Midlands Ockenden Final IEA returns Snapshot

Trust and LMNS stated position against the 15 IEAs

Reference Number	IEA 1: WORKFORCE PLANNING AND SUSTAINABILITY	Herefordshire & Worcestershire			
		Worcester Acute Hospital NHS Trust (WHAT) Evidence location M-Drive - Acute - Maternity - WRH - Ockenden Evidence	Comments [Actions to take place in order to meet IEA Standard]	Wye Valley Trust (WVT)	Comments
Principle 1: Financing a safe maternity workforce					
P1.1	Funding for maternity and neonatal services requires multi-year settlement to ensure workforce are enabled to deliver consistently safe maternity and neonatal care across england	NOT A TRUST OR SYSTEM RESPONSIBILITY			
P1.2	Recommendations from Health and Social Care Committee Report: The safety of maternity services in England must be implemented	some additonal wrk to do			
P1.3	If minimum staffing levels not agreed nationally, staffing should be agreed locally by LMNS. Staffing levels must account for: increased acuity, complexity of women, vulnerable families and additonal mandatory training to meet CNST and CQC requirements	Funded to BR+ requirements			
P1.4	Staffing level to include locally calculated uplift representative of 3 previous years' data for ALL absences inc sickness, annual leave, maternity leave and mandatory training	Uplift calculated at 24.5% to cover off increased training requirements for midwives.			
P1.5	Accuracy of BirthRate Plus must be reviewed nationally by all regulatory bodies. As a minimum these must include NHSE, RCOG, RCM and RCPCH	Maternity leave is not included in the uplift as we emply into all maternity leave.			
Principle 2: Training					
P2.1	Proportion of maternity budgets must be ring-fenced for training in every maternity unit	Email confirming trainng monies rigfenced from DoF. Awaiting budget sheets to demonstarte all monies shared			
P2.2	Trusts must implement robust preceptorship programme for newly qualified midwives (NQMs), which supports RCM (2017) position statement for supernumeray status and protected learning time	Jess Thompson 11.5.22 1. Preceptorship Handbook uploaded to M Drive 2. Unit Based Preceptorship Framework Model uploaded to M Drive 3. Current CoC framework model (dependent on decision) 4. Evidence of example supernumerary period for new starter 5. Example roster of new starter including supernumerary 6. SN New Starter Survey Responses and action plan 7. Preceptorship Database with evidence of training and protected learning time.	More robust preceptorship programme with Preceptorship Lead Midwife now in position. Supernumerary shifts are implemented for all NQM upon commencement to the trust and and upon rotation to new ward area. However, due to staffing, it is evident that this supernumerary status is not protected. [Plan as evidenced on survey response presentation.] Action Plan = 1. Higher staffing levels 2. Create escalation process if supernumerary not protected		
P2.3	ALL NQMs must remain in hospital setting for minimum 12 months post qualification.	Jess Thompson 11.5.22 - Currently 2 models of preceptorship, unit based and continuity. Unsure about certainty of contunity model currently therefore to be addressed once decision made. 6.5.22 Further information received from NHSE			
P2.4	ALL trust labour ward coordinators must attend a fully funded and nationally recognised labour ward coordinator education module	Some have attended RCOF LW Leaders course - to confirm numbers	Jane Wardlaw to source location, dates and funding for this training		
P2.5	Newly appointed labour ward coordinators should receive an orientation package to reflect individual needs and opportunity to focus on personal and professional development	Package in place competency documeted recently updated	Competency Document		
P2.6	ALL trusts must develop core team of senior midwives trained in high dependency maternity care. There should be one HDU trained midwife on each shift, 24/7	No provision currently , reficeted gap on Risk register	Further discussion regarding the provision of this within service required		
P2.7	ALL trusts must develop succession planning programme to develop for midwifery leaders and senior managers. To include gap analysis of all leadership and management roles.	No formal plan in place			
P2.8	Sustainable training programme across the country must be estalished for Maternal Medicine Networks	Currently Webinairs are being coordinated through Birmingham			
IEA 2: SAFE STAFFING					
2.1	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below minimum	12.5.22 - Maternity and Neonatal escalation policy. Evidence 1) Maternity and neonatal escalation policy			
2.2	If agreed staffing levels across maternity services are not achieved day-to-day, this must be escalated to services' senior management team, obstetric leads, chief nurse, medical director, patient safety chamption and LMNS	13.05.22 SIT Rep completed/ Maternity Escalation Policy / Safety Champion walkabouts.			
