Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 09 March 2022

TB2022.026

Title:	**Ockenden Review of Maternity Services: One Year On**

Status:	**For Discussion**
History:	**Discussed and approved at the Maternity Clinical Governance Committee (MCGC) 28/02/2022**

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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This paper provides the Committee with an overview of the position of this Trust in relation to the recommendations from the immediate and essential actions from the Ockenden report published in December 2020 one year on.
2. When the Ockenden report was published the first requirement was for an initial declaration by the Chief Executive Officer against 12 specific urgent clinical priorities to be submitted to NHSI by December 2021, which was completed.
3. The second requirement was for the Trust to implement the full set of seven Ockenden immediate and essential actions (IEAs) and for the Board to review an associated report was presented at the public Board meeting in March 2021 which was completed which was the initial gap analysis.
4. The third requirement was for the Trust to submit the evidence for the seven IEAs which were further divided into discreet actions. The evidence was submitted as part of the Ockenden review on the 30 June 2021 as requested.
5. In February 2022 the Trust received the results of phase 2 audit for the Ockenden evidence. The results identified gaps where the Trust had not been able to provide sufficient evidence and an action plan has been created to address these.

Conclusion

6. Maternity services have reviewed the evidence submitted as part of the review in June 2021. The Trust is compliant with the majority of the recommendations in the report and action plans have been developed where further work is required which will be reported to the Regional Midwife for NHSE and NHSI. The action plan has been agreed at the Maternity Clinical Governance Committee (MCGC) in February 2022 and progress on the actions will be monitored through this meeting.

Recommendations

7. The Trust Board is asked to discuss progress on the Ockenden Assurance tool which includes the recommendations from the Morecambe Bay investigation report and the Ockenden report at their next public Board meeting. The discussion is expected to include:
   a. Progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance.
   b. Maternity services workforce plans

Contents

Ockenden Review of Maternity Services: One Year On

1. Purpose

1.1. This paper provides the Committee with an update on the progress on the Ockenden Assurance tool that was published on the 10 December 2020 one year on. It also includes the recommendations from the Morecambe Bay investigation report.

2. Background

2.1. The Ockenden report was written following a review at The Shrewsbury and Telford Hospital NHS Trust following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at the hospital. The former Secretary of State for Health and Social Care, Jeremy Hunt instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at that Trust.

2.2. The first terms of reference for the review were written in 2017 for a review comprising of 23 families. Since the review commenced more families contacted the review team raising concerns about the maternity care and treatment they had received at the Trust. The terms of reference were amended in November 2019 to encompass over a thousand families.

2.3. Due to the size of the review the second and final independent report is due in 2021. Having performed the first 250 clinical reviews, the review team identified emerging themes. Recommendations were issued for all acute Trusts offering maternity care and the wider maternity community across England to be addressed as soon as possible.

2.4. There were seven immediate and essential actions (IEAs) within the Ockenden report comprising 12 specific urgent clinical priorities. An initial gap analysis was undertaken with the input of the Trust maternity safety champion, Local Maternity System and the executive leads.

2.5. In fulfilment of requirements a declaration against the immediate actions was submitted as required on the 21st December 2020.

2.6. At the time of the initial declaration the Trust was compliant with the majority of the recommendations with the exception of one which were reported to Trust board which was:

- The Immediate and Essential Action (IEA) 5: Risk Assessment throughout pregnancy – partially compliant

2.7. The second requirement made by the Regional Chief Midwife, NHS England and NHS Improvement for the Southeast was for the Trust to implement the full set of seven Ockenden immediate and essential actions (IEAs) and for the Board to review an associated report at the next public Board meeting.

2.8. In order to facilitate reporting a further overarching assessment using a National Health Service England (NHSE) designated toolkit was undertaken. This toolkit was devised to support providers to assess their current position against the seven 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.

2.9. As part of this review, and also as part of the reporting requirements associated with the maternity incentive scheme, maternity services were asked to review the workforce planning to demonstrate their compliance; with standards; this included neonatal services.

2.10. Maternity services were compliant with the requirement to complete birth-rate plus (BR+) which is a toolkit used to assess the maternity staffing requirements. At the time there was no workforce gap and therefore an action plan was not produced. However, there was a high risk of non-compliance with neonatal nursing workforce which was reviewed and addressed by NOTSSCaN Division. The business case was discussed at the Trust Management Executive (TME) in June 2021. They have been recruiting to their vacant posts.

2.11. The third requirement was for the Trust to submit the evidence for the seven IEAs which were further divided into discreet actions. The evidence was submitted as part of the Ockenden review on the 30 June 2021 as requested.

2.12. In February 2022 the Trust received the results of phase 2 audit for the Ockenden evidence. The results identified gaps where the Trust had not been able to provide sufficient evidence and an action plan has been created to address these.

3. Ockenden Report – One Year on

3.1. Maternity have been asked to discuss their progress on the Ockenden Assurance tool and to include the recommendations from the Morecambe Bay investigation at their next public board meeting.

3.2. There are discreet actions that maternity did not supply sufficient evidence for in June 2021 and an action plan has been developed for those areas (see appendix 1 Ockenden and Morecambe Bay action plan). This action plan also includes the actions from the review of the Morecambe Bay recommendations

that maternity have been asked to do. There were 2 areas that are rated as amber from the results received following the June submission of evidence. However, these have been actioned in July and August 2021 and an update is given in the action plan (appendix 1). This relates to IEA 1 Enhanced Safety, questions 7 and 11.

3.3. Work continues on the areas that maternity had supplied evidence for to ensure they remain compliant (see appendix 2 for an update on the evidence supplied for Ockenden along with the review of the Morecambe Bay recommendations).

3.4. The Immediate and Essential Action (IEA) 5 remains an area of concern for Maternity as they do not have a digital system to undertake ongoing audits to ensure risk assessments are completed at each antenatal contact and audit the personal care and support plans. The new Antenatal A3 Chart is being launched in March 2022, however an audit of these will not be able to be done until December 2022 at the earliest until the women give birth. If there was a digital system these audits could be done more frequently.

