NHS Resolution

Maternity Incentive Scheme – year five

Conditions of the scheme

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Questions and answers related to the scheme

V1.1 July 2023

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Introduction

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

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

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

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

Maternity incentive scheme year five: conditions

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution nhsr.mis@nhs.net by **12 noon** on **1 February 2024** and must comply with the following conditions:

- Trusts must achieve **all** ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
- The Trust Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:
    - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
    - There are no reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before **1 February 2024**.
- The Trust Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions'

evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution

- Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
- The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of
  MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions, then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution
  Website).

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested as explained above.
- Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.
- Trusts will need to report compliance with MIS by **1 February 2024** at **12 noon** using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) of Clinical Commissioning Group/Integrated Care System.

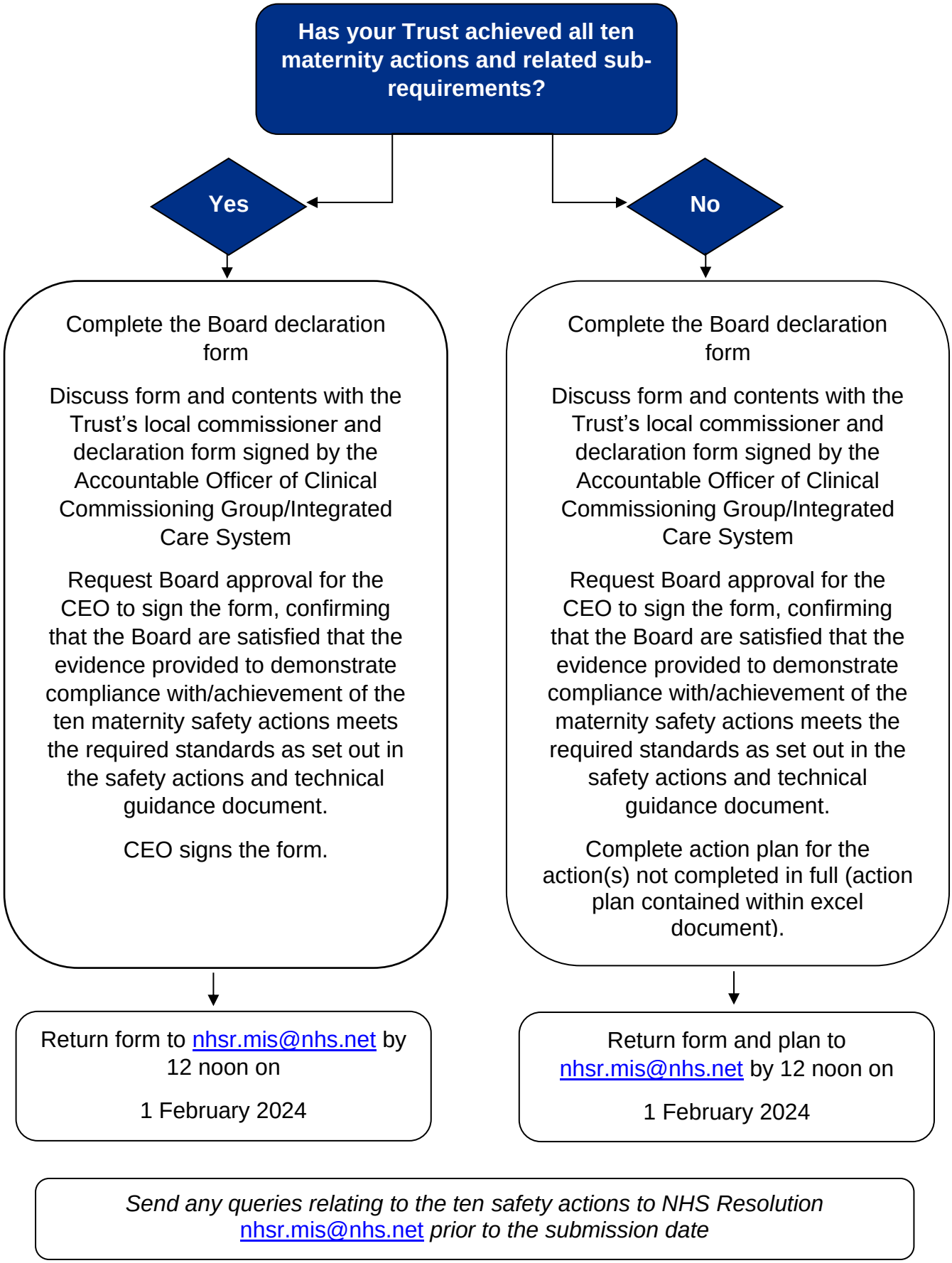
- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.
- The Board declaration form will be available on the MIS webpage at a later date.
- Trusts are reminded to retain all evidence used to support their position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described above) it must be made available as it was presented to support Board assurance at the time of submission.

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution nhsr.mis@nhs.net prior to the submission date.
- The Board declaration form must be sent to NHS Resolution nhsr.mis@nhs.net between **25 January 2024** and **1 February 2024** at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from submission date.
- Submissions and any comments/corrections received after **12 noon** on **1 February 2024** will not be considered.
- The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.
- There are two possible grounds for appeal:
    - alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation
    - technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.
- NHS Resolution clinical advisors will review all appeals to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.
- Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.
- Further detail on the results publication, appeals window dates and payments process will be communicated at a later date.

For Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 1 February 2024 to NHS Resolution nhsr.mis@nhs.net. The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the action plan template which will be provided within the Board declaration form. Action plans should not be submitted for achieved safety actions.


Has your Trust achieved all ten maternity actions and related sub-requirements?
Yes
No
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
CEO signs the form.
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
Complete action plan for the action(s) not completed in full (action plan contained within excel document).
Return form to nhsr.mis@nhs.net by 12 noon on
1 February 2024
Return form and plan to nhsr.mis@nhs.net by 12 noon on
1 February 2024
Send any queries relating to the ten safety actions to NHS Resolution nhsr.mis@nhs.net prior to the submission date

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

Required standard	a) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from **30 May 2023,** MBRRACE-UK surveillance information should be completed within one calendar month of the death. b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from **30 May 2023** onwards. c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from **30 May 2023.** 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months. d) Quarterly reports should be submitted to the Trust Executive Board from **30 May 2023.**
Minimum evidential requirement for Trust Board	Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see note below about the introduction of the NHS single notification portal). The PMRT must be used to review the care and reports should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter from **30 May 2023** that includes details of the deaths reviewed, any themes identified 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 b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Verification 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 **30 May 2023** until **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**12 noon** on **1 February 2024**

Technical guidance for safety action 1

Further guidance and information is available on the PMRT website: Maternity Incentive Scheme FAQs. This includes information about how you can use the MBRRACE-UK/PMRT system to track your notifications and reviews: www.npeu.ox.ac.uk/pmrt/faqsmis; these FAQs are also available on the MBRRACE-UK/PMRT reporting website www.mbrrace.ox.ac.uk.

