STANDARD

BHT Maternity services assessment and assurance tool- Ockenden report

STANDARD	What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and Trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
IEA REQUIREMENT 1 (ENHANCED SAFETY): Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.							
Ockenden safety requirement Clinical change where required must be embedded across Trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	1) Quarterly regional (BOB) governance meeting includes presentation of SIs and concise reports / incidents at each meeting, including shared learning, analysis of the incident and recommendations. This is an MDT meeting that includes Governance Leads, Obstetricians, Neonatologists, and Anaesthetists from each organisation in the network. There is also a service user representative as part of the quoracy of the meeting, and the HSIB regional lead also attends. The maternity team at BHT have a good relationship with RBH Trust, where we have undertaken SI investigations on their behalf, and they have been part of the investigating team for some of our maternity incidents. All processes maintained during pandemic. 2) LMS highlight reports , local and regional dashboards, quarterly safety report to board includes dashboard, monthly CCG steering group includes dashboard review, mat neo safety improvement projects tracked on dashboard, term admissions to neonatal unit (ATAIN) tracked on local and regional dashboard with neonatal network oversight.	1) Regional: Shared learning from cases is presented at network shared learning events and in national publications. 2) Trust: learning from SIs and HSIB investigations incorporated in staff mandatory training programme, shared at academic half days, displayed on learning boards in clinical areas, published in maternity practice development newsletter and on closed practice developemnt facebook group.	1) National/Regional: HSIB themed reports . 2) Regional dashboard in final stages of development. 3) Trust: HSIB 6 monthly Trust level feedback. Annual look back at themes and trends from SIs to assure that they are not cyclical and learning has been embedded. trends monitored on maternity dashboard.	1) Regional: All SIs to be shared at regional governance group and minutes of meeting to be submitted quarterly for BOB LMS board agenda. 2) Trust: SI monthly report submitted to board includes maternity SIs - the maternity section to be seperate and lessons learned section strengthened.	1)Network patient safety lead 2) Patient safety team and lead midwife for clinical governance and quality by March 2021	No additional support needed.	The current approach is not a risk
CNST Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Are you submitting data to the Maternity Services Dataset to the required standard? Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?	1) Compliant with PMRT standards. 2) Compliant with HSIB and NHSR reporting. 3) Currently non compliant with MSDS standards due to IT functionality.	1) PMRT enables MDT review of all perinatal deaths and essentially includes the involvement of parents in investigations. 2) HSIB and NHSR reporting enables publication of national reports of themes and trends/ recommendations for improvement see above approach to embedding the learning). 3) Data submission enables tracking of demography and clinical outcomes so that focused quality improvements are developed.	1) National PMRT annual report of themes and trends. 2) Quarterly reporting to Board of number of PMRT cases including when different care would have changed the outcome. 3) Rolling annual perinatal mortality rate.	Continue dialogue with System C who supply the maternity eletronic records to seek MMBI reporting solution. Currently weekly meetings between Head of Midwifery, digital midwife, head of IT and information team. If reporting solution not available from supplier in next week, risk to CNST will be escalated to Board. Risk added to divisional risk register.	Head of Midwifery by January 31st.	If the system supplier cannot provide a reporting solution, the Trust information team need additional resource to develop internal reporting workarounds.	Risk has been escalated to BOB LMS, NHS Digital and to be escalated to NHSE/I.
Link to urgent clinical priorities (a) A plan to implement the Perinatal Clinical Quality Surveillance Model (b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Perinatal quality surveillance model published December 19th 2020. Maternity SIs reported monthly in Trust SI report. Maternity section on lessons learned to be strengthened.	1) Regional: Shared learning from cases presented at network shared learning events and in national publications. 2) Trust: learning from SIs and HSIB investigations incorporated in staff mandatory training programme, shared at academic half days, displayed on learning boards in clinical areas, published in maternity practice development newsletter and on closed practice development facebook group.	2) Regional dashboard in final stages of development. 3) Trust: HSIB 6 monthly Trust level feedback. Annual look back at themes and trends from SIs to assure that they are not cyclical and learning has been embedded. Trends monitored on monthly maternity dashboard.	1) For review by board level safety champions with maternity and neonatal safety champions - to undertake gap analysis and develop implementation plan if required. Regional and national elements of the perinatal quality surveillance model to be reviewed and actioned byt regional and national teams. 2) Regional: All SIs to be shared at regional governance group and minutes of meeting to be submitted quarterly for BOB LMS board agenda. 3) Trust: SI monthly report submitted to board includes maternity SIs - the maternity section to be separate and lessons learned section strengthened.	1) Board and local level safety champions by April 1st 2021. Regional and national teams - no defined timeframe published yet. 2) Maternity and paediatric governance teams. 2) Network patient safety lead and BOB LMS chair.	Network patient safety lead to be appointed. LMS funding available.	Continue to follow SI sign off process with CCG. Continue to share SI reports and lessons learned in Trust monthly SI report and at regional governance meeting. Exception report to LMS via patient safety highlight reports.

