Paper Reference:

Manchester University NHS Foundation Trust

SAINT MARY'S MANAGED CLINICAL SERVICE

[Saint Mary's Quality and Safety Committee]

Report of:	Professor Edward Johnstone, Clinical Head of Maternity Services Division Mrs Beverly O'Connor, Head of Midwifery Mrs Faith Shiels, Head of Midwifery Miss Esme Booth, Head of Midwifery Mr Medwyn Jones, Interim Division Director	
Paper prepared by:	Jen Sager Associate Head of Midwifery, Saint Mary's Maternity Services Division	
Date of paper:	1st May 2022	
Subject:	Ockenden Final Report and review of compliance	
Purpose of Report:	Indicate which by ✓ (tick as applicable-please do not remove text)	
	Information to note	✓
	Support	✓
	Resolution	
	Approval	✓
	Ratify	
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Excels in quality, safety, patient experience, research, innovation, and teaching To improve patient safety, clinical quality, and outcomes To improve the experience of patients, carers, and their families	
Recommendations:	The SM QSC are asked to: note the information provided within the report in respect of Saint Mary's Managed Clinical Services Maternity Services Division,	

	including approval of the action plan for compliance against the Immediate and Essential Actions in the final Ockenden Report
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BACKGROUND

1.1. As reported to SM MCS Quality and Safety Committee in January 2022, SM MCS completed all provider led requirements for the 7 Immediate and Essential Actions (IEAS) identified in Donna Ockenden's first report (the Ockenden Report): Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust[1] and completed were awaiting the final report.

1.2. On 30th March 2022, the final Ockenden report[2] was published with 15 new Immediate and Essential Actions (IEA's) which are in addition to the previous 7 IEA's from the first report.

1.3. In the final report there are 15 IEA's with a focus on 4 key themes which are pertinent across the NHS:

- Safe staffing levels
- A well-trained workforce
- Learning from incidents
- Listening to families

1.4. This paper provides a full review of SM MCS position and action plans to address areas of non-compliance.

OCKENDEN FINAL REPORT

2.1. In the initial Ockenden report providers were asked to collate evidence to demonstrate compliance against all IEA's. This has not been asked of providers in the final review, however SM MCS have begun collating evidence where available in anticipation.

2.2. There are 15 IEAs, with 27 sections comprising of 97 separate elements which trusts must achieve to be compliant. These actions also include specific areas of focus for Newborn Service and Anaesthetic services.

2.3. A table demonstrating overall compliance is provided in Appendix 1.

2.4. On review of the 27 sections for SM MCS:

- 10 sections are compliant
- 4 sections require 1 identified piece of work completing to be compliant
- 4 sections require work to be completed by regional or national groups
- 8 sections require 2 or more pieces of completing to be compliant
- 1 section is considered non-compliant

[1] https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf
[2] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

2.5. Within these sections, of the 97 elements for SM MCS:

- 57 elements are compliant
- 25 elements are in progress
- 14 elements require work to be completed by regional or national groups
- 1 element is non-compliant

ELEMENTS WITH WORK IN PROGRESS

3.1. There are currently 25 elements which require additional work to be compliant. Progress can be found within Table 1 action plan.

3.2. These issues have been allocated to named leads and further updates will be provided via the maternity assurance report .

3.3. Table 1

Section Number	Detail	Action required	Lead	Expected date of compliance
Safety Action 1 -workforce planning and sustainability				
1.6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	Review current preceptors and amend rotation to remain within hospital setting in 1st 12 months	Rotation Leads SM MCS	May 2022
		Amend preceptorship package for community	Community Matron, Wythenshawe	July 2022
1.10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive	Strategy and SOP to be developed for Obs and Midwifery. Gap analysis required for Obs and midwifery	Deputy Head of Midwifery, supported by Head of Midwifery Clinical Head of Division	Sept 2022 Sept 2022

	organisational processes and relevant practical work experience.			
Safety Action 2 - Safe staffing				
2.4	All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.	MCoC teams are currently being reviewed and meetings with Community matrons arranged to discuss next steps	Associate HoM and Consultant Midwife	May 2022
2.5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	As above	As Above	As Above
2.6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change	Full obstetric TNA review required	Clinical Head of Division	July 2022
2.8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles	SOP to be developed regarding use of matron, ward manager and LW Coordinator handbook	Deputy Heads of Midwifery	July 2022
Safety Action 3 - Escalation and Accountability				
3.1	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals	Amend bleep holder policy to clearly reflect role and ongoing escalation process	Inpatient Matron/Labour Ward Matron	Aug 2022

Safety Action 5 - Clinical Governance Incident Investigation and complaints				
5.4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	SOP to be created	Divisional Governance Lead Obstetrician and Lead Midwife for Governance	Aug 2022
5.6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	To be discussed during15 steps walkarounds May/June	Associate HoM	June 2022
Safety Action 7 - MDT Training				
7.7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory	Review triage and LW workforce Support training compliance	IP Matrons / Lead Obs Education team/CTG champions	End of May 2022 End of June 2022
Safety Action 9 - Preterm Birth				
9.2	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	Review options to capture evidence of compliance	Consultant Lead for Preterm Labour	June 2022
9.3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	As above		
Safety Action 10 - Labour and Birth				

10.4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.	Update padlet information with transfer times	Consultant Midwife	July 2022
Safety Action 11 - Obstetric anaesthesia				
11.1	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia	Awaiting full review to demonstrate compliance and actions to address any gaps identified	Clinical and Scientific Services	TBC
11.2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	Awaiting full review to demonstrate compliance and actions to address any gaps identified	Clinical and Scientific Services	
11.3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC	Awaiting full review to demonstrate compliance and actions to address any gaps identified	Clinical and Scientific Services	
11.5	Obstetric anaesthesia staffing guidance to include: The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.	Awaiting full review to demonstrate compliance and actions to address any gaps identified	Clinical and Scientific Services	TBC

11.6	The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.	Awaiting full review to demonstrate compliance and actions to address any gaps identified	Clinical and Scientific Services	
11.7	The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.	Awaiting full review to demonstrate compliance and actions to address any gaps identified	Clinical and Scientific Services	
11.8	Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report	Awaiting full review to demonstrate compliance and actions to address any gaps identified	Clinical and Scientific Services	
Safety Action 12 - Postnatal Care				
12.1	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward.	Review consultant capacity amend Post natal guideline	Clinical Head of Division Lead Obstetrician for inpatients	June 2022 July 2022
12.2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.	Review consultant capacity amend Post natal guideline	Clinical Head of Division Lead Obstetrician for inpatients	June 2022 July 2022
12.3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.	Review consultant capacity amend Post natal guideline	Clinical Head of Division Lead Obstetrician for inpatients	June 2022 July 2022
Safety Action 15 - Supporting Families				

15.1	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	Birth Talk Clinic to be implemented at North	HoM at North Manchester and Consultant Midwife	Dec 2022
15.2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	Review capacity of current specialist maternity counsellor and link with SLA	Esme Booth, HoM at North Manchester	Oct 2022

ELEMENTS REQUIRING WORK FROM EXTERNAL GROUPS

4.1. There are currently 14 elements which require work to be completed by external groups.

4.2. With the exception of actions within Neonatal Services, it is not possible to provide further details until information has been provided by NHS E/I.

4.3. A request has been made via regional Chief Midwife with NHS E/I to confirm current status and identify leads and expected completion dates.

4.4. Table 2

Section Number	Detail	Current Status	Lead	Expected date of compliance
Safety Action 1 -workforce planning and sustainability				
1.1	The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented	Awaiting update from NHS England	TBC	TBC
1.2	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.	Awaiting update from NHS England	TBC	TBC

1.3	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	Awaiting update from NHS England	TBC	TBC
1.5	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.	Awaiting update from NHS England	TBC	TBC
1.8	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.	Awaiting update from NHS England	TBC	TBC
1.13	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	Awaiting update from NHS England	TBC	TBC
Safety Action 6 - Learning from Maternal Deaths				

6.1	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that a joint review panel is provided in any case of a maternal death.	Awaiting update from NHS England	TBC	TBC
6.2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.	Awaiting update from NHS England	TBC	TBC
Safety Action 7 - MDT Training				
7.3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should 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 LMS.	Current training includes human factors. Training plan submitted to GMEC LMS for approval in May 2022.	Lead Midwife for Education GMEC LMS	TBC
Safety Action 10 - Labour and Birth				
10.2	Midwifery-led units must complete yearly operational risk assessments.	Awaiting update from NHS England	TBC	TBC
Safety Action 11 - Obstetric anaesthesia				
11.4	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance	Awaiting update from NHS England	TBC	TBC
Safety Action 14 - Neonatal Care				

14.4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	Work ongoing	North West ODN	May 2022
14.5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	Work ongoing	North West ODN	May 2022
14.9	Implement recommendation from Neonatal Critical Care Review (2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families	Work ongoing	North West ODN	May 2022

ELEMENT WHERE SM MCS ARE NON-COMPLIANT

5.1. There is currently 1 element which SM MCS do not meet the requirement and would therefore be considered non-compliant.

5.2. It is a requirement that Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.

5.3. At present this is being met on the Neonatal units at North Manchester and Oxford Road. This standard is not currently met on the Neonatal unit at Wythenshawe.

5.4. Progress on actions can be found within Table 3 action plan.

5.5. Table 3

Section Number	Detail	Current Status	Lead	Expected date of compliance
Safety Action 14 - Neonatal Care				
14.8	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	Wythenshawe will be compliant for junior Doctors from September following recruitment. The service is not compliant with respect to consultants at Wythenshawe as there isn't sufficient consultant capacity to provide consistent review of all new admissions to neonatal care within 14 hours of admission which is the national standard for patient reviews	Clinical Head of Division Clinical Head of Division	September 2022 TBC

NEXT STEPS

6.1. SM MCS Maternity Division will monitor the progress on all 3 action plans via Divisional Quality and Safety Committee and hospital Quality and Safety Committee.

