NHS
Hull University Teaching Hospitals
NHS Trust

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Northern Lincolnshire and Goole
NHS Foundation Trust

AGENDA

A meeting of the Trust Boards-in-Common (meeting held in Public) to be held on Tuesday, 23 January 2024 at 1.00 pm to 2.00 pm via MS Teams

For the purpose of transacting the business set out below:

No.	Agenda item	Format	Purpose	Time
1.	**CORE / STANDING BUSINESS ITEMS**			
1.1	**Welcome, Group Chair's Opening Remarks and Apologies for Absence** Group Chair	Verbal	Information	5 mins
1.2	**Declarations of Interest** Group Chair	Verbal	Assurance	
2.	**ITEMS FOR DISCUSSION – QUALITY & SAFETY: CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST): MATERNITY INCENTIVE SCHEME – YEAR 5 SAFETY ACTIONS**			
2.1	**Quality & Safety Committees-in-Common Highlight / Escalation Report & Board Challenge** Non-Executive Director Committee Chair	BIC(24)001 Attached	Assurance	40 mins
2.1.1	**HUTH CNST SUBMISSION** Group Chief Medical Officer	BIC(24)002 Attached	Approval	
2.1.2	**NLaG CNST SUBMISSION** Group Chief Medical Officer	BIC(24)003 Attached	Approval	
3.	**ANY OTHER URGENT BUSINESS**			
3.1	**Any Other Urgent Business** Group Chair / All	Verbal	Discussion	5 mins
4.	**QUESTIONS FROM THE PUBLIC AND GOVERNORS**			
4.1	**Questions from the Public and Governors** Group Chair	Verbal	Discussion	5 mins
5.	**MATTERS FOR REFERRAL TO BOARD COMMITTEES-IN-COMMON**			
5.1	**To agree any matters requiring referral for consideration on behalf of the Trust Boards by any of the Board Committees-in-Common** Group Chair / All	Verbal	Discussion	5 mins
6.	**DATE OF THE NEXT MEETING**			
6.1	**The next meeting of the Boards-in-Common will be held on Thursday, 8 February 2024 at 9.00 am**			

KEY:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG - Northern Lincolnshire & Goole NHS Foundation Trust

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

- Any Director wishing to propose an agenda item should send it with 8 clear days' notice before the meeting to the Group Chair, who shall then include this item on the agenda for the meeting. Requests made less than 8 days before a meeting may be included on the agenda at the discretion of the Group Chair.
- Urgent business may be raised provided the Director wishing to raise such business has given notice to the Group Chief Executive not later than the day preceding the meeting or in exceptional circumstances not later than one hour before the meeting.
- Board members wishing to ask any questions relating to those reports listed under 'Items for Information' should raise them with the appropriate Director outside of the Board meeting. If, after speaking to that Director, it is felt that an issue needs to be raised in the Board setting, the appropriate Director should be given advance notice of this intention, in order to enable him/her to arrange for any necessary attendance at the meeting.
- Directors / Board members should contact the Group Chair as soon as an actual or potential conflict is identified. Definition of interests **–** A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold." Source: NHSE – Managing Conflicts of Interest in the NHS.
- When staff attend Board meetings to make presentations (having been advised of the time to arrive by the Board Secretary), it is intended to take their item next after completion of the item then being considered. This will avoid keeping such people waiting for long periods.

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Boards in Common

Agenda Item No: BIC(24)001

Name of the Meeting	Extra Ordinary Boards in Common – CNST Maternity Incentive Scheme Declarations – HUTH/NLAG
Date of the Meeting	23 January 2024
Director Lead	Group Chief Medical Officer/Group Chief Nurse/Group Chief Delivery Officer
Contact Officer/Author	Robert Chidlow, Interim Director of Quality Governance
Title of the Report	CNST Maternity Incentive Scheme HUTH/NLAG
Executive Summary	For HUTH, it is proposed that compliance is declared for **5/10** standards, with reference to the specified evidence criteria set out in the CNST technical guidance. For NLAG, it is proposed that compliance is declared for all 10 standards.
Background Information and/or Supporting Document(s) (if applicable)	The CNST 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.
Prior Approval Process	The escalation report has not been considered at any other meeting.
Financial implication(s) (if applicable)	HUTH £0.6m/NLAG £0
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ✓ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

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Committees-in-Common Highlight / Escalation Report to the Trust Boards

Report for meeting of the Trust Boards to be held on:	*23 January 2024*
Report from:	*Extraordinary meeting of the Quality and Safety Committees-in-Common*
Report from meeting held on:	*19 January 2024*
Quoracy requirements met:	*Yes*

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the extraordinary Quality and Safety Committees-in-Common at their meeting held on 19/01/2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

- CNST Maternity Incentive Scheme declaration

3.0 Matters for reporting / escalation to the Trust Boards

3.1 The committees agreed the following matters for reporting / escalation to the Trust Boards:

a. **For HUTH,** the Committees are satisfied that the evidence provided and scrutinised demonstrated achievement of **five** out of the **ten** maternity safety actions. The compliance is shown in summary form below:

Summary of Declaration

Safety Action	Compliant	Safety Action	Non Compliant
SA1 (PMRT)		SA4 (Medical staffing)	
SA2 (MSDS)		SA6 (SBLV3)	
SA3 (ATAIN/TC)		SA8 (Training)	
SA5 (Midwifery Staffing		SA9 (Safety Champions)	
SA7 (Listening to Women)		SA10 (HSIB/ENS/LEGAL)	

It was discussed that this is consistent with the recent review of the Year 4 declaration of compliance and follows the CQC Core Service rating of Inadequate in 2023. The Trust has not consistently had reference to the technical guidance, which whilst complex specifies the detail and frequency of reporting to Board which cannot be fully evidenced.

