Appendix 1 - Maternity Incentive Scheme (MIS) – Year two Declaration against standards

Background:

This is the second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS), intended to support the delivery of safer maternity care in all acute Trusts.

BTHFT was successful in achieving the ten safety actions in year one, and recovered the 10% maternity premium and a share of the unallocated funds.

The ten safety actions remain unchanged in year two. However, Trusts are required to provide Boards with additional evidence to demonstrate compliance than that required for year one.

Timetable for self-certification and submission to NHS Resolution:

Date	Action Required
11 July 2019	Board of Directors to review progress and delegate authority to Board Committee and Chief Nurse
24 July 2019	Workforce Committee reviews bi-annual midwifery staffing report and reviews the GMC action plan.
24 July 2019	Quality Committee to review any outstanding evidence required for self-certification and agree the draft Board declaration form.
August 2019	Completed Board declaration form to be discussed with the commissioners of the Trust's maternity services
12 noon, 15 August 2019	The designated Director completes and submits the Board declaration form and any required action plans to NHS Resolution

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

Required standard	a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death. b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death. c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought. d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.
Minimum evidential requirement for trust Board	A report has been received by the Trust Board each quarter from Wednesday 12 December 2018 until Thursday 15 August 2019 that includes details of the deaths reviewed and the consequent actions plans. The report should evidence that the required standards a) to c) above have been met.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use MBRRACE-UK data to cross-reference against trust self-certification the number of eligible deaths from Wednesday 12 December until Thursday 15 August 2019.
What is the relevant time period?	**From Wednesday 12 December until Thursday 15 August 2019**
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Safety Action 1 Evidence:

June Quality Committee received an extended Quarter 4 report, evidencing that the required standards a) to c) have been met for all babies who were born and died in the trust between 12 December 2018 and 31 March 2019.

Outstanding evidence required for Trust Board sign off:

A report of deaths occurring in Quarter 1, 1 April to 30 June 2019, will be presented to Quality Committee in July and each subsequent quarter will be reported thereafter.

Safety Action Status:

Green

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

Required standard	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and readiness for implementing the next version of the dataset (MSDSv2).
Minimum evidential requirement for trust Board	NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria (please see table below for details).
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will cross-reference self-certification against NHS Digital data.
What is the relevant time period?	The assessment will include data from the MSDS from January 2019. This data needs to be submitted to MSDS for the deadline of 31 March 2019. One MSDS criterion relates to data for six months, from October 2018 to March 2019, which needs to be submitted to MSDS for deadlines between 31 December 2018 and 31 May 2019. One criterion relates to the submission of data for the first month of MSDSv2. This data relates to April 2019 and needs to be submitted to the deadline of 30 June 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Safety Action 2 Evidence:

The Trust has successfully achieved the 3 mandatory criteria and at least 14 of the 19 other criteria, this evidences that we meet the requirement.

Criteria 1: MSDS data contained at least 90% of HES births.
Criteria 2: MSDSv2 readiness questionnaire completed and returned to NHS Digital.
Criteria 3: Submit MSDSv2 for April 19 by the submission deadline of the end of June 19.

Outstanding evidence required for Trust Board sign off:

None

Safety Action Status:

Green

Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into Neonatal units Programme?

Required standard	a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care. b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2. c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews. d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN
Minimum evidential requirement for trust Board	Local policy available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: 1. There is evidence of neonatal involvement in care planning 2. Admission criteria meets a minimum of HRG XA04 but could extend beyond to BAPM transitional care framework for practice 3. There is an explicit staffing model 4. The policy is signed by maternity/neonatal clinical leads Data is available (electronic or paper based) on transitional care activity which has been recorded as per XA04 2016 NCCMDS. An audit trail providing evidence and a rationale for developing the agreed action plan to address local findings from ATAIN reviews. Evidence of an action plan to address identified and modifiable factors for admission to transitional care. Action plan has been signed off by trust Board, ODN and LMS and progress with action plan is documented within minutes of meetings at Board ODN/LMS.

Safety Action 3 Evidence:

1. Neonates admitted to transitional care are reviewed daily as part of a consultant ward round. Neonates are seen on the day of admission, the day of discharge and when parents have any questions, or nursing staff request a review.
   Neonates who receive HRG XA04 care outside the transitional care unit are reviewed at the beginning of their course by a member of the neonatal team, NICE guidance mandates that a daily review considers on-going need for antibiotic therapy, and we certainly aim to meet this guidance. All such neonates should be, and are, reviewed at the end of any antibiotic course prior to discharge.

2. Admission criteria are defined for transitional care, and exist in a reviewed guideline. Almost all neonates admitted will count as eligible for HRGXA04, but as noted above, some HRGXA04 neonates are admitted to postnatal wards, where they receive this care. The data is collected by Badgernet which reports NCCMDS. NCCMDS is reported by the trust. NCCMDS allows calculation of HRGXA04 activity.

