidents, with updates documented through governance routes.
- Service user feedback, for example via MNVP input into communication elements of CTG interpretation or escalation scenarios, helping ensure the training reflects how monitoring and decision making are experienced by women and families.
- A simple training needs analysis informing the annual programme and identifying staff groups requiring targeted support.
- Fetal monitoring training compliance included within routine reporting to maternity/neonatal governance groups and the Board, ensuring oversight of any gaps.

4. In situ muti-professional maternity emergencies simulations

Trusts must deliver at least two in-situ multiprofessional maternity emergencies simulations during the MIS reporting period. One that begins in a hospital area (e.g., labour ward, obstetric theatre, triage, Emergency Department (ED), NICU) and another that begins in a community area. Where possible there should be involvement with relevant partners such as paramedics, ED and theatre teams. These should be based on local and/or national learning and include real time practice of escalation pathways.

What good might look like:

- A plan outlining at least one hospital based and one community based in-situ simulation each year, with scenarios informed by local incidents, national learning and Prevent Future Deaths (PFD) themes etc.
- Shared planning with relevant partners such as paramedics, ED, theatres or allied care teams to ensure realistic pathways and smooth MDT coordination.
- Evidence that human factors, teamwork and communication are explicitly practised, including challenging scenarios such as language barriers or unclear escalation chains.
- Participation records showing involvement from relevant professions and agencies, reflecting how teams work together in real emergencies.
- Debrief notes capturing key learning, system issues, and MDT reflections, with updates to scenarios or guidance documented through governance routes. Sharing of learning.
- Service user input, for example via MNVP, helping shape communication elements of scenarios or identifying where families experienced confusion during previous emergencies.

- Confirmation that learning from simulations is reviewed in maternity/neonatal governance and forms part of regular assurance reporting to senior leaders and the Board.

5. Training compliance oversight (as detailed in Safety Action F)

Trust Boards must have oversight of training compliance for all maternity and neonatal staff groups. Compliance must be reported quarterly through established governance routes, presented in a clear trend-based format (ideally using SPC charts), monitored against a trajectory towards 100 percent and working towards maintaining ≥90 percent compliance throughout future years.

What good might look like:

- A quarterly training report presenting clear trend-based data (e.g. SPC charts) for all maternity and neonatal staff groups, underpinned by verified local training registers.
- A locally maintained dashboard that distinguishes active staff requiring training from those who are temporarily exempt, such as staff on long-term sickness, maternity leave, or those still within their documented induction period.
- Monitoring arrangements for new and rotational staff, ensuring they either complete relevant training within three months of joining or can evidence that they were trained within the current year at their prior organisation.
- Clear governance oversight, with compliance themes, risks and improvement actions discussed at maternity/neonatal governance and reported onwards to the Board.
- Evidence of practical action where compliance falls, such as adjusting release time, increasing training availability, or targeted reminders for teams or staff groups.
- A maintained trajectory toward 100% compliance, with transparent explanations where temporary dips occur (e.g. high turnover, large intake of new starters).

Safety Action C – Learning from reviews and investigations

Reporting & Review

1. Notify all qualifying events

All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHSR Early Notification Scheme (EN) and Maternity and Newborn Safety Investigations (MNSI) as soon as possible after the death/diagnosis.

What good might look like:

- A local process that ensures all qualifying events are identified quickly and submitted via SPEN without delay, supported by clear guidance and accessible instructions for staff.
- Notification responsibilities that are shared across the team rather than resting with a single individual, so that reporting continues reliably during leave, sickness or out-of-hours periods.
- System checks (e.g. cross-referencing SPEN submissions with incident reports, neonatal dashboards or bereavement notifications) to ensure every eligible case is captured.
- Routine governance review highlighting any missed or late notifications, with actions agreed and monitored to strengthen reliability.
- Inclusion of notification timeliness and completeness within maternity/neonatal governance reporting and Board-level assurance, demonstrating consistent oversight.

2. Seek parents' views of care

For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.

What good might look like:

- A clear, sensitive process for approaching parents at appropriate times, ensuring they are offered more than one opportunity to share their views in the way that feels right for them (written, verbal, virtual or in person).
- Use of supportive materials such as leaflets and discussion prompts (linking to sub-actions C4 and D1) that explain the PMRT process and encourage parents to reflect on all aspects of their care experience.
- Evidence that staff record when and how opportunities were offered, ensuring the process does not rely on a single individual and remains consistent during leave, shift changes or busy periods.

- Feedback from parents captured in a structured, compassionate way (e.g. using PMRT parent forms, free-text reflections or facilitated conversations) and included in the evidence provided to reviewers.
- Governance oversight confirming that parent feedback is consistently sought, received and used to inform PMRT reviews, with trends or themes shared through maternity/neonatal governance and included in Board-level assurance.
- Where service users (e.g. MNVP representatives) have helped shape the parent-facing materials or approach, this is reflected in meeting notes or guidance updates.

3. External multi-disciplinary reviewers

For a minimum of 60% of the deaths reviewed external members of relevant specialties must be present at the multi-disciplinary review and this should be documented within the PMRT.

What good might look like:

- Clear arrangements for involving external reviewers from appropriate specialties (e.g. neonatology, obstetrics, midwifery, anaesthetics) to ensure the required 60% threshold is met.
- A reciprocal arrangement with neighbouring Trusts or network partners so that each organisation both provides and receives external reviewers, helping maintain availability and avoid reliance on a single individual.
- PMRT entries that clearly document who attended, their specialty, and whether they were external to the Trust, providing straightforward evidence of compliance.
- A small, reliable pool of external clinicians identified through local networks or LMNS arrangements, with contingency options to maintain reviewer availability during leave or periods of high activity.
- Governance oversight confirming external reviewer involvement, with any gaps explained and actions taken to strengthen arrangements.
- Summary outputs from reviews demonstrating how external perspectives have contributed to learning, challenge, and quality improvement, and included in routine maternity/neonatal governance reporting.

Sharing information with families

4. Provide relevant information

Provide relevant information regarding the role of MNSI, NHSR Early Notification (EN) scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.

What good might look like:

- Clear, accessible written and verbal information available for parents explaining MNSI, the EN scheme and the PMRT process, offered in a sensitive and timely way.
- Materials provided in different formats (including, but not limited to: 'Easy-read', translated versions, or interpreter-supported conversations, aligning with sub-action D1) to ensure families with language or communication needs can understand what is happening.
- Evidence that information is offered more than once (aligning with sub action C2) so families have multiple opportunities to ask questions or share their views before the PMRT review begins.
- Duty of Candour conversations and letters documented clearly, with families given time, support and contact details for follow-up.
- Feedback from families (where appropriate, via MNVP or bereavement services) informing improvements to the language, tone or accessibility of parent-facing materials.
- Confirmation through governance or assurance reports that families routinely receive the right information at the right time and that Boards have oversight of any gaps or improvements needed.

5. Offer parents a meeting with relevant specialists

Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.

What good might look like:

- Parents are proactively offered a meeting with the appropriate specialists (e.g. neonatology, obstetrics, midwifery, bereavement leads) once review findings are available, with the offer made in a sensitive and timely way.
- Evidence that offers are documented and made more than once where needed, ensuring families have opportunities to meet when they feel ready.
- Meetings arranged in a setting that supports open, compassionate discussion, with clear explanations of findings and space for parents to ask questions or share reflections.
- Documentation confirming who attended, what was discussed and any follow-up actions, ensuring continuity and avoiding reliance on a single team member to coordinate.
- Input from service users (e.g. MNVP or bereavement services) informing how meetings are structured, how information is shared and how any communication barriers (including language needs) are addressed.

