Cover Sheet

Public Trust Board Meeting: Wednesday 14 July 2021

Title:	**Maternity Incentive Scheme Update Report**

Status:	**For Discussion**
History:	**Maternity Clinical Governance Committee**
	Trust Board

Board Lead:	**Chief Nursing Officer**
Author:	**Kelly Davis, Quality Assurance & Improvement Midwife**
Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. The purpose of this paper is to provide an update on the status of OUH compliance with the NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year Three.
2. It is also intended to highlight to the Board areas of risk to compliance, facilitating discussion as to how the Trust Board could most effectively support the Maternity and Neonatal units with proposed mitigations.

Recommendations

3. The Trust Board is asked to:
   - Note the contents of the update report.
   - Note that evidence of compliance has now been provided for all Safety Actions including:
     - Safety Action 2: Are you submitting data to the MSDS to the required standard?
     - Safety Action 4: Can you demonstrate an effective system of clinic workforce planning to the required standard?
       - Neonatal Nursing Workforce
4. The deadline for the Board declaration to reach NHSR is now **12 noon on Thursday 15 July 2021**.
5. The Trust Board is asked to:
   - Complete the Trust Board declaration form stating that the Board is satisfied that the evidence provided to demonstrate achievement of the ten safety actions meets the required standards as set out in the 'Ten maternity safety actions with technical guidance' document.
     - The content of the declaration form must be discussed with the commissioner of the Trust's maternity services, and then it must be signed by the Trust Chief Executive.

Contents

1. Purpose

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1.2. It is also intended to highlight to the Board areas of risk to compliance, facilitating discussion as to how the Trust Board could most effectively support the Maternity and Neonatal units with proposed mitigations.

2. Background

2.1. The ten safety actions for year three of the scheme were first published by NHSR on 23rd December 2019, however, were subject to change as a direct result of the Covid-19 pandemic (see sections 3 and 5 below).

2.2. The deadline for the Board declaration of compliance with all ten standards to reach NHSR was extended, considering the Covid-19 pandemic, to noon on Thursday 15 July 2021. A twelve-page revision guide and revised Scheme were circulated by NHSR on the 1st February 2021. There was a further revision of the Scheme released on the 18th March 2021.

2.3. This paper outlines the required standards for each of the ten safety actions along with the current evaluation of the compliance status and perceived level of risk for each standard (see section 5 below).

3. October Re-launch and Revised Guidance from NHSR

3.1. After a pause on the scheme during the first wave of the pandemic, it was relaunched on the 1st October 2020. This relaunch included the addition of elements aiming to ensure key learning from important emerging Covid-19 themes were considered and implemented.

3.2. A report against compliance with the October 2020 revised standards and relaunch was presented to Trust Board in November 2020 (TB2020.76), January 2021 (TB2020.07), March 2021 (TB2021.20) and May (TB2021.36).

4. Compliance Updates - Q1 of 2021-22

4.1. **Safety Action 2: Are you submitting data to the MSDS to the required standard? Compliant**

4.2. **Safety Action 4: Can you demonstrate an effective system of Clinical Workforce planning to the required standard? Compliant**

4.3. Both Safety Actions 2 and 4 had areas with a high-risk of non-compliance. Mitigations for both have now been agreed by Trust Management Executives (TME); TME21/07A/06 Maternity EPR Solution [TME2021.179] and TME21/07A/09 Neonatal Unit Safe Staffing Establishments [TME2021.182].

