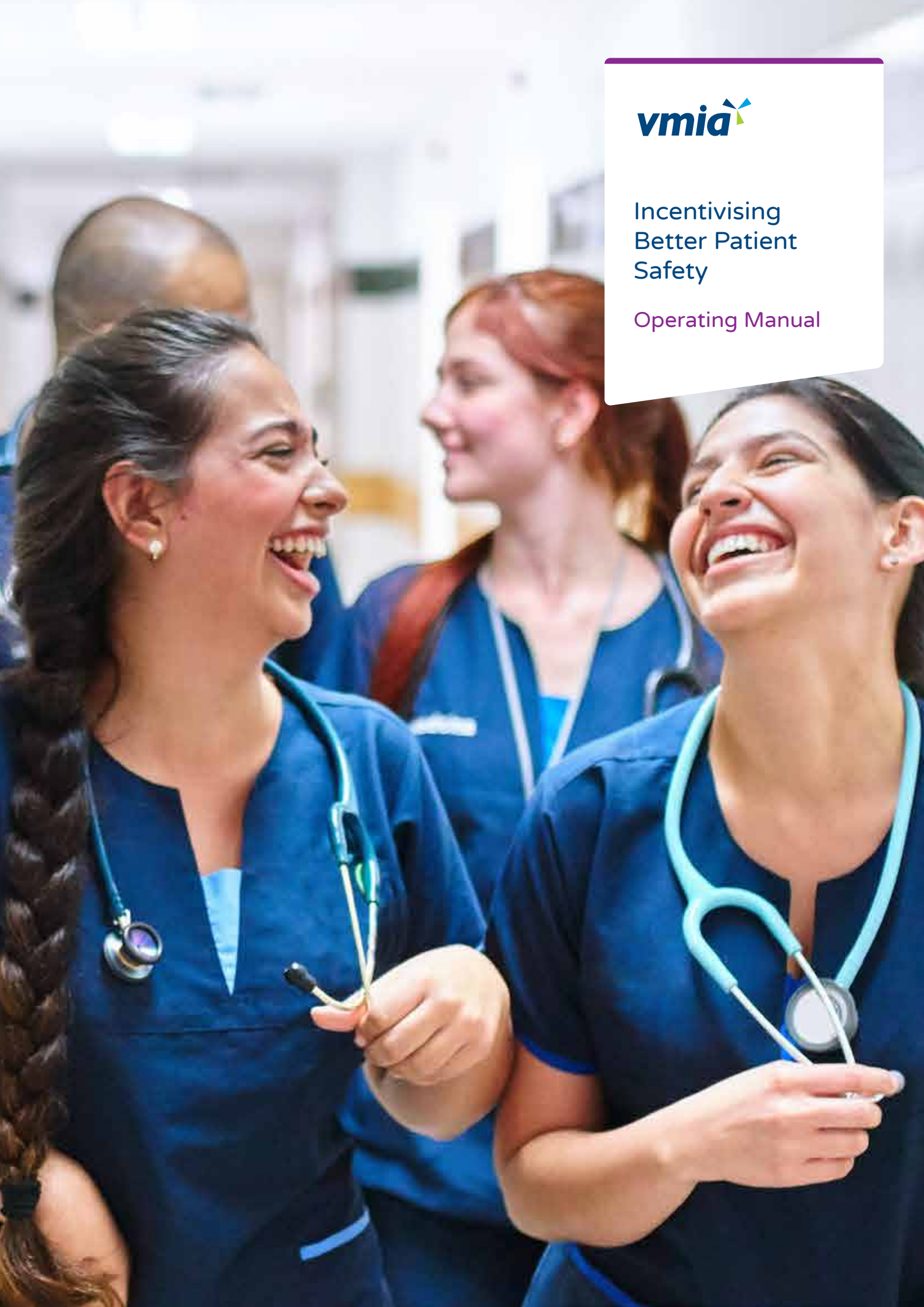


Incentivising Better Patient Safety

Operating Manual

Building a stronger and safer Victoria

At VMIA, we are 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 services to complete trainings needed to improve the care of women and babies.

