NHS Resolution

Maternity incentive scheme – year four

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

October 2021

Contents

Introduction

NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

As in year three, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

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

Maternity incentive scheme year four: conditions

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on 30 June 2022 and must comply with the following conditions:

- Trusts must achieve **all** ten maternity safety actions.
- The Board declaration form must be signed three times and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:
  - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
  - The content of the Board declaration form has been discussed with the commissioner(s) of the Trust's maternity services.
  - There are no reports covering either this year (2021/22) or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before 30 June 2022.
- The Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity

Services Data Set (safety action 2, standard 2 and 3), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

- The regional chief midwives will provide support and oversight to Trusts when receiving Trusts' update at Local Maternity System (LMS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested as explained above.
- Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.
- Trusts will need to report compliance with MIS by 30 June 2022 at 12 noon using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board.
- Only for a set amount of safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.
- The declaration form will be available on the MIS webpage in 2022.

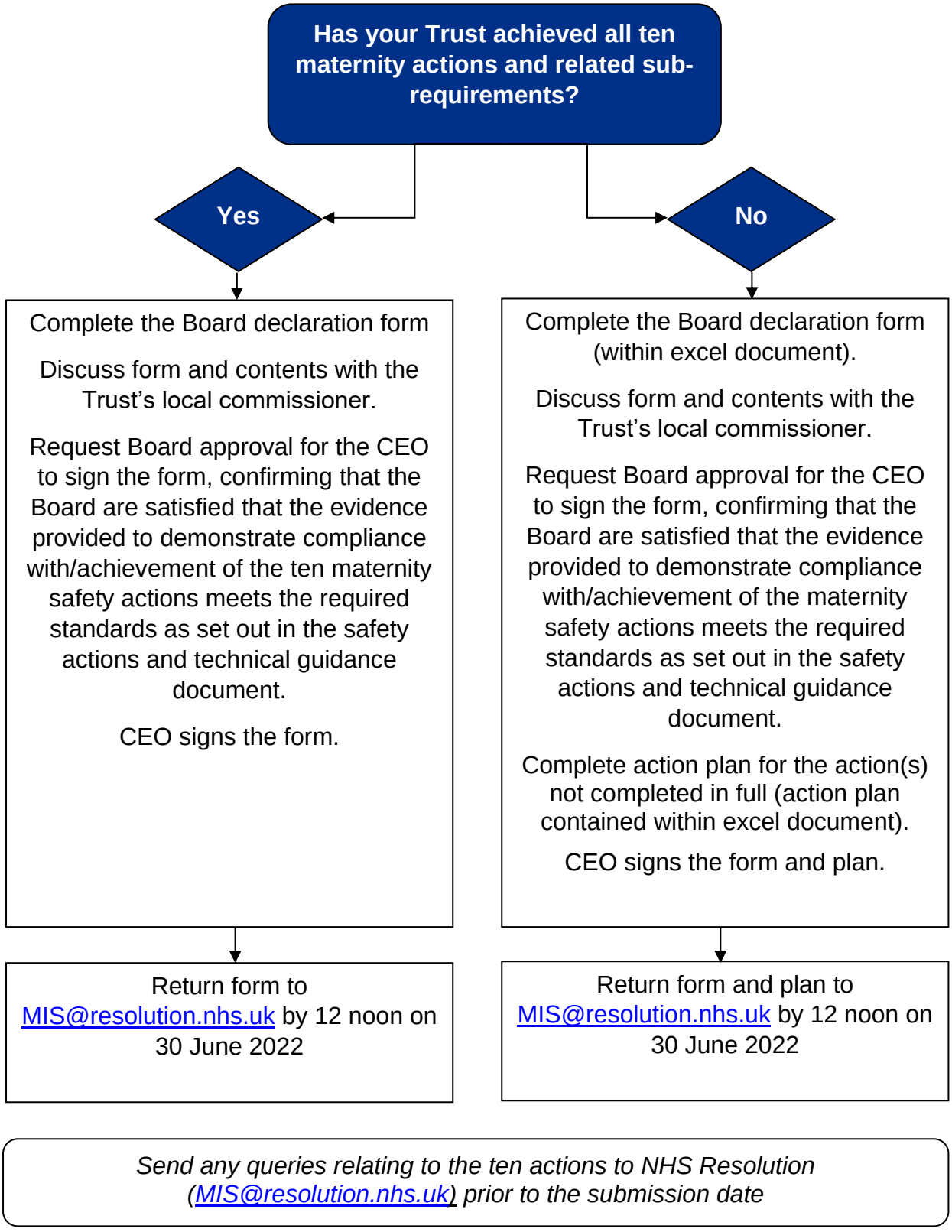
Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution (MIS@resolution.nhs.uk) prior to the submission date.

- The Board declaration form must be sent to NHS Resolution (MIS@resolution.nhs.uk) between Monday 27 June 2022 and Thursday 30 June 2022 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within ten working days from submission date.
- Submissions and any comments/corrections received after 12 noon on 30 June 2022 will not be considered.
- Further detail on the results publication, appeals and payments process will be communicated at a later date.

For Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 30 June 2022 to NHS Resolution (MIS@resolution.nhs.uk). The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the template (see Appendix 1). Action plans should not be submitted for achieved safety actions.

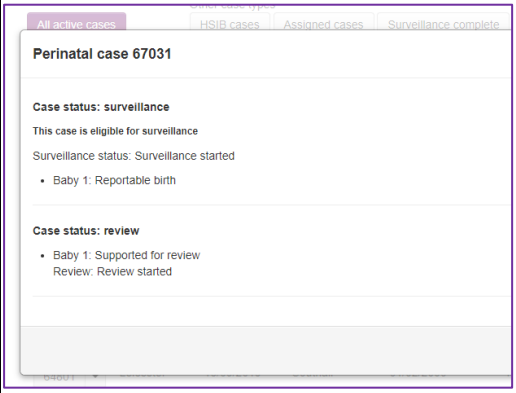

Has your Trust achieved all ten maternity actions and related sub-requirements?
Yes
No
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner.
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
CEO signs the form.
Complete the Board declaration form (within excel document).
Discuss form and contents with the Trust's local commissioner.
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
Complete action plan for the action(s) not completed in full (action plan contained within excel document).
CEO signs the form and plan.
Return form to MIS@resolution.nhs.uk by 12 noon on 30 June 2022
Return form and plan to MIS@resolution.nhs.uk by 12 noon on 30 June 2022
Send any queries relating to the ten actions to NHS Resolution (MIS@resolution.nhs.uk) prior to the submission date

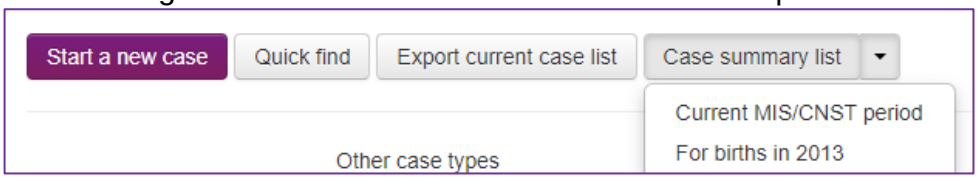
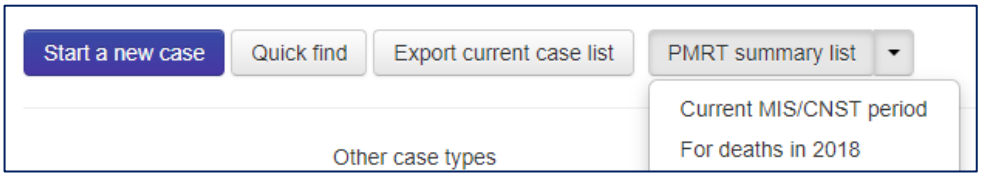
Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