3.5. Maternity Services are currently undertaking a review of staffing using BirthRate plus (BR+). Data collection is currently being undertaken and data will be submitted to BR+ at the beginning of March 2022. There are 12 months of Oxford University Hospitals (OUH) acuity data that will be submitted for BR+ to analyse and produce OUH specific recommendations. BR+ will then do the calculations and meet with the maternity leadership team to discuss the results and to look at what further actions are required. This is being done in conjunction with the Buckinghamshire, Oxfordshire and Berkshire (BOB) Local Maternity and Neonatal Services (LMNS).

3.6. One of the recommendations in the Morecambe Bay report is to have ensuite facilities on Delivery Suite (Question 17). The Trust are currently not in a position to action this within the 2022/23 financial year given the constraints associated with both the physical estate and capital funding.

4. Conclusion

4.1. Maternity services have reviewed their results from the evidence that was submitted and provided an update on the further work that has been undertaken and that needs to be undertaken to ensure safety in maternity services. The Trust is compliant with the majority of the recommendations in the report and action plans have been developed where further work is required which will be reported to the Regional Midwife for NHSE and NHSI. The action plan has been agreed at the Maternity Clinical Governance Committee (MCGC) in February 2022 and progress on the actions will be monitored through this meeting.

5. Recommendations

5.1. The Trust Board is asked to discuss progress on the Ockenden Assurance tool which includes the recommendations from the Morecambe Bay investigation report and the Ockenden report at their next public Board meeting. The discussion is expected to include:

a. Progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance.

b. Maternity services workforce plan.

6. Appendix 1 Action plan for Ockenden Report and Morecambe Bay Report

There were 7 immediate and essential actions (IEAs) and there were discreet actions included within each of these that maternity did not supply sufficient evidence for in June 2021 and an action plan has been developed for those areas to ensure full compliance with the Ockenden IEAs. This action plan also includes the actions from the review of the Morecambe Bay recommendations that maternity have been asked to do as part of this review.

Ockenden Review Action Plan

No.	Immediate and Essential actions (IEA)	Current Trust Position [results from audit]	Recommendation for Improvement	Action to be taken	Evidence of Action	Responsible Person	Date Action to be completed by	R.A.G. Action [1]
IEA 1 Q7	Enhanced Safety	The Trust could not provide full evidence in June 2021 that they had implemented the Perinatal Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.	The Perinatal Quality Surveillance Report to be submitted to Trust board and Berkshire, Oxfordshire and Buckinghamshire (BOB) local maternity and	The Perinatal Quality Surveillance Report has been sent to the Trust board and BOB LMNS since July 2021.	Maternity Clinical Governance	July 2021	

[1] R.A.G Action Completion Status: R (Red) – Action not started, A (Amber) – Action Underway, G (Green) – Action Complete

				neonatal systems (LMNS)				
IEA1 Q11	Enhanced Safety	The Trust were unable to supply evidence that the Non-executive Director (NED) into Maternity Voices Partnership (MVP) had met	Evidence of link for the Non-executive Director (NED) into Maternity Voices Partnership (MVP)	The NED and MVP to meet	The NED and MVP met via Microsoft Teams in August 2021	NED and the chairperson for the MVP	August 2021	
IEA3 Q17	Training and Working Together	The training needs analysis (TNA) that was submitted as evidence did not clearly articulate the expectation of all professional groups in attendance at all MDT training and core competency training.	Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all multidisciplinary team (MDT) training and core competency training.	The TNA to be updated to clearly articulate the expectation of all professional groups in attendance at all MDT training and core competency training.	Copy of the 2022-2023 TNA	Lead midwife for practice development and midwife education.	July 2022	
IEA5 Q30 and Q31	Risk Assessment Throughout Pregnancy	The Trust was unable to provide evidence that the risk assessments included an ongoing review of the intended place of birth based on the developing clinical picture as part of the Personal Care and	Maternity Antenatal documentation to be improved to evidence the Personal Care and Support Plans (PCSP) and to undertake and ongoing audit.	Update the Antenatal A3 chart to include risk assessment at each appointment and appropriate care pathway midwifery led care/consultant	A copy of the updated Antenatal A3 chart. Minutes of the community huddle from 21/02/2022. Paperwork distributed and explained to community	Community Matron Quality Assurance and Improvement Midwife	December 2022	

		Support plans or that there was an ongoing audit of 1% of records to demonstrate compliance due to their paper-based system.	To have an end-to-end digital solution for maternity records that would enable risk assessments and audit to be undertaken.	led care (MLC/CLC). To purchase a new digital system. This will include market appraisal and procurement process as well as customisation and implementation of the chosen solution.	midwives and hospital based antenatal clinic teams. The forms to be included as standard in the revised blue handheld maternity notes from March 2022. Audit to be added to the 2022-23 audit plan as we will be unable to audit this until the end of 2022. The use of an end-to-end digital solution across the maternity pathway	Digital Lead Midwife	Digital solution December 2023	
IEA6 Q35	Monitoring Fetal Wellbeing	The evidence the Trust submitted did not demonstrate that colleagues engaged in fetal wellbeing monitoring were adequately supported e.g. clinical supervision.	Ensure that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	A piece of work will be undertaken across the LMNS as all the BOB Trusts scored 0%.	Agree the evidence that is required for submission.	Director of Midwifery	April 2022	

IEA6 Q37	Monitoring Fetal Wellbeing	The evidence the Trust submitted did not clearly demonstrate that the fetal well being leads lead the review of cases of adverse outcomes involving poor fetal heart rate interpretation and practice.	For the fetal well being leads to undertake root cause analysis (RCA) training and to lead of reviews of cases of adverse outcomes involving poor fetal heart rate interpretation and practice.	Fetal wellbeing leads to undertake RCA training To be allocated as lead investigator on Ulysses	Confirmation from the fetal well being leads that they have undertaken RCA training. Report from Ulysses	Fetal wellbeing leads	May 2022	
IEA7 Q41	Informed Consent	The Trust were unable to provide evidence of an audit being undertake to demonstrate compliance of women participating in all decision making processes.	Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care	An audit of 1% of notes demonstrating compliance. CQC survey and associated action plans	Copy of the audit report. Copy of the CQC Maternity survey and the associated action plan.	Quality Assurance and Improvement Midwife Maternity Clinical Governance Manager	June 2022	
IEA7 Q44	Informed Consent	A gap analysis had been undertaken by the MVP however they were unable to meet with representatives from maternity to produce an action plan prior to the submission date in June.	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	Co-produced action plan to address gaps identified is already in place and has commenced. It is anticipated this work will not be completed until	Copy of the action plan to achieve compliance Confirmation at MCGC that actions have been addressed.	MVP chair and the Digital Midwife	October 2022	

