



Bradford Teaching Hospitals  
NHS Foundation Trust

# Maternity Sustainability Plan

**Document control:**

**Authors:** Sara Hollins, Director of Midwifery  
Carly Stott, Qulaity & Safety Lead Midwife  
Carolyn Robertson, Clinical Direct of Women's Services

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	Sustainability Action plan	Specific actions to be implemented to ensure ongoing sustainability	Progress	Measurement	Outcomes	RAG Rating	Senior Responsible Officer	Action Owners	Target date/Timeline
1	The trust must improve governance and oversight of risk in maternity service and ensure all levels of governance and management function effectively and interact with each other appropriately.	<p>1. A review of governance processes with clear lines of escalation from ward to board.</p> <p>2. Improvements to be made to ensure governance meets the CQC maternity services framework.</p> <p>3. Introduction of Outstanding Maternity Services Transformation Programme.</p> <p>4. Monthly Maternity Safety Champion Meetings with staff led by the Executive Director Maternity Safety Champion.</p> <p>5. Bi monthly safety champion leads meetings</p> <p>6. Perinatal Clinical Quality Surveillance meetings</p>	<p>July 2020 - The Director of Midwifery has membership at the Board committee's and Board Meeting where the monthly maternity update paper is discussed/ noted.</p> <p>August 2020 - Outstanding Maternity Services Transformation Programme launched.</p> <p>October 2020 - Terms of reference and agendas for CBU level meetings agreed, revised and approved at the Women's services Quality and Safety meeting in. Monthly Board level Safety Champion meetings with staff planned for the year.</p> <p>'you said we did posters' developed to feedback information to staff. Neonatal consultant safety champion introduced February 2020. Neonatal nurse safety champion introduced December 2021. The Bi monthly safety champions leads meet monthly in addition to meeting with staff. Maternity and Neonatal Ward to Board safety escalation SOP developed. Perinatal Clinical Quality Surveillance is undertaken at local level via a number of different forums and is shared with Trust Board within the Monthly Maternity Update paper, West Yorkshire &amp; Humber Clinical Network, WY&amp;H Local Maternity System, Bradford District &amp; Craven Clinical Commissioning Group.</p> <p>June 2021 - Monthly meetings with the Bradford and Craven Clinical Commissioning Groups to discuss Perinatal Clinical Quality Surveillance. BTHFT Local Perinatal Quality Surveillance SOP.</p> <p>September 2022 - Monthly CBU Governance chaired by clinical director or triumvirate.</p>	<p>CBU Meeting and Trust Board minutes. BTHFT Trust Board sits on alternate months; therefore the agreement is that the monthly update is presented to Quality Academy (Board committee) for discussion on the month that Board does not sit. The same report then goes to Trust Board for noting as an appendix to the current update paper being presented.</p> <p>OMS highlight reports and OMS Board minutes.</p> <p>Maternity Safety champion meetings annual programme and feedback posters.</p> <p>Bi monthly maternity safety champion meetings minutes and action plan.</p> <p>Quality oversight meeting minutes</p>	Effective governance oversight and processes with a good level of oversight by Board	complete - business as usual	C Robertson & S Hollins	J Anderson & C Stott	30/01/2021 with continued improvements.
2	The service must monitor and control infection risks in theatres consistently well and ensure mitigating actions (including incident reporting of theatre use) are implemented and closely monitored.	<p>1. Monitor, improve and continually assess infection rates of women who birth in maternity theatres.</p> <p>2. IPCC team oversight</p> <p>3. New maternity theatre build</p> <p>4. Ensure best practice to prevent SSI throughout the patient's surgical journey using the OneTogether prevention of surgical site infection (SSI) pathway.</p>	<p>SSI Audits undertaken - June-August 2019 and March-September 2021.</p> <p>Weekly datix of theatre usage were being submitted until new theatres were in place.</p> <p>Infection prevention and control (IPPC) is a standing agenda item on the Quality &amp; Safety Meeting. The minutes from the IPCC meeting are included on the agenda. The Matron who has membership at the IPCC meeting and produces a BI monthly paper to the IPCC team provides a verbal update each month.</p> <p>Action plan in place following 'one together' SSI pathway benchmarking.</p> <p>May 2022 New theatres in use which meet all ventilation standards.</p> <p>Postnatal readmission rates for infection monitored monthly and data included in IPCC reports since April 2022</p>	<p>SSI audit reports.</p> <p>Datix reports.</p> <p>IPCC papers and meeting minutes.</p> <p>Risk assessments.</p> <p>One together benchmarking and action plan.</p>	Obstetric theatres meet required Health and Safety and IPCC standards. Ongoing monitoring of postnatal readmission infection rates.		C Robertson & S Hollins	S Crowther, A Hardaker C Stott, V Jones & C Dinsdale	30/10/2022
3	The service must ensure that stillbirths are monitored, escalated when required, and actions are put in place to improve stillbirth rates.	<p>1. Detailed review of all stillbirths and early escalation of concerns to executive team.</p> <p>2. Monitoring of the stillbirth rate via the dashboard.</p> <p>3. Implementation of SBLSBv2.</p>	<p>July 2020 Appointment of Specialist Midwife for Safer Maternity Care.</p> <p>A 72 hour MDT clinical review has been undertaken for all stillbirths since January 2020 to date and a datix reported.</p> <p>Process in place for escalation to Medical Director &amp; Chief Nurse if there are over 4 stillbirths in a month.</p> <p>Monthly CBU oversight via dashboard and perinatal report included on Quality and Safety meeting.</p> <p>Board level oversight of the stillbirth position via monthly Maternity update papers.</p> <p>PMRT reporting of all cases which meet criteria and meeting MIS safety action 1 standards.</p> <p>Achieved SBLV2 standards and ongoing audits with exception of MSDS reporting.</p> <p>Monthly Perinatal mortality meetings. External representation from Leeds commenced May 2022. Annual thematic review of cases undertaken</p> <p>Learning from stillbirths shared with LMS safety forum</p>	<p>Datix reports</p> <p>Clinical reviews</p> <p>Monthly perinatal reports</p> <p>Q&amp;S Meeting minutes</p> <p>Monthly maternity update papers</p> <p>Trust Board meetings</p> <p>Perinatal mortality meeting minutes</p> <p>Presentation of annual thematic review</p> <p>LMS safety forum minutes</p>	Sustain the well embedded process of review and escalation that are in place and continue to monitor stillbirth rates.	complete - business as usual	C Robertson & S Hollins	A Hufton, J Anderson, C Stott, V Jones, J Key	5/30/2020