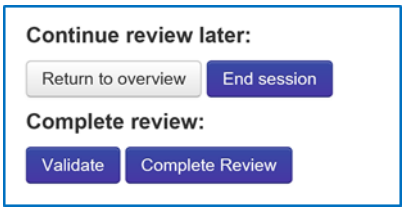
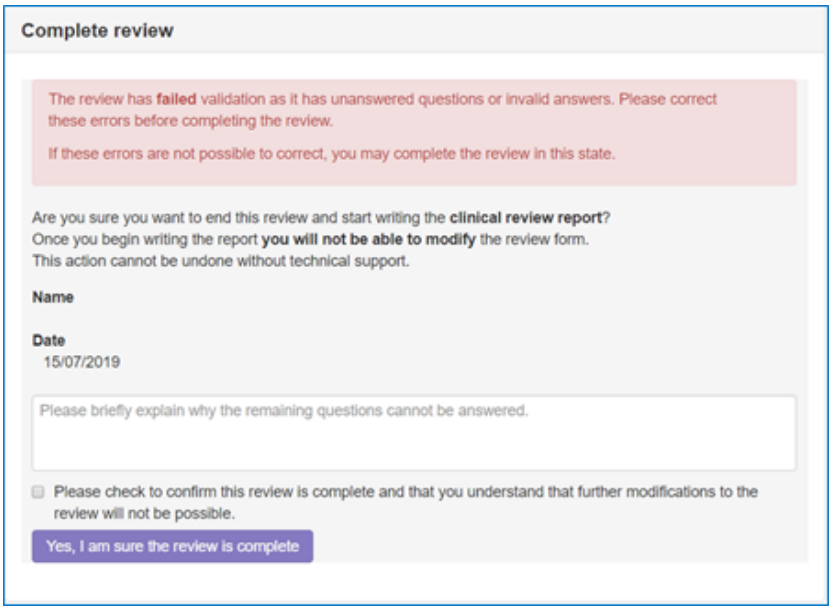
Required standard	a) i. All perinatal deaths eligible to be notified to MBRRACE-UK from 1 September 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 August 2021 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust. b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 8 August 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death. c) For at least 95% of all deaths of babies who died in your Trust from 8 August 2021, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required. d) Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.

Minimum evidential requirement for Trust Board	Notifications must be made and surveillance forms completed using the MBRRACE-UK reporting website. The perinatal mortality review tool must be used to review the care and draft reports should be generated via the PMRT. A report has been received by the Trust Board each quarter from 8 August 2021 onwards that includes details of the deaths reviewed and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard c) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.
What is the relevant time period?	From 8 August 2021 until 30 June 2022
What is the deadline for reporting to NHS Resolution?	Thursday 30th June 2022 at 12 noon

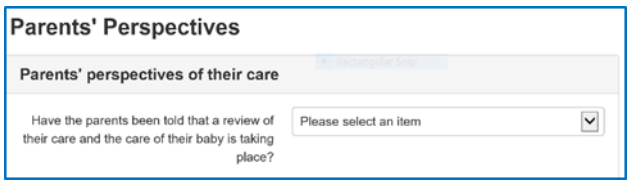
Technical guidance for safety action 1

Technical guidance	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal death must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection
What is the time limit for notifying a perinatal death?	Following notification within seven working days of the perinatal death, the surveillance form, where required, must be completed within one month of the death. If at that stage post-mortem or other investigations are not available and the final cause of death is not confirmed, indicate this in the "Cause of Death/Confirmation of cause of death" section, complete the rest of the information, and close the surveillance form. Once the additional information and the final cause of death is known and confirmed as part of the PMRT review discussion, the reporter should re-open the case, update the relevant sections and close it again. You can reopen the surveillance form from the case management screen. All perinatal deaths eligible to be reported to MBRRACE-UK from 1 September 2021 onwards must be notified to MBRRACE-UK within seven working days. When a notification is complete the notification status will show whether surveillance (and review) is required for each case. This is available from the case management screen by clicking on the Case ID and selecting Notification status. 
What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK are working with the National Child Mortality Database (NCMD) team to provide a single route of reporting for neonatal deaths which will be via MBRRACE-UK. Once this single

	route is established MBRRACE-UK will be the mechanism for directly notifying all neonatal deaths to the local Child Death Overview Panel (CDOP). At that stage, for any Trust not already doing so, a review completed using the PMRT will be the required mechanism for completing the local review for submission to CDOP. This will also be the required route for providing additional information about the death required by the NCMD. Work is underway to provide this single route of reporting with plans to have this in place in the forthcoming months.
How can we keep a check on which of our deaths require surveillance?	There is a report under 'Case summary list' on the MBRRACE-UK case management screen entitled 'Current MIS/CNST period'.  This includes ALL deaths in the Trust which have been notified to MBRRACE-UK and shows the status of the surveillance if required. This will also indicate if surveillance is required and not started/completed.
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: •All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) •All stillbirths (from 24+0 weeks' gestation) •Neonatal death (up to 28 days after birth) While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet safety action one.
How can we keep a check on which of our deaths are suitable for review using the PMRT and their review status?	Within the PMRT authorised users of the PMRT can generate a report for your Trust under 'PMRT summary list' entitled 'Current MIS/CNST period'. This list includes those deaths notified by your Trust which are suitable for review using the PMRT at the point when the report is generated.  This is a list of those deaths notified by your Trust which are suitable for review using the PMRT **at the point when the report is generated**. This report is of ALL deaths in the Trust which have been notified to MBRRACE-UK some of which (for example terminations of pregnancy) are not suitable for review using the PMRT.
What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to have been used to complete the first review session (which might be the

	first session of several) for that death. At a minimum all the 'factual' questions in the PMRT should be completed for the review to be regarded as started; it is not sufficient to just open the PMRT tool, this does not meet the criterion of having started a review.
What is meant by "completing a review to the point that at least a draft report has been generated"?	A multidisciplinary review team should have used the PMRT to review the death, then the review progressed to at least the stage of writing a draft report by pressing 'Complete review'.  The tool may raise validation errors at this point. If validation errors appear you need to deal with these in one of two ways: (i) resolve them and then press the 'Complete Review' button again OR (ii) complete the text box with an explanation of why the remaining questions cannot be validated (for example, the mother's hand held notes were lost). Confirm that the review is complete by ticking the box and pressing the button **'Yes I am sure that the review is complete'**.  The report entitled 'PMRT summary list' includes the status of the review, which should be 'Writing report' or 'Review complete'.
What does multi-disciplinary review mean?	The team conducting the review should include at least one and preferably two professionals relevant to the care of the woman and her baby. Ideally the team should include a member from a relevant professional group who is external to the unit who can provide peer review as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews and you may need to be selective as to which deaths are reviewed by the team including an external member.

	Where a HSIB investigation has been carried out the external member could be one or more of the HSIB reviewers involved in the HSIB investigation. Further guidance about multidisciplinary review can be found on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/implementation-support
Review assignment	A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided Issues with care identified are 'owned' by the Trust which identified them as are the related action plans, but a single report is generated. This ensures that when the report is discussed with the parents all aspects of the care they received can be covered; this should avoid potentially contradictory findings being conveyed and inappropriate advice being given regarding their next pregnancy.
Can the PMRT help by providing a quarterly report which can be presented to the Trust Board?	Reports for your Trust, summarising the results from completed reviews over a period, can be generated within the PMRT by authorised PMRT users for user-defined periods of time. 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 as the basis for your quarterly Board reports and should be discussed with your Trust maternity safety champion.
What deaths should we review outside the relevant time period for the safety action validation process?	We recommend Trusts review all eligible deaths using the PMRT as a routine process, irrespective of the MIS timeframe and validation process.
What should we do if our post-mortem service has a turn-around time in excess of four months?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than four months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death and complete it with the information you have available. When the post-mortem results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available

