James Paget University Hospitals NHS Foundation Trust

Improvement Plan – Maternity Services

Our Plan for Improving Maternity Services at JPUH

James Paget University Hospital (JPUH) Maternity and Neonatal services are part of the Norfolk and Waveney Local Maternity and Neonatal system (LMNS) and welcome approximately 1,800 babies annually.
In developing our maternity services, we aim to offer the very best care to women, birthing people, babies and families as we recognise that pregnancy and the birth of a child is a significant event and that what happens before, during and after that event has a long-term impact on the emotional and physical wellbeing of the child, their parents and carers.

In developing our services, we are able to focus on the learning from a number of maternity reviews that have taken place, starting with the Morecombe Bay Investigation Report in 2013 which identified significant failings in safety, effectiveness, team working, and poor service user experience.
Following this, a major review of Maternity Services nationally was undertaken in 2015 as part of the NHS Five Year Forward View. This identified seven priority areas for maternity services to focus on, and identified variation in mortality around the country along with inequalities in outcomes, including those that are influenced by deprivation and factors such as smoking or obesity.
Since the publication of the report in 2016, safety programmes have been rolled out including the Clinical Negligence Scheme for Trusts (CNST) in 2018 which rewarded services who incentivized 10 safety actions, and Saving Babies Lives in 2019, which set out a care bundle for reducing perinatal mortality.
The Ockenden Report (published in 2022) following the investigation into avoidable baby and maternal deaths in Shrewsbury & Telford Hospital Trust and identified 60 local actions for all Maternity Services to ensure that services were safely staffed, had a well trained workforce, that we listened to families an that we learned from incidents.

These investigations have all followed a theme of four pillars which all services should ensure they focus on, namely: ***safe staffing***, a ***well-trained workforce***, that we ***learn from incidents*** and that we ***listen to our families***.

The Trust's strategic vision is "Building A Healthier Future Together"

The four pillars for maternity services, namely: ***safe staffing***, a ***well-trained workforce***, that we ***learn from incidents*** and that we ***listen to our families*** are aligned to the Trust supporting priorities which are:

- Caring for Our Patients
- Supporting Our People
- Collaborating with Our Partners
- Enhancing Our Performance

As the four pillars for focus in maternity services are the actions identified following the January 2023 CQC Inspection and from the national reviews, these are aligned to the Trust priorities.
Therefore, the delivery of the priorities within this Improvement Plan for Maternity Services will use the Trust priorities as a framework for change.

To deliver this Improvement Plan, work streams are being developed which align to each of these priorities. As we deliver against them, we will improve the overall performance of the Maternity Service which will ultimately achieve the Trust's vision of 'Building A Healthier Future Together' for our pregnant people and families we serve.
This Improvement Plan is the start of a new chapter for James Paget University Hospital (JPUH) maternity services. Through the framework we have set out in this plan, we will provide assurance in relation to the quality and safety of our services. We will work together with women, pregnant people and their families to listen to, and learn from them, using their feedback to improve the experience of our service users and to develop a learning culture.

How will we begin this work ?

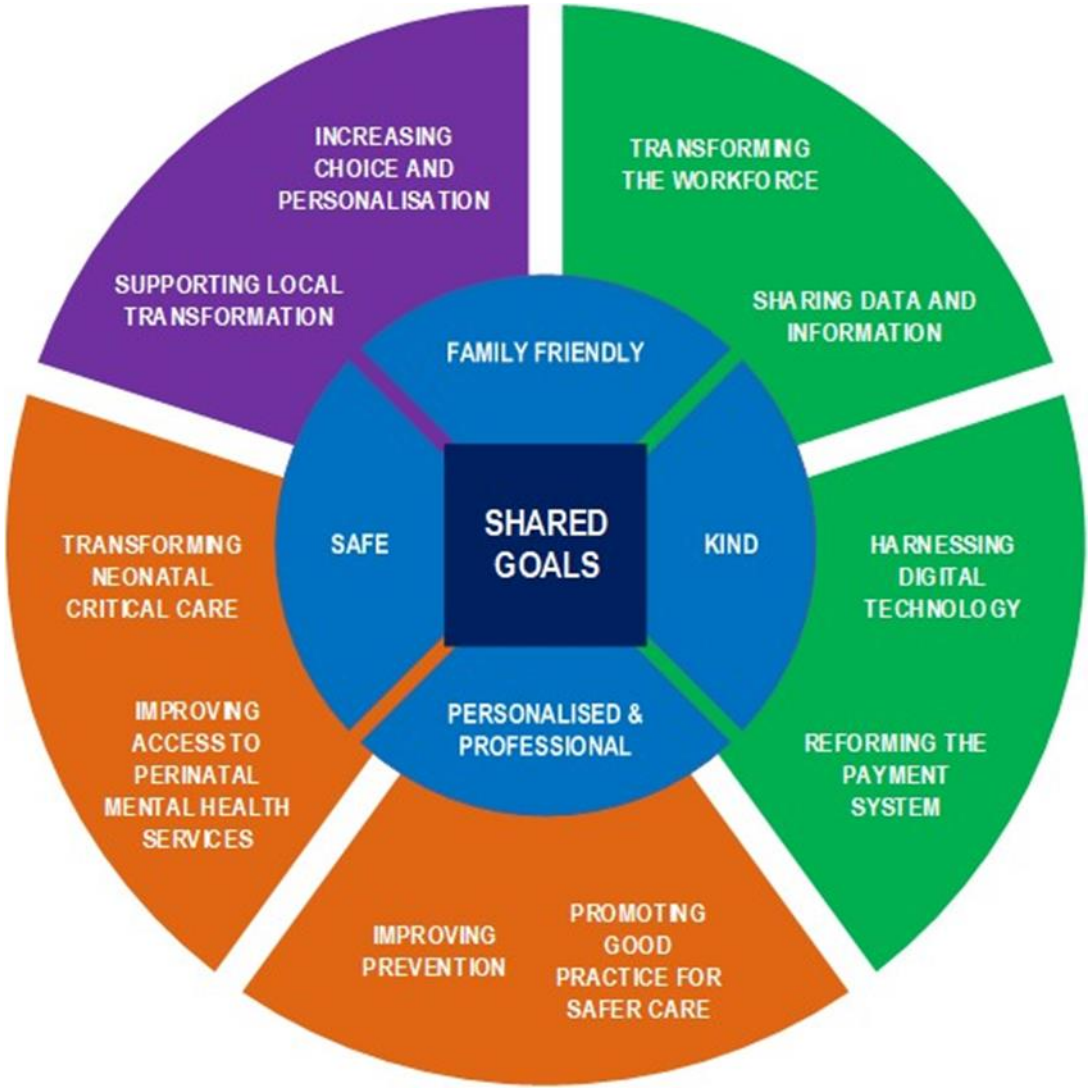
The first phase of the plan was to identify the variance, or gap between our performance and the targets that are in place nationally for Maternity Quality and Safety Standards.
Examples of these include: ensuring that we are booking our pregnant people before 10 weeks, providing 1:1 care in labour, the percentage of normal vaginal births when compared to national targets, smoking at time of booking into antenatal care and at time of delivery, breastfeeding initiation rates, induction rates and maternity service maternal morbidity metrics.

Other ways we can benchmark the effectiveness of our service will be how we are able to evidence we are reducing perinatal mortality against the six elements of Saving Babies Lives V3, and the Maternity Incentive Scheme which rewards Trusts under the Clinical Negligence Scheme for Trusts (CNST) framework

In parallel we also need to understand the recommendations in all of the Maternity Investigation Reports that have taken place including Morecambe Bay (Kirkup Report), East Kent Report, Ockenden Report, 60 Steps 2021, Ockenden Insight 2022 and Ockenden Regional Visit 2022 along with Care Quality Commission (CQC) Key Lines of Enquiry for Maternity Services and the Three Year Delivery Plan for maternity and neonatal services. We have benchmarked our service against these, which has allowed us to identify the areas for service development.

We have also included the “must do” and “should do” requirements following the January 2023 Care Quality Commission (CQC) Inspection.

Having identified the areas we need to develop, this Improvement Plan for Maternity Services focusses on all of the actions we need to take.



The National Maternity Review, published in 2016, set out a clear vision for what the provision of maternity services should look like in the future. The framework for delivery is set out under the Maternity Incentive Scheme.
There are 10 National work streams to this programme, which ensure that maternity services meet the shared goals of providing care that is ***family friendly***, ***safe***, ***personalised and professional*** and ***kind***.

There have been further updates recently published with the Three Year Delivery Plan for maternity and neonatal services.

The aim of the James Paget Improvement Plan for Maternity Services is to include the detailed information from each of the Investigation Reports, include National Guidance and recommendations from safety improvement programmes into practice along with General Medical Council (GMC) Good Medical Practice and Nursing and Midwifery Council (NMC) Codes of Professional Practice.

These reports and guidance are aligned to a specific set of expected outcomes and deliverables. Following this approach will enable transformational changes to take place over the next 3 years, with specific objectives which will be achieved in 2023/24.

Our Vision: Is to provide a safe and exemplary maternity service where women, pregnant people, babies, and their families are at the centre of how we plan and provide care.

The programme of work within this Improvement Plan for Maternity Services are aligned to 4 priorities:

Priority 1. **Ensure that standards, structures and processes are in place to deliver safe, personalised, and equitable care**
Work stream – Safe and Effective Service Provision – 'Caring for our patients'

OUR PATIENTS

Priority 2. **Grow, retain and develop our workforce in line with the needs of the service.**
Work stream – Caring, Compassionate and Competent Staff – 'Supporting Our People'

OUR PEOPLE

Priority 3. **Work with service users, staff and community voices to shape our services**
Work stream – Responsive Communication and Patient Voice – 'Collaboration with our partners'

OUR PARTNERS

Priority 4. **Create a collaborative culture of safety, learning and support through effective leadership.**
Work stream – Well-Led Continuous Improvement Culture – 'Enhancing our performance'

OUR PERFORMANCE

Priority 1 : Ensure that standards, structures and processes are in place to deliver safe, personalised, and equitable care.
SRO – Chief Medical Officer

What do we expect to achieve	What actions are we taking	What will this mean for our families
Antenatal Care, including care for patients with Diabetes • We will evidence a safer service in that pregnant people will be seen at the correct intervals. • This will lead to improved outcomes • This will support the development of our staff as decisions will be made by a multi professional team.	• We will ensure we have staffing in place to support women and pregnant people in line with national standards, and provide advice and support to inform women to make informed choices. • We will ensure we have capacity to manage women and pregnant people with Diabetes and that this care is provided at the appropriate clinical intervals.	• That we are better able to support women and pregnant people with Diabetes, and also, Gestational Diabetes during their pregnancy. This will ensure outcomes are optimized for mother and baby
Postnatal Care • We will develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward. • We will ensure that unwell postnatal women have timely consultant involvement in their care and are seen daily as a minimum whilst in hospital. • Postnatal readmissions must be seen by a Consultant within 14 hours of readmission or more urgently if necessary.	• Our medical team will review readmitted patients which will ensure we reduce the potential for incidents caused by delayed assessment. • By reducing the time women are waiting, we will support improved communication between the patient and our medical and midwifery team and clinical decisions will be made by the multi-professional team.	• Postnatal women who are readmitted to hospital will be seen by a Consultant Obstetrician within 14 hours, or sooner if clinically urgent. • As assessments are completed in a timely way, which will mean that unwell postnatal women will minimize time spent waiting to be seen in hospital.
Postnatal care for babies, and Neonatal Care • We will provide consistent care (regardless of where a baby is readmitted to hospital) with feeding support. • Medical staff will have direct access to the resuscitation team if required. • We will have dedicated space on Ward 11 for Transitional Care babies which will reduce separation.	• Immediate support will be available from the appropriate clinician where there are concerns about the baby. • This will support the delivery of a safer service and ensure families are fully informed about the next steps. • We will ensure babies readmitted for Jaundice are seen in the appropriate place to minimize separation.	• That we have staff with the appropriate skills available to support babies 24/7, which will optimize clinical outcomes. • Parental experience will be consistent, regardless of where their baby is admitted. • Parents will have consistent feeding support, regardless of where a baby is being cared for. • We will ensure that families are able to access telephone advice where they are worried about their baby.

Priority 1 (Continued): Ensure that standards, structures and processes are in place to deliver safe, personalised, and equitable care.
SRO – Chief Medical Officer

What do we expect to achieve	What actions are we taking	What will this mean for our families
Enhanced Maternal Care • We will ensure at all times we minimize separation between mother and baby. • That all our staff will be better able to identify a deteriorating patient and understand the escalation required. • The standard operating procedure (SOP) will formalise our current relationship with the Critical Care Outreach Team (CCORT). • We will have an Standard Operating Procedure (SOP) to support staff decision making and a care pathway. • We will evidence a safer service for women requiring enhanced maternal care (EMC).	• We will create a Standard Operating Procedure (SOP) to detail the current process and level of input given by Critical Care Outreach Team (CCORT) for patients needing Enhanced Maternal Care (EMC) on Central Delivery Suite (CDS). • We will review and update the current guideline for maternal transfer to Intensive Therapy Unit (ITU) or High Dependency Unit (HDU) to detail what constitutes enhanced maternal care (EMC) and who is qualified to provide this care.	• That we are able to identify any deterioration in the condition of the mother, or baby, sooner which would help us minimize separation between mother and baby. • We will be able to evidence a safe service for all women, including those who require enhanced care. • Our families can be confident in the knowledge their care needs have been identified appropriately and they will receive the correct clinical care.
Bereavement Care • Our Trust will provide bereavement care services for women and families who suffer pregnancy loss, and the follow up care should be available every day of the week. • We will ensure that there is a system so all families are offered follow-up appointments after perinatal loss or poor neonatal outcome.	• We are extending the hours for the Bereavement Midwife. • We have recruited a Midwifery Support Worker to ensure we are able to provide support to families on more days of each week. This will enable personalised care from a Bereavement specialist to provide ongoing support to the family.	• We will have staff in place to provide support and follow up care to all families suffering perinatal loss, who will also be able to onward signpost families as appropriate. • Families will feel supported at the most challenging time for them.
Governance Review and Improvements • Streamline our processes so we can demonstrate we are learning from incidents and patient complaints, and change our practice accordingly. • We will have monthly Maternity Governance Committee (MGC) meetings which will ensure learning from incidents. We will have weekly Maternity Incident Review & Escalation (MIRE) to review serious incidents. • This will support increased multi-disciplinary (MDT) working as the team will work collaboratively to review incidents. • These changed will evidence improved learning within the team.	• We are undertaking a full review of our Governance processes. • We have updated the trigger list to reinforce the issues that should be reported, and will ensure appropriate investigation into all incidents is undertaken and learning embedded in practice. • We will complete a retrospective review of outlined incidents. • We will ensure risks are on the Risk Register (RR). • We will ensure we monitor the themes and trends from incidents.	• Where incidents have impacted on patient care, we will be open and transparent about what happened, and evidence what we will change to ensure this does not happen again. • We will also share learning within the team to ensure that patient experience is improved.

Priority 1 (continued): Ensure that standards, structures and processes are in place to deliver safe, personalised, and equitable care.
SRO – Chief Medical Officer

What do we expect to achieve	What actions are we taking	What will this mean for our families
Safety Huddle Improvement • This will deliver cohesive multi disciplinary team (MDT) working , which means our women and pregnant people will receive a consistent message as staff will be communicating effectively with them about care decisions. • We will have a clear understanding of the staffing requirements for each shift based on the needs of our women and pregnant people. • Our team will work effectively together, sharing Key information.	• Relaunch of the Safety Huddle with key attendees including Consultant Obstetrician and Anaesthetist, and Midwifery staff. This will ensure we have multidisciplinary team (MDT) working effectively embedded within the service. • This will also help us improve the communication between our medical and midwifery teams, particularly around care planning and birthing choices.	• Our families will see decisions on care planning are made by the multi-professional team and will receive a consistent message, regardless of who they speak to. • All members of our team are aware of the priorities of the day so the care experience will improve as we will have the appropriate number of skilled staff in place with the relevant skills on each shift based on the level of activity. • Our staff are more aware of the expectations of our families and how we can better communicate with them around care planning.
Rostering and Job Plans • This will ensure there are enough staff on duty with the appropriate skills to support a safe service. • This will lead to an improved morale and wellbeing of staff. • The changes will ensure specialist midwives and managers work clinically on an occasional or ad-hoc basis, rather than frequently as we do at present. • For medical staff, we will ensure doctor job plans cover all required specialty roles within the service, and we will review current On Call roles to ensure we have the staff in place to review patients in a timely way.	• We will ensure that staffing is appropriate for both the activity and acuity and escalating appropriately when staffing needs are not met on a shift by shift basis. • Rosters are to be completed for all staff at least 6 weeks in advance of shift. • Completion of a full staffing review using the Birthrate+ tool (BR+) to ensure we have the staff in place to effectively support our families.	• We will ensure that we have the right staff with the relevant skills in place to deliver their care at all times. • This will ensure that women and pregnant people are consistently able to receive 1:1 care in labour.
Staff Induction and Training • We will ensure we have a well trained team who have the skills to support our families. • We will be compliant with Workforce Metrics as part of evidencing a well led service • We will ensure all of our staff are compliant with Trust Mandatory and role specific training.	• We will ensure there are comprehensive employment checks for locums and a clear induction pack for all staff joining the service. • We will ensure we provide effective leadership training to our line managers • We will embed service user feedback into our training so our staff better understand the needs of our families.	• That patients will feel reassured that we have the right staff with the relevant skills in place to deliver their care at all times. • We are listening to our families to embed the learning from their feedback into how we train our staff.

Priority 1 (Continued): Ensure that standards, structures and processes are in place to deliver safe, personalised, and equitable care.
SRO – Chief Medical Officer

What do we expect to achieve	What actions are we taking	What will this mean for our families
Audit and Documentation • We will be able to evidence a safer service through audit results, which will be shared with the team • There will be clarity for the staff on duty to escalate concerns about staffing, or patient acuity, and who they must escalate to. • This will demonstrate increasingly effective multi-disciplinary team (MDT) working, through clear escalation processes outlined for staff. • On call rosters will be shared widely with staff.	• Audit plan is required setting our the audits to be completed, and time frames. Findings/learning to be shared at Maternity Governance Committee and with all Maternity staff. • We will have a consistent approach for escalation for when consultant obstetrician attendance is required within the unit and for when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	• Our families can be reassured that their care will be safe, and that we will have the right number of staff on duty at all times to provide them with safe care. • Our team will be able to call in additional staff (medical) where the care needs of our patients require this, and the additional staff member will attend in a timely way.
Streamlining Digital Systems • Streamlining our systems will support more efficient data entry, and provide ease of access to information for staff. • We will provide streamlined reporting on activity, and staff mandatory training	• Our staff will optimize the use of appropriate prescribing on electronic prescribing and medicines administration (EPMA) an aim for one overall system to be used in the future. • Reporting information when appropriate via the Maternity dashboard. • Ensuring that there is an accurate system for the monitoring of maternity mandatory training.	• Our families will be able to obtain copies of their care records using a Subject Access Request (SAR), and when they do, their information will be accurate and complete. • All clinicians caring for the patient will have access to clinical information at each appointment.
Transitional Care • Mother and baby will be cared for in the most appropriate setting according to their needs.	• Where baby needs to remain in hospital for care postnatally or mother has ongoing postnatal care needs, we will ensure we provide care in an appropriate place to minimize separation. • We will ensure the appropriate medical and nursing support is accessible to optimise care.	• Mothers will be able to bond with their baby in a setting that is most appropriate for their needs. • Support with feeding will be consistent, regardless of where mother and baby are cared for.
Saving Babies Lives Care Bundle V2 and V3 • To meet full compliance with all five elements of the Saving Babies' Lives care bundle V2 and now 6 elements of V3.	• Evidencing compliance with all six elements of the care bundle will provide focus for the service, and help evidence safe care	• Our families can have confidence that we are not only delivering safe and effective care, but that we are able to evidence this against the Saving Babies Lives Care Bundle.

Priority 2: Grow, retain and develop our workforce in line with the needs of the service.
SRO – Director of People and Culture

