Maternity services assessment and assurance tool

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

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

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

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

Section 1

Immediate and Essential Action 1: Enhanced Safety

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

1. 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.

2. 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.

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

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

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

What do we have in place currently to meet all requirements of IEA 1?	1. Clinical change is fully embedded and timely in changing clinical practice following Trust and maternity governance processes. Themes and trends from incidents (Ulysses), audit findings, change in national recommendations and internal/external SI's reviewed and actions plans and MDT training to learn from incidents is put in place to enable clinical change in response to national and local learning from incidents. (for example – centralised fetal monitoring installed in 2019 with continued focus upon MDT staff training, escalation and human factors to optimise correct interpretation and management of fetal heart rate patterns) The Trust clinical quality dashboard is reviewed internally by the maternity senior leadership team monthly, and shared with the wider maternity team and across the Trust cluster and Executive Team at monthly quality performance review meetings. At the 3 monthly SWL Local Maternity System (LMS) Board meetings key maternity and neonatal safety metrics for all SWL maternity units are presented and actions from learning shared across Trusts. In addition the safety data metrics and learning are presented at the SWL LMS Safety sub-group. 2. The majority of intrapartum fetal deaths, maternal deaths, neonatal brain injuries and neonatal deaths undergo external clinical specialist opinion through the mechanism of the Perinatal Mortality Review Tool (PMRT) and Healthcare Safety Investigation Branch (HSIB) review. The Trust maternity service is compliant in referring all cases meeting HSIB, NHS Resolution, Early Notification Scheme (ENS) and PMRT investigating criteria. 3. Maternity serious incidents (SI's) are ratified at the trust serious incident group (SIG), chaired by the Trust Medical Director and Director of Nursing and Quality and shared with Kingston and Richmond CCG. A summary of the SI findings and SIG meeting are presented by the Medical Director at the Trust Quality Assurance Committee and at Trust Board meetings. Action 1: PMRT - used to review all qualifying cases Action 2. Required data provided to the Maternity services dataset Action 10: 100% of qualifying cases referred to HSIB and where required NHS Resolution ENS (a) The Trust has signed up to a draft plan to implement the perinatal clinical quality surveillance model. (b) See point 3 above

Describe how we are using this measurement and reporting to drive improvement?	1. Close monthly monitoring of clinical dashboard with RAG rating parameters set to highlight key performance indicators identified where areas of improvement and change may be needed. 2. Record of all cases that have proceeded to HSIB investigation. Register of those who have attended panel for non-HSIB cases. External representation should provide an extra dimension of impartial scrutiny to action planning in response to incidents and drive improvement. 3. Themes and trends from incidents reported and investigated by the maternity, neonatal and anaesthetic teams (Ulysses), clinical audit findings, change in national healthcare recommendations and internal/external SI's reviewed and actions plans put in place to enable clinical change to take place.
How do we know that our improvement actions are effective and that we are learning at system and trust level?	The dashboard is used to monitor trends in the RAG rating, leading to review of current clinical practice and quality improvement work; e.g; PPH rates. Year on year reduction since 2016 in rates of fetal neurological injury (HIE) during pregnancy and labour and perinatal death. Feedback gathered from women, their families and the maternity and neonatal teams regarding maternity and neonatal experiences of care provided.
What further action do we need to take?	1. Formalise process with SWL LMS to ensure external clinical specialist opinion and oversight from outside the Trust (but from within the region), for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death that do not meet HSIB or PMRT criteria 2. Need to formalise process for all maternity SI's to be shared with SWL LMS for scrutiny, oversight and transparency of clinical incidents and learning shared across the SWL maternity and neonatal services.
Who and by when?	1 and 2: SWL LMS Maternity Transformation Board and SWL LMS Chair – February 2021

What resource or support do we need?	1 and 2 Agreement from the SWL LMS regarding the updated process for sharing SI's and learning across SWL maternity and neonatal services.
How will mitigate risk in the short term?	1. The SWL DOM's and Obstetric and Neonatal Clinical Leads to share learning from incidents within the SWL LMS Safety Sub-Group to the LMS Board. 2. Continue reporting SWL maternity safety metrics to the SWL LMS Board and KHFT data via the Trust monthly Quality and Performance meetings.

