University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 1 July 2021

	Trust Board paper N2
Report Title:	**Quality and Outcomes Committee – Committee Chair's Report**
Author:	Gill Belton – Corporate and Committee Services Officer

Reporting Committee:	**Quality and Outcomes Committee (QOC)**
Chaired by:	Ms Vicky Bailey – Non-Executive Director
Lead Executive Director(s):	Andrew Furlong – Medical Director Carolyn Fox – Chief Nurse
Date of meeting:	24 June 2021

Summary of key public matters considered by the Committee:

This report provides a summary of the key issues considered at the Quality and Outcomes Committee meeting on 24 June 2021:- *(involving Ms V Bailey, QOC Non-Executive Director Chair, Professor P Baker, Non-Executive Director, Mr B Patel, Non-Executive Director, Mr I Orrell, Associate Non-Executive Director, Mr A Furlong, Medical Director, Ms C Fox, Chief Nurse, Ms B O'Brien, Director of Quality Governance, Ms C West, CCG Representative, Ms J Smith, Patient Partner and Mr A Haynes, Adviser to the Trust Board. Miss H Busby-Earle, Clinical Director (MSS), Dr D Barnes, Deputy Medical Director, Ms S Leak, Director of Operational Improvement and Ms E Broughton, Head of Midwifery attended to present their respective items.)*

- **Minutes and Summary of QOC meeting held on 27 May 2021** – paper A1 (public QOC Minutes from 27 May 2021) was accepted as an accurate record and paper A2 (public QOC summary from 27 May 2021) was received and noted, having been submitted to the Trust Board on 3 June 2021.

- **Matters Arising Log** – paper B noted.

- **Maxillo-Facial Workforce Update**
  Miss H Busby-Earle, Clinical Director for Musculo-Skeletal Services (MSS), attended to present paper C, which provided an update on the workforce status in the Maxillofacial Department, the challenges currently facing the department around recruitment and retention of staff and plans for mitigation, taking into consideration recovery and restoration. Due to the circumstances described within the report, the difficult decision to temporarily suspend the Head and Neck Cancer Service had been taken and patients referred on a cancer (two week wait) pathway would therefore be referred to other NHS Trusts, namely Northampton (NGH), Nottingham (NUH), Derby (RDH) and Coventry (UHC). Section 3 of paper C described, in detail, the actions implemented to mitigate the reduction in staffing levels, particularly with regard to the recovery and restoration of services, including the establishment of honorary contracts and Service Level Agreements (SLAs), the establishment of joint clinics, the appointment to, and advertisements of, vacant posts. Challenges in recruitment to the Maxillofacial Head and Neck post had been placed on the Trust's risk register at a score of 16, which would now need to be increased. The department had a harms review process in place for patients who had breached their 52 week target as a result of the pressures of the Covid-19 pandemic on the Trust, which had been presented at ESB on 1 June 2021 and had an associated risk score of 16. In discussion on this item, the Medical Director highlighted the good networking arrangements in place and also made reference to the national shortage of Head and Neck Consultants. He noted that management of the relevant issues would necessitate an on-going process and that, ultimately, dependent upon the success of the plans implemented, wider discussions regarding the services long term viability would potentially be required. Dr A Haynes, Advisor to the Trust Board, noted the need to work with Region to broker long-term support and he requested assurance around the process for harms reviews. In response, the MSS Clinical Director confirmed that 52 week harm reviews were being routinely undertaken and the Medical Director advised that the temporary suspension of the service was unlikely to cause harm as the process would involve directly transferring patients' care to the most appropriate Centre based upon their post code. The Medical Director further confirmed that the implementation of the Integrated Quality Assurance System within the Trust was facilitating the availability of real-time data. In concluding discussion on this item, Ms V Bailey, QOC Chair, thanked the MSS Clinical Director for all

of the work being undertaken by her and her team with regard to this service and the Committee noted the update provided. Specifically noted were the mitigations in place around the care of existing and future patients and, in particular, the ability of patients to continue to access follow-up care. QOC noted the need for discussions around the sustainability of this service over the next few months dependent upon continuing developments. Patient issues had been reviewed and individuals were being dealt with appropriately. The QOC Chair highlighted the potential need to review the governance around patient backlog issues and it was agreed that a further update on progress would be presented to QOC in six months' time (i.e. December 2021).

- **Thrombosis Committee Report**
  Dr D Barnes, Deputy Medical Director, attended to present paper D, which detailed an update from the VTE Prevention Task and Finish Group and built upon the outstanding actions highlighted in a previous report in January 2021 and the future Trust direction of VTE prevention and treatment strategy and governance. The report specifically highlighted the positive performance in 2019/20 and 2020/21 to date against the Quality Schedule for VTE prevention and the continued progress made on electronic reporting against the NICE VTE prevention Quality Standards, particularly with regard to appropriate prescribing of thromboprophylaxis in patients assessed as high risk. The e-meds pilot had proven successful and its use would continue to be actively promoted, since completion of a risk assessment on the Nerve Centre e-Meds module was not currently mandated. The VTE assessment process for long waiters in ED continued to be challenging; despite the fact that ED had appointed a doctor as a champion to oversee the process, there had been no significant improvement in assessment rates. A Trust risk register assessment was being completed based on data collected on the incidence of VTE in patients who were long waiters in ED versus non-long waiters. Data demonstrated there was a very low risk of VTE overall in either group with no significant increased risk for those patients waiting more than 12 hours for admission. The Deputy Medical Director referenced IT enabling requirements within Nerve Centre, which would help improve VTE RA compliance, as well as thromboprophylaxis and anticoagulation safety in line with current NICE guidelines and quality standards. The report documented the specific audit work undertaken and continued work in relation to VTE anticoagulation policies and guidelines with a view to rationalising the number and / or providing clear signposting to related documents. The report concluded that the Trust Thrombosis Committee work programme was advancing well and was in line with expectations. In response to this report, the Medical Director noted the significant progress made with regard to this work over the last 12-18 months, from which he took significant assurance. Dr Haynes, Advisor to the Trust Board, extended his congratulations for the significant amount of work undertaken and queried how UHL would benchmark on missed doses – in response to the query regarding benchmarking ability, the Deputy Medical Director noted the existence of various regional group and Committees, in which opinions and learning could be shared. It was also hoped that the large-scale audits would make a positive difference in this respect. Ms C West, CCG Representative, highlighted the issue of investigating how Independent Providers were performing on behalf of the Trust, which was acknowledged. In relation to the on-going policy work, the QOC Chair specifically highlighted that two of these guidelines (numbers 18 and 19 on appendix 9 of the report) continued to be RAG-rated 'red' after considerable time had elapsed, which she did not consider to be culturally acceptable and suggested the need for review of the Trust's internal processes in this respect. The contents of this report were received and noted and thanks were expressed to the teams involved for their work which had led to significant continued progress. It was agreed that a further progress report would be presented in 6 months' time (i.e. December 2021).

- **Cancer Performance Recovery**
  Ms S Leak, Director of Operational Improvement attended to present paper E, which noted that in April 2021, UHL had achieved four standards against the national targets, with the most significant challenges relating to 2 week wait capacity and 31 day surgery waits due to decreased theatre capacity. In response to a request from the QOC Chair to particularly focus her report in relation to patient harm, the Director of Operational Improvement advised that the quarterly harm review would be reported next month; however no physical harm had been reported for any patients as of the current time. Whilst the Trust was seeing the tail of the longest waiters decreasing, more patients were being booked. Each of the specialties had an action plan to support their recovery, the trajectory for which was outlined within the report. The CQC had undertaken a virtual visit with eight Trusts, including UHL, and the Trust had received very positive feedback in terms of its response to Covid-19 and cancer. The outcome of this visit would be published nationally and notable good practice would be shared. In discussion, note was made of the benefit in having the comparative data with the rest of the country, Specific note was made of the positive regional approach to benchmarking with a view to providing equity across the region, which would be of benefit to patients and further updates on this would be provided in future, as available. In conclusion, it was noted that this report provided on-going assurance with regard to cancer performance recovery. Whilst the Trust continued to be in a challenging position, with some specialties more challenged than others, realistic plans had been implemented. Specific note was also made in relation to the CQC review and an acknowledgement of good regional working.

- **CNST Evidence**
  Ms E Broughton, Head of Midwifery, attended to present paper F, which detailed the final submission of the NHS

Resolution (CNST) 10 Safety Standards for Maternity Services Year 3, including supporting evidence, as part of the Safer Maternity Care agenda; noting that the service was declaring itself compliant with all ten standards. The report documented maternity service performance against all ten standards and detailed any risks to the submission. It was a requirement that the evidence was thoroughly reviewed by the Trust Board, with a declaration then signed by the Chief Executive and uploaded to NHS Resolution by midday on 15 July 2021. The Chief Nurse noted that over the past three years (including this current year), the CNST evidence submission had been reviewed by the UHL Maternity Safety Board, Executive Quality Board and then the Quality Outcomes Committee in its role as sub-committee of the Trust Board. The Chief Nurse also confirmed that the documentary evidence had also been personally reviewed by herself and Ms Bailey, Non-Executive Director and QOC Chair. Noting that the full documentary evidence had been reviewed by the afore-mentioned groups including the Quality Outcomes Committee in its capacity as a Trust Board sub-committee, **appendix 1 to this report documented a shortened version for submission to the public Trust Board (with the full documentary evidence available to all Trust Board members) and was recommended to the Trust Board for approval at its meeting on 1 July 2021.** The Committee's thanks were expressed to the Head of Maternity Services, the Clinical Director of Women's and Children's Services and all other Women's and Children's Clinical Management Group staff involved in this work, which represented a significant undertaking. The Chief Nurse highlighted the need for agreement with the CCG of the most appropriate route for the flow of this information to the ICS to avoid receipt of multiple requests from multiple people and Ms West, CCG representative agreed that this would be helpful and would be taken forward accordingly outwith the meeting.

