East Kent Hospital University NHS Foundation Trust Maternity services assessment and assurance tool

IEA1	**IEA REQUIREMENT 1 (MANAGER SAFETY)** Safety of maternity units and services must be strengthened by increasing partnerships between Trusts and other local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into serious incidents (SIs) have regional and local Maternity System (LMS) oversight.	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 improvements?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further actions do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
IEA1.1	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 6 months. Improvement Committee into Trust Quality Sub Board Categories practice •Reviewed and improved Governance processes to ensure embedded learning from risk and incidents as well as good practice •Ongoing monitoring and surveillance of change i.e. through review of weekly ATAIN meeting themes, attendance of Consultants at Huddles and Ward Rounds, 1:1 care in labour, Supernumerary UN status, Maternity Triage review according to risk times •Monthly SPR meeting with Board	•Some shared learning through the LMS meetings e.g. Prevention of Case •LMS generated highlight reports •Commitment from LMS for reporting process to be in place by January 2020 • Peer review process between Maternity and LMS • Fetal Wellbeing Makaton and Better Births Midwives • New Maternity Dashboard refreshing national and local indicators to be in place by January 2020 •Maternity Patient Tracking List • Monthly reporting of Safety Improvement Plan Progress through the Maternity • Monthly Bereavee Reporting against improvement plan • Two weekly evidence review meetings with external membership to scrutinise evidence including embedding in	• Supports transparency, awareness, engagement and learning • Supported LMS funding for procurement of Maternity Safety Champions • Reporting into Maternity Improvement Committee and Trust Quality Sub Board has improved awareness and support/challenge Early enquiry and exploration of evidence to inform decision to escalate around • perinatal and/or neonatal mortality • concerns identified through the Ward Round • Bereavee reviews and deep-dive reporting • Coroner's inquiries • HSIB themes and action plan NHS Resolution • concerns raised by CQC • themes from GMC trainee and staff surveys	**Improved Safety Processes** Multidisciplinary Out of hours Safety Huddle embedded 100% 1:1 care in labour in May to September 2020 Ward Round Escalation Process in Labour Ward Status Initial Duty of Candour in 100% 100% CQC actions completed Issues and Board Item staff policy and induction process 100% QA Recommendations implemented improving Fantastic screening processes **Improvements in Fetal Monitoring** Staff Competency Framework and admission assessment implemented Embedded Physiological interpretation model for Fetal CTG monitoring MONDA centralised CTG monitoring embedded in practice Fetal Wellbeing Improvement Plan in progress **Improvements in Safety Outcomes** Reduction in referrals to HDR 62% reduction in neonatal deaths and stillbirths. Average Available Term Admission 2.7% (National ATAIN Target 5%) 3rd and 4th Degree Tear Rate 2.8% (National 3.5%) Reduction in babies <37weeks gestation requiring cooling **Improvements in Staff Support** •Feedback from Specialist sites that deepdive reporting to MSC build relationship and assist awareness of the work they are doing on behalf of women and families and the Trust •Positive feedback from MSC members around Deep Dive presentations •Safety Champion support in escalating and resolving issues raised by staff at Monthly feedback sessions	• Structured process to be agreed with LMS for 3-month minimum reporting and sharing of Safety themes and learning. • LMS reporting process to be in place by January 2021	LMS and Maternity Team January 2020	The National Dashboard will support shared learning and early alerting of outlying data trends Improved Governance about other shared risks/responsibilities and investment in Information and Digital Inserts to support development and reporting	Processes in place but ongoing monitoring will ensure sustained improvement and need to further refine
IEA1.2	External clinical specialist opinion from outside the Trust (but from within the region), as part of maternity support programme, Regional Chief Midwife to review the report, in the case of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	•External membership Perinatal review Meetings •SI reporting to NHSLA, CQC as part of maternity support programme, Regional Chief Midwife •External review of November 2020 SUI Birth cases Membership of all Improvement Plan Actions • External care group and trust	• Fresh eyes scrutiny of processes • Responsive to feedback and challenge • Early awareness and opportunity for shared learning • Positive relationships building • Bolstering through both qualitative and quantitative measures that improvement is embedded in staff feedback and deep-dive reports	• Learning from best practice • Feedback from external roles that deepdive reporting helps relationship building and assist awareness of the work they are doing on behalf of women and families and the Trust • Positive feedback from external members around Deep Dive presentations •Feedback has supported enhancement of reporting processes to maximise sharing of the right information •Safety Champion support in escalating and resolving issues raised by staff at Monthly feedback sessions • Positive feedback from LMS in collaboration working	Formal mandated process for peer review of serious cases aligned to LMS further feedback to evidence impact through external involvement	LMS and Maternity Team December 2020	LMS Support	Rapid mobilisation of plan
IEA1.3	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 6 months.	• Incs included in Safety Champion monthly report •Internal triggers in place to initiate deep-dives i.e. SBL and Cooling Mattress cases	•Supports early understanding or themes and learning/sharing	New process put in place December 2020 for including SI's in Board Safety Champion monthly report.	• Structured process to be agreed with LMS • LMS reporting process to be in place by January 2021	CNST Governance and Information Leads July 2021	LMS Support	NA
CNST SA1 CNST SA2 CNST SA20	**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 MBRRace (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?	•SA 1 • 100% Compliant Against standard. •Monitored through PMRT • Case summary and action plans generated through PMRT within 6-month required timeframe • Standard met CNST Year Level 2 •Parent/carer views sought. • Multidisciplinary representation at review meetings. • External membership at review panel. •SA 2 • 12/13 MBRR Standards met •SA 20 • 100% of cases reported against standard	•Monthly tracking of evidence with leads and Trust Board reporting supports awareness and oversight	•100% compliance achievement demonstrates effective systems and processes in place	•Must Board validation against evidence •BTO sign off on Board Declaration Form July 2021	Safety Action Leads Governance Team	We have been contacting the National Leads for CNST directly for any clarification requestion safety advice. Recent letter received December 2020 acknowledges impact due to Covid pandemic and currently Incentive Scheme document under review with national team	NA
UCP1a UCP1b	**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 NHSR	**To SBH to implement trial** Monthly reporting into Trust Board on safety and quality Non-executive director in post. New Maternity dashboard in place that draws on locally collected intelligence to monitor maternity and neonatal safety As part of the Maternity Support Programme, safety intelligence is shared with regional chief midwife to ensure early action and support for areas of concern or need. Same safety intelligence is shared across LMS **Plan in place** • External attendance at Perinatal Review Meetings takes place monthly •Serious Incidents reported to the Trust Boards subcommittee as part of the maternity safety champion report. •HSIB reporting of required cases and quarterly meeting held includes Executive team	NHS collaboratively supports Board Level safety Champions in providing oversight and supportive challenge workaround delivery of the improvement integrated Maternity Improvement Plan Monthly Safety Champion reporting of progress against improvement plan, safety messages shared with staff and through bi-monthly safety champion meetings. HSIB quarterly presentation shared with staff and presented at MDT forums Monthly SI reporting newly implemented Deep Dive reporting	Will monitor and track impact. Monthly monitoring of improvement plan.	**SI** Bereavee Perinatal clinical quality surveillance model in collaboration with the local maternity system (LMS) lead and regional chief midwife. Establish how local level intelligence will be shared to ensure early action and support for areas of concern or need. Review existing guidance, refreshed new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model. **SI. Will be implemented** Min have been advised by the LMS that they will have a system in place for SIs to be reviewed 3 monthly within the existing CCG nursing and quality structure to meet the recommendations of the report. However, external attendance at Perinatal Review Meetings takes place monthly	Governance and the LMS collaboration	LMS Support	
IEA2	**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?**
IEA2.1	**Outcome** Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	Discussed with Regional Chief Midwife We are awaiting national guidance but are committed to supporting.						
