Maternity Service Assurance

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Paper B

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	X
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)	28/02/22	Assurance
Executive Board	15/03/2022	Assurance
Trust Board Committee	31/03/2022	Assurance
Trust Board	31/03/2022	Assurance

Executive Summary

Context

The Ockenden and Kirkup reviews were undertaken in response to significant concerns around the safety of maternity services at Shrewsbury and Telford Hospitals NHS Trust and the University Hospitals of Morecambe Bay NHS Foundation Trust. The reports from both reviews made recommendations and outlined essential and immediate actions required by all maternity services across the UK to improve safety for women and babies.

Following the publication of the first Ockenden report in December 2020, all Trusts providing maternity services were required to undertake a Maternity Safety Self-Assessment and provide assurance to the Trust Board (and externally to The Local Maternity and Neonatal System (LMNS) and the NHSE/I regional maternity team) as to their compliance with the immediate actions required within the report. The attached version of the self-assessment tool (version 6 July 2021) has been further modified, influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme, the Kirkup Report (2015) and the areas of good practice that the CQC found to be common themes in Maternity Units that had been recently inspected and rated as Outstanding.

This report is intended to provide an updated response in relation to a request from the Regional NHSE/I team dated 10th February 2022. The request specifies that all Trusts must provide an update in relation to five actions set out below with responses discussed at Trust Public Board. The completed assessment templates related to the actions below can be found in

the appendices attached. All completed assessments have been undertaken by the Maternity team with compliance reported internally via CMG Quality and Safety Boards, Executive Boards and Trust Board Committees in addition to submission of reports to the regional maternity safety team, the LMNS and ICS Quality Executive Board.

Action 1 - *Your organisations progress against the Ockenden Immediate and Essential Actions*
Action 2 - *The status and progress of your maternity service workforce plans*
Action 3 - *Your organisations Morecombe Bay report (Kirkup 2015) action plan status*
Action 4 - *The completed Self-Assessment Assurance Tool*
Action 5 - *Confirmation you have discussed these at your Trust Public Board*

The self-assessment documents have been assessed on the basis of a green RAG rating if the service is compliant and there is evidence in place that can support this. An amber rating applies to a number of requirements where there is a process in place but a document describing the process needs to be completed as evidence or there is a document in place which requires review or updating. There are no red rag ratings against any of the requirements.

Action 1: Following the Ockenden report published in December 2020 evidence was submitted by June 2021 for assessment to the national and regional team, this was reviewed again in October 2021 and UHL Maternity services had one outstanding action to introduce an external buddy system for the LMNS and for external overview of serious incidents, this will be in place by April 2022.

Action 2: There is a comprehensive workforce report. The Trust has undertaken Birth rate plus assessments every 2 years from 2016 the outcome of these have been presented in staffing reports to the executive boards and business cases submitted resulting in further investment into midwifery staffing. However there is still a shortfall of 20 whole time equivalent midwives on budgeted establishment (despite temporary financial support from NHSE/I following the Ockenden report) so a further business case will be submitted to address this shortfall. Birth rate plus also includes support staff at Band 3 or 4. Traditionally UHL recruited to a Band 2 maternity care assistant role but has been gradually increasing the Band 3 workforce matched against a national job description. Nevertheless, based on the last assessment it was recognised there was a need to further increase Band 3 support by 10wte. Included in the workforce report are all the recruitment and retention drives that are underway as it highlights there is a significant vacancy, although attrition rates are average and UHL recruits well to Midwife posts, with the national shortage of midwives progress can be slow. The obstetric workforce has had investment to enable them to meet national requirements, job plan reviews are in progress to add PA's to align the findings of the Ockenden report

Action 3: The UHL Kirkup benchmarking confirms that the service is mainly compliant with required actions. There are two amber ratings linked to the requirement for locally held data bases for some midwifery competencies, and the need for a Maternity specific Standard Operating Procedure for Learning From Serious Events. The service will be compliant with both actions by Q2 2022.

Action 4: There is an Amber RAG rating for the maternity strategy, dynamic safety plan and

quality improvement plan, all of these documents are currently being reviewed to ensure they are robust and match the findings of the Ockenden report and national requirements. There is a plan in place to provide Trust Board regularly with a maternity overview report to cover requirements described in the self-assessment. Further recruitment is taking place to ensure there are ward rounds twice a day on weekend days take place with the consultant on site, so there are ongoing actions for this action rated as amber.

