Maternity services assessment and assurance tool

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

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

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

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

Section 1

Immediate and Essential Action 1: Enhanced Safety

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

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

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

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

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

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

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?	RAG

		system and trust level?					
Compliance as assessed by NHSE in 2021 was							**RAG**
Q1. Maternity Dashboard presented to LMS every 3 months.	Maternity Dashboard reviewed and reported on at Divisional Governance and through monthly reports to PSCEG, QPS and exception reported to Board. Quality Improvements are identified through monthly review of all data with subsequent progress reported through the same forums.	Assessment of progress through review of dashboard and measures set through QI programme.		QI Midwife Governance Team and LMNS partners			G
Q2. External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	Consideration of limited assurance audit of ESNEFT maternity incident reporting and assurance	Consideration of limited assurance audit of ESNEFT maternity incident reporting and assurance & identify a random sampling of actions to test the efficacy and deep dive where required.	Compliance progress against plan will be taken to the LMNS 3 times each year	Clinical effectiveness midwives	Final sign off reciprocal agreement with MSE. Audit will be added to the ACAP once implemented	Current resource across LMNS adequate to support external opinion. The Trust is committed to ensuring that clinicians are given the time and resource to support internal and external investigations in line with the recommendations of the report.	A

						(Audit & Risk Committee)	
Q3. Maternity SI's are presented to Trust Board & LMS every 3 months.	ESNEFT has recently adopted the Patient Safety Incident Response Framework (PSIRF). An additional SOP is under development to cover the required quarterly sharing of Patient Safety Incident Investigation (PSII) reports with Trust Board and the LMNS, and we are assessing how best to use existing reporting and governance structures. Recommendations from serious incidents support the development of training and quality improvements.	Incident trends and themes are monitored to provide assurance of actions and embedding of changes Detailed PSII added to the Patient Safety report since November 2021	Identify and record processes of assurance of effectiveness of change. Develop LMNS assurance framework.	Governance Team			G
Q4. Using the National Perinatal Mortality Review Tool to review perinatal deaths.	Quarterly reports to Trust Board confirming use of PMRT Guideline describing PMRT process and demonstrating parental	Finalise new guideline currently under development - Review process for perinatal morbidity and mortality cases; HSIB,	Maternity Governance Managers, obstetric PMRT lead. Expected by end April 2022.	Governance Team			A

	involvement in reviews Ppt presentation including audit 100% PMRT cases, demonstrating required standard (including parents notified). Finalise new guideline currently under development - Review process for perinatal morbidity and mortality cases; HSIB, MBRRACE and PMRT	MBRRACE and PMRT Ensure reporting structure and process as outlined in the Management of maternity dashboards SOP are fully embedded. Once final LMNS and partner LMNS approval is confirmed for the SOP for obtaining external clinical opinion - implement, embed and audit the process at ESNEFT.					
CNST Action 1 Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Year 3 achievement Year 4 progress						
Q5. Submitting data to the Maternity Services	Evidence of a plan for implementing the full MSDS	Action plan for implementing full	Review of action plan	Fiona Binnie David Grannell	Updated action plan in place		G

Dataset to the required standard	requirements with clear timescales aligned to NHSR requirements within MIS.	MSDS requirements					
CNST Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?	Year 3 achievement Year 4 progress						
Q6. Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme.	ESNEFT Quarterly reports produced						G
CNST Action 10: Have you reported 100% Qualifying cases to HSIB And or 2019/20 births To NHS Resolution Early Notification scheme?	Year 3 achievement Year 4 progress						
Q7. Plan to implement the Perinatal Clinical Quality Surveillance Model	Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed off via the trust governance structure.	Assessment of progress through review of dashboard and measures set through QI programme.					G
Link to Maternity Safety actions:							

