

## **Appendix 1 - Maternity Incentive Scheme (MIS) – Year three Declaration against standards**

### **Background:**

This is the third 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. The scheme was significantly delayed during the Covid 19 pandemic and the submission date is now 12 noon, 15 July 2021.

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

The ten safety actions remain unchanged in year three. However, Trusts are required to provide Boards with additional evidence to demonstrate compliance than that required for year one and two, including evidence regarding how services have managed the impact of Covid 19.

This paper also includes an appended report on progress with achieving Saving Babies' Lives Care Bundle Version 2 full compliance, including the associated audits for Trust Board assurance.

The contents of this paper were discussed with Michelle Turner, Director of Nursing, Bradford District and Craven Clinical Commissioning Group, and Gill Paxton, Associate Director of Nursing and Quality, Bradford District and Craven Clinical Commissioning Group on 1 July 2021.

Since this report was prepared there has been a further delay to the submission date which has been extended to 12 noon, Thursday 22 July 2021. The delay is due to a technical error with the Board declaration form and does not affect or alter the safety actions and associated evidence.

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

<p><b>Required standard</b></p>	<p>a)</p> <p>i. All perinatal deaths eligible to be notified to MBRRACE-UK from Monday 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.</p> <p>ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to 15 March 2021 will have been started before 15 July 2021.</p> <p>b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15 March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021.</p> <p>c) For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trust should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and these actions.</p> <p>d) i. Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.</p>
<p><b>Minimum evidential requirement for trust Board</b></p>	<p>Notifications must be made and surveillance forms completed using the MBRRACE-UK reporting website.</p> <p>The perinatal mortality review tool must be used to review the care and draft reports should be generated via the PMRT.</p> <p>A report has been received by the Trust Board each quarter from Thursday 1 October 2020 onwards that includes details of the deaths reviewed and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met.</p>

<b>Validation process</b>	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, provided by MBRRACE-UK, to cross-reference against Trust self-certification. Cross referencing will be used to check that the MBRRACE-UK/PMRT has been used to review eligible perinatal deaths and that standards a), b) and c) have been met using the PMRT between Friday 20 December 2019 until Thursday 15 July 2021.
<b>What is the relevant time period?</b>	From Friday 20 December 2019 until 15 July 2021
<b>What is the deadline for reporting to NHS Resolution?</b>	Thursday 15 July 2021 at 12 noon

## **Safety Action 1 Evidence:**

Quarterly PMRT Reports have been submitted to:

- October 2020, Trust Board
- February 2021, Quality Academy and Trust Board for noting
- May 2021, Regulation Committee and Trust Board for noting

The PMRT report is reviewed by the Board Level Safety champion prior to submission to Trust Board/Quality Academy.

The last quarterly report submitted in May 2021 met the submission standards a, b and d.

The May report did not meet the required standard 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 Friday 20 December 2020, 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. This was reported as 86%.

However, this is now at 95% but is closely monitored on a weekly basis to include the progress of any new cases.

## **Outstanding evidence required for Quality Academy/Trust Board/Executive sign off:**

The designated Trust Executive for final sign off will receive assurance for deaths occurring between the May report and the July submission due to be reported in the August 2020 quarterly update.

## **Safety Action Status:**

Green

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

<b>Required standard</b>	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.
<b>Minimum evidential requirement for trust Board</b>	NHS Digital will issue a monthly scorecard to data submitters (Trusts) that can be presented to the Board. It will help Trusts understand the improvements needed in advance of the assessment. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met All 13 criteria are mandatory. Items 1, 2, 4-13 will be assessed by NHS Digital and included in the scorecard. Item 3 will be reported to NHS Resolution. Item 14 related to the Maternity Record Standard has been removed from the MIS safety action two.
<b>Validation process</b>	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.
<b>What is the relevant time period?</b>	The relevant deadlines are shown against each of the criteria, the first deadline, for ensuring that two people are registered to submit the data is Friday 30 October 2020. A MSDS data submission for August 2020 data needs to be made by Friday 30 October 2020 and the deadlines for the following four months also need to be met. The assessment of data quality and completeness will consider data from the MSDS for December 2020. The deadline for the December 2020 data is Sunday 28 February 2021.
<b>What is the deadline for reporting to NHS Resolution?</b>	Thursday 15 July 2021 at 12 noon

**Safety Action 2 Evidence:**

The Trust has successfully submitted MSDS data to the required standard and has submitted a data quality action plan to the West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) as required. The plan was agreed by Board/Quality Academy as part of the April Maternity Services update presented in May 2021. A progress update has been requested by the LMS for presentation at their November 2021 Board.

