CUH Maternity Quality and Safety Improvement Plan

The National Maternity Quality and Safety Strategy - Progress and Next Steps

R	Red: Immediate remedial action required to progress this activity
A	Amber: Action required for successful delivery of this activity
G	Green: Activity on target
	Black: Completed activity

	Key Drivers	Action to address key drivers	Action progress against plan	Going forward	Action owner	CNST Standard	Forecast date	Current Status
1	**FOCUS ON LEADERSHIP**	**Maternity Safety Champions** Board level Maternity Champion (BSC) appointed Trusts will have one obstetrician (OSC) and one midwife (MSC) jointly responsible for championing maternity safety in their organisation	OSC – Patient Safety Lead Obstetrician appointed MSC –Safety lead midwife appointed NED – board level safety champion appointed	Bi monthly meetings of safety champions to update on safety issues and dashboard Board level Safety champion monthly feedback sessions with maternity and neonatal staff to raise concerns relating to safety issues	*Lorraine Szeremeta* *Cathy Bevens* *Mike Knapton*	**Standard 9** Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	In place	
		Maternity Safety Improvement Plan agreed and made public	Plan produced and to be disseminated to Maternity Staff, the Board and made public on Rosie Website	Any changes to plan escalated via the subcommittee to executive	*Cathy Bevens*		In place	

		Workforce planning	**Medical** RCOG workforce monitoring tool GMC National Training Survey	Tool completed record of proportion of trainees who disagreed with survey and action plan in place	*Hannah Missfelder Lobos*	**Standard 4 & 5** Can you demonstrate an effective system of midwifery and medical workforce planning?	In place	
			Midwifery "Birth Rate Plus" report March 2019	Workforce planning Priority 1 -3	*Amanda Rowley*			
2	**FOCUS ON LEARNING AND BEST PRACTICE**	**Saving Babies Lives Care Bundle** The Care bundle Version 1 was published in March 2016 and was designed to reduce stillbirths and early neonatal death. It brings together four elements that are recognised as evidence based and/or best practice Version 2 out March 2019 Added work streams: symphysis fundal height training Sonographer training Management of Growth Restricted Babies	**Saving Babies Lives Working Group** meet monthly to address all 4 elements of care bundle:	Minutes/ action log available to demonstrate work undertaken and planned by SBL Group	*Cathy Bevens* *Una Mannu* *Amanda Rowley* *Charlotte Patient* *Kimberley Skinner* *Sophie Clements* *Catharine Aiken* *Louise Langford*	**Standard 6** Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives care bundle?	In place	
			Element 1 Reducing Smoking in pregnancy Midwives must have up to date knowledge and skills	Smoking at booking /delivery No of referrals to cessation service to include feedback RCM Online training				
			Element 2 Risk assessment and surveillance for fetal growth restriction Low risk women fetal growth assessed SFH charts interpretation and referral	SGA audit ongoing Non customised growth chart build into EPIC				
			Element 3 Raising awareness of importance of reduced fetal movements	Audit written info by 24 weeks Standardised advice audit				
			Element 4 Effective fetal monitoring during labour	EFM competence data to be reviewed in monthly meetings				

				Fetal monitoring Midwife now in post				
		Avoidable Term Admissions into NICU (ATAIN) A package of publications and resources will be available for maternity and neonatal teams to support them to provide safer care and avoid unnecessary separation of mother and baby	**ATAIN** work streams in place to address the national avoidable term admission to NICU for hypoglycaemia/ jaundice/ respiratory symptoms/ asphyxia and recognising the importance for keeping mothers and babies together Links with LMS and the clinical network	Monthly meeting for ATAIN champions to update group on progress; RAG rating and hypoglycaemia Guideline updated Baseline temperatures introduced MDT Review monthly every admission QI projects in place	*Cathy Bevens* *Liz Hopkins* *Shazia Hoodbhoy* *Jennifer Brewster* *Carla Evans*	**Standard 3** Can you demonstrate that you have transitional care facilities in place and operational to support the implementation of the ATAIN Programme?	On going	
		RCOG's Each Baby Counts (EBC) programme began collecting and analysing data from all UK units in 2015 to identify lessons from stillbirths, neonatal deaths or intrapartum brain injury in term-babies.	**Each Baby Counts reporting and reviewing** – each case that meets criteria of term, intrapartum stillbirth or severe brain injury reported and reviewed.	External panel member now included in on review panel	*Cathy Bevens*		In place	
			EBC local reviewer Cathy Bevens Other trusts cases discussed at risk meetings for shared learning	Regular presentation at Perinatal meeting to share learning from external EBC cases	*Cathy Bevens*		On going	
		Each Baby Counts Learn and Support - a programme of work to enable greater collaboration between the Royal Colleges and the NHS via the Maternal and Neonatal Health Safety Collaborative (see driver 5)	Aims to align quality and safety improvement, multi-professional learning and clinical leadership into a consistent and sustainable safety strategy across the system. The RCM's Labour Ward Leaders programme 'Working together for safer care' was designed and delivered collaboratively by the RCM, RCOG and the patient safety team at NHS Improvement (NHSI),	Implemented	*Cathy Bevens*		On going	

		Better support for bereaved families or children with serious brain injuries: Better Births called for non-litigious route to early support and redress for children with serious birth related brain injury. Rapid Resolution and Redress scheme under design following consultation planned April 2019	**NHS Resolution's Early Notification scheme** – every baby who meets the RCOG Each Baby Counts criteria in regard to brain injury is reported to the NHS Resolution Early Notification scheme **HSIB notification** - improving patient safety through effective and independent investigations	Notified case by case – spread sheet for review at Quality Steering Group available Feedback received from ENS and HSIB fully shared with parents and staff	*Cathy Bevens*	**Standard 10** Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme?	In place	
3	**FOCUS ON TEAMS**	**Maternity Safety Training Fund**: Learning and development plan in place for entire multi-disciplinary team The maternity team will attend maternity safety training programme.	**Rolling programme of mandatory obstetric emergency training and skills drills**	All Maternity Staff Groups attended (Maternity Support Workers and Theatre Staff skills drills as minimum)	*Sophie Clements* *Tracey Christmas* *Hannah Missfelder Lobos*	**Standard 8** Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professi onal maternity emergencies training session within the last training year? **>90% of all maternity staff groups had attended training by end June 2018**	On going	
			Human Factors Faculty established 2017 training rolled out across the service Human factors golden thread through risk incident reviews	Programme for 2019/20 developed and updated staff groups now include NICU and resus officers	*Cathy Bevens*			
			PROMPT Team trained and to provide obstetric emergency training for all staff	Mandatory training for all staff from 2019	*Sophie Clements*			
			Skills Drills PROMPT Team to run skills drills – training package planned	Programme of drills each month	*Sophie Clements*			
			Fetal monitoring training package – K2 for e-learning package in place of training for all staff	Monthly compliance data presented through governance	*Sophie Clements*			
		Continuity of carer through pregnancy and labour including 1:1 support at this time	**Maternity Transformation Programme** Better Births	Aim March 2021 35% of women booked onto this pathway	*Amanda Rowley* *Lucy Warner*		On going	

		Maternity and neonatal teams are using the Standardised Perinatal Mortality Review Tool to review and share learning from every stillbirth and neonatal death.	**Use of Perinatal Mortality Review Tool since January 2018** for every stillbirth and perinatal death	Involvement of parents and external reviewer now standard	*Cathy Bevens* *Hsu Chong* *Shazia Hoodbhoy*	**Standard 1** Are you using the National Perinatal Mortality Review Tool to review perinatal deaths?	In place	
		Maternity team is using national indicators dashboard to track their outcomes over time and benchmark against other organisations in their local maternity system and across the region.	**Local use of Maternity dashboard** review in monthly business meeting and escalation to Board Clarity of benchmarking within dashboard work underway **Regional Maternity System review of dashboards** at Level 2 Regional Risk Meetings	Regional Dashboard	*Natalie Fenton* *Amanda Rowley*		On going	
		Patient feedback mechanisms	Maternity Voices Partnership Group. The Rosie has used "Whose Shoes" as a platform to ensure that we hear what women tell us and act on this. Whose shoes to be repeated in 2021 Friends and family questionnaires give women the opportunity to feedback about antenatal, birthing and postnatal care in the hospital and at home. Feedback from the National Maternity Survey	Update staff on National Maternity Survey Disseminate patient feedback to staff Dads and partners whose shoes completed and results disseminated User involvement in MatNeo work and PMRT Access to service user group for quick feedback	*Kimberley Skinner*	**Standard 7** Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	On going	

Process of escalation of safety improvement plans:

Patient Safety Lead - Division E board meeting (monthly)

Patient Safety Lead - Division E Performance and Quality Meeting - with Trust Executives (monthly)