4.4. Appendix 2 of the Evidence Paper provides confirmation of this and further detail.

5. Year 3 Safety Actions: Detail of Current Status and Risk Level

5.1. **Safety Action 1**: Perinatal Mortality Review Tool (PMRT)

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance	Evidence
a) i. All perinatal deaths eligible to be notified to MBRRACE-UK from Monday 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.	**Compliant**	Papers submitted to Confidential Trust Boards in November 2020 (TBC2020.76), January 2021 (TBC2021.11), May 2021 (TBC2021.31), and July 2021 (TBC2021.51) CNST will check our PMRT data. Standard Operating Procedure produced to provide assurance of reporting process in Maternity (see TB2021.36). Six completed Bereavement Checklists further demonstrating compliance with c). Three completed Neonatal Death checklists and three completed Intrauterine Death checklists. (See Appendix 1 of Evidence Paper).
a) ii. A review using the PMRT of 95% of all deaths of babies suitable for review, using the PMRT from Friday 20 December 2019 to 15 March 2021, will have been started before 15 July 2021.	**Compliant**	
b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15 March 2021, will have been reviewed using the PMRT by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15th July 2021.	**Complaint**	
c) For 95% of all deaths of babies who were born and died in your trust from Friday 20 December 2019, the Parents were told that a review of their baby's death will take place, and that the Parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trust should ensure that contact with the families continues during any delay and make an early	**Compliant**	

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance	Evidence
assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and these actions.		
d) Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust Maternity Safety Champion.	**Compliant**	As above and all reports have been discussed with the Maternity Safety Champions prior to Board submission.

5.2. **Safety Action 2**: Maternity Services Data Set (MSDS)

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. It will help trusts understand the improvements needed in advance of the assessment months. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met. Criteria 1-13 will be assessed by NHS Digital and included in the scorecard.		Compliance for all parts (part 3 aside) of safety action evidenced in May TB2021.36. The Maternity EPR Solution [TME2021.179] was approved by TME, demonstrating compliance with Safety Action 2, 3 (see Appendix 2 of the Evidence Paper).
1. At least two people registered to submit MSDS data to SDCS Cloud and still working in the Trust on Saturday 31 October 2020.	**Compliant**	
2. MSDSv2 webinar attended by at least one colleague from each trust in January/February 2020	**Compliant**	

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
3. Trust Boards to confirm to NHS Resolution that they have fully conformed to the MSDSv2 Information Standards Notice, DCB1513 and 10/2018, which was expected for April 2019 data; or that a locally funded plan is in place to do this and agreed with the Maternity Safety Champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-CT.	**Compliant**	
4. Made a submission relating to August 2020 - December 2020 data, submitted to deadlines October 2020 - February 2021.	**Compliant**	
5. December 2020 data included all following tables: MSD000 MSDS Header MSD001 Mother's Demographics MSD002 GP Practice Registration MSD101 Pregnancy and Booking Details MSD102 Maternity Care Plan MSD201 Care Contact (Pregnancy) MSD202 Care Activity (Pregnancy) MSD301 Labour and Delivery MSD302 Care Activity (Labour and Delivery) MSD401 Baby's Demographics and Birth Details MSD405 Care Activity (Baby) MSD901 Staff Details	**Compliant**	
6. December 2020 data contained at least 90% of the deliveries recorded in Hospital Episode Statistics (unless reason understood). (MSD401)	**Compliant**	
7. December 2020 data contained at least as many women booked in the month as the number of deliveries submitted in the month (unless reason understood). (MSD101)	**Compliant**	

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
8. December 2020 data contained Estimated Date of Delivery for 95% of women booked in the month. (MSD101)	**Compliant**	
9. December 2020 data contained valid postcode for mother at booking in 95% of women booked in the month. (MSD001)	**Compliant**	
10. December 2020 data contained valid ethnic category (Mother) for at least 80% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	**Compliant**	
11. December 2020 data contained antenatal Continuity of Carer Plan fields completed for 90% of women booked in the month. (MSD101/2)	**Compliant**	
12. December 2020 data contained antenatal personalised care plan fields completed for 90% of women booked in the month. (MSD101/2)	**Compliant**	
13. December 2020 data contained valid presentation at onset of delivery codes for 90% of births where this is applicable. (MSD401)	**Compliant**	

5.3. **Safety Action 3**: Avoiding Term Admissions into Neonatal Units Programme

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Expected Evidence
D) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the	**Compliant**	No request has been made for commissioner returns, however, email confirmation providing

