Inspection framework: NHS acute hospitals

Core service: Maternity and gynaecology

This includes all services provided to women that relate to gynaecology and pregnancy (including the planning and/or prevention of). Therefore ante and postnatal services are included, as well as labour wards, and theatres providing obstetric and gynaecology related surgery. Termination of pregnancy is included within the scope of this core service.

Some of these services will be provided by the hospital in the community setting and therefore we will consider the pathways being provided between the two settings.

If a new born baby requires treatment in a special care baby unit (SCBU) or neonatal unit where the care is delivered by a paediatrician, this will be included under the core service for children and young people.

Areas to inspect*
The inspection team should carry out an initial visual inspection of each area. Your observations should be considered alongside data/surveillance to identify areas of risk or concern for further inspection. • Antenatal clinics including booking appointment activities both hospital and community based • Maternity day assessment unit • Early Pregnancy Unit, antenatal ward, induction of labour facilities • Screening e.g. phlebotomy, ultrasonography, amniocentesis • Consultant led obstetric unit – (including triage labour, delivery, recovery and postpartum rooms)

- Midwife led birth unit (alongside and/or freestanding) - (including triage, labour, delivery, recovery, postpartum) rooms
- Obstetric theatres including recovery
- Newborn screening carried out by the maternity service.
- Post natal ward and high dependency beds (including after caesarean section)
- Bereavement facilities
- Family Planning / Family Spacing clinics
- Termination of pregnancies –outpatient clinic, day care beds, in-patient facilities
- Fetal medicine unit (where provided)

In the community the inspection team may wish to visit (as appropriate):

- Patients homes
- Birthing Centres – all types including:
    - Free standing midwifery led units
    - Co-located Midwifery led units (midwifery units alongside an obstetric unit)

Interviews/focus groups/observations

You should conduct interviews of the following people at every inspection:

- Women who are using/have recently used this maternity service and those close to them
- Women who are using/have used the TOP service
- Clinical Lead for maternity; clinical lead for gynaecology
- Directorate/Divisional Manager
- Head of Midwifery
- Senior nurse for gynaecology service
- Safeguarding lead / Risk Midwife

In the community you may wish to interview:

- A sample of community midwifery teams across the geographical area covered by the provider and from different bandings (*)
- Women and those close to them, who are using or recently used community based services (**)
- Community Midwifery Matron/ Manager
- Family planning nurses
- Clinical Governance Managers and risk Managers (for independent providers)

(* &)** It may be advisable to seek to schedule interviews in advance of the inspection to maximise the number of participants.

You could gather information about the service from the following people, depending on the staffing structure:

- Midwives and nurses at all levels e.g. Supervisor of Midwives (SoM), student midwives, maternity support workers, consultant midwives, specialist midwives; gynaecology nurse(s).
- Ultrasonographers and radiographers
- Clinical lead for perinatal mental health
- Maternity educator for the trust
- Staff from the neonatal team, neonatal nurses, paediatricians
- Community outreach groups for service users

In the community you may wish to gather information about the service from the following:

- Community midwives
- Health visitors and GPs (in terms of handover/discharge arrangements)
- Antenatal screening midwife
- Maternity services liaison committees (MSLC where in place)
- Healthwatch
- Maternity Service Liaison Committee chair
- Obstetricians (consultants, trainees) anaesthetists, gynaecologists and other medical staff
- Clinical risk midwife
- Early pregnancy service staff
- Maternity counsellors

Safe

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Key lines of enquiry: **S1 & S2**

S1. What is the **track record** on safety?

S2. . Are **lessons learned and improvements made** when things go wrong?

Report sub-heading: **Incidents**

Generic prompts	Professional Standard	Additional prompts
• What is the safety performance over time, based on internal and external information? • How does safety performance compare to other similar services? • Do staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally? • Have safety goals been set? How well is performance against them monitored using information from a range of sources? • Are people who use services told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result? • When things go wrong, are thorough and robust reviews or investigations carried out?	• Never Events should be investigated using the Revised Never Events Policy Framework • SI`s should be investigated using the Serious Incident Framework 2015. (Surgical SIs include SIs in anaesthesia). • Safer Childbirth: There is evidence of multi-professional input in protocol and standard setting and in reviews of critical incidents. • Safer Childbirth: Meetings involving all relevant professionals are held to review adverse events. • NICE QS 66 statement 4: For adults who receive intravenous (IV) fluid therapy in hospital, clear incidents of fluid mismanagement are reported as	Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers The criteria within the Serious Incident Framework describes the general circumstance in which providers and commissioners should expect Serious Incidents to be reported. • Serious Incidents(SIs) associated with maternity include: ➢ Unexpected admission to NICU ➢ Maternal unplanned admission to ITU ➢ Postpartum haemorrhage ≥1000 mls ➢ Venous thromboembolism (VTE)

Are all relevant staff and people who use services involved in the review or investigation? • How are lessons learned, and is action taken as a result of investigations when things go wrong? • How well are lessons shared to make sure action is taken to improve safety beyond the affected team or service?	critical incidents • RCOG: Improving Patient Safety: A meeting to review perinatal and maternal mortality and morbidity should normally be held monthly, involving multidisciplinary team members (MDT), Minutes and lessons learnt should be shared widely across the service. • Duty of Candour: As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. • Recommendation 8 of the MBBRACE report published June 2015 sets out that All organisations responsible for maternity services should report to MBRRACE-UK all births between 22+0 and 23+6 weeks gestational age who do not survive the neonatal period	➢ 3rd or 4th degree trauma (Obstetric Anal Sphincter Injury (OASIS) ➢ Abortion complications Consider looking at: • Copy of the last 3 Root Cause Analyses and subsequent action plans. • Last 3 months morbidity and mortality meeting minutes. • Evidence of dissemination of learning by staff from incidents. • Evidence of adherence to duty of candour regulation, including process and evidence of written apologies. • Does the service ensure that all births between weeks of 22+0 and 23 +6 gestational age who do not survive the neonatal period are report to MBRRACE-UK? **If you are inspecting a community based maternity service it is also important to ask the following:** • How many and what kind of incidents are reported in the community? Who maintains oversight of these?

		• Do members of the community team have appropriate access to computers or the internet to complete incident reports in a timely way; and do they receive feedback from investigations and what evidence of change in practices is available? • How are lessons shared from incidents occurring in the trust with the community team or provider? How well does this work?
Report sub-heading: **Safety Thermometer**		
Generic prompts	**Professional Standard**	**Additional prompts**
	• **The Maternity Safety Thermometer:** ➢ Perineal and/or Abdominal Trauma ➢ Post-Partum Haemorrhage ➢ Infection ➢ Separation from Baby ➢ Psychological Safety. ➢ Apgar scores < 7 at 5 minutes	• How does the service measure metrics on the safety thermometer? **If you are inspecting a community based maternity service it is also important to ask the following:** • Is this information displayed for patients, visitors and staff so they can see how the service is performing?

Key line of enquiry: **S3**		
Are there **reliable systems, processes and practices** in place to keep people safe and safeguarded from abuse?		
Report sub-heading: **Mandatory training**		
Generic prompts	**Professional Standard**	**Additional prompts**
• Do staff receive effective mandatory training in the safety systems, processes and practices?	• Safer Childbirth: Mandatory training for staff working in maternity would be expected to include neonatal and obstetric emergencies as a minimum.	• Statutory and mandatory training records: ➢ How is the content decided upon? ➢ Is it multidisciplinary? ➢ Does the content respond to incidents? • Is there evidence of learning through simulation? – e.g. major obstetric haemorrhage **If you are inspecting a community based maternity service it is also important to ask the following:** • Is there learning via simulation (skills and drills training) of an emergency situation in the community. For example: ○ Management of a haemorrhage ○ How to recognise the deteriorating health of a woman ○ A woman moving from low risk to high risk birth ○ Emergency evacuation from a birthing pool

		• How is this training delivered, do midwives attend the acute setting or is it delivered and practised in the community?
Report sub-heading: **Safeguarding**		
• Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff? • Is implementation of safety systems, processes and practices monitored and improved when required? • Are there arrangements in place to safeguard adults and children from abuse that reflect relevant legislation and local requirements? Do staff understand their responsibilities and adhere to safeguarding policies and procedures?	• Safeguarding Intercollegiate Document: Clinical staff working with children, young people and/or their parents / carers and who could contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to safeguarding at level 3. • Multi-agency statutory guidance on female genital mutilation 2016 This multi-agency guidance on female genital mutilation (FGM) should be read and followed by all persons and bodies in England and Wales who are under statutory duties to safeguard and promote the welfare of children and vulnerable adults. It replaces female genital mutilation: guidelines to protect children and women (2014). The above guidance should be considered together with other relevant safeguarding guidance including(but not limited to):	• What is the uptake of safeguarding training? (both acute and community) • What risk assessments are undertaken?(both acute and community) • Are there arrangements in place to safeguard women with, or at risk of, Female Genital Mutilation (FGM) • What guidance/protocols are in place if a girl under 13 years of age presents for a termination of pregnancy? • **For services treating under 18yrs:** ○ Do staff have an awareness of CSE and understand the law to detect and prevent maltreatment of children?(acute and community) ○ How do staff identify and respond to possible CSE offences? Are risk assessments used/in place? (community and acute)