- Governance oversight confirming that meetings are routinely offered, uptake is monitored and any gaps or learning about the process are acted on and reflected in reports to senior leaders.

Learning and governance

6. Thematic reports of learning and actions

The Trust must produce thematic reports that triangulate information and summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and Patient Safety Incident Response Framework (PSIRF) reviews, Maternity Outcomes Signal System (MOSS) critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes.

These thematic reports must be reviewed with the Trust Perinatal and Board level Safety Champions and submitted to the Trust Executive Board at least quarterly. Reports should clearly demonstrate the measures implemented to address recurrent themes, and progress with these, including how learning has been shared and, where appropriate, incorporated into existing multidisciplinary training.

What good might look like:

- A quarterly thematic report that brings together learning and actions across all relevant sources, with clear summaries and simple evidence of progress (e.g. action trackers, completed changes, updates from risk owners).
- Use of demographic data within the report to identify disparities in outcomes or experience, supported by analysis and follow-up actions where inequities are identified.
- Use of recognised improvement methodology (e.g. Plan-Do-Study-Act (PDSA), driver diagrams, measurable aims) to show structured actions and demonstrable progress.
- Evidence of routine discussion with the Trust's Perinatal and Board-level Safety Champions, captured through meeting notes and agreed actions.
- Reports that highlight recurrent themes and show how these have been addressed, including changes to pathways, escalation processes, documentation, or workforce plans.
- Clear examples of how learning has been shared across teams (e.g. safety huddles, newsletters, teaching sessions) and, where appropriate, incorporated into multidisciplinary training.
- Governance records demonstrating that these thematic reports are received and reviewed at Executive Board level each quarter, with any further actions or scrutiny clearly documented.

Safety Action D – Service-user voice and equity

1. Communication equity, language support and accessible information

Trusts should demonstrate continued progress towards ensuring that women and families, including those who may require translation, interpreting support, or reasonable adjustments, are supported to understand their care, options, and decisions at key points in the perinatal journey. Trusts should recognise that where information is not understood, consent may not be informed, valid or lawful. Reliance on family members, friends or informal interpretation must be treated as a patient safety, safeguarding and human rights risk.

What good might look like:

- Clear local processes ensuring timely access to professional interpreters (face-to-face, telephone or video), with usage evidenced in clinical records rather than reliance on relatives or friends.
- Accessible information provided in formats suited to individual needs. For example (and not limited to) translated materials, Easy read versions, visual prompts or communication aids, with records showing how these were offered.
- Staff routinely checking understanding, documenting how consent discussions were supported (e.g. interpreter present, communication aids used) and escalating concerns if communication barriers remain.
- Evidence of reasonable adjustments being made, such as adapted appointment formats, longer consultation times or additional follow-up for those with language or communication needs.
- Service user insight, for example via MNVP or community engagement, informing improvements to communication materials and identifying where families experienced barriers or misunderstandings.
- Governance oversight showing that any communication risks, interpreter usage and themes around informed consent are routinely monitored and included in reports to senior leaders and the Board.
- Use of recognised improvement methodology (e.g. PDSA, driver diagrams, measurable aims) to show structured actions and demonstrable progress.
- Evidence for Board assurance, including audit, spot checks, incident/complaint themes and service user feedback, demonstrates that communication equity processes are consistently applied.

2. Service-user voice driving safety and quality improvement

Trusts must demonstrate that insights from women, families and carers using maternity and neonatal services are captured and used to inform service

improvement plan. Trusts must use demographic data to understand their local population and demonstrate that the voices of women and families from different demographic groups, are actively captured and used to shape priorities within the service.

Progress with this plan should be monitored through established governance routes quarterly to ensure that actions lead to measurable improvements in safety, quality, or experience.

What good might look like:

- Multiple, accessible routes for women, families and carers to share their experiences. For example, through MNVP engagement, listening events, surveys (including Picker), 15 steps type exercises, friends and family tests, community outreach or digital platforms, with evidence that feedback is recorded and reviewed.
- Insights collected from a diverse range of demographic groups, using translation, interpreting support, targeted outreach or community partnerships to ensure under-represented voices are heard.
- A service improvement plan that clearly incorporates service-user feedback, showing how views and suggestions have shaped priorities, actions or pathway changes.
- Routine use of demographic data (e.g. ethnicity, deprivation, protected characteristics, language needs) to identify disparities in experience or outcomes, with associated actions documented and tracked.
- Governance minutes and regular reports demonstrating that progress is monitored, with improvements or gaps escalated as needed.
- Examples of how service-user themes have influenced practice, such as changes to communication materials, adjustments to antenatal or postnatal pathways, or updates to training scenarios.
- Use of recognised improvement methodology (e.g. PDSA, driver diagrams, measurable aims) to show structured actions and demonstrable progress.
- Board-level assurance reports highlighting key service-user themes, equity issues and actions taken, demonstrating that their voices inform decision making at every level (linking with Safety Action F).

Safety Action E – Care Bundles

1. Saving Babies' Lives Care Bundle (SBLCBv3.2) - Quarterly reporting to the Trust Board

The provider must report quarterly to the Trust Board on progress against SBLCBv3.2 implementation. Quarterly reports should demonstrate how the Trust has prioritised the requirements of the Care Bundle based on local progress, implementation status, and any relevant safety intelligence, including learning from local adverse incidents.

In light of the recent NHSE and RCOG fetal growth chart safety communication, Trusts should include a brief review within their local SBL priorities to confirm safe and appropriate fetal growth surveillance, confirming that fetal growth charts and surveillance pathways meet most recent national safety advice and identifying any local risks or improvement actions relating to fetal growth restriction (FGR) detection as highlighted.

What good might look like:

- A clear quarterly report to the Board summarising progress against each SBLCB v3.2 element, using indicators or dashboards (e.g. the national implementation tool where in use) to show implementation status, gaps and recent improvements.
- Evidence that local safety intelligence (e.g. incident themes, PSIRF findings, audit results or learning from MNSI/MBRRACE) is used to prioritise which Care Bundle elements need the most immediate focus locally.
- A short update confirming that fetal growth charts and surveillance pathways comply with current SBLCB v3.2 guidance, with any risks or actions around FGR detection clearly described.
- Documentation showing how actions arising from SBLCB audits or reviews are tracked, escalated and monitored through maternity governance.
- Board-level minutes demonstrating active discussion of SBLCB progress, areas of concern, and decisions about resourcing or improvement priorities.
- Examples of how SBLCB learning has been incorporated into training, communication materials or local pathways, particularly where FGR detection or monitoring processes have been strengthened.

2. Maternal Care Bundle – Implementation Plan

In collaboration with all relevant services, the provider agrees a plan with the Trust Board to implement the Maternal Care Bundle by March 2027. Progress with implementation is reviewed quarterly through established governance routes.

