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# NHSR Maternity Incentive Scheme Year 5 compliance and assurance

Prepared by:
Samantha Cole – AGM Maternity & Gynaecology

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# NHSR Incentive Scheme Background

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.

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.

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# Assurance process and approach

- NHSR MIS Year 5 Ten safety actions with technical guidance published 31st May 2023
- Safety Action leads and teams assembled in June 2023 who will have responsibility for ensuring each element is met, providing evidence for compliance
- AGM met with each Safety action team to go through requirements, setting out actions plans and expectations
- AGM set up NHSFutures platform to capture all the evidence relating to each safety action broken down to match each requirement set out in the guidance
- Tracker created to monitor progress
- Fortnightly meetings set up for each safety action lead to check in and report on progress and ask for any support with focus sessions set up to support with specific elements and evidence
- AGM and DoM set up regular catch up dedicated to NHSR
- Flash reports created to share with the divisional leadership team and LMNS
- NHSR added as a standing to the agenda and discussed in MAC, Maternity and Gynaecology Governance, LMNS oversight and assurance group Senior Leadership meetings. Progress also shared at service line and divisional leadership
- Safety actions allocated a date to be signed off at MAC – giving a deadline for internal validation of evidence
- Evidence matrix created listing all the evidence to support compliance, linked directly to the board declaration – this was taken to MAC who were supplied with the like to NHSFutures to review evidence. Safety action lead described how compliance with each element has been met to MAC, giving clear assurance with MAC agreeing sign off for each safety action
- 4 Safety actions (1,2, 6 and 10) have been externally validated and confirmed as compliant

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# Safety Action Tracker

## NHSR Maternity Incentive Scheme Year 5

**SUBMISSION DEADLINE: 1ST FEBRUARY 2024**

| Tracking RAG Rating |
|---|
| Completed |
| On track to complete |
| Off track, needs attention |

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| | | | | Tracking RAG Rating position by month | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SA1 | Safety Action Name | Safety Action ask | SA Lead/Teams | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Comments/Notes |
| 1 | Perinatal Mortality | Are you using the National Perinatal Mortality Review tool to review perinatal deaths to the required standard? | Hannah Lewis/Sarah Sarjant | | | | | | | | | Signed off in MAC & Externally Validated |
| 2 | MSDS | Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? | Lisa Butler/Samantha Cole/John Taylor | | | | | | | | | Signed off in MAC & Externally Validated |
| 3 | Transitional care services | Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies? | Rhian Cope/Kelly-Marie McMinn/Samantha Cole | | | | | | | | | Signed off in MAC |
| 4 | Clinical Workforce | Can you demonstrate an effective system of clinical workforce planning to the required standard? | Susie Al-Samarrai/Simon Rhodes/Sarah Hennell | | | | | | | | | Signed off in MAC |
| 5 | Midwifery Workforce | Can you demonstrate an effective system of midwifery workforce planning to the required standard? | Paula Shore/Lisa Butler/Lisa Foster/Samantha Cole | | | | | | | | | Signed off in MAC |
| 6 | Saving Babies Lives | Can you demonstrate that you are on track to compliance with all elements of the Saving Babies Lives Care Bundle Version Three? | Ruth Nanthambwe/Sarah Sarjant | | | | | | | | | Signed off in MAC & Externally Validated |
| 7 | Listening & coproduction | Listen to Women, parents and families using Maternity and Neonatal services and coproduce services with users | Gemma Boyd/Samantha Cole | | | | | | | | | Signed off in MAC |
| 8 | Training | Can you evidence the following 3 elements (in the SA breakdown) of local training plans and 'in-house', one day multi professional training? | Lisa Butler/Julie Vizzard/Samantha Cole/Nicola Wright | | | | | | | | | Signed off in MAC |
| 9 | Board Assurance | Can you demonstrate that there are robust processes in place to provide assurance to the Board on Maternity and Neonatal safety and quality issues? | Paula Shore/Samantha Cole | | | | | | | | | Signed off in MAC |
| 10 | HSIB/NHSR Early notification | Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolutions' early Notification (EN) scheme? | Hannah Lewis/Jenny Aldred/Sarah Sarjant | | | | | | | | | Signed off in MAC & Externally Validated |

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# Safety Action evidence matrix
# Each safety action previously presented to and signed off by MAC

## Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the requires standard?