4	The service must ensure that all staff are engaged with and participate in all steps of the World Health Organisation surgical safety checklist, the checklist is fully completed and observational and record audits are undertaken to monitor compliance.	1. Undertake observational audits of theatre practices to include WHO surgical safety checklist. 2. 5 Steps to safer surgery to be re-launched and to ensure assurance can be provided for the completion of all 5 steps.	A WHO audit took place as the report was shared and discussed at April 21 Women's Quality & Safety Meeting a further audit in regards to theatre timings took place which incorporated WHO steps which was shared and discussed at September 2021 Women's Quality & Safety meeting. All guidance and theatre SOP's (SOP 5 steps to safer surgery and Obstetric theatre SOP) have been revised and these were approved in February 2021. The progress of WHO and assurance of this is continuing through the maternity service improvement programme via the women's Journey.	Audit reports Guidelines and SOP's OMS highlight/progress reports	Annual audits with assuring findings to support standards are achieved in line with guidelines and best practice.	complete - business as usual	C Robertson & S Hollins	A Hardaker & J Inglis	30/11/2020 ext 30/02/2021
5	The service must ensure systems and processes are used to safely record the use of controlled drugs in the maternity service and compliance is monitored.	1. Audit controlled drug checks and provide ongoing assurance of compliance via the monthly CBU business meeting.	2 Department wide controlled drug audit have been completed and shared with the teams. Audit reports discussed at the Women's Quality & Safety Meeting in April 21 and Sept 21. Audit finding shared at Trust Medicines Safety meeting. Ongoing assurance is monitored via the ward assurance data at the Women's Business meeting.	Audit reports CBU Q&S and Business meeting minutes	Monthly Matron oversight of controlled drug checks with assurance oversight reported at Women's CBU governance meeting.	complete - business as usual	C Robertson & S Hollins	Matrons & Unit managers	9/14/2021
6	The trust must ensure the outcomes/recommendations of any serious case reviews are acted on, and midwives have the opportunity to regularly attend child protection conferences and submit reports to facilitate decision making and safety planning.	1. Review Ofsted/CQC Safeguarding action plan and work towards completing any unachieved actions. 2. Review demand and current rate of midwifery attendance at child protection conferences. 3. Process to be devised to share serious case reviews via the existing governance structure.	Serious case review action plan shared at October 2020 Q&S meeting. 2 outstanding actions - 1st re attendance at child protection conference and 2nd re use of interpreters. Audits completed for attendance at child protection conferences and use of interpreters. Approval given for 1 WFE uplift in community to improve attendance to child protection conferences. The uplift commenced in October 2020. Repeat attendance at case conference audits completed and presented at Q&S meeting which showed improvement. Midwife attendance to case conferences. QI in the use of interpreters progressing via the OMS programme. There has not been any further published Serious case reviews published since the last CQC visit. Any future action plans will be monitored via the monthly Q&S meetings	Audit reports Q&S meeting minutes	Annual audits for attendance at child protection conferences and use of interpreters. Any future serious case review action plans will be monitored via the monthly Q&S meetings	complete - business as usual	S Hollins	E McArdleRobins/A Powell	7/30/2021
7	The service must ensure all staff are up to date with mandatory training , including safeguarding children level three training.	1. Monthly mandatory training report received and reviewed on a monthly basis as a standing agenda item on the Q&S meeting agenda. 2. All managers to review and provide assurance to Matrons of training compliance for staff in their areas.	Monthly compliance reported at Quality and Safety meeting. Challenges have been experienced in maintaining acceptable training compliance rates due to the covid 19 pandemic and a pause in training for the cerner implementation. Figures have progressively improved over time. A risk assessment and action plan have been produced.	Monthly mandatory training update reports and Q&S meeting minutes. Mandatory training Risk assessment.	All mandatory training compliance within target and sustained.	Training compliance to be within expected target (>85%) for all mandatory training requirements.	C Robertson & S Hollins	C Stott, M English	2/28/2023