	before starting a review you risk missing learning opportunities earlier, especially if the turn-around time is considerably longer than four months. Where the post-mortem turn-around time is quicker than this information from the post-mortem can be included in the original reviews.
What should we do if we do not have any eligible perinatal deaths with the relevant time period?	If you do not have any babies that have died between 8 August 2021 and 30 June 2022 then you should partner up with a Trust with which you have a referral relationship to participate in case reviews.
How does the involvement of the Healthcare Safety Investigation Branch (HSIB) in investigations impact on meeting safety action one?	It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by HSIB. Your local review using the PMRT should be started but not completed until the HSIB report is complete. You should consider inviting the HSIB reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the HSIB review to be automatically incorporated into the PMRT review. Depending upon the timing of the HSIB report completion achieving the standards for these babies may therefore be impacted by timeframes beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an HSIB INVESTIGATION is taking place and this will be accounted for in the external validation process.
We have informed parents that a local review will take place and they have been asked if they have any reflections or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	In order to address any questions that parents have about their care and why their baby died, parents need to be informed that a review will take place and be given the opportunity to provide their perspective about their care and raise any questions that they have. In order that parents' perspectives and questions can be considered this information needs to be incorporated as part of the review and entered into the PMRT. So if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials 
We have contacted the	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that

parents of a baby who has died and they don't wish to have any involvement in the review process, what should we do?	of their baby will be undertaken by the Trust. In the case of neonatal deaths parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their perspective and raise any questions and/or concerns they may subsequently have about their care. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See especially the notes accompanying the flowchart.
Parents have not responded to our messages and therefore we are unable to discuss the review – what should we do?	As stated above, following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care, and that of their baby, will be undertaken by the Trust (as above). If this does not happen for any reason and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if causes for concern for the mother's wellbeing were raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process ask how they would like findings of the perinatal mortality review report communicated to them. Materials to support parent engagement in the local review process, including an outline of role of key contact, are available on the PMRT website at: materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.
Is the quarterly review of the Board report based on a financial or calendar year?	This can be either a financial or calendar year. Reports for your Trust summarising the results from reviews over a period time which have been completed can be generated within the PMRT by authorised PMRT users for a user-defined periods of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'.

	These reports can be used as the basis of your quarterly reports to your Trust Board and should be discussed with your Trust maternity safety champion.
What should we do if we experience technical issues with using PMRT?	All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK as soon as possible. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk
If there are any updates on PMRT for the maternity incentive scheme where will they be published?	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the maternity incentive scheme safety action, will be communicated via NHS Resolution email and will also be included in the PMRT "message of the day".

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

Required standard	This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1) Trust Boards to confirm that they have either: • already procured a Maternity Information System complying with the forthcoming commercial framework (to be published by NHSX) and are complying with Information Standard Notices DCB1513 and DCB3066 or • have a fully funded plan to procure a Maternity Information System from the forthcoming commercial framework and comply with the above Information Standard Notices and attend at least one engagement session organised by NHSX. 2) Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria on the national Maternity Services Dashboard for data submissions relating to activity in January 2022. The data for January 2022 will be available on the dashboard during April 2022. 3) January 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 14+1 weeks gestation for 90% of women reaching 14+1 weeks gestation in the month. 4) January 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month. 5) Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria on the national Maternity Services Dashboard for data submissions relating to activity in January 2022 for the following 5 metrics: **Continuity of carer (CoC)**

	1. The proportion (%) of women placed on a CoC pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation 2. The proportion (%) of women receiving CoC **Personalised Care and Support Planning** **Important note:** A woman's Personalised Care and Support Plan is a live document that should be reviewed at each appointment. The below timescales indicate the point at which a plan for the relevant phase should have been **started** in discussion with the woman and recorded in MSDS. Please see the technical guidance section for further information on the type of information that should be included within plans by these timescales. 3. The proportion (%) of women who have an antenatal care plan by 16+1 weeks gestation age (119 days) which is part of a personalised care and support plan. 4. The proportion (%) of women who have a birth care plan by 34+1 week's gestation age (245 days) which is part of a personalised care and support plan. 5. The proportion (%) of women who have a postpartum care plan by 36+1 weeks gestation age (259 days) which is part of a personalised care and support plan. The data for January 2022 will be available on the dashboard during April 2022. If the data quality for criteria 5 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information).
Minimum evidential requirement for Trust Board	1) Criteria 1 will be reported to NHS Resolution as part of trusts' self-declaration using the Board declaration form. 2) For criteria 2, the national Maternity Services Dashboard displays whether trusts have passed 9 out of the 11 data quality thresholds for the Clinical Quality Improvement Metrics being assessed. These data can be used as evidence presented to Trust Boards (see "Data Quality" table under the "CQIM" tab).

	3) For criteria 3, the national Maternity Services Dashboard displays whether trusts have passed data quality thresholds for measures of weight and height, or a calculated BMI by 14+1 weeks gestation as an indicator called "BMI of mother at booking". These data can be used as evidence presented to Trust Boards (see "Org Profile" tab and select "BMI of mother at booking" indicator). 4) For criteria 4, the national Maternity Services Dashboard displays whether trusts have passed data quality thresholds for measuring complex social factors at booking as an indicator called "Complex Social Factors". These data can be used as evidence presented to Trust Boards (see "Org Profile" tab and select "Complex Social Factors" indicator). 5) For criteria 5, the national Maternity Services Dashboard displays whether trusts have passed or failed data quality thresholds for the specified metrics being assessed. These data can be used as evidence presented to Trust Boards (see "Policy" tab). If this data quality is not met, trusts can still pass safety action 2 by evidencing sustained engagement (see technical guidance for further detail) with NHS Digital which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital.
Validation process	All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS England and Improvement will cross-reference self-certification of criteria 2 – 5 (inclusive) against NHS Digital data
What is the relevant time period?	From 8 August 2021 until 30 June 2022
What is the deadline for reporting to NHS Resolution?	Thursday 30 June 2022 at 12 noon

Technical guidance for safety action 2

Technical guidance	
When will I receive more information regarding the forthcoming commercial framework to be published by NHSX?	Further information on how to comply with criteria 1 will be communicated by 29 October 2021.
Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass CQIMs and other metrics specified above can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics
Will my trust fail this action if women choose not to receive continuity of carer or a Personalised Care and Support Plan?	No. This action is focussed on data quality only and therefore trusts pass or fail it based upon record completeness for each metric and not on the proportion (%) recorded as the metric output.
For criteria 5, having a completed Personalised Care and Support Plan by these timescales does not align with my clinical practice. What information is supposed to be captured by these dates?	The dates used align with current NICE guidance However, we recognise that a completed postpartum care plan is not possible by 36+1 weeks gestation. The dates indicate the point at which a plan should have been started and recorded as having happened in MSDS. For the postpartum care plan, we would not expect that a full care plan would have been agreed prior to birth, but would expect aspects such as feeding intentions, contraception, postnatal self-care (including pelvic floor exercises) or safeguarding plans to have been discussed, for example.
What is the Data Quality Submission Summary Tool? How does my trust access this?	The Data Quality Submission Summary Tool has been developed by NHS Digital specifically to support this safety action. The tool provides an immediate report on potential gaps in data required for CQIMs and other metrics specified above after data submission, so trusts can take action to rectify them. It is intended to be used alongside other existing reports and documentation in order for providers to be able to create a full and detailed picture of the quality of their data submissions. Further information on the tool and how to access it will be available on NHS Digital's website in due course. Information will be shared on this as soon as it is available.