2.3	Is risk assessment and escalation protocol in place for competing workload (as agreed at board level where there is no separate consultant rotas for Obs and Gynae)	Combined rota currently			

2.4	If staffing does not meet safe minimum requirement for ALL shifts within Midwifery Continuity of Carer (MCoC) then systems must review and suspend existing provision and further roll out of MCoC - MCoC reinstatement should not be agreed until robust evidence is available to support reintroduction	See Board report			
2.5	Job plans must demonstrate that consultants and locally employed doctors have additional time for maternity training. This will be in addition to generic trust mandatory training and reviewed as appropriate.	Addiotnal SPA time to complete training and also have agreed SL			
2.6	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support transition into leadership and management roles	Package in place and mentor agreed			
2.7	Evidence of a a bi-directional robust pathway between midwifery staff in the community setting and those based in hospital.	antenatal and postnatal guidance in place. Badgernet in place to ensure end to end documentation and access to records			
2.8	RCOG guidance should be followed for management of locums	Further clarification required			
2.9	Trust must demonstrate that there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	PDM in post - currently not able to work in the clinical setting but delivers training in the classroom setting			
2.1	Labour ward coordinator role should be recognised as specialist job role with appropriate job description and person specification	JD in place			
IEA 3: ESCALATION AND ACCOUNTABILITY					
3.1	Can trust demonstrate that there is a developed and maintainable conflict of clinical opinion policy to support staff members escalating clinical concerns	No written guidance at present			
3.2	If a middle grade or trainee obstetrician is managing the maternity service without direct consultant presence there must be an assurance mechanism demonstrating competency for the role	Further clarity on process and robust documentation needed			
3.3	Local guidelines should detail when consultant obstetrician and midwifery manager on-call should be informed of activity within maternity unit.	Escalation policy in place - needs strenghthening			
3.4	Clear local guidelines must be in place for when consultant obstetricians' attendance is mandatory within maternity unit.	As per RCOG guidelines			
IEA 4: CLINICAL GOVERNANCE-LEADERSHIP					
4.1	Trust boards must have oversight of quality and performance of maternity services	12.5.22 - Safety Champions monthly meeting with CNO , Monthly Maternity Safety Report that goes through CGG/ OGC & TB for oversight	Evidence - 1) Safety Champion SOP 2) monthly meeting reports		
4.2	Is there evidence of regular progress, exception reporting and assurance reviews developed by trust board and maternity department	13.5.22 Maternity Safety Report CGG/QCG & TB , Attendance at QSRM weekly, Maternity Governance	Evidence - to be uploaded		
4.3	Director of Midwifery and Clinical Director for obstetrics must be operationally responsible and accountable for maternity governance	13.5.22 Maternity Safety Report CGG/QCG & TB , Attendance at QSRM weekly, Maternity Governance.	Evidence - to be uploaded		
4.4	Clinicians with responsibility for maternity governance must have jobs plans which evidence sufficient time to engage with their management responsibilities	Clinical Lead for governance has 1PA CD has 2.5 PAs for role and 0.5 PA for PMRT	Evidence - to be uploaded		