**Outstanding evidence required for Quality Academy/Trust Board/Executive 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?

<p><b>Required standard</b></p>	<p>Standards A, B and C were removed in the revised safety actions published on 15 March 2021.</p> <p>D) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.</p> <p>E) A review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) is undertaken to identify the impact of: <input type="checkbox"/> closures or reduced capacity of TC <input type="checkbox"/> changes to parental access <input type="checkbox"/> staff redeployment <input type="checkbox"/> changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.</p> <p>F) An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19 period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion.</p> <p>G) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.</p>
<p><b>Minimum evidential requirement for trust Board</b></p>	<p>Evidence for standard D:</p> <p>As and when requested, commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are shared with the Local Maternity System (LMS), ODN or commissioner.</p> <p>Evidence for standard E:</p> <p>An audit trail is available which provides evidence that a review of term admissions during the period Sunday 1 March 2020 – Monday 31 August 2020 has been undertaken. Evidence that the review specifically considered the impact of changes to parental access; staff redeployment, closure or reduced TC capacity and changes to postnatal visits on admission rates including those for jaundice, weight loss and poor feeding.</p> <p>Evidence for standard F:</p> <p>An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from ATAIN reviews. <input type="checkbox"/> Evidence of an action plan to address identified and modifiable factors for admission to transitional care. <input type="checkbox"/> Evidence that the action plan has been revised in the light of learning from term</p>

	<p>admissions during Covid-19. Where no changes have been made, the rationale should be clearly stated. <input type="checkbox"/> Evidence that the action plan has been shared and agreed with the neonatal, maternity safety champion and Board level champion.</p> <p>Evidence for standard G:</p> <p>Evidence that progress with the revised ATAIN action plan has been shared with the neonatal, maternity safety champion and Board level champion.</p>
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### **Safety Action 3 Evidence:**

A Consultant Neonatologist reviews all term admissions to neonatal unit on a monthly basis. The ATAIN action plan is a standing agenda item at the Bi-monthly maternity safety champion meetings which resumed in February 2021, after a pause during the pandemic.

Standard D: Information is readily available to the ODN via Badgernet.

Standard E: Evidence of the audit trail is available via a locally held spreadsheet and files saved in shared ATAIN file.

Regular review has led to recognition of increased admissions from TCU to NNU potentially as a result of restrictions on visiting. This resulted in a wider audit of TCU to NNU admissions which were presented at Joint Governance Meeting 10/3/2021.

There has not been any staff redeployment, closures or reduced TC capacity. We have not seen an increase in TCU re-admission rates.

Standard F: The audit trail provides evidence that local finding from the ATAIN audit has resulted in improvement work and change including:

- NEWTT chart has now been implemented and is being integrated into OMS Cerner work.
- A presentation of ATAIN elearning is to be incorporated into PROMPT.

Standard G: The ATAIN action plan, neonatal outcomes and safety issues are discussed with the Executive and Non-Executive safety champions at the bi-monthly meetings. Minutes and an action log are available.

