Bradford Teaching Hospitals
NHS Foundation Trust

Maternity Improvement Plan

Document control:

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	Objective or Aim to be delivered	Actions and tasks to achieve the objective or aim	Named individual responsible	Others inputting	Completion Date	Progress Update	Status
	MUST dos						
1	The trust must improve governance and oversight of risk in maternity services.	A review of governance processes required with clear lines of escalation. Improvements to be made to ensure governance meets the CQC maternity services framework. See action plan - tab 2	C Robertson & S Hollins	J Anderson & C Stott	30/11/2020 ext 30/01/2021	Meeting agenda for Governance revised. Maternity Risk strategy update in progress. TOR and agenda agreed for Maternity services forum. TOR developed for speciality governance, clinical case review and perinatal mortality meeting.	
2	The service must monitor and control infection risks in theatres consistently well and ensure mitigating actions (including incident reporting of theatre use) are implemented and closely monitored.	Monitor, improve and continually assess infection rates of women who birth in maternity theatres until new theatre build is completed. See action plan complete.	C Robertson & S Hollins	S Crowther, A Hardaker C Stott, V Jones & C Dinsdale	10/30/2020	SSI Audit of all theatre cases is in progress and will be continous until after the new theatre build. Action plan in place following 'one together' benchmarking. Weekly data of theatre usage is being submitted. Theatre building project plans are in place. Bi Monthly SSI board paper being produced which includes an updated position. This is submitted to the infection control team.	
3	The service must ensure that stillbirths are monitored, escalated when required, and actions are put in place to improve stillbirth rates.	Detailed review of stillbirths and early escalation of concerns. Monitoring of the stillbirth rate via the dashboard. Implementation of SBLSBv2. see action plan - tab 3	C Robertson & S Hollins	A Hutton, J Anderson, C Stott, V Jones, J Key	9/30/2020	A 72 hour review has been undertaken for all stillbirths in 2020 to date. There is a process in place for escalation to Medical Director & Chief Nurse and monthly oversight of the stillbirth position. Some actions remain ongoing - see tab 3.	
4	The service must ensure that all staff are engaged with and participate in all steps of the World Health Organisation surgical safety checklist, the checklist is fully completed and observational and record audits are undertaken to monitor compliance.	Undertake observational audits of theatre practices to include WHO surgical safety checklist. Continue with monthly Trust documentation audits. The service needs to work with the Trust audit leads to ensure timely feedback and review of findings. Learning and successes to be cascaded to the team via the governance processes. 5 Steps to safer surgery to be re-launched and to ensure assurance can be provided for the completion of all 5 steps	C Robertson & S Hollins	A Hardaker & C Dinsdale	30/11/2020 ext 30/01/2021	Coordinator assigned as observational audit lead and in the implementation and embedding of the 5 steps to safer surgery. Observational audits complete but only 3 of the 5 steps are embedded. SOP in development to include 5 steps. 5 steps have been implimented and a re-audit will take place once the SOP has been in place and the processes embedded. SOP in draft. For ratification at January Q&S meeting	
5	The service must ensure systems and processes are used to safely record the use of controlled drugs in the maternity service and compliance is monitored.	Benchmark medicines management policy against CQC maternity framework. Audit controlled drug checks and provide ongoing assurance of compliance. Exceptions to be reported to the monthly governance meeting.	C Robertson & S Hollins	Matrons & Unit managers	9/14/2020	Department controlled drug audit completed and shared with the team. Audit finding to be shared at Trust Medicines Safety meeting. Ongoing assurance to be achieved by adding control check compliance to Meridian. Planned for September. In the interum departmental managers to report compliance at Quality & Performace Meeting. Meeting with Deputy Director of Pharmacy requested.	
6	The trust must ensure the outcome/recommendations of any serious case reviews are acted on, and midwives have the opportunity to regularly attend child protection conferences and submit reports to facilitate decision making and safety planning.	Review Ofsted/CQC Safeguarding action plan and work towards completing any unachieved actions. Review demand and current rate of midwifery attendance at child protection conferences. Midwife attendance to case conferences will improve with further roll out of continuity of care teams. Process to devised to share serious case reviews via the existing governance structure.	S Hollins	E McArdle/Robinson, J Beer & H Audlyoosh	7/30/2020	Serious case review action plan shared with the governance team but was from sept 2019. 2 outstanding actions. Update requested. Data collection has taken place in regards to staff attendance and input into child protection conferences. Audit report completed. Approval given for 1 WTE uplift to Acorn community continuity team to improve attendance to child protection conferences. The uplift will commence in October. Monitoring of midwifery attendance to continue.	
7	The service must ensure all staff are up to date with mandatory training , including safeguarding children level three training.	Monthly mandatory training report received and reviewed by Governance lead on a monthly basis. All managers to review and provide assurance to Matrons of training compliance for staff in their areas on a monthly basis. Monthly compliance reports to be included on monthly governance agenda. See action plan tab 2	C Robertson & S Hollins	C Stott, A Hardaker, A Powell & T Mori	20/10/2020 ext 30/01/2021	Non-compliance reports sent to department managers to action as urgent. Email sent with extensive list of training available online. Recovery plan in development. Risk assessment to be completed and added to risk register.	