Questions

1. Are the Board assured that there has been sufficient progress made with the national requirements / actions made within the Ockenden and Kirkup reviews and the local Maternity workforce plan?

Conclusion

1. The UHL Maternity Service has responded to the self-assessments with an open and transparent approach. The Ockenden essential and immediate actions being now fully compliant. The workforce plan includes retention, recruitment and consideration of other roles to support the service acknowledging the national challenges around midwifery supply, the service is reviewing a shortened degree programme for midwifery and international recruitment and ongoing work in the recruitment and investment in obstetric staff to achieve the requirements from Ockenden.
2. There are ongoing actions required for the Trust and the LMNS highlighted as amber within the maternity self-assessment has actions for the Trust that are not currently impacting on safety.
3. The Kirkup benchmarking, reflects amber and green outcomes, the processes are in place but currently not captured in a way that can be provided as evidence, there will be a robust action plan to ensure all areas achieve green status by the end of Q2 2022
4. Following the review of the self-assessments requested by NHSE/I, the service will continue to monitor the areas of improvement to meet the requirements set out in the self-assessments and to ensure actions are embedded. This work will continue to be monitored at monthly CMG Governance Board, Maternity safety meeting and included in the quarterly maternity safety report presented by the Head of Midwifery to the Executive Quality Board and Quality Committee and externally to the LMNS.
5. It should be noted that Trusts have recently received details of the proposed regional approach by the Midlands Perinatal Team who will be conducting insight visits to trusts to monitor Trusts ongoing compliance with Ockenden IEAs. Visits will be coordinated by the LMNS and will involve interviews with key Executives and clinical leads and review of evidence to monitor compliance with actions.

Input Sought

- Note the report and progress with national Maternity Safety Requirements and actions
- Agree the need for any additional actions or assurance

For Reference

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Not applicable]
Safely and timely discharge	[Not applicable]
Improved Cancer pathways	[Not applicable]
Streamlined emergency care	[Not applicable]
Better care pathways	[Yes]
Ward accreditation	[Not applicable]

2. Supporting priorities:

People strategy implementation	[Yes]
Estate investment and reconfiguration	[Not applicable]
e-Hospital	[Not applicable]
More embedded research	[Not applicable]
Better corporate services	[Not applicable]
Quality strategy development	[Yes]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? N/A

- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required N/A

- How did the outcome of the EIA influence your Patient and Public Involvement ? N/A

- If an EIA was not carried out, what was the rationale for this decision? N/A

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	Select	Risk Description:
Strategic: Does this link to a ***Principal Risk*** on the BAF?		
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register	X	Risk 3093 Insufficient Midwifery Establishment
New Risk identified in paper: What ***type*** and ***description***?		
None		

5. Scheduled date for the **next paper** on this topic: [TBC]
6. Executive Summaries should not exceed **5 sides** [My paper does comply]

7 Ockenden IEAs (including 12 Clinical Priorities):
Trust _____ Exec Sign off _____

	Compliant	Partially Compliant	Non-Compliant
1) Enhanced Safety			
A plan to implement the Perinatal Clinical Quality Surveillance Model	**Yes**		
All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	**Yes**		
2) Listening to Women and their Families			
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	**Yes**		
Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	**Yes**		
3) Staff Training and working together			
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	**Yes**		
The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	**Yes**		
Confirmation that funding allocated for maternity staff training is ringfenced	**Yes**		
4) Managing complex pregnancy			
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	**Yes**		
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	**Yes**		
5) Risk Assessment throughout pregnancy			
A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance	**Yes**		
6) Monitoring Fetal Wellbeing			
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.	**Yes**		
7) Informed Consent			
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.	**Yes**		

