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?**
(a) A plan to implement the Perinatal Clinical Quality Surveillance Model						
- Model released last Friday 18/12/20 - Commitment to review this and complete a gap analysis by end January 2021 in order to strengthen quality arrangements	- The Trust will use this tool to enhance perinatal safety through consistent delivery, measurement and reporting.	- Recommendations implemented - Reduction in avoidable perinatal harm/SI's - Benchmarking against other units, where available, to inform learning and improvement	- Gap analysis against each element and associated action required now the model has been received - Maternity Dashboard to be strengthened in line with the model - The Trust will seek to secure external review of all serious incidents - Pursue a partner LNMS relationship (single LNMS). This would strengthen our ability to benchmark externally and also reduce the burden on a single provider	- Care Group Senior leadership Team by end Jan 2021 CEO – end Jan 2021	- Project Management Office team - LMNS SRO to review actions for LMNS	- continue to view each death using the PNMRT and implement any immediate actions, and this is reported to Trust Board - the Trust will use its governance and assurance processes to ensure timely review, and response to any incidents to ensure immediate actions and any learning

			to action and deliver changes required.			
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB						
- Maternity SI's discussed at Maternity Clinical Quality review Meeting (**CQRM**) and Maternity Quality Operational Committee (**MQOC**) SI's are reviewed and discussed at Review and Learning from Incident Group (**RALIG)**, which is chaired by the DoN/MD - SI's are reported to the Trust Board but the content of this report will now be reviewed in line with this guidance. All SI's and timeliness of same are reviewed monthly at CQRM with commissioners.	- All SI's discussed at Maternity Governance monthly - Maternity CQRM is held monthly as is MQOC (chaired by an executive DoN/MD) - RALIG is held weekly and chaired by executives - Challenge is provided at all of these forums in terms of lessons learned and evidence and sustainability of same. - A SI rapid review process is in place, however timelines for HSIB reporting means that the ability to extract and apply learning points may be delayed	- Reduction in avoidable perinatal harm - Benchmarking against other units - Reduction in repeat causation incidents - Compliance with CNST MIS safety actions 1, 2 and 10	- Review and strengthen SI reporting process to Trust Board and LMNS. - Rapid implementation of Badgernet maternity EPR to support MSDS submission and data retrieval	- Director of Nursing/MD	- Support from corporate patient safety team.	- DoN/MD oversight - Escalation to Quality and Safety Assurance Committee (Board committee).

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?
(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 co-produce local maternity services.						
–Friends and Family Test in operation –Maternity Voices Partnership **(MVP)** attended by Deputy Head of Midwifery –Maternity Voices Partnership involved in: coproduction of information leaflets, interview panels, –Maternity Transformation Programme has MVP representatives' reps on work-streams. –2 'Who's Shoes' assessments have been held in 2020 –Maternity survey based on CQC maternity survey questions, conducted monthly.	–Monthly Patient Experience report to Maternity Governance, MQOC, CQRM, PACE –MVP minutes –LMNS work stream update to LMNS board –Increased responsiveness to complaints –CNST Maternity Incentive Scheme (MIS) safety action 7 compliance achieved	- FFT response rate of 20% or more - FFT score of 97% or more of extremely likely/likely - Increased evidence of service used involvement of service development and improvement – maternity Survey - Feedback from MVP members	- Invite MVP representative to attended Maternity Governance meeting. - Further work to link with other Trusts identified as exemplar in relation to patient engagement to understand their measure of success in regards to pt. involvement - Develop, in partnership with service users "always" events and commitment statement for the service - Develop a "you said, we have" process in maternity services	- Deputy Head of Midwifery, End Jan 2021 - Director of Midwifery, End Jan 2021 - Deputy Head of Midwifery, End Jan 2021 Deputy Head of Midwifery, End Jan 2021	- MVP Involvement - Dedicated PALS officer with 'in reach' service into maternity unit - Support to DoM to be agreed	

–"Patient stories" shared at Care Group Committee –NHS Choices website reviewed and feedback from women provided to staff involved. –Trust Website feedback reviewed and provided to staff involved. –Social media pages – both Trust and MVP –Patient and Carer Experience Panel meeting in place **(PACE)**			- An engagement plan is being developed to ensure women and families are listened to and their voices are heard. This will ensure an integrated approach. Ensure this work is part of the wider Trust culture programme	DoM – End Jan 2021		

