North West Anglia NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (PUBLIC)

REPORT TITLE	Baseline Assessment against the Fifteen Immediate and Essential Actions outlined in the Final Ockenden Report
AUTHOR	Penny Snowden, Director of Midwifery
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DATE OF MEETING	14th June 2022
PRESENTED FOR	Information
ITEM PREVIOUSLY CONSIDERED BY	Maternity Accountability Cabinet and Quality Assurance Committee on 31st May 2022

PURPOSE OF THE REPORT

Since the publication of the Final Ockenden Review on the 30th March 2022, Multi-professional leads were identified for the four national pillars as outlined in the letter received by all Acute Trusts from NHS England on 1st April 2022.

Those leads have completed a gap analysis against the 15 Immediate and Essential actions that related to their Pillar. The full document has then been discussed with the wider senior maternity team with two extraordinary Maternity Accountability Cabinets arranged for the 11th and 20th May 2022.

This paper summarises the gap analysis so the committee members are aware of the baseline position from which the maternity service will commence the improvement journey to full compliance with both Ockenden reports

The paper also highlights that the Trust welcomes the regional and national maternity team on the 30th and 31st May as part of reviewing progress made against both Ockenden reports

The paper also highlights the areas that require improvement at a Trust Level

RISKS RELEVANT TO THE PAPER

Risk ID	Risk Description
103074	Potential Risk to maintaining safe staffing levels in maternity services due to vacancies and maternity leave.
103400	Band 7 being unable to maintain supernumerary status to maintain safety oversight of the care of all women on delivery suite
103389	Insufficient obstetric workforce impacting on junior doctor training, morale and patient safety
103251	The risk of women and their families receiving poor pregnancy/ birth experience due to current practices and culture

RISK APPETITE RELEVANT TO THE PAPER **(insert relevant section from Risk Appetite Statement from Risk Management Policy)**

DOMAIN	TRUST RISK APPETITE LEVEL	DESCRIPTION OF RISK APPETITE
Quality Outcomes	**Cautious:** *Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward*	*Tolerance for risk taking limited to those events where there is little chance of any significant negative impact on quality or safety of care. Decision making authority generally held by senior clinicians*

THE BOARD IS ASKED TO:

1. *To note the current baseline and the improvement journey required from the Maternity Service*
2. *To agree quarterly full progress reports against the fifteen Immediate and Essential actions with a brief summary position included in the monthly maternity report*
3. *To monitor the progress made against the recommendations as outlined in the Ockenden Report*

STRATEGIC GOALS THIS REPORT SUPPORTS *(Check all that apply)*

Delivering outstanding care and experience	**X**
Recruiting developing and retaining our workforce	X
Improving and developing our services and infrastructure	X
Working together with local health and social care providers	X
Delivering financial sustainability	X

OTHER IMPLICATIONS OF THE PAPER

Legal/ Regulatory Relevance:	*Regulation 12: Safe Care* *Regulation 17: Good Governance* *Regulation 18: Appropriate Staffing*
NHS Constitution Delivery	*Outstanding care*
Freedom of Information Release	This report can be released under the Freedom of information Act 2000

Equality and Diversity Implications *(Check all that apply)*								
Age	Gender	Ethnicity	Disability	Pregnancy/ Maternity	Marriage/ Civil Partnership	Religion/ Belief	Sexual Orientation	Gender Reassignment
☐	☐	☐	☐	**X**	☐	☐	☐	☐
Additional comments								

1. Executive Summary

1.1. This Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust ("the Trust") reviewed the care provided to 1486 families and published findings on 30th March 2022.

1.2. Many of the issues highlighted in the final report are not unique to Shrewsbury and Telford Hospitals NHS Trust and have been highlighted in other local and national reports into maternity services in recent years.

1.3. As such, the review team has also identified 15 areas as Immediate and Essential Actions which should be considered by all Trusts in England providing maternity services.

1.4. No further instructions have been received by the National Team though this is likely once the Kirkup Report on East Kent is published September 2022.

2. Main Highlights from the Gap Analysis

2.1. The minimum evidence was reviewed by the maternity multi-professional team. At the time of writing the report, the only section outstanding is the Immediate and Essential action relating to obstetric anaesthesia with the Maternity Clinical Director leading the follow up for completion.

2.2. Table One below provides a high level view of the current position against each of the fifteen Immediate and Essential actions with the full gap analysis included in Appendix One.