- **Ockenden Update**

  Ms E Broughton, Head of Midwifery, attended to present paper G, which provided an overview of the progress of submissions to address immediate and essential requirements of the Ockenden Report published in December 2020. The Trust submitted a response to NHSE/I in January 2021, as mandated; this was to be assessed regionally and nationally to bench mark the service against the Ockenden recommendations. UHL received a report back reflecting the outcome of the submission and where further work needed to be completed. The development of a national portal to submit the evidence of compliance with the actions was rolled out and opened to submissions from 18th May 2021. The expectation was that the portal would close in four to six weeks to enable the national team to review the evidence and issue further updates to Trusts. The service had offered a secondment with external funding for four months, for a Senior Project Officer to collate the evidence and make the first submissions and initiate the development of pathways where needed. This was a focused post established to assist in achieving full compliance by December 2021, when the second Ockenden report was published. The information detailed within the report provided assurance that some actions had already been embedded, others required a guideline or Standard Operating Procedure (SOP) to support the pathway and others were completely new, however were not causing any risk to the service currently and an action plan would be developed to achieve these in time. The risks to delivery comprised staffing requirements and outcome of the bid for funding to support achieving Birth rate plus (with note made that even if funding were available, a pool of midwives to employ may not be available given their scarcity), the enhancing Midwifery Leadership criteria and implementation of an external advocate and twice daily MDT ward meetings on delivery suite at the weekends. However one of the most significant challenges was requesting an external regional clinical specialist to review certain cases relating to Brain injury and/or fetal loss. There were concerns in terms of how this could be supported with time and financial remuneration and support had been requested from the Regional Team in terms of identifying a regional solution. The contents of this report were received and noted, including acknowledgment of the specific risks referenced above.

- **Draft Quality Accounts 2020-21**

  The Director of Quality Governance presented paper H, which detailed the draft Quality Account 2020-21; an annual report from providers of healthcare about the quality of service delivered. It was noted that the Quality Account would be further updated and submitted to the Trust Board at its meeting on 1 July 2021 for formal approval ***(paper H on the Trust Board agenda of 1 July 2021 refers).*** The Committee received and noted the contents of this document, specifically noting that the usual processes were in place for stakeholder review and validation. It was also acknowledged that, whilst comprehensive, the document produced was realistic in light of challenges which had arisen due to the Covid-19 pandemic.

- **Nursing and Safe Staffing and Workforce Report**

  The Chief Nurse presented paper I, which highlighted a number of key points in relation to nurse staffing, including the fact that Registered Nurse (RN) vacancies for March 2021 were 443 wte (an increase compared to 19/20; 11.5% vacancy rate against a 10% vacancy rate nationally). The Chief Nurse noted that whilst significant progress had been made in terms of recruitment this had been adversely affected by the cessation of overseas recruitment, which could now re-commence. Challenges had also been brought about due to the Covid-19 pandemic, with a delay in the provision of training for student nurses. Healthcare Assistants (HCA) vacancies for March 2021 were 226 (a reduction compared to quarter 3, with a 12.8% vacancy rate against a 10% vacancy rate nationally). This report was triangulated with information held by the Freedom to Speak Up Guardian and with information arising from patient feedback and there were no particular themes to report. Ms West, CCG representative noted that the

staffing challenges faced by UHL were also those faced by LPT and, as such, it would be useful to follow this up at ICS level. Note was also made that, following changes to the Committee structure and membership, discussions were to be held with regard to which information was submitted to which Committee (e.g. the staffing workforce report was relevant to both the People, Process and Performance Committee and to the Quality Outcomes Committee) and feedback on this issue would be provided in due course (estimated to be within 2-3 months' time). The contents of this report were received and noted.

- **Decontamination of Medical Devices and Cytoscopes**
  The Chief Nurse presented paper J, for information, and provided assurance to QOC that medical equipment across UHL was decontaminated within a validated process. The contents of this report were received and noted and specific discussion took place regarding the need for an identified process to facilitate consultation with the Decontamination Lead in terms of medical equipment brought into the Trust through the Reconfiguration Programme.

- **Patient Experience End of Year Update 2020-21**
  The Chief Nurse presented paper K, which highlighted quarter four 2020/21 activity and provided an overview of the work completed within this year and all concluding activity to ensure full delivery of the Patient Feedback Plan 2019-21, prior to a new strategy being formulated and agreed. Particular points of note highlighted during the presentation of the report included UHL having been awarded in 2020 'Acute Trust of the Year 2019' by the Patient Experience Network National Awards as a result of them having been so impressed by the standard of Award entries from UHL. During 2020/21, approximately 142,000 Friends and Family Test feedback forms had been received, with 135,000 positive responses, 3000 suggestions for improvement and 4000 that were neither negative nor positive. The new Patient Feedback Driving Excellence Priorities for 2021-23 had been developed following a period of extensive engagement with staff, community organisations, carers and members of the public and would provide the direction, structure and pace with regard to how the Trust collected and responded to feedback from patients, families and carers over the next few years within the Trust. Also highlighted was the improvement in the Maternity Department's FFT scores and the fact that SMS texting had now been introduced in ED. The QOC Chair noted that the information detailed in appendix 1 was very helpful in terms of the analysis of positive FFT score by clinic code by mode of delivery, noting that post pandemic, there would continue to be virtual appointments as well as face to face appointments. The Chief Nurse noted that this data had generated significant discussion at the Executive Quality Board and that the raw data was to be passed to the Head of Strategy and Planning who would build this into the out-patients work being undertaken. The QOC Chair requested that this information was shared across the system given its value to others in terms of lessons learned. Note was also made of related work being undertaken by Professor Dias. The QOC Chair noted the need to view such service developments through the eyes of patients, in terms of the boundaries of 'normal' and the uniformity of expectation. The contents of this report were received and noted, as was the useful information detailed regarding the on-going delivery of services in the future.

