Appendix 2

Pride in Pennine | Quality-Driven Responsible Compassionate

The Pennine Acute Hospitals NHS Trust

Maternity Improvement Plan

Introduction

The purpose of the maternity improvement plan is to respond to an external review of maternity services that took place in 2014, ensure alignment with best practice and also to integrate learning from the Kirkup investigation into Morecambe Bay Foundation Trust. It is recognised as a continuous improvement document and with Incident Management Group approval may be subject to adjustment to best reflect the needs of the families we serve.

This document aims to outline how the Trust will implement the changes necessary as a result of the incidents and subsequent investigation that took place. The document will provide an overview of the high level targets and milestones that we will achieve as a Trust over the coming year.

From the external review twelve recommendations were made:

1. Staffing issues where safety is compromised must be appropriately escalated, and must include involvement of the duty Supervisor of Midwives.

2. Managers must ensure that the process for escalating concerns is clear.

3. The process for employing and managing locum doctors should be reviewed.

4. The directorate should review its management of obesity in pregnancy, labour and the postnatal period, and that guidelines are appropriately implemented.

5. All serious incident reports should be 'quality checked' before submission, to ensure that the root cause clearly established.

6. Recommendations made by the serious incident review panel must be clear and unambiguous.

7. Where individual failings have been identified, the reports must demonstrate that training/educational needs have been considered.

8. Senior managers must ensure that training / educational needs are addressed where leadership has failed.

9. Serious incident reviews must be signed off by a nominated senior manager from the appropriate specialty.

10. The directorate should ensure that all mandatory training is up to date for all disciplines of staff, including record keeping and interpretation of CTG.

11. All available methods should be used to ensure that standards of documentation are improved where necessary.

12. The Trust must be assured that a robust system is in place to ensure the regular and timely review, implementation and audit of guidelines in accordance with Trust policy.

What have we done to ensure improvement?

We have developed and commenced implementation of this specific and targeted service improvement plan to meet all of the recommendations put forward from the external review, and to deliver best practice.

The aim of the improvement plan is to increase the levels of care, safety and quality throughout the whole of Maternity services through:

- Ensuring all Staff, Obstetricians, Midwives and support staff are well trained.
- Ensuring clinical guidance is robust and followed providing a safe and sustainable maternity service.
- If incidents occur, we learn from them and are open and transparent with families, ensuring that we meet our Duty of Candour requirements.
- Ensuring that if a Serious Incident (SI) should occur, the process that follows is in line with the new national framework.

The Maternity Improvement Plan was developed based on these themes and linked to the Care Quality Commissioning (CQC) five key questions they ask to measure quality of services:

- **Are they safe?** (Are people are protected from abuse and avoidable harm?)
- **Are they effective?** (Does our care, treatment and support achieve good outcomes, promote quality of life, and are based on the best available evidence?)
- **Are they caring?** (Do staff involve and treat people with compassion, kindness, dignity and respect?).
- **Are they responsive to people's needs?** (Are services are organised so that they meet people's needs?)
- **Are they well-led?** (Leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture).

How we are going to implement our improvement plan

The plan will be delivered by:

- Increased patient safety through better quality care provision.
- Ensuring best practice is adhered to by robust auditing, evaluation and lessons learned.
- Benchmarking and setting standards of care levels in order to continually improve.

- Developing robust training programmes to ensure all clinical staff have the skills and experience required to provide the highest level of care.

- Conducting continual patient feedback exercises to ensure the service provided meets the needs of patients and their families.

- Embedding service improvement methodology to facilitate continual update and improvement of services.

- Integrating services across the Trust to ensure a smooth patient pathway and flow through the NHS system of care.

- Incorporating project management tools and techniques so as to assure the changes are implemented successfully.

- Continuous and on-going implementation of the Service Improvement Plan.

The full and detailed improvement plan is attached.

Gill Harris
Chief Nurse

June 2015

Pennine Acute Hospitals Trust - Maternity Improvement Plan

Executive Lead: Gill Harris (GH)
Project Owner: Jo Keogh (JK) / Gaity Ahmad (GA)
Medical Lead: Jonathan Moise (JM)
Professional/Clinical Lead: Cathy Trinick (CT)
Document Owner: Chris Chapman (CC)
Project Team: Jo Keogh (JK), Gaity Ahmad (GA), Cathy Trinick (CT), Jonathan Moise (JM), Morag Preston (MP), Chris Chapman (CC), Kimberley Salmon-Jamieson (KSJ) Belinda Jackson (BJ), Harry Vallance (HV), Chitra Jain (CJ), Paul Thornburn (PT) Kate McCartney (KMC), Eileen Stringer (ES), Caroline Rice (CR), Gillian Morton (GM), Sachin Maiti (SM), Denise Woods (DW), Christine Southall (CS), TBC Obstetric Leads (OL), Andrew Lynn (AL), Marcia Wild (MW) Ursula Martin (UM), Debbie Gould (DG), Kath Hingley (KH) Jon Lenney (JL), Anton Sinniah (AS), Gill Harris (GH), Cath Nee (CN), Jonathan Kenworthy (JK(A)), Victoria Hall (VH), Jane Harper (JH) Christine O'Loughlin (COL), Helen Hindle (HH), Viv Twomey (VT), Gareth Edwards (GE)

Status
Overdue
Extension Agreed (GOLD/IMG)
On Track
Complete

Key

EDS	**Educational Supervisor**
SOM	**Supervisor of Midwives**
DT	**Directorate Triumvirate**

Evidence Levels

Level 1 - document/policy generation
Level 2 - implementation/communication/roll-out
Level 3 - evaluation audit and testing

Updated: 15th June 2015

Update:
General - Need to align this plan, the exception reports and the Risk log (DG)

Safe
1.1 - RCA Training workshop title updated
1.1c - 11 places to allocate; Cath Nee to work with Matrons to draw up list of names for next course
1.2 - To go to Trust Board for final ratification
1.3 - Cathy Trinick to discuss with Jon Lenney regarding timescales
1.3c - Pulse check to be re-opened.
1.4c - Collating feedack until the end of June. Sign insheets / minutes to CO'L.
1.5c - Midwifery complete. Paediatric and Neonatal medical not yet complete. O&G Trust doctors complete. O&G locum doctors ongoing. Working to timescales described.
1.5d - Weekly monitoring meeting to be set up; DG to send the TOR to CN
1.6c - Process reviewed. Draft feedback letters ready. Evidence to be logged (letters, proforma). Discussion that potentially not sufficiently reviewed. ?T&F group.
Better use of the Feedback function on Safeguard.
2.1b/c - Still being tested.
2.1d - To review in light of live operational testing 12/06/2015; potential lessons to learn from this event
2.1f - Set up after action review of major escalations (e.g. diverts)
3.1a/b - Check with CO'L JK
3.1c - Closed
4.2a - Completed, however, queries raised at IMG which cannot be answered completely from the Audit data set collected. To be highlighted as risk.
5.1l - CTG Training to be included on the TOR for this group
5.1n - Update on training position given.
7.1c - Evidence required changed from '1' to '3'. To map appraisal / TNA / rotational patterns together. Exception report and extension to be requested.
7.1d - Closed. Evidence to be logged

Caring
5.1b - Audit of specific cases where transfer has occurred to see if communication is working well.

Effective
1.1e - Agreed to remain annually. Log TNA into evidence. Issue to be resolved around training capacity.
1.4d - DG to check with GH regarding any feedback from the initial feedback sessions to be added to the plan. Analysis of the submissions from the online submission.

Responsive
1.1a - DG to pick up with MM.

Well Led
1.1b - To discuss at GOLD.
1.1o - Extension agreed. National paper just been published.

IMPROVEMENT PLAN 1 - SAFE

No	ACTION	Executive/Divisional OWNER	Operational Lead	Evidence Logged	Evidence Level	STATUS	Week Beginning: 13/04/2015	20/04/2015	27/04/2015	04/05/2015	11/05/2015	18/05/2015	25/05/2015	01/06/2015	08/06/2015	15/06/2015	22/06/2015	29/06/2015	06/07/2015	13/07/2015	20/07/2015	27/07/2015	03/08/2015	10/08/2015	17/08/2015	24/08/2015	31/08/2015	07/09/2015	14/09/2015	21/09/2015	28/09/2015	05/10/2015	12/10/2015	19/10/2015	26/10/2015
1	**Serious Incident Investigations**																																	
1.1	**Root Cause Analysis Training (Effective Investigations Workshop)**	UM																																
1.1a	Commission training and identify key individuals for training places (Effective Investigations Workshop)	UM	CN	Y	1	C																												
1.1b	Initial training sessions for 8 individuals within W&C	UM	CN	Y	2	C																												
1.1c	Evaluate training and identify future training needs	UM	KH		3	C																												
1.2	**Review of serious untoward Incident policy**	UM	KH		1	OD																												
1.3	**Staff Survey and other Feedback Mechanisms**	JL	PT																															
1.3a	Review staff survey results regarding perception of providing care in safe environment	JL	PT		1																													
1.3b	Revised staff engagement strategy, launch and future actions	JL	PT		123																													
1.3c	Review Pride in Pennine feedback from staff and incorporate relevant feedback	JL	PT		1																													
1.4	**3 year retrospective review**	UM	COL/HH																															
1.4a	Undertake 3 year retrospective review of all incidents in maternity (inc STEIS status)	UM	COL/HH	Y	1	C																												
1.4b	Discuss review findings at Maternity Improvement Management Group	GA	COL	Y	1	C																												
1.4c	Share themes found to the wider clinical teams for the purposes of feedback, learning and awareness	GA	COL	Y	1, 2	OD																												
1.4d	identify any themes or areas of concern not addressed in current action plan and add as required	GA	COL	Y	1	C																												
1.5	**Any concerns regarding individuals from the external review are actioned through appropriate channels**	AS/GH	JM/CT																															
1.5a	Review external review document and SUI RCAs	AS/GH	JM/CT	Y	1	C																												
1.5b	Identify any individuals concerned and raise with registered bodies / training needs as required	AS/GH	JM/CT	Y	2	C																												
1.5c	Individual meetings and plans agreed and monitored accordingly	AS/GH	JM/CT		2,3	OD																												
1.5d	On going monitoring as required	AS/GH	JM/CT		3																													
1.6	**SUI Processes**	UM	JK/GA																															
1.6a	Agree revised SUI initial escalation, allocation, and sign off processes	UM	CO'L/DG		1	OD																												
1.6b	Circulate standard to all undertaking reviews	UM	JK/GA		2																													
1.6c	Review process for feedback to staff and sharing of lessons learned	UM	JK/GA		1																													
1.6d	Ongoing monitoring that SUI recommendations are appropriately incorporated and executed in action plans	UM	JK/GA		123																													
1.7	**Ensure improvements in Divisional SUI processes are embedded and sustained**	JM/CT	CN	Y																														
1.7a	Undertake audit (and peer review with other divisions)	JM/CT	SM		3																													
1.7b	Set up ongoing monitoring and audit programme	JM/CT	SM		1																													
2	**Escalation (staff/resource issues)**																																	
2.1	**Staffing Escalation Tools**	CT	ES/BJ/KMC																															
2.1a	Escalation tool (midwifery staffing) reviewed and revised	CT	ES/BJ	Y	1	C																												
2.1b	Revised midwifery staffing escalation tool launched (rounding tool) and circulated (An electronic version of the rounding tool to be developed, tested, and implemented electronic version awaited)	CT	ES/BJ	Y	2	OD																												
2.1c	Revised medical staffing escalation tool developed (in rounding tool 2.1b) An electronic version of the rounding tool to be developed, tested, and implemented	JM	KMC	Y	2	OD																												
2.1d	Revised maternity unit operational process for escalation / closures	AS/GH	JK/GA/KMC	Y	1	OD																												
2.1e	Guidance for on-call managers and directors distributed	CT	CC/KMC		2	OD																												
2.1f	Develop routine monitoring of escalation	CT	VT/BJ		1	OT																												
2.1g	Ongoing monitoring of compliance and results of escalation	ES	VT/BJ		3	OT																												
2.1h	Review escalation tool and amend as required	ES	VT/BJ	Y	1	C																												
2.2	**Ward Rounds**	JK/GA	MP/ES/BJ/VT																															
2.2a	Review current ward round and rounding tool arrangements for ante-/labour/post-natal wards	JK/GA	MP/ES	Y	1	C																												
2.2b	Develop and agree revised ward round schedule	JK/GA	MP/ES		1	C																												
2.2c	Implement new process, including visual presentation of rounding tool	CT	BJ/VT		2																													
2.2d	Evaluate impact of new process against agreed criteria	CT	BJ/VT		3																													
2.2e	Further review if required	CT	BJ/VT		1																													
2.3	**Review local criteria and process of employing locum doctors in maternity**																																	
2.3a	Develop and agree local locum policy	GA	CC/KMC	Y	1	C																												
2.3b	Implement and disseminate new policy	GA	CC/KMC	Y	2	C																												
2.3c	Audit compliance with local policy	GA	CC/KMC		3																													
2.3c	Revise policy if required	GA	CC/KMC		1																													
3	**Documentation and Review of Maternity Records Policy**																																	
3.1a	Review and revise if required Maternity Records Policy	JK	SM	Y	1	C																												

IMPROVEMENT PLAN 1 - SAFE

No	ACTION	Executive/Divisional OWNER	Operational Lead	Evidence Logged	Evidence Level	STATUS	Week Beginning: 13/04/2015	20/04/2015	27/04/2015	04/05/2015	11/05/2015	18/05/2015	25/05/2015	01/06/2015	08/06/2015	15/06/2015	22/06/2015	29/06/2015	06/07/2015	13/07/2015	20/07/2015	27/07/2015	03/08/2015	10/08/2015	17/08/2015	24/08/2015	31/08/2015	07/09/2015	14/09/2015	21/09/2015	28/09/2015	05/10/2015	12/10/2015	19/10/2015	26/10/2015
3.1b	Circulate standards to all staff, especially contemporaneous record keeping	JK	SM	Y	2	C																												
3.1c	Undertake baseline retrospective audit against criteria	JK	SM		3																													
3.1d	Devise system / tool to allow for individuals to receive feedback on their documentation if requires improvement	JK	SM		1	C																												
3.1e	Repeat retrospective audit	JK	SM		3																													
4	**Policies and Guidelines**																																	
4.1	**Anaesthetic Assessment Clinics**	ES	HV/JK(A)																															
4.1a	Antenatal anaesthetic clinics set up at NMGH and ROH		HV/JK(A)	Y	1	C																												
4.1b	Review and amend (if required) criteria for referral and/or assessment	ES	HV/JK(A)	Y	1	C																												
4.1c	Launch revised guidelines and implement	ES	HV/JK(A)		2	C																												
4.1d	Audit compliance and clinical effectiveness	ES	HV/JK(A)		3																													
4.2	**Review guidelines for Induction and Augmentation of Labour (inc. Propess)**			Y		C																												
4.2a	Audit of revised guidelines	JK	VH/CR	Y	3	C																												
4.2b	Audit results presented to Divisional Quality and Performance meeting	JK	VH/CR		2																													
4.3	**PROMPT mandatory training revised to include EWS**			Y	1	C																												
4.4	**Patient Care Alert re EWS/PET/ Thrombocytopenia**			Y	1,2	C																												
4.5	**Transfusion Guidelines**	JM	GM		1																													
4.5a	Update neonatal transfusion guidelines	JM	GM	Y	1	C																												
4.5b	Reminder to all staff regarding transfusion guidelines	JM	GM	Y	2	C																												
4.5c	Audit of compliance to revised guideline	JM	GM		3																													
4.6	**Fetal Growth Assessment**																																	
4.6a	Growth Assessment Programme for SFH measurement introduced				1	C																												
4.6b	Growth Assessment Programme incorporated into mandatory training				2	C																												
4.6c	Agree and trajectory for training completion and monitor	JM/CT	HH	Y	3	C																												
4.6d	Six-monthly rolling audit programme (10 sets of case notes) to measure GAP compliance	JM/CT	BJ/VT		3																													
4.6e	Analysis and presentation of audit findings to Divisional Q&P	JM/CT	BJ/VT		2																													
4.7	**Review Birth Centre Operational Guidelines**																																	
4.7a	Review guideline, especially in light of changes to Induction of Labour	JM/CT	COL	Y	1	C																												
4.7b	Sign off at Divisional Q&P	JM/CT	COL	Y	1	C																												
4.7c	Audit of compliance to revised guideline	JM/CT	COL		3																													
4.8	**Review Recognition & Management of the ill Pregnant Woman guideline**			Y	1	C																												
4.8a	Audit of compliance to revised guideline				3																													
4.9	**Review Guideline for Management of Asymptomatic Neonates at risk of early onset sepsis**			Y	1	C																												
4.9a	Guideline uploaded and implemented	JM	GM	Y	2,3	C																												
4.9b	Neonatal & Paediatric sepsis task and finish group set up	JM	GM	Y	1	C																												
4.9c	Patient Care Alert circulated re IV antibiotic administration	JM	CN	Y	2	C																												
4.9d	Audit of compliance to revised guideline	JM	GM	Y	3																													
5	**CTG**																																	
5.1a	Task and finish group set up			Y	1	C																												
5.1b	CTG master classes held at both sites			Y	1	C																												
5.1c	Rolling Programme for replacement monitors developed	GA	JS	Y	1	C																												
5.1d	Monitoring of replacement programme	GA	JS		3	OT																												
5.1e	Sign up to safety bid to purchase and implement Central Monitoring System				1	C																												
5.1f	CTG Training plan trajectory to be confirmed	JM/CT	HH	Y	1	C																												
5.1g	Implement short term process to mitigate risk whilst minimum number of trained staff achieved			Y	2	C																												
5.1h	Monitoring delivery of training against trajectory and take corrective action as needed. Report to GOLD regularly	JM/CT	HH	Y	3	C																												
5.1j	Escalation flow chart developed - Fetal Monitoring and Fetal Blood sampling				1	C																												
5.1k	Flow chart Ratification	GA	HH		2	C																												
5.1l	Central CTG monitoring implementation Task and Finish Group	CT	ES/HH/GE		1	OT																												
5.1m	Develop implementation plan for central CTG monitoring following successful bid	CT	ES/HH/GE		1	C																												
5.1n	Monitoring of the CTG trajectory and update following the revised NICE guidance	CT/JM	HH		3	OT																												

IMPROVEMENT PLAN 1 - SAFE

No	ACTION	Executive/Divisional OWNER	Operational Lead	Evidence Logged	Evidence Level	STATUS	Week Beginning: 13/04/2015	20/04/2015	27/04/2015	04/05/2015	11/05/2015	18/05/2015	25/05/2015	01/06/2015	08/06/2015	15/06/2015	22/06/2015	29/06/2015	06/07/2015	13/07/2015	20/07/2015	27/07/2015	03/08/2015	10/08/2015	17/08/2015	24/08/2015	31/08/2015	07/09/2015	14/09/2015	21/09/2015	28/09/2015	05/10/2015	12/10/2015	19/10/2015	26/10/2015
6	**Equipment**																																	
6.1a	Stock take of all equipment within Maternity	JK/GA	JS/CC/JB		1																													
6.1b	Draw up rolling equipment replacement programme	JK/GA	JS/CC/JB		1																													
7	**Birth Rate Plus (BR+) Review and Medical Workforce Model**																																	
7.1a	Commission and receive feedback from external BR+ review	GH	CT	Y	1	C																												
7.1b	Consider BR+ recommendations	GH	CT	Y	1	C																												
7.1c	General review training and skills of staff (Training Needs Analysis)	DG	JH/CS/BJ/VT		1	OT																												
7.1d	General review allocation method of staff vs. patient risk	DG	JH/CS/BJ/VT		1	C																												
7.1e	Recruitment and training of new staff (HCAs)	CT	VT/BJ/DC/DW		2	OT																												
7.1f	Review medical workforce model	JK/GA	CC/MP		1	C																												

IMPROVEMENT PLAN 2 - EFFECTIVE

No	ACTION	Executive/Divisional OWNER	Operational Lead	Evidence Logged	Evidence Level	STATUS	Week Beginning: 13/04/2015	20/04/2015	27/04/2015	04/05/2015	11/05/2015	18/05/2015	25/05/2015	01/06/2015	08/06/2015	15/06/2015	22/06/2015	29/06/2015	06/07/2015	13/07/2015	20/07/2015	27/07/2015	03/08/2015	10/08/2015	17/08/2015	24/08/2015	31/08/2015	07/09/2015	14/09/2015	21/09/2015	28/09/2015	05/10/2015	12/10/2015	19/10/2015	26/10/2015
1	**Clinical Risk Management**																																	
1.1	**Risk assessment and identification of deteriorating patient**																																	
1.1a	Baseline audit of all training records for PROMPT compliance	JK	HH		3	C																												
1.1b	Baseline audit of EWS use	JK	VT/BJ		3	C																												
1.1c	Identify training course dates and book all staff required	JK	HH		1,2	C																												
1.1d	Audit training records to check completeness of training	JK	AD/SM/PW/CB		3	OT																												
1.1e	Agree EWS and PROMPT training frequency for mandatory training	JK	AD/SM/PW/CB		1	C																												
1.2	**Review pathways of care, risk factors and early referral**																																	
1.2a	Review instrumental delivery guidelines	GA	COL	Y	1	C																												
1.2b	Circulate revised pathways of care for comments	GA	COL	Y	2	C																												
1.2c	Submit revised guideline to Divisional Q&P for ratification	GA	COL		1	OT																												
1.2d	Dissemination of revised pathways to medical staff	JM	COL/IS		2	OT																												
1.2e	Dissemination of revised pathways to midwifery/HCA staff	CT	COL/IS		2	OT																												
1.2f	Audit of compliance with revised pathways	GA	COL		3																													
1.2g	Individual feedback of instances of non-compliance	GA	JM/CT		2																													
1.2h	Training / capability / conduct action where required	GA	JM/CT		2																													
1.2J	Ensure Crash Bleep protocol is disseminated and displayed clearly	CT		Y	2	C																												
1.3	**Obesity management**																																	
1.3a	Review and revise obesity guidelines	ES		Y	1	C																												
1.3b	Develop obesity clinical management plan template	ES		Y	1	C																												
1.3c	Circulate revised guideline and template for comments	ES			2	C																												
1.3d	Submit revised guideline to Divisional Q&P for ratification	ES			1	C																												
1.3e	Dissemination of revised pathways to medical staff	JM			2	C																												
1.3f	Dissemination of revised pathways to midwifery staff	CT		Y	2	C																												
1.3g	Prospective audit of compliance with revised guideline	ES	SB/VG/MT		3																													
1.3h	Individual feedback of instances of non-compliance	JM/CT	EdS/SOM/MP		1																													
1.3i	Training / capability / conduct action where required	JM/CT	EdS/SOM/MP		2																													
1.4	**Staff engagement**																																	
1.4a	Feedback and engagement events	AS/GH	CT/GA/JK/JM	Y	1,2	C																												
1.4b	Online and physical suggestion boxes	AS/GH	AL	Y	1	C																												
1.4c	Collate feedback from all events	AS/GH	AL		1	C																												
1.4d	Add new actions identified by staff engagement into plan	AS/GH	CC		1	OT																												
1.4e	Regular and formal progress feedback to staff groups	AS/GH	CT		2																													

IMPROVEMENT PLAN 3 - CARING

No	ACTION	Executive/Divisional OWNER	Operational Lead	Evidence Logged	Evidence Level	STATUS	Week Beginning																														
							13/04/2015	20/04/2015	27/04/2015	04/05/2015	11/05/2015	18/05/2015	25/05/2015	01/06/2015	08/06/2015	15/06/2015	22/06/2015	29/06/2015	06/07/2015	13/07/2015	20/07/2015	27/07/2015	03/08/2015	10/08/2015	17/08/2015	24/08/2015	31/08/2015	07/09/2015	14/09/2015	21/09/2015	28/09/2015	05/10/2015	12/10/2015	19/10/2015	26/10/2015
1	**Review model of service provision for obstetric theatres**	GH	CT		1	OT																															
2	**Review allocation of high risk women to appropriately experienced/skilled midwife (inc. on transfer form birth centre to labour ward)**	CT	JH/CS	Y	1	C																															
3	**Review process for rapid senior review of women transferred to labour ward**	JM	COL	Y	1	C																															
5	**Communication**																																				
5.1a	Review debrief process for families following adverse outcome.	KH	CT/CR		1	OT																															
5.1b	Review process for communication and updating women at NMGH whose baby is transferred to ROH NICU	CT	LB/KH		1	C																															
5.1c	Review the use of interpreters	KSJ	CP	Y	1	C																															

IMPROVEMENT PLAN 4 - RESPONSIVE

No	ACTION	Executive/Divisional OWNER	Operational Lead	Evidence Logged	Evidence Level	STATUS	Week Beginning: 13/04/2015	20/04/2015	27/04/2015	04/05/2015	11/05/2015	18/05/2015	25/05/2015	01/06/2015	08/06/2015	15/06/2015	22/06/2015	29/06/2015	06/07/2015	13/07/2015	20/07/2015	27/07/2015	03/08/2015	10/08/2015	17/08/2015	24/08/2015	31/08/2015	07/09/2015	14/09/2015	21/09/2015	28/09/2015	05/10/2015	12/10/2015	19/10/2015	26/10/2015
1	**Handover process**																																	
1.1a	Review current handover process	JM	VH/CR/ES/CM/MM		1																													
1.1b	Review of multi-disciplinary ward rounds and escalation	JM	VH/CR/ES	Y	1	C																												
1.1c	Pilot revised handover process (if changed)	JM	VH/CR/ES		##																													
1.1d	Review, amend if required and embed as standard practice	JM	VH/CR/ES		1																													
2	**Antenatal Capacity and Demand**																																	
2.1	Review antenatal demand and capacity	GA	CC		1																													
2.1a	Review demand in specialist clinics, for specialist consultants and Specialist Midwives	GA	CC		1																													
2.1b	Review demand for USS	GA	MW		1																													
2.1c	Amend clinic templates, job plans etc as required	GA	CC		1																													
2.1d	Establish cross cover arrangements (and succession planning as appropriate),including training needs analysis	GA	MP		1																													
2.1e	Undertaking Training as appropriate	GA	MP		2																													
3	**Emergency Department (ED)**																																	
3.1a	Review entry and access out of hours to ED	CC	GM/PB	Y	1	C																												
3.1b	Perimortem section pack to be made available	CT		Y	1	C																												
3.1c	NICU parabag / snatchbag	JM		Y	1	C																												
4	**Labour Ward Capacity and Demand**																																	
4.1a	Review labour ward capacity and demand	CT	DW/CS		1																													
4.1b	Review antenatal and postnatal capacity and demand	CT	DW/CS		1																													
4.1c	Review process for when no labour ward beds available	CT	DW/CS		1																													
5	**Morecambe Bay Investigation Report - Lessons from the Kirkup Review**																																	
5.1	Evaluate Strategic Clinical Network Audit Tool	GH	CT	Y	1	C																												
	TBC	TBC	TBC																															

IMPROVEMENT PLAN 5 - WELL LED

No	ACTION	Executive/Divisional OWNER	Operational Lead	Evidence Logged	Evidence Level	STATUS	Week Beginning: 13/04/2015	20/04/2015	27/04/2015	04/05/2015	11/05/2015	18/05/2015	25/05/2015	01/06/2015	08/06/2015	15/06/2015	22/06/2015	29/06/2015	06/07/2015	13/07/2015	20/07/2015	27/07/2015	03/08/2015	10/08/2015	17/08/2015	24/08/2015	31/08/2015	07/09/2015	14/09/2015	21/09/2015	28/09/2015	05/10/2015	12/10/2015	19/10/2015	26/10/2015
1	**Staffing**																																	
1.1	**Directorate Triumvirate model**																																	
1.1a	Appoint Clinical Director	JM		Y	1	C																												
1.1b	Appoint Deputy Divisional Director of Midwifery	CT			1																													
1.1c	Appoint Directorate Manager	JK		Y	1	C																												
1.1d	Clinical Director commence in post	JM	JM	Y	1	C																												
1.1e	Interim Deputy Divisional Director of midwifery in post	CT		Y	1	C																												
1.1f	Advertise Obstetric Leads x 2	MP	CC		1	C																												
1.1g	Appoint Obstetric Leads x 2	MP	CC		1																													
1.1h	Obstetric Leads x 2 in post	MP	CC		1																													
1.1i	Commence weekly Triumvirate meeting				2	C																												
1.1j	Timetable and commence revised monthly Directorate Management Group	DT	DT		2	C																												
1.1k	Timetable and commence monthly Directorate Quality & Performance Group	DT	DT		2	C																												
1.1l	Commission Leadership Development Programme	JL	NH		1	C																												
1.1m	Run Leadership Development Programme Workshops; links with Trust action plan	JL	NH		2	OT																												
1.1n	Introduce 360° Feedback as part of medical and midwifery revalidation	JM/CT		Y	3	C																												
1.1o	Review SoM role in line with latest RCM guidance	CT	CT	N	1	OD																												
1.2	**Leadership Role of Consultant Obstetrician and Labour Ward Coordinator**																																	
1.2a	Review current job expectations for Consultants working on the Labour Ward	JM	MP/CR		1																													
1.2b	Review current job expectations for Labour Ward Coordinator	CT			1																													
1.2c	Leadership Training Programme for Consultants and Labour Ward Coordinators	JK/GA	DG/MP		2																													
1.3	**Staff moves between areas**																																	
1.3a	Develop a standardised Proforma to document staff moves between areas	CT		Y	1	C																												
1.3b	Implement the use of the standardised Proformas	CT		Y	2,3	C																												
1.4	**Regular Management Oversight**																																	
1.4a	Develop revised Maternity Clinical and Performance Dashboard	CC		Y	1	C																												
1.4b	Review Terms of Reference of Directorate Management Group	CC	MP	Y	1	C																												
1.4c	Review mandatory training compliance at Directorate Management Group	CC	MP/HH/COL	Y	1	C																												
1.4d	Review appraisal compliance at Directorate Management Group	CC	MP	Y	1	C																												
1.4e	Review sickness rates by cost centre at Directorate Management Group	CC	PT	Y	1	C																												
1.4f	Review staffing levels and vacancies at Directorate Management Group	CC	BJ/VT/DW/DC	Y	1	C																												
1.4g	Review Risk Register at Directorate Management Group	JK/GA	MP/DG/CC	Y	1	C																												
1.4h	Review revised maternity Dashboard at Directorate Management Group	JK/GA	MP/DG/CC	Y	1	C																												
1.4i	Exception report to Divisional Meeting / Divisional Q&P	JK/GA	DT		1	EA																												