	Immediate and Essential Action		Link to Maternity Safety actions	Link to urgent clinical priorities & *Minimum Evidence Required* *(Letter from Wendy Matthews OBE* *Regional Chief Midwife, Director of Nursing)*	What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
Section 1											
1	1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	• 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. • 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. • 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 monthse	Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Action 2: Are you submitting data to the Maternity Services Dataset to the required standard? 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?	(a) A plan to implement the Perinatal Clinical Quality Surveillance Model *A statement of commitment to agree and implement a plan.* *The quality surveillance document has now been published on Friday 18th December 2020.* (b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB *Accepting Trust Board only (not a sub-group to Boards). Evidence – Any sub boards or committees will not be accepted as compliant; examples of evidence may include* *Trust Board minutes as well LMNS Board minutes and a monthly return of cases submitted to HSIB.* *Please note that this is all SI's and not just HSIB cases*	ESNEFT is actively using the PMRT and submitting cases to MBRRACE. Maternity reporting is structured through the Trust-wide Clinical Governance Structure and Ward to Board assurance. At site level a monthly Risk & Governance Meeting takes place, with exception reporting to Divisional Governance Board. A quarterly report is provided to the Patient Safety & Clinical Effectiveness Group, the Patient Experience Group and to the Deteriorating Patient Group, with a monthly contribution to the Patient Safety Report and the Integrated Patient Safety & Experience Report which is provided to the Board Assurance Committee and then Board. Maternity performance is captured on every LMNS agenda.	Maternity Dashboard reviewed and reported on at Divisional Governance and through monthly reports to PSCEG, QPS and exception reported to Board. Quality Improvements are identified through monthly review of all data with subsequent progress reported through the same forums.	Assessment of progress through review of dashboard and measures set through QI programme.	Structure a 3 monthly report for serious incidents to be presented at Board level and to the LMNS. This will need to include the status of any actions from recommendations and ultimately the assurance of sustained improvement through audit, maternity dashboard, incident reporting, duty of candour/being open and other QI initiatives. The Trust commits to undertake further improvements to the PMRT participation through a review of current job plans ensuring attendance at MDT and adequate time for the members of the PMRT review team to review case work and attend meetings.	HOM's & LMNS, February 2021 Divisional Management Team, April 2021	Service review to ensure adequate time is allocated for both midwifery and medical staff to support LMNS with quality and safety agenda and to ensure the PMRT requriements are met.	Internal Governance processes continue to support processes, agreement at LMNS in January of agenda and verbal updates by each member of the LMNS
					ESNEFT external reporting is aligned to the national framework, with clinical specialist opinion from outside the Trust for the mandated cases of intrapartum fetal death, maternal death, neonatal brain injury and early neonatal death through the HSIB. Further cases will require development of external approach through the LMNS	Consideration of limited assurance audit of ESNEFT maternity incident reporting and assurance	Consideration of limited assurance audit of ESNEFT maternity incident reporting and assurance & identify a random sampling of actions to test the efficacy and deep dive where required.	Confirm a process of identification of resource across the LMNS for external specialist opinion and confirm cases to be reviewed outside of HSIB . Confirm internal audit process	HOM's & LMNS, February 2021	Current resource across LMNS adequate to support external opinion. The Trust is committed to ensuring that clinicians are given the time and ressource to support internal and external investigations in line with the recommendations of the report. (Audit & Risk Committee)	Informal agreement process currently in place.
					Trust Board receives themes and learning from SI reports and actions plans through exception reporting in the Integrated Patient Safety & Experience report.	Action plans developed as a consequence of recommendations are reviewed at service governance meetings to ensure imlplementation of actions and change	Incident trends and themes are monitored to provide assurance of actions and embedding of changes	Identify and record processes of assurance of effectiveness of change. Develop LMNS assurance framework.	HOM's & LMNS, February 2021	Service review to ensure adequate time is allocated for both midwifery and medical staff to support LMNS with quality and safety agenda	Thematic review of cases from past 12 months to assess current position with regards to progress against actions and opportunity for assurance of implementation
					Reports of Serious investigations are shared with CCG, discussion of overall numbers and themes at LMNS.	Recommendations from serious incidents support the development of training and quality improvements.	Incident trends and themes are monitored to provide assurance of actions and embedding of changes	Identify and record processes of assurance of effectiveness of change. Develop LMNS assurance framework.	HOM's & LMNS, February 2021	Service review to ensure adequate time is allocated for both midwifery and medical staff to support LMNS with quality and safety agenda	Ensure oversight of all Quality Improvement plans, assessing progress against plan
	Immediate and Essential Action		**Link to Maternity Safety actions**	**Link to urgent clinical priorities &** *Minimum Evidence Required* *(Letter from Wendy Matthews OBE* *Regional Chief Midwife, Director of Nursing)*	**What do we have in place currently to meet all requirements of IEA 2?**	**How will we evidence that we are meeting the requirements?**	**How do we know that these roles are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**

2	Listening to Women and Families Maternity services must ensure that women and their families are listened to with their voices heard.	• Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. • 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. • 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.	Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? 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? Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	(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. *Minutes of meetings where co-production has taken place with the outputs available i.e. service user information / involvement in guideline development etc.* (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. *Name of the Executive Director Board Maternity Safety Champion and the Name of the Non-Executive Director Board Maternity Safety Champion. Evidenced by minutes* *of meetings*	The Trust will follow future national guidance in the creation of an independent senior advocate role which will report to the Trust Board and to the LMNS	The Trust will follow national guidance in developing the responsibilities of the independent senior advocate, providing an assurance framework evidencing a forum of Safety Champions, the MVP and advocate	The Trust will develop a programme of assurance of effectiveness through the triangulation of feedback (FFT & Surveys), complaints and PALS	To create the advocate role in accordance with future guidance	Heads of Midwifery, within the timescales advised nationally	Resource to be determined based on future guidance	Current processes in place including patient feedback, PALS, complaints and Maternity Voice Partnership and actions taken as a result of the information received.
					The advocate will have a role which ensures availability to families in accordance with national guidance	The Trust will follow national guidance in developing the responsibilities of the independent senior advocate, providing an assurance framework evidencingRevised maternity safety champion meetings terms of reference and relaunch of the role	The Trust will develop a programme of assurance of effectiveness through the triangulation of feedback (FFT & Surveys), complaints and PALS	To create the advocate role in accordance with future guidance	Heads of Midwifery, within the timescales advised nationally	Resource to be determined based on future guidance	Service user feedback is received via the MVP with action plans in place to coproduce service improvements
					The Chief Nurse has Executive accountability for Nursing, Midwifery & AHP activities, the Chief Nurse is Giles Thorpe. A Non-executive Director, Hussein Khatib, with a clinical background has responsibility for maternity services, a requirement outlined in the ESNEFT CQC report published in January 2020. The non-executive oversight role is linked to the Chair of Quality & Patient Safety Assurance Committee.	Presence at Board level of both the Chief Nurse and NED responsible for Maternity services evidenced through minutes.	Maternity Safety Champions and MVP engagement and partnership working with the Trust	Revised terms of reference for the Patient Safety Champions Meetings and refresh of the MVP action plan to include the role of the NED for Maternity Services	Heads of Midwifery, March 2021	No further resource required	Active engagement with the MVP

	Immediate and Essential Action		**Link to Maternity Safety actions**	**Link to urgent clinical priorities &** *Minimum Evidence Required* *(Letter from Wendy Matthews OBE* *Regional Chief Midwife, Director of Nursing)*	**What do we have in place currently to meet all requirements of IEA3?**	**What are our monitoring mechanisms?**	**Where will compliance with these requirements be reported?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
