Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Response to Ockenden report	**Date: 4 February 2021**
Prepared By:	Penny Cole, Head of Midwifery Lisa Gowan, Divisional General Manager Srini Vindla, Clinical Chair	
Approved By:	Julie Hogg, Chief Nurse	
Presented By:	Julie Hogg, Chief Nurse	

Purpose		
This paper provides a further update to Trust Board on the Ockenden response following the Local Maternity & Neonatal System (LMNS) Board meeting on 11 January 2021 where our response was endorsed. Trust Board members are asked to note the updated commentary which is described below against the seven Immediate and Essential Actions (IEAs)	**Approval**	
	Assurance	**X**
	Update	
	Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
X		**X**	**X**	
Indicate which strategic objective(s) the report support				

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
Indicate the overall level of assurance provided by the report -		**Fully compliant with 5 out of 7 IEAs and partially compliant with the remaining 2**		

Risks/Issues	
Indicate the risks or issues created or mitigated through the report	
Financial	Additional investment required in staffing
Patient Impact	Anticipated increased assurance around patient safety
Staff Impact	X
Services	X
Reputational	Potential reputational impact if all IEAs are not fully implemented

Committees/groups where this item has been presented before

Trust Board – 7 January 2021
LMNS Board – 11 January 2021
Maternity Safety Champions;
W&C Divisional Governance

Executive Summary

This paper provides the Board with an updated position and assurance against the recently published 'Maternity Services assessment & assurance tool' which aligns to the Ockenden report.

The proposed response has been endorsed by the LMNS.

There are seven Immediate & Essential actions identified:

1.	Enhanced Safety	Fully compliant
2.	Listening to Women & Families	Partially compliant
3.	Staff training & working together	Partially compliant
4.	Managing complex pregnancy	Fully compliant
5.	Risk assessment throughout pregnancy	Fully compliant
6.	Monitoring fetal wellbeing	Fully compliant
7.	Informed consent	Fully compliant

The service is partly compliant with Section 2 of the tool which covers maternity workforce planning; midwifery leadership (five out seven domains); and NICE guidance related to maternity.

The Board are asked to note:

- The first iteration of this response was presented to the Board in January 2021 – a revised national timeframe was stipulated and further information provided by the national team which led to the attached version
- This version has been endorsed by the LMNS
- Non-compliance is highlighted in the paper below at **IEA2 (p8)**, **IEA3 (p10)** and **Midwifery Leadership (p22)**
- For IEA2 further national guidance is awaited regarding the role of the independent advocate
- For IEA3 further investment will be required in the obstetric consultant body
- For Midwifery Leadership the Trust is not compliant with recommendation to have a Director of Midwifery in post (with caveat that Chief Nurse is a member of the Board and a registered midwife)
- The Trust is not fully compliant with recommendation around consultant midwife – this post has been recruited to and post holder commences 15 Feb 21.

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Maternity services assessment and assurance tool

Response prepared for Sherwood Forest Hospitals NHS Foundation Trust by:

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Paula Shore	Matron for Maternity Governance
Susie Al Samarrai	Consultant Obstetrician & Service Lead

Reviewed/sponsored by:

Julie Hogg	Chief Nurse & Board Level Maternity Safety Champion
Lisa Gowan	Divisional General Manager, Women & Children's Division
Srini Vindla	Consultant Obstetrician & Clinical Chair, Women & Children's Division

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Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?

