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

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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

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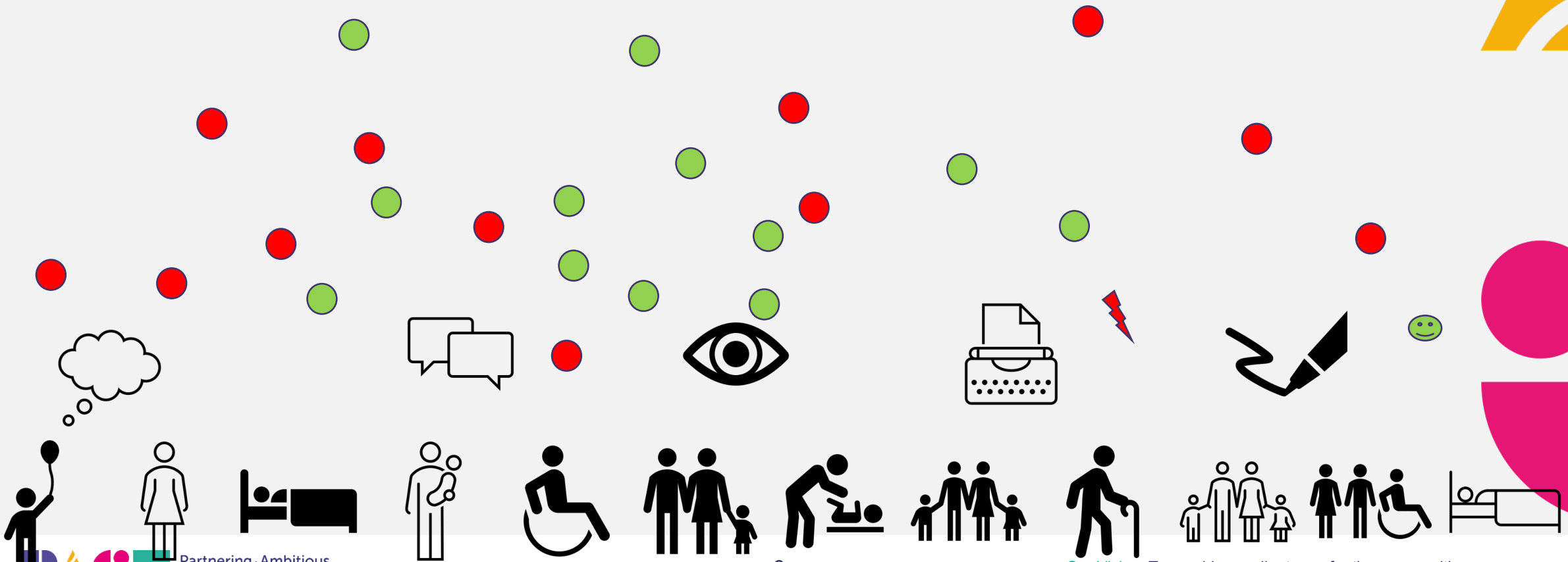
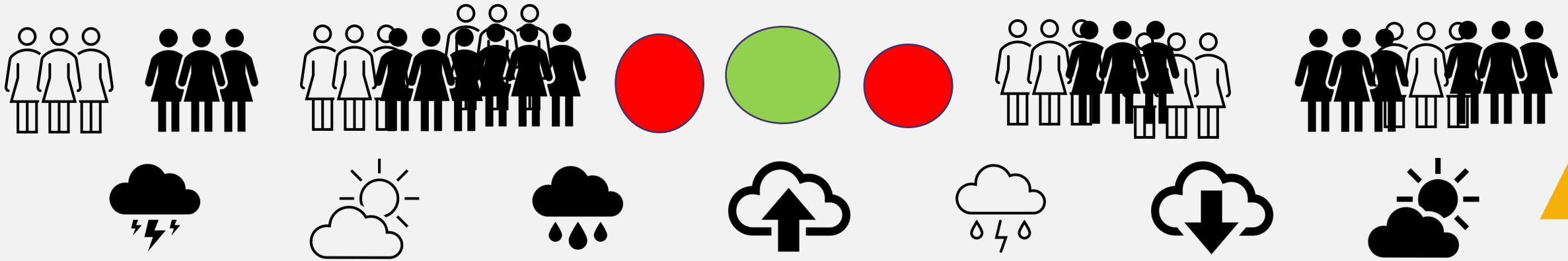
- Where does all the safety information come from?
- What happens to information?
- Why might safety information be missed?
- The golden thread