- **Support for Carers in Leicester's Hospitals 2013 to date**
  The Chief Nurse presented paper L, which illustrated the extensive work undertaken in the past and which continued to be undertaken focused upon promoting the needs of family members with a caring responsibility and carers within Leicester's Hospitals. It also provided detailed information about how the Trust had continued to collect feedback from families and carers during the pandemic and the plans to recommence activity to support families and carers with movement into the Trust recovery phase. The contents of this report were received and noted. The QOC Chair queried whether this report included young carers; whilst it did not include them specifically, the Trust would be participating in the ICS led work around carers and would highlight the issue of young carers within this forum.

- **Quality and Performance Report – Month 2**
  The Medical Director and Chief Nurse presented the Month 2 Quality and Performance report (paper M), the contents of which were received and noted. Specific note was made that this report was due to be received in its entirety at the Trust Board meeting due to be held on 1 July 2021 and note was made of work ongoing in relation to mortality and stroke TIA; with the latter discussed recently at EQB. The Chief Nurse highlighted the covid rates (probable and nosocomial), the positive FFT scores and that data relating to single sex accommodation was to feature again within the report once national reporting resumed. In discussion, it was agreed that the Chief Nurse and CCG Representative would discuss the management of falls further outwith the meeting, in terms of the ability to alert or flag, noting that the Quarterly Falls report contained more extensive data than that within the performance report. The QOC Chair noted that use of comparative data would be difficult in the near future given the likely skew of results caused by the pandemic year and subsequent backlog year.

- **Patient Safety Highlight Report**
  The Director of Quality Governance presented paper N, which detailed the latest patient safety data and she specifically highlighted the following information:- (1) the paper included on learning from claims which would form

helpful preparation for the Patient Safety Strategy. Key themes arising from this included consent to treatment, anti-coagulation and delay in the diagnosis of fractures (2) Serious Incidents, with two having occurred during May 2021. Note was made that SI figures were likely to increase in the future due to a change in reporting with HSIBs now reported as SIs, how falls were reported and also due to reporting requirements around nosocomial covid deaths and (3) complaints – there had been a decrease in the number of formal complaints and a decrease in the number of re-opened complaints. No new Ombudsman's cases had been opened and one such case had been closed. The Medical Director note that learning from claims data was tracked through the Adverse Events Group with information, which was quite historical in nature, sent to all of the Clinical Directors and CMG Safety Boards. Dr C Marshall, Deputy Medical Director, had been requested to undertake work on improving the current structure. The Medical Director also made note of the intention to introduce an electronic consent form in the future. The QOC Chair queried the possibility of undertaking a look back exercise, at an appropriate time interval, to determine whether any future increases in SI reporting were due to the criteria for reporting having changed. The Director of Quality Governance noted the robust process in place for investigating any discrepancies and undertook to undertake a look back exercise after a six-month interval. The contents of this report were received and noted.

- **Covid 19 Position and Updated Covid 19 Infection Prevention and Control Guidance**
  The Medical Director and Chief Nurse reported verbally and briefed the Committee on key issues in relation to the COVID-19 pandemic, highlighting the following matters in particular: (a) the number of Covid-19 patients being treated currently within the Trust which remained fairly static; (b) vaccination and testing update and (c) future planned work in relation to the identification of information required to form a Standard Operating Procedure or policy document within the organisation. The contents of this verbal report were noted.

- **Items for noting**
  The following reports were received and noted for information:-
  (1) Updated Action Plan relating to Dermatology Referrals (paper O) – with note made of the importance of continued progression against all indicators which were not yet RAG-rated as '5'
  (2) Quarterly Update re the ED Safety Checklist Audit Report (paper P)
  (3) Clinical Audit Quarterly Report (paper Q), and
  (4) EQB action notes from 11 May 2021 (paper R).

Public matters requiring Trust Board consideration and/or approval:

Recommendations for approval

- **CNST Evidence (please see attached report)**
- **Draft Quality Accounts 2020/21 (see separate report to Trust Board – paper H refers on the 1 July 2021 Trust Board agenda)**

Items highlighted to the Trust Board for information:

- **Maxillofacial Workforce Update;**
- **Cancer Recovery Performance, and**
- **The Ockenden Update**

Matters deferred or referred to other Committees: none.

Date of next QOC meeting:	Thursday 29 July 2021

Ms V Bailey – Non-Executive Director and QOC Chair

UHL Maternity service Year 3 CNST Submission

Author: Elaine Broughton Sponsor: Carolyn Fox

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	X
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)	28.06.21	Discussion
Executive Board	08.06.21	Discussion
Trust Board Committee	24.06.21	Discussion
Trust Board	01.07.21	Decision

Executive Summary

Context

This paper is to present to the Trust Board the final submission of the NHS Resolution (CNST) 10 Safety Standards for Maternity Services Year 3 as part of the Safer Maternity Care agenda. The CNST Standards are summarised in this paper having been presented at the Quality Outcomes committee for sign off and recommendation to Trust Board. The entire evidential requirement outlined by NHSR has been presented to both EQB and QOC. It is a requirement that Trust Board is assured the evidence is robust and a declaration is signed by the Chief Executive and then uploaded to NHS Resolution by midday on 15th July 2021. The evidence will also to be reviewed and approved by the Local Maternity and Neonatal System (LMNS). This is the final paper following the March 2021 update, once this submission is made a year 4 document will be published later in the year

Questions

1. How has UHL Maternity service performed against the 10 safety standards?
2. Are there any risks to the submission?

Conclusion

1. The Year 3 CNST safety standards have been revised three times during the Covid-19 pandemic and the actions were on hold from April 2020 to September 2020, this delayed some dates for evidence collection and reflected changes in National guidance due to the pandemic. The submission of evidence is based on the latest version of the standards published in March 2021. The evidence required is substantial, the CMG feel there is sufficient evidence to achieve the safety requirement in all of the 10 safety standards, however interpretation of some of the technical guidance could be ambiguous, in which case we have sought clarification from NHSR and supplied evidence to cover every aspect of interpretation.

