Classification: Official

Publication approval reference: PAR807

Maternity services system learning

Maternity self-assessment tool

Version 6, 19 July 2021

Introduction

This Safety Self-assessment tool has been designed for NHS maternity services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the trust's maternity quality improvement and safety plan and so keep the trust board and commissioners aware of their current position.

The tool has been developed in response to national review findings, and recommendations for good safety principles within maternity services. This version of the tool has been further influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme and the areas CQC found to be outstanding in other maternity services across England.

Please use this tool to as a benchmark for your organisation in the core principles of good safety standards within Maternity services.

The tool

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	**Clinically-led triumvirate** Ref 1,2	Trust and service organograms showing clinically led directorates/care groups	G	Organisation chart and organogram in evidence folder 1a, 1b, 1c
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes	G	JDs in evidence folder 2a, 2b, 2c, 2d
	Director of Midwifery (DoM) in post **(current registered midwife with NMC)** **Ref 2**	DoM job description and person specification clearly defined	G	JD in evidence folder 2a
		Agenda for change banded at 8D or 9	G	Band 9
		In post	G	
	Direct line of sight to the trust board **Ref 3**	Lines of professional accountability and line management to executive board member for each member of the triumvirate	G	JDs in evidence folder 2a, 2b, 2c, 2d
		Clinical director to executive medical director	R	No Clinical Director within DMT
		DoM to executive director of nursing	G	Organogram in folder 1c
		General manager to executive chief operating officer	G	Organogram in folder 1c

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity services standing item on trust board agenda as a minimum three- monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, AttAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockenden learning actions	A	January Board Performance Report 3a, although the training compliance update has not been included.
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]	G	January Board Performance report 3a
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]	G	January Board Performance report 3a
		There should be a minimum of three PAs allocated to clinical director to execute their role	G	Email confirmation from ADO for W&C -
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team	G	Organogram in evidence folder 1c

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Ref 4	Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave	G	HRBP in post – JD in folder, 4j Email from Recruitment BP, confirming meetings 4a
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate	G	JD Finance manager for W&C Div. Confirmation received, in evidence folder, 4b
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area	G	Finance team's meeting log for regular budget monitoring with W&C division – 4k.
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways	G	ADO for W&C – JD at 2c
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups	G	Governance meeting minutes, action logs, agendas 4c, 4d
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, eg senior midwifery leadership assembly	G	Minutes of DSF, Women's Service Governance, Perinatal M&M in evidence folder 4c, 4d, 4e, 4f, 4h, 4i

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Leadership culture reflects the principles of the '7 Features of Safety'.	A	Update re leadership culture 4g
	Leadership development opportunities	Trust-wide leadership and development team in place	G	Dedicated Trust Intranet page for Leadership and Development. Licence to Lead Programme.
		In-house or externally supported clinical leadership development programme in place	G	Licence to Lead Programme, Aspiring Co-ordinator course (RCM), Leading from the Middle.
		Leadership and development programme for potential future talent (talent pipeline programme)	G	Licence to Lead Programme, Aspiring Co-ordinator course (RCM), Leading from the Middle.
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship	G	Discussed and evidenced in appraisals. Trust Intranet Leadership and Development page. Staff encouraged to complete CPD registration forms for bespoke study days e.g neonatal cannulation course for TC midwives. NHS Leadership Academy provide Mary Seacole Leadership Programme.
	Accountability framework **Ref 5**	Organisational organogram clearly defines lines of accountability, not hierarchy	A	Organogram to be adjusted to show lines accountability.
		Organisational vision and values in place and known by all staff	G	Discussed at Appraisals Appraisal Document in evidence folder, 5a

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]	G	AF Policy in evidence Folder 5b Maternity Staff Charter introduced Aug 2019 5c
	Maternity strategy, vision and values **Ref 6**	Maternity strategy in place for a minimum of 3–5 years	A	PID for Mty Strategy project – commenced Dec 2021 – 6a
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan	A	PID for Mty Strategy project – commenced Dec 2021 – 6a
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	A	PID for Maty strategy project commenced in Dec 2021 – 6a

