We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the [Ockenden Report](https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf) and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams.  Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the [ten Maternity incentive scheme safety actions](https://resolution.nhs.uk/wp-content/uploads/2020/02/Maternity-Incentive-Scheme-year-three-guidance.docx) where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the [technical guidance](https://resolution.nhs.uk/wp-content/uploads/2019/12/Maternity-Incentive-Scheme-Year-three.pdf).

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

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

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

| **Section 1** | | | |
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| **Immediate and Essential Action 1: Enhanced Safety**  Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.   * Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. * External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. * All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months | | | |
| **Link to Maternity Safety actions:**  **Action 1:** Are you using the [National Perinatal Mortality Review Tool](https://www.npeu.ox.ac.uk/pmrt) to review perinatal deaths to the required standard?  **Action 2:** Are you submitting data to the Maternity Services Dataset to the required standard?  **Action 10:** Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to [NHS Resolution's Early Notification scheme?](https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/) | | | |
| **Link to urgent clinical priorities:**   1. A plan to implement the Perinatal Clinical Quality Surveillance Model 2. All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to [HSIB](https://www.hsib.org.uk/maternity/what-we-investigate/) | | | |
| **What do we have in place currently to meet all requirements of IEA 1?** | | | Barts Health NHS Trust sits within the East London Local Maternity System (ELLMS) and works collaboratively with providers across the system.  As a group of five hospitals across East London, Barts Health NHS Trust serves 2.5 million people every year and we aim for each setting to be a centre of excellence and innovation providing safe and compassionate care.  It has maternity units based in each of three hospital sites which work under the group hospitals model. These hospital sites are Newham University Hospital, Royal London Hospital and Whipps Cross University Hospitals. Each maternity unit has an Associate Director of Midwifery (ADOM) working in close collaboration with a lead obstetrician.. All three ADOMs and all three lead obstetricians are members of ELLMS. In addition they are members of the Trust’s Perinatal Network Board, a forum which improves safety in maternity care by aiming to reduce variance between the three sites; its work includes commissioning guidelines, reviewing maternity dashboards, and discussing strategy. The Perinatal Network Board allows sharing of learning from national reports (e.g. NMPA, MBRRACE), the site based maternity units then implement actions from these reports to improve safety.  The Trust has an Adverse Incident policy that states the process for incident reporting and escalation at service, then at site level and subsequent escalation to the Trust executives. Where indicated, investigation is led in sites and final reports are approved by Trust executives for external sharing. Monthly serious incident learning summary slides are produced at site level and shared within the hospital and with Trust executives. Some (but currently not all) maternity serious incidents are shared within the ELLMS as an opportunity for system learning.  The Director of Midwifery presents maternity services learning quarterly within a Quality Dashboard to the Trust’s Quality Board which is chaired by the Group Chief Medical Officer or Chief Nursing Officer.  All perinatal deaths are reviewed using the national perinatal mortality review tool (PMRT). On each site, PMRT reviews are completed by a multi-disciplinary team. This includes the cross site consultant midwife for public health organising external reviews in collaboration with bereavement midwives. Families are involved in this process. External clinical specialist opinion is used as part of the PMRT process in cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death, and we reciprocate by offering Barts Health clinicians to act as external clinical opinion for other Trusts.  Every week site-based multidisciplinary case review meetings deep dive into all cases of the unexpected admissions to neonatal unit, stillbirths, neonatal deaths and other potential incidents. The team makes a decision on whether the case meets the criteria to be referred to the Healthcare Safety Investigation Branch (HSIB). The Trust continues to report all qualifying cases to HSIB.  Data submissions are being made by the Trust Informatics department in accordance with the national expected standard laid out in the Maternity Services Data Set (MSDS). The Director of Midwifery’s central team ensure the quality and completeness of the submission) and our compliance with on-going national plans to make improvements. The Digital Midwifery Team and the Trust Information services ensure that MSDS submissions are made in accordance with the requirements of Safety Action 2 of the Clinical Negligence Scheme for Trusts (CNST). |
| **Describe how we are using this measurement and reporting to drive improvement?** | | | The Trust conducts gap analyses against recommendations from MBRRACE-UK reports on Perinatal Surveillance and the Confidential Enquiries into Stillbirth and Neonatal Deaths as well as Saving Mothers’ Lives Report. We use this to improve mortality rates, reduction in HIE 3 as well as maternal morbidity.  We report 100% of qualifying cases to HSIB. There is a regular communication with the sister sites on progress of investigations. The Trust receives quarterly update from HSIB on themes and learning, and disseminates the learning to teams in order to improve safety.  The Board level Safety Champion is the Trust’s Chief Nursing Officer, and she leads a team of Maternity Safety Champions who report back to her so that she can receive assurance that safety plans and projects are having an impact on the ground. The Safety Champions in turn promote a safety culture, and assist the site maternity leadership teams to disseminate learning from incidents to multidisciplinary teams (this includes learning from all three Barts Health sites, plus learning from the rest of ELLMS).  There are audit midwives in post who continuously assess on-going improvement projects. There is an annual multidisciplinary audit programme comprising of seven individual meetings per site and three cross site meetings where learning is shared. |
| **How do we know that our improvement actions are effective and that we are learning at system and trust level?** | | | We know that improvement actions are effective by monitoring the recurrence of similar incidents at site, Trust (via Perinatal Network) and regional (ELLMS) level. Barts Health monitors performance against national Key Performance Indicators.  Dashboards comprising KPI that are benchmarked against national standards in each site are validated and shared externally via ELLMS.  Weekly assurance meetings across the three sites aim to identify themes or red flags.  Thematic analyses from PMRT are shared across the sites & ELLMS. |
| **What further action do we need to take?** | | | Barts Health needs to:   1. Adopt the Perinatal Clinical Surveillance Model (PCSM) and conduct regular self-assessment against the recommendations of this Inquiry report as well as against other maternity providers within north east London. 2. Implement a process to ensure that every maternity SI is shared with the LMS for scrutiny, oversight and transparency. Maternity SIs will be shared with the trust board via bi-monthly reporting through the Quality Assurance Committee. 3. Work with ELLMS to ensure that sharing of serious incidents and the learning is a regular item on agenda for ELLMS Board for scrutiny, oversight and transparency. |
| **Who and by when?** | | | The Chief Nursing Officer (CNO) / Director of Midwifery will present SIs to the Trust board.  The three ADOMs and the three lead obstetricians will ensure the learning slides from SIs will be shared with the LMS.  Maternity Leads of sites with oversight of the Perinatal Network will adopt and implement the PCSM |
| **What resource or support do we need?** | | | The Trust needs to   1. work with ELLMS to add SI shared learning as standing agenda item in meetings 2. Support a Regional Lead Obstetrician with dedicated consultant time to prepare LMS reports 3. Agree PA in job planning for a Lead Obstetrician on each site to adopt the PCSM. 4. Agree PA in job planning for a Lead Obstetrician on each site to lead on PMRT. |
| **How will mitigate risk in the short term?** | | | We have process and pathways to complete PMRT reviews timely  The CMO or CNO sign off all decisions regarding the management of serious incidents relating to maternity services. They also sign off all Maternity Serious Incidents before they leave the Trust.. All SI reports are summarised and shared across the Trust for cross site learning  All completed SI reports are shared with all staff members in the department via email and these reports are again shared at learning experience meetings. |
| **Immediate and essential action 2: Listening to Women and Families**  Maternity services must ensure that women and their families are listened to with their voices heard.   * Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. * The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. * Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions. | | | |
| **Link to Maternity Safety actions:**  **Action 1:**  **Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?**  **Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?**  **Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?** | | | |
| **Link to urgent clinical priorities:**   1. 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. 2. In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. | | | |
| **What do we have in place currently to meet all requirements of IEA 2?** | | | The Barts Health maternity services work in partnership with women and their families via our three Maternity Voice Partnerships (MVP). In addition, service user feedback is gathered via a number of routes: Friends and Family Test (FFT), the internal 100 Voices survey, Complaints and SIs. The CQC complete a yearly Picker Survey Patient Feedback. The ADOMS on each site attend a bi-weekly Women’s Experience Forum (WEF) to share updates on service provision and women have the opportunity to share their experience and provide feedback. Feedback is used to improve and influence care delivered by the maternity service.  Our MVPs are heavily involved in co-production of, and modification and introduction of new services into maternity at Barts Health. They also identify themes that inform service improvement and training, monitor and improve the number of women of continuity of carer (CoC) pathway. The trust is rigorous in ensuring that genuine changes to service planning and direction is made because of service user engagement and care co-production. Examples of this include our Birth Reflections Clinic where women who have had a traumatic birth meet with a Consultant Midwife and/or Obstetrician to discuss their care and to debrief and reflect on their birth experience. These clinics also provide another opportunity to elicit feedback from women about the service and they can be signposted to services like PALS if relevant. We have also responded to a growing national appetite for choice in maternity experience by developing a pathway to support women requesting a caesarean section without an obstetric or medical reason as well as a Birth Options clinic led by a consultant midwives and obstetricians.  During the COVID-19 pandemic there were multiple changes to services and as part of our recovery plans we held 8 recovery sessions looking at restoration of services. This involved managers, midwives, doctors, and those involved in maternity care contributing to restoration plans. The MVP attended each session to provide a woman’s perspective. From the ELLMS level, there are bi-weekly calls with MVP chairs and wider public to discuss issues such as changes to homebirth provision and visiting arrangements within the Maternity services. Part of this group is our service users and during the pandemic this has been invaluable to update women on changes to maternity care and in particular visiting times within the maternity unit. The project is greatly benefiting from their insight and experience as it seeks to improve service user experience.  There is an extensive network of support for vulnerable women including Maternity Mates, perinatal mental health teams and safeguarding teams. Mothers with a need for additional support, including those from minority ethnic or disadvantaged backgrounds are referred to the Maternity Mates Doula service. A Maternity Mate is a female volunteer trained by a third sector organisation (Womens Health and Family Services Charity) working with the Trust to provide practical and emotional support to women during pregnancy, childbirth and the early weeks of motherhood.  The Trust is looking forward to appointing an independent senior advocate for maternity services.  A non-executive director who has oversight of maternity services , Kathy McLean has been appointed recently. |
| **How will we evidence that we are meeting the requirements?** | | | We can evidence this by providing meeting minutes: minutes from monthly Women’s Experience Forum, (WEF), 100 Voices survey reports, complaints response evidence, FFT responses, recovery plan, patient experience feedback.  We monitor effectiveness by   1. No of PALS, FFT, Complaints received 2. User feedback – informal or formal |
| **How do we know that these roles are effective?** | | | If you are referring to the new roles of an independent senior advocate for maternity services and a non-executive director who has oversight of maternity services, we aim to monitor effectiveness using whatever national or regional frameworks are put in place. |
| **What further action do we need to take?** | | | 1. Appoint an independent senior advocate role which would report to both the Trust and LMS Boards; when guidance is produced by NHS England 2. Further strengthen our users feedback mechanisms to ensure the voices of all women are heard and responded to as the Trust provides care to over 100 ethnic groups. This is particularly important in response to the evidence showing that BAME women suffer poorer health outcomes. We are going to adopt a collaborative approach with MVPs and other service users as a Trust and as an LMS member. 3. Set up a Maternity Board that supports the work of the Perinatal Network and our Women and Newborn Clinical Board. It will be chaired by the Group Chief Nursing Officer and the Non-Executive Director responsible for maternity. It will thus provide a novel forum for the Maternity voice to be heard by Trust board members. It will provide further Trust level assurance of maternity services, and problem solving functions as an additional surveillance tool of the maternity service. The independent senior advocate will attend as a core member to provide women’s experiences of services. 4. Agree Terms of Reference and Membership of the Maternity Board 5. Ensure there is representation from service users in all key forums of the maternity service. |
| **Who and by when?** | | | Maternity leads (lead obstetricians and ADOMs) of each site, chairs of the Perinatal Network and Women & Newborn Clinical Board, Director of Midwifery, Chief Nursing Officer  Time table for implementation will be agreed by the Women & Newborn Clinical Board |
| **What resource or support do we need?** | | | To support the appointment of an independent senior advocate once NHS E has agreed on the role and function of the advocate role. |
| **How will we mitigate risk in the short term?** | | | Regular MVP involvement, alongside all the other service user engagement mechanisms mentioned will continue, as will the activity of the trust safety champions and their accountability to staff, the trust board and service users via the Safety dashboard. We will utilise the additional recommendations of this report and the CNST Year 3 updates to deepen and develop this work and to further diversify our service user engagement and safety culture.  We will continue to place a focus on equity including race equity. Colleagues in maternity services at Barts Health have significant roles in the RCOG Race Equity Taskforce, and this will allow early implementation of national strategies.  The maternity safety champion meetings need to be re-invigorated following this acute wave of the pandemic.  Monthly Performance Review meetings provide an opportunity for any safety concerns within the department to be escalated to the Executive teams. |
| **Immediate and essential action 3: Staff Training and Working Together**  Staff who work together must train together   * Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. * Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. * Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only. | | | |
| **Link to Maternity Safety actions:**  **Action 4:**  **Can you demonstrate an effective system of clinical workforce planning to the required standard?**  **Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?** | | | |
| **Link to urgent clinical priorities:**   1. Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. 2. The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place | | | |
| **What do we have in place currently to meet all requirements of IEA 3?** | | The Trust has 'in-house' PROMPT training. This training is attended by Obstetric doctors, Anaesthetic doctors, Midwives, Maternity critical care/HDU staff and Maternity Support workers. The content of training is based upon RCOG PROMPT, current evidence and national guidelines as well as shared learning from local systems and risk issues and the sharing of local maternity and neonatal outcomes. The Trust reviews its Maternity MDT training and publishes a Training Needs Analysis 3 yearly or as required to respond to national recommendations. The Trust will work with the ELLMS to develop a process for validation of MDT training and working.  Within the funded establishment there are three O&G Education Fellows jointly hosted with the Barts Health Education Academy who work with the Practice Development Midwife (PDM) to run multidisciplinary additional courses and training sessions. This includes in situ “live drills” on the delivery suite and other areas within the maternity units and hospitals. These live drills by their nature are multidisciplinary.  Topics of the month are also provided throughout the unit which arise from learning from serious incidents, investigations or local intelligence. An example was GAP/GROW week. These are discussed at multidisciplinary forum, e.g. morning and evening handover  We also conduct monthly fetal monitoring study days – some elements are done virtually due to Covid-19 pandemic. The study days are attended by both doctors and midwives. The teachers are both doctors and midwives. Ad hoc training is provided as required by the education teams as the need is identified (e.g. as a result of shared learning from incidents either as a group or 1:1 led by the PDM, obstetric lead and college tutor.All sites hold weekly cardiotocograph discussions and governance teachings. All ward rounds on all sites are multidisciplinary in nature, as are the handovers that precede them. The standard is for ward round attendance to include obstetric, midwifery and anaesthetic staff. The College Tutors and PDMs encourage a culture of multidisciplinary learning on ward rounds, so that teams learn together as well as working together.  All three maternity units have twice daily ward rounds in the morning and in the evening Monday to Friday. Two of the units (Royal London, Newham) have twice daily ward round in the morning and evening on Saturday and Sunday. At Whipps Cross however the resident labour ward consultant is on site 8am-1pm on Saturday and Sunday, so currently there is no evening consultant ward round..  All three units have rotas whereby on some (but not most) occasions the labour ward consultant is cross covering gynaecology. The Clinical Board is monitoring how gynae emergency cover impacts labour ward consultant delivered services.  On all sites consultants are available to attend to review patients, if there are any concerns escalated from the junior staff or complex patients.  The original Maternity Services Training fund was allocated towards maternity and neonatology projects in each of our sites. At the Royal London this involved human factors training. At Whipps Cross it involved neonatal simulation. At Newham it involved intermittent auscultation workshops. We have not since then received externally allocated funding for improving maternity safety. If new funding became available via the LDA (as happened the first time) we would work closely with the Education Academy to ensure that the money went towards training. | |
