Appendix 1

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

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

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	**Trust:** • Currently maternity oversight is via the Trust integrated quality and performance report, this is shared at all levels from directorates to board. • The Trust maternity dashboard incorporates both local and LMNS key performance indicators. • Exception reporting as required via executive quality committee. • Executive safety champion – Medical director • Non-Executive safety champion is now in post • All qualifying cases are referred to healthcare safety investigation branch (HSIB), for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. • All HSIB cases discussed at perinatal risk management group (MDT) and reported to the Trust learning from deaths group. Number of cases that were reported to HSIB included in corporate governance report • All signed off SI's (trust wide) are shared at monthly executive quality committee and are reported quarterly through to board **LMNS:** • LMNS wide dashboard reviewed at monthly meeting of quality and safety work stream • Lessons learnt shared from individual organisations via quality and safety work stream Work commenced on LMNS wide guidelines

Describe how we are using this measurement and reporting to drive improvement?	**Trust:** The KPI's drive quality improvement, via deep dives into occurrence for rag rated flags, all cases are reviewed to improve service delivery and performance, where lessons can be learnt. There has been significant work done around perinatal mortality, with a reduction in term still births. Improved pathways for the deteriorating patient enhanced multidisciplinary training and live SIMs training. Morning multidisciplinary audit of cases requiring surgical intervention in the previous 24 hours**.** All qualifying cases are referred to HSIB and a quarterly report inclusive of meeting to disseminate learning and appraisal of trust compliance and any immediate actions required. **LMNS:** LMNS wide objectives are set against local KPI's to improve outcomes and prevent health inequality Work streams matched against specific local requirement's to implement maternity transformation System wide guidelines and models (smoking cessation, implementation of SBLCB V2) Improving management of diabetes LMNS wide work specific to BAME Shared learning on the implementation of continuity of care Working towards single pregnancy record Working towards integrated workforce models.
How do we know that our improvement actions are effective and that we are learning at system and trust level?	• Reduction in Harms and perinatal mortality • Improved maternal mortality and morbidity • Improved long term generational health and reduction in morbidities • LMNS wide objectives are set against local KPI's to improve outcomes and prevent health inequality • MDT training schedule incorporates learning from incidents and yearly schedule built around improving outcomes at local level based on KPI's • Overarching maternity transformation/improvement plan encompasses all actions

What further action do we need to take?	• Monthly reporting mechanism required at board and LMNS level on maternity services, to provide overview of quality and safety, mapped against core components, such as, workforce, SI's, Perinatal mortality and morbidity, regional and national drivers (CNST, saving babies lives etc.) including dashboard data (utilising national tool when available to provide board with benchmarking at LMNS and national level). • Formulation of Overarching quality improvement plan • Increased transformational project support • QA assurance framework to be implemented by LMNS to inform quality surveillance group, ensuring robust scrutiny across the system and provide detail for exception reporting to the regional chief midwifery officer, and support the implementation of the Perinatal Clinical Quality Surveillance Model.
Who and by when?	**Trust:** • Monthly board paper – Director of midwifery – February 2021 • Formulation of Overarching quality improvement plan –Maternity Triumvirate March 2021 **LMNS:** Adoption of the national performance framework across the LMNS for all maternity providers and the LMNS will also be developing a local assurance framework which will support the QSG approach at ICS level. This is a change in approach from the LMNS but will support the overall QSG approach we will be adopting across the BCWB ICS in the New Year, for formal go live April 2021.
What resource or support do we need?	• Agreement and closer working relationship with board and board to LMNS • Transformation project officer funding • Increased CD PA to release from clinical commitment

How will mitigate risk in the short term?	Continue with reporting mechanisms in place

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?	• Consultant midwife leads on MVP. • SWB MVP reinvigorated following the commissioning and tender lead by SWBCCG. Meeting is convened 4 meetings a year. • HoM has maintained contact with MVP CCG lead throughout COVID and prior to first reformatted meeting structure. • Chair of MVP is user rep and lay person. • LMNS engagement work stream continues with input from service users to inform services. • Have engaged with women through '15 steps' and have just completed an assessment. • Non-Executive Director champion newly in post • Executive safety champion – Medical Director • Monthly meeting chaired by Professor David Carruthers, Medical Director • Director of midwifery and Consultant Midwife currently advocate and champion maternity and women's voice, however this is not independent
How will we evidence that we are meeting the requirements?	• Terms of reference and minutes from meetings at all levels • Contract for commissioned MVP • Improved outcomes • Improved experience

How do we know that these roles are effective?	• Improved workforce engagement, ensuring voices are heard, concerns can be raised and lessons are shared • Improved safety culture leading to harm free care • Improved retention and recruitment • Positive results in local and national workforce surveys • Co-design of services to meet the needs of the population and seamless transition • Improved results in national maternity survey • Positive feedback in local maternity experience survey • Ongoing improvement with 15 steps • Reduced complaints
What further action do we need to take?	• Introduction of senior advocate role, following national agreement of role and job description, commitment from the board to support the addition of this role. • MVP voice to be heard at Board level • Non-Executive Director Champion role to be embedded and both roles to further prioritise visibility, listening and feedback to staff and championing services at board level.
Who and by when?	• National steer on Advocate role awaited TBA • Embedding further of roles by Non- executive and executive leads April 2021 • Continue further development of co-design with MVP and embed fundamental aim and aligned vision April 2021
What resource or support do we need?	• Time from Non exec and executive champion • National steer on Advocate role • Commitment from Board for Advocate role • Funding for Advocate role

How will we mitigate risk in the short term?	Risk is mitigated through commencement of collaboration, with MVP, local maternity user's survey, 'you said, we did', lessons learnt from reviews, complaints, surveys and incidents. Debriefs offered to all women and all cases that have required enhanced investigation via HSIB or local SI, offered debriefed and findings of reports discussed staff safety champions and through dynamic area leads. Executive safety champion is Professor David Carruthers, Medical Director Non- Executive Director is Harjinder Kang Safety champions are : • Midwives • Obstetrician • Neonatologist Monthly meeting chaired by Professor David Carruthers, Medical Director

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?	Twice daily consultant rounds already in place at 09.00/17.00 Mon-Fri and 09.00/15.00 weekends • Medical cons cover rota 98hrs/week resident on Unit • Consultant is present on labour ward for 12 hours (08.30-20.30) Mon-Fri • Cons presence 20.30-08.30 Mon/Tues • Out of hours on call is covered and weekend working is 08.30-15.30 resident; thereafter on call. • Dedicated cons ward rounds minimum of twice a day with LW team (junior doctors/MW Coordinator); all management plans recorded on badgernet • Support junior trainees in decision making and management in complex labours • Review of cases and care plan that have required surgical intervention are completed during the morning audit. • Morning LW audit undertaken 08.30 every day (Obstetrician/Anaesthetist/MW MDT) • Daily perinatal safety huddle at 12.30 – MDT involving Obstetrician/MW/neonates – clinical/safety/workload/staffing issues raised. Meeting then online-linked to LMS-Units for LMS daily perspective **Training:** Schedule of PROMPT/ K2 training for the forthcoming year Basic Life Support ,Resus of the Newborn, Fetal monitoring – CTG and fresh eyes, Human factors, Multiple births, Major Obstetric Haemorrhage, Pre-eclampsia, Sepsis leading to Maternal collapse, Breech Infant feeding (MSW's) In the presence of the pandemic and ceasing of face to face an online package was developed : Fetal monitoring, Human factors, Immediate care of the neonate, Saving babies lives care bundle V2 (CO monitoring and smoking), Fetal growth restriction, Electric fetal monitoring, Postpartum haemorrhage, Maternal collapse and cardiac arrest - including COVID-19, Team working In addition to PROMPT we have run skills drills and trolley dashes in order to include an MDT in practical learning: **Skills Drill** • Maternal Collapse • Cord Prolapse – transfer from IOL suite to delivery suite • Baby abduction • Bradycardia on ADAU – transfer to Delivery suite • maternal collapse in pool on MLU – transfer to Delivery suite • Eclamptic fit **Trolley Dashes** • Bladder filling • Vaginal examinations