### **Outstanding evidence required for Quality Committee/Trust Board/Executive sign off:**

None

### **Safety Action Status:**

Green

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

<b>Required standard</b>	<p>Anaesthetic medical workforce An action plan is in place and agreed at Trust Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.7.2.5, 1.7.2.1 and 1.7.2.6</p> <p>Neonatal medical workforce The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level</p> <p>Neonatal nursing workforce The neonatal unit meets the service specification for neonatal nursing standards. If these are not met, an action plan is in place and agreed at board level to meet these recommendations</p>
<b>Minimum evidential requirement for trust Board</b>	<p>Anaesthetic medical workforce Trust Board minutes formally recording the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met. Where Trusts did not meet these standards, they must produce an action plan (ratified by the Trust Board) stating how they are working to meet the standards.</p> <p>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, an action plan should be developed to meet the recommendations and should be signed off by the Trust Board.</p> <p>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, an action plan should be developed to meet the standards and should be signed off by the Trust board and a copy submitted to the Royal College of Nursing (doreen@crawfordmckenzie.co.uk) and Neonatal Operational Delivery Network (ODN).</p>
<b>Validation process</b>	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form
<b>What is the relevant time period?</b>	Any six month period between December 2019 and Thursday 15 July 2021. If a nursing workforce review has been undertaken from September 2019 onwards, this will be accepted
<b>What is the deadline for reporting to NHS Resolution?</b>	Thursday 15 July 2021 at 12 noon

## **Safety Action 4 Evidence**

ACSA Standards met in full therefore action plan not required. Evidence included in the Maternity Services Update May 2021 paper, presented to Quality Academy in June 2021 and will go to Trust Board in July.

Neonatal Medical Workforce paper and Neonatal Nursing Workforce papers presented at the CBU to Executive meeting on 9 June 2021 identified that the BAPM national standards of junior medical staffing and the Dinning neonatal nursing workforce calculation have not been met. Supporting papers and action plans on how the gaps will be addressed and resolved are to be submitted and agreed at Executive Team Meeting as a subsidiary to Trust Board on 12 July. The papers and action plan will then be presented to Trust Board for completeness on 22 July. Progress and monitoring of the action plans will be via the Children's and Neonatal CBU Core Governance Group.

The action plans will be submitted to the RCN and the Yorkshire and Humber Neonatal Operational Delivery Network on 13 July. Confirmation of submission will be provided to the Chief Nurse prior to submission of the Maternity Incentive Scheme Board Self Declaration on 15 July.

### **Outstanding evidence required for sign off:**

#### **Safety Action status:**

Amber pending confirmation of the completion of the neonatal elements on 12 July, which will make the safety action fully compliant.

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

<p><b>Required standard</b></p>	<p>a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.</p> <p>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</p> <p>c) All women in active labour receive one-to-one midwifery care</p> <p>d) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board at least once a year, during the maternity incentive scheme year three reporting period (December 2019 – July 2021).</p>
<p><b>Minimum evidential requirement for trust Board</b></p>	<p>The report submitted will comprise evidence to support a, b and c progress or achievement. It should include:</p> <ul style="list-style-type: none"> <li>• A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated</li> <li>• Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing.</li> <li>• 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.</li> <li>• Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.</li> <li>• The midwife to birth ratio</li> <li>• 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.</li> <li>• 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</li> </ul>

	<p>provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.</p> <p>Revised safety actions - updated March 2021 35</p> <ul style="list-style-type: none"> <li>• Did Covid-19 cause impact on staffing levels? - Was the staffing level affected by the changes to the organisation to deal with Covid-19? - How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves?</li> </ul>
<p>•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).</p>	
<b>Validation process</b>	Self-certification to NHS Resolution using the Board declaration form.
<b>What is the relevant time period?</b>	Any consecutive twelve month period between Wednesday 1 July 2020 and Thursday 15 July 2021.
<b>What is the deadline for reporting to NHS Resolution?</b>	Thursday 15 July 2021 at 12 noon

**Safety Action 5 Evidence:**

Midwifery workforce reports have been received by the committees of the Board in January 2020, July 2020 and January 2021, exceeding the requirement. The reports meet the recommended criteria and best practice including the impact of Covid. At the time of the 6 monthly midwifery workforce updates the service had met and indeed in the January 2021 paper had exceeded the recommendations of the 2017 Birth Rate Plus review and table top reviews.

The service commissioned and completed the Birth Rate Plus midwifery workforce review in March 2021 and received the analysis and recommendations in April 2021. A paper outlining the findings and the recommended increase to the Midwifery establishment was submitted to ETM/People's Academy and Board in May 2021. The recommendations were acknowledged at both meetings with the decision to await the outcome of the national maternity funding bid, submitted in May 2021. A subsequent paper will be submitted to Trust Board following the outcome of the bid. This is reflected in the attached action plan appendix 2.