University Hospitals of Leicester NHS Trust
Kirkup Self Assessment 2022-23

Area for Improvement	Description	Evidence	Required actions	UNIVERSITY HOSPITAL LEICESTER
5. Review the current preceptorship programme	Midwives/ Nurses are allocated a buddy in each clinical area and that this is supported by the clinical team.	6/52 supernumerary period Shift by shift buddy allocation (record on e-roster) preceptorship guideline		
	The buddy midwife is allocated time to support the preceptee	Current preceptorship educator allocated clinical hours to suoport NQMs 2nd post recruited to	2nd post being recruited to. Need to evidence time allocated to each NMQ	
	Midwives are supported throughout the programme, progress is monitored and there is a clear plan developed for any midwife that is struggling to attain certain clinical skills	Preceptor midwife in post; Evidence of action plans for preceptee's (CS and line managers)	Recruitment, retention and preceptorship midwife cross site - JDs	
	Midwives are confident and competent to go through the gateway within the agreed timeframe	Completed paperwork at progression points by line managers and matrons		
6. Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme	Utilise PMA feedback	PMA themes identified through RCS sessions	Undertake survey using microsoft forms with Preceptor midwife	
7. Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce	Develop a robust support package for new band 6 midwives	In place		
	Completion of the Mentoring module	Local SSSA training programme (1 day for new supervisors) and access to e-learning package		
	Suturing competency	CNST database	Review CNST database against staffing lists for each area; LCAT assessments	
	IV therapy competency	Medicines database	Review medicines database and triennial medicines reviews against staffing lists for each area	
	Care of women choosing epidural anaesthesia.	HELM competency	Review HELM for completed competency and update days against staffing list for each area	
8. Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care	Practice educator reports and feedback	Corporate and local induction procedure; band 6 registered midwife induction workbook Preceptorship for staff new to UHL included in preceptorship policy		
9. Review the current induction programme for locum doctors	Locum policies	The Trust Bank/agency office provide all HELM training and monitor compliance. Tailored local inductions Locums have all previously worked at UHL		
10. Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group.		as above		

11. Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session.	Practice educator meeting notes, discussion with DoMS/HoMs	SBL training day - attendance records, agenda, dashboard figures		
12. Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford	Practice educator reports and feedback	included in training: Saving Babies Lives NIPE e-learning - avoiding term admissions		
13. Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition	Incident review and feedback, related lessons learnt, training opportunities	Recognition of the deteriorating pregnant or postnatal women is included on SBL Training day guidelines and training programs		
14. Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, core huddles, NICU news		Quail, learning bulletins, HSIB reports, staff newsletters, EMAILS	SOP being developed for process of sharing lessons	
15. Review the current process for staff rotation to ensure that a competent workforce is maintained in all clinical areas.		There is a competent core team in each clinical area, the rest of the staff rotate throughout the clinical areas within the consultant units, as continuity progresses, individualised training plans will be assigned to ensure staff have the required skills in all areas .		
17. Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations		Supernummerary means not included in the staffing numbers and supported at all times. Orinetation with an area will depend on whether		
20. Develop and implement a recruitment and retention strategy specifically for the obstetric directorate		Recruitment and retention midwife JDs, HOM on national retention group, preceptor midwife on national retention workshops, rolling recruitment in place		
22. Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention		Currently online process new process for capturing face to face exit interviews launched		
23. Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns		In place - meeting minutes		
24.Improve working relationships between the different sites located geographically apart but under the same organization.		Both acute sites use the same guidelines, conultants workacross site on Hot weeks, the elective C/S lists are managed across site,		
26. Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported and the rationale for learning from incidents.		In place as part of preceptorship package and junior doctor induction		

28. Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively	All consultants to have completed RCA training	Not all consultants have had RCA training but the labour ward leads, risk lead and Heads of service have, and the risk team are present supporting the RCA process and all serious incidents chaired by a corporate chair		
	Identified midwives to have completed RCA training	The safety and risk team conduct and write reports in relation to RCA, with some senior midwives having had RCA training, since supervision of midwifery ended, midwives have not conduted investigations they are led by the risk and safety team		
	Staff who have completed RCA training undertake an investigation within 1 year and regularly thereafter in order to maintain their skills	adverse events training		
	Develop a local record of staff who have completed RCA training and the investigations undertaken (including dates)	There is no locally held database as this is not manadatory in the Trust	Governance team to hold database of all staff with relevant training	
36. Ensure that all staff are aware of how to raise concerns	Whistle blowing staff policy	Policy in place, Freedom to speak up guardian, maternity safety champions, evidence from	Survey? Tea Trolley teaching with questions?	
37. Provide evidence of how we deal with complaints		PILS team, governance reports, complaints are shared with staff anonymously to encourage learning and if individuals are involved the complaint is shared one to one to reflect on.	There is a Trust process, which we adhere to	
38.Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area	Identifying situations where local resolution is required	The Trust has a resolution policy in place which all line managers are encouraged to use to deal in the first instance with conflict or grievance		
41. Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained	MBRRACE action plan	MBRRACE action plan Actions are incorporated in local action plans Perinatal mortality overview meeting - ToR and action log		

Maternity self-assessment tool

Leicester Maternity, March 2022

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	**Clinically-led triumvirate**	Trust and service organograms showing clinically led directorates/care groups		Trust and CMG Organograms
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes		Triumvirate engagement – meeting papers
	Director of Midwifery (DoM) in post **(current registered midwife with NMC)**	DoM job description and person specification clearly defined		No JD for UHL Plan to appoint to DoM role
		Agenda for change banded at 8D or 9		HoM 8D
		In post		Have HoM not DoM
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate		Trust organograms
		Clinical director to executive medical director		Clinical director reports directly to Medical Director
		DoM to executive director of nursing		HoM report directly to Chief Nurse
		General manager to executive chief operating officer		Head of operations reports directly to COO

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity services standing item on trust board agenda as a minimum three-monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, AttAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockendon learning actions		UHL governance structure - maternity reports to TB through EQB and QOC every 3 months. Board reports are in place.
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		Monthly minimum data measures for TB paper
		There should be a minimum of three PAs allocated to clinical director to execute their role		Job description & work plan
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team		Clinical Management group structure
		Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave		JD of HR lead Monthly board meetings Quarterly confirm and challenge meetings
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate		JD of Head of Finance
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area		Meeting plan
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways		CMG & organisational structure
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups		ToR and meeting papers

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, eg senior midwifery leadership assembly		ToR and meeting papers
		Leadership culture reflects the principles of the '7 Features of Safety'.		
	Leadership development opportunities	Trust-wide leadership and development team in place		Evidence available from CMG education lead and UHL OD team
		In-house or externally supported clinical leadership development programme in place		
		Leadership and development programme for potential future talent (talent pipeline programme)		
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship		
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy		UHL organogram
		Organisational vision and values in place and known by all staff		UHL strategy & values
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]		UHL values, appraisals process and HR policies
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years		Development of strategy in progress with key stakeholders
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan		As above
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.		In progress

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		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 [Ockenden Assurance]		MVP ToR Patient experience feedback Co-production evidence (Ockenden)
		Maternity strategy aligned with trust board LMNS and MVP's strategies		As per strategy development above
		Strategy shared with wider community, LMNS and all key stakeholders		As above
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor		JD for NED
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor		Monthly maternity safety staff meetings Bi-monthly Maternity Safety meetings with CN and NED
		All Safety champions lead quality reviews, eg 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)		One held at each site in 2021 with MVP member and board level safety champion
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services		TB papers (presented by NED)
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]		Safety champion boards in clinical areas
Multi-professional team dynamics	**Multi-professional engagement workshops**	Planned schedule of joint multi-professional engagement sessions with chair shared between triumvirate, ie quarterly audit days, strategy development, quality improvement plans		Quarterly audit day QI meetings eg IOL,CTG
		Record of attendance by professional group and individual		Attendance record

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Recorded in every staff member's electronic learning and development record		Electronic training records (HELM) Appraisals
	Multi-professional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see		Education lead HELM
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority		TNA, Education lead
		All staff given time to undertake mandatory and job essential training as part of working hours		Staff rotas
		Full record of staff attendance for last three years		Education team data base & Helm
		Record of planned staff attendance in current year		HELM
		Clear policy for training needs analysis in place and in date for all staff groups		UHL policy
		Compliance monitored against training needs policy and recorded on roster system or equivalent		HELM Maternity Quality Board papers
		Education and training compliance a standing agenda item of divisional governance and management meetings		Agendas – internal meetings & LMNS
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]		MDT training programs TNA & appraisals
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal		
	Clearly defined appraisal and	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation		Job Descriptions

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	professional revalidation plan for staff	Compliance with annual appraisal for every individual		Due to Covid-19, compliance with appraisals lower than trust target 100% compliance with NMC revalidation
		Professional validation of all relevant staff supported by internal system and email alerts		Emails from HR
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities		Formally at appraisal Ongoing support from line managers
		Schedule of clinical forums published annually, eg labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings		Meetings are set times/days each month. E-mails/posters
	Multi-professional clinical forums	HR policies describe multi-professional inclusion in all processes where applicable and appropriate, such as multi-professional involvement in recruitment panels and focus groups		Not explicit in UHL policy however maternity practice is in line with standard
	Multi-professional inclusion for recruitment and HR processes	Organisational values-based recruitment in place		Recruitment policy & process
		Multi-professional inclusion in clinical and HR investigations, complaint and compliment procedures		HR policies & examples from practice
		Standard operating procedure provides guidance for multi-professional debriefing sessions following clinical incidents or complaints		No SOP however debriefs occur supported by MDT & PMAs
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy		Locally led by PMAs UHL TRiM support

