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‘How to’ guide

A resource pack to support implementing the Core Competency Framework Version 2

The Maternity Transformation Programme has developed this resource pack to support trusts and clinical teams to plan and implement training for their maternity services in alignment with the Core Competency Framework Version 2.

31 May 2023

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1. Introduction

In collaboration with national maternity and neonatal partner organisations including the Royal Colleges; Health Education England, Neonatal Critical Care Clinical Reference Group (NCCCRG); Healthcare Safety Investigation Branch (HSIB); Nursing and Midwifery Council (NMC); NHS Resolution and clinical leaders, the Maternity Transformation Programme (MTP) published a Core Competency Framework (CCFv1) in December 2020 and subsequently version two of the Core Competency Framework in May 2023.

In collaboration with the national maternity and neonatal partner organisations the national maternity and neonatal team in NHS England have developed this "How To" Guide to enable trusts to meet the minimum standards in the refreshed CCFv2. This "How To" Guide will answer frequently asked questions and provide practical advice on the implementation of the Core Competency Framework v2.

The CCFv2 provides an opportunity to meet stretch targets which demonstrate a commitment to high quality training and ensure improved safety (see page 5). Each module includes stretch targets which are more challenging to achieve, giving trusts the incentive to be aspirational in their training programmes. The implementation of CCFv2 will be supported and regulated in accordance with Safety Action 8 of the Maternity Incentive Scheme (MIS) Year 5 within the Clinical Negligence Scheme for Trusts.

While most people using maternity and perinatal services are women, the CQC Maternity Survey (2022) found that 0.65% of respondents stated that their gender was not the same as their sex registered at birth. Intersex, transgender, and non-binary people experiencing pregnancy and birth can experience particular health inequalities including poorer access and a lack of information and support in relation to their specific clinical and care needs within maternity services. The information in this "How To" guide also applies to these individuals.

1.1 Why do we need a core competency framework (CCF)?

The CCFv2 sets out clear expectations for all trusts, aiming to address variation in training and competency assessment across England. It ensures that training to

address significant areas of harm are included as minimum core requirements and standardised for every maternity and neonatal service.

The CCFv2 assists local, multi-professional education teams and their leadership team, to plan and implement their training programmes with the confidence that they are meeting evidence-based recommendations. Teams and individual members of staff working in maternity units across England can use the CCFv2 to identify the skills and behaviours needed to deliver safe care. It empowers individuals to take professional responsibility and ownership for their own learning and development.

The CCFv2 has six core modules (so no new modules have been added to this iteration) and the bespoke module seven related to the COVID-19 pandemic has been removed. Module eight relating to training targeted at local learning is now an embedded expectation within every module.

Each of the six modules included in the CCFv2 cover priority areas identified through analysis of reports and recommendations into maternity services and outcomes.

The six core modules comprise:

1	Saving Babies Lives Care Bundle v3
2	Fetal monitoring and surveillance (in the antenatal and intrapartum period)
3	Maternity emergencies and multiprofessional training
4	Equality, equity, and personalised care
5	Care during labour and the immediate postnatal period
6	Neonatal life support

1.2 How have the six core modules been developed?

In 2018 the safety workstream of the MTP led a programme of work to address known variation in maternity training throughout England. Six core modules were agreed, based on a range of factors including frequency of reference within report recommendations, MTP policy initiatives, litigation burden and impact on families.

The development of these into a CCFv1 gave the ability to respond quickly to related recommendations made in the Ockenden Interim Report (2020) and the Health and Social Care Committee (HSCC 2021) report.

The CCFv2 also reflects the ethos and priorities of the Maternity Transformation Programme, focussing on ensuring maternity care is **personal and safe** and that the **service user voice** is fundamental to the training provided to staff. This ensures that the CCFv2 is an integral part of maternity improvement and illustrates how staff training is key to positive outcomes.

The principles on which the CCFv2 is based:

1. Service user involvement in developing and delivering training
2. Training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports. This should include reinforcing learning from what went well.
3. Promote learning as a multidisciplinary team
4. Promote shared learning across a Local Maternity and Neonatal System.

It is anticipated that the 'Avoiding Brain Injury in Childbirth' (ABC) initiative will become embedded within the CCFv.2. The **ABC** project aims to give **maternity** staff tools and support to be able to provide the highest quality of care when there are concerns about the baby's wellbeing during labour.

