Maternity services assessment and assurance tool

We 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.

Section 1

Immediate and Essential Action 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.

- 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

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

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

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?	RAG Rate
National Perinatal Mortality Review Tool (PMRT) PMRT is used for all perinatal deaths to the required standard.	Learning shared within the Trust by specialist midwife. This includes information in newsletters and safety briefs Amendments/changes to clinical guidelines are made if required from review of cases Themes and trends identified Parents views of their care are included as part of the PMRT review. MDT will refer to perinatal meeting for wider discussion required	All cases have an Multidisciplinary Team (MDT) review with appropriate clinician involved Associated actions tracked through monthly PMRT meetings Monthly meetings with external (within the region) expert attendance. Attendance by trust patient experience lead Change of guidance for example aspirin prescription	Quarterly PMRT reports to be submitted to maternity safety champions meeting Any specific trends require further analysis and actions plans developed as appropriate Consider wider LMNS sharing of review outcomes	Divisional Director of Nursing and Midwifery March 2021 In place For discussion at LMNS programme board March 2021	Nil Link with Operational Delivery Networks to share good practice and learning	Continue with process in place for PMRT reviews. Evidence of meeting the standard: PMRT minutes Evidence of clinical guideline change – Aspirin Maternity Newsletters and Safety Catch	

Maternity Services Dataset The Trust is submitting data to the Maternity Services Data Set (MSDS) to the required standards	Data is submitted directly from the trust Business Intelligence Unit. The Maternity dashboard is reviewed monthly at Service Line management and monthly maternity governance meetings where the data is scrutinised and where these are outside of normal variation they are observed and discussed should performance trigger as a red flag for 4 months a thematic review is initiated. However reviews can be agreed outside of this criteria if felt to be necessary. . Quality Improvement (QI) projects are initiated to improve safety and quality.	The IT midwife shares updates with the midwife teams regarding best practice for data entry The Trust receives a MSDS scorecard monthly outlining compliance with all criteria. Data is complete > 90% To continue to investigate any discrepancies in data collation and submission.	To instigate action plans where appropriate Support clinical staff with training in accurate data inputting to reduce data validation errors.	Business Intelligence Unit (BIU) at the Royal United Hospitals Bath Foundation Trust (RUH) team are working with Digital midwife lead and Divisional Digital support lead – in place	Consider increased Digital midwife support to respond to increasing demands	Continue to work with the Trust digital teams Ambition to work towards future digital records – Continue with ongoing plans to work with LMNS	

Maternity Dashboard The trust has an established Maternity dashboard in place	Maternity service produce a quarterly Governance report shared internally through governance processes and externally with CCG. Dashboard reviewed at monthly maternity governance meetings, this reports into Divisional governance and maternity safety champions meeting and Trust Quality board. Areas that flag amber or red are reviewed and decisions made as to whether further understanding is required. Monthly data that is red for four consecutive months triggers a thematic review.	Maternity dashboard shared widely across the services including sharing with the Clinical Commissioning Group (CCG) Learning from thematic reviews is shared via the weekly maternity newsletter and team/unit meetings. Service learning is evidenced via the maternity audit framework	Supporting the Local Maternity Neonatal System (LMNS) to develop a BSW(Bath/ Swindon/ Wiltshire) dashboard There is a National Maternity Dashboard being launched which will pull data from MSDS submissions Share highlights of the maternity dashboard with frontline clinical staff highlighting amber or red areas.	LMNS midwife April 2021 Initial launch - currently working through data issues March 2021		Weekly LMNS weekly update in place for sharing of information Monthly LMNS programme board and safety group. <u>Evidence</u> – maternity dashboard	