For the Data Quality Submission Summary Tool, what does “sustained engagement” mean for the purposes of passing criteria 5?	By “sustained engagement” we mean that trusts must show evidence of using the tool in each month for at least four months prior to the assessment month,. Engagement should therefore start by November 2021 using data submitted for September and October 2021. To evidence this, trusts should save the Excel output file after running the report for a given month. Four copies of these (covering September, October, November and December 2021 data, respectively) should be provided to your trust Board as part of the assurance process for CNST. Note – this only becomes a requirement in the event your trust fails the requisite data quality for continuity of carer and personalised care and support plan metrics.
The Maternity Services Dashboard states that my trusts’ data has failed for a particular CQIM or policy metric. Where can I find out further information on why this has happened?	Details of all the data quality criteria can be found in the “Meta Data” file (see ‘CQIMDQ/CoCDQ/PCPDQ Measures construction’ tabs) which accompanies the Maternity Services Monthly Statistics publication series (https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics). The scores for each data quality criteria can be found in the “Measures” file within the same publication series.
The national Maternity Services Dashboard states that my trusts’ data is ‘suppressed’. What does this mean?	Where data is reported in low values for clinical events, the published data will appear ‘suppressed’ to ensure the anonymity of individuals. However, for the purposes of data quality within this action, ‘suppressed’ data will still count as a pass.
Where can I find out more about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported on the Maternity Services Dashboard please contact NHS Digital at maternity.dq@nhs.net. **For any other queries**, please email MIS@resolution.nhs.uk

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Required standard	a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter. c) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered. d) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), Local Maternity and Neonatal System (LMNS) and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies. e) Reviews of term admissions to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. The reviews should report on the number of admissions to the neonatal unit that would have met current TC admissions criteria but were admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were admitted to, or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety

	champions, LMNS and ICS quality surveillance meeting on a quarterly basis. f) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point e) has been agreed with the maternity and neonatal safety champions and Board level champion. g) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.
Minimum evidential requirement for Trust Board	Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: **Evidence for standard a) to include:** • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to BAPM transitional care framework for practice • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.
	Evidence for standard b) to include: • An audit trail is available which provides evidence that ongoing audits from year 3 of the maternity incentive scheme of the pathway of care into transitional care are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 3 of 2021/22 financial year. • Audit findings are shared with the neonatal safety champion on a quarterly basis. Where barriers to achieving full implementation of the policy are encountered, an action plan should be agreed and progress overseen by both the board and neonatal safety champions.
	Evidence for standard c) to include: • Data is available (electronic or paper based) on transitional care activity (regardless of place - which could be a TC, postnatal ward, virtual outreach pathway etc.). • Secondary data is available (electronic or paper based) on babies born between 34+0-36+6 weeks gestation at birth, who did not have surgery nor were transferred during any

	admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered to inform future capacity management for late preterm babies who could be cared for in a TC setting.
	Evidence for standard d) to include: • Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are available to share on request, for example to support service development and capacity planning, with the Local Maternity System (LMS), ODN and/or commissioner.
	Evidence for standard e) to include: • An audit trail is available which provides evidence that ongoing reviews from year 3 of the maternity incentive scheme of term admissions are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 3 of 2021/22 financial year. • Evidence that the review includes: the number of admissions to the neonatal unit that would have met current TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues and the number of babies that were admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. • Evidence that findings of the review have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting.
	Evidence for standard f) and g): • An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from the pathway audit (point b) and the ATAIN reviews (point e). • Evidence that progress with the action plan has been shared with the neonatal, maternity safety champion, and Board level champion, LMNS and ICS quality surveillance meeting each quarter.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form

What is the relevant time period?	a) The expectation is that the pathway has been in place since year 2 of the scheme and should now be business as usual. If for any reason this is not in place it should be by 10 January 2022 at the very latest. b) The expectation is that the audits have been in place since year 3 of the scheme and should now be business as usual. If for any reason, audits have been paused, they should be recommenced, using data from quarter 3 of 2021/22 financial year and be completed on a quarterly basis. There should be evidence that audit findings are shared with the neonatal safety champion each quarter. c) Data collection process should have been met and in place in year 3 of the scheme. If for any reason it was not, this should be achieved by no later than 10 January 2022. Secondary data collection process for late pre-terms in place by no later than 10 January 2022. d) Commissioner returns on request – as per ODN request e) The expectation is that the reviews have been in place since year 3 of the scheme and should now be business as usual. If for any reason, reviews have been paused, they should be recommenced using data from quarter 3 of 2021/22 financial year and be completed on a quarterly basis. There should be evidence that review findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting. f) Evidence of an action plan (to address points b and e) being agreed with the maternity and neonatal safety champions and Board level champion and signed off by the Board no later than 28 February 2022. g) Evidence of progress with the action plan being shared with the neonatal, maternity safety champion, Board level champion and LMNS and ICS quality surveillance meeting each quarter following sign off at the Board.
What is the deadline for reporting to NHS Resolution?	Thursday 30 June 2022 at 12 noon

Technical guidance for safety action 3

Technical guidance	
Does the data recording process need to be available to the ODN/LMNS/ commissioner?	The requirement for a data recording process has been carried over from year three of the maternity incentive scheme as a means of informing future capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies. This could be captured through existing systems such as BadgerNet or alternatives such as paper based or electronic systems. These returns do not need to be routinely shared with the ODN, LMNS and/or commissioner but must be readily available should it be requested.
What members of the MDT should be involved in Atain reviews?	The expectation is that this is a multi-professional review, as a minimum the care should be reviewed by representation from both maternity and neonatal staff groups. This should include as a minimum; a member of the maternity team (a midwife and / or obstetrician and /or trainee from maternity services) and a member of the neonatal team (neonatal nurse and / or neonatologist/paediatrician and/or trainee from neonatal services).
We have undertaken some reviews for term admissions to NICU, do we need to undertake more and do all babies admitted to the NNU need to be included?	Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the ATAIN work to date. The expectation is that reviews have been continued from year 3 of the scheme. If for any reason, reviews have been paused, they should be recommenced using data from quarter 3 of the 2021/22 financial year (beginning 01/10/2021). **This may mean that some of the audit is completed retrospectively.** We recommend **ongoing reviews, at least quarterly** of unanticipated term admissions to the NNU to determine whether there were modifiable factors which could be addressed as part of an action plan. A high-level review of the primary reasons for all admissions should be completed, with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed. For example, if 60% of babies are admitted for respiratory problems, then focus on this cohort of babies and complete a deep dive into identified themes or if 40% of babies were admitted with jaundice and 35% of babies were admitted with hypothermia then focus on these two cohorts of babies.

	In addition to this the number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues and the number of babies that were admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on.
What do mean by quarterly?	Occurring every three months. This would usually mirror the 4 quarters of the financial year, for example quarter 1 covering 01/04/2021-30/06/2021).
TC audit – what should the audit include and is there a standard audit tool?	An audit tool can be accessed below as a baseline template, however the audit needs to include aspects of the local pathway.  ATAIN%20CASE%20 NOTE%20REVIEW%2(We recommend that Trusts refer to the auditable standards included in their local TC pathway guideline/policy.
How long have the neonatal safety champions been in place for?	Trust board champions were contacted in February 2019 and asked to nominate a neonatal safety champion. The identification of neonatal safety champions is a recommendation of the national neonatal critical care review and have been in place since February/March 2019.
What is the definition of transitional care?	Transitional care is not a place but a service and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019 https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/ https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/

	https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/Illness-in-newborn-babies-leaflet-FINAL-070420.pdf Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk)

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

Required standard	**a) Obstetric medical workforce** 1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ 2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS. **b) Anaesthetic medical workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1) **c) Neonatal medical workforce** The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address

	deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies. **d) Neonatal nursing workforce** The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMS and Neonatal Operational Delivery Network (ODN) Lead.
Minimum evidential requirement for Trust Board	**Obstetric medical workforce** Sign off at Trust Board level acknowledging engagement with the RCOG document along with an action plan to review any non-attendance to the clinical situations listed in the document. Trusts should evidence their position with the Trust Board, Trust Board level safety champions and LMS meetings at least every 6 months. **Anaesthetic medical workforce** The rota should be used to evidence compliance with ACSA standard 1.7.2.1. **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce training action. If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies. **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, the Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies.