IEA REQUIREMENT 2 (LISTENING TO WOMEN & FAMILIES): Maternity services must ensure that women and their families are listened to with their voices heard.	**What do we have in place currently to meet all requirements of IEA 2?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and Trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
Ockenden Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	1) There is currently no independent senior advocate role in post as no national framework or job description. 2) NED appointed. First meeting re Ockenden actions held with Head of Midwifery and Lead midwife for clinical governance and quality. Invited to MVP and joint maternity neonatal safety champions meetings.	1) Awaiting national framework to determine measurment methodology. 2) Board level safety champion invited to MVP meetings and bi monthly safety champions meetings to review safety issues and provide check and challenge to improvement plans.	Not currently known as no post in place.	Await national role description. Seeking funding for post, recruit and train	Head of Midwifery	National framework.	Unable to determine risk as no clarity on the role description
CNST **Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?** **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?** **Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?**	1) Compliant with PMRT standards. 2) Compliant with MVP standards. 3) Two local maternity safety champions in place (1 obstetrician and 1 midwife) who meet bi monthly with Board level maternity safety champions.	1) PMRT enables MDT review of all perinatal deaths and essentially includes the involvement of parents in investigations. 2) User feedback influences, " you said we did" improvements, reported in quarterly patient feedback report. Quality improvement plans derived from user feedback including complaints, surveys, birth reflections forms, friends and family test narrative - examples include triage and early pregnancy unit. 3) Board level safety champion review of safety issues provides check and challenge to improvement plans.	1) National PMRT annual report of themes and trends. Quarterly reporting to Board of PMRT cases including when different care would have changed the outcome. Rolling annual perinatal mortality rate. 2) Quality improvement plans have quarterly tracking and repeat audit of issues that led to improvement requirement. Ongoing gathering of feedback and analysis of themes and trends to identify and cyclical occurences. MVP meetings minuted. 3) Bi monthly safety champions meetings minuted and included in quarterly maternity safety Board report.	Confirm MVP terms of reference in date. Confirmatory letter from MVP chair re financial renumeration.	Head of Midwifery by March 31st 2021	No additional support needed.	The current approach is not a risk
Link to urgent clinical priorities (a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. (b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.	Established MVP, regular minuted meetings, MVP presence at maternity /CCG steering group meetings and BOB LMS board. Co produced patient information leaflets, communications. Currently codesigning engagement project to reach out to women from BAME communities to ensure services meet their specific needs. Regular service user surveys through MVP social media pages. Patient experience midwife in post who collates friends and family test, birth reflections feedback - quarterly patient feedback report produced demonstrating responsive changes. NED appointed. First meeting re Ockenden actions held with Head of Midwifery and Lead midwife for clinical governance and quality. Invited to MVP and joint maternity neonatal safety champions meetings	1) User feedback influences, " you said we did" improvements, reported in quarterly patient feedback report. Quality improvement plans derived from user feedback including complaints, surveys, birth reflections forms, friends and family test narrative - examples include triage and early pregnancy unit. 2) Board level safety champion review of safety issues provides check and challenge to improvement plans.	1) Quality improvement plans have quarterly tracking and repeat audit of issues that led to improvement requirement. Ongoing gathering of feedback and analysis of themes and trends to identify any cyclical occurences. MVP meetings minuted. 2) Bi monthly safety champions meetings minuted and included in quarterly maternity safety Board report.	No further action needed	Head of Midwifery, lead midwife for clinical governance and quality, local and Board level safety champions.	No additional support needed.	The current approach is not a risk

IEA REQUIREMENT 3 (STAFF TRAINING & WORKING TOGETHER): Staff who work together must train together	**What do we have in place currently to meet all requirements of IEA 3?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and Trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
OCKENDEN Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	1) Established annual MDT emergency skills training programme that has met CNST requirements year 1 and 2 . All mandatory training provided in house by MDT faculty and all staff allocated study time to attend. Attendance compliance tracked on maternity dashboard. 2) Consultant led ward rounds three times daily weekdays and twice weekends. 3) There is a small allocated training fund in the midwifery cost centres for supplementary training needs and non recurring maternity transformation funding has been used in last two years to support supplementary training. CEO confirmation that CNST (MIS) refund will be ring fenced for improving maternity safety to be agreed for financial year 21/22.	1) Monthly tracking of attendance via maternity dashboard to monitor and address compliance issues. 2) Currently no formal tracking of consultant ward round frequency. 3) External funding bids for maternity training documented and archived. Spend against allocated funds tracked with divisional accountant. Monthly budget statements track spend against internal training fund.	1) Reduction in incidents related to management of obstetric emergencies, non recurrence of lessons learned from previous incidents. 2) Documentation of ward rounds currently in patients notes. 3) Not applicable.	Implement ward round attendance monitoring process.	1) Maternity practice development team. 2) SDU Lead and labour ward lead by January 31st 2021. 3) Head of Midwifery and divisional accountant.	No additional support needed.	Audit of patient notes for consultant ward round compliance.
CNST Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	1) Compliant with workforce standards. 2) Currently non compliant with training standards due to pause on training due to COVID 19. Recovery plan developed.	1) Workforce planning influences establishment setting, consultant job planning, business cases for required clinical posts. 2) Monthly attendance tracking identifies areas for improvement and instigates any required additional study day requirements to acheive standard.	1) Meet national and regional standards such as ACSA, neonatal network recommendations, RCOG standards, neonatal nursing ratios. 2) Annual look back at themes and trends from SIs to assure that they are not cyclical and learning has been embedded. Trends on maternity dashboard.	Evidence to be embedded in CNST action plan. Training recovery plan monitoring via monthly maternity dashboard.	Head of Midwifery, maternity practice development team by March 31st 2021.	No additional support needed.	Ensure compliance with training within last 15 months. Increase to weekly simulations of obstetric emergencies in clinical settings.
Link to urgent clinical priorities (a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. (b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	1) Consultant led ward rounds three times daily weekdays and twice weekends. Established annual MDT emergency skills training programme that has met CNST requirements year 1 and 2 . 2) All mandatory training provided in house by MDT faculty and all staff allocated study time to attend. Attendance compliance tracked on maternity dashboard.	1) Currently no formal tracking of consultant ward round frequency. 2) Monthly tracking of attendance via maternity dashboard to monitor and address compliance issues.	1) Documentation of ward rounds currently in patients notes. 2) Reduction in incidents related to management of obstetric emergencies, non recurrence of lessons learned from previous incidents.	Implement ward round attendance monitoring process.	SDU lead and labour ward lead by January 31st 2021.	No additional support needed.	Audit of patient notes for consultant ward round compliance.
IEA REQUIREMENT 4 (MANAGING COMPLEX PREGNANCY): There must be robust pathways in place for managing women with complex pregnancies	**What do we have in place currently to meet all requirements of IEA 4?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and Trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
OCKENDEN Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. • Women with complex pregnancies must have a named consultant lead • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	1) BHT are part of the Thames Valley maternal medicine network. BHT are associated with Oxford maternal medicine centre and follow Thames Valley network referral criteria and guidelines. 2) and 3) Sub specialty antenatal clinics with a named consultant lead have been in place since 2016.	1) Network clinical guidance monitored for pre term birth including pre term birth rates and administration of magnesium sulphate in preterm labour. Preterm births tracked on monthly maternity dashboard and reported quarterly to board in maternity safety report. Exception reporting for extreme preterm babies born in level 2 unit instead of tertiary centre and discussed at Trust maternity/paediatric forum. Magnesium sulphate compliance tracked at network level and discussed at Trust maternity/paediatric forum.	1) Preterm birth rates, preterm babies born in appropriate place of birth. 1) and 3) regional clinical guideline compliance audits including fetal monitoring, reduced fetal movements.	1) Thames Valley maternal medicine network to formalise regional MDT meetings (work in progresss) - this is not a BHT specific action . 2) and 3) Audit of appropriate triaging and referral to subspecialty clinics to be included on audit schedule.	1) Network maternal medicine centre. 2) Maternity audit team by March 2021.	No additional support needed.	Audit of triaging and referral to subspecialty clinic.
CNST Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	On trajectory to fully implement Saving Babies' Lives care bundle 2 in accordance with CNST requirements. Quarterly submissions to NHSE/I.	Measurement of perinatal mortality rate both at Trust level and regionally following bundle implementation. Development of a regional dashboard in progress as an action within this care bundle implementation plan to enable system wide learning and sharing of good practice.	Rate of term stillbirths, neonatal deaths and brain injury being tracked via monthly maternity dashboard and LMS.	Complete outstanding actions for care bundle implementation.	SDU lead and LMS by March 31st 2021	No additional support needed.	Only two outstanding acctions, both work in progress but no current clinical risk
Link to urgent clinical priorities: a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.	1) BHT are part of the Thames Valley maternal medicine network. BHT are associated with Oxford maternal medicine centre and follow Thames Valley network referral criteria and guidelines. 2) and 3) Sub specialty antenatal clinics with a named consultant lead have been in place since 2016.	1) Network clinical guidance monitored for pre term birth including pre term birth rates and administration of magnesium sulphate in preterm labour. Preterm births tracked on monthly maternity dashboard and reported quarterly to board in maternity safety report. Exception reporting for extreme preterm babies born in level 2 unit instead of tertiary centre and discussed at Trust maternity/paediatric forum. Magnesium sulphate compliance tracked at network level and discussed at Trust maternity/paediatric forum.	1) Preterm birth rates, preterm babies born in appropriate place of birth. 1) and 3) regional clinical guideline compliance audits including fetal monitoring, reduced fetal movements.	1) Thames Valley maternal medicine network to formalise regional MDT meetings (work in progresss) - this is not a BHT specific action. 2) and 3) Audit of appropriate triaging and referral to subspeciaity clinics to be included on audit schedule.	1) Network maternal medicine centre. 2) Maternity audit team by March 2021.	No additional support needed.	Audit of triaging and referral to subspecialty clinic.
IEA REQUIREMENT 5 (RISK ASSESSMENT THROUGHOUT PREGNANCY): Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	**What do we have in place currently to meet all requirements of IEA 5?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and Trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**

All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	All women are risk assessed at booking, at 28 weeks and if any change in pregnancy risk identified. Documented on front page of antenatal notes if the woman is midwifery or consultant led care pathway. If a woman changes pathway this is documented and dated wth reason for the change. Risk assessment in pregnancy guideline in place. All women are risk assessed on admission in labour, continuous risk assessment during labour and additionally hourly in midwifery led labour care. Personalised care plan use documented on electronic records system. Compliance tracked through personalised care highlight report to BOB LMS board. Consultant midwife and MDT care planning with women requesting care outside of guidelines.	This ensures that women are cared for on the correct clinical pathway by the correct lead professional.	1) Women on midwifery led care pathways appropriately referred to consultant led care if risk identified. 2) Births in appropriate care setting. 3) Improvement is monitored by rate of births in midwifery led settings both via monthly maternity dashbaord and LMS, audit of compliance with clinical risk assessment in labour guidelines, audit of midwifery unit transfers, audit of intermittent auscultation risk assessment. 4) Positive scores on annnual CQC survey of women's experiences re: place of birth, feeling involved in decisions about their care.	Ensure risk assessment is documented at each antenatal contact. Undertake record keeping audit to drive improvement in documentation.	Community and birth centres matron, Consultant midwife annually	No additional support needed.	Communication to all staff about risk assessment documentation
CNST Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	On trajectory to fully implement Saving Babies' Lives care bundle 2 in accordance with CNST requirements. Quarterly submissions to NHSE/I.	Measurement of perinatal mortality rate both at Trust level and regionally following bundle implementation. Development of a regional dashboard in progress as an action within this care bundle implementation plan to enable system wide learning and sharing of good practice.	Rate of term stillbirths, neonatal deaths and brain injury being tracked via monthly maternity dashboard and LMS.	Complete outstanding actions for care bundle implementation.	SDU lead and LMS by March 31st 2021	No additional support needed.	Only two outstanding acctions, both work in progress but no current clinical risk
Link to urgent clinical priorities: a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	All women are risk assessed at booking, at 28 weeks and if any change in pregnancy reported. Documented on front page of antenatal notes if the woman is midwifery or consultant led care pathway. If a woman changes pathway this is documented and dated wth reason for the change. Risk assessment in pregnancy guideline in place. All women are risk assessed on admission in labour, continuous risk assessment during labour and additionally hourly in midwifery led labour care. Personalised care plan use documented on electronic records system. Compliance tracked through personalised care highlight report to BOB LMS board. Consultant midwife and MDT care planning with women requesting care outside of guidelines.	This ensures that women are cared for on the correct clinical pathway by the correct lead professional.	1) Women on midwifery led care pathways appropriately referred to consultant led care if risk identified. 2) Births in appropriate care setting. 3) Improvement is monitored by rate of births in midwifery led settings both via monthly maternity dashbaord and LMS, audit of compliance with clinical risk assessment in labour guidelines, audit of midwifery unit transfers, audit of intermittent auscultation risk assessment. 4) Positive scores on annnual CQC survey of women's experiences re: place of birth, feeling involved in decisions about their care.	Ensure risk assessment is documented at each antenatal contact. Undertake record keeping audit to drive improvement in documentation.	Community and birth centres matron, Consultant midwife	No additional support needed.	Communication to all staff about risk assessment documentation

IEA REQUIREMENT 6 (MONITORING FETAL WELLBEING): All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	What do we have in place currently to meet all requirements of IEA 6?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and Trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
OCKENDEN All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - • Improving the practice of monitoring fetal wellbeing – • Consolidating existing knowledge of monitoring fetal wellbeing – • Keeping abreast of developments in the field – • Raising the profile of fetal wellbeing monitoring – • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported – • Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. • They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •	Fetal monitoring midwife in post - funded by maternity transformation funding for 20/21. Role included in workforce review paper submitted to Board. Lead obstetrician for fetal monitoring in place - lead weekly fetal monitoring training sessions, fetal monitoring training included in maternity madatory study days, staff annual competency assessment tracked on maternity dashboard.	Ensure high quality MDT education and up to date clinical guidance and pathways. Ensure lessons learned from fetal monitoring related incidents and adverse outcomes are embedded.	Reduction in adverse neonatal outcomes due to fetal monitoring interpretation or failure to follow guidance.	1) Approval of fetal monitoring midwife post in midwifery establishment from April 2021	Head of Midwifery by April 1st 2021	No additional support needed.	The current approach is not a risk.
CNST Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? 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?	1) On trajectory to fully implement Saving Babies' Lives care bundle 2 in accordance with CNST requirements. Quarterly submissions to NHSE/I. 2) Currently non compliant with training standards due to pause on training due to COVID 19. Recovery plan developed.	1) Ensure high quality MDT education and up to date clinical guidance and pathways. Ensure lessons learned from fetal monitoring related incidents and adverse outcomes are embedded. 2) Monthly attendance tracking identifies areas for improvement and instigates any required additional study day requirements to acheive standard.	1) Rate of term stillbirths , neonatal deaths and brain injury being tracked via monthly maternity dashboard and LMS.2) Annual look back at themes and trends from SIs to assure that they are not cyclical and learning has been embedded. Trends monnitored on monthly maternity dashboard.	Evidence to be embedded in CNST action plan. Training recovery plan monitoring via monthly maternity dashboard.	Head of Midwifery, maternity practice development team by March 31st 2021.	No additional support needed.	1) Only two outstanding actions, both work in progress but no current clinical risk 2) Ensure compliance with training within last 15 months. Increase to weekly simulations of obstetric emergencies in clinical settings.
Link to urgent clinical priorities a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	Fetal monitoring midwife in post - funded by maternity transformation funding for 20/21. Lead obstetrician for fetal monitoring in place - leads weekly fetal monitoring training sessions, fetal monitoring training included in maternity madatory study days, staff annual competency assessment tracked on maternity dashboard. Saving Babies' Lives care bundle 2 implementation in progress - reported quarterly to NHSE/I.	Ensure high quality MDT education and up to date clinical guidance and pathways. Ensure lessons learned from fetal monitoring related incidents and adverse outcomes are embedded.	Reduction in adverse neonatal outcomes due to fetal monitoring interpretation or failure to follow guidance.	1) Approval of fetal monitoring midwife post in midwifery establishment from April 2021	Head of Midwifery by April 1st 2021	No additional support needed.	The current approach is not a risk.