What good might look like:

- A Board-approved implementation plan setting out clear milestones, responsibilities and timescales for achieving full Maternal Care Bundle delivery by March 2027.
- Evidence of collaborative planning with all relevant services (e.g. maternity, anaesthetics, emergency medicine, critical care, community services) reflected in meeting notes or agreed action logs.
- A simple quarterly update that shows progress against each element of the bundle, highlights risks or delays, and outlines the actions being taken to address them.
- Governance oversight demonstrating that progress is monitored through existing maternity/neonatal safety groups, with escalation routes clearly documented.
- Board papers or minutes showing regular discussion of implementation status, resource needs and any required changes to support timely delivery.
- Examples of how learning from incidents, reviews or national guidance has shaped the local implementation approach.

3. Neonatal pulse oximetry testing

Trusts must develop a standardised, equitable, and governance-approved guideline for neonatal pulse oximetry testing, aligned to the BAPM framework. The guideline must describe the required clinical processes, data entry standards, and pathways for all birth settings (including homebirths) to ensure that every baby receives pulse oximetry screening between two and 24 hours of age, with clear escalation processes for babies in the amber and red pathways.

What good might look like:

- A single Trust-wide guideline, or an adopted regional guideline adapted locally if needed, describing consistent screening and escalation processes across all birth settings.
- Clear inclusion of when testing should occur (2–24 hours of age), how results should be documented and how amber/red pathways should be escalated.
- Evidence that the guideline has been approved through maternity/neonatal governance, with a plan in place for implementation and staff awareness.
- Routine review through governance to ensure the guideline remains aligned with BAPM expectations and that progress towards implementation continues.

Safety Action F – Board Oversight, Governance, Culture and Leadership

1. Board Oversight of Maternity and Neonatal Quality and Safety

Trusts must demonstrate that, through established governance routes, the Board routinely receives, reviews and responds to a comprehensive assessment of maternity and neonatal quality and safety. This assessment should cover training, workforce, staff and service user experience, and progress against the care bundles as **outlined in Safety Actions A–E**. Trusts must also ensure that findings arising from detailed scrutiny at the Quality Governance Committee are formally escalated to the Executive Board, providing full oversight in line with good governance practice and the expectations of the Perinatal Quality Oversight Model (PQOM). Where Trust-level mitigation is insufficient, escalation to Regional Midwifery Officer teams should be documented, alongside PQOM-aligned actions.

What good might look like:

- Regular Board-level maternity and neonatal quality and safety reports bringing together key themes from training, workforce, incidents, complaints, service-user feedback, clinical outcomes and care bundle progress.
- Evidence that the Quality Governance Committee (or equivalent with delegated authority) undertakes detailed scrutiny of these reports, with key metrics, themes, risks and required actions formally escalated to the Executive Board through established governance routes.
- Executive Board minutes showing active discussion, curiosity, challenge and follow-up, including requests for further assurance where needed, and decisions relating to resourcing, risk mitigation, targeted improvement work and alignment with wider strategic priorities and future planning.
- A consistent governance cycle ensuring all required information (e.g. from Safety Actions A–E) is reported at the correct frequency, supported by dashboards or trend analyses (ideally SPC-based) to demonstrate performance over time.
- Clear documentation of how deep-dive findings or emerging risks identified at the Quality Governance Committee level are escalated, recorded and tracked for impact at Executive Board level.
- Examples of improvements or policy changes made in response to Board scrutiny, demonstrating that oversight leads to measurable changes in safety, quality and experience.

2. Maternity Outcomes Signal System

Trusts must evidence that the critical safety check (Annex one of the MOSS standard operating procedures) was completed in the event of signals, or that a test drill was carried out. An accountable trust Board Executive (i.e. Chief Nurse, Chief Medical Officer or Executive Trust Board Safety Champion) must approve completed checks, including drills. This will be externally validated through regional assurance -

services must send a completed copy of critical safety check(s) or test drill to regions, for forwarding to the national team at england.moss@nhs.net.

What good might look like:

- A clear local process ensuring that whenever a MOSS signal is triggered, the critical safety check is promptly completed using the Annex 1 template, or a structured test drill (Annex 9) is undertaken as part of routine annual practice as per the standard operating procedures.
- Completion of Annex 1 showing timely completion of checks or drills, with the responsible executive reviewing and approving each one, and their approval clearly recorded.
- Checks and drills are not reliant on a single individual - perinatal leadership teams complete through co-production with staff working on the labour ward.
- Routine submission of each completed critical safety check or drill to the regional chief nurse, midwife, obstetrician and medical director (as per the standard operating procedures), and the regional assurance team.
- Perinatal leadership teams can arrange a meeting with the national MOSS project team at NHS England to discuss any aspect of MOSS. Half-hour slots are available on Mondays between 1.30pm-3pm. Please contact england.moss@nhs.net to arrange.
- Local governance oversight confirming that safety issues identified through MOSS checks are escalated for discussion to the next public trust board meeting for acting on.
- Continued trust board oversight and active engagement to ensure changes or improvements are made at the required speed, with examples of these highlighted at trust board meetings.

3. Maternity and Neonatal Board Safety Champions

Trusts must demonstrate that Maternity and Neonatal Board Safety Champions are actively supporting the perinatal leadership team (including the MNVP Lead where they are in commissioned in line with MNVP guidance), embedding a positive local safety culture, with regular two-way communication and clear escalation to the Trust Board.

What good might look like:

- Regular contact between Board Safety Champions and the perinatal leadership team (including MNVP representatives), with clear evidence of two-way communication about safety themes, service-user concerns and improvement priorities.
- Attendance or involvement of Safety Champions at key maternity and neonatal meetings, walk-arounds, listening events or MNVP sessions,

demonstrating visible leadership and active engagement with staff and families.

- A clear process for escalating risks, concerns or emerging themes from frontline teams and service users to the Executive Board, supported by brief notes or agreed actions.
- Documentation showing Safety Champions influencing priorities. For example, by supporting resource requests, endorsing improvement work, or ensuring alignment with wider Trust strategy.
- Inclusion of Safety Champion updates within regular governance and Board reports, demonstrating their ongoing role in oversight, assurance and the promotion of a positive safety culture.
- Examples of improvements or changes made as a result of Safety Champion involvement, showing impact rather than representation alone.

4. Perinatal Culture Improvement Plan

Trusts must demonstrate that they have a perinatal culture improvement plan in place which triangulates data and engagement from multiple sources, uses recognised improvement methodology to evidence progress and impact, and is reviewed by the Trust Board at least six-monthly.

What good might look like:

- A clear perinatal culture improvement plan that draws together insights from staff surveys, focus groups, staff walkarounds, service-user feedback (including MNVP), incident and audit findings, workforce data, and safety intelligence, user feedback (including MNVP), incident and audit findings, workforce data, and safety intelligence.
- Use of recognised improvement methodology (e.g. PDSA, driver diagrams, measurable aims) to show structured actions and demonstrable progress.
- Evidence that staff and service users are engaged in shaping priorities, with themes reflected in the plan and tracked over time.
- Regular updates through maternity/neonatal governance showing what has improved, what remains challenging, and what actions are underway.
- Inclusion in quarterly Board reports (aligning with sub-action F1) demonstrating scrutiny, discussion and follow-up actions, including requests for further assurance where needed.
- Examples of changes made in response to the plan, such as improvements to teamwork, communication, psychological safety, or escalation behaviours, showing real cultural impact.