Maternity SI reports The RUH has reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and NHS Resolution Early Notification Scheme Serious Incidents are discussed at • Divisional board via Patients safety updates and the maternity governance report • Trust Serious Incident (SI) Panel • Maternity Governance meetings • Divisional Governance meetings • Maternity safety Champions meetings • Summary of SIs as agenda item at Quality Board and Trust board	HSIB recommendations/ actions are reviewed and implemented. Learning is incorporated into mandatory training (Practical Obstetric Multi-Professional Training [PROMPT] and Maternity Professional Development day). High level incident description of all SI's/HSIB reports are sent to Trust Board HSIB reports are shared at the Trust Serious Incident panel where there is CCG representation reports and have LMNS analysis. Serious Incidents are shared at the LMNS Safety Sub Group All serious incidents will be submitted to Trust Board for oversight and review on a quarterly basis.	All cases that meet the criteria are reported to HSIB, Each Baby Counts and Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) and NHS Resolution. To inform the Board of the SI outcomes and the actions being taken to improve care. Discussion of clinical findings which may highlight areas for focus and improvement. Share learning with neighbouring Trusts Each report recommendations are shared in a variety of ways. This is via study days, Newsletters,, Unit meetings and safety briefs and can include clinical guidance changes, information sharing which are then audited to assure compliance	Agreement across the LMNS for specialist (Midwifery, neonatal and obstetric) to attend external perinatal (or equivalent) meetings. Quarterly LMNS sub safety group reviews SI and learning shared across the region. Continue to share learning from HSIB cases.	The trust is committed to ongoing work with exploring best practice ways to share learning Discuss at next programme board March 2021 In place In place	Dedicated SI LMNS quarterly meeting Confirm process of trust board oversight of each SI Learning from when things go well.	Established systems in place for reporting and review All maternity SI's and 72 hours reports in maternity are shared with BSW CCG Quality Team and LMNS Lead Midwife. <u>Evidence:</u> Trust board minutes where maternity SI's have been shared. Evidence of HSIB feedback HOM reports and Quarterly meetings <u>Evidence</u>: Minutes of Maternity and Divisional governance meetings <u>Evidence:</u> Minutes of Maternity safety champion meetings	SI to trust board

Perinatal Clinical Quality Surveillance Model	The Maternity Service are aware of the 5 Quality Surveillance principles • Strengthening trust oversight • Strengthening LMNS and Integrated Care Systems (ICS) role in quality oversight • Regional oversight for perinatal clinical quality • National oversight for clinical quality • Identifying concerns, taking proportionate action and triggering escalation RUH tool in development for submission to Trust board as part of Quality update	An open, transparent and a high reporting culture for risk and near misses Regular communication with internal support such as HR. Regular communication with LMNS midwife and Regional Chief Midwife Monthly LMNS safety sub groups where local risks and trends are discussed	Continue to support human factor work training, supporting escalation and resolution Frontline staff feedback to maternity safety champions Continue to liaise with HR as appropriate Continue to adhere to Trust values Continue developing the role of Trust and clinical safety champions	Divisional Director of Nursing and Midwifery/ LMNS lead midwife/Chief Midwife Senior Midwife leadership team Divisional Director of Nursing and Midwifery/Trust safety champion team	Establish a mechanism for external clinical specialist opinion from outside the Trust (but from within the region) for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. Increase obstetric team establishment RUH tool in development for submission to Trust board as part of Quality update	Evidence of established change from PMRT minutes Evidence of MatNeo QI projects embedded changes within multiprofessional team members. Evidence of PeriPrem collaborative working to improve outcomes. The Trust will submit a commitment and plan to follow the new regional process that will have been implemented in January 2021	Will be included in future trust board papers

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- 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.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: 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?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

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.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?	RAG Rate

Trusts must create an independent senior advocate role	The Trust doesn't currently have an independent senior Advocate Role who is available to families and reports to both Trust and LMNS boards. The aim is to nationally co-produce a framework, including a standard job description, training package and principles for establishing a network. There will be a clear process so that women and families know how to contact the advocates. This will also include mechanisms for contracting advocates so they remain independent and funding arrangements	When in place we will be able review women and families feedback as to the effectiveness of the role	Create an independent advocate role who is available to attend meetings with families and clinicians where concerns about neonatal or maternity care are discussed. Continue divisional discussions around a patient liaison role.	Awaiting information and guidance from the national team	Investment for independent advocate. Further guidance and job description to be agreed nationally.	Awaiting further information We currently have a Trust Patient experience lead and team who attend governance meeting and PMRT in order to provide a fresh eyes approach Robust PALS and complaints process in place where women and families can have timely access to a senior member of the midwifery team to discuss concerns.	