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		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 [Ockenden Assurance]		Maternity philosophy developed and incorporated in Ipswich Parents New Baby Guide, 6b MVP documentation as provided for CNST and Ockenden, 6d
		Maternity strategy aligned with trust board LMNS and MVP's strategies	A	Maty strategy project commenced in Dec 2021 – 6a
		Strategy shared with wider community, LMNS and all key stakeholders	A	Maty strategy project commenced in Dec 2021 – 6a
	Non-executive maternity safety champion **Ref 7**	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor	G	Chief Nurse Giles Thorpe in post from Dec 2020. Hussein Khatib appointed as NED for Maternity services. 7a
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor	G	MatNeo safety champion meetings documentation 7b.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All Safety champions lead quality reviews, eg 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)	A	15 steps completed Ipswich June 2019 and Colchester July 2019 "A" rating as not undertaken quarterly. 7c
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services	G	E-mail confirmation from Director of Governance, 7d
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]	G	Updated in September 2021, 7e
Multiprofessional team dynamics	**Multiprofessional engagement workshops** **Ref 8**	Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, ie quarterly audit days, strategy development, quality improvement plans	G	Bi monthly obstetric audit meeting agendas and Perinatal M&M - in evidence folder 4h, 4i, 8a.
		Record of attendance by professional group and individual	G	Minutes of Delivery Suite forum, Governance meetings and Perinatal M&M 4c, 4d, 4f, 4h, 4i
		Recorded in every staff member's electronic learning and development record	G	Recorded as part of mandatory midwifery training logs at Ipswich and Colchester, recorded by individuals for revalidation. Medical staff responsible for recording in their own training logs

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Multiprofessional training programme **Ref 9**	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see	G	Dates and content posted on Education notice boards Details e-mailed to staff week before mandatory training
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority	G	Maternity Training and Education Guideline – 9g.
		All staff given time to undertake mandatory and job essential training as part of working hours	A	Evidence to be provided
		Full record of staff attendance for last three years	A	Colchester - Training Needs Analysis - evidence in folder, 9a. Ipswich - Moodle records available but only 1 year records available for maternity specific mandatory training via the training spreadsheet. It will be amended for 2021-22
		Record of planned staff attendance in current year	G	Training database, 9b
		Clear policy for training needs analysis in place and in date for all staff groups	G	Training and Education Guideline 9c
		Compliance monitored against training needs policy and recorded on roster system or equivalent	G	Moodle records can be accessed and mandatory training is recorded on the shared Training database, 9b

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Education and training compliance a standing agenda item of divisional governance and management meetings	G	Risk and Governance agendas and minutes and ToR at 4c, 4d
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]	A	PROMPT format is MDT. Maternity Training and Education Guideline - 9g Email confirmation from Sam Copping – 9e. Email confirmation from Joanne Gardiner – 9f. Roles and responsibilities projects implemented as part of Every Birth Every Day Programme – project outline at 9h.
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal	G	Maternity Training and Education Guideline - 9g Email confirmation from Sam Copping – 9e. Email confirmation from Joanne Gardiner – 9f. See email confirmation from Haroona Khalil – 9d
	Clearly defined appraisal and professional revalidation plan for staff	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation	G	Job descriptions in evidence folder 10a
		Compliance with annual appraisal for every individual	G	Monitored via AF, Training Portal and Divisional Management Team