			Westminster website.	September 2022.				
Q48	Midwifery Leadership	In June 2021 Maternity had reviewed the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership and were compliant therefore an action plan was produced.	Maternity to review the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership and to identify any gaps due to recent vacancies.	Action plan in place and funding agreed for the vacancy. Recruitment has commenced.	Copy of the action plan. Vacancy filled	Director of Midwifery	August 2022	
Q49	NICE Guidance related to maternity	The Trust were unable to demonstrate that all guidelines were in date in June 2021 and that risk assessments were in place where guidance was not implemented.	NICE guidance – audit to demonstrate all guideline are in date. Evidence of risk assessment where guidance is not implemented.	Report monthly at clinical governance meeting on the number of out-of-date guidelines and any risks associated with this. Provide evidence of risk assessments if NICE guidance is not implemented.	Monthly report that is submitted to clinical governance meeting. Copy of the minutes.	Quality Assurance and Improvement team	Ongoing	

Review of Morecambe Bay Recommendations Action Plan

No.	Current Trust Position [results from audit]	Recommendation for Improvement	Action to be taken	Evidence of Action	Responsible Person	Date Action to be completed by	R.A.G. Action completion
Q2 Recommendation: Review the skills, knowledge, competencies, and professional duties of care of all obstetric, paediatric, midwifery and neonatal staff, and agency, locums caring for the critically ill in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. **Q14 Recommendation:** Review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support.							
Q2 & Q14	Currently not at 90% compliance for all staff groups in maternity as the new training year started in September 2021.	Staff are given 15 hours in addition to the 3 days they are given to undertake PROMPT, Fetal Monitoring, MSW and OXMUD study days where they can complete e-learning.	Staff to attend their allocated training weeks to undertake their mandatory training and core skills requirements.	Compliance reported monthly in the Perinatal Quality Surveillance Report	Lead midwife for practice development and midwife education	Ongoing	
Q4 Recommendation: Continuing professional development of staff and link this explicitly with professional requirements including revalidation. **Q16 Recommendation:** Ensure middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and provide appropriate guidance and training.							
Q4 & Q16	Currently appraisal rate is low	Appraisals - staff are given 15 hours in addition to the 3 days they are given to undertake PROMPT, Fetal	Staff to attend their allocated training weeks and to complete their appraisal	Compliance reported monthly through clinical governance.	There has been a requirement over the last 12 months to redeploy staff	Ongoing	

[2] R.A.G Action Completion Status: R (Red) – Action not started, A (Amber) – Action Underway, G (Green) – Action Complete

		Monitoring, MSW and OXMUD study days where they can complete e-learning and appraisals.	documentation during this time. Staff to arrange date and time of appraisal with their manager. Managers to manage their teams' appraisals.		from the time allocated for ward and team management days to clinical shifts to ensure safe patient care. The division is working with HR to secure additional support. Management time is now being release into the system.		
Q6 Recommendation: Protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of high or low risk care. **Q7 Recommendation:** Audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols.							
Q6 and Q7	Maternity are unable to undertake audits to ensure risk assessments are undertaken as they do not have a digital system.	Update the Antenatal Care guideline to include the risk assessments. To have an end-to-end digital solution for maternity records that would enable risk assessments and	Update guideline and share with staff. To purchase a new digital system. This will include market appraisal and procurement process as well	Copy of the undated guideline. Copy of the Antenatal A3 chart that includes the risk assessments. The use of an end-to-end digital solution across the maternity pathway	Deputy Head of Midwifery for community services. Digital Midwife	April 2022 December 2023	

		audit to be undertaken.	as customisation and implementation of the chosen solution.				
Q12 Recommendation: Review the structures, processes and staff involved in investigating incidents, RCA, learning, training. Include arrangements for staff debriefing and support following a serious incident.							
Q12	Maternity do not have an up-to-date Maternity Risk Strategy	For Maternity to have a specific Maternity Risk Strategy document	To develop a Maternity Risk Strategy in addition to the Trust document.	Copy of the strategy	Maternity Clinical Governance Manager and Maternity Clinical Governance Lead Obstetrician	May 2022	
Q17 Recommendation: Review access to theatres, and ability to observe and respond to all women in labour and ensuite facilities; arrangements for post-operative care of women.							
Q17	Lack of ensuite facilities on Delivery Suite. The Trust are currently not in a position to action this within the 2022/23 financial year given the constraints associated with both the physical estate and capital funding.	Refurbishment of the Women's centre	Maternity to propose a scoping exercise for 2022/2023 for complete refurbishment of the Women's centre	Options appraisal is required, and funding is to be bid for this project planning via 2022/23 capital prioritisation process	Maternity Operational Service Manager	Review financial year 2023/24	

7. Appendix 2: Ockenden and Morecambe Bay – One Year On

The spreadsheet demonstrates the progress on the Ockenden Assurance tool one year on and includes the recommendations from the Morecambe Bay investigation report. IEA 1 Enhanced Safety Questions 7 and 11 appear amber as sufficient evidence was not provided for the submission of evidence on the 30 June 2021 however evidence has been provided to maternity since (see action plan in appendix 1).

Ockenden - Minimum evidence requirements					
SECTION 1: Immediate and Essential Actions 1 to 7			**Minimum Evidence Requirements**	**Results of Phase 2 audit**	**Update February 2022**
Immediate and Essential Action 1: Enhanced Safety					
IEA 1	**Q1**	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.	• SOP required which demonstrates how the trust reports this both internally and externally through the LMS. • Submission of minutes and organogram, that shows how this takes place. • Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken. • Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	100% 100% 100% 100%	Work continues on this to ensure we are maintaining 100% compliance.

	Q2	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.		• Policy or SOP which is in place for involving external clinical specialists in reviews. • Audit to demonstrate this takes place.	100% 100%	Work continues on this to ensure we are maintaining 100% compliance
	Q3	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		• Submit SOP • Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed • Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	100% 100% 100%	Work continues on this to ensure we are maintaining 100% compliance
Link to Maternity Safety actions:						
IEA 1	**Q4**	Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	• Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. • Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	100%	The maternity and neonatal team continue to review perinatal deaths using the perinatal mortality review tool (PMRT). This is a mult-professional meting that is held weekly on a Monday from 13:00-14:00hrs via Microsoft teams. External reviewers are invited to attend from the regional governance group. Members of staff from this Trust attend PMRT meetings at other Trusts as their external reviewer in return.