Table One: Current Position with Ockenden One

IEA	IEA Heading	Current Position	RAG
1	Workforce planning and sustainability	• Uplift needs to be calculated for maternity • Lack of Midwives trained in Obstetric HDU care	
2	Safe Staffing	• Lack of separate Gynae and Obstetric Rotas • Not all labour ward co-ordinators completed the Labour Ward Co-ordinators course	
3	Escalation and Accountability	• Trust wide guideline on difference in clinical opinion required	
4	Clinical Governance Leadership		
5	Clinical Governance – Incident investigations and complaints		
6	Learning from Maternal Deaths	Need to secure regular external obstetric representation at SI MDt Panels	
7	MDT Training		

IEA	IEA Heading	Current Position	RAG
8	Complex ANC Care	Limited preconception care Lack of specialist Midwife for Twins	
9	Preterm Birth		
10	Labour and Birth		
11	Obstetric Anaesthesia	Not compliant with all A	
12	Postnatal Care		
13	Bereavement Care	Only operates Monday to Friday	
14	Neonatal Care	No split rotas at PCH to cover Neonatal Unit	
15	Supporting Families	Birth Reflections in place. Next steps to work more closely with perinatal mental health services	

2.3. The gap analysis has several areas which have been "greyed" out and these actions required either national/regional action or there is the requirement for greater professional discussion regarding the evidence base.

2.4. Full implementation of Ockenden 2 does bring cost implications to the Trust with specific requirements to have a tailored uplift for maternity services based on historic patterns of sickness, training and maternity leave, a split obstetrics and gynaecology rota at PCH and split paediatric neonatal rota at PCH.

2.5. There are areas that impact on the organisation most notably having a Difference in Clinical Opinion Policy, how the Divisional Clinical Directors, Nurse Directors have sight of their serious incidents, complaints and are involved in the MDT reviews in the same way that the Ockenden Report has made recommendations for the Director of Midwifery, Head of Midwifery and Clinical Director for Maternity. Additionally, there is a recommendation that the Maternity Voice Partnership have a voice in the Complaints and PALS process; it therefore seems reasonable that other service user groups are also involved in co-producing any revisions to these processes.

2.6. Given the significant transformation the maternity service is required to make, in terms of pathway redesign, the Divisional Leadership team are currently reviewing the resource required to achieve compliance, especially as this is in addition to the Year 4 Maternity Incentive Scheme (MIS) and the implementation of Continuity of Carer (COC).

2.7. Next steps have been identified with operational progress being monitored through the Maternity Transformation Committee and ultimately the Maternity Accountability Cabinet. Monthly updates will be included in the monthly Maternity Quality Report.

3. Regional Ockenden Assurance Visit

3.1. The East of England Maternity Team are visiting all maternity units across the region and North West Anglia NHS Foundation Trust's (NWAFTs) visit is scheduled for the 30th and 31st May 2022.

3.2. Request for evidence has been received by the regional team. The evidence has been collated and presented to the maternity safety champions as well as a member of the LMNS to approve evidence submission. All evidence requested was submitted on Wednesday 11th May 2022.

3.3. The external team have requested to meet with several teams including the Risk and Governance Team, Maternity Medicine Leads, Antenatal Screening Team, Education Team as well as the Saving Babies Lives Team.

3.4. The National Maternity Team will also be visiting on the 31st May 2022 to review progress of the organisation whilst on the National Maternity Safety Support Programme.

3.5. Feedback from both teams will be received at the end of the visit on the 31st May 2022.

3.6. Initial high level feedback will provided to QAC in June 2022.

4. Summary

The paper provides the initial baseline position of the maternity service against the Immediate and Essential Actions outlined in the Final Ockenden Report. Significant transformation is required to achieve all recommendations and the Divisional Leadership team need to consider the resource required to deliver.

Appendix One: Completed Gap Analysis

Immediate Action Description	Essential Action	Next Step Actions	NWAFT current position against Next Step Actions	Evidence	Status / RAG rating
1: WORKFORCE PLANNING AND SUSTAINABILITY	**<u>Essential action – Financing a safe maternity workforce.</u> The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.**	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.	External BR+ review undertaken in 2020 with investment paper approved at Trust Board in April 2020. Investment of £1.5m to achieve 1:23.3 acuity ratio. However, investment at risk due to CIP target of £0.5m 2021/22 and £1m in 22/23. Nationally, investment of £96m of which NWAFT awarded £2m and recurrent on a shared allocation. Further funding for maternity and neonatal for 22/21 announced	BR+ report, TB papers, monthly quality reports, MOI regarding external funding	
		Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure Trusts are able to safely meet organisational CNST and CQC requirements.	CNST Safety action 5 achieved for year 3 and on track for Year 5. Funded for 1:23.3. Biannual staffing reports submitted to Trust Board. Vacancy rate circa 50wte - risk is on risk register and TB and LMNS aware through the maternity dashboard and LMNS Safety Highlight report. Obstetric Staffing from April being reported to Trust Board and needs wider discussion with LMNS	Trust Board Papers, Risk Register, Risk action cards, risk assessment, maternity risk minutes, safety highlight reports, LMNS minutes and papers	
		Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.	Currently 22.5% which is Trust wide - need to calculate specifically for maternity due to higher maternity leave and sickness absence as well as the additional training needs analysis		
		The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.	This is for national action by NHSE and Royal Colleges		

	<u>Essential action – Training</u> **We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.**	All Trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.	All newly qualified midwives are provided with a Preceptorship programme which has been recently reviewed based on feedback from current NQM. There is a named PDM for NQM and a second PMA has been put in place to assist with clinical supervision. Supernumerary time is facilitated during the orientation period and protected time is provided for monthly supervision and learning. The Trust	Preceptorship programme, PD team organisational structure, PMA sessions, rosters	
		All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	Needs wider professional discussion regarding evidence base and awaiting further direction from the national and regional teams		
		All Trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.	The TNA needs further review to ensure that the coordinators skill set / portfolio are included. None of the current co-ordinators have attended a course. Leadership training has commenced with the first module focused on leading psychologically safe environments. Module 2 is being developed in partnership with ARU and will be a PgCert level course that will focus on core skills of co-ordinating a delivery suite - with a view of utilising retention monies to fund. This will take approximately 2 years to complete due to releasing midwives and backfilling.		

		All Trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Currently do not have a specific orientation package for labour ward co-ordinators. Email sent to EoE HOM/DOM to see if one that can be adapted for NWAFT with CUH to share theirs. Leadership programme just launched with MBTI funded for each Co-ordinator and plan for each one to have a personalised leadership plan	Leadership days, agendas for the day, MBTI , attendance lists	
		All Trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	Recognised that there is not a trained midwife on each shift so a Review of recovery/HDU process and pathways is planned. The CPD plan includes the obstetric high dependency course and the review will shape the model to be used. Shortened course midwifery training reintroduced which add to the skill mix and nurses utilised for high dependency women. All women needing an arterial line are cared for on ICU. Close monitoring task and finish group set up		
		All Trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.	Workforce lead now in place. OD support in place which includes talent mapping. OD plan in place. Leadership development commenced. Succession and talent mapping part of the annual appraisal. Gap Analysis to be completed following career clinics. Secondments supported	OD plan, Appraisal paperwork templates and examples completed. Leadership development. Secondments	
		The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be	For NHSE and Royal Colleges Action		

		established, to ensure the appropriate workforce long term.			
2: SAFE STAFFING	**<u>Essential action</u>** **All Trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals**	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.	Need to review escalation SOP to include obstetric staffing and need to review the need for a BCP for obstetric staffing. Need to discuss escalation of closure to CN and MD given that it upwardly reports through OPS and quality data forms part of the dashboard and performance reviews. LMNS and Chief Midwife informed of closures		
		In Trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.	Combined rotas on each site. Risk Assessment to be completed. To explore feasibility of two tier rota at PCH		
		All Trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	Specific job description in place. Also have a Midwifery Delivery suite manager in place	Job description	
		All Trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.	No current MCOC model in place. MCOC plan that has signed by Trust Board outlines implementation phases linked to achieving defined midwife to birth ratio (substantive) and that Trust Board approves that the service from a safety and quality perspective are ready to move to next implementation stage	MCOC plan. Trust Board Minutes	
		The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	Building Blocks being put in place most notably staffing	MCOC plan, LMNS minutes	

		The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic Trust mandatory training and reviewed as training requirements change.	Additional PA's being added to job plans for educational leads. Professional development included in study allocation time.	Job Plans	
		All Trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	Expanded PD team in place and 2 PMAs now in place providing support. Do participate in clinical duties as part of the escalation process however not counted in the numbers. Recruited a Clinical Skills facilitator to support/ develop support workers	Clinical Feedback from staff, Sessions,	
		Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	Several Band 8's are accessing coaching. Others have mentorship; however this is informal and the process needs to be formalised.		
		All Trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	need greater clarity on this		
		All Trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.	The Trust has not implemented the RCOG guidance on the management of locums		
					Overall Partial assurance

