

IMPROVEMENT ACTION PLAN

Maternity Care quality Commission (CQC) improvement action plan

Summary Description Action Plan

Action plan to address the 'must do' and 'should do' areas for improvement from the CQC inspection report.

Date of inspection visit: 4-6 January 2023

Date of publication: 26/05/2023

Combined action plan commencement date:	26/05/2023
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Action Plan Lead:	Women's CSU Leadership Team
Task and Finish Group Members:	<div style="display: flex; justify-content: space-between;"> <div> Clinical Director – Nada Sabir Director of Midwifery – Sara Hollins General Manager – Hannah Ackroyd Associate Deputy Director of Midwifery – Carly Stott Matron for Quality & Safety – Amanda Hardaker Midwifery Lead for Outstanding Maternity Services – Alison Powell Operational Matrons - Jo Beer, Mary Naylor, Jess Hodgins , Rukeya Miah Deputy General Manager – Claire Townsend Obstetric Lead Consultant – Nicola Cawley </div> <div style="border: 1px solid black; padding: 5px;"> Status: <div style="display: flex; justify-content: space-between; align-items: center;"> O Open </div> <div style="display: flex; justify-content: space-between; align-items: center;"> O Open and compromised </div> <div style="display: flex; justify-content: space-between; align-items: center;"> C Closed </div> <div style="display: flex; justify-content: space-between; align-items: center;"> OD Overdue </div> </div> </div>

No	Areas for Improvement – (Must dos)	Actions and tasks to achieve the objective or aim	Named Individual responsible	Completion Date	Progress Update	Status	Evidence of action completed	Method of assurance	Assurance Level (RAG Rating)
1	The service must ensure the safe and proper use, administration, recording and storage of medicines. (Regulation 12 (2) (g))	1. Continue monthly ward assurance audits of controlled drug per department. This will be monitored at the Women's CSU business meeting. 2. Explore alternative documentation methods for supply, administration and destruction of controlled drug infusions. 3. Documentation of medication audit to be undertaken including midwife exemptions. 4. Review the process for storage and checking of ward stock medication for each department. 5. Consistently implement the trust process of take home medication traceability dispensed from ward stock. 6. Ensure the women's CSU follows Trust policy in regards to medicines management. Audits will be undertaken to provide assurance.	Department Managers and Matrons.	30/11/2023	1. Monthly ward assurance audits are ongoing. 2. Other maternity units have been contacted regarding there processes for documenting supply, administration and destruction of controlled drug infusions.	O		Tracked through Clinical Service Unit (CSU) governance. Meeting minutes/audit reports.	

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2	The service must ensure medical staffing for maternity triage is reviewed so there are sufficient numbers of suitably qualified, competent staff to deliver the service in line with national guidance. Regulation 18 (1))	<ol style="list-style-type: none"> Review current provision of obstetric cover within the Maternity Assessment Centre (MAC) and undertake a gap analysis. Review care pathways to consider the implementation of midwifery led SOP's following training and competence assessment. Review the required skill set of staff working in the MAC and provide adequate training to ensure staff are confident and competent in the standardised skill set. This aims to reduce delays in care. Continue with the BSOT's QI programme of monitoring assessment timeframes and red flags. Undertake a scoping exercise by visiting other Trusts who operate BSOTS in a Maternity Triage Unit. 	<p>Nada Sabir – Clinical Director</p> <p>Nicole Wood – MAC manager</p> <p>Jo Beer – Maternity Matron</p> <p>Alison Powell – OMS lead</p> <p>Nicola Cawley – Obstetric Lead</p>	30/11/2023	1. BSOTs QI project is well established.	O		<p>Tracked through Clinical Service Unit (CSU) governance.</p> <p>Life QI reports.</p> <p>Meeting minutes</p>	

No	Areas for Improvement – (Should dos)	Actions and tasks to achieve the objective or aim	Named Individual responsible	Completion Date	Progress Update	Status	Evidence of action completed	Method of assurance	Assurance Level (RAG Rating)
1	The service should continue to ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of people who use the service.	<ol style="list-style-type: none"> Continue 'rolling' recruitment process throughout the year Actively engage with the LMNS central recruitment process Hold Midwifery recruitment days throughout the year Continued recruitment of International Midwives Facilitated MSW's to commence the apprentice midwifery programme Staff supported to return to work as per the sickness management policy. 6 monthly staffing paper submitted to Board. Birth rate plus commissioned Matrons and pastoral midwife to develop a staff rotation plan which will ensure staff regularly rotate and feel confident and competent to work in all areas. 	Sara Hollins – Director of Midwifery	30/03/2024	<ol style="list-style-type: none"> Actions 1 to 7 are all well established and will continue. The staffing risk assessments will be updated and monitored with ongoing developments and progress. Birth rate plus acuity exercise planned to commence in November 2023. 	O		<p>Tracked through Clinical Service Unit (CSU) governance.</p> <p>Staffing papers and Board minutes</p>	

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2	The service should continue to make improvements to the maternity services waiting areas to ensure effective oversight of patients waiting to be seen can be maintained.	1. Dedicated MAC/ANDU/ANC environment with dedicated waiting areas to be designed and built within the current Maternity footprint.	Sara Hollins – Director of Midwifery Nada Sabir – Clinical Director Alison Powell – OMS Lead	30/03/2024	1. Sign off of the waiting area / MAC / ANDU expansion plans (12 million capital) and the building works due to commence. 2. Design works commenced for new MACU/ANDU/ANC	O		Commissioned facility. Tracked through Clinical Service Unit (CSU) governance.	
3	The service should improve completion of equipment checks in line with trust policies and appropriate maintenance schedules.	1. All equipment servicing and maintenance checks to be undertaken in line with Trust policy 2. Asset tag devices throughout the Trust with new RFID tags. 3. Generate an access portal for end users to log on and track their devices via our e-Quip medical device management and/ or X Tracking RFID system	Department Managers Operational Matrons Andrew Wagstaff – Head of Clinical Engineering	30/03/2024	1. An inventory of equipment has been shared with all department managers and actions will be taken to ensure all equipment is present and had maintenance checks as required. 2. CEng is currently supporting the Scan4Safety project in asset tagging devices throughout the Trust with new RFID tags.	O		Tracked through Clinical Service Unit (CSU) governance.	
4	The service should continue improving access to interpretation services for women and pregnant people.	1. The service will continue to improve access to interpreting services for women and pregnant people by: - Evaluating the trial of the language line cart and insight app and present recommendations to the interpreting service and executive team. - Partnership with Maternity Voices Partnership (MVP) to review guidelines and associated patient information, videos/leaflets. - Auditing and monitoring of improvement in the use of interpreting services.	Carly Stott - Associate Deputy Director of Midwifery Alison Powell – OMS Lead Amanda Hardaker - Matron for Quality & Safety	30/03/2024	1. Trust agreement for continued use of the Language Line Cart and the Insight App following a very successful trial period. These now forms part of our options to increase access to language support 24/7, where and when needed. 2. Staff must first try BTHFT Interpreting services in the first instance. 3. Monitoring there usage and the cost impact will take place. 4. My next steps will be to try and obtain more than 1 device.	O		Tracked through Clinical Service Unit (CSU) governance. Meeting minutes/Audit reports	
5	The service should 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.	1. Implement the actions following recent risk assessment audits. 2. Develop audits of risks assessments on the new Genome audit platform to enable regular ongoing monitoring. 3. Implement an electronic personalised care plan which is editable and	Carly Stott - Associate Deputy Director of Midwifery Amanda Hardaker - Matron for Quality & Safety	30/03/2024	1. Improvement work following recent audits is ongoing 2. Options of electronic personalised care plan are being explored.	O		Tracked through Clinical Service Unit (CSU) governance. Meeting minutes/Audit reports	

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		accessible to both the staff and service users. This will support the service in ensuring ongoing risk assessment takes place at every maternity contact and is auditable in line with the Ockenden recommendations.							