• Maternity governance structure ensures that all cases are reported appropriately through weekly & monthly meetings • Failsafe process in place with input from Trust governance support unit • All serious incidents reported to Trust scoping which is chaired by exec • Most recent MSDS scorecard showed 11/11 compliance • Monthly exception/highlight report to Quality & Safety Committee	• All reports (divisional/STEIS/HSIB) have agreed SMART action plans which are agreed at Trust sign off (exec led) and tracked through divisional governance • SFH represented at LMNS and East Mids Clinical Network with contribution to learning systems	• Outcomes all monitored via monthly maternity dashboard highlighting better than national average rates for all indicators listed above as well as term admissions to NNU rates • Learning from incidents shared through MDT both within the Trust and at Clinical Network level	• Agreement of TOR for referral of cases to LMNS • Monthly board data pack to be developed via Maternity Safety Champions which will include all serious incidents and HSIB referrals • Maternity services local audit plan in draft, for sign off via governance meeting	• Maternity Safety Champions at LMNS work stream meeting 07.01.21 • HOM and Chief Nurse 29.12.20 • Clinical Governance Midwife 11.01.21	Improved engagement from provider partner in LMNS	Low level risk which does not require mitigation

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.

- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.

- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) 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.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
• Structured mechanisms in place for gathering service user feedback (FFT) • HOM and Chair of MVP meet regularly • Self referral 'Birth Afterthoughts' service for women • NED identified December 2020 • Bereavement specialist midwife plays active role in supporting and advocating for parents	• Reported via Board SOF and through NMAHP Board • Birth Afterthoughts email available • MVP Chair joined interview panel for SFH consultant midwife • PMRT can be externally validated • Trust Board minutes will reflect maternity agenda items from January 2021	• Positive service user feedback • MVP Chair is active member of LMNS Board	• Await further guidance from national team • Review impact of NED over 2021 • Review management of complaints • Strengthen co-production of services	• Regional Chief Midwife • Maternity Safety Champions April 2021 • Chief Nurse/HOM April 2021 • HOM/MVP Chair Feb 2021	• To be identified • Collaboration with Patient Experience lead/team • Resume pre-Covid levels of engagement with MVP	Other sources of advocacy available for women, families and staff until independent advocate role is developed, including Professional Midwifery Advocates team

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?

• MDT training is in place and all dates planned for 2021, including MDT faculty using PROMPT model • Full MDT handover occurs 7 days a week including incoming/outgoing team, anaesthetic & NICU colleagues and midwife co-ordinator • External funding allocated for maternity training in 20/21 can be tracked through finance spreadsheets and LMNS Board papers including reports to HEE	• Training planned and scheduled through Health Roster, attendance registers maintained • Attendance log maintained • Regular 1-1 meetings HOM and divisional finance manager	• Monthly training compliance figures to be reported via governance and quarterly to LMNS Board using standardised tool • NHSR MIS Yr3 reporting	• Job planning and SOP for introduction of second in person MDT ward round 7 days a week • Scoping and response to further guidance regarding MDT training when this is published	• Service lead (SAS); triumvirate; matron for maternity governance • Maternity team including safety champions & governance/practice development	Funding for additional consultant posts	• Strengthen current ward round governance including SOP • Introduce additional in person ward round within current job plans (ie Mon-Fri 5.30pm) • Continue telephone handover between consultants and from night reg to consultant until in-person resource is available • Add to risk register

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

• SFH use Perinatal Institute notes which include standardised risk assessment at booking (p13) and onward referral for consultant review where applicable • Antenatal Care Provision Guideline describes pathway of care including named consultant • Compliance with regional clinical network guidance around referral to tertiary services for Maternal Medicine	Not yet fully described – see actions	To be reported via Maternity clinical governance standing item – audit Progress against NHSR actions including SBLCBv2 is reported via governance and will form an element of the Board maternity safety data pack from Jan 21	• Design audit based on Perinatal Institute notes and register/upload onto AMAT	• Clinical Governance Midwife / audit working group – in progress now and will be live from January 21	N/A	No risks identified on pilot audit December 20