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? **Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?** **Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?**							
Link to urgent clinical priorities: (a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. (b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.							
What do we have in place currently to meet all requirements of IEA 2?	**How will we evidence that we are meeting the requirements?**	**How do we know that these roles are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**	
Q 11. Non-executive director who has oversight of maternity services	NED JD and NED in post	Hussein Khatib has been ESNEFT's lead NED for maternity since January 2020, having been a NED since April 2019. His responsibilities as lead NED for Maternity is not included in the JD, since the Chair awaits the					G

		outcome of a national review of the concept of Lead NEDs, by NHS Providers and Sir Andrew Morris.					
Q13. Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Monthly maternity and neonatal safety champion meetings in place, with membership which includes MVP, NED, Trust safety champions. MVP are currently drawing up their programme of work for 2022/23. "	Maternity Safety Champions and MVP engagement and partnership working with the Trust				Service user feedback is received via the MVP with action plans in place to coproduce service improvements	G
CNST 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?	Year 3 achievement Year 4 progress						
Q 14. Trust safety champions meeting bimonthly with Board level champions	The Chief Nurse has Executive accountability for Nursing, Midwifery & AHP activities,	TOR for Safety Champion meeting. SOP that includes role descriptors for					G

	the Chief Nurse is Giles Thorpe. Non-executive Director Hussein Khatib, who has a clinical background, has responsibility for maternity services, a requirement outlined in the ESNEFT CQC report published in January 2020. The non-executive oversight role is linked to the Chair of Quality & Patient Safety Assurance Committee. Monthly maternity and neonatal safety champion meetings in place, with membership which includes MVP, NED, Trust safety champions. MVP are currently drawing up their programme of work for 2022/23. Board level safety champion and midwifery safety champion undertake regular walkabouts within the service, and	all key members who attend by-monthly safety meetings. Presence at Board level of both the Chief Nurse and NED responsible for Maternity services evidenced through minutes.					

	meet regularly with the NED for maternity. "						
CNST 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?	Year 3 achievement Year 4 progress						
Q 15. 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.	TOR for MVPs MVP Meeting minutes and actions MVP engagement and co-production report IES MVP email re remuneration and BAME/Deprivation focus MVP survey Oct 2021 Log of actions arising from user feedback (complaints/FFT)	Current processes in place including patient feedback, PALS, complaints and Maternity Voice Partnership and actions taken as a result of the information received.					G
Q 16. Non-executive director support the Board maternity safety champion	Presence at Board level of both the Chief Nurse and NED responsible for Maternity services evidenced through minutes.						G

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?	
Compliance as assessed by NHSE in 2021 was							
Q 17. Multidisciplinary training and working occurs.	LMNS Training Tracker template utilised	LMNS Training tracker template to be	Confirmation that Training	PDM Team			G

Evidence must be externally validated through the LMS, 3 times a year.		implemented for next quarterly meeting	Tracker is implemented.				
Q 18. Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	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)	Details of arrangements approved by Women's and Children's Divisional Management Team. 6 months' funding for additional hours for weekend consultant at Ipswich, to cover the twice daily ward rounds.	A full staffing review will have been completed by the end of that 6 month period, to including ongoing coverage. Approval of SOP	General Manager			A
CNST Action 4: **Can you demonstrate an effective system of clinical workforce planning to the required standard?**	Year 3 achievement Year 4 progress						
Q 19. External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Evidence from Budget statements. Evidence of funding received and spent. Evidence that additional external funding has been spent on funding including staff can attend training in work time. MTP spend reports to LMS		Evidence from Budget statements. Evidence of funding received and spent. Evidence that additional external funding has been spent on funding	Finance Team	Evidence from Finance Manager		A

			including staff can attend training in work time. MTP spend reports to LMS				
Q 21. 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	Compliance is monitored at Trust level through reporting at Divisional level and at Executive level through the Divisional Accountability Meetings, together with the quarterly overview included in the Integrated Patient Safety and Experience Report.	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.		PDM Team			A
CNST 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?	Year 3 achievement Year 4 progress						
Q 22 Implement consultant led labour ward rounds twice daily (over 24	In accordance with the 7 day services programme, Consultant led MDT ward rounds take	Audit of assurance that the Labour Ward rounds are taking place and	Compliance will be monitored at Risk and Governance,				G

hours) and 7 days per week.	place every morning. In the evening MDT handover and board rounds take place Monday to Friday at the Ipswich Site and 7 days a week at the Colchester site (physical presence). For Saturday and Sunday evenings at the Ipswich site the consultant leads board round with the team via teleconference. Service and job plan reviews completed, with an additional three consultant posts established and recruited to.	that there is MDT involvement. Handover register (which includes those at the ward round) is audited.	with exception reporting to Divisional Governance and Board, reporting to LMNS to be established.				
Immediate and essential action 4: Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. • Women with complex pregnancies must have a named consultant lead • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team							