	Q5	Action 2	Are you submitting data to the Maternity Services Dataset to the required standard?	• Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	100%	Maternity services continue to submit data to the Maternity Services Dataset (MSDS) to the required standard.
	Q6	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?	• Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	100%	We reported all qualifying cases to HSIB for 2019/2020 births and we have continued to do this for the 2020/2021 births and continue to do this.
Link to urgent clinical priorities:						
IEA 1	**Q7**	(a)	A plan to implement the Perinatal Clinical Quality Surveillance Model	• Full evidence of full implementation of the perinatal surveillance framework by June 2021. • Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure. • LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	~~0%~~ ~~100%~~ 100%	At the time of the initial submission of evidence in June 2021, Maternity services had not submitted the Perinatal Quality Surveillance report to Trust board or to the LMNS. The report was sent to the confidential Trust board in July 2021 and to the LMNS at the same time and to each meeting.
	Q8	(b)	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	• Submit SOP • Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed • Individual Si's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion		same as Q3
Immediate and Essential Action 2: Listening to Women and Families						

IEA 2	**Q9**	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.				
	Q10	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.				
	Q11	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.		• Name of NED and date of appointment • Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions • Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed • Evidence of how all voices are represented: • Evidence of link in to MVP; any other mechanisms • NED JD	100% 100% 100% 100% 0% 100%	At the time the evidence was submitted in June 2021 for point 2 of the minimum evidence, the Non-Executive director (NED) had not had the opportunity to meet with the chairperson of the MVP. However, they have met in August 2021. The NED also attends the safety champions meetings.
Link to Maternity Safety actions:						
IEA 2	**Q12**	Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	• Local PMRT report. • PMRT trust board report. • Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. • Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.		Same as Q4

	Q13	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?	• Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. • Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) • Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	100% 100% 100%	Maternity services continue to use the MVP to review the patient information leaflets. Service user feedback is provided by the MVP at their quarterly meetings. Two of the matrons meet with the MVP regularly. Maternity have continued to utilise the MVP FaceBook live sessions.

	Q14	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?	• SOP that includes role descriptors for all key members who attend by-monthly safety meetings. • Log of attendees and core membership. • Action log and actions taken. • Minutes of the meeting and minutes of the LMS meeting where this is discussed.	100% 100% 100% 100%	The Trust safety champions (obstetrician, midwife and neonatal consultant) are meeting monthly with the Board level champion and the NED to escalate locally identified issues. Dates of meetings have been identified for the year and there are agendas and minutes of these meetings available.
Link to urgent clinical priorities						
IEA 2	**Q15**	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.	• Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. • Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) • Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	Same as Q13
	Q16	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.	• Name of ED and date of appointment • Name of NED and date of appointment • Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken Role descriptors	100% 100% 100% 100%	The maternity safety champions continue to work with the Board level safety champion and the NED.
Immediate and essential						

action 3: Staff Training and Working Together						
IEA 3	**Q17**	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.		• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. • Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0% 100% 100% 100%	When the training needs analysis (TNA) was produced last year, it did clearly articulate the expectation of all professional groups in attendance at all MDT training and core competency training. The training trajectory that was required as part of the Maternity Incentive Scheme (MIS) was on a separate spreadsheet. The training plan was updated in December 2021 as part of the Maternity Incentive Scheme year 4 requirements, and this includes the training trajectory. Training compliance is reported monthly as part of the Perinatal Quality Surveillance report which is also sent to the LMNS.
	Q18	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.		• SOP created for consultant led ward rounds. • Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	100% 100%	The twice daily ward rounds have continued and this is recorded as part of the bleep holder daily operational record.

	Q19		Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only (e.g. Maternity Safety Fund, Charities monies, MPET/SLA monies etc that is specifically given for training)	• Evidence that additional external funding has been spent on funding including staff can attend training in work time. • Evidence of funding received and spent. • Confirmation from Directors of Finance • Evidence from Budget statements. • MTP spend reports to LMS	100% 100% 100% 100% 100%	
Link to Maternity Safety actions:						
IEA 3	**Q20**	Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	**See section 2**		
	Q21	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?	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA. • Attendance records - summarised	0% 100% 100%	When the training needs analysis (TNA) was produced last year, it did not clearly articulate the expectation of all professional groups in attendance at all MDT training and core competency training. The training trajectory that was required as part of the Maternity Incentive Scheme (MIS) was on a separate spreadsheet. The training plan was updated in December 2021 as part of the Maternity Incentive Scheme year 4 requirements, and this includes the training trajectory. Training compliance is reported monthly as part of the Perinatal Quality Surveillance report.
Link to urgent clinical priorities						

IEA 3	**Q22**		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	• SOP created for consultant led ward rounds. • Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)	100% 100%	See Q18
	Q23		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	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data. • Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0% 100%	Same as Q17
Immediate and essential action 4: Managing Complex Pregnancy						
IEA 4	**Q24**		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.	• SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway. • Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians	100% 100%	

	Q25	Women with complex pregnancies must have a named consultant lead	• SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnanices but who do not require referral to maternal medicine network must have a named consultant lead. • Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	100% 100%	Stickers have been produced to put on the front of the maternity handheld record to identify the lead clinician at booking. The Antenatal A3 chart has been improved so that the care pathway is identified at each appointment (midwifery led care/consultant led care) and if there is a change in the care pathway and the reason why.
	Q26	Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	• SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams. • Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are devloped by the cinical team in consulation with the woman.	100% 100%	
Link to Maternity Safety actions:					

IEA 4	**Q27**	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	• SOP's • Audits for each element. • Guidelines with evidence for each pathway	100% 100% 100%	At the end of year 3 of the Maternity Incentive Scheme we had demonstrated compliance with all 5 aspects of the Saving Babies Lives care bundle version 2. As part of the Maternity Incentive Scheme year 4 we are working towards compliance with 3 out of the 5 elements - awaiting audits to be undertaken and we are compliant with the other 2 elements. Element 1 - Reducing smoking in pregnancy. **Working towards compliance.** Element 2 - Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction. **Working towards compliance.** Element 3 - Raising awareness of reduced fetal movement. **Compliant**. Element 4 - Effective fetal monitoring during labour. **Expected to be compliant.** Element 5 - Reducing the number of preterm births. **Working towards compliance.**
Link to urgent clinical priorities:						
IEA 4	**Q28**	A	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	• SOP that states women with complex pregnancies must have a named consultant lead. • Submission of an audit plan to regularly audit compliance	100% 100%	Repeat audit to be undertaken