- PPH guidelines and PPH
- Major obstetric haemorrhage
- Interactive CTG board
- Roles and responsibilities in emergencies

All midwives and doctors are also expected to complete our online learning package K2

K2 Perinatal Training Programme (online learning package)
Doctors and Inpatient Midwives:

- Fetal physiology
- Cord blood gas
- Errors and Limitations in Fetal Monitoring
- Antenatal CTG
- Intrapartum Intermittent Auscultation
- Intrapartum CTG
- 2x CTG case studies
- Community Midwives:
- Fetal physiology
- Intrapartum Intermittent Auscultation

Mental health awareness and safeguarding yearly updates
Safeguarding supervision training completed and commenced with 15 supervisors.

Funding:

Yearly training needs analysis is undertaken and funded.
Study leave is factored into uplift
HEE training funding now available for all midwives and nurses

What are our monitoring mechanisms?	Training compliance is monitored by the clinical educators and line managers, actioned with individuals > monitored at workforce confirm and challenge by Directorate leads> monitored via Group> monitored via Human resource Directors office Medical staffing, rota and reviews are monitored via Directorate leads
Where will compliance with these requirements be reported?	Compliance is reported at Directorate, Group and executive level, with improvement plans generated for non-compliance.
What further action do we need to take?	• To ensure board oversight Training and workforce will be monitored via the monthly board report moving forward • Review of uplift to enable training required, due to the additional requirements for the service to maintain safety and professional requirements. • Plan from LMNS required for external validation three times per
Who and by when?	• Monthly board paper – Director of midwifery – February 2021 • Review of uplift by Clinical educators and Directorate general manager -February 2021 • Plan from LMNS required for external validation three times per- April 2021
What resource or support do we need?	• Potential funding following review for uplift • Potential funding following clinical workforce review to ensure 24/7 consultant oversight, which may include overnight on site.
How will we mitigate risk in the short term?	• Training is robust and compliance monitored • Reviews on delivery suite are monitored in morning audit and incident reviews

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?	Complex pregnancy are those where attendance at specialty antenatal clinic is needed • Running dedicated Speciality clinics which are undertaken as a team/dual consultant approach. Named lead specific to each clinic • Currently we provide joint specialist clinics - renal clinic, diabetes in pregnancy, Obstetric neurology, Obstetric Haematology and Perinatal mental health clinic • Additional dedicated specialist clinics/services run in preterm labour, multiple pregnancy, Infectious disease, substance abuse, VBAC, maternal medicine, fetal growth, FGM, Hypertension in pregnancy, Obstetric Anaesthetic
What are our monitoring mechanisms?	• Notes Audit. • Positive feedback in local maternity experience survey. • SBLCB (V2) • Audit.
Where is this reported?	• Through Directorate Governance Board > Group Governance Board > expectation reporting through to Executive Quality committee. •
What further action do we need to take?	• Joint Obstetric/Rheumatology pending resolution of the pandemic • Options to work towards process for recording this named clinic/service lead consultant for each complex pregnancy case is in hand – IT/badgernet solution. • To commence peer reviews

Who and by when?	• Joint Obstetric/Rheumatology pending resolution of the pandemic- Clinical Director • Options to work towards process for recording this named clinic/service lead consultant for each complex pregnancy case is in hand – IT/badgernet solution- Clinical Director. (April2021) • To commence Peer Reviews – Risk and Governance lead (April 2021)
What resources or support do we need?	• Awaiting Continuation of regional work to develop tier system for maternal medicine centres. • Further scoping required following above consultation to understand what further steps are required to support the development of maternal medicine specialist centre in the Trust. • IT solution
How will we mitigate risk in the short term?	Complex pregnancy joint clinics are already well embedded within the organisation.