3	Staff Training and Working Together Staff who work together must train together	• 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. • 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. • Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? 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?	(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. *Standard Operating Procedure for a minimum of twice daily consultant obstetrician ward rounds with supporting* *audit (spot check audit to be completed prior to 15th Jan* *submission if not already available as part of annual audit* *cycle).* (b) 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 *One spot check audit undertaken by 15th January 2020* *c) A statement of commitment that all of year 3 (21/22) CNST incentive scheme refunds will be ringfenced for use within maternity services.*	Annual training needs analysis is undertaken which informs the annual training plan. Maternity training and education guideline with detailed training needs analysis by staff group.	Registers are kept and compliance matrix completed	Compliance is monitored at Trust level through reporting at Divisional level and at Executive level through the Divisional Accountability Meetings.	Compliance progress against plan will be taken to the LMNS 3 times each year	HOM's & LMNS, February 2021	Established Clinical Specialist Midwives in place - no further resource required.	No risks identified

					In accordance with the 7 day services programme, Consultant led MDT ward rounds take place every morning. In the evening MDT handover and board rounds take place Monday to Friday at the Ipswich Site and 7 days a week at the Colchester site (physical presence). For Saturday and Sunday evenings at the Ipswich site the consultant leads board round wiht the team via teleconference.	Current audit of assurance that the Labour Ward rounds are taking place and that there is MDT involvement. Handover register (which includes those at the ward round) is audited.	Compliance will be monitored at Risk and Governance, with excepetion reporting to Divisional Governance and Board, reporting to LMNS to be established.	Review Consultant Obstetricians job plans to bring into line with national receommendations. Review MDT requirements of attendance in accordance with the recommendations of the report.	HOM's & LMNS, February 2021 Clinical Leads & Divisional Director, April 2021	Service review and Job plan review and business case will determine resource required	24/7 Consultant on call rota
					Education money allocated to Maternity Services is ringfenced specifically for Maternity. The Trust is committed to following CNST requirements for funding.	Allocation of all funding monitored through Education and Training. CNST assessment tools, outcomes and annual financial review	Compliance monitored through Divisional oversight of education TNA plan and progress. Funding for education is allocated on receipt and ring-fenced for maternity.	Increase visibility at Divisional Governance & Board CNST finance requires increased visibility through Divisional Board and the Trust Finance & Performance Committee	HOM's, April 2021 Divisional Management Team, April 2021	No further resource required	No risks identified
	Immediate and Essential Action		**Link to Maternity Safety actions**	**Link to urgent clinical priorities &** *Minimum Evidence Required* *(Letter from Wendy Matthews OBE* *Regional Chief Midwife, Director of Nursing)*	**What do we have in place currently to meet all requirements of IEA4?**	**What are our monitoring mechanisms?**	**Where will compliance with these requirements be reported?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
4	Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies	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. • Women with complex pregnancies must have a named consultant lead • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. *Name of the Consultant Obstetric Lead with supporting audit from the previous 12-month annual audit cycle or spot check audit complete prior to submission on 15th January 2021* . b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres. *Standard Operating procedure and care pathway to which identifies how women are referred into a Regional Maternal Medicine centre if the Trust does not have its own on site.* *Commitment to support regional maternal medicine networks once established and what steps have been taken.*	Women with complex pregnancies have a named Consultant lead	Audits have been undertaken showing limited assurance	Audit results and the subsequent action plans will be presented and monitored at Risk & Governance monthly meetings and Divisional Board, exception reported to PSCEG, QPS and Board	Draft action plan following outcome of audit, identify action owners and monitor compliance. Review of Maternity Medway to understand and enhance the capture of data. Introduction of stickers placed in the notes to confirm actions have been taken and audit plan of assurance	HOM's & LMNS, February 2021	No further resource required	Introduction of stickers placed in the notes to confirm actions have been taken and audit plan of assurance
					Women identified as being complex are referred on to specialist consultant clinics following the booking and assessment guidelines. Specialist Maternal Medicines clinics are held on both sites, with referrals to tertiary centres as clinically appropriate. ESNEFT is committed to support the regional maternal medicine networks once established.	No monitoring mechanism in place at present.	Risk and Governance Meeting when established.	Review cross divisional working to support joint clinics with Consultant Obstetricians and Physicians.	Clinical Leads & Divisional Director, April 2021	Job plan review and business case will determine resource required.	Tertiary referral system in place
	Immediate and Essential Action		**Link to Maternity Safety actions**	**Link to urgent clinical priorities &** *Minimum Evidence Required* *(Letter from Wendy Matthews OBE* *Regional Chief Midwife, Director of Nursing)*	**What do we have in place currently to meet all requirements of IEA5?**	**What are our monitoring mechanisms?**	**Where will compliance with these requirements be reported?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**

5	Immediate and essential action 5: Risk Assessment Throughout Pregnancy: Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	• 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 must include ongoing review of the intended place of birth, based on the developing clinical picture.	Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	a) 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 (PSCP). Regular audit mechanisms are in place to assess PCSP compliance. *Spot check audit completed prior to the 15th January 2020 submission (if not already available as part of the annual audit cycle) plus a statement of commitment to sign up to the National Risk Assessment process when available.*	The Trust follows all NICE and National Guidelines ensuring Women are risk assessed at each antenatal appointment.	Risk assessment audits for all stages of pregnancy are established	Compliance is monitored at Trust level through reporting at Divisional level and at Executive level through the Divisional Accountability Meetings.	Maternity Medway review underway to establish any further record keeping capabilities. A sticker has been introduced to support confirmation of risk assessment at each established antenatal visit, audit programme established	Clinical Effectiveness Midwives	No further resource required	Actions to be established where audit outcomes show concern
					The Trust follows all guidelines in ensuring an on-going review of the intended place of birth is undertaken following CQC recommendations.	Maternity record keeping audit established	Compliance is monitored at Trust level through reporting at Divisional level and at Executive level through the Divisional Accountability Meetings.	Monitor FFT, PALS, Complaints and MVP forums and action where required. Maternity Survey (once re-established) outcomes to be monitored and consider further FFT question if applicable.	HOM's, April 2021	No further resource required	MVP forum discussions, FFT outcomes, Complaints & PALS and any action required
	Immediate and Essential Action		**Link to Maternity Safety actions**	**Link to urgent clinical priorities &** *Minimum Evidence Required* *(Letter from Wendy Matthews OBE* *Regional Chief Midwife, Director of Nursing)*	**What do we have in place currently to meet all requirements of IEA6?**	**How will we evidence that our leads are undertaking the role in full?**	**What outcomes will we use to demonstrate that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
6	Immediate and essential action 6: Monitoring Fetal Wellbeing: 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 monitoring.	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.	Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? 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?	a) 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. *• Name of the Midwife Lead for Fetal Monitoring and Well Being* *• Name of the Consultant Obstetrician Lead for Fetal Monitoring and Well Being.* *NOTE: where a Trust is a multi-site provider, there is a requirement for each consultant led unit /site to have both a named midwife and a named consultant obstetrician who are responsible for improving the standard of intrapartum risk assessment and fetal monitoring i.e. A Trust with 3 Consultant led Units will require 3 named midwives (1 on each site) and 3 named consultant obstetricians (1 on each site).*	Midwife Lead is Beverley Lynn (Colchester Site) and Jillian Hart (Ipswich Site). Obstetric Lead is Pippa Greenfield (Colchester Site) and Ruta Gada (Ipswich Site). All undertake continuing professional development, with a specific interest in fetal wellbeing. Saving Babies Lives care bundle V2 action plans in place and regularly monitored to ensure progress continues. The Trust follows PROMPT training guidance in ensuring the MDT training is in place.	Training certificates, lesson plans and participant feedback available Quality Improvement Midwives plan and report initiatives. Training database to support monitoring of compliance. Progress of Saving Babies Lives requirements included in audit plan with internal and external reporting on a quarterly basis.	Monitoring of incident and complaint trends and themes in accordance with the SBL action plan	Embed physiological fetal monitoring at Ipswich to align interpretation tool. Work collaboratively with the LMNS and region to deliver current work on fetal surveillance workstream.	For all midwives and doctors; training to take place during February and March 2021	Continual assessment of resources required to deliver Saving Babies Lives with associated capital investment through business planning processes.	NICE interpretation currently in use at Ipswich, but using FIGO across both sites is in line with recognised national guidance for understanding physiologic effects on the fetus during labour
	Immediate and Essential Action		**Link to Maternity Safety actions**	**Link to urgent clinical priorities &** *Minimum Evidence Required* *(Letter from Wendy Matthews OBE* *Regional Chief Midwife, Director of Nursing)*	**What do we have in place currently to meet all requirements of IEA7?**	**Where and how often do we report this?**	**How do we know that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**

7	Immediate and essential action 7: Informed Consent	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 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. Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care. Women's choices following a shared and informed decision-making process must be respected	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?	a) 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. *Pathways of care clearly described, on website -This needs to be evidenced and accessible on Trust website with links to be supplied*	ESNEFT has web pages dedicated to Maternity care at all sites. Within these pages is a link to ESNEFT's Mum & Baby app, with further information supporting informed consent. The maternity booking letter gives further information and signposts women to further information. ESNEFT provides further information through the women's birthplan, respecting birth choices, but informing of possible changes to plan according to clinical need. There is a strong partnership between ESNEFT and the Maternity Voices Partnership (MVP).	Outcomes of Maternity Survey, patient feedback, incidents, complaints & PALS reported at Maternity Risk & Governance, Divisional Board, PSCEG, PEG and with exception reporting to QPS and Board LMNS reports on access to Mum & Baby app	MVP partnership and monitoring of feedback through FFT, complaints, PALS and social media.	In partnership with the MVP, the Trust will undertake a patient survey to find out what information patients need, and what is missing. Review all current patient information tools to ensure they are in date and current and develop further pathways through co-production with our stakeholder partners. Ensure there is a comprehensive range of information leaflets including support for decision making and which is accessible according to national standards	HOM's, April 2021	The support of the MVP	Both electronic and hard copy versions of information leaflets available