8	The service must ensure staff always complete and update risk assessments and applicable key documentation (including modified early obstetric warning scores, and intrapartum 'fresh eyes') for each woman.	<p>1. Undertake fresh eyes audit.</p> <p>2. Undertake MEWS audit.</p> <p>3. Undertake risk assessment at booking and subsequent antenatal contacts audit</p> <p>4. Undertake risk assessment throughout labour audit</p> <p>5. Undertake risk of FGR/SGA audit</p> <p>6. Undertake risk of preterm birth audit</p> <p>7. Undertake perinatal mental health audit</p> <p>8. Undertake Routine Enquiry audit</p> <p>9. Undertake VTE audit</p>	<p>1. Fresh eyes audit initially undertaken monthly and findings presented at the Q&amp;S meeting. Following a good period of assurance that fresh eyes was being completed a decision was made to monitor data 6 monthly. An audit has taken place post Cerner implementation and changes to the system are in progress to enable improvement following the audit findings.</p> <p>2. A MEWS audit was completed and included on the Women's Quality &amp; Safety agenda in Dec 2020 and the audit was presented at the January 2021 Speciality Governance meeting. Cerner changes to MEWS in progress and will go live in November 2022. An audit will then be undertaken for assurance.</p> <p>3 &amp; 4. Antenatal and intrapartum risk assessment audits have been undertaken. The Antenatal risk assessment audit was included on February 2021 Women's Quality and safety meeting and presented on April 2021 Women's Speciality meeting and the intrapartum risk assessment audit included on July 2021 Women's Quality &amp; Safety agenda. This requires revisiting post cerner implementation and is included on the audit plan. An Antenatal risk assessment sticker for low risk women having intermittent auscultation was approved at June 2021 Women's Quality &amp; Safety meeting and an audit was completed and included on January 2022 Women's Quality &amp; Safety Agenda. This requires revisiting following changes to the cerner system.</p> <p>5&amp;6 A preterm risk assessment audit was also undertaken and included on July 21 Women's Quality and Safety agenda and a Fetal growth restriction risk assessment at booking have also been undertaken and included on May 2021 Women's Quality &amp; safety Agenda. Audits following cerner implementation are in progress.</p> <p>7. Perinatal mental health audit in progress</p>	<p>Audit reports.</p> <p>Q&amp;S meeting minutes.</p> <p>Digital Learning posters</p> <p>Lessons learnt</p> <p>SBL bitesize</p>	<p>Audits to be undertaken to provide assurance of risk assessments during the antenatal, intrapartum and postnatal period. The frequency of the audits will be dependant on findings and recommendations.</p>	Audits ongoing or planned	C Robertson & S Hollins	C Stott & A Mighell, M Naylor, J Stubbs, R Palethorpe	7/30/2021
9	The service must ensure a systematic programme of rolling internal and clinical audit (to include documentation audits) is in place to monitor quality and to identify where action should be taken; and robust action plans are in place from audits to facilitate improvement.	<p>1. Clinical audit lead to be assigned to support the process.</p> <p>2. An annual audit plan to be produced, monitored and achieved. This should include audits of local guidelines, NICE guidelines, NICE quality standards and recommendations from clinical incidents.</p> <p>3. Audit action tracker developed and monitored at the governance meeting.</p> <p>4. Learning from audit to be shared with the service.</p>	<p>1. August 2020 - Obstetric audit lead in post.</p> <p>2. 2020/2021, 2021/2022 and 2022/2023 audit plans agreed and reviewed at the Women's Quality &amp; Safety meetings.</p> <p>3. Audit action tracker in place.</p> <p>4. Learning from audit shared at speciality meetings and via lessons learnt.</p>	<p>Audit plan and action tracker.</p> <p>Women's Quality and Safety meeting minutes. Speciality governance meeting agendas. Newsletters.</p>	<p>Audit plan in place with evidence of actions for improvement</p>	complete - business as usual	C Robertson & S Hollins	C Stott & C Robertson	30/11/2020 ext 30/01/2021
10	The service must monitor the reporting of staffing related incidents (for example through the 'safe care' tool) and ensure all opportunities for learning from incidents are taken.	<p>1. All staffing related incidents and closures to be datixed.</p> <p>2. Red flags to be captured, monitored and actioned and shared.</p> <p>3. All service closures to be reviewed and a level 1 investigation completed with learning and successes shared.</p>	<p>6 monthly maternity staffing paper completed by DOM and submitted to Trust Board which incorporates red flag data.</p> <p>Unit closures and diverts are being reported to datix and captured on the excel log.</p> <p>The service commenced the reporting of red flags via the safe care tool in June 2021.</p> <p>Red flags and staffing is a standing agenda item on the Maternity services forum where the Matron's provide a verbal or written update of the red flags reported.</p> <p>The daily safety huddle takes place on labour ward each day at 12.45 and has been revised to include the escalation of open red flags and red flags reported within the previous 24 hours.</p> <p>Escalation policy updated in line with the regional escalation policy and published September 2022.</p>	<p>Bi annual staffing paper.</p> <p>Unit closure/divert log.</p> <p>Red flag reports.</p> <p>MSF meeting minutes.</p> <p>Daily safety huddle database</p> <p>Escalation policy</p>	<p>Learning from staffing related incidents shared with the CBU and wider organisation where required.</p>	Detailed review and learning to be shared from unit closures.	C Robertson & S Hollins	Maternity Matrons	30/09/2020 ext 30/09/2022