(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.						
–Non-executive director (NED) in place as maternity & neonatal safety champion and NED link with maternity services. They meet monthly and include visits to services. This will be reviewed in line with new requirements. – Executive Safety Champion in post – Trust Medical Director –Listening sessions (LS) secured and to be run throughout January 2021 to feed into cultural assessment and action planning	–Reporting to MQOC - reporting needs to be in line with CNST reporting requirements	–Improved staff survey results and reduced staff turnover –Increased staff survey response rates in all staff groups –Improved FFT and maternity survey response rates (as above) –Achieve compliance with associated CNST MIS safety actions –All staff able to identify Safety champions and articulate role plus one action completed by them in responses to feedback	- Roll out to feedback from patients - Staff and patient feedback to form part of local Maternity Transformation Plan's (MTP) culture and OD work stream - To be taken to Trust board bi-monthly - Listening Session Dates to be agreed and publicised throughout Care Group - Action plan to be developed in partnership with Corporate Nursing and OD - Review HEE Quality Intervention report to further develop cultural	- Exec and NED safety Champions and local maternity safety champions – ongoing action - Care Group Director, end of Jan 2021 - Deputy Director of Nursing / Director of Midwifery end Jan 2021	–Increase presence/ connection to Freedom to Speak Up (FTSU) guardian to ensure staff voices are heard independently of management	- FTSU guardians in place in Trust and visiting maternity areas. - Staff and service users on MTP work stream - Local maternity safety champions and PMAs in post

			workstream ensuring voices of students within maternity services are heard. - Seek support from Head of Leadership and Lifelong Learning – Midlands, NHS England and NHS Improvement for support and interventions to ensure staff voices are heard.			

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

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?
(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.						
- There is a twice daily ward round on delivery suite with a consultant in attendance. These occur at 08:30 and 20:30. - If there is a change of consultant there is an additional ward round at 17:00. - 7 day working of consultant in place within maternity services - 7 day rota in place to ensure obstetric consultant cover meeting	- Compliance with/performance against these is not reported, currently. This will form part of a routine audit - A process for measuring compliance these needs to be developed	- Maternity Governance - Care Group Board - Consultants meeting - By exception to MQOC	- Consultant to sign a daily sheet that records the ward round - Monthly audit of attendance at Ward Rounds. - Recruit 6 x additional consultant obstetricians to offer 24/7 cover by Summer 2021 - Achieve compliance with CNST MIS safety action 4	- All consultants – with immediate effect - Audits commence Feb 2021 - Care Group Medical Director – Sept 2021	- None - Dedicated Audit Resource required. Audit Midwife post has been agreed and will proceed to recruitment. - Funding approved. Recruitment support and RCOG approval	- NA - Clear escalation process in place for on call consultants to attend overnight if needed.

(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						
- New MDT triumvirate in post - MDT PROMPT training in place and occurring monthly. - Weekly MDT simulation exercises take place on delivery suite with ad hoc sessions on Midwifery Led Unit - Twice weekly CTG learning and feedback sessions on Delivery Suite – MDT delivered by CTG midwife and/or consultant - Weekly risk management meetings in place, which are MDT – with lead obstetrician and Clinical Director with MW managers and MW risk manager in attendance - Identified Obstetric anaesthetic lead with Human Factor	Oversight of training maintained by Practice development midwife - Monthly report to Maternity Governance detailing training stats - MDT faculty meetings to agree curriculum	Audit results to be received by: - Maternity Governance - Care Group Board - By exception to MQOC	- Attendance reporting to commence using CNST reporting template for all aspects - MDT skill drill to take place OOH to include an escalation scenario - Anaesthetic attendance at training sessions	- PD Midwife & CG MD – January 2021 to start March 2021	- Backfill for all to attend especially anaesthetic staff (and theatre staff in the future) - Appropriate uplift within midwifery workforce to support attendance to all mandated training.	- PROMPT Training is currently online due to COVID, with the exception of some elements such as airway management in newborn resuscitation - MDT SIMs continue - Programme responsive to incident themes e.g. in relation to Twin births

specialist interest attends MDT training						
(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						
- Not in place currently	- To be determined	- To be determined	- Identify which funding streams needs to be ring-fenced including money from HEE for students - Mechanism for this yet to be established with DoF	- Director of Finance	- NA	Funding received from NHSR for actions from year 2 CNST already being used to support maternity improvement such as fetal monitoring lead midwife, SBL lead midwife, Birthrate plus assessment

