Annex to Board paper: progress on interim Ockenden report by Region and Trust

Data source:

- All Trusts have discussed progress with implementation of the actions as outlined in the interim Ockenden Report at their Trust public Board by 30th March 2022
- All Trusts have presented the most up to date data signed off by the Trust Executive and hence it is possible that the data in this report may not be the same as that discussed at their Trust Public Board
- No Trusts reported that they were 'non-compliant' against any clinical priorities
- Responses may appear as 'not applicable' if the Trust does not provide intrapartum care

North East and Yorkshire

		County Durham and Darlington NHS FT	Gateshead Health NHS FT	Newcastle Upon Tyne Hospitals NHS FT	North Cumbria Integrated Care NHS Foundation	North Tees and Hartlepool NHS FT	Northumbria Healthcare NHS FT	South Tees Hospitals NHS FT	South Tyneside and Sunderland NHS FT	Hull University Teaching Hospitals NHST	Northern Lincolnshire and Goole NHS FT	York & Scarborough Teaching Hospitals NHS FT	Barnsley Hospital	Doncaster and Bassetlaw	Rotherham Hospital	Sheffield Teaching Hospitals NHS FT	Airedale General Hospital	Bradford Teaching Hospitals	Calderdale and Huddersfield	Harrogate & District NHSFT	Mid Yorkshire Hospitals NHST	Leeds Teaching Hospitals
1) Enhanced Safety	A plan to implement the Perinatal Clinical Quality Surveillance Model	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
2) Listening to Women and their Families	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	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Partial	Compliant	Compliant
	Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Partial	Compliant	Compliant
3) Staff Training and working together	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	Confirmation that funding allocated for maternity staff training is ringfenced	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
4) Managing complex pregnancy	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Partial	Partial	Partial	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
5) Risk Assessment throughout pregnancy	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	Partial	Partial	Partial	Compliant	Compliant	Compliant	Compliant	Partial	Partial	Partial	Partial	Partial	Partial	Compliant	Partial	Compliant	Partial	Compliant	Compliant	Partial	Compliant
6) Monitoring Fetal Wellbeing	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 and national guidelines.	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
7) Informed Consent	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 website.	Partial	Partial	Compliant	Partial	Partial	Compliant	Compliant	Partial	Compliant	Compliant	Partial	Partial	Partial	Partial	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Partial

North West

		Blackpool Foundation Trust	East Lancashire Hospitals NHST	Lancashire Teaching Hospital NHSFT	University Hospitals of Morecombe Bay NHSFT	Bolton NHSFT	East Cheshire NHST	Manchester University NHSFT	Northern Care Alliance	Stockport NHSFT	Tameside & Glossop Integrated Care NHSFT	Wrightington, Wigan and Leigh NHSFT	Countess of Chester Hospital NHSFT	Liverpool Women's Hospital NHSFT	Mid-Cheshire Hospitals NHSFT	St Helen's & Knowsley Hospital NHSFT	Southport & Ormskirk Hospital NHSFT	Warrington & Halton Teaching Hospitals NHSFT	Wirral University Teaching Hospital NHSFT
1) Enhanced Safety	A plan to implement the Perinatal Clinical Quality Surveillance Model	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Compliant	Partial	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
2) Listening to Women and their Families	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	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
3) Staff Training and working together	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	Compliant	Compliant	Partial	Partial	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	Confirmation that funding allocated for maternity staff training is ringfenced	Compliant	Partial	Partial	Compliant	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
4) Managing complex pregnancy	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Compliant	Compliant	Partial	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Partial	Compliant	Compliant	Partial	Compliant	Partial
5) Risk Assessment throughout pregnancy	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	Compliant	Compliant	Partial	Compliant	Compliant	Partial	Compliant	Partial	Compliant	Compliant	Partial	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant
6) Monitoring Fetal Wellbeing	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 and national guidelines.	Compliant	Compliant	Compliant	Partial	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
7) Informed Consent	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 website.	Partial	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Partial	Compliant	Partial	Compliant	Partial	Compliant	Compliant	Compliant	Partial	Compliant	Compliant

Midlands

Area	Action	Birmingham Women's and Childrens NHS Foundation Trust	University Hospitals Birmingham	Dudley Group NHS FT	Royal Wolverhampton Hospitals NHS Trust	Sandwell and West Birmingham Hospitals NHS Trust	Walsall Healthcare NHST	George Eliot Hospital NHST	South Warwickshire NHSFT	University Hospitals Coventry & Warwickshire NHST	Chesterfield Royal Hospital NHSFT	University Hospitals of Derby and Burton NHSFT	Worcestershire Acute Hospitals NHST	Wye Valley NHST	University Hospitals of Leicester NHST	United Lincolnshire Hospitals NHST	Kettering General Hospital NHSFT	Northampton General Hospital NHST	Nottingham University Hospitals NHST	Sherwood Forest Hospitals NHSFT	Shrewsbury and Telford Hospital NHST	University Hospitals North Midlands
1) Enhanced Safety	A plan to implement the Perinatal Clinical Quality Surveillance Model	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
2) Listening to Women and their Families	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	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
3) Staff Training and working together	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant
	The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	Confirmation that funding allocated for maternity staff training is ringfenced	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
4) Managing complex pregnancy	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Partial	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant
5) Risk Assessment throughout pregnancy	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	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Partial	Partial	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Partial	Partial	Compliant	Compliant	Compliant
6) Monitoring Fetal Wellbeing	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 and national guidelines.	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant
7) Informed Consent	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 website.	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Partial	Partial	Compliant	Partial	Compliant	Compliant	Compliant	Partial	Compliant	Compliant