3. There is a staffing model in place for transitional care.

4. The clinical guidelines relating to the admission criteria for transfer in to transitional care and discharge from are produced by the neonatal consultant team and were ratified by the Neonatal Guideline Group following consultation with relevant members of the maternity team. Both guidelines are currently in date and not due for review, therefore to meet the Safety Action 3 standard, the guidelines have had an additional review by the Clinical Lead for Obstetrics who agrees with the content with no additional recommendations. Moving forward, the process for the ratification of transitional care guidelines will directly involve obstetric clinical lead and will be taken through Women's Core Governance Group in addition to the Neonatal Guideline Group.

5. The ATAIN action plan was submitted to the West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) and the Yorkshire and Humber (Y&H) Operational Delivery Network (ODN) by the deadline of 10 March 2019. There was a delay in this being presented to Trust Board as feedback was not received until May. The action plan was shared with the Board 8 May 2019. Verbal communication with NHS Resolution confirmed that this meets the required standard. Progress with the action plan was submitted to WY&H LMS, Y&H ODN, and the Board Level Safety Champion by the deadline of 19 May 2019. The progress report was also presented to Quality Committee in June.

Outstanding evidence required for Trust Board sign off:

None

Safety Action Status:

Green

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

Required standard	a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: *'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'* In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps. b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.
Minimum evidential requirement for trust Board	a) Proportion of trainees formally recorded in Board minutes and the action plan to address lost educational opportunities should be signed off by the trust Board and a copy submitted to the Royal College of Obstetricians and Gynaecologists (RCOG) at workforce@rcog.org.uk b) Board minutes formally recording the proportion of ACSA standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 that are met. Where trusts did not meet these standards, they must produce an action plan (ratified by the Board) stating how they are working to meet the standards.
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) 2018 GMC National Training Survey (covers the period 20 March to 9 May 2018) b) Six month period between January 2019 and June 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon.

Safety Action 4 Evidence

- **a)** Workforce Committee in July 2019 will receive a copy of the GMC survey action plan in relation to obstetrics.
- **b)** We meet the ACSA standards which have been in place at BTHFT since 2017. The Anaesthetic department had their ACSA visit on 26 June 2019 and received verbal confirmation of continuation to meet the standards.

Outstanding evidence required for Trust Board sign off:

July Workforce Committee to approve the action plan prior to submission to the RCOG.

Safety Action status:

GREEN

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 has been done. b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service. c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on). d) A bi-annual report that covers staffing/safety issues is submitted to the Board.
Minimum evidential requirement for trust Board	A bi-annual report that includes evidence to support a-c being met. This 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. •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: birth ratio. •The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives. •Evidence from an acuity tool (which may be locally developed) and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation to cover any shortfalls.
•Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising (Please note: it is for the trust to define what red flags they monitor. Examples of red flag incidents are provided in the technical guidance).	
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	Any consecutive three month period between January to July 2019.

What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Safety Action 5 Evidence:

Midwifery workforce reports have been received by the committees of the Board in January 2019 and a subsequent report will be received in July 2019. The report meets the recommended criteria and best practice.

Outstanding evidence required for Trust Board sign off:

Workforce Committee to receive a further report in July 2019.

Safety Action status:

GREEN

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

Required standard	Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services. Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).
Minimum evidential requirement for trust Board	Board minutes demonstrating that the SBL bundle has been considered in a way that supports delivery and implementation of each element of the SBL care bundle or that an alternative intervention put in place to deliver against element(s).
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	The scheme will take into account the position of trusts at end July 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Safety Action 6 Evidence

A summary of progress and compliance against SBLV1 care bundle was included in the 2018/19 Annual Maternity Services Report, presented to Quality Committee in June 2019 for consideration.

We are fully compliant with all of the national survey criteria and submissions.

Outstanding evidence required for Trust Board sign off:

None

Safety Action status:

Green

Safety action 7: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

Required standard	User involvement has an impact on the development and/or improvement of maternity services.
Minimum evidential requirement for trust Board	Evidence should include: Acting on feedback from, for example a Maternity Voices Partnership. User involvement in investigations, local and or Care Quality Commission (CQC) survey results. Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	From January 2019 to July 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019

Safety Action 7 Evidence:

Bradford and Airedale Maternity Voices Partnership (MVP) launched in March 2018, replaced the Maternity Services Liaison Committee (MSLC).The MVP is still in its infancy and comprises of a minimum of 3 'main' meetings per year, and a number of themed sub-groups which feed in to the main meetings.

The maternity service is well represented at the main meeting by the Head of Midwifery and a range of clinical and specialist midwives, who provide the group with an update on the service. There is a standing agenda item for any issues and concerns raised by service users.

The Head of Midwifery regularly attends the Bradford Stillbirth and Neonatal Death Society (SANDS) monthly committee meetings, and responds to concerns raised and suggestions for service improvements for bereaved families. No formal minutes are recorded for this meeting.

The results of the annual Care Quality Commission (CQC) Maternity Survey 2018 were reviewed during a staff engagement meeting and an action plan developed. The action plan is monitored through the Maternity Services Forum monthly meeting and has been shared at the Trust's Patient Experience subcommittee.