2. There are standards that will be reviewed by NHSR from data submitted to a national tool, data submission referred to in Safety Standard 1, submission to the Perinatal Mortality Review tool (PMRT) and MBRRACE will be reviewed up to and including the submission date 15th July, therefore assurance in this document has been given to June 2021, likewise Safety Standard 8 which is the Training compliance standard, refers to the 'position' on 15th July. The evidence submitted is the position for May 2021; however compliance has improved month on month since training has resumed and the trajectory confirms compliance will be maintained throughout July 2021. Safety Standard 6, Saving babies lives, the CO monitoring compliance did not consistently achieve the required level of 80% of women having been tested at booking and 36 weeks and has not been reached in the quarterly report March-May 2021. But has reached compliance from the second week in June. However a query was submitted to NHSR for confirmation of this, and they have confirmed the compliance of asking women if they smoke at booking and 36 weeks will meet the standard , the evidence shows 100% compliance for this.

   Safety Standard 9 this is the Safety champion standard, this was identified as a risk to EQB, due to evidence required prior to the pandemic, although the gathering of evidence during the last week suggests the criteria has been met to have achieved compliance now. The expectation is that the numerous action plans, reports and audits have been approved and signed off at Trust Board; these are all included as evidence embedded within each safety action.

Input Sought

We would welcome the Trust Board's input regarding approval and assurance to the UHL Chief Executive to enable her to sign off the board reporting template for submission to NHSR by 15th July 2021. The maternity service have sought oversight and review of all the evidence by the Executive Quality Board and Quality Outcomes Committee to enable the Trust Board to be assured all the evidence meets the standard required for compliance.

Please note in particular NHSR certain reports and actions plans have been signed off by Trust Board
Safety Action 1-Quarterly Perinatal mortality reports
Safety Action 3-ATAIN action plan (Avoiding Term Admissions to Neonates), which includes monitoring the effects of COVID-19

Safety Action 4-Action plans working towards meeting the nationally recommended staffing ratios in Neonatal Nurse staffing, Neonatal Junior doctors and the anaesthetic standards
Safety Action 5-Midwifery staffing report and Action has to be signed off by board at least once in the past year
Safety Action 6-CO testing reaching 80% compliant at booking and 36 weeks, can now be compliant if women are ask if they smoke at booking and 36 weeks, UHL are 100% compliant with this criteria
Safety Action 9-Safety champion feedback to staff, for January 2020 and February 2020, evidence include of Chief Nurse (Maternity executive sponsor) feedback to staff. Safety feedback walkabout with local maternity champion and as Board level champion could not attend this session, Head of Midwifery stood in on her behalf, diary evidence and agenda.

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	Not applicable
Improved Cancer pathways	Not applicable
Streamlined emergency care	Not applicable
Better care pathways	Yes
Ward accreditation	Not applicable

2. Supporting priorities:

People strategy implementation	Not applicable
Investment in sustainable Estate and reconfiguration	Not applicable
e-Hospital	Not applicable
Embedded research, training and education	Not applicable
Embed innovation in recovery and renewal	Not applicable
Sustainable finances	Not applicable

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)?
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required
- How did the outcome of the EIA influence your Patient and Public Involvement ?
- If an EIA was not carried out, what was the rationale for this decision?

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	Select (X)	Risk Description:
Strategic: Does this link to a ***Principal Risk*** on the BAF?		
Organisational: Does this link to an		

Operational/Corporate Risk on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None	X	

5. Scheduled date for the **next paper** on this topic: TBC
6. Executive Summaries should not exceed **5 sides** My paper does comply

Appendix 1 Board reporting template

Maternity incentive scheme - Guidance

Trust Name	**University Hospitals of Leicester NHS Trust**
Trust Code	**T564**

This document must be used to complete your trust self-certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. **Your trust name will populate each tab. If the trust name box is coloured pink please**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.**

The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested.

There are multiple additional tabs within this document:

Tab A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed within the condition of the scheme with each maternity incentive scheme safety action. Note, 'N/A' (not applicable) is available only for set questions. The information which has been populated in this tab, will automatically populate onto tab D which is the board declaration form.

Tab B - action plan summary sheet - This will provide you information on your Trust's progress in completing the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet - This sheet will enable your Trust to insert action plan details for any safety actions not achieved.

Tab D - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution.

Upon completion of the following processes please add an electronic signature into the three allocated spaces within this document: one signature to declare compliance stated in the board declaration form with the safety actions and their sub-requirements, one signature to confirm that the maternity incentive scheme evidence have been discussed with commissioners and a third signature to declare that there are no external or internal reports covering either 2020/21 financial year or the previous financial year (2019/20) that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 15 July 2021.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **MIS@resolution.nhs.uk**
Technical guidance and frequently asked questions can be accessed here:
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

Submissions for the maternity incentive scheme must be received no later than 12 noon on **Thursday 15 July 2021** to MIS@resolution.nhs.uk
You are required to submit this document signed and dated. Please do not send evidence to NHS Resolution.

