Managers

What we look for

Safe

Learning culture

- How are you assured all incidents are reported?
- Is the level of harm recorded reflective of the harm suffered?
- How are equality characteristics recorded and analysed for all incidents?
- Describe the culture of improvement and change?
    - How supportive is this process for staff?
- Can you describe your duty of candour process?
- How is clinical data including socio-demographic characteristics, such as ethnicity, routinely recorded, analysed and used to improve the quality of services?

Effective

Monitoring and improving outcomes

- Are all themes, no matter the levels of harm, on the risk register to help drive improvement?
- How are you assured actions for improvement are implemented and monitored for effectiveness?

Well-led

Governance management and sustainability

- How are you assured that duty of candour is always carried out in accordance with regulation 20 of the Health and Social Care Act 2008?
- Describe any changes in the service following a duty of candour review.
- Is the compliance with the duty of candour audited?
- Do you have independent panel members, such as external professionals, invited to assist in incidents reviews?
- Does the service have an incident investigation procedure?
- How are you assured incidents are investigated consistently?
- How are themes and trends identified shared with frontline staff and reported to the board?
- Describe the current themes and trends of harm in your service, in line with NHS England's Patient Safety Incident Response Framework (PSIRF) guidance.
- How are you assured lower levels of harm are reviewed to drive improvement?
- How often are serious incidents review meetings held? How are these recorded and was there appropriate monitoring of action?
- Are all neonatal deaths reviewed by a multidisciplinary group using the Perinatal Mortality Review Tool?
- Are all reviews documented in detail?
- How many incidents in the last 6 months have been referred to the Maternity and Newborn Safety Investigations programme (MNSI) for investigation?
    - Do you have any examples of actions to address recommendations, and how are these monitored?

- How are you assured actions identified through incident investigation are resolved promptly to prevent harm?