



**Bradford Teaching Hospitals**  
NHS Foundation Trust

# Maternity Improvement Plan

**Document control:**

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[illegible]

EA.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	34	Non-Executive Director on LMS Board - revised TOR, BTHFT Openden Presentation includes NED, January 2021 Open Board minutes confirm Selina Ullah as NED and thank the previous maternity NEDs for their input. Word document confirms NED name and date of appointment. October 2021 bi-monthly maternity safety champion minutes available and welcome Jon Prather as new NED safety champion. Reflected in October Maternity Update paper to November Board.	NED present at 8 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.				October maternity update paper and November board minutes support new NED appointment. Evidence submitted supports the previous appointment of SJ	
				11.2 Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions		NED present at 8 monthly safety champion meetings. 1st NED walk round 05/11/21							
				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				evidence was submitted which supported NED input in Board minutes.	
				11.6 NED JD		Maternity and Neonatal Ward to Board safety escalation SOP final		SOP to be added to NED JD				NED undertaking Neonatal unit 15 steps with MVP. Needs to sit in OMS board and MVP meeting.	
												To evidence	
Link to Maternity Safety actions:													
EA.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. 13.2 Evidence of service user feedback being used to support improvement in maternity services (E.G. you said, we did, FFT, 15 Steps) 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.		MIS safety action 7  Working together to transform our maternity service 2020. Breastfeeding survey, 15 steps (ANC, LW, m4), OMS involvement, Antenatal classes, Multi language videos, clover team personalised midwifery project  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 bi-monthly with Board level champions to escalate locally identified issues?	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 bi-monthly safety meetings. 14.2 Log of attendees and core membership. 14.3 Action log and actions taken. 14.4 Minutes of the meeting and minutes of the LMS meeting where this is discussed.	LMS	Maternity and Neonatal Ward to Board safety escalation SOP final  Meetings resumed in February post Covid. Feb, April, June 2021 minutes. 2019,2020 and 2021 monthly safety meeting schedule.  June meeting minutes. Feedback email to staff member who raised concerns.  LMS plan Presentation to Safety Champions/Chief Nurses					LMS safety forum steering group and forum minutes
Link to urgent clinical priorities													
EA.2	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					
	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	Confirmation of an identified Trust Board Executive Director AND a Non-Executive Director		16.1 Name of ED and date of appointment		Openden presentation to Jan Board. Board minutes.					Narrative submitted and appendix supports that a ED safety champion is well established.

			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.		16.2 Name of NED and date of appointment.			Shenden 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			January Board minutes were submitted as evidence. November 21 Board minutes also supports this. STANDARD OPERATING PROCEDURE (SOP) Maternity and Neonatal 'Prior to Board' Sharing of Safety Intelligence includes Role descriptors.
Immediate and essential action 3: Staff Training and Working Together											
EA 3	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 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. 17.2 Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. 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. 17.4 Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. 17.5 A clear trajectory in place to meet and maintain compliance as articulated in the TNA. 17.6 Attendance records - summarised	V Nutter C Stott LMS V Nutter V Nutter V Nutter	2021 TNA PROMPT agendas, mandatory training report May, Group assignment posters Workforce data reports to LMS Board and Implementation groups minutes LMS Plan demonstrates multi-disciplinary training e.g. YAS and LMS training (in Aug 2020 highlight Report) NHS Operational planning guidance narrative submission Mandatory training reports Mandatory training reports Anonymised PROMPT database	NHSR core framework - gap analysis and review of 2021/2022 training programme Future performance reports to LMS Board will include training data			TNA update in progress in line with NHSR core framework PROMPT attendance database was submitted as evidence which shows attendance from each staff group. Also Mandatory training reports. Mandatory training reports include trajectory. No mitigation required as target met. PROMPT compliance database submitted with evidence	
	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.  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)	C Robertson  A Mighell	Medical Handover of care guideline  Audit report				Called Handover of care - Medical staff guideline and was submitted as evidence.	
	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, Charles 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.  19.2 Evidence of funding received and spent.  19.3 Confirmation from Directors of Finance  19.4 Evidence from Budget statements.  19.5 MTP spend reports to LMS	H Ackroyd  H Ackroyd H Ackroyd H Ackroyd	NHS Education Contract - Finance Schedule  LMS funding invoices etc Board sign off letter  LMS transformation funding spend - LMS Board minutes and spending plans.				To be revisited   Letter signed by CEO and Finance director was submitted to confirm this. To be revisited	
Link to Maternity Safety actions:											
EA 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 MS year three in December 2019?	90% achieved on MDT training of all Staff groups (Obstetrics / 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					TNA update in progress in line with NHSR core framework    TNA to include agreed trajectories.	
Link to urgent clinical priorities											
EA 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)							

