Incentivising Better Patient Safety

Providing insurance refunds to Victorian public hospitals for undertaking best practice training

vmia

2022-2023
Operating Manual

Building a stronger and safer Victoria

At VMIA, we're here to protect public services, including our public hospitals. A big part of this means helping you to manage your health service's risks, so that our community can lead healthier, safer and more rewarding lives.

It's this simple philosophy that drives the Incentivising Better Patient Safety (IBPS) program.

Putting women and babies first

The evidence is clear. When Birth Suite clinicians take part in best practice training, outcomes for women and babies improve.

The IBPS program aims to encourage health professionals to complete the training and education needed to improve the care of women and babies.

This approach can lead to greater satisfaction and experiences of care while also reducing liability claims. To ensure both, the program focuses on three key areas of education and training:

01 Multidisciplinary maternity emergency training,
02 Fetal surveillance and
03 Neonatal resuscitation.

Giving back for doing better

If you continue to train Birth Suite clinicians in these essential areas, we expect better outcomes for women, babies and your health service will improve.

If your hospital has trained more than 80% of Birth Suite clinicians in programs that meet the training criteria we've outlined in this manual, VMIA will refund part of the obstetric component of your medical indemnity (MI) premium.

For larger hospitals this refund will be 5% of your MI premium, while smaller health services will receive a minimum of $24,200.

If you can demonstrate that you've met the attestation criteria this financial year, you'll get a refund in October 2023.

The 2022-2023 program starts on 1 July 2022 and finishes on 31 August 2023. All public health services in Victoria at a maternity capability level 2 to 6 can participate.

Any questions?

Get in touch with your VMIA Risk Adviser: **contact@vmia.vic.gov.au**


Skilled staff
Better care
Improved outcomes for women and
Fewer claims

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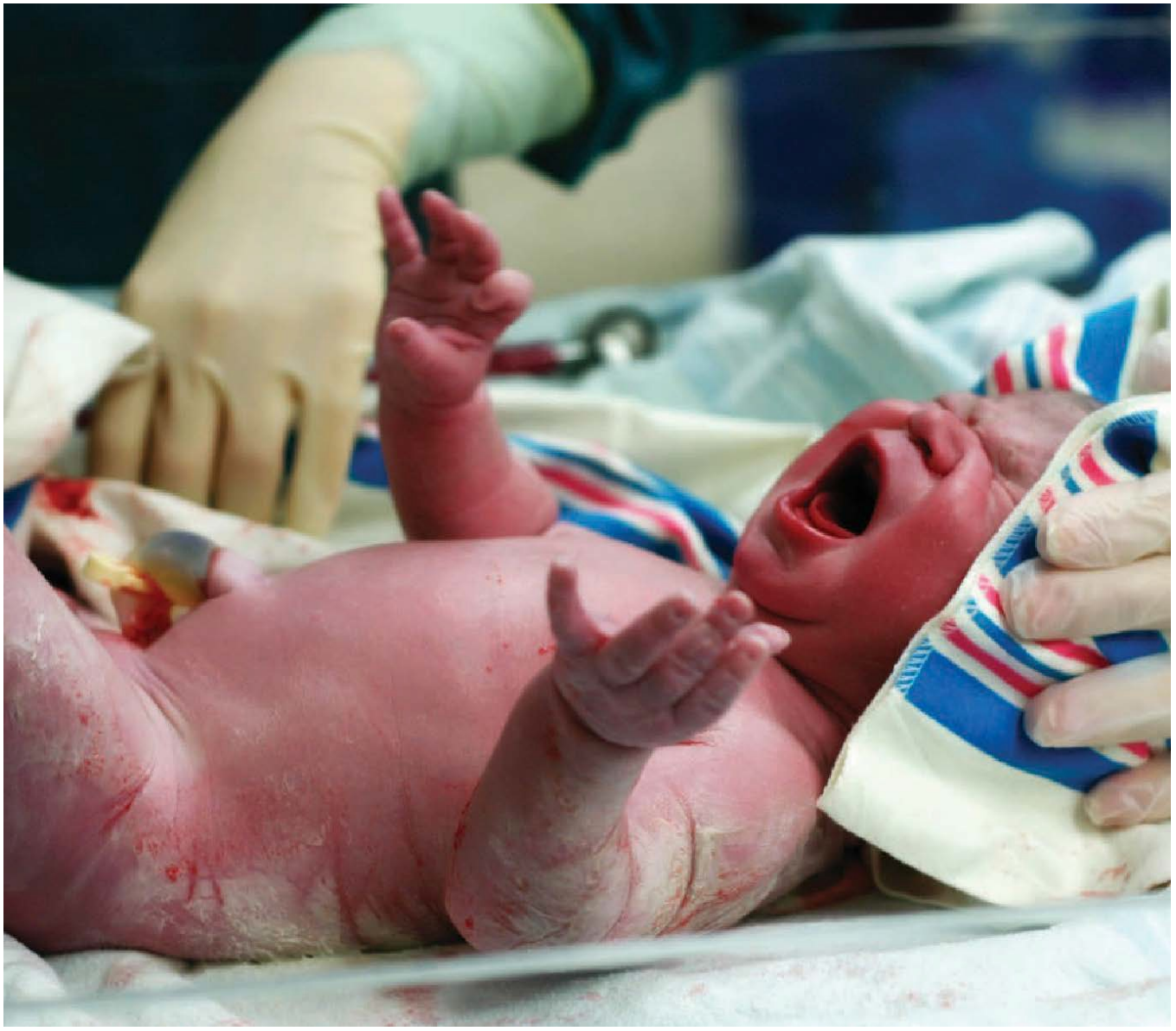


The 2022-2023 Eligibility Criteria

Eligibility criteria

General criteria

All public health services in Victoria (maternity capability level 2-6) are eligible to participate.

Training programs must be conducted in Australia or New Zealand and satisfy the training criteria requirements.

Clinical staff are AHPRA registered health care professionals who provide clinical services to women, babies and/or families in Birth Suite, whether or not they are employees of the eligible public health service.