**Safety Action Lead:** Hannah Lewis - Governance Specialist Midwife

**Safety Action Support:** Samantha Cole - Assistant General Manager Maternity & Gynaecology

**Futures link:** Safety Action 1 Perinatal Mortality - Sherwood Forest NHS Foundation Trust NHSR MIS Year 5 - FutureNHS Collaboration Platform

**Required standards and supporting evidence uploaded to Futures Platform**

| | |
|---|---|
| **Standard A** | **All eligible perinatal deaths should be notified to MBRRACE-UK within 7 working days. For deaths from 30th May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death** |
| **Evidence to support** | CNST Tracker - all reportable cases and compliance evidence<br>Case list showing compliance has been met<br>PMRT Board Report Summary |

| | |
|---|---|
| **Standard B** | **For 95% of deaths of babies in your trust eligible for PRMT review, parents should have their perspectives of care and questions they have sought from 30th May 2023 onwards** |
| **Evidence to support** | CNST Tracker - all reportable cases and compliance evidence |

| | |
|---|---|
| **Standard C** | **For deaths of babies who were born and died in your trust multi-disciplinary reviews using PMRT should be carried out from 30th 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** |
| **Evidence to support** | CNST Tracker - all reportable cases and compliance evidence |

| | |
|---|---|
| **Standard D** | **Quarterly reports should be submitted to the Trust executive board from 30th May 2023** |
| **Evidence to support** | PMRT Q1 Report submitted to Trust board and safety champions<br>PMRT Q2 Report submitted to Trust board and Safety champions |

**Minimum Evidence Requirement for Declaration**

| Number | Safety Action requirement (evidence above to cover / Safety Lead to discuss and provide assurance for sign off) | Met? |
|---|---|---|
| 1 | Have all eligible perinatal deaths from 30 May 2023 onwards been notified to MBRRACE-UK within seven working days? | Yes |
| 2 | For deaths from 30 May 2023, was MBRRACE-UK surveillance information completed within one calendar month of the death? | Yes |
| 3 | For at least 95% of all deaths of babies who died in your Trust from 30 May 2023, were parents' perspectives of care sought and were they given the opportunity to raise | Yes |
| 4 | Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 30 May 2023 been started within two months of each death? | Yes |
| 5 | Were 60% of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death? | Yes |
| 6 | Were 60% of the reports published within 6 months of death? | Yes |
| 7 | Were PMRT review panel meetings (as detailed in standard C) rescheduled due to the direct impact of industrial action, and did this have an impact on the MIS reporting compliance time scales? | Yes |
| 8 | Is there an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period. | Yes |
| 9 | If PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many meetings in total were impacted? | Yes |
| 10 | PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many cases in total were impacted? | Yes |
| 11 | Have you submitted quarterly reports to the Trust Executive Board from 30 May 2023 onwards? This must include details of all deaths reviewed and consequent action plans. | Yes |
| 12 | Were quarterly reports discussed with the Trust maternity safety and Board level safety champions? | Yes |

This Safety action has already been externally validated and has met compliance

**Safety Action 2: Are you submitting to the Maternity Services Data set (MSDS) to the required standard?**

**Safety Action Lead:** Lisa Butler - Deputy Head of Midwifery

**Safety Action Support:** Samantha Cole - Assistant General Manager Maternity & Gynaecology

**Futures link:** Safety Action 2 MSDS - Sherwood Forest NHS Foundation Trust NHSR MIS Year 5 - FutureNHS Collaboration Platform

Organisation Name: SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST

Reporting Period: July 2023

NHS England

1.

**CQIMApgar**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMApgar | 5 | 270 | | | Passed |
| CQIMDQ14 | 290 | 285 | 101.8 | | Passed |
| CQIMDQ15 | 290 | 290 | 100.0 | | Passed |
| CQIMDQ16 | 275 | 290 | 94.8 | | Passed |
| CQIMDQ24 | 270 | 275 | 98.2 | | Passed |

**CQIMBreastfeeding**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMBreastfeeding | 165 | 235 | 70.2 | Passed |
| CQIMDQ08 | 235 | 295 | 79.7 | Passed |
| CQIMDQ09 | 290 | 285 | 101.8 | Passed |

**CQIMPPH**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMDQ10 | 290 | 285 | 101.8 | | Passed |
| CQIMDQ11 | 105 | 290 | 36.2 | | Passed |
| CQIMDQ12 | 10 | 290 | 3.4 | | Passed |
| CQIMPPH | 10 | 290 | | 27 | Passed |

**CQIMPreterm**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMDQ09 | 290 | 285 | 101.8 | | Passed |
| CQIMDQ22 | 290 | 290 | 100.0 | | Passed |
| CQIMDQ23 | 275 | 290 | 94.8 | | Passed |
| CQIMPreterm | 15 | 285 | | 49 | Passed |

**CQIMTears**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMDQ14 | 290 | 285 | 101.8 | | Passed |
| CQIMDQ15 | 290 | 290 | 100.0 | | Passed |
| CQIMDQ16 | 275 | 290 | 94.8 | | Passed |
| CQIMDQ18 | 185 | 285 | 64.9 | | Passed |
| CQIMDQ20 | 10 | 175 | 5.7 | | Passed |
| CQIMTears | 10 | 175 | | 45 | Passed |

**Note:** The most recent available reporting period is based on provisional data. All Provisional figures are subject to change and will be reassessed after the final submission window has closed.

**CQIMVBAC**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ14 | 290 | 285 | 101.8 | Passed |
| CQIMDQ15 | 290 | 290 | 100.0 | Passed |
| CQIMDQ16 | 275 | 290 | 94.8 | Passed |
| CQIMDQ18 | 185 | 285 | 64.9 | Passed |
| CQIMDQ26 | 285 | 290 | 98.3 | Passed |
| CQIMDQ27 | 305 | 305 | 100.0 | Passed |
| CQIMDQ28 | 135 | 305 | 44.3 | Passed |
| CQIMVBAC | 5 | 25 | 20.0 | Passed |

**CQIMRobson01**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ30 | 290 | 285 | 101.8 | Passed |
| CQIMDQ31 | 295 | 295 | 100.0 | Passed |
| CQIMDQ32 | 275 | 295 | 93.2 | Passed |
| CQIMDQ33 | 295 | 295 | 100.0 | Passed |
| CQIMDQ34 | 185 | 295 | 62.7 | Passed |
| CQIMDQ36 | 290 | 290 | 100.0 | Passed |
| CQIMDQ37 | 150 | 290 | 51.7 | Passed |
| CQIMDQ38 | 295 | 295 | 100.0 | Passed |
| CQIMDQ39 | 275 | 290 | 94.8 | Passed |
| CQIMRobson01 | 5 | 50 | 10.0 | Passed |

**CQIMRobson02**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMRobson02 | 35 | 65 | 53.8 | Passed |

**CQIMRobson05**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMRobson05 | 30 | 35 | 85.7 | Passed |

**CQIMSmokingBooking**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ03 | 305 | 285 | 107.0 | Passed |
| CQIMDQ04 | 300 | 305 | 98.4 | Passed |
| CQIMDQ05 | 40 | 300 | 13.3 | Passed |
| CQIMSmokingBooking | 40 | 300 | 13.3 | Passed |

**CQIMSmokingDelivery**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ06 | 275 | 290 | 94.8 | Passed |
| CQIMSmokingDelivery | 35 | 275 | 12.7 | Passed |

2.

**EthnicityDQ**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| EthnicityDQ | 295 | 305 | 96.7 | Passed |

3.

**MCoC i**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| COC_DQ04 | 235 | 240 | 97.9 | Passed |

**MCoC ii**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| COC_DQ05 | 0 | 0 | 0.0 | Passed |

4.

**Provisonal Window Submission**

| Indicator | Result |
|---|---|
| Provisional Submission | Passed |

5.

**Submission Portal Registration**

| Indicator | Result |
|---|---|
| Registered Submitters | Passed |

This Safety action has already been externally validated and has met compliance

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

**Safety Action Lead:** Rhian Cope - Matron for Paediatrics

**Safety Action Support:** Samantha Cole - Assistant General Manager Maternity & Gynaecology

**Futures link:** Safety Action 3 Transitional care services - Sherwood Forest NHS Foundation Trust NHSR MIS Year 5 - FutureNHS Collaboration Platform

| | |
|---|---|
| **Standard A** | **Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care** |
| **Evidence to support** | Neonatal TC Guideline sent for comments<br>NTC Meeting minutes with SA3 as a standing agenda item July, Sep & Oct<br>Neonatal TC guideline Draft for comments<br>Neontatal TC Guideline - Final<br>TC slot on doctors induction<br>TC Guideline ratified in Maternity & Gynaecology governance<br>Mat & Gynae governance agenda<br>Establishment meeting follow up |

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| **Standard 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 as well as the Trust board, LMNS and ICB** |
| **Evidence to support** | Avoiding term admissions into Neonatal units 21/22<br>Example of admission reviewed by Maternity and Neonatal teams<br>Example of ATAIN paperwork completed by Maternity & Paediatrics<br>Neonatal Pillar ToR - ATAIN discussed evidence of LMNS/ICB attendance<br>Request to add TC to the Pillar meeting<br>Latest ATAIN report<br>Request to ICB to discuss ATAIN Report/action plan<br>Actions following investigations<br>Senior Leadership meeting agenda |

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| **Standard 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 preterm and term babies. There should be a clear, agreed timescale for implementing the pathway** |
| **Evidence to support** | Transitional care timeline for implementation<br>TC Guideline ratified in Paediatric clinical governance<br>TC action plan<br>Senior Leadership meeting agenda |

**Minimum Evidence Requirement for Declaration**

| Number | Safety Action requirement (evidence above to cover / Safety Lead to discuss and provide assurance for sign off) | Met? |
|---|---|---|
| a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. | | |
| 1 | Was the pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? | Yes |
| 2 | Are neonatal teams involved in decision making and planning care for all babies in transitional care? | Yes |
| 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. | | |
| 3 | Is there evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks? | Yes |
| 4 | Is there 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? | Yes |
| 5 | Is there 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? | Yes |
| 6 | Is there evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan? | Yes |
| 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. | | |
| 7 | Is there a guideline for admission to TC that include babies 34+0 and above and data to evidence this occuring? | Yes |
| 8 | 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 |

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

**Safety Action Lead:** Susie Al-Samarrai **-** Obstetric Service Director

**Safety Action Support:** Samantha Cole - Assistant General Manager Maternity & Gynaecology

**Futures link:** Safety Action 4 Clinical Workforce - Sherwood Forest NHS Foundation Trust NHSR MIS Year 5 - FutureNHS Collaboration Platform