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?	• Badgernet template which shows what is completed for each lady • Antenatal care guideline in place • Saving babies lives audit in place • Risk assessment is updated on every contact and documented on Badgernet
What are our monitoring mechanisms and where are they reported?	• Notes Audit. • Audit use of BadgerNet system by Digital Midwife.
Where is this reported?	Exception escalation through to Directorate leads
What further action do we need to take?	• Formalisation of monthly Audit surveillance report reporting mechanisms through to Risk and Governance Group. • BEEM trial to commence, this is a randomised cluster controlled trial across the Black Country LMNS to evaluate the knowledge of community midwives regarding place of birth for healthy low-risk women. The trial compares a standalone E-Learning package against one combined with additional support from a lead midwife. This training will potentially support the implementation of national policy and provide clear unbiased information to these women.

Who and by when?	• Formulisation of audit surveillance reporting via risk and governance group – Head of Midwifery in conjunction with digital midwife lead – February 2021 • BEEM trial to commence. Consultant Midwife (TBA as delayed due to Covid 19)
What resources or support do we need?	• Support with BEM trial from Birmingham University. • Further Education for community Midwives. • Review of community midwifery workforce, due to increasing workload against mandated requirements
How will we mitigate risk in the short term?	Monitoring is in place formalised reporting required.

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?	• Named Saving babies lead commenced substantively September 2020 • Lead obstetrician is identified and in place • Regular review of the morning audit and CTG interpretation • All midwives and doctors are also expected to complete our online learning package K2 • K2 Perinatal Training Programme (online learning package) • Doctors and Inpatient Midwives: • Fetal physiology • Cord blood gas • Errors and Limitations in Fetal Monitoring • Antenatal CTG • Intrapartum Intermittent Auscultation • Intrapartum CTG • 2x CTG case studies • Community Midwives: • Fetal physiology • Intrapartum Intermittent Auscultation • CTG also included in PROMPT training . • Weekly MDT incident review meeting. • Morning audit- MDT review of all cases requiring surgical intervention in last 24 hours, includes review and discussion of CTG's • Interactive CTG training board • Audit of care received by all women on serenity midwifery led unit
How will we evidence that our leads are undertaking the role in full?	• Training compliance • Audit • Improved documentation • Reduced incidents relating to Misinterpretation of CTG.

What outcomes will we use to demonstrate that our processes are effective?	• Improved documentation • Reduced incidents relating to Misinterpretation of CTG. • Reduction of perinatal morbidity and mortality.
What further action do we need to take?	• Continue to embed new posts • Further develop lessons learnt sharing in multiple formats in conjunction with staff • Return to face to face training when able • Increase number of PROMPT facilitators • Additional midwife lead for fetal monitoring • Increased PA's for Lead clinician (to be a minimum mandated requirement) • Increase to clinical midwifery educator
Who and by when?	• Continue to embed new posts- Ongoing • Further develop lessons learnt sharing in multiple formats in conjunction with staff – SBLCB leads in conjunction with R+G leads April 2021 • Return to face to face training when able • Increase number of PROMPT facilitators when courses are available due to impact of Covid 19 • Additional midwife lead for fetal monitoring – Head of Midwifery – Jan 2021
What resources or support do we need?	• Funding for increased PA's for Lead clinician (to be a minimum mandated requirement) • Funding for increase number of PROMPT facilitators • Funding for additional midwife lead for fetal monitoring • Funding for increase to clinical midwifery educator

How will we mitigate risk in the short term?	• Robust fetal monitoring training in place • Simulation training • Morning audit- MDT review of all cases requiring surgical intervention in last 24 hours, includes review and discussion of CTG's • Interactive CTG training board • Audit of care received by all women on serenity midwifery led unit

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?	• All pathways of care in written and posted on Trust website in different languages • In addition audio transcript is available • BadgerNet portal offers information in multiple languages
Where and how often do we report this?	This is currently not reported, website is updated as required following release of national guidance/NICE guidance etc.
How do we know that our processes are effective?	Scoping for formalisation of collating this data, to liaise with MVP
What further action do we need to take?	Scoping of requirement for reporting mechanism
Who and by when?	Scoping to be undertaken by Head of Midwifery in conjunction with Consultant Midwife
What resources or support do we need?	This will be clearer following scoping
How will we mitigate risk in the short term?	Maintenance of information to current high standard

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.

<table>
<tr>
<td>What process have we undertaken?</td>
<td>Birthrate plus was undertaken in 2019, work now required to revisit as requested by 31/1/21
<table>
<tr><th>Required WTE form BR+</th><th>Funded WTE</th><th>Actions taken following</th></tr>
<tr><td>245.74</td><td>234.68</td><td>• Birth rate reduced further 19/20 to
• Skill mix undertaken to provide 80/20 split in community (MW/B3)
• All new posts are fully rotational to provide fluidity in staffing and reduction of risk, allowing staffing moving forward to be based on real time acuity and capacity without generating risk. Preceptorship to be 2 year programme to cover all areas and negate skill mix issues.
• Ongoing recruitment to ensure both substantive and fixed term to cover maternity leave and ensure provision to cover emerging vacancies. Rolling offer of employment to all students to fill vacancies (maternity leave 13%)
• All MSW’s uplifted to B3 by Trust in line with living wage agenda, TNA to ensure compliance with HEE MSW framework
• Alternate workforce models under review</td></tr>
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How have we assured that our plans are robust and realistic?	All workforce plans will be scoped against BR+ requirement and aligned to safe staffing in a maternity setting. Work is ongoing at both a national and regional level to address the shortfall in registrants, in conjunction with HEE.
How will ensure oversight of progress against our plans going forwards?	Director of midwifery as Group representative will provide oversight of the work undertaken by the directorate leadership team, in conjunction with human resources business partner and finance. This will be reported through to board in the monthly maternity report.
What further action do we need to take?	Workforce analysis required by 31/1/21 utilising BR+ Clinical workforce analysis to be undertaken
Who and by when?	Workforce analysis required by 31/1/21 utilising BR+ by HOM and DGM Clinical workforce analysis to be undertaken by Clinical Director and DGM
What resources or support do we need?	• Funding dependent on analysis • Support from HR and finance • Data analyst support to ensure capacity given tight time scale
How will we mitigate risk in the short term?	Workforce BCP in place and escalation to minimise risk. Daily morning staffing huddle, to ensure staffing is mobile to meet needs of acuity and capacity. Weekly look forward for staffing requirements

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
Director of Midwifery in post, currently responsible to Group Director for Women and Child Health and accountable to Chief Nurse. To note the recommendation is that the Director of Midwifery has a seat at the board alongside the Chief Nurse as the expert in maternity care and service provision. Head of Midwifery in post, currently responsible to Directorate Clinical Director and accountable to Director of Midwifery Consultant Midwife in post, responsible and accountable to Head of Midwifery. To meet the above fully, responsibility for Director of Midwifery would need to move to Chief Nurse and Head of Midwifery would be responsible to the Director of Midwifery.

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?	Structure for oversight of NICE guidance sits corporately Multidisciplinary guideline group in maternity service

Where and how often do we report this?	Guideline group reports into directorate risk and governance group > Group Governance board > Exception reporting to executive quality committee Corporate governance monitor and report > Group Governance board > Exception reporting to executive quality committee
What assurance do we have that all of our guidelines are clinically appropriate?	As above
What further action do we need to take?	To work with corporate team on format for collation of NICE guidance gap analysis a Trust level
Who and by when?	Corporate governance April 2021
What resources or support do we need?	Support from corporate governance Agreement for overarching plan
How will we mitigate risk in the short term?	Robust pathway in place in maternity