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Core competency framework Version 2: Minimum standards and stretch targets

In collaboration with national maternity and neonatal partner organisations, the Maternity Transformation Programme (MTP) published a Core Competency Framework (CCFv1) in December 2020. This first version has been updated and replaced by the Core Competency Framework Version 2.

The CCFv2 sets out clear expectations for all trusts, aiming to address known 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.

31 May 2023

Contents

Module 1: Saving babies' lives care bundle (SBLCB)

Requirements for this module have been aligned to the third version of the Saving Babies Lives Care Bundle.

Minimum standard

- 90% attendance – annually for each element with eLfH module every three years.
- Training must include learning from incidents, service user feedback and local learning.
- Training must include local guidelines and care pathways.
- e-Learning can be appropriate for some elements.
- Learning must be responsive to local clinical incidents and service user feedback.

Stretch target – ambition/aspiration

- ≥95% attendance.
- Shared learning from incidents across LMS and Buddy LMNS relating to morbidity and mortality.
- Benchmarking against other organisations with a similar clinical profile, and national programmes.
- Staff evaluation on quality of training in place with evidence of improvement.
- Service users share their experiences as part of training day.
- Use of positive case examples to learn from.
- Training to be tailored to role and place of work for each element.

1.1 Smoking in pregnancy

Minimum standard

Training must include:

- all multidisciplinary staff trained to deliver Very Brief Advice to women and their partners NCSCT e-learning
- local opt-out pathways/protocols, advice to give to women and actions to be taken.

- CO monitoring and discussion of result.
- individuals delivering tobacco dependence treatment interventions should be fully trained to NCSCT standards

Stretch target – ambition/aspiration

- Smoke-free advisors have evidence-based behavioural training (i.e CBT/Risk perception)
- Use of service user case study.
- Every Contact Counts training.
- Evidence of Specialist smoke-free advisors sharing briefings and national publications, i.e Maternal and Neonatal Health Safety Collaborative. Action on Smoking and Health (ASH) briefings for Integrated Care Systems

1.2 Fetal growth restriction

Minimum standard

Training must include:

- local referral pathways, identification of risk factors and actions to be taken.
- evidence of learning from local Trust detection rates and actions implemented.
- symphysis fundal height measuring, plotting, and interpreting results practical training and assessment, and case reviews from examples of missed cases locally.

Stretch target – ambition/aspiration

- Use of service user case study.
- Review of trust's detection rates, compared to other similar organisations and national data.
- Audit of compliance against training action plan developed as a result of incidents related to fetal growth restriction.

1.3 Reduced fetal movements

Minimum standard

Training must include:

- local pathways/protocols, and advice to give to women and actions to be taken.

- evidence of learning from case histories, service user feedback, complaints, and local audits.

Stretch target – ambition/aspiration

- Use of service user case study.
- Audit of compliance against training action plan developed as a result of incidents related to fetal movements.

1.4 Fetal monitoring in labour

See Module 2.

1.5 Preterm birth

Minimum standard

Training must include:

- identification of risk factors and local referral pathways
- all elements in alignment with the BAPM/MatNeoSIP optimisation and stabilisation of the preterm infant pathway of care.
- a team-based, shared approach to implementation as per local unit policy.
- risk assessment and management in multiple pregnancy.

Stretch target – ambition/aspiration

- Evidence of impact using the improvement strategies to optimise preterm birth outcomes.
- Use of clinical simulations.
- Review of outcomes in relation to multiple births and identified improvement(s).
- Use of service user case study.

1.6 Diabetes in pregnancy

Minimum standard

Training must include:

- identification of risk factors and actions to be taken.
- referral through local multidisciplinary pathways including Maternal Medicine Networks and escalation to endocrinology teams.
- Intensified focus on glucose management in line with NHS Long Term Plan and NICE guidance, including continuous glucose monitoring.

- Care of the diabetic woman in labour

Stretch target – ambition/aspiration

- Learning from local and national case reviews are disseminated.
- Use of service user case study with diabetes in pregnancy.