Immediate and essential action 2: Listening to Women and Families

Maternity services must ensure that women and their families are listened to with their voices heard.

1. Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.

2. 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.

3. Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:

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

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

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

Link to urgent clinical priorities: (a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. (b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.	
What do we have in place currently to meet all requirements of IEA 2?	3. and (b) The Trust Board Maternity Safety Champion is the Director of Nursing & Quality and the Trust has a Trust Board Non-Executive Director with oversight of maternity and neonatal services who represent women and families at Trust board level, and work collaboratively with the Director of Midwifery and Clinical Lead Obstetrician as the Maternity Safety Champions and with the Neonatal Matron as the Neonatal Safety Champion. Action 1 - PMRT - used to review all qualifying cases Action 7 and (a) - The trust has active involvement with the MVP with bi monthly meetings and service changes/improvements co-produced with the MVP members Action 9 The trust safety champions meet at least bi monthly with the board level champions to escalate any locally identified issues, including review of maternity clinical safety metrics The Trust are awaiting further guidance from NHS England and the National Maternity Team regarding the job description and role of the independent senior advocate
How will we evidence that we are meeting the requirements?	Meeting minutes and reports, such as for PMRT, will demonstrate communication and actions to maintain transparency and collaborative working with women and families and the maternity and neonatal safety champions and Trust Board Safety Champions is in place and providing effective assurance of safety and quality of care. Reporting to Trust Board via the Quality and Assurance Committee and monthly Quality and Performance meetings. Examples of collaboration and co-production with the maternity services and MVP members.

How do we know that these roles are effective?	Quality and Safety clinical metrics are of a high standard and the Trust Board has oversight of any areas of concern or need for improvement within the maternity and neonatal services. Evidence that Trust Ward to Board governance processes and oversight are in place to demonstrate effective communication and responsiveness to any clinical or operational issues which may affect safety and quality of care. SWL LMS will also provide scrutiny of maternity and neonatal quality and safety measures via the LMS Board and report to the SWL Integrated Care System as per the draft Perinatal Clinical Quality Surveillance Model.
What further action do we need to take?	Trust and SWL LMS to finalise job plan for role of independent senior advocate once circulated by NHS England. Continue listening and implementing change using the above tools and evidencing changes and improvements made. Continue to broaden membership of MVP to include representation of women from all backgrounds. Include more MVP involvement in review of clinical guidelines.
Who and by when?	Trust Board and maternity and neonatal safety champions and SWL LMS to agree and approve.
What resource or support do we need?	Continue to support collaboration and co-production with Kingston and Richmond MVP. Maternity Clinical Governance Team to continue investigation of PMRT with external panel member and ensure learning is shared and appropriately resourced in order to put effective changes in place in response to safety recommendations. Additional guidance and resource to support implementation of Independent Senior Advocate role.
How will we mitigate risk in the short term?	Continue with collaborative working to develop Kingston Maternity Services with the local MVP. Maintain maternity and Trust clinical governance processes to ensure clinical incidents are investigated robustly with transparency and honesty and Duty of Candour requirements met.

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

1. 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.

2. 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.

3. Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

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

What do we have in place currently to meet all requirements of IEA 3?	1. The maternity service undertakes an annual rolling programme of multidisciplinary training (MDT), which is monitored closely to ensure at least 90% compliance, as per Maternity Incentive Scheme Safety Actions. 2. The Trust has 98 hour obstetric consultant cover on site, with at least twice daily consultant-led MDT ward rounds on the Labour Ward at 08:00 and 20:00. 3. The Trust has ensured that external funding allocated for training in maternity is ring fenced, for example; 2017, Maternity Training Safety Fund (£70k) ring fenced for MDT training of maternity staff. The SWL LMS also agrees maternity safety training programmes using external funding for SWL maternity services which is coordinated by the SWL LMS and ICS. Action 4: The BirthRate plus maternity workforce tool was under taken in 2016 (see Section 2, page 19).
What are our monitoring mechanisms?	Maternity MDT training compliance is monitored quarterly in the Maternity training group meeting and Trust Mandatory training compliance is monitored monthly at Maternity and Divisional Quality and Performance meetings. A twice daily Obstetric Consultant-led ward is embedded in practice, with midwifery and obstetric anaesthetist presence. This was audited for the purpose of assurance for this report and is compliant.
Where will compliance with these requirements be reported?	Maternity Quality and Performance Board and Divisional Planned Care Performance meetings. SWL LMS Board meetings.
What further action do we need to take?	The MDT maternity training programme and compliance data will be added to the SWL LMS Board agendas for three monthly review and regional oversight.

Who and by when?	SWL Steering Group, including the SWL LMS chair by April 2021.
What resource or support do we need?	Ensure maternity education and training programmes are resourced and agreed at Trust Board level and at SWL LMS Board board level with appropriate financial backfill of clinical staff to attend training.
How will we mitigate risk in the short term?	Virtual models of MDT multidisciplinary emergency skills drills and fetal heart rate training has been developed by the maternity and Trust education teams for staff unable to complete the usual face to face training during the pandemic. This virtual training was implemented in September 2020. The maternity MDT training meets the requirements of NHS Resolution 10 point plan during the COVID-19 pandemic.

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

1. Women with complex pregnancies must have a named consultant lead

2. Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities: a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.	
What do we have in place currently to meet all requirements of IEA 4?	1. Women with complex pregnancies have a named consultant. In addition the maternity service also provides specialist clinics for women who have a complex pregnancy, this includes; multiple pregnancy, diabetes, maternal medicine, preterm surveillance and hypertension. Action 6: The maternity service is compliant with the Saving Babies Lives Care Bundle version 2, with lower than the national average rates of perinatal and neonatal deaths reported since 2016. a) As above b) The maternity service is working collaboratively across SWL and the London region to implement a Maternal Medicine Service within SWL adopting a hub and spoke model as per national recommendations from NHS England and the Maternity Transformation Board. Maternal Medicine guidelines are being co-produced across the London region by clinicians and coordinated by the London Clinical Leadership Group.
What are our monitoring mechanisms?	1 & 2. The referral process for women with complex pregnancies to the specialist clinics is embedded within practice, with clear referral pathways in the maternity clinical records and Trust guidelines. Information for women in regards to their care is provided in collaboration with the MVP.
Where is this reported?	Maternity audit processes monitor if care provided has met the maternity Trust guidance standards. The formation of Maternal Medicine Clinics is overseen by the SWL LMS and the London Clinical Leadership Group.

What further action do we need to take?	Support the implementation of the SWL Maternal Medicine Group. Local audit needs to take place annually to ensure care to women with complex pregnancies has followed a specialist pathway with the correct management plans from the beginning of pregnancy.
Who and by when?	SWL LMS to monitor implementation of a Maternal Medicine hub and spoke model in SWL, linking to the London region. Audit of care pathways for women with complex pregnancies to be completed annually by the Maternity Risk and Audit Team reporting to the Trust Audit Team. First audit completed in January 2021.
What resources or support do we need?	Appropriate funding to ensure Saving Babies Lives Care Bundle version 2 can be met. Support from the SWL LMS and London Clinical Strategic Network to form the regional Maternal Medicine Networks using a hub and spoke model. SWL requires financial resource for an Obstetric Physician to support the Maternal Medicine Service model.
How will we mitigate risk in the short term?	Audit of care provided for women with complex pregnancies to ensure local and national care standards are met.