Safety action No. 1

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

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Were all perinatal deaths eligible notified to MBRRACE-UK from the 11 January 2021 onwards to MBRRACE-UK within 7 working days and the surveillance information where required completed within four months of each death?	Yes
2	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 20 December 2019 to 15 March 2021 been started before 15 July 2021?	Yes
3	Were 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 20 December 2019 to 15 March 2021 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 15 July 2021.	Yes
4	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents told that a review of their baby's death will take place? This includes any home births where care was provided by your Trust staff and the baby died.	Yes
5	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents' perspectives, questions and any concerns they have about their care and that of their baby sought? This includes any home births where care was provided by your Trust staff and the baby died.	Yes
6	If delays in completing reviews were anticipated, were parents advised of this and were they given a timetable for likely completion?	N/A
7	Have you submitted quarterly reports to the Trust Board from 1 October 2020 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
8	Were the quarterly reports discussed with the Trust maternity safety champion from 1 October 2020 onwards?	Yes

Safety action No. 2

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

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	NHS Digital will issue a monthly scorecard to data submitters (Trusts). Was this presented to your Trust Board?	Yes
2	Were your Trust compliant with all 13 criteria in either the December 2020 or the January 2021's submission?	Yes
3	Has the Trust Board confirmed to NHS Resolution that they have fully conformed with 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?	Yes

Safety action No. 3
Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Please note standard a), b) and c) of safety action 3 have now been removed.		
Standard D) Commissioner returns on request 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 Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.		
1	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 Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC. Is this in place?	Yes
Standard E) A review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) 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.		
2	Has a review of term admissions to the neonatal unit and to TC during the COVID period (Sunday 1 March 2020 – Monday 31 August 2020) been undertaken and completed by 26 February 2021 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	Yes
An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion.		
3	Do you have evidence of the following An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from ATAIN reviews. • Evidence of an action plan to address identified and modifiable factors for admission to transitional care. • Evidence that the action plan has been revised in the light of learning from term admissions during Covid-19. Where no changes have been made, the rationale should be clearly stated. • Evidence that the action plan has been shared and agreed with the neonatal, maternity safety champion and Board level champion.	• Yes
Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.		
4	Has the ATAIN action plan been revised in the light of learning from term admissions during Covid-19 and has it been shared and agreed with the neonatal, maternity and Board level champions, with progress on Covid-19 related requirements monitored monthly by the neonatal and board safety champions from January 2021?	Yes
5	Has the progress with the Covid-19 related requirements been shared and monitored monthly with the neonatal and maternity safety champion ?	Yes
6	Has the progress on Covid-19 related requirements been monitored monthly by theboard safety champions from January 2021?	Yes

Safety action No. 4

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

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Please note that the standards related to the obstetric workforce have been removed.		
1	**Anaesthetic medical workforce** Have your Trust Board minuted formally the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met?	Yes
2	If your Trust did not meet these standards, has an action plan been produced (ratified by the Board) stating how the Trust is working to meet the standards?	N/A
3	**Neonatal medical workforce** Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing?	No
4	If your Trust did not meet the standards outlined in requirement no.3, has an action plan been produced (signed off by the Board) stating how the Trust is working to meet the standards?	Yes
5	**Neonatal nursing workforce** Does the neonatal unit meet the service specification for neonatal nursing standards?	No
6	If your Trust did not meet the standards outlined in requirement no.5, has an action plan been produced (signed off by the Board) and shared with the RCN, stating how the Trust is working to meet the standards?	Yes

Safety action No. 5

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

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed?	Yes
2	Has your review included the percentage of specialist midwives employed and mitigation to cover any inconsistencies?	Yes
3	Has an action plan been completed to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent been completed, where deficits in staffing levels have been identified?	Yes
4	Do you have evidence that the Maternity Services detailed progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls?	Yes
5	Do you have 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 in the scheme reporting period? This must include mitigations to cover shortfalls.	Yes
6	If trust did not meet this standard, has an action plan been produced detailing how the maternity service intends to achieve 100% supernumerary status for the **labour ward coordinator** which has been signed off by the Trust Board, and includes a timeline for when this will be achieved?"	N/A
7	Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with **1:1 care in labour** in the scheme reporting period? This must include mitigations to cover shortfalls.	Yes
8	If trust did not meet this standard, has an action plan been produced detailing how the maternity service intends to achieve 100% compliance with **1:1 care in labour** has been signed off by the Trust Board, and includes a timeline for when this will be achieved?"	N/A
9	Do you have evidence that a review has been undertaken regarding COVID-19 and possible impact on staffing levels to include: - Was the staffing level affected by the changes to the organisation to deal with COVID? - How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves?	Yes
10	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board at least once every 12 months within the scheme reporting period?	Yes

Safety action No. 6

Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of Trust Board level consideration of how the Trust is complying with the Saving Babies' Lives Care Bundle Version 2 (SBLCBv2), published in April 2019?	Yes
2	Has each element of the SBLCBv2 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 the Clinical Network.	Yes
3	The quarterly care bundle survey must be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net. Have you completed and submitted this?	Yes
ELEMENT 1 - Reducing smoking in pregnancy		
Standard a) Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital. If CO monitoring remains paused 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.		
4	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
5	If the process metric scores are less than 95% for Element 1 **standard A**, has an action plan for achieving >95% been completed?	Yes
Standard b) Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.		
6	Has **standard b)** been successfully implemented (80% compliance or more)?	Yes

7	If the process metric scores are less than 95% for element 1 **standard b)**, has an action plan for achieving >95% been completed?	Yes
Standard c) Percentage of women where CO measurement at 36 weeks is recorded.		
8	Has **standard c)** been successfully implemented (80% compliance or more)?	Yes
9	If the process metric scores are less than 95% for element 1 **standard c)**, has an action plan for achieving >95% been completed?	Yes
ELEMENT 2 - Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction		
Standard a) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking.		
10	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
11	If the process metric scores are less than 95% for element 2 **standard a)**, has an action plan for achieving >95% been completed?	N/A
Do you have evidence that the Trust Board has specifically confirm that all the following 3 standards are in place within their organisation:		
12	1) women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards	Yes
13	2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation	Yes
14	3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation	Yes
15	If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board evidenced that they have followed the escalation guidance for the short term management of staff?	N/A
16	If the above is not the case, has your Trust Board described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice?	N/A
17	If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board confirmed that the Maternity Services are following the modified pathway for women with a BMI>35 kg/m2?	N/A

18	If Trusts have elected to follow Appendix G due to staff shortages related to the Covid-19 pandemic Trust Boards should evidence they have followed the escalation guidance for the short term management of staff (https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-Covid-19-information/). They should also specifically confirm that they are following the modified pathway for women with a BMI>35 kg/m2. If this is not the case, has your Trust Board described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice?	N/A
ELEMENT 3 Raising awareness of reduced fetal movement		
Standard a) Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy.		
19	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
20	If the process metric scores are less than 95% for element 3 **standard a)**, has an action plan for achieving >95% been completed?	N/A
Standard b) Percentage of women who attend with RFM who have a computerised CTG		
21	has **standard b)** been successfully implemented (80% compliance or more)?	Yes
22	If the process metric scores are less than 95% for element 3 **standard b)**, has an action plan for achieving >95% been completed?	N/A
ELEMENT 4 Effective fetal monitoring during labour		
Standard a) Percentage of staff who have received training on fetal monitoring in labour in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness.		
23	Has the Trust Board minuted in their meeting records a written commitment to facilitate local, in-person, fetal monitoring training when this is permitted?	Yes
24	If the process metric scores are less than 90% for Element 4 standard a), has the trust identify shorfall in reaching the 90% and commit to addressing those?	Yes
Standard b) Percentage of staff who have successfully completed mandatory annual competency assessment.		
25	Have training resources been made available to the multi-professional team members?	Yes

26	If the process metric scores are less than 90% for **Element 4 standard b)**, has the trust board identify shorfall in reaching the 90% and commit to addressing those when this is permitted?	N/A
ELEMENT 5 Reducing preterm births		
Standard a) Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth		
27	Has **standard a)** been audited? Completion of the audit for element 5 standards A should be used to confirm successful implementation.	Yes
28	If the process metric scores are less than 85% for Element 5 **standard a)**, has an action plan for achieving >85% been completed?	Yes
Standard b) Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.		
29	Has **standard b)** been audited? Completion of the audits for element 5 standards B should be used to confirm successful implementation.	Yes
30	If the process metric scores are less than 85% for Element 5 **standard b)**, has an action plan for achieving >85% been completed?	N/A
Standard c) Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).		
31	Has **standard c)** been audited? Completion of the audits for element 5 standards C should be used to confirm successful implementation.	Yes
32	If the process metric scores are less than 85% for Element 5 **standard c)**, has an action plan for achieving >85% been completed?	N/A
33	Do you have evidence that the Trust Board has specifically confirmed that: • 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 occurring more than seven days after completion of their first course of antenatal corticosteroids.	Yes

Safety action No. 7

Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have Terms of Reference for your Maternity Voices Partnership group meeting?	Yes
2	Are minutes of Maternity Voices Partnership meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback?	Yes
3	Do you have evidence of service developments resulting from coproduction with service users?	Yes
4	Do you have a 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?	Yes
5	Do you have evidence that the MVP is prioritising the voice of woman 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?	Yes

Safety action No. 8

Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
MULTI-PROFESSIONAL MATERNITY EMERGENCY TRAINING, including Covid-19 specific training, including maternal critical care training and mental health & safeguarding concerns training In the current year we have removed the threshold of 90% for this year. This applies to all safety action 8 requirements. We recommend that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible.		
Can you confirm that: Covid-19 specific e-learning training has been made available to the multi-professional team members listed below:		
1	Obstetric consultants	Yes
2	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
3	Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes
4	Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)	Yes
5	Obstetric anaesthetic consultants	Yes
6	All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota	Yes
7	Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)	Yes
8	Can you evidence that 90% of all staff groups in line 1-7 above have attended the the multi-professional training outlined in the technical guidance?	Yes
9	If the trust has identify any shortfall in reaching the 90% threshold described above in requirement no.8, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions when this is permitted?	N/A
NEONATAL RESUSCITATION TRAINING Can you evidence that the following staff groups involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since launch of MIS year three in December 2019:		
10	Neonatal Consultants or Paediatric consultants covering neonatal units	Yes
11	Neonatal junior doctors (who attend any deliveries)	Yes
12	Neonatal nurses (Band 5 and above)	Yes
13	Advanced Neonatal Nurse Practitioner (ANNP)	Yes
14	Midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) Maternity theatre midwives who also work outside of theatres	Yes
15	Can you evidence that 90% of all staff groups in line 10-14 above have attended the the neonatal resuscitation training as outlined in the technical guidance?	Yes
16	If the trust has identify any shortfall in reaching the 90% threshold described above in requirement no.15, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions once when this is permitted?	N/A