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Schedule of attendance from multi-professional group members available		These sessions are confidential however in practice they are multi-professional
	Multi-professional membership/ representation at Maternity Voices Partnership forums	Record of attendance available to demonstrate regular clinical and multi-professional attendance.		MVP ToR & meeting papers
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design		MVP representation at Maternity Quality Board & LMNS
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users		Development of strategy in progress which captures current QI workstreams
	Collaborative multi-professional input to service development and improvement	Roles and responsibilities in delivering the QIP clearly defined, ie senior responsible officer and delegated responsibility		As above, QI programs in practice to be captured in overarching plan
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP		As above (QIP)
		Identification of the source of evidence to enable provision of assurance to all key stakeholders		Achieved through LMNS, MVP, ICS QPIAC (quality board)
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access		Evidence available but need to ensure robust organised process in place
		Clear communication and engagement strategy for sharing with key staff groups		Governance reporting structure Monthly maternity safety newsletter & e-mails
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements		As above (QIP)

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Weekly/monthly scheduled multi-professional safety incident review meetings		PRG/PMRT ToR and papers
	Multi-professional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS		Developing Time to Train quarterly safety meetings to incorporate wider MDT & LMNS and include specific maternity focus
		Positive and constructive feedback communication in varying forms		Written, verbal and Facebook pages for shared learning
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach		Matrons contact lead PMA to arrange staff debriefs following incidents More work required for reporting and feeding back good outcomes
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]		PMA hold debrief and RCS sessions for all staff. TRIM practitioners available in every area for clinical support. Learning shared in QUAIL and safety newsletter as well as unit meetings
		Schedule of focus for behavioural standards framework across the organisation		
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month		Trust Friday Focus Trust values
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]		Evidence via HR meetings that inappropriate behaviour corrected. Appropriate MhPPS is followed accordingly for consultant body

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All policies and procedures align with the trust's board assurance framework (BAF)		UHL policy
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	Governance framework in place that supports and promotes proactive risk management and good governance		Risk Management policy
		Staff across services can articulate the key principles (golden thread) of learning and safety		Exec walkabout feedback
		Staff describe a positive, supportive, safe learning culture		Freedom to speak up guardian actively utilised within the service.
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams		Risk management policy
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife Clinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support		ToR All membership in place.
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member		Risk Management Policy
		Team capacity able to meet demand, eg risk register and clinical investigations completed in expected timescales		Risk assessment and actions to support capacity
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF		UHL Risk Management Policy includes BAF

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF		As above
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board		Governance structure Board reporting template ready for use by Trust Board
		Mechanism in place for trust-wide learning to improve communications		UHL learning bulletins from SI's Monthly safety bulletin
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication		Local examples in safety and learning bulletins
		Governance communication boards		Clinical area Hot Boards
		Publicly visible quality and safety board's outside each clinical area		Clinical area Hot Boards
		Learning shared across local maternity system and regional networks		EMCN MatNeo LLS Neonatal ODN
		Engagement of external stakeholders in learning to improve, eg CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups		Meeting ToR & papers e.g. LMNS, Midlands HoM meetings, EMCN
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.		Trust communication strategy being developed
		Multi-agency input evident in the development of the maternity specification		Completed jointly with CCG
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Approved through relevant governance process		Approved at LMNS and reviewed by provider contract team
		In date and reflective of local maternity system plan		Due for review

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Full compliance with all current 10 standards submitted		Achieved CNST year 3
	Application of CNST 10 safety actions	A SMART action plan in place if not fully compliant that is appropriately financially resourced.		Not applicable - action plan not required for year 2 and 3 as compliant
		Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance		LMNS & EQB ToR
		Clear process for multi-professional, development, review and ratification of all clinical guidelines		Guideline meeting ToR & papers
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multi-professional meetings for a rolling 12 months programme.		Dates for monthly guideline meetings
		All guidance NICE complaint where appropriate for commissioned services		Guideline meeting ToR & papers
		All clinical guidance and quality standards reviewed and updated in compliance with NICE		Guideline meeting ToR & papers
		All five elements implemented in line with most updated version		Guideline meeting ToR & papers
	Saving Babies Lives care bundle implemented	SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.		Monthly safety dashboard CNST actions
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan		Quarterly reports to national team Sign off by Trust Board
		All four key actions in place and consistently embedded		Achieved CNST year 3
	Application of the four key action points to	Application of equity strategy recommendations and identified within local equity strategy		In progress