Module 2: Fetal monitoring and surveillance (in the antenatal and intrapartum period)

Minimum standard

- 90% attendance.
- Annual update.
- All staff will have to pass an annual competency assessment that has been agreed by the local commissioner (ICB) based on the advice of the clinical network. Trusts should agree a procedure with their ICB for how to manage staff who fail this assessment. (Pass mark of 85%)
- One full day's training in addition to the local emergencies training day.
- Fetal monitoring lead trainers must attend annual specialist training updates outside of their unit.

- Training must:
  - be responsive to local clinical incidents, service user feedback and local learning, using local case histories.
  - include use of risk assessment at start of and throughout labour complying with fetal monitoring guidelines.
  - include antenatal fetal monitoring, intermittent auscultation, and electronic fetal monitoring.
  - be tailored for specific staff groups, e.g., homebirth or birth centre teams.
  - be multidisciplinary and scenario based.
  - include information about using the equipment that is available.
  - include the fetal surveillance of multiple pregnancies.
  - include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns; the content of human factor training must be agreed with the LMNS.

Stretch target – ambition/aspiration

- ≥95% attendance.
- ≥95% pass mark/evaluation.
- Use of positive case examples to learn from.
- Shared learning across LMNS and Buddy LMNS.

- Benchmarking against other organisations with similar clinical profile and national programmes.
- Evidence of multidisciplinary team (MDT) case scenario discussions and shared with wider team to increase accessibility.
- Evidence of improvement following staff evaluation on training when ≤95% feedback is evaluated as good or excellent.
- Lead specialists are in collaboration with the national network of fetal monitoring specialists to support own learning, practice developments and evidence-based care.
- Wider training, i.e., on neonatal hypoxic ischemic encephalopathy (HIE) and nervous system physiology.
- Intrapartum midwives attend additional high-level training to support fetal monitoring knowledge on the ABC programme when available.
- Independent external evaluation of local training.

Module 3: Maternity emergencies and multiprofessional training

Minimum standard

- 90% of each relevant maternity unit staff group has attended an ‘in-house’ MDT training day which includes a minimum of four maternity emergencies with all scenarios covered over a three-year period and priorities based on locally identified training needs:
  - Antepartum and postpartum haemorrhage.
  - Shoulder dystocia.
  - Cord prolapse.
  - Maternal collapse, escalation, and resuscitation.
  - Pre-eclampsia/eclampsia severe hypertension.
  - Impacted fetal head.
  - Uterine rupture.
  - Vaginal breech birth.
  - Care of the critically ill patient.
- Annual update.
- Training should be face-to-face (unless in exceptional circumstances such as the covid pandemic).

- Training must:
  - include the identification of deteriorating mother/baby and use of MEWS/NEWTT charts as locally relevant.
  - include communication, escalation of care and use of tools such as SBARD.
  - be sensitive and responsive to local safety insights, near misses or HSIB cases; lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.
  - use service user comments or feedback from investigations.
  - maternal and neonatal outcomes using exemplars from national programmes i.e., National Maternity Perinatal Audit (NMPA); Getting it Right First Time (GIRFT); Healthcare Safety Investigation Branch (HSIB)
  - include at least one scenario from a learning from excellence case study.
  - be tailored for specific staff groups, e.g., homebirth or birth centre teams/maternity support worker (MSW).

  - include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns.
  - include human factors training.
  - include at least one of the emergency scenarios to be conducted in the clinical area, ensuring full attendance from the relevant wider multi-professional team; this will enable local system and environmental factors within the clinical setting to be considered, any risks and issues identified, and an action plan developed to address these.

Stretch target – ambition/aspiration

- ≥95% attendance.
- Shared learning across LMNS or network.
- Use of positive case examples to learn from.
- Programme of clinical simulations at point of care in variety of settings including community and evidence of learning, actions, feedback and debrief.
- Staff evaluation on quality of training in place with evidence of improvement if ≤95% feedback is evaluated as good or excellent.

Module 4: Equality, equity, and personalised care

Minimum standard

- 90% attendance (three yearly programme of all topics).
- Training should cover local pathways and key contacts when supporting women and families.
- Training must include:
  - learning from incidents
  - service user feedback
  - local learning
  - local guidance
  - referral procedures
  - ‘red flags’
- One topic from each of the following lists must be covered as a minimum, identified from unit priorities, audit report findings, and locally identified learning, involving aspects of care which require reinforcing and national guidance:

  List A
  - ongoing antenatal and intrapartum risk assessment and risk communication
  - maternal mental health
  - bereavement care.

