The Shrewsbury and Telford Hospital NHS Trust

Maternity and Neonatal Safety Champions

Introduction for the Ockenden Report Assurance Committee

John Jones

Executive Safety Champion. Acting Medical Director

Tony Bristlin,

Non-Executive Director Safety Champion

"The prime responsibility for ensuring the safety of clinical services rests with the clinicians who provide them……

The prime responsibility for ensuring that they provide safe services, and that the warning signs of departure from standards are picked up and acted upon, lies with the Trust, the body statutorily responsible for those services."

Dr Bill Kirkup, CBE

Chair of the Morecambe Bay Investigation

Contents

- Background
- Who are your safety champions?
- Role of the safety champions
- How we work
- What we have achieved
- Areas for development

Background

- Safer Maternity Care (2016 and 2017) calls for strong leaders at every level of the system; working across boundaries to provide the professional cultures needed for better care.

- Safety Champions play a central role in ensuring that mother and babies continue to receive the safest care possible by adopting best practice

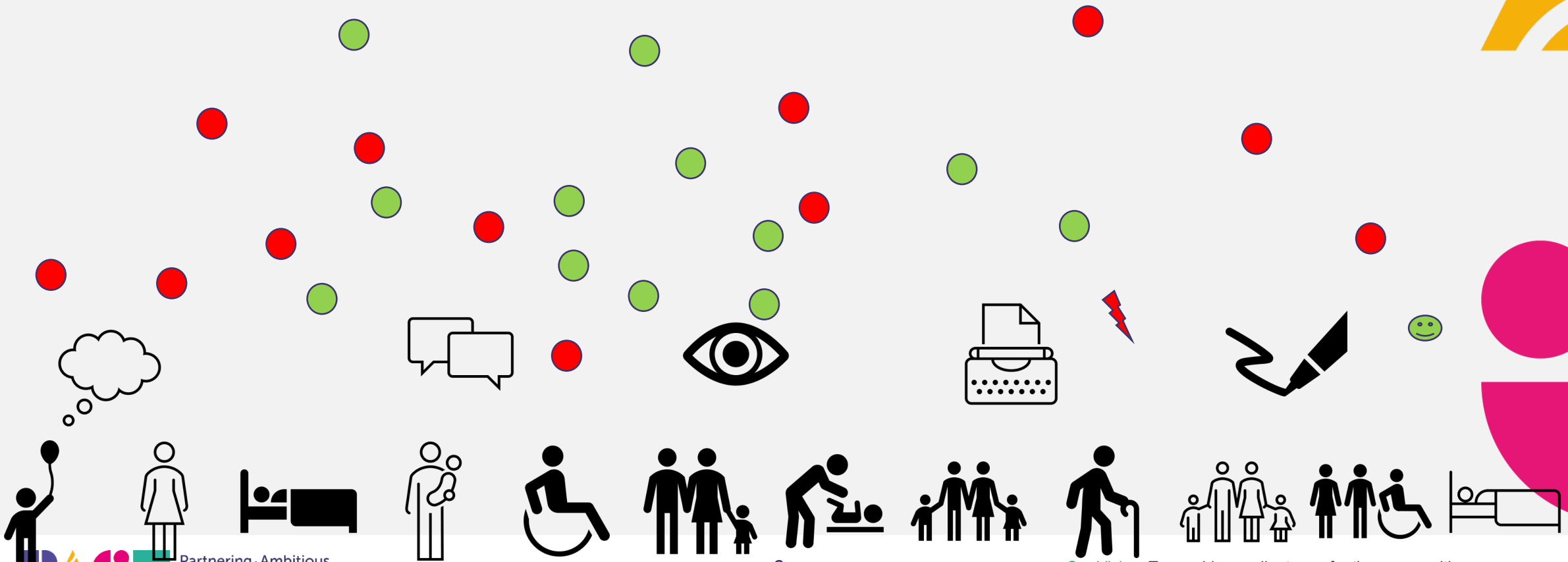
- National programme, led by Professor Jacqueline Dunkley-Bent (NHS Chief Midwifery Officer) and Matthew Jolly (NHS National Director for Maternity and Women's Health). The programme receives a strong focus regionally and locally within SaTH

Board Assurance

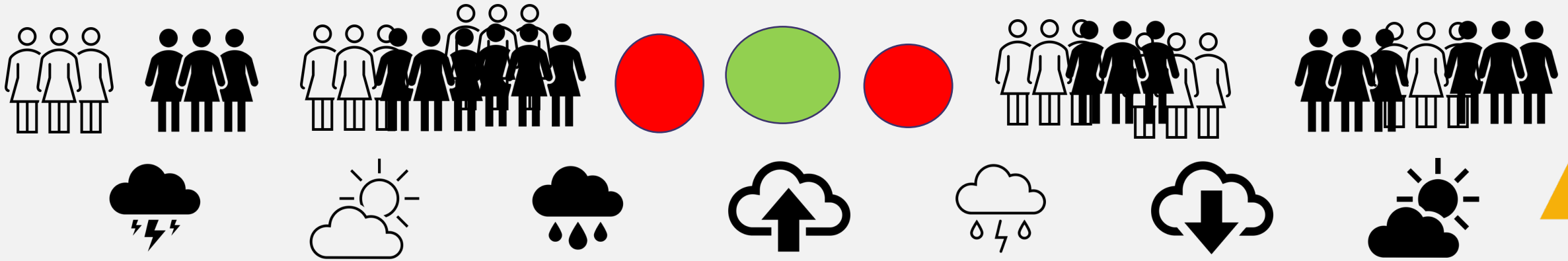
The Shrewsbury and Telford Hospital NHS Trust

- Where does all the safety information come from?
- What happens to information?
- Why might safety information be missed?
- The golden thread