Link to Maternity Safety Actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?**							
Link to urgent clinical priorities: a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.							
What do we have in place currently to meet all requirements of IEA 4?	**What are our monitoring mechanisms?**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	
Compliance as assessed by NHSE in 2021 was							
Q 24. Links with the tertiary level Maternal Medicine Centre & 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.	Pathways into the tertiary maternal medicine centres for the region (Addenbrooke's and N&N) are not yet agreed.	Confirmation & evidence of Agreement of pathways	Hannah Law Fadi Alfhally			A
Q 25. 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	Audits have been undertaken showing limited assurance, with re-audit currently underway.	Audit results and the subsequent action plans are presented and monitored	Fiona Binnie Clinical EffectivenessMidwives			A

	networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead. Identification of a named consultant lead is required on the handheld notes at Ipswich and in Maternity Medway at Colchester. Despite there being a mandatory. For Colchester site, improvement of completion of the relevant field (which has been made mandatory as far as is possible to do so) features within a wider Medway Maternity review which is underway with the consultant body, to streamline workflows within the system and ensure care givers have the time within a clinic to complete all the essential aspects of the patient record.	Review of Maternity Medway undertaken to understand and enhance the capture of data. Introduction of stickers placed in the notes (Ipswich) to confirm actions have been taken and audit plan of assurance.	at Risk & Governance monthly meetings and Divisional Board, exception reported to PSCEG, QPS and Board				

Q 26. Complex pregnancies have early specialist involvement and management plans agreed	Women identified as being complex are referred on to specialist consultant clinics following the booking and assessment guidelines. Specialist Maternal Medicines clinics are held on both sites, with referrals to tertiary centres as clinically appropriate. The service's recent Job plan review highlighted the need for additional consultant PAs allocated to maternal medicine clinics. The additional resource has been funded and identified. ESNEFT is committed to support the regional maternal medicine networks once established.	No monitoring mechanism in place at present.	Risk and Governance Meeting when established. The initial impact of increased clinical capacity for maternal medicine will be in the reduction of over-running of clinics and the need for ad-hoc additional clinics.				**A**

Q 27. Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Saving Babies Lives care bundle V2 action plans in place and regularly monitored to ensure progress continues.	Monitoring of incident and complaint trends and themes in accordance with the SBL action plan		QI Midwife	Continual assessment of resources required to deliver Saving Babies Lives with associated capital investment through business planning processes.		G
CNST Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Year 3 achievement Year 4 progress						
Q 28. All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	Audits have been undertaken showing limited assurance, with re-audit currently underway. Review of Maternity Medway undertaken to understand and enhance the capture of data. Introduction of	Audit results and the subsequent action plans are presented and monitored at Risk & Governance monthly meetings and Divisional Board, exception reported to	Clinical Effectiveness Midwives			A

	Identification of a named consultant lead is required on the handheld notes at Ipswich and in Maternity Medway at Colchester. Despite there being a mandatory. For Colchester site, improvement of completion of the relevant field (which has been made mandatory as far as is possible to do so) features within a wider Medway Maternity review which is underway with the consultant body, to streamline workflows within the system and ensure care givers have the time within a clinic to complete all the essential aspects of the patient record.	stickers placed in the notes (Ipswich) to confirm actions have been taken and audit plan of assurance.	PSCEG, QPS and Board				
Q 29. Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Criteria for referrals to MMC	No criteria yet agreed for referrals to Maternal Medicine Centres regionally – in progress.	Confirmation and evidence of agreed criteria.	Hannah Law Fadi Alfhally			G

Immediate and essential action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway. • All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.							
Link to Maternity Safety actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?**							
Link to urgent clinical priorities: a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.							
What do we have in place currently to meet all requirements of IEA 5?	**What are our monitoring mechanisms and where are they reported?**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	
Compliance as assessed by NHSE in 2021 was							
Q 30. 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. Risk assessment at every contact. Record keeping audits						G