	A copy of the action plan, outlining progress against each of the actions, should be submitted to the Royal College of Nursing (doreen@crawfordmckenzie.co.uk), LMS and Neonatal Operational Delivery Network (ODN) Lead.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	**a) Obstetric medical workforce** 1. By January 2022 2. By January 2022 and monitored monthly from then. **b) Anaesthetic medical workforce** Trusts to evidence position by Thursday 30 June 2022 at 12 noon **c) Neonatal medical workforce** A review has been undertaken any 6 month period before 30 June 2022. **d) Neonatal nursing workforce** Nursing workforce review has been undertaken at least once during year 4 reporting period.
What is the deadline for reporting to NHS Resolution?	Thursday 30th June 2022 at 12 noon

Technical guidance for safety action 4

Technical guidance	
Obstetric workforce standard and action	
How can the Trust board evidence that the department has acknowledged and committed to incorporating the principles of the RCOG document?	Documented evidence of discussion at relevant meetings e.g. consultant meeting, divisional governance meetings, new consultants' induction etc. Circulation to all staff who work in maternity and Gynaecology. Mandatory consultant attendance list to be included in departmental escalation policies.
How can the Trust monitor adherence with the standard?	For example, departments can audit consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Departments may also wish to monitor adherence via incident reporting systems. Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.
Can we self-certify compliance with this element of safety action 4 if consultants have not attended clinical situations on the mandated list?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non-attendances. These can be signed off by the Trust Board.
Where can I find the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/
For queries regarding this safety action please contact: MIS@resolution.nhs.uk and RCOG	

Anaesthetic medical workforce

Technical guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard and action	
1.7.2.1	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.

Neonatal medical workforce

Technical guidance	
Neonatal Workforce standards and action	
Do you meet the BAPM national standards of junior medical staffing depending on unit designation?	If no, Trust Board should outline progress with the action plan developed in year 3 of MIS and submit this to the Neonatal ODN. There should also be an indication whether the standards not being met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap). There should also be a record of the rota tier affected by the gaps.
BAPM **"Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice" 2021** **or** **"Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018**	
NICU **Neonatal Intensive Care Unit**	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff during office hours and out of hours. **Tier 1** Resident out of hours care should include a designated tier one clinician - Advanced Neonatal Nurse Practitioner (ANNP) or junior doctor ST1-3 NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice **Tier 2**

	A designated experienced junior doctor ST 4-8 or appropriately trained specialty doctor or ANNP NICUs with more than 2500 intensive care days should have an additional experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP. (A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative) **Tier 3** Consultant staff in NICUs should be on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on the neonatal unit alone NICUs undertaking more than 4000 intensive care days per annum with onerous on call duties should consider having a consultant present in addition to tier 2 staff and immediately available 24 hours per day. NICUs undertaking more than 2500 intensive care days per annum should consider the presence of at least 2 consultant led teams during normal daytime hours. NICUs undertaking more than 4000 intensive care days per annum should consider the presence of three consultant led teams during normal daytime hours.
LNU **Local Neonatal Unit**	**Tier 1** At least one resident tier 1 practitioner immediately available dedicated to providing emergency care for the neonatal service 24/7 In large LNUs (>7000 births) there should be two dedicated tier 1 practitioners 24/7 to support emergency care, in keeping with the NICU framework **Tier 2** An immediately available resident tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00 - 22.00, seven days a week LNUs undertaking either >1500 Respiratory Care Days (RCDs) or >600 Intensive Care (IC) days annually should have immediately available a dedicated resident tier 2 practitioner separate from paediatrics 24/7
SCU **Special Care Unit**	**Tier 1**

	A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours. **Tier 2** A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit
Our Trust do not meet the relevant neonatal medical standards and in view of this an action plan, ratified by the Board has been developed. Can we declared compliance with this sub-requirement?	If the requirements are not met, Trust Board should outline progress against the action plan developed as part of year three of MIS in order to meet the recommendations. Action plan and related progress details should be shared with the Neonatal ODN. This will enable Trusts to declare compliance with this sub-requirement.
Please access the followings for further information on Standards	BAPM Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021) A BAPM Framework for Practice https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021 Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018). A BAPM Framework for Practice https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018

Neonatal nursing workforce

Technical guidance	
Neonatal nursing workforce	
Where can we find more information about the requirements for neonatal nursing workforce?	Between 8 August 2021 until 30 June 2022, each neonatal unit should perform a nursing workforce calculation using the CRG work force staffing tool.

	Units that do not meet the service specification requirement for nursing workforce should have an action plan signed off by their Trust board, as per MIS year 3 requirements. Trust Board should evidence progress against the action plan and share those with the RCN, LMS and Neonatal ODN.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to meet the recommendations. The action plan and related progress, signed off by the Trust Board, should be shared with the Royal College of Nursing (doreen@crawfordmckenzie.co.uk) and Neonatal ODN Lead. This will enable Trusts to declare compliance with this sub-requirement.

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

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service c) All women in active labour receive one-to-one midwifery care d) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.
Minimum evidential requirement for Trust Board	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated • Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing. • An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified. • Maternity services should detail progress against the **action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls**. • The midwife to birth ratio • The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. **Must include plan for mitigation/escalation to cover any shortfalls.**

Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	From 8 August 2021 until 30 June 2022
What is the deadline for reporting to NHS Resolution?	Thursday 30 June 2022 at 12 noon

Technical guidance for Safety action 5

Technical guidance	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice**.	• Redeployment of staff to other services/sites/wards based on acuity • Staff absences due to illness/isolation/shielding/symptoms for Covid-19 • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637 https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/Redeploying-your-secondary-care-medical-workforce-safely_26-March.pdf
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board, and includes a timeline for when this will be achieved.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board, and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Required standard	1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract. 2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network. ~~3. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements.~~ Suspension of the quarterly care bundle surveys until January 2022 The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from January 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.
Minimum evidential requirement for Trust Board	**Element one** Process indicators: A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. B. Percentage of women where CO measurement at 36 weeks is recorded. Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing an average of 80% compliance over a six month period. If there is a delay in the provider trust's ability to submit these data to MSDS then compliance can be determined using their interim data recording method. The denominator should still be the total number of women at booking or 36 weeks gestation, as appropriate for each process indicator.

	#**A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.** **If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.** In addition, the Trust board should specifically confirm that within their organisation they: 1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric. 2) Have a referral pathway to smoking cessation services (in house or external). 3) Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service. 4) Have generated and reviewed the following outcome indicators within the Trust for January – April 2022: • Percentage of women with a CO measurement ≥4ppm at booking. • Percentage of women with a CO measurement ≥4ppm at 36 weeks. • Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment. **Additional information** If your Trust is planning on using the maternity dashboard to evidence an average of 80% compliance over six months, please be advised that there is a three month delay with MSDSv2 data. The last month to be included in this will be February 2022. If your Trust does not have an in house stop smoking service or a pathway to an external service, please contact your local authority stop smoking service or escalate to your local maternity system to enable the Trust to ensure provision is in place.
	Element two **Process indicator:** 1) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan (e.g. Appendix D). Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including

	SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. If there is a delay in the provider Trust Maternity Information System's ability to record these data at the time of submission an in house audit of 40 consecutive cases of women having a 20 week scan using locally available data or case records should have been undertaken to assess compliance with this indicator. **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.** **If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.** In addition the Trust board should specifically confirm that within their organisation: 2) Women with a BMI>35 kg/m^2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards 3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 4) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation. 5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT). 6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network. 7) They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care.
	Element three Process indicators:

	A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy. B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation). Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators. **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.** **If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.**
	Element four There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness. The Trust board should specifically confirm that within their organisation: • 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above. • A dedicated Lead Midwife (0.4 WTE) and Lead Obstetrician (0.1 WTE) per consultant led unit have been appointed by the end of 2021 at the latest. Please refer to safety action 8 for updates re training.
	Element five Process indicators: A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.

