Leeds Teaching Hospital NHS Trust

Maternity Incentive Safety Scheme for Trust's Year 5

Appendix 2, Evidence Table of Compliance Position November 2023

Safety Action 1	**Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?**	
Requirement	**Evidence**	**RAG**
a) All eligible perinatal deaths should be notified to MBRRACEUK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.	• Database in place and available to review in governance files which contains all elements of this requirement and confirms 100% case notification to MBRRACE. • Perinatal mortality data reported to Trust board via the IQPR data slides.	
b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.	• Quarterly PMRT reports downloaded from the MBRRACE portal and submitted for review and discussion at CSU assurance meetings, corporate governance meetings and safety champions meetings. • Evidenced in papers and minutes from above meetings. National Perinatal Mortality Review Tool Interim Summary Report 09/11/2023 confirms that 100% of the eligible families were contacted as part of PMRT process and offered support and to provide their feedback and any questions. • An Information leaflet detailing this process is given to families whilst in hospital and documented in their notes.	

c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.	• The LTHT maternity service undertake fortnightly PMRT multidisciplinary meetings with reciprocated external peer review from Bradford Teaching Hospitals. with MDT attendance. This provides an opportunity for external scrutiny and prevention of internal bias when assessing and grading care. The meeting minutes and action tracker are stored in the Women's CSU G:\Drive. • The PMRT database and downloadable MBRRACE reports evidence that 100% of the 56 eligible perinatal death reviews had been started within 2 months of the death, with a minimum of 94% of all factual data added, meeting the MIS criteria. 100% of multi-disciplinary reviews have been completed to the draft report stage within four months of the death and published within six months, meeting the MIS criteria. • External peer review has been undertaken with colleagues from Leicester Neonatal Services.	
d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.	• Detailed PMRT section included in bimonthly QAC report. • All deaths are reported to Trust Board Bimonthly via IQPR process. Individual details of cases are not provided to the Trust Board due to the small numbers and GDPR as these reports are publicly available papers. However, the redacted details are included in the WQAG and QAC assurance paper. • Perinatal mortality is discussed in depth at safety champion meetings and any trends or statistically significant changes noted associated actions discussed. • Maternity services also produce quarterly and annual thematic review reports, which are received at Women's CSU Quality Assurance Group and the Local Maternity & Neonatal System (LMNS)	

Safety Action 2	**Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?** *This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.*	
Requirement	**Evidence**	**RAG**
1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023.	• The CNST Scorecard in the Maternity Services Monthly Statistics publication series evidence that LTHT met all required criteria. • All CQIMs have passed the associated data quality criteria for July 2023. The scorecard with the achieved metrics is available in the G:\Drive.	
2. July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	• See Comment for Safety Action 1 criteria 1 above	
3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: Midwifery Continuity of carer (MCoC) Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable. i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.	• See Comment for Safety Action 1 criteria 1 above	

ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Final data for July 2023 will be published in October 2023. If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information).		
4. Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.	• See Comment for Safety Action 1 criteria 1 above	
5. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.	• LTHT have 2 named people registered to submit data; Misbah Mahmood, Deputy CCMIO and Alison Trafford working in the informatics service. The registered submitters are detailed on the scorecard.	
Safety Action 3	**Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?**	
Requirement	**Evidence**	**RAG**
a) Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies	• There is a clear pathway evident in Guideline ID 2215 which has been collaboratively developed by nursing and medical teams. The pathway is embedded in practice.	

in transitional care.	• Admission criteria is detailed and in accordance with the British Association of Perinatal Medicine (BAPM) principles. • The collaboration of neonatal and midwifery care planning in transitional care is evidenced by documentation in each electronic health record (EHR) for each service user and neonate. • A benchmark of the Transitional care data aligned with the BAPM standards is collated on the monthly maternity dashboard. • Guideline 2215 has clear auditable standards to measure compliance. • The data is used to inform the quarterly transitional care audit presented to the Womens Quality Assurance Group. Themes and trends are identified, and responsive actions developed and monitored.	
b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director, or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.	• A multidisciplinary perinatal team meet weekly to review all term admissions to the neonatal unit. • As LTHT is a larger tertiary unit, there are many babies that have an expected admission for complex medical or surgical care. • Although the team screen all term neonatal admissions the focus is on the identification of unexpected admissions and cases reviewed to identify whether the admission as avoidable. • A proforma is completed by the multidisciplinary team for every case reviewed and opportunities for improvement shared in the monthly newsletter alongside celebration of good practice. • Copies of the proformas and newsletters are available in the CSU governance files. • The primary reason for admission has remained unchanged and is related to respiratory observation or treatment.	

	• An action plan has been developed and monitored and shared with WQAG, QAC, Leeds Perinatal Quality Surveillance Group and the Maternity, Neonatal, Board Level safety champions and Non-Executive Director. • Data for the key indicators are collated on the maternity dashboard and the data disaggregated to show avoidable and unavoidable admissions. • Atain is a standing item within the WQAG, QAC and perinatal surveillance reports.	
c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.	• LTHT services have a well-established transitional care service on both maternity/neonatal sites. • There is a clear pathway embedded into practice having been developed by neonatal medical and nursing staff. • Guideline ID 2215 relating to admission to the neonatal service provides clear criteria and guidance.	
Safety Action 4	**Can you demonstrate an effective system of clinical workforce planning to the required standard?**	
Requirement	**Evidence**	**RAG**
Obstetric medical workforce 1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual	• LTHT have not used short term locums for either consultant or junior doctor cover in the past year. If this was required, the Medical Deployment department are aware of the need to provide an RCOG Certificate of Eligibility of Locum (CEL).	

Review of Competency Progressions (ARCP) or c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums		
a2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.	• Evidence is available to support engagement of long-term locum guidance.	
a3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties, the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.	• There are currently 26 consultants undertaking obstetrics practice. 25 of these currently undertake out of hours work with a majority at 1:11 frequency and 4 at 1:22 • All job plans are designed to allow a non-working day after a night on call to facilitate compensatory rest. • There is resident consultant cover 0830-2200 weekdays and 0830-1730 at weekends. Outside of these times, Consultants are expected to attend in line with scenarios as detailed in the RCOG Roles and Responsibilities of a Consultant document • There are 20 full time ST3-7 (inc SST) and Trust Doctors and 12 LTFT ST3-5 contributing to the O&G rota. There are arrangements in place to ensure the RCOG entrustability requirements are met.	

a4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service *https://www.rcog.org.uk/en/careers/training/workplace-workforce-issues/roles/responsibilities-consultant-report/ when a consultant is required to attend in person.* Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further nonattendance	• The Bi-monthly Women's Assurance Report includes information on workforce any deficits and plans to recruit. • Workforce data for all members of the multidisciplinary team is collated and evidenced on the maternity dashboard. • The SOP for obstetric consultant attendance which is aligned with the RCOG guidance is available in the CSU governance files. • Incidences where consultant not in attendance is monitored via the maternity dashboard and triangulated with Datix and the maternity electronic record system. • There have been no incidents of consultant non-attendance reported in the reporting period. • Workforce data and consultant attendance is reported monthly to the LMNS. • Workforce is a standing agenda item on CSU Quality Assurance meetings and the Safety Champion meeting. The minutes of these meetings are available to view in the CSU governance files.	
Anaesthetic medical workforce A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. *(Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)*	• Resident anaesthetic registrars are available on both sites 24 hours per day and consultant on-call available at both sites, with a dedicated obstetric anaesthetist on-call available at St James Hospital. • The live link to the anaesthetic rota is available in the evidence folders and past rotas are provided as additional evidence.	

Neonatal medical workforce The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements have not been met in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).	• A business case has been developed and approved by the Trust Board to support phased recruitment of Neonatologists and Advanced Clinical Practitioners between 2023/24 and 2025/26. There are clear actions, timelines and funding which have been agreed by the executive team to realise the neonatal medical workforce ambition. A copy of the BC is available to view in the governance files.	
Neonatal nursing workforce The neonatal unit meets the BAPM neonatal nursing standards. If the requirements have not been met in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies. If the requirements had been met previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).	• Neonatal nurse staffing is reviewed biannually as part of the nursing establishment reviews. The meetings are attended by Directors of Nursing and the Deputy/Chief Nurse, the Head of Nursing and other relevant members of the leadership and Chief Nurse team. • The most recent review It identified a difference in national calculations and local recommendations. There is an ongoing action to benchmark against other Trusts and submit a business case for the relevant funding to support the uplift. • The outcomes of the review and any risks and adjustments that are recommended are then reviewed by the executive team to support establishment setting. • Actions from the meeting in October were to undertake a further review of the nursing establishment and how this	

	aligns with other organisations and the BAPM standards. • A copy of the phase 2 establishment review is available to view in the CSU governance files. • Nursing establishment calculators are also available as evidence.	
Safety Action 5	**Can you demonstrate an effective system of midwifery workforce planning to the required standard?**	
Requirement	**Evidence**	**RAG**
a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	• LTHT maternity services commissioned a Birthrate Plus midwifery staffing review in 2021. The final report and recommendations were received in November 2021 which recommended a clinical midwifery workforce of 363.36 WTE and 40.39 WTE Specialist, non-clinical and managerial staff. • A further Birthrate Plus review has been commissioned in 2023 to identify whether the current workforce modelling remains appropriate for the complexity of care and current service requirements. The review will also incorporate an assessment of the midwifery workforce required to fully embed the Birmingham Symptom Specific Obstetric Triage System (BSOTS) in the LTHT Maternity Assessment Centres. • Data collection will commence imminently with a final report anticipated early 2024.	
b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.	• This report was shared with the Trust Board and the clinical budgeted establishment reflected to align with the recommendations which is evidenced through the budget reports. There is a phased plan to increase the non-clinical, specialist and managerial workforce. • This is evidenced through the budgeted establishment reports.	

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.	• This is monitored through the BR+ acuity tool and Datix • The findings are collated on the maternity services dashboard. • Throughout the reporting period the coordinator has maintained supernumerary status 100% of the time. • This data is also reported to the LMNS monthly.	
d) All women in active labour receive one-to-one midwifery care.	• This is monitored via BR+ and Datix • The findings are collated on the dashboard • During the reporting period all women have received 1:1 care in labour 100% of the time	
e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.	• A midwifery staffing reporting is developed and reported to QAC bimonthly and to Trust Board biannually. These are available to review in the local governance files and committee and Board files.	
Safety Action 6	**Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?**	
Requirement	**Evidence**	**RAG**
1) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.	• Q2 evidence to support compliance with version 3 of the Saving Babies Lives care bundle has been uploaded to the national implementation tool on the futures platform. The evidence submitted has been reviewed by the LMNS and the ICB and a validation process undertaken. • The requirement is to achieve a minimum of 50% in each element and 70% across all elements. • The LTHT validated compliance is: • Element 1 Smoking in Pregnancy = 70% • Element 2 Fetal Growth Restriction = 95% • Element 3 Reduced Fetal Movements =50% • Element 4 Fetal Monitoring in Labour = 100% • Element 5 Preterm Birth = 91% • Element 6 Management of Diabetes = 100%	

	• All Elements = 91% • Evidence for each element is supplied in the MIS evidence file G:\Drive and can also be viewed on the futures platform in collaboration with a member of the team with access rights to the tool. • The Trust have completed their first and second submissions and have received their stretch targets from the LMNS ahead of the next submission.	
2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool.	• Progress towards increased compliance was reviewed at the Leeds Perinatal Quality Surveillance meeting with representation from the LMNS and ICB on 8th November 2023. A record of the discussions is available in the meeting minutes and evidence files. • A timeline is provided to evidence the quarterly reviews in the shared drive.	
Safety Action 7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	
Requirement	**Evidence**	**RAG**
1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023). Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.	• Funding is provided for 21 hours a week to support MNVP collaborative activities. A letter from Women Health Matters confirms the funding arrangements and is available in the evidence files. • LTHT maternity services work in collaboration with the Maternity and Neonatal Voices Partnership (MNVP) to ensure that the voices of service users are inextricably linked with reviews, service design and improvements. • Feedback from the MNVP is a standing item on the Perfect Ward meeting agenda. This provides a real time feedback mechanism following walk the patch to facilitate timely response to any feedback. • Collaboration, coproduction, and design are further evidenced by examples in the evidence submission files of items that have had MNVP involvement in their production.	

	• A ’15 Steps’ review was undertaken jointly on both hospital sites in 22/23, with action plans developed following these visits. The action plans are available in the evidence files.	
2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.	• The CQC picker maternity survey for 2023 report is currently embargoed and publication is anticipated in January 2024. Following publication, the findings will be triangulated with other data sources to inform a coproduced engagement and improvement plan for the maternity services.	
3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions. Evidence that MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support. • The MNVP’s work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it. • Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses. • Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.	• LTHT have a Health Equity team led by a Consultant Midwife who are working with the Chair of the MNVP to develop strategies to support inclusion. • Workstreams are targeted based on proportionate universalism, resourced, and delivered at a scale and intensity proportionate to the degree of need. • Membership of the MNVP is not currently representative of the local demographic. The team are working closely with the MNVP chair to build and maintain reciprocal relationships with communities to support and optimise feedback from those communities who are having poorer experiences or outcomes. • Following service user feedback, from bereaved families the maternity team have worked with the MNVP to develop a patient information leaflet to support the Rainbow clinic. A copy is available in the evidence files. • A Birth Choices Patient Information Leaflet has been developed with the MNVP and is available in the files. • A MNVP annual work plan has been developed and reviewed by the Trust and LMNS and is available within the evidence folder. • Women Health Matters confirmed via letter to CSU on 9 October 2023 that remuneration will be undertaken for financial year 23/24.	

		• Focused workstreams and improvement projects have been undertaken using a Health Equity Lens. This has included audits on reduced fetal movement and stillbirth reviews. Learning from these reviews has been shared using multimedia platforms. • Targeted focus groups have been undertaken to increase understanding of experiences and expectations of the maternity services. To date focused groups have been held with Romanian and black African women. Thematic analysis has been developed and shared through governance and safety champion forums.	
Safety Action 8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?		
Requirement		**Evidence**	**RAG**
1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.		• The local and national training needs analysis has been reviewed and revised and received through the governance forums and are available in the evidence files. • A three-year plan for the implementation of the core competency 2 framework has been developed using the resource pack to support implementation. This has been received and approved through WQAG and QAC.	
2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.		• The Plan has been reviewed and approved by the quadrumvirate and at QAC and LMNS Board.	
3. The plan is developed based on the "How to" Guide developed by NHS England.		• See comments above • Compliance has been achieved with all training elements defined in Safety action 8. Evidence is available in the Governance files. • An action plan has been developed to achieve 90% compliance for trainee obstetricians and anaesthetists within 12 weeks of the end of the training calendar.	

Safety Action 9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	
Requirement	**Evidence**	**RAG**
a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.	• LTHT holds bimonthly perinatal quality surveillance meetings which includes attendance by the PLACE based ICB leads and LMNS leads. The meeting is well attended and provides an opportunity for sharing current practice and providing additional scrutiny and challenge. Meeting notes are available in the evidence files. • An assurance paper is presented bimonthly to the Quality Assurance Committee and then to members of the Leeds Perinatal Quality Surveillance Group. Any areas for escalation are included within the Chairs report to the LTHT Trust Board and the ICB Quality Board respectively. The Associate Director, Maternity Transformation Programme, NHS West Yorkshire Integrated Care Board (ICB) also reports into the Regional Perinatal Quality Surveillance Group. • In addition, summary slides are collated and presented at the group detailing key headlines of quality indicators, learning and improvements. LTHT engages well with the WY&H LMNS and the Yorkshire & Humber Clinical Network to support shared learning. • Appointment of NED, CMO and chief nurse is submitted in the evidence file. • Areas of risk are highlighted in the Safety Champions bi-monthly meeting to ensure safety intelligence is shared from floor to board. • Quality and safety of the service is also reviewed through presentations at QSAG, the biannual Quality Framework review, risk committee and workforce reviews. • The CSU has robust governance structures that enable oversight of quality and safety of the service and escalation if indicated. Agendas and minutes of such are included in the evidence file.	

b) Evidence that discussions regarding safety intelligence: concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.	• A Claims Report and the Claims Scorecard published August 2023 was received at WQAG in November 23 • A review of all the claims broken down by year has been undertaken. • As part of the Trust Patient Safety Incident Response Plan (PSIRP) work the CSU have undertaken a review 'reading the signals'. This review, triangulating claims data alongside other data such as incidents, and complaints, will be used as part of the Trust review of the Patient Safety Incident Response Framework and development of the Trust Patient Safety Incident Response Plan 23/24. • The Claims Scorecard published September 2022 was reviewed at WQAG October 2022 and all sub-speciality meetings September, October, and November 2023, with a presentation from NHS Resolution. • The Trust began review of PSIRP in September 2023 and invited CSUs to an initial workshop on 15/11/23.	
c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures	• The Perinatal Quadrumvirate (Clinical Director, Head of Midwifery, General Manager and Neonatal Lead clinician) are currently undertaking the national Perinatal Culture and Leadership Programme (PCLP). The PCLP is designed to support leaders and teams to create and craft the conditions for a positive culture of safety and continuous improvement. The aim is to have a positive impact on the experiences of women, families and babies and enable a more collaborative, supportive workplace for leaders and wider teams through enabling psychologically safe working environments and developing compassionate leadership. • The service will be rolling out a SCORE culture survey in January 2024 with support from NHSE. This is an opportunity to gain insight into the team's safety culture.	

Safety Action 10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	
Requirement	**Evidence**	**RAG**
A) Reporting of all qualifying cases to HSIB/ MNSI from 6 December 2022 to 7 December 2023.	• The CSU maintain a database of all eligible cases which demonstrates 100% compliance with reporting all qualifying cases. There are daily processes in place to triangulate data from K2, Badgernet and Datix to ensure all cases are identified and reported. Where there is any uncertainty of whether the case meets criteria, a referral is made to enable MNSI to make an independent decision. 100% of all qualifying cases are referred to NHSR early notification scheme (ENS). • All HSIB (MNSI) cases are included within the IQPR slides submitted to Trust Board.	
B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until 7 December 2023.	• LTHT Trust Claims Department have confirmed via email that all eligible families are advised of Early Notification Scheme and NHS Resolution involved.	
C) For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that: i. The family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	• HSIB cases and Duty of Candour are reported within the Bi-monthly Women's Assurance Report, QAC report and Leeds Perinatal Quality Surveillance report. • A Database of Duty of Candour (DOC) letters is maintained, and compliance monitored via the Datix reporting system. Compliance is included in the bimonthly assurance report. All DOC Apology letters for cooled babies include a section around ENS and the website link, informing parents that should MNSI accept the investigation their case will be reported to ENS by LTHT.	