# Maternity improvement resource

The National maternity inspection programme aimed to give an up-to-date view of quality and safety across all maternity services. Between August 2022 and December 2023, every maternity location that had not been inspected before March 2021 was inspected, allowing us to identify common issues as well as good practice shared across the country.

Now that the inspection programme is complete, we are in a unique position of having an overview of the quality and safety of all maternity services in England.

We identified 4 themes to focus on for this improvement resource. We chose these themes because we identified that services often performed poorly in these areas, and we frequently had to take enforcement action. These are:

- triage
- incidents
- leadership and culture
- health equity.

These themes were not exhaustive and more information about our findings and themes can be found in our national report.

The following guides are for staff, leaders at all levels, the board and integrated care boards. The guides outline our expectations for staff knowledge about their service and the key elements we want to see implemented. These guides aim to support staff at various levels in understanding what we consider to be the hallmarks of a good service.

Our integrated care system (ICS) level questions explore wider issues and trends, as we would expect ICS leaders and committees to have this high-level overview of maternity services across their system.

In this resource we refer to 'women', but we recognise that some transgender men, non-binary people and people with variations in sex characteristics or who are intersex may also use maternity services and experience some of the same issues.

# Triage

## Introduction to triage

The following guide outlines what we expect staff to know about their service's triage and the key elements we want to see implemented.

We have drafted questions that we would likely ask in assessing services to help us determine whether the service meets the quality statements relevant to triage in our single assessment framework.

We have broken the questions down into different staff groups:

- frontline staff
- managers
- board members
- integrated care systems.

We would expect each staff group to be able to give comprehensive answers to the questions we have set out for them.

While not exhaustive and focused exclusively on the 4 theme areas of our resource, these guides aim to support staff at various levels in understanding what we consider to be the hallmarks of a good service. We recognise that models may differ between organisations based on population needs.

This resource aims to set out the general principles that we are looking for and is to be read in conjunction with other guidance such as the Royal College of Obstetricians and Gynaecologists' good practice paper.

# Characteristics of good

We have developed the content below using national guidance and evidence from our recent inspection programme. This resource aims to set out the general characteristics of good maternity practice.

## The characteristics of good triage processes

Women and their babies are protected from avoidable harm.

There are clearly defined in-person and telephone triage processes. Midwives are trained in telephone triage. Women are assessed by a trained midwife in line with the trusts own policy. They are prioritised based on risk, not in the order in which they came in.

### Telephone triage

- There is standardised documentation to minimise the risk of potential error.

- There is a dedicated telephone triage line, which is in a protected place and as an emergency line 24 hours a day. There are continuity plans in place in the event of staff absence.
- Telephone triage call answering and abandonment rates are monitored.
- Documentation on the call and advice given is recorded, with the ability to monitor repeat callers to identify deteriorations in condition.
- Telephone triage calls are audited cyclically to ensure compliance with the trust policy, and improvements implemented when needed.

## In-person triage

- A prompt and brief assessment within 15 minutes, including a physiological assessment using a standardised obstetric early warning score.
- Triage assessment and prioritisation is carried out by clinical staff who are trained in triage.
- The seated waiting area is in the direct line of sight of clinical staff.
- There should be standardised assessment, investigations and ongoing management processes.
- Contemporaneous documentation using standard templates.
- Centralised monitoring of activity within triage to monitor the flow through the department.
- The activity within maternity triage is included with the maternity safety huddle, and triage activity is included in the consultant led ward rounds twice a day.

Information about women's triage care and treatment, and their outcomes, is routinely collected and monitored. This information is used to improve care. Outcomes for women who use services are positive, consistent and meet expectations. Feedback is actively sought from women and staff to improve the service.

Accurate and up-to-date information about triage services is audited and escalated so that there is board oversight of activity and the effectiveness of maternity triage. Audit data is used to improve care and treatment within the triage service, including call answering and abandonment rates in telephone triage.

# What you need to know

## The following guide outlines what we expect staff to know about their service's triage and the key elements we want to see implemented.

We have drafted questions that we would likely ask on inspection to help us determine whether the service meets the quality statements relevant to safety incident management in our single assessment framework.

We have broken the questions down into different staff groups:

- frontline staff
- managers
- board members
- integrated care system.

We would expect each staff group to be able to give comprehensive answers to the questions we have set out for them.

While not exhaustive and focused exclusively on the 4 theme areas of our resource, these guides aim to support staff at various levels in understanding what we consider to be the hallmarks of a good service.

# Frontline staff

## What we look for

### Safe

#### Safe systems, pathways and transitions

Telephone triage:

- Do you use a standardised form to document calls to triage?
    - Is there space to document the time of calls?
    - How are frequent callers identified?
    - Are the phone numbers clearly signposted?

In-person triage:

- How are women assessed and their care prioritised?
- Is there a standardised tool?
    - If so, can you talk us through it?
- Do you complete the patient care record?
- When women are classed as high-risk, how are they prioritised?
- When women present in early or established labour, do you carry out a full clinical assessment?
    - If not, are they on a different pathway?
- Do you use a formal tool when handing over care to other areas?
- What is the protocol in place for handling an obstetric emergency in triage?

- How do you ensure you listen and record the preferences and decisions communicated by women? Do you have time to do so?

### Safe environments

- What emergency equipment is available in triage?
- Do you complete checks on emergency equipment and how often?
- Is there space for privacy if needed?
- Is there a ligature point risk assessment of the environment?
- Is the triage waiting area visible to staff?

### Safe and effective staffing

- Do triage staffing and acuity issues feed into the maternity unit safety huddle?
    - Are you invited to attend in person or remotely?
- What training have you had to work in triage?
- What training have you had to answer telephone triage?
- Do you have targets for women to be seen by midwives and doctors?
    - What are they?
- Do you record the time of arrival of women?
- Do you record what time they are seen by a midwife?
- Do you record what time they are seen by a doctor?

### Safe medicines optimisation

- How are medicines prescribed (paper or electronic), by whom?
- Are you able to access medicines easily?

## Effective

### Assessing needs/delivering evidence-based care and treatment

- Are you able to access diagnostic results in a timely manner?
- Do you use the Modified Early Obstetric Warning Score (MEOWS) for clinical observations?
- Are you able review scans and sign the outcomes?

### Monitoring and improving outcomes

- Do you know how waiting times are monitored?
- Do you know how triage proformas are audited to include appropriate completion, prioritisation and escalation?
    - How are the results of these audits shared?

# Managers

## What we look for

### Safe

#### Safe systems, pathways and transitions

Telephone triage:

- How are you assured telephone triage is effective?
- What is the current performance of telephone triage?
- What systems do you have in place to monitor call times and call drop-offs?
- How does the monitoring of call times and drop-offs drive improvement in the service?

In-person triage:

- How are you assured women's care and treatment are assessed and prioritised effectively?
- Can you talk us through the triage process including:
    - your use of standardised tool
    - how you prioritise women.
- How are you assured handover care to other areas is effective?

### Safe environments

- How are you assured equipment is checked to ensure it is fit for purpose and ready for use in an emergency?
- How are you assured a ligature point risk assessment of the environment has been completed?
    - Can you please show us the latest assessment?

### Safe and effective staffing

- How are you assured triage staffing and acuity issues feed into the maternity unit safety huddle?
- How are you assured staff are appropriately trained to work in maternity triage?
- How are you assured staff are appropriately trained and competent in telephone triage
- How are you assured there is appropriate staffing levels in maternity triage?

## Effective

### Assessing needs and delivering evidence-based care and treatment

- How are you assured staff are able to access diagnostic results in a timely manner?
- How are you assured staff are completing MEOWS for clinical observations and escalating appropriately?
- How do you ensure triage standards, systems and processes are continuously reviewed and adapted as new evidence or information emerges?

### Monitoring and improving outcomes

- How are you assured women are seen in a timely way, prioritised and escalated effectively in line with your own policy?
- How are the results of these audits shared?

### How staff, teams and services work together

- Are there dedicated obstetric staff for triage?

### Consent to care and treatment

- How are you assured staff ask for consent before any assessment of women?
- How is this recorded and monitored?

## Caring

### Kindness, compassion and dignity

- Are women given news of poor outcomes with dignity and in a private space?

## Responsive

### Equity in access

- What is the process for assessment of women who attend triage without an appointment?

- How is triage reviewed to ensure equity of access, for example using ethnicity data or serious incident data?

## Well-led

### Capable, compassionate and inclusive leaders

- Is there a dedicated leadership for maternity triage?

### Governance, management and sustainability

- How are you assured processes in telephone triage are effective?
- Do telephone triage audits include:
    - completeness of the record
    - appropriate prioritisation/RAG rating.
    - What is the current performance?
- How are you assured processes in maternity triage are effective?
- Do maternity triage audits include:
    - completeness of record
    - time of arrival
    - time of assessment by midwife
    - time of review by Obstetric team
    - time of discharge
    - appropriate prioritisation/RAG rating
    - is the service meeting its own policy or guideline?

- Can you tell us the interval between:
    - arrival to initial assessment
    - initial assessment to full assessment by a midwife
    - from assessment to obstetric review.
- What is the current performance of triage?
- How do you monitor maternity triage audits?
- How are you assured audit results are shared and improvements made?
- Is there board oversight of maternity triage performance?

The importance of people's experience.

- How are you assured the views of women using the service and the Maternity and Neonatal Voices Partnership (MNVP) have been used in developing maternity triage?
- How has engagement taken into account views of women who might face more barriers in triage? For example, women who do not speak English as a first language or women with mental health needs.

# Board members

## What we look for

### Safe

Safe and effective staffing

- How are you assured maternity triage is staffed by trained and competent midwives and obstetricians in line with best practice guidance?

### Well-led

#### Capable, compassionate and inclusive leaders

- How are you assured the leadership of maternity triage is effective?

#### Governance, management and sustainability

- What is the overall Board oversight of maternity triage?
- How does the trust monitor data in relation to maternity services to ensure risks are mitigated across pathways and transitions, especially in high-risk areas such as maternity triage?

# Integrated care systems

## What we look for

### Safe

#### Safe systems, pathways and transitions

- How does the integrated care system (ICS) monitor local data in relation to maternity services to ensure risks are mitigated across pathways and transitions, especially in high-risk areas such as maternity triage?
- How does the ICS ensure there is collaboration between professionals and providers to promote timely and safe maternity care and there is clarity about responsibility, supervision and oversight?

#### Safe and effective staffing

- Is there a plan to address system and place workforce priorities which utilise clinical and non-clinical skills across integrated pathways and does this include maternity services?
- As an ICS are there any particular staff groups where there is a high level of vacancies and sickness? How well sighted is the ICS on recruitment to vacancies where there are known national shortages such as for midwifery staff in maternity care?

## Well-led

### Capable, compassionate and inclusive leaders

- How does the ICS work with the local maternity and neonatal system to gain assurance of effective leadership?

### The importance of people's experience

- How does the system support and work with the maternity and neonatal voices partnership to develop and improve maternity services, including triage services?

# Good practice in triage

## We had very clear feedback from our maternity workshop that providers and stakeholders want us to share more of the good practice we find on our inspections.

We analysed the inspection reports from the National maternity inspection programme and want to share the good practice we found in relation to triage. It is not exhaustive. But we hope that services can use the examples and get in touch with the trusts if they wish to learn more.

# Quality improvement approach to improving communication and escalation

**Portsmouth Hospitals NHS Trust - Queen Alexandra Hospital**

> "The service had implemented **a quality improvement project around patient safety and effective communication in triage,** which was shared with staff and external stakeholders at a learning event. The service had developed a clear escalation guideline which included a maternity trigger list and a clear pathway for staff to follow during high acuity. This guideline was shared with their local maternity network system and the maternity and neonatal safety improvement programme. All the triage rooms had computer[s] on wheels for assessment and [were] equipped with cardiotocography (CTG) machines to help the timely assessment of fetal monitoring to ensure patient safety."

# Strong awareness of maternity triage risks from the trust board and executive team

**North Bristol NHS Trust – Southmead Hospital**

The chief nurse had attended Birmingham Symptom-specific Obstetric Triage (BSOTS) training.

# Effective use of electronic systems to ensure safety

**South Tees Hospitals NHS Foundation Trust - The James Cook University Hospital**

> "In triage, **records were routinely checked for safeguarding alerts, including on an internal database and on a national system of safeguarding alerts.** Staff could see safeguarding concerns from other trusts for unscheduled out of area patients not known to this trust. Staff could contact the safeguarding team to update safeguarding information on the national system."

The service used a standardised prioritisation tool, which was included within the electronic patient records system (EPR).

This meant all staff had visibility of the number of times someone had called and could escalate their care appropriately. The use of electronic records meant telephone triage could be shared between sites. It also allowed the service to maintain oversight of repeat callers and deteriorations and adjust prioritisation.

## Effective use of telephone triage

**Milton Keynes University Hospital NHS Foundation Trust - Milton Keynes Hospital**

> "The service had appropriate midwifery staffing in place to manage the maternity telephone triage. There was a designated midwife on each shift allocated to respond to and manage the triage telephone line."

This meant staff taking phone calls were appropriately trained and experienced.

**Chelsea and Westminster Hospital NHS Foundation Trust - West Middlesex Hospital**

> "Telephone triage was staffed by midwives working from home, so these staff were protected from being pulled into the numbers on labour ward."

**Frimley Health NHS Foundation Trust - Frimley Park Hospital**

Some organisations were working with local ambulance hubs and supporting others in their local areas to develop the same processes.

> "The service used a 24-hour telephone triage line for maternity queries and labour advice which was staffed by midwives within the local ambulance call-handling hub. This meant women had access to professional advice at any time of the day or night to ensure safe care. The service monitored call numbers and waiting times. Data showed a monthly average call rate of 2681 for both Frimley Park and Wexham Park hospitals between January and March 2023, and 73% of these calls were answered within 60 seconds. Data collected between January 2023 and May 2023 showed 15% of calls were abandoned by the caller and these were reviewed on a weekly basis. The service did not receive any complaints or safety concerns about the telephone line during this time."

# Environment and equipment

**Birmingham Women's and Children's NHS Foundation Trust - Birmingham Women's Hospital**

The service had a dedicated environment for maternity triage with space that allowed privacy and dignity for sharing confidential and/or poor outcomes.

> "Triage is open 24 hours a day with a dedicated phone line that is manned from 10am to 10pm. There were assessment rooms as well as rooms dedicated for women that needed to be seen urgently by a doctor. Triage was for women from 17 weeks of pregnancy up to 6 weeks postnatal who were experiencing any problems related to pregnancy or following birth. Women also attended for early labour assessments. Fetal assessments were offered for reduced fetal movements. Triage was situated next to labour ward so women could be transferred immediately if needed."

**Wye Valley NHS Trust - The County Hospital**

> "The service had identified a lack of space in the triage area as a risk and was in the process of moving triage to a new area with more space to facilitate safer assessment and patient flow...The service had identified that triage posed a potential risk to women due to the lack of space and current staffing model, and consequently triage had been included on the risk register."

**George Eliot NHS Trust - George Eliot NHS Hospital**

As part of a pilot, the service relocated its triage service, which was originally co-located with the maternity day assessment unit, to the delivery suite. This allowed for assessment rooms to be used when activity on the ward increased and also meant that triage was situated closer to the midwifery station. Staff working in both triage and the maternity day assessment told us the changes allowed them to provide a better service.

# Staffing

We were encouraged to see leaders who were supportive and proactive in ensuring staff received the appropriate training to carry out their roles in triage, as well as providing opportunities to develop their skills further.

**George Eliot NHS Foundation Trust - George Eliot Hospital**

> "Leaders encouraged staff to take part in secondments and pilot projects to help all staff progress. For example, staff had been seconded to specialist midwife roles, and to manage the triage project."

**The Dudley Group NHS Foundation Trust - Russells Hall Hospital**

Leaders introduced training to help staff reach triage targets and aimed to achieve over 90% of women being seen within 15 minutes of arrival.

## Further information

- Birmingham Symptom Specific Obstetric Triage System (BSOTS) (future.nhs.uk) Requires a FutureNHS account. Accounts are free and available for everyone working in health and care.
- Information about BSOTS (midtech.org.uk)
- When to contact maternity services? Sands and Tommy's Joint Policy Unit discussion paper (sands.org.uk)

# Managing safety incidents

## Introduction to safety incidents

Our findings revealed, in some services incidents were not consistently reported. This meant leaders did not have clear oversight of safety incidents, which could impact their ability to foster an open, learning culture.

We found concerns with the grading of safety incidents in some services. Inaccurate grading of incidents could mean they are not correctly investigated, and services could miss vital learning opportunities.

It is important that staff feel able to report safety incidents. Safety incidents should be investigated in a timely manner, with oversight from leaders to ensure duty of candour and learning.

Failure to learn from incidents could result in more people being exposed to harm.

# Characteristics of good

We have developed the content below using national guidance and evidence from our recent inspection programme. This resource aims to set out the general characteristics of good maternity practice.

## The characteristics of good incident management

Staff are encouraged to report any safety incident without fear for reprisal and provided with the time to do so.

There is an open and transparent safety culture, encouraged throughout the service. All staff understand and fulfil their responsibilities in raising concerns and report incidents and near misses. All staff are fully supported when they do so. When reporting incidents and near misses, protected equality characteristics of the woman are recorded routinely and considered as part of the review to identify themes and trends.

The maternity service routinely collects and uses equality data as part of their incident reporting process. When reviewing safety outcomes, trends are identified for women from ethnic minority groups and action is taken to respond to any risk factors. All maternity staff understand the importance of collecting demographic information and how it is used to improve outcomes for women. The maternity service breaks down data by levels of deprivation and targets improvement initiatives to areas with the highest deprivation.

When something does not go as planned, a thorough review or investigation is undertaken and involves all relevant staff, the woman, and their family. Questions of the woman and their family should be answered in full as part of the review process. Women leave hospital with all the information they need to be able to process their individual birth experience. If a woman requests a conversation with a member of the multi-disciplinary team about their birth prior to them leaving hospital, this should happen. However, when this is unachievable, women should be informed of the next opportunity for this conversation to happen.

For those cases referred to a review panel, women are invited to attend and supported to co-produce improvements for future service provision and reviews.

The maternity service actively participates in learning with other providers within the local maternity and neonatal system. Learning is communicated widely and through a variety of different methods to support improvements in throughout the trust, as well as services within the local maternity and neonatal system. External safety events and patient safety alerts are considered and reviewed by the service and shared with staff.

Improvements made following learning from reviews within the service, trust or the wider local maternity and neonatal system, the resulting changes are monitored through audit and the effectiveness is reviewed.

# What you need to know

The following guide outlines what we expect staff to know about their service's safety incident management processes and the key elements we want to see implemented.

We have drafted questions that we would likely ask on inspection to help us determine whether the service meets the quality statements relevant to safety incident management in our single assessment framework.

We have broken the questions down into different staff groups:

- frontline staff
- managers
- board members
- integrated care systems.

We would expect each staff group to be able to give comprehensive answers to the questions we have set out for them.

While not exhaustive and focused exclusively on the 4 theme areas of our resource, these guides aim to support staff at various levels in understanding what we consider to be the hallmarks of a good service.

# Frontline staff

## What we look for

### Safe

### Learning culture

- Are incidents of harm understood and defined by staff?
- Are equality characteristics recorded for all incidents?
- What stops staff reporting incidents?
- Do staff feel there is a culture of improvement and change that is supportive of them?
- Are women offered a conversation and an apology?
- Does the service always follow an incident investigation procedure and policy?
- Do you consistently get feedback from incidents?
- Can you describe any changes or actions as a result of findings from an incident in the service?
- How is clinical data including socio-demographic characteristics such as ethnicity routinely recorded, analysed and used to improve the quality of services?

## Well-led

### Governance management and sustainability

- How often are serious incidents review meetings?
    - Are the correct staff involved?
    - How are these review meetings recorded and was there appropriate monitoring of action?

# 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?

# Board members

## What we look for

### Well-led

Governance, management and sustainability

- What is the overall Board oversight of maternity safety incidents?
- How is the board assured of effective oversight of reporting and monitoring of themes and trends?
- What are the current themes and trends of notes to the board?
- How is the board assured of effective implementation and monitoring of action?
- How does this service compare nationally for occurrences of safety incidents?

# Integrated care systems

## What we look for

### Well-led

Partnerships and communities

- How do local maternity services compare nationally for the occurrence reporting and investigation of safety incidents?
- What is the integrated care board (ICB) involvement in the investigation or oversight of maternity safety incidents? What assurance does the integrated care system (ICS) have that ICB and provider governance structures support reporting of and learning from maternity safety incidents?
- How is the system assured that deaths, including maternity and neonates, are reviewed using approved tools?
- How do governance structures take account of people's experiences in learning and improvement of maternity systems?

# Good practice in managing safety incidents

We had very clear feedback from our maternity workshop that providers and stakeholders want us to share more of the good practice we find on our inspections.

We analysed the inspection reports from the National maternity inspection programme and want to share the good practice we found in relation to managing safety incidents. It is not exhaustive. But we hope that services can use the examples and get in touch with the trusts if they wish to learn more.

## Effective incident review processes

**Norfolk and Norwich University Hospitals NHS Foundation Trust - Norfolk and Norwich University Hospital**

> "The trust moved to the Patient Safety Incident Response Framework (PSIRF) on 1 September 2023 and leaders triaged all incidents daily and RAG (red, amber, green) rated them in alignment with PSIRF guidance. Any incidents that were of moderate or severe harm, required further information or met national priorities were presented by the divisional weekly incident group to discuss the appropriate response and identify any lessons learned. Cases were then escalated to the trust complex case review group, as required."

> "Leaders told us an incident report was completed following every massive obstetric haemorrhage greater than 1.5 litres, all 3rd and 4th degree vaginal tears and any

> unanticipated admissions of newborns to the Neonatal Intensive Care Unit. All incidents had a case review by the investigation lead. If there were care issues or moderate or severe harm formal duty of candour was always completed, and the mother/family were always provided with an immediate debrief. Managers investigated incidents thoroughly and applied the Duty of Candour, although it was not clear from reports if they involved women, birthing people and their families in related investigations."

# Sharing and embedding learning

**Lewisham and Greenwich NHS Trust - University Hospitals Lewisham**

> "The service held **a weekly 'education bus' and quiz sessions in the maternity areas** and the governance teams focused on different themes each month. For example, the team were focused on managing fluid balance in August 2023. There was evidence that changes had been made following incidents investigations. Staff explained and gave examples of additional training, process, pathway, and policy implemented following a serious incident. Following a baby abduction incident which occurred last year, the trust had implemented a new baby abduction policy and employed security staff for the maternity wards to maintain patient safety. The service had also introduced 2 hourly security rounds and a sign in register to ensure oversight of everyone entering and exiting the maternity wards."

**North West Anglia NHS Foundation Trust - Hinchingbrooke Hospital**

> "The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff. For example, the rate of women who had a post-partum haemorrhage (PPH) of 1,500 millilitres or more was higher than the national average and in the highest 25% of all organisations. Further education and training was introduced to make sure practice was embedded to reduce the incidence of PPH."

## External peer review with a local trust

**Leeds Teaching Hospitals NHS Trust - Leeds General Infirmary**

> "The service had a weekly Perinatal Mortality Review tool (PMRT) meeting that was attended by a multidisciplinary team including the Women's CSU quality and safety team, consultants and midwives. There was an ongoing action tracker to monitor learning and improvements. Managers shared learning from PMRT meetings through the monthly 'sharing the learning' newsletter. The service had set up an external peer review process with a local trust of a similar size serving a similar community for PRMT."

# Healthcare equity

## Introduction to healthcare equity

We are concerned about the inherent inequalities in maternity care for some people with protected characteristics. Failings in this area results in harm to women and babies.

Data shows that compared to women from White ethnic groups, Black and Asian women are significantly more likely to die during, or up to 6 weeks after, pregnancy.

The impact of existing inequalities should be considered in all aspects of delivery of care.

Our findings revealed some trusts were taking steps to address inequalities. However, there is more to be done to ensure care can meet people's needs.

We found some good examples of providers understanding their local population and tailoring care accordingly. For example, through enhanced translation services.

We also saw some examples where healthcare inequalities were not being addressed. Ethnicity data was not routinely captured and analysed when services investigated safety incidents. Some staff raised concerns of discrimination due to their race and ethnicity.

Services that do not address healthcare inequalities are at risk of institutional discrimination and will fail to address the increased risk of significant harm for some women and their babies.

Listen to the Health equity in NHS maternity services podcast.

# Characteristics of good

## We have developed the content below using national guidance and evidence from our recent inspection programme. This resource aims to set out the general characteristics of good maternity practice.

## The characteristics of good healthcare equity

The needs and preferences of different women with protected characteristics under the Equality Act are considered when planning, delivering and coordinating the maternity service. Maternity services collaborate with other services and providers to provide a holistic package of support for women. The maternity service liaises with women, their families and carers to ensure all partners are informed of any diverse needs that should to be addressed. Any reasonable adjustments are made and communicated, and action is taken to remove barriers when women struggle to access services.

The maternity service routinely collects and uses ethnicity data as part of their incident reporting process. When reviewing safety outcomes, trends are identified for women from ethnic minority groups and action is taken to respond to any risk factors. All maternity staff understand the importance of collecting demographic information, and how it is used to improve outcomes for women. The maternity service breaks down data by levels of deprivation and targets improvement initiatives to areas with the highest deprivation.

The provision of translation and interpretation services is readily available for women whose first or preferred language is not English or those who are deaf. Adjustments are made for women who are unable to read.

Maternity services actively promote equality and diversity within their workforce. If there are any areas of inequality identified action is taken to remove them. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.

Maternity leaders at all levels promote equality and diversity. They encourage pride and positivity in the maternity service and focus attention on the needs and experiences of women who use the service. Behaviour and performance that are inconsistent with the vision and values is identified and dealt with swiftly and effectively, regardless of seniority.

A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture. The service proactively engages and involves all staff (including those with protected equality characteristics), and ensures that the voices of all staff are heard and acted on to shape services and culture.

# What you need to know

## The following guide outlines what we expect staff to know about their service's culture and leadership and the key elements we want to see implemented.

We have drafted questions that we would likely ask on inspection to help us determine whether the service meets the quality statements relevant to culture and leadership in our single assessment framework.

We have broken the questions down into different staff groups:

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- integrated care systems.

We would expect each staff group to be able to give comprehensive answers to the questions we have set out for them.

While not exhaustive and focused exclusively on the 4 theme areas of our resource, these guides aim to support staff at various levels in understanding what we consider to be the hallmarks of a good service.

# Frontline staff

## What we look for

### Safe

#### Learning culture

- How have you learnt about different outcomes for women and babies with protected characteristics?
    - Is this included in PROMPT, skills and drills and if so, how?
- How are equality characteristics recorded in all clinical records?
- Can you give examples of how learning about inequalities has led to a change in the service you provide?
- Is there a commitment to improving safety for those with equality characteristics at all levels in the organisation?

#### Safe systems pathways and transitions

- What action has been taken by the service to reduce safety risks for those with equality characteristics?

#### Involving people to manage risks

- How are risk assessments used to support the care of women and babies with equality characteristics?
- How are the preferences and choices, including religious and cultural preferences, of those who use services respected, and where possible incorporated into care?

### Effective

#### Assessing needs

- Are care plans personalised to include individual needs and choices for care and treatment including pain relief?

### Monitoring and improving outcomes

- How do staff record health inequalities data in incident reviews and how is data interrogated and trends monitored?

### Consent to care and treatment:

- How do you ensure women receive information about care and treatment being offered or recommended in a way they can understand before giving consent?
- Are interpretation services always offered, even where a family member would be able to translate?

## Responsive

### Care provision, integration and continuity

- How do you support women and families with additional healthcare needs? These could include:
    - people with a learning disability,
    - people whose preferred or known language is not English
    - people with sensory loss for hearing or sight
    - people who have mobility issues
    - people with mental health needs and risks associated with safeguarding.

### Providing information

- What information and advice are available to meet individual communication needs?
- How do you ensure that individual communication needs are fully recorded and shared across the maternity pathway?

## Well-led

### Shared direction and culture

- How are you supported to have a detailed knowledge of equality, diversity and human rights?

### Governance management and sustainability

- What data is discussed in your safety huddles and meetings about equality characteristics?

### Listening to and involving people

- Is feedback sought from people with protected characteristics and how have any findings influenced changes in your service?
- Is health inequality on your maternity service's risk register?

# Managers

# What we look for

## Safe

### Learning culture

- How are protected characteristics recorded and analysed for all incidents?
- Is there a commitment to improving safety for those with equality characteristics at all levels in the organisation?
- Have staff completed cultural awareness training that is tailored to the service's local population?

### Safe systems pathways and transitions

- Are you aware of national evidence about safety risks for particular groups of women, for example women from ethnic minority backgrounds and women with mental health needs?
    - Can you give examples of action that has been taken as a result, to increase safety for particular groups of women?

### Involving people to manage risks

- How are risk assessments developed to support the care of women and babies with protected characteristics?

## Effective

### Assessing needs

- Are care plans personalised to include individual needs and choices for care and treatment, including pain relief?
- Are personalised care and support plans (PCSPs) available in a range of languages and formats, including hard copy for those experiencing digital exclusion?
- How have you addressed NHS England's Core20PLUS5 approach's aims to ensure continuity of carer from Black, Asian and ethnic minority communities and from the most deprived groups?

### Monitoring and improving outcomes

- In what ways has the maternity service taken action to reduce inequality in negative outcomes for people?
- How do staff record health inequalities data in incident reviews?
    - How is data interrogated and trends monitored?

### Delivery evidence-based care and treatment

- How do different outcomes for women and babies get included in training such as PROMPT, skills and drills?
- How has the antenatal care offer been tailored to address health inequalities that impact the local population?

### Consent to care and treatment

- How do you ensure women receive information about care and treatment being offered or recommended in a way they can understand before giving consent?
- Are interpretation services always offered, even where a family member would be able to translate?

## Responsive

### Care provision, integration and continuity

- What are the diverse health and social care needs of your community?
- How is antenatal care for women with complex social factors being delivered, in line with NICE guidelines.
- How are services delivered for those more at risk of poor care in maternity services?
- How do managers ensure staff support, signpost and refer women and families with additional healthcare needs to specialist and community services? These could include:
    - people with a learning disability
    - people whose preferred or known language is not English
    - people with sensory loss for hearing or sight
    - people who have mobility issues
    - people with mental health needs and risks associated with safeguarding.

### Providing information

- Is information about pregnancy and antenatal services available in different formats and distributed to community settings?
- How do you ensure that individual communication needs are fully recorded and shared with staff throughout the maternity pathway?
- Where interpreting services are used, are length of appointments adjusted to allow for extra time?

### Involving and listening to people

- How do you engage women from ethnic minority groups and other equality groups in co-production of equality and equity interventions?

### Equity in access

- How is the impact of equality and equity initiatives or interventions measured?
- If services are provided digitally, how does the service mitigate against digital exclusion that some women face?

## Well-led

### Shared direction and culture

- How does the maternity service's vision and strategy encompass the needs of those with protected characteristics?
- How are you assured staff at all levels have a detailed knowledge of equality, diversity and human rights?

### Workforce equality, diversity and inclusion

- What action has been taken to improve the experience of staff with protected equality characteristics or those from excluded or marginalised groups?
    - How have these interventions been monitored to evaluate their impact?

### Governance management and sustainability

- What data is recorded about protected characteristics?
- Is health inequality on the maternity service's risk register?
    - How is this escalated to the board?

### Partnerships and communities

- How does the maternity and neonatal voices partnership (MNVP) work together with the trust to engage with women who represent the local population?
- How has the trust involved the MNVP in the maternity service's actions to promote equity for women from ethnic minority groups and women from socially deprived areas? This may include:
    - increasing support of at-risk pregnant women
    - reaching out and reassuring pregnant women from ethnic minority backgrounds with tailored communications
    - recording the ethnicity of every woman, as well as other risk factors.

# Board members

## What we look for

### Well-led

#### Shared direction and culture

- How does the maternity service's vision and strategy encompass the needs of those with protected characteristics and the local population?

- Have you implemented a local strategy based on the Local Maternity Systems Equity and Equality Action Plan?
- How does the board understand local communities' profile, health needs, and community assets and map them against the existing services to identify gaps in service delivery?
- What is the board oversight of the public sector equality duty?
- How have you created an enabling environment to reduce inequalities and inequities in terms of overall service model, for example community hubs?

## Governance, management and sustainability

- Does the board know what the action has been by the maternity service to reduce inequality of negative outcomes for individuals?
- Is health inequality on the maternity services risk register and how does this translate to the board for monitoring?
- Are you assured that protected characteristics are taken into consideration when incidents are reviewed and reported to the board?
- How do service-level safety champions ensure women's voices are represented at board level?

## Partnerships and communities

- How does the Maternity and Neonatal Voices Partnership (MNVP) work together with the trust to engage with women who represent the local population?

## The importance of people's experience

- Do you receive patient stories at board from those with direct experience of the maternity service?

# Integrated care systems

## What we look for

### Well-led

Shared direction and culture

- Health inequalities in maternity care continue to be an issue across the UK. What, if any, particular measures do the system take to ensure maternity outcomes and experiences for people facing health inequalities are equitable?
- Where did the Integrated care system use the funding it received to address health inequalities?
    - Was any of this specifically targeted to reduce health inequalities in maternity services?
- How is the integrated care system ensuring strategies for, and development of, maternity services meet the needs of the local population and address health inequalities?

# Good practice in healthcare equity

We had very clear feedback from our maternity workshop that providers and stakeholders want us to share more of the good practice we find on our inspections.

We analysed the inspection reports from the National maternity inspection programme and want to share the good practice we found in relation to improving healthcare equity. It is not exhaustive. But we hope that services can use the examples and get in touch with the trusts if they wish to learn more.

# Meeting language and communication needs

**Liverpool Women's NHS Foundation Trust - Liverpool Women's Hospital**

> "The Non-English-Speaking Team (NEST) provided care for those women and families who did not speak English. The trust hosted an antenatal clinic using translation services with midwifery and consultant support, and home visits could be arranged. Information was provided in the woman's own language so they could make the right choice for them and their baby."

# Reviewing clinical outcomes with a health inequalities lens

**Leeds Teaching Hospitals NHS – Leeds General Infirmary**

> "The service was focused on reviewing health outcomes to improve health equity in maternity services. The service completed a 12-month review of stillbirths and a 5-year review of stillbirth by maternal ethnicity to understand if disparities existed. The consultant midwife for health equity and an obstetric registrar led work on an audit of reduced fetal movements which highlighted disparities in the presentation of different cohorts of women for reduced fetal movements. Following the review the service worked with the MVP to set up focus groups with local Black African women to ensure advice on reduced fetal movements was accessible and inclusive."

> "The trust employed a Deputy Chief Midwifery Information Officer. The trust was the first organisation to create such a senior role for a digital midwife. The service had created a Maternity Health Inequalities Dashboard to review maternity data through a population health management lens reviewing social profiles and medical complexity across the city. The service used data from the dashboard to inform a business case for increased funding for gestational diabetes clinics due to increased prevalence of gestational diabetes. Data from the dashboard was also used to target smoking cessation advice across 7 high prevalence smoking areas in Leeds. "

**North Bristol NHS Trust - Southmead Hospital**

> "The service had a lead consultant obstetrician for equality and diversity who had examined outcomes reported nationally for still birth and neonatal deaths and looked for themes around health inequalities. This had led to project work with specific communities to break down barriers and improve outcomes for them."

## Working with local stakeholders to reduce health inequalities

**Warrington and Halton Teaching Hospitals NHS Foundation Trust - Warrington Hospital**

> "The trust demonstrated outstanding practice in relation to the commitment to the equality and equity agenda, working in collaboration with external stakeholders such as, people who use the service, Warrington Borough Council and integrated care boards. This had led to improvements in the offer available in the local communities and in people's homes."

> "Specific pieces of work had been carried out to address the barriers faced by the

> community the trust served.
>
> The service had established an antenatal and postnatal clinic in a hotel which was housing asylum seekers in the local area, to reduce barriers to accessing care and support some of society's people who are (or might be) made vulnerable or in vulnerable circumstances..
>
> The service created communication cards for non-English speaking women to support them in communicating their communication needs.
>
> The service provided care packages of essential items for parent and baby, to support women in need, working closely with local charities."

**North Bristol NHS Trust - Southmead Hospital**

The service focused on improving maternity care for women in local prisons. Here, complex care midwives developed 'separation boxes' specific to the needs of women with some contents that could return to prison with them. The service also worked with the prison catering department to ensure pregnant women received more nutritious meals and prison staff took part in unexpected birth scenario training.

**Liverpool Women's Hospital NHS Trust - Liverpool Women's Hospital**

The trust was hosting and supporting the C-GULL – Children Growing up in Liverpool research programme. The programme focused on improving the health and wellbeing of children and their families within the Liverpool City Region. It will trace the lives of over 10,000 local families to understand more about what influences the health and wellbeing of children and their families living in the region.

# Using Data to improve outcomes

**North Cumbria Integrated Care NHS Foundation Trust - Cumberland Infirmary**

> "The service used refugee pathway links with other regions to enable and promote care of women and babies for refugees and refugee communities. Data analysts in the trust had worked with public health colleagues to identify key vulnerable and refugee groups in the area and leaders used this information to help plan service delivery to improve access to these groups, addressing health inequalities in their population."

# Specialist roles

**Milton Keynes University Hospital NHS Foundation Trust - Milton Keynes Hospital**

> "The maternity service recognised and '…' the additional challenges the women and families who accessed the service faced, particularly around health inequalities, co-complexities and co-morbidities. As a response to these challenges, the service had created more specialist roles to support women in the hospital and community to improve the outcomes and experiences of the women."

**Manchester University NHS Foundation Trust - Wythenshawe Hospital**

The service ran 24-hour access mental health support and had a specialist midwife for mental health to support both staff and women, who carried out psychosocial assessments of women to identify risks of harm and suicide.

**North West Anglia NHS Foundation Trust- Peterborough City Hospital**

> "The trust had appointed an equality, diversity, and inclusion midwife to care for the diverse population and hard to reach community including the local females' prison to improve patient outcomes."

# Improving access

**Liverpool Women's Hospital NHS Trust - Liverpool Women's Hospital**

> "The service used charitable funds to fund several initiatives to meet the basic needs of women who were vulnerable. For example, they accessed funding for SIM cards for women who were digitally excluded. They issued food vouchers to women in need."

**George Eliot Hospital NHS Trust - George Eliot NHS Hospital**

The service offered information about bus routes, reimbursement schemes as well as free parking on-site to women who might have missed appointments and disengaged from the service due to the costs of transport.

**Leeds Teaching Hospitals NHS Trust**

One trust had made a video with local women including asylum seekers who shared their experiences and the impact of genuinely personalised, culturally competent care:



**Lewisham and Greenwich NHS Trust - University Hospital Lewisham**

The MNVP worked closely with local Muslim groups to improve bereavement facilities. Muslim support packages offered by the trust included prayer beads, anointing oils and shrouds and a list of Muslim funeral directors

## Training staff

**University Hospitals Bristol and Weston NHS Foundation Trust – UHBW Bristol Main Site**

Senior leaders at the service attended the 'Black Maternity Matters', a 6-month anti-racism education and training programme. It examined a range of topics, including unconscious biases and the role of the individual in perpetuating unsafe systems of care for Black women.

## Communication

**Portsmouth Hospitals University NHS Trust - Queen Alexandra Hospital**

As part of a learning disabilities and neurodiversity project, the service produced a maternity passport to support people with a learning disability. The passport was produced with a service user and staff group from the learning disability team in the local community. The service also had plans to develop easy read birth plans and post-natal plans.

The service had also recognised the impact of staff behaviours on communication and worked to embed principles from the 'civility saves lives' campaign, which aims to 'raise awareness of the power of civility in medicine'.

# Leadership and culture

# Introduction to leadership and culture



Compassionate and inclusive leadership and culture is essential for both patient safety and staff wellbeing.

A safe and effective workplace culture is marked by openness, staff empowerment, continued learning and improvement. It is vital that risks and challenges within maternity services are recognised and prioritised at Board level.

We found good and outstanding services had an open culture where challenge was accepted.

These services prioritised information sharing between staff and managers to reduce risk. This included information sharing of meeting minutes, learning from incidents, and safeguarding information.

We found that good decision making stemmed from:

- consistently addressing issues in a timely way

- strong succession planning
- transparency from leadership teams
- stability in leadership teams
- approachable leadership
- acting swiftly on identified risk
- driving continual improvement.

However, our findings revealed some examples of suboptimal leadership and culture.

We identified issues that led to:

- poor leadership, including failure to collect and analyse reliable data
- instability within the leadership structure across the trust
- repeated instances of failing to address risks raised by staff and a lack of access to senior decision makers when needed.

Not all services had board-level oversight of service-level issues. Some services did not have an open culture in which staff and service users could voice their concerns without fear. Staff were not always confident that leaders would address concerns they had raised, and staff did not always feel listened to. We discuss this in our National review of maternity services in England 2022 to 2024.

# Characteristics of good

We have developed the content below using national guidance and evidence from our recent inspection programme. This resource aims to set out the general characteristics of good maternity practice.

# The characteristics of good leadership and culture

The leadership, governance and culture of the service promote the delivery of high-quality person-centred care.

Maternity leaders should have the experience, capacity, capability and integrity to ensure that the maternity strategy can be delivered and risks to performance addressed.

Maternity leaders at every level, including board safety champions, should be visible and approachable. Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, deployment and support processes and succession planning.

The maternity leadership should be knowledgeable about issues and priorities for the quality and sustainability of their maternity services, understand the challenges and act to address them.

There is a clear statement of vision and values within the maternity service, which is driven by quality and sustainability. The vision and values have been translated into a robust and realistic maternity specific strategy with well-defined objectives, which are achievable and relevant. The vision, values and strategy should have been coproduced with women and staff. The maternity strategy should be aligned to local maternity and neonatal system (LMNS) and integrated care system (ICS) plans in the wider health and social care economy and services are planned to meet the needs of women.

Progress against delivery of the maternity strategy is monitored and reviewed, and there is evidence of this.

All staff in the maternity service know, understand and support the maternity specific vision, values and strategic goals and their role in achieving them.

Maternity leaders consistently demonstrate and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. Maternity leaders should at every level:

- live the vision and embody shared values
- prioritise high-quality, sustainable and compassionate care
- promote equality and diversity.

Pride and positivity are encouraged within the maternity service with a focus on the needs and experiences of women and their families. Where behaviours and performance are inconsistent with the maternity vision and values they should be swiftly identified and dealt with effectively, regardless of seniority.

Maternity leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Maternity leaders promote and actively contribute to an environment of continuous learning. There is a psychologically safe environment that enables maternity staff to actively raise concerns and leaders ensure they are supported. Candour, openness, honesty, transparency and challenges to poor practice are the norm.

Concerns are investigated sensitively and confidentially, and lessons learned are shared through a variety of methods and acted on. When something goes wrong, women receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.

The maternity team demonstrate a collective responsibility of care, where conflicts are resolved quickly and constructively and responsibility is shared.

Maternity staff at every level are supported in their development and this includes high-quality appraisal and career conversations. Equality and diversity are actively promoted within the maternity service, the cause of any workforce inequality are identified and action taken to address these. All maternity staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.

# What you need to know

The following guide outlines what we expect staff to know about their service's culture and leadership and the key elements we want to see implemented.

We have drafted questions that we would likely ask on inspection to help us determine whether the service meets the quality statements relevant to culture and leadership in our single assessment framework.

We have broken the questions down into different staff groups:

- frontline staff
- managers
- board members
- integrated care systems.

We would expect each staff group to be able to give comprehensive answers to the questions we have set out for them.

While not exhaustive and focused exclusively on the 4 theme areas of our resource, these guides aim to support staff at various levels in understanding what we consider to be the hallmarks of a good service.

# Frontline staff

## What we look for

### Well-led

#### Shared direction and culture

- Does the maternity service have a dedicated vision and strategy developed with you?
- Who do you raise concerns with, and how confident are you action will be taken?

#### Capable, compassionate and inclusive leaders

- Can you identify your board level safety champions?
- Describe how the service is led:
    - Is the service led by an operations director, midwifery director and clinical director for obstetrics, gynaecology and neonatology?
- Are your leaders, at all levels, visible in the clinical areas?
- Are the job plans clear and accurate about describing duties, responsibilities, accountabilities and objectives for medical staff, with enough time allocated to required duties and to attend meetings and training?
- How do you hear about staff vacancy and development opportunities?

#### Freedom to speak up

- Are you encouraged to speak up and are you given feedback after raising concerns?

#### Workforce equality, diversity and inclusion

- Are there any actions taken in the service following the trust staff survey results? This could include people with protected characteristics or bullying and harassment.

## Governance, management and sustainability

- Describe the governance arrangements:
    - including regular meetings and who can attend, sharing of minutes and actions.
- Describe how relevant information escalated to the leaders.
- How are you assured policies and procedures are up to date for your use? Are you up to date with their development?
- Are you involved with any audits?
- How are clinical records completed and what are the arrangements for information sharing across the maternity pathway from antenatal to postnatal care?

## Partnerships and communities

- How do you hear about the input from the maternity and neonatal voices partnership (MNVP)?

## Learning, improvement and innovation

- Describe your approach to continuous quality improvement for maternity services.
- What recent improvements have been made to the service?

## The importance of people's experience

- Do you receive feedback from women and families using the service?

# Managers

## What we look for

### Well-led

#### Shared direction and culture

- Does the maternity service have a dedicated vision and strategy developed with stakeholders and staff focused on sustainability of services and aligned to local plans within the wider health economy?
- Describe your access to the board for raising concerns, celebrating success and routine reporting.
- How do you encourage check and challenge in the service?

#### Capable, compassionate and inclusive leaders

- Describe how the service is led:
    - Is the service led by an operations director, midwifery director and clinical director for obstetrics, gynaecology and neonatology?
- How do leaders maintain visibility in the clinical areas?
- Are the job plans clear and accurate about describing duties, responsibilities, accountabilities and objectives for medical staff, with enough time allocated to required duties and to attend meetings and training?
- How do staff and the board hear about staff vacancy rates, sickness rates, other leave impacting the team, for medical and all grades of midwifery staff?
- Describe the strategy for succession planning and development of future leaders in the service.

#### Freedom to speak up

- How can you evidence changes made as a result of staff giving feedback or speaking up?
- How are staff encouraged to speak up freely?

## Workforce equality, diversity and inclusion

- Describe how you review and improve the culture of the service.
- Are there any actions in the service following the trust staff survey results? This could include people with protected characteristics or bullying and harassment?
- How reflective of the population is your workforce and what steps are taken to address any shortfalls?

## Governance, management and sustainability

- Describe the governance structure, including:
    - regular meetings and attendance against quoracy, minutes and actions
    - risk registers and maternity red flag responses
    - Maternity Incentive Scheme outcomes.
- Describe how relevant information escalated to the trust quality and safety committee.
- How are you assured policies and procedures are up to date and in line with Royal Colleges and NICE guidelines?
- What are the arrangements for an audit programme and to check improvements over time?
- How do leaders report maternity service staffing to the board (this includes the use of bank, agency and locums; planned versus actual for labour ward, postnatal, antenatal, antenatal clinical, triage, maternity assessment/maternity day unit and community staffing; specialist and supernumerary roles)?

- How are clinical records managed and what are the arrangements for data protection as well as for information sharing throughout the maternity pathway, from antenatal to postnatal care?

### Partnerships and communities

- How do leaders engage with Maternity and Neonatal Voices Partnership (MNVP), staff and women?
- How has the MNVP shaped the service?

### Learning, improvement and innovation

- Describe your approach to continuous quality improvement for maternity services.
- What recent improvements have there been to the service?

### The importance of people's experience

- Do you receive patient stories at board from those with direct experience of the maternity service?

# Board members

## What we look for

### Well-led

#### Shared direction and culture

- Does the maternity service have a dedicated vision and strategy, developed with stakeholders and staff which is focused on sustainability of services and aligned to local plans within the wider health economy?

- Describe how the maternity service leadership raise concerns, celebrate success and routinely report to the board?
- How do you demonstrate check and challenge of the service?

## Capable, compassionate and inclusive leaders

- How does the board maintain visibility in the clinical areas and use this visibility to feedback to board and sense-check against data presented at board?
- How does the board hear about staff vacancy rates, sickness rates, other leave impacting the team, for medical and all grades of midwifery staff?

## Freedom to speak up

- What has the board been made aware of as a result of staff giving feedback or speaking up?
- How do you encourage staff to raise concerns and demonstrate actions taken as a result?

## Workforce equality, diversity and inclusion

- Describe the board oversight of the culture of the maternity service.
- Are there any actions reflective of the findings of the trust staff survey results?
    - Including but not limited to protected characteristics and bullying and harassment?
- How reflective of the population is the workforce and what steps are being taken to address any shortfalls?

## Governance, management and sustainability

- Describe how relevant information is escalated to the board from the trust quality and safety committee.

- How are the board made aware of the risk registers and maternity red flag responses, compliance with Maternity Incentive scheme and the audit programme?
- To what extend is maternity service included on the board assurance framework?
- How do leaders report maternity service staffing to the board (this includes the use of bank, agency and locums; planned versus actual for labour ward, postnatal, antenatal, antenatal clinical, triage, maternity assessment/maternity day unit and community staffing; specialist and supernumerary roles)?
- How do the maternity service safety and quality outcomes compare nationally?

### Partnerships and communities

- How do senior leaders engage with relevant partners for maternity services?

### Learning, improvement and innovation

- What recent improvements have there been to the service?
- How do you ensure that multiple opportunities are available for staff to learn?

### The importance of people's experience

- Do you receive patient stories at board from those with direct experience of the maternity service?

# Integrated care systems

## What we look for

### Shared direction and culture

- How are specific strategies identified to support the development of particular services relevant to population or service improvement need, for example maternity services?
- How do you involve key stakeholders in the development of such strategies?

### Workforce equality, diversity and inclusion

- What measures are in place to demonstrate how the integrated care system (ICS) is driving equality, diversity and inclusion in the work and promoting a workforce that represents the ICS population?
- Are there system wide plans for maternity services to implement workforce and leadership which is representative of the population?

### Governance, management and sustainability

- What governance structure is in place to ensure safe and effective maternity care across the system? Are there lead/s for maternity within this structure and what is their role?
- How do providers report maternity performance and risk into the governance structure and how is learning shared with all relevant providers?

# Good practice in leadership and culture

We had very clear feedback from our maternity workshop that providers and stakeholders want us to share more of the good practice we find on our inspections.

We analysed the inspection reports from the National maternity inspection programme and want to share the good practice we found in relation to leadership and culture. It is not exhaustive. But we hope that services can use the examples and get in touch with the trusts if they wish to learn more.

# Inclusive culture

Maternity cultural safety champions

**Chelsea and Westminster NHS Foundation Trust – Chelsea and Westminster Hospital**

> "The service had 12 maternity cultural safety champions. **The purpose of the cultural safety champions was to address inequalities and improve equity for staff and people using services with protected characteristics.** The champions delivered cultural safety training as part of yearly mandatory training. The 2 hour long cultural competency training sessions aimed to encourage staff to reflect on unconscious biases, understand existing inequalities in maternal and neonatal outcomes and consider how staff can improve their practice to reduce inequalities."

# Staff engagement and recognition

**Northumbria Healthcare NHS Foundation Trust – Northumbria Specialist Emergency Care Hospital**

> "Senior leaders created a leadership ethos that encouraged all staff participation in the running of the service, which enabled staff to find solutions to problems and change the way they worked.

> The service had a culture of deep respect between all levels of staff that translated into an openness and joy at being at work, making this the top trust for staff satisfaction regionally and one of the top nationally.
>
> Senior leaders created Project Joy as a thank you to staff to show how much they appreciated their work and dedication."

## Effective engagement with the maternity and neonatal voices partnership

**Wirral Teaching Hospital NHS Foundation Trust - Arrowe Park Hospital**

> "The maternity and neonatal voices partnership (MNVP) Chair was well supported and received 16 hours per week funding. The relationship between the MNVP chair and leaders was strong and inclusive. The MNVP chair had access to leaders at all times and they responded quickly and efficiently to any concerns raised. The MNVP chair was involved in the recruitment of leaders and encouraged to attend regular meetings to feedback the voices of women. They were involved in a number of initiatives designed to reach out to all groups within the local community."

## Strong leadership and support for staff

**Kingston Hospital NHS Foundation Trust – Kingston Hospital**

> "Matrons often worked clinically on the central delivery suite to ensure staff could take breaks and to mitigate the risks of high acuity and low staffing levels. This was positive as it improved the safety of the unit when staffing levels were reduced. However, this sometimes impacted on matrons' non-clinical duties such as responding to complaints,

> reviewing incidents, organising staff training and completing appraisals."

**Lewisham and Greenwich NHS Trust- University Hospitals Lewisham**

> "The service was supported by the trust maternity safety champions and non-executive directors (NED). Staff told us the maternity safety champions and trust executives regularly carried out a walkaround of the maternity service, which was well advertised in advance. The service shared regular newsletters and posters of 'you said we did' with staff and patient feedback from recent NED visits."

**Chelsea and Westminster Hospital NHS Foundation Trust - Chelsea and Westminster Hospital**

> "The board safety champion ran open forums both virtually and in the maternity unit regularly to gather feedback from staff and listen to their concerns or queries. We reviewed activity logs from the maternity safety champions and saw evidence that they were regularly visible and approachable on the wards, taking a proactive stance in maintaining and improving standards of care within the maternity setting."

# Other helpful resources

## CQC publications

Getting safer faster: key areas for improvement in maternity services

Safety, equity and engagement in maternity services

State of Care

Maternity survey 2023

## Department of Health and Social Care (DHSC)

Leadership for a collaborative and inclusive future

Safer maternity care action plan

## Future NHS

Maternity Incentive Scheme Future NHS workspace Requires a FutureNHS account. Accounts are free and available for everyone working in health and care.

## Health Education England (HEE)

Core20+5 maternity learning module

## Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)

Report: Saving lives, improving mothers' care

## NHS England

Three year delivery plan for maternity and neonatal services (March 2023)

Safer staffing: nursing and midwifery

Learn from Patient Safety Events (LFPSE)

Patient Safety Incident Response Framework (PSIRF)

Health Technical Memorandum

NHS Long Term Plan

## NHS North West Genomic Medicine Service Alliance (NW GMSA)

Keeping MUM resources: red flags and making a referral

## NHS Race and Health Observatory

Maternity and neonatal working group

Review of neonatal assessment and practice in Black, Asian and minority ethnic newborns: Exploring the Apgar Score, the Detection of Cyanosis, and Jaundice

Mapping of existing policy interventions to tackle ethnic health inequalities in maternity and neonatal care in England

## NHS Resolution

Maternity Incentive Scheme

## National Institute for Health and Care Excellence (NICE)

NICE Antenatal Care Guideline 2021

NICE Intrapartum Care Guidelines 2023

NICE Postnatal Care Guideline 2022

Saving babies' lives version three: a care bundle for reducing perinatal mortality

National Bereavement Care Pathway

## Nursing and Midwifery Council (NMC)

Standards for midwives

## Royal College of Midwives (RCM)

Maternity Disadvantage Assessment Tool (MatDAT)

## Royal College of Obstetricians and Gynaecology (RCOG)

Maternity Triage (Good Practice Paper No. 17) (December 2023)

Prevention and Management of Postpartum Haemorrhage (Green-top Guideline No. 52)

## Independent reviews of maternity services

Maternity and neonatal services in East Kent: 'Reading the signals' report

Final report of the Ockenden review

Listen to Mums: Ending the Postcode Lottery for Perinatal Care

FiveXMore Black Maternity Experiences Report

House of Commons Library research briefing: Quality and safety of maternity care (England)

## Organisations promoting equity in maternity care

Birthrights

Five X More

Maternal Mental Health Alliance

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We want to make sure this page is kept up to date with the most useful resources. If you'd like to suggest a resource for inclusion, complete this short form.