Maternity self-assessment tool

Leicester Maternity, March 2022

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

			Evidence of link in to MVP; any other mechanisms	100%	
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	100%	
			Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	100%	
			Name of NED and date of appointment	100%	
			NED JD	100%	
		Non-executive director who has oversight of maternity services Total		**100%**	
	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	Consultant midwife supporting the development of the MVP The MVP is currently being reviewed with the support of the CCG
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%	
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%	
		Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total		**100%**	
	Q14	Trust safety champions meeting bimonthly with Board level champions	Action log and actions taken.	100%	Embedded system for communication of actions taken from concerns raised by staff in the monthly maternity safety bulletin "you said, we did" style
			Log of attendees and core membership.	100%	
			Minutes of the meeting and minutes of the LMS meeting where this is discussed.	100%	
			SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	100%	
		Trust safety champions meeting bimonthly with Board level champions Total		**100%**	

	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	
		Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Total		**100%**	
	Q16	Non-executive director support the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken	100%	
			Name of ED and date of appointment	100%	
		Non-executive director support the Board maternity safety champion Total		**100%**	
IEA2 Total				**100%**	
IEA3	**Q17**	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	Monthly monitoring of training data through Quality Board & LMNS Included in CNST year 4 workstream
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	100%	
			Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	100%	
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%	
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%	

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

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

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

	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Agreed pathways	100%	confirmed Leicester will become specialist centre - work in progress to meet all criteria
			Criteria for referrals to MMC	100%	
			The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	100%	
		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total		**100%**	
IEA4 Total				**100%**	
IEA5	**Q30**	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	How this is achieved within the organisation.	100%	included in monthly audit program and reviewed in safety dashboard
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	included in monthly audit program and reviewed in safety dashboard
			Review and discussed and documented intended place of birth at every visit.	100%	
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	100%	
			What is being risk assessed.	100%	
		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total		**100%**	
	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	100%	
			Out with guidance pathway.	100%	
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	included in monthly audit program and reviewed in safety dashboard

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

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

	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	
			Attendance records - summarised	100%	
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%	
		Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total		**100%**	
IEA6 Total				**100%**	
IEA7	**Q39**	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Information on maternal choice including choice for caesarean delivery.	100%	
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	
		Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total		**100%**	
	Q41	Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.	100%	included in monthly audit program and reviewed in safety dashboard
			CQC survey and associated action plans	100%	
			SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.	100%	

		Women must be enabled to participate equally in all decision-making processes Total		**100%**	
	Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	100%	included in monthly audit program and reviewed in safety dashboard
			SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	100%	
		Women's choices following a shared and informed decision-making process must be		**100%**	
	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%	
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%	
		Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total		**100%**	
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified	100%	
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	100%	Gap analysis complete - maternity website is currently being updated
			Information on maternal choice including choice for caesarean delivery.	100%	

			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	
		Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total		**100%**	
IEA7 Total				**100%**	
WF	**Q45**	Demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	100%	maternity staffing on risk register with associated mitigation & actions
			Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.	100%	
			Most recent BR+ report and board minutes agreeing to fund.	100%	
		Demonstrate an effective system of clinical workforce planning to the required standard Total		**100%**	
	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	Most recent BR+ report and board minutes agreeing to fund.	100%	
		Demonstrate an effective system of midwifery workforce planning to the required standard? Total		**100%**	
	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	100%	
		Director/Head of Midwifery is responsible and accountable to an executive director Total		**100%**	
	Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	Action plan where manifesto is not met	100%	
			Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	100%	

		Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: Total		**100%**
	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Audit to demonstrate all guidelines are in date.	100%
			Evidence of risk assessment where guidance is not implemented.	100%
			SOP in place for all guidelines with a demonstrable process for ongoing review.	100%
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total		**100%**
WF Total				**100%**