Appendix 1 - Technical Guidance

Safety Action B – Training

How will the 90% attendance compliance be calculated?	The training requires 90% attendance at two pre-determined points during the MIS Year (April to November 2026): 30 November (mandatory MIS checkpoint), and one other Trust selected checkpoint, at the following training where applicable dependant on staff group: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal resuscitation training
Which maternity staff should be included for Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have any antenatal or intrapartum obstetric responsibility must attend the fetal surveillance training, either through their substantive role, or in the event of escalation. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric Consultants and SAS Doctors. • All other Obstetric Doctors contributing to the obstetric rota (without the continuous presence of an additional resident-tier Obstetric Doctor). • Midwives (including Midwifery Managers and Matrons, Community Midwives; Birth Centre Midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity Theatre Midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Neonatal staff • Maternity Critical Care staff (including Operating Department Practitioners, Anaesthetic Nurse Practitioners, Recovery and High Dependency Unit Nurses providing care on the maternity unit) • MSWs • GP and Foundation Level Trainees
Which maternity staff should be included for Maternity emergencies and multi-professional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric Consultants and SAS Doctors. • All other Obstetric Doctors including Obstetric Trainees (ST1-7), Sub-Speciality Trainees, Locally Employed Doctors (LED), Foundation Year Doctors and GP Trainees contributing to the obstetric rota. • Midwives (including Midwifery Managers and Matrons), Community Midwives; Birth Centre Midwives (working in

	co-located and standalone birth centres) and bank/agency Midwives. • Maternity Support Workers and Health Care Assistants (to be included in the maternity skill drills as a minimum). • Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS Year 8 compliance assessment. • Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS Year 8 compliance.
What maternity emergencies and multi-professional training do anaesthetists need to attend?	The following anaesthetic team members are required to attend a minimum of half of the wider MDT maternity emergencies training day. The schedule of the day should ensure the anaesthetists are able to join those locally agreed scenarios most relevant to anaesthetic involvement (e.g. PPH) • Obstetric Anaesthetic Consultants and autonomously practising Obstetric Anaesthetic Doctors. • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota. This updated requirement is supported by the RCoA and OAA. Sharing of learning with the wider anaesthetic team (that do not have regular responsibilities in maternity, but may be called upon in escalation) after the training with a focus on local learning is best practice.
Training attendance for agency staff	It is the responsibility of the employing agency to provide training for their staff, so these staff will not be included in your MIS declaration. However, it is the responsibility of the Trust to ensure that all agency staff have met minimum training requirements before working in the Trust.
Long-term sickness and maternity leave	Any staff absent from work due to long-term sickness (>28 days) or on maternity / parental leave (28 days) will be unable to work clinically or attend training while absent, so these staff will not be included in your MIS declaration while they are absent from work, and for one month after their return. These staff should be prioritised to attend any outstanding training as soon as possible on their return.
Training attendance for	It is the gold standard that all staff attend training in the unit that they are currently working in, so that they can benefit from local learning and training alongside their multi-disciplinary

rotational medical staff	colleagues, however it is appreciated that this may be especially challenging for rotational staff. In the following circumstances, evidence from rotating resident doctors having completed their training in another maternity unit will be accepted: • Staff must be on rotation. • The training must have taken place in any previous Trust on their rotation during the MIS training reporting 12-month period. This evidence may be a training certificate or correspondence from the previous maternity unit.
Rotational staff, and staff new to the organisation	Staff still working in their formal induction period will not be included in your MIS declaration until their induction period is completed. For all staff, training should be completed as soon as is practicable, and no later than three months after starting with the organisation. Training attendance as part of a formal trust induction is best practice.
Where do the multidisciplinary obstetric emergency drills need to take place? **Do we need to include paramedics in the community scenario?**	At least two emergency scenario/drills should be conducted during the whole MIS reporting period. One in a hospital based clinical area, and another starting in a community / home location The hospital clinical area can be any area where clinical activity takes place e.g. Delivery Suite, any clinic, ED, theatre, a ward. This should not be a simulation suite. Attendance from the relevant wider professional team is strongly encouraged, including (where applicable) theatre staff, paramedics, porters, haematology services and neonatal staff. This will require shared planning and cross-agency support. Learning from recent PFD reports highlights the importance of this multi-agency approach.
Which staff should be included for neonatal resuscitation training?	The staff listed below are required to attend neonatal resuscitation training within MIS Year 8: • Neonatal Consultants/SAS Doctors or Paediatric Consultants/SAS Doctors covering neonatal units. • Neonatal resident Doctors (who attend any births) • Neonatal Nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including Midwifery Managers and Matrons), Community Midwives, Birth Centre Midwives (working in

	co-located and standalone birth centres) and bank/agency Midwives. The staff groups below are not required to attend in-house neonatal resuscitation training within this MIS year: • Staff who have already attended an external neonatal resuscitation training course consistent with BAPM basic capability Neonatal Airway Capability or above (including external courses such as NLS) during MIS Year 8 • NLS instructors that have taught on a course during MIS Year 8 • All Obstetric and Anaesthetic Doctors (Consultants, SAS, LE Doctors and Anaesthetic Trainees) contributing to the obstetric rota. • Maternity Critical Care staff (including Operating Department Practitioners, Anaesthetic Nurse Practitioners, Recovery and High Dependency Unit Nurses providing care on the maternity unit). • Local policy should determine whether Maternity Support Workers are included in basic neonatal resuscitation dependent on their role within the service. • If Nursery Nurses work within the service, this should also be recognised in your local training needs analysis.
Which members of the team can teach basic neonatal resuscitation?	Registered RC-trained NLS instructors should deliver the in-house neonatal resuscitation training annual updates and assessments in line with BAPM Neonatal Airway Basic Capability standards.
Neonatal resuscitation training	All staff that require training should be trained and assessed in line with The British Association of Perinatal Medicine Neonatal Airway Safety Standard Framework for Practice (April 2024). All neonatal [and maternity] staff undertaking responsibilities as an ***unsupervised*** first attender / primary resuscitator attending any birth must have reached a minimum of 'basic capability' as described in the BAPM Neonatal Airway Capability Framework. No specific training course is mandated. However, the Resuscitation Council UK Neonatal Life Support (NLS) provider certification includes all skills required for Basic capability and most skills required for Standard capability.

	Staff that attend births **with supervision at all times** will not need to complete this assessment process for the purpose of MIS compliance.
Enhanced neonatal resuscitation training	Where additional or enhanced neonatal resuscitation training is already in place for specific staff groups, this should continue (e.g. NLS or equivalent). Local decisions may determine which staff receive enhanced training, but priority should be given to staff who may act as the primary resuscitator at any birth, whether in hospital or in community settings. Organisations should consider neonatal resuscitation training for Tier 2 and Tier 3 neonatal staff, ensuring formal training on the skills and scenarios required to meet intermediate airway capability as described in the BAPM Neonatal Airway Safety Standard, with annual training for staff on Tier 2 and Tier 3 neonatal rotas.