IEA2.2	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.	Discussed with Regional Chief Midwife We are awaiting national guidance but are committed to supporting.						
IEA2.3	Each Trust Board must identify a non-executive director who has oversight of maternity services, with 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.	•NED in place and Chairs the Maternity Improvement Committee • Action plan includes requirements from external and regulator reports including CQC Inspections and CNST. •Reporting is to the Board and its Quality Sub Committee • TOR Maternity Improvement Committee. MVP and Healthwatch on the Committee • Safety Champion meetings with staff engagement directly Meeting Agendas/minutes •Board Papers •Safety Champion Posters	• Key function is to oversee delivery of the Maternity improvement plan which includes regulator recommendations and CQC and CNST actions	•Raised Board Awareness of Maternity Improvement Programme, CNST, Specialist Lead Roles and impact •Delivery of actions are robustly considered including supporting evidence	Update of Safety Champion Posters Review new guidance in relation to NED role and identify and plug and implement	Maternity Improvement Lead January 2020	NA	NA
CNST SA1 CNST SA2 CNST SA6	**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?	**CNST SA1:** •PMRT Quarterly report •Service user feedback repository •Maternity Strategy coproduced document •Safety Champion Improvement Action plan •MVP Meetings and Handbook •We do have a robust mechanism for gathering service user feedback in place and work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. •Quarterly updates are captured, within a repository, •This repository describes the feedback mechanism, how frequently it is captured, where it is captured, themes and examples of the feedback, examples of how this has been responded to and evidence documents to support the narrative. •Bimonthly meetings are in place **CNST SA7:** •Monthly tracking of evidence with leads and Trust Board reporting supports awareness and oversight •Examples of SA7 coproduction include development of the Maternity Strategy, Continuity of Carer Working Party Group, Whose Voices event, Members of the Maternity Improvement Committee •Repository of feedback •You Said We Did Boards •Agendas and meeting notes •Monthly Safety Champion Board reports **SA8:** •Monthly tracking of evidence with leads and Trust Board reporting supports awareness and oversight SA8 Coproduction include development of the Maternity Strategy, Continuity of Carer Working Party Group, Whose Voices event, Members of the Maternity Improvement Committee •Repository of feedback •You Said We Did Boards •Agendas and meeting notes •Monthly Safety Champion Board reports We have a SABN Maternity and Neonatal Safety Champion who chairs maternity improvement committee • Reporting is to the Board and its Quality Sub Committee	**SA 1** •100% compliance achievement demonstrates effective systems and processes in place **SA7** • Implementation of change as a consequence of feedback e.g. 1hr drops •Close working relationships with both the MVP and Healthwatch. Valued members of the Continuity of Care: working party, influenced Maternity Strategy and members of the Maternity Improvement Committee **SA8:** •Provides Board to Ward understanding of issues •Supports unblocking of issues •Opportunity to celebrate success	Progress Matters SHP Quality improvements • Trust Board validation against evidence •BTO sign off on Board Declaration Form July 2021	SA 1:CNST Governance lead SA7:Consultant Midwife SA8:EDM • Trust Board validation against evidence •CNST sign off on Board Declaration Form July 2021	Overall pressures impacting on Mat Nov Quality Improvement work progressing with Front line teams	
UCP2a UCP2b	**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 voice of service users and staff are heard.	**2a:Met** •We do have a robust mechanism for gathering service user feedback in place and work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. •Quarterly updates are captured, within a repository, •This repository describes the feedback mechanism, how frequently it is captured, where it is captured, themes and examples of the feedback, examples of how this has been responded to and evidence documents to support the narrative. Executive Board Maternity and Neonatal Safety Champion is our Chief Medical Officer Champion who chairs maternity improvement committee • TOR Maternity Improvement Committee •Meeting Agendas/minutes •Board Papers •Safety Champion Posters • Reporting is to the Board and its Quality Sub Committee	**2a** •Examples of SA7 coproduction include development of the Maternity Strategy, Continuity of Carer Working Party Group, Whose Voices event, Members of the Maternity Improvement Committee •Repository of feedback •You said We Did Boards •Agendas and meeting notes •Monthly Safety Champion Board reports **2b** •Very function is to oversee delivery of the Maternity integrated action plan which includes regulator recommendations and CQC and CNST actions. MVP and Healthwatch membership of Maternity Improvement Committee provides service user voice	**2a** •Implementation of change as a consequence of feedback e.g. 1hr drops •Close working relationships with both the MVP and Healthwatch. Valued members of the Continuity of Care: working party, influenced Maternity Strategy and members of the Maternity Improvement Committee **2b** •Raised Board Awareness of Maternity Improvement Programme, CNST, Specialist Lead Roles and impact •Delivery of actions are robustly considered including supporting evidence	**2a** Continued coproduction of services Service user involvement in staff appointments **2b** Update of Safety Champion Posters Review new guidance in relation to NED role and identify any gaps and implement	Consultant Midwife July 2021 Board Safety Champions/EDM	On Track	On Track
IEA3	**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?**
IEA3.1	**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.	90% of all relevant staff groups received training in line with CNST standard year one and two. Training has been reprioritised in light of new Coronavirus Bulletins for training. Providing a combination of approaches to facilitate the training package 100% update in maternity continues to be virtual Continue face to face fetal monitoring day which includes competency assessment in line with Ockenden Bundle. PROMPT version of training in place of ward based simulation sessions Virtual training- human factors training in relation to the management of obstetric emergencies and updates from other members of the maternity team such as anaesthetics, screening and risk. PROMPT training will also be used to include the Mental Health and Critical Care Training that was added to the CNST relaunch requirements in October 2020.	Training programme supports cross site multidisciplinary learning Training programme adapted to maximise opportunity to deliver training during pandemic and facilitate access Training programmes align to safety (best practice guidance and CNST standards) Training programme draws on safety themes taken from incidents, SIs as well as examples of celebratory practice Safe environment created to maximise sharing of concerns, agreement and observations Training tracker for review of compliance Multiprofessional Faculty of Learning in Maternity and regular meetings held	Feedback from staff and evaluation of sessions Monitoring training completion Tracking themes of SIs and incidents and close loop to training session plan CNST reporting against standards	Plans to be put in place for sharing with LMS Ockenden plan Robust plans to support Haglinscliffe Medical Team on GEM/Cate Implement PROMPT Online training for Mental Health and Critical Care Training Action plan continual review to mitigate Risks- RCOG/COVID 19 recommendations was to postpone Consultant training as now essential work activity during the pandemic. Since relaunch of year three, training remains a significant risk. Challenges include capacity to deliver training at a pace demanded to meet compliance requirements. High staff absence rates both within training and clinical teams, additional training requirements have been included CNST, Competency Matrix and compliance or supplement remains at 90%.	Education Leads, Care Group Leadership, Finance, HR	Access to National Training is limited to elearning packages. Some training certification e.g. certificated NLS training, or trainer programmes can't be accessed currently. Impact of Covid on unplanned absence rates is impacting on both delivering training and staff being able to attend.	Training is monitored through CNST data training and implementation action plan. Training Tracking list and Monthly compliance data is shared. Training compliance is on the Risk Register. PROMPT online training packages are to be used to supplement existing training.