Each Trust Board must identify a non-executive director	The Trust has a named Non-Executive who has oversight of maternity services Non-Executive works collaboratively with safety champions and Maternity Voices Partnership (MVP) chair	Non-executive and executive attendance at Maternity safety champion meetings and trust board meetings Executive 'go and see' meetings in place so clinical teams can feedback (floor to board)	In place	In place	In place		
Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions	Safety champion meeting scheduled Monthly with bimonthly attendance from Executive and Non-Executive attendance.	Transparency of maternity services with Executive level team The trust have further Identified front line local safety champions due to the geographical locations who will have direct access to the executive safety champions via the bi monthly meeting Executive Safety Champion	Continue with monthly meetings. Work towards increased feedback opportunities for front line staff to have direct feedback links Report Quarterly into Trust Quality Board Safety Champion pathway which identifies upstream and downstream feedback opportunities.	Maternity Safety Champions team April 2021	Scope how we increase the use of live virtual feedback platforms	Current 'go and see' walkarounds Senior leadership visibility Continued encouragement and support to use the datix reporting systems for near miss incidents Evidence Minutes / Terms of reference/ Agenda	

Gathering service user feedback	The RUH has a Lead for Patient & Carer Experience who manages a patient experience team who reports directly into trust board. Maternity services has a dedicated 0.2 (Whole Time Equivalent) WTE role that focuses on family experience/ feedback Birth reflections service is 0.3 WTE hours per week At the RUH this includes • weekly matron's questionnaires • dedicated maternity feedback email • graffiti ward board • Birth reflection's service Our services work closely with our Maternity Voices Partnership (MVP) who provide maternity services with themed feedback on a quarterly basis. The Head of Midwifery and Matron Team, hold quarterly meetings with non-midwifery birth working community to include National Childbirth Trust (NCT) trainers and doulas.	Individual feedback from concerns or complaints is actioned immediately, families are encouraged to directly contact matrons - themes from feedback are taken forward and discussed at our Maternity Governance Committee Evidence of emerging themes feedback and actions. Birth reflections newsletter. Patient story at Trust board and maternity newsletters. Birth worker meeting minutes. Trust Patient Experience Team collate information from Trust and arrange events to share with staff e.g. 'See It My Way' videos and Individual Patient Story events. Reduction of informal and formal complaints Responsive service to user feedback.	Continue to build ways to receive feedback and work with families to improve maternity services. Learning and feedback shared within LMNS meetings The division will consider family experience roles in order to further support engaging with women and families Consider ways to ensure themed feedback is fed back to clinical staff. Ensure that feedback is representative of women from all social and ethnic groups. By continuing to work with MVP and family experience nurse to individualise feedback mechanism from different groups	Senior midwifery team dedicated family experience role	Consider increased use of MVP and local group to gather themed feedback We will continue to explore innovate and creative ways to capture feedback	Continue to work with our MVP to co-produce services**.** Timely action on feedback where concerns or themes arise. LMS BAME operational policy supports a focus on gaining feedback from women from a BAME background. <u>Evidence</u>: Birth worker minutes <u>Evidence:</u> MVP 'you said we did' <u>Evidence</u> LMNS minutes MVP feedback	

Work with service users through your Maternity Voices Partnership (MVP)	Established MVP team across the LMNS Attendance at weekly LMNS meetings Monthly programme board and MVP meetings	Co-production and MVP oversight of trust communications and advice leaflets. MVP involvement with communication to Black Asian, Minority Ethnic (BAME) maternity service users. Sharing of user feedback across the LMNS at meeting therefore shared learning for all trusts	Continue to work closely with MVP and women and families to co-produce maternity services.	Divisional Director of Nursing and Midwifery/LMNS lead midwife/Chief midwife		Work with MVP to engage with women from harder to reach groups Plans to formalise communication with nonexecutive lead and MVP. Informal communications have already taken place	

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- 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.