Technical Guidance **Guidance for SA 1(a) – notification and completion of surveillance information**	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal death must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection
Where are perinatal deaths notified?	Notifications of deaths must be made, and surveillance forms completed, using the MBRRACE-UK reporting website. It is planned that a single notification portal (SNP) will be released by NHS England in 2024. Once this is released notifications of deaths must be made through the SNP and this information will be passed to MBRRACE-UK. It will then be necessary for reporters to log into the MBRRACE-UK surveillance system to provide the surveillance information and use the PMRT.
Should we notify babies who die at home?	Notification and surveillance information must be provided for babies who died after a home birth where care was provided by your Trust.
What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK from **30 May 2023** onwards must be notified to MBRRACE-UK within seven working days.
What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death. This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK are working with the National Child Mortality Database (NCMD) team to provide a single route of reporting for neonatal deaths that will be via MBRRACE-UK. Once this single route is established, MBRRACE-UK will be the mechanism for directly notifying all neonatal deaths to the local Child Death Overview Panel (CDOP) and the NCMD. At that stage, for any Trust not already doing so, a review completed using the PMRT will be the required mechanism for completing the local review for submission

	to CDOP. This will also be the required route for providing additional information about the death required by both CDOPs and the NCMD. Work is underway to provide this single route of reporting with plans to have this in place in the forthcoming months
Are there any exclusions from completing the surveillance information?	If the surveillance form needs to be assigned to another Trust for additional information, then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. Trusts, should however, endeavour to complete the surveillance as soon as possible so that a PMRT review, including the surveillance information can be started.
Guidance for SA1(b) – parent engagement	
We have informed parents that a local review will take place and they have been asked if they have any reflections or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	In order that parents' perspectives and questions can be considered during the review this information needs to be incorporated as part of the review and entered into the PMRT. So, if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. The importance of parents' perspectives is highlighted by their inclusion as the first set of questions in the PMRT. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
We have contacted the parents of a baby who has died and they don't wish to have any involvement in the review process. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their perspective and raise any questions and/or concerns they may subsequently have about their care. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See especially the notes accompanying the flowchart.

Parents have not responded to our messages and therefore we are unable to discuss the review. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will also be undertaken by the local CDOP. Verbal information can be supplemented by written information. If, for any reason, this does not happen and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if a cause for concern for the mother's wellbeing was raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process, ask how they would like findings of the perinatal mortality review report communicated to them. Materials to support parent engagement in the local review process, including an outline of the role of key contact, are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.
Guidance for SA1(c) – conducting reviews	
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: • All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) • All stillbirths (from 24+0 weeks' gestation) • Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth) While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet the safety action one standard.
What happens when an HSIB investigation takes place?	It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by HSIB. Your local review using the PMRT should be started but not completed until the HSIB report is complete. You should consider inviting the HSIB reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the HSIB review to be automatically incorporated into the PMRT review. Depending upon the timing of the HSIB report completion achieving the MIS standards for these babies may therefore be impacted by time frames beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an HSIB INVESTIGATION is taking place, and this will be accounted for in the external validation process.

What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to be used to complete the first review session (which might be the first session of several) for that death. As an absolute minimum all the 'factual' questions in the PMRT must be completed for the review to be regarded as started; it is not sufficient to just open and close the PMRT tool, this does not meet the criterion of having started a review. The factual questions are highlighted within the PMRT with the symbol: FQ
What is meant by "reviews should be completed to the draft report stage"?	A multidisciplinary review team should have used the PMRT to review the death, then the review progressed to at least the stage of writing a draft report by pressing 'Complete review'. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details of assistance in using the PMRT to complete a review.
What does "multi-disciplinary reviews" mean?	To be multi-disciplinary the team conducting the review should include at least one and preferably two of each of the professionals involved in the care of pregnant women and their babies. Ideally the team should also include a member from a relevant professional group who is external to the unit who can provide 'a fresh pair of eyes' as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews and you may need to be selective as to which deaths are reviewed by the team including an external member. Bereavement care staff (midwives and nurses) should form part of the review team to provide their expertise in reviewing the bereavement and follow-up care, and advocate for parents. It should not be the responsibility of bereavement care staff to run the reviews, chair the panels nor provide administrative support. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details about multi-disciplinary review.
What should we do if our post-mortem service has a turn-around time in excess of four months?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than four months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death and complete it with the information you have available. When the post-mortem results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing earlier learning opportunities, especially if the turn-around time is considerably longer than four months. Where the post-mortem turn-around time is quicker, then the information from the post-mortem can be included in the original review.

What is review assignment?	A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review, the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided.
How does 'assigning a review' impact on safety action 1, especially on starting a review?	If you need to assign a review to another Trust this may affect the ability to meet some of the deadlines for starting, completing and publishing that review. This will be accounted for in the external validation process.
What should we do if we do not have any eligible perinatal deaths to review within the relevant time period?	If you do not have any babies that have died between **30 May 2023** and **7 December 2023** you should partner up with a Trust with which you have a referral relationship to participate in case reviews. This will ensure that you benefit from the learning that arises from conducting reviews.
What deaths should we review outside the relevant time period for the safety action validation process?	Trusts should review all eligible deaths using the PMRT as a routine process, irrespective of the MIS timeframe and validation process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 5 MIS requirements.
Guidance for SA1(d) – Quarterly reports to Trust Boards	
Can the PMRT help by providing a quarterly report that can be presented to the Trust Executive Board?	Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews over a period, within the PMRT for user-defined time periods. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for quarterly Trust Board reports and should be discussed with Trust maternity safety champions.
Is the quarterly review of the Trust Executive Board report based on a financial or calendar year?	This can be either a financial or calendar year. Reports for the Trust Executive Board summarising the results from reviews over a period time which have been completed can be generated within the PMRT by authorised PMRT users for a user-defined periods of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'.

	Please note that these reports will only show summaries, issues and action plans for reviews **that have been published** therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months.
Guidance – Technical issues and updates	
What should we do if we experience technical issues with using PMRT?	All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk
If there are any updates on the PMRT for the maternity incentive scheme where will they be published?	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the maternity incentive scheme safety action 1, will be communicated via NHS Resolution email and will also be included in the PMRT 'message of the day'.

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

Required standard	This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023. 2. July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) 3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: **Midwifery Continuity of carer (MCoC)** **Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable.** i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Final data for July 2023 will be published in October 2023.

	If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information). 4. Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023. 5. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.
Minimum evidential requirement for Trust Board	The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.
Validation process	All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.
What is the relevant time period?	From **30 May 2023** until **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024** at 12 noon

Technical guidance for safety action 2

Technical guidance	
The following CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on these three months? • **Proportion of babies born at term with an Apgar score <7 at 5 minutes** • **Women who had a postpartum haemorrhage of 1,500ml or more** • **Women who were current smokers at delivery** • **Women delivering vaginally who had a 3rd or 4th degree tear** • **Women who gave birth to a single second baby vaginally at or after 37 weeks after a previous caesarean section** • **Caesarean section delivery rate in Robson group 1 women** • **Caesarean section delivery rate in Robson group 2 women** • **Caesarean section delivery rate in Robson group 5 women**	No. For the purposes of the CNST assessment Trusts will only be assessed on July 2023 data for these CQIMs. Due to this, Trusts are now directed to check whether they have passed the requisite data quality required for this safety action within the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series, as the national Maternity Services Dashboard will still display these data using rolling counts.
My maternity service has currently suspended Midwifery Continuity of Carer pathways. How does this affect my data submission for CNST safety action 2?	If maternity services have suspended Midwifery Continuity of Carer (MCoC) pathways, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102. This is a satisfactory response for safety action 2 criteria 3i. If your Trust has suspended all MCoC pathways, criteria 3ii is not applicable and does not need to be completed. If your Trust is continuing with some provision of MCoC pathways, then criteria 3ii does still apply.

Will my Trust fail this action if women choose not to receive continuity of carer?	No. This action is focussed on data quality only and therefore Trusts pass or fail it based upon record completeness for each metric and not on the proportion (%) recorded as the metric output. If women choose not to be placed onto a MCoC pathway, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102.
Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass CQIMs and other metrics specified above can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics
What is the Data Quality Submission Summary Tool? How does my Trust access this?	The Data Quality Submission Summary Tool has been developed by NHS England specifically to support this safety action. The tool provides an immediate report on potential gaps in data required for CQIMs and other metrics specified above after data submission, so Trusts can take action to rectify them. It is intended to be used alongside other existing reports and documentation in order for providers to be able to create a full and detailed picture of the quality of their data submissions. Further information on the tool and how to access it is available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/data-quality-submission-summary-tool
For the Data Quality Submission Summary Tool, what does "sustained engagement" mean for the purposes of passing criteria 3?	By "sustained engagement" we mean that Trusts must show evidence of using the tool for at least three consecutive months prior to the submission of evidence to the Trust Board. For example, for a submission made to the Board in November, engagement should be, as a minimum, in August, September and October. This is a minimum requirement, and we advise that engagement should start as soon as possible. To evidence this, Trusts should save the Excel output file after running the report for a given month. Three files representing each of the three consecutive months should be provided to your Trust Board as part of the assurance process for the scheme. Note – this only becomes a requirement in the event your Trust fails the requisite data quality for the continuity of carer metrics in criteria 3.

The monthly publications and Maternity Services DashBoard states that my Trusts' data has failed for a particular metric. Where can I find out further information on why this has happened?	Details of all the data quality criteria can be found in the "Meta Data" file (see 'CQIMDQ/CoCDQ Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics The scores for each data quality criteria can be found in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series
The monthly publications and national Maternity Services DashBoard states that my Trusts' data is 'suppressed'. What does this mean?	Where data is reported in low values for clinical events, the published data will appear 'suppressed' to ensure the anonymity of individuals. However, for the purposes of data quality within this action, 'suppressed' data will still count as a pass.
Where can I find out more about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services DashBoard please contact maternity.dq@nhs.net. **For any other queries**, please email nhsr.mis@nhs.net

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

Required standard	a) Pathways of care into transitional care (TC) 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) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies **equal to or greater than 37 weeks**. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director, or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB. c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.
Minimum evidential requirement for Trust Board	**Evidence for standard a) to include:** Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.
	Evidence for standard b) to include: • Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks. • Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks.

	• Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan. • Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan.
	Evidence for standard c) to include: Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring **OR** An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	**30 May 2023** to **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024**

Technical guidance for safety action 3

Technical guidance	
Does the data recording process need to be available to the ODN/LMNS/ commissioner?	The requirement for a data recording process from years three and four of the maternity incentive scheme was to inform future capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review. This should be in place and maintained in order to inform ongoing capacity planning of transitional care to minimise separation of mothers and babies. This could be captured through existing systems such as BadgerNet or alternatives such as paper based or electronic systems. These returns do not need to be routinely shared with the Operational Delivery Network (ODN), LMNS and/or commissioner but must be readily available should it be requested.
What members of the MDT should be involved in ATAIN reviews?	The expectation is that this is a multi-professional review, as a minimum the care should be reviewed by representation from both maternity and neonatal staff groups. This should include as a minimum; a member of the maternity team (a midwife and / or obstetrician and /or trainee from maternity services) and a member of the neonatal team (neonatal nurse and / or neonatologist/paediatrician and/or trainee from neonatal services).
We have undertaken some reviews for term admissions to NICU, do we need to undertake more and do all babies admitted to the NNU need to be included?	Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the Avoiding Term Admissions into Neonatal Units (ATAIN) work to date. The expectation is that reviews have been continued from year 4 of the scheme. If for any reason, reviews have been paused, they should be recommenced using data from quarter 4 of the 2022/23 financial year (beginning January 2023). This may mean that some of the audit is completed retrospectively. We recommend ongoing reviews, at least quarterly of unanticipated admissions of babies **equal to or greater than 37 weeks** to the NNU to determine whether there were modifiable factors which could be addressed as part of an action plan. A high-level review of the primary reasons for all admissions should be included, with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed. For example, if 60% of babies are admitted for respiratory problems, then focus on this cohort of babies and complete a deep dive into identified themes or if 40% of babies were admitted with jaundice and 35% of babies were admitted with hypothermia then focus on these two cohorts of babies.

	In addition to this, the number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues and the number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on.
What do you mean by quarterly?	Occurring every three months. This would usually mirror the 4 quarters of the financial year and should cover the period of the MIS **30 May 2023 – 7 December 2023**.
What should the Transitional Care audit include and is there a standard audit tool?	An audit tool can be accessed below as a baseline template; however, the audit needs to include aspects of the local pathway. ATAIN-CASE-NOTE-REVIEW-PROFORMA-Revised-2022-converted.pdf We recommend that Trusts refer to the auditable standards included in their local TC pathway guideline/policy.
How long have the neonatal safety champions been in place for?	Trust Board champions were contacted in February 2019 and asked to nominate a neonatal safety champion. The identification of neonatal safety champions is a recommendation of the national neonatal critical care review and have been in place since February/March 2019.
What is the definition of transitional care?	Transitional care is not a place but a service (see BAPM guidance) and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019 https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/ https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/

	https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/Illness-in-newborn-babies-leaflet-FINAL-070420.pdf Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk) Framework: Early Postnatal Care of the Moderate-Late Preterm Infant | British Association of Perinatal Medicine (bapm.org) B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk)

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

Required standard	a) **Obstetric medical workforce** 1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums. 2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf 3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-compensatory-rest.pdf 4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed 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/ 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. **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. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) **c) Neonatal medical workforce** The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements **have not been met** in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements **had been met** previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN). **d) Neonatal nursing workforce** The neonatal unit meets the BAPM neonatal nursing standards. If the requirements **have not been met** in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed

	and include new relevant actions to address deficiencies. If the requirements **had been met** previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).
Minimum evidential requirement for Trust Board	**Obstetric medical workforce** 1) Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses. Information on the certificate of eligibility (CEL) for short term locums is available here: www.rcog.org.uk/cel This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk) A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk 2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS. 3) Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working

	as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations. **NB**. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG 4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS. **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 relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN). **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form.
What is the relevant time period?	**Obstetric medical workforce** 1. After February 2023 – Audit of 6 months activity 2. After February 2023 – Audit of 6 months activity 3. 30 May 2023 - 7 December 2023 4. 30 May 2023 - 7 December 2023 **Anaesthetic medical workforce** Trusts to evidence position by 7 December 2023 at 12 noon **Neonatal medical workforce** A review has been undertaken of any 6 month period between **30 May 2023 – 7 December 2023** **a) Neonatal nursing workforce** Nursing workforce review has been undertaken at least once during year 5 reporting period **30 May 2023 – 7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2024**

Technical guidance for safety action 4

Technical guidance	
Obstetric workforce standard and action	
How can the Trust monitor adherence with the standard relating to short term locums?	Trusts should establish whether any short term (2 weeks or less) tier 2/3 locums have been undertaken between February and August 2023. Medical Human Resources (HR) or equivalent should confirm that all such locums met the required criteria.
What should a department do if there is non-compliance i.e. locums employed who do not meet the required criteria?	Trusts should review their approval processes and produce an action plan to ensure future compliance.
Can we self-certify compliance with this element of safety action 4 if locums are employed who do not meet the required criteria?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.
Where can I find the documents relating to short term locums?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to long term locums?	Trusts should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance for 6 months after February 2023 and prior to submission to the Trust Board and have a plan to address any shortfalls in compliance.
What should a department do if there is a lack of compliance demonstrated in the audit tool regarding the support and supervision of long term locums?	Trusts should review their audits and identify where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if long term locums are employed who are not fully supported/supervised?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.
Where can I find the documents relating to long term locums?	Safe staffing | RCOG

	All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to Standard operating procedures for consultants and SAS doctors acting down?	Trusts should provide documentary evidence of standard operating procedures and their implementation Evidence of implementation/compliance could be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.
What should a department do if there is a lack of compliance, either no Standard operating procedure or failure to implement such that senior medical staff are unable to access compensatory rest?	Trusts should produce a standard operating procedure document regarding compensatory rest. Trusts should identify any lapses in compliance and where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if we do not have a standard operating procedure or it is not fully implemented?	Trusts cannot self-certify if they have no evidence of any standard operating procedures by **October 2023**. They can self-certify if they have been unable to achieve appropriate compensatory rest in individual circumstances such as excessive staffing pressure have prevented the doctor accessing this. They should, however, demonstrate that they have an action plan to ensure future compliance and provide assurance to the Board that this is place.
Where can I find the documents relating to compensatory rest for consultants and SAS doctors?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.
How can the Trust monitor adherence with the standard relating to consultant attendance out of hours?	For example, departments can audit consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Departments may also wish to monitor adherence via incident reporting systems. Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.
Can we self-certify compliance with this element of safety action 4 if	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans

consultants have not attended clinical situations on the mandated list?	implemented to prevent subsequent non-attendances. These can be signed off by the Trust Board.
Where can I find the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/
For queries regarding this safety action please contact: nhsr.mis@nhs.net and RCOG	

Anaesthetic medical workforce

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

Neonatal medical workforce

Technical guidance	
Neonatal Workforce standards and action	
Do you meet the BAPM national standards of junior medical staffing depending on unit designation?	If not, Trust Board should agree an action plan and outline progress against any previously agreed action plans. There should also be an indication whether the standards not met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap) alongside a record of the rota tier affected by the gaps. This action plan should be submitted to the LMNS and ODN.
BAPM **"Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice" 2021** **or** **"Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018**	

NICU **Neonatal Intensive Care Unit**	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff during office hours and out of hours. **Tier 1** Resident out of hours care should include a designated tier one clinician - Advanced Neonatal Nurse Practitioner (ANNP) or junior doctor ST1-3. NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice. **Tier 2** A designated experienced junior doctor ST 4-8 or appropriately trained specialty doctor or ANNP. NICUs with more than 2500 intensive care days should have an additional experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP. (A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative) **Tier 3** Consultant staff in NICUs should be on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on the neonatal unit alone. NICUs undertaking more than 4000 intensive care days per annum with onerous on call duties should consider having a consultant present in addition to tier 2 staff and immediately available 24 hours per day. NICUs undertaking more than 2500 intensive care days per annum should consider the presence of at least 2 consultant led teams during normal daytime hours. NICUs undertaking more than 4000 intensive care days per annum should consider the presence of three consultant led teams during normal daytime hours.

LNU **Local Neonatal Unit**	**Tier 1** At least one resident tier 1 practitioner immediately available dedicated to providing emergency care for the neonatal service 24/7. In large LNUs (>7000 births) there should be two dedicated tier 1 practitioners 24/7 to support emergency care, in keeping with the NICU framework. **Tier 2** An immediately available resident tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00 - 22.00, seven days a week. LNUs undertaking either >1500 Respiratory Care Days (RCDs) or >600 Intensive Care (IC) days annually should have immediately available a dedicated resident tier 2 practitioner separate from paediatrics 24/7. **Tier 3** Units designated as LNUs providing either >2000 RCDs or >750 IC days annually should provide a separate Tier 3 Consultant rota for the neonatal unit. LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs. All LNUs should ensure that all Consultants on-call for the unit also have regular weekday commitments to the neonatal service. This is best delivered by a 'consultant of the week' system and no consultant should undertake fewer than 4 'consultant of the week' service weeks annually. No on-call rota should be more onerous than one in six and all new appointments to units with separate rotas should either have a SCCT in neonatal medicine or be a general paediatrician with a special interest in neonatology or have equivalent neonatal experience and training**.**

SCU **Special Care Unit**	**Tier 1** A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours. **Tier 2** A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit. **Tier 3** In SCUs there should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology).
Our Trust do not meet the relevant neonatal medical standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.
When should the review take place?	The review should take place at least once during the MIS year 5 reporting period.
Please access the followings for further information on Standards	BAPM Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021). A BAPM Framework for Practice https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021 Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018). A BAPM Framework for Practice https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018

Neonatal nursing workforce

Technical guidance	
Neonatal nursing workforce standards and action	
Where can we find more information about the requirements for neonatal nursing workforce?	Neonatal nurse staffing standards are set out in the BAPM Service and Quality Standards (2022) https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk The Neonatal Nursing Workforce Calculator (2020) should be used to calculate cot side care and guidance for this tool is available here: https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/08/Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf Access to the tool and more information will be available through your Neonatal ODN Education and Workforce lead nurse.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

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

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) 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 five 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?	30 May 2023 – 7 December 2023
What is the deadline for reporting to NHS Resolution?	**1 February 2023** at **12 noon**

Technical guidance for Safety action 5

Technical guidance	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice**.	• Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637 https://www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care or care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above. The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to

	midwives at birth when required, supporting junior midwives undertaking suturing etc. This should not be counted as losing supernumerary status.
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. As stated above, completion of an action plan will not enable the Trust to declare compliance with this sub-requirement in year 5 of MIS.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Required standard	1) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024. 2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool.
Minimum evidential requirement for Trust Board	1) The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024. A new implementation tool is now available to help maternity services to track and evidence improvement and compliance with the requirements set out in version three. The tool is based on the interventions, key process and outcome measures identified within each element, and is available at https://future.nhs.uk/SavingBabiesLives Providers should use the new national implementation tool to track compliance with the care bundle and share this with the Trust Board and ICB. To evidence adequate progress against this deliverable by the submission deadline in February, **providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.** These percentages will be calculated within the national implementation tool. 2) Confirmation from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust, using the implementation tool and includes the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.

	• Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.

Technical guidance for Safety action 6

Technical guidance	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: https://www.england.nhs.uk/publication/saving-babies-lives-version-three/ The implementation tool is available at https://future.nhs.uk/SavingBabiesLives and includes a technical glossary for all data items referred to in MSDS Additional resources are in production and will be advertised on this page. Any further queries regarding the tool, please email england.maternitytransformation@nhs.net Any queries related to the **digital aspects** of this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net Some data items are or will become available on the National Maternity Dashboard or from NNAP Online For any other queries, please email nhsr.mis@nhs.net
What is the rationale for the change in evidential requirements to SA6 in Year 5?	The broad principles that will apply to the implementation of the standards detailed in the Saving Babies' Lives Care Bundle (version 3) are: The use of the implementation tool will allow Trusts to track implementation and demonstrate local improvement using the process and outcome indicators within all six elements of the care bundle (for some elements this may only require evidence of a protocol, process, or appointed post). These data will form the basis of compliance with safety action 6 of this version of the maternity incentive scheme. This approach acknowledges the increased number and/or size of elements in this new version of the care bundle. The indicators for each of the six elements are set out below. Data relating to each of these indicators will need to be provided via the national implementation tool. ***Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and/or Neonatal System e.g Badgernet and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding.***

What are the indicators for Element 1	*Process Indicators* 1a. Percentage of women where there is a record of: 1.a.i. CO measurement at booking appointment 1.a.ii. CO measurement at 36-week appointment 1.a.iii. Smoking status** at booking appointment 1.a.iv. Smoking status** at 36-week appointment 1b. Percentage of smokers* that have an opt-out referral at booking to an in-house/in-reach tobacco dependence treatment service. 1c. Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date. *Outcome Indicators* 1d. Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks. 1e. Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks. *a "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). **Smoking status relates to the outcome of the CO test (>4ppm) and the enquiry about smoking habits.
What are the indicators for Element 2	*Process Indicators* 2a. Percentage of pregnancies where a risk status for Fetal Growth Restriction (FGR) is identified and recorded at booking. (This should be recorded on the provider's MIS and included in the MSDS submission to NHS Digital once the primary data standard is in place.) 2b. Percentage of pregnancies where a Small for Gestational Age (SGA) fetus (between 3rd to <10th centiles) is antenatally detected, and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital. 2c. Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT). *Outcome Indicators*

	2d. Percentage of babies <3rd birthweight centile born >37+6 weeks (this is a measure of the effective detection and management of FGR). 2e. Percentage of live births and stillbirths >3rd birthweight centile born <39+0 weeks gestation, where growth restriction was suspected.
What are the indicators for Element 3	*Process Indicators* 3a. Percentage of women who attend with Reduced Fetal Movements (RFM) who have a computerised Cardiotocograph (CTG). 3b. Proportion of women who attend with recurrent RFM* who had an ultrasound scan by the next working day to assess fetal growth. *Outcome Indicators* 3c. Percentage of stillbirths which had issues associated with RFM management identified using PMRT. 3d. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation. *There is no accepted definition of what recurrent RFM means; one region of the UK has successfully adopted a consensus definition of two or more episodes of RFM occurring within a 21-day period after 26 weeks' gestation.
What are the indicators for Element 4	*Process Indicators* 4a. Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors, and situational awareness. 4b. Percentage of staff who have successfully completed mandatory annual competency assessment. 4c. Fetal monitoring lead roles appointed. *Outcome Indicators* 4d. The percentage of intrapartum stillbirths, early neonatal deaths, and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor. *Using the severe brain injury definition as used in Gale et al. 2018[48].

What are the indicators for Element 5	*Process Indicators* 5a. Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU). 5b. Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth. 5c. Percentage of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth. 5d. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive intravenous (IV) intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection. 5e. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth. 5f. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. 5g. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth. 5h. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (5a – 5g above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation). *To minimise the need for local data collection to support these improvements the formal collection of process measure data can be restricted to the seven interventions listed in this section, the use of volume targeted ventilation and caffeine is recommended but these data are not currently recorded or presented with national datasets. In addition, the gestational limits for some of the indicators and/or the groups studies have been adjusted to align with current nationally collected data (e.g., data on babies born only below 34 weeks or data on the number of babies*

	receiving antenatal corticosteroids rather than the number of mothers) *Outcome Indicators* **5i. Mortality to discharge in very preterm babies** (National Neonatal Audit Programme (NNAP) definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner). **5j. Preterm Brain Injury** (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury: ✓ Germinal matrix/ intraventricular haemorrhage ✓ Post haemorrhagic ventricular dilatation ✓ Cystic periventricular leukomalacia 5k. Percentage of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation, or perinatal optimisation of preterm birth was a relevant issue. 5l. Maternity care providers will provide outcome data to the Trust Board and share this with the LMNS relating to the incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: ✓ In the late second trimester (from 16+0 to 23+6 weeks). ✓ Pre-term (from 24+0 to 36+6 weeks).
What are the indicators for Element 6	*Process Indicators* 6a. Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife) and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc). 6b. Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes.

	6c. Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets. 6d. Demonstrate compliance with Continuous Glucose Monitoring (CGM) training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes. 6e. Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with Diabetic Ketoacidosis (DKA) during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities, and availability of expertise. *Outcome Indicators* 6f. The percentage of women with type 1 diabetes that have used CGM during pregnancy – reviewed via the National Pregnancy in Diabetes (NPID) dashboard (aiming for >95% of women). 6g. The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the start of the third trimester (aiming for >95% of women). Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.
What considerations need to be made to ensure timely submission of data to evidence implementation and compliance with locally agreed progress measures?	Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.
Is there a requirement on Trusts to evidence SBLCB process and outcome measures through their data submissions to Maternity Services Data Set?	Trusts should be capturing SBLCB data as far as possible in their Maternity Information Systems/Electronic Patient Records and submitted to the MSDS. MSDS does not capture all process and outcome indicators given in the care bundle. A summary of this appears in the technical appendix for version 2 of the care bundle, available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/tools-and-guidance

	Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.
Would a Trust be non-compliant if <60% of smokers set a quit date?	As stated in SA6, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. The implementation tool will set out the evidence requirement for demonstrating compliance with each intervention. Where element process and outcome measures are listed in the evidence requirement, a performance threshold is recommended, but this is for agreement between a provider and their ICB in view of local circumstances.
The SBLCBv3 that was published on the 31st May 2023 included a typo in Appendix D Figure 6 with BMI as >18.5kg/m and it is not clear what "other features" mean	This has now been amended and states **<18.5kg/m** with further clarity provided regarding "other features".
How do we provide evidence for the interventions that have been implemented?	The evidence requirements for each intervention are set out within the implementation tool. You will need to verify that you have an implemented service locally.
Will the eLfH modules be updated in line with SBLCBv3?	The SBLCB eLearning for Health modules is currently being updated in line with the latest iteration, Version 3 of the Care Bundle and will include a new section to support implementation of element 6. We have asked for the ultrasound element to be reviewed for its relevance, this was developed separately, and we will make sure the completion of the e learning is focussed on elements 1-6.
What is the deadline for reporting to NHS Resolution?	**1 February 2024** at **12 noon**

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Required standard	1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group. 2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board. 3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.
Minimum evidential requirement for Trust Board	**Evidence should include:** • Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff. • Evidence that MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support. • The MNVP's work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it. • Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses. • Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.
Validation process	Self-certification to NHS Resolution using the Board declaration form.

What is the relevant time period?	Trusts should be evidencing the position as **7 December 2023**
What is the deadline for reporting to NHS Resolution?	**1 February 2023** at 12 noon

Technical guidance for Safety action 7

Technical guidance	
What is the Maternity and Neonatal Voices Partnership?	An MNVP listens to the experiences of women, birthing people, and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. MNVPs ensure that service user voice is at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider Trusts and feeding into the local maternity and neonatal system (LMNS). MNVPs ensure service user voice influences improvements in the safety, quality, and experience of maternity and neonatal care.
We are unsure about the funding for Maternity and Neonatal Voices Partnerships	It is the responsibility of ICBs to: Commission and fund MNVPs, to cover each Trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
What advice is there for Maternity and Neonatal Voices Partnership (MNVP) leads when engaging and prioritising hearing the voices of neonatal and bereaved service users, and what support or training is in place to support MNVP's?	MNVPs should work in partnership with local specialist voluntary, community, and social enterprise (VCSEs) with lived experience to gather feedback. Engagement needs to be accessible and appropriate, particularly for neonatal and bereaved families. It is essential that you consider how you will protect people from being retraumatised through giving feedback on their experience. Training for MNVPs to engage with seldom heard or vulnerable communities may be required to ensure unintentional harm is avoided. MNVPs can also work in collaboration with their trust bereavement leads to ensure adequate support is in place for themselves and the families they may engage with. Attendance at the trust training could be beneficial.
When will the MNVP guidance be published?	We are working with our stakeholders to publish the MNVP guidance as soon as possible. As it is not yet published, it is acknowledged that there may not be enough time ahead of the reporting period for full implementation of all the requirements of the MNVP guidance. Where an element of the guidance is not yet fully implemented, evidence must be presented that demonstrates progress towards full implementation within 12 months.

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Required standard and minimum evidential requirement	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework. 2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. 3. The plan is developed based on the "How to" Guide developed by NHS England.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	12 consecutive months should be considered from 1st December 2022 until 1st December 2023 to ensure the implementation of the CCFv2 is reported on and, an appropriate timeframe for trust boards to review. It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e Diabetes. 90% compliance is required for all elements that featured in CCFv1

Technical guidance for safety action 8

Technical guidance	
What training should be covered in the local training plan to cover the six modules of the Core Competency Framework?	A **training plan** should be in place to implement all six core modules of the Core Competency Framework over a 3-year period, starting from MIS year 4 in August 2021 and up to July 2024. NHS England » Core competency framework version two Trusts should update their existing training plans in alignment with Version 2 of the Core Competency Framework.
How will the 90% attendance compliance be calculated?	The training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups by the end of the 12 month period

Where can I find the Core Competencies Framework and other additional resources?	• https://www.england.nhs.uk/publication/core-competency-framework-version-two/
	• Includes links to the documents:
	  ○ Core competency framework version two: Minimum standards and stretch targets
	  ○ 'How to' guide - a resource pack to support implementing the Core Competency Framework version two
	  ○ Core competency framework: training needs analysis
	• NHS England V1 of the Core Competency Framework https://www.england.nhs.uk/publication/core-competency-framework/
	• https://www.resus.org.uk/library/2021-resuscitation-guidelines/newborn-resuscitation-and-support-transition-infants-birth

What training should be included to meet the requirements of the Core Competency Framework Version 2?	All 6 core modules in V2 of the Core Competency Framework (CCFv2) must be covered as detailed in the minimum standards. Trusts must be able to evidence the four key principles: 1. Service user involvement in developing and delivering training. 2. Training is based on learning from local findings from incidents, audit, service user feedback,

	and investigation reports. This should include reinforcing learning from what went well. 3. Promote learning as a multidisciplinary team. Promote shared learning across a Local Maternity and Neonatal System.
Which maternity staff should be included for Module 2: Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric consultants • All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor) • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • MSWs • GP trainees
Which maternity staff should be included for Module 3: Maternity emergencies and multiprofessional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric consultants. • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota. • Midwives (including midwifery managers and matrons), community midwives; birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) • Obstetric anaesthetic consultants. • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) **who contribute to the obstetric rota.**

	• Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS year 5 compliance assessment • Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS year 5 compliance • At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff
Does the multidisciplinary emergency scenarios described in module 3 have to be conducted in the clinical area?	At least one emergency scenario needs to be conducted in the clinical area or at point of care. You need to ensure that 90% of your staff attend a minimum of one emergency scenario that is held in the clinical area, but not all of the scenarios have to be based in a clinical area.
Which staff should be included for Module 6: Neonatal basic life support?	Staff in attendance at births should be included for Module 6: Neonatal basic life support. This includes the staff listed below: • Neonatal Consultants or Paediatric consultants covering neonatal units • Neonatal junior doctors (who attend any births) • Neonatal nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. The staff groups below are not required to attend neonatal basic life support training: • All obstetric anaesthetic doctors (consultants, staff grades and anaesthetic trainees) contributing to the obstetric rota and • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit). • Local policy should determine whether maternity support workers are included in neonatal basic life support training.

I am a NLS instructor, do I still need to attend neonatal basic life support training?	No, if you have taught on a course within MIS year 5 you do **not** need to attend neonatal basic life support training
I have attended my NLS training, do I still need to attend neonatal basic life support training?	No, if you have attended a course within MIS year 5 you do **not** need to attend neonatal basic life support training as well.
Which members of the team can teach basic neonatal life support training and NLS training?	Registered RC-trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates. A detailed response to this can be found on the CCF NHS Futures page CCF NHS Futures page - FAQ
What do we do if we do not have enough instructors who are trained as an NLS instructor and hold the GIC qualification?	Your Neonatal Consultants and Advanced Neonatal Practitioners (ANNP) will be qualified to deliver the training. You can also liaise with your Local Maternity and Neonatal System (LMNS) to explore sharing of resources. There may be difficulty in resourcing qualified trainers. Units experiencing this must provide evidence to their trust board that they are seeking mitigation across their LMNS and an action plan to work towards NLS and GIC qualified status by 31st March 2024. As a minimum, training should be delivered by someone who is up to date with their NLS training.
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally determined.
How do we involve services users in developing and <u>delivering</u> training?	Please refer to the "How To" guide for ideas on how to involve service users in the developing and delivering of training. This is **Principle 1** of the CCFv2 that recommends MNVP leads could be a member of the multidisciplinary educational teams (MET) to support the planning and selection of themes/local learning requirements to reflect in the training. Ways in which service users and service user representatives can support the delivery of training include with video case studies, inviting service users to tell their story or inviting charitable/support organisations for example local Downs Syndrome groups; LGBTQIA+ Communities; or advocates for refugees.

	NHS England will be sharing examples of practice over the year and on their NHS Futures page.
The TNA suggests periods of time required for each element of training, for example 9 hours for fetal monitoring training. Is this a mandated amount of time?	The TNA has been inputted with **example** times to demonstrate how the calculations are made for the backfill of staff that is required to put a training plan in place. The hours for each element of training can be flexed by the individual trust in response to their own local learning needs.
Do all the modules within the CCF require a multidisciplinary attendance?	Multidisciplinary team working has an evidence-base and has been highlighted in The Kirkup Report (2022). Key Action 3 (Flawed Team working) was a significant finding with the recommendation to improve teamworking with reference to establishing common purpose, objectives, and training from the outset. It is therefore a requirement that there is a strong emphasis on multidisciplinary training throughout the modules in response to local incidents. The staff groups within the multidisciplinary teams being trained may also vary, depending on the incident/emergency being covered.

