Maternal Care Bundle | Implementation plan

October 2026 | Delivery deadline: 31 March 2027

Purpose and Board decision

To seek endorsement of the delivery plan and trajectories for full implementation of all five Maternal Care Bundle (MCB) elements by March 2027; agree executive oversight, resource prioritisation and monthly exception reporting.

Executive assessment of current position

There is meaningful progress across the five elements, along with compliance this is being tracked using the national audit tool. Positive progress has been made with introduction of national MEWS across all clinical areas, existing epilepsy pathways, development of regional mental health screening, and established haemorrhage review and education. However, full implementation of the bundle cannot yet be declared: early VTE screening/prescribing, cross-setting MEWS, ambulance pre-alert arrangements, digital reporting, mental health screening and consistent haemorrhage processes require further evidence.

Care Bundle Delivery milestones

- October 2026 — confirm owners and baselines for every intervention; approve final trajectories; complete SWASFT visit, test red phone and draft pre-alert SOP; agree interim manual audit specification.
- November 2026 — draft and consult on required guideline and pathway changes, alongside piloting and training for VTE, epilepsy and mental health workflows; extend MEWS beyond maternity.
- December 2026 — aim to complete guideline approval/ratification and begin embedding revised pathways, subject to governance schedules; establish monthly reporting and gap closure.
- January–February 2027 — complete implementation in all applicable settings; undertake targeted audits, remedy exceptions and evidence sustained adoption.
- March 2027 — final evidence review for all interventions; element leads sign off evidence packs; report any outstanding gaps explicitly to Board and regional team.

Element 1 | Venous thromboembolism | Element lead: Akeisha Robinson Senior Matron

Position: National early-pregnancy self-assessment, rapid prescribing and timely high-risk review remain key delivery requirements. Local pathway and digital flagging are in development.

- October–November: agree ICB and maternity-unit responsibilities; map early pregnancy contacts and establish a baseline from BadgerNet/EPMA. Develop accessible VTE screening at self-referral with a manual failsafe until digital flagging is available.
- November–December: establish daily review of positive responses, a seven-day urgent assessment and prescribing pathway, and clear communication with GP, ED, EPU and

gynaecology. Draft guideline and patient-information changes in November for anticipated December ratification.
- By January 2027: implement timely clinical assessment and an offer of indicated thromboprophylaxis within 72 hours, documented follow-up within four weeks and booking reassessment for missed or late referrals.
- January–March 2027: train relevant teams and audit screening, referral and prescribing times, four-week follow-up, accessibility and missed cases; address capacity, prescribing and digital transition risks.

Assurance: approved pathway, accessible information, referral/failsafe log, training record and monthly time-stamped audit.

Element 2 | Prehospital and acute care| Element lead: Gabby Garbett Matron

Position: National MEWS has gone live within maternity; wider embedding is underway. Signage is in place, SWASFT site visit is planned for October, red telephone is installed and SOP is being written.

- October 2026: complete SWASFT site visit, document signage and pre-alert arrangements, test the red telephone and agree downtime and escalation contingencies.
- November–December: co-produce the pre-alert SOP with SWASFT, emergency and receiving teams; aim for December ratification. Undertake a simulated call and transfer, and brief staff across relevant areas.
- November–January: embed national MEWS across applicable maternity, emergency, theatre, recovery, community and non-maternity settings, with clear equipment, escalation and training responsibilities.
- By December: confirm maternal medicine referral criteria, red flags, urgent transfer arrangements and the route for multidisciplinary advice, including out-of-hours provision.
- January–March: monitor MEWS use and escalation, pre-alert reliability, transfer learning and maternal medicine referrals; address gaps through simulation and monthly feedback.

Assurance / evidence: SWASFT visit report; signed SOP; test log; area-by-area MEWS rollout matrix; training records; referral pathway; monthly audit.

Element 3 | Epilepsy in pregnancy | Element lead: Helen Preece, Clinical Director and Anna Eaton, Matron

Position: The national audit tool records the local guideline as substantially aligned, with outstanding explicit referral-to-review timescales and a resilient system for identifying eligible women.

- November: consult on guideline changes covering timely identification, referral and specialist review, epilepsy medication and safety planning, and roles within the neurology–obstetric MDT.
- December: aim for guideline ratification and confirm maternal medicine network pathways for complex cases, including cross-boundary referrals and women booked to birth elsewhere.
- By January: establish a monitored epilepsy referral list and failsafe, cover for staff absence, and coordinated antenatal, birth and postnatal care plans.

