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.

TRUST: North West Anglia NHS Foundation Trust

LMNS: Cambridgeshire and Peterborough

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?
PMRT The Trust has fully implemented the PMRT and is 100% compliant with notifying all cases to MBRRACE within 7 days and commencing the review within 4 months of the baby's death. A quarterly PMRT report together with lessons learnt is presented at Maternity Divisional Governance Meetings and Trust Board. The Model adopted at NWAFT has included best practice so the MDT review is cross site, external representation is present and terms of reference are in place MBRRACE Board Performance Reports are submitted as part of the quarterly reports and NWAFT is currently compliant	**Promotion of learning:** Risky Business Newsletter which includes the lessons identified from the PMRT's are shared with the wider maternity Team Quarterly report is presented at the Trust Mortality Steering Committee to share learning Trust wide Implementation of Saving babies Lives and outcomes being monitored monthly Specified Topics are shared for individual clinical managers to discuss at team	Rolling Stillbirth Rate and Neonatal Death metrics on the Maternity Dashboard. Current Stillbirth Rate is below national average Annual Trust MBRRACE report presented and discussed at Maternity Divisional Governance Meeting National Benchmarking (MBRRACE) shows the service is not an outlier with similar organisations and national themes.	A planned review of Maternity governance structures and processes. Which will inform the revision of the Maternity Risk Management and Quality Governance Strategy. The scope of the review includes a plan to implement the Perinatal Clinical Quality Surveillance Model The review will also review efficacy of learning lessons processes The Risk Management will formalise local arrangements regarding external panel members at PMRT panels	Director of Midwifery (DOM) End Feb 2021	There needs to be a consistent System wide approach to the identification of external reviews panel members agreed at the LMNS Strategic Meeting	. To agree formalise local arrangements whilst holding wider system discussions regarding the utilisation of external review panel members To support the compliance team in ensuring there is robust evidence of the embedding of lessons learnt

with all the metrics outlined in Year 3 Maternity Incentive Scheme The reviews includes the views and concerns of the parents with a compliance rate of over 95% The review follows a national template and the quality of care provided is graded. A summary of the reviews with lessons identified is presented to Divisional Governance on a quarterly basis	meetings for wider service learning. Line managers informed and individual reflection sessions arranged with targeted objectives. These objectives are monitored by the line managers.		System wide approach to shared learning and education needs to be strengthened			
MSDS Version 2 NHS Digital Scorecard has reported the Trust as being fully compliant with the minimum data set (11 criteria) Work is progress with K2 regarding the plan to be compliant with the Information Standard Notice as outlined Safety Action 2 of the Maternity Incentive Scheme	The Maternity Service has the ability to generate real time data in terms of clinical out Amendments to the digital system have been made in response to learning or new guidance such as Saving Babies Lives Metrics The Digital system is able to support a full audit reporting requirements	Full Implementation on the Hinchingbrooke site completed in 2020 and that was part of the Trust's Digital Roadmap Report compliance with Safety Action two through the Governance Process up to and including Trust Board. Additionally progress is reported through to the LMNS Necessary upgrades to hardware is integral to Capital Rolling Programme	A plan to achieve the Information Maternity Standards is being developed which will increase compliance with the wider MSDS metrics	General Manager End of February 2020	Financial cost of upgrading from Version 5 to Version 6	Risk mitigated through the use of data cards whilst waiting for the new portals which is Quarter 1 2022/2023
HSIB The Service has reported 100% of qualifying cases to HSIB. Performance is reported through the monthly risk management report. 72 hour reports are completed with immediate actions undertaken as part of the HSIB referral and the Trust's Serious Incident management process Regular relationship meetings with HSIB are undertaken to	HSIB cases are reviewed and learning shared through Governance structures down to floor level through team meetings HSIB action plans are produced and shared. Actions and learning evidenced and monitored in collaboration with	National HSIB publications are discussed and action taken accordingly	To ensure that the process of reporting to HSIB is clearly outlined in the Maternity Risk Strategy The efficacy of learning from national publications is within the scope of the Governance Review that is currently being undertaken	Director of Midwifery March 2021	None Identified	None Identified