For the purposes of the program, clinical staff* are defined as:

- Midwife
- Midwife in charge
- Junior medical staff **
- Obstetric registrar
- Obstetric fellow
- GP obstetrician
- Obstetric consultant

*clinical staff who left permanently your hospital and were not trained in the IBPS focus areas, clinical staff replacing a clinician who left permanently and were trained in the IBPS focus areas,

**Junior medical staff who: i) provide Birth Suite care for <13 weeks
ii) do not make independent medical decisions about Birth Suite patients
iii) and are fully supervised when practising in Birth Suite

are excluded from the total pool of clinical staff who should be trained for the purpose of this program.

Eligibility criteria

Focus area 1:

Multidisciplinary maternity emergency training

When emergencies in Birth Suite aren't managed in the right way, it can cause significant harm to women and babies. This can have an overwhelming impact on both families and the Birth Suite clinicians involved in their care.

Our claims data shows us where we can improve and avoid harm. These areas relate to:

- systems, communication and teamwork among clinicians, which lead to errors and delay in decision-making
- taking the right steps to deliver the baby within a safe period (after deterioration has been identified)

A smarter way of improving safety

We suggest that Birth Suite clinicians take part in multidisciplinary maternity emergency training which helps improve patient safety culture, teamwork communication and emergency management skills. For the best results, this training should be carried out in a real-time, simulated environment every year.

Training like this means that your Birth Suite clinicians get the current, evidence-based training they need to make the most impactful difference to the lives of their patients. It's been shown that multidisciplinary training programs (and other risk management activities) have reduced obstetric claims by 64% since 2003.

Giving back to get ahead

The better your clinicians work together, the bigger the benefits are for women and their babies. We suggest starting with the programs listed on Page 7.

You can organise this yourself, or through another provider. If you meet the 'attestation criteria' for each of the three focus areas, you'll get a premium refund.

Focus area: Multidisciplinary maternity emergency training

Training criteria

The training program chosen by the health service needs to meet all the following criteria.

The program must:

Be **multidisciplinary** – the training group must include staff from at least **two** of the following disciplines that provide care in Birth Suite:

Discipline 1:
- Registered midwife
- Midwife/nurse in charge
- Registered nurse

Discipline 2:
- Anaesthetist (registrar, fellow or consultant)
- GP anaesthetist
- ED consultant or registrar

Discipline 3:
Paediatrician (registrar, fellow or consultant)

Discipline 4:
- Junior medical officer*
- Obstetric registrar
- Obstetric fellow
- Obstetric consultant
- GP Obstetrician

*Junior medical officers who:

i) provide Birth Suite care for <13 weeks
ii) do not make independent medical decisions about Birth Suite patients and
iii) are fully supervised when practising in Birth Suite

are excluded from the total pool of clinical staff who should be trained for the purposes of this program.

Focus on improved communication and teamwork.

Provide a **theoretical learning opportunity**. Theoretical learning opportunities must include content on the **tools** (algorithms, documentation and hospital specific pro formas etc.) and **systems** (emergency boxes/trolleys, local and external emergency call systems etc.) to manage maternity emergencies in Birth Suite.

Simulate at least **two maternity emergency scenarios in two separate simulations**. These can be facilitated in your birth suites and should represent a clinical improvement priority for your hospital. Maternity emergency scenarios may be simulated in another hospital area where births may occur, in a training environment such as a **clinical simulation laboratory or in a video-simulation platform, whenever face-to-face training is not possible**.

Face-to-face scenarios must involve the use of high-fidelity mannequins and/or actors and may include:

- Shoulder dystocia
- Post-partum haemorrhage
- Maternal collapse
- Personal Protective Equipment Training and COVID-19 emergency
- Maternal cardiac arrest and advanced life support
- Cord prolapse
- Maternal sepsis
- Emergency transfer preparation and management of the deteriorating maternity patient
- Uterine inversion
- Vaginal breech birth
- Twin birth
- Perimortem birth and caesarean section
- Obstetric anaesthetic emergencies
- Pre-eclampsia and eclampsia

Provide a dedicated **feedback and debrief opportunity** at the completion of each simulated maternity emergency scenario and/or at the conclusion of the multidisciplinary maternity emergency training session.

Attestation criteria

Between 1 July 2022 and 31 August 2023, **80%** of **clinical staff** providing care in Birth Suite have completed a multidisciplinary maternity emergency training program that meets the training criteria.

Suggested training programs

- Practical Obstetric Multi-Professional Training (PROMPT)
- PROMPT e-learning
- Maternity Services Education Program (MSEP) CTEME program

Focus area 2:

Fetal surveillance

In Victorian Birth Suites, it's been shown that most events that lead to a baby developing hypoxic ischaemic encephalopathy (HIE) are avoidable.

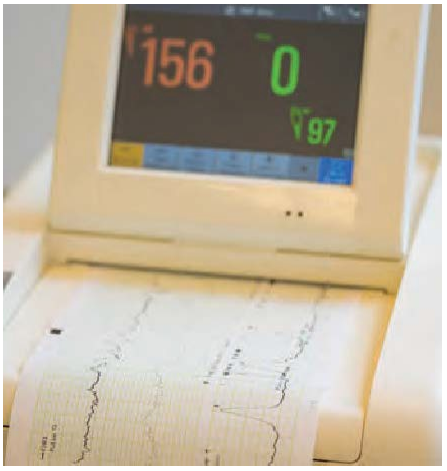
This is a crucial insight, as HIE – depending on how severe it is at birth – can lead to permanent disability, which can be devastating for parents, carers and families.

Our claims data shows us that the main cause of HIE is a failure to recognise fetal deterioration through correct use of fetal heart monitoring (cardiotocography [CTG] or intermittent auscultation) during labour and birth.

Fetal surveillance education and training tackles this head on. Since its introduction, death caused by intrapartum fetal hypoxia has reduced by 51%, which is a great testament to best practice training.