What do we expect to achieve	What actions are we taking	What will this mean for our families
Enhanced Maternal Care • Staff are able to identify deterioration in a patient, and understand the escalation process in cases where enhanced support is required • With the additional training, we will achieve an enhanced skill set for staff.	• Midwives and Maternity Nurses to be given training in advanced maternal care in parallel to the onward management from Intensive Care. Standard operating procedure (SOP) to be written to support this training package setting out the escalation process. • Clear Observation Charts for staff to identify any deterioration in the condition of a patient.	• Our families can be reassured that we will have staff on shift, and clinical pathways in place to manage a deterioration in a patients condition. • Services will have been developed following feedback from our families, so we evidence tangible improvements in our care provision.
Education and Training • Training courses will ensure staff have a better understanding of patient choice and preferences, and how we should support these. • Key training will be available to appropriate staff such as: Birthrights training package, human factors, fetal wellbeing, labour ward coordinator education module, skills drills etc. • We will evidence increased multi-disciplinary team (MDT) training which will lead to improved care • Additional training opportunities will provide increased support for staff, and we expect this to lead to improved staff retention.	• We will reintroduce face-to-face training which will improve compliance. • Increasing Registrar posts will significantly improve training for our Junior Doctors. • We will support newly qualified midwives (NQMs) with a purpose-built preceptorship which supports supernumerary status during their orientation period, including support to remain within the hospital setting for one-year post-qualification. • We will complete a succession planning exercise for all staff to identify future leaders and potential skills gaps.	• Our families can feel reassured that we have a well trained, experience workforce, who will listen to their care planning decisions and be able to advise and support appropriately. • Our patients will feel reassured by the multi-professional approach to care planning, and will receive a more consistent message.
Staffing and Workforce • The service will have an appropriate level of senior midwifery Leadership support in place to deliver and sustain improvements in the service. • We will have the right number of trained staff on duty on each shift, and we will fill existing vacancies to support the team.	• We will recruit a Deputy Head of Midwifery (HoM) role and will ensure that key roles such as: Duty Manager, Clinical Skills Facilitator and Labour Ward Coordinator are in place. • We will complete a Consultant job plan review to ensure we can meet service requirements with time allocated to attend key training and meetings. • We will undertake a full review of Maternity Continuity of Carer (MCoC) and suspend if necessary. • That we are consistent with banding for roles within the service and that our staff are trained effectively for their role.	• Our women and pregnant people will receive 1:1 care in labour. • Throughout their pregnancy, our women and pregnant people will feel supported and experience safe and effective care.

Priority 3: Work with service users, staff and community voices to shape our services
SRO – Chief Nurse

What do we expect to achieve	What actions are we taking	What will this mean for our families
Patient Choices and Preferences • Our women and pregnant people will experience shared decision making with our women and pregnant people • Patient choice and personalisation of care planning will be in place in line with national requirements • Our staff will understand patient feedback and be able to adapt their practice as appropriate. • That our communication is clear, open and transparent and in line with Trust values and behaviours. • That we provide consistent information for women through antenatal classes.	• We will work with service users and our Maternity and Neonatal Voices Partnership (MNVP) on shaping service development. • Ensure we are providing women with information to make informed choices about their care. Ensure that we are sharing feedback and learning from complaints and patient feedback with all members of staff to demonstrate we are caring and transparent. • That we are gathering feedback from families through Friends and Families.	• Women and pregnant people will be better informed to make birth choices appropriate to them and understand the options available to them • Our information will be consistent, and will better support all of our women and pregnant people in pregnancy to make the choices appropriate for them
Patient Documentation and Communication • We will better evidence robust care planning is documented • We will be better able to deliver personalised, individualised care • Improved understanding and clarity for patients will improve the patient to clinician relationship • We will have an improved digital presence online. • We will continue to work with service users through baby loss awareness groups to provide compassionate, individualised, high quality bereavement care for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway. • We will minimize any delay in patient counselling following bereavement • Anaesthetists must be proactive in recognising situations where improved explanations may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	• Following complaints, or an investigation, we will ensure that the language used in reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms. • We will provide women who choose to birth outside a hospital setting accurate and up to date written information about the transfer times to the Central Delivery Suite (CDS) in line with local ambulance trust agreements. • We must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth.	• Our families will find it easier to digest the content of our complaint responses, and investigation reports. This will enable improved understanding between the hospital and our families • The support provided to families following the loss of a baby will be improved in terms of timeliness, and availability of staff trained to support families following bereavement. • Women and pregnant people who choose to birth at home will understand transfer times in the event they need to change their delivery plans during labour. • Our families will find it easier to access information about Maternity Services online to be better informed about their care planning options.

Priority 4: Create a collaborative culture of safety, learning and support through effective leadership.
SRO – Chief Operating Officer

What do we expect to achieve	What actions are we taking	What will this mean for our families
Data and Reporting • Maternity Services will be able to clearly monitor key performance indicators (KPIs) as a way of measuring the effectiveness of the service. • This reporting will provide assurance to Trust Board regarding activity data, incidents and themes, including patient and staff experience measures. • This will ensure that the Trust board has oversight of the quality and performance of the maternity service. • There will be clear pathways of care for provision of neonatal care.	• We are developing clear methods of performance monitoring, which will support us to evidence improvements in service delivery. • Our reports will be visual and clear and will evidence accountability. • We are developing a formal structure for triumvirate leadership. This will include underpinning systems and processes to provide assurance to our Trust Board and stakeholders that the measures in place to monitor the safety and performance of the service are robust.	• Our women, pregnant people and their families can feel assured that Maternity Services have addressed the issues identified by the CQC, and they can feel confident that their care at James Paget will be excellent. • That where a baby is admitted to the Neonatal Unit, we are able to minimize separation. • Where families have questions about their care, they will be involved in the response and we will use language that is clearly understood.
Staffing and Workforce • We will demonstrate that risks relevant to the delivery of Maternity Services will be managed effectively, and robustly. • We will have appropriate Consultant and Midwifery support dedicated to the lead roles which will ensure the improvement in patient care and experience. • We will ensure that the additional investment in Maternity Services has addressed the staffing required to support effective service delivery. • There will be increased opportunities for staff to have their voices heard, which will ensure all staff feel valued and have the skills and time to be effective in their role. • By increasing the number of Obstetric and Gynaecology (O&G) Registrar level posts, we will improve the teaching experience for our Registrars and Junior Doctors.	• We are recruiting: Obstetric Consultant dedicated to Obstetric Governance, Obstetric Clinical Lead and other key clinical leadership roles. A Quality & Audit Midwife within the risk and governance team. • We will increase teaching to support our staff provide information in regards to patient preferences and choices. • We will finalise Consultant job plans and specialist job roles. • We will ensure we have Professional Midwifery Advocates (PMA's) available to increase presence in clinical areas and offer scheduled drop ins for staff. Professional Midwifery Advocate (PMA) work plan to be in place for the remainder of 2023. • We will have workshops to develop shared vision for the service and to circulate to team for input. • All clinicians with responsibility for maternity governance will be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	• Where families have given feedback about their care, we will provide assurance that we have learned from their experience, and be able to demonstrate the learning has been shared to improve the care for other women and pregnant people. This should give our families increased confidence in the delivery of their care.