It also aims to improve communication with everyone using **maternity** services and make sure they are listened to and involved in decisions about their care (https://www.thiscovery.org/project/abc/). The project will be in the pilot stage later in 2023.

1.3 How does the Core Competency Framework align with other levers and incentives for maternity services?

The Three Year Delivery Plan for Maternity and Neonatal services sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. Version 2 of the CCF is a key part of this plan. It is designed to facilitate maternity services in achieving other requirements such as the Maternity Incentive Scheme (MIS), the essential actions

from the Ockenden Review (2022) and enhance the value of multidisciplinary team training as recommended in the Kirkup Report (2022).

Training requirements have also been informed by themes from national reports such as HSIB (2020), MBRRACE-UK (2022) and the Early Notification Scheme (2022), as well as programmes for improvement such as the Saving Babies Lives Care Bundle and the NHS Long Term Plan (2019).

2. Minimum standards and stretch targets

2.1 What are the minimum standards?

Developed in response to the Health Select Committee recommendation, the minimum standards are mandatory training requirements that all maternity staff in England must complete. All providers must implement them. Trusts will also be able to design their local training programmes to include other opportunities for multidisciplinary training and learning together as a team.

This should be based on learning from local incidents and reviews, or to reinforce good practice identified from clinical scenarios. A nationally standardised Training Needs Analysis (TNA) template has been developed to assist providers with this. The content can be adapted as training needs are likely to vary according to the priorities of individual maternity services (see page 12).

Striving for more opportunities to develop team-based learning will help establish shared purpose and improved team working.

The minimum standards supported by the TNA include:

- the proportion of staff who are required to attend
- the frequency of training
- the content of training.

2.2 What are the stretch targets?

Stretch targets are designed to be aspirational, enriching training offered within individual maternity units. Having a set of aspirational targets will create opportunities for training teams to be innovative and creative in their training programmes.

Stretch targets encourage trusts to ensure higher uptake in training and look more broadly at what should inform the content of training programmes. Shared learning across the Local Maternity and Neonatal Systems is encouraged as well as input from Maternity and Neonatal Voices Partnerships (MNVP). Co-produced and even co-delivered training with the MNVP will provide further opportunities for training programmes to be enriched by local learning and service user feedback. (See page 8 for ideas of how this may be achieved)

3. Implementation

3.1 What is expected from trusts when implementing the Core Competency Framework v2?

All trusts must have a local training plan using a Training Needs Analysis that includes the six core modules in the CCFv2. The training programme should run over three years. As the CCFv2 follows on from CCFv1, many trusts will be in year 2 of their training programmes from April 2023 and should review their programmes to encompass the additional requirements of CCFv2, republishing a new 3-year programme, but prioritising their final year for CCFv1 in the first year of CCFv2.

The frequency for each element of training, has been agreed by the national muti-organisational Core Competency Steering Group as minimum:

Module No.	Module Name	Frequency of training
1	Saving Babies Lives Care Bundle v3	Yearly
2	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	Yearly
3	Maternity emergencies and multiprofessional training	Yearly with 3-year programme of scenarios
4	Equality, equity, and personalised care	3-year programme
5	Care during labour and the immediate postnatal period	3-year programme
6	Neonatal life support	Yearly

3.2 How much time needs to be allocated to the Core Competency Framework v2?

Trusts should undertake a Training Needs Analysis (TNA) to consider mandatory training and additional training needs, alongside the requirements of the CCFv2 for each staff group. A nationally standardised TNA has been developed; using this TNA will ensure that all training is considered and is uniformly planned. Programmes may consist of face-to-face training as well as utilising e-learning resources.

It is acknowledged that high quality training requires resources and time. It is estimated that to deliver this for the CCFv2 it will require an average of 5 days of training time annually, with the number of days required for each individual staff member dependent on their role. Once completed, the TNA provides each maternity unit with the required number of hours and days needed to comply with the requirements of the CCFv2 each year.

It is important that training is of a high quality, is beneficial to staff in their day-to-day practice, and improves outcomes. While the proportion of staff who undertake the training is an important metric, it does not give assurances for quality. Trusts must seek to ensure that the training provided is effective in improving safety and staff knowledge. Qualitative feedback should be sought from staff following training sessions as well as evidencing that learning outcomes have been met.