Giving back to get ahead

It's clear that training in this area makes a real impact, so we suggest training Birth Suite clinicians in the programs listed in the table below. You can organise this yourself, or through another provider. And if you meet the 'attestation criteria' for each of the three focus areas, you'll get a premium refund.



Focus area: Fetal surveillance

Training criteria

The training program chosen by the health service needs to meet all the following criteria.

The program must:

Be supported by evidence of the **program's efficacy** in providing high quality fetal monitoring, CTG interpretation and clinical management.

Be developed for the **Australian and New Zealand context**.

Be presented in the following formats:

1. **Every two years:**

   -**Face-to-face** with an assessment score >65

   Or, when face-to-face is unavailable:

   -**Minimum two hours of interactive CTG** interpretation and clinical management learning sessions (internal or RANZCOG webinars) led by a senior clinician who attained an assessment score >75 in the past 2 years

2. **Every other year : online education program.**

Attestation criteria

Between 1 July 2022 and 31 August 2023, 80% of clinical staff providing care in Birth Suite have:

- completed a fetal surveillance education and training program that meets the training criteria, and

Between 1 July 2022 and 31 August 2023, **80%** of **Birth Suite shifts** have had access to an onsite[1] senior clinician who:
- Attained the equivalent to a Practitioner Level 3 score of achievement after 1 July 2021.

Suggested training programs

Training programs your hospital may use include:

- RANZCOG Fetal Surveillance Education Program (face-to-face, **webinar** and Online)
- K2 Perinatal Training Program (online only)
- Internal CTG reviews
- Clinical management committees

[1] Maternity Capability Level 2 - 4 hospitals without senior clinicians onsite, may attest that shifts can access a senior clinician by using technology within the hospital's escalation policy timeframe, after identifying an abnormal CTG requiring escalation.

Focus area 3:

Neonatal resuscitation

Most babies in Victoria are born healthy and well. However, around 10% will need some help with those first few breaths, with around 1% needing extensive resuscitation.

Neonatal resuscitation can be a difficult experience to go through for both families and the Birth Suite clinicians involved. With the right level of skills and training, clinicians can better anticipate when resuscitation is needed and coordinate their efforts to deliver the highest quality, lifesaving care required. This gives babies the best chance of survival when they're born needing a little extra help to begin breathing, or there aren't any neonatal specialists on hand.

The program encourages Birth Suite clinicians across Victoria to train every year in best practice neonatal resuscitation, helping babies and their families get through one of the hardest – and most special - moments of their lives.

Giving back to get ahead

In the table below, you'll see the programs we suggest. You can organise this yourself, or through another provider. And if you meet the 'attestation criteria' for each of the three focus areas, you'll get a premium refund.

Focus area: Neonatal resuscitation

Training criteria

The training program chosen by the health service needs to meet all the following criteria.

The program must:

- Be **independent** from the multidisciplinary maternity emergency training (focus area 1) program
- Provide a **theoretical learning opportunity**. Theoretical learning opportunities must include content on current, evidence-based neonatal resuscitation theory as determined by the Australian Resuscitation Council (ANZCOR Neonatal Guidelines).
- Be facilitated by an **Australian Health Practitioner Regulation Agency (AHPRA)** registered healthcare provider
- **Either provide 'first response' practical education** using neonatal mannequins and resuscitaires that covers:
  - the initial steps of assessment of the newborn infant
  - determining if the infant requires assistance to establish and maintain effective breathing
  - assisting the infant to breathe using a variety of positive pressure ventilation devices
  - providing external chest compressions if effective positive pressure ventilation fails to restore an adequate heart rate and circulation.
- **Or individually assess** the practical competency of the skills described above

Attestation criteria

Between 1 July 2022 and 31 August 2023, **80%** of **clinical staff** providing neonatal care at birth have completed (at minimum), a first response neonatal resuscitation program(s) that meets the training criteria.

Suggested training programs

Training programs your hospital may use include:

- NeoResus first response (Paediatric Infant Perinatal Emergency Retrieval – PIPER)
- NeoResus advanced resuscitation (PIPER)
- Online NeoResus Learning package (PIPER)
- a local program developed by your health service

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Frequently Asked Questions

1

Eligibility

1.1 What is the Incentivising Better Patient Safety (IBPS) program?

Errors, failures and deficiencies in maternity care can endanger life and lead to substantial liability claims. To reduce harm and the factors that lead to adverse outcomes, VMIA has worked closely with the health sector to identify three main areas where patient safety in the maternity setting can be improved through evidence- based skills training and education:

- Multidisciplinary maternity emergency training
- Fetal surveillance,and
- Neonatal resuscitation.

These three areas were used to develop the IBPS program, which will improve safety, lead to better health outcomes and deliver financial benefits to eligible Victorian public health services.

The eligibility criteria contains:

- **Focus areas:**
  The three areas of maternity care in which VMIA is incentivising further education and training.
- **Training criteria:**
  The elements within education and training programs that must be included to be eligible for consideration within the attestation criteria. VMIA has suggested several education and training programs that meet the training criteria (not an exhaustive list), however, health services are able to choose their own, provided it meets the criteria.
- **Attestation criteria:**
  The percentage of clinical staff who must complete training according to the training criteria to receive a refund.

1.2 Is my health service eligible for the 2022-2023 IBPS program?

Victorian public health services that offer a planned birthing service (Maternity Capability Levels 2 to 6) are eligible to participate in the program.

1.3 Is the IBPS program valuable for my health service?

Improving patient safety is a priority for VMIA, which manages medical indemnity claims arising from adverse events. Many of these are avoidable.

VMIA's analysis of claims data shows clear evidence that where clinical staff providing care in Birth Suites undertake training in multidisciplinary maternity emergency management, fetal surveillance and neonatal resuscitation, the number and severity of adverse events are substantially reduced.

From 1 July 2022, if your health service provides education and training which meets the training and attestation criteria, a refund of 5% (minimum $24,200) on the obstetrics component of your medical indemnity premium will be paid.