4.5	Individuals leading maternity governance teams must be trained in human factors, causal analysis and family engagement	13.5.22 Divisional Governance Lead - Trained , Maternity Governance Managers. VN and SS attended Healthcare Incident Investigation Q2 2022	13.5.22 Need to determine others training, training certificates needed from Healthcare Incident Investigation course		
4.6	Maternity services must have co-leads for developing guidelines and performing audits. This should be a consultant midwife or equivalent and obstetric lead	13.5.22 Guideline & Audit Midwife recruited , to start in 3 months time	Further information required regarding Con MW & Obstetric Lead allocated time		
4.7	National Maternity Self-Assessment tool must be completed by appreciative enquiry and comprehensive report inc. governance structures and remedial plans must be shared with trust board	First self assessment completed - recent version not yet completed			
4.8	Patient safety specialist must be in place with specific dedication to maternity services	13.5.22 Governace Managers in place each responsible for Mortality & Morbidity within matermity Services. PSIRF and review of governance structures within organisation currently taking place.	PSIRF & Governance review at WAHT		
IEA 5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATION AND COMPLAINTS					
5.1	Incident investigations must demonstate meaningful lessons for families and staff. These should be taught and implemented in practice in a timely manner.	13.5.22 HSIB invetsigations shared with families. Shared with staff via Effective handover, mandatory training, displayed on governance boards , lessons of the week	G & T Newsletter to be developed		
5.2	Complaints themes and trends must be monitored by maternity governance team	13.5.22 Monitored weekly and shared through maternity governance , shared via effective handover and governance baords.	Upload evidence of how complaints are monitored and shared by Gov team		
5.3	Lessons learnt from clinical incidents must inform local multidisciplinary training plan	13.5.22 HSIB & local investigations and action plans where approiate are linked to the PROMPT Training sessions and MMT.	Evidence to be uploaded 2 examples , CTG Lead / wire , DV case.		
5.4	Actions following serious incident investigation which involve a change in practice must be audited	13.5.22 Guideline & Audit midwife now recruited to. Learning from SI report moniotred through Maternity & by the Patient Safety team at SIRG	Learning from SI report & actions / to confirm any audits that have been undertaken		
5.5	Change in practice arising from an SI investigation must be evidenced within 6 months after incident occurred	13.5.22 Learning from SI quarterly report submitted to SIRG & evidenced through governance . Datix captures and monnitors actions assigned from incident investigation	Action monitoring , completed SI learning report		

5.6	Complaints which meet SI threshold must be investigated accordingly	13.5.22 All incidents required to be investsigated at SI level are completed in line with trust guidance. Duty of Candour is integral to maternity services and this allows the opportunity for any additional concerns to be raised and be included within the report. The complaint process is reiterated at this point should the complainant feel that the investigation may not address their concerns however this is rare. Complaints are reviewed and monitored and triangulted with incidents and escalated accordingly.	Evidence to be uploaded - Duty of Candor, complaints procedure, To explore the trust guideline on SI's and ensure complaints are considered for escalation.		
