

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 system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
<p>All cases are reported to HSIB and NHS Resolutions ENS.</p> <p>PMRT is used and quarterly reports are submitted to the Board in line with MIS requirements.</p> <p>Quarterly stillbirth data is submitted to Yorkshire and Humber Maternity Dashboard</p> <p>BHTFT maternity dashboard is monitored locally and discussed in a variety of forums at CBU level and is also presented to the Board.</p> <p>A Trust SI report goes to both Board and Regulation Committee. These meetings are alternative months and therefore Board members see the</p>	<p>There are systems in place for early review, recognition and escalation of serious incidents. There are mechanisms in place for sharing learning from SI's locally and regionally to ensure improved outcomes for mothers and babies.</p> <p>There is a good level of engagement from the Trust within the LMS work streams to share learning and improve outcomes both locally and regionally.</p>	<p>Sharing of the data enables identification of good practice which can be implemented locally.</p> <p>LMS work streams support reduction in variation of practice and shared guidance is being developed.</p> <p>Learning from best practice and SI locally and regionally will support a reduction in poor outcomes.</p>	<p>The maternity service at BTHFT will commit to follow the Perinatal Clinical Quality Surveillance Model, agreed regional, when it is implemented in 2021.</p> <p>We commit to participation and adherence to the structured reporting mechanisms determined by the LMS.</p> <p>The service commits to seeking a regional external clinical specialist opinion from outside the Trust for intrapartum fetal deaths including cases which do not meet HSIB criteria, as per the agreed regional process when implemented</p>	<p>Regional and WY&H LMS to provide the Trust with a process.</p> <p>The Maternity service and Trust will endeavour to achieve all requirements for MIS year 3</p>	<p>The resource and support required is as yet undetermined until regional process is agreed and implemented.</p>	<p>Until LMS process agreed the HOM will notify LMS PMO and lead midwife of any new SI's.</p>

<p>report monthly.</p> <p>All new SI's and an update on progress and learning, are included in the monthly maternity update to Board.</p> <p>HSIB reportable cases have been added as a new indicator on the Yorkshire and Humber Maternity Dashboard. This is already an indicator on BTHFT dashboard.</p> <p>The service is on track to meet safety action 1 of MIS year 3</p> <p>All relevant stakeholders have been informed of the requirement to report all HSIB cases as SI's moving forward.</p>			<p>Meetings are planned with Programme Analyst for West Yorkshire and Harrogate and Trust IT team to support achievement of Safety action 2 of MIS year 3</p>			
<p>Immediate and essential action 2: Listening to Women and Families</p> <p>Maternity services must ensure that women and their families are listened to with their voices heard.</p> <ul style="list-style-type: none"> • Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. • The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. • Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for 						

ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

- (a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
- (b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
Midwifery, Obstetric and Neonatal maternity safety champions meet bi-monthly with Chief Nurse, Karen Dawber, Board level maternity safety champion. Trust nominated non-executive director is	Safety champion Meeting minutes MVP meeting minutes The Fifteen Steps for Maternity – Quality from the perspective of people who use maternity services	All the surveys have demonstrated a positive patient experience on the whole. There is good staff engagement with the monthly maternity	Await further national guidance in regards to the advocate role from the LMS. We will commit to participation and adherence to the guidance determined by the LMS.	National team and WY&H LMS	It is unclear if any additional resources will be required in regards to the advocate role.	Families will continue to be involved in incidents and complaints. The service will continue to promote patient