1.4 Do all clinical staff who provide care in Birth Suites need to be trained in the three focus areas?

This depends on their role. The program is designed to ensure that most clinical staff providing care in Birth Suite complete training in all three focus areas. However, for the purposes of the attestation criteria, only clinicians defined as clinical staff need to be trained.

This is because certain specialty groups who provide Birth Suite care do not need to undertake training in all three focus areas, as one or more may not be relevant to their practice. For example, an anaesthetist or neonatal nurse may intermittently provide Birth Suite care, however, will not necessarily require training in fetal surveillance.

1.5 Which clinical staff need to attend education and training to meet the IBPS attestation criteria for a premium refund?

For some specialty groups, only certain focus areas will be relevant to their practice (see Q1.4).

To receive the insurance premium refund, only the following clinical staff – whether or not they are employees of the health service – who provide Birth Suite care will be required to complete education and training in the three focus area:

- Midwife
- Midwife in charge (NUM or ANUM)
- Junior medical officer*
- Obstetric registrar
- Obstetric fellow
- GP obstetrician
- Obstetric consultant.

*Please note that junior medical officers who provide Birth Suite care for <13 weeks, do not make independent medical decisions about Birth Suite patients and are fully supervised when practising in Birth Suite are excluded from the total pool of clinical staff who should be trained for the purposes of this program.

For focus area 1 (multidisciplinary maternity emergency training), a multidisciplinary workforce mix will be required for your training program to meet the training criteria. This means other specialist clinicians i.e. anaesthetists and paediatricians, may be required to attend education and training in this area of practice.

2

Health services and hospitals

2.1 My hospital is part of a broader health service. Am I eligible?

Yes. Although VMIA collects the total medical indemnity premium at the health service level, the obstetric component is calculated based on the services provided by the individual hospital. This means that all Victorian public hospitals who offer a planned birthing service (maternity capability Levels 2 – 6) are eligible whether or not they are part of a broader health service.

2.2 My health service incorporates individual hospitals. Can I aggregate my hospitals' results to be eligible for a refund?

No. Each hospital must individually meet the attestation criteria.

3

Clinical staff

3.1 I have a high number of casual and part-time clinical staff. Do they need to be trained?

Yes. Any clinical staff member from the list of specialities covered in Q1.5 will be counted towards the total pool of staff who may be trained. This includes casual, bank and part-time clinicians.

Casual and part-time clinical staff who have completed an education and training program at another Australian or New Zealand health service or training organisation that meets the training criteria will be counted towards the 80% of clinical staff required to meet the attestation.

3.2 I use agency midwifery staff to provide care in my Birth Suite. Do they need to be trained?

Yes. Any clinical staff member from the list of specialities covered in Q1.5 will be counted towards the total pool of staff who may be trained. This includes agency midwives if they provide care in your Birth Suite.

Agency midwives who have completed an education and training program at another Australian or New Zealand health service or training organisation that meets the training criteria will be counted towards the 80% of clinical staff required to meet the attestation criteria.

3.3 My Birth Suite is staffed by locum or visiting medical officers. Do they need to be trained?

Yes. Any clinical staff member from the list of specialities covered in Q1.5 will be counted towards the total pool of staff who may be trained. This includes locum or visiting medical officers if they provide care in your Birth Suite.

Locum or visiting medical officers who have completed an education and training program at another Australian or New Zealand health service or training organisation that meets the training criteria will be counted towards the 80% of clinical staff required to meet the attestation criteria.

3.4 Are obstetric residents, resident medical officers (RMOs) and hospital medical officers (HMOs) included in the total pool of staff who need to be trained?

For the purposes of the IBPS program, obstetric residents, RMOs and HMOs are all classified as junior medical officers. If your hospital has junior medical officers that meet the following criteria, they will not count towards the total pool of clinical staff working in your Birth Suite that are required to be trained for the purposes of this program. Any other junior medical officer will be captured in your total clinical staff workforce pool and should be trained.

The junior medical officer who:

i) provided Birth Suite care for <13 weeks;
ii) did not make independent medical decisions about Birth Suite patients and
iii) was fully supervised when practising in Birth Suite

will be excluded from the total pool of clinical staff who should be trained for the purposes of this program.

3.5 I have junior medical officers who will provide less than 13 weeks of care in my Birth Suite, but they will be making independent medical decisions about Birth Suite patients. Are they included in the total pool of staff who need to be trained?

Yes. If junior medical officers are making independent medical decisions about Birth Suite patients, they must be captured in your total clinical staff workforce pool and should be trained.

3.6 I have junior medical officers who provide less than 13 weeks (65 days) of care in my Birth Suite, but over an extended period of time across the 2022-2023 financial year. Are they included in the total pool of staff who need to be trained?

No. If junior medical officers work in your Birth Suite for less than 13 weeks (65 days) in total, they don't make independent medical decisions about Birth Suite patients and are fully supervised when practising in Birth Suite, they will be excluded from the total pool of clinical staff who should be trained for the purposes of this program.

3.7 My Birth Suite clinicians have attended training in the focus areas overseas. Do they need to retrain in Australia?

To be eligible for the refund, focus area 1 and focus area 3 training must have been completed in Australia or New Zealand and meet the training criteria.

For focus area 2, the RANZCOG Fetal Surveillance Education Program is offered across the Asia Pacific region and occasionally in Europe. Attendance at a RANZCOG Fetal Surveillance Education Program outside of Australia and New Zealand will be accepted.

3.8 My health service has clinicians who provide Birth Suite care on a very infrequent basis i.e. neonatal code blue teams, Urgent Care Centre (UCC) staff or endocrinologists providing high-risk patient reviews. Do these clinicians need to be trained?

No. Your health service may wish to include these clinicians in maternity education and training programs. However, they will not count towards your total pool of clinical staff required to meet the attestation criteria.

Only the defined group of clinical staff (Q1.5) is required to complete the training in the focus areas to receive a premium refund.

3.9 I have staff members who completed education and training externally (not at my health service) within the 2022-2023 financial year. Do they have to retrain at my health service?

The requirement to provide training at your health service varies depending on the focus area. If clinical staff have completed an education and training program externally, it's the responsibility of the health service to ensure they are satisfied the program meets the training criteria and that appropriate records are kept. Health services may be subject to audit – see Q7.1.

Focus area 1: Multidisciplinary maternity emergency training

Clinical staff who provide Birth Suite care during the 2022-2023 financial year must complete a multidisciplinary maternity emergency training program held within their principal hospital of practice.

Only clinical staff who provide Birth Suite care at more than one Australian or New Zealand health service in the 2022-2023 financial year, i.e. new starters, agency midwives or visiting medical officers, may complete a multidisciplinary maternity emergency training program at another health service, if it meets the training criteria.

Clinical staff who meet these requirements will count towards the 80% of Birth Suite staff eligible to meet the attestation criteria.

Focus area 2: Fetal surveillance

Clinical staff who attend a fetal surveillance education and training program that meets the training criteria at another health service or education provider (in Australia or New Zealand) within the 2022-2023 financial year, will count towards the 80% of clinical staff eligible to meet the attestation criteria.

Please note that the RANZCOG Fetal Surveillance Education Program is offered across the Asia Pacific region and occasionally in Europe. Attendance and achievement of an appropriate Practitioner Level at a RANZCOG Fetal Surveillance Education Program outside of Australia and New Zealand will be accepted.

Focus area 3: Neonatal resuscitation

Clinical staff who attend a neonatal resuscitation education and training program that meets the training criteria at another health service or education provider (in Australia or New Zealand) within the 2022-2023 financial year, will count towards the 80% of clinical Birth Suite staff eligible to meet the attestation criteria.

Only clinical staff who provide Birth Suite care at more than one Australian or New Zealand health service in the 2022-2023 financial year, i.e. new starters, casual/bank/agency midwives or visiting medical officers, may complete their practical competency assessment at another health service. Please ensure evidence of all practical competency assessments are maintained.

3.10 What about my clinical staff who provide maternity care in other areas of my hospital i.e. postnatal, antenatal and/or domiciliary services?

Clinical staff who exclusively provide care to patients outside of Birth Suite will not count towards the total workforce pool required to meet the attestation criteria.

3.11 Does it matter if the training my staff member received externally was at a private hospital?

Clinical staff who attended an education and training program that meets the training criteria at a private hospital in Australia or New Zealand will count towards the 80% of clinical staff eligible to meet the attestation criteria.

3.12 I held education and training in July and August of 2022. Will staff who trained then need to retrain in the 2022-2023 financial year?

Yes. Clinical staff who provide care in Birth Suite will need to be trained in the focus areas within the 2022-2023 financial year. The program is designed to provide an incentive to implement an annual program of education and training to keep Birth Suite clinicians' skills and knowledge current.

3.13 Are staff who no longer provide care in Birth Suite after 1 July 2022, required to be trained to be counted towards the 80% of clinical staff to meet the attestation criteria?

No. Staff who no longer provide care in Birth Suite after 1 July 2022 are not counted towards the 80% of clinical staff to meet the attestation criteria.

3.14 Are staff finishing their rotation in August 2023, required to train to be counted towards the 80% of clinical staff to meet the attestation criteria?

Yes, staff finishing their rotation in August 2023 are required to be trained to be counted towards the 80% of clinical staff to meet the attestation criteria.

3.15 Are staff starting their Birth Suite rotation in September 2023 required to train to be counted towards the 80% of clinical staff to meet the attestation criteria?

Staff starting their rotation in September 2023 must be counted in the number of clinicians required to be trained in the 2023-2024 financial year.

3.16 Are all Birth Suite staff required to train in Focus Area 3: Neonatal resuscitation?

You need to refer to your organisation's policy and guidelines. All staff required by your organisation to provide the first response neonatal resuscitation to a newborn at birth are required to train in Focus Area 3: Neonatal resuscitation.

4

Suggested training programs

4.1 I don't currently offer the programs listed under 'suggested training programs'. Can I still participate?

Yes. If you have a locally developed education and training program that meets the training criteria, you will be eligible for the 2022-2023 IBPS program.

For example, many health services in Victoria use online learning platforms to provide newborn resuscitation theory to their clinicians. These health services then train their staff in practical newborn resuscitation skills through internally developed programs. If these education and training programs meet the training criteria, you will be eligible to count attendees at these sessions towards your 80% clinical staff target.

VMIA is responsible for assessing each health service's compliance with the training and attestation criteria. Your VMIA Risk Adviser can help you if you're unsure whether your education and training program meets the training criteria. Get in touch with them early so you ensure you're in the best position to secure the 5% premium refund.

4.2 My health service uses the K2 Perinatal Training Program. Does this meet the training criteria?

The K2 Perinatal Training Program is an online learning platform. Completion of a K2 Perinatal Training Program assessment meets the online component of focus area 2 (fetal surveillance).

4.3 My health service wishes to use the CTEME program. Can my clinical staff participate in this program be counted towards the 80%?

Yes, staff attending the MSEP CTEME programs are trained in multidisciplinary maternity emergency training from the IBPS program perspective.

4.4 PROMPT sessions have both facilitators and participants. If a clinician facilitates a PROMPT day (but did not attend as a participant), do they count as having completed a multidisciplinary maternity emergency training session for the purposes of this program?

PROMPT facilitators who facilitate a PROMPT session will count as having completed a multidisciplinary maternity emergency training program for the purposes of this program.

PROMPT facilitators must stay for the full duration of the PROMPT session. PROMPT facilitators who attend components of a PROMPT session i.e. provide the theoretical learning opportunity but are unable to stay for skills and drill stations or simulated maternity emergency scenarios, will not count as having completed a multidisciplinary maternity emergency training program for the purposes of this program.

4.5 Multidisciplinary maternity emergency training programs, i.e. PROMPT, must be multidisciplinary for the purposes of this program. If a hospital only has a small number of medical staff in their community, can a facilitator who is a doctor (i.e. discipline 2, 3, or 4) make the training session multidisciplinary, even when all participants are midwives and nurses (i.e. discipline 1)?