5.7	Service users must be involved in developing complaints response processed that are caring and transparent	13.5.22 Not currently , they are managed by the MDT team	To explore the option of a service user from the MVP being involved in reviewing the complaints process		
5.8	Language used in investigation reports must be easy to understand for families inc. medical terms	13.5.22 All reports have a glossary, they are involved at the outset and asked for input. The Trust has adopted the report structure to align more with HSIB language based on feedback.	Evidence to be uploaded HSIB report / local CI reports		
IEA 6: LEARNING FROM MATERNAL DEATHS					
6.1	All maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies	Compliant in West midlands			
6.2	Following a maternal death, a joint investigation of all services involved in care must include representation from all applicable hospitals and clinical settings	All Maternal Deaths are reported to HSIB & MBRACE all appropiate services and departments included in the care provision are involved as appropiate. Maternal Death Policy	BHAM, ITU examples of cases , HSIB Criterai, Maternal Death policy , MBRACE		
6.3	Joint review must have an independent chair and be aligned to local and regional staff, and seek external clinical opinion where required.	As above			
6.4	Learning must be implemented within 6 months of the completion of the investigation and must be shared across the LMS	11.5.22 - Evidence uploaded from Maternal Death - Lesson's learn't. 13.5.22 Datix Actions plans, Learning from SI & monitoring of actions as above			
IEA 7: MULTIDISCIPLINARY TRAINING					
7.1	Staff who work together must train together	Jane Wardlaw - MMT, PROMPT, Manual Handling attendance. Evidence uploaded 1) signing in sheets from courses (2022 Jan-May)			
7.2	Regular multidisciplinary training skills drills for management of obstetric emergencies including but not limited to: haemorrhage, hypertension, cardiac arrest and deteriorating patient	Jane Wardlaw 11.5.22 Multiprofessional PROMPT courses are delivered as per CNST standards and core competency framework. Evidence uploaded - PROMPT package joining instructions with agenda for course	13.5.23 - to action - Cardiac arrest and deteriating patient to be added to course.		
7.3	Emotional and psychological support for staff, both individually and within teams must be in place	Jane Wardlaw 11.5.22 WAHT supporting staff strategy, PMA strategy Evidence uploaded 1) support our staff powerpoint 2) communicating with staff on Facebook Staff group			
7.4	Multidisciplinary training must integrate the local handover tools such as SBAR into teaching programmes	Jane Wardlaw 11.5.22 SBAR within PROMPT and MMT sessions. Evidence uploaded 1) MMT programme 2) SBAR presentation			
7.5	It is mandatory for clinicians NOT to work on labour wards or provide intrapartum care without havng appropriate CTG and emergency skills training	Fetal Surveillance Lead in post and substantive post now recruitred too. K2 package to monitor compliance and is monitored through Governance meeting.	Evidence available for escalation regarding staff no completing training - to be uploaded		
7.6	System should be in place to ensure CTG and emergency skills training is completed and up to date for all staff	12.5.22 Jane Wardlaw and Fetal Surveillance Lead, Procedure to be developed with admin support to ensure adequate time to book and perform training prior to going out of date.			
7.7	Staff should attend regular mandatory training, and job planning should ensure all staff can attend	12.5.22 Jane Wardlaw All staff allocated to 2 yearly MMT training, backfill arrangments have been made within work force planning.			
7.8	Clinicians must NOT work on labour ward without appropriate CTG and emergency skills training	12.5.22 Jane Wardlaw/ fetal surveillance lead/ clinical CD to plan SOP regarding this			
7.9	Annual human factor training must be mandated for all staff working in maternity setting and content must be agreed with LMNS. To include: - Principles of psychological safety - Upholding civility in the workplace	12.5.22 PDM to develop this currently only human factors are delivered on MMT and principles reinforced on PROMPT	to go through LMNS & include principles of psycolohocal safety & upholding civility in the workplace		
IEA 8: COMPLEX ANTENATAL CARE					
8.1	LMS, Maternal Medicine Networks and trusts must ensure that women have access to preconception care	Needs exploration across the system			
8.2	Women with pre-exisiting medical disorders inc. but not limited to cardiac disease, epilepsy, diabetes and chronic hypertension must have preconception care with a specialist in managing women's condition	Outlined in ANC guideline and CHC maternal med lead consultant			