11	The service must ensure the findings of external incident investigation reviews are duly considered and action plans include all findings to address the issues identified.	1. All investigation reports are cascaded to the team for comments. 2. Actions plans to be agreed and approved by the service. 3. Actions from investigations to be included on the incident action tracker and monitored at the monthly governance meeting.	All investigation reports; internal and external are included on the monthly Women's services Q&S agenda. An incident update report is produced and discussed each month with includes a summary of the progress of ongoing incidents and any new serious or level 1 incidents. The report includes the initial 72 hour clinical reviews and any immediate learning recognised for action. Once internal and external investigation reports are completed these are included on the agenda and discussed in more detail including a review of the recommendations and action plans. Actions are tracked on the incident action tracker. Once an action plan is complete the evidence for this is discussed and agreement is sought that the action plan is complete and signed off.	Q&S Meeting agendas and minutes. Incident action tracker	Continue with agreed governance process for oversight if incidents and action plans.	complete - business as usual	C Robertson & S Hollins	C Stott & J Anderson	6/30/2020
12	The service must ensure regular checks of adult resuscitation equipment are undertaken in maternity.	1. Continued departmental monitoring of resuscitation checks 2. Matron sign off of weekly checks.	A process is in place for monitoring adult resuscitation equipment with Matron oversight and assurance. Compliance with adult resuscitation checks is presented at the Women's CBU meeting	Women's CBU business meeting minutes and ward assurance reports.	Assurance of safety checks being completed daily	complete - business as usual	C Robertson & S Hollins	Maternity Matrons	19/05/2020
13	The service must ensure clinical guidance for staff is clear and not contradictory, particularly with regards to foetal growth monitoring.	1. The service to agree and decide on a fetal growth and surveillance pathway and update the Fetal growth guideline based on best practice. 2. Implementation of saving babies lives 2 recommendations.	July 2020 Specialist Midwife for safer maternity care commenced in post. September 2020 to February 2021 - Workshops, face to face and virtual information sharing events, quizzes etc with clinical staff in regards to the new fetal growth pathway. February 2021 - Fetal growth guideline implemented. Compliant with SBLV2 with the exception of MSDS reporting. FGR MDT review meetings commenced July 2021 FGR and SGA data monitored via the maternity dashboard and shared with Trust board. Audits of risk assessment SGA/FGR at booking and missed FGR cases in line with MIS requirements.	Guideline FGR MDT terms of reference and meeting minutes SBL bitesize newsletter Maternity dashboard Audit reports	Foetal growth guideline and clinical care provided in line with local and national guidelines. Ongoing monitoring and action where improvements required.	complete	C Robertson & S Hollins	P Munjaluri & M Naylor	3/30/2021
<b>SHOULD dos</b>									
1	The service should consider reviewing and revising the summary information pages of patients' electronic records; so that safeguarding concerns or mental health information are clearly shown	A review of the Medway system is required to ensure that Safeguarding and Mental Health information can be easily located and these risk clearly identifiable on the summary information page of the patient record. A SOP is required and education to staff to ensure they are aware of how and where to locate this information. This also needs to be an essential requirement for the new electronic maternity system.	Nov & Dec 2020 - SOP's on how and where to identify Mental health and safeguarding alerts and information within Medway. These documents were approved at the Women's Quality & Safety meeting. Changed to Cerner Maternity EPR 26.3.22. Revised SOP's for safeguarding in place. SOP for perinatal mental health notification in progress.	Audit	Safeguarding and mental health information clearly identifiable in the EPR records and staff are aware how and where to access the relevant information.	complete	C Robertson & S Hollins	R Palethorpe & E McArdleRobinson	12/30/2020
2	The service should consider developing an agreed maternity vision with relevant stakeholders, and a strategy to implement it; ensuring that all key business risks (including the replacement of obstetric theatres) are detailed in the clinical business unit planning 2019-2020 strategy.	1. Outstanding Maternity Services Programme. 2. Develop a Maternity Services Strategy. 3. Maternity Transformation Matron post required to lead programme	1. The OMS programme launched August 2020 - 5 work streams. The progress of this then reports to OMS Board which the chief nurse chairs. 2. Outstanding Maternity Service (OMS) strategy developed and published November 2020. 3. Maternity Transformation Matron post agreed within Maternity staffing establishment	Work stream progress reports OMS Board minutes	Evidence of progress and Quality improvements in line with Maternity Services Strategy	complete	C Robertson & S Hollins	C Robertson, S Hollins, H Ackroyd	30/10/2020 - Maternity transformation programme to continue.