The maternity unit participates in the Friends and Family Test (FFT).

The maternity service hosts a Facebook page 'Bradford Antenatal, Birth and Beyond', which has reached over 1000 'likes'. The page provides service users and families with pregnancy and birth related information, public health information and general updates about the service. Service users frequently share their 'birth stories' with us and we receive 100% positive feedback. In addition we are planning an annual open day.

Outstanding evidence required for Trust Board sign off:

None

Safety action status:

Green

Safety action 8: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Required standard	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year.
Minimum evidential requirement for trust Board	Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year through Board sight of a staff training database or similar.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	The scheme will take into account the position of trusts by Thursday 15 August 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Safety Action 8 Evidence

Following PROMPT emergency training in June, the majority of the individual staff groups are already over 90% compliant. There are 2 remaining training days before the 15 August submission date and it is anticipated that this will be achieved for all staff groups.

Outstanding evidence required for Trust Board sign off:

Training dates are planned between now and the final submission to maintain the 90% compliance.

Safety action rating:

Green

Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Required standard	a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the trust ii. the Local Learning System (LLS). b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues. c) The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff.
Minimum evidential requirement for trust Board	• Evidence of executive sponsor engagement in quality improvement activities led by the trust nominated Improvement Leads for the MNHSC as well as other quality improvement activity for Trusts in waves one and three. • Evidence that the trust Board have been sighted on the local improvement plan, updated on progress, impact and outcomes with the quality improvement activities being undertaken locally. • Evidence of attendance at one or more National Learning Set or the annual national learning event. • Evidence of engagement with relevant networks and the collaborative LLS. • Evidence of a safety dashboard or equivalent, visible to staff which reflects action and progress made on identified concerns raised by staff. • Evidence that safety concerns raised by staff feedback sessions are reflected in the minutes of Board meetings and include updates on progress, impact and outcomes relating to the steps and actions taken to address these concerns.
Validation process	Self-certification to NHS Resolution using the Board declaration form

Safety Action 9 Evidence

The Board Level Maternity Safety Champion, Karen Dawber who is also the Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) meets bi-monthly with the nominated trust safety champions (Clinical Lead for Obstetrics and the Head of Midwifery). Meetings follow a set agenda and minutes are available.

The Board Level Champion has engaged with the MNHSC during wave one of the collaborative, including attendance at a national event in early January 2019. The Board Level Safety Champion has been supportive of the improvement activities led by Alison Powell, the nominated improvement lead for the MNHSC, and has pro-actively showcased the excellent outputs of the chosen work streams.

In February 2019, the Board Level Safety Champion implemented monthly feedback sessions for maternity and neonatal staff to raise concerns relating to relevant safety issues.

Any significant safety concerns raised during the feedback sessions will be directly escalated to Trust Board by the Board Level Safety Champion. A summary of safety issues raised is included in the quarterly maternity services update provided to Quality Committee. Quarter 1 feedback was included in the Annual Maternity Services report to Quality Committee in June, where it was noted that there were no significant issues to escalate to Trust Board during that time period.

The Board Level Champion and Head of Midwifery attended the first North Region Maternity Safety Champion conference in June 2019, sharing a poster presentation of local quality improvement work undertaken at Bradford. Quality Committee also received a presentation on the progress, impact and outcomes of maternal and neonatal quality improvement activities at the June meeting.

Outstanding evidence requiring Trust Board sign off:

None

Safety action rating:

Green

Safety action 10: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

Required standard	Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria.
Minimum evidential requirement for trust Board	Trust Board sight of trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team.
Validation process	Self-certification to NHS Resolution using the Board declaration form NHS Resolution will cross reference Trust reporting against the National Neonatal Research Database (NNRD) number of qualifying incidents recorded for the Trust.
What is the relevant time period?	1 April 2018 to 31 March 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Safety Action 10 Evidence

NHS resolution is currently cross referencing Trust reported cases against the National Neonatal Research Database (NNRD) and has informed us that there are 9 eligible cases, all of which have been reported.

Outstanding evidence requiring Trust Board sign off:

Safety action rating:

Green

Conclusion:

The table below is taken from the first page of the NHS Resolution Board declaration form and has been completed to reflect the position as of 1 July 2019.
Green boxes reflect that the maternity service believes that the required standard is met and no further evidence is required for Trust Board.
Yellow boxes reflect the need for additional evidence to be signed off by Committees in July.

Action No.	Maternity safety action	Action met? (Y/N)
1	**Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?**	**Y**
2	**Are you submitting data to the Maternity Services Data Set to the required standard?**	**Y**
3	**Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?**	**Y**
4	**Can you demonstrate an effective system of medical workforce planning to the required standard?**	**Y**
5	**Can you demonstrate an effective system of midwifery workforce planning to the required standard?**	**Y**
6	**Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?**	**Y**
7	**Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?**	**Y**
8	**Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?**	**Y**
9	**Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?**	**Y**
10	**Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?**	**Y**