**Required standards and supporting evidence uploaded to Futures Platform**

| | |
|---|---|
| **Standard A Part 1** | **Obstetric Medical Workforce - Ensure criteria is met for employing short-term locum doctors in Obstetrics and Gynaecology on tier 2 or 3 rotas: a) Currently work in their unit on the tier 2/3 rota, b) have worked on unit within past 5 years as a postgraduate in training and remain in the training programme with satisfactory ARCP or c) hold a RCOG certificate of eligibility to undertake short-term locums** |
| **Evidence to support** | Narrative of audit taken place to comply with safety action 4 standard A part 1 |

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| **Standard A Part 4** | **Obstetric Medical Workforce - Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document "roles and responsibilities of the consultant care in Obstetrics & 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 learning with agreed strategies and action plans implemented to prevent further non-attendance** |
| **Evidence to support** | Narrative describing compliance with safety action 4 standard A part 4 with action plan<br>Roles and responsibilities of the consultant workforce report<br>Responsibilities consultant on call SOP |

| | |
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| **Standard D** | **Neonatal Nursing Workforce -The neonatal unit meets the BAPM national standards of nursing staffing. If NOT met Trust board should evidence the progress against the previous action plan including new relevant actions to address deficiences. If met previously but not in Year 5 Trust board should develop an action plan. All action plans should be shared with the LMNS and ODN.** |
| **Evidence to support** | Neonatal workforce tool<br>E-mail sharing workforce tool with ODN |

| | |
|---|---|
| **Standard A Part 2** | **Obstetric Medical workforce - Trusts should implement RCOG guidance on engagement of long term locums and provide assurance that they have evidence of compliance or a plan to address any shortfalls to the Trust Board , Safety Champions and LMNS Meetings** |
| **Evidence to support** | Narrative of audit taken place to comply with safety action 4 standard A part 2<br>RCOG guidance on the engagement of long-term locums in |

| | |
|---|---|
| **Standard B** | **Anaesthetic Medical Workforce - A duty Anaesthetist is immediately available for the Obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to Obstetric patients (ACSA standard 1.7.2.1)** |
| **Evidence to support** | 24 hour cover confirmation e-mail<br>4 x Anaesthetic weekly on call rota's SBU with contact details |

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| **Standard A Part 3** | **Obstetric Medical Workforce - Trusts should implement RCOG guidance on compensatory rest where consultants and 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 to the Trust Board, Safety Champions and LMNS Meetings** |
| **Evidence to support** | Responsibilities consultant on call SOP<br>A review of planned activity on the day following an overnight on-call with action plan<br>RCOG guidance on compensatory rest |

| | |
|---|---|
| **Standard C** | **Neonatal Medical Workforce - The neonatal unit meets the BAPM national standards of medical staffing. If NOT met Trust board should evidence the progress against the previous action plan including new relevant actions to address deficiences. If met previously but not in Year 5 Trust board should develop an action plan. All action plans should be shared with the LMNS and ODN.** |
| **Evidence to support** | BAPM staffing guidance for Local Neonatal Units<br>SFH Current Neonatal medical workforce staffing model<br>Action plan including optimising medical staff shared with SMT, LMNS and ODN |

**Minimum Evidence Requirement for Declaration**

| Number | Safety Action requirement (evidence above to cover / Safety Lead to discuss and provide assurance for sign off) | Met? |
|---|---|---|
| **a) Obstetric medical workforce** | | |
| Has the Trust ensured 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 after February 2023 following an audit of 6 months activity : | | |
| 1 | a. Locum currently works in their unit on the tier 2 or 3 rota? | Yes |
| 2 | **OR** | Yes |
| 3 | **OR**<br>c. they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums? | Yes |
| 4 | Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance? | Yes |
| 5 | **OR**<br>Was an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and Local Maternity and Neonatal System (LMNS) meetings? | Yes |
| 6 | Has the Trust implemented 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 | Yes |
| 7 | **OR**<br>Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings? | Yes |
| 8 | Has the Trust monitored 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? | Yes |
| 9 | Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance? | Yes |
| Do you have evidence that the Trust position with the above has been shared: | | |
| 10 | At Trust Board? | Yes |
| 11 | With Board level safety champions? | Yes |
| 12 | At LMNS meetings? | Yes |
| **b) Anaesthetic medical workforce** | | |
| 13 | Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, 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) | Yes |
| | The rota should be used to evidence compliance with ACSA standard 1.7.2.1 (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) | Yes |
| **c) Neonatal medical workforce** | | |
| 14 | Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing and is this formally recorded in Trust Board minutes? | Yes |
| 15 | If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies.<br>If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies.<br>Does the Trust have evidence of this? | Yes |
| Was the agreed action plan shared with: | | |
| 16 | LMNS? | Yes |
| 17 | ODN? | Yes |
| **d) Neonatal nursing workforce** | | |
| 18 | Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes? | Yes |
| 19 | If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies.<br>If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies.<br>Does the Trust have evidence of this? | Yes |
| Was the agreed action plan shared with: | | |
| 20 | LMNS? | Yes |
| 21 | ODN? | Yes |