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?
(a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.						
- All complex pregnancy women have a named consultant lead	- Reviewed at weekly risk meeting but not formally audited	- Not formally reported at present.	- Implement a formal auditing process and report to respective local governance meetings - Review of Midwifery led cases for appropriate referral onwards -	22/12/20 – commence as part of weekly risk meeting	- Personnel to undertake audit	- Appropriate risk assessment documented at each contact – ongoing audit as in action number 5
(b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.						
- Obstetric Clinical Director engaged in discussions with network. This is an on-going discussion regionally and nationally in terms of how SaTh dovetails with these and connects to them	Not yet in place	Not yet in place	- Gain an updated understanding of this across the region – regional leads are taking this forward. SaTH has determined that we do not wish to be a maternal medicine centre but we are currently awaiting further guidance.	- Clinical Director for Obstetrics to lead on this – end Feb 2021	- National team to develop specialist maternal medicine centres – advised 18 currently under development	Pathways in place for transfer to specialist centres if required i.e. cardiac

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?
- Documentation contained within each woman's handheld PSCP/notes requires risk assessment to be reviewed at each contact.	- Not currently formally audited but this is reviewed at the Maternity MDT weekly risk meeting, chaired by risk midwife and risk obstetrician. This is to ensure that care is safe and appropriate.	- Maternity Governance Committee (monthly)	- Formalised audit to be implemented - Rapid Implementation of Badgernet EPR system to allow data extraction and analysis.	- 22/12/20 – commence as part of weekly risk meeting - DoN to liaise with IT project team	- Additional audit resource within the Care Group required. IT team to support rapid implementation	Manual audit to commence 22/12/20 with weekly feedback

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?
- Named project MW responsible for Saving Babies Lives in place 1.0 WTE secondment - Lead MW for fetal monitoring 0.4 WTE in place on secondment - Lead obstetrician in place with SPA time and SPA job description – 1 SPA per week incorporating PROMPT, Fetal monitoring (0.5) & Education and training - Twice weekly training and review MDT meetings in place reviewing cases and identifying learning. - Lead Midwife attends weekly risk meetings to ascertain if CTG is a key or incidental	- Monthly report to Maternity governance meetings - Dedicated time to undertake work – rostered and PA time - Staff able to articulate the roles and impact - Improved outcomes for women and babies	- No incidents that have fetal monitoring issues identified as a contributory (or incidental) factor. - Appropriate monitoring methods used for each woman - Improved CTG interpretation as detailed in monthly report - Compliance with Guideline - Full implementation of SBL element 4	- Both midwifery posts need to be substantive posts and this will be included in the workforce review and associated business cases - Audit compliance with new guideline	- SBL – post in place end September - Fetal monitoring lead post in place – end June - DoM July 2021 responsible for above -audit of guidelines by FM / SBL lead March 2021	- Funding realised - Recruit to vacant posts.	- Secondments in place - Incidents reviewed for contributory / causative factors to inform required actions

finding in any incident. - K2 training for midwives and obstetricians in place			-			

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?
- Maternity services information on SaTH website – see link: - https://www.sath.nhs.uk/wards-services/az-services/maternity/patient-info/ - https://www.sath.nhs.uk/wards-services/az-services/maternity/covid19/ - There are links to NHS guidance pages, videos, leaflets, general info about SaTH maternity services - Baby buddy app in place for the Trust, which is auditable - Friends and Family Test in place, with positive results - Patient feedback notice boards in place on inpatient areas	- Patient experience report received monthly at Maternity Governance Meeting then on to MQOC	- Co-produce pages for the website and any leaflets we publish with the local Maternity Voices Partnership – this enables the voice of women in the community to be heard and provide feedback - A website page is also available which is dedicated to care during Covid including a Q&A list with the questions being asked by women.	- Review of other websites for best practice. - Link with local LMNS and units who also provide care to women from Shropshire to ensure consistent approach to information. - Rapid Implement Badgernet, which will enable women to access their maternity records – requires intervention from DoN to hasten programme Need to establish a mechanism for collecting and collating compliments - A formal report that triangulates sources of patient feedback, concerns and	Deputy HOM – March 2021 DoN January 2021 Deputy HOM – March 2021 Deputy HOM – March 2021	- Badgernet implementation required at pace	Website pages in place

- Translation services available - Communications lead in maternity			complaints via Trust and/or commissioner mechanisms needs be developed. To be agreed with commissioners. Dedicated PALS officer to be appointed to Maternity Services to offer in-reach and provide real time feedback	Head of Complaints services		