3.3 What does shared learning across a Local Maternity and Neonatal System (LMNS) look like?

This can take several different forms:

- It could mean that partner trusts within one LMNS join for training. This could be particularly useful where liaison between trusts is required, for example when co-ordinating preterm birth.
- It could involve sharing learning from incidents, or positive examples between trusts or with a buddy LMNS. This may be particularly useful for smaller trusts or for issues that occur rarely.
- It may be particularly appropriate for certain staff groups to visit other trusts for training. For example, labour ward leaders or specialist services such as

fetal monitoring specialists, will learn from each other and share best practice, providing an opportunity for independent observation and feedback of training offered, which can then help to inform their local unit training.

- It may give an opportunity for independent observation and quality assurance of training offered, facilitating feedback and improvement ideas.
- A local multi-professional improvement network or forum could be established to share learning across the LMNS. This may include learning from significant events, developing strategies to reduce harm across the system and a chance for informal networking and collaboration for all grades of staff.
- Another example is coproduction of guidelines or improvement initiatives which can be shared across the LMNS and with buddy LMNSs.

3.4 How do trusts involve the Maternity and Neonatal Voices Partnership (MNVP) in training programmes?

It is recommended that early and continued engagement with the MNVP enables learning to be co-designed. Using local examples in clinical incidents, complaints, and service user feedback, provides an opportunity for clinical and non-clinical staff to appreciate how their words and actions can make people feel and impact outcomes. These can be used to inform training where gaps are identified, develop case studies to share and highlight positive practice.

Involving members of the MNVP in the co-designing of training programmes and the delivery of educational activity can be hugely impactful. Members of the MNVP may wish to be involved in scenario training as well as be given the opportunity to feedback on the quality of training and provide reflections for improvement.

Ensuring the service user voice is embedded in training will create opportunities for staff to reflect on how their actions can affect service users, can provide focus on what requires improving locally and facilitate further collaboration. This is particularly beneficial for training related to informed consent, personalisation, and choice, as well as in emergency situations.

The CCFv2 encourages trusts to be innovative in their training delivery and demonstrates where the use of the service user voice can be emphasised, within case studies or leading discussions directly.

Example of good practice

At **The Royal Cornwall Hospital Trust,** the Maternity Voices Partnership co-designed the Personalised Care and Support Plan (PCSP) and delivered face to face training with Midwives, Doctors, and Maternity Support Workers. Practical examples of how to use the PCSP were given from a service user perspective. Examples from complaints were also used to demonstrate how the PCSP could have avoided miscommunication and ensured the service user felt heard.

Training on the use of the PCSP has now been integrated into mandatory training sessions for “Informed Consent” and delivered by a Consultant Obstetrician, Practice Development Midwife and the MNVP Chair. Feedback and discussion points from staff are collected during and after the session. Sessions have been described as “powerful,” “impactful” and “thought-provoking.” Discussions have included topics such as language used, bias, and documentation.

At **Southampton General Hospital** the maternity and theatre team have implemented a quality improvement initiative to impact on service user experiences when undergoing a General Anaesthetic Caesarean Section birth. With a strong service user voice to co-design materials and deliver training, the team have embedded personalised booklets that provide women with information and pictures of their births while they were asleep.

The initiative has supported multidisciplinary team working and a shared purpose as well as opportunities to develop the theatre culture for women with the service user at the centre of improvements.

3.5 How can trusts ensure locally tailored learning, informs training?

Trust specific local learning needs should be identified from clinical incidents, birth reflection services, complaints and feedback received from service users and staff. This may require the local learning to be included in more than one training module of the CCFv.2 or may provide scope for combining teaching sessions and allowing for innovative educational opportunities.

In addition, training gaps should be considered when learning from local and national investigations and audits. Planning training around these elements will allow training to be locally responsive and focused on areas where staff require additional support.

Developing training that is tailored and relevant to different staff group needs, will enrich, and personalise learning experiences, ensuring bespoke learning objectives and outcomes are met. For example, point of care training for home births with community multidisciplinary teams or training for the perinatal team implementing the preterm optimisation bundle.

