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

Background:

This is the fourth 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 delayed during 2022 in response to ongoing pressures experienced by acute Trust's in the aftermath of the Covid 19 pandemic and subsequent recovery period.

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

The ten safety actions remain unchanged in year four. However, there are subtle amendments to the evidence required to demonstrate compliance in some of the domains, which have been updated on a number of occasions following the original publication of the year 4 scheme.

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 and agreed with Michelle Turner, Director of Nursing, Bradford District and Craven Integrated Care System (ICS) in her position as accountable lead for commissioning maternity services, on 3 January 2022. This is to avoid any conflict of interest that may arise as a result of Professor Mel Pickup being both the CEO for the Trust and the Accountable Officer of the ICS.

The Board Declaration Form must be signed by the Chief Executive and the Accountable Lead for commissioning maternity services at the ICS, and submitted no later than 12 noon on Thursday 2 February 2023.

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 6 May 2022 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. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter. ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 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 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews 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 6 May 2022, 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 6 May 2022 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 reports should be generated via the PMRT. A report has been

	received by the Trust Board each quarter from 6 May 2022 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 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Safety Action 1 Evidence:

Quarterly PMRT Reports have been submitted to:

- Trust Board 12 May 2022
- Trust Board 22 September 2022
- No Trust Board in December, therefore final report will go to January 2023 Board

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

The service has met the required standard with the exception of 1 baby where the surveillance form was started in time but not completed within one month of the death (4 days late). This was a complex case where the baby was stillborn and the mother died shortly after the birth. The delay was due to uncertainty regarding whether or not this was a criminal and/or coronial case. Given the unique and mitigating circumstances, and the fact that 100% compliance in this element is consistently achieved, the service have asked NHS Resolution to consider allowing this one exception.
NHS Resolution has agreed that mitigating circumstances are apparent in this case and that this information should be included in the Board return to this effect.

NHS Resolution also confirm that in the case of 3 babies born in other organisations but died in Bradford, the surveillance forms were submitted to another Trust for additional information therefore those deaths will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. The Trust will be compliant if this is declared on the Board declaration form.

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

Nil

Safety Action Status:

Green, pending the inclusion of the narrative described on the Board submission form.

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 ongoing plans to make improvements.
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. For criteria 2 to 7, the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series displays whether trusts have passed the requisite data quality thresholds.
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 to 7 (inclusive) against NHS Digital data
What is the relevant time period?	From 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2022 at 12 noon

Safety Action 2 Evidence:

- Maternity Digital Strategy shared with the LMNS
- July MSDS data published in October 2022 passed the required data quality criteria

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 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, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter. c)A data recording process (electronic and/or paper based for capturing **all** term babies transferred to the neonatal unit, regardless of the length of stay, is in place. d) 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. e) 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), 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. f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the

	neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted 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. g) 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 f) has been agreed with the maternity and neonatal safety champions and Board level champion. h) 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 As 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 X 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 • The policy has been fully implemented and quarterly audits of compliance conducted.
	Evidence for standard b) to include: • An audit trail is available which provides evidence that ongoing audi maternity incentive scheme of the pathway of care into transitional care as a minimum of quarterly. If for any reason, reviews have been pa recommenced using data from quarter 1 of 2022/23 financial year. • Audit findings are shared with the neonatal safety champion on a q barriers to achieving full implementation of the policy are encountered, be agreed and progress overseen by both the board and neonatal safety
	Evidence for standard c) to include: • Data is available (electronic and/or paper based) on all term admitted to the neonatal unit. This will include admission data capt well as transfer data which may be captured on a separate paper or • If a data recording process is not already in place to capture all admitted to the NNU this should be in place no later than **Monday 1**
	Evidence for standard d) to include: • Data is available (electronic or paper based) on transitional care activity which could be a TC, postnatal ward, virtual outreach pathway etc.). • Secondary data is available (electronic or paper based) on babies bor