There has been a significant, sustained improvement in the monthly rates of 1:1 care in labour. The service now consistently achieves >90% and rates <90% are reported by exception to Trust Board via the monthly maternity update paper.

Not achieving 1:1 care in labour is a red flag event captured by the Labour ward co-ordinator team. The mitigation in place is reflected in the action plan attached as appendix 2.

Not achieving supernumerary labour ward co-ordinator status is also a red flag incident, but rarely occurs and not within the required reporting period.

**Outstanding evidence required for sign off:**

None

**Safety Action status:**

GREEN

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

<p><b>Required standard</b></p>	<p>1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2019/20 standard contract.</p> <p>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</p> <p>3. The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBv2 including the data submission requirements. The corroborating evidence is the SBLCBv2 survey and MSDS data, availability of this depends on the COVID-19 status.</p> <p>The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to <a href="mailto:England.maternitytransformation@nhs.net">England.maternitytransformation@nhs.net</a>.</p>
<p><b>Minimum evidential requirement for trust Board</b></p>	<p>Evidence of the completed quarterly care bundle surveys for 2020/21 should be submitted to the Trust board.</p> <p>Element one:</p> <p>A. Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital.</p> <p>B. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.</p> <p>C. Percentage of women where CO measurement at 36 weeks is recorded.</p> <p>Note: The relevant data items for these 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.</p> <p>Trust board should receive data from the organisation's MIS evidencing 80% compliance.</p>

	<p>If CO monitoring remains paused within the Trust due to Covid-19 or if there is a delay in the provider trust MIS's ability to record these data at the time of submission an in-house audit of 40 consecutive cases using locally available data or case records should have been undertaken to assess compliance with this indicator. The audit described above needs to be based on the percentage of women asked whether they smoke at booking and at 36 weeks. The Very Brief Advice and referral to smoking cessation services remain part of the pathway. This is in line with guidance issued by NHS England and NHS Improvement (<a href="https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-covid-19-information/">https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-covid-19-information/</a>) when CO monitoring was initially paused. The timing of the audit is at the Trust's discretion but should include the dates when women booked, and reference to the national CO testing policy at that time.</p> <p>If CO monitoring remains paused due to Covid-19, the audit described above needs to be based on the percentage of women asked whether they smoke at booking and at 36 weeks. The Very Brief Advice and referral to smoking cessation services remain part of the pathway. The timing of the audit is at the Trust's discretion but should include the dates when women booked, and reference to the national CO testing policy at that time.</p> <p>A threshold score of 80% compliance should be used to confirm successful implementation. If the process metric scores are less than 95% Trusts must also have an action plan for achieving &gt;95%.</p> <p>Element two:</p> <p>A. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking.</p> <p>Note: The relevant data items for these 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 80% compliance.</p> <p>If there is a delay in the provider Trust MIS's</p>
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	<p>ability to record these data at the time of submission an in house audit of 40 consecutive cases using locally available data or case records should have been undertaken to assess compliance with this indicator.</p> <p>A threshold score of 80% compliance should be used to confirm successful implementation.</p> <p>If the process indicator scores are less than 95% Trusts must also have an action plan for achieving &gt;95%. In addition the Trust board should specifically confirm that within their organisation:</p> <ol style="list-style-type: none"> <li>1) women with a BMI&gt;35 kg/m<sup>2</sup> are offered ultrasound assessment of growth from 32 weeks' gestation onwards</li> <li>2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation</li> <li>3) There is a quarterly audit of the percentage of babies born &lt;3rd centile &gt;37+6 weeks' gestation.</li> </ol> <p>If Trusts have elected to follow Appendix G due to staff shortages related to the Covid-19 pandemic Trust Boards should evidence they have followed the escalation guidance for the short term management of staff (<a href="https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-Covid-19-information/">https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-Covid-19-information/</a>). They should also specifically confirm that they are following the modified pathway for women with a BMI&gt;35 kg/m<sup>2</sup>. If this is not the case the Trust board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice.</p> <p>Q: How should Trust board specifically confirm that within their organisation standard 1-2 above have been implemented? This should be confirmed as a minimum via inclusion in the Trust's standard operating procedure/guidelines</p> <p>Element three:</p> <ol style="list-style-type: none"> <li>A. Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy.</li> <li>B. Percentage of women who attend with RFM who have a computerised CTG.</li> </ol>
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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 whichever is the smaller to assess compliance with the element three indicators.

A threshold score of 80% compliance should be used to confirm successful implementation. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

Element four:

A. Percentage of staff who have received training on intrapartum fetal monitoring in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness.

B. Percentage of staff who have successfully completed mandatory annual competency assessment. Note: An in-house audit should have been undertaken to assess compliance with these indicators. Each of the following groups should be attending the training:

Obstetric consultants.

All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota

Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres.

In the current year we have removed the threshold of 90%. This applies to fetal monitoring requirement of safety action 6. We recommend that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible. Trust Board should minute in their meeting records a written commitment to facilitate local, in-person, fetal monitoring training when this is permitted.

Element 5:

	<p>A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.</p> <p>B. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.</p> <p>C. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).</p> <p>Note: The relevant data items for these 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.</p> <p>The Trust board should receive data from the organisation's MIS evidencing 85% compliance. If there is a delay in the provider Trust MIS's ability to record these data at the time of submission an in-house audit of a minimum of four weeks' worth of consecutive cases up to a maximum of 20 cases to assess compliance with the element five indicators. Completion of the audits for element 5 standards A, B and C should be used to confirm successful implementation.</p> <p>If the process indicator scores are less than 85% Trusts must also have an action plan for achieving &gt;85%. In addition, the Trust board should specifically confirm that within their organisation:</p> <ul style="list-style-type: none"> <li>• Women at high risk of pre-term birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice.</li> <li>• An audit has been completed to measure the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.</li> </ul>
<b>Validation process</b>	<p>1) Self-certification to NHS Resolution using the Board declaration form.</p> <p>2) Shadow validation using relevant indicators will be possible for Trusts submitting MSDS data for the month of December 2020. The</p>

	December data will be published by NHS Digital by the end of March 2021. The last opportunity to submit data for the assessment will be March 2021, which will be published on the last Thursday of June 2021. 3) Shadow validation will be by the NHS England/NHS Improvement national team drawing on the self-reported position using the SBLCB survey if available.
<b>What is the relevant time period?</b>	The scheme will take into account the position of trusts at 15 July 2021 at 12 noon
<b>What is the deadline for reporting to NHS Resolution?</b>	Thursday 15 July 2021 at 12 noon

### **Safety Action 6 Evidence**

We are fully compliant with all of the national survey criteria and submissions. Survey 5 demonstrated full compliance following the removal of the MSDS elements. This was shared with Quality Academy in June and included the progress of all 5 surveys (appendix 3).

The associated audits and any actions required are described within appendix 4 and are attached as appendices 5 to 13 for Board's information

Trust Board should minute in their meeting records a written commitment to facilitate local, in-person, fetal monitoring training when this is permitted. This statement is not applicable at BTHFT as this approach has continued during the pandemic.

### **Outstanding evidence required for sign off:**

None

### **Safety Action status:**

Green

**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?

<b>Required standard</b>	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?
<b>Minimum evidential requirement for trust Board</b>	<p>Evidence should include:</p> <ul style="list-style-type: none"> <li>• Terms of Reference for your MVP</li> <li>• A minimum of one set of minutes of MVP meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback</li> <li>• Evidence of service developments resulting from coproduction with service users</li> <li>• Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses</li> <li>• Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of UKOSS 2020 coronavirus data.</li> </ul>
<b>Validation process</b>	Self-certification to NHS Resolution using the Board declaration form.
<b>What is the relevant time period?</b>	Friday 20 December 2019 until Thursday 15 July 2021
<b>What is the deadline for reporting to NHS Resolution?</b>	Thursday 15 July 2021 at 12 noon

#### **Safety Action 7 Evidence:**

Bradford and Airedale Maternity Voices Partnership (MVP) hold a minimum of 3 'main' meetings per year, and a number of themed sub-groups which feed in to the main meetings. The terms of reference and written confirmation regarding the remuneration arrangements are available as supporting evidence.