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Expected Evidence
Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.		assurance of compliance provided. (see Appendix 2 of Evidence Paper).
E) Review of term admissions should be an ongoing process. The review of admissions during Covid-19 should be completed by the Friday 26 February 2021 is undertaken to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.	**Compliant**	Evidence submitted to Safety Champions Meeting and to January Trust Board meeting as per the Chief Nursing Officer's request.
F) An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19 period as in point e) above has been agreed with the Maternity and Neonatal Safety Champions and Board Level Champion.	**Compliant**	
G) Progress with the revised ATAIN action plan has been shared with the Maternity, Neonatal and Board level safety champions.	**Compliant**	

5.4. **Safety Action 4**: Clinical Workforce Planning

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
Anaesthetic medical workforce An action plan is in place and agreed at Trust Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.7.2.5, 1.7.2.1 and 1.7.2.6	**Compliant**	Compliance evidenced in May TB2021.36.

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
Neonatal medical workforce The Neonatal Unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at Board level.	**Compliant**	The Neonatal Unit Safe Staffing Establishments [TME2021.182] was approved by TME, demonstrating compliance with Safety Action 4 (see Appendix 2 of the Evidence Paper).
Neonatal nursing workforce The Neonatal Unit meets the service specification for neonatal nursing standards. If these are not met, an action plan is in place and agreed at Board level to meet these recommendations.	**Compliant**	

5.5. **Safety Action 5**: Midwifery Workforce Planning

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	**Compliant**	Compliance evidence in March TB2021.20.
b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.	**Compliant**	
c) All women in active labour receive one-to-one midwifery care.	**Compliant**	
d) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board at least once a year, during the MIS Year Three reporting period.	**Compliant**	

5.6. **Safety Action 6**: Saving Babies Lives Care Bundle Version Two (SBLCBv2)

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
1. Trust Board level consideration of how its organisation is complying with the SBLCBv2, published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2019/20 standard contract.	**Compliant**	In recommendations section for Board considering papers: TB2020.76, TB2020.07 and TB2021.20.
2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.	**Compliant**	See below for compliance with each element.
3. The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBv2 including the data submission requirements. The corroborating evidence is the SBLCBv2 survey and MSDS data, availability of this depends on the COVID-19 status.	**Compliant**	Compliance evidenced in May TB2021.36.
The following rows outline the assurance required to assess compliance with each element of the care bundle		
Element 1: A. Recording of Carbon Monoxide (CO) reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' MSDS submission to NHS Digital. B. Percentage of women where CO measurement at booking is recorded. C. Percentage of women where CO measurement at 36 weeks is recorded. Note: The relevant data items for these indicators should be recorded on the provider's MIS and included in the MSDS submission to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The	**Compliant**	Compliance evidenced in May TB2021.36.

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
Trust Board should receive data from the organisation's MIS evidencing 80% compliance. If CO monitoring remains paused within the Trust due to Covid-19 the audit described above needs to be based on the percentage of women asked whether they smoke at booking and at 36 weeks. The Very Brief Advice and referral to smoking cessation services remain part of the pathway. This is in line with guidance issued by NHS England and NHS Improvement when CO monitoring was initially paused. The timing of the audit is at the Trust's discretion but should include the dates when women booked, and the reference to the national CO testing policy at that time. A threshold score of 80% compliance should be used to confirm successful implementation. If the process metric scores are less than 95% Trusts must also have an action plan for achieving >95%.		
Element 2: A. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking. Note: The relevant data items for these indicators should be recorded on the provider's MIS and included in the MSDS submission to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust Board should receive data from the organisation's MIS evidencing 80% compliance. If there is a delay in the provider Trust MIS's ability to record these data at the time of submission an in-house audit of 40 consecutive cases using locally available data or case records should have been undertaken to assess compliance with this indicator.	**Compliant** For the Year 2 MIS, an exception report was submitted to and agreed by local governance, Trust Board, CCG and Clinical Network in relation to an alternative to offering ultrasound assessment from 32 weeks' gestation for women with BMI>35kg/m^2	Compliance evidenced in May TB2021.36. Growth Scan Pathway demonstrating compliance with Element 2, 2) – uterine artery Doppler flow velocimetry (see Appendix 4 of the Evidence Paper).