Safety Action C – Learning from Reviews and Investigations

1. Reporting and review: Notify all qualifying events and deaths	
1a. Qualifying events and deaths are defined as:	• Details of which perinatal deaths must be notified to **MBRRACE-UK** are available at: www.npeu.ox.ac.uk/mbrrace-uk/perinatal-programme • Notification and surveillance information must be provided for babies who die after a home birth where the care was provided by your Trust and those babies who die at home having been discharged from your Trust. • All maternal deaths during pregnancy and up to one year following the end of the pregnancy (regardless of how the pregnancy ended) must be notified to **MBRRACE-UK.** • Details of which maternal deaths, perinatal deaths and babies with brain injury must be notified to Maternity and Newborn Safety Investigations (**MNSI)** programme are available at: https://www.mnsi.org.uk/for-nhs/investigation-overview-for-nhs/#what-we-investigate • Details of which babies with brain injury must be notified to **NHS Resolution (NHSR) EN** scheme are available at, we strongly recommend that reporting occurs within 14 days, this is to support NHS Resolution commence engagement with families: https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/support-for-nhs-trusts-or-member-organisations/
1b. The process and timeline for event/death notification and use of the data:	• Notifications of all the events and deaths listed above are made through the NHS England Submit a Perinatal Event Notification (SPEN) portal, which automatically directs information about the appropriate deaths/events to MBRRACE-UK, MNSI and the NHSR EN scheme. • For the purposes of the maternity incentive scheme (MIS), all eligible perinatal deaths and events for MBRRACE-UK and MSNI must be notified via SPEN within seven working days of the death/event. • Neonatal deaths notified via SPEN to MBRRACE-UK continue to be automatically and

	immediately transferred to the appropriate local Child Death Overview Panel (CDOP) via the Cascade system. See 1(c) below for the timings for notifying neonatal deaths. • Once eligible perinatal deaths have been notified to MBRRACE-UK via SPEN, MBRRACE-UK users should log on to the MBRRACE-UK/PMRT system to complete the surveillance information; and PMRT users should log on to start the PMRT review for eligible deaths. • When referring through SPEN an event that meets MNSI and NHSR EN criteria the portal will provide guidance to complete the submission as an MNSI reference number will be requested to support referral to NHSR EN. • The MOSS system also automatically receives a Trust-specific data feed from the relevant events notified via SPEN.
1c. The statutory obligation to notify neonatal deaths to local CDOPs:	• The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification of neonatal deaths to local Child Death Overview Panels. • Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) within two working days of the death (where working days are regarded as Monday to Friday). • This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england
1d. Checking notifications:	• MBRRACE-UK system users can log on to the MBRRACE-UK/ PMRT system to check the deaths they have notified are complete and correct. • MBRRACE-UK system users must log on to MBRRACE-UK to complete the surveillance information and to start a PMRT review.
2. Reporting and review: Seek parents' views of care	
2a. For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all	• Parents must be informed following the death of their baby, and preferably in person before leaving hospital, that a local review of all elements of their care and that of their baby will take place. • In the case of a neonatal death, parents should also be told that a local CDOP review will also be undertaken.

elements of care and the impact of that care, and raise any questions and comments they may have prior to the PMRT review starting.	• Verbal information should be supplemented with written information using plain language and translated formats where necessary. • Parents' experience of all elements of their care must be treated as essential information required to complete the clinical picture for a meaningful review. The review process is primarily for parents, and only by incorporating parents' experiences, perspectives and questions can the Trust understand how care was offered, given and received by parents. This information must be entered into the PMRT to enable it to form part of the review; the parent questions appear first in the PMRT to reflect their central importance. • Without being intrusive parents should be given multiple opportunities to meaningfully provide information about their experience of care, and the impact of that care, and to raise any questions and comments they may have. • The process of gathering parents' experiences must start at least two weeks before the review begins. A trauma-informed approach should be considered. https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice Trauma-informed care in the UK: where are we? A qualitative study of health policies and professional perspectives | BMC Health Services Research • It is important to recognise that gathering parent experiences across antenatal, intrapartum, postnatal, bereavement, and neonatal care may require more than one conversation or meeting, including in-person discussions where appropriate. Templates for gathering this as written information can also be used where appropriate and examples are provided on the PMRT website: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials. Other materials to support the parent engagement process are also provided on that page. • If information about parent experiences is held in another data system it needs to be brought to the review meeting, entered into the PMRT and considered as part of the review discussion. • In communications with parents' staff should ensure they approach this with the principles of equity in mind to ensure that socially

	disadvantaged, disabled and ethnic minority parents are positively included. It also is important that the process of parent engagement is guided by the parents. A single key professional contact can help parents navigate this difficult process. • Parents should be given the opportunity to review, amend or add to their reflections before the review begins if they wish.
2b. Ensure parents' feedback informs the review, the findings and actions, and that unmet requirements are addressed.	• Trusts should conduct quarterly audits of whether family feedback has been reflected upon in PMRT reviews and whether their feedback influenced review findings and actions, including clear "you said, we did" examples. • Where requirements are not met for all eligible deaths, this should be escalated to the Board through the quarterly report, setting out the reasons and the resulting SMART actions. • SMART actions must be co-developed with MNVPs and service user representatives and integrated into the wider service-level improvement plan, aligned with other quality, safety and equity priorities. Progress should be monitored and reported through existing governance and assurance structures.
2c. Ensure all parents are given the opportunity to be involved in the review process, including where they choose not to engage or do not respond.	• Trusts must ensure that all parents are informed that a review will take place and should ensure that participation options are accessible to all parents, including through plain language and translated or interpreted materials where required (see point 2b). • Parents' decisions not to engage must be respected. However, some parents may change their mind; without being intrusive, Trusts must provide more than one opportunity for them to contribute. • Where parents do not respond, Trusts should consider the steps set out in the PMRT parent engagement guidance, including use of the flow chart and where appropriate the translated parent-facing materials available on the PMRT website.
3. Reporting and Review: Include external reviews in the PMRT review panel	
3a. For a minimum of 60% of the deaths reviewed external	• External panel member(s) must be relevant senior clinician(s) who are currently practicing clinically and work in a hospital external to the

members of relevant specialties must be present at the multi-disciplinary review and this should be documented within the PMRT.	trust undertaking the review and external to any trust involved in the care at any stage. Ideally, the external reviewer(s) should be the specialist(s) relevant to the care provided, for instance an obstetrician for all deaths, and a neonatologist for neonatal deaths. • A gold standard review of a neonatal deaths would involve an external obstetrician and an external neonatologist. • In addition to currently practicing clinically an external reviewer could be, for example, a member of another Trust/Health Board governance team. However, they must possess relevant clinical expertise, be up-to-date with training and continuing professional development (CPD), and either currently undertake clinical shifts or be in a position to do so if required. This is crucial because externality demands clinical credibility, requiring the experience and current knowledge necessary to reflect on care provision and offer authoritative, robust, objective challenge when required. • If more than one Trust is involved in the review because more than one Trust was involved in the care, none of these staff members are 'external' panel members because they cannot provide an independent view of the care. They should not be listed as 'external' members in the PMRT participant list. • Although an MNVP member is not employed directly by the Trust they should not be regarded, nor documented as, an 'external' member. They are present to represent the wider parent voice. • Parents value highly the independence of review that comes with the involvement of externals as otherwise Trusts are regarded as 'marking their own homework'. **Note** that this is a minimum requirement for Year 8 of 60% of reviews having an external member present for the MDT meeting.
4. Sharing information with families: Provide relevant information to parents about the role of investigations and reviews	
4a. Provide relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews to families in a	• Information provided to parents and families should clearly explain, in plain language what reviews and/or investigations are relevant to their circumstances. For example, all perinatal deaths (but not babies with brain injury) will have a