6.2. In line with SM MCS perinatal surveillance model, an update on progress will be provided within the Maternity Assurance Paper, presented to SM MCS Quality and Safety Committee and MFT Group Board of Directors bi-monthly.

Paper Reference:

Manchester University NHS Foundation Trust

Appendix 1

Key for Overall Section

Complete – All Evidence obtained
Outstanding External Evidence
Outstanding MFT Evidence for 1 Element
Outstanding MFT Evidence for 2 or more Elements
Non-Compliant

Key for RAG rating

Complaint
Work ongoing MFT
Work ongoing externally
Non-Compliant

IEA	Section		Element Evidence Requirement	RAG
Safety Action 1 - workforce planning and sustainability	Essential action – financing a safe maternity workforce	1.1	The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented	
		1.2	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.	
		1.3	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	
		1.4	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.	
		1.5	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.	

	Essential action – training	**1.6**	**All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this**	
		1.7	**All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.**	
		1.8	**All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.**	
		1.9	**All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.**	
		1.10	**All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.**	

		1.11	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.	
		1.12	We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.	
		1.13	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	
Safety Action 2 - Safe staffing	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals	2.1	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.	
		2.2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.	
		2.3	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	
		2.4	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.	

		2.5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	
		2.6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change	
		2.7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings	
		2.8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles	
		2.9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication	
		2.10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction	
Safety Action 3 - Escalation and Accountability	Staff must be able to escalate concerns if necessary	3.1	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals	

	There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. **If not resident there must be clear guidelines for when a consultant obstetrician should attend.**	**3.2**	**When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role**	
		3.3	**Trusts should aim to increase resident consultant obstetrician presence where this is achievable**	
		3.4	**There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit**	
		3.5	**There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit**	

Safety Action 4 - Clinical Governance Leadership	**Trust boards must have oversight of the quality and performance of their maternity services.**	**4.1**	**Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans**	
	In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	**4.2**	**All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board**	
		4.3	**Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services**	
		4.4	**All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities**	
		4.5	**All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement**	
		4.6	**All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research**	

		4.7	All maternity services must ensure they have midwifery and obstetric co-leads for audits	
Safety Action 5 - Clinical Governance Incident Investigation and complaints	Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner	5.1	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms	
		5.2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	
		5.3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred	
		5.4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	
		5.5	All trusts must ensure that complaints which meet SI threshold must be investigated as such.	
		5.6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	
		5.7	Complaints themes and trends must be monitored by the maternity governance team.	

Safety Action 6 - Learning from Maternal Deaths	**Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.**	**6.1**	**NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.**	
	In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings	**6.2**	**This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.**	
		6.3	**Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.**	
Safety Action 7 - MDT Training	**Staff who work together must train together**	**7.1**	**All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.**	
		7.2	**Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.**	
	Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.	**7.3**	**All trusts must mandate annual human factor training for all staff working in a maternity setting; this should 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 LMS.**	

		7.4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	
		7.5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	
	Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	7.6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	
		7.7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory	

Safety Action 8 - Complex Antenatal Care	**Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.**	**8.1**	**Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.**	
	Trusts must provide services for women with multiple pregnancy in line with national guidance	**8.2**	**Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.**	
	Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	**8.3**	**NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.**	

		8.4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	
		8.5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	
Safety Action 9 - Preterm Birth	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.	9.1	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	
		9.2	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	
		9.3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	
		9.4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	
		9.5	Trusts must implement NHS Saving Babies Lives Version 2 (2019	

Safety Action 10 - Labour and Birth	**Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.**	**10.1**	**All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made**	
		10.2	**Midwifery-led units must complete yearly operational risk assessments.**	
		10.3	**Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.**	
		10.4	**It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.**	
		10.5	**Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.**	
	Centralised CTG monitoring systems should be mandatory in obstetric units	**10.6**	**Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.**	

Safety Action 11 - Obstetric anaesthesia	**In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.**	**11.1**	**Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.**	
		11.2	**Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.**	
	Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.	**11.3**	**All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC**	
		11.4	**Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance**	
	Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe	**11.5**	**Obstetric anaesthesia staffing guidance to include:** **The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.**	

	obstetric anaesthesia services throughout England must be developed.	**11.6**	**The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.**	
		11.7	**The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.**	
		11.8	**Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report**	
Safety Action 12 - Postnatal Care	**Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.**	**12.1**	**All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward.**	
		12.2	**Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.**	
		12.3	**Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.**	
	Postnatal wards must be adequately staffed at all times	**12.4**	**Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies**	
Safety Action 13 - Bereavement Care	**Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services**	**13.1**	**Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.**	
		13.2	**All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.**	
		13.3	**All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.**	

		13.4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway	
Safety Action 14 - Neonatal Care	There must be clear pathways of care for provision of neonatal care.	14.1	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	
		14.2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.	
		14.3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	
		14.4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	
		14.5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	
		14.6	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	
		14.7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.	

		14.8	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	
		14.9	Implement recommendation from Neonatal Critical Care Review (2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experince of families	
Safety Action 15 - Supporting Families	Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision.	15.1	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	
		15.2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	
		15.3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care	
		15.4	Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	