East of England

		Bedfordshire Hospitals Trust	Milton Keynes University Hospital	Cambridge University Hospital	North West Anglia NHS Foundation Trust	East & North Hertfordshire NHS Trust	The Princess Alexandra Hospital NHS Trust	West Hertfordshire NHS Trust	Mid & South Essex Hospitals Trust	Norfolk & Norwich University Hospital	James Paget University Hospital NHS Foundation Trust	The Queen Elizabeth Hospital Kings Lynn	East Suffolk & North Essex NHS Foundation Trust	West Suffolk NHS Foundation Trust
1) Enhanced Safety	A plan to implement the Perinatal Clinical Quality Surveillance Model	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Partial
	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
2) Listening to Women and their Families	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	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
3) Staff Training and working together	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Partial	Compliant	Compliant	Partial	Compliant	Compliant
	The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Partial
	Confirmation that funding allocated for maternity staff training is ringfenced	Compliant	Compliant	Compliant	Compliant	Partial	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
4) Managing complex pregnancy	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant
	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant
5) Risk Assessment throughout pregnancy	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	Partial	Compliant	Compliant	Compliant	Compliant	Partial	Partial	Partial	Compliant	Compliant	Partial	Compliant	Partial
6) Monitoring Fetal Wellbeing	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 and national guidelines.	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Partial	Compliant	Compliant	Compliant	Compliant
7) Informed Consent	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 website.	Partial	Partial	Compliant	Compliant	Partial	Partial	Partial	Partial	Partial	Compliant	Partial	Partial	Compliant

London

		Barking, Havering And Redbridge University Hospitals NHST	Barts Health NHST	Homerton University Hospital NHSFT	North Middlesex University Hospital NHST	Royal Free London NHSFT	University College London NHSFT	Whittington Health NHST	Chelsea and Westminster Hospitals NHSFT	Imperial Healthcare NHST	London North West University Healthcare NHST	The Hillingdon Hospitals NHSFT	Croydon Health Services NHST	Epsom And St Helier University Hospitals NHST	Kingston Hospital NHSFT	St George's University Hospitals NHSFT	Guy's and St Thomas'	King's College Hospital NHSFT	Lewisham and Greenwich NHST
1) Enhanced Safety	A plan to implement the Perinatal Clinical Quality Surveillance Model	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
2) Listening to Women and their Families	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	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
3) Staff Training and working together	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant
	Confirmation that funding allocated for maternity staff training is ringfenced	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
4) Managing complex pregnancy	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
5) Risk Assessment throughout pregnancy	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	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
6) Monitoring Fetal Wellbeing	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 and national guidelines.	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
7) Informed Consent	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 website.	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant

South East

		Buckinghamshire Healthcare NHST	Oxford University Hospitals NHSFT	Royal Berkshire NHSFT	Frimley Health NHSFT	University Hospital Southampton NHSFT	Hampshire Hospitals NHSFT	Isle Of Wight NHST	Portsmouth Hospitals NHST	Dartford And Gravesham NHST	Medway NHSFT	East Kent Hospitals University NHSFT	Maidstone And Tunbridge Wells NHST	Royal Surrey County Hospital NHSFT	Ashford And St Peter's Hospitals NHSFT	Surrey And Sussex Healthcare NHST	East Sussex Healthcare NHST	University Hospitals Sussex
1) Enhanced Safety	A plan to implement the Perinatal Clinical Quality Surveillance Model	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
2) Listening to Women and their Families	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	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
3) Staff Training and working together	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	Confirmation that funding allocated for maternity staff training is ringfenced	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
4) Managing complex pregnancy	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Partial
	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Partial	Compliant	Compliant	Compliant	Partial	Compliant	Compliant
5) Risk Assessment throughout pregnancy	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	Compliant	Partial	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Partial	Partial	Partial	Compliant	Compliant	Partial	Partial	Partial	Partial
6) Monitoring Fetal Wellbeing	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 and national guidelines.	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial
7) Informed Consent	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 website.	Compliant	Partial	Compliant	Compliant	Compliant	Partial	Compliant	Partial	Partial	Partial	Partial	Partial	Compliant	Partial	Compliant	Compliant	Partial

South West

		Great Western Hospital NHSFT	Royal United Hospitals Bath NHS FT	Salisbury NHSFT	Gloucestershire Hospitals NHSFT	Royal Cornwall Hospitals NHST	Dorset County Hospital NHSFT	University Hospital Dorset NHSFT	North Bristol NHST	University Hospitals Bristol NHSFT & Weston Area Health NHST	Taunton and Somerset NHSFT	Yeovil District Hospital NHSFT	Northern Devon Healthcare NHST	Royal Devon And Exeter NHSFT	Torbay and South Devon NHSFT	University Hospitals Plymouth NHST
1) Enhanced Safety	A plan to implement the Perinatal Clinical Quality Surveillance Model	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
2) Listening to Women and their Families	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	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Partial	Compliant	Compliant	Partial	Compliant
	Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
3) Staff Training and working together	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant
	The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
	Confirmation that funding allocated for maternity staff training is ringfenced	Compliant	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
4) Managing complex pregnancy	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Partial	Partial	Compliant	Partial	Partial	Partial	Compliant	Compliant	Compliant
	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
5) Risk Assessment throughout pregnancy	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	Partial	Partial	Partial	Partial	Compliant	Partial	Partial	Partial	Partial	Partial	Partial	Partial	Compliant	Partial	Compliant
6) Monitoring Fetal Wellbeing	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 and national guidelines.	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Partial	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
7) Informed Consent	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 website.	Compliant	Compliant	Compliant	Partial	Partial	Compliant	Partial	Partial	Compliant	Partial	Partial	Compliant	Partial	Compliant	Partial