format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.	PMRT review. Whereas, for example, early neonatal deaths at term will have a PMRT review, be eligible for an MNSI investigation, a statutory CDOP review will take place, and the death may be referred to the coroner. • Information could include a link to 'Learn Together', to support parents' and families' understanding of learning and improvement following adverse outcomes and reinforcing principles of openness, shared learning, and partnership with parents. • Where relevant, information must include a link to the Duty of Candour (Regulation 20) guidance, explaining families' rights to openness and honesty following incidents. • Using branded MNSI materials where available will help to ensure consistency and clarity. If there are any queries in relation to MNSI these can be directed through the trust MNSI link team member or Enquiries@mnsi.org.uk • PMRT parent-facing materials are available to be used to explain the local review process, the role of parent experience within the review, and how parents' questions and perspectives are included. These materials are available to be modified in line with Trust-specific processes. • During the development of local written and digital materials, an accessibility assessment should be completed for all written and digital materials, considering language, literacy, disability, sensory needs, digital access, and cultural appropriateness. Materials should be provided in translated or alternative formats where required. Translated materials are provided by PMRT and NHSR EN scheme. • When interacting with parents an assessment of comprehension should be undertaken, to ensure parents understand the information provided. This should include opportunities for parents to ask questions, check understanding, and request further explanation or support, rather than relying solely on written information. • Information should be provided in a trauma-informed way https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice, recognising that families may need time and more than one opportunity to engage with and

	understand complex processes. The following is a list of links and advice to consider when providing information for parents and families: • PMRT parent engagement materials (including materials translated into some other languages): Parent Engagement Materials | PMRT | NPEU • MNSI information for families: https://www.mnsi.org.uk/for-families/ • NHS Resolution family pages: Support for families or carers - NHS Resolution • NHS Resolution Early Notification Scheme information animation: Early Notification Scheme animation on Vimeo • NHS Resolution translated resources: Translated resources - NHS Resolution • Consideration of information accessibility: https://www.england.nhs.uk/accessible-information-standard/ • Duty of candour: https://www.cqc.org.uk/guidance-regulation/providers/regulations-service-providers-and-managers/health-social-care-act/regulation-20/incidents • Learn Together: https://learn-together.org.uk/
5. Sharing information with families: Offer parents a meeting to share report findings	
5a. Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.	• Trusts must ensure that parents are offered a meeting to share the findings with them from PMRT reviews, MNSI investigations, and other relevant reviews or incident reports. These meetings should be centred on the needs of parents. https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf • Where this meeting is to discuss care of a baby who received neonatal care ensure that that this is a joint meeting with both maternity and neonatal staff. • The purpose of this meeting is to discuss with parents what has been reviewed, what has been found, and what learning or actions have been identified, using plain language and avoiding technical or defensive terminology. This should also include discussion of any implications for their future care.

	• The discussion should be at a pace and in a format that is guided by the parents. This may require more than one meeting and must allow families time to process information and ask questions. • Families should be supported to understand how their experiences, perspectives, and questions were considered within the PMRT and other review processes, and how these influenced findings and actions. • Where review findings are shared in writing, these must be accompanied by a verbal explanation and opportunities for clarification. Written materials must use plain language and be provided in translated or alternative formats where required. The letter should describe what was discussed in the meeting and provide a summary of the PMRT report in understandable non-technical language. • Trusts should avoid one-off or transactional communication. Follow-up contact must be offered so families can raise further questions after receiving or reflecting on the information they have received so far. • Where families do not wish to engage directly, or find direct engagement too distressing, they should be offered the option to receive information. For example, the offer of an on-line appointment for parents who do not wish to attend the hospital where their baby died. Providing a letter which summarises the review findings which in two envelopes so if they do not wish to read the review information they can decide not two open the second envelope – a covering letter should explain this. Offering a follow-up appointment for a later date when they feel ready to receive the information. Offering an open appointment which they can take up in the future if and when they feel ready to receive the information. • Trusts should ensure that learning and actions shared with families are consistent with what is reported through governance structures, including Boards and PQOM, to avoid conflicting messages or loss of trust. • MNSI has a tripartite meeting process in place, this is where they support the trust to meet with the family when a safety investigation has been completed. This enables a discussion to go through the findings and recommendations and

	for the Trust to share how these will be taken forwards.
6. Learning and Governance: Implement system and process actions	
6a. Implement system and process actions in response to learning from investigations (including MNSI, NHSR EN scheme), local reviews (including PMRT reviews) and national reports which will improve the provision of safe care in your trust.	• Learning from MNSI investigations, PMRT reviews, NHSR EN reports, other local reviews/investigations and national reports must be translated into SMART system and process actions which are clearly owned. • Actions must not sit in isolation. They must be incorporated into an existing service-wide action plan and/or improvement tracker, aligned with wider priorities for quality, safety, equity, and subject to formal Board oversight. • Where appropriate actions should be co-developed with MNVPs and/or service user representatives, ensuring that proposed changes reflect family experience. • For multi-site Trusts, learning should be assessed at site level, with evidence of site-specific actions and implementation. Trusts should develop more than one action where learning applies differently across sites. • When deciding which system-level actions to implement, Trusts should explicitly consider and align actions with themes reported to the Board, prioritising actions most likely to deliver meaningful and sustained change. This approach supports effective Board scrutiny and facilitates access to resources where required. • Progress against actions should be monitored through existing governance arrangements, with clear reporting on delivery, impact, and any barriers to implementation.
7. Learning and Governance: Thematic reports of learning, actions and outcomes	
7a. Thematic reports of learning and actions that triangulate information and summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards and	• See below for the guidance on the contents of the thematic reports. • Submit and discuss these reports with the Trust Perinatal and Board Level Safety Champion prior to submission to the Trust Executive Board with a minimum frequency of quarterly. • Larger Trusts with larger number of deaths/events may report more frequently than quarterly. • Authorised PMRT users can generate reports for their trust which summarise the results from completed PMRT reviews over a period of time

relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes. These must be discussed with the Trust Perinatal and Board Level Safety Champions and submitted to the Trust Executive Board at least quarterly. Reports should clearly demonstrate the measures implemented to address recurrent themes, including how learning has been shared and, where appropriate, incorporated into existing multidisciplinary training.	defined by the user. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used to support the writing of the quarterly reports. Note that these reports will only show summaries, issues and action plans for reviews that have been completed and published, therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months. • These reports should be a synthesis of learning and emerging findings. For learning based on events and deaths in the trust the learning should be cumulative and emergent, rather than just relating to the specific quarter. This way recurrent issues and themes across longer periods of time can be highlighted rather than treating the findings, based on a relatively small number of events/deaths, in each quarter in isolation. • These reports provide the important evidential basis for escalating key risks, recurrent themes, and resource requirements to the Executive Board
Suggested report headings	
(i) Where the learning has come from	• Describe where the learning reported this quarter has come from. This may be from MNSI investigations of events in your trust, local PMRT reviews, a MOSS critical safety check(s), recent PSIRF findings, a recent national report issued by MNSI, a recent national report issued by MBRRACE-UK, a recent national report from a hospital specific enquiry e.g., the East Kent Inquiry, your Trust CQC report, Coronial Prevention of Future Deaths notices, and the NHS Resolution EN scheme. • Trusts with larger numbers of deaths are encouraged to submit reports more frequently than quarterly. • For smaller trusts there may not have been any specific deaths/events in the particular quarter to report. In this situation include the analysis of recent national reports and how their relevance has been considered in the trust and what actions, if any, have followed

		• Important evidence of learning also comes from service user feedback, and this should be triangulated with other relevant learning.
(ii)	What learning and actions have been prioritised	• Describe what learning and actions you have identified and how have these been prioritised to support safe care in your perinatal services. Describe how, in this process, the learning and actions have been triangulated with information about parents' experience, quarterly insight reports from MNVPs, complaints, CQC survey findings etc.
(iii)	What actions have been implemented	• Describe the actions you have implemented to provide safer care in response to your learning priorities.
(iv)	What impact have earlier actions had	• Describe the safer care impacts and outcomes that have been seen following the implementation of earlier actions. This is to demonstrate sustained actions and impact.
(v)	What you need help with from the Executive Board	• Highlight areas of challenge, key risks and recurrent themes, and whether these have been included on your risk register and what mitigation has been put in place. Describe what additional help/resources are required to meet these challenges.