	Q29	B	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	• The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs. • Criteria for referrals to MMC • Agreed pathways	100% 100% 100%	
Immediate and essential action 5: Risk Assessment Throughout Pregnancy						
IEA 5	**Q30**	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		• SOP that includes definition of antenatal risk assessment as per NICE guidance. • How this is achieved within the organisation. • What is being risk assessed. • Review and discussed and documented intended place of birth at every visit. • Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100% 100% 100% 0%	The Antenatal Care guideline is currently being updated as an action from the recent CQC action plan. Personal Care and Support plan (PCSP) - data has been submitted to MSDS to show that antenatal personalised care plan fields have been completed for 90% of women booked in July, August, September, October, November and December 2021. The A3 Antenatal chart has been updated which will make it easier to audit the risk assessments being undertaken - this is being launched in March 2022 and audit will be done after 6 months which will give the cohort audit data. This will be added to the audit plan for 2022/2023. There currently is not a digital solution for this. which makes it difficult to audit in real time.

	Q31		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	• SOP that includes review of intended place of birth. • Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. • Out with guidance pathway. • Evidence of referral to birth options clinics	100% 0% 0% 100%	A new Birth Choices clinic has commenced at the end of 2021. Guideline updated. It has been difficult to audit the PCSP as there is no digital solution for this. The Antenatal Care guideline is currently being updated and the A3 Antenatal chart has been updated which will make it easier to audit the risk assessments being undertaken - this is being launched in March 2022 and audit will be done after 6 months which will give the cohort audit data. This will be added to the audit plan for 2022/2023. There currently is not a digital solution for this. which makes it difficult to audit in real time.
Link to Maternity Safety actions:						
IEA 5	**Q32**	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	• SOP's • Audits for each element • Guidelines with evidence for each pathway		Same as Q27
Link to urgent clinical priorities:						
IEA 5	**Q33**		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.	• SOP to describe risk assessment being undertaken at every contact. • What is being risk assessed. • How this is achieved in the organisation. • Review and discussed and documented intended place of birth at every visit. • Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above. • Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	100% 100% 100% 100% 0% 0%	The new A3 Antenatal Chart will make it easier to see the risk assessments that have been undertaken and if there is a change in the care pathway which is being launched in March 2022.

Immediate and essential action 6: Monitoring Fetal Wellbeing					
IEA 6	**Q34**	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 wellbeing.	• Name of dedicated Lead Midwife and Lead Obstetrician • Copies of rotas / off duties to demonstrate they are given dedicated time. • Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. • Incident investigations and reviews	100% 100% 100% 100%	There has been a change in the lead midwife this year due to a relocation. We successfully appointed into the lead midwife role, and they position is filled. The lead midwives and lead obstetrician have been leading on the fetal wellbeing training and leading on the introduction of the new CTG stickers that were introduced in February 2022.

	Q35	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.	• Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post • Improving the practice & raising the profile of fetal wellbeing monitoring • Consolidating existing knowledge of monitoring fetal wellbeing • Keeping abreast of developments in the field • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision • Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training. • Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	100% 100% 100% 100% 0% 100% 100% 0%	From the evidence submitted in June 2021 maternity were unable to demonstrate that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision. We have asked for a definition of this as no Trust in the BOB LMNS as achieved this. We were not able to demonstrate that the fetal wellbeing leads lead on the review of cases of adverse outcome involving poor fetal heart rate interpretation and practice. All clinicians involved in cases of adverse outcomes where fetal monitoring is identified as a contributing factor are offered 1:1 or group case reflection and learning. These cases are also discussed in the weekly intrapartum shared learning meeting. The fetal wellbeing leads are involved in the inital summary review (ISR) where fetal monitoring has been a contributing factor and this is recorded within the ISR. The fetal well being leads are attending root cause analyse (RCA) training in March 2022. They are recording on a spreadsheet the incidents they have been leading on as evidence.
Link to Maternity Safety actions:					

IEA 6	**Q36**	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	• SOP's • Audits for each element • Guidelines with evidence for each pathway		See Q27
	Q37	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?	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. • Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA. • Attendance records - summarised	0% 100% 100%	See Q21 re. TNA
IEA 6						
	Q38		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.	• Name of dedicated Lead Midwife and Lead Obstetrician • Copies of rotas / off duties to demonstrate they are given dedicated time. Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. • Incident investigations and reviews		See Q34
Immediate and essential action 7: Informed Consent						

IEA 7	**Q39**	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.	• Information on maternal choice including choice for caesarean delivery. • Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100% 100%	Birth Choices clinic commenced at the end of 2021. All of the patietn infroamtion leaflets are reviewed by the MVP.

	Q40	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	• Information on maternal choice including choice for caesarean delivery. • Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.		
	Q41	Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care	• SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded. • An audit of 1% of notes demonstrating compliance. • CQC survey and associated action plans	100% 0% 0%	When the evidence was submitted in June 2021 we were unable to demonstrate compliance with the SOP as the SOP had only recently been launched. The audit has not been undertaken yet but is planned for this year. The CQC survey had been undertaken in February 2021 and the results published on teh 10/02/2022. Maternity serivces have reviewed the results and are in the process of finalising the action plan for

						this. The results of the audit are to be shared with the MVP.
	Q42		Women's choices following a shared and informed decision-making process must be respected	• SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded. • An audit of 5% of notes or a total of 150 which is ever the least from january 2021, demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction. • CQC survey and associated action plans	100% 100%	A repeat audit to be undertaken as part of the audit plan for 2022-2023.
Link to Maternity Safety actions:						
IEA 7	**Q43**	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?	• Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. • Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) • Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100% 100% 100%	