8	The service must ensure staff always complete and update risk assessments and applicable key documentation (including modified early obstetric warning scores, and intrapartum 'fresh eyes') for each woman.	See tab 7 for action plan regarding fresh eyes audit. A review of MEWS documentation to be undertaken and an audit of use. Review current documentation of risk status during the antenatal, intrapartum and postnatal period and undertake an audit. See action plan tab 2	C Robertson & S Hollins	C Stott & A Hardaker	30/10/2020 ext 30/01/2021	The monthly 'Fresh eyes audit is being undertaken on Meridian and monitored monthly. The findings are being shared with the team. Action plan in development for areas where standards are not being met. MEWS auditcompleted and shared. Included on December Q&S meeting agenda and will be presented at January Specialty Governance Meeting. Risk assessment audit has been assigned and requires priority in view of Okenden Report	
10	The service must ensure a systematic programme of rolling internal and clinical audit (to include documentation audits) is in place to monitor quality and to identify where action should be taken; and robust action plans are in place from audits to facilitate improvement.	An audit plan for 2020/2021 to be produced and achieved. This should include audits of local guidelines, NICE guidelines, NICE quality standards and recommendations from clinical incidents. Clinical audit lead to be assigned to support the process. Audit action tracker to be developed and monitored at the governance meeting. Learning from audit to be shared with the service. See action plan tab 2	C Robertson & S Hollins	C Stott & C Robertson	30/11/2020 ext 30/01/2021	Obstetric audit lead to be agreed and commence 2020/2021 audit plan agreed and reviewed at the Women's Quality & Safety meeting. Action tracker in development.	
11	The service must ensure all levels of governance and management function effectively and interact with each other appropriately.	A review of governance processes is required to ensure all requirements are achieved within a variety of maternity forums. Clear terms of reference are required for each forum which underpin the governance structures from ward to board. Update the governance and risk strategy. See action plan tab 2	C Robertson & S Hollins	C Stott & J Anderson	20/09/2020 ext 30/01/2021	Meeting agenda for Governance revised. Maternity Risk strategy update in progress.	
12	The service must monitor the reporting of staffing related incidents (for example through the 'safe care' tool) and ensure all opportunities for learning from incidents are taken.	All staffing related incidents and closures to be datixed. All service closures to be reviewed and a level 1 investigation completed with learning and successes shared. A letter will be sent to women diverted to other units due to closures. Red flags to be captured, monitored and actioned. Development of a midwifery guideline.	C Robertson & S Hollins	Maternity Matrons	20/09/2020 ext 30/01/2021	6 monthly maternity staffing paper completed. Red flag data is being collated from the intrapartum area and submitted in the Trust board papers. Closures are being datixed. Scoping of how Trusts in the region are collating Red Flags complete. Red flag SOP in development. Meeting with Head of Midwifery required to ensure staff can input red flags in the relevant areas. Permissions are currently a barrier but options have been provided by J Hilton. Amber risk assessment to be reviewed and updated to ensure closures can be robustly reviewed and	
13	The service must ensure the findings of external incident investigation reviews are duly considered and action plans include all findings to address the issues identified.	All investigation reports are cascaded to the team for comments. Actions plans to be agreed and approved by the service. Actions from investigations to be included on the incident action tracker and monitored at the monthly governance meeting. See action plan - tab 2	C Robertson & S Hollins	C Stott & J Anderson	4/30/2020	HSIB investigations discussed at women's governance meetings. Reports sent to QuCC for review. Findings and action plans presented at Trust Patient safety committee.	
14	The service must ensure regular checks of adult resuscitation equipment are undertaken in maternity.	Continue departmental monitoring of resuscitation checks to be implemented. Daily spot checks to be undertaken. Matron sign off of weekly checks. Resuscitation team to provide early feedback of findings to the service.	C Robertson & S Hollins	Maternity Matrons	28.05.2020	A process is in place for monitoring adult resuscitation equipment with Matron oversight and assurance.	
15	The service must ensure clinical guidance for staff is clear and not contradictory, particularly with regards to foetal growth monitoring.	The service to agree and decide on a fetal growth and surveillance pathway and update the Fetal growth guideline based on best practice. Work towards the implementation of saving babies lives 2 recommendations. See action plan - tab 7	C Robertson & S Hollins	N Sabir	1/30/2021	Symphyseal fundal height competence package approved and being rolled out. Workshops took place to engage clinical staff in the pathway update. Fetal growth guideline has been updated and circulated for comments. For approval and roll out in January 2020. Radiology have confirmed scan bundle can be commenced in January.	
	SHOULD dos						
16	The service should consider reviewing and revising the summary information pages of patients' electronic records; so that safeguarding concerns or mental health information are clearly shown	A review of the Medway system is required to ensure that Safeguarding and Mental Health information can be easily located and these risk clearly identifiable on the summary information page of the patient record. A SOP is required and education to staff to ensure they are aware of how and where to locate this information. This also needs to be an essential requirement for the new electronic maternity system.	C Robertson & S Hollins	R Pallethorpe & E McArdle/Robinson	9/30/2020	SOP's approved. Staff spot checks to be completed	
17	The service should consider developing an agreed maternity vision with relevant stakeholders, and a strategy to implement it; ensuring that all key business risks (including the replacement of obstetric theatres) are detailed in the clinical business unit planning 2019-2020 strategy.	Obtc vision	C Robertson & S Hollins	C Robertson, S Hollins, H Ackroyd	10/30/2020	complete	
18	The service should work to improve the time taken to investigate and close complaints, in line with the trust's complaints policy.	A monthly update of complaints numbers, position, themes and trends to be included within the governance meeting to ensure sufficient support is in place to meet the required deadlines. See action plan - tab 2	C Robertson & S Hollins	D McMahon	7/30/2020	A meeting has been held with the Complaints coordinator to agree the requirements of this action. A monthly report was produced and included on the last few months Governance agenda.	

