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| Maternity services system learning |
| Maternity self-assessment tool |
| Version 6, 19 July 2021

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| Where updates have been made to the content of this document since the previous version was published (version 5, February 2020), they have been highlighted in yellow. |

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## Introduction

This Safety Self-assessment tool has been designed for NHS maternity services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the trust’s maternity quality improvement and safety plan and so keep the trust board and commissioners aware of their current position.

The tool has been developed in response to national review findings, and recommendations for good safety principles within maternity services. This version of the tool has been further influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme and the areas CQC found to be outstanding in other maternity services across England.

Please use this tool to as a benchmark for your organisation in the core principles of good safety standards within Maternity services.

## The tool

| 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 |  |  |
| Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes |  |  |
| **Director of Midwifery (DoM) in post****(current registered midwife with NMC)** | DoM job description and person specification clearly defined |  |  |
| Agenda for change banded at 8D or 9 |  |  |
| In post |  |  |
| **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 |  |  |
| Clinical director to executive medical director |  |  |
| DoM to executive director of nursing |  |  |
| General manager to executive chief operating officer |  |  |
| Maternity services standing item on trust board agenda as a minimum three- monthlyKey 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
 |  |  |
| Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model] |  |  |
| There should be a minimum of three PAs allocated to clinical director to execute their role |  |  |
| **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 |  |  |
| Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorateMonthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave |  |  |
| Adequate senior financial manager is in place to support clinical triumvirate and wider directorate |  |  |
| Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area |  |  |
| 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 |  |  |
| From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups |  |  |
| Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, eg senior midwifery leadership assembly |  |  |
| Leadership culture reflects the principles of the ‘7 Features of Safety’.  |
|  |  |  |  |
| **Leadership development opportunities** | Trust-wide leadership and development team in place  |  |  |
| Inhouse 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 |  |  |
| Organisational vision and values in place and known by all staff |  |  |
| 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]  |  |  |
| **Maternity strategy, vision and values** | Maternity strategy in place for a minimum of 3–5 years |  |  |
| 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 |  |  |
| Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups. |  |  |
| 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] |
| Maternity strategy aligned with trust board LMNS and MVP’s strategies  |  |  |
| Strategy shared with wider community, LMNS and all key stakeholders  |  |  |
| **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 |  |  |
| 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 |  |  |
| All Safety champions lead quality reviews, eg 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place) |  |  |
| Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services |  |  |
| **Multiprofessional team dynamics** | **Multiprofessional engagement workshops** | 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] |  |  |
| Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, ie quarterly audit days, strategy development, quality improvement plans |   |  |
| **Multiprofessional training programme** | Record of attendance by professional group and individual |  |  |
| Recorded in every staff member’s electronic learning and development record |  |  |
| 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  |  |  |
| A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority |  |  |
| All staff given time to undertake mandatory and job essential training as part of working hours |  |  |
| Full record of staff attendance for last three years |  |  |
| Record of planned staff attendance in current year |  |  |
| Clear policy for training needs analysis in place and in date for all staff groups |  |  |
| Compliance monitored against training needs policy and recorded on roster system or equivalent |  |  |
| Education and training compliance a standing agenda item of divisional governance and management meetings |  |  |
| 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] |  |  |
| **Clearly defined appraisal and professional revalidation plan for staf**f | Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal |  |  |
| All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation |  |  |
| Compliance with annual appraisal for every individual |  |  |
| Professional validation of all relevant staff supported by internal system and email alerts |  |  |
| Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities |  |  |
| **Multiprofessional clinical forums** | Schedule of clinical forums published annually, eg labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings |  |  |
| **Multiprofessional inclusion for recruitment and HR processes** | HR policies describe multiprofessional inclusion in all processes where applicable and appropriate, such as multiprofessional involvement in recruitment panels and focus groups |  |  |
| Organisational values-based recruitment in place |  |  |
| Multiprofessional inclusion in clinical and HR investigations, complaint and compliment procedures |  |  |
| Standard operating procedure provides guidance for multiprofessional debriefing sessions following clinical incidents or complaints |  |  |
| Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy |  |  |
| **Multiprofessional membership/ representation at Maternity Voices Partnership forums** | Schedule of attendance from multiprofessional group members available |  |  |
| Record of attendance available to demonstrate regular clinical and multiprofessional attendance. |  |  |
| Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design |  |  |
| **Collaborative multiprofessional input to service development and improvement**  | Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users |  |  |
| Roles and responsibilities in delivering the QIP clearly defined, ie senior responsible officer and delegated responsibility |  |  |
| Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP |  |  |
| Identification of the source of evidence to enable provision of assurance to all key stakeholders |  |  |
|  The organisation has robust repository for collation of all evidence, clearly catalogued and archived that’s has appropriate shared access  |  |  |
| Clear communication and engagement strategy for sharing with key staff groups |  |  |
| QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements |  |  |
| **Multiprofessional approach to positive safety culture** | Weekly/monthly scheduled multiprofessional safety incident review meetings  |  |  |
| Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS |  |  |
| Positive and constructive feedback communication in varying forms |  |  |
| Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach |  |  |
| 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] |  |  |
| **Clearly defined behavioural standards** | Schedule of focus for behavioural standards framework across the organisation |  |  |
| Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month |  |  |
| Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don’t become normalised. [7 steps] |  |  |
| **Governance infrastructure and ward-to-board accountability** | **System and process clearly defined and aligned with national standards** | All policies and procedures align with the trust’s board assurance framework (BAF) |  |  |
| Governance framework in place that supports and promotes proactive risk management and good governance |  |  |
| Staff across services can articulate the key principles (golden thread) of learning and safety |  |  |
| Staff describe a positive, supportive, safe learning culture |  |  |
| **Maternity governance structure within the directorate** | 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 |  |  |
| 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 leadsAudit midwifePractice development midwifeClinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support |  |  |
| Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member |  |  |
| Team capacity able to meet demand, eg risk register, and clinical investigations completed in expected timescales  |  |  |
| **Maternity-specific risk management strategy** | In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF |  |  |
| **Clear ward-to-board framework aligned to BAF** | Clearly defined in date trust wide BAF |  |  |
| Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board |  |  |
| **Proactive shared learning across directorate** | Mechanism in place for trust-wide learning to improve communications |  |  |
| Mechanism in place for specific maternity and neonatal learning to improve communication |  |  |
| Governance communication boards |  |  |
| Publicly visible quality and safety board’s outside each clinical area |  |  |
| Learning shared across local maternity system and regional networks |  |  |
| Engagement of external stakeholders in learning to improve, eg CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups |  |  |
| Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum. |  |  |
| **Application of national standards and guidance** | **Maternity specification in place for commissioned services** | Multi-agency input evident in the development of the maternity specification |  |  |
| Approved through relevant governance process |  |  |
| In date and reflective of local maternity system plan |  |  |
| **Application of CNST 10 safety actions** | Full compliance with all current 10 standards submitted |  |  |
| A SMART action plan in place if not fully compliant that is appropriately financially resourced. |  |  |
| 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 |  |  |
| **Clinical guidance in date and aligned to the national standards** | Clear process for multiprofessional, development, review and ratification of all clinical guidelines |  |  |
| Scheduled clinical guidance and standards multiprofessional meetings for a rolling 12 months programme. |  |  |
| All guidance NICE complaint where appropriate for commissioned services |  |  |
| All clinical guidance and quality standards reviewed and updated in compliance with NICE |  |  |
| **Saving Babies Lives care bundle implemented** | All five elements implemented in line with most updated version |  |  |
| SMART action plan in place identifying gaps and actions to achieve full implementation to national standards. |  |  |
| Trajectory for improvement to meet national ambition identified as part of maternity safety plan |  |  |
| Application of the four key action points to reduce inequality for BAME women and families  | All four key actions in place and consistently embedded |  |  |
| Application of equity strategy recommendations and identified within local equity strategy  |  |  |
|  |  |
| Implementation of 7 essential learning actions from the Ockenden first report | All actions implemented, embedded and sustainable |  |  |
|  Fetal Surveillance midwife appointed as a minimum 0.4 WTE  |  |  |
| Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs |  |  |
| **A-EQUIP implemented** | Plan in place for implementation and roll out of A-EQUIP |  |  |
| Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team |  |  |
| Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered |  |  |
| **Maternity bereavement services and support available** | Service provision and guidance aligned to national bereavement pathway and standards |  |  |
| Bereavement midwife in post |  |  |
| Information and support available 24/7 |  |  |
| Environment available to women consistent with recommendations and guidance from bereavement support groups and charities |  |  |
| **Quality improvement structure applied** | Quality improvement leads in place |  |  |
| Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation |  |  |
| Recognised and approved quality improvement tools and frameworks widely used to support services |  |  |
| Established quality improvement hub, virtual or otherwise |  |  |
| **MatNeoSip embedded in service delivery** | Listening into action or similar concept implemented across the trust |  |  |
| Continue to build on the work of the MatNeoSip culture survey outputs/findings. |  |  |
| **Maternity transformation programme (MTP) in place** | MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan |  |  |
|  |  |  |  |  |
| **Positive safety culture across the directorate and trust** | **Maternity safety improvement plan in place** | Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy) |  |  |
| Standing agenda item on key directorate meetings and trust committees |  |  |
| Human factors training lead in post |  |  |
| **Freedom to Speak Up (FTSU) guardians in post** | FTSU guardian in post, with time dedicated to the role |  |  |
| **Human factors training available** | Human factors training part of trust essential training requirements |  |  |
| Human factors training a key component of clinical skills drills  |  |  |
| Human factors a key area of focus in clinical investigations and formal complaint responses |  |  |
| Robust and embedded clinical handovers in all key clinical areas at every change of staff shift | Multiprofessional handover in place as a minimum to includeBoard 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.
 |  |  |
| Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern |  |  |
| **Safety huddles** |  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 |  |  |
| Guideline or standard operating procedure describing process and frequency in place and in date |  |  |
| Audit of compliance against above |  |  |
| **Trust wide Swartz rounds** | Annual schedule for Swartz rounds in place |  |  |
| Multiprofessional attendance recorded and supported as part of working time |  |  |
| Broad range of specialties leading sessions |  |  |
| **Trust-wide safety and learning events** | Trust-wide weekly patient safety summit led by medical director or executive chief nurse |  |  |
| Robust process for reporting back to divisions from safety summit |  |  |
| Annual or biannual trust-wide learning to improve events or patient safety conference forum |  |  |
| Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes |  |  |
| **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** | In date business plan in place |  |  |
| Meets annual planning guidance |  |  |
| Business plan supports and drives quality improvement and safety as key priority |  |  |
| 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 |  |  |
| Consultant job plans in place and meet service needs in relation to capacity and demand |  |  |
| 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 |  |  |
| Business plans ensures all developments and improvements meet national standards and guidance |  |  |
| Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas. |  |  |
| Business plans include dedicated time for clinicians leading on innovation, QI and Research |  |  |
| **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.**  | 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. |  |  |
| 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. |  |  |
| 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.  |  |  |

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| **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 |

## Key supporting documents and reading list

1. NHS England National Maternity review: Better Births. February 2016; <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>
2. Royal College of Obstetricians and Gynaecologists Maternity Standards 2016; <https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/maternitystandards.pdf>
3. NHS England NHS Long Term Plan: January 2019; <https://www.longtermplan.nhs.uk/>
4. Report of the Investigation into Morecambe Bay March 2015; <https://www.gov.uk/government/publications/morecambe-bay-investigation-report>
5. Royal College of Midwives. Birth-rate plus tools; <https://www.rcm.org.uk/media/2375/working-with-birthrate-plus.pdf>
6. Royal College of Midwives State of Maternity Services 2018; <https://www.rcm.org.uk/media/2373/state-of-maternity-services-report-2018-england.pdf>
7. NHS England. Spotlight on Maternity: Safer Maternity care. 2016; <https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/11/spotlight-on-maternity-guide.pdf>
8. Department of Health Safer Maternity care. The National Ambition. November 2017; <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560491/Safer_Maternity_Care_action_plan.pdf>
9. NHS Resolution. Maternity Incentivisation Scheme 2019/20; <https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/>
10. NHS staff survey. (2018); <https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/>
11. Maternity Picker Survey. 2019; <https://www.picker.org/wp-content/uploads/2014/10/Maternity-4-pager-for-website-ARe-V2-18122018.pdf>
12. National Maternity Perinatal Audit. (NMPA) report; <https://www.hqip.org.uk/resource/national-maternity-and-perinatal-audit-nmpa-clinical-report-2019/#.XdUiX2pLFPY>
13. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. (MBRACE) report; <https://www.npeu.ox.ac.uk/mbrrace-uk>
14. Organisations Monthly Maternity Dashboards; <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard>
15. Organisational Maternity and Neonatal Cultural Score Survey; <https://improvement.nhs.uk/documents/5039/Measuring_safety_culture_in_matneo_services_qi_1apr.pdf>
16. NHS England Saving babies lives Care bundle. V2 March 2019; <https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf>
17. 7 Features of safety in maternity services framework; <https://for-us-framework.carrd.co/>
18. Ockendon Report: investigation into maternity services at Shrewsbury and |Telford NHS hospitals 2020; <https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust>
19. Perinatal Surveillance Model; <https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf>
20. Maternity Incentive Scheme; <https://resolution.nhs.uk/wp-content/uploads/2021/03/Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf>