Maternity services assessment and assurance tool

NHSE have devised this **tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report** and provide assurance of effective implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams.

Rather than a tick box exercise, the tool provides a **structured process to enable providers to critically evaluate their current position** and identify further actions and any support requirements.

We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have assurance that the 10 safety actions and 7 IEAs are being met.

As part of the assessment process, **actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited.** This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report.

We would also like providers to **undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards** and take a **refreshed view of the actions set out in the Morecambe Bay report**.

We strongly **recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment** process and that **input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.**

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation.

We expect boards to robustly assess and challenge the assurances provided and would ask **providers to consider utilising their internal audit function to provide independent assurance** that the process of assessment and evidence provided is sufficiently rigorous.

If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

STANDARD

SASH Maternity services assessment and assurance tool

IEA REQUIREMENT 1 (ENHANCED SAFETY): **Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.**	**What do we have in place currently to meet all requirements of IEA 1?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**at resource or support do we ne**	**How will mitigate risk in the short term?**
Ockenden safety requirement Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	SaSH Maternity dashboard monitored via Divisional Governace and Board performance meetings LMS Dashboardincludes SaSH data and is reviewed at regional meetings alongside the other Trusts within the LMS The service works collaboratively with HSIB, NHS Resolutions, PMRT Serious incident reports shared with Trust Board which sits bi-monthly and currently sent to CCG scrutiny panel for comment and sign off. Currently share all maternity SIs when first declared at the subsequent board meeting and the full closure report when available.Public Board meetings are bi monthly and and private board meetings are held monthy as required.	The local maternity dashboard enables the service and Trust Board to monitor clinical performance and governance within the service, allowing early identification of patient safety issues to enable timely intervention and appropriate action to be taken. The LMS Dashboard enables the service to benchmark performance against those maternity units within the LMS identify best practice, share lessons learnt and support quality improvement working towards consistency in delivery of maternity care across the LMS SaSH maternity service requests external expert opinion on an ad hoc basis to aid SI investigations SI reports are shared with Trust Board and most importantly through a variety of processes to ensure staff in the clinical	Reduction in recurrence of adverse incidents Performance improvemnts Improvement in maternity survey responses Improvement in staff survey response	LMS dashboard to continue to be presented to Divisional Meetings LMS to advise on process for inclusion of external clinical specialist for mandated cases. SI reports to be sharedwith the LMS and Board..LMS to advise on how process for 3 monthly scrutiny will work what is required and how it will align to current Trust and CCG processes.	MC Director of Midwifery Feb 21	Clear processes / pathways for cohesive working and reporting through LMS . Time and admin support	Trust has robust clinical governance processes in place.
CNST Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Are you submitting data to the Maternity Services Dataset to the required standard? Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?	Yes the Trust uses the National Perinatal Mortality Review Tool to review perinatal deaths The Trust submits data to the Maternity Service Dataset but due to a recent techinal issue with the system provided compliance has not been 100%. Cerner has given assurance that this will be complaint prior to year end Yes the Trust has reported 100% of qualifying cases to HSIB and for 2019/20 100% of cases reported to NHS Resolution's	Perinatal mortality review informs service of any actions required to improve practice enables identification of themes / trends associated with pregnancy loss contributes to saving babies lives agenda. The service utilises data to inform and gain assurance regarding level of performance, safety .The service works in close collaboration with HSIB, has overarching HSIB action plan to ensure any safety recommendations received are actioned and completed. Monitored through Divisional and Trust Board	Reduction in stillbirth rate Data analysis demonstates high quality performance compliant with national targets Reduction in cases referred to HSIB which fulfill criteria of intrapartum stillbirth, early neonatal death, potential severe brain injury,maternal death	Process for inclusion / participation of external reviewer for perinatal reviews agreed but needs to be tested . Work ongoing with Cerner to resolve technical issues encountered when submitting / uploading maternity services Dataset to ensure full instead of partial compliance. Change of maternity information system to Badgernet estimated for April 2021 which resolve issue.	MC Director of Midwifery AS Head of Midwifery May 21	Clear process for access to and inclusion of external reviewer participation in PMRT reviews Implementation of Badgernet Maternity Information System Staff training strategy for implementation and use of new maternity information system	Robust referal and reporting mechanisms for PMRT, NHS Resolutions, HSIB in place
Link to urgent clinical priorities (a) A plan to implement the Perinatal Clinical Quality Surveillance Model (b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	quality Surveillance model guidance published December2020 requires multI agency involvement across the maternity systems - Provider, LMS, ICS, CCG (b) Serious incident reports shared with Trust Board which sits bi-monthly and currently sent to CCG scrutiny panel for comment and	Awaiting LMS input into external oversight	Improved oversight of Maternity Services	**On clarification of process SI's to be shared with LMS. Trust Board to monitor maternity safety by monthly review of minimum data measures**	MC Director of Midwifery MG Clinical Lead Consultant AA Lead Clinician Neonatal / Paediatrics March 21	Collaborate and cohesive working between all stakeholders Time resource	Trust has robust risk management and governance processes in place Works in collaboration with HSIB
IEA REQUIREMENT 2 (LISTENING TO WOMEN & FAMILIES): **Maternity services must ensure that women and their families are listened to with their voices heard.**	**What do we have in place currently to meet all requirements of IEA 2?**	**patient safety issues in advance so that timely and appropriate action can be instituted to ensure a womancentred,**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
Ockenden Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	Currently the Trust does not have an independant senior advocate role . Trust policy for Duty of Candour embedded into practice and all parents involved in incident investigations whether local or HSIB are provided with a named contact in the Trust to provide ongoing support and information and attend Being Open meetings NED appointed to the role of Maternity Safety Champion. Chief Nurse and Medical Director both Exec Leads	Initial contact and DOC process encourage parents' involvement in investigation processes. Issues of concern raised by parents included into investigation and reports and actioned appropriately	Monitoring of compliance with DOC Evidence of Being Open meetings Parent feedback	**The service does not currently have an independent advocate role -National team to advise how this role will be appointed / funded . A national JD currently being developed.**	MC Director of Midwifery June 21	Clear guidance on role specification for senior advocate Information regarding funding and recruitment of advocacy role	Adherence to DOC statutory requirements Maintain robust process for open and transparent communication with parents involved in incident investigations. Cotninue to implement local communication plan.

CNST Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	Yes service uses PMRT to review perinatal deaths MVP meetings bi-monthly Walking the patch, whose shoes proactive recruitment for representation from all groups who utilise service to allow diversity and inclusion of minority representatives. User representation involved in QI projects in response to feedback from and to women. Feedback also gathered via FFT, national survey, focus groups, live insta events,complaints and call for concerns. Trust has in place a pro active MVP group. Recently appointed new MVP chair MVP chairs report to Trust and LMS Yes the Maternity safety champions meet monthly with the Board level champions.	PMRT reviews inform learning and change .MVP meetings bi-monthly MVP members undertake 'Walking the patch', and provide realtime feedback from women utising the service that initiates immediate response from maternity team. Significant user involvement in 'Whose Shoes' exercise to resolve concerns raised related to conduct and attitude Proactive recruitment for representation from all groups who utilise service to allow diversity and inclusion of minority representatives. User representation involved in QI projects in response to feedback from and to women. Feedback also gathered via FFT, national survey, focus groups, live insta events,complaints and call for concerns, social media and access to virtual midwife. Birth Reflections service which inform reponse and appropriate action. Monthly safety champion meetings enable escalation of concerns/challenges and inform/direct support for appropriate action to ensure safety	Impact of PMRT reviews and subsequent actions - reduction in perinatal deaths Improvement in maternity patient survey results Reduction in complaints Increase in positive feedback Triangulation of all feedback received to demonstrate that changes made / quality improvement projects had positive impact.	Test agreed process with LMS for external reviewer participation in PMRT reviews.	AS Head of Midwifery June 21	Cohesive working between Trusts/LMS	Trust currently utilises PMRT for all perinatal deaths that meet criteria Robust process for effective communication/escalation between service and Board safety champions. The Trust has robust mechanisms for resourcing user feedback and involvement that informs improvement and supports the develepment of high quality women centred care.
Link to urgent clinical priorities (a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. (b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.	MVP meetings bi-monthly MVP members undertake 'Walking the patch', Proactive recruitment for representation from all groups who utilise service to allow diversity and inclusion of minority representatives. Feedback also gathered via FFT, national survey, focus groups, live insta events,complaints and call for concerns, social media and access to virtual midwife. Birth Reflections service which inform reponse and appropriate action. NED appointed to the role of Maternity Safety Champion. Chief Nurse and Medical Director both Exec Leads	MVP members undertake 'Walking the patch', and provide realtime feedback from women utising the service that initiates immediate response from maternity team. Significant user involvement in 'Whose Shoes' exercise to resolve concerns raised related to conduct and attitude User representation involved in QI projects in response to feedback from and to women. Monthly safety champion meetings enable escalation of concerns/challenges and inform/direct support for appropriate action to ensure safety	Improvement in maternity patient survey results Reduction in complaints Increase in positive feedback Triangulation of all feedback received to demonstrate that changes made / quality improvement projects had positive impact. Evidence of Board level support for maternity and neonatal services	Focus on marginal groups Engagement with BAME women	AS Head of Midwifery Jan 21	Time and staff resource	Service utilises a multitude of processes for sourcing user feedback and engagement Robust process for effective communication/escalation between service and Board safety champions
IEA REQUIREMENT 3 (STAFF TRAINING & WORKING TOGETHER): Staff who work together must train together	**What do we have in place currently to meet all requirements of IEA 3?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	
OCKENDEN Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	Multidisciplinary MAST ,MDT simulation training , MDT training schedule in place-monthly sessions are facilitated and staff rostered to attend. During Covid face to face session sizes reduced and non face to face sessions implemented MDT joint simulation training embedded into training programme and facilitated in simulation lab and drills in clinical areas Evidenced via training attendance data MDT ward rounds evidenced in coordinators activity log Twice daily consultant led and present ward rounds in place and audit tool devised to monitor compliance. Outcome of this audit will be shared by Chief of Division	MDT training compliance is a performance indicator reported and reviewed through Divisional and Trust Board performance meetings Informs training needs analysis and utilisation of staff resource within the clinical environment eg only staff who have completed annual CTG training and competency requirements are allocated to work in areas where CTG monitoring is utilised.	Qualitative evidence of open and safe culture one team approach within a psychologically safe working environment evidenced through staff survey, incident reporting, safety huddles, AAR and clinical debriefs Evidence of senior obstetric involvement in the care,management plans and decision making for high risk women.	Currently MDT training is not validated by LMS. LMS to advise on requirements and process for external validation of MDT training and working Undertake audit of ward round compliance audit tool devised to monitor compliance. Outcome of this audit will be shared by Chief of Division and DOM at monthly safety meetings and remedial action taken should this be required. Funding over and above the CNST refund was allocated to the Maternity Budget from the Quality fund I 2019/2020. It unlikey to be compliant due to CoC	MG Clinical Lead Consultant KJ Chief of Division MC Director of Midwifery AS Head of Midwifery March 21	Guidance from LMS regarding requirements and process for quarterly validation of MDT training	Exploring non face to face options such as online Prompt training. Escalation of staffing shortfall
CNST Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	4. Yes annual workforce paper submitted to Trust Board obstetric and Anaesthetic workforce requirements in line with national guidance. Birth rate plus analysis utilised to inform midwifery workforce planning 8. Risk of non achievement of 90% target `for the 2019/20 as a result of clinical / resource pressures related to Covid-19, staff resources, activity, infection control restrictions ...	Informs Safer Staffing Provision of one to one care and staffing ratios reported through dashboard, performance indicator monitored via Divisional and Trust governance meetings. Informs business case to secure funding for increase in midwifery establishment to be in line with national raitios.	Safe staffing levels with appropriate skill mix Evidence of staff training and competenct - reduction in adverse incidents	**Achieve midwifery ratio of 1:24 Achieve 90% MDT obstetric emegency training target for 2019/20 Recovery plan in place owing to the impact of Covid on the workforce.**	MG Clinical Lead Consultant KJ Chief of Division MC Director of Midwifery AS Head of Midwifery March 21	Funding to address shortfall in midwifery staffing circa £1.7 million. Capacity and resources required to facilitate and support training whilst at peak of second wave of pandemic and staff being wholly deployed in the delivery of clinical care. Reinvestment of incentive money into Maternity to support training.	Exploring non face to face options such as online Prompt training. Escalation of staffing shortfall