Link to Maternity Safety actions:

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?

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
(c) Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?	RAG Rate

A MDT training as part of annual Mandatory training schedule is in place which includes: • **Monthly MDT** • **PROMPT training** • **Human Factors** • **Sepsis** • **Recognition of deteriorating patient.** • **Covid updates/ training** • **Ad hoc/ monthly skills simulations for** • **Obstetric** • **Emergencies**	Maternity dashboard reports compliance for all staff groups The senior leadership team have oversight and are informed if staff do not attend in order to support compliance Trust STAR records indicate individual and team compliance Attendance logs and Feedback Current MDT training has been via the virtual platform with interactive sessions due to covid-19 restrictions Completion of K2 training packages • Electronic Fetal monitoring • Interpretation of Cardiotocograph (CTG) • Intermittent Auscultation.	Compliance reporting through • Service line management • Maternity governance Reported in maternity governance report Oversight at maternity safety champions meetings Each staffing group compliance reported via maternity dashboard	Monthly Fetal Monitoring training and competency assessment plans to be finalised Trust to share evidence of MDT training and compliance through the LMNS three times a year	Divisional Director of Nursing and Midwifery/Maternity Matrons/Quality and Education Midwife	Increase CTG Champion Midwife WTE to deliver addition training and support. Consultant SPA sessions to be reviewed for training and Governance requirements.	Current CTG training includes live learning (.2 WTE of live learning focused fetal heart monitoring in labour, this include risk assessment and escalation of concerns in labour). Continue with training package planning <u>Evidence</u>: MDT training needs analysis and compliance of training	Each staffing group not yet at 90%- action plan in place

Twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.	The trust is currently not compliant with 7 day MDT consultant led ward rounds. Compliant for 5 days twice daily (Monday – Friday). Currently once daily at weekends. Standard Operating Procedure (SOP) in place for ward rounds which describes the duties and requirement for Key individuals on Bath Birthing Centre to ensure safety, leadership and oversight of the unit. Attendance is monitored at each MDT ward round by use of signed attendance sheets	Maternity governance Audit meetings Maternity safety champions meetings	Division currently identifying the funding to enable an increase ward round to twice a day 7 days a week Quarterly audit of ward rounds to become part of the annual audit cycle.	Lead Obstetrician and Divisional Operational director.	**1wte obstetrician required to comply with urgent clinical priorities** Increased requirements to current establishment - posts to be advertised as soon funding available	Virtual attendance to ensure twice daily consultant oversight When consultant not in attendance (weekends and Bank Holidays) a record of virtual ward round is recorded on the attendance sheet Escalation policy/ process in place. Evidence: SOP of labour ward staffing/ward round Evidence: Audit of ward round and attendance	Increased staffing requirements

Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety	Agreement has been sought from Trust Board in regards to ring fencing CNST refunds. External funding HEE used for maternity staff training LMNS funding used for maternity purposes only.	Maternity finance meetings		Director of Finance. Chief Executive.	Statement of commitment that year 3 CNST incentive scheme refunds will be ring-fenced for supporting the safety agenda	Business case development for additional funding for either staffing or resource requirement. <u>Evidence:</u> Statement of commitment that year 3 CNST incentive scheme refunds will be ring-fenced for supporting the safety agenda	

Trusts must demonstrate an effective system of clinical workforce planning to the required standard	BirthRate Plus® (BR+) Maternity Framework for workforce planning undertaken and Final report shared with division and reported into workforce paper which reports into Trust board. The neonatal unit requires workforce planning to be complaint with the BAPM and Dinning tool recommendations Acuity tools and escalation of red flags Action plan for workforce planning completed	Reporting through trust datix systems of any workforce risks including red flags Maternity BR+ Acuity for labour ward and maternity inpatient ward tool reports Red flag and staffing issues daily. Trust workforce planning group	Trust oversight on action plans for both maternity and neonatal systems in order to achieve compliance	Senior Matron for maternity services Consultant Neonatal Nurse and neonatal matron Lead Obstetrician Lead Anaesthetist	Investment is required in order to comply with the external assessment of workforce requirements. **The investment required in total is** **8.6wte for midwifery** **Obstetrician 1wte** **Neonatal staff includes** **2wte paediatric consultant** **3.45wte Middle grade Doctors**	<u>Evidence:</u> Business planning for increased establishments across midwifery, obstetric and neonatal disciplines <u>Evidence:</u> Workforce planning action plans	Increased staffing requirements
Immediate and essential action 4: Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies 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							