discuss progress of HSIB investigations Initial Duty of Candour is completed by the Maternity Team and Duty of Candour compliance is monitored monthly	the maternity compliance and performance officer and the maternity risk team Reportable incidents such as HIE are including the monthly maternity dashboard which is presented within the division and through the monthly Trust Quality Report to the Trust Board					
Maternity Serious Incidents All Maternity Serious Incidents are summarised in the monthly Trust Quality Report which is reported to both the Sub Board Quality Assurance Committee (QAC), Trust Board. The LMNS SRO attends QAC. Serious Incidents are discussed at the Maternity Risk Management Meeting which is attended by LMNS through the CCG Quality Midwife Number of Serious Incidents are reported to the LMNS through the Trust LMNS Performance Report The CCG Quality Midwife is involved in the CCG quality assurance process of Serious Incident Reporting for Maternity related issues	All Maternity Serious Incidents are reviewed and learning shared through Governance structures down to floor level through team meetings Action plans are produced and shared across the Maternity Division Actions and learning is evidenced and monitored by the compliance and performance officer, Maternity Risk Team and Trust Risk Team Risky Business Newsletter assists with disseminating lessons across the Maternity Trust Patient Stories Learning informs clinical pathways, guidelines formation, and training provision	The Trust quarterly CLAEP (Complaints, Litigation, Adverse Events, and PALS) meeting triangulates lessons across the Trust so sharing lessons organisation wide. Maternity is a section of that report and meeting Cross divisional working task and finish groups to review pathways are established e.g. Emergency Department, Diabetes Clinical Audit Programme is in place Learning from incidents regarding fetal monitoring utilised by the fetal wellbeing midwife for training.	A full review of the Maternity Risk and Governance Process, Policies and Structures is currently being undertaken by the Director Midwifery which will include Serious Incident Management System wide agreement regarding the LMNS role in oversight and scrutiny as well as agreed processes to be determined	Director of Midwifery March 2021	National examples of best practice	SI reports are already submitted to CCG and Trust Board.

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?
MVP is in place that works with the Trusts reporting women's views on the service. The MVP is represented on the LMNS Board.	MVP chair in place with Terms of reference and evidence of remuneration Evidence of coproduction with the MVP on service changes such as visiting arrangements MVP provides an update at the LMNS as evidenced in presentation slides and agenda items Evidence of the work commissioned by the Trust and the LMNS of the MVP in advocating and representing communities within the Trust's locality Coproduction of Maternity website redesign and implementation.	Increased service user feedback. Increased Engagement with social media site The views from the MVP encompass and reflect all sections of the demographic the Trust serves Personalised care plans that meet the cultural requirements and needs of women and families	Co-production plan to be developed	Head of Midwifery February 2021	Need to review the meeting schedule due to new HOM being in post	MS Team meetings in place with the Deputy Head of Midwifery and Matron
Friends and Family Test collected across the unit on a monthly basis.	Women and families satisfaction with the service	All areas of maternity services participate in	Continue to encourage feedback, seek new ideas from	NWAFT Area Managers	None Identified	None Identified

	are benchmarked against other Trusts. Monthly Reports are generated and discussed at Divisional Governance Meetings	monthly family and friends test survey Monthly "You Said We Did" are displayed in inpatient clinical areas. Monthly Patient experience report is presented to the Maternity Leadership Board and Trust Board. Patient feedback is now able to be given via K2 "my maternity notes" Families Experience added to Mandatory Training for discussion with NWAFT maternity staff.	patients and their families	Lead Midwives, DHoM, Matron Monthly collection. Annual report March 2021		
NWAFT response to the CQC Maternity User Survey	Action Plan in place in response to the Trust's survey results with updates presented at Divisional Maternity Governance meetings Report created from results of survey including benchmarking within the East of England region.	NWAFT participate in CQC patient survey. Next survey due to take place February 2021. Improved Feedback from women through reduction in complaints, increase accolades and higher FFT recommendation score	Place information material around the units for patients to see and use QR code. Progress action plan and continue to action recommendations. Create new action plan when next survey results are available.	Matron Annual survey, March 2021	None Identified	None identified
The Trust is currently involved in the innovative Rehman project which works closely with the local Asian communities	The involvement has led to Increased service user feedback from those communities.	Improved outcomes for communities. Benchmarked by a reduction in HSIB cases, SI's, unplanned caesareans, reduction in unplanned admissions to NICU of full term babies BAME action plan in place	Contribute to the listening events created by the Rehman Project Work closely with the lead to consider "going out into the community" for listening events.	DHoM, HoM. NWAFT Lead Midwives, Matron, March 2021	None Identified	N/A None Identified