Link to urgent clinical priorities (a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. (b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	**(a)** Twice daily Consultatnt led labour ward rounds in place (b) MDT training schedule in place	Consultant led ward rounds enable facilitation of MDT learning Senior involvement in the care and management of high risk women	Evidence of senior obstetric involvement in the care,management plans and decision making for high risk women. Appropriate and timely intervention evident through case reviews Reduction in adverse incidents	Exploring introduction of on line PROMPT training Await publication of further guidance to inform future delivery of MDT training in maternity services	MG Clinical Lead Consultant AS Head of Midwifery March 21	Published guidance on future training requirements	Twice daily Consultant led ward rounds in place MDT training schedule in place
IEA REQUIREMENT 4 (MANAGING COMPLEX PREGNANCY): **There must be robust pathways in place for managing women with complex pregnancies**	**What do we have in place currently to meet all requirements of IEA 4?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
OCKENDEN Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. • Women with complex pregnancies must have a named consultant lead • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	As a DGH we currently have adhoc arrangements to refer women to tertiary centres as required. Antenatal Care pathway clearly outlines which women should be referred to a Consultant. Mechanisms are in place for midwives and lead obstetricians to be highlighted within the Maternity notes. The community midwife will refer to the appropriate specialist Consultant for specific conditions such as diabetes, haematology, fetal medicine Policy in place Shared decision making tools utilised for certain conditions.	Awaiting development of tertiary centres	Improvement in maternal and neonatal outcomes Evidence of continuity of care by Lead Professional	Awaiting development of centres We will continue to work with the system when regional centres are developed Audit of compliance with pathways for Consultant referral Review of criteria / pathway for referal to Tertiary centres Continue to work with system to achieve regional integration of maternal mental health services	MG Clinical Lead Consultant March 21	Time and staff resource	staff have been reminded of the local policy and need to ensure compliance
CNST Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Yes	Compliance level with all elements of the Saving Babies lives care bundle is reported and monitored via Divisional and Board governance meetings. Provides foundation for ongoing quality improvement projects utilising methodology of mat/neo collaborative Informs staff training and education	Improved outcomes Reduction in maternal and neonatal morbidity/perinatal mortality	**Secure funding for Saving Babies Lives Lead midwife role for which funding expires in March 2021**	MC Director of Midwifery	Financial resource 1wte Band 7	Trust is compliant with all 5 elements of Saving Babies Lives care bundle version 2
Link to urgent clinical priorities: a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.	Policy in place to drive process. Stickers on notes to identify named consultant. Existing system does not cover the enitre pregnancy journey	Ensuring that risk assessments result in the apporpirate evel of care	Audit of practice. National maternity survey	Currently reviewing the allocation of high risk women to lead consultants and aligning this to CoC models	JP Consultant Obs	Time to review current organisation of care and IT system to ensure timely sharing of information	Audit of current process
IEA REQUIREMENT 5 (RISK ASSESSMENT THROUGHOUT PREGNANCY): **Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.**	**What do we have in place currently to meet all requirements of IEA 5?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	The Trust Antenatal Programme / policy defines and guides staff in the requirements for antenatal booking assessment and at each point of contact .New notes provide prompt for risk assesments with additional personalised risk assesment and management plan page clearly visible to all health professionals. Electronic maternity records include risk assesments and risk Alerts evident on opening record Local policy in place which which stipulates the need for ongoing risk assessment. A risk assessment tool is included in the new maternity notes to ensure an ongoing review at every contact. Personalised risk assesment and management plan page clearly visible to women and all health professionals and inclusive of plan for birth	Review of risk categories/acuity in accordance with Birth Rate Plus informs staffing establishment requirements to ensure safe service Risk assesment utilised to ensure appropriate care pathways and appropriate place of birth.	Clinical incident reviews and audit demonstrates compliance with ongoing risk assessment, identification of changing risks resulting in care provision by appropriate lead professional and correct place of birth Evidence of clear management plans for pregnancy, birth and the postnatal period	Compliance with risk assessment process to be formally audited to provide full assurance and subsequent monitoring. Awaiting SH PSCP development	AS Head of Midwifery MG Clinical Lead Consultant April 21	Time and staff resource SH PSCP	Antenatal Care policy provides clear direction in relation to risk assessment .Trust has new maternity records that focus on continued risk assessment at each point of contact All staff reminded of the local policy in regard to risk assesment, escalation and documentation and the need to ensure compliance.
CNST Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	**Yes This is repetition of section 4 number 16**						