Only Victorian public health services of maternity capability level 2 and level 3 may deem multidisciplinary maternity emergency training sessions as multidisciplinary if facilitators are from disciplines 2, 3, or 4 (medical staff) and the participant group is exclusively from discipline 1 (midwifery and nursing staff).

Multidisciplinary maternity emergency training session facilitators must stay for the full duration of the training session. Multidisciplinary maternity emergency training facilitators from disciplines 2, 3 or 4 who attend components of a training.

4.6 PROMPT sessions were delivered online, do they still count as multidisciplinary maternity emergency training?

The training program chosen by the health service must meet all the criteria listed on Page 7. If the content of the PROMPT sessions delivered online meets all the criteria listed, the training can count as multidisciplinary maternity emergency training.

4.7 Face-to-face FSEP sessions have both facilitators and participants. If a clinician facilitates a face-to-face FSEP session (but did not attend as a participant), do they count as having completed a fetal surveillance education and training program for the purposes of this program?

To achieve focus area 2, clinical staff must complete either a face-to-face or online fetal surveillance education and training program during the 2022-2023 financial year. Additionally, they must have attained the equivalent to a practitioner level 2 (or greater) score of achievement after 1 July 2021.

To attain a practitioner level, clinicians must complete and sit the assessment component of a face-to-face fetal surveillance education and training program. This means that clinical staff who facilitate FSEP will need to complete and sit the assessment component of an FSEP day that is not facilitated by themselves to attain a practitioner level for the purposes of this program.

4.8 Do clinical staff need to be trained in face-to-face and online fetal surveillance in the 2022-2023 financial year)?

No. Clinical staff must complete a face-to- face program at least every second year. This can be supplemented with an online program in addition to the two hours of interactive CTG learning every other year.

Please note that the RANZCOG Fetal Surveillance Education Program will only award a practitioner level through the face-to-face program.

4.9 Are staff required to attend a webinar if they attained a practitioner level 2 or 3 after 30 June 2021?

No. Staff who attended a face-to-face workshop and attained a level 2 or 3 practitioner, between 30 June 2021 and 1 July 2022, are not required to attend a webinar. Attendance of the webinar will be counted towards the 80% of clinical staff to meet the attestation criteria.

4.10 Are staff required to complete another online training this year if they completed a fetal surveillance online training between 1 July 2021 and 30 June 2022?

Staff who completed an online training between 1 July 2021 and 30 June 2022 are required to complete another online training plus a webinar or two hours minimum of interactive CTG interpretation and clinical management learning sessions (internal or FSEP webinars), or a face-to-face training, in the period of 1 July 2022 and 31 August 2023.

4.11 What are the two hours minimum of interactive CTG interpretation and clinical management learning sessions?

The interactive CTG interpretation and clinical management learning sessions could be a meeting where clinical cases with CTG are reviewed, for example a Morbidity and Mortality meeting. It could also be dedicated learning sessions on CTG interpretation and clinical management led by a senior clinician (like a Maternity Educator, an Assistant Unit Manager, a Unit Manager or an Obstetric Consultant/ Senior Registrar) with a level 3 practitioner gained in the past two years.

4.12 My Morbidity and Mortality meetings last for one hour. How can staff meet the two-hour minimum of interactive CTG interpretation and clinical management learning sessions?

Staff can attend two Morbidity and Mortality meetings that last for one hour each. They can also attend one My Morbidity and Mortality meeting plus one one-hour education session on CTG interpretation and clinical management led by a senior clinician (like a Maternity Educator, an Assistant Unit Manager, a Unit Manager or an Obstetric Consultant/ Senior Registrar) with a level 3 practitioner gained within the past two years. The required two hours are cumulative and do not need to happen in one single session.

4.13 Staff attended two My Morbidity and Mortality meetings lasting for one hour each. Are they required to attend a RANZCOG FSEP webinar?

No. Staff who have attended a minimum of two hours of interactive CTG interpretation and clinical management learning sessions by a senior clinician with a level 3 practitioner gained in the past three years are not required to attend RANZCOG FSEP webinar.

4.14 My health service has developed its in-house fetal surveillance training program. Does it meet the training criteria?

Yes, as long as the fetal surveillance training includes content on current, evidence-based RANZCOG guidelines. The face-to-face training must include an evaluated and independently scored assessment component, giving a practitioner level score. Independently scored means the assessments must be scored by a competent body independent from the hospital.

4.15 Is there any other meeting that's considered an interactive CTG interpretation and clinical management learning session?

Yes, any other meeting moderated by senior clinician (like a Maternity Educator, an Assistant Unit Manager, a Unit Manager or an Obstetric Consultant/Senior Registrar) with a level 3 practitioner gained in the past two years where CTG interpretation and clinical management are discussed with an opportunity to ask questions, is considered as an interactive CTG interpretation and clinical management learning session.

4.16 Do staff need to be individually assessed in neonatal resuscitation?

Staff who attended the 'first response' practical education using neonatal mannequins and resuscitaires are not required to be individually assessed.

4.17 Do staff need to attend the practical training of neonatal resuscitation?

Staff who can demonstrate all the 'first response' practical skills with neonatal mannequins and resuscitaires during an individual assessment are not required to attend the 'first response' practical education.

4.18 Where can I get information on the education and training programs?

We have suggested several education and training programs that meet the training criteria. These lists are not exhaustive.

Your VMIA Risk Adviser can provide you with more information on maternity education and training and support if needed.

5

Attestation

5.1 How do I attest that I have achieved the IBPS eligibility criteria for the 2022-2023 financial year?

Your CEO will complete an attestation form stating your hospital has achieved the IBPS program's attestation criteria. These forms will be released closer to the end of the 2022-2023 financial year. Hospitals that are part of a broader healthcare system will need their CEOs to complete more than one Attestation Form. Only hospitals that achieve all the attestation criteria will be refunded.

5.2 Does the period of attestation differ from the period of training?

No. This year, the period of attestation is the same as the period of the period of training : 1 July 2022 and 31 August 2023.