	• Multi-agency statutory guidance on female genital mutilation 2016 DH • Working together to safeguard children: HM Gov. 2015 • FGM Mandatory reporting of FGM in healthcare • fgm-video-resources for healthcare professionals • Under Section 5 of the Sexual Offences Act 2003, a girl under 13 years of age is not considered capable of giving her consent to sexual intercourse. Disclosure is not invariably required but it is usual in order that the interests of the child, which are paramount, may be protected. • For women under 16 years of age, refer to page 24 RGOC section 3.8 • Guidance for physicians on the detection of child sexual exploitation. RCP 2015	○ What safeguarding actions are taken to protect possible victims of CSE? Are timely referrals made? And is there individualised and effective multi-agency follow up? ○ Are leaflets available about CSE with support contact details? • Does the trust have an abduction policy? **If you are inspecting a community based maternity service it is also important to ask the following:** • Do community midwives have sufficient time to carry out safeguarding activities? • How do community midwives assess and provide early help to: ○ Young adults 16-18yrs ○ Families in need ○ FGM women • Have there been any important local safeguarding/serious case reviews/domestic murder/FGM reviews, if so how have the community team been involved and responded to these? • Has there been a recent local QCQC and safeguarding looked after children's review? If so, what were the

		recommendations and how have the community team responded to it? • What systems are in place to check whether families are subject to a child protection/child in need plan; and ensure that staff such as health visitors work with others to ensure they are followed? • Is information on safeguarding shared in a timely way and are reports and learning from safeguarding incidents available to community staff? • Does the handover to health visiting in the postnatal period incorporate safeguarding? • Who is accountable and responsible for the quality and impact of child protection arrangements? • Do the maternity SG leads attend MDT meetings with lead agencies (local authority) for the purposes of sharing good practice and policy updates? • Is there a lead for teenage pregnancy? • What are the safeguarding arrangements in the community setting for women with perinatal mental health concerns or substance misuse problems?

		• What training is provided to community maternity staff in relation to the Government's 'prevent' strategy?
Report sub-heading: **Cleanliness, infection control and hygiene**		
• How are standards of cleanliness and hygiene maintained? • Are reliable systems in place to prevent and protect people from a healthcare-associated infection? • Is implementation of safety systems, processes and practices monitored and improved when required?	• Pregnant women at any stage of pregnancy should be offered the influenza vaccination.[1] Pregnant women should also be offered the Pertussis vaccination. • NICE QS61 statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. • NICE QS61 statement 4: People who need a urinary catheter have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter and its removal as soon as it is no longer needed. • NICE QS61 statement 5: People who need a vascular access device have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device and its	• Are people using the service screened for C-diff / MRSA? • What local arrangements are in place for women to receive vaccinations? • What is the incidence of Puerperal sepsis and other puerperal infections within 42 days of delivery and readmission rates for infections in mothers and baby? **If you are inspecting a community based maternity service it is also important to ask the following:** • How are standards of cleanliness and hygiene maintained in community clinics and within patients home e.g. hand washing, availability of hand gel, BBE (Bare Below the Elbow) • What procedures are in place to obtain aprons and gloves? • How is equipment cleaned between use?

	removal as soon as it is no longer needed.	
Report sub-heading: **Environment and equipment**		
• Does the design, maintenance and use of facilities and premises keep people safe? • Does the maintenance and use of equipment keep people safe? • Do the arrangements for managing waste and clinical specimens keep people safe? (This includes classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.) • Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff? • Is implementation of safety systems, processes and practices monitored and improved when required?	• Safer Childbirth: At a minimum a maternity unit offering obstetric care should have: ➢ Cardiotocography (CTG) machines ➢ Resuscitation equipment – for adults and the new-born ➢ Fetal blood analyser ➢ Fetal heart rate monitoring for high risk pregnancies. ➢ Laboratory facilities with availability of blood and blood products. • Safer Childbirth: Facilities should be reviewed at least biannually and plans made to rectify deficiencies within agreed timescales • Maternity care facilities should be designed in keeping with the DH guidance Health Building Note 09-02	• How far are the obstetric theatres/ Neonatal unit from the delivery suite? Are lifts required to transfer women and babies to these locations (potential sources of delay)? • All equipment must conform to the relevant safety standards and be regularly serviced. Electrical equipment must be PAT tested. **If you are inspecting a community based maternity service it is also important to ask the following:** • Do community midwives have their own baby scales, sonicaids and bilirubinometers? If so, how and when are these calibrated? • Do they have access to Carbon monoxide monitors? • Are weighing scales and BP cuffs available for mothers in settings for community based ante natal care? Do the weighing scales allow the full weight range to be measured?

	https://www.resus.org.uk/quality-standards/equipment-used-in-homebirth/	• Do community midwives have access to specific equipment for raised BMI patients? • What emergency equipment do community midwives carry and how is this maintained and checked? • How do community midwives transport equipment, is this safe and secure and compliant with local protocols and legislation? • In births using a birthing pool in the home, are community midwives able to check for new liners and how the parents plan to use the pool in line with PHE/HSE guidance? • Do they have access to resus trolleys at clinics and GP practices • What equipment is routinely supplied to a woman's home in advance of a home birth; and how is this equipment monitored to ensure it is fit for purpose when required? • How are urine samples/ testing strips, sharps, placenta (unless the woman has opted to retain their placenta) and other waste disposed of when working in the home?

		• How are community midwives kept safe in the community: for example, what is the lone worker policy? What equipment are they given when working alone and how is their welfare checked upon? • What happens if there are concerns about the patient's partner, another family member or pet in the patient's home? • If they have to collect equipment or birth packs from closed or empty facilities late at night how is this managed?
Report sub-heading: **Medicines**		
• Do arrangements for managing medicines, medical gases and contrast media keep people safe? (This includes obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.) • Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff? • Is implementation of safety systems, processes and practices monitored and improved when required?	• NMC - Standards for Medicine Management • NICE QS 61: People are prescribed antibiotics in accordance with local antibiotic formularies. https://www.rcm.org.uk/news-views-and-analysis/analysis/changes-to-midwives-exemptions	• Are allergies clearly documented in the prescribing document used? • Are there local microbiology protocols for the administration of antibiotics and are prescribers using them? **If you are inspecting a community based maternity service it is also important to ask the following:** • How are community medicines managed in terms of obtaining, storage and returned to pharmacy? What audits are undertaken to show procedures are safe and medicines are in date?

		• In the case of home births how are Controlled Drugs including pethidine obtained, stored and used; what audits are completed? • How are medical gases obtained and stored in the community? What risk assessments are conducted to ensure the midwife or their car or premises are not a target for someone wanting to access medical gases inappropriately? • How do midwives ensure they do not run out of medical gases? • How are medical gases transported by community midwives? How would emergency services be made aware their vehicle may contain nitrous oxide? • Do community midwives administer the flu or pertussis vaccines? How are these transported and stored? Is there a PGD in place?

Report sub-heading: **Records**		
• Are people's individual care records written and managed in a way that keeps people safe? (This includes ensuring people's records are accurate, complete, legible, up to date and stored securely). • Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff? • Is implementation of safety systems, processes and practices monitored and improved when required?	• NICE QS22 Statement 3: Pregnant women have a complete record of the minimum set of antenatal test results in their hand-held maternity notes. • Safer Childbirth: The standard of record keeping and storage of data is clear, rigorous and precise • records-management-code-of-practice-for-health-and-social-care	• Are documents dated, timed, with a signature and identifiable name? (acute and community settings) • Do records accurately record the woman's choice; are risk assessments documented clearly and patients individualised care plans clear? Are referrals to specialist services documented? **If you are inspecting a community based maternity service it is also important to ask the following:** • Are patient records transported between the acute trust and the community; if so, how are they kept safe and confidential? • Is there sufficient storage for records to comply with data protection issues? • Are the women's held records kept with them at all times, what happens if the woman's held records are lost? • If I-pads and laptops are used are they encrypted and what happens if they are lost or stolen?