3: ESCALATION AND ACCOUNTABILITY	**<u>Essential action</u>** **Staff must be able to escalate concerns if necessary** **There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times.** **If not resident there must be clear guidelines for when a consultant obstetrician should attend.**	All Trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.	A Trust wide policy is required		
		When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence Trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	Training log, RCOG portfolio, ACRP evidences and educational supervision in place. Education forms also submitted for considerations	Training Logs	
		Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Have obstetric presence until 9.30pm at PCH and 9pm at HH. This will require additional investment. Have funding for 2 additional consultants through the recurrent Ockenden investment. Awaiting for the RCOG staffing tool to be developed and released	Rotas, Ockenden funding MOI	
		There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	RCOG guidance discussed at both Consultant Meetings, policies have been reviewed to include the guidance. Monthly audit is in place and focus now needs to be on accurate data capture and improving compliance levels	Policies, CNST reports, audit	
		There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	Escalation Policy required revision		
					Lack of compliance

4: CLINICAL GOVERNANCE-LEADERSHIP	**<u>Essential action</u>** **Trust boards must have oversight of the quality and performance of their maternity services.** **In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.**	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.	Monthly maternity reports presented to QAC and Trust Board. Dom attends public TB. Executive Directors meet the operational team monthly as part of the Integrated performance review and an information pack is developed for this. Board Safety Champion and Maternity NED in place	Maternity papers, board reports, performance reports	
		All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their Trust board.	The NHS Improvement Self-assessment version one and two have been completed and presented at MAC, QAC and Trust Board with current compliance at approx 97% with the need to develop a strategy outstanding	Maternity Report, completed self-assessment, Papers	
		Every Trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Being explore nationally		
		All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	Named consultant for governance and PA's recently increased in view of workload.	Job Plan and rotas	
		All Trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.	All staff are trained in RCA, human factors etc. Risk team accessing additional training that is facilitated by HSIB. Obstetric Lead a trainer in Human factors and it is included in the Maternity TNA as a mandatory session	Training attendance and certificates, TNA and Teaching sessions	
		All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	Have a patient safety team in place - guideline and audit multi-professional leads and meetings in place for each. Guideline planner in place and performance monitored monthly as too are guidelines against the audit plan	Guideline development that provides names of contributors and authors, Auditors, minutes of meetings	
		All maternity services must ensure they have midwifery and obstetric co-leads for audits.	Have a patient safety team in place - guideline and audit multi-professional leads and meetings in place for each. Guideline planner in place and performance monitored monthly as too are guidelines against the audit plan	Guideline development that provides names of contributors and authors, Auditors, minutes of meetings	

					Strong evidence of compliance
5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS	**<u>Essential action</u>** **Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.**	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.	Reports updated to use names, includes family concerns and glossary, HISB also revised format	Si Reports	
		Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	Local learning section to the TNA	TNA	
		Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.	Included in audit programme, evidence of compliance required prior to closing action plan		
		Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	New requirement so not been monitored. Outstanding actions of SI reports monitored through maternity risk management, Maternity Quality Committee, QAC and TB	Reports	
		All Trusts must ensure that complaints which meet SI threshold must be investigated as such.	Corporate Complaints team will triage all complaints and all complaints are submitted to the weekly rapid review. The grade threes are discussed to whether they meet the SI criteria. The ones lower than that are reviewed to double check the grading is accurate. Further support by quarterly CLEAP	TOR for Weekly Rapid Review, Papers of meetings demonstrating process. WRR tracker. Complaints policy. CLEAP report	
		All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	MVP attend the Women's Experience Committee where complaints are discussed; though they are not involved at an individual level. Where themes occur this then may get transferred to the MVP action plan. The complaints process has not been formulated with user involvement. Being added to the MVP Workplan for 22/23		
		Complaints themes and trends must be monitored by the maternity governance team.	Yes , this has recently been developed through the introduction of the Women's Experience Committee	TOR, agenda, papers, minutes	

					Strong evidence of compliance
6: LEARNING FROM MATERNAL DEATHS	**<u>Essential action</u>** **Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.** **In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.**	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.	Not applicable to individual Trust		
		This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.	All maternal deaths investigated by HSIB. Discussed feasibility with CUH regarding joint working. CUH have been involved in ad-hoc way. West Suffolk open to working in partnership which is currently being explored by the clinical director and the DOM to email the HOM. A buddy system with Norfolk and Waveney is in operational which enables an external midwife to be involved. Raised by the clinical team with the regional obstetric lead for wider professional discussion	Minutes of meeting of HOM attending case review	
		Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	Learning shared through the safety highlight report and LMNS SI report. For example LMNS learning event on diabetes. 6 month implementation a new standard so not been monitored as of yet.	LMNS minutes, details of LMNS learning events	
					Partial compliance due to new standards