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

1. 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

2. Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities: a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	
What do we have in place currently to meet all requirements of IEA 5?	1. There is a formal risk identification performed at the maternity booking appointment using a risk assessment tool within the maternity clinical records. For subsequent antenatal care appointments there is an ongoing risk assessment at every contact with the woman. Any identified risk is escalated accordingly, with appropriate referral in line with trust guidance and the change in care pathway discussed and agreed with the woman. 2. The risk assessment process and discussion regarding the plan of care with the woman (as described above) take places in the antenatal period, which includes women making an informed choice about their baby's place of birth. A further assessment is then undertaken on admission to maternity triage and the labouring areas (including home birth) to ensure maternity care meets the woman's and her unborn baby's needs. a) As above, and will be audited annually to ensure compliance.
What are our monitoring mechanisms and where are they reported?	Through clinical audit of care pathways provided, which will be added to the annual maternity audit work plan. Audits are presented at the maternity Risk Governance departmental meeting and reported the Trust Audit Team, with areas for improvement monitored via an action plan to improve compliance if needed.
Where is this reported?	Maternity Clinical Governance meeting and the Trust Audit Team.
What further action do we need to take?	To implement regular audit of compliance with the Personalised Care and Support Plan.

Who and by when?	Maternity Risk and Audit Lead Midwives. Audit last completed January 2021.
What resources or support do we need?	Continued support and resource to carry out clinical audits with support of the Trust Audit Team.
How will we mitigate risk in the short term?	The maternity guidelines and maternity records signpost staff with a risk assessment and documentation to describe maternal and fetal risks in at all stages of the maternity pathway. Processes for complex pregnancies are also audited when woman require more specialist care, for example multiple pregnancy and pre-term surveillance antenatal care.

Immediate and essential action 6: Monitoring Fetal Wellbeing

1.All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?** **Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?**	
Link to urgent clinical priorities: 1. Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	
What do we have in place currently to meet all requirements of IEA 6?	1. The Trust maternity service has a lead midwife and lead obstetrician in post to lead the monitoring of fetal wellbeing. In addition the Labour Ward lead consultant and a senior registrar clinical fellow also support the training and review of clinical incidents involving fetal heart rate monitoring. The Fetal Wellbeing team also provide training to external staff from other maternity services and have lectured at both national and international conferences regarding best practice for fetal heart rate monitoring. The Trust maternity service won an HSJ award in 2018 for Improving Outcomes Through Learning and Development in relation to fetal wellbeing and training, which has improved health outcomes for babies. The fetal wellbeing leads jointly deliver MDT fetal monitoring training sessions, with a rolling annual programme to ensure all midwives and obstetricians have attended training and have passed a fetal monitoring competency assessment each year. The team also ensures they are abreast of any new developments in the field, interface with external maternity services and agencies whilst ensuring the Trust is compliant with national recommendations.

How will we evidence that our leads are undertaking the role in full?	• Job description and job plan of the team structure • Saving babies lives quarterly external audit results • Ongoing reduction in cases of brain injury, stillbirth and neonatal death in relation to fetal heart rate misinterpretation • >90% compliance with fetal surveillance training in line with the NHS Resolution Maternity Incentive Scheme (MIS), safety standards
What outcomes will we use to demonstrate that our processes are effective?	• Saving Babies Lives Care Bundle Version 2, quarterly external audit results reported to NHS England • Ongoing reduction in cases of brain injury, stillbirth and neonatal death in relation to fetal heart rate misinterpretation • >90% compliance with fetal surveillance training in line with MIS Safety Standards.
What further action do we need to take?	Nil
Who and by when?	N/A
What resources or support do we need?	To continue with the resource to ensure the Lead Midwife and Obstetrician can continue with the existing training programme and oversight of the monitoring of fetal wellbeing, and midwives and obstetricians can attend training.
How will we mitigate risk in the short term?	N/A

<table>
<tr><td colspan="2">Immediate and essential action 7: Informed Consent
1. 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.

2. 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

3. Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

4. Women’s choices following a shared and informed decision-making process must be respected</td></tr>
<tr><td colspan="2">Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>What do we have in place currently to meet all requirements of IEA 7?</td><td>• Information for women and families is in place and accessible via a number of platforms (via appointments / website / leaflets/ clinical notes) across all aspects of maternity care – antenatal, intrapartum and postnatal periods, including choice regarding place and mode of birth.
• The maternity team liaises closely with Kingston and Richmond MVP and the SWL LMS to develop information tools for women to explain their choices for maternity care, for example; a SWL motion video has been co-produced with the SWL MVP’s to explain birth choices and care pathways for women.
• The maternity team runs a weekly quality improvement (QI) meeting with the Trust QI team called “The Big Room”. The aim is to collaboratively work together to improve areas of our Trust maternity service, with representation from maternity staff, QI Team, a local GP and the Kingston and Richmond MVP Chair. This meeting is now held virtually with the current focus upon sharing and improving care across the maternity service using innovative changes to support communication and care of women and babies during the COVID-19 pandemic.</td></tr>
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Where and how often do we report this?	Kingston and Richmond MVP meetings take place every three months with the Trust maternity service. Bi-monthly SWL MVP meetings take place between SWL LMS and the SWL MVP Chairs. Feedback from women and families is also received via the Trust Friends and Family survey with support from the Trust Patient Experience Team, along with feedback via the Trust Patient and Liaison Service.
How do we know that our processes are effective?	The maternity service actively seeks feedback from women and families and the Kingston and Richmond MVP is a very active group who support communication from women to the Trust maternity service which ensures women are signposted to the maternity team if they have any concerns, questions or compliments about their maternity care.
What further action do we need to take?	Continue to support the central allocation of funds from the SWL LMS/ICS to the MVP members to pay expenses for MVP work undertaken. Improved interpretation of communications with women whose first language is not English.
Who and by when?	To continue collaborative working with the SWL LMS and SWL MVP's to improve translation of written and visual information for women who require maternity care.
What resources or support do we need?	Continue to receive central funds from the National Maternity Team via the CCG to support payment of MVP expenses. SWL LMS to co-produce information translated into the most commonly spoken languages in SWL.
How will we mitigate risk in the short term?	Monitoring of woman and families experiences at all stages of the maternity pathway. Continue the active co-production in regards to any improvements or changes to care which are required, particularly regarding feedback from women and families who have experienced maternity care within the Trust.

Section 2	
MATERNITY WORKFORCE PLANNING	
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**	
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.	
What process have we undertaken?	The service undertook a BirthRate plus maternity workforce review in 2016. A funded 1:28 midwifery ratio was established – with the service aiming for a 1:26 ratio as recommended by the Birthrate Plus review. A recent workforce gap analysis has been carried out within the Trust maternity service supported by the Trust's finance department to establish the midwifery resource and financial investment requirements to meet the 1:26 midwifery ratio standard in 2021. The Trust maternity service is also planning a BirthRate plus re-review in 2021 to ensure the Trust has an updated review of the required maternity workforce.
How have we assured that our plans are robust and realistic?	The maternity service and finance team have based requirements for a 1:26 midwifery ratio on 5000 deliveries per annum (our forecasted delivery plan for 2021/22). In order to meet this ratio standard the service will need to recruit an additional 15.6 wte midwives (at bands 5/6).
How will ensure oversight of progress against our plans going forwards?	The Kingston Hospital finance team provide midwifery ratio detail to the Maternity Triumvirate (Director of Midwifery, Clinical Lead and General Manager) on a monthly basis. The ratio is reviewed and monitored at the monthly Maternity Performance Review Meeting to ensure compliance and to support departmental workforce planning. This information is regularly shared at Divisional and Executive level within the Trust and also forms part of business planning on a yearly basis. Maternity births and booking numbers are routinely forecasted within the service business planning and expected/ potential increases in the forecast will be factored in to recruitment plans to avoid an unexpected increase in the midwifery ratio. In addition, a 6 monthly nursing and midwifery report is presented to the Trust Board, to ensure Trust oversight of the Maternity Workforce establishment, to maintain quality and safety of maternity care.