		UKOSS 2020 Coronavirus Report Reviewed and presented to the Division and Safety Champions	Discussions with LMNS regarding project lead to enhance service to women from a BAME or vulnerable background	DOM/HOM March 2021	LMNS funding would be required to progress this role	Progress would continue but at a slower pace due to capacity
The Maternity tem is currently working with other marginalised groups Prisoners, Travellers, Eastern European communities is underway The Maternity Service provides services to HMP Peterborough	There will be evidence of service user and advocate engagement in developing services for specific community groups. SLA agreement between HMP Peterborough and NWAFT Caseload figures	Improved outcomes for communities. Benchmarked by a reduction in HSIB cases, SI's, unplanned caesareans, reduction in unplanned admissions to NICU of full term babies Increased early booking rates, reduced smoking in pregnancy rates and improved breastfeeding rates 100% Implementation of personalised care plans	Facebook live Q&A sessions being currently being created with NWAFT interpreters. Links are currently being made with the Charity Compass to support Romanian families. Links are currently being made being made with local Travelling communities to support families. Dedicated midwife for women in the prison is planning to discuss feedback during postnatal visits.	DHoM, Matron, Lead Midwives, Trust Interpreters. End Feb 2021		
The Trust has a named Executive and Non-Executive Director with responsibility for Maternity Services and are the Trust's Board Safety Champions. A robust Safety Champions structure is in place with Board and service level champions in both Obstetric, Midwifery and Neonatal across both sites. of the Trust holds a bi-monthly safety champion meetings where the Board Level Champions receive safety	Minutes of the Safety Champion meeting are available A record of "what you said, what we did" is maintained. Trust Board CNST Progress papers refer to Safety Champion's activities and papers presented at the safety champion meeting There are posters across the maternity service advertising the role and people	Assists the Board's understanding of maternity services and in obtaining oversight of safety Staff feedback and uptake at drop in sessions which will could positive impact on the safety culture and staff surveys	To include the roles and responsibilities of the safety champions in the Risk Management Strategy following the Governance Review To review the clinical safety champions to ensure separation from line management To strengthen the relationship between safety champions and Freedom to Speak Up Guardian and Champions .	Director of Midwifery, Clinical Director, Board Safety Champions, Head of Midwifery End of February 2021	None Identified	None Identified

performance data and update on service transformation Terms of Reference for the meeting are in place together with a standard agenda Monthly safety champion drop in, and walk round sessions are scheduled with both Board and service Safety Champions participating The Non-Executive Director is very engaged and attends the Governance meetings of the Maternity service, local LMNS meeting as well as regional learning lessons events	Diary Invites into Calendars of the Safety Champion walkabouts and drop in sessions. Attendance records and minutes of meetings capture the attendance and engagement of the Executive and Non-Executive Director					
Advocate role... This is a new role and national guidance is currently being drafted	Once National guidance has been implemented the service will be able to evidence this requirement through: Decrease in formal complaints Job Description and recruitment to the role Attendance at Trust Board and LMNS Monthly reports	National guidance is required for the roles and responsibility of the advocate and the expected outcome measures required.	National guidance is required for the roles and responsibility of the advocate. .	DOM March 2021.	National and LMNS support.	To continue to meet with families who have raised concerns as part of the complaints process To continue to include the views of the families in the PMRT and Serious Incident Framework