The maternity service is well represented at the main meeting by the Director 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. Meetings continued to be held virtually during the pandemic with minutes of the main meetings available as supporting evidence.

The MVP have worked alongside the service to perform 15 steps reviews in a number of the clinical areas, with further reviews planned for the inpatient ward areas. The feedback is being addressed and monitored through the Outstanding Maternity Services programme. The MVP leads are core members of the OMS programme board.

The MVP have co-produced and collated 2 recent service user surveys regarding maternity unit visiting arrangements during Covid and infant feeding. The MVP is involved in the review and co-production of the visiting guideline.

The BTHFT parent education team and the MVP have co-produced a series of pregnancy wellbeing information videos in multiple languages, to ensure that women from BAME and vulnerable backgrounds receive targeted messages.

**Outstanding evidence required for sign off:**

None

**Safety action status:**

Green

**Safety action 8:** Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

<b>Required standard</b>	<p>Can you confirm that: a) Covid-19 specific e-learning training has been made available to the multi-professional team members?</p> <p>b) team required to be involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since the launch of MIS year three in December 2019?</p> <p>c) there is a commitment by the trust board to facilitate multi-professional training sessions, including fetal monitoring training once when this is permitted.</p>
<b>Validation process</b>	Self-certification to NHS Resolution using the Board declaration form.
<b>What is the relevant time period?</b>	Trusts should be evidencing the position as Thursday 15 July 2021 at 12noon

### Safety Action 8 Evidence

The 90% target for all staff groups to attend an in-house multi-professional maternity emergencies training session has been removed from the standard in response to Covid. However, the service has continued to strive towards this target and has achieved it for midwives, obstetricians, midwifery support staff and operating department practitioners (ODP'S).

Consultant Anaesthetist attendance at PROMPT has been challenging during the pandemic as the priority was providing clinical care in intensive care. However, 85% compliance has been achieved and this will increase to 91% by 28 July. ETM/Regulation and Assurance Committee are asked to note this.

PROMPT training incorporates Covid specific learning regarding resuscitation and the use of PPE. E-learning is also available to the team.

Immediate newborn life support is incorporated into PROMPT training, attended by midwives including midwifery managers, bank midwives and theatre midwives who also work outside of theatre.

In addition, relevant staff have attended NLS training in the period December 2019 to July 2021, including neonatal nurses, neonatal consultants and neonatal advanced practitioners.

90% compliance has been achieved or exceeded for midwives, neonatal consultants, neonatal junior doctors and neonatal advanced practitioners. At the time of this paper, 82% of neonatal nurses have attended NLS training since the launch of MIS year 3 in December 2019.

There is a current training plan in place over the next few months to capture the staff who still need training which they missed last year due to training cancellations (Covid) and the new starters within the service. In view of this plan, by the end of the year our training compliance will be in excess of 90%. ETM/Board is asked to note and support that this plan is in place.

Face to face fetal monitoring training as required for compliance with the Saving Babies' Lives Care Bundle Version 2, is included in PROMPT and ad hoc training sessions have continued during the pandemic. This will become a regular session during the 21/22 training year.

