Women & Children's Care Group

Safety Improvement Plan Update: June 2018

(Please Note: This is a working, adapting, improvement plan, rather than an action plan with definitive action statuses)

Safer Maternity Care

Safer Maternity Care is an action plan setting out the vision for making NHS maternity services some of the safest in the world, by achieving a national ambition to halve the rates of stillbirths, neonatal deaths, brain injuries that occur during or soon after birth and maternal deaths, by 2030.

A structured action plan around the five key drivers for delivering safer maternity care, which are based on the guidance set out in **Spotlight on Maternity**

SaTH Maternity Services have been benchmarked against the Safer Maternity Care Action Plan

Maternity Safety Improvement Plan

As outlined in Spotlight on Maternity, trusts should ensure that a bespoke Maternity Safety Improvement Plan is agreed and made public

SaTH Maternity Services have developed a bespoke Maternity Safety Improvement Plan, corresponding to the Sign Up To Safety High Level Themes:

SIP-Building Strong Leadership,
SIP-Building Skills and Capability,
SIP-Sharing Progress and Lessons Learnt,
SIP-Data Capture and Knowledge

Monitoring of Maternity Safety Improvement Plan:

This action plan is monitored via Operational Maternity Governance, is overseen by Care Group Board and will be reported by Exception to the Trust Quality & Safety Committee

Safer Maternity Care – Progress

AIMS	PROGRESS - June 2018
Team Work and Service User Engagement:	Former MEG Group will become part of the Maternity Voices Workstream (LMS) LMS plan approved by NHSE Maternity Voices Workstream established Management of transition from MEG to Maternity Voices will now be the shared responsibility of the 2 Maternity Matrons and the DHoM
Leadership	Care Group Senior Management Team (SMT) are to undertake the Aston Team Journey with input from HR Senior Midwifery Management Team have commenced Aston Team Journey, Team Leader in place (HoM) and Coach in place
RCA Training sessions:	2-day training New dates launched in March 2018 for next cohort
Investigating Incidents:	National Perinatal Mortality Review Tool (PMRT) to replace SCORE W&C undertaking the Patient Safety Value Stream (VMI) #5Patient Safety - to date, that has included RPIWs for Safety Huddles and Datix Incident Reporting Safety Huddles include standardisation across all areas of Maternity of daily feedback to staff regarding immediate lessons to learn from incidents
Leadership at all levels:	Direct communication with Trust Board (Maternity Champion) See Safety Improvement Plan (DoNMQ) - May 2017
Ward to Board	Direct communication with Trust Board (Maternity Champion) See Safety Improvement Plan (DoNMQ) - May 2017 Exemplar Program (Trust-wide) commenced. Antenatal Ward - Diamond Status achieved Feb 2018 Continue with Exemplar Program within Maternity
Shared Learning: national	Publication of the SIP online Membership of Networks HoM representation at Regional and National levelMaternity Safety Thermometer to commence Each Baby Counts MBRRACE NMPA Neonatal Maternal Perinatal Audit GIRFT benchmarking

Improving the quality of care across the maternity pathway, from the first booking appointment to delivery and postnatal care:	Access targets not being met – 10+0 Week target monitored via Risk Register. Meetings on-going Bounty Patient Information App launched February 2017 Bounty review demonstrates 47% uptake - plans to increase uptake underway Reviewing Antenatal and Postnatal Pathways - Commenced Transitional Care Bundle – reviewed Implementation of the CNST Incentivisation Scheme April 2018 - End April to include 34 week babies on PN Ward Neo NEWS process and guideline to be reviewed in line with NEWTT
Saving Babies' Lives care bundle:	Some funding has been identified for Scanning machines from LMS CNST Incentivisation Scheme will include funding for Midwife Sonographers to enable additional scanning and will incorporate training relevant to Saving Babies' Lives
Keep mother and baby together	Transitional Care Bundle – reviewed Implementation of the CNST Incentivisation Scheme April 2018 - End April to include 34 weekers on PN Ward
Standardised Perinatal Mortality Review Tool	National Perinatal Mortality Review Tool (PMRT) to replace SCORE W&C undertaking the Patient Safety Value Stream (VMI) #5Patient Safety - to date, that has included RPIWs for Safety Huddles and Datix Incident Reporting Safety Huddles include standardisation across all areas of Maternity of daily feedback to staff regarding immediate lessons to learn from incidents
Multidisciplinary: train together	PROMPT Proposal to replace Day 1 (April 2017) - Commenced
Appropriate staffing levels:	Birth-rate Plus findings (April 2017) and staffing levels will require a review on completion of the public consultation in to the proposed model of care (CCG MLU Review) Current position: CCG MLU Review Proposed Model awaiting NHSE sign-off - next steps include Health Overview Scrutiny Committee (HOSC) 22/03/18, and Clinical Senate 28/03/18 Clinical Senate will inform and advise NHSE with regards to decision to commence Public Consultation

Maternity information systems will be in place and compliant with reporting data to the Maternity Services Data Set:	Clinical Quality Indicators for Maternity (CQIMs) National Maternity Indicators (NMIs) as per the National Maternity Transformation Program are now incorporated in to our dashboard. In addition, dashboard to reflect learning from Wave 1 of the Maternity Neonatal Safety Collaborative (Run rates to replace dashboard)
MBRRACE- UK to monitor and report on rates of stillbirth and neonatal deaths.	National Perinatal Mortality Review Tool (PMRT) to replace SCORE W&C undertaking the Patient Safety Value Stream (VMI) #5Patient Safety - to date, that has included RPIWs for Safety Huddles and Datix Incident Reporting Safety Huddles include standardisation across all areas of Maternity of daily feedback to staff regarding immediate lessons to learn from incidents

Safety Improvement Plan: Building Strong Leadership - Progress

AIMS	PROGRESS –June 2018
Agree Safety Improvement Plan:	Update to the Q&S Committee with Safety Improvement Plan progress April 2018
Executive sponsor for safety in maternity	Director of Nursing, Midwifery and Quality
Develop at Corporate Quality and Safety level a specific work stream for safety in maternity	W&C Care Group report quarterly to Q&S Committee
SAFER MATERNITY CARE: Ward to Board	Direct communication with Trust Board (Maternity Champion) See Safety Improvement Plan (DoNMQ) - May 2017 Exemplar Program (Trust-wide) commenced. Antenatal Ward - Diamond Status achieved Feb 2018 Continue with Exemplar Program within Maternity

Safety Improvement Plan: Building Skills and Capability- Progress

AIMS	PROGRESS – June 2018
Gain data on current workforce pressures	Models of Care Plan presented to Executives on the 21st December 2016. Amendments to Models of Care rejected by executives and required consultation. CCGs made aware of current service provision challenges. CCGs (Telford & Wrekin and Shropshire) jointly commissioned a MLU Review. CCG MLU review commenced summer 2017 and completed November 2017. CCG Proposed Model of Care requires sign-off from NHSE prior to public consultation. HOSC 22/03/18 to consider CCG proposals Clinical Senate 28/03/18 to consider and advise NHSE regarding a public consultation
	Trust Board 29/06/17 approved recommendations (Transitional Model) from the Care Group Board to suspend intrapartum and postnatal care in three smaller MLUs as an interim solution to the workforce issues. Transitional Model in place 01/07/17 - 31/12/17
Review of Escalation policy	Escalation Policy under review. Review to include: Roles and responsibilities of the DS Coordinator; Supernumery status of the DS Coordinator and the discussion with executives prior to decision for suspension of services
Review Triage service opening hours	Current workforce on DAU consolidated with Triage to enable 24/7 operation. Overnight trial in progress
Develop evidence base for workforce allocation using Birthrate plus project and Safer Staffing tool	Birthrate Plus findings (April 2017) and staffing levels will require a review on completion of the public consultation in to the proposed model of care (CCG MLU Review) Current position: CCG MLU Review Proposed Model awaiting NHSE sign-off - next steps include Health Overview Scrutiny Committee (HOSC) 22/03/18, and Clinical Senate 28/03/18 Clinical Senate will inform and advise NHSE with regards to decision to commence Public Consultation