# Safety Action 5: Can you demonstrate an effective system of Midwifery workforce planning to the required standard?

**Safety Action Lead:** Lisa Butler - Deputy Head of Midwifery

**Safety Action Support:** Samantha Cole - Assistant General Manager Maternity & Gynaecology

**Futures link:** Safety Action 5 Midwifery Workforce - Sherwood Forest NHS Foundation Trust NHSR MIS Year 5 - FutureNHS Collaboration Platform

| Standard A | A systematic evidence-bases approach to calculate midwifery staffing establishment is completed |
|---|---|
| Evidence to support | SFH Birthrate plus report |

| Standard B | Trust Board to evidence midwifery staffing budget reflects establishment as calculated in standard A |
|---|---|
| Evidence to support | Budget Plan Maternity establishment 23/24<br>Public board Minutes and staffing report signed off by the board |

| Standard C | The midwifery coordinator in charge of labour ward must have supernumerary status (defined as having no caseload if their own during their shift) to ensure there is oversight of all birth activity within the service |
|---|---|
| Evidence to support | Supernumerary status report from birthrate plus May - Oct 23<br>Supernumerary status report from birthrate plus Oct - Dec 23<br>Supporting narrative on Supernumerary status May - Oct 23<br>Supporting narrative on Supernumerary status Oct - Dec 23 |

| Standard D | All Women in active labour receive one-to-one midwifery care |
|---|---|
| Evidence to support | Maternity Dashboard<br>Perinatal quality surveillance report |

| Standard 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 |
|---|---|
| Evidence to support | Maternity Staffing monthly papers - May & Sept 2023<br>Bi Annual Maternity Staffing Report - September 2023 (this goes to MAC, QC and Board) includes red flags |

**Minimum Evidence Requirement for Declaration**

| Number | Safety Action requirement (evidence above to cover / Safety Lead to discuss and provide assurance for sign off) | Met? |
|---|---|---|
| 1 | a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed? Evidence should include:<br>A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated | Yes |
| 2 | b) Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated in a) above? Evidence should include:<br>• 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.<br>• 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.<br>• 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.<br>• Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.<br>• The midwife to birth ratio<br>• 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. | Yes |
| 3 | 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.<br><br>Can you provide 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?<br><br>The Trust can report compliance with this standard if failure to maintain supernumerary status is a one off event, however the Trust cannot report compliance with this standard if the coordinator is required to provide any 1:1 care for a woman and/or care in established labour during this time.<br><br>If the failure to maintain supernumerary status 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 an action plan. This plan must include mitigation/escalation to cover any shortfalls. Please note - Completion of an action plan will not enable the Trust to declare compliance with this standard. | Yes |
| 4 | d) Have all women in active labour received one-to-one midwifery care? | Yes |
| 5 | If you have answered no to standard d, have you submitted an action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour? | Yes |
| 6 | Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board? | Yes |
| 7 | e) Have you submitted 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 |

**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?**

**Safety Action Lead:** Ruth Nanthambwe - Saving Babies Lives Specialist Midwife
**Safety Action Support:** Samantha Cole - Assistant General Manager Maternity & Gynaecology
**Futures link:** Safety Action 6 SBLCBv3 - Sherwood Forest NHS Foundation Trust NHSR MIS Year 5 - FutureNHS Collaboration Platform

**Required standards and supporting evidence uploaded to Futures Platform**

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|---|---|
| **Standard A** | **Provide assurance to the Trust board and ICB that you are on track to fully implement all 6 elements of SBLCBv3 by March 2024** |
| **Evidence to support** | Board report and action plan on implementation of the SBLCBv3 Implementation % report by element |

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| **Standard B** | **Hold quarterly quality improvement discussions with the ICB, using new national implementation tool once available** |
| **Evidence to support** | SBLCBv3 1st quarterly meeting LMNS/ICB/SFH - meeting invite<br>SBLCBv3 2nd quarterly meeting LMNS/ICB/SFH - meeting invite |

**Minimum Evidence Requirement for Declaration**

| Number | Safety Action requirement (evidence above to cover / Safety Lead to discuss and provide assurance for sign off) | Met? |
|---|---|---|
| 1 | Have you provided assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024? | Yes |
| 2 | Do you hold quarterly quality improvement discussions with the ICB, using the new national implementation tool?<br><br>Confirmation is required 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 that included the following:<br><br>• Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.<br>• Progress against locally agreed improvement aims.<br>• Evidence of sustained improvement where high levels of reliability have already been achieved.<br>• Regular review of local themes and trends with regard to potential harms in each of the six elements.<br>• Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts. | Yes |
| 3 | Using the new national implementation tool, can the Trust demonstrate implementation of 70% of interventions across **all** 6 elements overall? | Yes |
| 4 | Using the new national implementation tool, can the Trust demonstrate implementation of at least 50% of interventions within **each** of the 6 individual elements? | Yes |