3	The service should work to improve the time taken to investigate and close complaints, in line with the trust's complaints policy.	A monthly update of complaints numbers, position, themes and trends to be included within the governance meeting to ensure sufficient support is in place to meet the required deadlines.	July 2020 - Meeting held with the Complaints coordinator to agree the requirements of this action. A monthly report is produced and included on the monthly Quality & Safety agenda.	Monthly Complaints overview reports and Quality & Safety Meeting minutes	CSU oversight of complaints and timescales for closure with action and mitigation if timescales are not being achieved.	complete - business as usual	C Robertson & S Hollins	D McMahon	7/30/2020
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Key

	Complete
	On track
	Ongoing

Ockenden - Minimum evidence requirements											
SECTION 1: Immediate and Essential Actions 1 to 7				Assessment Criteria	Minimum Evidence Requirements	Lead	RAG	Existing evidence/measurement	Action required to achieve compliance	Target date/deadline	comments
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.		Confirmation of a Maternity Services Dashboard  Confirmation this is seen by the LMNS at least Quarterly	1.1 SOP required which demonstrates how the trust reports this both internally and externally through the LMS.  1.2 Submission of minutes and organogram, that shows how this takes place. 1.3 Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken. 1.4 Dashboard to be shared as evidence.	LMS/Carly		Perinatal surveillance SOP		complete	
						Carly/Sara		maternity update papers. Board committee and Board minutes. Organogram in SOP.		complete	
								LMS Plan		complete	
								Performance reports to the LMS Board - last 3 Boards		complete	
								Implementation agenda, minutes & presentation - demonstrating dashboard discussion LMS Safety Steering group meeting agendas & minutes			
	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.		Confirmation of external specialist opinion on reviews	2.1 Policy or SOP which is in place for involving external clinical specialists in reviews.  2.2 Audit to demonstrate this takes place.	LMS/ HSIB		LMS Plan Agenda and action notes from CD and HoMs meetings Baby Lifeline training dates SI Process task & finish group agenda and action notes. MIS action 10		complete	
								No cases outside HSIB criteria reportable to date. MIS action 10		complete	
	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		Confirmation that SI GO TO Trust Board (nab not a sub group of board such as Quality group)  Confirmation that a SUMMARY of SI key issues goes to Trust Board  Confirmation that SI GO TO LMNS Board  Confirmation that a SUMMARY of SI key issues goes to LMNS Board  Each of the above happen quarterly	3.1 Submit SOP  3.2 Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed  3.3 Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	Carly		LMS plan, Fl ow chart and T&FG minutes in the evidence file.Refreshed ToR and membership of Safety Forum. LMS SI SOP		complete	
						Sara		Dec - April BTHFT Jan & May Board papers.		complete	
						Carly		1 SI's since Ockenden recommendations. SBAR for completed SI's included in February maternity update paper for Board. This will be maintained moving forward.		complete	
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?	Confirmation that PMRT is undertaken see PMRT Tab	4.1 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.  4.2 Audit of 95% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	Carly, Iram &Amy		MIS reports. Maternity update April 21 paper. May Reg committee. October, January and April PMRT updates included. Nov Reg committee. May board agenda		complete	
						Carly, Iram &Amy		Safety Forum Minutes - evidence PMRT themes discussed. External peer review now in place. -Leeds since May 22		complete	
	Q5	Action 2	Are you submitting data to the Maternity Services Dataset to the required standard?	Confirmation that Monthly score card completed (13 mandatory criteria)	5.1 Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	Sara & Keeley		MSDS DEC score card. MSDS action plan. MSDS LMS Board minutes May 2021. BTHFT April maternity paper to Reg. Reg committee minutes. May Board agenda		complete	
	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?	Confirmation that 100% of cases are reported to HSIB & NHS Resolution	6.1 Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	Carly		MIS action 10 submission documents		complete	
Link to urgent clinical priorities:											

IEA 1	Q7	(a)	A plan to implement the Perinatal Clinical Quality Surveillance Model	Confirmation that Trust / LMNS / ICS responsibilities of the model are implemented	7.1 Full evidence of full implementation of the perinatal surveillance framework by June 2021.	Sara & Carly		Benchmark perinatal surveillance framework by June 2021.		complete	
					7.2 Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed off via the trust governance structure.	Sara & Carly		SOP		complete	
					7.3 LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	LMS		Revised LMS Governance structure (March 2021) Minutes of ICS QSG Report submitted & Minutes of SOAG Presentation at Regional QSG NHS Operation Planning guidance submission Minutes of Accountable Officers meeting - regarding commissioning		complete	
	Q8	(b)	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Confirmation that SI go to Trust Board (nab not a sub group of board such as Quality group)  Confirmation that SI go to LMNS Board  Each of the above happen Monthly	8.1 Submit SOP 8.2 Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed 8.3 Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion			See 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.	No expectation that this action is met - national guidance awaited							



