



Bradford Teaching Hospitals
NHS Foundation Trust

Maternity Improvement Plan

Document control:

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Ockenden - Minimum evidence requirements										
SECTION 1: Immediate and Essential Actions 1 to 7				Assessment Criteria	Minimum Evidence Requirements	Lead	RAG	Existing evidence	Action required to achieve compliance	By when:
Immediate and Essential Action 1: Enhanced Safety										
IEA 1	Q1		Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.	Confirmation of a Maternity Services Dashboard Confirmation this is seen by the LMNS at least Quarterly	1.1 SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	LMS/Carly				
					1.2 Submission of minutes and organogram, that shows how this takes place.	Carly/Sara		Perinatal surveillance SOP maternity update papers, Board committee and Board minutes. Organogram in SOP.		
					1.3 Minutes and agendas to identify regular review and use of common data dashboards and the responses / actions taken.			LMS Plan Performance reports to the LMS Board - last 3 Boards Implementation agenda, minutes & presentation - demonstrating dashboard discussion LMS Safety Steering group meeting agendas & minutes CDs and HoMs meeting minutes Local dashboard		
					1.4 Dashboard to be shared as evidence.					
	Q2	External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	Confirmation of external specialist opinion on reviews	2.1 Policy or SOP which is in place for involving external clinical specialists in reviews. 2.2 Audit to demonstrate this takes place.	LMS/ HSIB		LMS Plan Agenda and action notes from CD and HoMs meetings Baby Lifeline training dates SI Process task & finish group agenda and action notes, MIS action 10			
							No cases outside HSIB criteria reportable to date. MIS action 10			
	Q3	All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	Confirmation that SI GO TO Trust Board (nab not a sub group of board such as Quality group) Confirmation that a SUMMARY of SI key issues goes to Trust Board Confirmation that SI GO TO LMNS Board Confirmation that a SUMMARY of SI key issues goes to LMNS Board Each of the above happen quarterly	3.1 Submit SOP	Carly		LMS plan, Flow chart and T&FG minutes in the evidence file.Refreshed ToR and membership of Safety Forum, LMS SI SOP			
				3.2 Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	Sara		Dec - April BTHFT Jan & May Board papers.			
				3.3 Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	Carly		1 SI's since Ockenden recommendations.			
	Link to Maternity Safety actions:									
IEA 1	Q4	Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Confirmation that PMRT is undertaken see PMRT Tab	4.1 Local PMRT report, PMRT trust board report, Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. 4.2 Audit of 95% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	Carly, Iram &Amy Carly, Iram &Amy Sara & Keeley		MIS reports, Maternity update April 21 paper, May Reg committee October, January and April PMRT updates included, Nov Reg committee May board agenda Safety Forum Minutes - evidence PMRT themes discussed.	SOP required.	Iram
	Q5	Action 2	Are you submitting data to the Maternity Services Dataset to the required standard?	Confirmation that Monthly score card completed (13 mandatory criteria)	5.1 Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.			MSDS DEC score card. MSDS action plan, MSDS LMS Board minutes May 2021, BTHFT April maternity paper to Reg. Reg committee minutes, May Board agenda	MSDS action plan in place resubmit outstanding items once dependencies are met (supplier investigations, NHS Digital clarification etc.) and a progress report will be provided to the LMS and Trust Board in six months' time, November 2021	
	Q6	Action 10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?	Confirmation that 100% of cases are reported to HSIB & NHS Resolution	6.1 Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	Carly		MIS action 10 submission documents		
Link to urgent clinical priorities:										
IEA 1	Q7	(a)	A plan to implement the Perinatal Clinical Quality Surveillance Model	Confirmation that Trust / LMNS / ICS responsibilities of the model are implemented	7.1 Full evidence of full implementation of the perinatal surveillance framework by June 2021.	Sara & Carly		Benchmark perinatal surveillance framework by June 2021.		
					7.2 Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed off via the trust governance structure.	Sara & Carly		SOP		
					7.3 LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	LMS		Revised LMS Governance structure (March 2021) Minutes of ICS QSG Report submitted & Minutes of SOAG Presentation at Regional QSG NHS Operation Planning guidance submission Minutes of Accountable Officers meeting - regarding commissioning		
	Q8	(b)	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Confirmation that SI go to Trust Board (nab not a sub group of board such as Quality group) Confirmation that SI go to LMNS Board Each of the above happen Monthly	8.1 Submit SOP 8.2 Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed 8.3 Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion			See Q3		
Immediate and Essential Action 2: Listening to Women and Families										

IEA 2	Q9	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	No expectation that this action is met - national guidance awaited						
	Q10	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	No expectation that this action is met - national guidance awaited						
	Q11	Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	Confirmation of an identified Trust Board Non Exec	11.1 Name of NED and date of appointment	SH		Non-Executive Director on LMS Board - revised ToR. BTHFT Okenden Presentation includes NED. January 2021 Open Board minutes confirm Selina Ullah as NED and thank the previous maternity NED's for their input. Word document confirms NED name and date of appointment. October 2021 bi-monthly maternity safety champion minutes available and welcome Jon Prashar as new NED safety champion. Reflected in October Maternity Update paper to November Board.		
				11.2 Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions			NED present at Bi monthly safety champion meetings. 1st NED walk round 05/11/21	NED to establish ward level engagement. 1st engagement walk around taken place and included in newsletter.	
11.3 Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed						January 2021 Board minutes evidence NED presence and contribution at Board.			
11.4 Evidence of how all voices are represented									
11.5 Evidence of link in to MVP; any other mechanisms						OMS links	NED to establish links with MVP once OMS programme complete		
			11.6 NED JD			Maternity and Neonatal Ward to Board safety escalation SOP final	SOP to be added to NED JD		
Link to Maternity Safety actions:									
IEA 2	Q12	Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Confirmation that PMRT is undertaken Confirmation that Parents are involved	12.1 Local PMRT report. 12.2 PMRT trust board report. 12.3 Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. 12.4 Audit of 95% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.			See Q4	
	Q13	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 Voices Partnership to coproduce local maternity services?	Confirmation of approach to gathering Service User feedback (i.e. 15 steps / FFT / You Said We Did) AND MVP in place that COPRODUCEs services	13.1 Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.			MIS safety action 7	
					13.2 Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)			Working together to transform our maternity service 2020. Breastfeeding survey, 15 steps (AMC, LW, mid), OMS involvement, Antenatal classes, Multi language videos, clover team personalised midwifery project	
					13.3 Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.			As above. MVP links with OMS. LMS MVP network action plan and minutes MVP reports to LMS Board. MVP Network meeting minutes - demonstrate feedback during COVID MVP website - www.maternityvoices.co.uk	
Q14	Action 9	Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified	Identified Safety Champions WORKING WITH Exec and Non Exec Board Leads for Maternity	14.1 SOP that includes role descriptors for all key members who attend by-monthly safety meetings.			Maternity and Neonatal Ward to Board safety escalation SOP final		
				14.2 Log of attendees and core membership.			Meetings resumed in February post Covid. Feb, April, June 2021 minutes. 2019-2020 and 2021 monthly safety meeting schedule.		
				14.3 Action log and actions taken.			June meeting minutes. Feedback email to staff member who raised concerns		

			Issues?		14.4 Minutes of the meeting and minutes of the LMS meeting where this is discussed.	LMS		LMS plan Presentation to Safety Champions/Chief Nurses		
Link to urgent clinical priorities										
	Q15	A	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Same score as Q13	15.1 Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. 15.2 Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) 15.3 Clear co-produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.			See Q13		
IEA 2	Q16	B	In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.	Confirmation of an identified Trust Board Executive Director AND a Non Executive Director	16.1 Name of ED and date of appointment			Okenden presentation to Jan Board. Board minutes.		
					16.2 Name of NED and date of appointment			Okenden presentation to Jan Board . Board minutes. October Maternity Services update paper to November Board reflect appointment of new NED safety champion.		
					16.3 Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken Role descriptors			Bi monthly meeting minutes. SOP. May maternity update paper		
Immediate and essential action 3: Staff Training and Working Together										
Q17	Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.			Training together: Confirmation of MDT training AND this is validated through the LMS x 3 per year	17.1 Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	V Nutter		2021 TNA	NHSR core framework - gap analysis and review of 2021/2022 training programme	
					17.2 Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	C Slott		PROMPT agendas, mandatory training report May, Group assignment posters Workforce data reports to LMS Board and Implementation groups - minutes		
					17.3 LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	LMS		LMS Plan demonstrates multi-disciplinary training e.g. YAS and UAD training (in Aug 2020 Highlight Report) NHS Operational planning guidance narrative submission Future performance reports to LMS Board to include training data	Future performance reports to LMS Board will include training data	
					17.4 Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	V Nutter		Mandatory training reports		
					17.5 A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	V Nutter		Mandatory training reports		
					17.6 Attendance records - summarised	V Nutter		Anonymous PROMPT database		
IEA 3	Q18	Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.		Working together: Confirmation of ALL criteria requested	18.1 SOP created for consultant led ward rounds.	C Robertson		Medical Handover of care guideline		
					18.2 Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)					
Q19	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only (e.g. Maternity Safety Fund, Charities monies, MPET/SLA monies etc that is specifically given for training)			Confirmation of ring fenced Maternity training budget	19.1 Evidence that additional external funding has been spent on funding including staff can attend training in work time.	A Mighell		Audit report		
					19.2 Evidence of funding received and spent.	H Ackroyd		NHS Education Contract - Finance Schedule		
					19.3 Confirmation from Directors of Finance	H Ackroyd		LMS funding invoices etc		
					19.4 Evidence from Budget statements.	H Ackroyd		Board sign off letter		
					19.5 MTP spend reports to LMS			LMS transformation funding spend - LMS Board minutes and spending plan.		
Link to Maternity Safety actions:										

IEA 3	Q20	Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	See Section 2	See section 2					
	Q21	Action 8	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	90% achieved on MDT training of all Staff groups (Obsterics / Anaesthetists / Maternity / Neonates / Support Workers)	21.1 Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. 21.2 Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. 21.3 LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. 21.4 Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. 21.5 A clear trajectory in place to meet and maintain compliance as articulated in the TNA. 21.6 Attendance records - summarised	see Q17				
Link to urgent clinical priorities										
IEA 3	Q22		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	See Q18	22.1 SOP created for consultant led ward rounds. 22.2 Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)			See Q18		
	Q23		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	See Q17	-23.1 Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. -23.2 Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session -23.3 LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data. 23.4 Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. 23.5 A clear trajectory in place to meet and maintain compliance as articulated in the TNA. 23.6 Attendance records - summarised			See Q17		
Immediate and essential action 4: Managing Complex Pregnancy										
IEA 4	Q24	Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	Agreement reached on Criteria for referral to Mat Med Specialist Centre		24.1 SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway. -24.2 Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians	Nada/Carolyn		Benchmarking of current services submitted to CD Regionally led Obstetric meeting 11 June Presentation at ICS Clinical Forum, LMS SOP, Local SOP.		
	Q25	Women with complex pregnancies must have a named consultant lead	Named consultant lead for all women identified = Yes		-25.1 SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead. 25.2 Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.			BTHFT Maternal Medicine Clinic SOP BTHFT SOP for Responsible Clinician in Obstetrics Criteria for Consultant Antenatal Referral guideline	Audit required - Nada or Amy	
								Antenatal risk assessment snap shot audit	Audit required - to inform John re center	
	Q26	Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	Referenced to specialist involvement AND management plans developed		-26.1 SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams. -26.2 Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.			BTHFT Maternal Medicine Clinic BTHFT SOP for Responsible Clinician in Obstetrics Criteria for Consultant Antenatal Referral guideline	Audit required	
								Antenatal risk assessment snap shot audit	Audit required	
Link to Maternity Safety actions:					27.1 SOP's					

IEA 4	Q27	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Confirmation of compliance with ALL elements	27.2 Audits for each element. 27.3 Guidelines with evidence for each pathway		Mary & Carly	Update on SBL reported to regional team - Power Point slides LMS finance plan 2020/21 - funding for SBL MSDS plan support ICS Smoke Free Forum minutes demonstrate future support/roles		
Link to urgent clinical priorities:										
IEA 4	Q28	A	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	Confirmation of consultant lead AND regular Audit of Compliance in place	28.1 SOP that states women with complex pregnancies must have a named consultant lead.			BTHFT Maternal Medicine Clinic BTHFT SOP for Responsible Clinician in Obstetrics Criteria for Consultant Antenatal Referral guideline		
					28.2 Submission of an audit plan to regularly audit compliance			Antenatal risk assessment snap shot audit. Presentation and speciality agenda	Audit to commence in June. Develop an ongoing audit from the Maternity system to identify where a named clinician is not recorded.	
	Q29	B	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Confirmation that Trust is developing their local actions as part of an agreed Network approach	29.1 The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.			see Q24		
					29.2 Criteria for referrals to MMC					
29.3 Agreed pathways										
Immediate and essential action 5: Risk Assessment Throughout Pregnancy										
IEA 5	Q30		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	Risk Assessment at EVERY AN Contact	30.1 SOP that includes definition of antenatal risk assessment as per NICE guidance. - How this is achieved within the organisation. - What is being risk assessed. - Review and discussed and documented intended place of birth at every visit.			Risk Assessment inc intended place of birth. PCSP. WY & H Local Maternity System Choice & Personalisation Steering Group LMS plan. Antenatal risk assessment snap shot audit		
					30.2 Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.			LMS Plan demonstrates audit of PCSPs will be co-produced later in the year	Once LMS audit tool devised undertake an ongoing audit of 1% of records	
	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Review of place of birth in risk assessment at ALL AN contacts	31.1 SOP that includes review of intended place of birth.			Risk Assessment inc intended place of birth SOP Memorandum	Once LMS audit tool devised undertake an ongoing audit of 1% of records		
				31.2 Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.			see Q30			
31.3 Out with guidance pathway.						birth choices guideline, homebirth guideline, ICS, waterbirth, BBC. STANDARD OPERATING PROCEDURE (SOP) Supporting Womens' informed Choices Throughout Maternity Care				
Link					31.4 Evidence of referral to birth options clinics			Guideline and referral form. Maternity matters service summary		
IEA 5	Q32	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	See Q27	32.1 SOP's 32.2 Audits for each element 32.3 Guidelines with evidence for each pathway			See Q27		
Link										
IEA 5	Q33	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Are PCSPs in place AND are they audited	33.1 SOP to describe risk assessment being undertaken at every contact. What is being risk assessed. How this is achieved in the organisation. Review and discussed and documented intended place of birth at every visit.			See Q30 See Q30 See Q30 See Q30			
				33.2 Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.				Q31 says 1%. This says ongoing but Q31 doesn't to clarify with C Keegan. LMS to coproduce audit tool and audit annually. The ask is ongoing audit so should we look at this now or wait until cerner implementation		
				33.6 Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)			LMS Plan demonstrates development and plans for audit Choice & Personalisation minutes Co-creation of LMS PCS www.mypregnancyjourney.co.uk. national team video and posters for staff and women. Add a copy of BTHFT My Pregnancy and Birth booklet Appendix 5			
Immediate and essential action 6: Fetal Wellbeing										
IEA 6	Q34	All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal wellbeing.	BOTH MW and Obstetrician in place	34.1 Name of dedicated Lead Midwife and Lead Obstetrician			Maryanne Naylor- Lead Midwife, Zebia Thomas- Lead Obstetrician			
				34.2 Copies of roles / off duties to demonstrate they are given dedicated time.	Carolyn/Carly		Job plan/ JD's			
				34.3 Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	Zebia & Mary Zebia & Mary		LMS Fetal Monitoring group in place. CTG meetings, presentations, training plan. CTG meetings. Datix report			
	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - Improving the practice of monitoring fetal wellbeing - Consolidating existing knowledge of monitoring fetal wellbeing - Keeping abreast of developments in the field - Raising the profile of fetal wellbeing monitoring - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. - The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. - They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. - The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	JD fulfils ALL criteria	* Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post * Improving the practice & raising the profile of fetal wellbeing monitoring * Consolidating existing knowledge of monitoring fetal wellbeing * Keeping abreast of developments in the field * Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision * Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. * Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training. * Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.		Mary's Job description with fetal monitoring JD addendum.	Obs lead JD to be agreed and fulfilled with approval of business case for 1 PA			
Link to Maternity Safety actions:										
	Q36	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	See Q27	36.1 SOP's 36.2 Audits for each element 36.3 Guidelines with evidence for each pathway			See Q27		

IEA 6	Q37	Action 6	Can you evidence that at least 90% of each maternity unit staff group have attended an in-house multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	See Q21	37.1 Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. 37.2 Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. 37.3 LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. 37.4 Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. 37.5 A clear trajectory in place to meet and maintain compliance as articulated in the TNA. 37.6 Attendance records - summarised			See Q21		
IEA 6	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 so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	See Q34	38.1 Name of dedicated Lead Midwife and Lead Obstetrician 38.2 Copies of rotas / off duties to demonstrate they are given dedicated time. Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. 38.3 Incident investigations and reviews			See Q34		
Immediate										
IEA 7	Q39		All Trusts must ensure women have ready access to accurate information to enable their 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 MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.			ACOG choosing to have a c-section leaflet, BTHFT My Pregnancy and Birth booklet WY&H my pregnancy journey		
	Q40		All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. 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 MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.			LMS benchmarking tool See Q39	Await electronic tool and arrange for MVP to assess.	
	Q41		Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care	Confirmation that trust HAS a method of recording decision making processes that includes women's participation & informed choice	41.1 SOP which shows 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 CDC survey and associated action plans			STANDARD OPERATING PROCEDURE (SOP) Supporting Women's Informed Choices Throughout Maternity Care in draft	SOP to be approved at core Audit to be scheduled	
	Q42		Women's choices following a shared and informed decision-making process must be respected	Reference made to how Women's choices are respected and evidenced	42.1 SOP 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 5% of notes or a total of 150 which is over the least from January 2021, demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction. 42.3 CDC survey and associated action plans			STANDARD OPERATING PROCEDURE (SOP) Supporting Women's Informed Choices Throughout Maternity Care	SOP to be approved at core Audit to be scheduled	
Link								2019 survey & action plan	Minutes MSF June 2021	
IEA 7	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 Voices Partnership to coproduce local maternity services?	See Q13	43.1 Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. 43.2 Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) 43.3 Clear co-produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.			See Q13		
Link										
IEA 7	Q44		Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted 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 MVP 44.2 Co-produced action plan to address gaps identified. 44.3 Information on maternal choice including choice for caesarean delivery. 44.4 Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.			WY&H my pregnancy journey. Link to maternity website See Q39	LMS developed a tool which will be produced electronically by the end of June/Arrange for MVP to undertake gap analysis and rating of information	
SECTION 2: WORKFORCE 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 clinical workforce planning to the required standard	Midwifery workforce planning system in PLACE NATIONAL ASK: That there is also specification on evidence of workforce planning against medical workforce		<ul style="list-style-type: none"> Most recent BR report and board minutes agreeing to fund. Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan. MIS action 4			Word doc narrative listing appendices, July 2020, January 2021 Bi-annual staffing papers, BR + final report, BR + recommendation paper for ETM in the file. ETM and bi-monthly paper exec minutes. ACSA. Neonatal staffing plan. Medical staffing business case. BR + paper presented to board as an appendix to the Nursing and Midwifery staffing review. Board approved the paper.		

Q46	Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Confirmation of a maternity workforce gap analysis AND a plan in place (with confirmed timescales) to meet BR+ standards	To be compliant trusts need to have an up to date Birthrate plus assessment (i.e. within the last three years) and for the trust to have fully funded it. It was notable that a drop in birth rate was a challenge for full funding at present for some trusts who were on a trajectory approach. NATIONAL ASK: Absolute clarity on these criteria	• Most recent BR+ report and board minutes agreeing to fund. MIS action 5			Same as above - another board paper produced and will be submitted in september. BR+ paper presented to Board as an appendix to the Nursing and Midwifery staffing review. Board approved the paper.		
Midwifery Leadership										Board needs to agree
Q47	Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director		Evidence the Director/Head of Midwifery responsible and accountable to an executive Director	It was acceptable that the Director or Head of Midwifery was accountable to the Chief Nurse. None are directly line managed.	• HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director			Supporting narrative included. HoM JD and accountability evidence -		
Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: 1. A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service 2. A lead 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 midwifery leadership in education and research 6. A commitment to fund ongoing midwifery leadership development 7. Professional input into the appointment of midwife leaders		Meets ALL that apply <i>Note - Trusts should not lead on achieving all seven steps</i>	NATIONAL ASK: Ensure template clear this is about applicable standards - original version circulated wasn't	• Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care not met • Action plan where manifesto is			Gap analysis	Gap analysis and action plan completed To be included in next core agenda and monitored via CBU business meeting	
NICE Guidance related to maternity										Sara
Q49	We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.		ALL guidance assessed & implemented = Yes (GREEN)	NATIONAL ASK: Clarity on the need to report number of guidelines that are outstanding and need updating	• SOP in place for all guidelines with a demonstrable process for ongoing review. Audit to demonstrate all guidelines are in date. • Evidence of risk assessment where guidance is not implemented.	• Carly		Trust NICE Policy. Trust local guideline highlight report. Guideline guideline. QMS. Women's business and MSF minutes. QMS workstream update. Current NICE position	Develop National benchmarking tracker and improve guideline update and NICE position	

Key

	Submitted and no further action required
	submitted and further action required
	duplicate 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	Benchmarking complete - action plan in progress.
National Perinatal Mortality Review Tool	Learning from Standardised Reviews When Babies Die National Perinatal Mortality Review Tool & MBRRACE Perinatal report	Dec-20	Amy & Iram	Benchmarking complete - action plan in progress.

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	2	leaflet and guideline to be updated
NG207	Induction of labour	Nov-21	N Cawley	yes	Yes	40	emailed 21.05.21

NICE Baseline assessments to complete			
NG3	Diabetes	Dec-20	S Kakara
NG194	Postnatal care	Apr-21	Lucy Jackson
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
NG201	Antenatal Care	Aug-21	N Cawley
Historic NICE baseline assessments			
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 Cawley/T crocker 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		Audit Report	

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 and approved	
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 at CPAG	
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 Rowllins - 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 PPRM.	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	presented Dec 2021	
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 produced and in use	
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 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 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 Hufton, 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 be 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.	

[illegible]

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 Palethorpe & 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 McMahan	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 f Monthly rate <90% is investigated b Monthly rate <90% is exception repd	Sara Hollins/Labour Ward co-ordinators			Open