**Outstanding evidence required for sign off:**

None

**Safety action rating:**

| Green



**Safety action 9:** Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?

<p><b>Required standard</b></p>	<p>a) A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks.</p> <p>b) Board level safety champions are undertaking feedback sessions every other month, for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to Covid-19 service changes and service user feedback and can demonstrate that progress with actioning named concerns are visible to staff.</p> <p>c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. Taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas, a revised action plan describes how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve.</p> <p>d) Together with their frontline safety champions, the Board safety champion has reviewed local outcomes in relation to: I. Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of Covid-19, drawing on resources and guidance to understand and address factors which led to these outcomes. II. The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK. III. The MBRRACE-UK SARS-Covid-19 <a href="https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK_Maternal_Report_2020_v10_FINAL.pdf">https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK_Maternal_Report_2020_v10_FINAL.pdf</a> IV. The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups And considered the recommendations and requirements of II, III and IV on I. Revised safety actions - updated March 2021 56</p> <p>e) The Board Level Safety Champion is actively supporting capacity (and capability) building for all staff to be actively involved in the following areas:</p> <ul style="list-style-type: none"> <li>• Maternity and neonatal quality and safety improvement activity within the Trust, including that determined in response to Covid-19 safety concerns</li> <li>• Specific national improvement work and testing lead by MatNeoSIP that the Trust is directly involved with</li> </ul>
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<p><b>Minimum evidential requirement for trust Board</b></p>	<p>a) Evidence of a written pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) the LMS and d) Patient Safety Networks.</p> <p>b) Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff.</p> <p>c) Evidence that discussions regarding safety intelligence, concerns raised by staff and service users in relation to, but not exclusively, the impact of Covid-19 on maternity and neonatal services; progress and actions relating to the local improvement plan(s) and QI activity are reflected in the minutes of Board, LMS and Patient Safety Network meetings. Minutes should also include discussions on where efforts should be positively recognised.</p> <p>d) Evidence of a safety dashboard or equivalent, visible to both maternity and neonatal staff which reflects action and progress made on identified concerns raised by staff and service users. This should include concerns relating to the Covid-19 pandemic.</p> <p>e) Evidence that Board level safety champions have reviewed their continuity of carer action plan in light of Covid-19. Plans should reflect how the Trust will continue or resume continuity of carer models so that at least 35% of women booking for maternity care are being placed onto continuity of carer pathways. In light of the increased risk facing, women from Black, Asian and minority ethnic backgrounds and women from the most deprived areas, local systems should consider bringing forward enhanced continuity of carer models primarily targeting these groups.</p> <p>f) Evidence of Board level oversight and discussion of progress in meeting the revised continuity of carer action plan.</p> <p>g) Evidence that the frontline and Board safety champions have reviewed local outcomes as set out in standard d) above and are addressing relevant learning, drawing on insights and recommendations from the two named reports and undertaking the requirements within the letter targeting perinatal support for Black, Asian and Minority Ethnic groups.</p> <p>h) Evidence of how the Board has supported staff involved in the four key areas outlined in part e) of the required standard and specifically to:</p> <ul style="list-style-type: none"> <li>• work with Patient Safety Networks, local maternity systems, clinical networks, commissioners and others on Covid-19 and non Covid-19 related challenges and safety concerns, ensuring learning and intelligence is actively shared across systems</li> <li>• utilise SCORE safety culture survey results to inform the Trust quality improvement plan</li> <li>• active participation in system level improvement through the Patient Safety Networks, aligned to the ambitions of</li> </ul>
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	MatNeoSIP
<b>Validation process</b>	Self-certification to NHS Resolution using the Board declaration form
<b>What is the relevant time period?</b>	<ul style="list-style-type: none"> <li>• A written pathway, visible to staff and meeting the requirements detailed in part a) and b) of the action is in place by Friday 28 February 2020.</li> <li>• Monthly feedback sessions continue to be undertaken in January 2020 and February 2020 and again every other month from no later than 30 November 2020.</li> <li>• Progress with actioning named concerns from staff workarounds are visible from no later than 26 February 2021.</li> <li>• An action plan relating to a minimum of 35% of women being placed onto a continuity of carer pathway, which prioritises women from Black, Asian, Minority Ethnic and the most vulnerable groups served by the Trust,</li> </ul>