Q 31. 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.		Colchester Antenatal Care guideline is under review and is being merged with Ipswich and it will contain more detail on risk assessment.	Julie Edgcumbe			A
Q 32. A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	The Trust follows all NICE and National Guidelines ensuring Women are risk assessed at each antenatal appointment. At Colchester, Maternity Medway reviewed, to maximise record keeping capabilities. At Ipswich, a sticker has been introduced to support confirmation of risk assessment at each established antenatal visit. Audit programme established	Risk assessment audits for all stages of pregnancy are established	Compliance is monitored at Trust level through reporting at Divisional level and at Executive level through the Divisional Accountability Meetings.	Clinical Effectiveness Midwife			G
Q 33. A risk assessment at every contact. Include ongoing review and	ACAP audits on plan	Audit schedule showing timeframes for	Confirmation and evidence that Ockenden	Clinical Effectiveness Midwives			G

discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.		Ockenden audits	audits are taking place.				
CNST Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Year 3 achievement Year 4 progress						
Immediate and essential action 6: Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - • Improving the practice of monitoring fetal wellbeing – • Consolidating existing knowledge of monitoring fetal wellbeing – • Keeping abreast of developments in the field – • Raising the profile of fetal wellbeing monitoring – • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported – • Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. • They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. • • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.							
Link to Maternity Safety actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?**							

Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?							
Link to urgent clinical priorities: a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.							
What do we have in place currently to meet all requirements of IEA 6?	**How will we evidence that our leads are undertaking the role in full?**	**What outcomes will we use to demonstrate that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	
Compliance as assessed by NHSE in 2021							
Q 34. Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Midwife Lead is Beverley Lynn (Colchester Site) and Jillian Hart (Ipswich Site). Implementation of FIGO physiological fetal monitoring interpretation (disapplying NICE) approved at Ipswich, aligning approach cross-site.	Training certificates, lesson plans and participant feedback available Quality Improvement Midwives plan and report initiatives. Training database to support monitoring of compliance. Progress of Saving Babies	Monitoring of incident and complaint trends and themes in accordance with the SBL action plan	Lead Midwives and Lead Obstetricians	Continual assessment of resources required to deliver Saving Babies Lives with associated capital investment through business planning processes.		A

	Obstetric Lead for Colchester site is open to expressions of interest, with Pippa Greenfield covering the role in the interim. Ruta Gada is the lead for Ipswich Site. As part of the service review of obstetrician job plans, additional PAs were allocated to the role of CTG lead, in accordance with requirements. All undertake continuing professional development, with a specific interest in fetal wellbeing. Saving Babies Lives care bundle V2 action plans in place and regularly monitored to ensure progress continues. The Trust follows PROMPT training guidance in ensuring the MDT training is in place.	Lives requirements included in audit plan with internal and external reporting on a quarterly basis.					

Q 35 The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Copies of the new JD's	Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision. Improving the practice & raising the profile of fetal wellbeing monitoring. Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	Out for Expression of Interest at present	Obstetric Clinical Lead	Implement within Job plans by end March		A

		Keeping abreast of developments in the field Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.					
Q 36. Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Saving Babies Lives care bundle V2 action plans in place and regularly monitored to ensure progress continues.	Monitoring of incident and complaint trends and themes in accordance with the SBL action plan		QI Midwife	Continual assessment of resources required to deliver Saving Babies Lives with associated capital investment through business		A

					planning processes.		
CNST Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Year 3 achievement Year 4 progress						
Q 37. 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?	Compliance is monitored at Trust level through reporting at Divisional level and at Executive level through the Divisional Accountability Meetings, together with the quarterly overview included in the Integrated Patient Safety and Experience Report.	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.					A
CNST 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	Year 3 achievement Year 4 progress						

three in December 2019?							
Immediate and essential action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected							
Link to Maternity Safety actions: **Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?**							
Link to urgent clinical priorities: a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.							
What do we have in place currently to meet all requirements of IEA 7?	**Where and how often do we report this?**	**How do we know that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	
Compliance as assessed by NHSE in 2021 was							
Q 39. Trusts ensure women have ready access to accurate	Outcomes of Maternity Survey, patient feedback,	MVP partnership and monitoring of feedback					G

information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	incidents, complaints & PALS reported at Maternity Risk & Governance, Divisional Board, PSCEG, PEG and with exception reporting to QPS and Board LMNS reports on access to Mum & Baby app	through FFT, complaints, PALS and social media.					
Q 41. Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance. CQC survey and associated action plans 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.			Clinical Effectiveness Midwives CQC Compliance Officer			A
Q 42. Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care			Clinical Effectiveness Midwives			A