<p>Selina Ullah.</p> <p>The maternity services have a good relationships with the MVP – 3 meetings are attended as a minimum per year.</p> <p>The Fifteen Steps for Maternity – Quality from the perspective of people who use maternity services, has been undertaken in the Antenatal outpatient department.</p> <p>FFT is currently on hold due to Covid 19 but discussions have taken place in regards to reintroducing this.</p> <p>A patient experience action plan is in place.</p> <p>A survey of women's experience of maternity services during Covid has been undertaken.</p>	<p>action plan</p> <p>National maternity survey action plan</p> <p>A survey of women's experience of maternity services during Covid results</p> <p>Antenatal birth and beyond page - https://www.facebook.com/BTHFTMaternity/</p> <p>OMS Board meeting minutes</p> <p>Level 1 investigation reports.</p>	<p>and neonatal ward to board safety feedback sessions.</p>	<p>The newly appointed Non-executive director will be invited to bi-monthly safety champion meetings from February 2021.</p>	<p>Maternity team - February 2021</p>		<p>feedback.</p>
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<p>An Infant feeding survey is in progress.</p> <p>The Maternity service introduced an Antenatal birth and beyond facebook page in 2016 and is well used by the local community.</p> <p>An MVP representative sits on OMS board</p> <p>Families involved in adverse events are provided with an opportunity to be involved in the internal investigations.</p> <p>MVP have been involved in developing the visiting policy and will be involved in developing local guidance</p>						
<p>Immediate and essential action 3: Staff Training and Working Together Staff who work together must train together</p> <ul style="list-style-type: none"> 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:

- Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
- 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?
Consultant led labour ward rounds routinely take place 4 times a day and is multidisciplinary (midwifery, medical, anaesthetic and neonatal when required)	<p>BTHFT Handover of care Medical Guideline</p> <p>BTHFT Education strategy 2021</p> <p>PROMPT Training attendance and</p>	<p>Women's Quality & Safety meetings monitor training compliance and the audit plan.</p> <p>Finance is a standing agenda item on the Women's CBU</p>	The LMS are to agree a process for the validation of MDT training. We will commit to adherence to the agreed process determined by the LMS.	WY&H LMS	No additional resource or support required.	Appropriate measures are already in place and therefore there is no risk.

<p>The roles and responsibilities of the consultant on call have been reiterated by the clinical director to the consultant body</p> <p>An audit has been undertaken in January 2021 which supports that at least 2 MDT labour ward rounds take place every day.</p> <p>Monthly PROMPT MDT emergency training takes place and this has continued during Covid.</p> <p>Maternity services education Strategy for 2021 has been developed and approved.</p> <p>External funding received i.e LMS training funds or national safety directives are ring fenced.</p>	<p>compliance records.</p> <p>Audit of consultant ward round.</p> <p>Letter from the relevant stakeholder committing to ring fence money for training and CNST MIS year 3.</p>	<p>business meeting.</p>	<p>A further consultant ward round audit will take place in 6 months' time.</p> <p>We will consider implementing a red flag for absent ward round at 8am and 8pm to safecare.</p>	<p>Audit lead July 2021</p> <p>Matrons</p>		
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<p>The Trust has agreed to ring fence any MIS and external funding allocated for the training of maternity staff money awarded.</p> <p>Time for mandatory training is already built into the funded establishment.</p>						
<p>Immediate and essential action 4: Managing Complex Pregnancy</p> <p>There must be robust pathways in place for managing women with complex pregnancies</p> <p>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.</p> <ul style="list-style-type: none"> • 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 						
<p>Link to Maternity Safety Actions:</p> <p>Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?</p>						
<p>Link to urgent clinical priorities:</p> <ul style="list-style-type: none"> 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?
<p>Referral to consultant care guidelines are in place</p> <p>An SOP is in place to ensure a named consultant is assigned and identifiable on the woman's Medway record.</p> <p>There is a local agreement in place to refer women to Leeds General Infirmary who require specialist maternal medicine. BTHFT Cardiac Disease in Pregnancy - Congenital and Acquired guideline includes referral criteria.</p> <p>A specialist midwife - Safer maternity care is</p>	<p>Guidelines and SOP's</p> <p>Spot check audit completed January 2021 for assigned consultant.</p> <p>SBLV2 action plan</p>	<p>Audits are presented at Women's Specialty meeting and included on Women's Quality & Safety meeting agenda.</p> <p>SBLV2 quarterly surveys are submitted to the clinical network and regular local monitoring takes place.</p>	<p>The LMS are developing a SOP for referral to maternal medicine units. This is in first draft.</p> <p>Continue to work towards achieving SBLV2.</p> <p>A further audit will take place in 6 months' time to include the assignment of the named consultant for women with complex pregnancies.</p>	<p>WY&H LMS</p> <p>Maternity services</p>	<p>Unknown until the LMS structure and process for maternal medicine is agreed.</p>	<p>Achieve recommendations and actions from the spot check audit.</p> <p>Continue with existing process for referring women requiring specialist maternal medical.</p>