		• Are records returned to medical records in a time manner after discharge from maternity services/ • How are care documents handed over to the health visitor? • How do staff access records remotely for example in GP surgeries? • What is the process for collecting midwives diaries and ensuring they are stored securely? • Is the redbook completed (personalised child record given to each parent/carer at the child's birth to record the child's health and development)?

Key line of enquiry: **S4**		
How are **risks to people who use services** assessed, and their safety monitored and maintained?		
Report sub-heading: **Assessing and responding to patient risk**		
Generic prompts	**Professional Standard**	**Additional prompts**
• Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively? • How do staff identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing, medical emergencies or behaviour that challenges?	• NICE CG 190: Section 1.10: Monitoring in labour. • Safer Childbirth: The consultant obstetrician must be contacted prior to emergency caesarean section and must be involved when a patient's condition gives rise for concern and attend as required. • MBRRACE-UK report: Saving Lives, Improving Mothers' Care – Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13 (published Dec 2015). • NICE QS3 statement 1: All patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool. • NICE QS3 statement 4: Patients are re-assessed within 24 hours of admission for risk of VTE and	• Use of Modified Early Obstetric Warning (MEOWs) Score – is this audited to ensure compliance? • Do risk assessments at booking (around 10 weeks pregnancy) include social and medical assessment and referral, as well as assessment of maternal mental health? • What is the maternity triage process? • Is there use of WHO surgical safety checklists in maternity and gynaecological surgery? • What are their policies for transfer to secondary care (e.g. from a midwife-led unit or home birth)? • Are there local agreements with the ambulance service on attendance at emergencies or when transfer is required? • What happens when a woman arrives in labour without having booked?

	bleeding. • The service should ensure compliance with the 5 steps to safer surgery World Health Organization for patients undergoing surgery and the modified Maternity WHO surgical safety checklist in maternity. • Pre-operative assessment should be in line with NICE CG3: Pre-operative assessments • NICE QS 22: Risk assessments for raised BMI, Gestational diabetes, smoking and pre-eclampsia, VTE.	• How does the provider ensure that appropriate liaison with critical care is available in the event of a patient requiring transfer or input from critical care services? **If you are inspecting a community based maternity service it is also important to ask the following:** • Is the booking appointment undertaken before 10 weeks of pregnancy and certainly before 12 weeks? What percentage of bookings, are undertaken by 12 weeks? • Are women with risk factors identified and referred appropriately to an obstetrician? What is the working relationship like with obstetricians and what is the care pathway for escalation? • Is there evidence of ongoing risk assessment, review and revision of care plans as necessary throughout the pregnancy? What are the arrangements for pregnant women and new mothers with mental health concerns or substance misuse problems?

		• How are plans managed for those women with high risk factors wanting a home birth, or for those declining care or wishing to have a freebirth? • How are such plans communicated across the (multi-disciplinary) team? How is this information shared and communicated with others i.e. consultants/ambulance service? • What processes are in place within the community for identifying and managing a deteriorating woman? • What process is in place for sharing information with the local acute trust i.e. Service Level Agreement? For example, do they notify the acute trust of a woman in labour and how is that done? • Is there a transfer policy in place and how does this operate? Are midwives familiar with the policy? • Are there local agreements with the ambulance service on attendance at emergencies or when a transfer is required? • Are women advised about influenza and pertussis vaccination? What are the arrangements in place to monitor

		uptake?
Report sub-heading: **Midwifery and Nurse staffing**		
• How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times, in line with relevant tools and guidance, where available? • How do actual staffing levels compare to the planned levels? • Do arrangements for using bank, agency and locum staff keep people safe at all times? • How do arrangements for handovers and shift changes ensure people are safe?	• NICE NG4: Safe Midwifery Staffing ➢ Women in established labour should receive on-to-one care. ➢ A systematic process must be undertaken to calculate the midwifery staffing establishment every 6 months. The calculation should take into account historical data and acuity and dependency of patients. • Safer Childbirth: An experienced midwife (shift coordinator) is available for each shift on the labour ward. • Safer Childbirth: All midwifery units must have one WTE consultant midwife. • Safer Childbirth: Student midwives should be supernumerary to the midwife establishment. • Staffing numbers need to be displayed outside all inpatient areas in line with NHS England / CQC: Hard Truths. • Birthrate Plus	• What is the midwife to birth ratio? How does the service take into account the skill mix of staff and complexity of case mix? • What is the number of and role of Maternity Support Workers, what training do they receive and how is this updated? • NICE NG4: **Staffing Red flags** ○ Delayed or cancelled time critical activity. ○ Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing). ○ Missed medication during an admission to hospital or midwifery-led unit. ○ Delay of more than 30 minutes in providing pain relief. ○ Delay of 30 minutes or more between presentation and triage. ○ Full clinical assessment not carried out when presenting in labour. ○ Delay of 2 hours or more between admission for induction and beginning of process. ○ Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). ○ Any occasion when 1 midwife is not able to provide continuous

		one-to-one care and support to a woman during established labour . **If you are inspecting a community based maternity service it is also important to ask the following:** • How do actual staffing levels compare to the planned levels? • What are the midwife caseload numbers? • How is sickness and maternity cover dealt with i.e. agency/bank staff? • How does the trust's escalation policy impact on community midwifery? For example, on women wishing to have a home birth, general staffing in the community, on call service and staff numbers and planned clinics? • How are skills maintained for community midwives to work in the hospital setting, what buddying arrangements are in place, training provided? Are skills and drills customised for community settings? • What is the level of supervisory midwives numbers and ratio?

		• What are the handover arrangements within their own teams? • Do staff have access to a link hospital support service, do they know which consultant to contact for example? • How do community midwives work with other staff such as maternity support workers and community administrator? (MSWs are often used as part of Birthrate+ - admin provide essential info i.e. if there has been miscarriage)
Report sub-heading: **Medical staffing**		
• How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times, in line with relevant tools and guidance, where available? • How do actual staffing levels compare to the planned levels? • Do arrangements for using bank, agency and locum staff keep people safe at all times? • How do arrangements for handovers and shift changes ensure people are safe?	• Safer Childbirth/RCOG: The Future Workforce: Recommended Consultant **presence** on labour ward per week: ➢ <2500 births: 40 hours or based on risk assessments ➢ 2500 – 6000 births: 40 hours ➢ >6000 birth: 60 hours • Safer Childbirth: Outside consultant hours, there should be a minimum twice daily ward rounds, including bank holidays and weekends. They should be available within 30 minutes if required. • AAGBI Obstetric Anaesthetic Guidance: ➢ A duty anaesthetist must be	• Is the recommended obstetric consultant staffing levels being met? Is an anaesthetist available immediately throughout the whole of the day and night and at weekends? Are they free from other duties? **If you are inspecting a community based maternity service it is also important to ask the following:** • In the case of high risk women what are the escalation pathways and policies in place across antental,intrapartum and postnatal services and for escalating to a consultant for a review?

	immediately available 24/7. There must be 12 consultant sessions per week to cover emergency work on delivery suite. Scheduled obstetric anaesthetic activities (e.g. elective caesarean section lists, clinic) require additional consultant sessions over and above the 12 for emergency cover. http://www.rcoa.ac.uk/document-store/guidance-the-provision-of-obstetric-anaesthesia-services-2015 • Staffing numbers need to be displayed on boards outside all inpatient areas in line with NHS England / CQC: Hard Truths	• Are there consultant led clinics in the community?
Key line of enquiry: S5		
How well are potential risks to the service **anticipated** and **planned** for in advance?		
Generic prompts	**Professional Standard**	**Additional prompts**
Report sub-heading: **Major incident awareness and training**		
• How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing? • What arrangements are in place to respond to emergencies and major incidents? How		• What arrangements are in place in case of suspension of maternity services? **If you are inspecting a community based maternity service it is also important to ask the following:**

often are these practised and reviewed? • How is the impact on safety assessed and monitored when carrying out changes to the service or the staff?		• How sustainable is the home birth service and if appropriate FMUs? • What arrangements are in place in the case of suspension of homebirth services? • What arrangements are in place in the case of suspension/closure of a free standing midwifery unit? • What major incident awareness and training takes place in the community for example, EBOLA, pandemic flu episode? • What plans are in place for severe weather conditions? • How would community based services manage increased capacity if required by the acute trust. For example, if the hospital is closed?

Effective

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Key line of enquiry: **E1**

Are people's needs assessed and care and treatment delivered in line with legislation, standards and **evidence-based guidance**?