The questions below may provide a useful framework to inform your local training plans. It is recommended that your local multi-professional education team consider them **annually**. Trusts can devise their own methods to evidence this within a local learning needs analysis framework for example. This list of questions is not exhaustive but designed to encourage thought and innovation.

- Have any local guidelines, policies or pathways changed and what has been the motivation for this i.e, new fetal monitoring equipment; optimisation of premature infant bundle of care; personalised care and support plans?
- Using your local dashboard, are there any areas that have flagged with trends indicating a decline in outcomes?
- Have there been any “learning from excellence” examples that illustrated the positive impact of training or where excellent multidisciplinary teamwork was demonstrated?
- Consulting with members of your local Maternity and Neonatal Voices Partnership and governance teams, are there any recurring themes from service user feedback or complaints that indicate a training gap?
- Have any themes emerged from incident reports, audits, ATAIN reviews, or the Perinatal Mortality Reporting Tool (PMRT)?
- Are there any training recommendations from local or national HSIB investigations or other national publications such as the Early Notification Scheme?
- Using the National Maternity & Perinatal Audit Results and Maternity Data Set are there any areas where your trust are outliers? For example, a high

"Smoking at Time of Delivery" rate (SATOD) may lead you to look at the training offered for smoke-free pregnancy.

- Considering the trusts results from the Care Quality Commission (CQC) and the CQC maternity survey, can you identify any areas where improvement is needed?
- Has there been any MNVP surveys or "15 Steps" reports submitted to inform improvement recommendations which identify training requirements?
- Have you conducted any evaluation on your training programmes where staff have identified gaps in training or where improvements are required that can inform your future training programmes?
- Has there been any service user experiences where the woman(or MNVP advocate) would like to be involved in sharing their story in person or through case studies? For example, including the service user perspective during obstetric emergency training will ensure a woman-centred approach.

4. Resources

4.1 Future NHS Platform

There is a Future NHS platform that has been created to share resources and learning nationally (Core Competency Framework Version 2 (CCFv2) - FutureNHS Collaboration Platform). This incorporates e-learning resources and a network for those designing and delivering training in maternity services.

4.2 Training Needs Analysis (TNA)

What is the purpose of a TNA?

A **Training Needs Analysis** is a process to identify the gap between the actual and the desired knowledge, skills and attitudes in each job or service. There are three primary drivers:

- Insight
  - drawing insight from multiple sources of information including policy and national recommendations
- Involvement

  - to give staff the skills and support they need
- Improvements
  - to increase quality and safety in key areas by improving design, planning and provision of robust training and education to all maternity staff.

A **Training Plan** is a detailed record of training that will be provided within a given time frame to specific groups of people to bridge the gaps identified within the training needs analysis.

Every trust is required to evidence a training programme which encompasses a **TNA** and **training plan**. The MTP has developed a nationally standardised document using Excel.

For ease of explanation the document produced by the MTP will be known as a TNA and can function as both. It can be localised and developed to meet local training needs, based on the actual headcount of staff across a maternity unit not the whole-time equivalent count, therefore giving a practical representation of the number of hours required, and the estimated cost.

It has been agreed that five days annually is required, as an average, to deliver the CCFv2 and can be tailored dependent on discipline. This will be used as a guide by trusts to plan in training and assign funding. Trusts should identify ringfenced funding for maternity training as a proportion of their maternity budget.

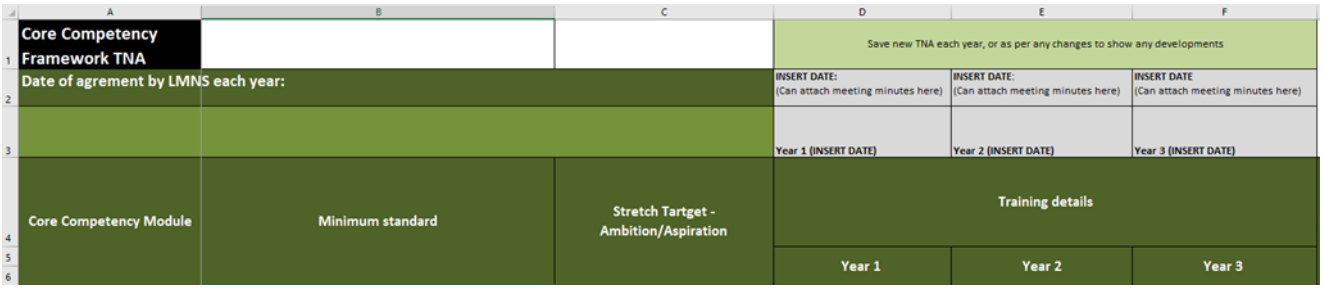
The purpose of the national TNA is to formally document the training required for staff to complete their jobs safely and competently and to support planning. A TNA helps to ensure the safety of a maternity unit. It mandates what training staff are required to do and can be cited in relevant policies or guidelines. It can be formally named in the trust or maternity training policy to ensure all staff are compliant.