There is a financial impact for the current years' declaration of £0.609m.

b. **For NLAG,** the Committees are satisfied that the evidence provided and scrutinised demonstrated achievement of **ten** out of the **ten** maternity safety actions. There was discussion with regard to two safety actions that were presented with qualifying points. The standards with qualifying points and mitigation are detailed below in summary form.

Summary of Compliance

Safety Actions	Declaration
1. Perinatal Mortality Review Tool (PMRT)	Compliant
2. Maternity Services Data Set (MSDS)	Compliant
3. Avoiding Term Admissions into Neonatal Units (ATAIN)	Compliant
4. Medical Workforce	*Compliant
5. Midwifery Workforce	Compliant
6. Saving Babies Lives v3	Compliant
7. Service User Feedback	Compliant
8. Mandatory Training – Core Competency Framework	Compliant
9. Board Assurance	Compliant
10. NHS Resolution – MNSI / EN Scheme	Compliant

Safety Action 1 – PMRT surveillance data submissions impacted by a late closure confirmation of 1 of 15 cases and another delayed review due to an external organisation contribution delay. These points have been reviewed with NHS Resolution and MBRRACE (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) exploring the rules, thresholds, and allowances, which is described in the paper.

Safety Action 4 – Submission of Board approved action plans for for the following indicators: Compensatory rest, Neonatal medical workforce & Neonatal nursing workforce (BAPM Compliance (British Association of Perinatal Medicine)).

4.0 Matters on which the committees received assurance

4.1 The committees received assurance on the following items of business:

a. HUTH reported the reviews and assurance internal scrutiny and action plans to address non-compliance into Year 6 were in place, with external consultancy support, and ICB peer review. MSSP oversight will also add to the scrutiny and support to improve the position.

b. NLAG reported the evidence submitted, the internal assurance process, external scrutiny and assurance steps. LMNS is scheduled to review through a confirm and challenge meeting in the next week

c. The opportunity to report the Trust's performance and compliance side-by-side in reporting to Committees-in-Common and the Trust Board-in-Common will provide peer comparison on an ongoing basis.

d. The Committee membership was asked to consider if there were any reports that would conflict with either of the proposed declarations of either Trust. None were identified. The Committees were supportive of the proposed declarations.

7.0 Trust Board Action Required

7.1 The Trust Boards are asked to:

- Note the Quality and Safety Committees in Common endorsement that they were satisfied with the evidence provided demonstrated:
    - HUTH achievement of 5/10 standards.
    - NLAG achievement of 10/10 standards.
- Note the Quality and Safety Committees in Common are not aware of any reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to the declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.)

Sue Liburd, Non-Executive Director

19/01/2024

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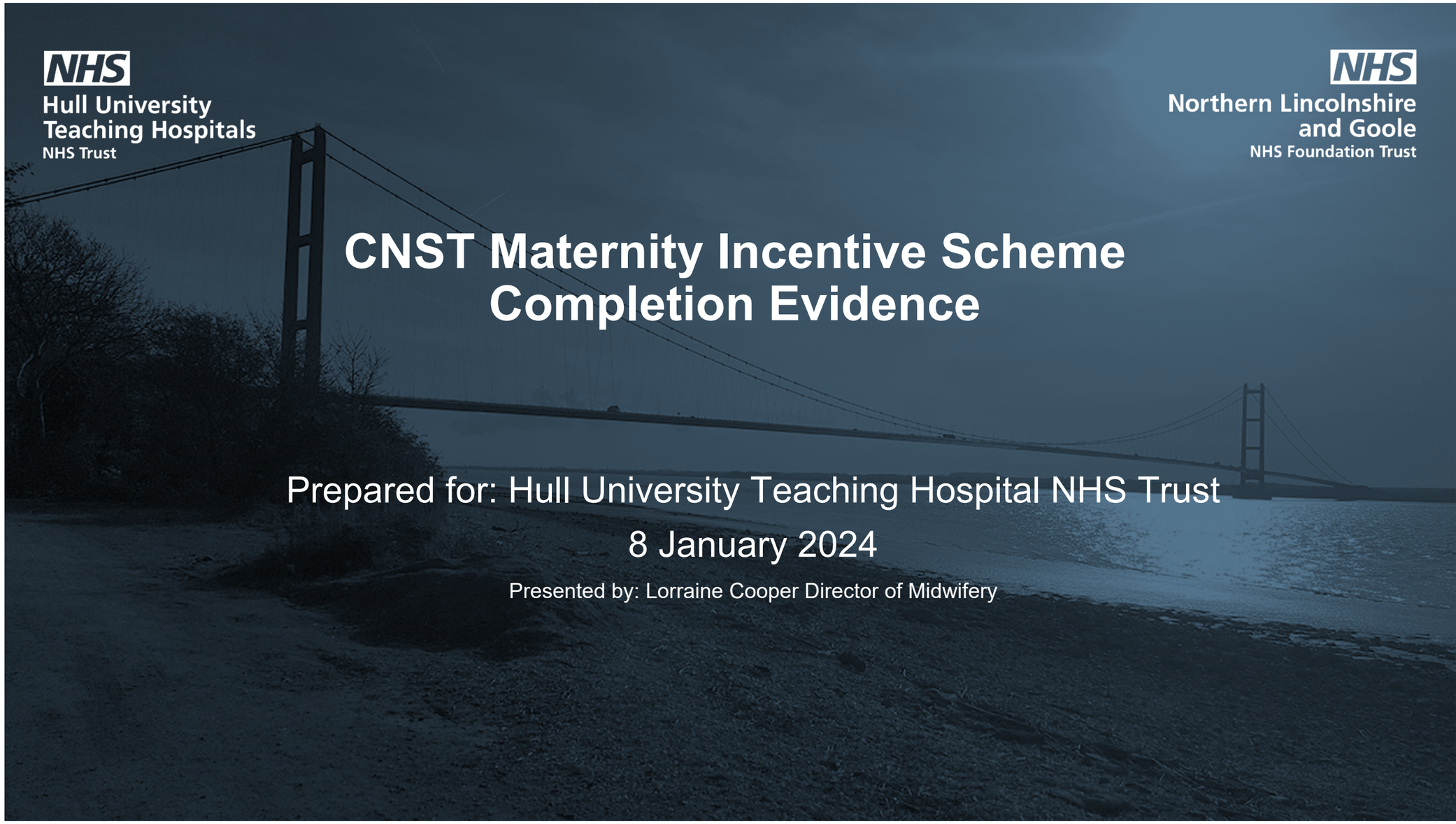
Group Boards in Common Front Sheet