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	reduce inequality for BAME women and families	All actions implemented, embedded and sustainable		We have embedded all four actions set out in the COVID document
	Implementation of 7 essential learning actions from the Ockendon first report	Fetal Surveillance midwife appointed as a minimum 0.4 WTE		JD & job plans
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs		1PA for training lead who oversees fetal surveillance
		Plan in place for implementation and roll out of A-EQUIP		Monthly PMA meeting minutes
	A-EQUIP implemented	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team		Monthly PMA meeting minutes
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered		Training programs available from PMA lead
		Service provision and guidance aligned to national bereavement pathway and standards		Bereavement guideline
	Maternity bereavement services and support available	Bereavement midwife in post		JD and job plans
		Information and support available 24/7		Bereavement team rotas & labour ward numbers Information for families
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities		Bereavement suites
		Quality improvement leads in place		Trust QI lead
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation		QI projects in line with national transformation but not formally documented

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Recognised and approved quality improvement tools and frameworks widely used to support services		Available via UHL QI hub
		Established quality improvement hub, virtual or otherwise		UHL hub and team
		Listening into action or similar concept implemented across the trust		Transformation hub and QI team UHL Quality Strategy
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.		
	MatNeoSip embedded in service delivery	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan		MatNeoSip ToR and papers
	Maternity transformation programme (MTP) in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy) – *in place, needs updating*		Maternity safety plan
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Standing agenda item on key directorate meetings and trust committees		Quarterly CMG Board and exec board papers
		FTSU guardian in post, with time dedicated to the role		FTSU JD and job plan
	Freedom to Speak Up (FTSU) guardians in post	Human factors training lead in post		UHL have 3 leads in post
	Human factors training available	Human factors training part of trust essential training requirements		Helm training records
		Human factors training a key component of clinical skills drills		Training programs
		Human factors a key area of focus in clinical investigations and formal complaint responses		Fishbone used for RCAs including human factors

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Multiprofessional handover in place as a minimum to include Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas eg, antenatal/postnatal ward/triage.		Safety huddles in place with appropriate people
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern		Monthly audits for care of high risk women & consultant ward rounds
		A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's		In place
	Safety huddles	Guideline or standard operating procedure describing process and frequency in place and in date		Safety huddles in practice, SOP being written
		Audit of compliance against above		Spot check audits
		Annual schedule for Swartz rounds in place		Trust schedule
	Trust wide Swartz rounds	Multi-professional attendance recorded and supported as part of working time		Evidence from UHL wellbeing team
		Broad range of specialties leading sessions		As above

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse		Weekly senior clinical cabinet Weekly Friday focus
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit		Information shared by UHL comms team, e-mails
		Annual or biannual trust-wide learning to improve events or patient safety conference forum		Conference dates & agendas
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes		Trust board minutes
		In date business plan in place		CMG business plan
Comprehension of business/ contingency plans impact on quality. **(ie Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)**	**Business plan in place for 12 months prospectively**	Meets annual planning guidance		CMG business plan
		Business plan supports and drives quality improvement and safety as key priority		CMG business plan
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups		CMG business plan Workforce papers
		Consultant job plans in place and meet service needs in relation to capacity and demand		Job plans
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans		Job plans
		Business plans ensures all developments and improvements meet national standards and guidance		CMG business plan
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.		CMG business plan
		Business plans include dedicated time for clinicians leading on innovation, QI and Research		Business plans Compliant in practice

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.		through maternity research team, innovation in JDs
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidances.	**That Employment Policies and Clinical Guidances meet the publication requirements of Equity and Diversity Legislation.**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.		UHL policy
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.		Diversity & deprivation work plans

Key lines of enquiry	Kirkup recommendation number
Leadership and development	2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18
Governance: Covers all pillars of Good governance	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Quality Improvement: application of methodology and tools	5, 6, 9, 12, 13, 15, 16, 17, 18
National standards and Guidance: service delivery	2, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Safety Culture: no blame, proactive, open and honest approach, Psychological safety	2, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Patient Voice: Service user involvement and engagement through co-production and co-design. MVP and wider	6, 9, 11, 12, 13, 15, 17, 18

Staff Engagement: Harvard System two leadership approach, feedback and good communication tools	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Business Planning: aligned with LMNS plans and the National Maternity Transformation agenda, Maternity safety strategy and the Long term plan	8, 9, 10, 14, 15, 16, 17, 18

Results of Phase 2 Audit			UNIVERSITY HOSPITAL LEICESTER NHS TRUST		
RAG rating from national review team					
IEA	**Question**	**Action**	**Evidence Required**	**UNIVERSITY HOSPITAL LEICESTER NHS TRUST**	**Updates & Actions**
IEA1	**Q1**	Maternity Dashboard to LMS every 3 months	Dashboard to be shared as evidence.	100%	Further safety dashboards have been developed to monitor CNST & Ockenden standards
			Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	100%	
			SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	100%	
			Submission of minutes and organogram, that shows how this takes place.	100%	
		Maternity Dashboard to LMS every 3 months Total		**100%**	
	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Audit to demonstrate this takes place.	0%	Evidence submitted June 2021 which demonstrates external reviews for SI's and also evidence where SI has been downgraded following external review. The need for agreement on the process for external reviews which supports regional maternity centres discussed at LMNS Oct 21, joint meeting planned 22/11/21 with Birmingham & Northampton. Request for update at LMNS meeting 1/3/22. Midlands Maternity Clinical Network are currently developing a team of experienced reviewers. Audit to be completed once process for external review agreed and implemented
			Policy or SOP which is in place for involving external clinical specialists in reviews.	100%	
		External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total		**50%**	
	Q3	Maternity SI's to Trust Board & LMS every 3 months	Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	100%	
			Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	100%	

			Submit SOP	100%	
		Maternity SI's to Trust Board & LMS every 3 months Total		**100%**	
	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	100%	
			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.	100%	
		Using the National Perinatal Mortality Review Tool to review perinatal deaths Total		**100%**	
	Q5	Submitting data to the Maternity Services Dataset to the required standard	Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	100%	
		Submitting data to the Maternity Services Dataset to the required standard Total		**100%**	
	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	100%	audits planned for eligible cases - 2020/21 being completed Feb 22 2021/22 being completed April 22 by audit midwife
		Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total		**100%**	
	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.	100%	
			LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	100%	
			Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	100%	
		Plan to implement the Perinatal Clinical Quality Surveillance Model Total		**100%**	
IEA1 Total				**94%**	
IEA2	**Q11**	Non-executive director who has oversight of maternity services	Evidence of how all voices are represented:	100%	

			Evidence of link in to MVP; any other mechanisms	100%	
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	100%	
			Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	100%	
			Name of NED and date of appointment	100%	
			NED JD	100%	
		Non-executive director who has oversight of maternity services Total		**100%**	
	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	Consultant midwife supporting the development of the MVP The MVP is currently being reviewed with the support of the CCG
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%	
			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.	100%	
		Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total		**100%**	
	Q14	Trust safety champions meeting bimonthly with Board level champions	Action log and actions taken.	100%	Embedded system for communication of actions taken from concerns raised by staff in the monthly maternity safety bulletin "you said, we did" style
			Log of attendees and core membership.	100%	
			Minutes of the meeting and minutes of the LMS meeting where this is discussed.	100%	
			SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	100%	
		Trust safety champions meeting bimonthly with Board level champions Total		**100%**	

	Q15	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.	Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	
		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. Total		**100%**	
	Q16	Non-executive director support the Board maternity safety champion	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	100%	
			Name of ED and date of appointment	100%	
		Non-executive director support the Board maternity safety champion Total		**100%**	
IEA2 Total				**100%**	
IEA3	**Q17**	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	Monthly monitoring of training data through Quality Board & LMNS Included in CNST year 4 workstream
			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.	100%	
			Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	100%	
			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.	100%	
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%	

		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total		**100%**	
	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	100%	Consultant posts recruited to in order to achieve standard Audit required
			SOP created for consultant led ward rounds.	100%	
		Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total		**100%**	
	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Confirmation from Directors of Finance	100%	
			Evidence from Budget statements.	100%	
			Evidence of funding received and spent.	100%	
			Evidence that additional external funding has been spent on funding including staff can attend training in work time.	100%	
			MTP spend reports to LMS	100%	
		External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only Total		**100%**	
	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	
			Attendance records - summarised	100%	
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%	

		90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total		**100%**
	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)	100%
		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total		**100%**
	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.	100%
		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 Total		**100%**
IEA3 Total				**100%**
IEA4	**Q24**	Medicine Centre & agreement reached on the criteria for those cases to be discussed and	implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has	100%
			SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	100%
		Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total		**100%**

