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?** | **Describe how we are using this measurement and reporting to drive improvement?** | **How do we know that our improvement actions are effective and that we are learning at system and trust level?** | **What further action do we need to take?** | **Who and by when?** | **What resource or support do we need?** | **How will mitigate risk in the short term?** |
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| **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?** | **How will we evidence that we are meeting the requirements?** | **How do we know that these roles are effective?** | **What further action do we need to take?** | **Who and by when?** | **What resource or support do we need?** | **How will we mitigate risk in the short term?** |
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| **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?** | **What are our monitoring mechanisms?** | **Where will compliance with these requirements be reported?** | **What further action do we need to take?** | **Who and by when?** | **What resource or support do we need?** | **How will we mitigate risk in the short term?** |
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| **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?** | **What are our monitoring mechanisms?** | **Where is this reported?** | **What further action do we need to take?** | **Who and by when?** | **What resources or support do we need?** | **How will we mitigate risk in the short term?** |
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| **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 ongoing review of the intended place of birth, based on the developing clinical picture. | | | | | | |
| **Link to Maternity Safety actions:**  **Action 6:**  **Can you demonstrate compliance with all five elements of the Saving Babies’ Lives care bundle Version 2?** | | | | | | |
| **Link to urgent clinical priorities:**   1. A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance. | | | | | | |
| **What do we have in place currently to meet all requirements of IEA 5?** | **What are our monitoring mechanisms and where are they reported?** | **Where is this reported?** | **What further action do we need to take?** | **Who and by when?** | **What resources or support do we need?** | **How will we mitigate risk in the short term?** |
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| **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?** | **How will we evidence that our leads are undertaking the role in full?** | **What outcomes will we use to demonstrate that our processes are effective?** | **What further action do we need to take?** | **Who and by when?** | **What resources or support do we need?** | **How will we mitigate risk in the short term?** |
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| **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?** | **Where and how often do we report this?** | **How do we know that our processes are effective?** | **What further action do we need to take?** | **Who and by when?** | **What resources or support do we need?** | **How will we mitigate risk in the short term?** |
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| **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?** | **How have we assured that our plans are robust and realistic?** | **How will ensure oversight of progress against our plans going forwards?** | **What further action do we need to take?** | **Who and by when?** | **What resources or support do we need?** | **How will we mitigate risk in the short term?** |
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| | **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](https://www.rcm.org.uk/media/3527/strengthening-midwifery-leadership-a4-12pp_7-online-3.pdf) | | --- | |  | | | | | | | |
| **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?** | **Where and how often do we report this?** | **What assurance do we have that all of our guidelines are clinically appropriate?** | **What further action do we need to take?** | **Who and by when?** | **What resources or support do we need?** | **How will we mitigate risk in the short term?** |
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