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Ref 10	Professional validation of all relevant staff supported by internal system and email alerts	G	Midwifery e-mail alerts sent from NMC and locally throughout the Trust
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities	G	Appraisals, e-learning, Identification and Draft copy of Management of Learning Needs SOP, 10b
		Schedule of clinical forums published annually, eg labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings	G	Ipswich: Known dates of LWF (4th Friday of the month) and risk and governance meetings (1st Friday of the month) Colchester: Service Governance 2nd Friday of the month, DSF alternative Tuesdays, PMRT 1st Friday of the month, Risk Management twice monthly, Perinatal M&M monthly, Audit halfdays 8 times per year, Friday Case review every Friday
	Multiprofessional clinical forums **Ref 11**	HR policies describe multiprofessional inclusion in all processes where applicable and appropriate, such as multiprofessional involvement in recruitment panels and focus groups	G	HR Policies
	Multiprofessional inclusion for recruitment and HR processes **Ref 12**	Organisational values-based recruitment in place	G	HR Policies
		Multiprofessional inclusion in clinical and HR investigations, complaint and compliment procedures	G	HR Policies
		Standard operating procedure provides guidance for multiprofessional debriefing sessions following clinical incidents or complaints	A	Debriefing SOP to be circulated and submitted through internal Governance in March 2022 Email trail confirming status 12a, 12b, 12c

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy	R	Update from Sarah Carter – Debriefs not embedded and daily Datix meetings faltered - 12a
		Schedule of attendance from multiprofessional group members available	R	Email update from Sarah Carter – 12a
	Multiprofessional membership/ representation at Maternity Voices Partnership forums **Ref 13**	Record of attendance available to demonstrate regular clinical and multiprofessional attendance.	G	LMNSB minutes available from CCG
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design	G	LMNSB minutes available from CCG. Minutes from Local MVP meetings MVP meetings re-established in November, multiprofessional attendance confirmed. 13a, 13b
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users	G	QI projects are registered via the Trust QI Team. All maternity projects are part of ESNEFT QI plan and are either registered with the Trust Quality Oversight. Group or the Quality Improvement Team. Colchester - QI notice boards updated regularly in main corridor of ANC and Delivery Suite, updates are given at monthly Stat Training. QIP in evidence folder 13c. Ipswich - Information sent to staff regarding PPH QIP. Full plan delayed due to Covid

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Collaborative multiprofessional input to service development and improvement **Ref 14**	Roles and responsibilities in delivering the QIP clearly defined, ie senior responsible officer and delegated responsibility	G	Cross-site QI Lead Midwife in post on both sites. JD in evidence folder, 13c
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP	G	Each QI project has clearly defined aims and measures stated in the registration documents (13c).
		Identification of the source of evidence to enable provision of assurance to all key stakeholders	R	TBC
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access	A	Governance drive, with folders for each programme of work
		Clear communication and engagement strategy for sharing with key staff groups	A	Comms channels include: Sway, Word on thhe block, facebook, email, newsletters, governance boards
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements	G	QI projects are initiated from outlier from national data or identified from the Risk Register e.g. PPH >1500ml and LSCS rate (VBAC). National or regional QI projects e.g. SBL, ATAIN, PReCePT, Thermoregulation, Smoking cessation and Kaiser project, 13a
		Weekly/monthly scheduled multiprofessional safety incident review meetings	G	Daily Datix meetings, PMRT PPH review meetings Monthly MatNeo Safety champion meetings, 7b

