



Bradford Teaching Hospitals
NHS Foundation Trust

Maternity Improvement Plan

Document control:

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EA 6	Q36	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies Lives new bundle version 2?	See Q27	36.1 DGPAs 36.2 Audit for each element 36.3 Guidelines with evidence for each pathway 36.4 Adult training needs analysis (TNA) that clearly articulates the requirement of all professional groups in attendance at all MCT training and core competency training. Also aligned to NICE 37.2 36.5 Subject evidence of training evidence being attended, with clear evidence that all MCT members are represented for each session 36.6 L&D reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates evidence of effectiveness in checking the accuracy of the data 36.7 Of course inaccuracy or not meeting targeted target what actions and what risk reduction mitigations have been put in place 36.8 Other maternity in place to meet and maintain compliance as articulated in the TNA 36.9 Documented evidence - summarized	See Q27			
	Q37	Action 8	Can you evidence that at least 95% of each maternity unit staff group have attended an in-house multi-professional training emergency training session since the launch of MBS year five in December 2019?	See Q21	37.1 Adult training needs analysis (TNA) that clearly articulates the requirement of all professional groups in attendance at all MCT training and core competency training. Also aligned to NICE 37.2 37.3 Subject evidence of training evidence being attended, with clear evidence that all MCT members are represented for each session 37.4 L&D reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates evidence of effectiveness in checking the accuracy of the data 37.5 Of course inaccuracy or not meeting targeted target what actions and what risk reduction mitigations have been put in place 37.6 Other maternity in place to meet and maintain compliance as articulated in the TNA 37.7 Documented evidence - summarized	See Q21			
	Q38		Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified as that every unit has a lead maternity and a lead obstetrician to plan to lead best practice, training and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives core bundle 2 and national guidelines	See Q34	38.1 Name of dedicated Lead Maternity and Lead Obstetrician 38.2 Copies of notes of dates of dates to demonstrate they are given dedicated time. Examples of what the leads do with the dedicated time (i.e. effectiveness of internal best wellbeing event, training, meeting minutes and action logs) 38.3 Trained investigators and reviews	See Q34			
EA 7	Q39		39.1 To ensure women have ready access to accurate information to enable them informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	ALL place of birth information easily accessible	39.1 Information on maternal choice including choice for caesarean delivery 39.2 Submission from MRP chair rating that information in terms of accessibility (translation, language and quality of info (clear language, ultrasound topic covered) other evidence could include patient information leaflets, apps, websites	See Q39	39.3 Choosing to have a c-section safely, START My Pregnancy and Birth Bundle to help the pregnancy journey		
	Q40		All maternity services must ensure the provision to women of accurate and comprehensive evidence-based information to support informed choice. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care	ALL information is easily accessible	40.1 Information on maternal choice including choice for caesarean delivery 40.2 Submission from MRP chair rating that information in terms of accessibility (translation, language and quality of info (clear language, ultrasound topic covered) other evidence could include patient information leaflets, apps, websites	See Q40	40.3 Choosing to have a c-section safely, START My Pregnancy and Birth Bundle to help the pregnancy journey		
	Q41	Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care	Confirmation that trust M&S a method of recording decision making process that includes women's participation in informed choice		41.1 DGPAs about choice how women are enabled to participate equally in all decision-making processes and to make informed choices about their care. And where that is recorded 41.2 An audit of 1% of notes demonstrating compliance 41.3 DGPAs survey and associated action plans	See Q41	STANDARD OPERATING PROCEDURE (SOP) Supporting Women's Informed Choice Throughout Maternity Care in 2021 SOP to be updated as per		
	Q42	Women's choices following a shared and informed decision-making process must be respected	Witness made to how Women's choices are respected and evidenced		42.1 DGPAs to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded 42.2 An audit of 0.5% of notes or a total of 100 which is over the last from January 2021. Demonstrating compliance. This should include women who have specifically requested a care pathway which may differ from that recommended by the clinical team for the antenatal period, and also a selection of women who request a caesarean section during labour or induction 42.3 DGPAs survey and associated action plans	See Q42	STANDARD OPERATING PROCEDURE (SOP) Supporting Women's Informed Choice Throughout Maternity Care in 2021 SOP to be updated as per		
EA 8	Q43	Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voice. (Previously to incorporate trust maternity services)	See Q13	43.1 Phases of your DGPAs evidence of no production. If sufficient then updated completed template for production to successfully address maternity safety action 7. DGPAs template to be signed off by the MRP 43.2 Evidence of service user feedback being used to support improvement in maternity services (0.5% of notes, not all) 43.3 Close to production plan, with M&P's that demonstrate that no production and no change of all services (maternity, obstetrics, and gynaecology) will be in place and not be evidenced by December 2021	See Q43			
EA 9	Q44		Every trust should have the pathways of care clearly described, in written information in formats consistent with NICE policy and practice on the trust website. An example of good practice is available on the Chelsea and Westminster website	All information on trust website	44.1 Gap analysis of website against Chelsea & Westminster conducted by the MRP 44.2 To understand action plan to address gaps identified 44.3 Submission from MRP chair rating that information in terms of accessibility (translation, language and quality of info (clear language, ultrasound topic covered) other evidence could include patient information leaflets, apps, websites	See Q44	44.4 Developed a tool which will be produced electronically by the end of June 2021 for MRP to check website is consistent with NICE policy		
SECTION 2: REINFORCE PLANNING			Assessment Criteria	London Regional narrative on process and ratings & clarity from national team					
Link to Maternity Safety Actions									
Q45	Action 4	Can you demonstrate an effective system of maternity workforce planning to the highest standard?	Maternity workforce planning system in PLACE	If a system of maternity workforce planning was in place that was accepted as per the criteria NATIONAL ASK: That there is also identification on evidence of workforce planning against medical workforce	* Most recent B&P report and board minutes agreeing to fund * Consider evidence of workforce planning at L&D level given this is the direction of travel of the people plan M&P action 4	See Q45	Board decision-making agreement, July 2021, January 2022 to extend staffing plans, B&P - clear report, B&P - recommendation paper for C&M in the 18th and 19th monthly paper was received. ACA - workload staffing plan - Medical staffing business case - B&P - paper presented to Board as an appendix to the training and maternity staffing review. Board approved the paper.		
Q46	Action 5	Can you demonstrate an effective system of maternity workforce planning to the required standard?	Confirmation of a maternity workforce plan which meets AND a plan to plan with confirmed resources) to meet B&P standards	To be compliant trusts need to have an up to date Workforce plan (maternity) (i.e. within the last three years) and for the trust to have fully funded it. It is notable that a deep in 2019 was a challenge for full funding agreement for some trusts who were on a temporary approach NATIONAL ASK: Absolute clarity on these criteria	* Most recent B&P report and board minutes agreeing to fund, M&P action 5	See Q46	Clear to show - another board paper produced and will be submitted to September. B&P - paper presented to Board as an appendix to the training and maternity staffing review. Board approved the paper.		
Executive Leadership									
Q47	Please confirm that your Director/Head of Maternity is responsible and accountable to an executive director	Evidence the Director/Head of Maternity responsible and accountable to an executive Director	If now acceptable that the Director or Head of Maternity was accountable to the Chief Nurse. None are directly the manager	* Head/Chief Nurse designation with explicit signposting to responsibility and accountability to an executive director		See Q47	Supporting initiatives included: NICE D and accountability evidence -		
Q48	Describe how your organisation meets the national leadership requirements set out by the Royal College of Midwives in strengthening maternity leadership - a checklist for better maternity care 1. A Director of Midwifery in every trust and health board, and more than one in every health board 2. A head midwife at a senior level in all parts of the NHS, both nationally and regionally 3. More Consultant midwives 4. Specialist midwives in every trust and health board 5. Strengthening and supporting sustainable maternity leadership in education and research 6. A commitment to fund ongoing maternity leadership development 7. Professional paid into the development of midwifery leaders	Meet ALL that apply 1. A head midwife at a senior level in all parts of the NHS, both nationally and regionally 2. A head midwife at a senior level in all parts of the NHS, both nationally and regionally 3. More Consultant midwives 4. Specialist midwives in every trust and health board 5. Strengthening and supporting sustainable maternity leadership in education and research 6. A commitment to fund ongoing maternity leadership development 7. Professional paid into the development of midwifery leaders	NATIONAL ASK: Ensure template clear this is about applicable standards - original version circulated next	* Gap analysis completed against the RCM strengthening maternity leadership - a checklist for better maternity care * Action plan where necessary	Gap analysis	See Q48	Gap analysis and action plan completed. Trusts included in next care update and monitored as Q48 business meeting		
NICE guidance related to maternity									
Q49	How are existing guidelines to review their approach to NICE guidelines in relation to maternity and ensure that these are assessed and implemented when appropriate (where non-evidence based guidelines are utilized, the trust must undertake a robust assessment process before implementation and ensure that the evidence is clearly justified)	ALL guidance assessed & implemented - Yes (GREEN)	NATIONAL ASK: Clearly on the need to report number of guidelines that are out of date and need updating	* DGPAs for all guidelines with a demonstrable process for ongoing review * Audit of compliance of guidelines are in date * Evidence of risk assessment where guidance is not implemented	Only	See Q49	Trust NICE Policy, Trust clinical guidelines highlight report, Guidance guidelines, Q48, maternity business case and M&P minutes, Q48 assessment update, Current NICE position	Review National Recommendation, Trust, and maternity guidance update and NICE position	

Key

Submitted and no further action required

Submitted and further action required

Agreement recommendation

No	Title	Date published	Lead	update
MBRRACE 2020	Saving Lives, Improving Mothers' Care	Dec-20	Nada	Benchmarking complete - action plan in progress.
MBRRACE 2020	MBRRACE-UK Perinatal Confidential Enquiry Stillbirths and neonatal deaths in twin pregnancies	Jan-21	Janet & Padma	sent via email 21.05.21. Janet W confirmed she will complete
National Perinatal Mortality Review Tool	Learning from Standardised Reviews When Babies Die National Perinatal Mortality Review Tool & MBRRACE Perinatal report	Dec-20	Amy & Iram	sent via email 21.05.21

No	Title	Date published	Lead	Baseline assessment complete	Action plan in progress	Number of outstanding actions	
CG192	Antenatal & Postnatal Mental Health	Feb-20	N Cawley	Yes	Yes	5	emailed 21.05.21. Guideline currently being updated
NG133 & QS35	Hypertension in pregnancy	Jun-19	A Mighell	yes	Yes	7	emailed 21.05.21
NG123	Urinary incontinence in women	Apr-19	C Ramage	Yes	Yes	19	emailed 21.05.21
NG126 & QS69	Ectopic pregnancy	Apr-19	S Elton	yes - revisit section 3.0	Yes	1	Take 2 serum hCG measurements as near as possible to 48 hours apart (but no earlier) to determine subsequent management of a pregnancy of unknown location. Take further measurements only after review by a senior healthcare professional.
NG137 & QS46	Twins & Triplets	Sep-19	P Munjaluri	Yes	Yes	10	completed and signed off at Governance
NG140	Abortion care		A Mighell	Yes	Yes	5	emailed 21.05.21

NICE Baseline assessments to complete				
NG3	Diabetes	Dec-20	S Kakara	
NG194	Postnatal care	Apr-21	Lucy Jackson	
CG62 & QS22	Antenatal Care	Apr-19		
NG192 & QS32	Caesarean birth	Apr-21	Sam Crowther	
NG121	intrapartum care for women with existing medical conditions or obstetric complications and their babies	Apr-19	N Cawley	Partially complete
Historic NICE baseline assessments				
CG170	Induction of labour	2008	no baseline assessment in the file	Plan made to review 5 guidelines at a time, benchmark against NICE, national guidelines, add to new guideline template and add auditable standards. Nada & Carly leading on this
CG122 & QS 18	Ovarian cancer	2011	Tayo	
CG110	Pregnancy and complex social factors	2010		
CG156 & QS 73	Fertility		Shiva	
CG192	Intrapartum care for healthy women and babies			
NG4	safer midwifery staffing		Matrons	
NG73	Endometriosis diagnosis		Complete - needs review. Nick	
NG88 & QS47	Heavy menstrual bleeding	Mar-20	Hama - 5.8.21	
QS105	Intrapartum Care		none in file	

Audit Add auditable standards to guidelines

	Objective or Aim to be delivered	Actions and tasks to achieve the objective or aim	Named Individual responsible	Others inputting	Initial completion date	Completion Date	Progress Update	Status
HSIB & SI actions								
	1 Consider removing surgical tampons from the standard birth packs. Consider a supplementary single surgical tampon inclusive of a cord clamp.	Review the contents of the birth pack	A Hardaker - Matron	C Dinsdale - Labour ward manager		Jul-21	Tampons removed from packs email	
	2 A review of processes for obstetric review when women attend ANDU	Develop a scan review competency package. Incorporate roles and responsibilities into MAC SOP	N Cawley		N Sabir Oct 2020	Jul-21	Competency package approved at October 21 Governance Meeting. OMS looking at ambulatory care plans. BSOTS - guidance being produced.	
	3 Improvements are required with documenting clinical care and advice on the electronic Medway system	Undertake a record keeping audit	T Mori - Matron		Oct-20	End June	Audit report complete	
	4 The speciality should work to develop and implement processes to improve communication between separate IT systems	Improved documentation			Oct-20		ETM minutes and view point paper	
	5 Review guidelines and standard operating procedures	A clear and standardised process in place regarding Obstetric Triage	T Crocker		01/08/2020	End June	BSOTS implimentation. N Cawley producing guidance	
	6 The Trust should follow its policy and national guidelines to escalated concerns related to the baby's heart rate immediately identified to be prepared with appropriate staff when baby delivered	Paediatric presence for babies born in poor condition	J Stubbs		Aug-20		Report in final draft	

7	The Trust to ensure the use of a structured communication tool during the transfer of women between clinical settings takes place and at the safety huddles.	SBAR audit to be undertaken. Dr's to audit SBAR communication during telephone conversations. Coordinators to observe handovers of midwives when transferring women to labour ward.	Vanessa & J Stubbs		J Anderson/ C dinsdale	End July 21	To be incorporated into next PROMPT training plan commencing. SBAR guideline to be updated and relaunched.	
8	The Trust to follow national and local guidelines and arrange for an interpreter for non-English speaking mothers at all appointments	Undertake a retrospective audit of women who have birthed to review if an interpreter was arranged and present at antenatal appointments			A Mighell		Use of Interpreter audit and staff survey completed. Recommendations to be monitored via audit action plan	
9	The Trust ensure there is a system where records of previous telephone calls to the maternity assessment centre are available to clinicians at each subsequent telephone consultation	Telephone Triage. Update of advice call sheet. Implementation of electronic process	T Crocker - MAC manager				Telephone triage sheet updated. To be implemented electronically with new cerner roll out	Signed off at June Q&S
10	The importance of early escalation of CTG concerns should be reinforced. The Trust to ensure staff are supported to follow national guidance to ensure accurate and consistent CTG categorisation.	CTG audit	Z Thomas & M Naylor		Sep-20	end August		
11	Guidelines should reflect national guidelines in regards to early pregnancy loss	EPAU Guideline is in the process of being updated to ensure guidance is clear - pregnancy of unknown location	S Elton		Mar-21		Guidelines updated and circulated awaiting approval	
12	Streamline the ED pathway process, out of hours. To liaise with Dr Taggart	Share updated guideline with ED Identify variations in care when women attend AED and EPAU and streamline where possible	S Elton		Mar-21			

12	Ensure junior staff are aware of best practice in regards to women attending AED out of hours with early pregnancy loss	Teaching/education sessions to be delivered to the junior doctors and the ED staff - pregnancy of unknown location	S Elton		Mar-21	complete but require presentation ideally or email confirmation		
13	Overview of the Miscarriage leaflets to be completed and shared with the ED department	Current Miscarriage Leaflets and EPAU contact information to be reviewed and made available to AED	A Hardaker - Matron		Mar-21		Leaflet circulated for approval	
14	The Trust to ensure when a mother with a complex or unknown history is admitted the priority of care is an assessment of fetal and maternal wellbeing by a qualified clinician, with urgent escalation for obstetric review where required.	Audit admission via YAS and timeframes for review	N Ruff	End June	Jul-21		data collection in progress	
15	Trust to support staff to transfer a mother to the operating theatre for interventions to expedite birth, unless birth is immediately imminent.	Audit of grade 1 LSCS and timeframe for decision making	N Ruff & Reg		Jul-21			

Level 1								
1	Explore if Medway could include 40-42 week SFH on their charts	SFH to be integrated into Maternity Cerner	J Anderson - OMS digital lead	K Rowlin - Digital Midwife	01/03/2020	Mar-22	Viewpoint approval. Board paper. Screen shot of EFW chart >42 weeks	
		Risk assessment to be completed in view of system C not actioning request	C Stott - Governance & Risk Lead Midwife			Jun-21		

2	To implement a process to ensure USS and obstetric follow up is arranged and aligned when women attended the unit out of hours or referred from community.	Review current processes and work with the administration and ultrasound team to implement a process to align scan and ultrasound appointments	OMS - Women's Journey		Padma 01/06/2020		Alison/Padma to provide document to demonstrate work and improvements. Admin staff have access to Cris in the interim. Will be captured in the moving to digital workstream	
3	A clear documented process is required to support staff in requesting ANC appointments in line with ultrasound scans	Develop a SOP	OMS - Women's Journey		N Sabir 01/03/2021		Padma to share documents on work to date.	
4	The unit should evaluate the role and cost impact in the use of the fetal pillow for the deeply impacted head at full dilatation caesarean section and failed instrumental deliveries.	Business case required if decision made to impliment. Risk assessment to be completed if decision made to not impliment.			S Kakara Jan 2020	Jun-21		
		Training to be provided to coordinators and senior midwifery staff for push up at full dilitation LSCS			S Kakara Jan 2020	Jun-21		
5	An information leaflet should be available to provide advice and information in relation to confirmed and or suspected PPROM.	Audit of documentation to support that information is provided	J Stubbs - Specialist midwife		Oct-20	Jun-21	SROM advice audit complete	
6	Teaching and training in the interpretation of growth charts is required for both midwifery and obstetric staff.	Ensure all staff undertake the recently developed fetal growth competency assessment tool	S Kakara		Nov-20		>85% compliance	
7	The importance of undertaking an overview of the cases on labour ward prior to commencement of an elective case in theatre by the labour ward team must be reinforced.	Undertake an audit of all elective caesarean sections, including the rational for any delays.	G Butterfield		Aug-20	Jun-21	Audit complete	

8	All staff to attend a bespoke simulation training for vaginal breech which includes the risks and management of a complicated vaginal breech birth.	Correspondence from Consultant college tutor to evidence ongoing training sessions.	S Kakara		Oct-20	complete	PROMPT	
9	Baby born in poor condition - grade 2 hypoxic ischemic encephalopathy following uterine rupture	This case will be presented at the Speciality Meetings to highlight the importance of early consultant involvement.			H Dadi Sept 2020	Jul-21		
10	The importance of contemporaneous, comprehensive documentation of the risks of vaginal birth after caesarean section at the time of oxytocin augmentation should be reinforced. A discussion with consultant obstetrician prior to commencing oxytocin in a woman with previous caesarean section is essential as per Trust guidelines.	VBAC audit	Marzina Ahmed		Feb-21	Jul-21	Audit complete	
11	Trust guidelines should be developed or include antenatal CTG interpretation and documentation during induction of labour.	Update the fetal monitoring guideline and approve via the governance processes. cascade guideline changes to be to the maternity team	Z Thomas & M Naylor		Sep-20	Jul-21	Antenatal CTG sticker has been produces and is in circulation. End July	
12	Further development of systems (already underway) to identify missed appointments and ensure there is a clinical review or response to these	Encompassed in the on-going ANC transformation planning. Guideline to be updated. An audit of missed appointments should be included on the audit plan for 2021/2022			Jan-21		Guideline update almost complete. Audit to be assigned. OMS QI project. Zebia/Alison to send progress to date	
13	All postnatal women who are re-admitted, should have their urea and electrolytes tested as part of their investigations.	SOP	TBC		J Stubbs & L Jackson - Nov 2020	Jul-21	Postnatal guideline in development	

14	The antenatal/postnatal ward bladder scanner should be tested by medical physics and training reviewed and provided for staff who use it frequently.	A training and competency package in the use of the bladder scanner is required for staff. Training complete & recorded on ESR	A Orr/C Townsend		Nov-20		New bladder scanner purchased and in use. 70% of staff on M4 have been trained. CT emailed for evidence	
15	If a woman has a dating scan after 22 weeks gestation, an induction of labour at her estimated due date should be offered and advised	Develop a guideline for women who book late.	N Cawley		Mar-21	Jul-21	Guideline approved	

	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. Ongoing work within OMS linking learning workstream.	
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 - tab 3	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 continuous until after the new theatre build. Action plan in place following 'one together' benchmarking. Weekly data of theatre usage is being submitted. Theatre building protect 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 Hufon, 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. Obstetric theatre and 5 steps SOP developed and approved. Repeat audit of 5 steps planned. Audit to be incorporated within ward assurance framework which is being developed via the OMS workstreams.	
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 shared at Trust Medicines Safety meeting. Ongoing assurance to be achieved via the ward assurance framework being developed via the OMS workstreams. In the interim the previous audit will be repeated and presented at April Governance meeting.	
6	The trust must ensure the outcomes/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 McArdleRobinson, J Beer & H Avdiyovski	7/30/2020	Serious case review action plan shared with the governance team but was from sept 2019. 2 outstanding actions. Data collection has taken place in regards to staff attendance and input into child protection conferences. Audit report completed. Approval given for 1 WFE uplift in community to improve attendance to child protection conferences. The uplift commenced in October 2020. Monitoring of midwifery attendance to continue. Community managers included in requests for attendance at case conference meetings to improve attendance rates.	
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	30/10/2020 ext 30/01/2021	Non-compliance reports sent to department managers to action as urgent. Compliance rates have improved over the last few months. Additional safeguarding sessions have been arranged to improve training rates. Monthly compliance monitoring reported to quality and safety meeting.	
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	7/30/2021	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 audit completed and shared. Implementation of BSOPs will improve use of MEWS charts in MAC. Antenatal risk assessment audit completed and repeat audit on audit plan. Labour and birth record updated to include SBAR on admission and CTG stickers include ongoing risk assessment. Antenatal risk assessment sticker for low risk women having intermittent auscultation approved at June Q&S meeting. Audit to be completed once embedded - data collection to commence in August 2021	
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. Audit action tracker in place. Learning from audit shared at speciality meetings and via lessons learnt. Further work ongoing via OMS linking learning workstream to improve the sharing of learning	
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	30/08/2020 ext 30/01/2021	Meeting agenda for Governance revised. Maternity Risk strategy update in progress. As per action 1	
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	30/09/2020 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 following agreement of indicators. Changes made to ensure staff have access to input red flags in the relevant areas. Amber risk assessment updated to ensure closures can be robustly reviewed and learning shared. Meeting planned for 18.3.21 to discuss recording of closures and red flags and the governance process for review and sharing of information. Red flags agreed and rolled out. Red flag data discussed at Maternity services forum. Escalation policy and management of red flag guidance in progress.	
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	6/30/2020	HSIB investigations discussed at women's governance meetings. Reports sent to QuOC 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	19.05.2020	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	3/30/2021	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, approved and rolled out in February 2021.	
	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 Paethorpe & E McArdleRobinson	9/30/2020	SOP's approved. Staff spot checks to be completed	
17	The service should consider developing an agreed maternity vision with relevant	OMS 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 is produced and included on the monthly Quality & Safety agenda.	

	Objective or Aim to be delivered	Actions and tasks to achieve the objective or aim	Named Individual responsible	Outcome	Progress Update	Status
Safety Action 5: Birth Rate Plus Midwifery Workforce Recommendations						
1	Achieving the Birth Rate Plus 2021 recommended increase to establishment	Birth Rate Plus paper and recommendation presented to Executive Team Meeting 17 May 2021.	Sara Hollins	ETM requested that the paper and recommendations be revised if required and resubmitted following confirmation of the national maternity funding bid submission. Complete September 2021.	Outcome of national funding bids not announced as of 29/06/2021. 09/08/21 awarded 33.6 WTE from the national bid. Birth rate plus paper to be re-presented to Board in September. Revised ppaer submitted to Board as an appendix to the Nursing and Midwifery staffing review. Approved.	Closed
2	Mitigation in place to maintain safe staffing levels until recommended increase to establishment is achieved.	Escalation policy in place Use of Bed Manager role Monday to Friday Senior Midwife On Call rota out of hours in place Staffing red flag system 6 monthly Midwifery workforce staffing paper presented to Board	Sara Hollins/Senior Midwifery team		Bi-annual midwifery workforce staffing paper submitted as an appendix to the Nursing and Midwifery staffing review September 2021 Board.	Open
Safety Action 5: Achievement of 100% 1:1 care in labour and mitigation to address shortfalls						
3	Aim to achieve 100% 1:1 care in labour. Rates have significantly improved and have been consistently >90% for 12 months.	Failure to achieve 1:1 care is a red Monthly rate <90% is investigated Monthly rate <90% is exception re	Sara Hollins/Labour Ward co-ordinators			Open