Fill vacant Band 8 Assurance lead position	Quality Improvement leads for both Paediatrics/Gynae and Maternity/Neonates
Midwifery resource: Improve oversight of SOM's at SATH	Professional Midwifery Advocates (PMAs) have replaced Supervisors of Midwives PMA bridging program undertaken x 3. Further 3 PMAs to undertake.

Safety Improvement Plan: Sharing Progress and Lessons Learnt- Progress

AIMS	PROGRESS - June 2018
Enhance handover; safety briefings	W&C undertaking the Patient Safety Value Stream (VMI) #5Patient Safety - to date, that has included RPIWs for Safety Huddles and Datix Incident Reporting Safety Huddles include standardisation across all areas of Maternity of daily feedback to staff regarding immediate lessons to learn from incidents - This is in addition to currently established DS handovers and DS board rounds
Receptive to Patient Feedback and Staff feedback	Maternity Patient Survey 2018 demonstrates sustained/improved satisfaction and further improvements to be implemented. Staff Survey completed - Improvements Actions developed
Develop dashboards with KPIs	Clinical Quality Indicators for Maternity (CQIMs) National Maternity Indicators (NMIs) as per the National Maternity Transformation Progam are now incorporated in to our dashboard. In addition, dashboard to reflect learning from Wave 1 of the Maternity Neonatal Safety Colaborative (Run rates to replace dashboard) Submission of data to National Safety Thermometer
HRCR/SI recording	Standardisation of training for Investigating Officers Trust are developing a pool of IO's, trained to the same level to undertake objective investigations in other Care Groups (impartiality)

Safety Improvement Plan: Data Capture and Knowledge - Progress

AIMS	ACTION	PROGRESS - June 2018
Compliance with national requirements	Compliance with maternity safety thermometer	National Maternity Safety Thermometer to commence April 2018
Demonstrate Midwifery Community Compliance with practice guidelines	Risk assessment at booking and during pregnancy	2017 audit undertaken
	Recording and plotting of SFH on grow chart	2017 audit undertaken
	Appropriate action when variation from normal progress seen on grow chart	2017 audit undertaken
	Correct application of diabetes screening guideline	2017 audit undertaken
	Risk assessment on admission to community services in labour	Audit scheduled May 2018
	Maternal and fetal observations in labour	Audit scheduled May 2018
Demonstrate compliance of Triage pathways	Reduced fetal movements	Risk paper submitted to W&C RR group April 2018 regarding Medway Implementation, Plastic Wallets in use, Updated guidance regarding attendance, Leaflet given at 15-16 weeks
Demonstrate Antenatal inpatient compliance with practice guidelines	Identification and action on sepsis pathway	MEWS review undertaken Clinical Audit Department - Sepsis audit undertaken
Demonstrate Labour ward inpatient compliance with practice guidelines	Massive PPH	Audit undertaken and presented 2018
	Shoulder dystocia	Monitored via Maternity dashboards Birth injury monitored via Obs Risk Meeting
Demonstrate post natal compliance with practice guidelines	Post natal maternal and neonatal observations	Audit complete 2018
	New born examination	Audit complete 2017
Medical compliance with practice guidelines	Completion of all steps of VBAC pathway	Audit Complete April 2018
Neonatal compliance monitoring	Continuous Audit on the babies transferred from MLU to Neonatal unit	Transfers included within MLU dashboard and it is a requirement that each transfer is reported as an incident