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Multiprofessional approach to positive safety culture **Ref 15**	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	G	LMNS Safety forum TOR and sample agenda – ref 15b, 15c
		Positive and constructive feedback communication in varying forms	G	Friends and Family Test relaunched after being paused during Covid. Positive working group set up on both sites, tasked to work on the feedback from staff surveys and staff listening events to improve culture – 15a
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach	R	Ipswich - Some staff trained in after action reviews. Colchester - No one trained in After Action Reviews. Rapid Debrief proforma designed and to be implemented – not yet successfully launched. Debrief SOP in development from LMNS – request update.
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]	A	Confirmation and content of scheduled sessions to be confirmed by PDMs and PMA.Policies in place: (FINAL) 02885-19 ESNEFT **Values** and **behaviours.pdf** https://www.nmc.org.uk/standards/code/ Maintaining High Professional Standards – Additional Disciplinary and Capability Policy for Medical and Dental Staff v1.0 - ESNEFT.pdf
		Schedule of focus for behavioural standards framework across the organisation		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Clearly defined behavioural standards **Ref 16**	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	G	Trust policy in place - Disciplinary Policy and Procedure and General Rules of Conduct for Trust Staff. Civility and Psychological Safety is on the Stat Training programme.
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]	A	We have secured the Emotional resilience training & Action learning sets which are focussed around behaviours and supporting whilst experiencing Compassion fatigue
		All policies and procedures align with the trust's board assurance framework (BAF)	G	NICE baseline assessment tracker and overdue guideline tracker - in evidence folder 16b. Guidelines are developed in line with the Trust Documents Policy. Corporate Governance Framework Version 2.0 specifically in Appendix 6 - 16a
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards** **Ref 17**	Governance framework in place that supports and promotes proactive risk management and good governance	A	Governance Team in place both sites with effective working. Women's Governance meeting minutes and agenda in evidence folder 4c, 4d. Maternity-specific Risk Management Policy is required
		Staff across services can articulate the key principles (golden thread) of learning and safety	A	New Governance notice board will help share risks and learning.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Staff describe a positive, supportive, safe learning culture	A	Staff survey responses – 17a. New Staff survey results just published March 2021. SOP in draft for Identifying learning needs as a platform for safe and just learning culture, 17b. Positive culture is discussed at Stat Training - presentation in evidence folder (17c). Staff listening events have been held by HoM and Positive Working Group started on each site - minutes in evidence folder (17d)
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams	A	Job descriptions 10a. Organogram for Governance needed.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity governance structure within the directorate **Ref 18**	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife Clinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support	A	Governance team organogram attached at 18a (although not showing Obstetrician governance lead)
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member	A	Job descriptions (10a). Organogram for Governance team is at 18a. Project to confirm roles and responsibilities within the governance team is underway – see 9h. Eve is continuing with this currently.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Team capacity able to meet demand, eg risk register, and clinical investigations completed in expected timescales	A	Ipswich: Serious incidents completed within time frame. Internal investigations outstanding and team working to support completion and division updated. Reported to Womens board meeting, Patient safety and Clinical effectiveness meetings. Governance spreadsheets. Colchester: All SI's and internal investigations are completed in expected timescales
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF	R	Trust Risk Management Policy in place. No maternity-specific risk management strategy in place
	Maternity-specific risk management strategy **Ref 19**	Clearly defined in date trust wide BAF	R	Trust policy - Corporate Governance Framework. Trust AF Guideline in evidence folder – 16a No maternity-specific risk management strategy in place
	Clear ward-to-board framework aligned to BAF **Ref 20**	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board	A	Two at the top documents – 20a. Key issues raised from ward meetings, DS Forum, Risk Management are escalated to governance - process to be included in maternity risk management strategy.
		Mechanism in place for trust-wide learning to improve communications	G	Cases presented quarterly at learning from deaths. Quarterly update of SI's and HSIB sent to Trust Board. Quarterly report presented to PSCEG, Deteriorating Patient, Patient Experience Group, Infection Control Committee.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Proactive shared learning across directorate **Ref 21**	Mechanism in place for specific maternity and neonatal learning to improve communication	G	Neonatal safety champions meeting every month, 7b. Monthly perinatal mortality and morbidity meetings – 4h, 4i. Bi-monthly Obstetric audit meeting – 8a.
		Governance communication boards	A	Ipswich - Governance folder and notice boards on wards. Colchester - SI folders on Lexden Ward and DS. Governance Board is on order.
		Publicly visible quality and safety boards outside each clinical area	A	Ipswich: Boards in situ - monitored via CQC 'should do' spreadsheet Colchester - Display cases arrived, to be put up
		Learning shared across local maternity system and regional networks	G	Strong links with LMS. Joint meetings arranged. Meeting agendas available from LMNS.
		Engagement of external stakeholders in learning to improve, eg CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups	G	Maternity Leads attend LMNS meetings monthly and new monthly LMNS Safety meetings. Regular meetings take place between Chief Midwife for the region attended by HoM. QI midwives, specialist leads attend clinical network meetings. CTG specialist midwife attending fetal monitoring regional meetings and QI midwife attends MSW regional meeting. QI Lead seconded to EBC. SI's sent to CCG for approval.
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.	A	Trust-wide comms and engagement strategy under development, awaiting Trust Board sign off on 6th January 2022. Maternity services are included – see update from Deputy Director of Comms and Engagement – 21a.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Multi-agency input evident in the development of the maternity specification	R	TBC
Application of national standards and guidance	**Maternity specification in place for commissioned services** **Ref 22**	Approved through relevant governance process	R	TBC
		In date and reflective of local maternity system plan	R	TBC
		Full compliance with all current 10 standards submitted	G	NHSR confirmed Year 3 compliance. Year 4 scheme is currently paused.
	Application of CNST 10 safety actions **Ref 23**	A SMART action plan in place if not fully compliant that is appropriately financially resourced.	N/A	
		Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance	G	PSR, RPQOG
		Clear process for multiprofessional, development, review and ratification of all clinical guidelines	G	Trust Document Management Policy in place. Email trails and risk and governance agendas and minutes – 4c, 4d - along with Guideline oversight spreadsheet – 23a (3 & 20d).
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multiprofessional meetings for a rolling 12 months programme.	R	TBC