MIS FAQ

What do you mean by Trust Board?	Unless explicitly stated, Trust Board can be interpreted as 'the Trust Board or appropriate sub-committee with delegated authority' as long as these sub-committees provide Trust Board with output following their review and discussion.
Why aren't we reporting everything directly to Trust Boards?	Trust Boards have a broad scope of responsibility, covering all aspects of the Trust's governance, strategy, and finances. They provide strategic direction and oversight, while sub-committees such as the Quality Governance Committee takes a more hands-on role in monitoring quality and safety performance reviewing and scrutinising operational detail. It is vital that the most pertinent information that is conveyed to Trust Boards is clearly recognised and not lost in the operational detail of reporting. A sub-committee's in-depth examination of data, reports, and practices provides the Board with a clear understanding of the Trust's performance on quality and safety, including any immediate priorities or exceptions.
How can I evidence an appropriate sub-committee?	A Board Assurance Framework should highlight the decision-making processes within a Trust and detail those committees with delegated authority from the Board. Individual Terms of Reference from sub-committees should also contain this information. Minutes of sub-committee meetings should demonstrate that the required discussion around MIS safety actions have taken place, including any output which will be conveyed to the Trust Board. This must be recognised within Trust Board minutes.
What is a Quality Governance Committee (or equivalent), and how does it differ from a Trust Board?	A QGC (or equivalent) is a committee of the Trust Board responsible for overseeing the Trust's quality and safety governance arrangements. It provides assurance to the Trust Board that the Trust has robust systems in place to identify, assess, and mitigate risks to patient safety. The QGC also reviews the Trust's quality improvement initiatives and provides recommendations to the Trust Board. The information presented to a QGC will be more detailed and specific than the information presented to the Trust Board. They should receive regular updates on the Trust's performance in key quality and safety areas, as well as specific data on individual incidents and concerns. The QGC should also have the opportunity to discuss the

	Trust's quality improvement plans and provide feedback and recommendations. A QGC is appropriate to review evidence around safety actions, provide additional scrutiny **and then report to the Trust Board, delivering a summary and highlighting any exceptions or particular areas of concern.** **It is important to ensure that this process facilitates Trust Board oversight, rather than replaces it.**
Where can I find more information about Board Reporting via Quality Governance Committees?	Effective Board Assurance Committees Quality Governance in the NHS
Does 'Board' refer to the Trust Board or would another committee suffice for the Board notification form?	Trust Boards must self-certify the Trust's final MIS declaration following consideration of the evidence provided. It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we will escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the CQC for their consideration if any further action is required, and to the NHS England regional director, the Deputy Chief Midwifery Officer, Regional Chief Midwife and Department of Health and Social Care (DHSC) for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the Trust CEO and AO (ICB). Where relevant, an action plan is completed for each action the Trust has not met. **Please send only the Board notification form to NHS Resolution. Do not send your evidence or any narrative related to your submission to NHS Resolution unless requested to do so for the purpose of reverification.**

	Any other documents you are collating should be used to inform your discussions with the Trust Board. These documents and any other evidence used to assure the Board of your position must be retained. In the event that NHS Resolution are required to review supporting evidence at a later date it must be made available as it was presented to support Board assurance at the time of submission.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2026 and all Trusts will be notified. It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12:00 on 2 March 2027, NHS Resolution will treat that as a nil response.
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12:00 on 2 March 2027**. If not returned to NHS Resolution by this time, NHS Resolution will treat that as a nil response.
Our Trust has queries, who should we contact?	Any queries prior to the 2 March 2027 must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net
Please can you confirm who outcome letters will be sent to?	The MIS outcome letters will be sent to Trust's nominated MIS leads.
What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated MIS link contacts via the link on the NHS Resolution website.
What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for appeals this year?	Yes, there will be an appeals process. Trusts will be allowed 14 days to appeal the decision following the communication of results. The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe. There are two possible grounds for appeal:

	• Alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation. • Technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate. NHS Resolution clinical advisors will review all appeals to ensure validity, to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC. Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered. Further detail on the appeals window dates will be communicated when final results are confirmed and sent to Trusts.
How does the financial element of the scheme work?	NHS Resolution introduced the MIS to support the delivery of safer maternity care through the introduction of an incentive element to contributions to the CNST. NHS Trusts that provide maternity services are charged an amount in addition to their CNST maternity contribution for the MIS. Where a trust has successfully demonstrated achievement against the ten safety actions, it will recover its element of MIS contribution that went into the maternity incentive fund, plus a share of any unallocated funds. **This rebate will be returned to the original funding source**. Trusts unable to demonstrate achievement of the ten actions may be able to apply for a lesser sum from the fund to help them achieve any unmet actions. Where a reverification of a prior year takes place, if the trust is found to have mis-declared compliance it must immediately repay to NHS Resolution the funds originally awarded for that MIS year. This is irrespective of the reverification being conducted in a different financial year. Any funds retrieved from non-compliant trusts will be redistributed to all trusts that achieved compliance for the applicable MIS year. This redistribution will take place within in the same financial year that NHS Resolution receives the returned funds. As NHS Resolution is not deemed a supplier in this arrangement and the arrangement does not meet the definition of a contract, the monies received from the scheme are considered out of scope of IFRS 15. Instead,

	they are treated as per IAS 1, in that the receipts of funds are offset against the cost of the scheme.
If we haven't spent our MIS funds, can we carry them over to the next financial year.	You will need to adhere to the relevant statutory accounting standards for NHS bodies that this may fall under. NHS Resolution has no influence over this, and if you need any further guidance on the accounting treatment then we recommend speaking to your regional finance contact at NHS England.
Merging Trusts	Trusts that will be merging during the Year 8 reporting period (March 2026 – March 2027) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed. In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2026/27 and the reporting of claims and management of claims going forward.