This 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:

- multidisciplinary maternity emergency training
- fetal surveillance
- neonatal resuscitation.

Giving back for doing better

If your health service continues to train birth suite clinicians[1] in these essential areas, we can expect better outcomes for women and their babies.

When your health service has trained more than 80% of birth suite clinicians in the training criteria outlined in this manual, VMIA will refund part of the obstetrics 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 (including GST and stamp duty).

Attestation

If you can demonstrate that you have met the attestation criteria, you will get a refund in October each year.

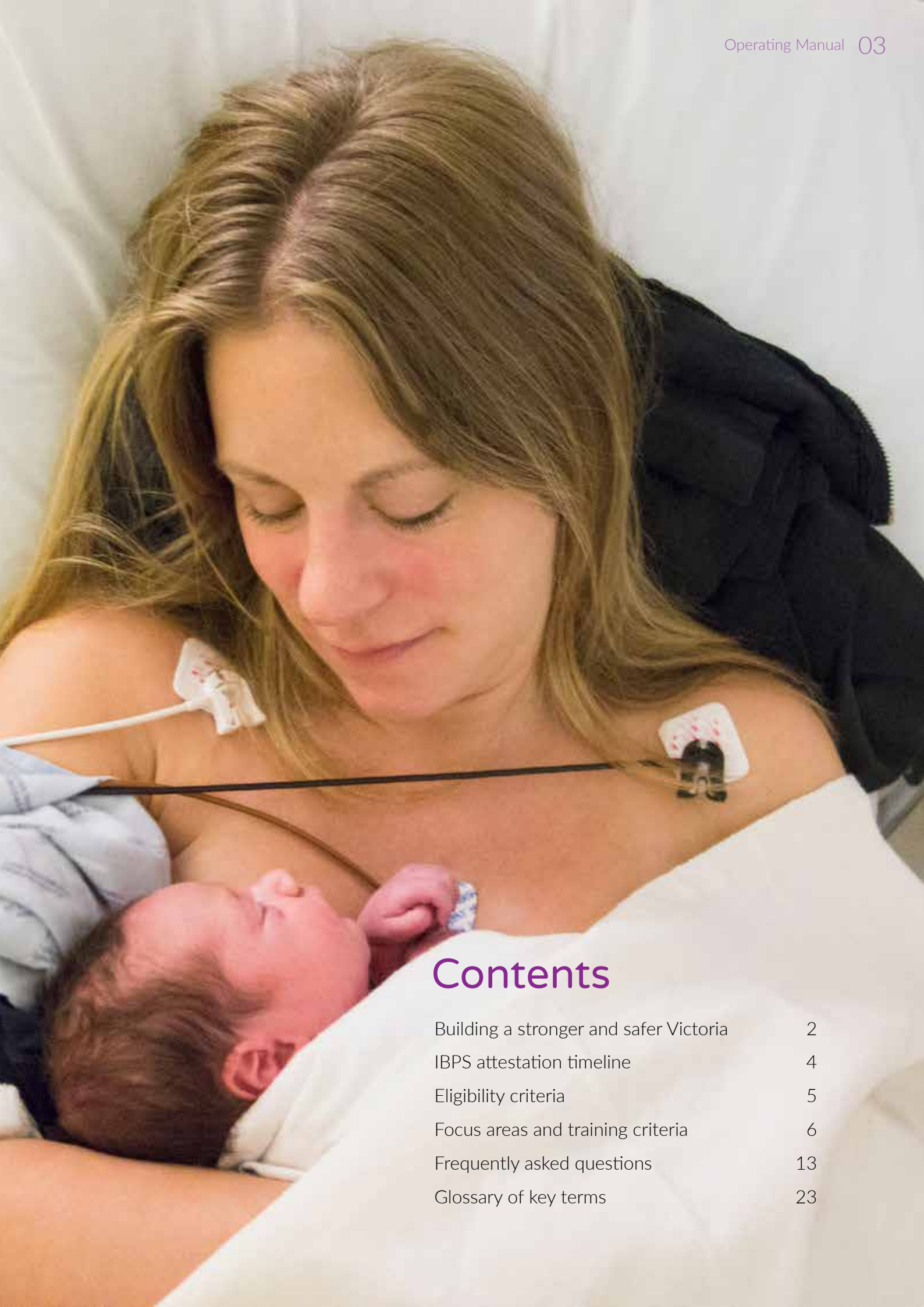
Each IBPS training year starts on 1 September and finishes on 31 August the following year. All public health services in Victoria with a maternity capability level 2-6 can participate.