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
A threshold score of 80% compliance should be used to confirm successful implementation. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. In addition, the Trust Board should specifically confirm that within their organisation: 1) women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards 2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation. If this is not the case the Trust Board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice.		
Element 3: A. Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy. B. Percentage of women who attend with RFM who have a computerised CTG. Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases whichever is the smaller to assess compliance with the element three indicators.	**Compliant**	Compliance evidenced in May TB2021.36.

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
A threshold score of 80% compliance should be used to confirm successful implementation. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.		
Element 4: A. Percentage of staff who have received training on intrapartum fetal monitoring in line with the requirements of Safety Action 8, including: intermittent auscultation, electronic fetal monitoring, human factors, and situational awareness. B. Percentage of staff that have successfully completed mandatory annual competency assessment. Note: An in-house audit should have been undertaken to assess compliance with these indicators. Each of the following groups should be attending the training: • Obstetric Consultants • All other obstetric doctors • Midwives Trust Board should minute in their meeting records a written commitment to facilitate local, in-person, fetal monitoring training when this is permitted.	**Compliant**	Compliance evidenced in May TB2021.36.
Element 5: A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. B. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. C. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).	**Compliant**	Evidence of compliance provided in January TB2020.07. Further evidence of compliance pulled from National Neonatal Audit Programme (NNAP) data collated by Operational Delivery Network (ODN) analyst (see Appendix 5 of Evidence Paper).

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
Note: The relevant data items for these indicators should be recorded on the provider's MIS and included in the MSDS submission to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust Board should receive data from the organisation's MIS evidencing 85% compliance. If there is a delay in the provider Trust MIS's ability to record these data at the time of submission an in-house audit of a minimum of four weeks' worth of consecutive cases up to a maximum of 20 cases to assess compliance with the element five indicators. Completion of the audits should be used to confirm successful implementation. If the process indicator scores are less than 85% Trusts must also have an action plan for achieving >85%. In addition, the Trust Board should specifically confirm that within their organisation: • women at high risk of pre-term birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the Board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • an audit has been completed to measure the percentage of singleton live births (less than 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids		

5.7. **Safety Action 7**: Maternity Voices Partnership (MVP)

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	See below for details of evidence required.	Evidence of compliance provided in January TB2020.07.
Terms of Reference for your MVP	**Compliant**	
A minimum of one set of Minutes of MVP meetings demonstrating explicitly how a range of feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback.	**Compliant**	
Evidence of service developments resulting from coproduction with service users	**Compliant**	
Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses	**Compliant**	
Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of UKOSS 2020 coronavirus data.	**Compliant**	

5.8. **Safety Action 8**: In-House Training

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
a) Can you confirm that Covid-19 specific e-learning training has been made available to the multi-professional team members?	**Compliant**	Compliance evidenced in May TB2021.36.

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
b) Can you confirm that the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since the launch of MIS year three in December 2019?	**Compliant**	Compliance evidenced in May TB2021.36.
	Compliant	See Compliance Tables (Appendix 6,7,8,9) and agreed action plan (Appendix 10)
c) Can you confirm that there is a commitment by the Trust Board to facilitate multi-professional training sessions, including fetal monitoring training once when this this is permitted?	**Compliant**	Compliance evidenced in May TB2021.36.

5.9. **Safety Action 9**: Safety Champions

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
a) A pathway has been developed that describes how frontline Midwifery, Neonatal, Obstetric and Board safety champions share safety intelligence from floor to Board and through the LMS and MatNeoSIP Patient Safety Networks (PSNs).	**Compliant**	Evidence of compliance provided in January TB2020.07.
b) Board level safety champions are undertaking feedback sessions every other month for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to Covid-19 service changes and service user feedback and can demonstrate that progress with actioning named concerns are visible to staff.	**Compliant**	Evidence of compliance provided in January TB2020.07 and evidence of ongoing feedback sessions available on request.

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. Taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas, a revised action plan describes how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve.	**Compliant**	Evidence of compliance provided in January TB2020.07.
d) Together with their frontline safety champions, the Board safety champion and MatNeoSIP PSNs has reviewed local outcomes in relation to: I. Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of Covid-19, drawing on resources and guidance to understand and address factors which led to these outcomes. II. The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK. III. The MBRRACE-UK SARS-Covid-19 IV. The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups and considered the recommendations and requirements of II, III and IV on I.	**Compliant**	Three comprehensive papers shared and approved by Board level Safety Champion and November 2020. MatNeoSIP PSNs in Evidence of compliance provided in January TB2020.07.
e) The Board Level Safety Champion is actively supporting capacity (and capability) building for all staff to be actively involved in the following areas: - Maternity and neonatal quality and safety improvement activity within the Trust, including that determined in response to Covid-19 safety concerns.	**Compliant**	Evidence of compliance provided in January TB2020.07 as well as in May TB2021.36.

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
- Specific national improvement work and testing lead by MatNeoSIP that the Trust is directly involved with.		

5.10. **Safety Action 10**: NHSR Early Notification Scheme

Required Standards following re-launch of MIS	July update on status and R.A.G. rating for risk of non-compliance*	Evidence
a) Reporting of all outstanding qualifying cases for the year 2019/20 to NHSR's EN scheme.	**Compliant**	Evidence of compliance provided in January TB2020.07
b) Reporting of all qualifying cases to HSIB for 2020/21.	**Compliant**	Evidence of compliance provided in January TB2020.07
c) For qualifying cases which have occurred during the period 1 October 2020 to 31 March 2021 the Trust Board are assured that: 1. the family have received information on the role of HSIB and the EN scheme; and 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	**Compliant**	Compliance evidenced in May TB2021.36.

6. Conclusion

6.1. This paper outlines the Trust's full compliance with all ten safety actions with the re-launched MIS requirements.

7. Recommendations

The Trust Board is asked to:

- Note the contents of the update report.
- Note that evidence of compliance has now been provided for all Safety Actions including:
  - Safety Action 2: Are you submitting data to the MSDS to the required standard?
  - Safety Action 4: Can you demonstrate an effective system of clinic workforce planning to the required standard?
    - Neonatal Nursing Workforce

The deadline for the Board declaration to reach NHSR is now **12 noon on Thursday 15 July 2021**.

The Trust Board is asked to:

- Complete the Trust Board declaration form stating that the Board is satisfied that the evidence provided to demonstrate achievement of the ten safety actions meets the required standards as set out in the 'Ten maternity safety actions with technical guidance' document.
  - The content of the declaration form must be discussed with the commissioner of the Trust's maternity services, and then it must be signed by the Trust Chief Executive.

Appendix A: Evidence

The evidence referred to in the table above is available to the Board and has been reviewed by the Trust Assurance Team.

The list of evidence is as follows:

- Appendix 1: Bereavements Checklists
- Appendix 2: Company Secretary Confirmation of TME Approval
- Appendix 3: Data shared with ODN – SA3 (D)
- Appendix 4: Growth Scan Pathway
- Appendix 5: SBLCBv2 Element 5 KPIs

- Appendix 6: Table Outlining EFM Training Compliance
- Appendix 7: Multi-Professional Maternity Emergencies Training Compliance
- Appendix 8: Maternity Directorate NLS Training Compliance
- Appendix 9: Neonatal Directorate NLS Training Compliance
- Appendix 10: SMART Action Plan – Band 5 Neonatal Nurses Training