8.3	Women identified with chronic hypertension must be seen in specialist consultant clinic. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with NICE Hypertension and Pregnancy Guidance (2019)				
8.4	NICE Diabetes and Pregnancy Guidance (2020) must be followed when managing all pregnant women with pre-existing and gestational diabetes	Roll out of new guidelline delayed			
8.5	Evidence of joint discussion when considering and planning deliery for women with diabetes must be documented in maternity records. Clinicians should provide the woman with relevant evidence-based advice and national recommendations	Documented on Badger - not audited to date			
8.6	Trusts must provide services for women with multiple pregnancies in line with NICE guideline Twin and Triplet pregnancies 2019	Guideline in place but due for review			
IEA 9: PRETERM BIRTH					
9.1	LMNS, commissioners and trusts must work collaboratively to ensure sytems are in place for management of women at high risk of preterm birth	27 week pathway in place. Exception reports completed for those babies born in inappropriate setting and overseen by ODN. Preterm clinic in place and further service			
9.2	Senior clinicians must be involved in conselling women at high risk of preterm birth, especially if pregnancy is at threshold of viability	Guideline in place			
9.3	Local and tertiary neonatal teams must be part of discussions so women and partners are aware of risks and chances of survival	As above			
9.4	Audit process for all in utero transfers and cases where a decision is made NOT to transfer to Level 3 neonatal unit must be in place	See exception reports +ODN process			

9.5	Women and partners must receive expert advice about the most appropriate fetal monitoring and mode of delivery dependent on gestation of pregnancy	Audit			
9.6	Trusts must implement SBLCB v 2 (2019)	Audit			
	IEA 10: LABOUR AND BIRTH				
10.1	Women who birth outside a hospital setting must receive accurate advice regarding transfer times to obstetric unit. If planned to birth outside hospital, written information should be provided in agreement with local ambulance trust	Part of the checklist for HB. WMAS transfer times shared daily			
10.2	All women should receive full clinical assessment when in early or established labour. This should include review of risk factors and complications which might change recommended place of birth.	Mnadatory field on Badger			
10.3	Evidence of regular multidisciplinary team skill drills which correspond with training needs analysis plan	12.5.22 Cross reference to 7.1 and 7.2			
10.4	Evidence of yearly operational risk assessments within midwifery led units				
10.5	All maternity units must have pathway for induction of labour (IOL) Processes which identify clear, safe pathways if IOL is delayed should be demonstated	12.5.22 - Trust guideline present August 2020 (with amendments) Evidence uploaded to file 1) Trust guideline. IOL Working Group . Part of the MSIP			
10.6	All women should be part of decision making process and be enabled to make informed decision regarding place of birth	at 35/ 40 there is a discuisson regarding place of birth, with information included within a leaflet and recorded on Badgernet as part of the PCP	Evidence to be uploaded Bagernet screen shot and leaflets		
10.7	Centralised CTG monitoring systems are mandatory in obstetric units	On main delivery suite this is already in place			
	IEA 11: OBSTETRIC ANAESTHESIA				
11.1	Pathway for outpatient postnatal anaesthetic follow-up must be available in every trust. Conditions which require further follow-up include, but are not limited to, postdural puncture headache, accidental awareness, intraoperative pain and conversion to general anaesthesia, neurological injury and failur of labour analgesia	Guidance in place			
11.2	Anaesthetists are required to be proactive in recognising when a woman would benefit from explanation and opportunity for questions to improve overall experience and reduce risk of long term psychological consequences	Follow up service in place but no evidence of audit			
11.3	Anaesthetic departments must review documentation of maternity patient records and improve where necessary in line with GMC recommendations	Need audit			
11.4	Resources must be readily available for anaesthetic professional bodies to determine consensus on good anaesthetic record	**NOT A TRUST OR SYSTEM RESPONSIBILITY**			
11.5	Obstetric anesthesia staffing guidance should include role of consultants, SAS doctors and doctors in training	In place but evidence needs strengthening			
11.6	Obstetric anesthesia staffing guidance should include full range of obstetric anaesthesia workload	In place but evidence needs strengthening			
11.7	Obstetric anesthesia staffing guidance should include participation by anaesthetists in maternity multidisciplinary ward rounds	Sign in regiater on DS - poorly completed by anaesthetic team at present			