### Safety Action 9 Evidence

- A written pathway produced by West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) is available to staff and included in the evidence file.
- A Maternity Safety Champion poster and information leaflet including the names of the Board and Trust level champions is available in all clinical areas. This has recently been updated to include the non-executive director.
- Feedback and safety concerns raised at both the bi-monthly maternity safety champion meetings and the ward to board monthly meetings are included in the monthly maternity services update presented to Board/Quality Academy.
- A safety dashboard has not yet been devised. However, feedback and progress on safety concerns raised by staff is shared directly with the staff raising the concern and is included in the monthly Outstanding Maternity Services programme newsletter. A 'You Said/We Did' summary is also circulated in the clinical areas.
- The Continuity of Carer action plan including progress on pathways for BAME/vulnerable women is discussed monthly by the Board level champion, Director of Midwifery and CoC lead midwife.
- A continuity of carer update including percentage of BAME women on a pathway is provided to Board/Quality Academy as part of the monthly maternity services update paper.
- Reports and letter reviewed and benchmarked by the maternity Trust level champions and shared with Board level champion.
- Attendance records of BTHFT staff presence at MatNeoSipsafety network meetings. Includes executive and non-executive attendance. Board level support for the OMS programme which includes focused work on safety culture. Evidence of participation at meetings where safety learning is shared.

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. From early 2021, the meeting has extended to include the Non-Executive Director. Meetings follow a set agenda and meeting notes and an action log are available.

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. These meetings continued throughout the pandemic on a variety of platforms including virtual meetings and unit walk rounds. Issues raised are included in the monthly maternity update paper to Board/Quality Academy and are now captured on an action log.

Feedback from the safety champion monthly meetings is shared directly with the staff member raising a concern, to the wider team via the OMS monthly update and via You Said/We Did posters in the clinical areas.

**Outstanding evidence requiring Trust Board sign off:**

None

**Safety action rating:**

Green

**Safety action 10:** Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?

<b>Required standard</b>	<p>a) Reporting of all outstanding qualifying cases for the year 2019/20 to NHS Resolution's EN scheme.</p> <p>b) Reporting of all qualifying cases to the Healthcare Safety Investigation Branch (HSIB) for 2020/21.</p> <p>c) For qualifying cases which have occurred during the period 1 October 2020 to 31 March 2021 the Trust Board are assured that:</p> <ol style="list-style-type: none"> <li>1. the family have received information on the role of HSIB and the EN scheme;</li> <li>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.</li> </ol>
<b>Minimum evidential requirement for trust Board</b>	<p>Trust Board sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to HSIB and the NHS Resolution Early Notification team.</p> <p>Trust Board sight of evidence that the families have received information on the role of HSIB and EN scheme.</p> <p>Trust Board sight of evidence of compliance with the statutory duty of candour.</p>
<b>Validation process</b>	<p>Self-certification to NHS Resolution using Board declaration form. NHS Resolution will cross reference Trust reporting 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.</p>
<b>What is the relevant time period?</b>	<p>Reporting to NHS Resolution Monday 1 April 2019 to Tuesday 31 March 2020. Reporting to HSIB Wednesday 1 April 2020 to Wednesday 31 March 2021.</p>
<b>What is the deadline for reporting to NHS Resolution?</b>	<p>By Thursday 15 July 2021 at 12 noon.</p>

#### **Safety Action 10 Evidence**

All eligible incidents and cases referred. Duty of Candour met in all eligible cases. Appendices 14 and 15 include the qualifying cases during the required time frame.

#### **Outstanding evidence requiring sign off:**

None

#### **Safety action rating:**

Green

## Conclusion:

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?	
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 mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	Y
8	Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	Y
9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Y
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Y

## Appendices:

2. Appendix 2 MIS Safety action 5 action plan
3. Appendix 3 Copy of SBL Survey 5 - RAG for RAE
4. Appendix 4, summary of Saving Babies' Lives care bundle Version 2 audits and action plans
5. Appendix 5 Audit report - Risk status for FGR at booking
6. Appendix 6 CO monitoring April 21
7. Appendix 7 FGR audit 3rd centile Oct 2020
8. Appendix 8 FGR audit report- march 2021
9. Appendix 9 FGR Risk Assessment Action Plan
10. Appendix 10 RFM Tommy leaflet audit feb21
11. Appendix 11 RFM, audit Jan 2021
12. Appendix 12 Steroids 34 weeks audit
13. Appendix 13 Steroids audit report
14. Appendix 14 NHSR ENS reportable cases 1.4.2019-31.3.2020
15. Appendix 15 HSIB investigations 1.4.20 to 31.3.21