Complete

All actions complete and ongoing monitoring

Ongoing

Date	Source	OBJECTIVE	ACTION	BY WHEN	BY WHOM	UPDATE	COMPLETED	EVIDENCE
4/9/2020	CQC action plan	The trust must improve governance and oversight of risk in maternity services.	Meeting to be held to streamline meetings and agendas.	Apr-20	C Stott, J Anderson, C Robertson, N Sabir, S Hollins, V Jones, J Stubbs, K Pitts	complete		Agendas updated and TOR agreed
		The service must ensure all levels of governance and management function effectively and interact with each other appropriately.	Develop Terms of Reference for Maternity meetings	7/30/2020	C Stott & J Anderson	complete		Agendas updated and TOR agreed
			Update the Maternity Risk Strategy	30/11/2020 ext 30/01/2021	C Stott & J Anderson	Ongoing		
		The service must ensure all staff are up to date with mandatory training , including safeguarding children level three training.	Women's services mandatory training report to be reviewed and non-compliance reported by Governance lead on a monthly basis.	7/30/2020	C Stott	Non-compliance report sent to managers		Monthly mandatory training report included on Governance agenda
			All managers to review and provide assurance to Matrons of training compliance for staff in their areas on a monthly basis.	7/30/2020	Ward Managers	Managers to bring compliance to the October Quality & Performance meeting		Managers collating data on a monthly basis to the assurance spreadsheet.
			ESR training reports to be streamlined for accuracy	30/11/2020 ext 30/01/2021	V Nutter & K Pitts	Matrix received from education. To be discussed with Matrons.		
			Monthly compliance reports to be included on monthly governance agenda.	7/30/2020	C Stott & J Anderson			
		The service must ensure a systematic programme of rolling internal and clinical audit (to include documentation audits) is in place to monitor quality and to identify where action should be taken; and robust action plans are in place from audits to facilitate improvement.	An audit plan for 2020/2021 to be produced and achieved. This should include audits of local guidelines, NICE guidelines, NICE quality standards and recommendations from clinical incidents.	6/30/2020	C Stott & A Mighell	complete	Audit plan in place	
			Clinical audit lead consultant to be assigned to support the process.	6/30/2020	C Robertson	complete	A Mighell agreed to be a lead.	
			Audit action tracker to be developed and monitored at the governance meeting.	30/11/2020 ext 30/01/2021	C Stott, K Pitts & J Stubbs			
			Learning from audit to be shared with the service.	6/30/2020	C Stott & A Mighell	complete	Audit findings are shared at the speciality meeting, lessons learnt, reports delivered to the clinical areas and shared in relevant forums. Further progress to be made via the OMS programmes	Speciality agenda, lessons learnt
		The service must ensure staff always complete and update risk assessments and applicable key documentation (including modified early obstetric warning scores, and intrapartum 'fresh eyes') for each woman.	A review of MEWS documentation to be undertaken. Audit the use of MEWS in line with Guideline.	9/30/2020	A Hardaker & J Stubbs		Audit completed and included on December Q&S meeting agenda	
			Review current documentation of risk assessment at each contact during the antenatal, intrapatrum and postnatal period and undertake an audit.	30/09/2020 ext 30/01/2021	V Brown & A Mighell	Fresh eyes audit completed monthly and findings shared with the team		
		The service must ensure the findings of external incident investigation reviews are duly considered and action plans include all findings to address the issues identified.	All investigation reports are cascaded to the team for comments.	6/30/2020	C Stott & J Anderson	complete		Governance Minutes
			Actions plans to be agreed and approved by the service.	6/30/2020	C Stott & J Anderson	complete		Governance Minutes
			Actions from investigations to be included on the incident action tracker and monitored at the monthly governance meeting.	6/30/2020	C Stott & J Anderson	complete		Governance Minutes
		The service should work to improve the time taken to investigate and close complaints, in line with the trust's complaints policy.	A monthly update of complaints numbers, position, themes and trends to be included within the governance meeting to ensure sufficient support is in place to meet the required deadlines.	7/30/2020	C Stott & D Mcmahon	complete		Governance Minutes
			Complaints coordinator to include deadline date within the emial sent to the Matrons when complaint first opened.	6/15/2020	D Mcmahon	complete		Governance Minutes

