House of Commons Committees

PLANNING GRID: GOVERNMENT COMMITMENTS AND QUESTIONS

	Government Commitment under evaluation	**Was the commitment met overall? or** (in the case of a commitment whose deadline has not yet been reached) **Is the commitment on track to be met?**	**Was the commitment effectively funded (or resourced)?**	**Did the commitment achieve a positive impact for service users?**	**Was it an appropriate commitment?**
1	**By 2025, halve the rate of** **Stillbirths; neonatal deaths; maternal deaths; brain injuries that occur during or soon after birth** **Achieve a 20% reduction in these rates by 2020.** **To reduce the pre-term birth rate from 8% to 6% by 2025.**	1) Does the commitment have a clear and fixed deadline for implementation? If so, has the deadline been met or is it on track to be met? 2) Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?	1) Were specific funding and/or resourcing arrangements made to support the implementation of the commitment? If not, why? If so, what were these, when and how were they made? If extra funding or resourcing was provided, did it go to directly to maternity units or elsewhere, for example, to NHS Trusts? 2) If funding and/or resourcing was provided, was this taken from a "new" resource stream? Or did it involve a reallocation of pre-existing resources? What was the consequence of this? 3) What factors were considered when funding and/or resourcing arrangements were being	1) What was the direct and indirect impact of the commitment on different groups (including women from Black, Asian and minority ethnic backgrounds; disabled women; and women from lower socio-economic backgrounds)? Were there equitable outcomes for different groups? 2) Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment? 3) Has (or will) there been (or be) a	1) Was (or is) the commitment likely to achieve meaningful improvement for service users, maternity staff and/or the maternity services as a whole? 2) Is the commitment wide enough in scope? Is the commitment specific enough? 3) Has the commitment had any unintended consequences (either positive or negative)? 4) Was the level of ambition as expressed by the commitment reasonable at the time the commitment was made

		3) Does data show achievement against the target? 4) To what extent (if at all) has the NHS's Covid-19 response affected progress in achieving the targets?	determined (including what barriers and enablers existed at individual/trust/service provider level)? What evidence was used to determine the level of funding and/or resource to support the delivery of the commitment? 4) Who was involved in determining the funding and/or resourcing arrangements? Who was ultimately responsible for determining such arrangements? 5) Do healthcare stakeholders view the funding and/or resourcing as sufficient?	meaningful improvement in process measures reasonably attributable to the policy? 4) Have service users been hindered by the commitment and its implementation? If so, how as this been monitored and evaluated? 5) By focusing on the target(s) contained in the commitment, have other aspects of care been reprioritised or removed?	(i.e. was it addressing an identified need or responding to a particular issue)? Has the commitment's appropriateness been reviewed since its creation?
2	**The majority of women will benefit from the 'continuity of carer' model by 2021, starting with 20% of women by March 2019.** **By 2024, 75% of women from BAME communities and a similar percentage of women from the most deprived groups will**	1) Were continuity of carer commitments met in 2019 and 2021? If not, why? Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met? How significant are these? Was appropriate	1) Were specific funding and/or resourcing (including, in particular, on staffing levels) arrangements made to support the implementation of the commitment? If not, why? If so, what were these, when and where were they made? If extra funding and/or resourcing was provided, did it go to directly to	1) What was the direct and indirect impact of the commitment on different groups (including women from Black, Asian and minority ethnic backgrounds; disabled women; and women from lower socio-economic backgrounds)? Were	1) How was "continuity of carer" defined by the Government when creating the related commitment(s)? Was this definition informed by evidence of what is meant by continuity of carer? Was this definition and the commitment effectively

	receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period.	action taken to account for any mitigating factors? 2) What guidance was provided to support NHS staff in implementing the commitment? 3) Does the submitted count include those placed on a continuity of carer pathway or in receipt of continuity of care? If not, what is the rate of achievement based on the full commitment? 4) Does the commitment have a clear and fixed deadline for implementation? Has the numerical target contained in the commitment been achieved or is it on track to be achieved? 5) What is meant by "similar percentage of women"? How has this been defined? Has this or will this be achieved by 2024? 6) Does data show achievement against the target (where applicable)?	maternity units or elsewhere, for example, to NHS Trusts? 2) If funding and/or resourcing was provided, was this taken from a "new" resource stream? Or did it involve a reallocation of pre-existing resources? What was the consequence of this? 3) What factors were considered when funding and/or resourcing arrangements were being determined (including what barriers and enablers existed at individual/trust/service provider level)? What evidence was used to determine the level of funding and/or resource to support the delivery of the commitment? Did the system have relevant support to the deliver the change set out in the commitment? 4) Who was involved in determining the funding and/or resourcing arrangements? Who was ultimately responsible for determining funding and resourcing arrangements? 5) Do healthcare stakeholders view the funding and/or resourcing as sufficient?	there equitable outcomes for different groups? (In particular, for the "continuity of carer" commitment for 2019 and 2021). 2) Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment? 3) Has (or will) there been (or be) a meaningful improvement in process or access measures (i.e. are women able to access the service; quality of feedback when things go wrong etc), reasonably attributable to the policy? 4) Have service users been hindered by the commitment and its implementation? If so, how as this been monitored and evaluated? 5) By focusing on the target(s) contained in the commitment, have other	communicated to NHS Trusts and staff at different levels? If so, how? If not, why? 2) Is the commitment wide enough in scope? Is the commitment specific enough? 3) Has the commitment had any unintended consequences (either positive or negative)? 4) Was the level of ambition as expressed by the commitment reasonable at the time the commitment was made (i.e. was it addressing an identified need or responding to a particular issue)? Has the commitment been reviewed since its creation? 5) Were any type of approaches or attempts to "scale up" the programme more successful than others? 6) Is the target contained in the commitment an

		7) To what extent has the NHS's response to Covid-19 affected progress on policy goals/targets?		aspects of care been reprioritised or removed?	effective measure of policy success?
3	Safe staffing – "**Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm."**	1) Does the commitment have a clear and fixed deadline for implementation? If not, why? If so, how was this determined? 2) Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors?	1) Were specific funding and/or resourcing (including, in particular, on staffing) arrangements made to support the implementation of the commitment? If not, why? If so, what were these, when and how were they made? 2) If funding and/or resourcing was provided, was this taken from a "new" resource stream? Or did it involve a reallocation of pre-existing resources? What was the consequence of this? 3) What factors were considered when funding and/or resourcing arrangements were being determined (including what barriers and enablers existed at individual/trust/service provider	1) Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment? 2) Has (or will) there been (or be) a meaningful improvement in process measures (i.e. staff in training / recruitment strategies etc), reasonably attributable to the policy? 3) By focusing on the target(s) contained in the commitment, have other aspects of care been reprioritised or removed?	1) How are the terms "appropriate number", "mix" and "avoidable harm" defined? Were these definitions appropriately communicated to NHS Trusts and staff? If so, how? If not, why? 2) Is there evidence to support what a standard level of staffing commitment is for all staff groups? 3) Is the commitment wide enough in scope? Is the commitment specific enough?

		3) Does data show achievement against the target? 4) Are there national standards for safe staffing for midwifery and obstetrics? If not, why? If so, have such standards been met? 5) Do staffing levels vary across NHS Trusts and unit? If so, how? 6) To what extent (if at all) has the NHS's Covid-19 response affected progress on targets?	level)? What evidence was used to determine the level of funding and/or resource to support the delivery of the commitment? 4) Who was involved in determining the funding and/or resourcing arrangements? Who was ultimately responsible for determining funding and/or resourcing arrangements? 5) Do healthcare stakeholders view the funding and/or resourcing as sufficient? In particular, are there sufficient midwives and specialist in training to fulfil and maintain staffing levels now and in the future?		4) Has the commitment had any unintended consequences (either positive or negative)? 5) Was the level of ambition as expressed by the commitment reasonable at the time the commitment was made (i.e. was it addressing an identified need or responding to a particular issue)? Has the commitment been reviewed since its creation? 5) Is the target contained in the commitment an effective measure of policy success (if applicable)?
4		1) Does the commitment have a clear and fixed deadline for implementation? Has the commitment been met? If not, why?	1) Were specific funding and/or resourcing arrangements made to support the implementation of the commitment? If not, why? If so,	1) Are there any groups of women who were less likely or did not receive a personalised care plan? What was the direct and indirect impact of the commitment on different	1) How is "personalised care" defined? Was this definition informed by evidence of what is meant by personalised care? Was this definition appropriately

	'**All women to have a personalised care and support plan by 2021'.**[1]	2) Does data show achievement against the target (if applicable)? 3) Are there any mitigating factors or conflicting policy decisions that may have led to the commitment not being met or not being on track to be met? How significant are these? Was appropriate action taken to account for any mitigating factors? 4) To what extent (if at all) has the NHS's Covid-19 response affected progress on targets?	what were these, when and how were they made? 2) Were staff adequately trained to work with parents to develop care plans? 3) If funding and/or resourcing was provided, was this taken from a "new" resource stream? Or did it involve a reallocation of pre-existing resources? What was the consequence of this? 4) What factors were considered when funding and/or resourcing arrangements were being determined (including what barriers and enablers existed at individual/trust/service provider level)? What evidence was used to determine the level of funding and/or resource to support the delivery of the commitment? Did the system have relevant support to the deliver the change set out in the commitment? 5) Who was involved in determining the funding and/or	groups (including women from Black, Asian and minority ethnic backgrounds; disabled women; and women from lower socio-economic backgrounds)? Was there equitable distribution in outcomes for different groups? 2) Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the commitment? 3) Has (or will) there been (or be) a meaningful improvement in process or access measures (i.e. are women able to access the service; quality of feedback when things go wrong etc), reasonably attributable to the policy? 4) Have service users been hindered by the commitment and its	communicated to NHS Trusts, staff and service users (patients), or has it been interpreted differently by these groups? If so, how? If not, why? 2) Is the commitment wide enough in scope? Is the commitment specific enough? 3) Has the commitment had any unintended consequences (either positive or negative)? 4) Was the level of ambition as expressed by the commitment reasonable at the time the commitment was made and now (i.e. was it addressing an identified need or responding to a particular issue)? Has the commitment been reviewed since its creation? 5) Is the target contained in the commitment an

[1] See, for example: NHS England, Maternity Transformation Programme [webpage]. The webpage states (highlight added): **Increasing choice and personalisation**: we have concluded working with seven Maternity Choice and Personalisation Pioneers to test new approaches to widen and deepen choices available to women through personal maternity care budgets. Evaluation for this is now available. All women can expect to be offered a personalised care and support plan by 2021.

			resourcing arrangements? Who was ultimately responsible for determining funding and resourcing arrangements? 6) Do healthcare stakeholders view the funding and/or resourcing as sufficient?	implementation? If so, how as this been monitored and evaluated? 5) By focusing on the target(s) contained in the commitment, have other policy ambitions been reprioritised or removed?	effective measure of policy success?