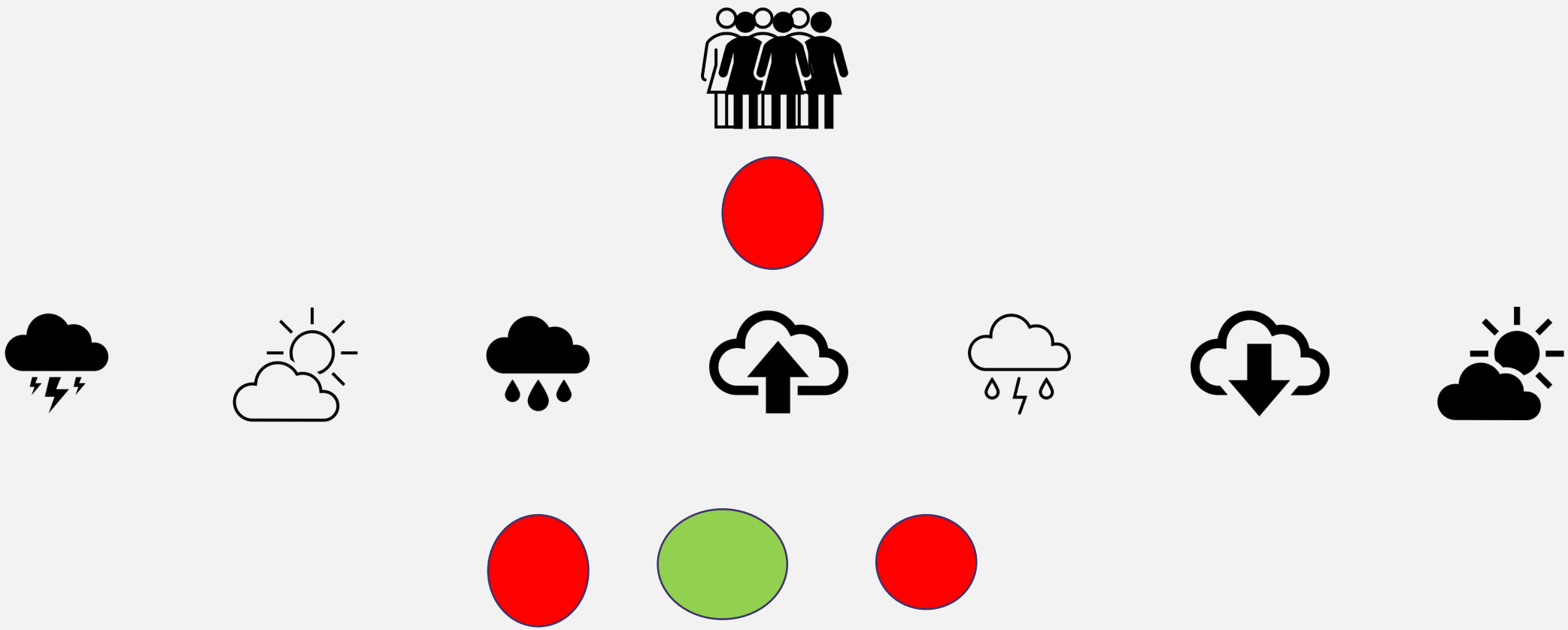
Board Assurance



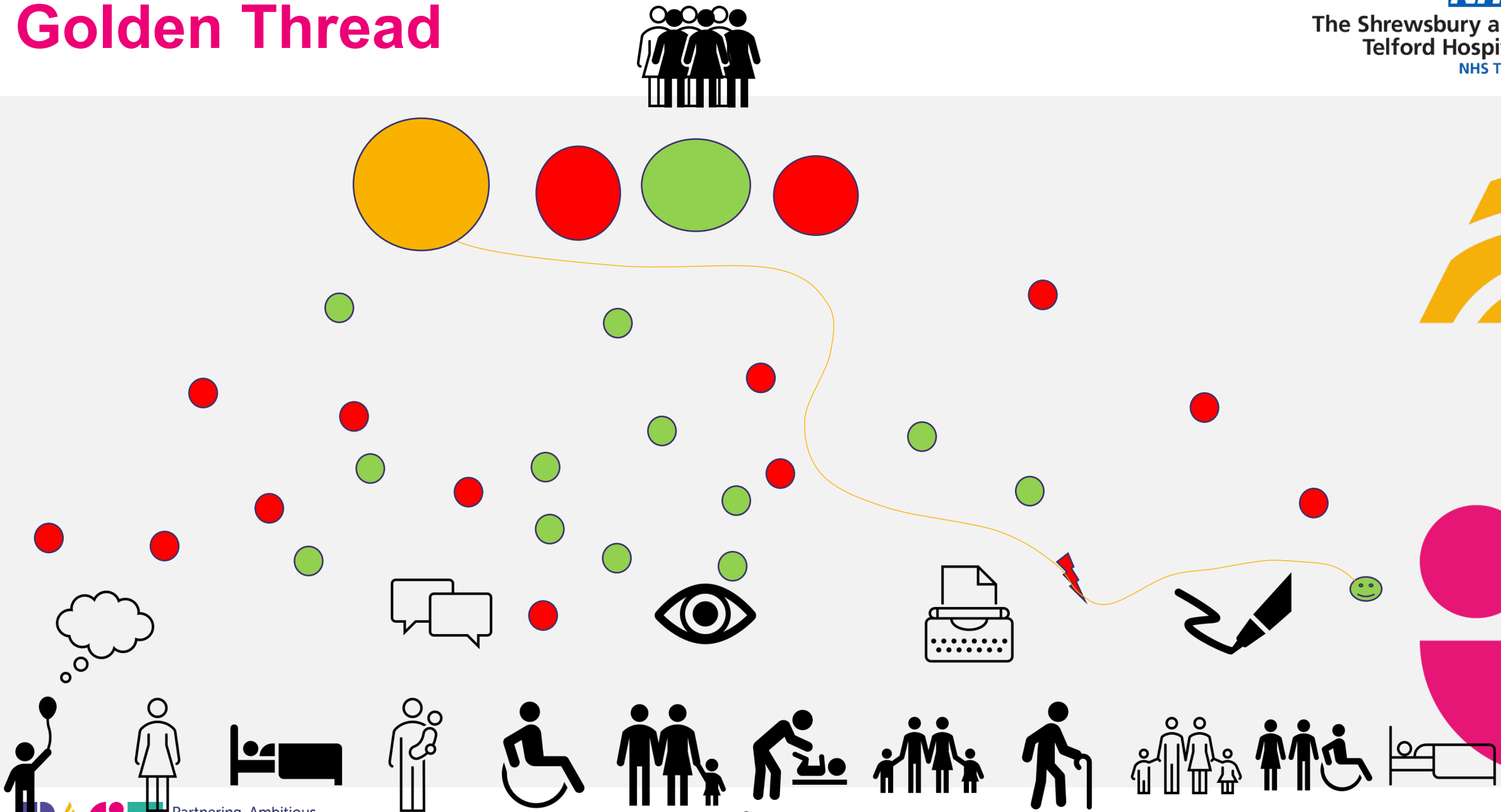
Committees



Board



Golden Thread



NHS
The Shrewsbury and Telford Hospital
NHS Trust

Who are your Safety Champions?

Who are your Safety Champions?
National-level, Board-level and CCG

The Shrewsbury and Telford Hospital NHS Trust

National Maternity Safety Champions

Prof. Jacqui Dunkley-Bent

Chief Midwifery Officer NHSE/I

Dr. Matthew Jolly

National Clinical Director for the Maternity Review and Women's Health

SaTH Board-Level Maternity and Neonatal Safety Champions

Dr. John Jones

Acting Medical Director

Mr Tony Bristlin

Non-Executive Director

NHS Shropshire, Telford and Wrekin CCG

Ms. Sharon Fletcher

Senior Quality Lead and Patient Safety Specialist

Who are your Safety Champions?
CCG Representation and Midwifery Leadership

The Shrewsbury and Telford Hospital NHS Trust

SaTH Midwifery Leadership

Ms. Shirley Jones

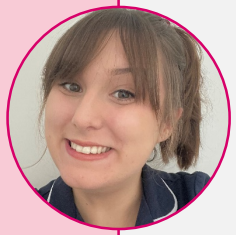
Interim Head of Midwifery

Ms. Annette Barton

Quality Improvement Matron

Midwifery Safety Champions

Sarah Ellement – Professional Midwifery Advocate



Rebecca Gwilt

Midwife

Sara Skellern

Midwife

Who are your Safety Champions?

Obstetrics and Neonatology

Dr. Dorreh Charlesworth

Obstetric Consultant

Obstetrics Safety Champion

Ms. Sarah Kirk

Lead Advanced Neonatal Nurse Practitioner

Neonatal Safety Champion

NHS
The Shrewsbury and Telford Hospital
NHS Trust

The Role of the Safety Champions

Why do we have Safety Champions?

- There is a national ambition to make measurable improvements in safety outcomes for women, their babies and their families who receive care from maternity and neonatal services.
- The national aim is to halve the rate of stillbirths, neonatal deaths, intrapartum brain injuries and maternal deaths by 2025.
- Maternity and Neonatal Safety Champions have been introduced to work on a national, local and Trust level to promote a culture in which better care can be delivered to women, babies and their families which is safe and evidence based.

What do your Safety Champions do?

- Central role in adopting best practice.
- Board Safety Champions engage with our staff and service users on walkabouts to obtain views on safety
- Frontline Safety Champions who are Midwives, Obstetricians and Advanced Neonatal Nurse practitioners. They link with the Trust Board and the Local Maternity and Neonatal System to advocate for safety in their clinical areas. They will work with the Maternity Voices Partnership leads to ensure that our service is responsive to the needs of women, babies and their families.
- The monthly Safety Champion Walkabout is an opportunity for staff to raise and discuss any safety concerns. Feedback from these walkabouts is shared with service leads so that appropriate action plans can be developed, and also on the Safety Champions notice board so the team are aware of progress.

The role of the Executive and Non-Executive Safety Champions

The Executive

- Acts as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, LMNS leads, the Regional Chief Midwife and Lead Obstetrician and the Trust board to understand, communicate and champion learning, challenges and successes.

The Non-Executive

- Supports the Executive Board Safety Champion by:
  - Bringing a degree of independent, supportive challenge to the oversight of maternity services
  - Ensuring that they are resourced to carry out their role
  - Challenging the board to reflect on the quality and safety of its maternity services
  - Ensuring that the views and experiences of patients and staff are heard

How the Board-Level Champions work together

The Shrewsbury and Telford Hospital NHS Trust

- Adopt a curious approach to understanding quality and safety of services
- Jointly, with frontline safety champions, draw on a range of intelligence sources to review outcomes, including staff and user feedback to fully understand the services they champion. In particular this includes monthly safety ward 'walkabouts'
- Update the Trust Board on a monthly basis on issues requiring board-level action (the Board is updated using a board level dashboard on key safety matters). This is mainly achieved through the trusts standard AAA (Alert, Assure and advise) report which is shared at MTAC, QSAC and the Trust Board
- Providing oversight and appropriate challenge in relation to evidence for the CNST maternity incentive scheme safety actions
- Ensuring that learning as well as improvement activity is are shared with the LMS, Regional Chief Midwife and Lead Obstetrician and Patient Safety Networks as part of revised oversight and governance structures.