DATE	SOURCE	OBJECTIVE	ACTION	BY WHEN	BY WHOM	UPDATE	COMPLETED	EVIDENCE
9/1/2019	Stillbirth Action Plan	To ensure oversight and ward to board reporting of stillbirths	Stillbirth to be a standing agenda item on the core group.	9/30/2019	C Stott	Review identified stillbirths are already a standing agenda item.	Jan-20	Agendas and meeting minutes
			Still birth figures to be submitted to quality committee report	9/30/2019	S Hollins	Review of the reports identified still birth figures are reported within the quarterly reports.	Jan-20	Quarterly report
			Any adverse deterioration in performance or themes in cases to be reported to Patient Safety Sub Committee and the Quality Committee through the Quarterly report.	1/30/2020	S Hollins	2019/20 Q3 report will detail any spikes in performance, themes and learning generated from the case reviews.	Jan-20	Quarterly report
			Daily stillbirth and neonatal death report generated from Medway and reviewed by the governance team to ensure a 72 hour review is commenced and completed	1/30/2020	C Stott		Jan-20	database can be located U:\Womens Services - CNST - Risk Management\Maternity Data
			Clinical reviews have a fortnightly oversight and meeting attended by Medical director, Chief nurse, Clinical Director, HOM, General Manager, Governance and Risk Leads and Obstetric clinical leads. Any immediate concerns are escalated at the time.	1/30/2020	S Hollins	Meetings well attended. Cases extended to now include neonatal deaths and HIE cases.	Apr-20	
	Perinatal Mortality Review Tool (PMRT) Report 2019, Perinatal Mortality Surveillance Report & Stillbirth Action Plan	To review all stillbirths in line with local and national recognised best practice	Completion of action plan for Saving Babies Lives Bundle2	6/30/2020	S Hollins	Action plan completed. Will be added to this action plan as a tab.	Jan-20	see separate tab
			Ensure use of cause of death and associated condition system for classification of cause of death, in order to ensure comparability of data	3/31/2020	A Hufton	completed and MBRACE data submitted	Jan-20	
			Undertake comparative work with previous years and present findings at speciality meeting to further define trends in causes of stillbirth to previous years	3/31/2020	A Hufton	Planned for 11.3.2020	Mar-20	agenda & Presentation
			Perform case note audit of antenatal care to ensure robust risk assessments specifically for aspirin and any other risk factors	30/06/2020 ext 30/02/2021	A Hufton	Delays due to Covid 19. Included on audit plan as part as risk assesment audit. Registrartion form received.		
			Through the use of PMRT increase multi-professional participation in the learning process	2/28/2020	A Hufton	Increased medical attendance and case presentation by middle grades in January and February 2020	Feb-20	Minutes
	Stillbirth Action Plan	To evidence continuous learning from stillbirths	Review the process for sharing learning from stillbirths via the weekly lessons learnt bulletin.	2/28/2020	C Stott	We continue to issue lessons learnt in relation to learning from stillbirths, this is shared via a number of forums and electronic formats.	Jan-20	Lessons learnt bulletins. Maternity FB page
			Learning from still birth case reviews to be reported to the Patient Safety Sub-Committee and on to Quality Committee through the Quarterly report.	1/30/2020	S Hollins	2019/20 Q3 report details spikes in performance, themes and learning generated from the case reviews. Attended PSSC in January 20	Jan-20	Quarterly report. PSSC minutes.
	Perinatal Mortality Review Tool (PMRT) Report 2019 & Stillbirth Action Plan	To improve experience of women and families experiencing stillbirth	Use of MBRRACE patient engagement materials to increase discussion and documentation of investigations offered.	3/31/2020	A Hufton/J Key	Emailed JK and AH x 3		
			Continue to support families undergoing a pregnancy with a known severe abnormality to facilitate patient choice (Butterfly pathway) and provide ongoing support after a pregnancy loss (Snowdrop and TLC clinics).	3/31/2020	A Hufton/J Key/ C Vasudevan		Continuous	Pathways
	Perinatal Mortality Review Tool (PMRT) Report 2019	Improve the recording of the staff involved in PMRT reviews.	Lead Obstetrician for perinatal mortality reviews (Amy Hufton) supported by midwife Julie Key. PMRT will document who is present and involved in discussions and members of the neonatal team can also be involved. Minutes from all meetings produced and emailed to all members of staff. Minutes document people present for meetings.	9/30/2019	S Hollins	Acknowledgment through a thank you email to staff as meeting national requirement for PMRT completion and review.	Jan-20	Meeting minutes
12/1/2019	Perinatal Mortality Surveillance Report	Trusts and Health Boards should aim to notify all deaths via the MBRRACE-UK system within 30 days of the death occurring. Mechanisms for timely notification should be incorporated into local processes, and must have adequate staff, time allocation and resources. Trusts and Health Boards should aim for completion of all surveillance data within 90 days in order to facilitate data sharing with the PMRT and aid discussions with parents at follow-up appointments.	Review barriers and develop an action plan	8/30/2020	A Hufton	100% of reporting of stillbirths and 87% of neonatal deaths are reported within 30 days. Completion of surveillance is limited to the completion of investigation results, i.e. placental histology performed externally to the organisation. Paper sent to H Jepps regarding requirements for Neonatologist to lead on PMRT		
		Trusts and Health Boards should use the MBRRACE-UK real time data monitoring tool to monitor the completeness of their data. Particular emphasis should be placed on carbon monoxide monitoring and other data items feeding into national initiatives such as the Saving Babies' Lives Care Bundle version 2.	Perinatal leads to look at the monitoring tool and provide reports of data completeness within the relevant forums.	8/30/2020	A Hufton/J Key	use of the tool reviewed at perinatal meeting 10.1.20. To review how tool can be utilised to support the PMRT update within the quarterly report. Hayley Edwards is collating information from PMRT to meet requirements from Saving babies lives.		
		Trusts and Health Boards with a stabilised & adjusted stillbirth, neonatal mortality or extended perinatal mortality rate that falls into the red or amber band should carry out an initial investigation of their data quality and possible contributing local factors. Organisations should review their performance against national outcome measures with a view to understanding where improvement may be required.	Extended perinatal meeting on February to discuss report findings and develop an action plan.	8/30/2020	A Hufton/S Seal/J Key			
		Trusts and Health Boards should work to implement fully the National Bereavement Care Pathway to ensure that all parents are offered high quality, individualised bereavement care after the loss of their baby.	Undertake benchmarking exercise against the National Bereavement Care Pathway standards.	6/30/2021	S Hollins/ J Key	Registration for completed and sent to National Bereavement Care Pathway. Trust now registered. Benchmarking undertaken and action plan to be agreed 03/07/20		
12.9.19	National Maternity and Perinatal Audit - Clinical Report 2019	Maternity Services and Information Technology will work together to review data quality submissions	Review 'breast milk at discharge', 'breast milk at first feed' and 'skin to skin contact' data quality and submissions Review submission of neonatal information !!	30/08/2020 ext 30/02/2021	C Stott	Review of data required and quality being undertaken as part of OMS programme. Technical specification sent to Z Thomas.		
30.12.19	Stillbirth risk assessment	Improve stillbirth data monitoring and review	Increase in dashboard reporting measures: o Stillbirths per 1000 births o Stillbirths numbers per month Stillbirth excluding lethal abnormalities !!	1/30/2020	C Stott, K Pitts M Rooney		Jan-20	Maternity dashboard
			Dashboard data discussed and minuted at monthly governance meeting.	1/30/2020	J Anderson, C Stott & K Pitt		Mar-20	Meeting agenda & minutes

DATE	SOURCE	OBJECTIVE	ACTION	BY WHEN	BY WHOM	UPDATE	COMPLETED	EVIDENCE
30.12.2019	Risk assessment	Ensure staffing levels are to agreed establishment	Recruitment of 19 WTE midwives	10/30/2019	S Hollins	All staff in post and supernumerary period complete	**Jan-20**	Maternity staffing paper
		Ensure staffing levels are to agreed establishment and improve sickness rates	Produce and circulate guidelines for the management of sickness for staff and managers	12/30/2019	A Hardaker		**Jan-20**	Guidance
			Review compliance with attendance management policy to ensure that all staff with a high Bradford Factor are managed appropriately with effective monitoring and target setting.	2/28/2019	S Hollins	Delayed due to Covid		
1/10/2020	Bi-annual Midwifery Staffing Report	The Trust board should be sited on the maternity staffing position twice yearly	SLT / Workforce Committee is asked to note the report and the assurance this provides.	1/30/2020	S Hollins		Jan-20	Meeting minutes
		Improve one to one care in labour rates	SLT/Workforce Committee is asked to consider the request to increase the midwifery establishment by 5.22 WTE to enable an additional intrapartum midwife per shift.	3/30/2020	Senior leadership team	Approval received. Recruitment in progress. 4 WTE appointed. 03/07/20 additional hours now recruited following NQM recruitment drive	Jun-20	Headcount
		Ensure maternity staffing establishment meets the requirements of the service	Birth Rate Plus Midwifery Staffing tool to be re-commissioned in summer 2020, noting the caveat that it does not take account of continuity of carer pathways.	9/30/2020	S Hollins	starting potentially in November 2020		
		Achieve one to one care in labour	Audit to assess the consistency of which the one to one care in labour definition is applied (March 2020). Maternity 'Work as One' week planned in March. Focus on One to One care.	3/30/2020	C Stott	Significant improvement in one to one care rates for last 4 months.	Sep-20	Dashboard
		Improve staff sickness rates	Further work to address sickness and absence in collaboration with the Royal College of Midwives and the Human Resource department.	2/28/2020	S Hollins	Meeting with RCM colleagues held in February. Re-launched caring for you campaign.		
		Maintain staffing levels during period of high rate of maternity leave	Continue to recruit over establishment by 6.33 WTE to cover maternity leave.	3/30/2020	S Hollins	ongoing recruitment. 2 rounds of recruitment already undertaken. Further recruitment planned in March. 03/07/20 Proactive recruitment continues.		
30.12.19	1:1 care risk assessment	Improve one to one care in labour rates	Proforma to be designed to capture 'No' for 1;1 care first before Medway completion		Matrons			
			Re-launch 1 to 1 care in labour definition	1/30/2020	C Stott	Definition re launched	Jan-20	Posters Poster to be placed in clinical areas and be discussed at safety huddle and ward meeting.
			Proforma to be completed by the midwife for women defined as a 'NO' re receiving 1:1 care in labour.	4/30/2020	A Hardaker			
			Daily Medway report to identify women who have not received 1 to 1 care to ensure a proforma is completed and understand reasons why.	4/30/2020	K Pitts			
			Discuss progress and present run chart at Monthly Safety and Quality meeting.	7/14/2020	C Stott & T Mori			Governance minutes and MSF

Objectives	Action required	By Whom	review date/	Resource requirements/Action updateo	Target date	Completion date	Evidence
1. Lead implementation Midwife required	1.1 LMS funding in place for Band 7 Continuity Lead	Sara Hollins	Mar-21	Post recruited to and LMS funding achieved from March 2019	2019	2019	Midwife in post
2. Communication Plan	2.1 Provide regular information in a variety of formats to inform workforce on national, regional and local updates	Abbie Wild	Monthly	Monthly virtual forums in place. Regular updates in clinical areas and social media. Formats embedded.		Jun-20	Highlight reports
	2.2 Monthly Continuity Forums open to all staff	Abbie Wild & Alison Powell	Commence Nov 2019	Dates for the forums are in place and generating interest and engagement from staff	Nov-19	Jan-19	Forum dates
	2.3 LMS CoC forums/working groups Provide monthly highlight reports for LMS	Abbie Wild	Monthly	Process in place and monthly highlight reports are consistently provided to the LMS	2019	2019	Highlight reports
	2.4 Share highlight reports, actions plan and timeline with Maternity Board Level Safety Champion (BLSC), CNU Director, and workforce	Sara Hollins, Abbie Wild & Alison Powell	Jan-20	Action plan shared with Board Level Safety Champion and circulated to CNU Director and wider workforce following approval	30.1.20-BLSC	29.01.20	Core Governance meeting minutes Feb 2020
	2.5 BLSC to agree process for sharing monthly update of progress against this action plan with Trust Board.	Karen Dawber & Sara Hollins	Jan-20	Copy of the monthly highlight report and action plan progress to be presented to Quality Committee, subsidiary of Trust Board, on a monthly basis from February 2020.	29.01.20	29.1.20	Quality committee reports
3. Workforce engagement and training needs	3.1 Scoping Exercise to engage with staff to explore ideas, questions and concerns	Abbie Wild, Matrons & Department managers	Feb-20	'CoC Reviews'-All midwives to complete with line manager 78% response rate.	29.2.20	29.02.20	Report
	3.2 Create a Training Needs Analysis document/personal learning plan	Abbie Wild	Jan-20	Completion delayed due to Covid 19. Review date reset to September	29.2.20 now Sept 20		completed. Included in Midwifery education strategy
	3.3 Participate in LMS core skills requirements review for all departments	Abbie Wild & Department managers	Mar-20	Completed and returned to LMS Midwife	29.2.20	29.2.20	
	3.4 Expressions of interest approach for staff in planning teams	Abbie Wild		17 new Midwives recruited to CoC teams to fill gaps in existing teams and commence new pathways		Jun-20	Recruitment to new teams. On track with targets
	3.5 Staff engagement regarding core positions	Abbie Wild					
4. Workforce configuration planning	4.1 Partnership working with RSB to achieve Clover Team	Alison Powell & Tracey Hall	Apr-20	Clover Team launched in March 2019	Apr-19	Apr-19	COC presentation. Clover Team launched in March 2019 Funding extended to February 2021
	4.2 Capture existing pathways provided by specialist midwives/teams	Abbie Wild & Sara Hollins	Apr-20	Teenage Pregnancy, Palliative Care Pathway and Goldstar Pathway in place	Apr-19	Apr-19	COC presentationTeenage Pregnancy on-going with limited intrapartum care. Multiples & Acorn team (vulnerable women pathway) commenced 1/3/20. Staff recruited to Butterfly team (previous loss and current poor prognosis/palliative care) and diabetic (T1&T2) to commence early 2021.
	4.3 Set up and progressive development of Homebirth team	H. Avdiyovski, J Beer & A Powell	Apr-20	Homebirth Team went live in April 2019	Apr-19	Apr-19	COC presentation. Homebirth Team went live in April 2019
	4.4 Set up Birth Centre integrated model-Willow Team	C. Dyson, A Field & T Mori	Feb-20	Willow Team launched November 2019	Nov-19	Nov-19	COC presentation. Willow Team launched November 2019
	4.5 Development of Acorn team-case-loading vulnerable groups	Jo Beer & H. Avdiyovski	Mar-20	Acorn Launched	Mar-20		Launched 1/3/20. On-calls to commence December 2020.
	4.6 Development of 2nd integrated Team	A. Wild,Jo Beer & H Avdiyovski	Feb-20	Amber Launched	01/03/2020 now Nov 20		Team relaunched November 2020.
	4.7 Development of multiples pathway	Alison Powell & Gill Shaw	Feb-20	Launched 1/3/20 but halted due to Covid 19 20/04/20 Revised target date September 20	01/03/2020 now Nov 20		Launched 1/3/20. Team to be fully staffed in November.
	4.8 Develop a strategy for staffing core areas to support the implementation of CoC	Abbie Wild Alison Powell					
5. Human Resources review of relevant processes/ requirements to support CoC context	5.1 Review of trust on-call guidance	L. Traynor & Alison Powell	Mar-20	HR have reviewed and failed to find a workable solution that fits with rooster and continuity modelling. To be included in OMS investing in our workforce workstream.			
	5.2 Review of E-roster usage to capture CoC models of working	Tracey Hall & Sary Lupton	Mar-20				
	5.3 Review of job descriptions, person specifications and contracts to include CoC models of working	L. Traynor & P Cantbell	Mar-20				
6. Governance	6.1 CoC agenda requirements on risk register	Carly Stott	3-Monthly	Added to Risk Register September 2019. To be reviewed 3 monthly	Sep-19	Sep-19	Risk assessments attached to risk register
	6.2 CoC part of PCG vision 22 strategy	Sara Hollins, C Robertson & H Acleoyd	Feb-20	Agreed as a work stream	Dec-19	Dec-19	PCG version 22 strategy
	6.3 Standing Operating Procedures for team-approval process to be agreed	Sara Hollins & Abbie Wild		SOP's written for Willow, Acorn, Multiples & Amber – awaiting feedback from teams prior to approval process (agreed).			SOP's written for Willow, Acorn, Multiples & Amber
7. Financial impact assessment	7.1 Review of resource impact and requirements for each team set up	A. Wild & A Powell		To review October 2020	Oct-20		
8. Monitoring and Evaluation	8.1 Each team to provided monthly stats of CoC achievements as per LMS reporting requirements	Each team leader		March stats 45%, exceeding 35% target. Monthly data collection on hold due to Covid-19. Review September.	Sep-20	Monthly	Date collection tool being used by every CoC team. Quarterly outcome data reported to LMS.
	8.2 Each team to apply an ongoing self-evaluation and provide a summary of learning and developments for service wide update	Each team leader		Evaluation tool developed 11/3/20. Willow evaluation complete 20.7.20.	Sep-20		Evaluation tool
	8.3 Review Evaluation tool and use to design a developmental tool for future CoC teams	Abbie Wild		To discuss at next Willow meeting date tbc.	Dec-20		
	8.4 Meet the revised trajectory of 35% of women booked / placed onto a CoC pathway by March 2021, prioritising women from BAME and vulnerable groups.	Sara Hollins Alison Powell Abbie Wild		Post-covid reset plan shared with the LMS: Prediction for March 2021 = 38%. 5 of the 7 current CoC teams have a significant majority BAME caseload. Geographical teams with high BAME and low social deprivation populations to be prioritised for future CoC pathways.	Mar-21		

DATE	SOURCE	OBJECTIVE	ACTION	BY WHEN	BY WHOM	UPDATE	COMPLETED	EVIDENCE
1/1/2019	MBRRACE Saving Lives, Improving Mothers' Care 2018 report	Share the findings from the 2018 MBRRACE Maternal Mortality report	The findings and recommendations from the Saving Lives, Improving Mothers Care MBRRACE Report 2018 will be presented at the Obstetrics Speciality Meeting by the audit lead.	1/30/2020	N Sabir		Jan-20	Agenda & presentation
		Compliance with MBBRACE recommendations	A PPH Audit will be carried out.	6/30/2020	A Mighell		Decemebr 2020	December Core group minutes. Audit report
			A VTE audit will be carried out.	5/30/2020	N Sabir	Report in progress		
			Recommendations from the report will be incorporated in to PROMPT obstetrics / midwifery teaching.	3/30/2019	A Hufton		Dec-19	Presentation
			Develop a robust process to ensure electronic patient records are accessible from outside individual units need to be taken into account, not only for direct patient care but also for external review processes such as the Confidential Enquiries.	9/30/2019	C Stott		Dec-19	Process now in place with wider collaboration with LMS ongoing
			Prescriptions for the entire postnatal course of LMWH should be issued in secondary care. This will help ensure that women receive the full course without the need to visit their GP to obtain another prescription. This also provides a double safety net since the prescription will be checked by a hospital pharmacist, who ensures the correct weight-appropriate dose is dispensed. (Knight, Tuffnell et al. 2015)	01/01/2020	N Sabir	Currently giving 10 day supply, new process agreed and being rolled out in January 2020.	Jan-20	Process now in place and women discharged with the full course.
			Offer the woman a named midwife or doctor who has specialised knowledge of, and experience in, the care of women who misuse substances, and provide a direct-line telephone number for the named midwife or doctor	30.07.2019	S Hollins		Dec-19	Midwife within the Acorn team is currently case loading women who misuse substances. This is also achieved with the support of the specialist midwife for women with complex needs. Pathways in place
			In women facing multiple adversity, changes in frequency or nature of presentations may reflect worsening mental state or the emergence of new complications, and should prompt renewed attempts at engagement, diagnosis and care co-ordination.	30/04/2020	B Palethorpe	Specialist midwife appointed in November 2019, currently reviewing guidelines. Unexpected leave of guideline author has delayed the update of the guideline. Extension agreed until April 2020		Becky emailed for an update 16.4.2020
			Perinatal mental health clinical networks should be established to develop local services and clear pathways of care to prevent care being fragmented and uncoordinated. Networks should always include specialist addictions services.	30/04/2020	B Palethorpe	Specialist midwife appointed in November 2019, currently reviewing guidelines. Wider LMS action - work is progressing. Unexpected leave of guideline author has delayed the update of the guideline. Extension agreed until April 2020		Becky emailed for an update 16.4.2020
			Neurological examination including fundoscopy is mandatory in all women with new onset headaches or headache with atypical symptoms.	01/02/2020	N Sabir	Guideline developed and approved at March Governance meeting	Feb-20	Guideline
			There should be an early multidisciplinary discussion about the care of any woman with complex medical conditions in pregnancy. This is particularly important if the woman is managed across several centres. A named individual needs to take overall responsibility for coordinating her care	11/30/2019	N Sabir		01/11/2019	Care of sick mother meeting. Commenced regular monthly meeting from November 2019. Organised by N Sabir and includes Obstetric consultants, trainees, specialist nurses and anaesthesia. N Sabir and A Hufton are allocated consultant responsibility for these ladies. All booking referrals are screened by N Sabir and J Wright to ensure appropriate consultant allocation.
			Women with complex and multiple problems require additional care following discharge from hospital after birth and there is a need for senior review prior to discharge, with a clear plan for the postnatal period. This review should include input from obstetricians and all relevant colleagues. The postnatal care plan for women with complex and multiple problems should include the timing of follow up appointments, which should be arranged with the appropriate services before the women is discharged and not left to the general practitioner to arrange.	30/06/2020	N Sabir/ A Hufton	All women with complexities should have an individualised care plan, in addition we have achieved specific care plans for women with Neurological, diabetes, haematological, Learning disabilities, Mental Health and women who have experienced a pregnancy loss. To further strengthen this we want to amend the post natal care pathway to include prompts to aid in decision making / discharge planning.		Guideline in draft. Circulated for approval. For ratification at January 2021 core group meeting

Saving babies lives v2 action plan is located - U:\Womens Services - Risk Management\Saving babies lives

DATE	SOURCE	OBJECTIVE	ACTION	BY WHEN	BY WHOM	UPDATE	COMPLETED	EVIDENCE
01.06.19	Risk assessment	Ventilation in maternity theatres to meet the required health and safety standards	Preparation of an options appraisal paper for further executive review of the operational options to achieve the required ventilation in obstetric theatres. To review risk assessment once option agreed.	Sep-19	Janet Wright / Diane Daley	A paper with detailed proposals for the locating of a Vanguard unit was presented to EMT on 4th September and was further discussed at the EMT meeting in November when a revised paper was tabled which included an options appraisal (attached). Note the paper presented in September is embedded into the November paper.	Nov-19	Paper
			Maternity Theatres Build and Labour Ward Theatre extension and ventilation project	Jun-21	H Ackroyd / S Embleton	The project has commenced and is in the design and ground testing phase		
		Achieve the recommendations of the Post infection audit	• Reinforcing the principles of reducing post op infection • Reviewing dress code for theatre and when theatre wear should be worn. • Reviewing movements to and from theatre to reduce potential contamination • Maintaining infection control measures e.g. scrub procedure	Nov-19	Claire Dinsdale/ Nicola Cawley/Tina Mori	Completed	Nov-19	Completed
		monitor, improve and continually assess infection rates of women who birth in maternity theatres.	Reviewing use of dressing and wound care post op • Obtaining costings • Develop a role out and monitoring action plan.	8/30/2020	H Dadi	Dressings have been purchased. Use of Honey comb dressing commenced 18.5.2020 until 18.8.2020	Aug-20	Completed
			As part of continuous learning and improvement it is planned to use the 'One Together Assessment Toolkit', 2019, to benchmark practice and highlight areas for ongoing improvements.	6/30/2020	Claire Dinsdale/ H Dadi / C Chadwick	Benchmarking complete. Action plan in in progress.	Jan-21	Benchmarking tool and action plan in place will be monitored via IPCC and Women's Q&S meeting
			Develop an audit tool and plan to undertake a robust surgical infection audit	3/30/2020	Claire Dinsdale/ H Dadi/A Powell/ C Chadwick	Public health surveillance tool being used. Roll out planned for March 2020		Public health surveillance tool rolled out March 2020
			Ensure weekly datix report is submitted for the number of times theatre 2 is used	Ongoing	C Stott/V Jones	Theatre usage and Datix report 2019 completed	Dec-19	
			Reinstate theatre audits on meridian	complete	C Dinsdale		Dec-19	Meridian reports
			Commence audit using Public health surveillance tool of all women having a caesarean section	until new theatre in use	C Dinsdale/ S Crowther	Maternity theatre file created on shared drive. Excel database commenced to include all women who have had a caesarean section. First 7 weeks of audit completed and presentation available	ongoing and will continue for 2 to 5 years.	Will be monitored at IPCC and Women's Quality & Safety meeting
			QI application completed to support this project		A Powell	Awaiting assignment of QI lead	Aug-20	

DATE	SOURCE	OBJECTIVE	ACTION	BY WHEN	BY WHOM	UPDATE	COMPLETED	EVIDENCE
Oct-18	CTG fresh eyes audit.	To improve staff documentation of maternal pulse at commencement of CTG and fresh eyes	• All intrapartum staff to be made aware of the results from initial audit on CTG documentation. Target questions identified. • To produce Informatics and placed in every room. • Educating on the expected standard of documentation. • Remind staff at hand over of the importance of hourly fresh eyes and recording and documentation of the maternal pulse via pulse oximeter at commencement of CTG for 20 minutes,	Oct-19	Band 7's and labour ward manager	All actions completed, poster in all room and on the learning and messaged board in the staff room and at the midwives station. Handover message delivered for 8 weeks First audit data shared via lessons learned. Outline to all staff of the areas requiring improvement.	Oct-19	
		Improve quality of audit data particularly in relation to fresh eyes hourly documentation	• Set standards to question and circulate to staff • To review data to highlight areas of data inaccuracy to inform the standards • Review audit tool questions to enable not applicable option to relevant questions	March 2019	Ward manager/Matrons and risk manager	Meridian audit record created in December 2019 initial launch in December but slow to generate data. Re- Launch as active February 2020.	Mar-19	
		Improve the number of audits undertaken per month	• A minimum of 10 audits a month to be completed. • To allocate a rota system of responsibility amongst the band 7 co-ordinators for the month. This is for them to coordinate the collection of data not to be responsible for singularly collecting data.	Oct-19	Labour ward manager & Coordinators	In August it was identified that volume of audits had not been specifically set. Discussion with Dr Dadi Consultant Obstetrician. Plan for 10 per month to be completed.	Oct-19	
		Monitoring of the audits	• Number of audits completed to be monitored monthly and reported on monthly assurance record • Non-compliance with audit to be actioned and escalated. • Data quality to be checked in relation to negative responses to questions until assurance that staff are aware of the newly introduced set standards	June 2020	Labour ward manager, Matron & Risk Manager	Meridian being reviewed by Matron and Risk Manager regularly. Monitoring through unit managers assurance dashboard. Template decided and approved February 2020		
		Continuous learning and feedback	• Introduce sharing the findings from the audit with staff on a monthly basis • Provide individual feedback to staff	Oct-19	Labour ward manager, Matron & Risk Manager		Oct-19	

Maternity action plan commenced following unannounced CQC visit November 2019

DATE	SOURCE	ACTION	BY WHEN	BY WHOM	UPDATE	COMPLETED
11/18/2019	Unannounced inspection feedback from staff - staff feel one of pressures in achieving better staffing levels is due to the availability of bank staff	Increase number of midwives working on Trust Bank, by reviewing the barrier to staff joining	12/31/2019	Chief Nurse	20/12/19 Staff reluctant to join bank as the are asked to pay for a repeat DBS check. This only applies to existing staff who have been in post for over 2 years - any new started in last 2 years is automatically enrolled to the bank unless they opt out. Paper presented to SLT on 26/11/19 and agreed to waiver the DBS fee for existing registered nurses and midwives that are already substantively employed by the Trust. Update 20/12/19 bank application forms are available in areas of maternity, staff are joining the bank and the message has been fully communicated	12/20/2019
11/18/2019	Unannounced inspection feedback from staff, inspectors commented that they did not know who was who on the Labour Ward - all staff wear theatre scrubs.	Review and Implement new uniforms for all staff on Labour Ward	1/31/2020	Head of Midwifery	20/12/19 Staff consulted on in relation to uniforms and identified moving towards colour coordinated scrub suits. Costings have been obtained, funding agreed and samples are in place for staff to try for sizes. 20/01/2020 Staff have sampled and agreed style and colour schemes, uniforms being ordered.	1/20/2020
11/18/2019	Unannounced feedback from CQC - Difficult to understand the maternity staffing numbers in relation to staff in post and 1 to 1 care in labour	Head of Midwifery to meet with the CQC inspectors during well led inspection to discuss staffing and staffing methodology	12/13/2019	Head of Midwifery	15/12/2019 Interview arranged with CQC. CQC requested the Clinical Director to attend. Interview completed and KLOE in relation to Still Birth Rate, staffing levels and use of GROW	12/15/2019
12/14/2019	KLOE from well led inspectors in relation to still birth rates	Undertake a diagnostic review of Labour ward, focussing on patient experience and staff culture	2/28/2020	Chief Nurse	23/12/2020 - Piece of work commissioned with the improvement academy, cultural surveys plus patient level experience surveys using the Patient Experience Toolkit. This will be worked up as part of the wider Maternity improvement program and is planned to be later in the year to avoid "doing to" - want to be inclusive in our decision making	1/17/2020
12/14/2019	KLOE from well led inspectors in relation to still birth rates	Review the current status of Still Births YTD and assess the risk with consideration to an entry on the Risk Register	12/23/2019	Chief Nurse	20/12/19 Chief Nurse met with Clinical Director, Risk Midwife. Head of Midwifery, Obstetric safety lead. Discussed the current run rate of still births and any concerns in relation to safety. Aware of the increase in 2019 and these are all being considered as part of the PNMRT - no serious omissions in care identified, no intrapartum IUD's, no repeat trends of previous issues (failure to identify CTG changes, delayed induction of labour). Identified that we could improve on a more real time thematic analysis of any trends and further breakdown of the overarching reason for IUD - Currently only breakdown by 500grams normal and total. Discussed enhancing ways of reporting and statistical significance of reporting in different ways.	12/20/2019
12/20/2019	Meeting with Clinical team 20/12/2019	Review risk in relation to still births, both clinical and reputational - risk assessment to be completed and risk added to the risk register	12/30/2019	Triumverate	17//01/2020 - Completed and discussed at Governance and Risk Committee	1/17/2020
12/20/2019	Meeting with Clinical team 20/12/2019	Review reporting structures within the CBU, review terms of reference, roles and responsibilities within the teams in relation to still births and how this is reported	12/30/2019	Triumverate	30/12/2020 - Reviewed with clinical teams and changes implemented.	12/30/2020
12/20/2019	Meeting with Clinical team 20/12/2019	Consider how the CBU can be supported to describe the current trends in relation to the review of still births and population health	12/23/2019	Chief Nurse	23/12/2019 Chief Nurse to discuss with wider Executive team how the CBU can be supported going forward in relation to work with still births and in providing further assurance to the CQC. Assurance tracker developed.	12/23/2019
12/20/2019	Meeting with Clinical team 20/12/2019	Review the actions in relation to the 2018 MBRACE report	12/30/2019	Triumverate	30/12/2020 - met with teams and completed	12/30/2020
12/20/2019	Meeting with Clinical team 20/12/2019	Follow up meeting with clinical team / triumverate on 30/12/2019 to review progress	12/30/2019	Chief Nurse	20/12/19 30 and 31 December blocked out to review progress and support CBU	12/30/2019
12/20/2019	Meeting with Clinical team 20/12/2019	Provide additional assurance in relation to safe staffing levels in maternity	12/30/2019	Head of Midwifery	30/12/2020 Completed	12/30/2019
12/20/2019	Additional assurance required by CQC in relation to midwifery staffing	Provide additional assurance in relation to safe staffing levels in maternity	12/30/2019	Head of Midwifery	30/12/2020 Completed	12/30/2019
		Revise risk assessment and staffing safeguards in relation to safe midwifery staffing	12/30/2019	Head of Midwifery	30/12/2020 Completed	12/30/2019
		Develop a recovery plan in relation to 1 to 1 care in Labour	12/30/2019	Head of Midwifery	30/12/2020 Completed	12/30/2019
12/20/2019	Additional assurance required by CQC in relation to theatre 2	Review submission of evidence, this includes risk assessment documents, risk register entries, check for inconsistencies and gaps in evidence / assurance	12/27/2019	Tim Gold	30/12/2020 Completed	12/30/2019
		note that provides a list of evidence provided and narrative / timeline	12/30/2019	Tim Gold	30/12/2020 Completed	12/30/2019
12/20/2019	Additional assurance required by CQC in relation to still births	See additional assurance required	12/30/2019	CBU Triumverate	30/12/2020 Completed	12/30/2019
12/20/2019	Meeting with Clinical team 20/12/2019	Root and Branch review of clinical governance within the Cbu, including reporting and tracking of actions. Formal Quality summit to be held in January 2020	1/20/2020	Chief Nurse	17/01/2020 - Chief Nurse and Chief Medical Officer have met with CBU and we are progressing regular meetings and a Maternity Improvement Programme	1/17/2020