What further action do we need to take?	Recruitment of 15.6 wte is required to achieve a 1:26 midwifery ratio. Approval to recruit to these additional posts will require sign off by the Trust board and Executive Committee and a recurring budget of £810,000 will need to be allocated to the Maternity Services pay budget. The Trust will also liaise with the other SWL Acute Trusts regarding allocation of budgets to the SWL maternity services to ensure equity across the SWL system in ensuring the BirthRate Plus recommendations are met and maternity services staffed accordingly.
Who and by when?	• The Director of Nursing and Quality the Director of Midwifery, General Manager, Maternity Services, Maternity Finance Manager and Associate Director, Planned Care to carry out a gap analysis of workforce midwifery ratios. • Maternity workforce gap analysis presented to Executive Management Committee on 20/1/2021 • Presentation to Trust Board on 27th January 2021 • Trust approval required for a plan to meet the BirthRate Plus standard by 31/01/21 and to confirm timescales for implementation
What resources or support do we need?	£810,000 revenue investment (recurring) to cover full costs of recruiting 15.6 wte midwives.
How will we mitigate risk in the short term?	Non-recurring South West Transformation budget has been used to recruit an additional 6 wte midwives in the interim and support backfill of posts. Once approval has been sought for the additional 15.6 wte posts, additional bank shifts can be arranged to support with meeting the 1:26 midwifery ratio standard whilst the service undertakes a substantive recruitment process. Maternity staffing levels are monitored through the maternity clinical governance processes to maintain safety of the maternity service.

MIDWIFERY LEADERSHIP **Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in** Strengthening midwifery leadership: a manifesto for better maternity care
The Trust Director of Midwifery is professionally responsible and accountable to the Trust Board Director of Nursing and Quality who is also the Trust Board Maternity Safety Champion. Trust Board support and oversight of maternity services is also maintained between the Director of Midwifery, Director of Nursing and Quality and a Trust Board Non-Executive Director. The Trust Director of Midwifery forms part of the maternity leadership trio advocating for safe, high quality maternity care, managing the strategic and operational delivery of maternity services within the Trust. The Director of Midwifery holds accountability for the strategic planning of maternity services and the provision of midwifery care, the provision of strategic, professional leadership and advice, and acts as both an advocate for women and the expert voice of the profession. The Trust Director of Midwifery is also the Chair of the SWL Local Maternity System and a member of the London Maternity Clinical Leadership Group and thereby contributing to both Trust and regional strategic decisions to improve how maternity services link into what is happening across health and social care sectors, both locally and more widely via the NHS England and the National Maternity Team.

NICE GUIDANCE RELATED TO MATERNITY	
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	
What process do we have in place currently?	The Trust maternity service is compliant with all maternity related NICE guidelines with the exception of NICE fetal heart rate monitoring guidance as the Trust has implemented physiological guidance and STAN fetal heart rate monitoring to improved fetal heart rate interpretation. The current Trust physiological fetal heart rate monitoring guideline with the use of STAN monitoring has continued to provide assurance that abnormalities in fetal heart rate patterns are recognised by the midwifery and obstetric team and appropriate clinical action taken to reduce the chance of fetal brain injury due to misinterpretation of fetal heart rate patterns via cardiotocograph (CTG) monitoring.

Where and how often do we report this?	Incidents involving fetal hypoxic brain injury are reported monthly within the maternity service Quality and Performance Meeting and reported quarterly to the Trust Quality Assurance Committee via the perinatal mortality report. This is also a safety measure metric which is reported to the SWL LMS monthly. Fortnightly Maternity Risk meetings are held with MDT attendance to share clinical incidents and learning from incidents with action plans to monitor dissemination of learning and changes required to clinical care.
What assurance do we have that all of our guidelines are clinically appropriate?	Through clinical governance processes to report clinical incidents and maternal and neonatal clinical outcome measures. Clinical audit to measure compliance with guidelines and clinical outcomes metrics.
What further action do we need to take?	To continue with current Trust clinical governance processes.
Who and by when?	N/A
What resources or support do we need?	Continued existing resource to support maternity clinical governance processes, including clinical audit.
How will we mitigate risk in the short term?	N/A