Generic prompts	Professional Standard	Additional prompts
Report sub-heading: **Evidence-based care and treatment**		
• How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies). • Do people have their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice? How is this monitored to ensure compliance? • Is discrimination, including on grounds of age, disability, , gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation avoided when making care and treatment decisions? • How is technology and equipment used to enhance the delivery of effective care and treatment?	• Safer Childbirth: Comprehensive evidence-based guidelines and protocols for intra-partum care are agreed by the labour ward forum or equivalent, ratified by the maternity risk management group and reviewed at least every 3 years. • NICE QS22 - 12 quality statements in respect of antenatal care. • NICE QS32 - 9 quality statements in respect of caesarean section. • NICE QS37 - 11 quality statements in respect of postnatal care. • NICE CG192: Antenatal and post-natal mental health: clinical management and service guidance. • MBRRACE-UK Perinatal Confidential	• How does the service ensure that maternity is managed in accordance with RCOG: *'Safer childbirth: minimum standards for the organisation and delivery of care in labour'?* • Is the service managed in accordance with NICE guidelines and quality standards for maternity and gynaecology? • How does the service ensure that the care of women with a multiple pregnancy is planned and provided in accordance with NICE quality standards for management of twin and triplet pregnancies in the antenatal period?

• Are the rights of people subject to the Mental Health Act (MHA) protected and do staff have regard to the MHA Code of Practice?	Enquiry into Term, singleton, normally formed, antepartum stillbirths (November 2015). • NICE guideline: Diabetes in pregnancy: management from preconception to the postnatal period (NG3, 2015). • NICE Clinical Guideline: Antenatal care for uncomplicated pregnancies (CG62) (See 1.10 Fetal growth and well-being) • RCOG: Reduced fetal movements, Green-top Guideline No. 57 • NICE CG 190: Recommendations for intra-partum care. • NICE QS3 statement 5: Patients assessed to be at risk of VTE are offered VTE prophylaxis in accordance with NICE guidance. • NICE QS46 statement 1: Determining chorionicity and amnionicity • NICE QS46 statement 2: Labelling the foetuses • NICE QS46 statement 4: care planning • NICE QS46 statement 5: monitoring	• Are all women with risk factors for gestational diabetes identified and offered glucose tolerance testing as highlighted by MBRRACE-UK (2015) and in line with the current NICE guideline (NG3, 2015). • Is growth monitored from 24 weeks by measuring and recording the symphysis fundal height as highlighted by MBBRACE-UK (2015) and in line with current NICE Guideline (CG62,) and is there a clear escalation policy and pathway for any abnormal findings? • Do midwives and obstetricians emphasise the importance of fetal movements to women at each antenatal contact as a method of fetal surveillance, as highlighted by MBRRACE-UK (2015) and in line with the current RCOG guideline (Green-top Guideline No. 57), and document the detail of this conversation? • How does the service ensure that appropriate evidence based advice and treatment is provided in respect of sexually transmitted infection and family planning/contraception advice to women using the **termination of pregnancy** service? • How does the service ensure that methods of **termination of pregnancy**,

	for fetal complications
	
	• RCOG guidance: The care of women requesting induced abortion
	
	• RCOG Third- and Fourth-degree Perineal Tears, Management (Green-top Guideline No. 29)
	
	• NICE QS90 urinary tract infections in adults
	
	  • RCOG: Reduced fetal movements Green-top Guideline No.57
	
	  • NHSE Care bundle for still birth
		including feticide are carried out in accordance with the RCOG guidelines?
		
		NB: In assessing whether NICE guidance in followed, take the following into account: Details of the provider's Clinical Audit programme to support and monitor implementation of NICE guidance
		
		Details of additional prescribing audits that may be completed by junior doctors on rotation.
		
		Utilisation of NICE implementation support tools such as the baseline assessment tools.
		
		A Provider submission demonstrating good practice to the NICE shared learning database. NICE checks that the examples are in line with their recommendations and quality statements.
		
		Participation in National benchmarking clinical audits

Report sub-heading: **Nutrition and hydration**		
• How are people's nutrition and hydration needs assessed and met?		• How does the service ensure that new mothers are supported in feeding their baby / babies as they choose? • What food is offered to women in labour; and after caesarean section

		• How is the patient's hydration checked during labour? (Applies to both acute and community setting) **If you are inspecting a community based maternity service it is also important to ask the following:** • What processes and policies are in place to monitor weight loss in babies in the community including specialist support services? • What processes and policies are in place to monitor jaundice in babies in the community including specialist support services? • What processes are in place in the community to support breast feeding? • Are the community midwives trained to complete the newborn baby checks within 72 hours of birth?
Report sub-heading: **Pain relief**		
• How is the pain of an individual person assessed and managed?	• NICE CG 190: Recommendations for non-regional and regional pain relief during labour. • AAGBI Obstetric Anaesthetic Guidance: ➢ Women should have antenatal	• How does the service ensure that there is 24hr availability of choice of pharmacological (e.g. opioids, epidural) and non-pharmacological (e.g. immersion in water, support to use relaxation techniques) pain relief?

	access to evidence based information about the availability and provision of all types of analgesia and anaesthesia. ➢ When a 24-hour epidural service is offered, the time from the anaesthetist's being informed that a woman is requesting an epidural and ready to receive one should not normally exceed 30 minutes. ➢ This period should only exceed one hour in exceptional circumstances. • Safer Childbirth: 95% of women should receive regional anaesthesia for elective CS and 85% for emergency CS. • RCOG guidance 'the care of women requesting induced abortion' sets out: ➢ Women should routinely be offered pain relief (for example, NSAIDs) during surgical and medical abortion. • Core Standards for Pain (6.4) Management Services in the UK (Faculty of Pain Medicine, 2015).	• What is median time from women requesting an epidural to when they receive one (Should be 30mins) • How does the service ensure that during and following termination of pregnancy people using services receive effective pain relief? **If you are inspecting a community based maternity service it is also important to ask the following:** • What methods of pain relief are used in the community setting? What arrangements does the service make for providing pain relief at home for women requesting a homebirth or for women giving birth in an FMU?

Key line of enquiry: **E2**		
How are people's care and treatment **outcomes monitored** and how do they **compare** with other services?		
Generic prompts	**Professional Standard**	**Additional prompts**
Report sub heading: **Patient outcomes**		
• Is information about the outcomes of people's care and treatment routinely collected and monitored? • Does this information show that the intended outcomes for people are being achieved? • How do outcomes for people in this service compare to other similar services and how have they changed over time? • Is there participation in relevant local and national audits, benchmarking, accreditation, peer review, research and trials? • How is information about people's outcomes used and what action is taken as a result to make improvements? • Are staff involved in activities to monitor and improve people's outcomes?	• Safer Childbirth: There is an evaluation of midwifery and obstetric care through continuous prospective audit to improve outcomes, which are published as an annual report • National audits and enquiries in respect of **maternity services** include the following: ○ UK national screening committee antenatal and new born screening education audit ○ Royal College of Obstetricians and Gynaecologists Clinical Indicators Project, 2013 (RCOG 11 quality indicators) ○ Local audits (e.g. reason for unplanned caesarean section) ○ LSA Midwifery Officer – annual report ○ Unexpected admissions to neonatal intensive care unit (NICU) ○ Maternal unplanned admission to critical care services ○ National Patient Safety Agency Intrapartum Scorecard ○ Intrapartum death	• Is there evidence that the service regularly reviews the effectiveness of care and treatment through local audit and national audit/enquiry? • Is there evidence that the service is making measurable improvements in the light of audit(s)? • Are there national audits that the service does not contribute to and what is/are the reason(s) for this? **If you are inspecting a community based maternity service it is also important to ask the following:** • What are the numbers of women choosing to birth at home or in an FMU, what is the number transferred before labour, and what are the numbers beginning labour in their chosen care setting. What is the total number of transfers before and after birth and what are the reasons for this?