| **What are our monitoring mechanisms?** | | Maternity Services Department Multi-Disciplinary Training Needs Analysis and monitoring of staff groups trained is produced by site.  Our Practice Development Midwives and College Tutors keeps detailed and regularly updated databases of MDT training schedules for PROMPT and Newborn Life Support (NLS) training compliance and work closely with colleagues in the neonatal unit, anaesthetics, and obstetrics to monitor compliance.  Following the multi-professional system testing (live drills) in the clinical area the PDM team record the feedback and recommendations with any feedback, recommendations and learning and publicise these to the wider MDT team. A spread sheet is kept of these outcomes with Actions and Learning identified to allow for accountability with following up on this. A Training Report is submitted by the sites to the Perinatal Network & Trust Board as part of our compliance with CNST safety action 8. | |
| **Where will compliance with these requirements be reported?** | | .  Departmental compliance with mandatory training is reported as part of the monthly Divisional Performance pack.  Additionally we report the compliance of these requirements in the following forums:   * Quality and Safety Meeting * Women’s and Newborn Board * Perinatal Network * Site / Division Performance Review   CNST/NHS Resolution  Going forward we will report training compliance three monthly to ELLMS. | |
| **What further action do we need to take?** | | 1. Consider twice daily consultant led ward rounds 7 days a week morning and night at Whipps Cross, by team job planning and a potential business case for additional consultant PA.. 2. Develop an audit tool to check consultant attendance at twice daily ward rounds, and to check if these ward rounds are multidisciplinary learning experiences. 3. work with the ELLMS for external validation MDT training & working 4. Agree the external allocated funding for training is ring fenced for improving maternity safety. | |
| **Who and by when?** | | The Consultant Midwife for Education, Practice Development Midwives (PDM) and RCOG College tutors on all sites will work together via the Womens and Newborn Clinical Board to develop an updated MDT training programme within 2021  The divisional directors and divisional managers will be working with finance and the Director of Midwifery’s Central Team re appointing further consultants to fill necessary gaps in service, including consideration of twice daily ward rounds 7 days per week. | |
| **What resource or support do we need?** | | We are waiting for further published guidance with respect to how the Ockenden Report impacts the delivery of collocated obstetric and gynaecological services in the context of consultant job planning, which we expect from the RCOG. | |
| **How will we mitigate risk in the short term?** | | We have asked sites to consider an arrangement whereby a backup consultant can come in if the on call consultant is tied up with a gynae emergency.  At the Whipps Cross site, we have put in place a mandatory telephone check-in with the consultant on call following the evening handover on weekends.  To maintain maternity mandatory training and regional training sessions, we use a blended approach of face to face and virtual while the pandemic inhibits face to face teaching, plus in situ “live drills” sessions on the wards with clinical staff.  The Trust has also acquired the PROMPT online learning package and is planning to implement this soon.  Consultants are available to attend 24/7 for any complex patients or if the junior medical staff or midwifery team escalate concerns. | |
| **Immediate and essential action 4: Managing Complex Pregnancy**  There must be robust pathways in place for managing women with complex pregnancies  Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.   * Women with complex pregnancies must have a named consultant lead * Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team | | | |
| **Link to Maternity Safety Actions:**  **Action 6:**  **Can you demonstrate compliance with all five elements of the Saving Babies’ Lives care bundle Version 2?** | | | |
| **Link to urgent clinical priorities:**   1. All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. 2. Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres. | | | |
| **What do we have in place currently to meet all requirements of IEA 4?** | | | The organisation has engaged with ELLMS to agree the location of the maternal medicine hub as the Royal London Hospital and has established multidisciplinary links across East London and Essex including cardiac, renal, neurology and gastroenterology care at all Barts Health sites, Homerton and BHR.  All women booked for Maternity Services within Barts Health are risk assessed at antenatal booking, and if the pregnancy is deemed ‘complex’ get allocated to a named consultant. At the Royal London an antenatal vetting process is in place whereby all women flagged as high risk get a very rapid consultant remote opinion, followed by a care plan and appropriate consultant allocation. This is being rolled out across the Trust having been discussed in Perinatal Network. There are a series of high risk obstetric clinics on each site and established and robust pathways in place to provide rapid obstetric support and advice for women in the community on midwifery led pathways. This is not currently audited but will form part of our future cycles.  Teams at Barts Health strive to work collaboratively with women to achieve agreed care plans in pregnancy, and such plans are flexible over time as risk profiles can change in both directions over the course of a pregnancy. |
| **What are our monitoring mechanisms?** | | | Digital midwives serve as a safety net by checking all Maternity bookings to ensure that the women are placed on the correct care pathways by reviewing the digital maternity notes, blood results and East London Patient Record.  Full compliance with the SBLCV2 care bundle is a key priority for the trust and forms part of CNST requirements. Our achievements are monitored by an internal RAG rated gap analysis as well as by quarterly semi-qualitative self-assessments by NHS England. |
| **Where is this reported?** | | | Trust and LMS to agree on developing a reporting and scrutiny mechanism. |
| **What further action do we need to take?** | | | Trust needs to:   1. Use the Clinical Risk Assessment tool and use the audit of women with complexities referred to the correct consultant. 2. We need to develop local Antenatal Care guideline for Complex Care, acknowledging that ‘complex’ has not been defined nationally.   The organisation has committed to working together with ELLMS members on the next steps:   1. Formalising the appointment of a networked obstetric physician, obstetrician and midwife 2. Establishing care and referral pathways for women with complex medical problems before, during and after pregnancy 3. The integration of multidisciplinary education into medical problems in pregnancy across the network. 4. Develop a JD for a multiple pregnancy lead midwife. |
| **Who and by when?** | | | Lead obstetricians and ADOMs at site level and Perinatal Network. |
| **What resources or support do we need?** | | | In terms of the high risk obstetric clinics:   * Support to fund a cross site multiple pregnancy lead midwife to for this cohort of women. * Bridging funding for obstetric physician (in post, awaiting sector funding recently agreed) |
| **How will we mitigate risk in the short term?** | | | The following are the short term mitigating factors:   * Pathways in place for third trimester clinical risk assessment but requires assurance of effectiveness of the process. * Maternal medicine hub plans being developed. * Joint obstetric and medical clinics for complex specialities. * NICE guidance is the referred document in the absence of local guideline. * The specialist obstetric teams and dedicated specialist midwives will continue to provide care to women with complex pregnancies based on evidence based guidelines |
| **Immediate and essential action 5: Risk Assessment Throughout Pregnancy**  Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.   * All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional * Risk assessment must include on-going review of the intended place of birth, based on the developing clinical picture. | | | |
| **Link to Maternity Safety actions:**  **Action 6:**  **Can you demonstrate compliance with all five elements of the Saving Babies’ Lives care bundle Version 2?** | | | |
| **Link to urgent clinical priorities:**   1. A risk assessment must be completed and recorded at every contact. This must also include on-going review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance. | | | |
| **What do we have in place currently to meet all requirements of IEA 5?** | | | All women are risk assessed at the start of their pregnancy, with documentation of care plans within both hand held and electronic records at every encounter. A formal assessment is undertaken at 36 weeks to determine the pathway the woman will follow, including place of birth. There are also formal risk assessments undertaken when women present in labour, for induction of labour, and in maternity triage, to ensure timely transfer from midwifery led to obstetric lead pathways if necessary. There is no standardised risk assessment tool that is completed at every contact.  Trust uses the Perinatal Institute handheld Pregnancy notes which have a section for management plan at each visit. Although women are risk assessed at every appointment as part of the care received to enable subsequent plans to be made, recordkeeping of the risk assessment needs monitoring.  In terms of the Saving Babies Lives Care Bundle v2:   * Smoking – all women are asked about smoking at booking. Their CO levels are screened and they are referred for smoking cessation as necessary * Reduced fetal movements – all women are given a leaflet at booking advising them about fetal movements and they are asked about this at every clinical encounter. There is a cross site fetal movements care bundle for reduced fetal movements * Fetal Growth restriction – the trust uses the GAP/GROW protocol and a complementary trust wide “small for gestational age fetus” guideline to appropriately risk assess, treat (with an aspirin protocol) and mange women whose babies are at risk of FGR * Preterm birth –there is a well-established preterm birth clinic to risk assess and manage women who are at risk of preterm birth. Additionally there is a guideline for management of women presenting with threatened or actual preterm labour incorporating optimisation or women who may give birth early. This includes use of the QUiPP app, steroids, magnesium sulphate, tocolysis and in utero transfer to tertiary units as necessary * Fetal monitoring – this is considered in detail in IEA 7. |
| **What are our monitoring mechanisms and where are they reported?** | | | There is no standardised risk assessment tool completed at every contact. The risk assessments done in pregnancy are however audited at yearly documentation audit.  SBLCBV2 audits take place on all sites including smoking audits, preterm birth clinic audits, and GAP/GROW audits via the GAP/GROW midwife  The data is presented as part of the annual audit programme. |
| **Where is this reported?** | | | These are reported to:   * Within sites * Perinatal Network Clinical Effectiveness Unit (CEU) / Risk & Regulation Committee   Full compliance with the SBLV2 care bundle is a key priority for the trust and forms part of CNST requirements. Our achievements are monitored by an internal RAG rated gap analysis as well as by quarterly semi-qualitative self-assessments by NHS England. |
| **What further action do we need to take?** | | | All sites’ continuity of care (CoC) projects have been affected by the pandemic redeployment.  The Trust will develop a risk assessment process/tool and implement it once approved so that we can switch to risk assessing women at every encounter. |
| **Who and by when?** | | | The organisation will develop, implement and audit this process in 2021 |
| **What resources or support do we need?** | | | Funding to backfill staff while they are undergoing the training in using a new risk assessment tool.  Prioritise the group to be trained once the tool has been agreed.  Consider additional funding for admin support for audit teams.  Funded support for Quality Improvement activities. |
| **How will we mitigate risk in the short term?** | | | Women continually are being assessed; the challenge is to being able to evidence this.  Perinatal Institute notes have a section after each contact to detail if a management plan has been reviewed or revised, this is not explicitly a risk assessment but can serve as one. The current challenge is that record keeping is often electronic on Cerner Millenium because in the height of the pandemic Barts Health followed RCOG guidance and developed remote working in maternity.  Message of the week has been cascaded to staff about using the perinatal notes as part of the risk assessment process.  Consultant Midwives for Public Health will continue to monitor the progress of the SBLV2 care bundle and ensure it full implementation as well as working with all staff to ensure consistent risk assessment and care planning. |
| **Immediate and essential action 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.  The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -   * Improving the practice of monitoring fetal wellbeing – * Consolidating existing knowledge of monitoring fetal wellbeing – * Keeping abreast of developments in the field – * Raising the profile of fetal wellbeing monitoring – * Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported – * Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. * The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. * They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. • * The Leads must ensure that their maternity service is compliant with the recommendations of [Saving Babies Lives Care Bundle 2](https://www.england.nhs.uk/wp-content/uploads/2019/03/Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-Final-Version.pdf) and subsequent national guidelines. | | | |
| **Link to Maternity Safety actions:**  **Action 6:**  **Can you demonstrate compliance with all five elements of the Saving Babies’ Lives care bundle Version 2?**  **Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?** | | | |
| **Link to urgent clinical priorities:**   1. Implement the saving babies’ lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with [saving babies lives care bundle 2](https://www.england.nhs.uk/wp-content/uploads/2019/03/Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-Final-Version.pdf) and national guidelines. | | | |
| **What do we have in place currently to meet all requirements of IEA 6?** | | | Best practice training in the monitoring of fetal wellbeing is undertaken within all maternity services. Each site has a midwifery fetal wellbeing specialist midwife except Whipps Cross (where the practice development midwife covers these duties). Consultant obstetricians on all sites support fetal monitoring teaching and education without dedicated time in their job plans. All cases with CTG or fetal monitoring concerns are discussed at a multidisciplinary weekly risk meeting and escalated to the site risk meeting or for external (HSIB or other) review if necessary.  Going forward we will be required to ensure each site has a consultant who oversees the fetal wellbeing element of SBLCV2 to implement best practice, learning and support. Much of this work is already undertaken in consultants’ own time but needs to be identified and formalised in the review of job plans.  The Trust provides training in the form of: K2, CTG Masterclasses and annual CTG competency assessment (Compliance management SOP available).  The Trust has pathways and guidance in place to meet the standards within the SBLCV2.  Barts Health Maternity provides 'in-house' PROMPT training. This includes CTG training. |
| **How will we evidence that our leads are undertaking the role in full?** | | | There will need to be formal job descriptions detailing clear roles and responsibilities including maintenance of the 90% compliance with maternity emergencies training.  There will need to be logs of training sessions and evidence within annual appraisal that the leads are regularly maintaining and updating their skills  Job Descriptions (JD) for Fetal Monitoring Specialist Midwives are available. Consultant JD is being developed at present. |
| **What outcomes will we use to demonstrate that our processes are effective?** | | | We can provide evidence of   1. Annual audit programme of fetal monitoring and compliance with use of CTG interpretation & use of classification stickers & fetal heart rate auscultation. 2. CTG training compliance and assessment results. The proportion of eligible staff who have attended fetal monitoring sessions in the period of monitoring indicated by the CNST is closely monitored and despite the challenges posed to face-to-face training during the pandemic, training figures are expected to be >95% by the end of the financial year. 3. Reduction in antenatal and Intrapartum stillbirths, HIE 3 as well as reduction in legal claims for cerebral palsy. |
| **What further action do we need to take?** | | | Trust needs to ensure :   1. Improve compliance with “Fresh eyes” standard across the group. 2. Appoint Obstetric consultant leads for SBLCBv2 and dedicated PAs for fetal monitoring. 3. Appoint Fetal monitoring specialist midwife for WXH site. 4. develop a business case to implement the recommended an options appraisal for the K2 intrapartum package that includes centralised fetal monitoring |
| **Who and by when?** | | | Site divisional directors  Perinatal Network  College Tutors and Consultant Midwives for Education oversees the training compliance record. |
| **What resources or support do we need?** | | | Funding will be required for   1. Consultants’ PAs to lead on Fetal Monitoring and 2. PAs to lead on Growth Assessment Protocol (GAP) 3. Dedicated Fetal monitoring Specialist Midwife at WXH site. 4. Staff training and QI support to change of culture for hourly fresh eyes. 5. Funding to support the business case for centralised monitoring |
| **How will we mitigate risk in the short term?** | | | Practice Development Midwife (PDM) for WXH site is providing Fetal Monitoring training for WXH staff.  O&G consultants on all sites are providing training in their own time. |
| **Immediate and essential action 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.  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  Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care  Women’s choices following a shared and informed decision-making process must be respected | | | |
| **Link to Maternity Safety actions:**  **Action 7:**  **Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?** | | | |
| **Link to urgent clinical priorities:**   1. Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the [Chelsea and Westminster](https://www.chelwest.nhs.uk/services/maternity) website. | | | |
| **What do we have in place currently to meet all requirements of IEA 7?** | All women are given a booklets at booking that details what they can expect during their antenatal, Intrapartum and postnatal course. This includes information on place of birth. There are a large variety of different information leaflets available and offered to women to inform them about different aspects of their pregnancy journey. This may include routine information such as screening or reduced movements information, or leaflets available to women with specific pregnancy complications. A mixture of trust leaflets (for example postpartum contraception), site leaflets (for example induction of labour) and leaflets from national organisations (such as RCOG, FASP and the OAA) are used.  Working in partnership with women and their families via the MVP forms part of the trust’s compliance with the Clinical Negligence Scheme for Trusts (CNST). Service user feedback is gathered via a number of routes: Friends and Family Test (FFT), the internal 100 Voices survey, Maternity Voices Partnership, Complaints and SIs. The CQC complete a yearly Picker Survey Patient Feedback. The Associate Directors of Midwifery attend a bi-weekly Women’s Experience Forum (WEF) to share updates on service provision and women have the opportunity to share their experience and provide feedback. Feedback is used to improve and influence care delivered by the maternity service. See also IE 2 (above).  We have various other social media platforms which are monitored.  We offer Parent Education classes and infant feeding support to women. During the pandemic, the Trust has offered this virtually.  Consultant midwife and obstetric led Birth Options clinic are held for women requesting caesarean birth without obstetric indication where women are supported to make informed personalised choices.  They will be counselled regarding their individual risks in terms of mode of birth but will be supported in whatever birth plan they choose. They will be offered information from the RCOG to support these discussions  All women who have had one previous caesarean birth will be referred to the “Birth Options - VBAC clinic for an individualised discussion about the pros and cons of different birth choices for them. Their decision is supported.  Women who have had previous traumatic birth or who are requesting care outside of guidelines can be referred to a “Birth Choices” clinic for a personalised discussion with a consultant midwife and an individualised birth plan. Consultant obstetricians will be involved as required to support these birth plans.  The organisation is strengthening the process of creation of policies and guidelines to ensure that they are in a standardised format, are stored and accessible to relevant staff and specialities on the trust website, with an enhanced search function to ensure timely and easy access.  Patient Information Group of the trust provides the oversight and support for publications of information leaflets. Trust website is being redesigned to enable easier access to the patient information online. | | |
| **Where and how often do we report this?** | We monitor   * Birth Reflection & Birth Option clinics by our programme of clinical audit * Choice And Place of Birth is monitored by the Continuity of Care audit and these are reported to monthly Maternity Women’s Forum meeting. NHS E/I monitor the performance. * Perinatal Network monthly * Women’s Clinical Board monthly * Audit via Clinical Effectiveness Unit (CEU) / Risk & Regulation Committee * Trust Patient Information Review Group (PIRG) for patient information/leaflets | | |
| **How do we know that our processes are effective?** | We seek patient feedback at different stages of their pregnancy.  As part of certain quality improvement projects (QIP) patient feedback is sought. For example we did this in the induction of labour and postpartum contraception QIPs and developed patients specific information based on women’s feedback. We gathered stakeholder feedback on the induction of labour leaflet as they were developed.  MVPs are reviewing our website and associate literature. Patient information leaflets are reviewed by a dedicated group Patient Information Review Group (PIRG) in the trust to look at content, wording and language used. Patient representatives are part of this group.  Audit outcomes inform our service provision. | | |
| **What further action do we need to take?** | The Trust needs to   1. Improve and the ways it informs women pathways and display in Trust website. 2. Ensure inclusivity in its patient information provision – for example most of our leaflets are only available in English and we have a highly diverse population. We need to consider how we can make information available and accessible in other languages and to more vulnerable patients who either may not ask for or who may not be able to read the information we give them. 3. Ensure/facilitate the national leaflets need to be made available on our local website – such as “Where to have your baby”. 4. Informed consent ‘video’ for website has been written and will be uploaded in the near future; the options for birth e.g.: Antenatal and Postnatal booklets will be produced. 5. Formally implement Personalised Care Planning (PCP) function on Cerner via targeted education. | | |
| **Who and by when?** | The senior Midwifery and Obstetric Consultant team as well as the trust communications team, the digital midwives, and the Trust IT Division to ensure that pathways are in the correct format and that the trust website is delivering effective messaging of this to women. | | |
| **What resources or support do we need?** | Investment required to create a digital platform/tool, which enables the service to deliver the *Better Births* Digital strategy.  We would need translation support to widen the reach of our information e.g. Language on wheels.  We would also need tech / IT support if we were to consider producing information in different formats. We will need to link with the ELLMS (and more nationally) in working on the digital arm of Better Births in order to enhance our information giving and link this with electronic patient records | | |
| **How will we mitigate risk in the short term?** | Ensuring that staff maintain aware of the process of informed consent and that all patient facing material are exposed to the checks required by the patient information department such circulation amongst colleagues, distribution to service users for comment a check for appropriate language use, form and clear communication.  Hard copies of leaflets are provided at Booking and subsequent appointments.  Baby Buddy App available free to download for all women.  PCP plans will be available shortly. | | |

| **Section 2** | |
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| **MATERNITY WORKFORCE PLANNING** | |
| **Link to Maternity safety standards:**  **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard**  **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?** | |
| **We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.** | |
| **What process have we undertaken?** | Midwifery: Maternity Safe Staffing is reviewed yearly to ensurea safe and effective system of clinical andmidwifery workforce planning in accordance with the required standard outlined in Safety Actions 4 and 5 of the Clinical Negligence Scheme for trusts (CNST).  Midwifery staffing is reviewed biannually in line with our Nursing and Midwifery Safe staffing Policy\* \*\*. Birthrate Plus® (BR+) is the evidenced based tool used, this tool is recognised by NICE and the Royal College of Midwives. Our most recent BR+ audit was undertaken in 2018 with the final report published in January 2019. .  The outcome of the BR+ assessment and the changes needed as a result of this based upon the professional judgement of the Group Director of Midwifery and the Directors of Nursing in the formal the biannual \*safe staffing reviews. The midwifery staffing reports are presented to the trust board on a bi-annual basis by the Group Chief Nurse as part of the wider safe staffing reviews (the most recent was published in November 2020).  Medical: The service undertakes an annual job planning process that involves demand and capacity, service development and professional development requirements. For additional investment the service presents business cases during the annual business planning process.  The junior doctor rota is staffed with a mixture of GPVTS, deanery trainees and foundation trainees. Gaps in the rota are managed with the production of a Clinical Fellow rota, which has the benefit of providing professional development opportunities whilst providing for gap cover in the rota. The service also presents business cases for any additional FTE required¹.  *\**[*https://www.rcm.org.uk/media/2375/working-with-birthrate-plus.pdf*](https://www.rcm.org.uk/media/2375/working-with-birthrate-plus.pdf) *and*  *\*\*Kings Fund 2012: Safer Births; Maternity Toolkit; Improving Safety in Maternity Services. London*  ¹RCOG (2016) Providing Quality Care for Women. RCOG. <https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/ogworkforce.pdf> |
| **How have we assured that our plans are robust and realistic?** | Midwifery: To ensure realistic and robust maternity workforce planning, BR+ are commissioned to a complete an assessment of midwifery staffing against Trust birth rate and acuity. Following this a report is published of the findings of the assessment and the staffing level required to ensure the safety of services users.  This report clearly communicates the required establishment of midwifery staffing and communicates this in relation to actual midwifery staffing levels. It includes evidence of mitigation/escalation for managing a shortfall in staffing as well as an action plan to address the findings from BR+) where deficits in staffing levels have been identified.  The BR+) tool is used as the basis of the biannual safe staffing reviews between BR+ assessments noting any changes in local demand and complexity. Safe staffing reviews consider the data from the evidenced based tool alongside outcomes for services users, experience of service users and staff and professional judgement.  The recommendations of biannual safe staffing reviews are presented to the Trust Board and funded as part of business planning and budget setting processes. For example in 2020 the Trust Board agreed to develop a strategic approach to midwifery staffing across the group including the development of repatriation model and a maternity capacity model to enable flexible and effective use of resources in the face of changing demand.  Medical: For consultant workforce planning the service reviews activity data and business planning targets to establish workforce requirements according to RCOG standards¹. |
| **How will ensure oversight of progress against our plans going forwards?** | Midwifery: The BR+ and midwifery staffing ratios are monitored and reported on a monthly basis through the Divisional Performance Meeting, monitoring against the birth and bookings performance.  Oversight of safe staffing reviews is provided by Trust Board.  Medical: The service has to report on job planning progress and implementation and all job plans are uploaded to Zircadian. Oversight is from the Women and Newborn Clinical Board. |
| **What further action do we need to take?** | Midwifery: Our next BR+ audit will be commissioned t as part of our 2021 safe staffing review.  Trust will reassessed itself against the NHS Resolution CNST standards and revised as indicated to meet the updated expectations and timeframes for compliance with safety action 5. It is expected to be published in Spring 2021.  Medical: The investment in O&G consultant workforce beyond the current complement, reflecting the new and increasing workload of a modern obstetric team,. and a review of the junior medical workforce to reflect the increased requirements and consultant expansion. |
| **Who and by when?** | Group Director of Midwifery will commission the next Group BR+ assessment in Q1 2021/2022  Business planning and budget setting will be completed by March 2021 via Clinical Board |
| **What resources or support do we need?** | Commitment to fund additional roles:   * Multiple Pregnancy Specialist Midwives * Site based Quality Improvement Midwives to support PMRT and QI Projects * Fetal Monitoring Specialist Midwife for WXH site * Haemoglobinopathy counselling Midwife for WXH site * Additional two Obstetric Consultants for WXH site * Additional number of O&G consultants (TBD) at the Newham and Royal London sites * PAs for Dedicated Fetal Monitoring, GAP/GROW and LMS link Consultants on all sites * Administrative support for audit teams |
| **How will we mitigate risk in the short term?** | Agreement to increase staffing requirements with periods of activity/acuity. MDT continues to work within our limited resources. |
| **MIDWIFERY LEADERSHIP** | |
| Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care | |
| Each hospital has an Associate Director of Midwifery in post that is supported by a Deputy Head of Midwifery. The Associate Director of Midwifery works closely with the Triumvirate of Midwifery, General Management and Medical teams. The Associate Director of Midwifery reports to hospital sites Directors of Nursing and professionally reports to Group Director of Midwifery. These four directors have a dotted line professional relationship to the Group Chief Nurse who is a member of the Trust Board. They are line managed by the Hospital Chief Executives.  The Associate Directors are responsible for the strategic and operational elements of the maternity services as well as maintaining good governance and high standards of midwifery care in their hospital. | |
| **NICE GUIDANCE RELATED TO MATERNITY** | |
| **We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.** | |
| **What process do we have in place currently?** | NICE compliance is overseen by Clinical Effectiveness Unit.  The maternity guidelines are coordinated via the Perinatal Network. The chair of the Perinatal Network has created an up to date document detailing which guidelines need commissioning, which need updating and which can be archived. Guidelines are commissioned and ratified by the Perinatal Network before being put on the intranet.  Guidelines are commissioned based on local need and on updated national guidelines (as well as NICE: RCOG, BAPM, OAA).There is a nominal obstetrician and midwife on each site who work on producing or delegating the production of these guidelines. |
| **Where and how often do we report this?** | Management of Guideline is a standing item on the Perinatal Network agenda.  Twice a year the list of outstanding guidelines is scrutinised at Perinatal Network. |
| **What assurance do we have that all of our guidelines are clinically appropriate?** | Trust wide Clinical Guidelines Committee & Policy Group oversee all guidelines and policies to ensure they meet NICE and drugs and therapeutic safety standards. |
| **What further action do we need to take?** | **Formal allocation of 0.5 PA for an O&G Consultant at each site to support guideline development.** |
| **Who and by when?** | O&G Consultant job planning round will be completed in March 2021 |
| **What resources or support do we need?** | The Hospital leadership teams will need to   1. either allocate administrative support to the guideline lead or   Fund posts to support guideline development |
| **How will we mitigate risk in the short term?** | The obstetric leads and consultant midwives provide nominal oversight of the guidelines process for maternity until O&G consultant job planning is completed. A sustainable solution is being explored at present. |