	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	-Q3.1 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 NHRSP requirements. -Q3.2 Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. -Q3.3 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				
<b>Immediate and essential action 4: Managing Complex Pregnancy</b>									
EIA 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.  -Q4.2 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/Carolyne	Benchmarking of current services submitted to CD Regionally led Obstetric meeting 11 June Presentation at ICS Clinical Forum; LMS SGP, Local SOP,	Audit required - Nada or Amy		Audit in draft
	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.		ETHHT Maternal Medicine Clinic SOP ETHHT SOP for Responsible Clinician in Obstetrics Criteria for Consultant Antenatal Referral guideline			Audit in draft
	Q26	Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	Referreroad 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.		ETHHT Maternal Medicine Clinic: ETHHT SOP for Responsible Clinician in Obstetrics Criteria for Consultant Antenatal Referral guideline			Audit in draft
<b>Link to Maternity Safety Actions:</b>									
EIA 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	-27.1 SOP's -27.2 Audits for each element. -27.3 Guidelines with evidence for each pathway	Mary & Carly	Update on SBLL reported to regional team Power Point slides LMS finance plan 2020/21 funding for SBLL MSDS plan support ICS Smoke Free Forum minutes demonstrate future support/notes	We've declared compliance with MSB year 3. All guidelines are in place and all audits were undertaken		
<b>Link to urgent clinical priorities:</b>									
EIA 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.		ETHHT Maternal Medicine Clinic: ETHHT SOP for Responsible Clinician in Obstetrics Criteria for Consultant Antenatal Referral guideline			
	Q29	B Understand what further steps are required by your organisation to support the development of maternal medicine specialised centres	Confimation that Trust is developing their local actions as part of an agreed Network approach	-28.2 Submission of an audit plan to regularly audit compliance -28.1 The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs, -28.2 Criteria for referrals by MMC -28.3 Accred pathways	see Q24				Audit in draft
<b>Immediate and essential action 5: Risk Assessment Throughout Prenancy</b>									
EIA 5	Q30	All women attending family risk assessment & pre-natal contact so they have continued access to care provision by the most appropriately trained professional	Risk Assessment at EVERY AN Contact	SOP that include definition of antenatal risk assessment as per NICE guidance. How this is achieved within the organisation. What is being risk assessed  Reviews 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	Included in Risk assessment and intended place of birth SOP. Criteria for consultant referral and the booking appointment guideline include risk assessment.		
	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 if ALL AN contacts	-31.1 SOP that describes risk assessment being undertaken at every contact. What is being risk assessed. How this is achieved in the organisation. Reviews and discussed and documented intended place of birth at every visit. -31.2 Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. -31.3 Out with guidance pathway. -31.4 Evidence of referral to birth options clinics	LMS Plan demonstrates audit of PCSP's will be co-produced later in the year see Q30	Once LMS audit tool devised undertake an ongoing audit of 1% of records Once LMS audit tool devised undertake an ongoing audit of 1% of records	Unable to audit PCSP's as these are held by the women PCSP's are being integrated into the new maternity corner electronic record Unable to audit PCSP's as these are held by the women. PCSP's are being integrated into the new maternity corner electronic record. Guidelines and SOP's submitted as evidence to support the evidence for this action		
<b>Link:</b>									
EIA 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				
<b>Link:</b>									
EIA 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 Personalized Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	An PCSP's 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. Reviews and discussed and documented intended place of birth at every visit. -33.2 Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.  -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)	See Q30 See Q30 See Q30 See Q30	Q31 says 1%, This isn't ongoing but Q31 doesn't say it annually. This risk is ongoing until our implementation	Credentialed Q31 assessment Unable to audit PCSP's as these are held by the women. PCSP's are being integrated into the new maternity corner electronic record.		
Ann						LMS Plan demonstrates development and plans for audit Choice & Personalization minutes Co creation of LMS PCS www.mymaternityjourney.co.uk national team video and posters for staff and women. Add a copy of ETHHT My Pregnancy and Birth booklet Appendix 5			



				workforce planning against midwifery workforce	Consider evidence of workforce planning at LMS/NCS level given this is the direction of travel of the people plan. MS action 4			Word doc narrative listing appendices, July 2020, January 2021 80 annual staffing papers, BR + final report, BR + recommendation paper for FTM in the file, FTM and 60-monthly paper exec minutes, JCSA, 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.				Birth rate plus completed. Ockendon provided funding for full birth rate plus recommendations. Recruitment in progress. Board approved in September 2021. (Minutes not yet available)
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. <b>NATIONAL ASK:</b> Absolute clarity on these criteria	• Most recent BR+ report and board minutes agreeing to fund. MS 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.	Board needs to agree			
Midwifery Leadership												
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.	• NOM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director			Supporting narrative included. NOM ID and accountability evidence -				
			Meets ALL that apply <i>being reviewed and need on outlining all seven steps</i>	<b>NATIONAL ASK:</b> 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			Gap analysis	Gap analysis and action plan completed. To be included in next core agenda and monitored via CRU business meeting			
Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives				Action plan where manifesto is not met	Sara		Action plan				Action plan submitted - tab 2 of the document
NICE Guidance related to maternity												
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		ALL guidance assessed & implemented - Yes (GRE/EN)	<b>NATIONAL ASK:</b> Clarity on the need to report number of guidelines that are outstanding and need updating	GDIP in place for all guidelines with a demonstrable process for ongoing review Audit to demonstrate all guidelines are in date	Carly						
					Evidence of risk assessment where guidance is not implemented.			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			This is a standing agenda item at the monthly Quality and safety meeting. NICE benchmarking ongoing

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 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	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
<b>MUST dos</b>							
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 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 auti 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 datix'd. 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.	
<b>SHOULD dos</b>							



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 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
<b>Safety Action 5: Birth Rate Plus Midwifery Workforce Recommendations</b>						
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
<b>Safety Action 5: Achievement of 100% 1:1 care in labour and mitigation to address shortfalls</b>						
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