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) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded. b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings. c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.
Minimum evidential requirement for Trust Board	**Evidence for point a) is as per the six requirements set out in the Perinatal Quality Surveillance Model and specifically:** • Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues. • Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs). • To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need. **Evidence for point b)** • Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaints data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. This should continue to be undertaken quarterly as detailed in MIS year 4. These discussions

	must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting. **Evidence for point c):** Evidence that the Board Safety Champions have been involved in the NHS England Perinatal Culture and Leadership Programme. This will include: • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available. • Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team at a minimum of quarterly (a minimum of two in the reporting period) and that any support required of the Board has been identified and is being implemented.
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 should be in place based on previous requirements. The expectation is that if work is still in progress, this will have been completed by 1st December 2023. • The expectation is 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 and service user feedback; minimum staffing in maternity services and training compliance are continuing to take place at Board level monthly. If for any reason they have been paused, they should be reinstated no later than 1 July 2023. • The expectation is for ongoing engagement sessions with staff as per year 4 of the scheme. If for any reason these have been paused, they should be recommenced no later than 1 July 2023. 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 the 17th July 2023. • Evidence that a review of 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 by 17th July 2023. At least one additional meeting must have been undertaken before the end of the year 5 scheme demonstrating oversight of progress with any identified actions from the first review as part of the PSIRF plan. This should continue to be undertaken quarterly as detailed in MIS year 4. **Time period for points c)** • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have **registered** to the dedicated FutureNHS workspace to access the resources available no later than 1 August 2023. • Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of quarterly and that any support required of the Board has been identified and is being implemented. There must have been a minimum of 2 meetings held by 1 February 2024
What is the deadline for reporting to NHS Resolution?	By **1 February 2024** at 12 noon
Where can I find additional resources?	implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) Measuring culture in maternity services: Safety Culture Programme for Maternal and neonatal services: https://drive.google.com/file/d/1bzAqOcf5A5XHR8HWBZnLzH6qsG_SgXoa/view?usp=sharin Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk) NHS England » Maternity and Neonatal Safety Improvement Programme The Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace is a dedicated place for Non-Executive Director and Executive Director maternity and neonatal Board safety champions to access the culture and leadership

	programme, view wider resources and engage with a community of practice to support them in their roles. The Perinatal Culture and Leadership Programme - Maternity Local Transformation Hub - Maternity (future.nhs.uk) is a dedicated space for NHS England's Perinatal Culture and Leadership Programmes, with resources for senior leaders and their teams to support local safety culture work.

Technical guidance for safety action 9

Technical guidance	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local pathway for sharing intelligence updated. This revised pathway should: • Describe the local governance processes in place to demonstrate how intelligence is shared from the floor to Board. • Formalise how Trust-level intelligence will be shared with the LMNS/ICS quality group and regional quality groups involving the Regional Chief Midwife and Lead Obstetrician.
What do we need to include in the dashBoard presented to Board each month?	The dashboard can be locally produced, based on a minimum data set as set out in the Board level measures. It must include the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; SUV feedback; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. The dashboard can also include additional measures as agreed by the Trust.
We had not continued to undertake monthly feedback sessions with the Board safety champion what should we do?	Parts a) and b) of the required standards build on the year three and four requirement of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board safety champions to raise concerns relating to safety. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions as described above. Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three of the maternity incentive scheme and the expectation is that this should have been continued. If these have not been continued, this needs to be reinstated by no later than 1 July 2023.
We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site?	Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis.

What is the rationale for the Board level safety champion safety action?	It is important to ensure all staff are aware of who their frontline and Board safety champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names of the relevant leaders, will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here 2021 Scorecards launch - NHS Resolution https://resolution.nhs.uk/2020/10/27/claims-scorecards-for-2020/
What are the expectations of the Board safety champions in relation to quality improvement work undertaken by the maternity and neonatal quality improvement programme?	The Board safety Champions will be expected to continue their support for quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Networks. Trusts will be required to undertake improvement including data collection and testing work aligned to the national priorities.
What is the expectation for Trusts to undertake culture surveys?	Every maternity and neonatal service across England will be involved in the Perinatal Culture and Leadership Programme. As part of this programme every service will be undertaking work to meaningfully understand the culture of their services. This diagnostic will either be a SCORE culture survey or an alternative as agreed with the national NHSE team. It is expected that diagnostic findings are shared with the Trust Board to enable an understanding and garner support for the work to promote optimal safety cultures, based on the diagnostic findings.
What if our maternity and neonatal services are not undertaking the SCORE culture survey as part of the national programme?	The national offer to undertake a SCORE culture is a flexible, opt out offer. If your maternity and neonatal services demonstrated that they were already completing work to meaningfully understand local culture, and therefore opted out of the SCORE survey, the expectation is that the Board receives updates on this alternative work.
What are the expectations of the NED and Exec Board safety champion in relation to	As detailed in previous years MIS guidance, regular engagement between Board Safety Champions and senior perinatal leadership teams provide an opportunity to share

their support for the Perinatal Culture and Leadership Programme (PCLP), culture surveys and ongoing support for the Perinatal 'Quad' Leadership teams? / What should be discussed at the bi-monthly meetings between the Board Safety Champion(s) and the Perinatal 'Quad' Leadership teams?	safety intelligence, examples of best practice and identified areas of challenge. The meetings should be conducted in an appreciative way, with the perinatal teams being open and transparent and the Board Safety Champions being curious and supportive. As a minimum the content should cover: - Learning from the Perinatal Culture and Leadership Development Programme so far - Plans to better understand their local culture. This will be use of the SCORE culture survey, or suitable alternative as agreed by the national NHS England team. - Updates on the SCORE survey, or alternative when undertaken. - Updates on identified areas for improvement following the local diagnostic, along with any identified support required from the Board. NB, a formal report following this work should be presented at Board by the Perinatal leadership team. Progress with interventions relating to culture improvement work, and any further support required from the Board
Clarification as to evidence required to meet the standard: *Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available.*	The NED and Exec Board Safety Champion will be able to evidence they have registered on the FutureNHS Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace through minutes of a trust board meeting providing confirmation of specific resources accessed and how this has been of benefit. This will be reported as part of the board submission to NHS Resolution.
How often should the Board Safety Champions be meeting and engaging with the perinatal 'Quad' team?	Meetings between the Board Safety Champion(s) and Quad member(s) should be occurring a minimum of quarterly. We would expect a minimum of two meetings during this reporting period.
Who is expected to have undertaken the Perinatal Culture and Leadership Quad programme?	The expectation is that the senior perinatal leadership team (the Quad) have undertaken the PCLP. This will be representation from the midwifery, obstetric, neonatal, and operational professional groups, usually consisting of the

	DoM/HoM, clinical lead / CD for obstetrics, clinical lead for neonates and the operational manager.
Is there an expectation that the board safety champions have undertaken the programme?	The Board Safety Champions should be supporting the Quad and their work as part of the PCLP, but there is no expectation for them to attend the programme.
Evidence that a monthly review – Most Trust meet bi-monthly (every other month) & are unable to meet this requirement	A review must be undertaken at every board meeting. If this is bi-monthly that will be sufficient, but this is the minimum requirement.
Examples have been requested for how to review the data from scorecards	The key to making this exercise meaningful is the triangulation of the data. Categorisation of the historic claims on the scorecard and any action taken, then presenting these alongside current incidents and complaints. This allows identification of potential themes or trends, identification of the impact of any learning, and allows you to act quickly if any historic themes re-emerged. An example is now available from the MIS team at NHS Resolution, and staff are happy to talk through this process if it is helpful.
The perinatal quality surveillance model requires review in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife to provide evidence of trust-level intelligence being shared and actions reported on areas of concern. This needs to happen before 1st July and therefore does not give trusts enough time to carry out this review	The expectation is that this process should already be in place as it was a requirement in previous years, with the year 4 requirement for this to be in place by 16th June 2022. However, in recognition of the challenges of embedding a new quality surveillance model the timeframe of the 1st July has been amended to 1st December 2023 to allow additional time for trusts.
Clarification as to what constitutes a trust board, can sub committees be categorised as a board?	This refers solely to the Board of the trust, and it is a requirement that the board oversees the quality of their perinatal services at every meeting.

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) *(known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023)* and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

Required standard	A) Reporting of all qualifying cases to HSIB/ MNSI from 6 December 2022 to **7 December 2023.** B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until **7 December 2023**. C) For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that: i. the family have received information on the role of HSIB//MNSI and NHS Resolution's EN scheme; and ii. 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//MNSI/EN incidents and numbers reported to HSIB//MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of HSIB/MNSI 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/MNSI 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 advised 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 6 December 2022 to **7 December 2023** Reporting period to HSIB **and** to NHS Resolution – from 6 December 2022 to **7 December 2023**
What is the deadline for reporting to NHS Resolution?	By **1 February 2024** at 12 noon

Technical guidance for Safety action 10

Technical guidance	
Where can I find information on HSIB?	Information about HSIB/ MNSI and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/ From October 2023 this website will no longer be available and the HSIB maternity programme will be hosted by the CQC. Further details will be circulated once available.
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website: • EN main page • Trusts page • Families page
What are qualifying incidents that need to be reported to HSIB/MNSI?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [or] • Was therapeutically cooled (active cooling only) [or] • Had decreased central tone AND was comatose AND had seizures of any kind. Once HSIB/MNSI have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury.
What is the definition of labour used by HSIB and EN?	The definition of labour used by HSIB includes: • Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation. • When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking). • Induction of labour (when labour is started artificially). • When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.
Changes in the EN reporting requirements for Trust from	With effect from 1 April 2022, Trusts have been required to continue to report their qualifying cases to HSIB via the electronic portal. In addition, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once HSIB have confirmed

1 April 2022 going forward	they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must share the HSIB//MNSI report with the EN team within 30 days of receipt of the final report by uploading the HSIB/MNSI report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading HSIB/MNSI reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the HSIB/MNSI report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation.
What qualifying EN cases need to be reported to NHS Resolution?	• Trusts are required to report cases to NHS Resolution where HSIB are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury. • Where a family have declined a HSIB investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution. There is more information here: ENS Reporting Guide - July 2023 (for Member Trusts) - NHS Resolution
Cases that do not require to be reported to NHS Resolution	• Cases where families have requested a HSIB/MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a HSIB/MNSI investigation where the baby has a normal MRI. • Cases that HSIB/MNSI are not investigating.
What if we are unsure whether a case qualifies for referral to HSIB/MNSI or NHS Resolution?	For cases from 1 April 2022, if the baby has a clinical or MRI evidence of neurological injury and the case is being investigated by HSIB/MNSI because of this, then the case should also be reported to NHS Resolution via the claims wizard along with the HSIB/MNSI reference number (document the HSIB reference in the “any other comments box”). Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard. Should you have any queries, please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or HSIB/MNSI maternity team (maternity@hsib.org.uk).
How should we report cases to NHS Resolution?	Trusts’ will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once they have been confirmed by HSIB/ MNSI as under investigation. They must also complete the ***EN Report*** form and attach this to the Claims Reporting Wizard: https://resolution.nhs.uk/wp-content/uploads/2023/05/EN-Report-Form.pdf
What happens once we have	Following the HSIB/MNSI investigation, and on receipt of the HSIB/MNSI report and MRI report, following triage, NHS Resolution will overlay an

reported a case to NHS Resolution?	investigation into legal liability. Where families have declined an HSIB/MNSI investigation, no EN investigation will take place, unless the family requests this.
Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20 In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by HSIB and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all incidents to HSIB/MNSI as soon as they occur and to NHS Resolution as soon as HSIB/MNSI have confirmed that they are taking forward an investigation. Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to HSIBMNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and HSIB/MNSI and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme.

FAQs for year five of the maternity incentive scheme

Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice?	**We expect Trust Boards to self-certify the Trust's declarations following consideration of the evidence provided.** It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we will escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the Care Quality Commission for their consideration if any further action is required, and to the NHS England and NHS Improvement regional director, the Deputy Chief Midwifery Officer, regional chief midwife and Department of Health and Social Care (DHSC) for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
Do we need to discuss this with our commissioners?	Yes, the CEO of the Trust will ensure that the Accountable officer (AO) for their ICB is apprised of the MIS safety action evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution The declaration form must be signed by both CEO and the Accountable Officer of Clinical Commissioning Group/Integrated Care System before submission.
Our current commissioning systems are changing, what does this mean in terms of sign off?	There have been structural changes for NHS Commissioning as a result of 2022 Health and Care Act. Where this has caused significant reconfiguration and adjustment of commissioning systems, sign off by the accountable lead for commissioning maternity services can be considered
Will NHS Resolution cross check our results with external data sources?	Yes, we will cross reference results with external data sets from: MBRRACE-UK data (safety action 1 point a, b, c), NHS England& Improvement regarding submission to the Maternity Services Data Set (safety action 2, sub-requirements 2 and 3), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable to HSIB (safety action 10,

	standard a)). Your overall submission may also be sense checked with CQC maternity data, HSIB data etc. For more details, please refer to the conditions of the scheme.
What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the Trust CEO and Accountable Office (IBC). Where relevant, an action plan is completed for each action the Trust has not met. **Please do not send your evidence or any narrative related to your submission to NHS Resolution.** Any other documents you are collating should be used to inform your discussions with the Trust Board. These documents and any other evidence used to assure the Board of your position must be retained. In the event that NHS Resolution are required to review supporting evidence at a later date it must be made available as it was presented to support Board assurance at the time of submission.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2023. **It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12 noon on 1 February 2024, NHS Resolution will treat that as a nil response.**
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on 1 February 2024**. If not returned to NHS Resolution by 12 noon on **1 February 2024**, NHS Resolution will treat that as a nil response.
What happens if we do not meet the ten actions?	Only Trusts that meet all ten maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet all ten safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.

Our Trust has queries, who should we contact?	Any queries prior to the submission date must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net
Please can you confirm who outcome letters will be sent to?	The maternity incentive scheme outcome letters will be sent to Trust's nominated MIS leads.
What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated link contacts via link on the NHS Resolution website. https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-Trusts/maternity-incentive-scheme/maternity-incentive-scheme/
What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for appeals this year?	Yes, there will be an appeals process. Trusts will be allowed 14 days to appeal the decision following the communication of results. The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe. There are two possible grounds for appeal: • alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation • technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate. NHS Resolution clinical advisors will review all appeals to ensure validity, to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC. Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered. Further detail on the appeals window dates will be communicated at a later date.

Merging Trusts	Trusts that will be merging during the year four reporting period (30 May 2023 – 7 December 2023) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed. In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2022/23 and the reporting of claims and management of claims going forward.

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

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

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

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

Q2) Why have these safety actions been chosen?

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

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

Q3) Who has been involved in designing the scheme?

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

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

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

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

Completed Board declaration forms must be discussed with the commissioner(s) of the Trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at nhsr.mis@nhs.net **by 12 noon on 1 February 2024**

Please note:

- Board declaration forms will be reviewed by NHS Resolution and discussed with the scheme's Collaborative Advisory Group.
- NHS Resolution will use external data sources to validate some of the Trust's responses, as detailed in the technical guidance above.
- If a completed Board declaration form is not returned to NHS Resolution by 12 noon on **1 February 2024**, NHS Resolution will treat that as a nil response.