Agenda Item No: BIC(24)002

Name of the Meeting	*Group Boards in Common*
Date of the Meeting	23 January 2024
Director Lead	*Joanne Ledger – Interim Chief Nurse*
Contact Officer/Author	*Lorraine Cooper – Director of Midwifery*
Title of the Report	*Year 5 CNST Maternity Incentive Scheme*
Executive Summary	The Group Boards in Common are requested to approve the evidence submission following scrutiny at the Quality and Safety Committees in Common. For HUTH, it is proposed that compliance is declared for **5/10** standards, with reference to the specified evidence criteria set out in the CNST technical guidance. Exceptions to evidence specified in the technical guidance have been identified for the following safety actions: 4. Medical Staffing; 6. Saving Babies' Lives Care Bundle Version Three; 8. Mandatory Training – Core Competency Framework; 9. Processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues; 10. NHS Resolution – MNSI / EN Scheme reporting. In preparing for the Year 5 submission, the Maternity and governance teams have had reference to the full technical guidance. As part of Group Collaboration and sharing best practice, full reference of the technical requirements will be incorporated into the embedding monitoring arrangements for Year 6 of the scheme.
Background Information and/or Supporting Document(s) (if applicable)	The CNST 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. In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form by1 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.).
Prior Approval Process	The attached has been scrutinised by the Quality and Safety Committees in Common and recommended for approval to the Group Boards in Common.
Financial implication(s) (if applicable)	The implication to HUTH of not meeting the ten standards is a loss of the CNST Year 5 allocation of £0.6m.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	No implications
Recommended action(s) required	✓ Approval ✓ Discussion ✓ Assurance ☐ Information ☐ Review ☐ Other – please detail below: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CNST Maternity Incentive Scheme
Completion Evidence
Prepared for: Hull University Teaching Hospital NHS Trust
8 January 2024
Presented by: Lorraine Cooper Director of Midwifery

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Introduction

- CNST MIS now in its fifth year
- Administered by NHS Resolution
- Comprises ten Safety Actions, calculated to ensure delivery of safest, highest quality care
- Applies to all NHS acute Trusts who deliver maternity services and are members of CNST
- Members contribute an additional 10% of their maternity premium, which is returned (along with a share of unallocated funds) if they can evidence compliance with all 10 actions
- Trust who do not meet all ten actions will not recover this contribution, though may be eligible for a small discretionary payment
- There have been several iterations of the technical guidance published this year on 31st May 2023.

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Conditions of the scheme

- Trusts must have delivered and evidenced all 10 actions by the deadline: 7th December 2023 (noon).
- Trusts must submit a Board declaration form by the deadline of 12 noon 1st February 2024.
- The declaration form must be submitted to the Board of Directors, accompanied by this presentation.
- The form must be signed and dated by the CEO, who must first be authorised to sign by the Board of Directors
- The CEO must attest that:
  - The Board of Directors are satisfied with the completion evidence.
  - There are no reports covering 2021-2023 financial years that conflict with the declaration. Any such reports should be brought to the MIS teams attention before Thursday 1 February 2024.
- The form must be countersigned by an accountable officer from the ICB, who must be apprised of the content of the form and supporting evidence.

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Assurance

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.