  List B
  - personalised care and support planning (including plans when in use locally)
  - informed decision making, enabling choice, consent, and human rights
  - equality and diversity with cultural competence.

Stretch target – ambition/aspiration

- ≥95% attendance.
- Involving MNVPs/Service Users in coproducing and/or delivering training based on lived experiences.

- Service user feedback gained from Personalised Care and Support Plans (PCSP) audits are embedded into training.
- Use of positive case examples to learn from.
- Benchmarking against other organisations with similar clinical profile and national programmes.
- Training on learning disabilities and Autism, that is maternity specific, is embedded in personalised care training.
- Equality and diversity training includes unconscious bias, LGBTQ+.
- Risk assessment and risk communication includes genetic risk.
- Staff evaluation on quality of training in place with evidence of improvement where ≤95% feedback is evaluated as good or excellent.
- Yearly training on any subject.
- Stakeholder support, i.e., SANDS involved in supporting delivery of training.

Module 5: Care during labour and immediate postnatal period

Minimum standard

- 90% attendance (three-yearly programme of all topics).

- Training must:
  - include learning from incidents, audit reviews and investigations, service user feedback and local learning
  - learning from themes identified in national investigations, e.g., HSIB
  - have a focus on deviation from the norm and escalating concerns
  - include national training resources within local training, e.g., OASI Care Bundle (obstetric anal sphincter injuries), RoBUST Operative Simulation Birth Course, prevention and optimisation of premature birth.
  - be tailored for specific staff groups depending on their work location and role, e.g., homebirth or birth centre teams/maternity support worker (MSW).

- Subjects must include:
  - management of labour including latent phase
  - VBAC (vaginal birth after caesarean) and uterine rupture
  - GBS (Group B Streptococcus) in labour
  - management of epidural analgesia and recovery care after general anaesthetic
  - operative vaginal birth
  - pelvic health and perineal trauma – prevention of and OASI pathway and pelvic floor muscle training (PFMT)
  - multiple pregnancy
  - infant feeding
  - ATAIN (Avoiding Term Admissions into Neonatal Units).

Stretch target – ambition/aspiration

- >95% attendance of relevant staff group.
- Shared learning across LMNS.
- Use of positive case examples to learn from.
- Benchmarking against other organisations with similar clinical profile and national programmes.

- Staff evaluation on quality of training in place, with evidence of improvement where ≤95% feedback is evaluated as good or excellent.
- Use of service user case studies and service users to share their experiences.

Module 6: Neonatal basic life support

Minimum standard

- 90% attendance at a neonatal basic life support annual update, either as an in-house neonatal basic life support training or newborn life support (NLS).
- Only registered RC-trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates.
- Training must:
  - be ‘hands-on’ and scenario based and tailored to learning from incidents, service user feedback and local learning priorities
  - include knowledge and understanding of NLS algorithm
  - include recognition of the deterioration of Black and Brown babies
  - include recognition of deteriorating newborn, action to be taken and local escalation procedures, and the use of SBARD tool for handovers (or local equivalent)
  - include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns
  - include human factors
  - be tailored for specific staff groups depending on their work location and role, e.g., homebirth or birth centre teams/MSW
  - cover scenarios in different environments and must include training on use of the equipment available in those environments to ensure staff are familiar.

Stretch target – ambition/aspiration

- ≥95% attendance.
- Attendance on separate certified NLS training for maternity staff should be locally decided; but this would be the gold standard with updates every four years.
- Evidence of MDT point of care simulation programme, attendance records and learning from them with innovative practices to ensure wide attendance from all staff groups/unsocial shifts/community staff.
- Learning from national investigations and programmes, e.g., HSIB and ATAIN.
- Benchmarking against other organisations with similar clinical profile and national programmes.

- Staff evaluation on quality of training in place with evidence of improvement plans where ≤95% feedback is evaluated as good or excellent.
- Use of service user case studies and parents sharing their experiences including the use of positive case examples to learn from.

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