	D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. If there is a delay in the provider Trust MIS's ability to record these data then an audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators. **The Trust board should receive data from the organisation's Maternity Information System evidencing 80% compliance.** **A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must have an action plan for achieving >80%.** In addition, the Trust board should specifically confirm that within their organisation: • They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. (Best practice would be to also appoint a dedicated Lead Midwife. Further guidance/information on preterm birth clinics can be found on https://www.tommys.org/sites/default/files/2021-03/reducing%20preterm%20birth%20guidance%2019.pdf • Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway. The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local CCGs following advice from the Clinical Network.

	• Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	Trusts should be evidencing the position as of 30 June 2022 at 12 noon

Technical guidance for Safety action 6

Technical guidance	
Where can we find guidance regarding this safety action?	SBL care bundle: https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/ The SBLCB v2 Technical Glossary which includes the numerators and denominators for all of the process indicators can be found on the NHS Digital webpages here: https://digital.nhs.uk/binaries/content/assets/website-assets/data-and-information/data-sets/maternity-services/sblcbv2-msds-v2.0-technical-glossary-for-publication.xlsx Any queries related to the **digital aspects** of this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net For any other queries, please email MIS@resolution.nhs.uk
Further guidance regarding element 2 of the SBL care bundle V2	Compliance with the intervention for surveillance of low-risk women does not mandate participation in the Perinatal Institute's Growth Assessment Protocol (GAP) or the use of customised fundal charts. Providers should however ensure that for low risk women, fetal growth is assessed using antenatal symphysis fundal height charts by clinicians trained in their use. All staff must be competent in measuring fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated.
What is the deadline for reporting to NHS Resolution?	30 June 2022 at 12noon

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

Required standard	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?
Minimum evidential requirement for Trust Board	**Evidence should include:** • Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems • Minutes of MVP meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff • Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme. Remuneration should take place in line with agreed Trust processes. • The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMS board that ratified it • Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including childcare costs in a timely way. • Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	Trusts should be evidencing the position as of 30 June 2022 at 12 noon

What is the deadline for reporting to NHS Resolution?	Thursday 30 June 2022 at 12 noon

Technical guidance for Safety action 7

Technical guidance	
What is the Maternity Voices Partnership?	A Maternity Voices Partnership is a multidisciplinary NHS working group for review and coproduction of local maternity services. For more information see: • Implementing Better Births: A resource pack for Local Maternity Systems Chapter 4 and Annex B • National Maternity Voices
How often should the Maternity Voices Partnership meeting be held?	MVP should meet "no less than four times per year" in line with MVP Terms of Reference template, available here: http://nationalmaternityvoices.org.uk/toolkit-for-mvps/setting-up-an-mvp/mvp-resources/. This should include meeting with Maternity Leadership to ensure progression of the work plan.
We are unsure about the funding for Maternity Voices Partnerships	The maternity commissioner is responsible for facilitating and organising any agreed funding, this may be provided by the commissioner alone or in conjunction with local providers. Local discussions will need to take place to agree how the costs of the Maternity Voices Partnership will be shared between commissioner and provider organisations

Safety action 8: Can you evidence that a **local training plan** is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', **one-day, multi-professional training day** which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

Required standard and minimum evidential \requirement	Can you evidence that: a) **A local training plan** is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4 in August 2021. b) 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, to include maternity emergencies starting from the launch of MIS year four on 8 August 2021? c) 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four on 8 August 2021. d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four on 8 August 2021.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	From 8 August 2021 until 30 June 2022

Technical guidance for safety action 8

Technical guidance	
What training should be covered in the local training plan to cover the six modules of the Core Competency Framework?	A training plan should be in place to cover all six core modules of the Core Competency Framework. The training plan will span a 3-year time period and will include; • Saving Babies Lives Care Bundle • Fetal surveillance in labour • Maternity emergencies and multi-professional training. • Personalised care • Care during labour and the immediate postnatal period • Neonatal life support
Covid-19 impact on training	We encourage the reinstatement of face to face training however for situations where this is not possible. Face to face, remote or digital training (which covers the requirements within the safety actions) will be accepted to count towards the training percentage. It is recognised that temporary modifications may be necessary in light of the Covid-19 pandemic. In such cases the Board must ensure that these are mitigated and agreed to ensure the safe provision of services. Details of any modifications, and the agreed mitigations will be expected to be shared with the Trust Board by Friday 31 December 2021.
What training should be covered for the one-day multi-professional training	The one-day training programme should include training on: • Fetal monitoring and surveillance (in the antenatal and intrapartum period) • Maternity emergencies training scenarios, • Neonatal life support There should be sharing of local maternal and neonatal outcomes, ideally benchmarked against other organisations with a similar profile. These data may be local, drawing on learning from case studies, incidents, exemplars or from National programmes e.g. National Maternity Perinatal Audit (NMPA), Getting It Right First Time (GIRFT) and others. **Fetal monitoring and surveillance (in the antenatal and intrapartum period)**

What should be covered in the training programme	Should be consistent with the Ockenden Report (2021) recommendations, and include as a minimum: • Risk assessment • Intermittent auscultation • Electronic fetal monitoring • System level issues e.g. human factors, classification, escalation and situational awareness • Use of local case histories • Using their local CTG machines In addition to training, both a fetal monitoring and surveillance Lead Midwife (0.4 WTE) and a Lead Obstetrician (0.1 WTE) per consultant-led unit should be appointed to focus on, and champion, best practice in fetal monitoring – see examples. In addition, these leads should register with the forthcoming national intrapartum fetal surveillance programme. **Multi-professional maternity emergencies training** • The training day should include 4 of the minimum requirements for multi-professional maternity emergency scenarios, as set out in the Core Competency Framework, with the aim that all scenarios will be covered over a 3-year period. • The 4 scenarios will be based on locally identified training needs relating to emergency scenarios, drawing on learning from local serious incidents, near misses, audits and thematic reviews. • At least one scenario should include a learning from excellence case study. • At least one of the four emergency scenarios should be conducted in the clinical area, ensuring full attendance from the relevant wider multi-professional team. This will enable local system and environmental factors within the clinical setting to be considered, any risks and issues identified and an action plan developed to address these. **Neonatal life support** • All staff in attendance at births should attend local neonatal life support training every year.

	• Attendance on separate certified NLS training for maternity staff should be locally decided but this would be the gold standard. • Those attending a NLS programme every 4 years will attend annual local neonatal life support training in between. Training should include as a minimum: • Preparing for neonatal resuscitation, including suitability of the clinical environment and preparing the resuscitation device(s) • Identification of a baby requiring resuscitation after birth • Knowledge and understanding of the NLS algorithm, annual updates should ideally be following NLS 5th edition and all updates after 1st January 2022 should be using this version • The timing and how to call for help within the organisation • Situation, Background, Assessment Recommendation (SBAR) or equivalent communication tool handover on arrival of help.
How do maternity units include the remaining components of the Core Competencies Framework that are not listed above? The remaining 2 components are: • Personalised care • Care during labour and the immediate postnatal period	For the remaining 2 components of the Core Competencies Framework, maternity teams should choose 2 subjects per year from those listed in each of these core competencies, and these should be based on identified unit priorities, audit report findings and locally identified learning (e.g. ATAIN reviews) involving aspects of care which require reinforcing and national guidance. The aim is that all subjects within the Core Competencies Framework will be covered over the three-year period.
Which maternity staff attendees should be included for the 'in house' maternity emergencies multi-professional training day?	Maternity staff attendees should include 90% of each of the following groups: • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)

	• Obstetric anaesthetic consultants • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota
Should the anaesthetic and maternity support workers (MSWs) attend fetal surveillance in labour and neonatal life support training?	Anaesthetic staff and MSWs are not required to attend fetal monitoring and the below staff groups are not required to attend neonatal resuscitation training. This includes: • Obstetric anaesthetic consultants • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota and • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)
What compliance is required for maternity theatre staff?	Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the one-day maternity emergencies and multi-professional training, however they will not be part of MIS year four compliance assessment.
Which staff should be included for immediate neonatal life support training?	Staff in attendance at births should be included for immediate neonatal life support training as listed below: • Neonatal Consultants or Paediatric consultants covering neonatal units • Neonatal junior 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) and Maternity theatre midwives who also work outside of theatres.
Which maternity staff attendees should be included for the local intrapartum fetal surveillance in labour and Saving Babies Lives Care Bundle (SBLCBv2)?	Maternity staff attendees should be 90% of each of the following groups: • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives).

	Maternity theatre midwives who also work outside of theatres.
What if staff have been booked to attend training after (add in date) for the 'in-house' multi-professional training day?	Only staff who have attended the training will be counted toward overall percentage. If staff are only booked onto training and/or have not attended training, they cannot be counted towards the overall percentage.
Will we meet the action if one of our staff group is below the 90% threshold for the 'in-house' maternity emergencies and multi-professional training day?	No, you will need to evidence to your Trust Board that you have met the threshold of 90% for each of the staff groups before (add date).
What if Covid-19 restrictions are still in place for in house training?	If social distancing guidelines preclude face to face training then remote or digital training will be acceptable.
I am a NLS instructor, do I still need to attend neonatal resuscitation annual training?	Those holding Newborn Life Support (NLS) provider status will need to attend annual local neonatal life support training for the years between any provider status recertification and so will not require to attend the annual local update.
Which members of the team can teach in house neonatal resuscitation training?	Best practice would be for this training to be delivered by a trained NLS instructor. The minimum standard would be for training to be provided by staff who hold an in-date NLS provider certificate and also have a teaching role such as a clinical skills facilitator.
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally decided but this would be the gold standard.
What is the required timeframe?	One day training on multi-professional, maternity emergencies, including a learning from excellence case study and intrapartum fetal surveillance should be undertaken by each staff groups within the MIS reporting period.
Where can I find the Core Competencies Framework and other additional resources?	• NHS England and NHS Improvements Core Competency Framework (December 2020) https://www.england.nhs.uk/publication/core-competency-framework/ • https://www.resus.org.uk/library/2021-resuscitation-guidelines/newborn-resuscitation-and-support-transition-infants-birth

	• All link to forthcoming national intrapartum fetal surveillance programme • Toolkit for high quality neonatal services (October 2009) http://www.londonneonatalnetwork.org.uk/wp-content/uploads/2015/09/Toolkit-2009.pdf

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Required standard	a) The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need. b) Board level safety champions present a locally agreed dashboard to the Board on a quarterly basis, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 31 October 2021. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 31 December 2021. c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2023, prioritising those most likely to experience poor outcomes. d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)
Minimum evidential requirement for Trust Board	**Evidence for points a) and b)** • Evidence of a revised pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) new LMNS/ICS quality group and d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action

	and support is provided for areas of concern or need in line with the perinatal quality surveillance model. • Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff. • Evidence that discussions regarding safety intelligence, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walkabouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 31 October 2021. **NB-** The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 31 December 2021. • Evidence of monthly feedback / staff walkaround sessions being undertaken by a member of the Board. • Evidence of progress with actioning named concerns from staff workarounds are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users. • Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting. **Evidence for point c):** Evidence of an action plan that describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2023. The plan covers: • The number of women that can be expected to receive continuity of carer, when offered as the default model of care • A midwifery redeployment plan into CoC teams, phased alongside the fulfilment of safe staffing levels • How continuity of carer teams are established in compliance with national principles and standards • How rollout will be prioritised to those most likely to experience poor outcomes, including ensuring most women from Black, Asian and mixed ethnicity

	backgrounds and also from the most deprived areas are placed by on a continuity of carer pathway by March 2022. • How care will be monitored locally, and providers ensure accurate and complete reporting on provision of continuity of carer using the Maternity Services Dataset • Evidence of Board level oversight and discussion of this revised continuity of carer action plan **Evidence for point d):** Evidence of how the Board and Safety Champions have supported staff involved in part d) of the required standard and specifically in relation to: • active participation by staff in **contributing to the delivery** of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities • **engagement** in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient Safety Networks, of which the Trust is a member • support for clinicians identified as MatNeoSIP Improvement Leaders to facilitate and lead work through the MatNeo Patient Safety Networks and the National MatNeoSIP network • utilise insights from culture surveys undertaken to inform local quality improvement plans • maintain oversight of improvement outcomes and learning, and ensure intelligence is actively shared with key system stakeholders for the purpose of improvement
Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	**Time period for points a and b)** • Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action is in place no later than 10 January 2022. The expectation is that work has already commenced on this in line with the Ockenden response (Ockenden, 2021).

	• Evidence that discussions regarding safety intelligence, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 31 October 2021. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 31 December 2021. • The expectation is that monthly feedback sessions have continued from year 3 of the scheme. If for any reason these have been paused, they should be recommenced no later than 31 October 2021. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions. • Progress with actioning named concerns from staff workarounds are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 10 January 2022 • Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (board or directorate) quality meeting each quarter, beginning no later than quarter 4 (ending 31 March 2022). **Time period for points c)** • An action plan to evidence how Continuity of Carer will be the default model of care offered to all women by March 2023, prioritising those most likely to experience poor outcomes, agreed by the Board safety champion by 31 March 2022. **Time period for points d)** • Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event by 30 April 2022. • Evidence that insights from culture surveys undertaken have been used to inform local quality improvement plans by 30 April 2022.

What is the deadline for reporting to NHS Resolution?	By Thursday 30 June 2022 at 12 noon
Where can I find additional resources?	implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) Measuring culture in maternity services: Add in link to Safety Culture Programme for Maternal and neonatal services: https://drive.google.com/file/d/1bzAqOcf5A5XHR8HWBZnLzH6qsG_SgXoa/view?usp=sharin Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk) NHS England » Maternity and Neonatal Safety Improvement Programme

Technical guidance for Safety action 9

Technical guidance	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local pathway for sharing intelligence updated. This revised pathway should: - Describe the local governance processes in place to demonstrate how intelligence is shared from the floor to Board - Formalise how Trust-level intelligence will be shared with the LMNS/ICS quality group and regional quality groups involving the Regional Chief Midwife and Lead Obstetrician
What do we need to include in the dashboard presented to Board each month?	The dashboard can be locally produced and must include; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance. The dashboard can also include additional measures as agreed by the Trust.
We had not continued to undertake monthly feedback sessions with the Board safety	Parts a) and b) of the required standards build on the year three requirement of the maternity incentive scheme in building visibility and creating the conditions for staff to meet

champion what should we do?	and establish a relationship with their Board safety champions in order to raise concerns relating to safety. The expectation is that Board safety champions have continued to undertake monthly feedback sessions. Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three of the maternity incentive scheme and the expectation is that this should have been continued. If these have not been continued, this needs to be reinstated by no later than 31 October 2021. There will be no flexibility of this date.
We are a Trust with more than one site. Do we need to complete the same frequency of walkabouts in each site as a Trust on one site?	Yes. The expectation is that the same number of walkabouts are completed at each individual site.
What is the rationale for the Board level safety champion safety action?	It is important to ensure all staff are aware of who their frontline and Board safety champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names the relevant leaders will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Our Trust board meetings are scheduled every two months and not every month. How can the progress with the CoC action plan be discussed and shared at Board level?	In the months that the board does not meet, the named Board safety champion for maternity should oversee progress with the plan. This will ensure consistency with the individual understanding the progress being made and where barriers need to be overcome.
What should we include in our action plan for continuity of carer?	The updated action plan should describe how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2023. In light of the increased risk facing women from Black, Asian and minority ethnic backgrounds and from the most deprived areas of poor outcomes, local systems should prioritise women from these groups. The updated plan should include:

	1) The number of women that can be expected to receive continuity of carer, when offered as the default model of care 2) A midwifery redeployment plan into CoC teams, phased alongside the fulfilment of safe staffing levels 3) How continuity of carer teams are established in compliance with national principles and standards 4) How rollout will be prioritised to those most likely to experience poor outcomes, including ensuring most women from Black, Asian and mixed ethnicity backgrounds and also from the most deprived areas are placed by on a continuity of carer pathway by March 2022. 5) How care will be monitored locally, and providers ensure accurate and complete reporting on provision of continuity of carer using the Maternity Services Dataset
What are the expectations of the Board safety champions in point d) as it asks that all Trust safety champions are supporting MatNeoSIP?	The Board safety Champions will be expected to continue their support for quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Networks. Trusts will be required to undertake improvement including data collection and testing work aligned to the national driver diagram and key enablers. The Board level safety champion will continue to support staff as detailed in the minimum evidential requirements for Trust Board.
What do mean by bi-monthly?	Occurring every two months

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?

Required standard	A) Reporting of all qualifying cases to HSIB for 2021/22. B) For qualifying cases which have occurred during the period 1 April 2021 to 31 March 2022 the Trust Board are assured that: 1. the family have received information on the role of HSIB and the EN scheme; and 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum evidential requirement for Trust Board	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB. **Trust Board** sight of evidence that the families have received information on the role of HSIB and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Validation process	Self-certification to NHS Resolution using Board declaration form. Trusts' reporting will be cross-referenced against HSIB database and the National Neonatal Research Database (NNRD) for the number of qualifying incidents recorded for the Trust and externally verify that standard a) and b) have been met in the relevant reporting period.
What is the relevant time period?	Reporting to HSIB Wednesday 1 April 2021 to 31 March 2022.
What is the deadline for reporting to NHS Resolution?	By Thursday 30 June 2022 at 12 noon.

Technical guidance for Safety action 10

Technical guidance	
Where can I find information on HSIB	Information about HSIB and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website • EN main page • Trusts page • Families page • Trust communication http://createsend.com/t/i-FB2EFF5DC99369812540EF23F30FEDED • Panel communication http://createsend.com/t/i-D8E797C1B8475B52540EF23F30FEDED • Stakeholder communication http://createsend.com/t/i-6F72B4E26B4693D92540EF23F30FEDED
Changes in the EN reporting requirements for Trust from 1 April 2021	Following communication to Trusts in April 2021 all eligible maternity incidents should still be reported to HSIB. HSIB will then inform NHS Resolution of the case. Should you wish to discuss further, please contact a member of the Early Notification team via (ENTeam@resolution.nhs.uk).
Changes in the EN investigation processes from 1 April 2021	From 1 April 2021, due to a number of factors such as advances in neonatal cooling, NHS Resolution made two key improvements to streamline the investigation process: • No steps will be taken to investigate eligibility for compensation until HSIB has completed a safety investigation. This will reduce duplication and enable Trusts to focus on liaison with HSIB and the family. Instead, on receipt of the HSIB report on relevant cases, NHS Resolution will overlay an investigation into legal liability. Where families have declined an HSIB investigation, no EN investigation will take place, unless the family request this. • The criteria for an investigation by NHS Resolution will be narrowed to those cases where there is evidence of or the potential for a brain injury. This will ensure that the scheme is focused on those cases where there is potential for a high value compensation payment. The changes were formally communicated to panel, external stakeholders and Trusts in March 2021 via comms letters.

What are qualifying incidents which need to be reported to HSIB?	• Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) **[OR]** • Was therapeutically cooled (active cooling only) **[OR]** • Had decreased central tone **AND** was comatose **AND** had seizures of any kind.
Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20 In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by HSIB and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry'. Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
What if we are unsure whether a case qualifies for referral to HSIB?	If the case meets Each Baby Counts criteria it should be reported to HSIB only. Should you have any queries, please contact a member of the Early Notification team to discuss further (ENTeam@resolution.nhs.uk) or HSIB maternity team (maternity@hsib.org.uk).

FAQs for year four of the maternity incentive scheme

Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice?	**We expect Trust Boards to self-certify the Trust's declarations 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 may escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the Care Quality Commission for their consideration if any further action is required, and to the NHS England and NHS Improvement regional director, the Deputy Chief Midwifery Officer, regional chief midwife and 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).
Do we need to discuss this with our commissioners?	Yes, your submission should be discussed with commissioners prior to submission to NHS Resolution.
Do we need to declare that there are no conflicting national reports that may contradict compliance with MIS?	Yes the Trust Board will need to confirm that there are no national reports within the reporting period (8 August 2021 to 30 June 2022) that may contradict the declared MIS compliance by signing the related section included in the Trust Board declaration form. This can be done by completing section d) of the Board declaration form. If there are conflicting reports, Trusts will need to contact NHS Resolution via MIS@resolution.nhs.uk and outline the reports and possible impact on MIS declaration.
Will NHS Resolution cross check our results with external data sources?	Yes, we will cross reference results with external data sets from: MBRRACE-UK data (safety action 1 point a, b, c), NHS England& Improvement regarding submission to the Maternity Services Data Set (safety action 2, sub-requirements 2 and 3), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable to HSIB (safety action 10, standard a)). Your overall submission may also be sense checked with CQC maternity data, HSIB data etc. For more details, please refer to the conditions of the scheme.

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 CEO and, where relevant, an action plan is completed for each action the Trust has not met. **Please do not send your evidence or any narrative related to your submission to us.** Any other documents you are collating should be used to inform your discussions with the Trust Board.
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 2022. **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 noon on Thursday 30 June 2022, NHS Resolution will treat that as a nil response.** **The declaration form will be published in 2022.**
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 noon on Thursday 30 June 2022**. If not returned to NHS Resolution by 12 noon on Thursday 30 June 2022, NHS Resolution will treat that as a nil response.
What happens if we do not meet the ten actions?	Only Trusts that meet all ten maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet all ten safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.
Our Trust has queries, who should we contact?	Any queries prior to the submission date must be sent in writing by e-mail to NHS Resolution via MIS@resolution.nhs.uk
Please can you confirm who outcome letters will be sent to?	The maternity incentive scheme 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 link contacts via link on the NHS Resolution website.

	https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-Trusts/maternity-incentive-scheme/maternity-incentive-scheme-year-two/
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 and Trusts will be allowed 14 days to appeal the decision following the communication of results.
Merging Trusts	Trusts that will be merging during the year four reporting period (August 2021 to June 2022) must inform NHS Resolution of this via MIS@resolution.nhs.uk 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 Contributions@resolution.nhs.uk 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 2022/23 and the reporting of claims and management of claims going forward.

Q&A regarding Maternity Safety Strategy and CNST maternity incentive scheme

Q1) What are the aims of the maternity incentive scheme?

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

Using CNST to incentivise safer care received strong support from respondents to our *2016 CNST consultation* where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in our *Five year strategy: Delivering fair resolution and learning from harm.*

Q2) Why have these safety actions been chosen?

The ten actions have been agreed with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, in partnership with NHS Digital, NHS England, NHS Improvement, the Care Quality Commission (CQC), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Obstetric Anaesthetists Association, Royal College of Anaesthetists, HSIB, Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

The Collaborative Advisory Group (CAG) previously established by NHS Resolution to bring together other arm's length bodies and the Royal Colleges to support the delivery of the CNST maternity incentive scheme has also advised NHS Resolution on the safety actions.

Q3) Who has been involved in designing the scheme?

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England & Improvement
- NHS Digital
- MBRRACE-UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Anaesthetists
- Royal College of Paediatrics and Child Health
- Care Quality Commission
- Department of Health and Social Care
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff
- HSIB

Q4) How will Trusts be assessed against the safety actions and by when?

Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission.

Completed Board declaration forms must be discussed with the commissioner(s) of the Trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at MIS@resolution.nhs.uk **by 12 noon on 30 June 2022**.

Please note:

Board declaration forms will be reviewed by NHS Resolution and discussed with Collaborative Advisory Group.

NHS Resolution will use external data sources to validate some of the Trust's responses, as detailed in the technical guidance above.

If a completed Board declaration form is not returned to NHS Resolution by 12 noon on Thursday 30 June 2022, NHS Resolution will treat that as a nil response.