Supporting evidence

All CNST evidence is stored on the maternity Y drive system and all evidence is available for the Executive Team to review

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Summary of Declaration

Safety Action	Compliance declared	Safety Action	Compliance declared
SA1 (PMRT)		SA4 (Medical staffing)	
SA2 (MSDS)		SA6 (SBLV3)	
SA3 (ATAIN/TC)		SA8 (Training)	
SA5 (Midwifery Staffing		SA9 (Safety Champions)	
SA7 (Listening to Women)		SA10 (HSIB/ENS/LEGAL)	

After undertaking a thorough review with external adviser input from Lesley Heelbeck (MIA) , Mike Wright, Heather McNair (Director of Midwifery ICB) and as the Board has been advised previously, HUTH will be declaring compliance with **5/10** safety actions; therefore meaning **overall non-compliance.**

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Safety Action 1

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

Overall Current Status: **Compliant**

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Safety Action 1

Required Standard		Evidence Requirements	Attained?	Comments
a)	All eligible perinatal deaths from 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.	Notifications must be made, and surveillance forms completed using the MBRACE-UK reporting website.	Yes	• The Trust is compliant to date with reporting to the MBRRACE-UK website • The Board of Directors has received a report each quarter since 30 May 2023 this includes details of the deaths reviewed and the consequent action plans. • Quarterly reports filed as evidence along with agendas and minutes demonstrating they have been received by the Trust Executive Board. • The most recent reports covers 30 May 2023 to Midnight on December 7th 2023 with an audit to evidence compliance with standard c). • Q2 is the last reportable quarter. • A final confirmation that the standard has been maintained up to the end of the required timeframe (7 Dec-23) will be conducted and confirmation passed to the signatories (CEO and ICB representative) prior to their final declaration.
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.		Yes	
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.	The PMRT must be used to review the care and reports should be generated via the PMRT.	Yes	
d)	Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.	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.	Yes	

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Safety Action 2

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

Overall Current Status: **Compliant**

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Safety Action 2

Required Standard		Evidence Requirements	Attained?	Comments
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.	The “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.	Yes	• NHS Digital who oversee this Safety Action have confirmed that HUTH have uploaded all required data points to the Maternity Services Data Set (including the 11 Clinical Quality Information Metrics) at the required standard of data quality, for the month of July (which was the month against which the standard is tested). • The final step required is to attest to completion as part of the final declaration.
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.	The “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.	Yes	

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Safety Action 2

	Required Standard	Evidence Requirements	Attained?	Comments
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. 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 29weeks gestation 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 August2023. 5. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.	The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.	Yes	• NHS Digital who oversee this Safety Action have confirmed that HUTH have uploaded all required data points to the Maternity Services Data Set (including the 11 Clinical Quality Information Metrics) at the required standard of data quality, for the month of July (which was the month against which the standardis tested). • Trusts are not expected to deliver against a target level of MCoC and this will remain in place until maternity services in England can demonstrate sufficient staffing levels to do so.

Hull University Teaching Hospitals NHS Trust

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Safety Action 3

Can you demonstrate that you have Transitional Care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Overall Current Status: **Compliant**

Hull University Teaching Hospitals NHS Trust

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Safety Action 3

	Required Standard	Evidence Requirements	Attained	Comments
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.	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 minimumof 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 areconducted	Yes	• Transitional care policy with admission criteria and pathway based on BAPM transitional care framework which includes an explicit staffing model. This policy was approved by both Maternity and Neonatal teams and includes auditable standards. • Quarterly audits for compliance are undertaken and are compliant..

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.	• 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	Yes	• ATAIN quarterly reports for Q1 and Q2, which are the applicable quarters for this declaration, have been collated as evidence. • The ATAIN Annual action plan has also been collated as evidence. The action plan was signed of by the Trust Board, LMNS and ICB. • Any additional actions from ATAIN in addition to the annual review are presented in the quarterly reports along with any progress on previous actions. • Agendas and minutes demonstrating that all reports have been received by Clinical Governance meetings, Divisional Committees, LMNS, PQSAG and the Trust Executive Board.

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Safety Action 3

Required Standard		Evidence Requirements	Attained?	Comments
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.	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	Yes	• Transitional care policy with admission criteria and pathway based on BAPM transitional care framework which includes an explicit staffing model. This policy was approved by both Maternity and Neonatal teams and includes auditable standards.

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Safety Action 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

Overall Current Status: **Non Compliant**

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Safety Action 4

	Required Standard	Evidence Requirements	Attained?	Comments
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	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.	No	• There has been a registered audit to monitor compliance with this standard which has been undertaken but the results have not been published or reviewed at the required governance forums
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	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.	No	• HUTH is currently working with the HR department to ensure they have a robust evidence on engagement of long term locums

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Safety Action 4

	Required Standard	Evidence Requirements	Attained?	Comments
Obstetric Medical Workforce				
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	Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working 28 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.	Yes	The service is complaint with 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 the rota coordinators ensure this is built into the rota plans. All Consultant job plans are built in line with this RCOG recommendation and standards and signed off by the RCOG before appointments are made.
4)	Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 26 ‘Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology’ into their service when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance	Trusts’ positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.	No	There has been a registered audit to monitor compliance with this standard which has been undertaken but the results have not been published or reviewed at the required governance forums

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Safety Action 4

Required Standard		Evidence Requirements	Attained?	Comments
Anaesthetic medical workforce				
b)	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.	The rota should be used to evidence compliance with ACSA standard 1.7.2.1.	Yes	• Anaesthetic rotas have been provided as evidence along with confirmation from the Clinical Director for Anaesthetics that this requirement is met in full.
Neonatal medical workforce				
c)	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).	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).	Yes	• The evidence toshow that HUTH has a BAPM-compliant Neonatal Medical Workforce