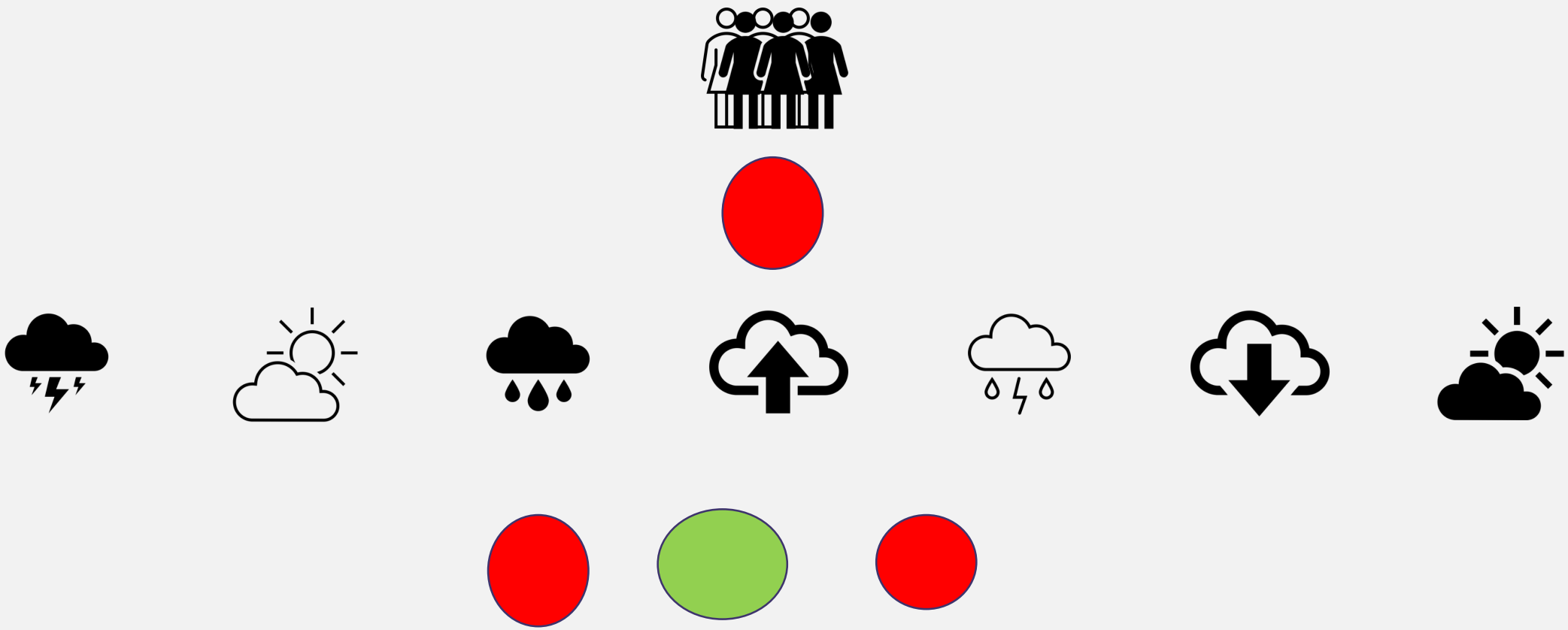
Board Assurance



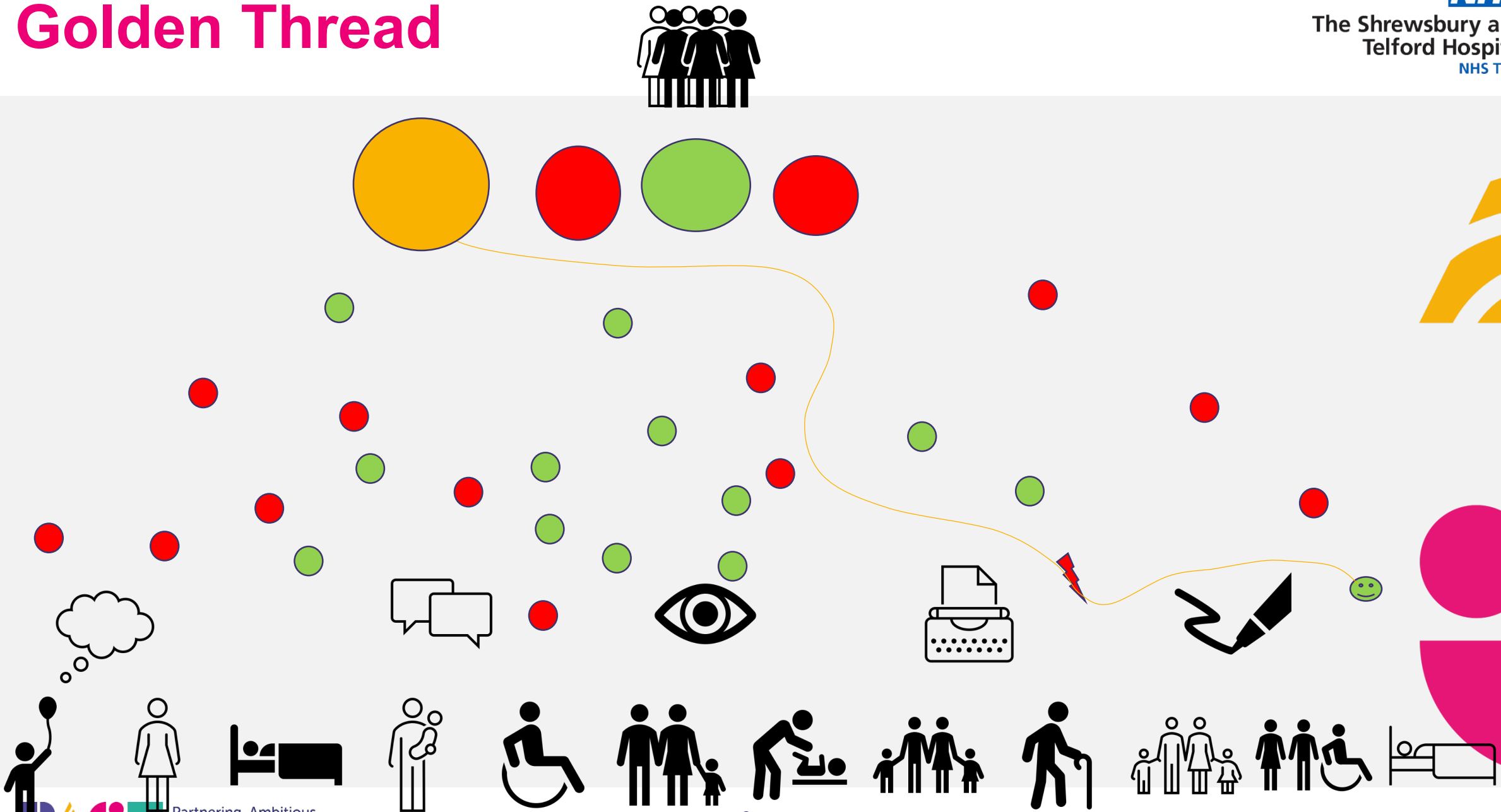
Committees



Board



Golden Thread



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Who are your Safety Champions?

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

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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

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SaTH Midwifery Leadership

Ms. Shirley Jones

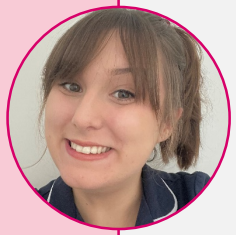
Interim Head of Midwifery

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

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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

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- 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)

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- 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.

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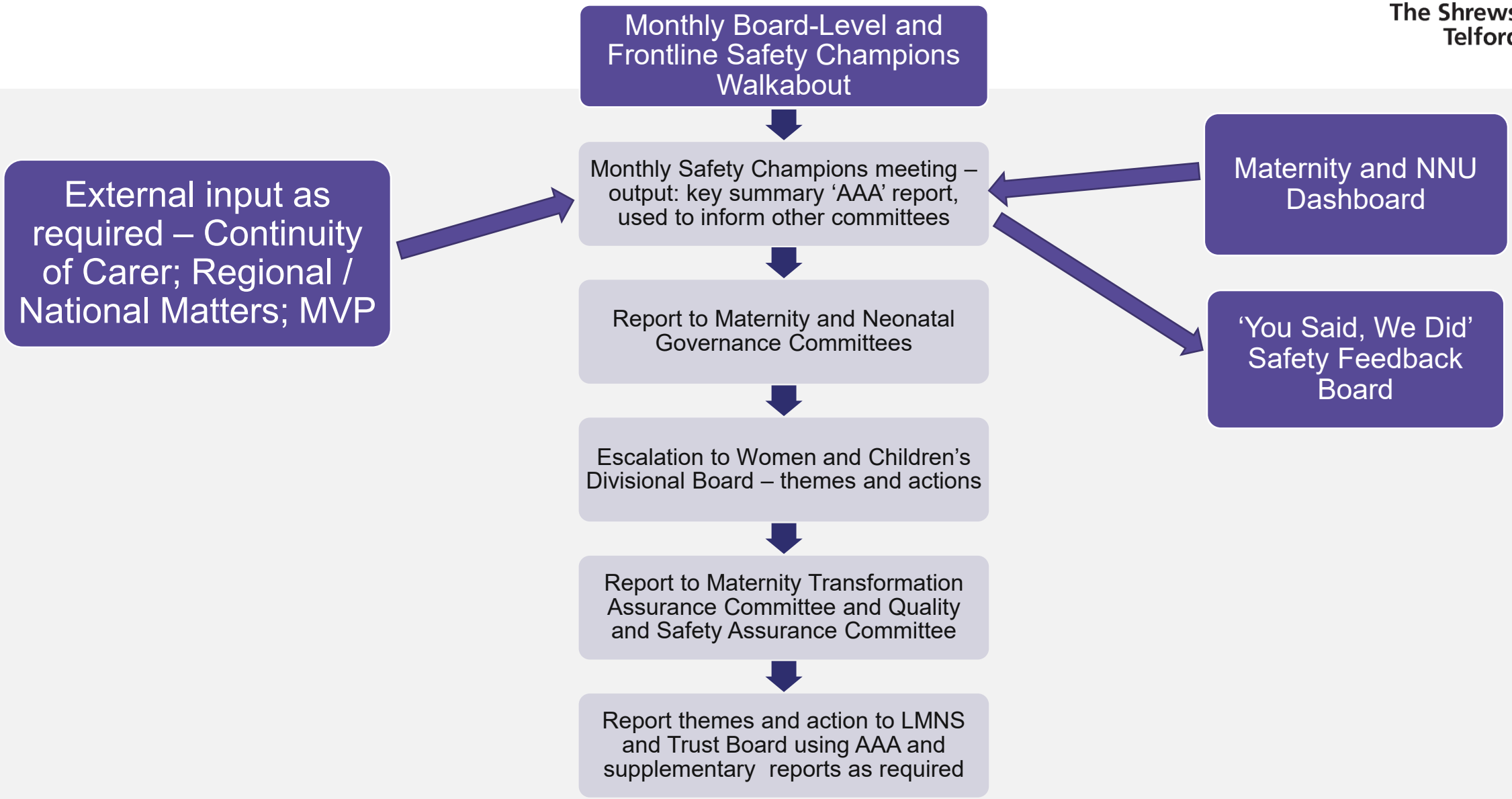
How the Safety Champions Operate


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

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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