IEA3.2	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.	In place and embedded. Captured on the Huddle Sheet Ward Rounds take place 0900 and 2030 on the NNH site and 0800 and 1830 on the QEQM site	Auditing of compliance attendance Escalation to Manager on call if Consultant not in attendance to lead Safety Huddle which provides Ward Round Opportunity for teaching and raise questions using workplace risk examples MDROS Centralised fetal monitoring supports Huddle and ward round teaching/training	Feedback from staff Examples of supported learning Compliance audits of attendance Escalation of concerns Early Raised awareness of all cases and risk across areas to anticipate and mitigate issues	Audit Anaesthetic attendance at huddle in line with CNST SA3 Standard	Site leads in place	On Track	On Track
IEA3.3	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	Training funding is ringfenced in finance budgets for Maternity. NHS Safer Maternity training funds supported the implementation of a programme aligning to National Safety Improvement ambition Cultural Leadership Training funding assessed through NHSR(T) training assessed NHSR action plan training element used for IKF leadership development Training Policy outlines the training requirements and defines the mandated and trust specific requirements for delivery Training fund requirements are reviewed on an ongoing basis and funding is ringfenced in the finance budgets Mitchcliffe Maternity Strategy Register of all funding and how it was spent available	Mentor and enhance training programme in line with National Guidance and agreed requirements Demonstrate requirements against identified gaps through feedback, benchmarking, regulatory recommendations, incidents and learning	Feedback from staff Feedback from reporting themes to influence programme Demonstrating meeting of best practice processes and policies around training	Ensure continued arrangements for ringfenced funding is maintained and able to easily track	Education Leads, Care Group Leadership, Finance, HR	None identified	NA
CNST SA4 CNST SA8	**CNST** Action 6: 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 completed training in 'in-house' multi-professional maternity emergencies training session since the launch of MB year three in December 2019?	**CNST SA4 Obstetric Medical Workforce** The updated action plan for the 2019 Several Medical Council National Training Survey findings is being implemented Responses were documented within Trust Quality Sub Board Papers.!! Forms part of the CQC action plan under the headings of: 1. Attendance at teaching sessions 2. Training Needs Analysis for workforce plan 3. LCS training sessions Learning Faculty Group (LFG) meetings All training action plans are presented to the Strategic Workforce Committee, with the Medical Director being our Board sponsor. **Anaesthetic Medical Workforce** Auditing against the ACDA Standard including: Dedicated theatre lists with a named Obstetric and anaesthetic Consultant with no other clinical commitment Rota system in place that ensures that there always is one anaesthetic consultant allocated to Labour Ward Daily consultant availability at a time when labour ward rounds are taking place The Anaesthetist attend the Labour Suite Safety Huddles and then join the Ward round to see ap pregnate women. **Neonatal Medical Workforce** A six-month audit of junior medical staffing has been completed for both sites. NNH and QEQM sites meet BAPM Standard. The Neonatal Nursing Workforce Develop Tool workforce modelling tool has been completed for both sites against BAPM Standard **Training** The training has been reassessed in light of new Coronavirus Bulletins for training. Providing a combination of approaches to facilitate the training package for Maternity within RNNR(T). 100% update in maternity continues to be virtual PROMPT version of training in place of ward based simulation sessions Continue face to face fetal monitoring day which includes competency assessment in line with Ockenden Bundle. Virtual training- human factors training in relation to the man-agement of obstetric emergencies and updates from other members of the maternity team such as anaesthetics, screening and risk. PROMPT training will also be used to include the Mental Health and Critical Care Training that was added to the CNST relaunch requirements in October 2020.	**SA4** Action plans against elements support raised awareness from Front line to Board on work being undertaken to mitigate and improve **SA8** Training programme supports cross site multidisciplinary learning Adapted training programme and make as easy as possible for staff to access Training programmes align to safety (best practice guidance and CNST standards Training programme draws on safety themes taken from incidents, SIs as well as examples of celebratory practice Safe environment created to maximise sharing of concerns, agreement and observations Training tracker shows compliance of staff groups Multiprofessional Faculty of Learning in Maternity in place with regular meetings	**SA4** Reporting through leadership team, Safety Champion and Trust Quality sub Board all support raised awareness of position and delivery of action plans against any gaps **SA.8** Feedback from staff and evaluation of sessions Monitoring training completion Tracking themes of SIs and incidents and close loop to training session plan. CNST reporting against standards	**CNST SA 4** Action plans to support audit findings. A review of impact of Covid-19 on the service is being mainlined to align with standards and requirements. This is challenging due to minimising Covid-19 second wave pressures. **CNST SA8** Training compliance to be included on Maternity Dashboard against staff groups	SA 4 Consultant lead SA8 Education Lead Improvement Lead July 2021	Audit Staff time and access to training not within control as Covid influenced Training Team Lead Succession plan	Continue to monitor, mitigate and progress as able
UCP2a UCP2b	**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 at the moment we are seeking assurance that a MDT training schedule is in place	**2:Met** Ward Rounds take place 0900 and 2030 on the NNH site and 0800 and 1830 on the QEQM site MDT training schedule is in place. Focus on cross site multiprofessional training programme, sharing and learning. Training Policy describes MDT Training schedule. Action plan in development to support Anaesthetic and theatre staff group attendance at training through dedicated Anaesthetic and Theatre Maternity Team. During Covid-19 training has been impacted but Simulation Training resolves continuing with adaptations to meet safety requirements.	In place and embedded. Captured on the Huddle Sheet **3:Met** Embedding supported through BBXT Maternity Transformation Programme with a dedicated MDT training schedule.	See SA4.2 and CNST SA8	See SA4.2 and CNST SA8	See SA4.2 and CNST SA8	Implemented 18.12.20	See SA4.2 and CNST SA8	See SA4.2 and CNST SA8
IEA4	**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?**
IEA4.1	**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.	Specialist Consultant Leads for perinatal Mental Health, Diabetes, Pre-term, Twins and Fetal Medicine We have acute and tertiter sites for Renal Medicine We are the Regional Stillbirth Centre which makes us possibly the best placed Trust for a Maternal Medicine Centre. Cardiac, Neurology and Sepsis through links to London Hospitals	Early referral and care planning	Formalise referral pathways external to trust	Committed to supporting Regional Tertiary Maternal Medicine Centres and contributing to plans	MvP, Trust Exec Team, LMS, Regional Teams	Further guidance and support as available	Continue with internal early referral to Fetal Medicine Team
IEA4.2	•Women with complex pregnancies must have a named consultant lead	Every woman who is high risk has a named Consultant Auditing regularly required	Early referral and care planning Best practice care and monitoring Continuity of care	Monitoring and tracking compliance	Committed to supporting Regional Tertiary Maternal Medicine Centres and contributing to plans	MvP, Trust Exec Team, LMS, Regional Teams	Further guidance and support as available	Continue with internal early referral to Fetal Medicine Team
IEA4.3	•Without a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	Referral pathways are within specific Medical Related Policies Antenatal Assessment Guideline to support early referral of defined conditions Early Consultant Appointment to enable early referral and shared care	Early referral and care planning	Formalise referral pathways external to trust	Committed to supporting Regional Tertiary Maternal Medicine Centres and contributing to plans	MvP, Trust Exec Team, LMS, Regional Teams	Further guidance and support as available	Continue with internal early referral to Fetal Medicine Team
CNST SA6	**CNST** Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	**CNST SA6 Element 1: Reducing smoking in pregnancy** Lead Midwife in place making tangible changes in line with standard **Element 2: Risk assessment and surveillance for fetal growth** Risk status for fetal growth restriction (FGR) is identified and recorded at booking in 99.9% Babies born <3rd centile <37+0 weeks' gestation is 51.9%. This is above the national average and an action plan to further improve has been developed. **Element 3: Raising awareness of reduced fetal movements** 96% of women booked for antenatal care received safety information by 28+0 weeks of pregnancy Lead Midwife for Stillbirth Prevention is working closely with Steven Redman, compassionate CTG capability. **Element 4: Effective fetal monitoring during labour** 32% of staff trained on fetal monitoring in labour. 37% of staff trained in human factors and situational awareness. A competency assessment now in place **Element 5: Reducing preterm birth** 87.5% of singleton live births (less than 37+0 weeks) receiving magnesium sulphate within 24 hours prior birth 96.8% of women give birth in an appropriate care setting for gestation Quarterly Care Bundle submissions	Deep dive reporting into Maternity Improvement Committee CNST reporting into Trust Quality Sub Board Board, staff and leadership awareness of progress, compliance position against standard Quarterly care bundle reporting into LMS and National team lens. understand position and benchmarking against other Trusts through analysis of MBLRIS now on New Maternity Dashboard Bundling maternity information supplier inclusion of questions to support data capture quality and prompt staff to respond/discuss Fetal Wellbeing Midwives and Smoking Cessation Midwife in post to implement, Lead and drive improvement in practice and outcomes	Continual tracking and monitoring against care bundle and CNST standards Improved compliance against process and outcome metrics Monitoring on dashboard of MBLIR KPIs Improved compliance tracked on audit, dashboard, CNST reporting and quarterly reporting	90% of staff are required to receive training on fetal monitoring. Due to the impact of Covid-19, current training compliance is 51%. Workplace learning and virtual training are being facilitated but there is reduced capacity to both deliver and access training. We have asked NHSR for guidance on training risks. We have developed a mandatory annual competency assessment tool and process but there is a risk linked to above in terms of process implementation and completion. Delay in Sleeve Resection Computerised CTG Training and use due to Covid 19. The percentage of singleton live births (less than 37+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth is not currently known due to a data recording issue that is being explored. A- 38%% currently in test Unable to progress plans to provide uterine artery Doppler flow velocimetry in antenatal clinics due to Covid 19 pandemic. Fetal Medicine Midwife leads, but 24 completed weeks gestation. Action plan is being developed which NHSR have said is an acceptable mitigation to support action. Women at high risk of pre-term birth must have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. The preterm clinic was due to be implemented just as Covid-19 pandemic started. This has been delayed but will start once the position improves. An action plan is being developed by the Care Group on how to implement transvaginal scans. NHSR have agreed that if this is approved, and as there is no existing service, then it will be acceptable evidence.	MvP, Trust Exec Team, LMS, Regional Teams	Further guidance and support as available	Continue with internal early referral to Fetal Medicine Team
UCP4a UCP4b	**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.	**a:Met** Every woman who is high risk has a named Consultant Future auditing regularly required **b:Met** Covid-19 2020 LMS initiated discussions through questionnaire and expression of interest with Trusts Steps required to support development of maternal medicine specialist centres are: •Appropriate sites to become specialist centres as a regional hub and spoke model •Feedback from NHSR regarding questionnaire findings and to support forward decision-making •Locals to support regional conversations and East Kent Maternal Medicine expertise •Already in place is early discussion of complex maternity cases with expert clinicians.	a) Early referral and care planning Best practice care and monitoring Continuity of care Processes in place to ensure staff involved in care are aware of plans	Delivery in appropriate care setting Safety outcomes for individual case situation Awareness and anticipation of needs	Best practice care and monitoring Continuity of care Processes in place to ensure staff involved in care are aware of plans		Implemented 18.12.20		
IEA5	**IEA REQUIREMENT 5 (RISK ASSESSMENT THROUGHOUT PREGNANCY):** **Staff must ensure the 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?**

IEA5.1	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	Currently risk assessed at points throughout pregnancy journey. This will be altered to ensure this is done at each contact. Will be added as a question to the MB The 'Trumovate message has been shared with all staff that a risk assessment will need to be performed at each Ante Natal visit. Ante Natal Clinical Risk Assessment Guideline will be updated to reflect this	Supports early escalation, referral and care planning. Best practice care and monitoring. Ensures staff involved in care are most appropriate to support personalised needs and supports safe outcomes	Care provided by most appropriate clinical teams Management plans are communicated early with women and care teams	A risk assessment will need to be performed at each Ante Natal visit. Ante Natal Clinical Risk Assessment Guideline will be updated to reflect this 01.12.20	Head of Midwifery Implemented 21.12.20	Audit of effectiveness to be considered as part of impact assessment	Ante Natal Clinical Risk Assessment Guideline will be updated
IEA5.2	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Questions added to Maternity Information System to ensure that risk assessment, including place of delivery reviewed at each contact. Trumovate message shared with all staff that a risk assessment will need to be performed at each Ante Natal visit. Birth planning discussion embedded Ante Natal Clinical Risk Assessment Guideline will be updated to reflect this	Women are given information around risk assessment to inform decision making around care and place of birth Place of birth is most appropriate setting for risk and need Women and families are informed of choice and associated risk Where there is a difference in clinical recommendation and women informed choice, mitigations can be put in place to support safety	Care provided by most appropriate clinical teams Management plans are communicated early with women and care teams	Ante Natal Clinical Risk Assessment Guideline will be updated to reflect this Assessment including review of place of delivery will be reviewed at each contact	Head of Midwifery Implemented 21.12.20	Messaging to converge to staff around importance of these assessments	Ante Natal Clinical Risk Assessment Guideline will be updated to reflect this
CNST SA6	**CNST** Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version 2?	MB IBAS CNST SA6 Compliance	MB IBAS CNST SA6 Compliance	MB IBAS CNST SA6 Compliance	MB IBAS CNST SA6 Compliance	MB IBAS CNST SA6 Compliance	MB IBAS CNST SA6 Compliance	MB IBAS CNST SA6 Compliance
UCP5.a	**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.	**Implemented 21st December** Trumovate message shared with all staff that a risk assessment will need to be performed at each Ante Natal visit. Ante Natal Clinical Risk Assessment Guideline will be updated to reflect this	Women are given information around risk assessment to inform decision making around care and place of birth Place of birth is most appropriate setting for risk and need Women and families are informed of choice and associated risk Where there is a difference in clinical recommendation and women informed choice, mitigations can be put in place to support safety	Care provided by most appropriate clinical teams Management plans are communicated early with women and care teams	The Trumovate message shared with all staff that a risk assessment will need to be performed at each Ante Natal visit. Ante Natal Clinical Risk Assessment Guideline will be updated to reflect this	NEM Implemented 21.12.20	Personalised Care plan electronic solution to be programmed by Bunking/supplier	Trumovate message shared with all staff that a risk assessment will need to be performed at each Ante Natal visit.
IEA6	**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?**	**Ante Natal Clinical Risk Assessment Guideline will be updated to reflect this**
IEA6.1	**OCKNDEN** 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 supportive – • Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	•Lead Consultant and Midwifery Leads in Place. •Supported by Fetal Wellbeing Midwives leading on implementation of MBCBVO •Fetal Wellbeing Midwives in place both acute sites who lead with Fetal Wellbeing on: •Multiprofessional learning sessions ; •Drills -simulation sessions •Training through the Faculty of Multiprofessional Learning in Maternity (FMLM). •Development of training needs based on local and national requirements, mandatory training and learning through real time risk and incidents. •Based site based SBI forums which provide opportunities to highlight updates, new learning/changes, Feedback from case reviews, external/internal learning events and audits. •Support staff to engage and lead in audit and present learning through the Trustwide audit days. •Support staff to engage and lead in quality improvement projects and PDSA cycles. •Monitoring and tracking of training compliance levels of all appropriate staff •Rotation of Labour Ward Huddles and Ward Rounds for Training opportunities •Training sessions to capture medical staff on Friday •Two Fetal Surveillance Midwife posts have been appointed to who will lead on embedding learning into practice, using the workplace as the main source of learning •Clinical Skills Midwives lead on training and competency assessment •Monitoring and tracking of training compliance levels of all appropriate staff •Fetal Surveillance Midwives are supernumerary to ensure they can perform their Fetal Surveillance MW, the lead for the MBCB role and CSP role •Mr Obstetric leads have teaching and training activity and responsibility within their JDs including GM forum and attendance at GMS Quality and Safety Meetings and MNP meetings •Being forward there is a plan to more explicitly define the Fetal Monitoring and MBCB responsibility within JDs and job plans •Band 7 Medical Education and JDs and Senior Consultant unique post leading on future development of Medical Education for both Post graduate and Undergraduate Medical Education Post holder also leads on the Multiprofessional Faculty of Maternity Education •Social media sharing of messages and updates to training PM	Feedback from GMC and staff surveys Change in HEIA and SI themes showing impact of learning PLT associated Fetal monitoring themes Training compliance tracker list Closed loop Governance reporting of themes to influence training plans	Feedback from GMC and staff surveys Change in HEIA and SI themes showing impact of learning	Computerised CTG implementation once training can progress Virtual training developed	Fetal Wellbeing Midwives	None-Covid dependant or staff resource to access	
IEA6.2	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	•Friday Training sessions and ashook for Medical and Midwifery staff. Mandatory training using learning from risk and themes from SIs/Incidents In-situ training at Ward Rounds and Huddles	Feedback from GMC and staff surveys Change in HEIA and SI themes showing impact of learning PLT associated Fetal monitoring themes Training compliance tracker list Closed loop Governance reporting of themes to influence training plans	Feedback from evaluation and within training sessions Monitoring and tracking outcomes Feedback from staff involved in fetal monitoring MPLM training assessment forms Feedback from GMC and staff surveys Change in HEIA and SI themes showing impact of learning	Continue to assess best day and time for staff to access training sessions	Site MBCBVO and LW leads	Staff time and ongoing investment in training	
IEA6.3	The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	Deep Dive Reporting Quarterly Care Bundle National Reporting Thinking against Improvement Plan CNST Reporting Shared messages from Fetal Wellbeing Midwives re audit findings, reporting and compliance levels-escalating any mediable actions to be implemented MPLMS training messages. Training tracker and alerts to staff when training is close to expiry	Care Bundle Reports Foundation Force Fetal Monitoring Lead Staff Feedback from GMC and staff surveys Change in HEIA and SI themes showing impact of learning PLT associated fetal monitoring themes Training compliance tracker list Closed loop Governance reporting of themes to influence training plans	Submissions to Quarterly Care Bundle Survey and CNST reporting. Feedback from GMC and staff surveys Change in HEIA and SI themes showing impact of learning	Ongoing Team to remain in post to maintain and improve position	Multidisciplinary Faculty of Learning in Maternity Consultant and Midwifery Lead Clinical Skills Facilitators Site MBCBVO and LW leads	Staff time and ongoing investment in training	
CNST SA6/ CNST SA8	**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 MN year three in December 2019?	MB IBAS CNST SA6 MB IBAS CNST SA6	MB IBAS CNST SA6 MB IBAS CNST SA6	MB IBAS CNST SA6 MB IBAS CNST SA6	MB IBAS CNST SA6 MB IBAS CNST SA6	MB IBAS CNST SA6 MB IBAS CNST SA6	MB IBAS CNST SA6 MB IBAS CNST SA6	MB IBAS CNST SA6 MB IBAS CNST SA6
UCP6a	**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, training and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	**Mer:** The role of the leads does include supporting training and learning, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	There is a lead Fetal Wellbeing Midwife and Lead Obstetrician for each site	Care Bundle Reports completed Feedback from evaluation and training needs Feedback from GMC and staff surveys Change in HEIA and SI themes showing impact of learning PLT associated fetal monitoring themes Training compliance tracker list Closed loop Governance reporting of themes to influence training plans	Feedback from evaluation and within training sessions Monitoring and tracking outcomes PPI, associated themes relating to fetal monitoring MPLMS training assessment forms Feedback from GMC and staff surveys Change in HEIA and SI themes showing impact of learning			Implemented 18.12.20	
IEA7	**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?**
IEA7.1a	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.	Our Trust Maternity Webpage has easily accessible information to enable informed choice of place and types of birth including video tours of all birth locations and sites. Following self referral, all women are provided access to the trusts own Maternity App, MOMA, which has information about choice of place of birth including video tours, types of birth and maternal choice for caesarean also with a video to support.	We monitor through our Patient Tracking List which the access to the MOMApp is. We have a robust process of checking for PTL 7 days after referrals have been received, and where a red envelope is still showing (meaning the patient has not registered to the MoMA invite email) we triggers a re-send of the email, to prompt and encourage women to access	Feedback from women Feedback from staff Monitoring of outcomes	We are developing phase two of the MOMApp to make the information sent to women more personalised i.e. if diagnosed with twin pregnancy then information around twins will be shared to support choice	Digital Transformation Leads. Funding in place and development began March 2020	Continued support from trust digital and information teams	Continue with current information sharing platforms and processes. This is an enhancement of service
IEA7.1	**OCKNDEN** 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	Information available through Kent Kent Maternity MOMA App and Trust Maternity Website. Supported by paper information if required including different languages Links to National documents and information via MOMA and Website ensure always up to date information is provided Electronic Personalised Health Records and paper notes Personalised plans including birth preferences MIS/bunking workflows at each AN contact Electronic Discharge Notifications Information updates to staff to support information sharing	MOMA and Trust site are repositories that women are directed to for information that is the most up to date national guidance available Staff training is based on best practice guidance and local learning themes to ensure information sharing is current Responding to staff and women feedback to develop Bunking Maternity information System Access to pre-booking questionnaire to inform conversations Access of birth preferences and care plans	Feedback from women Feedback from staff Monitoring of outcomes	Personalised Care Plan solution while waiting for Bunking MIS upgrade	Consultant Midwife February 2020	Bunking MIS upgrade	Paper interim solution
IEA7.2	Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care	Supported through verbal and supportive information sharing Discussions and choices clearly documented including risk and mitigations	MOMA and Trust site are repositories that women are directed to for information that is the most up to date national guidance available Staff training is based on best practice guidance and local learning themes Tracking number of women accessing MOMA Development of phase Two MOMA app Audit of womens experience of using MM Responding to staff and women feedback to develop Bunking Maternity information System	Feedback from women Feedback from staff	Personalised Care Plan solution while waiting for Bunking MIS upgrade	Consultant Midwife February 2020	Bunking MIS upgrade	Paper interim solution
IEA7.3	Women's choices following a shared and informed decision-making process must be respected	Supported through verbal and supportive information sharing Discussions and choices clearly documented including risk and mitigations Birth after Thoughts and Birth After Caesarean clinics available	Records reflect women's choices MOMA and Trust site are repositories that women are directed to for information that is the most up to date national guidance available Staff training is based on best practice guidance and local learning themes Tracking number of women accessing MOMA Development of phase Two MOMA app Audit of womens experience of using MM Responding to staff and women feedback to develop Bunking Maternity information System	Feedback from women Feedback from staff	Personalised Care Plan solution while waiting for Bunking MIS upgrade	Consultant Midwife February 2020	Bunking MIS upgrade	Paper interim solution
CNST SA7	**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?	**CNST SA7:** •Service user feedback repository •Maternity Strategy coproduced document •Safety Champion feedback repository/action plan •MVP Meetings well represented •We do have a robust mechanism for gathering service user feedback in place and work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Feedback is shared at the MVP Meetings •Quarterly updates are captured, within a repository. •This repository describes the feedback mechanism, how frequently it is captured, where it is captured, themes and examples of the feedback, examples of how this has been responded to and evidence documents to support the narrative	**SA7** • Examples of co-production include development of the Maternity Strategy, Continuity of Care Working Party Group. Whose Voices event, Members of the Maternity Improvement Committee. • Repository of feedback • You Said We Did Boards	**SA7** • Implementation of change as a consequence of feedback e.g. 15 steps •Close working relationships with both the MVP and Healthwatch. Valued members of the Continuity of Care working party, influenced Maternity Strategy and members of the Maternity Improvement Committee	• Trust Board validation against evidence • CEO sign off on Board Declaration Form July 2021	SA7 Consultant Midwife • Trust Board validation against evidence • CEO sign off on Board Declaration Form July 2021	NA	No
UCP7a	**Link to urgent clinical priorities** a) Every trust should have the pathways of care clearly described, in accessible information consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	**Mer:** In addition we have developed the MOMA App which provides information and is subject to ongoing development. Pathways of care are available on the Trust Website.	Guideline in place				Implemented 18.12.20	
	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?**
OCKNDG1	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.	As part of the process for reviewing Maternity Guidelines against their renewal dates, alignment to NICE guidelines takes place. An example of this is the NICE Diabetes in Pregnancy Guideline which was released on 16 December 2020 and has triggered early review of our Guideline to ensure alignment. This is currently only applicable to New staff joining the team. Where there is a need to do this more immediately, it will be done outside of the guidance specific date. Pregnancy Guideline which was released on 16 December 2020 and has triggered early review of our Guideline to ensure alignment. If we are operating outside of NICE Guidance then Trust Board and CEO approval is sought. our Fetal Monitoring Guideline that follows the SI Ockgies Model of Physiological Interpretation. Staff are informed of changes to guidance through mandatory training and training as part of induction and guidelines shared. Guideline group in place to robustly review content, updates and additions to meet changing local and national requirements Guideline Policy defines governance process for writing, updating and ratification All guidelines and policies are easily and readily accessible through the trust electronic 'Policy Centre' ensuring only the most recent versions can be accessed Refused Guidelines are shared with Leave staff prior to working in the trust and a robust process has been implemented to check that these are reviewed and understood	An example of this is the NICE Diabetes in Pregnancy Guideline which was released on 16 December 2020 and has triggered early review of our Guideline to ensure alignment. All Maternity Guidelines site NICE alignment where appropriate and are referred to in development and delivery of Maternity Multi-professional training programme	Audit against guidelines to monitor compliance and impact Maternity dashboard tracking of outcomes Risk and incident Reviews Monitoring of guidelines review dates and process/team in place to ensure this takes place	An online learning package will soon be available to our short notice staff to support external teams of relevant guidelines	Maternity Governance Team	Maintain current Governance processes for updating Guidelines and align to training	Monitoring and tracking guideline reviews within approved time periods

East Kent Hospital University NHS Foundation Trust

MATERNITY WORKFORCE PLANNING -	What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Can you demonstrate an effective system of clinical workforce planning to the required standard?	**CNST SA4** **Obstetric Medical Workforce** The updated action plan for the 2019 General Medical Council National Training Survey findings is being implemented The responses were documented within Trust Quality Sub Board Papers.0 Forms part of the O&G action plan under the headings of: 1. Attendance at teaching sessions 2. Workforce plan – O&G workforce plan 3. L/S training sessions Learning Faculty Group (LFG) meetings took place in February, June and November 2020. All training action plans are presented to the Strategic Workforce Committee, with the Medical Director being our Board sponsor. Obstetric Staffing guideline in place, increase consultant presence on each site allocated consultant, rotas **Anaesthetic Medical Workforce** Auditing against the ACoA Standard including: Dedicated theatre lists with a named Obstetric and Anaesthetic Consultant with no other clinical commitment Anaesthetic rota shows that there is always someone allocated to Labour Ward. Duty consultant availability at a time when labour ward rounds are taking place The Anaesthetist attend the Labour Suite Safety Huddles and then join the Ward round to see appropriate women. **Neonatal Medical Workforce** A six-month audit of junior medical staffing has been completed for both sites. WHH and QEQM sites meet BAPM standard. **The Neonatal Nursing Workforce** Birning Tool workforce modelling tool has been completed for both sites against BAPM standard	**SA4** Action plans against elements support raised awareness from front line to Board on work being undertaken to mitigate and improve	**SA4** Reporting through leadership team, Safety Champion and Trust Quality sub-board all support raised awareness of position and delivery of action plans against any gaps	**CNST SA 4** Findings have been shared with the Obstetric and Anaesthetic Site Leads to inform the action plan to be developed for this standard.	SA 4 Consultant Lead	Audit programme for ongoing review and monitoring	Continue to monitor, mitigate and progress as able
Can you demonstrate an effective system of midwifery workforce planning to the required standard?	• Biannual report to Strategic Workforce Committee • The 24-hour Triage service on the WHH site is to be commenced, away from Labour Suite • Monitoring of changing daily workloads, staff on duty, staff in post and changing clinical activity. • A rolling, central monthly audit of midwifery staff captures the number of midwives, hours worked, posts offered, annual leave, sickness, maternity leave and leavers. • Maternity E Roster systems for the shift allocation of staff • labour wards have an identified Band 7 midwifery coordinator providing the clinical leadership within supernumerary status and supports the requirement for one-to-one care in active labour. Operational Midwifery Manager guideline, role embedded in practice Escalation Guideline updated and Midwifery Staffing Guideline in place	Monthly monitoring of maternity dashboard and incidents for any significant impact on outcomes and changes in RAG ratings set; •Clinical Incidents •Complaints •Friends and Family Test (FFTs). •Patient experience •1 to 1 care in labour •Clinical outcomes •Unit diverts •SFs and Maternal deaths •Healthcare Safety Investigation Branch (HSIB) recommendation and investigations •Monitoring of the midwifery workforce is from a variety of sources and this includes: •Electronic Health Roster •Staffing Establishment- monthly update •Intrapartum Acuity Tool •Safety Huddles, which include in and out of hours provision for this multidisciplinary team over view. •Monitoring staffing red flags	Continue with robust surveillance of Midwifery staffing to allow responsive address of any anticipated or actual risk	Training and implementation of BirthRate Plus Intrapartum Acuity Tool upgraded version This has been approved by Procurement, IT and funding is in place through an NHSR action plan.Once the new acuity tool goes live, this will be reviewed in real time with escalations and themes captured in a timely way.	DOM,HOMs, Matrons, Coordinators	Progress implementation of upgraded Intrapartum acuity tool and associated staff training	
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.	A full BirthRate Plus exercise has been commissioned by the Kent and Medway Local Maternity Service (LMS) with an additional focus on the Continuity of Care calculation. This has been completed and draft reports received. Once the report content has been fully reviewed, an update will be provided to the Quality Committee as subcommittee to Trust Board on findings and recommendations.	Working with Continuity of Carer National Lead to carry out workforce modelling to support team implementation and cross reference staffing requirements against the BirthRate Plus findings Leadership and Executive oversite of findings and Business Case Support to meet staffing gaps to be developed	Will support implementation of further Continuity of Care Teams	Findings to be reviewed and finalised	Midwifery Leadership Team Board Safety Champion	Business case to meet staffing gaps	
MIDWIFERY LEADERSHIP (RCM Manifesto standards)							
Director of Midwifery in every trust: Every trust should have a Director of Midwifery, with a Head of Midwifery in every maternity unit within the organisation. This would help protect people from the risk posed by dysfunctional maternity services by enabling problems to be identified and escalated more quickly.	Director of Midwifery in post Head of Midwifery in post QEQM Site and appointed for WHH site awaiting start date.						
Regional & national lead midwives: A lead midwife at a senior level in all parts of the NHS, both nationally and regionally	Regional Chief Midwife in post						
Midwifery Leadership Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director	Yes, Director of Midwifery is responsible and accountable to an Executive Director- Chief Nurse/ Director of Quality and Patient Experience. This is defined within the Job Description, governance structures and organograms.						
More consultant midwives: We would like to see at least one consultant midwife in every maternity unit. For those responsible for providing services in remote and rural areas, one option could be to appoint a consultant midwife across more than one trust / health board, providing consistency and clarity of professional guidance for this very specific kind of midwifery service.	Consultant Midwife in post leading on Public Health						
Specialist midwives in every trust: A range of specialist midwife roles should be the norm in every trust / health board across the United Kingdom. The mix of specialisms will depend upon the needs of the service locally. Midwives should have access to and be able to draw upon these midwives' skills and experience as they strive to deliver and improve care e.g.: smoking cessation FGM specialist substance misuse mental health specialist	Specialist Midwives in post include: Fetal Wellbeing Midwives each acute site Smoking cessation Midwife Perinatal mental health specialist midwives Bereavement Midwives each site Better Births Lead Midwife Diabetes in Pregnancy Midwives Digital Midwife Screening Midwife Fetal Medicine Midwife on each site Fetal Surveillance Midwives recruitment in progress	**Fetal Wellbeing Midwives** Leading on Tracking, monitoring and reporting Implementation of all five elements of the Saving Babies Lives Care Bundle Version 2 demonstrating progress and impact **Smoking cessation Midwife** demonstrating improvements in referrals, information sharing, education data capture Stop Smoking in Pregnancy Referrals 94%. Quits during pregnancy 22.4% October **Mental health** service developments and improved screening, training and data capture. Service user informed bid for mental health service to focus on both trauma foss. Consultant leads in post **Better Births Midwife** leading on Continuity of Carer service implementation **Diabetes midwives** leading on Midwife led pathways, virtual clinics **Infant Feeding Midwives** Breastfeeding training videos, assessment tool and plan. AN conversations. Elective CS and skin to skin review. Training **Multi-professional Faculty of Learning in Maternity** Team Additional 2x Fetal Surveillance Midwives joining team, adapting training to facilitate access **Digital Transformation** Multi-professional Team Maternity App-phase two alerts and automation, PHR readiwrite capability, VTE, e-GROW, MSDS 1111 CNST, FFT, e-referrals	Improved Outcomes Audit outcomes Monitoring KPIs Deepdive presentations to the Maternity Improvement Committee Feedback from Women	Review gaps in specialist roles with consideration of the population accessing maternity services	Senior leadership team and Consultant Midwife	Continued suppport locally and regionally	
Strengthening midwifery leadership in education & research: Lead Midwives for Education (LMEs) are experienced, practising midwife teachers who lead on the development, delivery and management of midwifery education programmes 13. They help to ensure high standards in midwifery education and are a vital intermediary between the professional regulator (the Nursing and Midwifery Council) and the universities.	There is a Lead Midwife for Education (LME) in place who meets the statuatory standard. LME has a place place LMS forum. It is a conduit for information sharing from other National Forums such as the NMC, back into the Trust The LME provide accurate action plans to the NMC when an issue which might affect the student learning environment or where there may be a patient safety concern. If there's the potential that standards are not being met then this should be raised via our exceptional reporting.	Feedback from LME on strength of relationship with East Kent and robustness of processes and communication channels	Via exception reports and continued communication and contact		LME, Education Lead x, DOM		
Fund ongoing midwifery leadership development: A commitment to fund ongoing midwifery leadership development.	Internal Programmes that staff are encouraged and supported to access include Clinical Leadership Programme, KENT programme and Matrons Leadership Development Programme. External programmes include Florence Nightingale and Rosalind Franklyn Leadership Programme have been undertaken by senior midwives in 2020	Feedback from attendees. Impact on practice and leading areas of change	Combined appraisal and self assessment processes. Retention and career progreasion of staff.	Continue to support and encourage staff to access leadership training in support of appraisal and self assessment processes	Midwifery and Obstetric Leadership Team, HR Team	Ongoing support and access to training funds to continue	Continue to recognise importance as part of ongoing training needs. Continue to support staff through time and funding to attend.
Professional input into the appointment of midwife leaders: Directors and Heads of Midwifery must have the skills, experience and credibility to lead and manage maternity services. The appointment of the right individual is an important matter, and selection procedures within the NHS should be focused on ensuring that the right people get into the right jobs.	Rigorous formal recruitment process. Interview panel with wide multidisciplinary representation as well as regional midwifery support. Stakeholder event includes MDT , MVP, LMS, CCG and other stakeholders represented. Documented in line with Trust Values	Celeber of staff appointed Feedback on process	Continue to align with national guidance and local requirement	Continue to seek feedback. Ongoing monitoring and performance of appointments. Robust HR processes Recognise need for support through peers, regional and national team. Mentors to support new in post staff and comprehensive induction programme	SMT , Trust Exec Team.	Ongoing support and feedback	Continue to monitor and review current processes to inform need for improvement