Link to Maternity Safety Actions: **Action 6: Can you demonstrate compliance with all five elements of the 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.							
What do we have in place currently to meet all requirements of IEA 4?	**What are our monitoring mechanisms?**	**Where is this reported?**	**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?**	**RAG Rate**

Consultant Leads in place for high risk women with complex medical conditions such as: • **Multiple pregnancy** • **Maternal medicine Endocrine** • **Gestational Diabetic Haematology clinic** • **Fetal surveillance /bereavement** • **perinatal mental health**	Maternity audit framework in place Quarterly audit schedule commenced Reported and oversight through Audit meetings Lead consultants identified and referral pathways published to enable midwifery team to refer to relevant lead obstetrician Joint clinics undertaken with trust specialist support – for example endocrine, epilepsy, mental health. Recent commencement of perineal trauma clinic with physiotherapy support	Maternity governance meeting Divisional governance meeting	Named Consultants to be clearly identified on women's case notes. Clearly documented care plan in women's notes which is reviewed throughout pregnancy Audit of named consultant lead to be added to annual maternity audit cycle.	Consultant team. Audit midwife		Trust consultant team are named for complex pregnancy – where this falls outside of their expertise early referral to Tertiary unit is made. Evidence: Spot check audit <u>Evidence:</u> The Trust is committed to developing maternal medicine pathways when regional maternal medicine centres are established.	Women with multiple complexities – further audit evidence required

Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.	Audit process commenced. Will be added to the maternity audit plan framework that will be submitted into the portal as evidence	Audits of risk assessment at every contact Audit discussions of place of birth have taken place at booking and 36 weeks.	Add audit to maternity audit framework Await further guidance and funding for the specialist centres to be implemented The Trust will develop a Standard Operating procedure identifies how women are referred into a Regional Maternal medicine	Clinical Lead for Obstetrics Band 7 leads/Audit midwife	The Trust will develop a Standard Operating procedure identifies how women are referred into a Regional Maternal medicine	Continue with locally agreed pathways Participate in further development of maternal medicine specialist centres <u>Evidence:</u> SOP for risk assessment at every contact.	
The trust is required to demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2	The Trust can demonstrate compliance with all five elements of SBLv2 via the maternity dashboard data	Maternity governance meeting Divisional governance meeting Maternity quarterly governance report	Continue to work to maintaining compliance Escalate concerns appropriately	Maternity Matrons/Maternity Patient Safety team/Quality and Education midwife	Increased workforce establishment as described in workforce analysis	<u>Evidence:</u> Compliance on all 5 elements of SBLv2	

Immediate and essential action 5: Risk Assessment Throughout Pregnancy

Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- 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.

Link to Maternity Safety actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?**							
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.							
What do we have in place currently to meet all requirements of IEA 5?	**What are our monitoring mechanisms and where are they reported?**	**Where is this reported?**	**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?**	**RAG Rate**