Appendix 2 - Abbreviations

A

- **ABC** – *Avoiding Brain Injury in Childbirth* (RCOG programme)
- **ACSA** – *Anaesthesia Clinical Services Accreditation*
- **AAC** – *Appeals Advisory Committee*
- **ARCP** – *Annual Review of Competency Progression*

B

- **BAPM** – *British Association of Perinatal Medicine*
- **BR+ / BR Plus** – *Birthrate Plus® midwifery workforce planning tool*

C

- **CAG** – *Clinical Advisory Group*
- **CCFv2** – *Core Competency Framework Version 2*
- **CDOP** – *Child Death Overview Panel*
- **CEO** – *Chief Executive Officer*
- **CNST** – *Clinical Negligence Scheme for Trusts*
- **CODP** – College of Operating Department Practitioners
- **CPD** – *Continuing Professional Development*
- **CQC** – *Care Quality Commission*
- **CRG** – *Clinical Reference Group*
- **CTG** – *Cardiotocography*

D

- **DoC** – *Duty of Candour*

E

- **EN** – *Early Notification scheme* (NHS Resolution)
- **ESR** – *Electronic Staff Record*

F

- **FGR** – *Fetal Growth Restriction*
- **FTSU** – *Freedom to Speak Up*

G

- **GPAS** – *Guidelines for the Provision of Anaesthesia Services*

H

- **HSIB** – *Healthcare Safety Investigation Branch* (previous structure)
- **HSSIB** – *Health Services Safety Investigations Body* (current)

I

- **IOL** – *Induction of Labour*
- **IFH** – *Impacted Fetal Head*

L

- **LNU** – *Local Neonatal Unit*
- **LMNS** – *Local Maternity and Neonatal System*

M

- **MBRRACE-UK** – *Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries*
- **MCB** – *Maternal Care Bundle*
- **MNSI** – *Maternity and Newborn Safety Investigations*
- **MNVP** – *Maternity and Neonatal Voices Partnership*
- **MIS** – *Maternity (Perinatal) Incentive Scheme*
- **MOH** – *Massive Obstetric Haemorrhage*
- **MOSS** – *Maternity Outcomes Signal System*
- **MVP** – *Maternity Voices Partnership (previous terminology)*

N

- **NHSR** – *NHS Resolution*
- **NICU** – *Neonatal Intensive Care Unit*
- **NICE** – *National Institute for Health and Care Excellence*
- **NMC** – *Nursing and Midwifery Council*
- **NND / ND** – *Neonatal Death* (used within PMRT definitions)

O

- **ODN** – *Operational Delivery Network*
- **OKTA** – *Identity authentication system for NHS England applications*

P

- **PALS** – *Patient Advice and Liaison Service*
- **PFD** – *Prevention of Future Deaths Notices*
- **PMA** – *Professional Midwifery Advocate*
- **PM** – *Post-Mortem*
- **PMRT** – *Perinatal Mortality Review Tool*
- **PQOM** – *Perinatal Quality Oversight Model*
- **PSIRF** – *Patient Safety Incident Response Framework*

Q

- **QGC** – *Quality Governance Committee*

R

- **RCoA** – *Royal College of Anaesthetists*
- **RCOG** – Royal College of *Obstetricians and Gynaecologists*
- **RCM** – *Royal College of Midwives*
- **RTDM** – *Real Time Data Monitoring* (MBRRACE-UK)

S

- **S4N / SMaRT4NIPE** – *Newborn and Infant Physical Examination data system*
- **SAS** – *Specialist and Associate Specialist Doctors*
- **SBLCBv3.2** – *Saving Babies' Lives Care Bundle Version 3.2*
- **SCU** – *Special Care Unit*
- **SitRep** – *Situation Report* (NHS England operational data)
- **SOP** – *Standard Operating Procedure*
- **SPEN** – *Submit a Perinatal Event Notification system*

T

- **TN / Tier 2 / Tier 3** – *Neonatal medical staffing tiers*
- **TNA** – *Training Needs Analysis* (not explicit but related; excluded unless you want included)

W

- **WTE** – *Whole Time Equivalent*

Appendix 3 - References

Safety Action A

- NHS England – *Neonatal Critical Care Service Specification (March 2024)*
- British Association of Perinatal Medicine (BAPM) – *Service and Quality Standards for Provision of Neonatal Care in the UK*
- BAPM – *Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK*
- Neonatal ODN – *Guidance for the Neonatal Nursing Workforce Tool*
- Royal College of Obstetricians and Gynaecologists (RCOG) – Certificate of Eligibility for short-term locums (CEL)
- Royal College of Obstetricians and Gynaecologists (RCOG) – Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology
- Royal College of Obstetricians and Gynaecologists (RCOG) – *Workforce Census 2025*
- Royal College of Anaesthetists (RCoA) – *Guidelines for the Provision of Anaesthesia Services (GPAS), Chapter 9: Obstetric Anaesthesia*
- Royal College of Anaesthetists (RCoA) – *Anaesthesia Clinical Services Accreditation (ACSA)*
- Birthrate Plus® – *Midwifery Workforce Planning Tool*
- Ockenden Report (Final and Interim) – *Independent Review of Maternity Services*
- MBRRACE-UK – *Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries*
- Embrace – *Perinatal Mortality and Morbidity Reports*
- NHS Resolution – *Early Notification Scheme and Maternity Claims Reports*

Safety Action B

- NHS England » Core competency framework version two
- NHS England – Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)
- NHS England – Patient Safety Incident Response Framework (PSIRF)
- Making Data Count on NHS Learning Hub
- BAPM Neonatal Airway Safety Standard | British Association of Perinatal Medicine
- BAPM Neonatal Airway Safety Standard (NHS Learning Hub)
- Avoiding Brain Injury in Childbirth (ABC) Programme – Royal College of Obstetricians and Gynaecologists (RCOG)
- UK Government announcement on national rollout of the ABC Programme
- Health Innovation Oxford & Thames Valley – ABC Programme Overview
- HSSIB National Learning Report – Assessment of Risk During the Maternity Pathway
- HSIB/HSSIB National Learning Reports – Emphasis on MDT response and communication
- Maternity and Newborn Safety Investigations (MNSI) – Publications and National Learning

- NICE Guideline NG121 – Intrapartum Care for Healthy Women and Babies (Teamworking & Escalation)
- NICE Guideline NG229 – Fetal Monitoring in Labour
- e-Learning for Healthcare (e-LfH) – Neonatal Airway Programme
- RCOG – Multi-disciplinary Team Working
- PROMPT Maternity Foundation – PROMPT Obstetric Emergencies Training
- Royal College of Anaesthetists (RCoA) – Anaesthesia and MDT Maternity Care Standards
- NHS Resolution – Early Notification Scheme Reports (MDT learning themes)

Safety Action C

See technical guidance

Safety Action D

- Ockenden Review – Final Report
- MBRRACE-UK – Maternal and Perinatal Mortality Reports
- CQC – National Review of Maternity Services in England (2022–2024)
- NHS England – Improvement Framework: Community Language, Translation and Interpreting Services
- NHS England – Accessible Information Standard
- NHS England – Equity and Equality Guidance for Local Maternity Systems
- NHS England – Core20PLUS5
- NHS England – Working in Partnership with People and Communities
- NHS England – Patient Safety Incident Response Framework (PSIRF)
- Maternity and Neonatal Safety Improvement Programme
- Preventing Future Deaths (PFD) – Judiciary Reports
- Nottingham / Amos Maternity Review (official site)

Safety Action E

- NHS England » Saving babies' lives: version 3

Safety Action F

- Maternity Outcomes Signal System (MOSS) – NHS England Applications Portal
- OKTA Registration for NHS England Applications
- MBRRACE-UK Real-Time Data Monitoring (RTDM)
- Perinatal Quality Oversight Model (PQOM)
- Maternity and Neonatal Voices Partnerships (MNVP) Guidance
- Freedom to Speak Up (FTSU) Guardian Guidance
- Professional Midwifery Advocate (PMA) Guidance
- NHS England Culture and Leadership Improvement Resources
- NHS Staff Survey
- Model Region Blueprint (for regional oversight transfer)

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