	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.						
Q 43. 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?	MVP Meeting minutes and actions MVP engagement and co-production report IES MVP email re remuneration and BAME/Deprivation focus MVP survey Oct 2021 Log of actions arising from user feedback (complaints/FFT)	Current processes in place including patient feedback, PALS, complaints and Maternity Voice Partnership and actions taken as a result of the information received.					A
CNST 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?	Year 3 achievement Year 4 progress						

Q 44. Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Gap analysis of website against Chelsea & Westminster conducted by the MVP Information on maternal choice including choice for caesarean delivery.	Confirmation and evidence that gap analysis has been completed and any actions arising.		Deputy HOMs	Matrons to produce action plan		A

Section 2

MATERNITY WORKFORCE PLANNING

Link to Maternity safety standards:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard
Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.

What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Q 45. Demonstrate an effective system of clinical workforce planning to the required standard	A review of Consultant job plans was completed in September 2021, resulting in three additional consultant posts being established, now recruited to. The review took into account the requirements of both Obstetrics and Gynaecology and considered the allocation of time for Consultant	Monthly reports to Divisional Board and quarterly reports to the Patient Safety and Clinical Effectiveness Group; Quality & Patient Safety Board Assurance Committee; and the Board.				

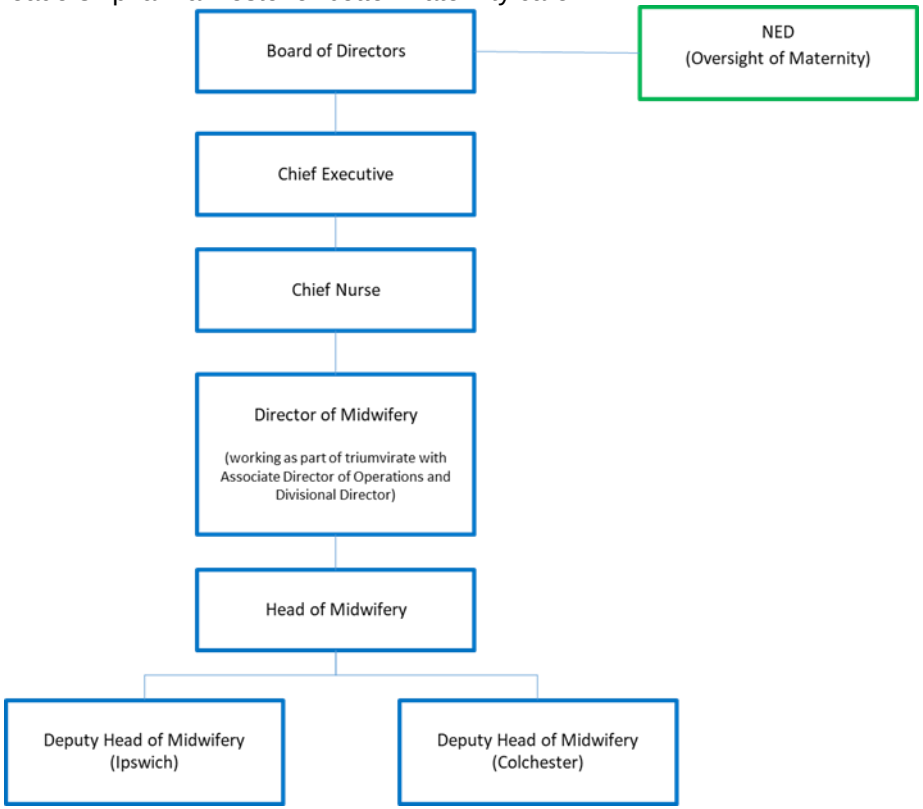
	support to deliver the Maternity & Trust Quality & Safety agenda as well as regional and national requirements.					
CNST Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?	Year 3 achievement Year 4 progress					
Q 46. Demonstrate an effective system of midwifery workforce planning to the required standard?	Birthrate+ review was undertaken in 2019, with recommendation for additional midwives above the current establishment.	24 wte additional midwife posts were approved for funding in 2021, which comprised £1.4m of investment to increase midwifery establishment to meet Birthrate+ recommended levels. Recruitment is staggered over 18 months to enable recruitment, induction and professional development.	Monthly reports to Divisional Board and quarterly reports to the Patient Safety and Clinical Effectiveness Group; Quality & Patient Safety Board Assurance Committee; and the Board.			
CNST Action 5: Can you demonstrate an effective system of midwifery workforce						

planning to the required standard?						
Q 47. Director/Head of Midwifery is responsible and accountable to an executive director	The Director of Midwifery is professionally accountable to the Chief Nurse (Executive Director) and line managed by the Divisional Director for Women and Children's Services.					