Safety action No. 9

Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a pathway been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions, share safety intelligence between each other, the Trust Board, the LMS and MatNeoSIP Patient Safety Networks?	Yes
2	Do you have evidence that the written pathway is in place, visible to staff and meeting the requirements detailed in part a) and b) of the action is in place by Friday 28 February 2020?	Yes
3	Do you have evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff?	Yes
4	Are Board level safety champions undertaking monthly feedback sessions for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to COVID-19 service changes and service user feedback?	Yes
5	Was a monthly feedback sessions for staff undertaken by the Board Level safety champions in January 2020 and February 2020?	Yes
6	Were feedback sessions for staff undertaken by the Board Level safety champions every other month from 30 November 2020 going forward?	Yes
7	Do you have a safety dashboard or equivalent, visible to both maternity and neonatal staff which reflects action and progress made on identified concerns raised by staff and service users? This must include concerns relating to the Covid-19 pandemic.	Yes
8	Is the progress with actioning named concerns from staff workarounds visible from no later than 31 December 2020?	Yes
9	Has the CoC action plan been agreed by 26/02/2021 and progress in meeting the revised CoC action plan is overseen by the Trust Board on a minimum of a quarterly basis commencing January 2021?	Yes
10	Has the Board level safety champion reviewed the 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? The revised action plan must describe 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.	Yes
11	Do you have evidence of Board level oversight and discussion of progress in meeting the revised continuity of carer action plan?	Yes
Together with their frontline safety champions, has the Board safety champion has reviewed local mortality and morbidity cases has been undertaken and an action plan, drawing on insights from the two named reports and the letter has been agreed		
12	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 lec to these outcomes by Monday 30 November 2020?	Yes
13	II) The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK.	Yes
14	III) The MBRRACE-UK SARS-COVID19 report	Yes
15	IV) The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups	Yes
16	Together with their frontline safety champions, has the Board safety champion considered the recommendations and requirements of II, III and IV on I by Monday 30 November 2020?	Yes
Do you have evidence that the Board Level Safety Champions actively supporting capacity (and capability), building for all staff to be actively involved in the following areas:		
17	• work with Patient Safety Networks, local maternity systems, clinical networks, commissioners and others on Covid-19 and non Covid-19 related challenges and safety concerns, ensuring learning and intelligence is actively shared across systems	Yes
18	• utilise SCORE safety culture survey results to inform the Trust quality improvement plan	Yes
19	Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event held in March 2020 by 30 June 2021	Yes

Safety action No. 10

Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all outstanding qualifying cases for 2019/2020 been reported to NHS Resolution EN scheme?	Yes
2	Have all qualifying cases for 2020/21 been reported to Healthcare Safety Investigation Branch (HSIB)?	Yes
3	For cases which have occurred from 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 EN scheme: and 2. there has been compliance with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	Yes
4	Have the Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team?	Yes

Section A : Maternity safety actions - University Hospitals of Leicester NHS Trus

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	8	0	0
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes	3	0	0
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes	6	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	4	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	8	0	0
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?	Yes	33	0	0
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes	5	0	0
8	Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 201	Yes	14	0	0
9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes	19	0	0
10	Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme? a) Reporting of all outstanding qualifying cases to NHS Resolution EN scheme for 2019/2020 b) Reporting of all qualifying cases to Healthcare Safety Investigation Branch (HSIB) for 20	Yes	4	0	0

Section B : Action plan details for University Hospitals of Leicester NHS Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		

Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off **Action plan agreed by head of midwifery/clinical director?**

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

How?	**Who?**	**When?**

Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action			
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner			
Lead executive director			
Amount requested from the incentive fund, if required	-		
Reason for not meeting action			
Rationale			
Benefits			
Risk assessment			

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off ☐ **Action plan agreed by head of midwifery/clinical director?** ☐

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required ☐

Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off ☐ **Action plan agreed by head of midwifery/clinical director?** ☐

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Board level safety champions to review local mortality and morbidity cases and agree action plan in line with 2 reports*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner			
Lead executive director			
Amount requested from the incentive fund, if required			
Reason for not meeting action			
Rationale			
Benefits			

Risk assessment	

	How?	Who?	When?
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	Who?	When?
Monitoring			

Maternity incentive scheme - Board declaration Form

Trust name	**University Hospitals of Leicester NHS Trust**
Trust code	**T564**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	-		
Total sum requested			-	

Sign-off process:

Electronic signature

For and on behalf of the board of University Hospitals of Leicester NHS Trust

Confirming that:
The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

Electronic signature

For and on behalf of the board of University Hospitals of Leicester NHS Trust

Confirming that:
The content of this form has been discussed with the commissioner(s) of the trust's maternity services

Electronic signature

For and on behalf of the board of University Hospitals of Leicester NHS Trust

Confirming that:
There are no reports covering either **this year (2020/21) or the previous financial year (2019/20)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.

Electronic signature	
For and on behalf of the board of	University Hospitals of Leicester NHS Trust

Confirming that:
If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance

Name:	
Position:	
Date:	