7: MULTI-DISCIPLINARY TRAINING	**<u>Essential action</u>** **Staff who work together must train together** **Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.** **Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training**	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	Membership of all governance meetings multi-professional as per TOR. Rolling clinical governance in place which is open to all. Weekly Briefing sessions open to all and uploaded onto the maternity teams' Facebook. MDT training in place. Weekly MDT CTG case reviews in place	Minutes of meeting, Monthly maternity reports to QAC showcasing learning, briefing sessions,	
		Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all Trusts.	MDT safety huddles in place and being audited on a quarterly basis. SBAR has been implemented and included in training	TNA	
		All Trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	Human factor training part of the MDT obs emergency day and is mandatory for all staff. Incivility Training has just commenced with Band 8 and 7 with planned roll out across all staff groups and grades. Freedom to Speak Up champion in place. Cultural review commissioned and being undertaken by workforce PMO, OD and FTSU. Psychological safety included in leadership days.	TNA	
		There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Skill Drills impacted by C19 - however, MOH skill drill undertaken on HH site, Baby Abduction skill drills completed on each site. MOH undertaken at HH. Skill drill video and monthly skill drills reintroduced	Skill drills evaluation	
		There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	PMA in place provide restorative supervision. ICS offer of staff support provided to all staff. Supportive sessions provided to students and NQM. Time out currently being provided for all Band 7 team leaders and Band 8 managers. Trust also has a range of wellbeing offers	Diary dates of PMA sessions, newly qualified sessions	
		Systems must be in place in all Trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	Included in TNA. Competency test through the K2 training system which can be done at home. Training trajectory in place with monthly reporting. Training undertaken in work time.	TNA, audits	

		Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	Training compliance below 90%. Co-ordinators at HH 92% and 87% at PCH for training attendance. 100% HH and 81% PCH competency test. Trajectory in place. Fresh Care in Place. Unable to implement currently and risk assessment regarding lack of training compliance on risk register		
					partial visit
8: COMPLEX ANTENATAL CARE	**<u>Essential action</u>** **Local Maternity Systems, Maternal Medicine Networks and Trusts must ensure that women have access to pre-conception care.** **Trusts must provide services for women with multiple pregnancy in line with national guidance** **Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy**	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	Do have a limited preconception clinic facilitated by diabetic nursing service and is part of the workplan. Any perception advice is not in a separate clinic so difficult to evidence		
		Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Specialist clinic in post. Need to invest in a specialist midwife		
		NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	Complaint with NICE guidance		
		When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	Clear guidelines in place regarding birth plans in accordance with diabetes management- documentation is on the K2 notes and this is improving in compliance		

		Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	To improve compliance Aspirin just been made a PGD for midwives. Needs to be discussed regionally		
9: PRE-TERM BIRTH	**<u>Essential action</u>** **The LMNS, Commissioners and Trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.** **Trusts must implement NHS Saving Babies Lives Version 2 (2019)**	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	Preterm risk assessment in place. Preterm clinic in place at both sites. Element 5 of SBL implemented	Preterm guideline. Clinic data	
		Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	Included in guideline	Preterm guideline, fetal wellbeing guideline	
		Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	100% with babies born in the correct neonatal unit- except 1 case was someone who came and rapidly delivered	Birth Optimisation data	
		There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	Part of the birth optimisation project. Compliance monitored by the Neonatal ODN	Birth Optimisation data	
					On track for delivery overall

10: LABOUR AND BIRTH	**<u>Essential action</u>** **Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.** **Centralised CTG monitoring systems should be mandatory in obstetric units**	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made	All areas of birth, including low risk, must have electronic records. Currently paper notes are used on MLBU at PCH. Ensure all women in established laboured have a fully documented discussion in regard to place of birth and any change to their management plan. Risk assessment wizard on K2. Need audit data		
		Midwifery-led units must complete yearly operational risk assessments.	This is not undertaken as alongside - need to seek clarity regarding whether this just applies to freestanding		
		Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	Need to strengthen skills and drills that are undertaken on the MWL units		
		It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local Ambulance Trust.	Regional improvement work with EEAST regarding midwifery conveyancing		
		Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	The Induction of labour pathways is being reviewed given the findings of the audit into delayed inductions which includes a risk stratification for delaying an induction of labour		
		Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	both sites have centralised monitoring		
					Only partial compliance