11.8	Obstetric anesthesia staffing guidance should ensure maintenance of safe services by outlining need for prospective cover	In place but evidence needs strengthening			
	IEA 12: POSTNATAL CARE				
12.1	Trusts must ensure that women readmitted to postnatal ward and unwell postnatal women have timely consultant review. Evidence of a system to ensure consultant review of these women, including those on non-maternity ward, must be in place	PN guideline in draft - need to include standard and then audit			
12.2	Unwell postnatal women must be seen daily as a minumum	Current practice			

12.3	Postnatal readmissions MUST be seen within 14 hours of readmission or urgently if required	As above			
12.4	Staffing levels must be appropriate for activity and acuity of care on postnatal ward both day and night, for both mothers and babies.	Staffing levels as per BR+ 2018			
	IEA 13: BEREAVEMENT CARE				
13.1	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care	New Bereavement Lead starting in post 27.06.22			
13.2	Bereavement care must be available 7 days a week for both women and families who suffer pregnancy loss				
13.3	Adequate numbers of staff must be trained to take post-mortem consent so counselling can take place within 48 hours of birth				
13.4	Trusts must have developed a system to ensure families are offered follow-up appointments following perinatal loss or poor neonatal outcome				
13.5	Compassionate, individualised, high quality bereavement care must be delivered to ALL families who have experienced perinatal loss				
13.6	Evidence of guidance such as National Bereavement Care Pathway	Not yet complete - working towards			
	IEA 14: NEONATAL CARE				
14.1	Must be clear pathways for provision of neonatal care				
14.2	Work to expand neonatal critical care, nenonatal cot numbers, development of workforce and enhance experience of families must progress at pace following recomendations from the Neonatal Critical Care Review (2019)	**NOT A TRUST OR SYSTEM RESPONSIBILITY**			
14.3	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including designation of each unit and level of care provided				
14.4	85% of births at less than 27 weeks gestation should take place at a maternity unit with an onsite NICU				
14.5	Neonatal ODNs must allow staff within providers units the opportunity to share best practice and education to ensure units are not operating in isolation from their local support network	Self assessmnt and visit			
14.6	Each ODN must report to commissioners annually what measures are in place to prevent units from working in isolation	Self assessmnt and visit			
14.7	During course of neonatal resuscitations, neonatal providers must ensure there are processes in place to allow telephone instructions and advice to be given				
14.8	If consultant is not immediately available, there must be mechanism for real-time dialogue to take place between consultant and resuscitating team if required				
14.9	Practitioners must ensure that once airway is established, appropriate early consideration is given to increasing inflation pressure, if required Pressures above 30cmH20 in TERM babies Pressures above 25cmH20 in PRE-TERM babies	This is NLS guidance which is taught in the Trust			
1410	Neonatal providers must have sufficient numbers of appropriately trained consultants, middle grade doctors or ANNPs and nurses available in every type neonatal unit to deliver safe care 24/7	No seperate rota. Not yet at BAPM			
14.11	Care that is outside agreed pathway must be monitored by quarterly exception reporting and reviewed by providers and network. The activity and results of reviews must be reported to commissioners and LMNS quarterly.	Pathway in place for MDT oversight of all cases. Quarterly report to be cre			
	IEA 15: SUPPORTING FAMILIES				

15.1	Care and consideration of mental health and wellbeing of mothers, their partners and the family must be integral to maternity service provision	PMH service -collaborative working needs strengthening			
15.2	Robust mechanisms for identification of psychological distress must be in place, and clear pathways for women and families to access support	New MMHS in place			
15.3	Access to timely emotional and psychological support should be without need for formal mental health diagnosis	New MMHS in place			
15.4	Complex psychological support should be delivered by specialist psychological practitioners who have expertise in maternity care	New MMHS in place			
15.5	Maternity care providers must actively engage with local community, MVP, women with lived experience, to deliver informed services	12.5.22 MVP worcester Evidence uploaded - MVP meetings, minutes, agenda's, news letters, MVP training video, co production course attended by PDM (WAHT)			