	○ Maternal death ○ RCOG Maternity Dashboard ○ Outcomes Framework for the NHS 2013/14 (maternity specific indicators) ○ Public Health Outcomes Framework 2013-2016 (maternity specific indicators) • Audits in respect of **termination of pregnancy services** as recommended by the RCOG: The care of women requesting induced abortion	• What is the transfer rate from midwifery to /community home births? • What is the outcome for women who started labour at home and transferred into hospital? • How are unplanned transfers reviewed for themes and action plans put in place, who does this and how often? • How is high risk care assessed, and how are high risk births communicated to the acute trust? • What arrangements are in place for newborn hearing tests at home or in FMUs • What arrangements are in place to babies born before arrival (BBA)? • Have benchmarking exercises been undertaken against national reports? ○ Kirkup ○ National Maternity Service Review ○ MBRRACE • Are perineal tears monitored separately for home births – are there any trends, actions in place

Key line of enquiry: **E3**		
Do **staff** have the **skills, knowledge and experience** to deliver effective care and treatment?		
Generic prompts	**Professional Standard**	**Additional prompts**
Report sub heading: **Competent staff**		
• Do staff have the right qualifications, skills, knowledge and experience to do their job when they start their employment, take on new responsibilities and on a continual basis? • How are the learning needs of staff identified? • Do staff have appropriate training to meet their learning needs? • Are staff encouraged and given opportunities to develop? • What are the arrangements for supporting and managing staff? (This includes one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.) • How is poor or variable staff performance identified and managed? How are staff supported to improve?	• Safer Childbirth: A professional (midwife, neonatal nurse, and paediatrician) trained and regularly assessed as competent in neonatal basic life support must be immediately available for all births, in any setting. • Safer Childbirth: There should be adequate clinical support and supervision for newly qualified midwives, junior doctors and students. • Safer Childbirth: Multi-professional in-service education/training sessions should be mandatory and attendance documented. And recommendation 5.2 of the National Maternity review Feb 2016 • RCOG: The care of women requesting induced abortion: When using manual vacuum aspiration (MVA) clinicians must be aware of their skill level when using this method at gestations higher than 9 weeks	• How does the service ensure the arrangements are in place for training to deliver competence in: ○ Interpretation of Cardiotocogram(CTG) ○ newborn screening ○ Assessment of fetal growth in all setting including recording and escalation • Is multi-professional training a standard part of professionals' continuous professional development, both in routine situations and in emergencies? • How does the service ensure that in particular where abortions are carried out beyond nine weeks gestation, that healthcare professionals have received additional training and maintain competency? • Are counsellors who see / treat women that require formal therapeutic counselling (with respect to termination of pregnancy), trained counsellors with

		appropriate expertise in this field?
		
		If you are inspecting a community based maternity service it is also important to ask the following:
		
		• Are midwives competent to work across the service as a whole?
		
		• How often do community midwives work in the hospital? What impact does this have on community services?
		
		• What is the staff rotation policy?
		
		• What training and support is provided to keep their skills current?
		
		• How are newly qualified or early career midwives supported in community settings? How are midwifery units staffed and by whom, how is continuity of care ensured?
		
		• Depending on the setting (in the home or FMU), how does the service ensure appropriate arrangements are in place for training to deliver competence in:
		  • Obstetric emergencies
		  • Newborn screening
		  • Resusitation
		  • Perinatal suturing

		• Do they use MEWS (modified early warning systems) charts? • What support is provided from SoM and managers when there has been poor outcomes in the community in terms of de-brief?
Key line of enquiry: E4		
How well do **staff, teams and services work together** to deliver effective care and treatment?		
Generic prompts	**Professional Standard**	**Additional prompts**
Report sub-heading: **Multidisciplinary working**		
• Are all necessary staff, including those in different teams and services, involved in assessing, planning and delivering people's care and treatment? • How is care delivered in a coordinated way when different teams or services are involved? • Do staff work together to assess and plan ongoing care and treatment in a timely way when people are due to move between teams or services, including referral, discharge and transition? • When people are discharged from a service is this done at an appropriate time of day; are all relevant teams and services informed and is this only done when any ongoing care is in place?	• Safer Childbirth: Local multi-disciplinary maternity care teams, comprising midwives, obstetricians anaesthetists, paediatricians, support staff and managers, are established. • Safer Childbirth: There are effective systems of communication between all team members and each discipline, as well as with women and their families. • Safer Childbirth: There must be 24-hour availability in obstetric units of senior paediatric colleagues, who have advanced skills for immediate advice and urgent attendance, who	• Examples of how the maternity service works with other services to meets the needs of women: • Access to medical care from other specialities during stay on maternity unit • Communication with community maternity team during ante-natal care/ home births/ discharge from maternity unit. • If community midwives are employed by a different trust, how does the service being inspected liaise with them to ensure quality care? • Continuity of care on transfer between midwife led care and consultant led care • Joint working with mental health teams. • How does the service ensure that the objectives of The Academy of Royal Colleges Guidance for Taking

	will attend within 10 minutes • AAGBI Obstetric Anaesthetic Guidance: There should be an agreed system whereby the anaesthetist is given sufficient advance notice of all potentially high-risk patients. • NICE QS46: statement 3 Women with a multiple pregnancy are cared for by a multidisciplinary core team • NICE QS46: statement 6 Women with a higher-risk or complicated multiple pregnancy have a consultant from a tertiary level fetal medicine centre involved in their care.	Responsibility: Accountable Clinicians and Informed Patients has been implemented? • Are women with a multiple pregnancy cared for by a multidisciplinary core team that have the expertise needed to provide high-quality care for women with a multiple pregnancy? • What are the discharge arrangements for women following a TOP? Does this include a detailed discharge letter and a review of contraception? **If you are inspecting a community based maternity service it is also important to ask the following:** • How does the service work with other services to meet the needs of women, examples of working arrangements e.g. Family nurse Partnerships (FNP), GPs, learning disability services, Social Services, health visitors, ambulance service? • How does it work with the early pregnancy unit?
Report sub-heading: **Seven-day services**		
	• NHS Services, Seven Days a Week,	• Does the provider meet NHS England's

	Priority Clinical Standard 2 Time to first consultant review All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital • NCEPOD (2007): Emergency Admissions: A journey in the right direction? • RCS (2011): Emergency Surgery, Standards for unscheduled surgical care • Safer Childbirth: Outside consultant hours, there should be a minimum of physical twice daily ward rounds, including bank holidays and weekends. • AAGBI Obstetric Anaesthetic Guidance: An anaesthetist must be immediately available for emergency work on the delivery suite 24/7. • NHS Services, Seven Days a Week, Priority Clinical Standard 2 *Time to first consultant review* ○ All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the	seven day services priority standards around ○ Time to First Consultant Review? ○ Diagnostics? ○ Intervention / key services? ○ Ongoing review? • Do hospital inpatients have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and pathology? **If you are inspecting a community based maternity service it is also important to ask the following:** • What are the on call arrangements, how do women contact a midwife; communicate with maternity services out of hours? • How do they access triage, and escalate out of hours? • What are the staffing arrangements for the FMUs and sustainability of home birth services if delivered by a separate team?

	time of arrival at hospital • NHS Services, Seven Days a Week, Priority Clinical Standard 5 *Diagnostics* ○ Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: ▪ Within 1 hour for critical patients ▪ Within 12 hours for urgent patients ▪ Within 24 hours for non-urgent patients • NHS Services, Seven Days a Week, Priority Clinical Standard 6 *Intervention / key services* ○ Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with	

	clear protocols, such as: ▪ Critical care ▪ Interventional radiology ▪ Interventional endoscopy ▪ Emergency general surgery • NHS Services, Seven Days a Week, Priority Clinical Standard 8 ○ All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks. ○ Once transferred from an acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway. • RCS (2011): Emergency Surgery, Standards for unscheduled surgical care	

Key line of enquiry: **E5**		
Do staff have all the **information they need** to deliver effective care and treatment to people who use services?		
Generic prompts	**Professional Standard**	**Additional prompts**
Report sub-heading: **Access to information**		
• Is all the information needed to deliver effective care and treatment available to relevant staff in a timely and accessible way? (This includes care and risk assessments, care plans, case notes and test results.) • When people move between teams and services, including at referral, discharge, transfer and transition, is all the information needed for their ongoing care shared appropriately, in a timely way and in line with relevant protocols? • How well do the systems that manage information about people who use services support staff to deliver effective care and treatment? (This includes coordination between different electronic and paper based systems and appropriate access for staff to records).	• NICE QS15 statement 12: Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals. • RCOG guidance The care of women requesting induced abortion: ➢ 8.2 On discharge, all women should be given a letter providing sufficient information about the procedure to allow another practitioner elsewhere to manage any complications.	• How is any discharge communicated to GPs? How soon after discharge does this occur? What information is provided for GP reviews and follow up arrangements for example women with risk factors such as gestation diabetes? • How does the service ensure timely communication on transfer of woman and baby's care from a maternity unit to community midwifery team; then to Health Visitors (HVs) and the GP? • Are care summaries sent to the patient's GP on discharge to ensure continuity of care within the community? **If you are inspecting a community based maternity service it is also important to ask the following:** • How are test results, reports made available to community midwives, uploaded or shared appropriately with staff in a timely way? • How does the service ensure timely communication on transfer of a woman and baby's care from a maternity unit to

		the community midwifery team, and then to health visitors and the GP? If appropriate what happens in relation to out of area births? • How is communication managed between local agencies and the maternity unit? • What information about pregnancy is shared across different parts of the service, for example, how is the midwife informed of pregnancy loss?

Key line of enquiry: **E6**		
Is people's **consent** to care and treatment always sought in line with legislation and guidance?		
Generic prompt s	**Professional Standard**	**Additional prompts**
Report sub-heading: **Consent, Mental Capacity Act and DOLs**		
• Do staff understand the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004? • How are people supported to make decisions? • How and when is a person's mental capacity to consent to care or treatment assessed and, where appropriate, recorded? • When people lack the mental capacity to make a decision, do staff make 'best interests' decisions in accordance with legislation? • How is the process for seeking consent monitored and improved to ensure it meets responsibilities within legislation and follows relevant national guidance? • Do staff understand the difference between lawful and unlawful restraint practices, including how to seek authorisation for a deprivation of liberty? • Is the use of restraint of people who lack mental capacity clearly monitored for its	• Two doctors need to authorise a termination of pregnancy (NHS abortion act 1967) • RCOG - The care of women requesting induced abortion: Women may choose to use family or friends as interpreters, in gaining consent to a procedure. The provider needs to be absolutely certain that the woman is fully consenting. This can be guaranteed only if an independent professional interpretation service is used. • Consent: patients and doctors making decisions together GMC) • Department of Health Reference guide to consent for examination or treatment • BMA 2015 consent toolkit • Consent - The basics (Medical Protection)	• How does the service ensure that consent is sought appropriately for women undergoing procedures including caesarean section, instrumental delivery, episiotomy or suturing? • As part of the consent process, how does the service ensure that women attending for abortion are certain of their decision and understand its implications? • Are midwives able to demonstrate understanding of 'best interests 'decision making and when this is applicable. **If you are inspecting a community based maternity service it is also important to ask the following:** • Do community midwives working with young mothers understand the law relating to Fraser Guidelines?

necessity and proportionality in line with legislation and is action taken to minimise its use?		• What is done in the community to support and enable women with learning disabilities and /or poor reading skills to make informed decisions and take an active role in their planned care- e.g. with screening tests

Caring

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Key line of enquiry: C1

Are people treated with kindness, **dignity**, **respect** and **compassion** while they receive care and treatment?

Generic prompts	Professional Standard	Additional prompts
Report sub-heading**: Compassionate care**		
• Do staff understand and respect people's personal, cultural, social and religious needs, and do they take these into account? • Do staff take the time to interact with people who use the service and those close to them in a respectful and considerate manner? • Do staff show an encouraging, sensitive and supportive attitude to people who use services and those close to them? • Do staff raise concerns about disrespectful, discriminatory or abusive behaviour or	• NICE QS15 statement 1: Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty. • NICE QS15 statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills. • NICE QS15 statement 3: Patients are introduced to all healthcare	• Is appropriate help and support provided for mothers in labour before arrival at the acute setting? E.g. when a woman contacts the hospital for advice? • Is appropriate non-directive help and support provided for women by the staff before and after TOP? • How does the service ensure that any company representative maintains privacy and dignity of women and

attitudes? • How do staff make sure that people's privacy and dignity is always respected, including during physical or intimate care? • When people experience physical pain, discomfort or emotional distress do staff respond in a compassionate, timely and appropriate way? • Do staff respect confidentiality at all times?	professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team. • NICE QS15 statement 13: Patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care	families especially at those times when women may be more vulnerable?
Key line of enquiry: C2		
Are people who use services and those close to them **involved as partners** in their care?		
Generic prompts	**Professional Standard**	**Additional prompts**
Report sub-heading**: Understanding and involvement of patients and those close to them**		
• Do staff communicate with people so that they understand their care, treatment and condition? • Do staff recognise when people who use services and those close to them need additional support to help them understand and be involved in their care and treatment and enable them to access this? (This includes language interpreters, sign language interpreters, specialist advice or advocates.) • How do staff make sure that people who use services and those close to them are able to find further information or ask questions about their care and treatment?	• NICE QS 15 statement 4: Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care. • NICE QS15 statement 5: Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences. • RCOG - The care of women requesting induced abortion: Women attending an abortion service will require a discussion to determine the degree of certainty of their decision	• Do discussions include advice and explanation tailored to women's needs about the benefits and risks of each location for birth (including home birth)? • Are women are given the opportunity of making an informed choice about all available birth settings that are appropriate and safe for their clinical need and risk? **If you are inspecting a community based maternity service it is also important to ask the following:** • How is feedback from community service users obtained?

	and their understanding of its implications. Careful and sensitive enquiry as to the reasons for requesting an abortion should be made, with the opportunity for further discussion, especially where women express any doubts or suggestion of pressure or coercion.	• What are the results from Friends and Family Tests and other forms of feedback in relation to community services? • Are patient's empowered and supported in their individualised care plans? How is this done if the patient has complex needs? • Does the service make use of social media platforms to provide information to patients and receive feedback e.g. facebook.

Key line of enquiry: **C3**

Do people who use services and those close to them receive the support they need to **cope emotionally** with their care, treatment or condition?

Generic prompts	**Professional Standard**	**Additional prompts**
Report sub-heading**: Emotional support**		
• Do staff understand the impact that a person's care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially? • Are people given appropriate and timely support and information to cope emotionally with their care, treatment or condition? • What emotional support and information is	• NICE QS15 statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety • Sands Guidelines - Pregnancy loss	• How are the appropriate assessments of perinatal mental health provided, including assessment for post natal anxiety and depression? • How is support provided during and after stillbirth/unexpected death/unexpected abnormality?

provided to those close to people who use services, including carers and dependants? • Are people who use services empowered and supported to manage their own health, care and wellbeing and to maximise their independence? • How are people enabled to have contact with those close to them and to link with their social networks or communities?	and death of a baby • Human Tissue Authority (HTA) Guidance on the disposal of pregnancy remains following pregnancy loss or termination. March 2015	• How is support provided following maternal/neonatal death? • How is appropriate specialist bereavement support provided that meets the individual circumstances of the women. • How does the trust make sure that bereavement support includes appropriate support with funeral, burial or sensitive disposal of pregnancy remains (in the case of termination of pregnancy or early pregnancy loss)? **If you are inspecting a community based maternity service it is also important to ask the following:** • How do community midwives support bereaved women at home? For example, are bereavement services made available to women within their own home; are women referred to counselling services or signposted appropriately? • How do community midwives provide support when a baby has been diagnosed with a deformity or genetic condition or where a stillbirth is suspected?

		• What support is provided to patient's following an ultrasound and a referral to a consultant unit for further tests? What information is provided to the women and what are they told they are being referred for?

Responsive

By responsive, we mean that services are organised so that they meet people's needs

Key line of enquiry: **R1**

Are **services planned** and delivered to meet the needs of people?

Generic prompts	Professional Standard	Additional prompts
Report sub-heading: **Service planning and delivery to meet the needs of local people**		
• Is information about the needs of the local population used to inform how services are planned and delivered? • How are commissioners, other providers and relevant stakeholders involved in planning services? • Do the services provided reflect the needs of the population served and do they ensure flexibility, choice and continuity of care? • Where people's needs are not being met, is this identified and used to inform how services are planned and developed?	• NICE QS22 statement 2: Pregnant women are cared for by a named midwife throughout their pregnancy. • NICE CG 62: Midwife- and GP-led models of care should be offered to women with an uncomplicated pregnancy. • NICE CG 62: Antenatal care should be readily and easily accessible to all pregnant women and should be sensitive to the needs of individual women and the local community. • NICE CG 62: Information should be given in a form that is easy to understand and accessible to pregnant women with additional needs, such as	• How well does the service provided reflect the local community – i.e. specific service users such as travellers, women with disabilities? • What facilities are there for relatives/ partners to stay/ visit? • How does the service work with the Maternity Service Liaison Committees (MSLC) or its local equivalent to design services that meet the needs of women and their families?

• Are the facilities and premises appropriate for the services that are planned and delivered?	physical, sensory or learning disabilities, and to pregnant women who do not speak or read English.	• How does the service ensure continuity of care and support on transition between antenatal, labour and birth and postnatal care during hospital stay? • What information leaflets and website information are available? **If you are inspecting a community based maternity service it is also important to ask the following:** • What does the community midwifery service understand about the local population needs? For example, socio-economic profile of the area, urban/rural locations, concentrations of deprivation - how does this inform service planning and meet the needs of the local population? • Do the community midwives participate with others to jointly facilitate classes with health visitors or practice nurses on health promotion initiatives such as smoking cessation or lifestyle programmes?