Link to urgent clinical priorities:						
IEA 7	**Q44**	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.		• Gap analysis of website against Chelsea & Westminster conducted by the MVP • Co-produced action plan to address gaps identified • Information on maternal choice including choice for caesarean delivery. • Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100% 0% 100% 100%	When the evidence was submitted we had not had the opportunity to meet with the MVP to co-produce an action plan to adress the gaps identified. The MVP have met with representatives from maternity to produce a plan to close the gaps. It is not anticipated that this will be completed until September 2022.
SECTION 2: WORFORCE PLANNING						
	Q45	Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard	• Most recent BR+ report and board minutes agreeing to fund. • Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. • Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	100% 100% 100%	A refresh of the Birth rate plus (BR+) is currently being undertaken in maternity and this will be expected to go to the Trust Board in May 2022. The safe staffing paper has been sent to the Trust board as part of the Maternity Incentive Scheme requirments and it last went in September 2021 and the next paper is due March 2022.
	Q46	Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	• Most recent BR+ report and board minutes agreeing to fund.	100%	A refresh of the Birth rate plus (BR+) is currently being undertaken in maternity and this will be expected to go to the Trust Board in May 2022

	Midwifery Leadership					
	Q47	Please confirm that your Director /Head of Midwifery is responsible and accountable to an executive director		• HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	100%	There is a Director of Midwifery in place

	Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: 1. A Director of Midwifery in every trust and health board,		• Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care • Action plan where manifesto is not met	100% 0%	When the evidence was submitted following the gap analysis there was no gaps identified in materntiy at that time therefore an action plan was not submitted. This has been reviewed in February 2022 and there is a plan to recruit to post where gaps have been identifed. There was a high risk of non-compliance with the Maternity Incentive Scheme (MIS) in relation to the neonatal nursing workforce and a paper with a plan was submitted to TME in July 2021. The neonatal team have been recutiing to the vacant posts.

		and more Heads of Midwifery across the service 2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally 3. More Consultant midwives 4. Specialist midwives in every trust and health board 5. Strengthening and				

		supporting sustainable midwifery leadership in education and research 6. A commitment to fund ongoing midwifery leadership development 7. Professional input into the appointment of midwife leaders				
	NICE Guidance related to maternity					

	Q49	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		• SOP in place for all guidelines with a demonstrable process for ongoing review. • Audit to demonstrate all guidelines are in date. • Evidence of risk assessment where guidance is not implemented.	100% 0% 0%	When NICE guidance is published the baseline assessment is reviewed to identify any gaps in our service. NICE Quality Standard (QS) audits are undertaken. Maternity are currently updating their Antenatal Care guideline sue to the recent update NICE guidnace. A baseline assessment is being undertaken in relation to the NICE guidance published in Novmeber 2021 on Inducing Labour. We currently do not follow the NICE guidance for intrapartum fetal monitoring. In 2017 the Maternity and Neonatal network agreed to adopt a new predominantly FIGO based, more physiological approach to intrapartum fetal monitoring. This was registered as a quality improvment project at the time and a risk based approach was taken by the Thames Valley/Oxofrd Patient Safety Collaborative (PSC) materntiy network. A formal comparison was carried out and published in a peer reviewed international journal which clearly pointed to the superiority of the FIGO guidelines. Guideline compliance is reproted monthly at the Maternity Clinical Governance Committee meeting and is reported in the

		process before implementation and ensure that the decision is clinically justified.				quality reports. Compliance has improved over the past year.

Review of Morecambe Bay report

Recommendations for the University Hospitals of Morecambe Bay NHS Foundation Trust for other Trusts to benchmark against.+A1:E10	**Linked to further reviews/regulation**	**Examples of evidence (not limited to)**	**Embedded Compliance** **Red none** **Amber partially** **Green fully**
1. Is an apology given to those affected, for the avoidable damage caused and any previous failures to act. **Action: Trusts**	Duty of Candour legislation regulation 20 CQC Safe Domain	Duty of Candour Policy Meeting timeframes Exception reports and escalation	Copy of Duty of Candour (DoC) policy in folder. Assurance that all DoC requirements have been addressed are covered in the SIRI Forum – exceptional circumstances are actively discussed and a solution identified.

2. Review the skills, knowledge, competencies, and professional duties of care of all obstetric, paediatric, midwifery and neonatal staff, and agency, locums caring for the critically ill in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. **Action: Trusts**	CNST SA8 Ockenden IEA 3 CQC Effective Domain	Mandatory Training Compliance is 90% for all groups Recovery Training Scrub technique training HDU level 2 training Induction guidelines for all staff	Currently not at 90% as the new training year started in September 2021. Staff attend at the Trust Nursing and Midwifery Induction which is 2 day induction including fire safety, information governance, manual handling. Doctors induction - For the 'routine' inductions (i.e. August and other times when a cohort is starting), copy of the induction programme At other times, when 1 individual is starting alone, they will attend the Trust induction training programmes before working on the ward 'supernumerary' for a minimum of 2 weeks followed by an interview / feedback conducted by the Clinical Director (CD) to ensure they are ready to start working clinically

3. Identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. **Action: Trusts**	CNST SA8 Ockenden IEA 3 CQC Well led Domain	Preceptorship Programme Number of staff currently on secondment Induction Programme Individual action plans in line with HR policy	There is the Oxford Preceptorship Programme and preceptees attend this and this consists of 6 training days. Maternity run a preceptorship programme and all staff are given a preceptorship booklet. They have to achieve certain competencies before they can progress to a band 6. This covers perineal suturing, cannulation and administration of IV's. They are supported by the practice educators to help them achieve their competencies. There are currently no staff on secondment to other units. Induction programme - New staff to the Trust attend the Trust Induction programme which is consists of two study days. Individual action plans in line with HR policy – Community training plans in place, including topics such as Appraisal, managing absence, respect and dignity and Enhancing your Leadership Skills. Wider training available through Divisional education lead. Staff have been supported to undertake local and national secondments and this process will continue.