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Safety Action 4

Required Standard		Evidence Requirements	Attained?	Comments
Neonatal nursing workforce				
d)	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 27 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)	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).	Yes	• HUTH Trust currently meets this standard

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Safety Action 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Overall Current Status: **Compliant**

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Safety Action 5

Required Standard		Evidence Requirements	Attained?	Comments

a)	A systematic, evidence-based process to calculate midwifery staffing establishment is completed	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
			Yes	• A Birthrate+ review was conducted in November 2021 and a refresh in December 2023. As there have been changes with the implementation of maternity triage at HUTH.
				
				• This action requires two papers covering midwifery staffing be sent to Trust Board.
				  • The first was provided in July 2023.
				  • The second was provided in December 2023
				
				• The Director of Midwifery paper was shared with the Quad, Safety Champions, LMNS and Trust Board.
				
				• These papers included:
				  • a full explanation of the pause in further rollout of Midwifery Continuity of Carer.
				  • Evidence of 1 to1 care in labour
				  • Compliance with supernumerary coordinator status
				
				• This safety action is therefore complete.

b)	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above	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	Yes	
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	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.	Yes	
d)	All women in active labour receive one-to-one midwifery care		Yes	
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		Yes	

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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?

Overall Current Status: **Non Compliant**

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Safety Action 6

Required Standard		Evidence Requirements	Attained?	Comments
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	• The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024 • 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	No	• The new National Implementation Tool was used to track compliance with the care bundle implementation. • We have not met the 70% overall and 50% thresholds for each standard. **See next page.**
2)	Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool.	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	Yes	Trusts are asked to hold quarterly improvement discussions with the ICB using the new national implementation tool and there mus t be 2 meetings held before March 2024. The initial discussion meeting was held in August 2023, and the first formal meeting took place in September 2023, with the second and final meeting taking place on 27 November 2023. Minutes from those meetings have been provided as evidence.

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Safety Action 6

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	50%	Partially implemented	40%	CNST Not Met
Element 2	Fetal growth restriction	Partially implemented	70%	Partially implemented	50%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	20%	Partially implemented	20%	CNST Not Met
Element 5	Preterm birth	Partially implemented	44%	Partially implemented	48%	CNST Not Met
Element 6	Diabetes	Partially implemented	33%	Partially implemented	17%	CNST Not Met
All Elements	TOTAL	Partially implemented	50%	Partially implemented	43%	CNST Not Met

ACTION for SBLV3

- Audit evidence for all 6 elements
- Task and Finish has been established for diabetes
- Increase in PA time for dedicated obstetric lead for fetal monitoring, to 1PA (4hrs)

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Safety Action 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Overall Current Status: **Compliant**

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Safety Action 7

Required Standard		Evidence Requirements	Attained?	Comments
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	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 Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses	Yes	• A statement from the MNVP evidences adequate remuneration, expenses, and infrastructure is in place.
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	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	Yes	• The MNVP have provided their workplan along with evidence of progress against that plan as evidence. • The MNVP funding business case along with the minutes of funding agreement from the LMNS have been provided. • Co-produced CQC Maternity Survey Action plan has been received and monitored 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	Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff 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	Yes	• MNVP feedback reports along with the minutes of the meetings at which they are presented have been collated as evidence. • In addition, the Safety Intelligence Dashboards, presented at Safety champions, have been collated. They include evidence of the improvement carried out from the obtained feedback. • Evidence of the MNVP's priorities are included in their workplan.

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Safety Action 8

Can you evidence the following 3 elements of local training plans and ‘in-house’, one day multi professional training?

Overall Current Status: **Non Compliant**

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Safety Action 8

Required Standard		Evidence Requirements	Attained?	Comments
1)	A local training plan is in place for implementation of Version 2 of the Core Competency Framework Has the plan been developed based on the four key principles as detailed in the "How to" Guide for the second version of the core competency framework developed by NHS England?	Evidence within the training policy that it matches the Version 2 Core Competency Framework and is based on the four key principles	Yes	The Maternity Specific Training Guideline was updated to comply with version 2 of the Core Competency Framework.
2)	Training has been signed off by the Quad, Trust Board, LMNS and ICB	HUTH have minutes of Quad, Trust Board and ICB as evidence.	No	HUTH do not have explicit minutes that the Trust Board has signed off the maternity training plan
3)	Can you evidence service user involvement in developing training?	Evidence of training plan has been coproduced with service users	No	HUTH do not have explicit evidence that training has been coproduced with service users
4)	Can you evidence that training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports?	Training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports.	yes	Teaching Presentations are available for review if required

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Safety Action 8

	Required Standard	Evidence Requirements	Attained?	Comments
5)	Can you evidence that you promote shared learning across a Local Maternity and Neonatal System? Can you demonstrate the following at the end of 12 consecutive months ending December 2023? 80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period. In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12-month period) will be accepted. If this is the case, please select'Yes' Can you demonstrate that at least one emergency scenario is conducted in a clinical area. Can you demonstrate that 90% of team members have attended an emergency scenario in a clinical area or does the local training plan include a plan to implement this. Have you declared compliance above 80%	**Fetal Monitoring Surveillance** (in the antenatal and intrapartum period) 90% Obstetric Consultants 90% all other Obstetric doctors contributing to the Obstetric Rota (without the continuous presence of an additional resident tier Obstetric doctor)? 90% Midwives (including managers and matrons), community, birth centre, bank and agency and theatre midwives. **Maternity Emergencies and multi-professional training** 90% Obstetric consultants, other obstetric doctors including staff grades, trainees (ST1-7), sub speciality trainees, clinical fellows, foundation year and doctors contributing to Rota. 90% Midwives (including managers and matrons), community, birth centre, bank and agency. 90% MSW including HCAs attending maternity emergency scenarios. 90% Obstetric anaesthetists including all staff grades and trainees. **Neonatal Basic Life Support** 90% Neonatal and Paediatric Consultants, covering neonatal units. Junior doctors and neonatal nurses band 5 and above who attend births. ANNPs, midwives including midwifery managers, matrons, community midwives, birth centre and bank/agency midwives.	No	The delivery of all mandatory training has been extremely challenging in 2023 due to a number of factors 1. Exceptionally high maternity leave 17wte midwives 2. The impact of the junior doctors strike 3. High number of midwifery vacancies 4. Extra BadgerNet training requirements for BadgerNet go live in February 2024 Final training figures for December were: • CTG training 75.9% • PROMT training 77.1% • Neonatal training 63% Therefore the Trust has not met the reduced 80% compliance threshold with an action plan approved to get to 90%. This is a known risk that that The Board of Directors has been made aware of earlier in the year and was flagged on the risk register.

Hull University Teaching Hospitals NHS Trust

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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?

Overall Current Status: **Non Compliant**

Hull University Teaching Hospitals NHS Trust

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Safety Action 9

	Required Standard	Evidence Requirements	Attained?	Comments
a)	All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded	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	Yes	• A Non-Executive Director has been appointed for safety Champions. • Evidence PQSAG report
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	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 at Board or directorate level meeting.	No	• There is not evidence that the Trust Claims Scorecard has been presented or discussed quarterly and that the Trust Board has sight of qualifying ENS cases.
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	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	No	• There is a lack of evidence in Board minutes of Safety Champions meeting the Quad leadership team on a quarterly basis.

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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?

Overall Current Status: **Non Compliant**

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Required Standard		Evidence Requirements	Attained?	Comments
a)	Reporting of all qualifying cases to HSIB/ MNSI from 6 December 2022 to 7 December 2023.	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	Yes	• As with Safety Action 1, the need to report appropriately to the HSIB/MNSI and the NHS Resolution Early Notification Scheme (ENS) is ongoing, hence this action is never 'completed'.
b)	Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until 7 December 2023.	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	No	• There is no evidence that the Trust Board has had sight of the required maternity clinical governance records of qualifying HSIB//MNSI/EN incidents and numbers reported to HSIB//MNSI and NHS Resolution. This is be will be included in the new Maternity Bi-Monthly report from January 2024
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.	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	No	• The Perinatal Quality Surveillance report is not explicit on the number of families that have received information on the role of HSIB and ENS. .

Hull University Teaching Hospitals NHS Trust

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Summary of Declaration

Safety Action	Complaint	Safety Action	Non Complaint
SA1 (PMRT)		SA4 (Medical staffing)	
SA2 (MSDS)		SA6 (SBLV3)	
SA3 (ATAIN/TC)		SA8 (Training)	
SA5 (Midwifery Staffing		SA9 (Safety Champions)	
SA7 (Listening to Women)		SA10 (HSIB/ENS/LEGAL)	

After undertaking a thorough review with external adviser input from Lesley Heelbeck (MIA) , Mike Wright, Heather McNair (Director of Midwifery ICB) and as the Board has been advised previously, HUTH will be declaring compliance with **5/10** safety actions; therefore meaning **overall non-compliance.**

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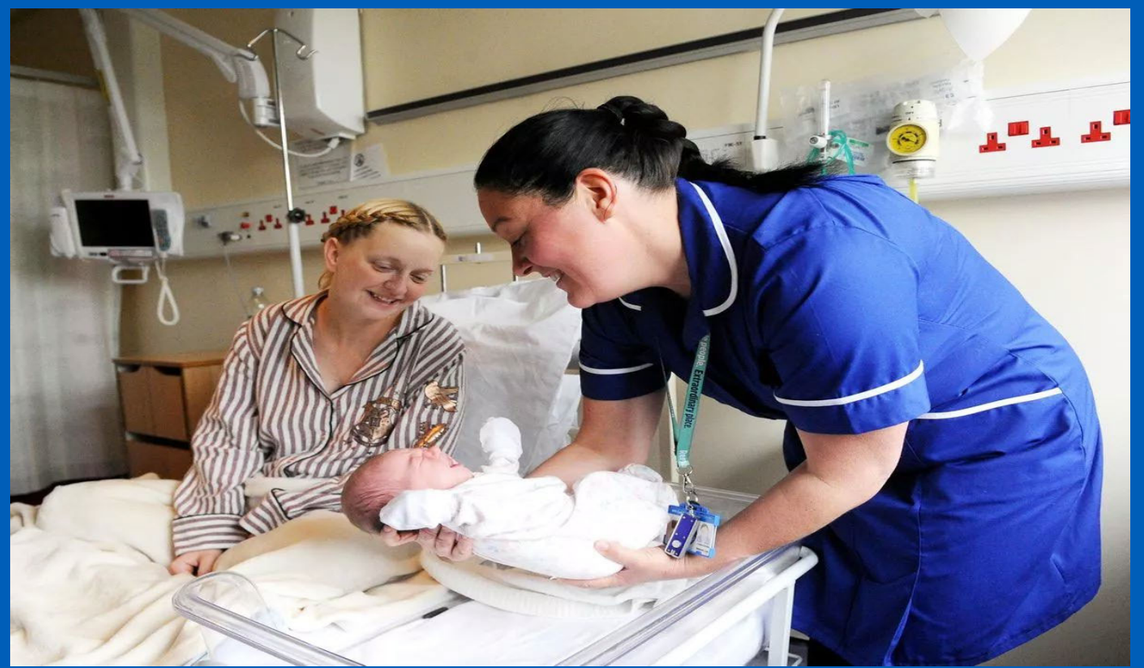
Questions



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Group Boards-in-Common Front Sheet

Agenda Item No: BIC(24)003

Name of the Meeting	*Group Boards in Common*
Date of the Meeting	23 January 2024
Director Lead	*Kate Wood – Group Chief Medical Officer*
Contact Officer/Author	*Nicola Foster / Preeti Gandhi / Ant Rosevear*
Title of the Report	*Year 5 CNST Maternity Incentive Scheme*
Executive Summary	The Group Boards in Common are requested to approve the evidence submission following scrutiny at the Quality and Safety Committees in Common. For NLAG, it is proposed that the Group Board in Common approves the following actions: • compliance is declared for **10/10** standards, with reference to the specified evidence criteria set out in the CNST technical guidance. • With respect to Standard 1 (PMRT compliance), whilst the 95% threshold is not met due to one case of non compliance,the guidance provides for mitigating factors to be taken into account in the validation process set out in the report. It is therefore proposed to approve compliance with this standard. • With respect to Standard 4 (Medical workforce), the exceptions identified are noted, but in recognition that the action plan in place to address deficiencies has been approved by the LMNS and the ODN, this standard is approved. There are no reports covering 2021-2023 financial years that conflict with this declaration.
Background Information and/or Supporting Document(s) (if applicable)	The CNST 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. In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form by1 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.).
Prior Approval Process	The attached has been scrutinised by the Quality and Safety Committees in Common and recommended for approval to the Group Boards in Common.
Financial implication(s) (if applicable)	There are no financial implications on the basis that the Trust is declaring 10/10.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	No implications
Recommended action(s) required	✓ Approval ☐ Information ✓ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

NHS Resolution – Maternity Incentive Scheme – Year 5 submission

Extra-ordinary Trust Board Meeting

23 January 2024

Nicola Foster / Preeti Gandhi / Ant Rosevear

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.

Trusts that can demonstrate they have achieved all 10 of the safety actions will recover the element of their contribution to the CNST MIS fund.

Trusts that do not meet the 10 standards will not recover their contribution but will be eligible for a small discretionary payment from the scheme.

Conditions

Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on the 1 February 2024 and must comply with the following conditions:

- Trusts must achieve all ten safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions.
- The Trust Board declaration form must be signed off by the Trust's Chief Executive Officer.
- The CEO must attest that:
- The Board of Directors are satisfied with the completion evidence
- There are no reports covering 2021-2023 financial years that conflict with the declaration. Any such reports should be brought to the MIS teams attention before Thursday 1 February 2024.
- The form must be countersigned by an accountable officer from the ICB, who must be apprised of the content of the form and supporting evidence.

Ten Safety Actions

1. Perinatal Mortality Review Tool
2. Maternity Services Data Set (MSDS)
3. Avoiding Term Admissions into Neonatal Units (ATAIN)
4. Medical Workforce
5. Midwifery Workforce
6. Saving Babies Lives v3
7. Service User Feedback
8. Mandatory Training – Core Competency Framework
9. Board Assurance
10. NHS Resolution – MNSI / EN Scheme

Evidence submitted

- **SA1** PMRT – quarterly board reports, MIS Year 5 summary report, triangulated with MBRRACE UK data and PMRT process documentation.
- **SA2** MSDS –July 2023 CNST Scorecard showing full compliance and confirmation of two registered MSDS submitters within the Trust.
- **SA3** ATAIN – case review process and supporting documentation, quarterly ATAIN audit reports & action plans, board reports, Transitional Care guideline and audit reports & actions plan.

Evidence submitted

- **SA4** Clinical workforce – anaesthetic rota evidence, locum staffing SOP and audit, compensatory rest proposal paper to Exec Team and action plan, consultant attendance in clinical situations guideline and audit demonstrating compliance, neonatal medical and neonatal nursing workforce action plans against BAPM standards.
- **SA5** Midwifery workforce – Birthrate+ Report, monthly supernumary and 1:1 care in labour audit results, Nursing & Midwifery Assurance Report, Maternity & Neonatal Oversight Report including; staffing levels, midwife: birth ratios

Evidence Submitted SA6: Saving Babies Lives

CNST Requirement: Implementation of 70% of interventions across all 6 elements and implementation of at least 50% of interventions in each individual element.