This Safety action has already been externally validated and has met compliance

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

**Safety Action Lead:** Gemma Boyd - Consultant Midwife & Professional Midwifery Advocate

**Safety Action Support:** Samantha Cole - Assistant General Manager Maternity & Gynaecology

**Futures link:** Safety Action 7 Listening and Co-production - Sherwood Forest NHS Foundation Trust NHSR MIS Year 5 - FutureNHS Collaboration Platform

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| **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. Parents with Neonatal experience may give feedback via the MNVP and Parent Advisory Group.** |
| **Evidence to support** | Summary of MVP workload plan 23/24<br>Confirmation of appointment of NVP<br>Sign off of workplan by LMNS<br>Reimbursement of out of pocket expenses<br>MVP training offers to volunteers and chairs<br>DRAFT funding proposal for new MVP Model<br>MVP Chair renumeration<br>LMNS Ratification of MVP workplan<br>MVP Chair extension to contract<br>ICB MVP coproduction officer JD and Person spec<br>Feedback process for MVP<br>DMNV Training Package<br>MVP Newsletter inc Training offers<br>RAID Log<br>MVP ToR<br>NVP Contract<br>MVP Hours invoice<br>MVP Meeting Agenda<br>LMNS Exec Partnership ToR<br>Volunteer expense Claim<br>LMNS Transformation Board ToR<br>Volunteer expenses Log<br>MVP Chair appointment Letter<br>Notts MVP Annual Work Plan<br>MVP New Workplan sign off responses<br>Minutes LMNS discussion MVP workplan funding |

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| **Standard 2** | **Ensuring an action plan is coproduced with the MNVP following the annual CQC survey data publication including analysis of free text data, and progress monitored regularly by safety champions and LMNS board.** |
| **Evidence to support** | Request for MVP Feedback<br>Safety Champions agenda - 3 months<br>Safety Champions Minutes - 3 months<br>Co-produced Action plan following CQC Survey<br>CQC Inspection Report<br>CQC Maternity Survey<br>LMNS Transformation board Agenda |

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| **Standard 3** | **Ensuring Neonatal and Maternity service user feedback is collated and acted upon with the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.** |
| **Evidence to support** | Personalised care and support plans<br>MVP Highlight Report<br>MVP Feedback flash Report<br>MVP & N&N Ethnic minorities working group findings<br>SFH-MVP Service user feedback<br>MVP Meeting Minutes - 4 Months<br>Maternity Service User Feedback<br>N&N Maternity Equity Strategy<br>Health Inequalities working group notes<br>Health Inequalities Workshop - areas of focus<br>Service user feedback action plan<br>Whose shoes report<br>Safety Champions Agenda - 3 months<br>What good looks like co-produced analysis |

**Minimum Evidence Requirement for Declaration**

| Number | Safety Action requirement (evidence above to cover / Safety Lead to discuss and provide assurance for sign off) | Met? |
|---|---|---|
| 1 | Is a fundeed, user-led Maternity and Neonatal Voices Partnership (MNVP) in place which is in line with the Delivery Plan and MNVP Guidance (once published in 2023)? | Yes |
| 2 | Has an action plan been co-produced with the MNVP following annual CQC Maternity Survey data publication (January 2023), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board? | Yes |
| 3 | Is neonatal and maternity service user feedback collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions? | Yes |
| 4 | Can you provide minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from co-production between service users and staff? | Yes |
| 5 | Do you have evidence that MNVPs have the infrastructure they need to be successful such as receiving appropriate training, administrative and IT support? | Yes |
| 6 | Can you provide the local MNVP's work plan and evidence that it is funded? | Yes |
| 7 | Do you have evidence that the MNVP leads (formerly MVP chairs) are appropriately employed or remunerated (including out of pocket expenses such as childcare) and receive this in a timely way? | Yes |
| 8 | Can you provide evidence that the MNVP is prioritising hearing the voices of families receiving neonatal care and bereaved families, as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation? | Yes |

**Safety Action 8: Local Training Plans and 'in-house', one day multi professional training**

**Safety Action Lead:** Lisa Butler - Deputy Head of Midwifery

**Safety Action Support:** Samantha Cole - Assistant General Manager Maternity & Gynaecology

**Futures link:** Safety Action 8 Training - Sherwood Forest NHS Foundation Trust NHSR MIS Year 5 - FutureNHS Collaboration Platform

| **Standard 1** | **A local training plan is in place for implementation of version 2 of the Core Competency Framework** |
|---|---|
| **Evidence to support** | 3 Year Training plan matrix 24-25<br>Training compliance update report Nov & Dec 23<br>SI Shared governance group minutes (LMNS/NUH/SFH)<br>TNA excel format based on how to and stretch targets<br>NLS Instructor certificate x 2<br>NLS intention of new instructor e-mail<br>Women's voices - service user involvement plan<br>Shared learning - Clinical educator from NUH attending SFH<br>PROMPT and date of SFH educator to attend NUH PROMPT<br>How service user feedback is used in training |

| **Standard 2** | **The Plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB** |
|---|---|
| **Evidence to support** | Review of 3 Year TNA by LMNS<br>SMT agenda TNA signed off by Triumvirate<br>Trust Board agenda for TNA oversight |

| **Standard 3** | **The plan is developed based on the "How to" guide developed by NHS England** |
|---|---|
| **Evidence to support** | TNA excel format based on how to and stretch targets |