Key line of enquiry: **R2**		
Do services take account of the **needs of different people**, including those in vulnerable circumstances?		
Generic prompts	**Professional Standard**	**Additional prompts**
Report sub-heading: **Meeting people's individual needs**		
• How are services planned to take account of the needs of different people, for example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation? • How are services delivered in a way that takes account of the needs of different people on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation? • How are services planned, delivered and coordinated to take account of people with complex needs, for example those living with dementia or those with a learning disability? • Are reasonable adjustments made so that disabled people can access and use services on an equal basis to others? • How do services engage with people who are in vulnerable circumstances	• NICE QS15 statement 9: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions • NICE QS32 statement 3:. Pregnant women who request a caesarean section because of anxiety about childbirth are referred to a healthcare professional with expertise in perinatal mental health support. http://www.england.nhs.uk/ourwork/accessibleinfo/ • NICE CG 110: Recommendations for pregnant women who have complex social factors such as: ○ Substance misuse ○ Migrants, asylum seekers, refuges. ○ Women aged under 20 ○ Women who experience domestic abuse. • NICE CG 192: Antenatal and postnatal mental health: clinical management and service guidance. • NICE QS46: statement 4 care planning for women with a multiple pregnancy. • NICE QS46: statement 7 Advice and preparation	• Do hand-held records show that women's antenatal, labour, birth and postnatal needs have been assessed and provided according to their individual needs? (e.g. English not being their first language) • Are there arrangements in place for people who need translation services? • Are there suitable arrangements in place for people with a learning disability? • Does the provider comply with Accessible Information standard by identifying, recording, flagging, sharing and meeting the information and communication needs of people with a disability/sensory loss? • How well does the service care for people with other complex needs, e.g. substance misuse deaf/blind/wheelchair access? • How well does the service meet

and what actions are taken to remove barriers when people find it hard to access or use services?	for pre-term birth women with a multiple pregnancy • NICE QS46: statement 8 preparation for birth for women with a multiple pregnancy • Recommendation 4 of the the MBRRACE UK findings (published on 10th June 2015) sets out that units should ensure that a post-mortem examination is offered in all cases of stillbirth and neonatal death in order to improve future pregnancy counselling of parents • Human Tissue Authority (HTA) Guidance on the disposal of pregnancy remains following pregnancy loss or termination. March 2015 • RCN guidance about managing disposal of pregnancy remains October 2015	women's antenatal, labour, birth and postnatal mental health needs? • How do staff ensure that there are local arrangements to ensure that women with a multiple pregnancy have a care plan that specifies the timing of antenatal care appointments with the multidisciplinary core team appropriate for the chorionicity and amnionicity of their pregnancy? • How do staff ensure that there is local arrangements to ensure that women with a multiple pregnancy have a discussion by 24 weeks with one or more members of the multidisciplinary core team about the risks, signs and symptoms of preterm labour and possible outcomes of preterm birth? • Are there local arrangements to ensure that women with a multiple pregnancy have a discussion by 32 weeks about the timing of birth and possible modes of delivery so that a birth plan can be agreed? • Does the service ensure that a post-mortem examination or CT scan is offered in all cases of **stillbirth and neonatal death i**n order to improve future pregnancy

		counselling of parents? Is placental histology made available? • In respect of maternity, family planning and abortion services: How do staff ensure that women are given the opportunity of making informed individual choice about disposal of pregnancy remains or burial or cremation following pregnancy loss or termination? **If you are inspecting a community based maternity service it is also important to ask the following:** • What is the range of antenatal and postnatal services provided in the community? How is information provided about these services? • Are there local community groups/networks that midwives routinely get invited to or attend? • Does the community midwifery service provide any additional services for their clients e.g. Aqua aerobics. • Do community midwifery services provide preparation for parenthood classes? Are these provided out of hours to support

		working parents and in accessible locations within the community? • What framework is in place for mental health referrals and access to perinatal nurses?
Key line of enquiry: R3		
Can people access care and treatment in a **timely** way?		
Generic prompts	**Professional Standard**	**Additional prompts**
Report sub-heading: **Access and flow**		
• Do people have timely access to initial assessment, diagnosis or urgent treatment? • As far as possible, can people access care and treatment at a time to suit them? • What action is taken to minimise the time people have to wait for treatment or care? • Does the service prioritise care and treatment for people with the most urgent needs? • Where there is an appointments system, is it easy to use and does it support people to access appointments?	• NICE QS22 statement 1: Pregnant women are supported to access antenatal care, ideally by 10 weeks 0 days. • NICE CG 62 :A schedule of antenatal appointments should be determined by the function of the appointments. For a woman who is nulliparous with an uncomplicated pregnancy, a schedule of 10 appointments should be adequate. For a woman who is parous with an uncomplicated pregnancy, a schedule of 7 appointments should be adequate • RCOG - The care of women requesting induced abortion: A 24-hour telephone helpline number should be available for women to use after abortion if they have any concerns.	• How does the service ensure women are not in labour and giving birth in areas not designated as labour ward (e.g. in antenatal care, triage)? • How does the service ensure patients are regularly seen through their pregnancy? Is attendance for high risk patients monitored? • How are women triaged to appropriate areas? E.g. to prevent labour wards getting overcrowded? • How many women have their planned induction delayed?

• Is care and treatment only cancelled or delayed when absolutely necessary? Are cancellations explained to people, and are people supported to access care and treatment again as soon as possible? • Do services run on time, and are people kept informed about any disruption?		• How does the provider ensure that women are offered the abortion procedure within five working days of the decision to proceed, and that the total time from access to procedure does not exceed ten working days? • How does the provider ensure that women who present beyond 12 completed weeks or require abortion for urgent medical reasons, receive care promptly to minimise further risk to health? **If you are inspecting a community based maternity service it is also important to ask the following:** • Do women know how to access the service directly or are they still required to access services via the GP? What is the proportion of women who access midwifery services directly? • How does the service ensure patients are regularly seen through their pregnancy? Is attendance for low risk/high risk patients monitored and followed up e.g. missed community midwifery appointments?

		• Is there a Do Not Attend Policy in place? • When a community visit has to be cancelled or rescheduled how is the risk to the patient assessed? • When a patient presents at triage how is this information relayed back to the community midwifes, how effective is the process in practice? • How does the trusts escalation policy impact on access and flow issues e.g. visits to women in their home? Are any identified issues on the maternity risk register
Key line of enquiry: **R4**		
How are people's **concerns and complaints** listened and responded to and used to improve the quality of care?		
Generic prompts	**Professional Standard**	**Additional prompts**
Report sub-heading: **Learning from complaints and concerns**		
• Do people who use the service know how to make a complaint or raise concerns, are they encouraged to do so, and are they confident to speak up? • How easy is the system to use? Are	• The NHS constitution gives people the right to ○ Have complaints dealt with efficiently and be investigated. ○ Know the outcome of the investigation. ○ Take their complaint to an independent	• How many complaints have been referred to the Parliamentary and Health Service Ombudsman? **If you are inspecting a community based maternity service it is also important to ask the following:**

people treated compassionately and given the help and support they need to make a complaint? • Are complaints handled effectively and confidentially, with a regular update for the complainant and a formal record kept? • Is the outcome explained appropriately to the individual? Is there openness and transparency about how complaints and concerns are dealt with? • How are lessons learned from concerns and complaints, and is action taken as a result to improve the quality of care? Are lessons shared with others?	Parliamentary and Health Service Ombudsman. ○ Receive compensation if they have been harmed.	• Does the main provider analyse community complaints is there evidence of how this links to service improvements? • How are complaints triangulated across teams and where is this done e.g. trust wide, within teams etc? • Are trends, learning and changes to practice monitored and reviewed as part of the complaints process and is this shared across teams?

Well-led

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Key line of enquiry: **W1**

Is there a clear **vision** and a credible **strategy** to deliver good quality?

Generic prompts	Professional Standard	Additional prompts
Report sub-heading: **Vision and strategy for this service**		
• Is there a clear vision and a set of values, with quality and safety the top priority?		• Is there a Non-Executive Director with responsibility for Maternity Services?