Comprehensive Risk assessment completed at booking and recorded at every contact	Audit commencing with immediate effect – Quarterly results due March 2021 'snap shot' audit to be undertaken February 2021. Choosing place of birth documentation aid for staff developed – this needs to be embedded within practice and is part of QI work within maternity services	Maternity governance meeting Divisional governance meeting Audit meetings Maternity quarterly governance report	This risk assessment will be documented at each contact with immediate effect. Risk assessment at every contact SOP developed, Documentation of this assessment will be made with reference to risk assessment pages in the maternity hand held notes	Band 7 leads and Audit midwife February 2021 - X2 audits completed with improving compliance	Consider reformatting Shared South West notes to accommodate risk assessments Embed Risk assessment SOP Embed place of birth documentation within service and audit to ensure conversations are taking place. Consider how risk assessment can be captured in digital maternity records.	All staff have been informed of the need to complete a risk assessment at each contact and prior to labour and birth. SOP developed and shared. Monitoring of compliance will be ongoing until the action is embedded in practice. To consider how risk continued risk assessment is captured in digital records.	Practice needs to be embedded
Personal Care and Support Plan (PCSP) discussed at booking and recorded on MIS	PCSP currently being created by the LMNS Women booked onto a Continuity of Carer pathway compliance 50%	LMNS meetings	To continue to work to increase the number of BAME families on a continuity model of care (national current aim 75%) Quarterly Audit to ensure risk assessment at every contact, discussions of intended place of birth and PCSP compliance. PCSP added to maternity dashboard.	LMNS lead midwife/Better birth lead midwife. Awaiting distribution of PCSP for roll out		Our services will be rolling out a Personalised Care and Support Plan which has been developed with our LMNS.	

Immediate and essential action 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.

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.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
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?

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.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	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?	RAG Rate

Trusts must have a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	The trust has a lead midwife and a lead obstetrician Both actively participate in training and development of staff and in the development of guidance, pathways and competencies. Regular audit and review in place for all elements of Saving Babies Lives V2. Ongoing monitoring and review of clinical incidents. Holding regular training sessions to take place (at least yearly face to face training specifically on fetal wellbeing) Attendance at MDT weekly meetings to enable dissemination of learning. Daily 'Live learning' sessions Ensuring annual competency is > 90% for assessments in intermittent auscultation and intra partum CTG Auditing of saving lives care bundle elements Monthly Perinatal mortality review meetings and case discussion. CTG masterclass training for identified staff supporting training provision	Reduction in Stillbirths. Recognition of the small for gestational age infant. Reduction in pre term birth. Optimisation of pre term infants Reduction in HIE/unexpected admissions to the NNU	Commence full day CTG training sessions In the absence of CO monitoring (due to covid) all smokers are having an USS. Working towards reintroduction on CO monitoring with appropriate risk assessment CTG masterclass training for identified staff supporting training provision 24	Lead Obstetrician and Midwife Lead Obstetrician and Midwife	Increase needed in Midwife and Obstetrician CTG Champions hours dedicated to CTG training to ensure compliance with requirements Saving Babies Lives	'Live Learning' in practice learning focused on fetal heart monitoring in labour, risk assessment and escalation of concerns in labour) Frontline safety champions attending MDT patient safety meetings and cascading learning to clinical teams K2 CTG training online work package for all staff Mandatory CTG training on PROMPT study day Evidence Attendance records from Perinatal meetings. Completion of percentage of staff who have undertaken K2 fetal monitoring Evidence of 'Live learning' taking place on BBC.	Increased staffing required to enable 1day training

Immediate and essential action 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.

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

Link to Maternity Safety actions:

Action 7: 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?

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.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	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?	RAG Rate

All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth	Leaflets and guidelines are monitored visa the trust Clinical effectiveness Forum All leaflets reviewed by the patient experience team for readability and fresh eyes Place of birth work completed with LMS 'Handi App' available to all women	When families wish to undertake care not in line with national guidance these are discussed with risk explained. Documentation of these discussions are held within the maternity notes (handheld and/or computerised)	Ensure MVP, family and non-executive involvement to review leaflets/information/ website Continue with QI project regarding introduction of a place of birth sticker to ensure informed conversations are taking place Review support and information to encompass families with diverse needs – Braille, updating language availability in response to changing local populations	Maternity Matrons/MVP/non-executive Better birth lead midwife Trust patient experience team	Digital Midwife who will support the implementation of digital maternity records and access to patient portals.	Leaflets provided in Handi-App or paper copies backed up with verbal information. Documentation in maternity notes. <u>Evidence</u> 'spot check audit' for place of birth conversations. Add audit to midwifery annual audit cycle. <u>Evidence:</u> Minutes from Birth worker meetings where involvement with leaflets/website have been discussed. <u>Evidence</u>: QI work on place of birth stickers. <u>Evidence:</u> Link to maternity web pages	

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.	Leaflets provided depending on individual risk assessment or need. Monitoring by audit of risk assessment and place of birth discussions. All records contain contact number for 24 hour access to midwifery advice	Pathways of care are clearly identified on the Trust maternity website pages.	The current trust website is being updated to provide more up to date information in an easily accessible format	Maternity matron team and IT Midwife	Review of Maternity website to be reviewed by the MVP to identify any areas for improvement from the family perspective.	Website links shared Active facebook engagement and cross posting from MVP pages Evidence: link provided directly to maternity web pages. Evidence: link to maternity facebook pages.	