11: OBSTETRIC ANAESTHESIA	**<u>Essential action</u>** **In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every Trust to address incidences of physical and psychological harm.** **Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.** **Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.**	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.			
		Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.			
		All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC			
		Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.			
		Obstetric anaesthesia staffing guidance to include: • The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave. • The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity. • The competency required for consultant staff who cover obstetric			

		services out-of-hours, but who have no regular obstetric commitments. • Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.			
12: POSTNATAL CARE	**<u>Essential action</u>** **Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.** **Postnatal wards must be adequately staffed at all times**	All Trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward.	twice daily ward rounds 7 days a week in place and is audited	Policy and Audit	
		Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.	twice daily ward rounds 7 days a week in place and is audited	Policy and Audit	
		Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.	achieved through the twice daily ward rounds		
		Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	Real time BR+ data captured for all postnatal wards. BR+ external review completed 2020. Operational Safety huddles for staffing in place		
					On track for delivery
13. BEREAVEMENT CARE	**<u>Essential action</u>** **Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.**	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.	Only available Mon - Fri at PCH and part time at HH so need to invest in service to provide 7 day a week cover		
		All Trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	Contract with CUH to undertake post-mortems. Bereavement training in the TNA but only for midwives and support staff so needs review to include obstetricians		

		All Trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.	6 week follow up appointments are scheduled		
		Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	National Bereavement Guidelines being progressed		
					Overall RAG Rating: Amber as only partial compliance
14: NEONATAL CARE	**<u>Essential action</u>** **There must be clear pathways of care for provision of neonatal care.** **This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.**	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	EoE ODN Capacity review completed 2020. Activity review undertaken by EoE ODN in line with BAPM and NCCR recommendations. HH and PCH deemed to have correct capacity.		
		Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.	All care delivered outside of agreed pathways is reported to EoE ODN on case by case basis. Exception reports are submitted to commissioners via EoE ODN. All care pathways for escalation, surgical review and specific conditions established with providers and supported by EoE ODN and commissioners		
		Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	NWAFT Neonatal Services and NWAFT Maternity Services ratified EoE ODN In-utero policy Oct 2020 in place. 2022 - 2x 24/40 delivered (twins) 2021 - 2x 23/40 delivered Compliance reported monthly via Neonatal Services report. Surveillance via EoE ODN		

		Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example. senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	EoE ODN action		
		Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	EoE ODN action		
		Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	Consultants may be resident on site OOH depending on distance from hospital. Consultant to consultant handover process in place. Medical staff contact on call consultants directly by phone when assistance required for resuscitation purposes. NLS protocols in place. Consultant for week (neonatal) attend resuscitation episodes when requested.		
		Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.	Resuscitation Council UK NLS guidelines 2021 in place (inspired oxygen 28-31 weeks 21-30%, <28 weeks 30%). Pressures set to 30cm H2O for all term deliveries. Algorhythm placed on each resuscitaire . All QIS nursing staff 4 yearly NLS update (current compliance 96%). All neonatal nursing staff yearly neonatal resuscitation update (current compliance 89%). Higher pressures(cm H2O) delivery expectation - discussion with Consultant		

		Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	HH- BAPM standards 2018 compliant: Tier 1 immediately available within daytime hours Tier 1 shared with co-located paediatric unit out of hours if immediately available to SCBU Tier 2 covering paediatrics and immediately available to the neonatal unit Consultant lead PCH - Non - compliant. Expectation to have a split Tier 2 rota and consider a split Cons rota. However non-neonatal colleagues should not be covering out-of-hours as they do not do Cons of the week (which they should do x4/year).		
					On Track for Delivery as overall Rating
15: SUPPORTING FAMILIES	**<u>Essential action</u> Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision** **Maternity care providers must actively engage with the local community and those with lived**	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	Ensuring that specialist roles return to full time hours, JP is actioning Building relationships with 3rd party sector, e.g. MIND, Barnardos, Raham project.		
		Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	Improved signposting to self-help support groups and talking therapies. To set up maternal mental health clinics as per long term plan. To consider PNMH champions on ward areas.		

	experience, to deliver services that are informed by what women and their families say they need from their care	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.	Require an integrated perinatal mental health team with a specialised consultant and psychiatric pathway. Very high risk PNMH women they require caseloading by specialist midwives. Priority for MCoC team		
					Overall Rag rating: Amber due to the number of outstanding actions