in post and is leading on the implementation of SBLV2.						
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. <ul style="list-style-type: none"> 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 (PCSP). 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?
Medway patient electronic record includes mandatory questions to ensure a risk assessment is documented at each	Antenatal risk assessment audit report. MSDSv2 includes a PCSP data submission.	Audits are presented at Women's specialist governance meeting and included on Women's Quality & Safety meeting	PCSP to be rolled out for all women accessing the service. There is a plan to	Maternity services	The maybe a potential financial resource to sign up to the National	Achieve recommendations and actions from the spot check audit

<p>contact. This includes a review and discussion of intended place of birth at booking and if risk changes.</p> <p>A paper based Personalised Care and Support Plan is being rolled out for women in a CoC pathway.</p> <p>Women with complex needs i.e safeguarding and perinatal mental health have a PCSP in place.</p> <p>Safer maternity care specialist midwife in post and leading on the implementation of SBLV2.</p>		<p>agenda.</p> <p>SBLV2 quarterly surveys are submitted to the clinical network and regular local monitoring takes place.</p>	<p>incorporate PSCP electronically with a portal for women to access their own records within the new maternity Cerner system.</p> <p>We will commit to sign up to the National antenatal risk assessment process when this is available.</p> <p>A further detailed Antenatal risk assessment audit will take place in 6 months' time.</p>		antenatal risk assessment process	
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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?
A specialist midwife - Safer maternity care is in post who's role includes 15 hours a week CTG lead role – Mary Anne Naylor An Obstetric fetal	CTG meeting minutes Roster monitoring Staff confidence and competence in CTG interpretation.	Monitoring of HIE cases and stillbirths where fetal monitoring was a concern Monitoring of incidents/near misses.	Consider joint CTG meetings with Airedale Hospital to share learning and good practice CTG meetings are new to the service	Maternity service	A financial resource requirement for increased job plan time for Consultant obstetric t fetal monitoring lead.	

<p>monitoring lead has been appointed - Zebia Thomas.</p> <p>We are on track to meet action 6 and action 8 of MIS year 3.</p> <p>Saving babies lives funding is being used for staff to attend CTG masterclasses.</p>			<p>and need to be embedded with improved engagement.</p> <p>Await National and or Regional guidance on the time required for Obstetric fetal monitoring lead. It is anticipated that this will be a minimum of 1 PA per week.</p>			
<p>Immediate and essential action 7: Informed Consent</p> <p>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.</p> <p>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</p> <p>Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care</p> <p>Women's choices following a shared and informed decision-making process must be respected</p>						
<p>Link to Maternity Safety actions:</p> <p>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?</p>						
<p>Link to urgent clinical priorities:</p> <p>a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and</p>						

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?
<p>The current website includes information leaflets for women on separate subjects.</p> <p>All patient information leaflets have service user input as part of their development.</p> <p>We are on track to achieve safety action 7 of MIS year 3</p> <p>Birth Matters clinics support women who wish to birth out of guidance and allow evidence based information sharing and birth planning.</p>	<p>A Women's services leaflet tracker is in place</p> <p>Trust Communication with Patients Approval Group monitoring and approval process</p>	<p>Monitoring of Women's services leaflet tracker and CPAG processes</p> <p>Complaints monitoring – there have not been any complaints from women with regards to not respecting birth choices.</p>	<p>The Maternity internet page requires further development to ensure all pathways of maternity care throughout the antenatal, intrapartum and postnatal period are clearly described.</p> <p>Continued role out of PSCP</p> <p>Approach LMS leads to consider development of LMS wide information resource for women.</p>	<p>Maternity Services – OMS</p> <p>LMS</p>	<p>There is a finance resource required for the development of new information and the website.</p>	<p>Continue to keep website updated with evidence based information.</p>