- January–March: audit referral-to-review intervals, documented individualised plans, multidisciplinary communication and postnatal follow-up; review exceptions at MDT.

Assurance / evidence: Guideline ratification targeted for December 2026; joint neurology/obstetric pathway; referral tracking; quarterly sample and case review.

Element 4 | Maternal mental health | Element lead: Emily Seddon, Perinatal Mental Health Midwife

Position: Regional work is progressing on a Healthier Together screening tool, previously anticipated for November; actual delivery date remains to be confirmed anticipated before the end of 2026 Local referral policy and education need updating.

- October–November: agree the regional Healthier Together prototype, data ownership, accessibility and a clinically safe process for self-completion, review of results and urgent escalation.
- November–December: update the guideline for Whooley screening at booking, 25–28 weeks, 31–34 weeks and 10–14 days postnatally; specify EPDS, referral criteria and crisis assessment. Aim for December ratification.
- By December: agree pathways A–D and referral acceptance with local mental health services, including clear clinician responsibility for reviewing high-risk responses and access to interpreters.
- November–January: pilot appointment prompts, documentation and referral processes; provide education to community and hospital teams, with a contingency if the regional tool is delayed.
- January–March: audit screening at each time point, EPDS and appropriate referrals, safety follow-up and equity of access; reconcile platform activity against the eligible UHD population.

Assurance / evidence: Signed pathway and crisis SOP; platform safety testing; training; denominator-based screening dashboard/manual audit; referral outcome checks.

Element 5 | Obstetric haemorrhage | Element leads: Bea Chubb, Consultant midwife and Kate Goulds, Labour ward lead consultant

Position: Established guideline, proforma, multidisciplinary reviews and continuing education. Current compliance is improving and the changes are being embedded, but documented measurement and escalation remain priority areas. These improvement are being monitored through Perinatal Quality Oversight Model.

- October–March: continue multidisciplinary education, emergency drills and monthly ward-level feedback; use case review to embed improvements and respond to emerging themes.
- October–December: standardise objective cumulative blood-loss measurement across hospital and community settings, with 15-minute documentation during ongoing bleeding and reliable availability of equipment.
- October–January: reinforce early escalation, coordinator involvement, emergency calls, use of the structured proforma, medication sequence and documentation, including TXA and consultant involvement.

- Monthly: review haemorrhage cases against agreed thresholds, examine sampled moderate bleeds for missed escalation, share learning and track closure of improvement actions.
- By December: confirm access to timely fibrinogen testing and the local coagulation/point-of-care pathway with laboratory and transfusion teams.
- January–March: demonstrate sustained improvement using consistent monthly audit definitions, targeted refresher teaching and feedback across all birth settings.

Assurance / evidence: Monthly audit run charts; training attendance; proforma samples; case-review minutes; laboratory SLA and protocols; evidence of action closure.

Programme governance and escalation

- Executive sponsor: Director of Midwifery. Overall programme coordination: Consultant Midwife with maternity audit lead; each element retains accountable clinical, operational and digital owners.
- A monthly implementation meeting will review trajectory, overdue actions, risks and evidence; a consolidated report will go to maternity governance and the Trust Board within the perinatal Quality Oversight Model..
- Digital and business intelligence capacity is a cross-cutting risk. Manual audits will be required until validated reporting is available, additional need for Business intelligence resource to support monitoring and early identification of concerns to be outlined within the service risk register
- Cross-organisational dependencies: ICB and prescribing services (E1); SWASFT, emergency medicine and maternal medicine network (E2); neurology and maternal medicine (E3); regional Healthier Together and Dorset Healthcare (E4); laboratories and blood transfusion (E5). System C(All elements)
- Escalate slippage, unsafe gaps, lack of staff time, incomplete data and any likely deviation from national timelines promptly to the Senior maternity leadership and executive safety champions and, where required, NHS England regional team.

Board assurance framework

Each element lead will maintain the national implementation tool, evidence references and a monthly position statement. The Board should receive a monthly summary showing interventions fully implemented, partially implemented or not implemented, trend against trajectory, overdue actions, key risks and decisions required. “Fully implemented” will only be reported where every relevant national intervention is in operation and supported by evidence; a proposed internal ambition of ≥95% for selected process measures does not override any national metric or threshold.