Section 2							
MATERNITY WORKFORCE PLANNING							
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**							
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.							
What process have we undertaken?	**How have we assured that our plans are**	**How will ensure oversight of progress against our**	**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?**	**RAG Rate**

	robust and realistic?	**plans going forwards?**					
Birth rate + Analysis published in July 2020 for understanding of the RUH maternity workforce planning	Regular review of staffing levels Monthly finance meetings regarding budgets	Red Flag incidents such as: Labour ward Co-ordinators unable to remain supernumerary. Unable to provide One-to-one care in labour. Staffing Escalation policy in place and escalation of Opel status Oversight via trust workforce planning meeting	Request further analysis from Birth rate plus for workforce planning in order to continue to implement Continuity of Carer	Senior Matron Request for updated review from Birth Rate plus March 2021	Any additional funding requirements as identified through Birth rate+ There is a current gap in compliance with the recommended staffing levels from the birth rate plus report this equates to 5.82wte midwives and 2.05wte specialist roles. We currently have 3wte midwives funded by the LMNS in order to support continuity of carer models and 0.6wte Better Births project midwife also funded by LMNS	Weekly staffing planning meeting by Sisters to ensure equity of staffing Maternity manager on call rota <u>Evidence</u> Birth rate plus report Birth rate plus action plan	

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

There is a Divisional Director of Nursing and Midwifery in place, but not a Head of Midwifery who is directly accountable to the Director of Nursing and Midwifery and regularly meets to discuss strategic and operational issues.

Due to a number of senior leader changes the RUH is currently in the process of reviewing its leadership within the maternity services in line with the recommendations defined in the RCM document 'Strengthening midwifery leadership manifesto for better maternity care'.
The RUH has a senior midwife (Band 8a) leading on the Better Births initiative, her role is focused on leadership that is directly about the frontline care and includes quality improvement, and implementation of evidence-based similar to a Consultant midwife role.
Given the national imperatives for high quality and safe maternity care, current and future focus is on succession planning and this will include the role of the consultant midwife.

The RUH already have a number of specialist midwives in place (perinatal mental health, bereavement, IT, infant feeding and diabetes) who provide expert advice to women, colleagues and are a resource on issues relating to their area of specialism. Further planning for the expansion and possible new roles in relation to the local population needs will be included in the wider staffing structure reviews.
The RUH supports coaching and mentoring programmes and staff are supporting with CPD activities in order to future proof the service in terms of developing effective and compassionate leaders.

NICE GUIDANCE RELATED TO MATERNITY

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.

What process do we have in place currently?	Where and how often do we report this?	What assurance do we have that all of our guidelines are clinically appropriate?	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?	RAG Rate

MDT clinical effectiveness forum (CEF) which reviews all guidelines, policies and standard operating procedure **Trust Clinical Guidance Implementation Manager attends governance meetings to support monitoring of NICE guidance compliance**	Quarterly CEF meetings Divisional governance routes. • Maternity governance monthly • Divisional Governance- Bi monthly New and updated guidelines and Standard Operating Procedure (SOP) are reported in the quarterly Maternity Governance report. Guidelines are shared at safety brief and weekly Maternity Newsletters as well as face to face training.	Guidelines taken from NICE guidance and ratified as per Trust process Monitored outside of Maternity by Trust Clinical Guidance Implementation manager. No guidance outside of NICE recommendations	Currently 94% are in date – remaining 6% are in progress.	Quality Improvement and Education Midwife Divisional Governance lead March 2020		Continue with current processes	