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?
Multi-professional Training Over 90% of midwives have attended obstetric emergency training but not multi-professional. Multi-professional skill drills are being arranged (social distance compliant) to supplement existing training Multi-professional training commenced in 2021 Given the transition to Multi-professional training, two sets of compliance figures are provided monthly to the Maternity Governance Meeting An annual programme has been developed for the year for the new multi-professional training and staff booked on.	Compliance with Multi-professional Training is being monitored through fortnightly CNST progress meetings. This monitoring is being strengthened through a creation of a training dashboard which is currently in the progress of being developed	The fortnightly CNST progress meeting upwardly reports to the Divisional Maternity Governance Meetings and leadership Board as well as the Bimonthly Safety Champion Meeting. CNST progress reports are also presented quarterly to Sub Board Quality Assurance Committee (QAC) and Trust Board through CNST progress reports A schedule of papers that provide further detail on each safety action to Trust Board and QAC is also in post	Given the requirement to socially distance E-learning packages are being developed for Theatre Staff and Maternity staff Human factors, mental health, COVID and critical care E-learning packages also developed Reporting mechanisms to the LMNS need to be agreed To review Training Needs Assessment for maternity staff	Director of Midwifery, Head of Midwifery, Labour Ward Clinical Leads for PCH, HH, Practice Development Midwives July 2021 Director of Midwifery LMNS SRO March 2021 Associate Director for Non-Medical Education, Director of Midwifery, Obstetric Education Lead	Collaboration with LMNS to determine reporting processes Support to formulate E-learning packages Approval of two additional Practice Development posts that are due to be advertised Support from HR to align revised TNA to ESR Core learning	Training Compliance monitored internally and CCG Quality Midwife attends the Maternity Strategic Leadership Board so receives CNST progress reports Financial funding has been received from the LMNS to support the development of the “Charlotte” training which will include Human factors Current TNA mapped on ESR Core learning

Collaborative Working with the Theatre Team is underway so that relevant multi-professional training can be delivered to a specified cohort of staff identified for Theatres.				May 2021		
Ward Rounds Multidisciplinary Twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward on both sites are in place.	Ward Assurance books, Real-time audit of digital patient notes (K2).	. Audit report Consultant Job Plans	Audit of compliance with requirement for MDT walk rounds	Audit Midwife and Clinical Audit Lead March 2021 for audit completion	None Identified	No risk to mitigate as compliant
Ring-Fenced Funding Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only. CNST discretionary funds from Year 2 submission have been agreed by Trust Board and NHS Resolution and allocated for 20/21 to the Maternity service	A full costed plan that outlines the discretionary funding allocation to improve compliance with CNST safety actions is in place and has been approved by Trust Board and NHS Resolution	The plan is monitored by the Executive Directors at the monthly Divisional Accountability meetings	The process of future CNST premium awarded to the Maternity Service in the event being compliance with Ten Safety Actions need to be agreed by the Trust Board	Director of Finance/DOM/HOM/GM August 2021	Agreement to resource allocation	New requirement. Allocation for 20/21 made so no risk to this financial year

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?
High Risk pathways Guidelines in place that outline the requirement that all high risk obstetric care women are assigned a named Consultant Obstetrician There are multi-professional ANC clinics in place for conditions such as diabetes Guidelines are in place that outline the referral pathways to Tertiary Centres (Addenbrookes and Leicester) for both the mother and baby Close collaborative working between the Tertiary Units is in operation through	Monthly Guideline Compliance report produced by the Trust Quality Governance Team Baseline audit regarding named Consultant Obstetrician, risk assessments at each ANC appointment, has been undertaken and an improvement plan is in place	Guideline compliance is reported through Divisional Governance Meetings and at the Trust Quality Governance Operational Committee. Trust wide compliance and exception reporting is also reported in the monthly quality report A baseline audit has been completed and will be presented at the Maternity Audit Meeting. Leads have been assigned to Improvement actions	Alterations to the K2 Digital Maternity System to be undertaken to strengthen risk assessments throughout pregnancy To update Guidelines regarding risk assessments at each antenatal contact Further national Guidance is required as to develop Maternal Medicine Specialist Centres.	Digital Midwife March 2021 Guideline Midwife Clinical Leads DOM HOM Date to be confirmed	LMNS, Regional and National support in developing Maternal Medicine Specialist Centres	Progression of the Audit Improvement plan Referral pathways for Tertiary referral for Fetal Medicine are in place