IEA REQUIREMENT 7 (INFORMED CONSENT): All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	What do we have in place currently to meet all requirements of IEA 7?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and Trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
OCKENDEN 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 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. Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected	Trust maternity services have dedicated section on Trust website including care pathways, birth options, support available, including maternal choice ofr caesarean delivery . Trust consent policy, respect for women's preferences is included in clinical guidelines. Support maternal request Caesarean and care outside of guidelines via obstetric and consultant midwife pathways. Respect for women's preferences is included in clinical guidelines.	User feedback influences, " you said we did" improvements, reported in quarterly patient feedback report.	Measured via annual CQC survey of women's experiences, patient feedback from birth reflections, surveys, compliments and complaints. CQC survey annnual action plan developed - including women's experiences of involvement in decision making, choices about their care.	Consider implementation of I decide framework once developed by Birthrights and NICE	Consultant midwife and Lead midwife for clinical governance and quality annually	No additional support needed.	The current approach is not a risk
CNST 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?	Established MVP, regular minuted meetings, MVP presence at maternity /CCG steering group meetings and BOB LMS board. Co produced patient information leaflets, communications. Currently codesigning engagement project to reach out to women from BAME communities to ensure services meet their specific needs. Regular servicer user surveys through MVP social media pages. Patient experience midwife in post who collates friends and family test, birth reflections feedback - quarterly patient feedback report produced demonstrating responsive changes.	1) User feedback influences, " you said we did" improvements, reported in quarterly patient feedback report. Quality improvement plans derived from user feedback including complaints, surveys, birth reflections forms, friends and family test narrative - examples include triage and early pregnancy unit. 2) Board level safety champion review of safety issues provides check and challenge to improvement plans.	1) Quality improvement plans have quarterly tracking and repeat audit of issues that led to improvement requirement. Ongoing gathering of feedback and analysis of themes and trends to identify any cyclical occurences. MVP meetings minuted. 2) Bi monthly safety champions meetings minuted and included in quarterly maternity safety Board report.	Confirm MVP terms of reference in date. Confirmatory letter from MVP chair re financial renumeration.	Head of Midwifery by March 31st 2021	No additional support needed.	The current approach is not a risk
Link to urgent clinical priorities a) Every Trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the Trust website. An example of good practice is available on the Chelsea and Westminster website.	Trust maternity servcies have dedicated section on Trust website including care pathways, birth options, support available. All patient information leaflets on Trust website. All leaflets co produced with MVP.	User feedback and MVP is part of co production of leaflets and communcations shared on social media	Review and feedback from users via MVP	Clinical guidelines ? Open access online	Consultant Midwife	Trust communications team and guideline leads	The current approach is not a risk
NICE GUIDANCE RELATED TO MATERNITY	**What do we have in place currently to meet all requirements of IEA 1?**	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and Trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the Trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	Upon the issue of new NICE guidance, the Trust clinical audit and effectiveness department disseminate the new guidance to SDU leads/Quality and Safety leads for consideration. If the new guidance requires implementation, this is managed through the maternity department's guidelines committee for gap analysis in relation to existing Trust guidance and updates to Trust guidelines as required. The department does endorse the use of non-evidence based guidelines. The department has one guideline that is evidence based but not NICE, this is the fetal monitoring guideline which is based on FIGO international evidence based guidelines.	Upon identification that current practice is not in line with new guidance, local guidelines and SOPs are revised and reviewed via the maternity guidelines committee and new practice in embedded with support of the maternity practice development team where required.	The effectiveness of implementation of new guidance is audited. The audit process is monitored via the maternity clinical audit group. Any deviations from the guideline are identified via clinical audit or through exception reporting. This results in the idenitification of recommendations and subsequent development and implemenation of any required action plans. Action plans are monitored through the associated committee/forum for the relevant clinical area eg labour ward forum. Audit findings are presented at academic half days, and improvements are shared at regional learning events if system learning is identified from audits or incidents where guidelines have been a contributory factor.	1) Ensure that ongoing oversight of action plans is maintained to ensure timely completion of actions and therefore assurance that practice is in line with local and national guidance. 2) Ensure that guidelines have SDU ratification within 10 working days of approcal at the maternity guidelines meeting . 3) Ensure that guidelines are uploaded to the Trust intranet within 10 working days of SDU approval.	1)Maternity governance team, consultant midwife, SDU lead, Head of Midwifery 2)Maternity guidelines committee and SDU lead. 3) Trust clinical guidelines sub group and guidelines administrator.	Support from Trust clinical guidelines subgroup and adminstrtor to reduce time frame for approvals and upload.	Ensure updates and reviews of guidelines are undertaken in timely manner to allow for potential delays in the approvals and upload process. Undertake monthly guidelines risk assessment.