Minimum Evidence Requirement for Declaration

| Number | Safety Action requirement (evidence above to cover / Safety Lead to discuss and provide assurance for sign off) | Met? |
|---|---|---|
| 1 | A local training plan is in place for implementation of Version 2 of the Core Competency Framework | Yes |
| **Can you evidence that the plan has been agreed with:** | | |
| 2 | Quadrumvirate? | Yes |
| 3 | Trust Board? | Yes |
| 4 | LMNS/ICB? | Yes |
| 5 | 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? | Yes |
| 6 | Can you evidence service user involvement in developing training? | Yes |
| 7 | Can you evidence that training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports? | Yes |
| 8 | Can you evidence that you promote learning as a multidisciplinary team? | Yes |
| 9 | Can you evidence that you promote shared learning across a Local Maternity and Neonatal System? | Yes |
| **Can you demonstrate the following at the end of 12 consecutive months ending December 2023?** | | |
| **Fetal monitoring and surveillance (in the antenatal and intrapartum period)** | | |
| 10 | 90% of obstetric consultants? | Yes |
| 11 | 90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)? | Yes |
| 12 | 90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres? | Yes |
| **Maternity emergencies and multiprofessional training** | | |
| 13 | 90% of Obstetric consultants? | Yes |
| 14 | 90% of 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? | Yes |
| 15 | 90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and | Yes |
| 16 | 90% of maternity support workers and health care assistants attend the maternity emergency scenarios training? | Yes |
| 17 | 90% of obstetric anaesthetic consultants? | Yes |
| 18 | 90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota? | Yes |
| 19 | Can you demonstrate that **at least one** emergency scenario is conducted in a clinical area or at point of care? | Yes |
| 20 | Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area | Yes |
| **Neonatal basic life support** | | |
| 21 | 90% of neonatal Consultants or Paediatric consultants covering neonatal units? | Yes |
| 22 | 90% of neonatal junior doctors (who attend any births)? | Yes |
| 23 | 90% of neonatal nurses (Band 5 and above who attend any births)? | Yes |
| 24 | 90% of advanced Neonatal Nurse Practitioner (ANNP)? | Yes |
| 25 | bank/agency midwives)? | Yes |
| 26 | All trusts must have an agreed plan in place, including timescales, for registered RC-trained instructors to deliver the in-house basic neonatal life support annual updates and their local NLS courses by 31st March 2024. | Yes |

**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?**

**Safety Action Lead:** Paula Shore - Director of Midwifery

**Safety Action Support:** Samantha Cole - Assistant General Manager Maternity & Gynaecology

**Futures link:** Safety Action 9 Board assurance - Sherwood Forest NHS Foundation Trust NHSR MIS Year 5 - FutureNHS Collaboration Platform

| **Standard A** | **All six requirements of principle 1 of the Perinatal Quality Surveillance model must be fully embedded** |
|---|---|
| **Evidence to support** | SI Report sent to Quality Committee - Oct 2023<br>Confirmation of NED appointment<br>NED Job Description<br>Maternity Safety champions poster<br>Maternity perinatal quality surveillance report for Aug 2023<br>Maternity perinatal quality surveillance report for Oct 2023<br>MNSC Agenda featuring perinatal scorecard<br>LMNS perinatal surveillance quality group minutes<br>Maternity Forum and MNSC walk round dates 2023<br>MAC ToR<br>MNSC Pathway flowchart |

| **Standard B** | **Evidence that dicussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relation to local improvement plan utilising the Patient Safety incident Response Framework are reflected in the minutes of the Board, LMNS/ICB/Local and Regional Learning system meetings** |
|---|---|
| **Evidence to support** | Quality Committee agenda - MAC escalations Oct 2023<br>Bi Annual staffing report Sep 2023 going to MAC, QC and board<br>Private Trust board minutes - Qtr1<br>Private Trust board minutes - Qtr 2<br>Maternity Staffing paper May 23 going to MAC, QC and Board<br>Maternity Staffing paper Sep 2023 going to MAC, QC and Board |

| **Standard C** | **Evidence that the Maternity and Neonatal Board Safety Champions are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures** |
|---|---|
| **Evidence to support** | Perinatal culture and leadership future session dates<br>Perinatal Culture and leadership quad programme<br>The Quad Culture & Leadership invite<br>Perinatal quad confirmation of training<br>Perinatal culture and leadership learning contract<br>MatNeo webinar - safety champion support<br>MatNeo attendance certificate<br>Confirmation of Board safety champions registered<br>FuturesNHS workspace by 1st August 2023 |