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All guidance NICE complaint where appropriate for commissioned services	G	Completed NICE baseline assessments. Overseen by NICE compliance team - Monthly report in evidence folder – 23b.
		All clinical guidance and quality standards reviewed and updated in compliance with NICE	G	Completed NICE baseline assessments. Overseen by NICE compliance team - Monthly report in evidence folder – 23b.
		All five elements implemented in line with most updated version	G	Compliant with all 5 elements. SBLCB2 action plan ongoing (21)
	Saving Babies Lives care bundle implemented **Ref 24**	SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.	G	SBL project managed cross-site by QI midwife. Action plan at 24e.
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan	A	TBC
		All four key actions in place and consistently embedded	G	Support for BAME women in pregnancy SOP - 24a
	Application of the four key action points to reduce inequality for BAME women and families	Application of equity strategy recommendations and identified within local equity strategy	A	SNEE Equity Plan – 24d.
		All actions implemented, embedded and sustainable	G	Support for BAME women in pregnancy SOP - 24a
	Implementation of 7 essential learning actions from the Ockendon first report	Fetal Surveillance midwife appointed as a minimum 0.4 WTE	G	In post. JDs – 24b, 24c
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs	A	2PAs /1PA. Tbc

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Plan in place for implementation and roll out of A-EQUIP	G	Colchester - funding for 3 midwives for 20/21 and further funding has been requested for 2 places 21/22.
	A-EQUIP implemented **Ref 25**	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team	G	PMA plan - 25a
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered	G	Ipswich: Training course commenced by Risk and Governance Midwife, course commenced Jan 2021 Ipswich: Training course commenced by Risk and Governance Midwife, course commenced Jan 2021 Colchester: 2 qualified PMA's, 1 further MW commenced training Jan 2021. PMA course to be part of yearly CPD bid.
		Service provision and guidance aligned to national bereavement pathway and standards	G	Bereavement Guidelines in place.
	Maternity bereavement services and support available **Ref 26**	Bereavement midwife in post	G	In place on each site
		Information and support available 24/7	G	Bereavement Midwives available 4 days per week during office hours. Additional support available via Midwives on Lexden Triage and DS outside office hours. Bereavement update is included on Stat Training plan 21/22. Stat Training programme for 21-22 in evidence folder in draft form (13d)

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities	G	Ipswich: Ensuite shower room in private, sound-proofed allocated bereavement room. However, plans in place to improve environment in collaboration with service users. Colchester:Rosemary Suite is the dedicated Bereavement Suite with a Living area, bedroom, delivery room and bathroom within the suite.
	Quality improvement structure applied **Ref 27**	Quality improvement leads in place	G	Cross-site QI Midwife in post. JD at 27a.
		Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation	G	QI projects are registered via the Trust QI Team. All maternity projects are part of ESNEFT QI plan and are either registered with the Trust Quality Oversight Group or the Quality Improvement Team. Colchester - QI notice boards updated regularly in main corridor of ANC and Delivery Suite, updates are given at monthly Stat Training. Ipswich - Information sent to staff regarding PPH QIP. Full plan delayed due to Covid QIP in evidence folder – 27b
		Recognised and approved quality improvement tools and frameworks widely used to support services	G	ESNEFT use Model for Improvement which includes MDT approach, aims and measures, PDSA cycles, SPC charts. Ipswich: QI projects paused during Covid.
		Established quality improvement hub, virtual or otherwise	G	Trust QI hub where all QI projects are registered and highlight reports are sent. Ipswich: Mat Neo QI portal.
		Listening into action or similar concept implemented across the trust	A	To be determined

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.		
	MatNeoSip embedded in service delivery **Ref 28**	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan	A	LMNS strategy in progress
	Maternity transformation programme (MTP) in place **Ref 29**	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)	G	MatNeo Safety Champions meetings relaunched Feb 21 - minutes and draft ToR in evidence folder – 7b
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place** **Ref 30**	Standing agenda item on key directorate meetings and trust committees	G	Patient Safety and Clinical Effectiveness Group attended monthly and quarterly exception report. Highlight report sent quarterly to Quality Oversight Group
		FTSU guardian in post, with time dedicated to the role	G	Trust FTSU in post. Posters on display in all areas
	Freedom to Speak Up (FTSU) guardians in post **Ref 31**	Human factors training lead in post	G	Practice Development Midwives are human factors leads and deliver the training (both sites) is Human Factors Lead. Also fully trained Obstetric Consultant and Anaesthetic Consultant.
	Human factors training available	Human factors training part of trust essential training requirements	G	Included in Stat Training and PROMPT emergency obstetric training. Stat Training programme draft 21-22 in evidence folder 13d

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Ref 32	Human factors training a key component of clinical skills drills	G	Included in PROMPT training program
		Human factors a key area of focus in clinical investigations and formal complaint responses	G	Trust Guideline Reporting and Management of Incidents, Patient Safety Incident Response Framework Policy - in evidence folder 32a
		Multiprofessional handover in place as a minimum to include Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas eg, antenatal/postnatal ward/triage.	G	Delivery Suite Ward rounds guideline – 32b
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern	A	Additional handover hours funded from Ockenden not yet in place at Ipswich - Beatty

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's	R	One safety huddle per day Review escalation policy re additional urgent huddles - DM
	Safety huddles **Ref 33**	Guideline or standard operating procedure describing process and frequency in place and in date	G	Safety Huddle takes place daily (virtually during pandemic) - Huddle sheets in evidence folder (33a)
		Audit of compliance against above	A	Audit to be completed
		Annual schedule for Swartz rounds in place	A	Trust Schwartz rounds postponed throughout Pandemic
	Trust wide Swartz rounds **34**	Multiprofessional attendance recorded and supported as part of working time	A	Trust Schwartz rounds postponed throughout Pandemic
		Broad range of specialties leading sessions	A	Trust Schwartz rounds postponed throughout Pandemic
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse	R	TBC
	Trust-wide safety and learning events **35**	Robust process for reporting back to divisions from safety summit	R	TBC
		Annual or biannual trust-wide learning to improve events or patient safety conference forum	R	TBC
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes	G	Email confirmation from Director of Governance – 7d