Intervention Elements	Description	Element Progress (LMNS Validated Q2)	% Of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in Pregnancy	Partially Implemented	70%
Element 2	Fetal Growth Restriction	Partially Implemented	70%
Element 3	Reduced Fetal Movements	Fully Implemented	100%
Element 4	Fetal Monitoring in Labour	Partially Implemented	80%
Element 5	Preterm Birth	Partially Implemented	70%
Element 6	Diabetes	Partially Implemented	67%
All Elements	TOTAL	Partially Implemented	71%

Clinical guidelines, audit results & action plans, job descriptions submitted via the national implementation tool.

Evidence submitted

- **SA7** Service User Feedback– MNVP Funding Review, minutes, remuneration, workplan, LMNS board minutes re ratification of workplan, out of pocket expenses paid, Diversity Champion work plan, co-produced Maternity Survey, examples of service user involvement e.g. ANC QIP, Patient Experience Report and minutes.
- **SA8 Mandatory Training** – TNA inclusive of Core Competency framework, 3-year Training Plan, MDT training compliance figures, evidence of quad and LMNS approval of TNA, examples of shared learning through ODN and LMNS/ICB.

Evidence submitted

- **SA9** Board Assurance – 15 steps reviews, safety champions walk rounds, Shout Out Wednesday 'floor to board' action plan, PQSM dashboard, CLIP reports, staff survey results, structure chart, Board Safety champion sign up to NHS Futures, PQSAG minutes, PQSOG Highlight Report, Q&SC minutes.
- **SA10** MNSI & EN Reporting – SOP for referral to MNSI / EN, Duty of Candour compliance, MNSI confirmation of case rejection, local rapid review evidence, Claims Reporting Wizard log confirmation, Serious Incident Reports, evidence of family provided with information, Q&SC minutes.

Points for consideration

Safety Action 1 – PMRT - required compliance 95%

a) **Surveillance information should be input within 1 calendar month.** **Outcome: 14/15 (93%).** 1 case non-compliant as whilst the surveillance information was input within the specified time period, the case was not closed on the system.

b) **Reviews should be started within two months.**

Outcome: 15/16 (94%). 1 case non-compliant as the MDT meeting had to be cancelled as a representative from the Trust (with shared care) and a neonatal consultant from NLAG could not attend. Meeting planned for 22/01/24 – confirmation of attendance received from the other Trust.

Communication with MBRRACE UK and NHS Resolution has stated that the mitigating circumstances around point a will be taken into consideration. Further details are included within the safety action summary report.

CNST guidance for point b states that the external validation process will take into consideration the circumstances where cases have been assigned to another Trust (with shared care) and deadlines have been breached. Further information is provided as evidence in the SA1 Summary report.

Points for consideration

Safety Action 4 – Medical Workforce

Shortfalls/deficiencies have been identified in the areas detailed below. To enable the Trust to declare compliance, action plans have been developed to address deficiencies, approved by the Q&SC, LMNS and the ODN (where required).

Compensatory rest

- An action plan has been developed and the next step is to meet with HUTH colleagues to discuss resolutions.

Neonatal medical workforce (BAPM Compliance)

- Progress has been delayed due to awaiting confirmation of future local neonatal care model through HASR. Action plan reviewed and in place.

Neonatal nursing workforce (BAPM Compliance)

- DPOW: establishment and funding in place to allow B6 supernumary. staffing vacancy position does not allow this to be a consistent feature of the rota. SGH: Not BAPM compliant, to be incorporated into business case as part of the 2024/25 business planning process.

Assurance: Internal

- Quality & Safety Committee and Maternity Transformation & Improvement Board oversight/scrutiny
- Quad oversight / escalation
- Fortnightly multidisciplinary CNST meetings
- Confirm & Challenge – Group Chief Medical Officer, 24/11/23 and 02/01/24
- Evidence collated for all 10 Safety Actions
- Signed Submission by CEO to NHS Resolution.

Assurance: External

External validation points

- Safety Action 1: Standards a, b and c – triangulated with MBRRACE-UK data.
- Safety Action 2: NHS England
- Safety Action 10: standard a, MNSI referrals
- Safety Action 6: national implementation tool, LMNS/ICB quarterly check & challenge
- Safety Action 8: Training Needs Analysis and 3-year Training Plan signed off by LMNS/ICB
- All Safety Actions: Confirm & challenge with LMNS and ICB 26 January 2024.

Summary of Compliance

Safety Actions	Declaration
1. Perinatal Mortality Review Tool (PMRT)	Compliant
2. Maternity Services Data Set (MSDS)	Compliant
3. Avoiding Term Admissions into Neonatal Units (ATAIN)	Compliant
4. Medical Workforce	*Compliant
5. Midwifery Workforce	Compliant
6. Saving Babies Lives v3	Compliant
7. Service User Feedback	Compliant
8. Mandatory Training – Core Competency Framework	Compliant
9. Board Assurance	Compliant
10. NHS Resolution – MNSI / EN Scheme	Compliant

***Submission of Board approved action plans for Safety Action 4 (Medical Workforce) for the following indicators:** Compensatory rest, Neonatal medical workforce & Neonatal nursing workforce (BAPM Compliance).

Many Thanks

Any Questions?