	weeks gestation at birth, who did not have surgery nor were transferred to monitor the number of special care or normal care days where supp not delivered to inform future capacity management for late preterm cared for in a TC setting.
	Evidence for standard e) to include: • Commissioner returns for Healthcare Resource Groups (HRG) 4/ Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are request, for example to support service development and capacity plan ODN and/or commissioner.
	Evidence for standard f) to include: • An audit trail is available which provides evidence that ongoing reviev maternity incentive scheme of term admissions are being complete quarterly. If for any reason, reviews have been paused, they should be data from quarter 1 of 2022/23 financial year. • If not already in place, an audit trail is available which provides evide Monday 18 July 2022, now include **all** term babies transferred or a irrespective of their length of stay, are being completed as a minimum reviews already included all babies transferred or admitted to the N continue using data from quarter 1 of 2022/23 financial year. • Evidence that the review includes: the number of transfers or admissio that would have met current TC admission criteria but were transferr neonatal unit due to capacity or staffing issues and the number of babies or admitted to, or remained on NNU because of their need for nasoga could have been cared for on a TC if nasogastric feeding was supported • Evidence that findings of all reviews of term babies transferred or adm are reviewed quarterly and the findings have been shared quarterly v neonatal safety champions and Board level champion, the LMNS and IC meeting.
	Evidence for standard g) and h): • An audit trail is available which provides evidence and rationale for c action plan to address local findings from the pathway audit (point b) a (point f).Evidence that progress with the action plan has been shar maternity safety champion, and Board level champion, LMNS and IC meeting each quarter.

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 and quarterly reports have been presented to Board during the relevant time period. There has been some delay in the timing of presentation to Board during the reporting year as a result of Consultant Neonatologist capacity and clinical care taking priority. However, all reports are complete from quarter 1 onwards, meeting the required standard.

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.

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

- The NEWTT alerts and risk stratification have been incorporated in to Cerner. There are ongoing challenges with ensuring they are used properly which are being addressed both through feedback relating to individual cases as well as wider improvements in Cerner use.
- ATAIN education has been incorporated into the Maternity Education Day 2. Unfortunately this day is being changed so this will not continue. Ongoing education with additional timely sharing of learning from cases will continue in an alternative form, which is as yet to be confirmed.
- As the majority of admissions are due to respiratory causes we are assessing a decision tool. If deemed useful it will be introduced later this year.

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 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 LMNS. 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, LMNS 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 LMNS meetings at least once from the relaunch of MIS year 4 in May 2022. 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. 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 (cypadmin@rcn.org.uk), LMNS 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 16 June 2022 2. By 29 July 2022 and monitored monthly from then. b) Anaesthetic medical workforce Any six month period between August 2021 and 5 December 2022 c) Neonatal medical workforce A review has been undertaken any 6 month period between August 2021 and 5 December 2022. d) Neonatal nursing workforce Nursing workforce review has been undertaken at least once during year 4 reporting period (August 2021 and 5 December 2022).
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Safety Action 4 Evidence

Obstetric Workforce:

A paper acknowledging engagement with the RCOG document was presented to People Academy in November 2021 accompanied by an audit of compliance with consultant attendance at specified clinical situations, which demonstrated 100% compliance.
A repeat audit is to be presented to Trust Board in January 2023.

An Obstetric staffing update is provided to Quality and Patient Safety Academy and/or Trust Board on a monthly basis and any non-compliance against the RCOG workforce document would be presented here.

Anaesthetic Workforce:

ACSA Standards met in full electronic copies of rotas are available as evidence to support.

Neonatal Medical and Nursing Workforce:

The Neonatal Staffing update paper and associated action plans were received and approved at November 2022 People Academy, and presented to December 2022 Quality and Patient Safety Academy in lieu of Trust Board. They will be presented to Trust Board in January 2023 for completeness.
The Neonatal service remains non-compliant against the national service specification. However, significant progress has been made since the Year 3 submission and the associated action plans describe the ongoing plans.

The action plans were submitted to the Royal College of Nursing and the Yorkshire and Humber Neonatal Operational Delivery Network on 7 December 2022.

Outstanding evidence required for sign off:

None pending presentation of the obstetric attendance audits to January 2023 Board

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 is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) 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 d) All women in active labour receive one-to-one midwifery care e) 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 · In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. · Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. · The 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 must be shared with the local commissioners. · Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. -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 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Safety Action 5 Evidence:

Midwifery workforce reports were received by the Board in May and September 2022.The reports meet the recommended criteria described in the standard.

Birth Rate Plus table top reviews were undertaken in both 6 monthly papers and the calculated establishment was supported and funded by Board as requested. The funded establishment is broken down into 2 components:

- Birth rate Plus traditional calculation for safe staffing based on acuity, birth rate and existing models of care
- Birth rate Plus calculation for 100% Midwifery Continuity of Carer (MCoC) as a default position for all women

Due to the ongoing national midwifery recruitment issues, the service have prioritised the achievement of safe staffing but have consistently received Trust Board support to work towards the larger MCoC establishment as and when safe staffing is achieved and sustained.
The recruitment and retention action plan included as appendix X describes the service plans to achieve both figures and highlights the progress made during 2022.