Section 2						
MATERNITY WORKFORCE PLANNING						
<p>Link to Maternity safety standards:</p> <p>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?</p> <p>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.</p>						
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?
<p>Birth Rate Plus has been commissioned and data collection commenced in November 2020. Analysis is expected in February/March 2021</p> <p>A Bi-annual midwifery staffing paper is presented to Board – last paper was submitted in January 2021</p> <p>We are on target to achieve safety</p>	<p>Escalation policy and tools are used and red flags in place.</p> <p>Staffing and workload is continually monitored and a hot desk midwife in place 8am – 17.00 Monday to Friday to support this.</p> <p>Staffing related incidents are datix'd.</p>	<p>Staffing update to board.</p> <p>Staffing is a standing agenda at Maternity services forum and Women's Business unit meetings.</p> <p>Birth rate plus findings will be reviewed and recommendation presented to board.</p>	<p>Analysis of Birth rate plus results and a subsequent report to Board with recommendations including any required increase to the existing establishment.</p> <p>The service is currently undertaken a gap analysis of clinical and non-clinical activity and will produce a business case requesting an</p>	Head of Midwifery, April 2021	Potential financial resource dependant on Birth Rate plus findings	Ongoing monitoring of staffing levels and escalation

action 4 - MIS year 3	Robust sickness and absence monitoring.		increase in the current medical staffing model to meet the National requirements and deliver a safe service.			
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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](#)

Head of Midwifery is responsible and accountable to the Chief Nurse. There is no Director of Nursing currently in post or planned. The HOM has good working relationships and is visible at Board level.

The Consultant Midwife role was removed from the maternity leadership structure as the role was not adding any value to the service. The role was replaced with a Midwife lead for Risk and Governance. A Consultant midwife post is not being considered at present.

The service has an array of Specialist Midwives in post:

- Risk and Governance
- Quality in practice
- Safer Maternity Care
- Infant feeding
- 2 Safeguarding Midwives
- Perinatal Mental Health
- Teenage pregnancy
- Antenatal and Newborn Screening
- Continuity of care
- Practice Education
- Parent education
- Bereavement

There is a Strong focus on research at BTHFT. Research midwives are seconded into Research posts.

There are no funded plans to develop midwifery leadership posts. Internal development opportunities are in place i.e deputy ward manager posts. Internal leadership programmes are available and Band 7 midwives are supported to attend.

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	Where and how	What assurance	What further action	Who and by	What resources	How will we
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we have in place currently?	often do we report this?	do we have that all of our guidelines are clinically appropriate?	do we need to take?	when?	or support do we need?	mitigate risk in the short term?
<p>A GAP analysis is undertaken for all NICE guidelines</p> <p>Any areas of non-compliance require an action plan which is monitored at Women's Quality & safety meeting.</p> <p>An exceptions report is completed for any areas where compliance will not be achieved by the service</p> <p>All GAP analysis are monitored by the Trust clinical audit and effectiveness meeting.</p>	<p>NICE guidelines are a standing agenda item at Maternity Services Forum and Women's Quality & Safety Meetings.</p>	<p>Gap analysis</p>	<p>Ensure all current ongoing NICE action plans are completed.</p> <p>A review of all guidelines in line with National guidelines is being undertaken as part of the OMS</p>	<p>Maternity Service - OMS</p>	<p>None</p>	<p>Monitoring of ongoing work.</p> <p>Follow current processes for NICE benchmarking and approval</p>