	<b>Q10</b>	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.	No expectation that this action is met - national guidance awaited							
	<b>Q11</b>	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.	Confirmation of an identified Trust Board Non Exec	11.1 Name of NED and date of appointment	SH		Non-Executive Director on LMS Board - revised ToR. 8THFT Okenden Presentation includes NED. January 2021 Open Board minutes confirm Selina Ullah as NED and thank the previous maternity NED's for their input. Word document confirms NED name and date of appointment. October 2021 bi-monthly maternity safety champion minutes		complete	
				11.2 Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions			NED present at Bi monthly safety champion meetings. 1st NED walk round 05/11/21		complete	
				11.3 Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed			January 2021 Board minutes evidence NED presence and contribution at Board.		complete	
				11.4 Evidence of how all voices are represented:					complete	
				11.5 Evidence of link in to MVP; any other mechanisms			OMS links	NED to establish links with MVP		
				11.6 NED JD			Maternity and Neonatal Ward to Board safety escalation SOP final		complete	
Link to Maternity Safety actions:										
IEA 2	<b>Q12</b>	Action 1 Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Confirmation that PMRT is undertaken Confirmation that Parents are involved	12.1 Local PMRT report. 12.2 PMRT trust board report. 12.3 Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. 12.4 Audit of 95% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.			See Q4			
	<b>Q13</b>	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?	Confirmation of approach to gathering Service User feedback (i.e. 15 steps / FFT / You Said We Did) <b>AND</b> MVP in place that <b>COPRODUCES</b> services	13.1 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. 13.2 Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)			MIS safety action 7		complete	
							Working together to transform our maternity service 2020. Breastfeeding survey, 15 steps (ANC, LW, m4). OMS involvement, Antenatal classes, Multi language videos, clover team personalised midwifery project		complete	

					13.3 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.			As above. MVP links with OMS. LMS MVP network action plan and minutes MVP reports to LMS Board. MVP Network meeting minutes - demonstrate feedback during COVID MVP website - www.maternityvoices.co.uk		complete	
	<b>Q14</b>	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?	Identified Safety Champions <b>WORKING WITH</b> Exec and Non Exec Board Leads for Maternity	14.1 SOP that includes role descriptors for all key members who attend by-monthly safety meetings.			Maternity and Neonatal Ward to Board safety escalation SOP final		complete	
					14.2 Log of attendees and core membership.			Meetings resumed in February post Covid. Feb, April, June 2021 minutes. 2019,2020 and 2021 monthly safety meeting schedule.		complete	
					14.3 Action log and actions taken.			June meeting minutes. Feedback email to staff member who raised concerns		complete	
					14.4 Minutes of the meeting and minutes of the LMS meeting where this is discussed.	LMS		LMS plan Presentation to Safety Champions/Chief Nurses		complete	
<b>Link to urgent clinical priorities</b>											
IEA 2	<b>Q15</b>	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.	Same score as Q13	15.1 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. 15.2 Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) 15.3 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.			See Q13		complete	
	<b>Q16</b>	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.	Confirmation of an identified Trust Board Executive Director <b>AND</b> a Non Executive Director	16.1 Name of ED and date of appointment			Okenden presentation to Jan Board. Board minutes.		complete	
					16.2 Name of NED and date of appointment			Okenden presentation to Jan Board. Board minutes. October Maternity Services update paper to November Board reflect <del>appointment of new NED safety champion</del> Bi monthly meeting minutes. SOP. May maternity update paper		complete	
					16.3 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					complete	
<b>Immediate and essential action 3: Staff Training and Working Together</b>											
IEA 3	<b>Q17</b>	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.		<b>Training together:</b> Confirmation of MDT training <b>AND</b> this is validated through the LMNS x 3 per year	17.1 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.	V Nutter		TNA updated in line with NHSR core framework. 3 year training proposal developed and agreed by DOM.		complete	
					17.2 Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	C Stott		PROMPT agendas, mandatory training report May. Group assignment posters		complete	
					17.3 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.	LMS		Workforce data reports to LMS Board and Implementation groups - minutes LMS Plan demonstrates multi-disciplinary training e.g. YAS and UAD training (in Aug 2020 Highlight Report) <del>NHS Operational planning guidance</del> Mandatory training reports		complete	
					17.4 Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in	V Nutter				complete	
					17.5 A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	V Nutter		Mandatory training reports		complete	
					17.6 Attendance records - summarised	V Nutter		Anonymised PROMPT database		complete	
	<b>Q18</b>	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.		<b>Working together:</b> Confirmation of <b>ALL</b> criteria requested	18.1 SOP created for consultant led ward rounds.	C Robertson		Medical Handover of care guideline		complete	