The role of the Frontline Safety Champions (1 of 2)

The Shrewsbury and Telford Hospital NHS Trust

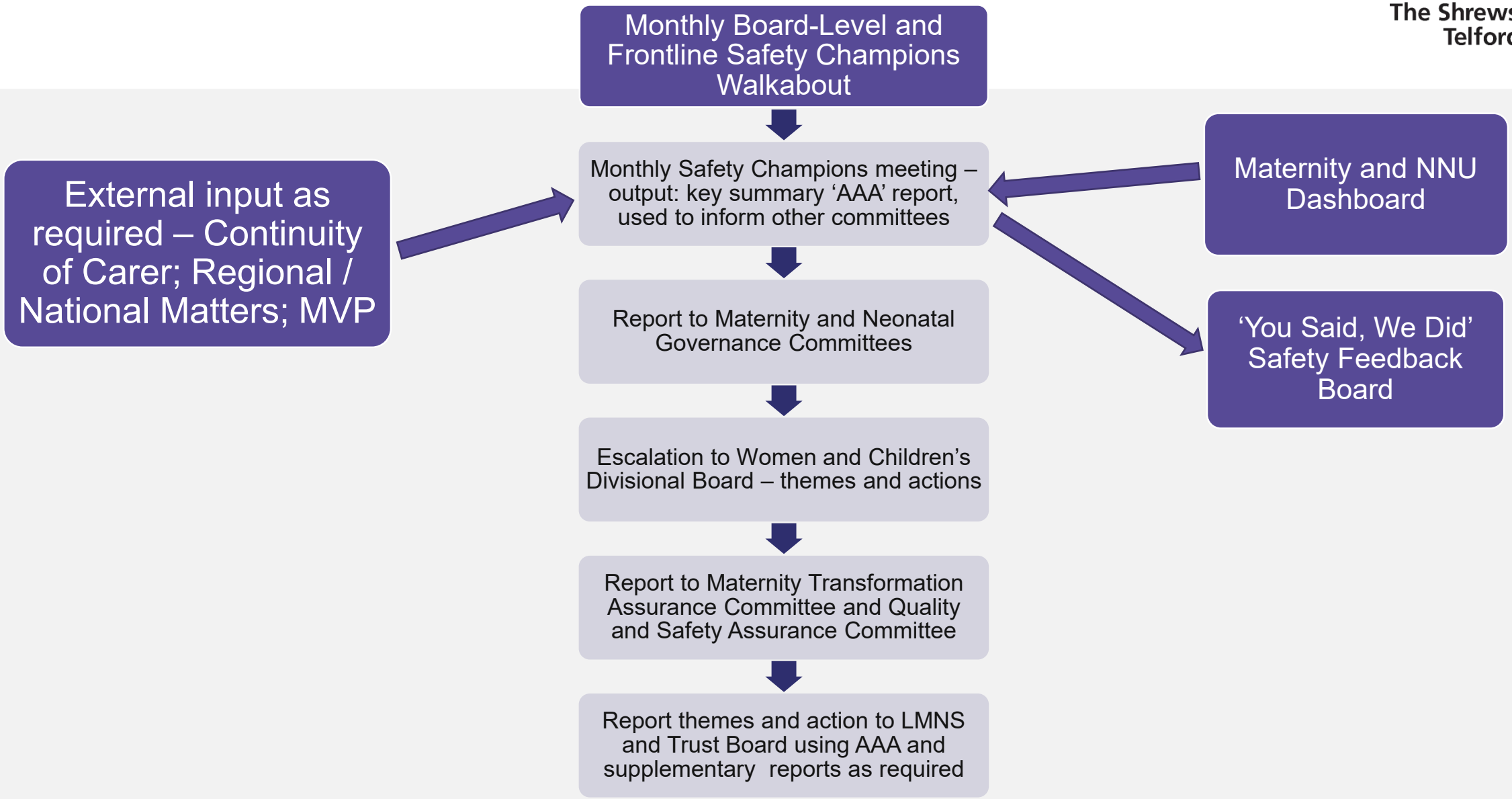
- Champion Staff Engagement in maternity safety initiatives at all levels.
- Support and embrace a culture for raising concerns relating to maternity safety. In particular this includes monthly maternity champion ward level walkabout sessions
- Be a conduit between all levels of staff and the board level safety champions
- Develop ways to obtain feedback from staff in relation to maternity safety which can be shared at the safety improvement group.
- Ensure that mothers and families voices are fully represented
- Review, monitor and support the Continuity of care action plan

The role of the Frontline Safety Champions (2 of 2)

- Develop links with Saving Babies Lives Care bundle elements by working with Saving Babies Lives Lead.
- Monitor and drive compliance with CNST year 4 safety action 9 and other relevant actions
- Support any safety related initiatives identified in the Independent Maternity Review interim Report from Dec 2020
- Support staff involvement in a future SCORE culture survey to measure safety culture.
- Attendance at Strategic Maternal and Neonatal Safety improvement group to ensure alignment with national initiatives. Current areas of focus are smoke-free pregnancy, optimisation and stabilisation of preterm infant and early recognition and management of deterioration of women and babies.
- Identify schemes / actions to be added to the bespoke safety improvement plan
- Work together to co-produce initiatives and innovation in relation to maternity safety.

NHS
The Shrewsbury and Telford Hospital
NHS Trust

How the Safety Champions Operate


Monthly Board-Level and Frontline Safety Champions Walkabout
External input as required – Continuity of Carer; Regional / National Matters; MVP
Monthly Safety Champions meeting – output: key summary 'AAA' report, used to inform other committees
Maternity and NNU Dashboard
'You Said, We Did' Safety Feedback Board
Report to Maternity and Neonatal Governance Committees
Escalation to Women and Children's Divisional Board – themes and actions
Report to Maternity Transformation Assurance Committee and Quality and Safety Assurance Committee
Report themes and action to LMNS and Trust Board using AAA and supplementary reports as required

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Examples of actions identified by safety champions –

‘You Said, We Did’

Area	You said	We did
Maternity Outpatients	A need to improve the distance between service users to support improved infection prevention and control practices	Escalated with Trust estates team to expedite seat spacing and screens - November schedule for completion
Maternity Outpatients	A need to improve the number of 'centile' measurements being recorded on booking.	Raised with Badgernet implementation team and in the meantime ensured completed manually until IT fix in place
Post Natal ward	There was a need to improve the mask fit testing provision for midwives to support service users with Covid	Arranged extra training slots to increase availability of midwives to support covid patients
Wrekin MLU	A need to extend the Wrekin Midwifery Led Unit (MLU) emergency buzzer to other areas outside of the MLU.	Worked with estates to ensure buzzer fitted that sounded in external areas (DS) processes put in place and such as '222' training as a mitigation whilst this was being completed. SOP being put in place and communicated for use of buzzer when MLU reopens

Area	You said	We did
Delivery suite and other wards	Midwifery staffing levels were noted as a potential safety concern on occasions	Checked there was mitigation in place - twice daily monitoring and risk management via safety huddles, allocating staff as appropriate and reporting of acuity and red flags. Note: Intake of new midwives in September
Community midwives / MLU	Not all midwifes who visit patients homes have lone working alert devices.	Investigated and identified devices were available but not issued due to training requirements to ensure correctly used. Raised with maternity leadership who implemented a training programme which the safety champions monitor going forward
Neonatal Unit	Identified raised escalation levels due to shortages of key consumables – Dräger Nasal Prongs	Proposed these were purchased with immediate effect and stocks maintained – which has happened
Neonatal Unit	Specialist Neonatal staff are required to attend Postnatal unit to administer IV antibiotics to infants, thereby temporarily reducing staff numbers on the Neonatal unit	An ongoing process is now in development to enable the Neonatal unit and Postnatal unit to work together on how to most efficiently and safely administer IV antibiotics to infants

Areas for Improvement

- Pace of delivery of actions
- Involvement of service users
- Improve communications with some bodies external to the Trust
- CNST year 4 – meeting some challenging deadlines related to Safety Action 9
- Update and improve feedback mechanisms to Maternity team

Thank You and Questions

Ockenden Report Assurance Committee

Maternity Voices Partnership (MVP) – Working with Women & Families

The Shrewsbury and Telford Hospital NHS Trust

Date: 19 October 2021

Presenter:

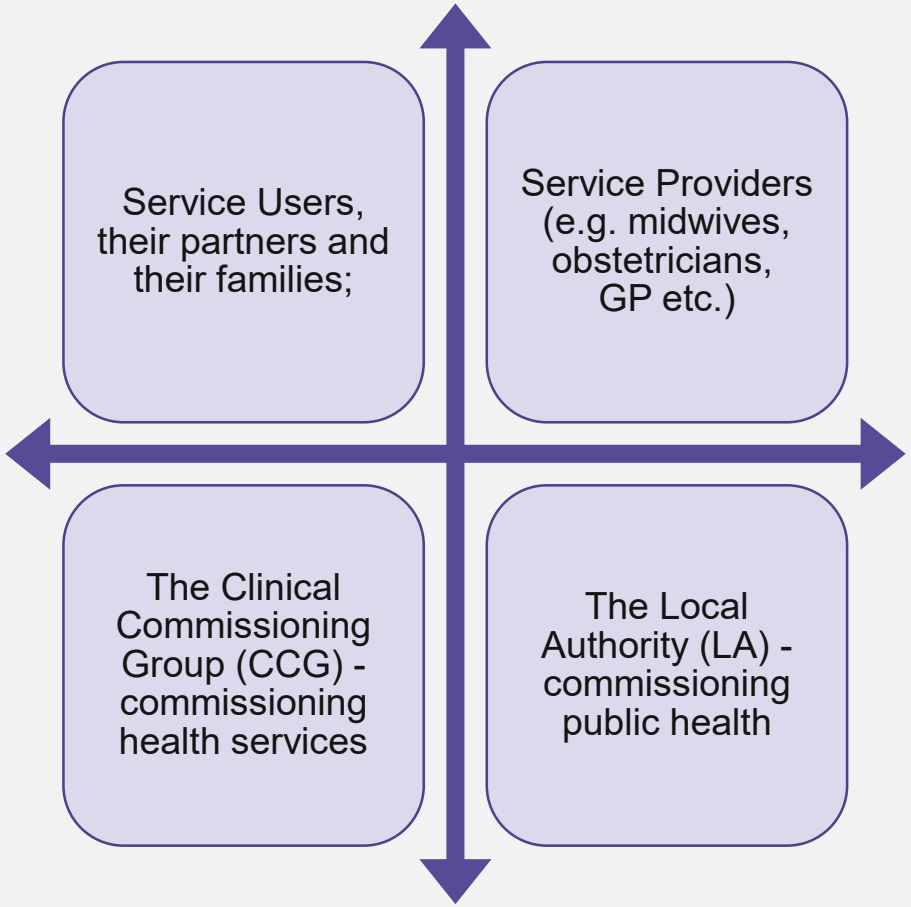
Louise Macleod

MVP Development Co-ordinator, Shropshire, Telford and Wrekin Clinical Commissioning Group

MVP Background

Who, What & Why

A Maternity Voices Partnership (MVP) is an independent team made up of:



- ✓ An MVP provides a way for this team of people to design & improve maternity care together. All these different people working together to **share ideas** and **identify solutions** for the design and **improvement of maternity care is called co-production.**

- ✓ The function of the MVP is more than simply to listen; it is a way of discussing challenges and ways of overcoming them. The group aims to **constantly support the development and improvement maternity care for everyone,** regardless of who they are or where they live, so everyone has access to the same quality of care.

Five Key Principles

SHROPSHIRE AND TELFORD & WREKIN Maternity Voices
Working in partnership to improve maternity services

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Five key principles:

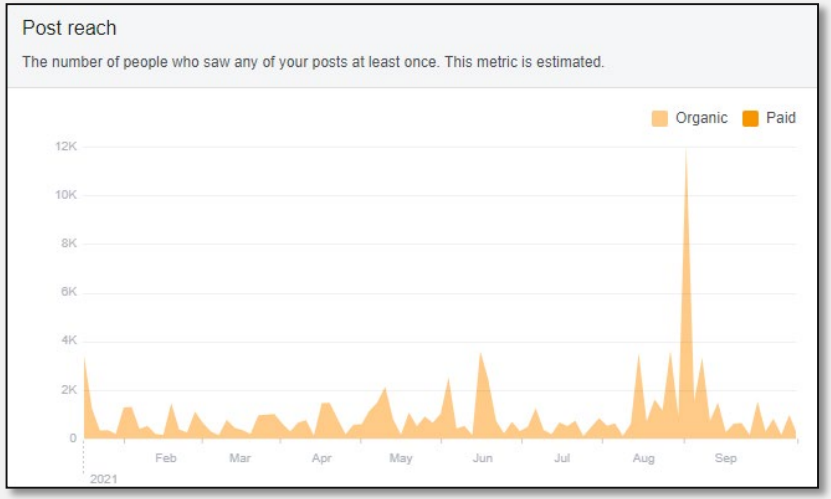
1. Coproduce as equals, promoting and valuing participation.
2. Seek out and listen to service user experiences.
3. Champion the use of service user experience when reviewing services.
4. Understand the interdependency of staff experience and positive outcomes.
5. Pursue continuous improvement in maternity services.

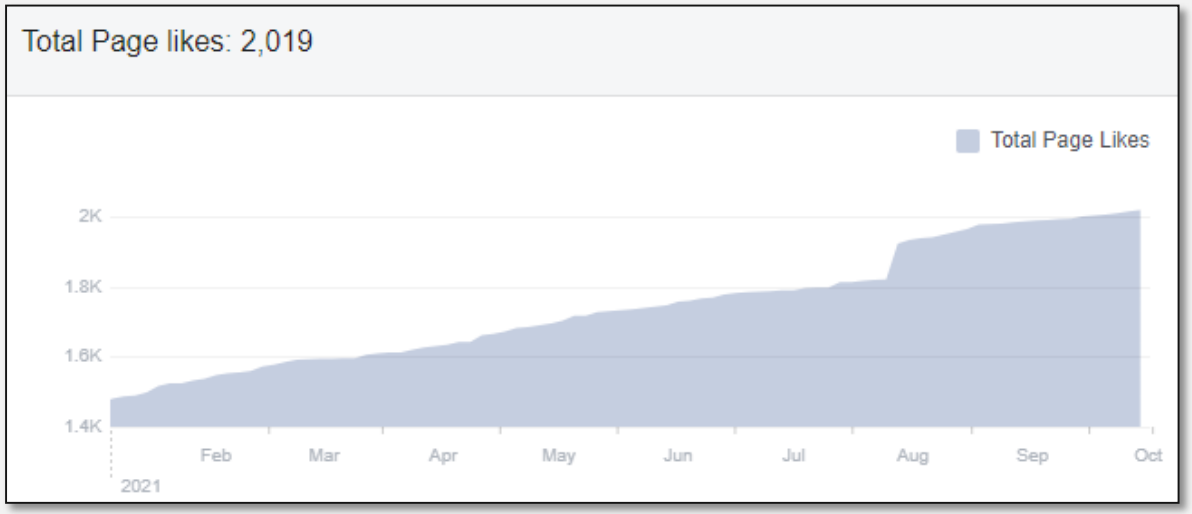
Ways we Involve & Hear
The Voices of Our Communities

SHROPSHIRE AND TELFORD & WREKIN Maternity Voices
Working in partnership to improve maternity services

NHS
The Shrewsbury and Telford Hospital
NHS Trust

- ✓ Social Media – Facebook, Twitter, Instagram
- ✓ Newsletter
- ✓ Mailing list
- ✓ Focus groups
- ✓ Feedback survey
- ✓ Ad Hoc surveys
- ✓ Volunteer community





History of Our MVP

SHROPSHIRE AND TELFORD & WREKIN Maternity Voices
Working in partnership to improve maternity services

NHS
The Shrewsbury and Telford Hospital
NHS Trust

2017 — LMNS Funded

2018 — Set up

2018-19 — Awareness raised by Development Coordinator & Key-relationships built (MVP hub meetings)

2020 — Extra support received from Healthwatch Telford and Wrekin

2020 — MVP Expansion:
- MVP chair
- Volunteers

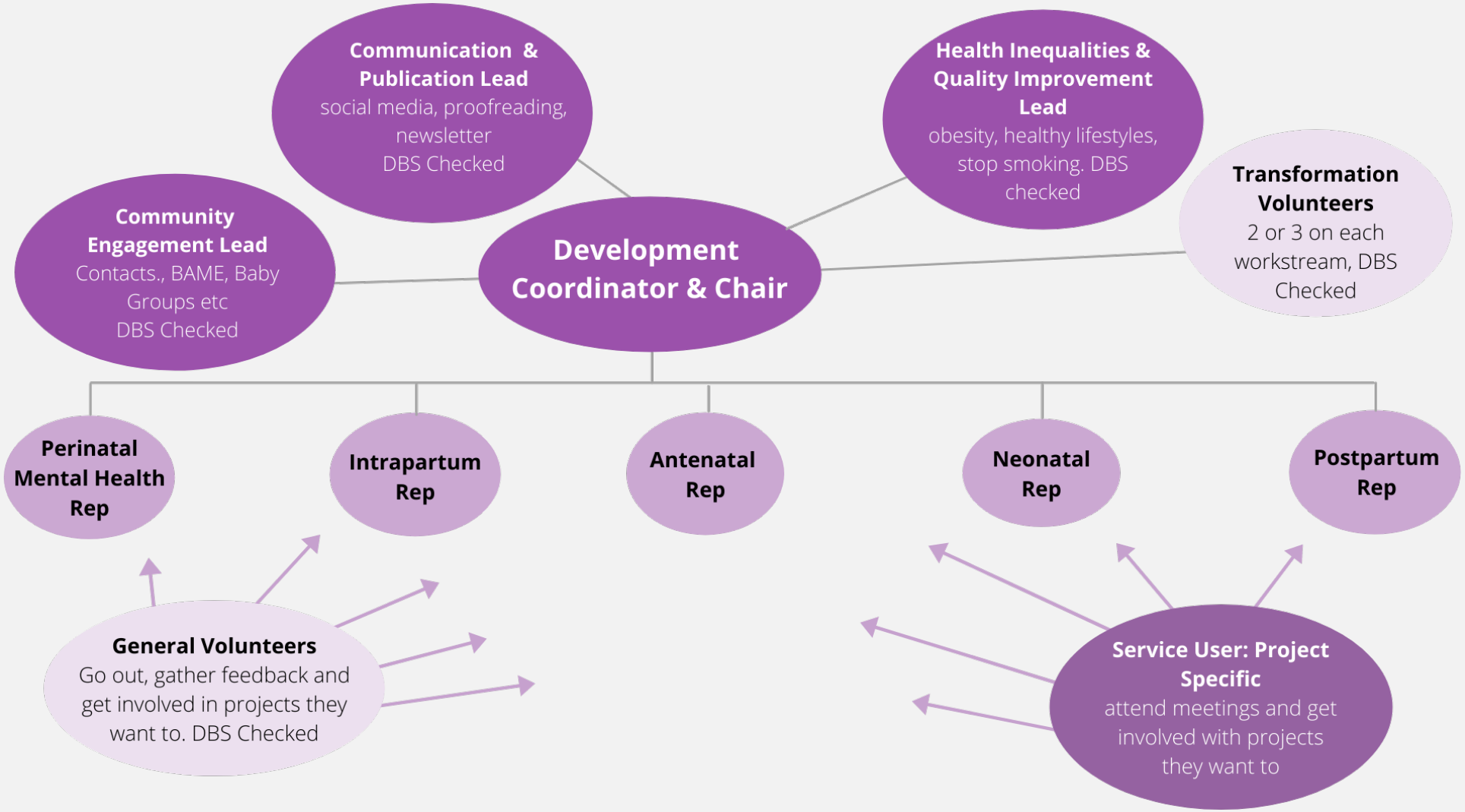
2020 — MVP supported key-message sharing & Developed service user voice at focus groups

2021 — Developed online feedback form (Launched Apr-21), key role in MTP & more!

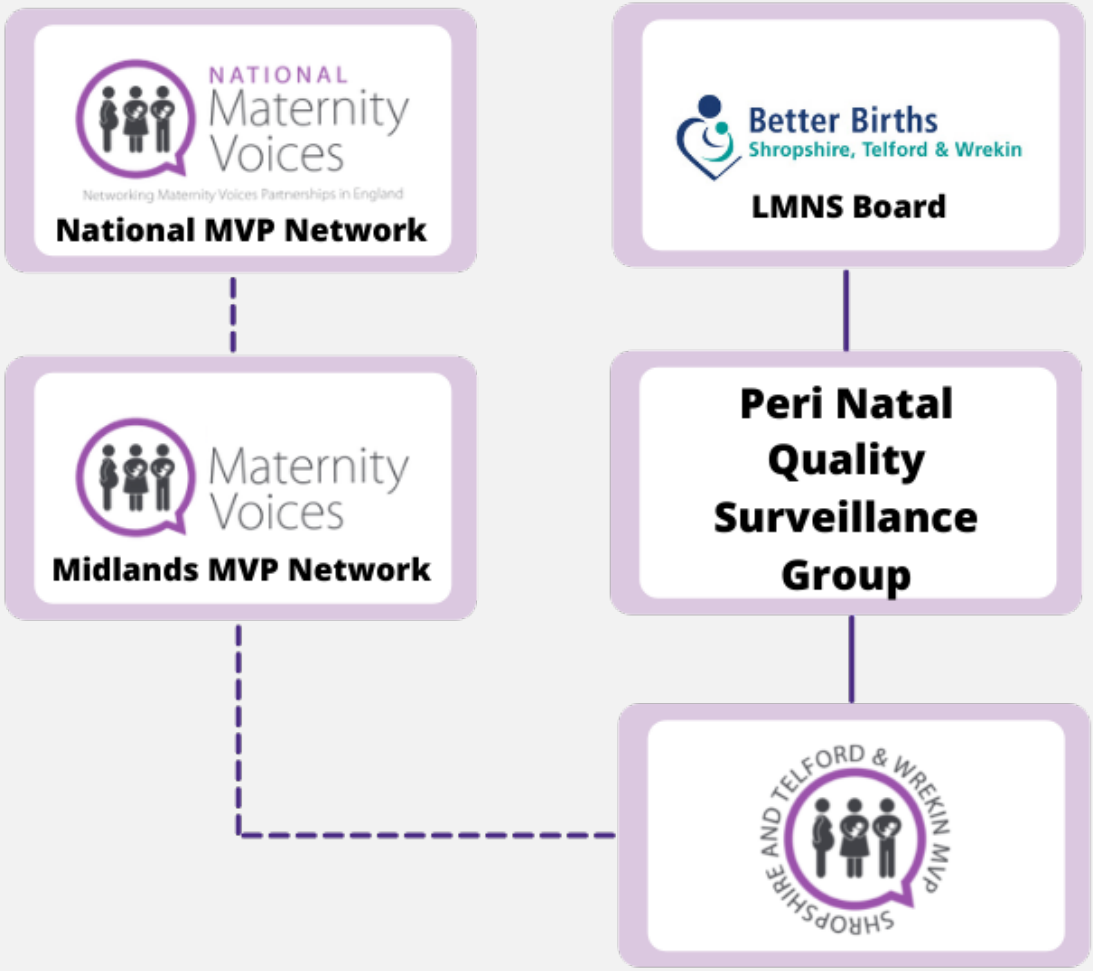
MVP Structure

SHROPSHIRE AND TELFORD & WREKIN Maternity Voices
Working in partnership to improve maternity services

The Shrewsbury and Telford Hospital NHS Trust



MVP Structure



MVP Projects

Meetings We Attend

SHROPSHIRE AND TELFORD & WREKIN Maternity Voices
Working in partnership to improve maternity services

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Nature of meeting	Meeting name
Maternity Transformation Programme (MTP)	• Ockenden Report Assurance Committee (ORAC) • Maternity Transformation Assurance Committee (MTAC) • MTP Comms & Engagement workstream • MTP People & Culture workstream • User Experience workshops & catch up meetings
Internal SaTH	• Labour ward forum • Guidelines • Weekly Head of Midwifery (HOM) meeting • SaTH engagement • SaTH Equality, diversity & Inclusion panel
Local Maternity and Neonatal System Programme board (LMNS)	• Perinatal Quality Surveillance Group (PQSG) • LMNS Programme board • Perinatal mental health workstreams • Healthy Pregnancy & Healthy Families Workstream • Neonatal workstream
MVP	• Quarterly MVP hub meetings • Regional MVP catch ups • National MVP catch ups

*Plus ad-hoc focus groups and more…

Project Involvement

SHROPSHIRE AND TELFORD & WREKIN Maternity Voices
Working in partnership to improve maternity services

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Development of new Lighthouse mental health service	Labour and Birth Choices Leaflet	Antenatal education	Perinatal mental health leaflet designs	Enhanced Recovery Leaflet
Bid for Perinatal Pelvic health service	Recruitment and interviews	Breastfeeding peer support program	LMNS cookbook and exercise videos	Midwife Led Unit upgrade
360 Virtual tours	Saving babies lives information leaflet	Birth Reflections service development	Partners COVID-19 Passport	MVP/SaTH Standard operating procedure
Birth Place Choice Leaflet	SaTH Postnatal Survey	Reduced fetal movements campaign	COVID-19 Support	Communication & language training
Personalised Care and Support Plans	SaTH postnatal development plan	Website analysis and redesign	Continuity of Carer	Cross border working

Examples of Great Co-production

SHROPSHIRE AND TELFORD & WREKIN Maternity Voices
Working in partnership to improve maternity services

The Shrewsbury and Telford Hospital NHS Trust

✓ MLU Upgrade

✓ 360 Tour

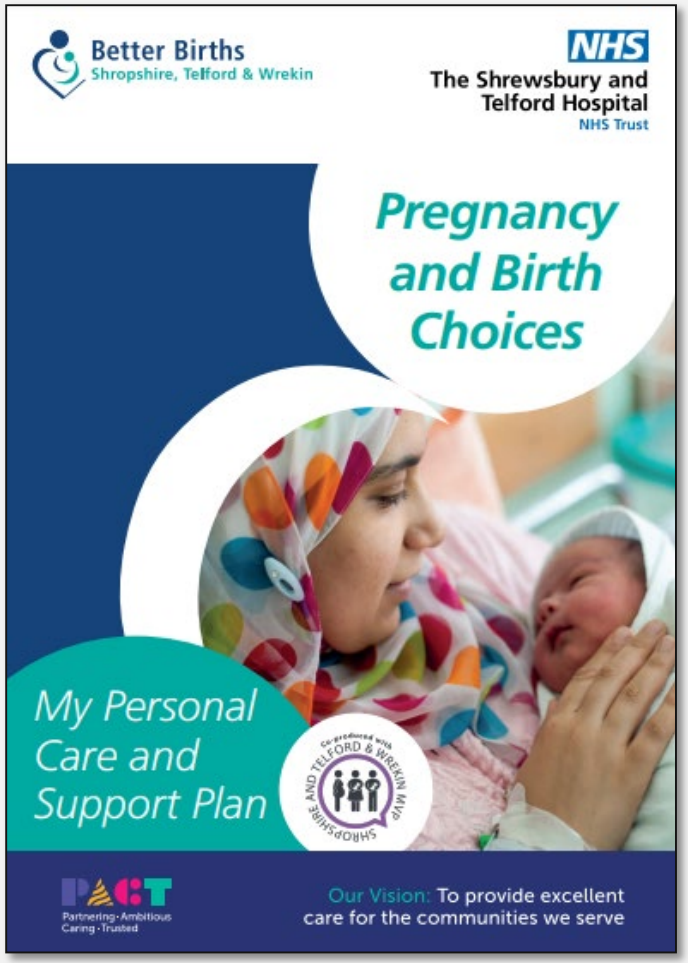
Co-produced with SHROPSHIRE AND TELFORD & WREKIN MVP

Examples of Great Co-production

SHROPSHIRE AND TELFORD & WREKIN Maternity Voices
Working in partnership to improve maternity services

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Personalised Care & Support Plan



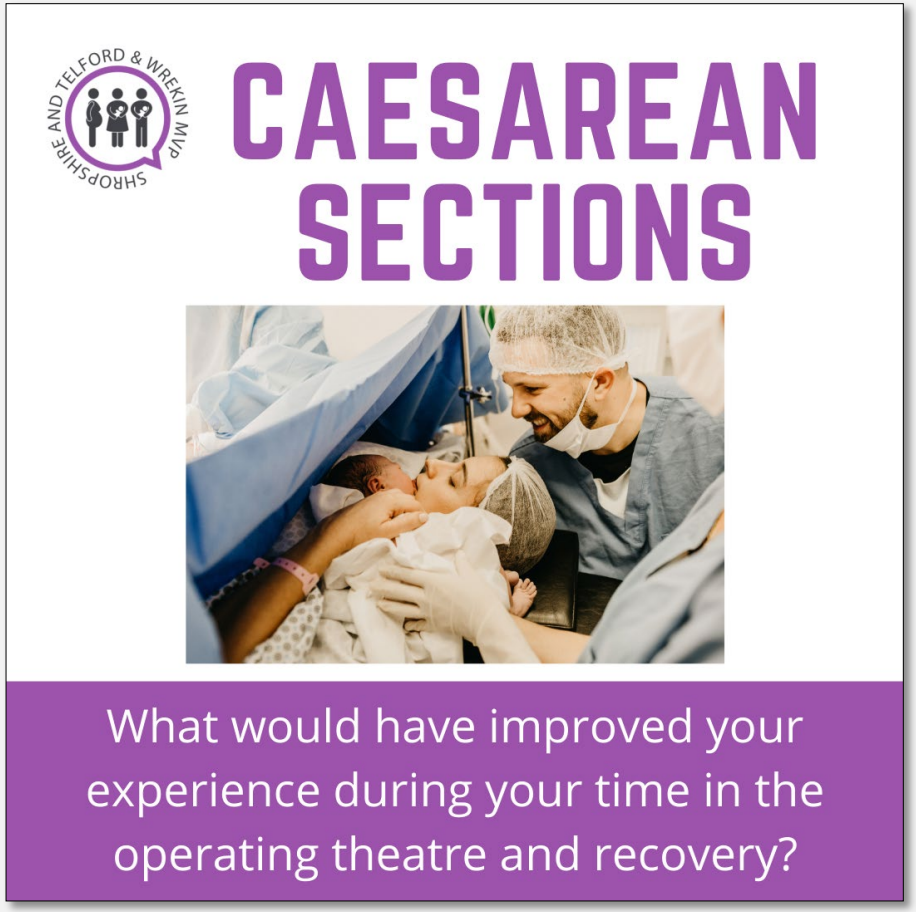
Co-produced with SHROPSHIRE AND TELFORD & WREKIN MVP

Birth Place Choice Leaflet

MVP Feedback

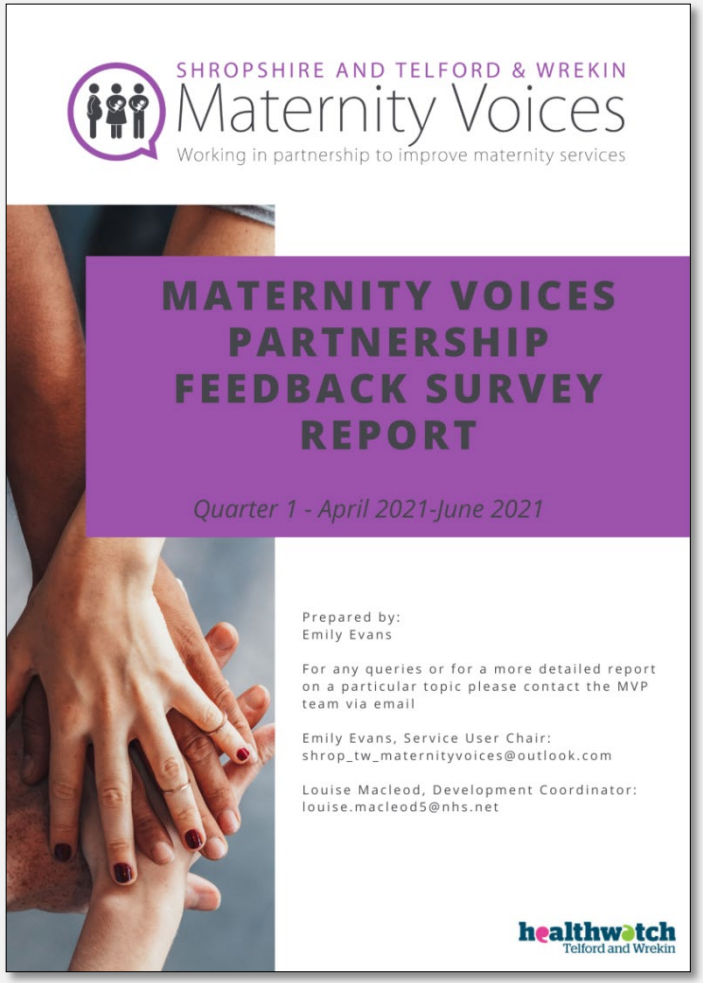
Surveys We Have Carried Out

- ✓ Antenatal Education
- ✓ Friends of Princess Royal Shop
- ✓ Caesarean Section Experience
- ✓ Personalised Care baseline survey – Supported SaTH survey
- ✓ Continuity of Carer Survey
- ✓ Reduced fetal movements survey
- ✓ Regular gathering of experiences and general feedback which is given to SaTH monthly



MVP Feedback Survey

- Launched in April 2021.
- Hosted on Healthwatch Telford and Wrekin Website. https://www.healthwatchtelfordandwrekin.co.uk/shropshire-and-telford-wrekin-maternity-voices-feedback-form
- Range of in depth questions covering the whole perinatal experience.
- We also gather demographics on people completing the form.
- Shared on social media regularly, business cards with QR code link delivered to SaTH.
- Open to women and birthing people who have used services within last 2 years.
- Reported quarterly to MVP hub meeting to inform MVP work programme.
- Informs the Perinatal Quality Surveillance process.
- Results published on our website and social media. https://www.healthwatchtelfordandwrekin.co.uk/maternity-voices-partnership



The MVP Feedback Survey Report Q1

MVP Feedback Survey:

- 100 respondents during April 2021-June 2021
- 60% first time parents
- 94% White British
- 85% aged between 25-39

Key Themes:

- Continuity of Care
- Language, communication and information
- Postnatal contact

Key Themes Q1

Continuity of Care:

- This encompasses not only midwifery care (Continuity of Carer) but also continuity of consultants, locations of care and standards of care.
- When asked 'what would improve antenatal care' a third of the responses mentioned continuity of care. Building a trusting relationship with service providers is highly important.

Language, Communication & Information:

- The way people are spoken to, the words used and body language can have a huge impact on how people feel about the care they received.
- Information must be provided clearly and without bias or pressure so people can make an informed choice about their care.

The continuity was key for me personally. I needed to build up trust. The support I had from all three (midwife, EPAS and consultant) was incredibly important in my case

Individualised, catered for my mental health needs and kept me well antenatally and postnatally. My midwife was brilliant, she took the time to answer my questions and develop a plan with

I felt as though I was told what to do without any full explanations or information/ evidence, rushed through any decisions (like induction) without a single piece of info or evidence, and was too nervous and overwhelmed to speak up.

Key Themes Q1 & Going Forwards

Postnatal contact:

- Services users indicated that they wanted or expected more contact and support postnatally. This is both physical support around recovery but also emotional support. Many postnatal services were impacted by Covid including home visits (from midwives and health visitors), weigh-in clinics and feeding support.

Follow up physical exam to check C-section scar (3 and 6 months maybe) and advice on how to massage it. Up to date advice on pelvic floor exercises. Advice and support on how to manage a newborn and an older child after major surgery.

Going Forwards:

- Reports will continue to be published quarterly, highlighting key themes. We will also report on actions and improvements made based on the feedback reports.
- MVP focus will be on ensuring we are gathering feedback from a representative sample of service users.

More Midwife appointments and check ups and lots more health visitor check ups, I haven't seen or heard from and health visitor since I rung at 6 weeks old! He's now nearly 8 months old.

Maternity Transformation Programme (MTP) –

Involvement with MTP: Workstreams & recruitment

How does the MVP work with the MTP team?

SHROPSHIRE AND TELFORD & WREKIN Maternity Voices
Working in partnership to improve maternity services

NHS
The Shrewsbury and Telford Hospital
NHS Trust

- ✓ Worked with the team since summer of 2020.
- ✓ Built relationships with the core MTP team.
- ✓ Regularly sit on MTP workstreams for Comms and Engagement and People and Culture.
- ✓ Developed User Experience Card System to increase Service User voice in developments.
- ✓ MTP and MVP team work well together and really spend time to work with and include the MVP in the work that is going on.

User Experience Card System

1. **UX cards completed** and compiled by MVP based on theme.

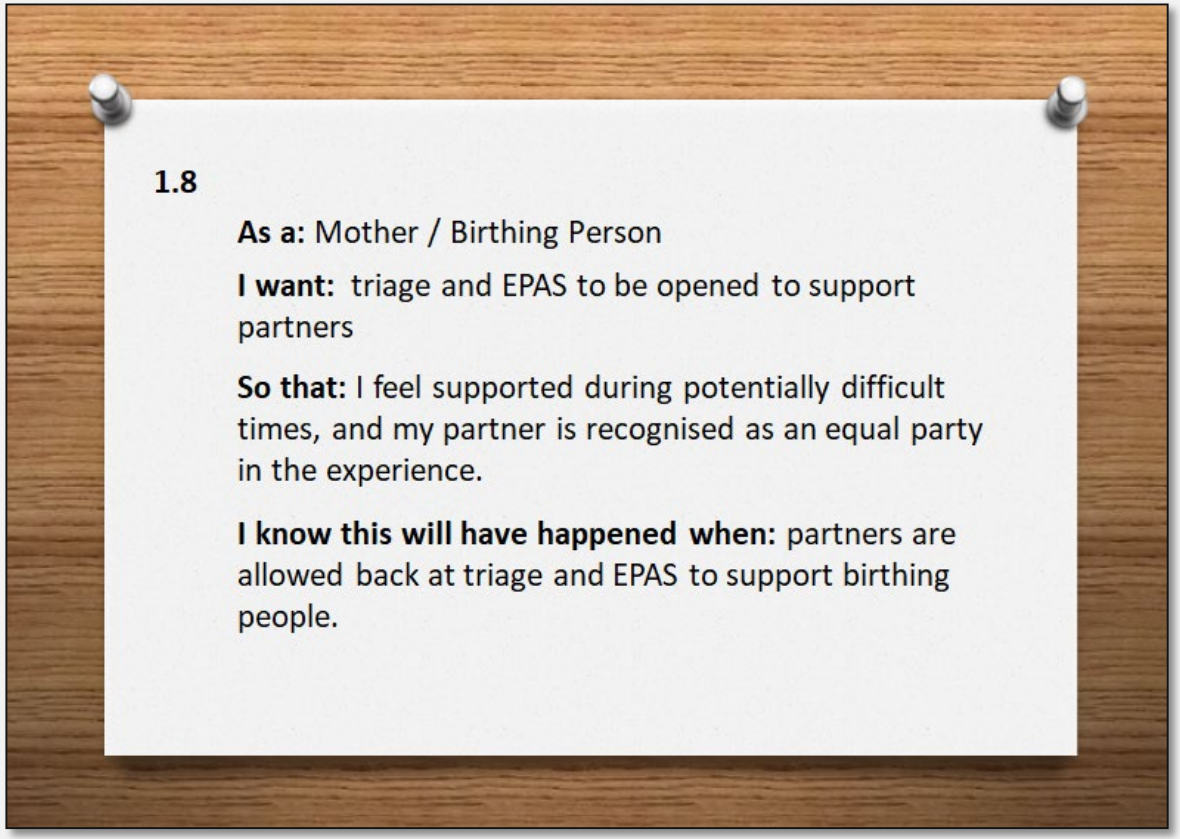
2. **UX cards explained** at UX workshop with service-users & staff. UX cards **prioritised** based on MoSCoW. Then, categorised based on effort (S, M, L, XL).

3. In a separate meeting with MVP, **actions are produced** from the UX cards in priority order.

4. UX actions are **delivered**

5. **Meaningful change** is achieved as expressed on UX card and fed back to service-users/staff.

2-month cycle



Next steps

Next Steps

1. Increase MVP Membership (service users, support people and staff).
2. Increase reach to seldom heard groups.
   - Use volunteers to get out and about in the community to take survey out to more people.
   - Use Community Engagement Lead to make links with key community leaders to increase knowledge of MVP and support seldom heard voice communities interaction.
3. Fully embed MVP feedback as evidence within the quality surveillance process.
4. Develop feedback app to enable volunteers to take feedback form out into rural communities.
5. Develop partners feedback form to gather partners experiences.
6. Encourage more Health professionals to engage with us and refer families to us and our feedback form.

Thank you

Shropshire, Telford & Wrekin
Integrated Care System

How do we receive assurance on maternity safety and good patient experience?
An overview of Maternity Governance

- The role of the Integrated Care System (ICS), the Clinical Commissioning Group (CCG) and the Local Maternity and Neonatal System (LMNS)
- The role of NHS England/Improvement (NHSE/I) and NHS Regional Team

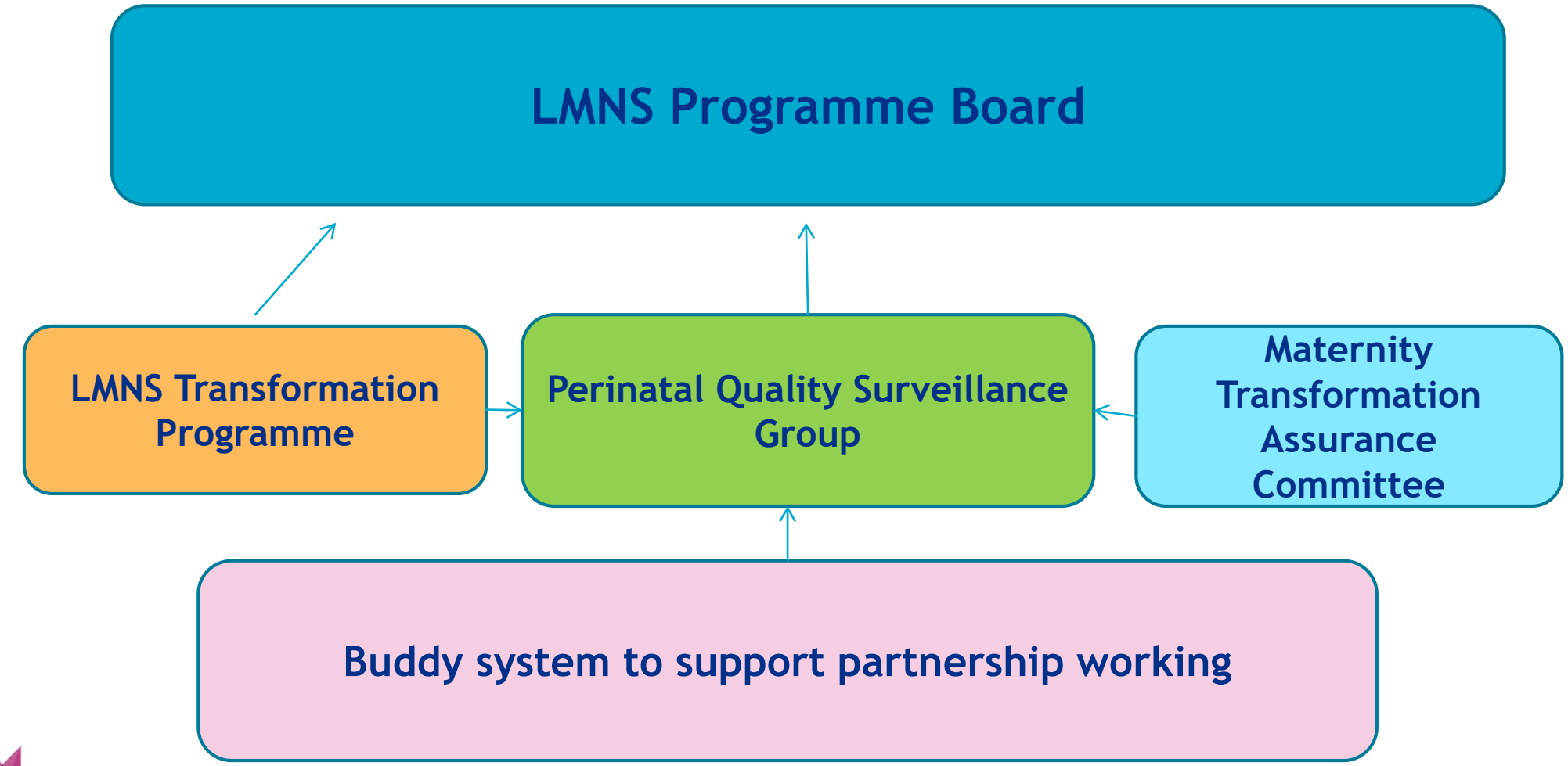
19 October 2021, Ockenden Report Assurance Committee (ORAC)

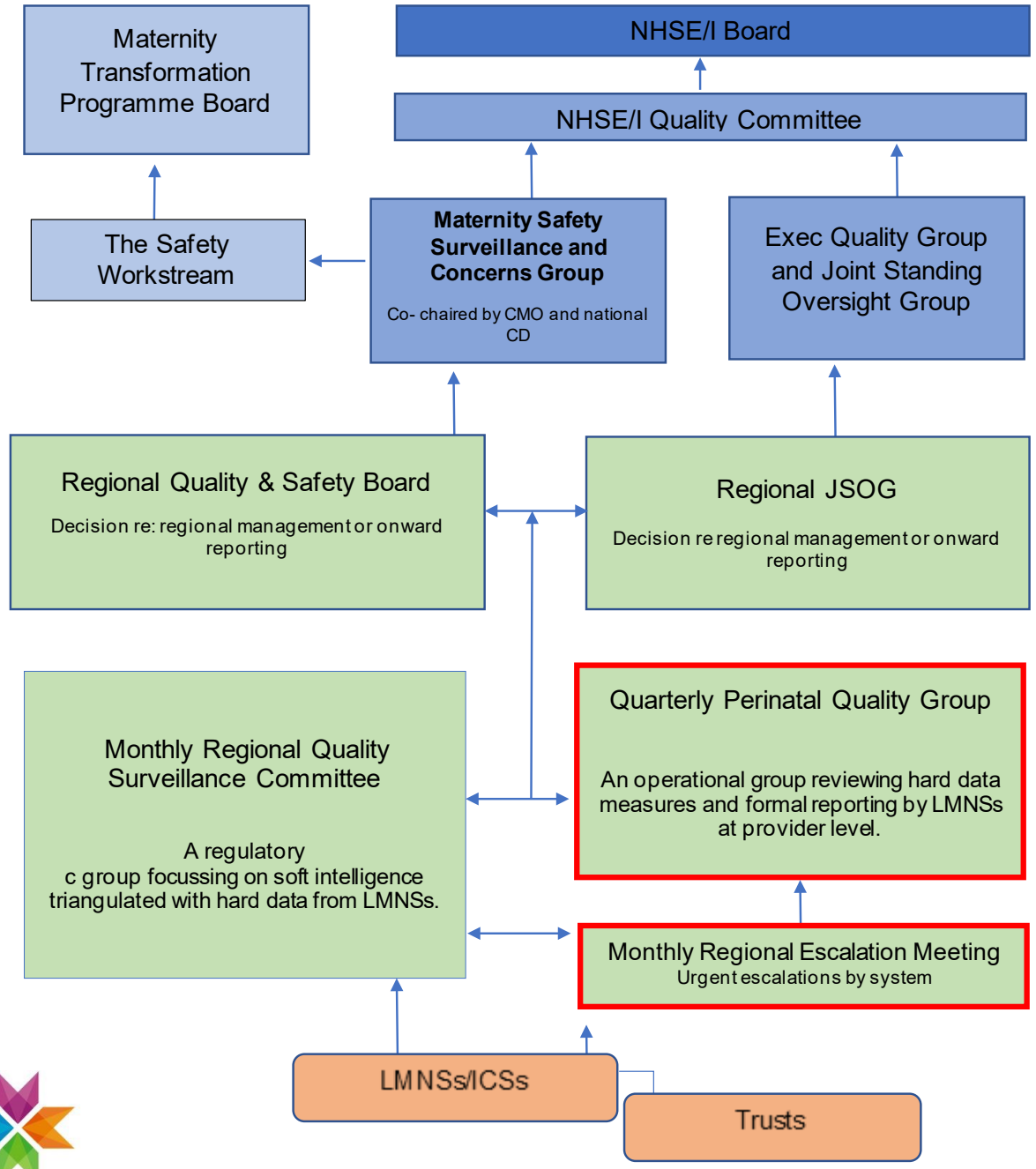
Presenters:
Zena Young – *Executive Director of Nursing & Quality, Shropshire/Telford & Wrekin CCG & LMNS Senior Responsible Officer (SRO)*
Kerry Forward - *Programme Transformation Lead & Perinatal Services & NHSE/I Improvement – Midlands Region*

Immediate and Essential Actions (IEA): To improve Care & Safety in Maternity Services not yet achieved

Reference	Description
IEA 1.3	LM(N)S must be given greater responsibility and accountability so that they can ensure the maternity services they represent provide safe services for all who access them.
IEA 1.4	An LM(N)S cannot function as one maternity service only.
IEA 2.1	Trusts must create an independent senior advocate role which reports to both the Trust and the LM(N)S Boards.
IEA 2.2	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
IEA 4.3	The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.
IEA 4.4	This must also include regional integration of maternal mental health services.

The LMNS responsibilities





Regional interface

In line with national guidance, systems and regulators feed into a national quality oversight process.

System meeting highlighted Red here.

SaTH and STW LMNS are well engaged in this process.

What assurance and reports do we see:

PNQSG receives information regarding:

- Provider Dashboard of key indicators
- Quality & Assurance reports
- Workforce reports
- Serious Incident reviews & themed reviews
- Patient experience reports including Maternity Voice Partnership (MVP)
- Reports on Stillbirths, neonatal deaths, maternal deaths & brain injury

LMNS receives information regarding:

- Assurance & Exception report from PNQSG
- System-wide Dashboard
- Assurance on progress against key transformation priorities, including:
  - Continuity of Carer
  - Tobacco Dependence
  - Pandemic Recovery
  - Ockenden Review
  - Pre-term birth clinics & maternal medicine network
  - Saving Babies Lives Care Bundle

Buddying up with other LMNS

- There are arrangements for Shropshire, Telford & Wrekin LMNS to ‘buddy’ or work in partnership with:
  - Jointly with Staffordshire and Stoke LMNS and Derby and Burton LMNS
  - Black Country and West Birmingham LMNS
- There are on-going discussion with formal plans and a Memorandum of Understanding (MoU) to be finalised.
- Across the Staffs/ Derby systems,clincial staff have recently been deployed to front line services. We are now able to recommence discussions to finalise the MoU.
- This honest and collaborative approach will provide greater assurance for service users by connecting best practice and learning from experience.

IEA 2.1/2.2 – Senior Advocate Roles

- System letters shared January 2021 which confirmed that to ensure consistency and equity across England a national framework would be produced to support NHS trusts to implement a network of advocates.
- A working group is developing the model and it will be communicated to systems once it is complete.

Timescales not yet confirmed.

IEA 4.3 /4.4 – Maternal Medicine / Perinatal Mental Health

Maternal Medicine

- West Midlands lead Provider and CCG confirmed as Birmingham & Solihull
- Network ‘go live’ anticipated April 22
- SaTH and STW LMNS well engaged in the process

Perinatal Mental Health

- Early implementer sites developing extended services
- Roll out of extended services provision across all sites by 23/24
- Networked element to be developed, supported by Regional PMH team

Thank you and any Questions?