Eligible health services have four weeks to submit their attestation form between 1 September and 30 September each year.

Any questions?

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

[1] *Please refer to page 5 for definition of birth suite clinicians.*



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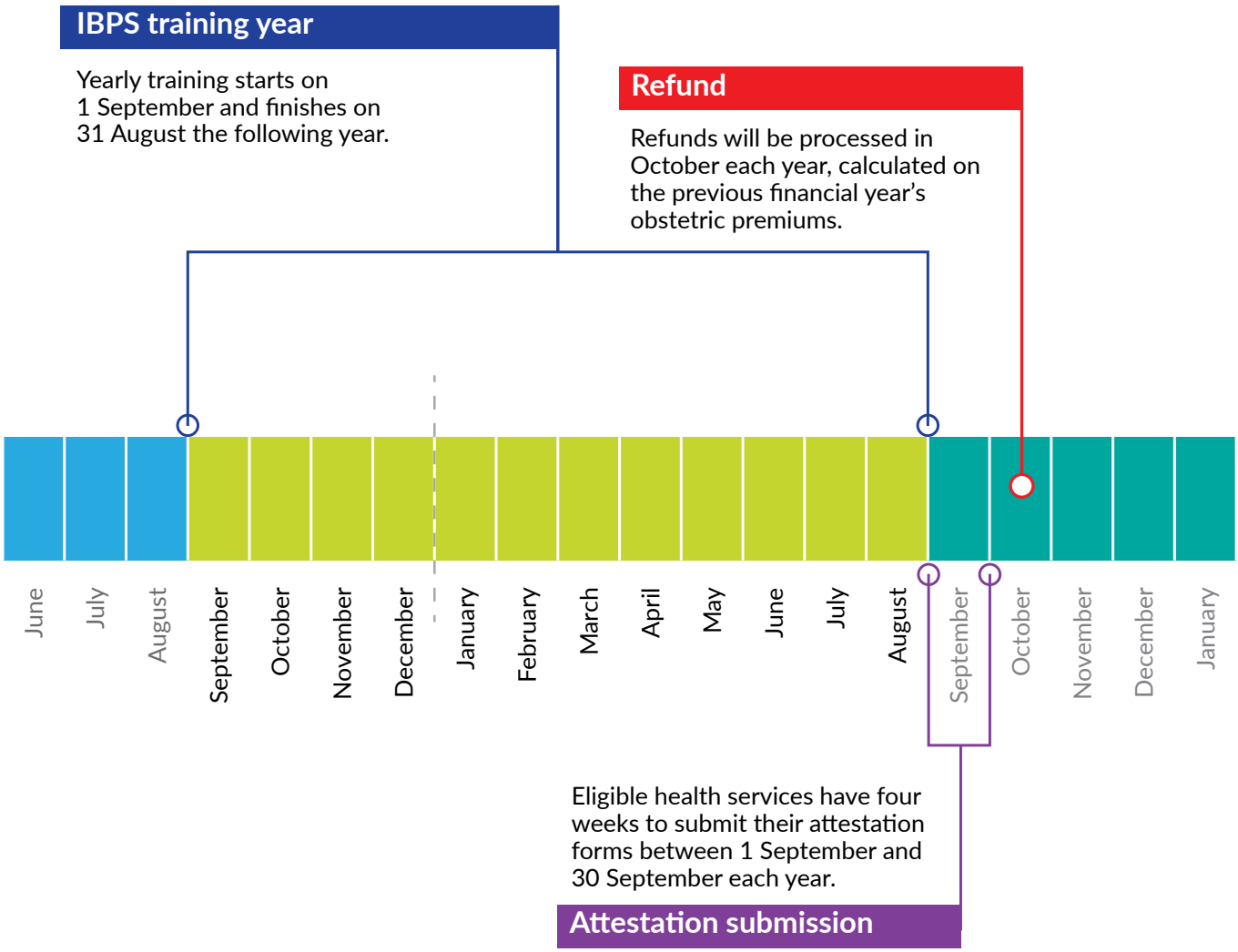
IBPS attestation timeline



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 **Australian Health Practitioner Regulation Agency (AHPRA)** registered health care professionals who provide clinical services to women, babies and/or families in birth suites of the eligible public health service.

For the purposes of this program, clinical staff or birth suite clinicians are defined as:

- midwife
- midwife in charge
- junior medical staff
- obstetric registrar
- obstetric fellow
- GP obstetrician
- obstetric consultant.

Exclusions

The following are excluded from the total pool of staff who should be trained for the purposes of this program:

- clinical staff who left your hospital permanently and were not 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. are fully supervised when practising in birth suites.

Focus areas and training criteria

Focus area 1:
Multidisciplinary maternity emergency training

When emergencies in birth suites 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 to avoid harm. These areas relate to:

- systems, communication and teamwork among health professionals, leading to error and delays 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** to help 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.

By taking such training, your birth suite clinicians can get the current, evidence-based training they need to make the most impactful difference to the lives of their patients. Multidisciplinary training programs, Fetal Surveillance Education Program (FSEP) 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 greater the benefits for women and their babies. Hospitals have the option to arrange in-house training or participate in external training programs that meet the attestation criteria.

Focus area 1:
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** disciplines[2] that provide care in birth suites.

Focused on improved communication and teamwork

- Be delivered within your hospital and underpinned by a focus on improved communication and teamwork.
- Provide a **theoretical learning session supported by scenario-based (drill) training**. 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 suites.
- Provide skills and drill stations[3] using mannequins and/or training pelvises.
- Simulate **at least two maternity emergency scenarios in two separate simulations[3]** that are a clinical improvement priority for your hospital. Scenarios must **involve the use of high-fidelity mannequins and/or actors**. These should be facilitated in your birth suite and represent a clinical improvement priority for your hospital. If a birth suite is unavailable, maternity emergency scenarios may be simulated in another hospital area where births may occur or a training environment such as a clinical simulation laboratory.
- Provide **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

During the current training year, 80% of clinical staff providing care in birth suites must complete **Multidisciplinary Maternity Emergency Training** that meets the training criteria.

2 See Appendix 1: Glossary of key terms – Multidisciplinary

3 See Appendix 1: Glossary of key terms – Skills and drill stations

Focus area 2: Fetal surveillance

In Victoria, most cases of baby Hypoxic Ischaemic Encephalopathies (HIE) that can lead to permanent disability are avoidable.

Our claims data show that the main cause of HIE is the failure to recognise fetal deterioration through the correct use of fetal health monitoring during labour and birth.

Fetal monitoring education tackles this head on. Since the Fetal Surveillance Education Program (FSEP) was introduced, death caused by intrapartum fetal hypoxia has reduced by 51%.

Giving back to get ahead

It is clear that training in this area makes a real impact, so we suggest training birth suite clinicians in these programs (see table next page). This can be organised by your health service or through a training provider.

Focus area 2: 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, cardiograph (CTG) interpretation and clinical management.
- **face-to-face** training that includes an assessment component, as follows:
  - > Score above 75% = practitioner level 3.
  - > Score between 66-75% = practitioner level 2.
- developed for the **Australian and New Zealand context.**

Attestation criteria

During the current training year, **80% of clinical staff** providing care in birth suites have:

- at least once every two years completed a face-to-face fetal surveillance education that meets the training criteria[4]
- attained the equivalent of a practitioner level 2 (or greater) score
- completed an online fetal surveillance education every other year, plus a minimum two hours of interactive CTG training **(see definition of frequently asked question 4.11).**

During the current training year, **80% of birth suite shifts** have had access to an onsite senior clinician[5] who attained the equivalent of a practitioner level 3 score of achievement within the past two training years.

4 Birth suite clinicians can opt to attend face-to-face CTG training every year if they are unable to attend the two hours of interactive CTG interpretation learning sessions or the online training.

5 Maternity capability level 2-4 hospitals without senior birth suite clinicians on site, 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 newborns in Victoria are born healthy and well. However, about 10% will need some assistance at birth to begin breathing, with approximately 1% requiring extensive resuscitation activity.

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. This gives babies the best chance of survival.

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

Giving back to get ahead

The programs that we suggest (see table next page) can be organised by your health service or through another provider.

Focus area 3:
Neonatal resuscitation

Training criteria

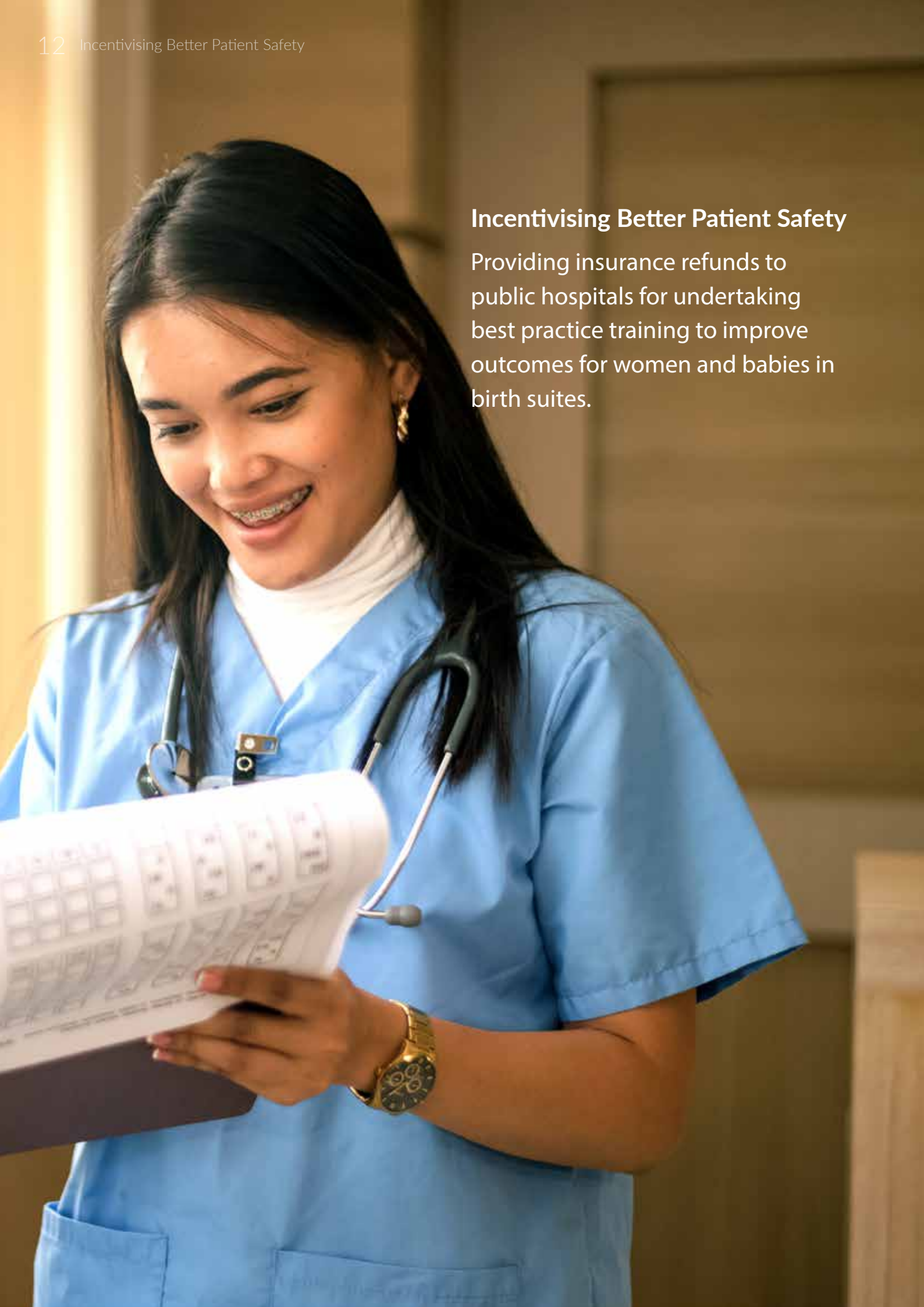
The training program chosen by the health service needs to meet all of the following criteria. The program must:

- be **independent** from the multidisciplinary maternity emergency training **(focus area 1: multidisciplinary maternity emergency training)** program
- provide a theoretic learning opportunity. The 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 hear rate and circulation.

  or, individually assess the practical competency of the skills described above.

Attestation criteria

During the current training year, **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.



Incentivising Better Patient Safety

Providing insurance refunds to public hospitals for undertaking best practice training to improve outcomes for women and babies in birth suites.

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. Working closely with the health sector, VMIA has identified 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
- neonatal resuscitation.

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

The eligibility criteria comprises three components:

- **Focus areas**
  The three areas of maternity care that 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 IBPS program?

Victorian public health services that offer a planned birthing service (maternity capability level 2-6) 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 as many medical indemnity claims arising from adverse events are avoidable.

VMIA's claims data shows clear evidence of a substantial decline in the number and severity of adverse events when clinical staff providing care in birth suites undertake training in multidisciplinary maternity emergency management, fetal surveillance and neonatal resuscitation.

From 1 September each year, if your health service provides education that meets the training and attestation criteria, you will get a refund of 5% (minimum $24,200 including GST and stamp duty for smaller hospitals) on the obstetrics component of your MI premium.

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 suites 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.

Frequently asked questions

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 clinical staff who provide birth suite care – whether or not they are employees of the health service – will be required to complete education and training in the three focus areas:

- midwife
- midwife in charge (NUM or ANUM)
- junior medical officer*
- obstetric registrar
- obstetric fellow
- GP obstetrician
- obstetric consultant.

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.

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

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 level 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 the results of my hospitals 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 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 program that meets the IBPS training criteria within 12 months of their shift in your birth suite 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 program that meets the IBPS training criteria within 12 months of their shift in your birth suite 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 who 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

iii. was fully supervised when practising in birth suites.

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.

Frequently asked questions

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 training 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, 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: multidisciplinary maternity emergency training** and **focus area 3: neonatal resuscitation** training must have been completed in Australia or New Zealand and meet the training criteria.

For **focus area 2: fetal surveillance**, 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?

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 (see 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 training 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 is 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 Q7.2).

Focus area 1: Multidisciplinary maternity emergency training

Clinical staff who provide birth suite care during the training 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 services in the training 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 training 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 training 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 training 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 the 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 previous year. Will staff who trained then need to retrain in the current training year?

Yes. Clinical staff who provide care in birth suites will need to be trained in the focus areas within the current training 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 suites after the current training year, 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 suites after the training year are not counted towards the 80% of clinical staff to meet the attestation criteria.

3.14 Are all birth suite staff required to train in focus area 3: neonatal resuscitation?

Only first responders for a neonatal resuscitation are required to train in focus area 3. You need to refer to your health service's policy and guidelines to determine your health service's neonatal resuscitation first responders.

Frequently asked questions

4. Suggested training programs

4.1 I don't currently offer the training programs suggested by VMIA. 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 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 can include 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 to 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 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?

PRactical Obstetric Multi-Professional Training (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.

4.4 Multidisciplinary maternity emergency training programs, such as 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 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.

4.5 Are PROMPT sessions delivered online counted as multidisciplinary maternity emergency training?

The training program chosen by the health service must meet all the criteria listed on page 7.

4.6 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: fetal surveillance**, clinical staff must complete a face-to-face session at least every second year and have attained the equivalent of a practitioner level 2 (or greater) score.

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

4.7 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.

4.8 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 Morbidity and Mortality meeting plus a 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. The birth suite clinicians also have the option to attend face-to-face CTG training annually instead.

4.9 Is there any other meeting that is considered an interactive CTG interpretation and clinical management learning session?

Yes, when a meeting is moderated 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, and where CTG interpretation and clinical management are discussed with an opportunity to ask questions.

4.10 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.

Frequently asked questions

4.11 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.

4.12 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 each of the training year?

Your CEO will complete an attestation form stating that your hospital has achieved the attestation criteria for the IBPS program. These forms will be released closer to the end of the training year. Hospitals that are part of a broader healthcare system will need their CEOs to complete more than one attestation form. Only hospitals that have achieved all the attestation criteria will be refunded.

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

No. The attestation period will always be between 1 September and 30 September each year.

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 (including GST and stamp duty).

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, where does the refund go if I achieve compliance with the IBPS program?

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 spent. 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 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?

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

It is the responsibility of your health service 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.

Frequently asked questions

8. Development of the IBPS 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 birth suites.

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.

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

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

Since 2003, medical indemnity claims have decreased by 64% following the rollout of maternity education and training programs such as the PROMPT program in Victorian hospitals. VMIA will be evaluating the program and may extend it beyond the maternity sector 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 for women and babies. 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

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Term	Definition
Access	In person. Capability level 2-4 hospitals without senior clinicians on site may attest that birth suite 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 a 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 a birth suite, whether or not the clinical staff member was rostered for the shift.
Clinical staff	AHPRA registered health care professionals who provide clinical care or services to women, babies and/or families in birth suites, 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. * *To be excluded from the total pool of clinical staff who should be trained for the purposes of this program, if all of the following conditions apply:* *i. provide birth suite care for <13 weeks* *ii. do not make independent medical decisions about birth suite patients* *iii. are fully supervised when practising in birth suites.*
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.

Term	Definition
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 suites, 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 (DH) capability framework for maternity and newborn services. Current capability levels are contained in the DH Policy and Funding Guidelines.
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:** • Anaesthetic (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. * *To be excluded from the total pool of clinical staff who should be trained for the purposes of this program, if all of the following conditions apply:* *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 suites.*

Glossary of key terms

Term	Definition
Neonate	Newborn baby – from birth until 28 days of life. For the purposes of the IBPS program, a neonate is defined as a newborn from birth until discharge from the birth suite.
Onsite	The presence of a clinician on the health service premises where a birth suite is located for the 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 • maternal cardiac arrest and advanced life support • obstetric anaesthetic emergencies • vaginal breech birth • perimortem birth and caesarean section • post-partum haemorrhage • maternal collapse • personal protective equipment training and COVID-19 emergency • cord collapse • maternal sepsis • emergency transfer preparation and management of the deteriorating maternity patient • uterine inversion • twin births • pre-eclampsia and eclampsia.
Senior clinician	A senior member of a hospital's clinical staff group.

Term	Definition
Training criteria (Focus area 1)	The criteria that a training program must meet in order to satisfy **focus area 1: multidisciplinary maternity emergency training**. The training criteria is contained within the IBPS eligibility criteria.
Training criteria (Focus area 2)	The criteria that a training program must meet in order to satisfy **focus area 2: fetal surveillance**. The training criteria is contained within the IBPS eligibility criteria.
Training criteria (Focus area 3)	The criteria that a training program must meet in order to satisfy **focus area 3: neonatal resuscitation**. The 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.

vmia

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Victorian Managed Insurance Authority (VMIA) acknowledges the Traditional Owners of the land on which we do business, and we pay our respects to Elders past, and present. We acknowledge the important contribution that Aboriginal and Torres Strait Islander peoples make in creating a thriving Victoria.

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