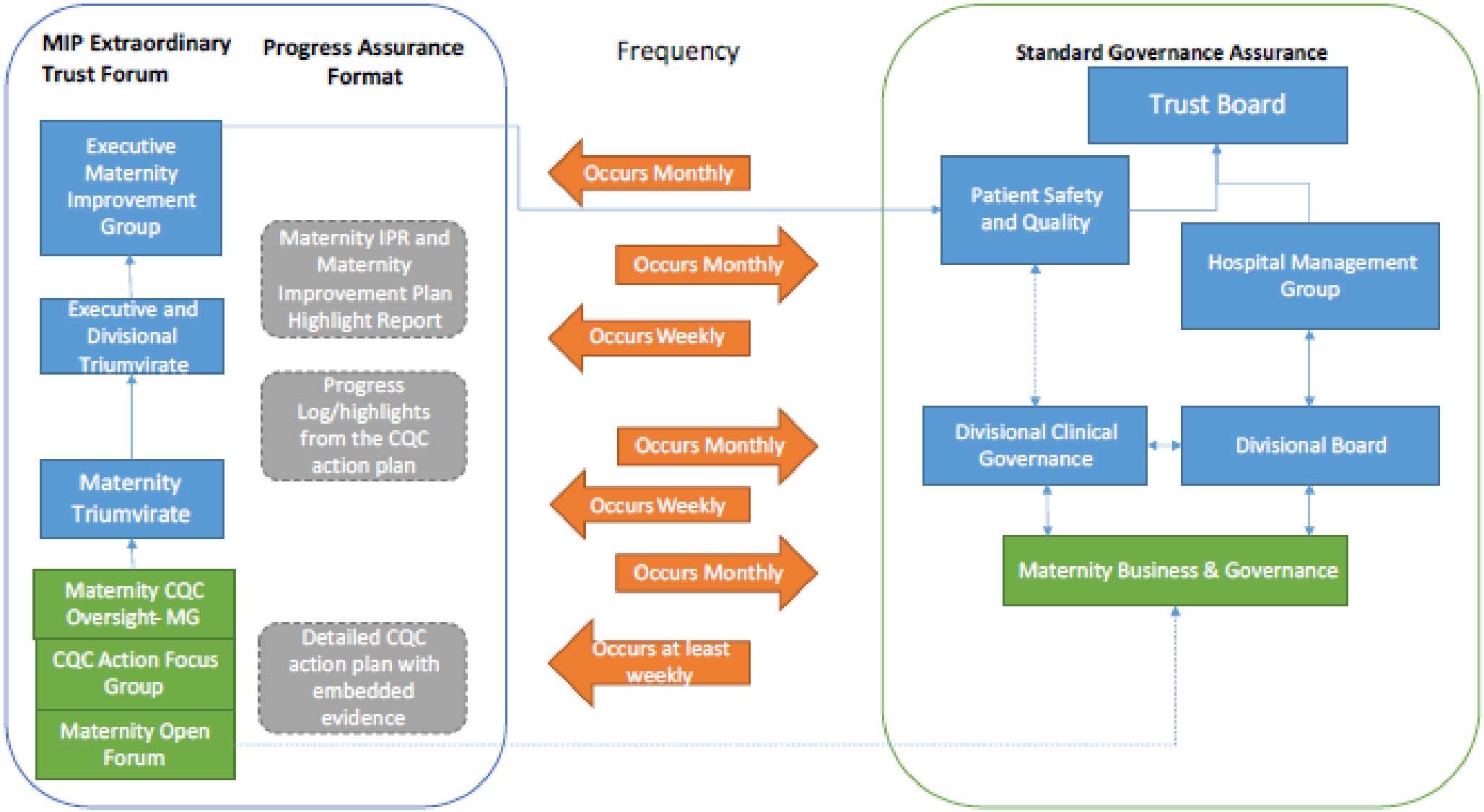
Priority 4 (Continued): Create a collaborative culture of safety, learning and support through effective leadership.
SRO – Chief Operating Officer

What do we expect to achieve	What actions are we taking	What will this mean for our families
Education and Training • Our patient records will be accurate and we will demonstrate we have contemporaneous patient notes which are accessible to all clinicians involved in the care of the patient. • We will have an improved culture within Maternity Services and staff will feel valued. • The learning experience of our junior doctor workforce will be significantly improved. Trainees will have increased teaching to gain sub-specialty expertise, and be an integral part of the learning cycle within the service for audit, incidents and patient feedback. • There will be increased education and training opportunities for staff. • Our Professional Midwifery Advocate (PMA) will support all members of staff to raise concerns, or make suggestions about changes they would like to see within the service.	• We are developing an education package to support staff training on record keeping and documentation. • This will be supported by a standard operating procedure (SOP) for maternity record keeping and documentation. • We will mimic the leadership to care programme and offer this to all staff. • Staff will be offered the opportunity to raise concerns across various platforms and remind them of the routes of escalation. • We will increase Professional Midwifery Advocate (PMA) presence. • Creation of skills amnesty for all staff. Rollout of an emergency skills drills schedule in all clinical areas. • Band 7/8 midwives must be allocated an experienced mentor to support their transition into leadership and management roles. • We will develop a competency package for Midwifery Manager on Call.	• Our women and pregnant people will be cared for by highly trained staff, who work effectively together. • Our families can feel confident that the staff caring for them are also supported effectively and are well trained. • The experience of our families will improve throughout their pregnancy journey with us.
Documentation and SOPs • That we are able to evidence effective shift handovers. • That we have empowered our staff to speak up where they have concerns and that they can be confident these will be addressed. • Through improved multi-disciplinary team (MDT) working, we will improve shared learning within the multi professional team. • With an open safety culture, easy access to Policies and Guidelines and through effective shift handovers, these will evidence a well led, safe and effective clinical environment	• We will develop and maintain a ‘conflict of clinical opinion’ policy to support staff members in being able to escalate their clinical concerns regarding a woman’s care in case of disagreement between healthcare professionals. • Midwifery-led units must complete yearly operational risk assessments. • Access to Policies and Guidelines to be streamlined, including using quick response (QR) codes.	• Our patients can be confident in our care knowing that all members of staff are able to escalate clinical concerns in an effective way. • All of our staff will be fully informed about the workload for the team throughout the shift, so our families can receive individualized and personalized care.

In order to support the oversight to evidence how effective we have been in the delivery of the Improvement Plan for Maternity Services, we have also completed a review of the Governance and oversight processes within Maternity Services. This review has ensured that we have a framework in place to robustly monitor the effectiveness of the improvement of the changes as we implement them, and also how we are monitoring the ongoing delivery to ensure changes are sustainable.

The detailed steps and activities for this cycle are illustrated on slides 7 to 14, along with the accountability framework and how progress updates are to be reported. The oversight for this cycle is the Trust's Standard Governance Assurance Framework (slide 16) . The Accountability Framework is on slide 17.

Maternity Improvement Plan (MIP) and Standard Governance Assurance



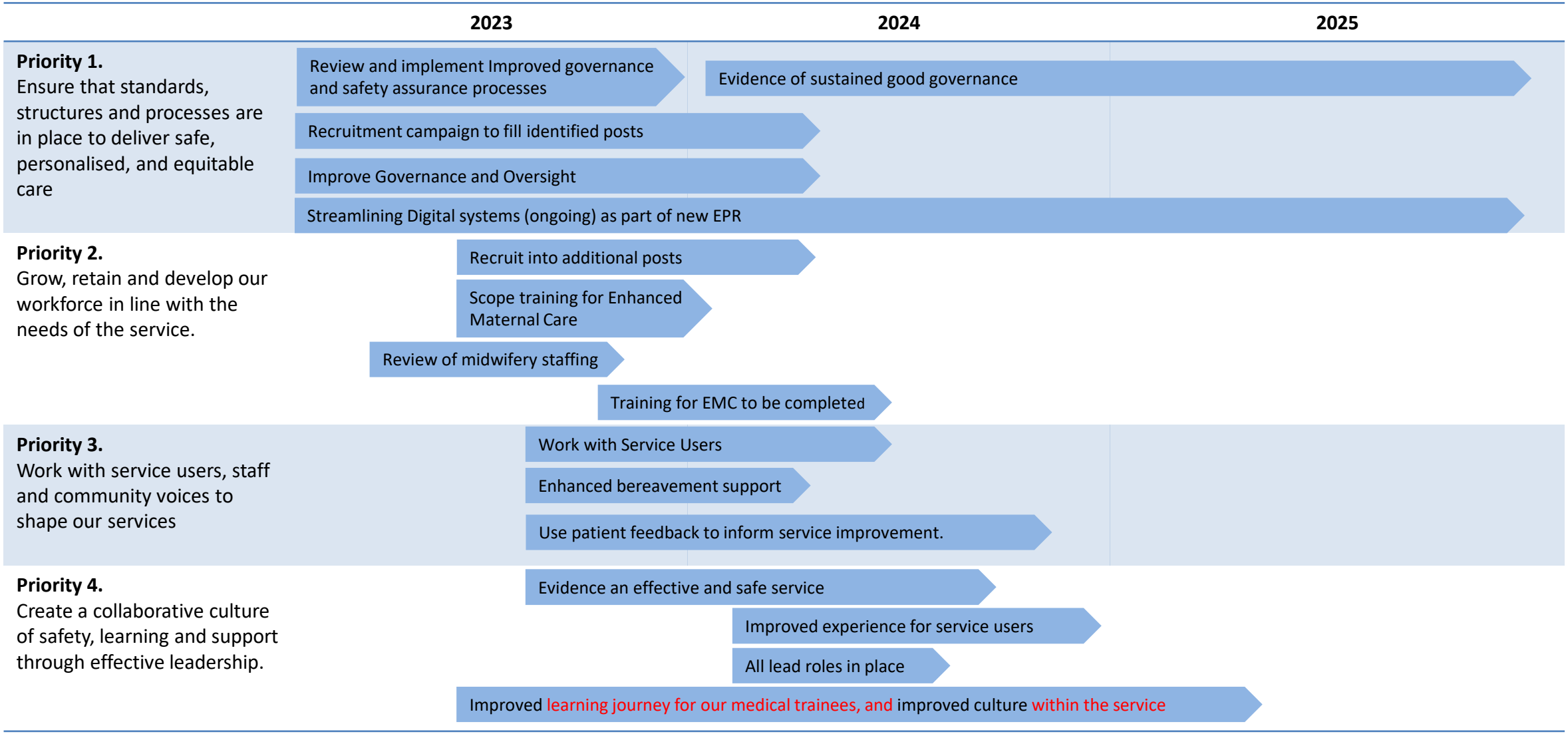
Accountability Framework

This sets out the responsibilities for all of our staff, and how the hospital leadership team will have oversight of the rate of improvement within Maternity Services. This framework will also provide assurance that changes have been made and are embedded in practice.

Board of Directors	1. Ensuring we have realistic delivery plans underpinning each workstream which support overall improvement of maternity services 2. Assurance on progress through the Board of Directors.
Patient Safety and Quality Committee	1. Supporting delivery through effective challenge and monitoring against plans 2. To lead staff in line with the direction and achievement of delivery plans 3. Escalating key issues to delivery to Trust Board of Directors when required
Executive Maternity Improvement Group	1. Ensuring that each priority has a clear plan for delivery. 2. Reporting against key metrics within each workstream and developing remedial actions where projects are not on track. 3. Adopting an open and honest approach with Divisional Leads and updating on any support required.
Maternity – Divisional Governance	1. Ongoing monitoring of maternity service improvement from a divisional perspective. 2. Providing support to Executive Maternity Improvement Group if required. 3. Ongoing monitoring of key metrics for maternity which are agreed as Business as Usual.
Maternity Service Staff	1. Consistently striving to achieve the priorities and deliverables included within the Improvement Plan. 2. Engaging in opportunities to continuously improve our services 3. Taking responsibility for a personal and professional growth and development.

Steps	1	2	3	4	5
	Agree Improvement Plan Goals	**Develop Improvement Plan**	**Deliver Improvement Plan**	**Monitoring, Reporting and Sustainability**	**Governance and Assurance**
Activities	Align local, regional and national strategic targets	Identify, quantify and agree focus of projects	Set KPIs, resource and implement plans; assess impact	Monitor and report progress against KPIs and identify and escalate risks/issues	Seek assurance, make decisions, resolve issues and support risk management
Accountability					
Improvement SRO	Agree focus areas	Agree priority list	Oversee delivery Challenge delivery Align assumptions	Report and provide assurance Resolve issues	Seek assurance Decision making Manage risks
JPUH Change Resource	Support development of goals	Completion of project documentation – outcomes/ KPIs, any risks	Support delivery and managing milestones/ action completion	Monitor, measure and collate progress report	Support BAU handover when required
Delivery Teams – Clinical, Ops, Admin Processes	Input clinical / operational priorities	Identify key areas for improvement	Agree KPIs Implement plans Plan for BAU	Report progress	Handover to BAU when required
Updates	Improvement team mobilised as part of Executive Maternity Improvement Group which CEO Chairs	All guidance documents relating to maternity used to inform approach **Priorities established from all local, regional and national requirements**	Agreement of workstreams and leads for each **Workstreams proposed and clear milestones and targets in development for each.**	Specific projects to deliver along with SMART outcomes developed aligned to workstreams **Once workstream structure in place, these can be agreed.**	**Ongoing –** reporting structure agreed, Maternity Group, Patient Safety Committee and Trust Board.	**Ongoing –** agreed template to update against each workstream and any escalations required.

The delivery timeline for actions within this Improvement Plan



Appendix A

The GMC Good Medical Practice (gmc-uk.org) outlines four distinct domains in the provision of medical care
The NMC Code of Professional Practice (nmc.org.uk) outlines four distinct requirements in the provision of maternity care
Saving Babies Lives Care Bundle Version 2: Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-Final-Version.pdf (england.nhs.uk)
Maternity Incentive Scheme Year 4: Maternity incentive scheme - NHS Resolution
OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (ockendenmaternityreview.org.uk)
The Maternity and Neonatal Safety Improvement Programme supports five national workstreams, applying quality improvement methodology to the continuous improvement of services.
The Three Year Delivery Plan for Maternity and Neonatal Services (NHS England » Three year delivery plan for maternity and neonatal services) aims to make care safer, more personalised, and more equitable,
The CQC (Care Quality Commission (cqc.org.uk) domains assess maternity services against five key areas including; Safe, Effective, Caring , Responsive, Well Led
We work closely with our Maternity Voices Partnership (Birth Voices East (Maternity Feedback) - Home) to co-produce services, ensuring that the experience of our service users supports the development and progression of maternity services which meet the needs of those accessing care.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1111992/reading-the-signals-maternity-and-neonatal-services-in-east-kent_the-report-of-the-independent-investigation_print-ready.pdf