This TNA has been pre-populated in response to the training requirements of the CCFv2. There will be other mandatory and non-mandatory training requirements for trusts, therefore this TNA should be used in conjunction with a local TNA which details these.

A named lead within the education team can complete the TNA. It should then go through a local governance process to ensure all the multidisciplinary teams are satisfied the content meets the requirements of the CCFv2. The Local Maternity and Neonatal System (LMNS) board must agree the TNA. Row two, Column D, E, and F can be used to document the date which this occurred, and any minutes can be attached as evidence (Figure 1).

This document can be used as evidence of a trust's training programme by LMNS; MIS; CQC; Staff, Trust Boards and referenced within local policies and guidelines. Strengthening trust-level oversight for quality in training also responds to the Perinatal Quality Surveillance Model Principle one.

Figure 1



	A	B	C	D	E	F
1	Core Competency Framework TNA			Save new TNA each year, or as per any changes to show any developments		
2	Date of agrement by LMNS each year:			INSERT DATE: (Can attach meeting minutes here)	INSERT DATE: (Can attach meeting minutes here)	INSERT DATE (Can attach meeting minutes here)
3				Year 1 (INSERT DATE)	Year 2 (INSERT DATE)	Year 3 (INSERT DATE)
4	Core Competency Module	Minimum standard	Stretch Tartget - Ambition/Aspiration	Training details		
5						
6				Year 1	Year 2	Year 3

How do trusts use the Training Needs Analysis excel spreadsheet?

The spreadsheet has been designed according to the Core Competency Framework v.2 modules. The minimum standards and stretch targets are detailed for trusts to benchmark and plan their programmes over three years.

Tip: Any grey boxes can be used by the trust to document supporting evidence local to the trust. All boxes which are in a colour should not be altered, as this information will not change and is mandatory.

Trust to complete

To Unlock the spreadsheets: You can alter the information cells that your trust may wish to input. However, to preserve the spreadsheet calculations and documentation which are not required to be changed, the spreadsheet is locked. If you wish to change any of this information for any reason you will need to unlock the spreadsheet or the tables. To do this go to "**Review***", "***Unprotect sheet**;" *and* **"Enter password"** which is in capitals **CCF**.

Spreadsheet Tab 1: Core Competency 3-year plan

Row 1 Column B and C Here you can see the links to the "How to" Guide and the Core Competency Framework v.2. Use these links to be directed to these documents.

Row 2 Insert hyperlinks to help to evidence any external work. For example, use this to evidence meeting minutes and/or presentations used to evidence TNA to the LMNS. To do this right click on the cell for either year 1,2, or 3 and click LINK. You can then attach the correct link so these can be referred to at any point.

Row 3 Column D, E, and F should be used to insert the start date of each year training plan.

Spread sheet Tab 1: Core Competency Framework 3-year plan. Column specific information (See Figure 2)