					18.2 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)	A Mighell		Audit report		complete	
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)	Confirmation of ring fenced Maternity training budget	19.1 Evidence that additional external funding has been spent on funding including staff can attend training in work time.	H Ackroyd		NHS Education Contract - Finance Schedule		complete			
			19.2 Evidence of funding received and spent.	H Ackroyd		LMS funding invoices etc		complete			
			19.3 Confirmation from Directors of Finance	H Ackroyd		Board sign of letter		complete			
			19.4 Evidence from Budget statements.	H Ackroyd				complete			
			19.5 MTP spend reports to LMS			LMS transformation funding spend - LMS Board minutes and spending plans.		complete			
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	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?	90% achieved on MDT training of all Staff groups (Obstetrics / Anaesthetists / Maternity / Neonates / Support Workers)	21.1 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. 21.2 Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. 21.3 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. 21.4 Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. 21.5 A clear trajectory in place to meet and maintain compliance as articulated in the TNA. 21.6 Attendance records - summarised	see Q17					
Link to urgent clinical priorities											

[illegible]

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.	Confirmation of consultant lead <b>AND</b> regular Audit of Compliance in place	28.1 SOP that states women with complex pregnancies must have a named consultant lead.			BTHFT Maternal Medicine Clinic BTHFT SOP for Responsible Clinician in Obstetrics Criteria for Consultant Antenatal Referral guideline		complete	
	Q29	B	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Confirmation that Trust is developing their local actions as part of an agreed Network approach	28.2 Submission of an audit plan to regularly audit compliance			Audit complete	see Q24	complete	
					29.1 The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.					complete	
					29.2 Criteria for referrals to MMC					complete	
					29.3 Agreed pathways					complete	
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	Risk Assessment at EVERY AN Contact	SOP that includes definition of antenatal risk assessment as per NICE guidance. How this is achieved within the organisation What is being risk assessed					complete	
					Review and discussed and documented intended place of birth at every visit.			Risk Assessment inc Intended place of birth. PCSP. WY & H Local Maternity System Choice & Personalisation Steering Group LMS plan. Antenatal risk assessment snap shot audit		complete	
					30.2 Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.			LMS Plan demonstrates audit of PCSPs will be co-produced later in the year. Women's Choice and Personalised Care Audit	Discussions underway to explore an electronic solution following confirmation that Cerner cannot		Unable to audit PCSP's as these are held by the women.
	Q31		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Review of place of birth in risk assessment at ALL AN contacts	31.1 SOP that includes review of intended place of birth.			Risk Assessment inc Intended place of birth SOP. Memorandum		complete	
					31.2 Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.			see Q30	Discussions underway to explore an electronic solution following confirmation that Cerner cannot deliver on this ask.		Unable to audit PCSP's as these are held by the women.
					31.3 Out with guidance pathway.			birth choices guideline, homebirth guideline, ISCS, waterbirth, BBC. STANDARD OPERATING PROCEDURE (SOP) Supporting Women's Informed Choices Throughout Maternity Care		complete	
					31.4 Evidence of referral to birth options clinics			Guideline and referral form. Maternity matters service summary		complete	
Link to											
IEA 5	Q32	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	See Q27	32.1 SOP's 32.2 Audits for each element 32.3 Guidelines with evidence for each pathway			See Q27			
Link to											
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 (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Are PCSPs in place <b>AND</b> are they audited	33.1 SOP to describe risk assessment being undertaken at every What is being risk assessed. How this is achieved in the organisation. Review and discussed and documented intended place of birth at 33.2 Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.			See Q30 See Q30 See Q30 See Q30		complete complete complete complete	
					33.6 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)			Women's Choice and Personalised Care Audit completed	Discussions underway to explore an electronic solution following confirmation that Cerner cannot deliver on this ask.		Unable to audit PCSP's as these are held by the women.
								LMS Plan- demonstrates development and plans for audit Choice & Personalisation minutes Co-creation of LMS PSCS www.mypregnancyjourney.co.uk. national team video and posters for staff and women.		complete	
Imme											
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.	BOTH MW and Obstetrician in place	34.1 Name of dedicated Lead Midwife and Lead Obstetrician			Maryanne Naylor- Lead Midwife, Zebia Thomas- Lead Obstetrician. Job plan/ JD's		complete	
					34.2 Copies of rotas / off duties to demonstrate they are given dedicated time.	Carolyn/Carly		Diaries being maintained to evidence hours		complete	
					34.3 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.	Zebia & Mary		LMS Fetal Monitoring group in place. CTG meetings, presentations, training plan.		complete	
					34.4 Incident investigations and reviews	Zebia & Mary		CTG meetings. Datix report		complete complete complete	

	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.		JD fulfils ALL criteria	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.					complete		
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?	See Q27	36.1 SOP's 36.2 Audits for each element 36.3 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?	See Q21	37.1 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. 37.2 Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. 37.3 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. 37.4 Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. 37.5 A clear trajectory in place to meet and maintain compliance as articulated in the TNA. 37.6 Attendance records - summarised			See Q21				
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.		See Q34	38.1 Name of dedicated Lead Midwife and Lead Obstetrician 38.2 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. 38.3 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.		ALL place of birth information easily accessible	39.1 Information on maternal choice including choice for caesarean delivery.  39.2 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.			RCOG choosing-to-have-a-c-section leaflet. BTHFT My Pregnancy and Birth booklet WY&H my pregnancy journey		complete		
	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		ALL information is easily accessible	40.1 Information on maternal choice including choice for caesarean delivery. 40.2 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.			See Q39		complete		
								See Q39	Informal assessment undertaken. Official benchmarking tool to be completed. Recent changes to MVP commissioning and chairs impacted on the delivery of this			

	<b>Q41</b>	Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care	Confirmation that trust <b>HAS</b> a method of recording decision making processes that includes women's participation & informed choice	41.1 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.			STANDARD OPERATING PROCEDURE (SOP) Supporting Womens' Informed Choices Throughout Maternity Care in draft		complete	
				41.2 An audit of 1% of notes demonstrating compliance.			Audit completed		complete	
				41.3 CQC survey and associated action plans			2019 survey & action plan. Minutes MSF June 2021		complete	
	<b>Q42</b>	Women's choices following a shared and informed decision-making process must be respected	Reference made to how Women's choices are respected and evidenced	42.1 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.			STANDARD OPERATING PROCEDURE (SOP) Supporting Womens' Informed Choices Throughout Maternity Care		complete	
				42.2 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			Audit completed		complete	
				42.3 CQC survey and associated action plans			2019 survey & action plan. Minutes MSF June 2021		complete	
Link to IEA 7										
	<b>Q43</b>	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?	See Q13	43.1 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. 43.2 Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) 43.3 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.		See Q13			
Link to IEA 7										
	<b>Q44</b>	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.	All information <b>ON</b> trust website	44.1 Gap analysis of website against Chelsea & Westminster conducted by the MVP			WV&H my pregnancy journey. Link to maternity website	Informal assessment undertaken. Official benchmarking tool to be completed. Recent changes to MVP commissioning and chairs		
				44.2 Co-produced action plan to address gaps identified				action plan to be developed following survey		
				44.3 Information on maternal choice including choice for caesarean delivery.			See Q39		complete	
				44.4 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.			See Q39	Informal assessment undertaken. Official benchmarking tool to be completed. Recent changes to MVP commissioning and chairs impacted on the delivery of this		
SECTION 2: WORKFORCE PLANNING			Assessment Criteria	London Regional narrative on process and ratings & clarity from national team						
Link to Maternity Safety Actions:										
<b>Q45</b>	Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard	Midwifery workforce planning system in <b>PLACE</b>	If a system of midwifery workforce planning was in place that was accepted as per the criteria.  <b>NATIONAL ASK:</b> That there is also specification on evidence of workforce planning against medical workforce	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.		Bi annual staffing papers		complete complete	
					Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan. MIS action 4		Word doc narrative listing appendices, July 2020, January 2021 Bi-annual staffing papers, BR + final report, BR + recommendation paper for ETM in the file. ETM and bi-monthly paper exec minutes. ACSA. Neonatal staffing plan. Medical staffing business case. BR + paper presented to Board as an appendix to the Nursing and Midwifery staffing review. Board approved the paper.		complete	

Q46	Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Confirmation of a maternity workforce gap analysis <b>AND</b> a plan in place (with confirmed timescales) to meet BR+ standards	To be compliant trusts need to have an up to date Birthrate plus assessment (i.e. within the last three years) and for the trust to have fully funded it. It was notable that a drop in birth rate was a challenge for full funding at present for some trusts who were on a trajectory approach. <b>NATIONAL ASK:</b> Absolute clarity on these criteria	• Most recent BR+ report and board minutes agreeing to fund. MIS action 5			Same as above - another board paper produced and will be submitted in september. BR + paper presented to Board as an appendix to the Nursing and Midwifery staffing review. Board approved the paper.		complete	
Midwifery Leadership											
Q47	Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director		Evidence the Director/Head of Midwifery responsible and accountable to an executive Director	It was acceptable that the Director or Head of Midwifery was accountable to the Chief Nurse. None are directly line managed.	• HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director			Supporting narrative included. HOM JD and accountability evidence -		complete	
			Meets ALL that apply <b>Note - Trusts would not lead on actioning all seven steps</b>	<b>NATIONAL ASK:</b> Ensure template clear this is about applicable standards - original version circulated wasn't	Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care			Gap analysis		complete	
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, 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				Action plan where manifesto is not met	Sara		Action plan		complete	
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 process before implementation and ensure that the		ALL guidance assessed & implemented = Yes (GREEN)	<b>NATIONAL ASK:</b> Clarity on the need to report number of guidelines that are outstanding and need updating	SOP in place for all guidelines with a demonstrable process for ongoing review. Audit to demonstrate all guidelines are in date	Carly				complete	
					Evidence of risk assessment where guidance is not implemented.			This is a standing agenda item at the monthly Quality and safety meeting		complete	
								Trust NICE Policy. Trust local guideline highlight report. Guideline guideline. Q&S, Women's business and MSF minutes. OMS workstream update. Current NICE position	NICE benchmarking ongoing. U:\Womens Services - Risk Management\National benchmarking\NICE	31/12/2022	

Key

	Submitted and no further action required
	submitted and further action required
	duplicate recommendation