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

Perinatal Institute notes accommodate risk assessment documentation at every contact – however current antenatal care provision guidance stipulates formal full risk assessment at booking & at 31 weeks, with review of place of birth choice at 36 weeks Distribution of PCP recorded as part of MSDSv2 Regular risk assessment is an explicit factor in local guidelines including Intrapartum Fetal Monitoring Guideline (Nov 20); Antenatal Fetal Monitoring Guideline (Nov 20); Induction of Labour Guideline (Dec 19); Physiological Labour Guideline (under review Dec 20)	Not yet fully described – see actions	• To be reported via Maternity clinical governance standing item – audit • Progress against NHSR actions including SBLCBv2 is reported via governance and will form an element of the Board maternity safety data pack from Jan 21 • MSDSv2 in place to record PCP distributed	• Design audit based on Perinatal Institute notes and register/upload onto AMAT • Formalise twice daily consultant led ward rounds • Devise effective monitoring process for the use of PCP	• Clinical Governance Midwife / audit working group – in progress now and will be live from January 21 • Linked to IEA 3 Agree LMNS approach	• Audit plan in progress • Linked to IEA 3 Sufficient printed resource PCP & cultural shift to support their use	Develop SOP for formal risk assessment using criteria from guidelines Continue with regular safety huddles led by maternity unit co-ordinator Consultant ward round to include women undergoing IOL and new antenatal admissions Birth plans discussed regularly as part of routine antenatal care, with regular risk assessments and place of birth updated at booking, 31 and 36 weeks.

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) 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.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

• Fetal Monitoring midwife role (0.4WTE) job planned to current PDM • Lead Obstetrician identified (Labour Ward Lead) • SFH representation on regional fetal monitoring group • Regular (weekly) MDT reviews of trigger cases which are escalated to Trust scoping/HSIB in accordance with current criteria CTG breakfast meetings in place for informal MDT debate/learning Compliance with SBLCBv2 reported regionally and via NHS MIS Yr3	• Joint planning of job roles and objectives for 2021 • Monitor training compliance through governance • Attendance logs maintained for all MDT meetings	• Clinical outcomes as reported via maternity dashboard, PMRT, MBRRACE, NHSRENS, Each Baby Counts • Competency assessments pass rate	Establishment review of specialist midwife team following BR+ workforce report – additional resource required for FM lead & PDM role	Triumvirate, end March 2021	Trust Board sign off and financial investment to comply with recommendations of BR+ Recommended 2-3 PAs for lead obstetrician role	FM lead midwife role in place using some PDM establishment Some aspects of lead obstetrician role included in scope described above

Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) 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.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

Regularly updated web page on Trust public facing internet Active collaboration with MVP Chair Personalised Care Plans distributed to all women at booking appointment Support for midwives and women from Professional Midwifery Advocates where choices may be outside of clinical guidance Respect for women's choices reflected in clinical guidance and professional practice	Maternity link in Trust communications team SFH representation at regular MVP meetings and on monthly LMNS Board	Actions tracked through MVP & LMNS minutes Annual maternity survey planned to take place Feb 2021 – this will be reviewed and benchmarked to identify actions Monthly FFT responses reviewed and reported by exception to Trust Board	N/A	N/A	N/A	No risks identified

Section 2						
MATERNITY WORKFORCE PLANNING						
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**						
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.						
What process have we undertaken?	**How have we assured that our plans are robust and realistic?**	**How will ensure oversight of progress against our plans going forwards?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**

June – Sept 2020: BR+ workforce review using clinical data from Feb – Apr 2020 Review of NHSR Yr3 and SFH ACSA report	Iterative approach to final version of the BR+ report, with resulting confidence in the recommendations	Divisional workforce group established Sept 20 (triumvirate, finance, HR & PMO team) to oversee progress of plans	Continue	N/A	Executive support already in place Transformation funding (12 months) approved by LMNS for 6.77WTE midwives	Risk 1970 – midwifery staffing levels = current score 6 & mitigations described Risk 1683 – medical staffing levels = current score 2
HOM and senior management team worked with BR+ teams to agree terms of reference and agree final version of report.	Various staffing models have been proposed and trialled by the senior team, supported by BR+ and national planning tool piloted in Oct 20	MCOC plans presented to LMNS Board with agreed trajectory and actions required	Acknowledge that current service is safely staffed using BR+ standards	Trust Board Jan 21	N/A	N/A

Confirm **no gap in MW establishment** to maintain current service. Maternity Transformation (@51% receiving CoC) = **14.46WTE Bands 3-8** gap Confirm **no gap in obstetric** establishment to maintain current service. Additional **3WTE obstetric consultants** required for introduction of ward rounds & elective CS list	Presentation of BR+ results and confirm & challenge with divisional triumvirate, finance and HR colleagues Articulated using standard job planning approach	Oversight of plans through divisional workforce group, divisional performance review (exec led) and LMNS Board ACSA report submitted to Quality & Safety Committee Sept 20	Presentation of workforce plan to Trust Board Jan 20 which describes business case proposal for 21/22 Update Risk 1683 to include Ockenden IEA and elective CS service	Lisa Gowan John Mason 31.12.20 Susie Al Samarrai 31.12.20	None – routine business planning and exec colleagues sighted to issues None	N/A

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

Head of Midwifery is responsible and accountable to the Chief Nurse (who is also a registered midwife).

Strengthening midwifery leadership (RCM 2018)

1. **A Director of Midwifery in every trust and health board, with direct access to the Board**. **Not compliant**

SFH structure has Head of Midwifery accountable to Chief Nurse (who is a registered midwife and Board member)

2. **A lead midwife at a senior level in all parts of the NHS Compliant**

The HOM has weekly access to the regional chief midwife via MS Teams meetings. Other aspects of this standard are outwith provider level.

3. **More consultant midwives Not compliant**

All maternity units required to have at least one consultant midwife – SFH appointed to this role in November 2020 with start date February 2021.

4. **Specialist midwives in every trust Compliant**

SFH has a range of specialist midwife roles within establishment, all at Band 7 and with the specialisms relevant to local service needs. The specialist midwife establishment is reviewed annually and staffed according to BirthRate Plus principles.

5. **Strengthening & supporting sustainable midwifery leadership in education Compliant**

This standard applies to Higher Education Institutions. At SFH there is an active Practice Learning Team with senior midwifery and student representation. There are two registered midwives working in the Research Team at SFH.

6. **A commitment to fund ongoing midwifery leadership development Compliant**

A separate midwifery training fund is ring fenced within the maternity budget each year. Individual midwives (including HOM) have been supported to undertake leadership development programmes including an NHS Leadership Academy programme leading to Masters in Healthcare Leadership; and an in house strategic leadership Masters programme. There is a popular and vibrant Band 7 leadership development programme within the acute maternity service.

7. **Professional input into the appointment of midwife leaders Compliant**

Interview panel for the incumbent HOM included two registered midwives as well as divisional triumvirate members. RCM representation was included in focus group panel for the consultant midwife interviews in November 2020.

NICE GUIDANCE RELATED TO MATERNITY						
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.						
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all of our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**

There is a Trust wide process for the review of NICE guidelines: **NICE Guidance Implementation Policy (Nov 19)** This is managed by the Trust Governance Support Unit A clinical guideline dashboard is also presented monthly at the Nursing, Midwifery & AHP Board (chaired by the Chief Nurse) The East Midlands Clinical Network has a documented process to consider & approve exceptions to the SBLCBv2 recommendations (SFH – growth scans related to BMI)	NICE guidance is a standing agenda item on monthly Maternity & Gynaecology Clinical Governance meeting (chaired by HOM) Any exceptions or 'compliance with caveats' are reported by exception to Quality & Safety Committee	All guidelines have a review date and are managed/administered by the Governance Support Unit. The guidelines due for review/renewal are sent to the division three months in advance with specialist approach dependent on major or minor amends. Guidelines are also reviewed or updated in response to findings from divisional/STEIS/HSIB investigations and reports	N/A	N/A	N/A	N/A