• Is there are a robust, realistic strategy for achieving the priorities and delivering good quality care? • How have the vision, values and strategy been developed? • Do staff know and understand what the vision and values are? • Do staff know and understand the strategy and their role in achieving it? • Is progress against delivering the strategy monitored and reviewed?		• Does the HOM have direct access to the trust board when maternity is under considerations? **If you are inspecting a community based maternity service it is also important to ask the following:** • Is there a clear vision and set of values specific to community midwifery services, with quality and safety the top priority? How is this embedded? • How does the community service link to the broader maternity services within the region? • Are community services part of the 'maternity review' and committed to supporting home birthing, how is that being done?

Key line of enquiry: **W2**		
Does the **governance** framework ensure that **responsibilities** are clear and that **quality, performance and risks** are understood and managed?		
Generic prompts	**Professional Standard**	**Additional prompts**
Report sub-heading: **Governance, risk management and quality measurement**		
• Is there an effective governance framework to support the delivery of the strategy and good quality care? • Are staff clear about their roles and do they understand what they are accountable for? • How are working arrangements with partners and third party providers managed? • Are the governance framework and management systems regularly reviewed and improved? • Is there a holistic understanding of performance, which integrates the views of people with safety, quality, activity and financial information? • Are there comprehensive assurance system and service performance measures, which are reported and monitored, and is action taken to improve performance? • Are there effective arrangements in place to ensure that the information used to monitor and manage quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are	• National Safety Standards for Invasive Procedures (NatSSIPs) Version number: 1 published: 7 September 2015 (NatSSIPs sets out on page seven specific responsibilities for members of a Trust Board, Medical Director or Chief Nurse and local governance or safety lead), • NICE QS 61 statement 2: Organisations that provide healthcare have a strategy for continuous improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance systems. • NICE QS 66 statement 1: Hospitals have an intravenous (IV) fluids lead who has overall responsibility for training, clinical governance, adult and review of IV fluid prescribing, and patient outcomes. • Safer Childbirth: A maternity risk management group meets at least	• Have managers ensured that there is a plan in place to develop local Safety Standards for Invasive Procedures using the national Safety Standards for Invasive Procedures. Have they assessed the need for these against all invasive procedures carried out? • How does the service make sure that staff provide TOP care and treatment in accordance with the Abortion Act 1967? • Does the service have a strategy for continuous improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance systems? • What are the governance procedures for managing and monitoring any SLAs the provider has with third parties?

identified? • Is there a systematic programme of clinical and internal audit, which is used to monitor quality and systems to identify where action should be taken? • Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? • Is there alignment between the recorded risks and what people say is 'on their worry list'?	every 6 months. • Safer Childbirth: There is a written risk management policy, including trigger incidents for risk and adverse incident reporting. • TOP Governance (Abortion Act 1967): ○ HSA1 form must be completed by two doctors before an abortion is performed. ○ HSA2 must be completed (by one doctor) before an emergency abortion being performed or, if that is not reasonably practicable, within 24 hours of an emergency abortion. ○ HAS4 to be completed by a doctor and sent to CMO (by post or electronically) within 14 days. DH strongly encourage the use of electronic reporting as this is a more secure system and reduces the risk of lost or misplaced forms or missing data.	**If you are inspecting a community based maternity service it is also important to ask the following:** • Are senior community staff assured they have an overview of the current issues/concerns within the community service; and there are appropriate processes in place to mitigate against identified concerns? • Is there a specific governance dashboard for community services which monitors risk, safety and performance issues? • Do the community services participate in the overall acute trust audits, if so, which ones and what are the outcomes for community services? • Do they conduct their own audits, what are they; and how are these acted upon? • If guidelines are modified or tailored to the community setting, are staff able to explain why they have been modified for the community setting, is this documented clearly and justified e.g. responding to specific local circumstances?

Key line of enquiry: **W3**

How does the **leadership** and **culture** reflect the vision and values, encourage openness and transparency and promote good quality care?

Generic prompts	Professional Standard	Additional prompts
Report sub-heading: **Leadership of service**		
• Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis? • Do leaders have the capacity, capability, and experience to lead effectively? • Do the leaders understand the challenges to good quality care and can they identify the actions needed address them? • Are leaders visible and approachable? • Do leaders encourage appreciative, supportive relationships among staff?	• Safer Childbirth: ○ To ensure 24-hour managerial cover, each labour ward must have a rota of experienced senior midwives as labour ward shift coordinators, supernumerary to the staffing numbers required for one-to-one care. ○ There should be one supervisor of midwives to every 15 midwives. ○ Every unit should have a consultant obstetrician as clinical lead, a consultant midwife and a labour ward manager. • National Safety Standards for Invasive Procedures (NatSSIPs) Version number: 1 published: 7 September 2015 • Recommendation 3.1 of the National Maternity Review February 2016	• Do all midwives have a named supervisor of midwives (SOM) with whom they have an annual review? • Does the Head of Midwifery have access to the Trust Board? • How do leaders ensure that employees who are involved in the performance of invasive procedures develop shared understanding be educated in good safety practice, as set out in the national standards. • Has the organisation designated a board member as the board level lead for maternity services? And does the Board routinely monitor information about quality, including safety and take necessary action to improve quality? **If you are inspecting a community based maternity service it is also important to ask the following** • What is the leadership structure for community services?

		• How is the community service linked to the leadership and governance of the acute trust? Is there leadership at all levels? • Do the community team feel part of the acute trust? Are leaders visible to the community staff? • Are leader champions encouraged within the service?
Report sub-heading: **Culture within the service**		
• Do staff feel respected and valued? • Is action taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority? • Is the culture centred on the needs and experience of people who use services? • Does the culture encourage candour, openness and honesty? • Is there a strong emphasis on promoting the safety and wellbeing of staff? • Do staff and teams work collaboratively, resolve conflict quickly and constructively and share responsibility to deliver good quality care?	• NMC Openness and honesty when things go wrong: the professional duty of candour • NRLS - Being Open Communicating patient safety incidents with patients, their families and carers • Duty of Candour – CQC guidance • Recommendation 3.2 of the National Maternity Review February 2016	• How the provider is preparing/meeting the requirements related to Duty of Candour? (for example, training, support for staff, audits and monitoring) • How do Boards promote a culture of learning and continuous improvement to maximise quality and outcomes from their services, including multi-professional training? **If you are inspecting a community based maternity service it is also important to ask the following** • What is the working relationship and culture like between community midwives, hospital midwives and Doctors/consultants? • Do the community staff feel part of the overall maternity service, do they feel

		respected and valued? • Are staff rewarded for example submitted for local, regional or national award schemes?
Key line of enquiry: **W4**		
How are **people** who use the service, the **public** and **staff engaged** and **involved?**		
Generic prompts	**Professional Standard**	**Additional prompts**
Report sub-heading: **Public and staff engagement**		
• How are people's views and experiences gathered and acted on to shape and improve the services and culture? • How are people who use services, those close to them and their representatives actively engaged and involved in decision-making? • Do staff feel actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? • How do leaders prioritise the participation and involvement of people who use services and staff? • Do both leaders and staff understand the value of staff raising concerns? Is appropriate action taken as a result of concerns raised?		**If you are inspecting a community based maternity service it is also important to ask the following** • How are the views of users of community services obtained? What does it tell us about the service? • How does the leadership take an inclusive approach to involving community staff? Do staff feel involved? **For independent providers:** • What are the opportunities for the public and staff to be engaged in the service?

Key line of enquiry: **W5**		
How are services **continuously improved** and **sustainability** ensured?		
Generic prompts	**Professional Standard**	**Additional prompts**
Report sub-heading: **Innovation, improvement and sustainability**		
• When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? • Are there examples of where financial pressures have compromised care? • In what ways do leaders and staff strive for continuous learning, improvement and innovation? • Are staff focused on continually improving the quality of care? • How are improvements to quality and innovation recognised and rewarded? • How is information used proactively to improve care?		• How does the service work with the Supervisor of Midwives to improve aspects of the service that require improvement? • How has the service considered and acted on the MBRRACE annual and perinatal reports? How has the service considered and acted on serious incident investigations and action plans? • How has the service considered and acted on the MBRRACE UK (Mothers and Babies Reducing Risk through Audits and Confidential Enquiries) report published December 2014? (about congenital diaphragmatic hernia (CDH)) • How has the service considered and acted on the MBRRACE UK findings (published on 10th June 2015) of the UK Perinatal Mortality Surveillance for 2013: Audits and Confidential Enquiries? **If you are inspecting a community**

		based maternity service it is also important to ask the following • What opportunities exist for learning from other trusts e.g. site visits • Are they engaged in Sustainability Transformation Partnerships (STP)? • Do regional groups/clusters have a community input? Are staff encouraged to develop the service and not just provide the service are there good examples of development?

1. NHS UK guidelines on Flu vaccination in pregnancy