MDT Case Review meetings Specialist team of midwives who provide care to social high risk women		Not currently monitored		once guidance published		

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?
Saving Babies Lives Action Plan and Dashboard developed Full guidelines in place that meet the requirements outlined in all five elements Current position is that full compliant with Element 3, on track to fully implement Element 1, 4 and 5. A plan to bring element 2 back on track is in place Implemented revised care bundle following wave 1 of Covid	Monthly compliance will be demonstrated by the dashboard Audit programme to evidence implantation of SBLv2 has been identified and progressing Real time audit is available through maternity digital record system (K2)	Reported Monthly to Maternity Leadership Board, Audit meeting, Bi-monthly Safety Champions meeting Quarterly reporting to Trust Board and Quality Assurance Committee. Also report bimonthly to the LMNS	To undertake audits of Small for Gestational Age babies To continue to improve training compliance		Funding of a Gap and Grow Midwife	To utilise a midwife who is currently shielding on a temporary basis
Currently all women are risk assessed at the point of entry to Maternity care by risk assessments	Real time audit is available through maternity digital record system. The service hasn't formally audited the process, but this has been	This will be reported through the audit programme to Maternity Leadership Board and	Implement risk review at every point of antenatal contact	Community and Outpatient Lead Midwives. Clinical Leads PCH and HH by	No further resources required	Where there are deviations from appropriate care pathways this is reported through the Datix system and MDT review of cases is completed and appropriate actions implemented.

completed at the booking appointment	added to the Audit programme for the service.	Safety Champions meetings		31st January 2021		
Ongoing review of the intended place of birth, based on the developing clinical picture	Real time audit is available through maternity digital record system. The service hasn't formally audited the process, but this has been added to the Audit programme for the service.	Where there are deviations from appropriate care pathways and Women's choice of place of birth they are reviewed by an MDT.	Audit of women delivering in other locations other than their intended place of birth to be developed Full implementation of Personalised Care and Support Plans	Audit Midwife March 2021 Community and Outpatient Lead Midwives, Digital midwives March 2021	None Identified	Where there are deviations from appropriate care pathways this is reported through the Datix system and MDT review of cases is completed and appropriate actions implemented.

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?
Saving Babies Lives Action Plan in place and being monitored monthly A digital Saving babies Lives dashboard has recently been created which will report on all outcome measures Service has restored Carbon Monoxide Test as stated in recent guidance following Wave 1 CoVID 19 Monitoring of Antenatal Steroids and use of Magnesium Sulphate recently	Monthly compliance will be demonstrated by the dashboard Audit programme to evidence implementation of SBLv2 has been identified and being progressed	Reported Monthly to Maternity Leadership Board, Audit meeting, Bi-monthly Safety Champions meeting Trust Board and LMNS reporting in place Utilising the Perinatal Institute data base and reporting function	Continue monitoring compliance of SBLv2 Develop systematic system wide learning throughout the service that is embedded in clinical practice	Fetal Wellbeing Midwife, Lead Midwife for ANC and Community, Clinical Leads, DOM, DHOM, HOM	Need to resource a GAP and GROW midwife to focus on small gestational babies	Temporary support identified to assist with auditing small for gestation date babies Action plan in place supported by monthly meetings