	Q25	Women with complex pregnancies must have a named consultant lead	Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	100%	included in monthly audit program and reviewed in safety dashboard
			SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	100%	
		Women with complex pregnancies must have a named consultant lead Total		**100%**	
	Q26	Complex pregnancies have early specialist involvement and management plans agreed	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	100%	included in monthly audit program and reviewed in safety dashboard
			SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	100%	
		Complex pregnancies have early specialist involvement and management plans agreed Total		**100%**	
	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Audits for each element.	100%	included in monthly audit program and reviewed in safety dashboard
			Guidelines with evidence for each pathway	100%	
			SOP's	100%	
		Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total		**100%**	
	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states women with complex pregnancies must have a named consultant lead.	100%	
			Submission of an audit plan to regularly audit compliance	100%	
		All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total		**100%**	

	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Agreed pathways	100%	confirmed Leicester will become specialist centre - work in progress to meet all criteria
			Criteria for referrals to MMC	100%	
			The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	100%	
		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total		**100%**	
IEA4 Total				**100%**	
IEA5	**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	How this is achieved within the organisation.	100%	included in monthly audit program and reviewed in safety dashboard
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	included in monthly audit program and reviewed in safety dashboard
			Review and discussed and documented intended place of birth at every visit.	100%	
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	100%	
			What is being risk assessed.	100%	
		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 Total		**100%**	
	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	100%	
			Out with guidance pathway.	100%	
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	included in monthly audit program and reviewed in safety dashboard

			SOP that includes review of intended place of birth.	100%	
		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total		**100%**	
	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	100%	
			How this is achieved in the organisation	100%	
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	100%	included in monthly audit program and reviewed in safety dashboard
			Review and discussed and documented intended place of birth at every visit.	100%	
			SOP to describe risk assessment being undertaken at every contact.	100%	
			What is being risk assessed.	100%	
		A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total		**100%**	
IEA5 Total				**100%**	
IEA6	**Q34**	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Copies of rotas / off duties to demonstrate they are given dedicated time.	100%	
			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.	100%	
			Incident investigations and reviews	100%	

			Name of dedicated Lead Midwife and Lead Obstetrician	100%	
		Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total		**100%**	
	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Consolidating existing knowledge of monitoring fetal wellbeing	100%	
			Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	100%	
			Improving the practice & raising the profile of fetal wellbeing monitoring	100%	
			Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	100%	
			Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	100%	
			Keeping abreast of developments in the field	100%	
			Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	100%	
			Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	100%	
		The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total		**100%**	
	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Audits for each element	100%	included in monthly audit program and reviewed in safety dashboard
			Guidelines with evidence for each pathway	100%	
			SOP's	100%	
		Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total		**100%**	

	Q37	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?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	
			Attendance records - summarised	100%	
			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.	100%	
		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? Total		**100%**	
IEA6 Total				**100%**	
IEA7	**Q39**	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Information on maternal choice including choice for caesarean delivery.	100%	
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	
		Trusts 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 Total		**100%**	
	Q41	Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.	100%	included in monthly audit program and reviewed in safety dashboard
			CQC survey and associated action plans	100%	
			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.	100%	

		Women must be enabled to participate equally in all decision-making processes Total		**100%**	
	Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	100%	included in monthly audit program and reviewed in safety dashboard
			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.	100%	
		Women's choices following a shared and informed decision-making process must be		**100%**	
	Q43	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?	Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%	
			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.	100%	
		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? Total		**100%**	
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified	100%	
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	100%	Gap analysis complete - maternity website is currently being updated
			Information on maternal choice including choice for caesarean delivery.	100%	

			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	
		Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total		**100%**	
IEA7 Total				**100%**	
WF	**Q45**	Demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	100%	maternity staffing on risk register with associated mitigation & actions
			Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.	100%	
			Most recent BR+ report and board minutes agreeing to fund.	100%	
		Demonstrate an effective system of clinical workforce planning to the required standard Total		**100%**	
	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	Most recent BR+ report and board minutes agreeing to fund.	100%	
		Demonstrate an effective system of midwifery workforce planning to the required standard? Total		**100%**	
	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	100%	
		Director/Head of Midwifery is responsible and accountable to an executive director Total		**100%**	
	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:	Action plan where manifesto is not met	100%	
			Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	100%	

		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: Total		**100%**
	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Audit to demonstrate all guidelines are in date.	100%
			Evidence of risk assessment where guidance is not implemented.	100%
			SOP in place for all guidelines with a demonstrable process for ongoing review.	100%
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total		**100%**
WF Total				**100%**