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

Q 48.
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:



The Director of Midwifery is professionally accountable to the Chief Nurse and line managed by the Divisional Director for Women and Children's Services.

The Head of Midwifery is responsible and accountable to the Director of Midwifery.

The Division's management team comprises a Divisional Clinical Director, Director of Midwifery, supported by ENSEFT Head of Midwifery and 2 Deputy HOMs who are site specific, Head of Nursing for Paediatrics and Gynaecology and Associate Director of Operations.

1	A Director of Midwifery in Every Trust and Health Board and more Heads of Midwifery across the service.	Establishment for a Director of Midwifery, one whole time equivalent cross-site Head of Midwifery and two whole time equivalent site specific deputy heads of midwifery.	
2	A lead midwife at a senior level in all parts of the NHS, both nationally and regionally	Senior Lead Midwife at a regional level in post (Regional Chief Midwife) - weekly meeting with DoMs and HoMs.	
3	Increase number of Consultant Midwives		No Consultant Midwives at present, but this is being considered as part of a wider workforce review.
4	Specialist Midwives in every Trust and Health Board	Specialist midwives in post for: -Smoking cessation, -Mental health, -Diabetes, -Bereavement, -Infant feeding, -Safeguarding, -Fetal monitoring, -Practice development, -Quality Improvement (QI), -Clinical effectiveness, -Governance/risk management, -Parent education	
5	Strengthening and supporting sustainable midwifery leadership in education and research	Links with education at local Universities Lead Midwives for Education at ARU, EEA and UoS.	
6	A commitment to fund ongoing midwifery leadership development	ESNEFT is committeed to the ongoing midwifery leadership, both in terms of mentoring and coaching for DoM and HoMs; leadership courses for HoMs. ESNEFT has a talent mapping procedure aligned to its annual appraisal / development reviews which enables the idnetification and support for matrons who would be suitable to progress through the Aspiring Heads of Midwifery course.	
7	Professional input into the appointment of midwife leaders		Consider senior RCM representation on interview panels for future very senior midwifery posts (no current vacancies)

Compliance						
NICE GUIDANCE RELATED TO MATERNITY						
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.						
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all of our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
We are fully compliant with NICE Guidance related to Maternity and received feedback from NHS England in December 2021 to demonstrate that we were 100% compliant						
Q 49. Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	ESNEFT's NICE & National Audit Lead gives an update on progress of all guidance to divisional teams on a monthly basis. In addition, a quarterly report on the status of all NICE guidance is reported to ESNEFT's Patient Safety & Clinical Effectiveness Group, which is chaired by the	Audit to demonstrate all guidelines are in date. Evidence of risk assessment where guidance is not implemented. Baseline Assessment Tool completed for each piece of NICE guidance. Where NICE guidance is not followed e.g. FIGO, a rationale is given for deviation and local	Continue to adhere to NICE guidance processes already in place. Ensure that the annual clinical audit programme captures areas where new practice has been put in place and where risks are identified.	Clinical Effectiveness Midwives Obstetric Consultants	Within existing resources	**No short term risks**

	Chief Medical Officer and whose membership includes senior corporate and clinical leaders from all divisions. Identified gaps are risk assessed and where appropriate escalated to the divisional risk register. All new risks are subject to executive oversight through the Executive Risk Oversight Committee.	guideline is in place (approved through governance forum). Completed Baseline Assessment Tools are reviewed at Risk and Governance meetings to agree any further actions and who will lead and timeframe for completion, and to ratify those baseline assessments where no further actions are required as all actions have previously been implemented. On an annual basis the service develops a clinical audit plan which by its nature assesses standards of clinical practice.				