1:1 care in labour. The service consistently achieved >90% for the majority of the reporting period, but has noted a decrease to 87, 90 and 88% in the last 3 months. It is unclear whether this is a midwifery reporting issue following the change from Medway to Cerner, and the Labour Ward Co-ordinators have recommenced validation of records where 1:1 care is reported as not being achieved. This approach has proved successful in previous years where percentages have dropped and it is anticipated that this will result in an improvement. 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?

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. 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 May 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 four month period (i.e. four consecutive months in during the MIS year 4 reporting timeframe). 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. If the provider Trust is unable to record these data on their maternity information system an audit of 60 consecutive cases would be acceptable evidence to demonstrate >80% of women having a CO measurement recorded at 36 weeks. The denominator for the audit should be 60 consecutive women at 36 weeks gestation, whereas the denominator for the electronic audit would be the total number of women at 36 weeks gestation. In addition to this, the audit should be accompanied by a brief description of the stop smoking strategy within the Trust and any plans for improvement. 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 four consecutive months within the MIS year 4 reporting period: · 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 four months, please be advised that there is a three

	month delay with MSDSv2 data, for example data submitted at the end of August 2022 will be published on the dashboard at the end of November 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. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. Women declining CO testing at booking / 36 weeks appointment Standard A and B of element 1 require Trusts to demonstrate that 80% of women had CO testing at booking and at 36 weeks respectively and that this is recorded in the Trusts' information system. In the event of a high number of women declining CO testing a Trust would be at risk of failing standard A and B by not reaching the 80% testing rate. We suggest Trusts proactively monitor their testing rate and consider interventions to maintain adequate compliance.
	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 at 20 weeks 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/m2 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 organization 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above. Please refer to safety action 8 for more information 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 with process indicators A, C and D. The percentage for process indicator B should be as low as possible and can be reported as the proportion. 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 2 February 2023 at 12 noon
What is the deadline for reporting to NHS Resolution?	2 February 2023 at 12noon

Safety Action 6 Evidence

Appendix 3 is a summary of the year 4 submission evidence, and includes the relevant audits required to demonstrate compliance with the standard.

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

The associated audits and any actions required are embedded within appendix 3 for Board's information. Audits will continue up until the submission deadline. However, any audit results will only serve to enhance the submission as the standard has been met at the time of this report.

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.

Saving Babies' Lives Care Bundle, Version 3, is expected to be released in early 2023, which may result in changes to the safety action standard in year 5.

Outstanding evidence required for sign off:

None although some audits will continue up to the date of submission but will only serve to enhance the compliance which has already been met.

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?

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 service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place 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 LMNS 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 travel, parking and 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. · Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings,

	including complaints' response processes, trends and themes, are shared with the MVP.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	From 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Safety Action 7 Evidence:

Bradford, Airedale and Craven Maternity Voices Partnership (MVP) have held 4 main meetings during 2022 despite the step down of the Chair and Project Manager during the reporting period, which resulted in a hiatus in MVP activity during the late summer/autumn period.
MVP activities are currently being overseen by the ICB whilst the appointment of a new Chair is completed.

The terms of reference and written confirmation regarding the remuneration arrangements are available as supporting evidence. In the absence of a current Chair, this has been confirmed by Maternity Leads at the ICB.

The proposed MVP work plan for 2022/23 was presented and approved at the November 2022 West Yorkshire and Harrogate Local Maternity and Neonatal System Board meeting.

The maternity service is well represented at the main meetings 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.

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.

MVP members have participated in the recruitment process of senior midwives at BTHFT during 2022, to ensure that the service user voice is considered and recognised by candidates.

Outstanding evidence required for sign off:

None

Safety action status:

Green

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	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 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, that includes maternity emergencies starting from the launch of MIS year four in August 2021? c) 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring, starting from the launch of MIS year four in 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 in-house neonatal life support training or a Newborn Life Support (NLS) course starting from the launch of MIS year four in August 2021.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	Any 12 consecutive months within the period 1st August 2021 until 5th December 2022

Safety Action 8 Evidence

A local training plan incorporating all 6 core modules of the Core Competency Framework was proposed at the Women's CSU Business meeting in March 2022 and commenced in April 2022.
The overarching education strategy for the Women's CSU was ratified at the July 2022 Women's Core Governance Group.

90% of each relevant maternity unit staff group attended an in house multi professional training day (PROMPT) which included maternity emergencies, fetal monitoring and newborn life support, during the relevant time period.

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 1 August 2021 to 5 December 2022, 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.

Face to face antenatal and intrapartum fetal monitoring training as required for compliance with the Saving Babies' Lives Care Bundle Version 2, is included in PROMPT multi professional training

Outstanding evidence required for sign off:

None

Safety action rating:

Green

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 quarterly, 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 16 June 2022. 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 16 June 2022. c) Trust Boards have reviewed current staffing in the context of the letters to systems on 1 April 2022 and 21 September 2022 regarding the roll out of Midwifery Continuity of Carer as the default model of care. A decision has been made by the Board as to whether staffing meets safe minimum requirements to continue rollout of current or planned MCoC teams, or whether rollout should be suspended 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 engagement sessions; minimum staffing in maternity services and training

	compliance are taking place at Board level no later than 16 June 2022. 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 16 June 2022. · Evidence of the engagement sessions (e.g. staff feedback meeting, staff walkaround sessions etc.) 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): This is to be evidenced by a minuted Board level discussion and decision since 1 April 2022 on how a Trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent evidence should be submitted. 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 16 June 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 16 June 2022. 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 16 June 2022. · The expectation is that quarterly engagement sessions have continued from year 3 of the scheme. If for any reason these have been paused, they should be recommenced no later than 16 June 2022. 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 engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 16 June 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 2 of 2022/23 (July 2022). Time period for points c) · Board level discussion and decision since 1st April 2022 on how a trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent evidence should be submitted. 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 5th December 2022. · Evidence that insights from culture surveys undertaken have been used to inform local quality improvement plans by 5th December 2022.

Safety Action 9 Evidence

a) The written pathway produced by West Yorkshire and Harrogate (WY&H) Local Maternity and Neonatal System (LMNS) is included in the evidence file. During Year 4 of the scheme, the maternity service have shared the Board level monthly Maternity and Neonatal Update papers at the monthly ICS Maternity Oversight Group, attended by a member of WY&H LMNS.
b) The monthly Maternity and Neonatal Update paper includes all of the elements described in the Perinatal Quality Surveillance Model, including the number of incidents reported as serious harm, ward to board safety champion feedback and obstetric and midwifery staffing updates. Feedback from these meetings is shared with staff in a 'You Said/We Did' poster format. A training update is included within the report on a quarterly basis.
c) Following the letters to systems regarding the rollout of Midwifery Continuity of Carer (MCoC) as a default position in April 2022, an update was provided to May Board in the monthly update period. The decision was that rollout of further MCoC pathways would be paused until safe staffing levels are achieved and maintained, but that existing teams focusing on BAME/Vulnerable women would

be maintained with close monitoring. This approach has continued and an update provided on a monthly basis.

d) Members of the BTHFT Maternity and Neonatal teams regularly attend and represent at Patient Safety Network meetings and MatNeoSIP webinars and events. BTHFT were not invited to complete the score culture survey during this reporting year, but have been selected to join the first wave of the Perinatal Culture and Leadership programme commencing in January 2023. Undertaking the culture survey will be included in the programme. However, feedback from staff surveys, ward to board intelligence etc has been used to inform local quality improvement plans through the Outstanding Maternity Service programme.

Outstanding evidence requiring Trust Board sign off:

None

Safety action rating:

Green

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 from 1 April 2021 to 5 December 2022?

Required standard	A) Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022 2. B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022 3. C) For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that: 4. 1. the family have received information on the role of HSIB and NHS Resolution's EN scheme ; and 5. 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 and NHS Resolution. 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 the HSIB database and the National Neonatal Research Database (NNRD), and NHS Resolution database 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. In addition, for standard C1 there is a requirement to complete field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.
What is the relevant time period?	Reporting to HSIB – from Wednesday 1 April 2021 to 5 December 2022 Reporting period to HSIB and to NHS Resolution - from 1 April 2022 to 5 December 2022

What is the deadline for reporting to NHS Resolution?	By 2 February 2023 at 12 noon

Safety Action 10 Evidence

All eligible incidents and cases referred. Duty of Candour met in all eligible cases. Appendix 4 is a copy of the eligible HSIB cases during the required time frame.

NHSR informed us in December of a 'missed case'. However on further investigation NHSR retracted this statement confirming that they have received notification of all eligible cases in the reporting period.

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 clinical* 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 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 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?**	**Y**
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?**	**Y**
10	**Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?**	**Y**

Appendices:

2. Appendix 2 Midwifery Workforce Plan Year 4 submission
3. Appendix 3 Saving babies lives year 4 submission
4. Appendix 4 HSIB investigations 1 April 2021 to 5 December 2022