**Minimum Evidence Requirement for Declaration**

| Number | Safety Action requirement (evidence above to cover / Safety Lead to discuss and provide assurance for sign off) | Met? |
|---|---|---|
| 1 | **Required Standard A.**<br>**Evidence that all six requirements of Principle 1 of the Perinatal Quality Surveillance Model have been fully embedded and specifically the following:-** | Yes |
| 2 | Does your Trust have evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues? | Yes |
| 3 | Does your Trust have evidence that a review of maternity and neonatal quality is undertaken by the Trust Board at every Trust Board meeting, using a minimum data set to include a review of the thematic learning of all maternity Serious Incidents (SIs)?<br>It must include:<br>• number of incidents reported as serious harm<br>• themes identified and action being taken to address any issues<br>• Service user voice feedback<br>• Staff feedback from frontline champions' engagement sessions | Yes |
| 4 | Do you have evidence that the perinatal clinical quality surveillance model has been reviewed in full in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife? And does this evidence show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need. | Yes |
| **Required standard B.**<br>**Have you submitted 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:** | | |
| 5 | The Trust Board? | Yes |
| 6 | LMNS/ICS/Local & Regional Learning System meetings? | Yes |
| 7 | Do you have evidence that the progress with actioning named concerns from staff feedback sessions is visible to staff? | Yes |
| 8 | Do you have evidence that Trust's claims scorecard is reviewed alongside incident and complaint data? Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trust's Patient Safety Incident Response Plan. These quarterly 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. | Yes |
| 9 | **Required standard C.**<br>**Have you submitted evidence that the Maternity and Neonatal Board Safety Champions are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures?** | Yes |
| 10 | Have you submitted the evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace with confirmation of specific resources accessed and how this has been of benefit? | Yes |
| 11 | Have there been a minimum of two quarterly meetings between board safety champions and quadrumvirate members between 30 May 2023 and 1 February 2024? | Yes |
| 12 | Have you submitted evidence that the meetings between the board safety champions and quad members have identified any support required of the Board and evidence that this is being implemented? | Yes |

**Safety Action 10: Have you reported 100% of qualifying cases to HSIB/MNSI/NSHR EN Scheme from 6th December 2022 to 7th December 2023?**

**Safety Action Lead:** Hannah Lewis - Governance Midwife
**Safety Action Support:** Samantha Cole - Assistant General Manager Maternity & Gynaecology
**Futures link:** Safety Action 10 HSIB/NHSR/EN Reporting - Sherwood Forest NHS Foundation Trust NHSR MIS Year 5 - FutureNHS Collaboration

| | |
|---|---|
| **Standard A** | **Reorting of all qualifying cases to HSIB/CQC/MNSI from 6 December 2022 - 7 December 2023** |
| **Evidence to support** | HSIB family information leaflet<br>SFHFT HSIB NHSR EN compliance report<br>MNSI/ENS Tracker<br>HSIB report May 2023<br>Maternity governance case reference template |

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| **Standard C** | **For qualifying cases which have occurred during 6 December 2022 - 7 December 2023, the trust board are assured that: a. the family have received information on the role of HSIB/CQC/MNSI and NHSR EN scheme and b. there has been compliance, where required, with regulation 20 of the health and social act 2008 Regulations 2014 in respect of duty of candour** |
| **Evidence to support** | Link to NHSR EN scheme website for families<br>Duty of candour leaflet<br>MNSI information sent to families<br>Draft letter to families SFH<br>Letter sent to parents of qualifying case |

| | |
|---|---|
| **Standard B** | **Reporting of all qualifying EN cases to NHS Resolutions Early Notification (EN) Scheme from 6 December 2022 until 7 December 2023** |
| **Evidence to support** | Referral to NHSR EN Scheme<br>SFHFT HSIB NHSR EN compliance report<br>MNSI/ENS Tracker<br>Rejected claim from NHSR EN Scheme |

This Safety action has already been externally validated and has met compliance

**Minimum Evidence Requirement for Declaration**

| Number | Safety Action requirement (evidence above to cover / Safety Lead to discuss and provide assurance for sign off) | Met? |
|---|---|---|
| 1 | Complete the field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated. | Yes |
| 2 | Have you reported all qualifying cases to HSIB/CQC/MNSI from 6 December 2022 to 7 December 2023? | Yes |
| 3 | Have you reported all qualifying EN cases to NHS Resolution's EN Scheme from 6 December 2023 until 7 December 2023? | Yes |
| | **For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:** | |
| 4 | The family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme | Yes |
| 5 | 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 | Yes |
| | **Can you confirm that the Trust Board has:** | |
| 6 | 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 |
| 7 | Sight of evidence that the families have received information on the role of HSIB/MNSI and the EN scheme? | Yes |
| 8 | Sight of evidence of compliance with the statutory duty of candour? | Yes |