6

The refund

6.1 How much money will I receive?

If you achieve the attestation criteria in each of the three focus areas, you will receive a refund of 5% of the obstetrics component of your medical indemnity premium. For smaller health services who may not pay a large obstetrics premium, VMIA will issue a minimum refund of $24,200.

6.2 When will I receive the money?

VMIA will issue the refund payment in October each year.

6.3 As part of a broader health service, if I achieve compliance with the IBPS program, where does the refund go?

VMIA calculates the obstetric component of medical indemnity premium at the hospital level and collects the total medical indemnity premium at the health service level. This means all refunds will be paid at health service level.

It is up to the health service to determine how the refund is disbursed, and VMIA does not stipulate how it can be used.

We do, however, encourage health services' management teams to continue their focus on continuous improvement, staff training and education that will improve patient safety.

7

Audit

7.1 Will my indemnity premium be affected by this program?

No. The program will not impact your 2022-2023 premium. However, by implementing continuous improvement initiatives such as the IBPS program, there is significant potential to reduce claims (and therefore premiums) by preventing harm and improving care over the long term.

7.2 Will VMIA audit my health service?

VMIA always reserves the right to conduct retrospective audits on a portion of participating health services for attestation verification purposes. The health services to be audited will be chosen at random.

It is the responsibility of health services to ensure appropriate education and training records are kept, including assurance of external programs attended by your clinical staff. Your VMIA Risk Adviser can provide you with more information and support if needed.

8

Development of the Incentivising Better Patient Safety program

8.1 How was the attestation criteria developed?

The attestation criteria was created by VMIA in partnership with the Victorian maternity sector, following a review of our claims data and the factors that typically cause adverse events in the birthing suite.

Some of the key factors contributing to poor outcomes in maternity care are repeated failures in:

- recognising fetal deterioration through appropriate fetal heart rate monitoring (cardiotocography or 'CTG') during labour and birth
- systems, communication and teamwork among health professionals, leading to errors and delays in decision making
- appropriate escalation to deliver the baby within a safe period after deterioration is identified.

Evidence demonstrates that when the majority of Birth Suite clinicians are trained in programs that reduce the risk of these events, it leads to safer outcomes for women and babies.

We've consulted with a wide range of subject matter experts and representatives from metropolitan and rural maternity services, as well as the Department of Health and Human Services, Safer Care Victoria, consumers, government, peak bodies, professional colleges, unions, obstetricians and midwives to understand what the maternity sector needs.

8.2 Why is this program only available for maternity services? Are there plans to roll out this initiative beyond maternity services?

Following the roll-out of maternity education and training programs such as the PRactical Obstetric Multi-Professional Training (PROMPT) program in Victorian hospitals, medical indemnity claims have decreased by 64% since 2003.

VMIA will be evaluating the program and may extend it beyond the maternity sector and into other specialty areas if measurable health improvements and a reduction in claims are achieved.

9

Support

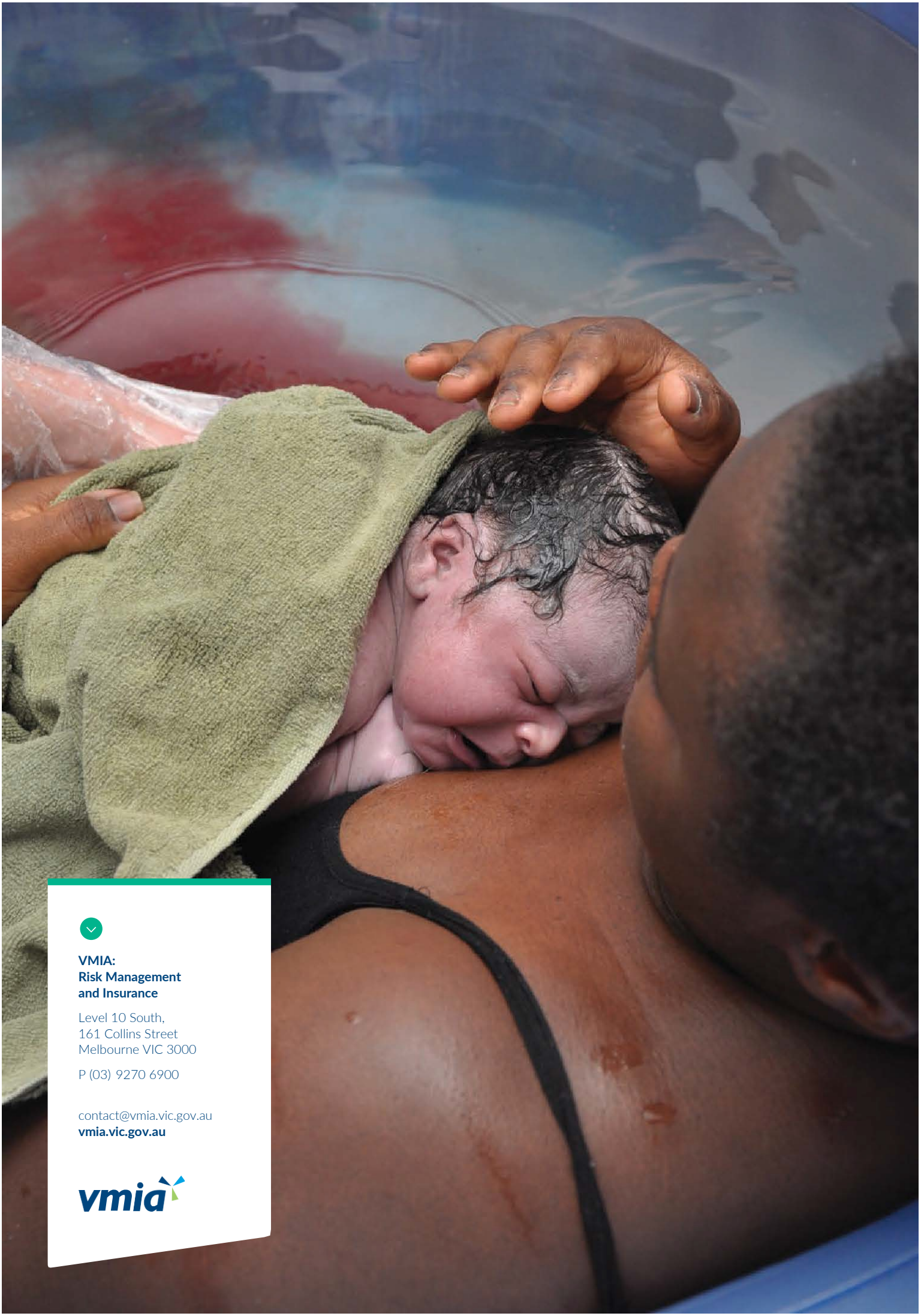
9.1 What support is available to help me?

VMIA wants to reward Victorian maternity services for improving safety and outcomes. Your VMIA Risk Adviser can offer tailored support to ensure you implement a program that meets the overarching training and attestation criteria. This may include co-developing systems and processes, action plans, meeting with your staff or talking to your Board of Management.

Appendix 1: Glossary of key terms

Term	Definition
Access	In person. Capability level 2 - 4 hospitals without senior clinicians onsite, may attest that shifts can access a senior clinician by using a technology within the hospital's escalation policy timeframe, after identifying an abnormal CTG requiring escalation.
Birth Suite shifts	The segments of time within a 24-hour cycle that Birth Suite is periodically staffed across. For example: – 0700 – 1530: AM shift – 1330 – 2200: PM shift – 2130 – 0730: Night shift
Care	Any form of clinical care or service provided within Birth Suite, whether or not the clinical staff member was rostered on for the shift.
Clinical staff	AHPRA registered health care professionals who provide clinical care or services to women, babies and/or families in Birth Suite, whether or not they are employees of the health service. For the purposes of the program, clinical staff are defined as: – Midwife – Midwife in charge (MUM or AMUM) – Junior medical officer* – Obstetric registrar – Obstetric fellow – GP obstetrician – Obstetric consultant *Junior medical officers who: i) provide Birth Suite care for <13 weeks ii) do not make independent medical decisions about Birth Suite patients and iii) are fully supervised when practising in Birth Suite are excluded from the total pool of clinical staff who should be trained for the purposes of this program.
Face-to-face	Training that is provided in person as opposed to an online-only or written format. VMIA does not prescribe what face-to-face training must offer.
High-fidelity mannequin	A mannequin with computer hardware technology that has the capacity to simulate a clinically deteriorating and recovering patient.
Intrapartum	During labour – the period from the onset of labour to the end of the third stage of labour.
Junior medical officer	A junior medical officer is an AHPRA registered medical practitioner that encompasses interns, obstetric residents, resident medical officers and hospital medical officers directly involved in Birth Suite care, whether or not they are employees of the health service i.e. on rotation, secondment or locum. Only junior medical officers who provide Birth Suite care for <13 weeks in total, do not make independent medical decisions about Birth Suite patients and are fully supervised when practising in Birth Suite are excluded from the total pool of clinical staff who should be trained for the purposes of this program.
Maternity capability level	The capability level defined by the Department of Health and Human Services (DHHS) capability framework for maternity and newborn services. Current capability levels are contained in the DHHS Policy and Funding Guidelines.

Term	Definition
Multidisciplinary	The combination of two or more clinical discipline groups in an approach to a topic or problem. Multidisciplinary participation should include at least two of the following disciplines: **Discipline 1:** – Registered midwife – Midwife/nurse in charge (MUM, NUM, AMUM or ANUM) – Registered nurse **Discipline 2:** – Anaesthetist registrar, fellow or consultant) – GP anaesthetist – ED consultant or registrar **Discipline 3:** – Paediatrician (registrar, fellow or consultant) **Discipline 4:** – Junior medical officer* – Obstetric registrar or – Obstetric fellow – Obstetric consultant – GP obstetrician *Junior medical officers who: i) provide Birth Suite care for <13 weeks ii) do not make independent medical decisions about Birth Suite patients and iii) are fully supervised when practising in Birth Suite are excluded from the total pool of clinical staff who should be trained for the purposes of this
Neonate	Newborn baby – from birth until 28 days of life. For the purposes of the Incentivising Better Patient Safety program, a neonate is defined as a newborn from birth until discharge from Birth Suite.
Onsite	The presence of a clinician on the health service premises where a birthing suite is located forthe duration of the shift.
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists.
RANZCOG practitioner level 2	An award or score, derived from a face-to-face RANZCOG fetal surveillance assessment,which reflects retention and application of information. To be awarded a RANZCOG practitioner level 2, clinicians must achieve a score between 66-75%.
RANZCOG practitioner level 3	An award or score, derived from a face-to-face RANZCOG fetal surveillance assessment,which reflects retention and application of information. To be awarded a RANZCOG practitioner level 3, clinicians must achieve a score of >75%.
Skills and drill stations	Practical training using mannequins and/or training pelvises that provide clinical staff with the opportunity to practise response and treatments to maternity emergencies. Using mannequins and/or training pelvises and drill stations may include: – Shoulder dystocia – Breech birth – Maternal cardiac arrest and advanced life support – Perimortem birth and caesarean section – Obstetric anaesthetic emergencies – Post-partum haemorrhage
Senior clinician	A senior member of a hospital's clinical staff group.
Training criteria (Focus area 1)	The criteria which a training program must meet in order to satisfy focus area 1: multidisciplinary maternity emergency training. The focus area 1 training criteria is contained within the IBPS Eligibility Criteria.
Training criteria (Focus area 2)	The criteria which a training program must meet in order to satisfy focus area 2: fetal surveillance. The focus area 2 training criteria is contained within the IBPS Eligibility Criteria.
Training criteria (Focus area 3)	The criteria which a training program must meet in order to satisfy focus area 3: neonatal resuscitation. The focus area 3 training criteria is contained within the IBPS Eligibility Criteria.
Theoretical	Academic education provided through non-practical means i.e. online learning packages, lecture content, reading modules etc.



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