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 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?
- Unit working to 2017 Birthrate Plus levels - Further Birth Rate + review commissioned (2020) and draft report received. Awaiting final report whereupon a workforce gap analysis will be presented to the next available Public Trust Board meeting, with timeframes for implementation. - Workforce review and plan in progress	- Report received monthly to committees and Trust Board. This includes data on staffing acuity and red flags - Commissioned Birthrate plus assessment – draft report received & will be used to determine staffing requirements of the current configuration of services. Any	- Acuity tool for inpatient areas – wards and delivery suite - Number of red flags with harm, levels of negative acuity – red or amber - Dynamic approach to escalation supported by twice daily huddles Mon - Fri – out of hours supported by manager on call - Monthly report to Trust Board	- Report to be taken to maternity governance in January and onward progression through the normal trust governance structures - Maternity specific on call rota staffed by senior midwifery team	- 31/01/2021 DoM & CGMD - CGD Feb 2021 Awaiting final BR+ report whereupon a workforce gap analysis will be presented to the next available Public Trust Board meeting, with timeframes for implementation.	Additional funding to support to be agreed through Trust normal processes	Use of acuity tool and twice daily staffing review – also includes weekly look ahead to identify any midwifery staffing issues to facilitate early resolution

- Increase in obstetric cover agreed to move to 24/7 consultant cover by Summer 2021	additional resource required yet to be agreed through Trust standard processes.					

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

1) **Every trust or health board delivering maternity care should have a Director of Midwifery, with a Head of Midwifery in every maternity unit within the organisation**
   Director of Midwifery (DoM) in post who reports to the Executive Director of Nursing. The DoM is supported by a Deputy Head of Midwifery and two Matrons. Further support to the DoM is under consideration.
2) **A Lead Midwife at senior level in all parts of the NHS, both nationally and regionally - N/A -** Applicable to region / national team
3) **More consultant midwives** – consideration will be given to this as part of the aforementioned workforce review. SaTH currently does not have a Consultant Midwife
4) **Specialist Midwives in every Trust**
   SaTH currently has a range of Specialist midwives – the roles will be reviewed in the workforce plan
5) **N/A - Strengthening and supporting sustainable midwifery leadership in education and research – applicable to HEIs**
6) **A commitment to fund ongoing midwifery leadership development** – there is a commitment to fund on-going midwifery leadership development. SaTH offers some leadership development but more work is required to ensure midwives are supported with bespoke leadership programmes. This is under review currently as part of the Maternity Transformation Programme
7) **Professional input into the appointment of midwife leaders**
   The recruitment panel for the current DoM included the NHSEI Maternity Advisor (MSSP) (now Deputy Chief Midwifery Officer for England)

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?
Guidelines Midwife reviews all new / updated guidance, including NICE, and completes a gap analysis A Named Midwife is in place for Maternity Guidelines. This midwife monitors clinical guidelines, SOP's and Policies to ensure compliance with NICE guidelines. Named Consultant Obstetrician for Maternity Guidelines in place	Maternity Guidelines Group meets 9 times a year. Clinical Guidelines and SOPs are approved through Maternity Guideline Group and ratified by Maternity Governance Maternity Guideline Group meeting held at least 9 times per year (with the exception of Covid-19 this year)	Guideline Midwife responds to updates on National Guidelines. Where required benchmarking is undertaken to ensure clinical guidelines are appropriate for the service. Maternity Audit Group commenced and active audit plans in place. Link with Clinical Education Midwife to ensure that the clinical guidelines align with training,	Continue to maintain a named Midwife for Guidelines. Submit reports to Maternity Governance	Named Midwife for Guidelines	- Audit Midwife - PMO team to support with data analysis Administration Support	

Benchmarking is undertaken when National Guidelines are published. This is then reported to Maternity Governance. Compliance with NICE Quality Standards and Clinical Guidelines are monitored and RAG assessed. These are reviewed at the Trust's Clinical Audit The Maternity Network reviews any policies and guidelines at variance with NICE	Full report to Maternity Governance 3 times per year.	based on national guidelines Weekly Risk Meetings identify any guideline issues Quality Improvement action plans Maternity Improvement Plan We are registered Stakeholders with NICE and submit during consultation process where applicable. Development of clinical guidelines with Specialist Midwives for Fetal Monitoring, Saving Babies Lives, Bereavement, Infant Feeding, Antenatal Screening, Perinatal Mental Health, Public Health,				

		Safeguarding, Professional Midwifery Advocates Part of the West Midlands Network have consulted Network Guidelines				