4. Continuing professional development of staff and link this explicitly with professional requirements including revalidation. **Action: Trusts**	CNST SA8 Ockenden IEA 3 CQC Safe Domain	All staff met revalidation requirements Appraisals TNA PMA support	Revalidation - The Trust NMC Revalidation Policy mandate's the use of the Trust electronic portfolio for NMC revalidation evidence collection which is directly linked to annual appraisal and uses the NMC format. All line managers have access to a dashboard from this portfolio where they can view their staff's progress, and this is also reviewed at annual appraisal. The electronic aspects of the portfolio, dashboard and appraisal, provide an electronic audit trail and reports for assurance. Reminders are sent to staff and managers via the Trust NMC revalidation leads, to prevent lapses unfortunately, despite these robust processes, the Trust saw 14 lapses in 2021. These lapses are actively managed, supported back to the register and reported to the CNO. There have been no lapses in 2022 so far. Appraisal rate reported monthly to Trust board - currently at the lowest compliance for over a year. There is an annual training needs analysis (TNA) undertaken and in December 2021 the training plan to meet the Maternity Incentive Scheme (MIS) was agreed. PMA support - there are currently 9 number of PMA's however 3 are on maternity leave. Each PMA gets 7.5hrs per month. Bespoke training has been offered across professional groups for example leadership courses and mental health first-aid. There is currently one member of staff undertaking a masters course in Healthcare Analytics and Artificial Intelligence which was identified as part of the persons continued professional development. Staff have also been supported to undertake training to be Mental Health First Aiders.

5. Promote effective MDT working, joint training sessions. **Action: Trusts**	CNST SA8 Ockenden IEA 3 CQC Effective Domain	MDT Mandatory Training CTG training Live skills & drills	MDT training is running and staff attend training weeks. During the same week they undertake CTG training. Live skills and drills are undertaken, and these are advertised for staff to attend - posters are up and information is also sent via email.
6. Protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of high or low risk care. **Action: Trusts**	Ockenden IEA 5 CQC Safe Domain	Clinical risk assessment guidelines in date Audits	The Antenatal Care guideline is currently being updated. An audit will be undertaken as part of the implementation. The antenatal A3 chart has been updated and is due to be launched in March 2022. This will Audit part of the guideline implementation process. There is a section on it to record the care pathway e.g. midwife or consultant led care, when the pathway has been reviewed and the reason for the change. An update is given each month on the number of out-of-date guidelines through the governance process.
7. Audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols. **Action: Trusts**	CNST SA6 Ockenden IEA 5 CQC Efffective Domain	Clinical risk assessment guidelines in date Audits	It is difficult to undertake the audits to ensure risk assessments are carried out due to the paper based system. There is a plan to undertake an audit after the new antenatal A3 chart has been embedded. We are awaiting a digital system.

8. Identify a recruitment and retention strategy achieving a balanced and sustainable workforce with the requisite skills and experience. **Action: Trusts**	CNST SA 4 & 5 Ockenden IEA Workforce CQC Safe Domain	Internal policy Regional task and finish groups BR+ assessments and evidence to agree funding Board reviews 6 monthly of midwifery and clinical work force Ongoing workforce challenges HR report including return to work policy and procedure	Internal policy – Recruitment and Selection Procedure, Secondment and Acting up Procedure, Workforce Equality Diversity and Inclusion Procedure. BR+ assessment currently being undertaken. The next Safe staffing paper is due to go to Trust board in March 2022. At middle grade the medical staff are nearly 100% recruited - advert is going out this week and a new member of staff is currently undergoing induction. The prospective Consultant hours on Delivery Suite is reported monthly through the dashboard and there are twice daily consultant ward rounds on Delivery Suite. Human Resources (HR) report including return to work policy and procedure – Monthly workforce reports produced to include Context/ drivers, current performance and action plans. Further work being undertaken on KPI action planning.
9. Joint working between its main hospital sites, including the development and operation of common policies, systems and standards. **Action: Trusts**	CNST SA9 Ockenden IEA 1 & NICE CQC Effective Domain	Joint LMNS policies/guidelines/projects Perinatal Quality Surveillance Framework embedded June 2021 Evidence of cross site governance processes and procedures where applicable	The materntiy unit works jointly with other areas of the Trust and attends Trustwide meetings. There are joint policies/guidelines and projects between materntiy and the neonatl unit and we utilise other Trust wide guidance too. There are terms of reference (ToR) which captures joint projects and working via the Berkshire Oxfordshire and Buckinghamshire (BOB) local maternity and neonatal services (LMNS). There is the Perinatal Quality Surveillance meeting for governance where the Perinatal Quality Surveillance report is presented. The Perinatal Quality Surveillance (PQS) reports have been going to the Trust board since July 2021 - the meeting is held every second month and it is also sent to MCGC each month. This is also sent to the LMNS. There are no joint policies and guidelines for the LMNS.

10. Forge links with a partner Trust, to benefit from opportunities for learning, mentoring, secondment, staff development and sharing. **Action: Trusts**	CNST SA 8 Ockenden IEA 1&4 CQC Well Led Domain	Regional PDM forum Regional PMA forum Lead MW Educator meetings LMNS buddy SOP External review of SI's and PMRT	The Trust has linked up with the Royal Berkshire practice development team and the South Central Ambulance Service (SCAS) practice educators to facilitate community based emergency scenarios for skills and drills. This is based at the SCAS simulation centre in Newbury. The practice development team attend the Trust practice development meetings. The Professional Midwifery Advocates (PMA's) attend BOB LMNS PMA meetings and they also attend the Professional Nursing Advocate (PNA's) meetings within the Trust. In relation to fetal monitoring the fetal wellbeing leads are part of the Academic Health Science Network (AHSN) and they have developed a new fresh eyes screening tool that is currently being rolled out across the BOB LMNS. The fetal wellbeing leads are also part of the fetal monitoring network which is a national sharing platform for the fetal monitoring leads to share best practice and they meet monthly to update on the latest guidance and current learning. The clinical governance team also attend the Regional Governance meetings and are on a national group via email for clinical governance to share learning and guidelines. As part of the AHSN we have linked in with them to arrange external reviewers for SI's and to arrange a rota for the PMR meetings. The Health Safety Investigation Branch (HSIB) also act as the external reviewer for SI's. Staff within maternity are also involved and lead on the maternal medicine network.