added to the Maternity Dashboard						
Fetal Monitoring Lead Midwife in post Pan site which equates to 0.5 WTE per consultant led unit (national requirement of 0.4 per consultant led unit) Lead clinician appointed and in post on both sites External speciality training events for clinical staff have been held. Online training package for Consultants and Midwives. Specific assessment tool in use for antenatal monitoring including the use of computerised CTG. Specific assessment tool in use for intrapartum monitoring. Human Factors and situational awareness education in annual mandatory training	Current Guidelines are in place that covers all points outlined in the Saving babies Lives Care Bundle Monthly Fetal Monitoring Training sessions for Midwives and Consultants via the K2 system which includes a competency test Fetal Monitoring newsletter in place for the maternity staff which includes lessons learnt from reviews E-learning for Intermittent Auscultation in place Current (January 2021) Training compliance is 90% for midwives and 86% for all grades of obstetricians (national standard = 90%). Further training is place Attendance at Case reviews where all CTG's of Category One Caesarean sections are reviewed by the MDT team Attendance at Labour Ward Forum	Reduction in concerns regarding fetal heart monitoring in ATAIN, PMRT reviews and SI Reduction in HIE, avoidable term admissions, still birth rate as monitored on the maternity dashboard	Focus on Obstetric Staff training compliance To review training compliance reporting as part of the governance review	Fetal well-being Lead Midwife. Consultant Fetal monitoring leads March 2021	None identified	Action plan in place

	and ATAIN review meetings Acts as an expert reviewer if concerns raised regarding a CTG					

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?
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 through all women have access online and in MAMA Academy packs that each issued to each patient before 20 weeks gestation. This information is evidence based. Women's choices leaflet was coproduced with the LMNS and MVP, and is available on the CCG and Trust website. Digital Midwifery working in collaboration with the CCG and LMNS to ensure that development of personal care planning is consistent across the LMNS. My Maternity notes (women's maternity online	Reporting Structure needs to be included in the Internal Governance Review	Monthly Patient Experience report presented at the Maternity Leadership Board	Ongoing work to update the Maternity website is underway to ensure that all pathways of care are in a format that is consistent and provides women with evidenced based information. Increased compliance with Personalised Care Planning and ensure associated auditing This information will be translated in written and video form into languages that are most commonly used within our local communities. No Further action required Ongoing system development	Audit Midwife/ Digital Midwife/ Clinical Director/Communications lead. February April 2021	Assistance with Interpretation of information	Use of Interpreting Service

care record) was launched in December 2020				Digital Midwives March 2021	LMNS support for developing consistent system wide approach	
Social media forums created and undertaken to engage with service users views. Virtual Tours of both sites, and Covid question and answers Live sessions have been held	Patient feedback and experience	Patient feedback and comments on social media platforms	Further online live sessions are planned with community groups and service users	DHOM/ Matron March 2022	None Identified	None identified

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?
Obstetric Medical Review of Obstetric Workforce has been completed as part of CNST, safety 4	We have ensured that we meet the recommendations of the Safer Childbirth/RCOG – the future workforce recommendations HH <2000 birth, 56 hrs of consultant presence (recommended – 40 hrs or as per risk assessment) PCH – 4600 births. 91 hrs of consultant presence provided (recommended – 40hrs, with aspirational target of 98 hrs/week) No red flags on GMC trainee survey so no action plan required. A nil return is due to be submitted to the RCOG for both sites	Progress discussed at the fortnightly CNST Progress Meeting with upward reporting to the Maternity Leadership Board and bi-monthly Safety champions Board. Trust Board will be updated as part of the CNST compliance and oversight reporting schedule	Board paper regarding medical maternity workforce is currently being prepared Three month audit of Rotas to be undertaken to review the percentage of consultant time acting down on labour ward Plans to establish a maternity workforce committee	DOM/ Clinical Leads for PCH and HH, Neonatal Service Lead End of February 2021 Clinical Leads and Rota co-ordinators April 2021 General Manager March 2021	non identified	Non identified
Anaesthetic medical workforce The Trust has lead Obstetric Anaesthetists on both sites and they are members of the Labour Ward Forum. Additionally there is anaesthetic attendance at the monthly multi-professional case review meeting PCH is compliant with the Anaesthesia Clinical Services Accreditation Standards 1.7.2.5, 1.7.2.1 and 1.7.2.6. Hinchingbrooke is not currently compliant with the standards and advice from the Royal Colleges	Minutes of meetings Job plan of the Obstetric Anaesthetist	Plans are reviewed by the Surgery governance meeting. Progress discussed at the fortnightly CNST Progress Meeting with upward reporting to the Maternity Leadership Board and bi-monthly Safety champions Board. Trust Board will be updated as part of the CNST compliance and oversight reporting schedule	Action Plan to be drafted for Hinchingbrooke Compliance position to be included in the medical workforce paper being developed as part of the CNST reporting schedule	Clinical Director for Surgery/Divisional Director for Surgery/Clinical Director for Maternity/DOM Date March 2021	Resources have been allocated to meet the actions To received guidance from Royal Colleges about implementation of standards in small obstetric units	Rotas in place Red flag reporting regarding delayed analgesia in place as part of Birthrate Plus APP DATIX reporting in place

has been requested due to being a small obstetric unit						
Neonatal medical workforce The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards for medical staffing	Neonatal Clinical Leads have reviewed compliance and provided evidence The most recent Neonatal Quality Assurance Peer Review did not report any concerns or lack of compliance in terms of neonatal medical workforce	Clinical Leads for Neonatal Services collaborative working with Safety Action Four lead Data has been submitted as evidence of compliance	To be included in the Trust Board CNST workforce paper to evidence compliance with Safety Action Four	Clinical Lead for Neonates/Service lead for Neonates End of January 2021	None Identified	None Identified
Neonatal nursing workforce Both Neonatal Units (Local Neonatal Unit at PCH and SCBU at Hinchingbrooke) meeting the BAPM standards of having sufficient nursing staff providing direct clinical care. The Local Neonatal Unit at PCH is complaint with the percentage of Qualified in Speciality (QIS) nurses to meet activity and acuity levels. The SCBU at Hinchingbrooke does not currently meet the QIS standard of 70% and an improvement plan is in place The annual Dinning CRG neonatal calculator was undertaken in September 2020 There is a Neonatal Outreach Service in operation	An action plan is place that considers the Toolkit for Quality Neonatal Services (DH,2009), British Association of Perinatal Medicine Standards as well as the workforce recommendations outlined in the National review of Neonatal Critical Care	The action plan is led by the Neonatal Lead Nurse and Divisional Nursing Director through the Children's Division. CNST Safety Action Five requirements regarding neonatal nursing has been monitored through the fortnightly CNST progress meetings with upward reporting to Trust Board through Divisional and organisational governance processes	A Neonatal Staffing paper has been drafted and due to be submitted to Quality Assurance Committee and Trust Board as part on on-going progress monitoring of CNST Submission of nursing position to the RCN is required	Neonatal Lead Nurse, Divisional Nurse Director End of February 2021	N To secure funding from HEE for two QIS training places To receive financial support to backfill staff with Bank whilst undertaken their training	mitigate Open cots to reflect staffing skill mix and competency
Midwifery The midwifery senior team have successfully undertaken a recruitment campaign over the past 6 months The Trust has already commissioned Birth Rate and a draft report on the workforce was presented to the Senior Maternity team in 23/12/20. Further work is currently being undertaken regarding workforce requirements	The service has a recruitment plan in place Birth rate Plus Workforce review has included an independent assessment of the Trust's last 12 month's activity and acuity data by BR+ team.	Oversight of staffing at a Daily Maternity operational level and during COVID there is a Trust Non-Medical Staffing Workforce Bronze Cell E-roster in place with Key Performance Indicators in place Staffing reports are provided at the Maternity Leadership	A final report from BR+ is expected and this will inform the investment appraisal and implementation plan An investment appraisal will be developed to meet the national safe midwifery staffing standards. This is in the region of an additional 25wte clinical midwives	Finance team/ DOM/HOM February 2021 March 2021	Trust Board approval of the Investment appraisal Approval to appoint an external recruitment agency to support a large recruitment campaign	Incentive scheme for Midwives in place to increase up take of bank shifts. Longer term booking of agency staff Robust sickness management of current staff absence Temporary increase in part-time hours

to implement Continuity of Care (CoC) Biannual Midwifery staffing reports are presented to Trust Board, with the most recent presented in August 2020 Planned and Actual Fill Rates are reported monthly in the Trust's Staffing paper which is presented to Trust Board Birthrate Plus APP has recently been implemented to capture Staffing Red Flags Supernumerary Status of the Labour Ward Co-ordinator and One to One Care in Labour are monitored monthly on the Maternity Dashboard which is upwardly reported to Trust Board through Divisional and Trust Governance Processes Improvement plans are in place regarding Supernumerary Status and One to One Care Continuity of Carer Implementation Plan has been developed	A plan to achieve the Birthrate Plus Standard will be formulated for Board approval by 30th January 2021 which will include timescale to address the need for investment approval and recruitment. Staffing levels are monitored daily through operational meetings Completion of the Birthrate Plus APP is discussed at the Labour Ward Co-ordinator meetings Action is taken where actual fill rates are red RAG rated Insufficient implementation of Continuity of Carer	Board and upwardly reported to the Maternity Safety Champion Meeting Midwifery staffing levels are also included in the Non-Medical Workforce Committee which upwardly reports to the sub Board Workforce Committee The Trust Board received a monthly staffing report in which midwifery staffing is incorporated Biannual review of staffing is undertaken Biannual midwifery staffing report is submitted to Trust board Midwifery to Birth ratio is a metric included in the maternity dashboard which is incorporated in the Trust's monthly quality report Midwifery staffing position is also provided at LMNS meetings	The Investment Appraisal will be presented to the Executive Team for consideration and Board for approval A Birthrate Plus implementation plan will also be developed for Board Approval Recruitment plan to be developed with trajectory in place. Plan to include the employment of an external recruitment agency to assist with pace of recruitment	March/ April 2021 March/April 2021 April 2021		Workforce planning and achieving E-roster KPI's

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
Compliance with the Seven Steps is outline below Step One: The Trust has recently appointed a Director of Midwifery who has a place at Trust Board on maternity related matters (non-voting post)This posts sits Corporately and reports into the Chief Nurse who is the accountable Executive Director and is a voting Board member. The Trust has a Head of Midwifery (8D) in post that covers both sites and is operationally focussed. The Post is supported by a Deputy Head of Midwifery (8b) in post, with a further 8b post being developed to strengthen the management structure. There are lead Midwife posts for each service area. Step Two: The Trust Liaises with the Regional Chief Midwife and the CCG Quality Midwife so demonstrating that senior level midwife at all parts of the system Step Three: The Trust currently does not employ a Consultant Midwife but the Service is hoping to address in future workforce plans Step Four: The Trust has a range of specialist midwives such as for bereavement, diabetes, fetal wellbeing, antenatal and newborn screening Step Five: The local Health Education Institute has a Lead Midwife for Education who regularly meets with the senior team at the Trust Step Six: There is a range of leadership development opportunities at the Trust and Midwives also access external courses such as the aspiring HOM course. Step Seven: External Midwifery representation has been involved in the recent senior midwifery appointment

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?**
Trust Policy in place regarding Guidelines All new or updated NICE standards or quality statements (QS) are sent to the guideline midwife from the Trust Quality Governance lead. Guideline midwife will lead the completion of the NICE gap analysis against guideline/current practice liaising with the wider multi-professional team where required The NICE Gap analysis are RAG rated and returned to Trust Quality Governance Team once agreed by the Maternity Division with a copy sent to the Maternity Triumvirate team. In accordance with Trust policy, every Guideline has a version control to each document and the reason for any changes documented. Quarterly meetings between the Guideline midwife and Trust governance to discuss current position Any NICE non- compliance would be reviewed at Maternity Leadership Board in regards to outstanding actions	All new guidance and quality statements Completed within an agreed time frame with Trust Quality Governance lead Monthly Divisional Quality Governance Reports include status on guideline and NICE compliance Compliance is upwardly reported through the monthly Quality Report and the Trust's Quality Governance Operational Committee	Guidelines are reviewed every 5 years or sooner if relevant national guidance or reports such as NICE, MBRRACE, RCOG is published process New guidelines are formulated by clinical lead/specialist with input received by the multi-professional team Guidelines are approved by the Maternity Guideline Group. Ratification occurs at a Trust wide Governance Strategy such as Quality Governance Operational Committee, Drug and Therapeutic Committee. The approval and ratification process is outlined in the Trust Policy	Review of currently processes are within the scope of the current governance review	Director of Midwifery End of February 2021	None identified	None Identified