Link to urgent clinical priorities: a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	Antenatal care programme provides clear guidance for staff on risk assessment at booking and at each point of contact . States requirement for preparation for birth from 34 weeks gestation and review of birth plan and place of birth following risk assessment at 36weeks.	Compliance with policy considered during MDT reviews of high risk cases to gain assurance of escalation and management of existing and new risk factors	Reduction in adverse incidents Improved maternal and neonatal outcomes	Compliance with risk assessment process to be formally audited to provide full assurance and subsequent monitoring.	AS Head of Midwifery MG Clinical Lead Consultant April 21	Time and staff resource	Antenatal Care policy provides clear direction in relation to risk assessment .Trust has new maternity records that focus on continued risk assessment at each point of contact All staff reminded of the local policy in regard to risk assesment, escalation and documentation and the need to ensure compliance.
IEA REQUIREMENT 6 (MONITORING FETAL WELLBEING): **All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.**	**What do we have in place currently to meet all requirements of IEA 6?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
OCKENDEN All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - • Improving the practice of monitoring fetal wellbeing – • Consolidating existing knowledge of monitoring fetal wellbeing – • Keeping abreast of developments in the field – • Raising the profile of fetal wellbeing monitoring – • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported – • Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. • They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. • • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	The service has employed a lead midwife for Saving Babies Lives and also a Band 8 clinical lead midwife. Both positions work alongside staff in the clinical environment and have a specific focus on CTG interpretation,escalation & action, real time education and training as well provision of training both face to face and virtual CTG policy and training in line with NICE Guidance including Fresh eyes stickers . Dawes Redman computerised analysis utilised for antenatal CTG in addition to NICE interpretation guidance All staff receive annual CTG trainng during MAST and there is a mandatory requirement to complete K2 CTG on line training programme and competency assesment annually 24 hour CTG case reviews at handover, Restorative clinical supervision facilitated by PMA's	Informs saving babies lives agenda specifically in relation to CTG/ fetal surveillance Learning disseminated real time in clinical environment through 1:1 support, safety huddles, handover , Saftey Pins and briefings Identification of themes and trends related to CTG related incidents shared via leading learning communications to all staff Informs training needs and focus on elements of CTG interpretation, escalation, rescue	Reduction in CTG related adverse incidents Reduction in unexpected admissions to the Neonatal unit Reduction in referals to HSIB, NHS Resolutions	**An obstetric champion has been identified but clarity required on amount of dedicated time within job plan exclusively for provision of CTG champion role** **Secure funding for Saving Babies Lives Lead Midwife role as not funded after March 2021**	AS Head of Midwifery MG Clinical Lead Consultant March 21	Time resource for obstetric input Financial resource for Saving Babies Lives Lead Midwife role	Trust has robust process in place for training, development and competency assessment in relation to CTG Compliant with the 5 elements of Saving Babies Lives Care Bundle
CNST Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	The service is compliant with the 5 elements of Saving Babies Lives Care bundle Risk of non achievement of 90% target `for the 2019/20 as a result of clinical / resource pressures related to Covid-19, staff resources, activity, infection control restrictions ...	**This is a repetition of the information requested in section 4 number 16 and 3 number 12 and**					
Link to urgent clinical priorities a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	There is an identified Obstetric Lead and a Lead midwife for the SBL bundle. The Lead midwife role is externally funded by the LMS and funding ceases in March 2021. Funding arrangements to be determined after March 2021	To ensure best evidence based practice , learning from clinical incident reviews with input from saving babies lives perspective /focus Improve outcomes for mothers and babies Inform quality improvement incentives	Reduction in maternal and neonatal morbidity / perinatal mortality Reduction in pre term birth	Review time allocated for obstetric lead role in saving babies lives Secure funding for Midwifery Lead role	MG Clinical Lead Consultant March 21	Time resource for obstetric input Financial resource for Saving Babies Lives Lead Midwife role	Trust is compliant with the 5 elements of the Saving Babies Lives Care Bundle
IEA REQUIREMENT 7 (INFORMED CONSENT): **All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.**	**What do we have in place currently to meet all requirements of IEA 7?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**

OCKENDEN All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected	Early pregnancy appointment -information provided pre booking appointment on a range of relevant pregnancy topics. New maternity records contain information and prompts for discussion including birth plan National evidence based leaflets available and provided when appropriate/ relevant in a variety of languages. Local Maternity website. Use of shared decision making tool. Choice of place of birth, Birth Options clinic, Bump to Birth service, access to vitual midwife Sasha. Women who choose to opt out of traditional care models considered appropriate for presenting risk are provided with evidence based information to ensure informed decision making and supported in their choice with a clear plan agreed between mother and health professional Information available in different languages consistent with NHS policy. Maternity information posted on Trust website. Women provided with information to inform choice of intended place of birth at booking and during pregnancy. Bump to Birth service to allow women to receive more information related to optimal birth choices and Birth options clinic to provide opportunity for detailed discussion / information sharing re mode of birth. Shared Decision making tool.	To empower women to make informed choices Promote effective communication and relationships between women and healthcare professionals Enable equity of information and support available to all women who use our service Increase awareness of pregnancy and birth surveillance - purpose and response Education to promote maternal and fetal health and wellbeing	Women empowered to make informed choices evidence of personalised care / birth plans Improved maternity survey results related to provision of information and support with birth choices	Work is ongoing regarding further development of the maternity web site and patient leaflets in other languages Audit of utilisation of shared decision making tool	MJ Maternity Matron March 21	IT and communications support Financial resource to review as a project	Trust utilises National Patient Information leaflets Information packs distributed at early booking appointment Links to additional evidence based information shared with women Access to Maternity web site. Communications plan includes targetted communication.
CNST Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	**This is a repetition of the information requested in Section 2 number 8**						
Link to urgent clinical priorities a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	Maternity website in place	To provide instant access to on line information in relation to all elements of pregnancy, birth and the postnatal periods	Reliant on patient feedback	Review of maternity website by MVP and service users to inform current work in progress to ensure user friendly for all users including marginalised groups and that all information is relevant, in line with NHS policy and can be accessed iwith ease n a variety of languages	MJ Maternity Matron April 21	IT and communications support	Trust has numerous processes in place by which women can access relevant and evidence based information and are supported in their birth choices

NICE GUIDANCE RELATED TO MATERNITY	What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	There is a central process for monitoring NICE guidelines in the Trust. All newly published guidelines, applicable to the division are sent to the respective clinicians for review and the NICE baseline assessment is completed for the percentage of recommendations that are compliant. A bespoke baseline assessment document is created for any guidelines published without a NICE assessment. Action plans are drawn up for any recommendation that is deemed non or partially compliant. All NICE guidelines are monitored by the Clinical Effectiveness Committee for assurance purposes. Additionally, the process works in reverse and all departmental policies /guidelines andSOP's are updated in accordance with recent NICE publications or new guidelines are produced.	Action plans and QIP work is used to review the non compliant areas within each NICE guideline. All compliant guidelines are audited and are built into the the annual audit programme. Departmental guidelines are updated on the back of audited outcomes.	All compliant guidelines are audited and are built into the the annual audit programme. QIP projects are also added to the audit programme to demonstrate the success of newly introduced processes or equipment to name a few. Patient experience is also a included as part of the compliance measure where applicable	Continue process	Maha Gorti/ MC		Compliant

MATERNITY WORKFORCE PLANNING -	**What process have we undertaken?**	**How have we assured that our plans are robust and realistic?**	**How will ensure oversight of progress against our plans going forwards?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
Can you demonstrate an effective system of clinical workforce planning to the required standard?							
Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Birthplace Plus review in keeping with CNST standards						
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.	Timescales for implementation to be agreed						
MIDWIFERY LEADERSHIP (RCM Manifesto standards)							
Director of Midwfiery in every trust: Every trust should have a Director of Midwifery, with a Head of Midwifery in every maternity unit within the organisation. This would help protect people from the risk posed by dysfunctional maternity services by enabling problems to be identified and escalated more quickly.	Compliant						
Regional & national lead midwives: A lead midwife at a senior level in all parts of the NHS, both nationally and regionally	Compliant						
More consultant midiwves: We would like to see at least one consultant midwife in every maternity unit. For those responsible for providing services in remote and rural areas, one option could be to appoint a consultant midwife across more than one trust / health board, providing consistency and clarity of professional guidance for this very specific kind of midwifery service.	No Consultant midwives currently						
Specialist midwives in every trust: A range of specialist midwife roles should be the norm in every trust / health board across the United Kingdom. The mix of specialisms will depend upon the needs of the service locally. Midwives should have access to and be able to draw upon these midwives' skills and experience as they strive to deliver and improve care e.g.: smoking cessation FGM specilaist substance misuse mental health specialist	Workforce review includes analysis of specialist roles and shortfall included in overall shortfall. Smoking cessation lead currently funded by LMS with funding being withdrawn in March 2021.No FGM or substance misue specialists						
Strengthening midwifery leadership in education & research: Lead Midwives for Education (LMEs) are experienced, practising midwife teachers who lead on the development, delivery and management of midwifery education programmes 13. They help to ensure high standards in midwifery education and are a vital intermediary between the professional regulator (the Nursing and Midwifery Council) and the universities.	Not for providers to respond to						
Fund ongoing midwifery leadership development: A commitment to fund ongoing midwifery leadership development.	HEE money ring fenced for Maternity						
Professional input into the appointment of midwife leaders: Directors and Heads of Midwifery must have the skills, experience and credibility to lead and manage maternity services. The appointment of the right individual is an important matter, and selection procedures within the NHS should be focused on ensuring that the right people get into the right jobs.							