11. Staff awareness of incident reporting, review its policy of openness and honesty. Duty of Candour compliance. **Action: Trusts**	CNST SA8 Ockenden 2 & 9 CQC Safe Domain	Mandatory training Ward to board round (NEDS) Safety Champion meetings ward to board rounds Co-production notice boards	Incident reporting awareness is included as part of the PROMPT study day and includes duty of candour. Ward to board round - the last one was in May 2021, further dates are planned. Dates for safety champions meeting have been provided for the year.
12. Review the structures, processes and staff involved in investigating incidents, RCA, learning, training. Include arrangements for staff debriefing and support following a serious incident.	CNST SA 3 Ockenden IEA 1 CQC Safe Domain	Maternity Risk Management strategy in date Psychological support for staff – debriefs sessions PMA support RCA training After Action Reviews Psychological first aid and de-briefs Lessons learnt shared at handovers, newsletter, notice boards, email, closed media forums	There currrently is not a Maternity Risk Management strategy Pyschological support for staff - debriefs are offered following an incident. We have utilised members of the medical team, clinical pyschologist and the resus team to assist with these. The PMA's and clinical supervisors are also informed if a staff member has been involved in an incident. RCA training is provided by the Trust Patient Safety Team and a number of staff in maternity have undertaken this.
13. Review the structures, processes and staff involved in responding to complaints, and learning are the public involved. **Action: Trusts**	CNST SA 1&7 Ockenden IEA 2 CQC Effective Domain	Complaints policy in date PALS You said we did responses MVP involvement All PMRT cases, SI's and HSIB reports reflect the family's voice/feedback	There is the Trust complaints policy. Number of complaints are given at MCGC each month. Information available on the website about PALS. Maternity Voices Partnership (MVP) involvement - the MVP give us themes of feedback, focus group and actions. These are reported back at the quarterly MVP meetings. Parents are invited to give their voice feedback for all PMRT cases, SI's and HSIB reports.

14. Review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. **Action: Trusts**	CNST SA 8 Ockenden IEA 3 and workforce CQC Well Led Domain	Mandatory Training compliance 90% Workforce Board Papers midwifery and clinical staff RCM leadership requirements RCOG workforce issues/role-responsibilities guidance Evidence of Leadership development programme and succession planning for Clinicians	Currently not at 90% as the new training year started in September 2021 for PROMPT, fetal monitoring and newborn life support (NLS) - reported monthly through Maternity Clinical Governance Committee (MCGC) and the Perinatal Quality Surveillance (PQS) Report. Other mandatory training is below 90% and is reported through MCGC and the PQS report. A safe staffing paper is submitted to Trust Board. The RCOG workforce issues/role-responsibilities guidance was reviewed and approved at the consultants meeting in December 2021. Following this, the relevant clinical guidelines were updated to include the requirement for consultant presence and these were ratified at MCGC. A poster to remind midwives of when a consultant should attend in line with the RCOG paper was circulated to band 7 midwives and consultants. This is also on display on the Delivery Suite. Leadership Development - the Clinical Director (CD) has attended CD development course run by the Trust. Two consultants have attended the Kings Fund Leadership course (1 in 2020 and 1 in 2021). In 2021, 4 new full time consultant posts were appointed with excellent candidates with job plans to address the needs of the unit as a tertiary referral centre. In addition, 6 LTFT posts were appointed. Two members of staff have undertaken the head of midwifery development programme and currently there is a member of staff undertaking her MBA in leadership through Henley College.

15. Review of governance systems clinical governance, so that the Board has adequate assurance of the quality of safe care. **Action: Trusts**	Ockenden IEA 1 CQC Well led Domain CNST SA10	Maternity Risk Management strategy in date Maternity Dashboard Risk register Governance structure HOM/DOM presents directly to Board not sub-committees Highlight Reports	Maternity Dashboard presented monthly to MCGC and the red highlights are included in the Divisional Quality report that is presented at the Trust Clinical Governance Committee. The highlights are also presented on a slide as part of the Trust performance review. The dashboard is also sent to the BOB LMNS board review.
16. Ensure middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and provide appropriate guidance and training. **Action: Trusts**	CNST SA 4,5 & 8 Ockenden IEA workforce CQC Well led domain	TNA Appraisals JD include roles and responsibilities NED walk rounds and engagement SLT visibility Safety Champions walk round engagement	The TNA for 2022-2023 is currently being developed. Appraisal rate reported monthly to Trust board - currently at the lowest compliance for over a year. Job descriptions include roles and responsibilities. NED walkround - there was a NED walkround in May 2021 and other walkrounds are planned for the future. Senior Leadership Team (SLT) visibility - the maternity leadership team undertake matrons walkrounds, they bleep hold and are visible to staff. They also undertake monthly maternity and neonatal feedback meetings. Safety Champions walkround engagement - the safety champions (Obstetricain and midwife) do regular walkrounds of maternity and the Director of Midwifery also visits the Midwifery Led Units (MLU's).

17. Review access to theatres, and ability to observe and respond to all women in labour and ensuite facilities; arrangements for post-operative care of women. **Action: Trusts**	CNST SA 9 Ockenden IEA 4 & 5 CQC Safe Domain	Immediate access to 2nd theatre Any midwives still scrubbing for theatre? If yes have they the required training and competency assessments Recovery staff are trained, and competency assessed in line with national guidance Staff providing level 2 HDU care are trained and competency assessed in line with national guidance LW coordinators supernumerary 1-1 care given in established labour Are there ensuite facilities	Emergency theatres are staffed to open two theatres with scrub and anaesthetic assistance. There is a resident duty anaesthetist (registrar or fellow 24/7). The duty anaesthetic consultant is resident from 0730-2030 weekdays, and for 3 hours on each weekend day, outside of which they are on call and available to attend within 30 minutes. Help can be requested from the anaesthetist on duty in the West Wing or JR. The midwives do not scrub for procedures as there is a scrub team. Labour ward coordinators are supernumerary and if this was not able to happen then it would be escalated to the bleep holder and an incident form completed. 1:1 care is provided in labour and this is monitored 24/7 and exceptions reported in the staffing paper. There are no ensute facilities for women on Delivery Suite or the Observation area. There are 4 number of rooms in the post operative ward that are ensuite. There are core staff based on the Observation area who have undertaken training in High Dependency Care.
18. All of above should involve CCG, and where necessary, the CQC and Monitor. **Action: Trusts**	CCG Assurance visits CQC regulation visits	Outcomes of visits CQC ratings Action plans Action plans monitored governance floor to board Feedback to staff	The CCG attend the Trust SIRI forums, the Trust Clinical Governance Committee and the BOB LMNS SI meeting. The recent CQC report following the unannounced visit was published on the 02 September 2021. The results of this with the must do and should do actions have been presented to staff at staff engagement meetings. It was also presented to the university and the materntiy voices partnership (MVP) in January 2022. An action plan was created and this is reported monthly to MCGC and to the Divisional Governance meeting and the Trust Clinical Governance Committee (CGC). It is also discussed with the safety champions.