Figure 2

Column	Details
Column A:	• Shows the 6 Core Modules: as you move along the columns this column will stay still so it makes it easy to see what module you are referring to. • The dark green, and numbered modules are the 6 core modules, the lighter green shows the 6 elements involved in module 1 for saving babies lives v3.
Column B:	• Shows the minimum standards exactly as described in the CCFv2
Column C:	• Shows the stretch targets exactly as described in the CCFv2
Column D, E, F:	• Are used to evidence and plan your 3-year training programme. Use the boxes underneath to describe your trusts training plans. This is broken down into sections A and B A) Can be used to describe the training plan and should be mapped out for all 3 years to ensure all topics are completed B) Can be used on a yearly basis as an area to document your evidence local learning. MRN numbers, HSIB case numbers, Audit numbers or Datix numbers can be used here to evidence what local learning has been applied. • This space is free text so can be used to add as much detail as stakeholders may wish.
Column G:	• Use this space to document the monitoring system/s you are using to assess compliance with that module
Column H:	• Shows trust compliance. This can be used to demonstrate the overall compliance. If no number is entered the box will stay grey. As you enter a compliance percentage it will RAG rate this number, this has been set to under 70% = Red, 70-89%= Amber, 90-94%= Green, 95% and over = Shaded green. • You can use this immediately to see areas which may require more support.
Column I:	• Use this column to write down any action plans, or mitigation which you have. This can be either to meet the minimum standards or to meet the stretch targets. You can attach a file or document to this section of the spreadsheet if it is separate. To do this right click on the cell and click LINK. You can then attach the

	correct link so these can be referred to at any point and stops repetition of documents.
Columns J, L, N, P, R	• These columns are used to put a yes (Y) or no (N) to demonstrate if this staff group will be attending the training. (These have been pre-populated as a recommendation) • Trusts are encouraged to be responsive and flexible when developing their training programmes.
Columns K, M, O, Q, S	• These columns do not need to be changed; the numbers will show once spread sheet 2 has been completed. • These columns show how many whole-time equivalent (WTE) are needed to back fill this training and how much this will cost based on Mid-point salary. • This information can be used as required to help support your training.

Spread Sheet Tab 2. Expenditure input data

This tab calculates what the required expenditure would be for individual trusts to implement the Core Competency Framework V.2. Figure 3 explains the purpose of each table.

Tip: All the information required for trusts to enter will be on the lighter coloured squares/cells. The information entered will aid calculations for the total cost to train a staff group based on headcount; and will then calculate and display how many whole-time equivalent staff would be required to backfill the total headcount of a unit. All darker coloured boxes are locked and do not need to be altered.

Figure 3

Table number	Details
Table 1 (department inputs)	Enter your total number of staff you need to train for each staff group (**head count**), and the mid-point salary for that staff group (this will change slightly each year and has been populated for the national 2023-24 salary)
Table 2 (department outputs)	This table shows the total annual cost for each staff group to complete all the training. It also shows the total whole-time equivalent which would be required for back fill, and the total amount of hours the training will take for each staff discipline.
Table 3 (individual module data)	Input the locally decided training time in hours to this column (C). You can then see the outputs for total cost and total WTE. This is calculated as an annual sum. All the training hours required, including both e-learning and face to face hours should be added together and input as one total number of

	hours. (This is the case for any types of blended learning). For example, 15 mins would be input as 0.25.

Spread Sheet Tab 3.

Please note this spread sheet works the same as spread sheet two, however the data can be used and input for neonatal staff.

4.3 Evidence

The Recommendations Register and its associated User Guide supports the evidence base for the second version of the Core Competency Framework.

5. Summary

This 'How To' Guide has been developed by the Maternity Transformation Programme, NHS England, to support the use of the Core Competency Framework v.2 and the Training Needs Analysis tool. It is advisable that training programmes are planned as a multidisciplinary training faculty, which is inclusive of service user representation.

Consulting with trust quality improvement teams can support a quality improvement methodology to embed the new framework and ensure sustainability. Identifying local themes in response to clinical incidents; complaints and service user feedback will ensure local learning is highly relevant in addressing any knowledge gaps and training requirements.

Having a national standardised CCFv.2 will support trusts in addressing variation of content and quality of education for front line staff. It should be clear and transparent what education and training needs have been identified, what is priority, what each person is required to achieve, and how they can achieve it over the year.

Ensuring adequate promotion of the education on offer from your service will not only be relevant for staff, but also reassure service users that they will benefit from a more highly trained local workforce.

There should be clear governance arrangements for service oversight, sign-off and monitoring of progress, evaluation, and compliance. This needs to be at system level as well as by maternity services and trust boards, and in line with the Perinatal Quality Surveillance Model. There should be a clear process to escalate concerns and support made available to make improvements.

We have created this “How To” Guide to support everyone involved in leading or providing maternity services education and training to complete a robust training needs analysis for their service, and ultimately to make care safer, more personalised, and more equitable for women, babies, and their families.

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This publication can be made available in a number of alternative formats on request.

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