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		In date business plan in place	G	Current year's business plan (2020/21) – 36a
Comprehension of business/ contingency plans impact on quality. **(ie Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)**	**Business plan in place for 12 months prospectively** **36**	Meets annual planning guidance	A	Current year's business plan (2020/21) – 36a
		Business plan supports and drives quality improvement and safety as key priority	R	TBC
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups	A	21-22 business plan in evidence folder – 36a
		Consultant job plans in place and meet service needs in relation to capacity and demand	R	Email received from VP in evidence folder – 36b
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans	G	Email from VP – 36b
		Business plans ensures all developments and improvements meet national standards and guidance	R	TBC
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.	R	TBC

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Business plans include dedicated time for clinicians leading on innovation, QI and Research	A	Response from VP in evidence folder – 36b
		That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.		
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidances.	**That Employment Policies and Clinical Guidances meet the publication requirements of Equity and Diversity Legislation.**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.	R	TBC
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.	R	TBC

Key lines of enquiry	Kirkup recommendation number
Leadership and development	2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18
Governance: Covers all pillars of Good governance	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18

Quality Improvement: application of methodology and tools	5, 6, 9, 12, 13, 15, 16, 17, 18
National standards and Guidance: service delivery	2, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Safety Culture: no blame, proactive, open and honest approach, Psychological safety	2, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Patient Voice: Service user involvement and engagement through co-production and co-design. MVP and wider	6, 9, 11, 12, 13, 15, 17, 18
Staff Engagement: Harvard System two leadership approach, feedback and good communication tools	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Business Planning: aligned with LMNS plans and the National Maternity Transformation agenda, Maternity safety strategy and the Long term plan	8, 9, 10, 14, 15, 16, 17, 18

Key supporting documents and reading list

1. NHS England National Maternity review: Better Births. February 2016; https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

2. Royal College of Obstetricians and Gynaecologists Maternity Standards 2016; https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/maternitystandards.pdf

3. NHS England NHS Long Term Plan: January 2019; https://www.longtermplan.nhs.uk/

4. Report of the Investigation into Morecambe Bay March 2015; https://www.gov.uk/government/publications/morecambe-bay-investigation-report

5. Royal College of Midwives. Birth-rate plus tools; https://www.rcm.org.uk/media/2375/working-with-birthrate-plus.pdf

6. Royal College of Midwives State of Maternity Services 2018; https://www.rcm.org.uk/media/2373/state-of-maternity-services-report-2018-england.pdf

7. NHS England. Spotlight on Maternity: Safer Maternity care. 2016; https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/11/spotlight-on-maternity-guide.pdf

8. Department of Health Safer Maternity care. The National Ambition. November 2017; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560491/Safer_Maternity_Care_action_plan.pdf

9. NHS Resolution. Maternity Incentivisation Scheme 2019/20; https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

10. NHS staff survey. (2018); https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/

11. Maternity Picker Survey. 2019; https://www.picker.org/wp-content/uploads/2014/10/Maternity-4-pager-for-website-ARe-V2-18122018.pdf

12. National Maternity Perinatal Audit. (NMPA) report; https://www.hqip.org.uk/resource/national-maternity-and-perinatal-audit-nmpa-clinical-report-2019/#.XdUiX2pLFPY

13. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. (MBRACE) report; https://www.npeu.ox.ac.uk/mbrrace-uk

14. Organisations Monthly Maternity Dashboards; https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard

15. Organisational Maternity and Neonatal Cultural Score Survey; https://improvement.nhs.uk/documents/5039/Measuring_safety_culture_in_matneo_services_qi_1apr.pdf

16. NHS England Saving babies lives Care bundle. V2 March 2019; https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

17. 7 Features of safety in maternity services framework; https://for-us-framework.carrd.co/

18. Ockendon Report: investigation into maternity services at Shrewsbury and |Telford NHS hospitals 2020; https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

19. Perinatal Surveillance Model; https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf

20. Maternity Incentive Scheme; https://resolution.nhs.uk/wp-content/uploads/2021/03/Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf