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CREATING THE CONDITIONS FOR SAFER MATERNITY AND NEONATAL CARE

A practical listening and improvement pack

2026

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Purpose of this pack

"Nurses and midwives are deeply engaged in the work they do and strongly motivated to make a positive difference to the lives of patients and their families.

...[but] the growing risk of mental health problems and work-related stress faced by nurses and midwives has serious implications for retention, sickness absenteeism and presenteeism, and the quality of patient care."

Mental Health and Wellbeing of Nurses and Midwives in the UK, SOM & RCN, 2020

Maternity and neonatal services are navigating a period of intense focus on safety, culture and learning. Leaders are increasingly asked to demonstrate not just compliance, but a genuine, sustained approach to listening, acting on what they hear, and creating environments where staff feel confident to contribute improvement ideas.

This pack is a practical, grounded resource, drawing on real NHS experience and independent evaluation evidence. It offers tools, examples and guidance to help teams make meaningful progress in strengthening culture and everyday improvement.

The content here uses publicly available evidence, including independent evaluation reports and NHS case examples. It avoids sensational language, and does not imply that any single approach can prevent rare or extreme events. Instead, it focuses on the everyday conditions that help services be safer, more resilient and more responsive.

Lara Mott
Founder, ImproveWell

Creating space to listen, learn and improve

Maternity and neonatal care is delivered in environments where clinical complexity, emotional intensity and operational demand intersect. Staff manage unpredictable clinical pathways and balance safety with compassion and personalisation.

Recent national attention on maternity care has reinforced the importance not only of clinical standards, but also of culture, listening and learning.

Independent commentary and regulatory signals have made clear that services must be able to show how they understand and respond to the experiences of staff and families.

National reporting, including analysis in the British Journal of Healthcare Management, draws attention to the scale of quality challenges in some services. In that context, Care Quality Commission reporting indicated that **49%** of maternity services were rated as inadequate or requiring improvement, alongside ongoing workforce stress and burnout.

In this environment, listening to staff is not an optional extra. It is a core component of safe, reliable care. Enabling people to raise issues early, to share insight about local challenges, and to see improvement efforts progress visibly helps services adapt, learn and improve.

This document is offered to help services create and strengthen these conditions in ways that are practical, proportionate and grounded in everyday practice.

Learn more

Freedom to Speak Up, made practical

Supporting existing routes through continuous listening

An accessible feedback pathway

ImproveWell enables staff to:

- Raise observations as they occur
- Share practical improvement ideas
- Flag operational pressures
- Provide sentiment feedback about their working environment

This is not intended to replace formal Freedom to Speak Up channels. Instead, it complements them by capturing everyday signals that might otherwise go unnoticed until they become more entrenched.

Freedom to Speak Up Guardians have a vital role in helping staff raise safety concerns via protected, confidential routes. They help identify barriers to speaking up and support individuals through formal processes.

However, not all staff feel ready to use formal channels even when they have valuable insight to share. Some may be uncertain whether an issue merits formal escalation. Others may feel more comfortable contributing operational observations or improvement ideas that do not fall under a formal concern.

A complementary approach offers an always-on, low-friction way for staff to signal experience, ideas and concerns. This supports Freedom to Speak Up by capturing insight in the moment, in a structured and confidential way.

ImproveWell provides a continuously available way for colleagues to give real-time input, with feedback structured into categorised themes that support proportionate review and escalation where appropriate.

A simple model for action

Teams have found it useful to adopt a shared model that supports structured handling of feedback:

Signal

Staff share insight through an accessible digital channel.

Triage

Feedback is reviewed, themes are identified and appropriate responses are agreed.

Act

Actions are taken quickly, prioritising low cost, high impact improvements.

Close the loop

Feedback and actions are shared back with staff, supporting transparency, assurance and continuous improvement.

Evidence

Themes, actions and outcomes are recorded for governance and learning.

This model supports both Freedom to Speak Up and broader quality and safety leadership by helping teams understand what matters most to staff and act accordingly.

Support for Freedom to Speak Up processes

Ready-to-use listening prompts

Turning listening into everyday practice

For listening to genuinely support safety and improvement, it needs to be timely, focused and embedded into everyday work. In maternity and neonatal services, risks and pressures often emerge through small, repeated signals rather than isolated incidents. These signals can be missed if listening relies solely on infrequent surveys or retrospective reviews.

Real-time listening prompts provide a way to capture how work is actually experienced on the ground. They help staff articulate friction, risk and opportunity in the moment, while pressures are still manageable. Over time, these insights build a richer picture of system reliability, staff experience and emerging themes.

Crucially, these prompts are not investigative and are not intended to assess individual performance. They are designed to support Quality Improvement by highlighting where systems are under strain and where small changes could make a meaningful difference.

01 Operational reliability

Operational reliability underpins safe maternity and neonatal care. When systems are fragile, staff often compensate through informal workarounds, which increases cognitive load and can introduce risk.

Suggested prompts include:

- Where are we relying on workarounds today and what is driving the need for them?
- Which processes or tools regularly slow us down or create duplication?
- What equipment, information or support is hardest to access when we need it most?

These prompts help teams identify patterns rather than isolated frustrations, allowing leaders to prioritise improvements that strengthen reliability.

02 Safety, flow and pressure points

Maternity and neonatal services often experience fluctuating demand, staffing pressures and flow challenges. Listening prompts can help teams surface where pressure is most acute.

Examples include:

- What would make the next shift safer or calmer for staff and families?
- Are there particular pinch points in handover, documentation or staffing flow?
- Is anything currently increasing distraction or cognitive load unnecessarily?

Capturing this insight in real time supports earlier intervention and more targeted improvement.

03 Culture and speaking up

Psychological safety is central to Freedom to Speak Up and effective improvement. Staff are more likely to raise concerns and ideas when they believe their voice will be respected and acted upon.

Culture-focused prompts might include:

- Have you been able to raise a concern and feel heard this week?
- Have you noticed something recently but felt unsure how to raise it?
- What would make it easier to share ideas or concerns in this team?

Independent evaluation evidence from maternity services shows that when staff have accessible, real-time ways to share feedback, improvements are prioritised and implemented more quickly.

Further reading:

- ImproveWell Evaluation Report
- ImproveWell maternity services overview

Small but mighty safety and reliability ideas

Learning from frontline insight

Across maternity services using ImproveWell, one of the most consistent findings is that effective improvement is often driven by small, practical ideas suggested by frontline staff. Independent evaluation shows that around **80%** of ideas submitted required no additional funding.

In high pressure environments, these incremental improvements are particularly valuable. They are achievable, locally owned and can be implemented quickly, reducing frustration and supporting safer working.

Improving emergency readiness

Frontline staff highlighted that repeatedly checking emergency equipment was time consuming and created uncertainty. Introducing security tags and sealed trolleys for emergency kits enabled staff to confirm readiness at a glance.

This change:

- Reduced time spent checking equipment
- Increased confidence in emergency preparedness
- Supported quicker, safer responses in critical situations

Supporting staff wellbeing as a safety enabler

Staff wellbeing is closely linked to safety and reliability. Feedback from maternity teams identified the lack of appropriate rest spaces for colleagues working long shifts.

Creating dedicated staff break rooms provided a practical way to:

- Reduce fatigue
- Support recovery during demanding shifts
- Enable safer working practices

Strengthening documentation reliability

Accurate timing is essential in maternity and neonatal care. Feedback highlighted inconsistencies between clocks across delivery rooms, which created unnecessary risk and documentation discrepancies.

Installing centrally controlled digital clocks addressed this issue simply and effectively, supporting:

- Accurate and consistent time recording
- Reduced discrepancies in clinical notes
- Greater confidence in documentation during reviews and assurance processes

These examples demonstrate how listening to frontline insight can lead directly to improvements that support both safety and staff experience.

From small ideas to sustained improvement

How frontline insight becomes lasting change

The “small but mighty” examples show how simple, practical changes can improve safety, reliability and staff experience. This section explains what enables those changes to happen, how they are sustained over time, and what maternity and neonatal leaders can learn from this experience.

Sustaining engagement over time

One of the key findings from the evaluation is that engagement with improvement tools naturally fluctuates. When ImproveWell was first introduced, activity was high, supported by strong enthusiasm and an active local champion. Over time, activity reduced and then stabilised as early ideas were implemented and the organisation went through periods of change, including role changes and system redesign.

This pattern is normal and expected. It reflects three important realities:

- Staff often hold many improvement ideas that surface quickly when a new channel is introduced
- After this initial phase, idea flow becomes steadier and more reflective of day to day improvement
- Organisational change, such as restructuring or role changes, can temporarily reduce engagement if support is not maintained

This highlights that improvement platforms do not “run themselves”. Sustained benefit depends on continued leadership attention, reinforcement and support.

The evaluation emphasises that sustainability requires active stewardship, not passive availability. Without this, even valuable tools risk becoming underused.

The role of champions and local leadership

A consistent theme in the evaluation is the importance of local champions. The success of ImproveWell in maternity services was strongly associated with having motivated, visible and trusted individuals who:

- Promoted the platform regularly
- Encouraged participation
- Responded to ideas promptly
- Followed ideas through to action
- Publicly acknowledged contributions

Staff repeatedly highlighted that the presence of an engaged champion made the difference between the platform feeling alive and useful, or distant and irrelevant.

Quotes from the evaluation illustrate this clearly:

- *"I think it needs a highly motivated and driven lead to make it as successful as it has been with us."*
- *"You need to keep reminding staff."*
- *"I like the idea of acknowledging people's ideas and encouraging staff to be more involved."*

The champion role is not primarily technical. It is relational and cultural. It signals that staff input matters, that leadership is listening, and that ideas are valued.

Importantly, the evaluation also notes that this requires time and resource. Responding to ideas, providing feedback and maintaining visibility all require protected time and organisational commitment.

Closing the feedback loop builds trust

Another key finding is the importance of closing the feedback loop. Staff expressed a clear desire to know what had happened to their ideas. When feedback was not received, some contributors felt discouraged and less likely to engage again.

Requests included:

- Updates on idea progress
- Visibility of other ideas and actions
- Opportunities to discuss ideas collectively

This reinforces that listening alone is not enough. Trust is built when staff can see:

- That their input is reviewed
- That it leads to action where appropriate
- That progress is communicated openly

This transparency transforms engagement from a one way submission process into a shared improvement journey.

Supporting learning, development and professional identity

The evaluation also highlights that ImproveWell supported staff development, not just operational improvement.

Staff and leaders described how contributing ideas helped individuals:

- Build confidence
- Develop leadership skills
- Feel more professionally engaged
- Move from "learned helplessness" to proactive problem solving

This shift is culturally significant. It moves teams from seeing problems as imposed, to seeing improvement as something they own and shape.

The platform was also seen as supporting professional development and revalidation by:

- Providing evidence of quality improvement activity
- Recognising contributions through certificates and "idea of the month"
- Creating tangible records of engagement and learning

This reinforces that improvement is not just a technical process, but a human one tied to motivation, identity and professional pride.

What makes improvement work in practice

The evaluation identifies a set of "vital ingredients" for success:

- Dynamic local champions
- Flexibility to submit ideas anytime, anywhere
- Ownership at team and ward level, not just centrally
- Protected time to lead change
- Ongoing coaching and support
- Senior oversight and visibility
- Recognition and celebration of ideas
- A system that tracks, audits and evidences improvement

These elements together create the conditions where improvement becomes normal practice rather than an occasional initiative.

Crucially, the evaluation warns against treating ImproveWell as a standalone solution. It works best as part of a broader strategy for engagement, learning and culture change.

Summary

The "small but mighty" ideas show what can change. This evaluation shows how and why those changes happen and persist.

Sustained improvement depends on:

- Visible leadership
- Active champions
- Closing feedback loops
- Recognition and development
- Integration into everyday work
- Alignment with organisational culture and priorities

Together, these elements turn individual ideas into collective learning, and small improvements into lasting cultural change.

This is how frontline insight becomes not just action, but a safer, more resilient maternity and neonatal service.

Board and Governance and Assurance

Demonstrating culture, listening and learning

Service leaders are increasingly expected to provide evidence not only of safe practice, but of a robust Governance and Assurance framework that includes listening to frontline insight, learning and acting on what is heard.

Governance in practice

At Shrewsbury and Telford Hospital NHS Trust, ImproveWell was explicitly referenced as part of the Governance and Assurance response following the Ockenden Review. Staff feedback collected through the platform was incorporated into the Maternity Transformation Programme, where culture was a core workstream.

Insights from staff were reported through the Ockenden Report Assurance Committee, providing visible evidence that views from across the workforce were being considered and acted upon. By early 2023, the Trust had delivered **77%** of actions from the Ockenden reports, ahead of its projected schedule.

Evidence leaders can use

Using structured real-time feedback, services can demonstrate:

- Levels of engagement and participation across roles
- Longitudinal sentiment trends
- Thematic insights that highlight operational risk signals
- Actions taken in response to feedback
- Time taken to close the feedback loop
- Concrete examples of improvements and their outcomes

Independent evaluation at Royal Cornwall Hospitals NHS Trust showed that:

- **75%** of staff using ImproveWell felt able to improve their area of work (vs 53%Trust wide)
- **85%** felt empowered to implement change

These metrics provide measurable evidence that services are listening, learning and improving - important components of both internal assurance and external review.

Further reading (Governance and Assurance):

- Ockenden review and response reference
- Improve CQC ratings and engagement

A 90-day rollout blueprint

Making improvement feel achievable

For maternity and neonatal services under pressure, improvement approaches must feel realistic and proportionate. A clear, time-bound structure helps teams focus effort, build momentum and demonstrate early impact without overwhelming staff.

This 90 day blueprint provides a practical starting point that services can adapt to their local context.

Weeks 1 to 2: Laying the foundations

The initial phase focuses on clarity, trust and shared purpose.

Key actions include:

- Identifying local champions across maternity and neonatal teams, including a mix of clinical and non-clinical roles
- Agreeing feedback categories and escalation routes, aligned with existing Freedom to Speak Up and governance processes
- Communicating the purpose clearly, emphasising support, listening and improvement rather than scrutiny

This stage is critical for building confidence and setting expectations.

Weeks 3 to 6: Focused listening and early action

Once foundations are in place, teams can begin listening at pace.

Key actions include:

- Run prompts on national priorities like safety, continuity, workforce wellbeing and documentation
- Review feedback for themes and risks
- Act early on visible improvements
- Share actions to demonstrate learning, responsiveness and trust

Early action helps demonstrate that feedback leads to change, reinforcing engagement and trust.

Weeks 7 to 12: Embedding learning and assurance

The final phase focuses on sustainability and assurance.

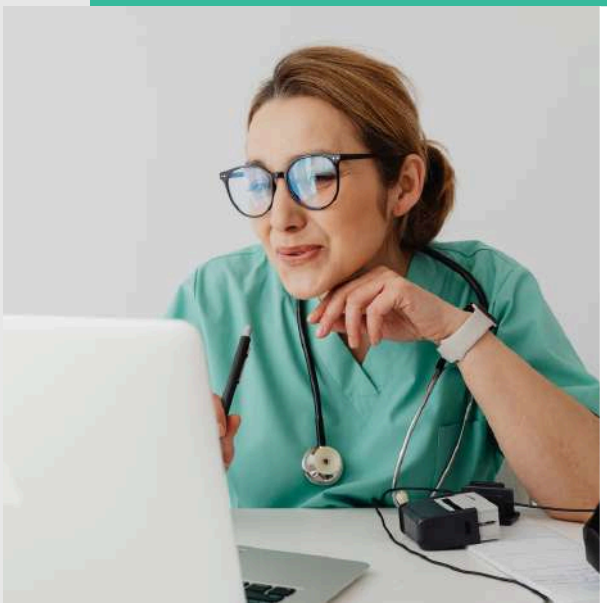
Key actions include:

- Publishing regular “you said, we did” updates to close the feedback loop
- Recognising and celebrating implemented ideas in team and leadership forums
- Reporting themes, actions and outcomes through Governance and Assurance structures

Regional experience, including the Black Country maternity collaboration, shows that this combination of listening, action and visibility helps embed improvement into routine practice.

Further reading and examples: Black Country maternity regional rollout, Black Country awards recognition.

Why now?



How improvement activity is framed matters deeply in maternity and neonatal services. Language that feels alarmist or implies blame risks creating fear and disengagement, rather than learning and improvement.

This pack deliberately avoids suggesting that any single tool or platform can prevent extreme or rare events. Instead, it focuses on strengthening the everyday conditions that support safer, more reliable care.

A proportionate, improvement focused narrative

The current national context places renewed emphasis on Quality Improvement, culture and learning within maternity and neonatal services. This includes expectations that services can demonstrate how they:

- Listen to staff experience
- Identify emerging risk signals
- Act on feedback and learn over time

These expectations align closely with Governance and Assurance, Improving CQC ratings, and the NHS Resolution Maternity Incentive Scheme, all of which place increasing emphasis on evidence of engagement, learning and a strong safety culture.

What ImproveWell supports in this context

Within this framing, ImproveWell supports teams to:

- Surface operational risk signals earlier, such as workarounds, missing equipment or documentation friction
- Strengthen psychological safety and Freedom to Speak Up, particularly for junior staff, bank staff and new starters
- Close the feedback loop visibly, so staff see action and feel their contribution matters
- Create clearer, more consistent evidence for regulators and assurance by demonstrating continuous listening and improvement cycles

This approach supports proportionate assurance without increasing burden on already stretched teams.

Alignment with CQC regulations and national quality standards

Maternity and neonatal services are increasingly expected to demonstrate that they are well led, safe, responsive to feedback and committed to continuous learning and improvement.

The ImproveWell platform supports this by embedding structured listening and improvement into everyday practice, and by providing evidence that staff and service user feedback is actively captured, reviewed and acted upon.

CQC Well-led and Safe domains
The CQC's Well-led and Safe domains place strong emphasis on organisational culture, learning, and responsiveness to concerns.

ImproveWell supports these requirements by:
- Providing a real-time route for staff to raise concerns and contribute improvement ideas
- Supporting structured review and escalation of feedback
- Creating an audit trail of themes, actions and outcomes

This enables services to demonstrate that staff voices are heard, that risks are identified early, and that learning leads to action.

CQC Regulation 18 (Staffing)
CQC Regulation 18 requires organisations to ensure safe and sufficient staffing.

ImproveWell contributes by:
- Providing insight into workforce morale, pressures and stressors
- Highlighting areas that may affect retention, sickness or wellbeing
- Supporting targeted interventions to improve staff experience

This helps services strengthen workforce sustainability and assurance around safe staffing.
Workforce engagement and development

ImproveWell strengthens workforce engagement by:
- Giving staff a visible voice in improvement
- Recognising and valuing contributions
- Supporting leadership and improvement skills

This supports a culture of ownership, learning and continuous improvement.

Case example: Royal Cornwall Hospitals NHS Trust
At Royal Cornwall Hospitals NHS Trust, the maternity department was rated 'Inadequate' in 2017. ImproveWell was introduced in 2018 as part of a wider engagement strategy. Within one year, the service improved to 'Requires Improvement', and by 2023 it had reached a 'Good' rating.

Independent evaluation showed:
- 75 percent of ImproveWell users felt able to improve their area of work, compared with 53 percent Trust-wide
- 85 percent felt empowered to implement change

This illustrates the link between engagement, improvement culture and regulatory progress.

Alignment with the NHS Resolution Maternity Incentive Scheme

The NHS Resolution Maternity Incentive Scheme focuses on learning, assurance and safety culture.

ImproveWell supports this through:

Safety Action 7: Listening and co-production

ImproveWell enables:
- Real-time capture of learning and feedback from women, parents and families
- Structured recording of service user insight
- A dedicated module for stakeholder participation

This supports co-production and visible responsiveness.

Safety Action 9: Board assurance

ImproveWell supports Board assurance by:
- Providing data on engagement, themes and improvement activity
- Creating transparency around risks, actions and outcomes

At Shrewsbury and Telford Hospital NHS Trust, ImproveWell was referenced in Board papers as part of the Trust's assurance response following the Ockenden Review.

Summary

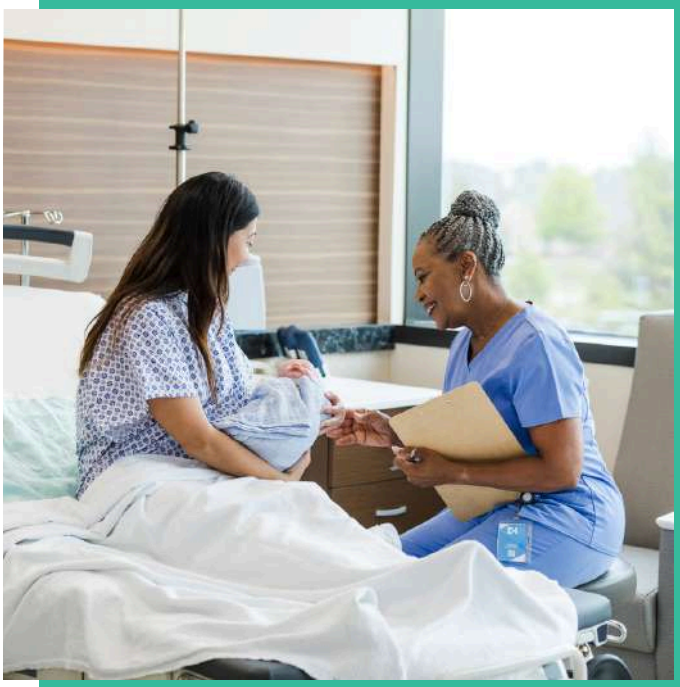
ImproveWell supports maternity and neonatal services to:
- Meet regulatory expectations
- Strengthen listening and learning
- Support workforce wellbeing and retention
- Provide assurance to Boards and regulators

In doing so, it helps create the conditions for safer, more reliable and more compassionate care.

National context and leadership focus

The appointment of Baroness Amos to lead the independent investigation into NHS maternity and neonatal care reflects a strong national focus on learning, improvement and safety.

Related publication:
UK Government announcement on the Baroness Amos review.



A shared guiding principle

A gentle, unifying principle underpins this work:

When services are under strain, the safest organisations are the ones that listen early, act consistently and help staff feel able to speak up and improve care together.

Want to continue the conversation?

improvewell.com

hello@improvewell.com

07834 322 366

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ImproveWell and Silicon Practice are the trading names of Schappit Ltd., 79-93 Ratcliffe Road, Sileby, Loughborough, Leicestershire, England, LE12 7PU