National Patient Safety Improvement Programmes

NHS

Maternity and Neonatal

Maternity and Neonatal Safety Improvement Network (MatNeoSIP) Event

Wednesday 21 September 2022, 13:00- 16:00

@AHSN_NENC

ahsn-nenc.org.uk

Delivered by:

North East and North Cumbria
Patient Safety Collaborative

The AHSN Network

Maternity and Perinatal Mental Health Clinical Networks North East and North Cumbria

Northern Neonatal Network

North East and North Cumbria Local Maternity System

Led by:

NHS England
NHS Improvement

House Keeping

- Please ensure your microphone and video are turned off during the session unless asked otherwise. This is to help with the streaming of the session.
- If you need to take a break, please feel free to drop off the call at any time and re-join.
- Live captions are available if required.
- This event will be recorded and photographs may be taken.
- Please ask any questions you have through the chat facility. We will try to address questions during the event, but if we don't manage to do this we will follow up after the event.
- If you can't see the chat please email your question/s to gemma.todd@ahsn-nenc.org.uk
- Speaker presentations and the recording will be circulated following the event.

National Patient Safety Improvement Programmes

NHS

Maternity and Neonatal

Welcome

Julia Wood
MatNeoSIP Lead – NENC
Academic Health Science Network NENC

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TheAHSNNetwork

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Agenda

Overview of MatNeoSIP – key messages
13:00 – 13:15

Management and Deterioration of Women and Babies
13:15 – 14:15

Optimisation and stabilisation of the preterm infant
14:25 – 15:15

Problem solving
15:20 – 16:00

National Patient Safety Improvement Programmes

Maternity and Neonatal

NENC Overview – Key messages

Julia Wood
MatNeoSIP Lead – NENC
Academic Health Science Network NENC

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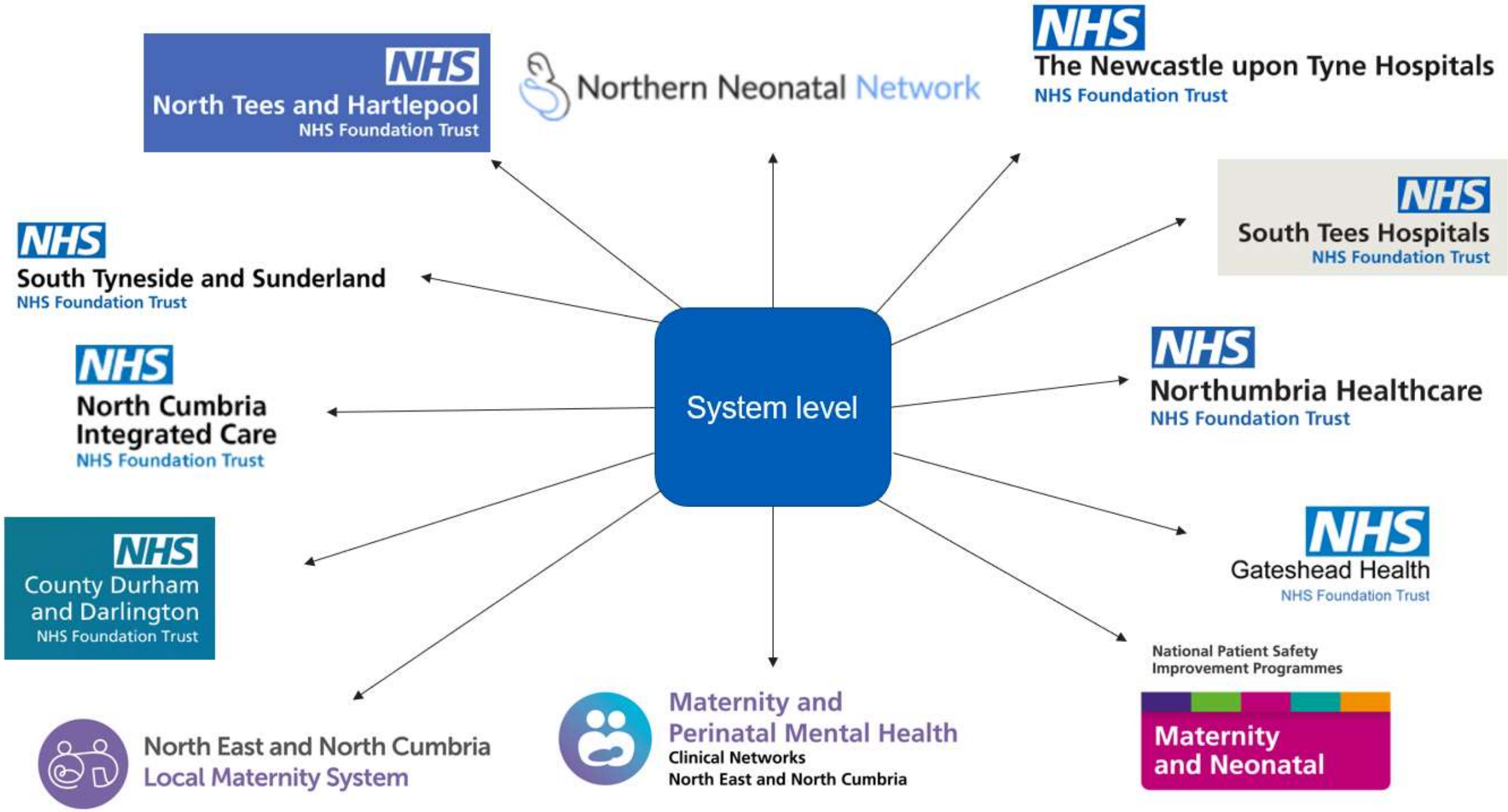
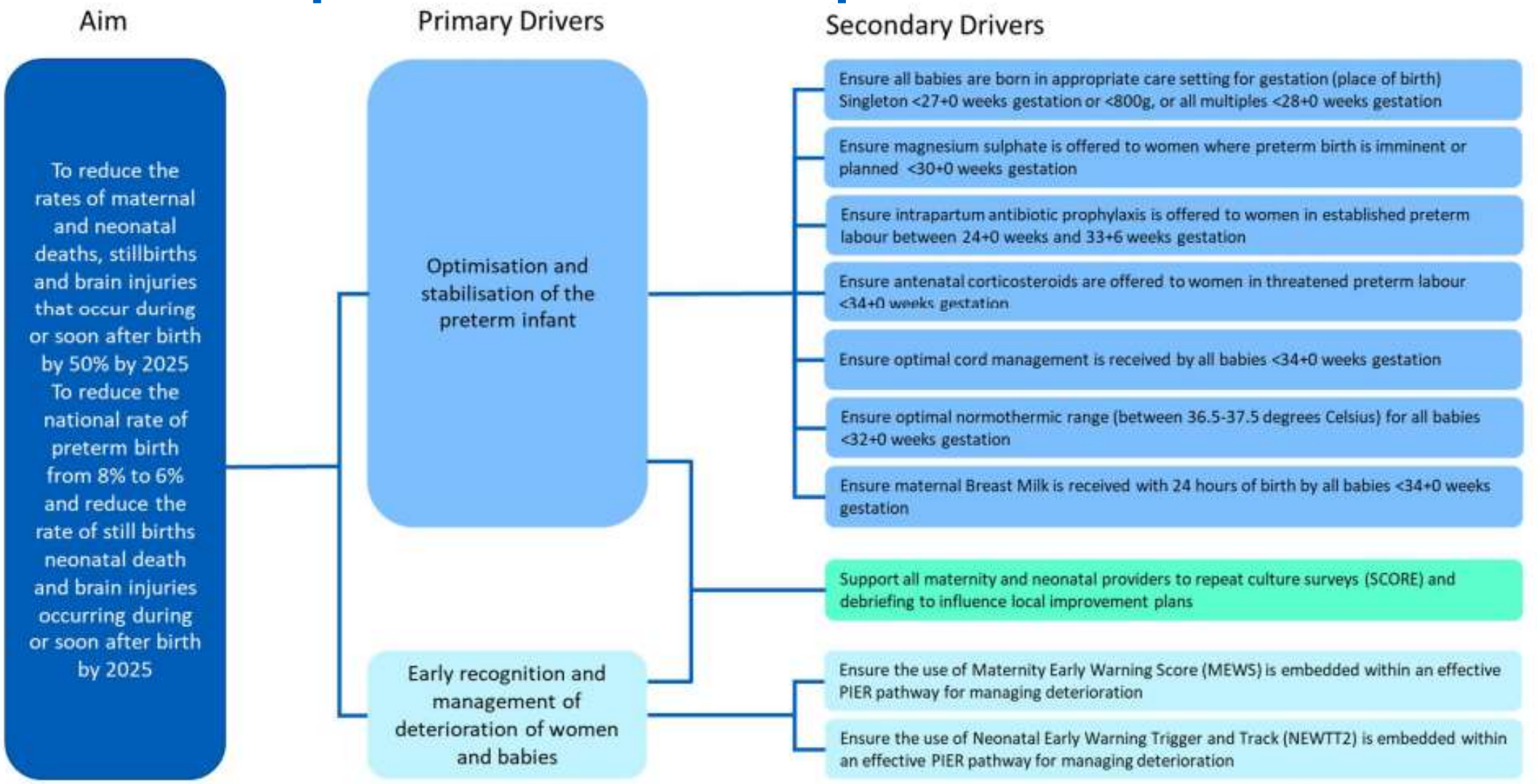

NHS
North Tees and Hartlepool
NHS Foundation Trust
Northern Neonatal Network
NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust
NHS
South Tees Hospitals
NHS Foundation Trust
NHS
South Tyneside and Sunderland
NHS Foundation Trust
System level
NHS
Northumbria Healthcare
NHS Foundation Trust
NHS
North Cumbria
Integrated Care
NHS Foundation Trust
NHS
County Durham
and Darlington
NHS Foundation Trust
NHS
Gateshead Health
NHS Foundation Trust
National Patient Safety
Improvement Programmes
Maternity
and Neonatal
Maternity and
Perinatal Mental Health
Clinical Networks
North East and North Cumbria
North East and North Cumbria
Local Maternity System

MatNeoSIP Specification from April



FutureNHS

Regional Hub

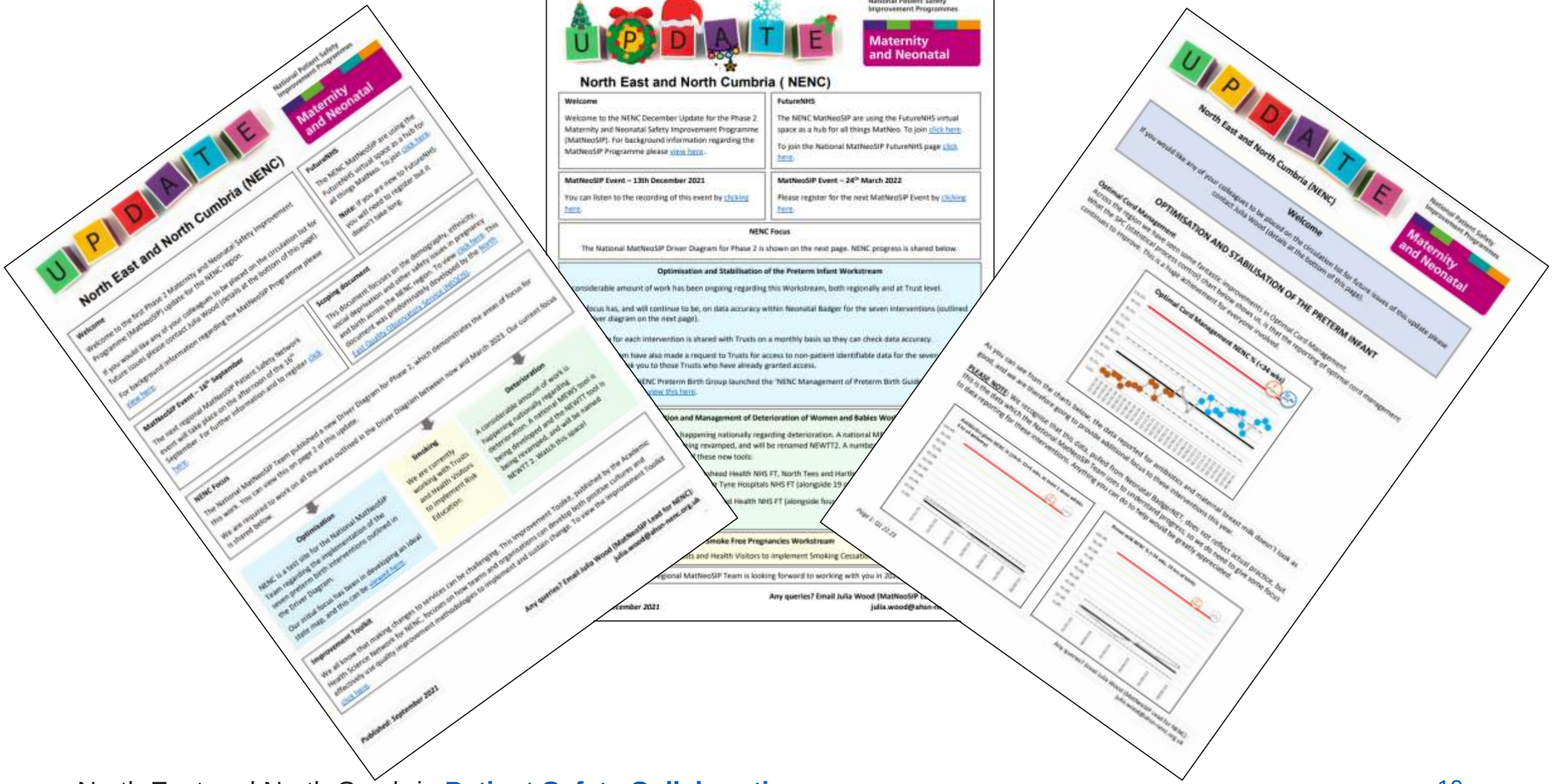
- MatNeoSIP Patient Safety Network for North East and North Cumbria - FutureNHS Collaboration Platform

National Hub

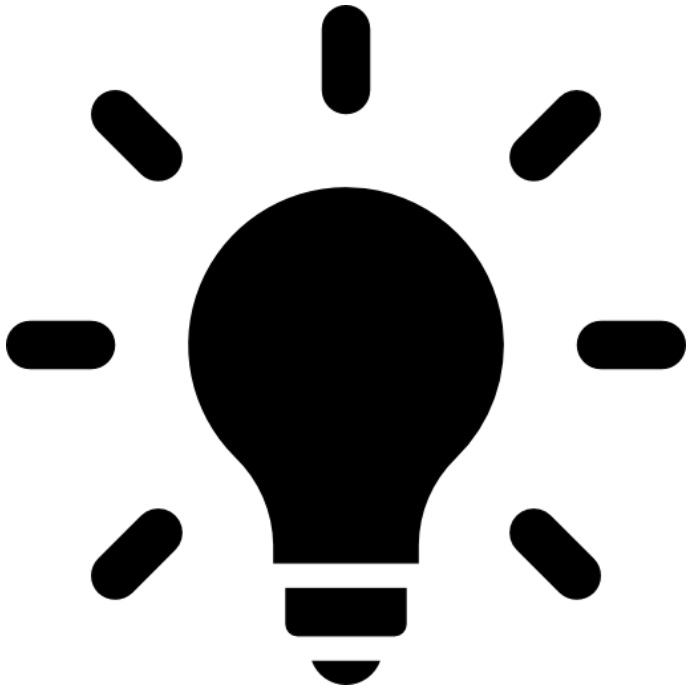
- Maternity and Neonatal Safety Improvement Programme - FutureNHS Collaboration Platform

Considerable information on both

Need to register with FutureNHS to join


UPDATE
North East and North Cumbria (NENC)
National Patient Safety Improvement Programmes
Maternity and Neonatal
Welcome
FutureNHS
MatNeoSIP Event – 13th December 2021
MatNeoSIP Event – 24th March 2022
NENC Focus
Optimisation and Stabilisation of the Preterm Infant Workstream
Smoke Free Pregnancies Workstream
Any queries? Email Julia Wood (MatNeoSIP Lead for NENC):
julia.wood@ahsn-nenc.org.uk
Scoping document
Improvement Toolkit
Optimisation
Smoking
Deterioration
Published: September 2021
OPTIMISATION AND STABILISATION OF THE PRETERM INFANT
Optimal Cord Management

Quality Improvement Bitesized Training



MatNeoSIP - YouTube

Next event: 14th December 1 – 4

[Maternity and Neonatal Safety Improvement Network (MatNeoSIP) Event Registration, Wed 14 Dec 2022 at 13:00 | Eventbrite]

Get involved

julia.wood@ahsn-nenc.org.uk

National Patient Safety Improvement Programmes

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Maternity and Neonatal

Early recognition and management of deterioration of women and babies

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National Patient Safety Improvement Programmes

Maternity and Neonatal

National Overview

Charlie Merrick, Senior Improvement Manager – Patient Safety Improvement Team
NHS England and NHS Improvement

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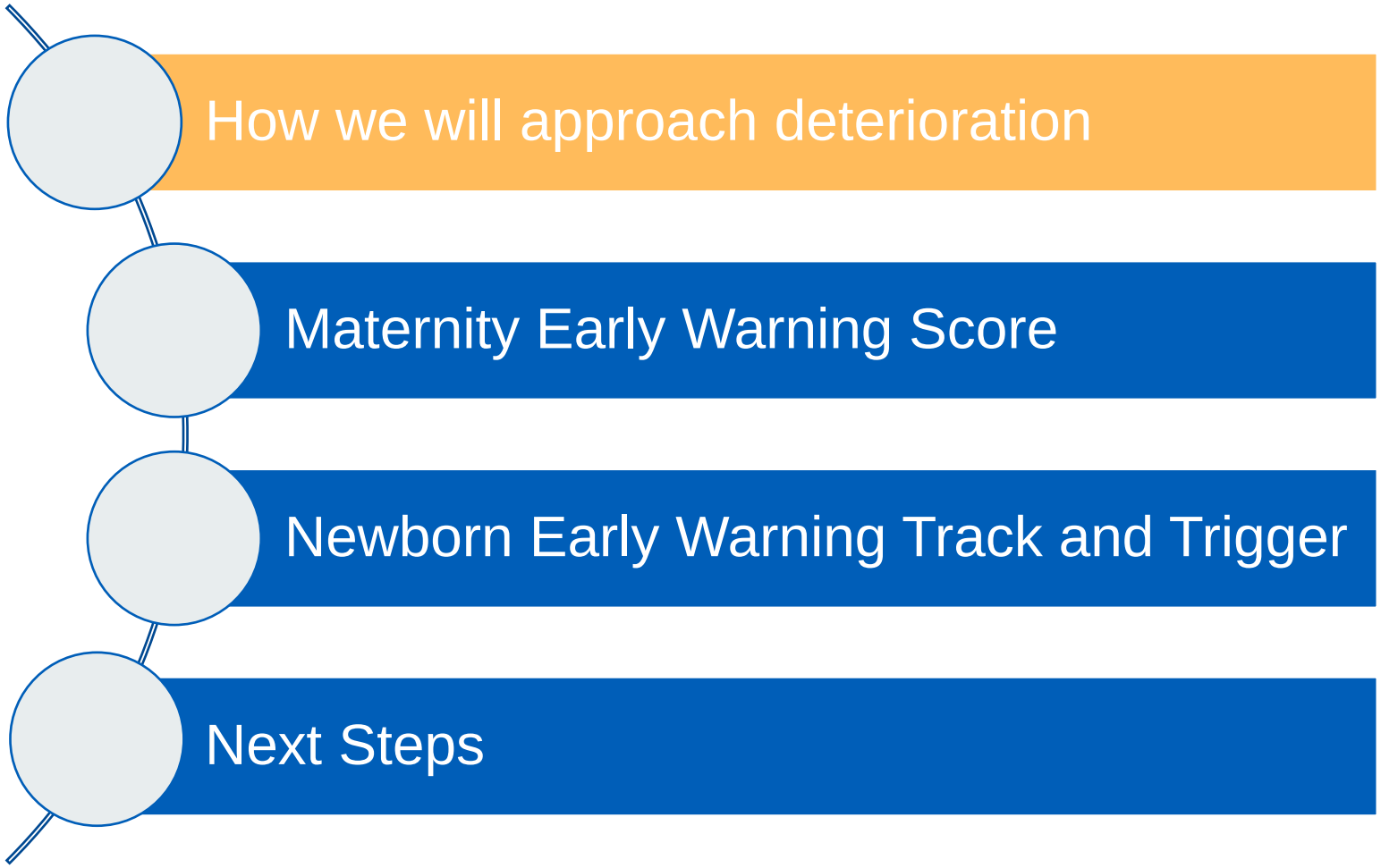
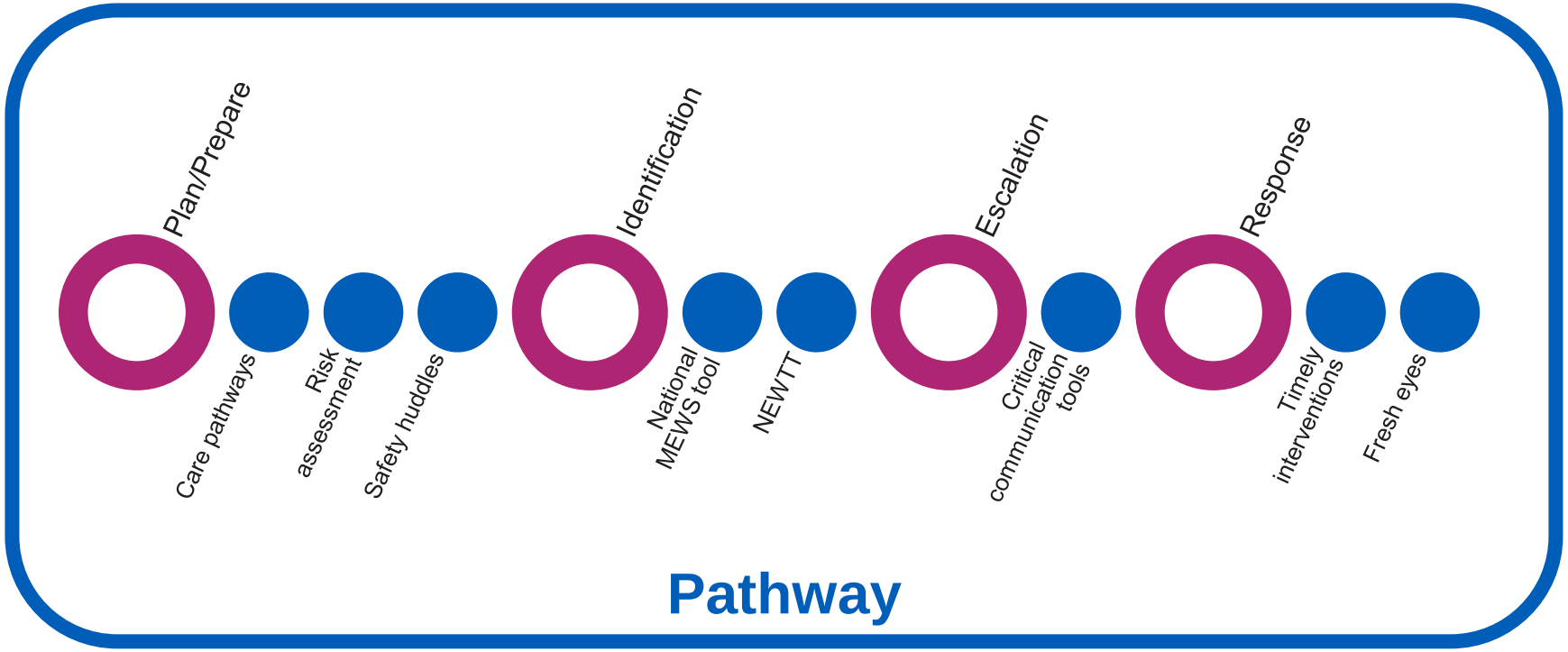

How we will approach deterioration
Maternity Early Warning Score
Newborn Early Warning Track and Trigger
Next Steps

How will we approach deterioration?



- Better reliability and effective management
- Consistency of approach
- Standardisation

How will we approach deterioration?

P — **Plan / Prepare / Prevent:** developing systems and processes that support the design of a reliable and safe care pathway that includes the continuous assessment of risks, appropriate interventions that will help monitor or reduce individual risk, improved access to services, and ensuring women and families are provided with consistent information as to their available options, ensuring care is personalised and responsive to their choices and needs.

I — **Identification**: the expeditious recognition of deterioration through the reliable monitoring, identification and assessment of all mothers and babies' conditions in all environments.

E — **Escalation**: using standardised protocols and the reliable escalation and communication of deterioration using a 'common language' recognised across the NHS with high quality, structured communication.

R — **Response**: the timely response and review by senior clinicians and reliable activation of clinical interventions including acute intervention and ongoing monitoring.

How will we approach deterioration?

P

Plan / Prepare / Prevent: developing systems and processes that support the design of a reliable and safe care pathway that includes the continuous assessment of risks, appropriate interventions that will help monitor or reduce individual risk, improved access to services, and ensuring women and families are provided with consistent information as to their available options, ensuring care is personalised and responsive to their choices and needs.

- Early well-being assessment
- Collaborative approach

I

Identification: the expeditious recognition of deterioration through the reliable monitoring, identification and assessment of all mothers and babies' conditions in all environments.

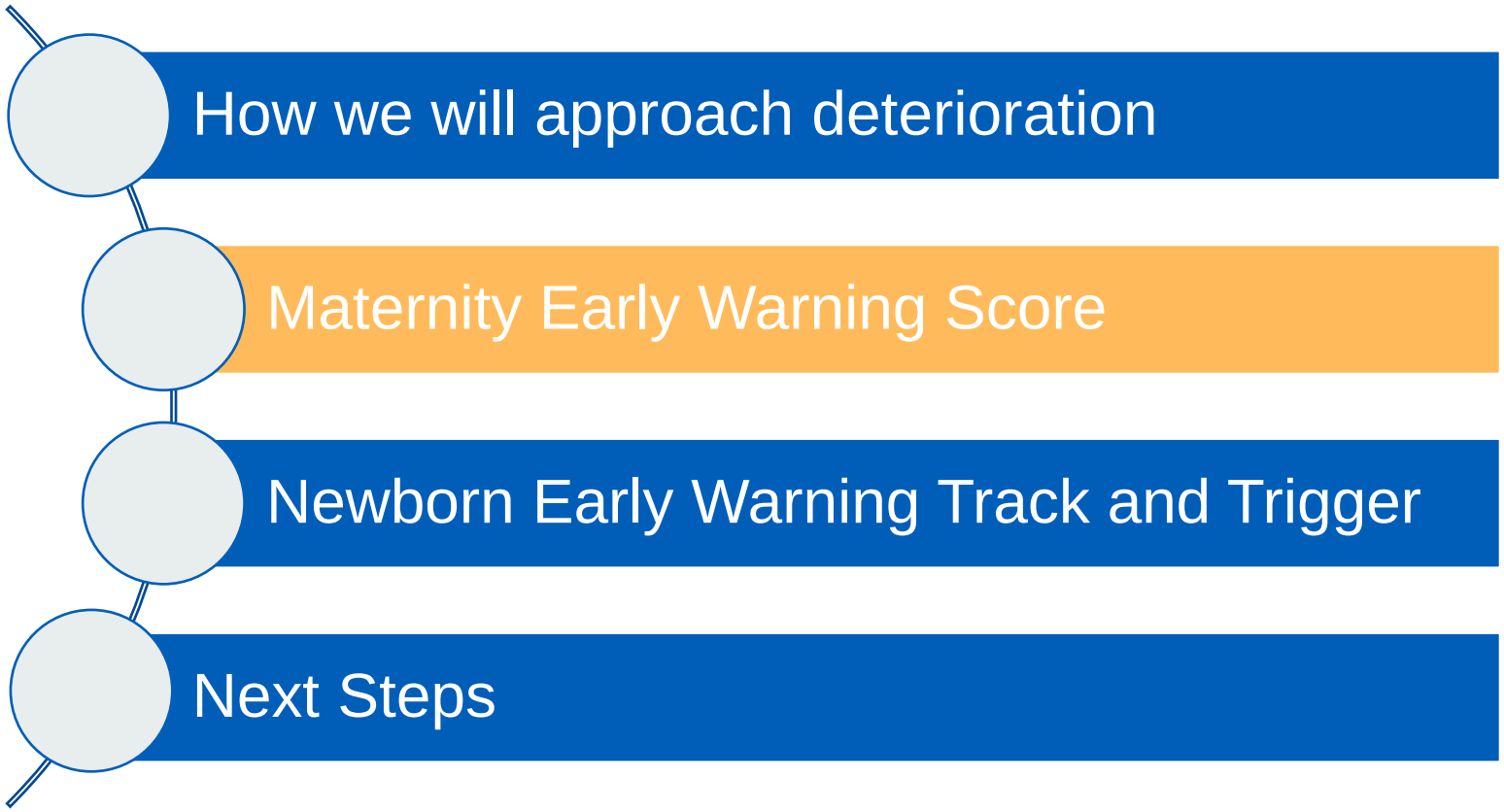
- Core design group
- Population data - physiology
- Additional Concerns
- Consensus building and prototyping

How will we approach deterioration?

Escalation: using standardised protocols and the reliable escalation and communication of deterioration using a 'common language' recognised across the NHS with high quality, structured communication.

Response: the timely response and review by senior clinicians and reliable activation of clinical interventions including acute intervention and ongoing monitoring.

- Graduated escalation and response
- Promotes collaborative decision making
- Safety critical language
- Underpinned by effective local team cultures and psychological safety


How we will approach deterioration
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Maternity Early Warning Score

NHS England

Maternity Early Warning Score (MEWS)

Hospital sticker with patient details

NHS

MEWS score: 0 | 1 | 2 — A score for each vital sign is required at each entry

Vital sign	Range	Score
Respirations Breaths/min	>=25	2
	22-24	1
	18-21	0
	13-17	0
	9-12	0
	7-8	1
	<=6	2
Sp0$_2$ Oxygen saturation (%)	>=95	0
	93-94	1
	<=92	2
Temperature °C	>=37.5	2
	37.3-37.4	1
	36.8-37.2	0
	36.2-36.7	0
	35.7-36.1	1
	<=35.6	2
Pulse Beats/min	>=131	2
	122-130	2
	113-121	1
	99-112	0
	86-98	0
	71-85	0
	63-70	1
	<=62	2
Pulse - from 48 hours post birth ONLY Beats/min (Date & time to commence monitoring:)	>=108	2
	99-107	1
	85-98	0
	71-84	0
	58-70	0
	51-57	1
	<=50	2
Systolic blood pressure mmHg	>=175	2
	160-174	2
	145-159	2
	136-144	1
	121-135	0
	111-120	0
	101-110	0
	94-100	1
	77-93	2
	61-76	2
	<=60	2
Diastolic blood pressure mmHg	>=110	2
	97-109	2
	89-96	1
	80-88	0
	70-79	0
	62-69	0
	57-61	1
	<=56	2
MEWS TOTAL		

Additional concerns - Please see overleaf for additional concern table. If one or more additional concern is present, consider escalation and review.

- Healthcare professional concerned
- Woman/family concerned
- Increased pain (analgesic requirement)
- Significant vaginal bleeding
- Reduced urine output
- Altered level of consciousness/responsiveness
- Other

Monitoring frequency / Escalation of care YES/NO / Initials

Refer to back page for thresholds and triggers

Maternity Early Warning Score (MEWS)

Taking the total MEWS score generated, escalate according to the threshold and trigger table.

Vital Sign	Score 2	1	0	1	2
Respirations Breaths/min	<=6	7-8	9-21	22-24	>=25
Sp0$_2$ Oxygen satuartion (%)	<=92	93-94	>=95	-	-
Temperature °C	<=35.6	35.7-36.1	36.2-37.2	37.3-37.4	>=37.5
Pulse Beats/min	<=62	63-70	71-112	113-121	>=122
Pulse (from 48 hours post birth) Beats/min	<=50	51-57	58-98	99-107	>=108
Systolic blood pressure mmHg	<=93	94-100	101-135	136-144	>=145
Diastolic blood pressure mmHg	<=56	57-61	62-88	89-96	>=97

+

Additional concerns

If one or more of these additional concerns are present, consider:

1. Increasing the frequency of observations to a minimum of every 30 minutes
2. Escalate in line with a low-medium level of concern even if MEWS less than 2
3. Where MEWS is greater than 2 raising the level of concern to the next category.

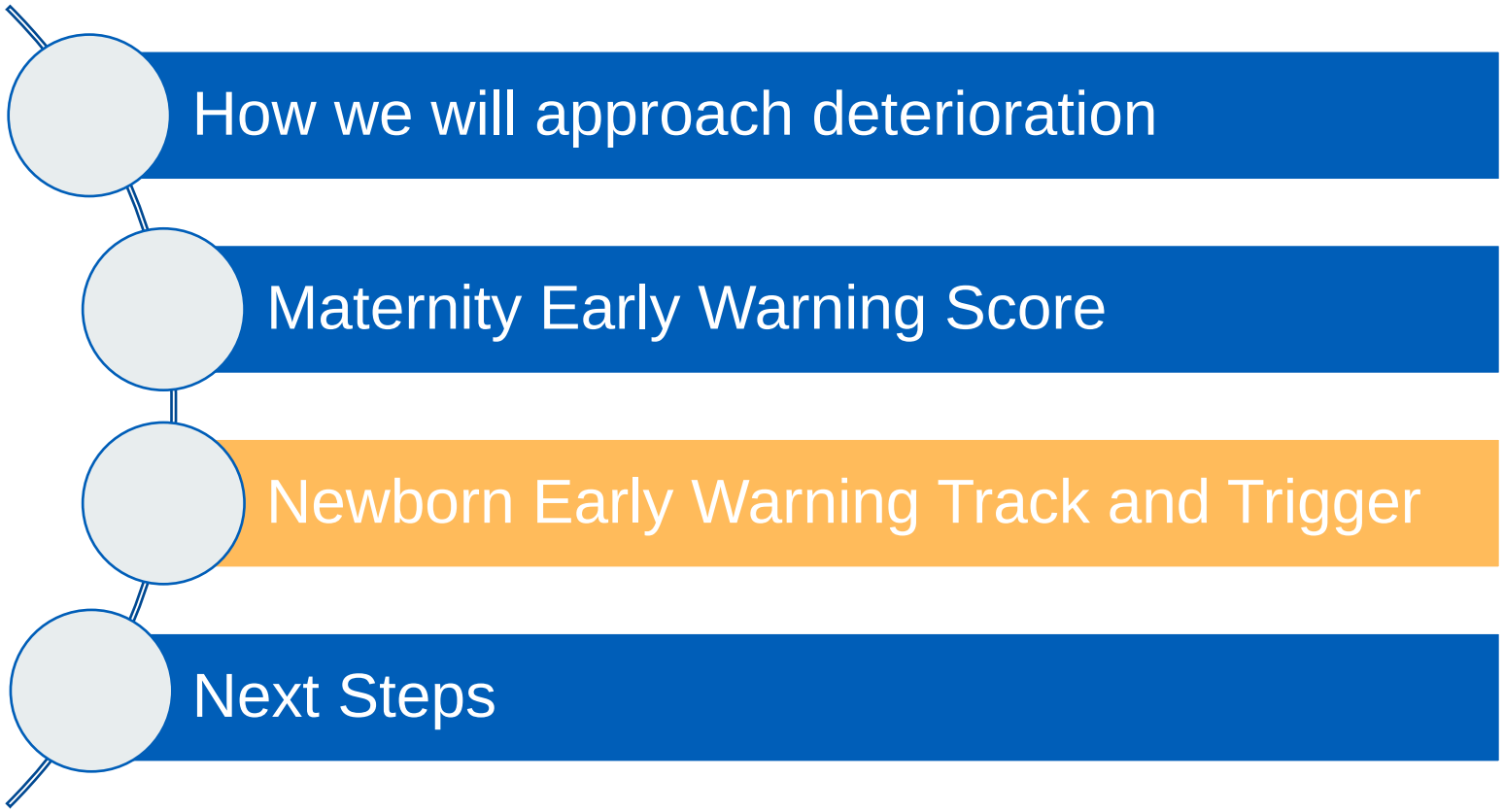
- Healthcare professional concerned
- Woman/family concerned
- Increased pain (+/-or analgesic requirement)
- Significant vaginal bleeding
- Reduced urine output
- Decreased level of consciousness/responsiveness
- Other

Thresholds and triggers

- The grade of medical team member indicated as the primary contact for each level of clinical concern is a guide and may need to be adapted depending on the local skill mix within that care setting or organisation
- It is also advised that early input from anaesthetic team members is also considered when escalation is indicated

Level of concern	Low	Low-medium	Medium	High
MEWS	0-1	2-4	5-7	8 or more
Primary escalation & response (Use SBAR framework)		Review by midwife in charge	Urgent review by midwife in charge	Immediate review by midwife in charge
		Request review by ST1/2 or equivalent	Urgent review by ST3+ or equivalent and consultant made aware of plan	Immediate review by ST3+ or equivalent and consultant. Consider review by outreach team
Medical review timing		Within 30 minutes	Within 15 minutes	Immediate
Minimal vital signs recording until medical review/ongoing plan	Continue with current observation frequency	Reassess observations withinn 30 minutes & document ongoing plan	Reassess observations within 15 minutes & document ongoing plan	Continuous observations
Secondary contact		ST3+ or equivalent	Consultant or equivalent	Clinical outreach team or equivalent

- When the primary team member(s) contacted is unable to attend or fails to attend within the expected time for the level of clinical concern, escalation to the secondary contact is required
- The secondary contact would be expected to attend within the initial medical review timing, calculated from the documented time of primary escalation
- The section **pulse (from 48 hours after birth)** cut-offs should be used for all women from 48 hours after birth. The time and date from which these values should be used should be entered on the front of the chart.


How we will approach deterioration
Maternity Early Warning Score
Newborn Early Warning Track and Trigger
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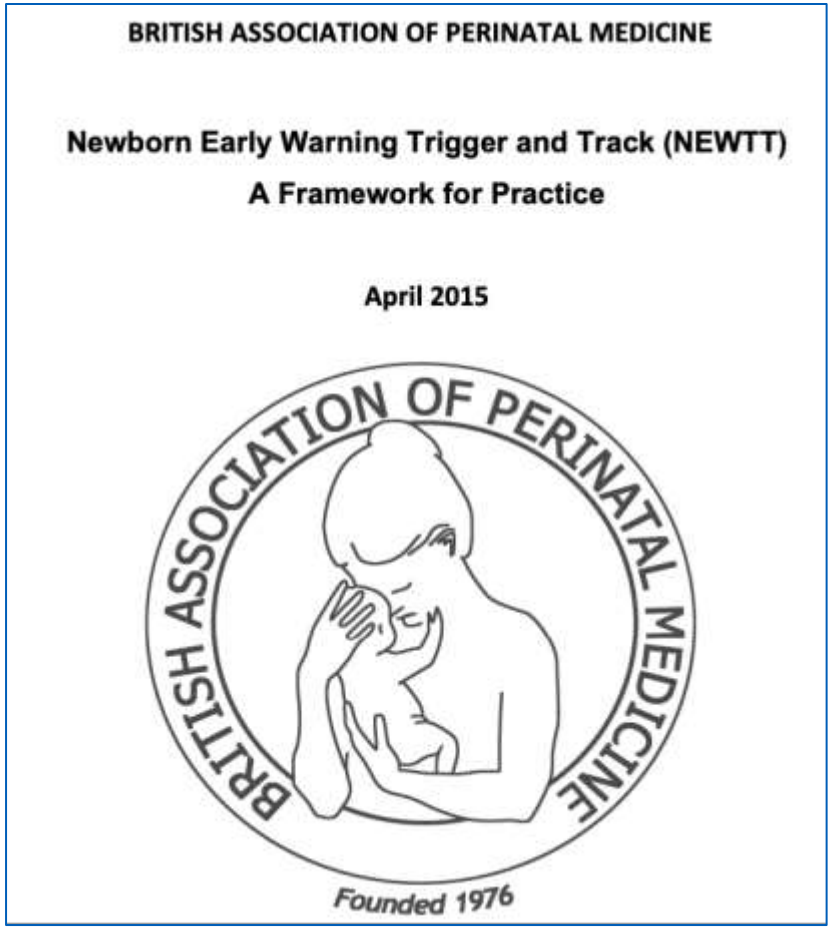
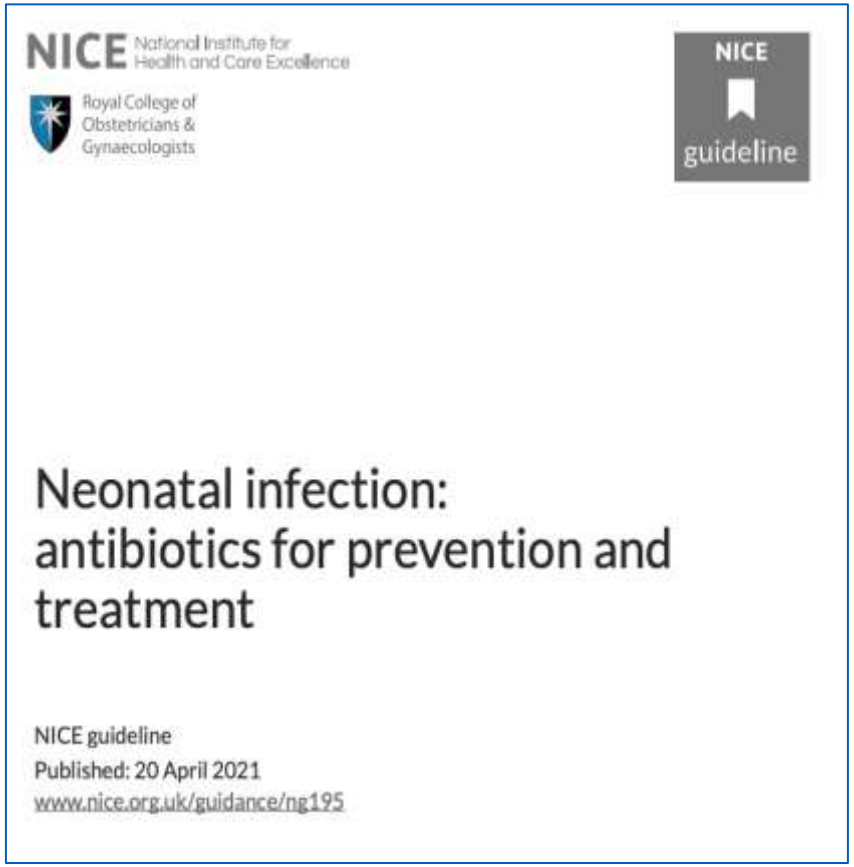
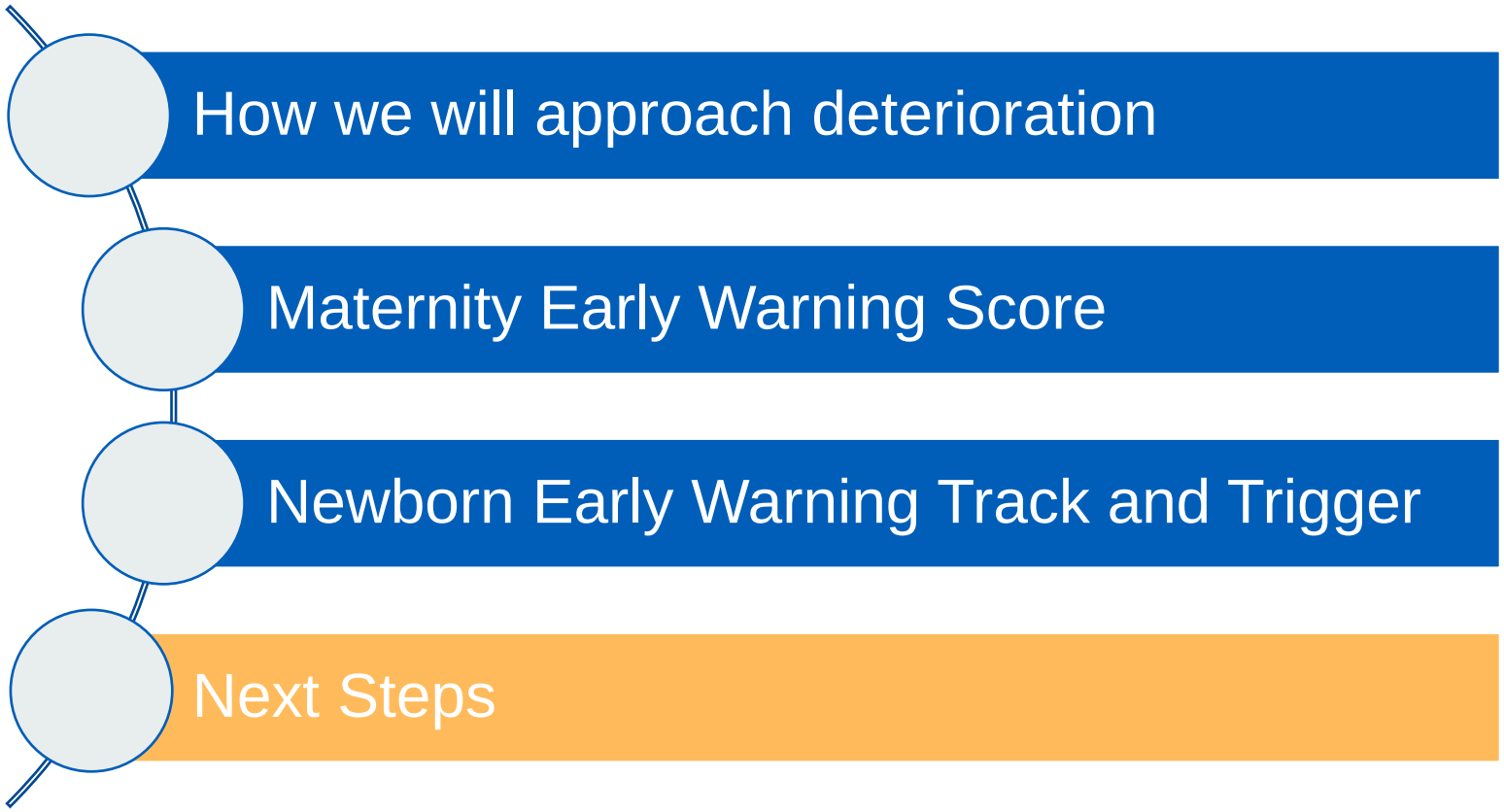
Newborn Early Warning Track and Trigger2



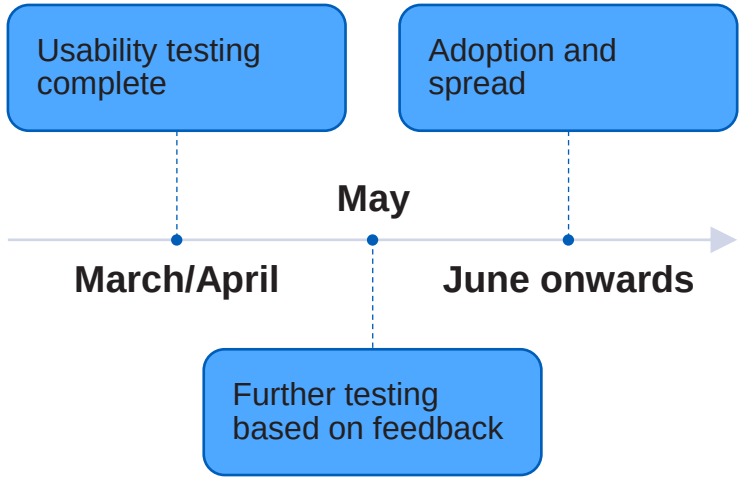



How we will approach deterioration
Maternity Early Warning Score
Newborn Early Warning Track and Trigger
Next Steps

Next steps

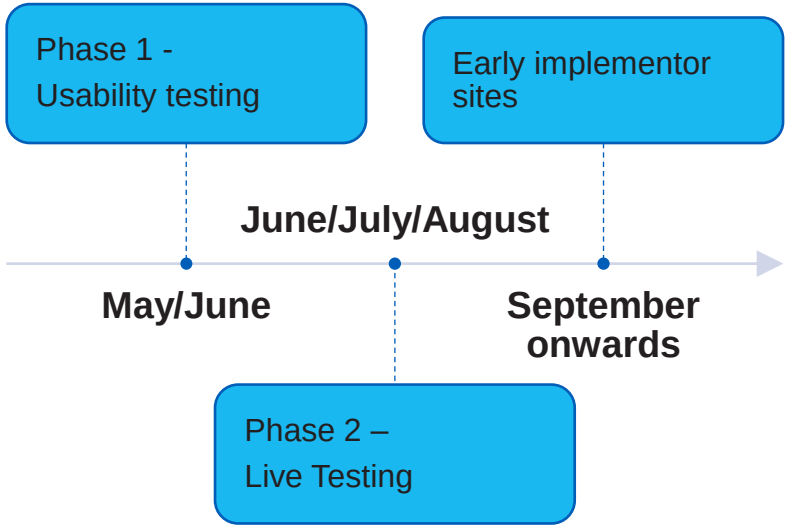
NEWTT2

- Usability testing complete
- BAPM design group
- Support adoption and spread



MEWS

- Testing in two phases over spring/summer
- Final sign off
- Adoption and spread



National Patient Safety Improvement Programmes

Maternity and Neonatal

Regional Overview

Julia Wood, MatNeoSIP Lead - NENC
Patient Safety Collaborative NENC

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Patient Safety Collaborative

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NHS Improvement

Shout out!

- **MEWS – next steps**
  - North Tees and Hartlepool NHS FT
  - South Tees Hospitals NHS FT
- **NEWTT2 – next steps**
  - Newcastle Hospitals NHS FT
  - North Tees and Hartlepool NHS FT
  - South Tees Hospitals NHS FT

Podcasts

1) How and why the National MEWS was developed
2) Operational and clinical factors, benefits and challenges

MEWS Podcasts - Maternity and Neonatal Safety Improvement Programme - FutureNHS Collaboration Platform

Feedback from June Event

Thanks again to Kent Surrey and Sussex PSC

Question 1:
What behaviours need to be present on a shift to encourage escalating a concern?

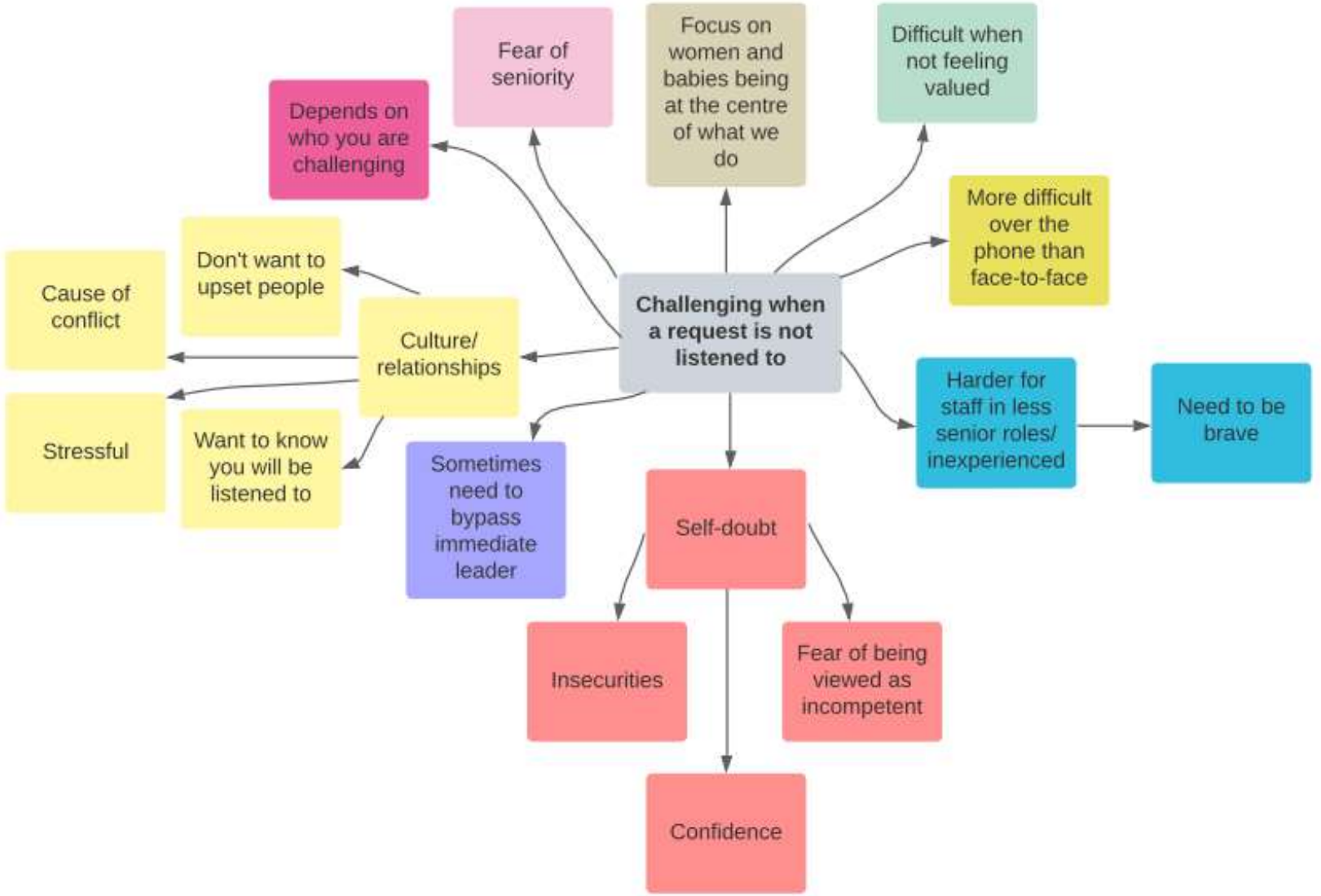
Question 2:
What can stop you from timely and appropriately escalating a concern?

Question 3:
How easy do you find it to challenge when a request for escalation is not listened to, and why?

Put them into themes


Behaviours needed to encourage escalating a concern
Communication
Opinions valued
Approachable
Respectful
Environment to challenge
Being aware of outcome
Psychological safety
Listening to each other
Trust
Honesty
Civility
Collaboration
Access to person to escalate
Education
What is a concern?
What is the process?
Evidence based practice
Increased confidence
Leadership
Effective leadership
Approachable
Non-hierarchical
Leaders knowing their team
Culture
Psychological safety
Civility
Openess
Empowering staff to escalate concerns
Trust
Empowering staff to question
Calm
Non-judgemental


What stops us from timely and appropriately escalating a concern?
Communication
Communication breakdowns
Poor interpersonal relationships
Lack of freedom to talk without retribution
Incivility
Not having previous concerns addressed
Fear of being dismissed
Fear of confrontation
Cannot find them
No one to escalate to
Education
Lack of knowledge as to how to escalate concerns
Data availability
Lack of awareness
No clear policy
Lack of confidence (self and others)
Unsure if concern is relevant
Lack of knowledge as to what is a concern
Workload
Competing pressures
Staff absences/ staffing levels/ skill mix
Too many concerns to escalate
Poor previous experience
Leadership
Unsupportive
Unapproachable
Top-down managerial approach
Undermining leadership
Fear of leaders
Culture
Lack of confidence in escalation being acted upon
Lack of psychological safety
Lack of support from colleagues
Fear of criticism/ repercussions
Lack of confidentiality
Fear of management
Culture of bullying
Lack of respect
Sense of not belonging
Incivility
Fear of being wrong
Fear of not being supported


Challenging when a request is not listened to
Fear of seniority
Focus on women and babies being at the centre of what we do
Difficult when not feeling valued
Depends on who you are challenging
More difficult over the phone than face-to-face
Don't want to upset people
Cause of conflict
Culture/ relationships
Stressful
Want to know you will be listened to
Sometimes need to bypass immediate leader
Harder for staff in less senior roles/ inexperienced
Need to be brave
Self-doubt
Insecurities
Fear of being viewed as incompetent
Confidence

National Patient Safety Improvement Programmes

Maternity and Neonatal

NHS

Each Baby Counts: Learn and Support

Amanda Andrews, Programme Manager
Innovation Agency

@AHSN_NENC

ahsn-nenc.org.uk

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NHS Improvement

Royal College of Midwives

Royal College of Obstetricians & Gynaecologists

each baby counts + learn & support

Programme Overview

Enabling maternity teams to work safely

each baby counts
learn & support

Our throughline

Helping maternity units to build the right culture, behaviours and conditions that enables effective clinical escalation

The Programme

“Learn”

Each Baby Counts Learn and Support was a joint RCOG / RCM DHSE funded programme aiming to build the capacity of 16 NHS Maternity Professionals in clinical leadership skills, safety thinking, and quality improvement using behavioural science approach to design, test and evaluate interventions.

”Support”

This network of midwives and obstetricians from across England worked together co-design and implement interventions improve the culture, behaviours and conditions that enable **effective clinical escalation in maternity units.**

Background

- Started in 2019 – finished March 2022
- Core team: Midwives (x2), obstetrician, behavioural psychologist, research assistant, project manager, plus safety expert consultancy.
- Built on the finding of EBC reports – putting recommendations into action

EBCL&S Approach

Learn:

Identify learning points on escalation from both national reports and local practice (diagnostics).

Workshops for the local leads focussed on developing clinical leadership skills, build capacity in Quality Improvement methodology and awareness of key safety concepts including psychological safety Safety II, civility, and strategies to aid effective communication.

Support:

Identify the barriers and facilitators of effective escalation in their settings

Co-produce interventions with input from their teams and women

Implement, test and evaluate interventions in their settings

Share widely across all maternity services

Maternity Safety

each baby counts + learn & support

NHS Resolution

NATIONAL Maternity Voices
Networking Maternity Voices Partnerships in England

CareQuality Commission

National Patient Safety Improvement Programmes

Maternity and Neonatal

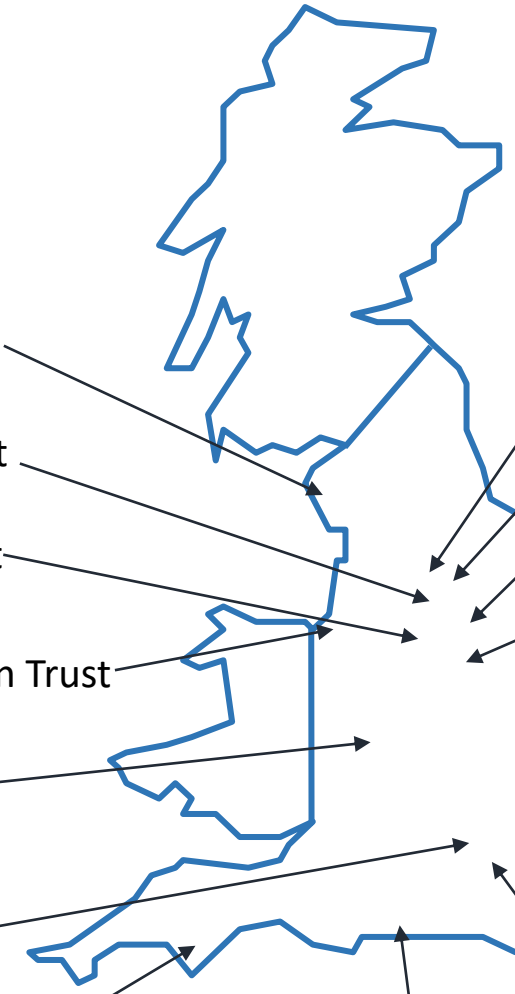
MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

each baby COUNTS.

HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH
WWW.HSIB.ORG.UK

Participating units

each baby counts
learn & support



University Hospitals of Morecambe Bay

Chesterfield Royal Hospital NHS Foundation Trust

East Cheshire NHS Trust

Wirral University Teaching Hospital NHS Foundation Trust

Royal Wolverhampton NHS Trust

West Hertfordshire Hospitals NHS Trust

Royal Devon and Exeter NHS Foundation Trust

Leeds Teaching Hospitals Trust

Calderdale and Huddersfield NHS Foundation Trust

Sherwood Forest Hospitals NHS Foundation Trust

United Lincolnshire Hospitals NHS Trust

Norfolk and Norwich University Hospital NHS Foundation Trust

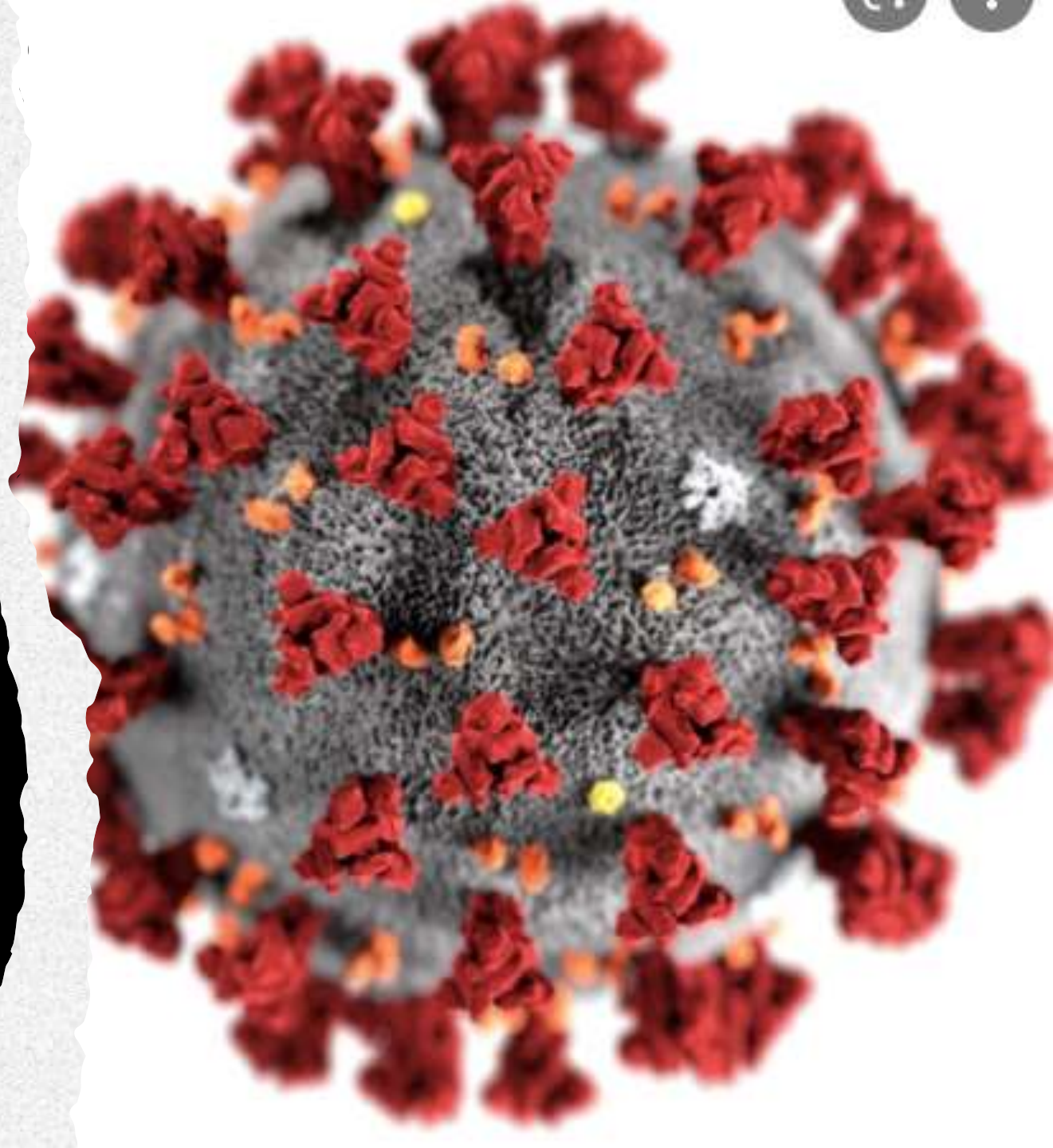
East Suffolk and North Essex NHS Foundation Trust

Medway Foundation Trust

Kingston Hospital NHS Foundation Trust

University Hospitals Southampton NHS Foundation Trust

What no one was expecting….

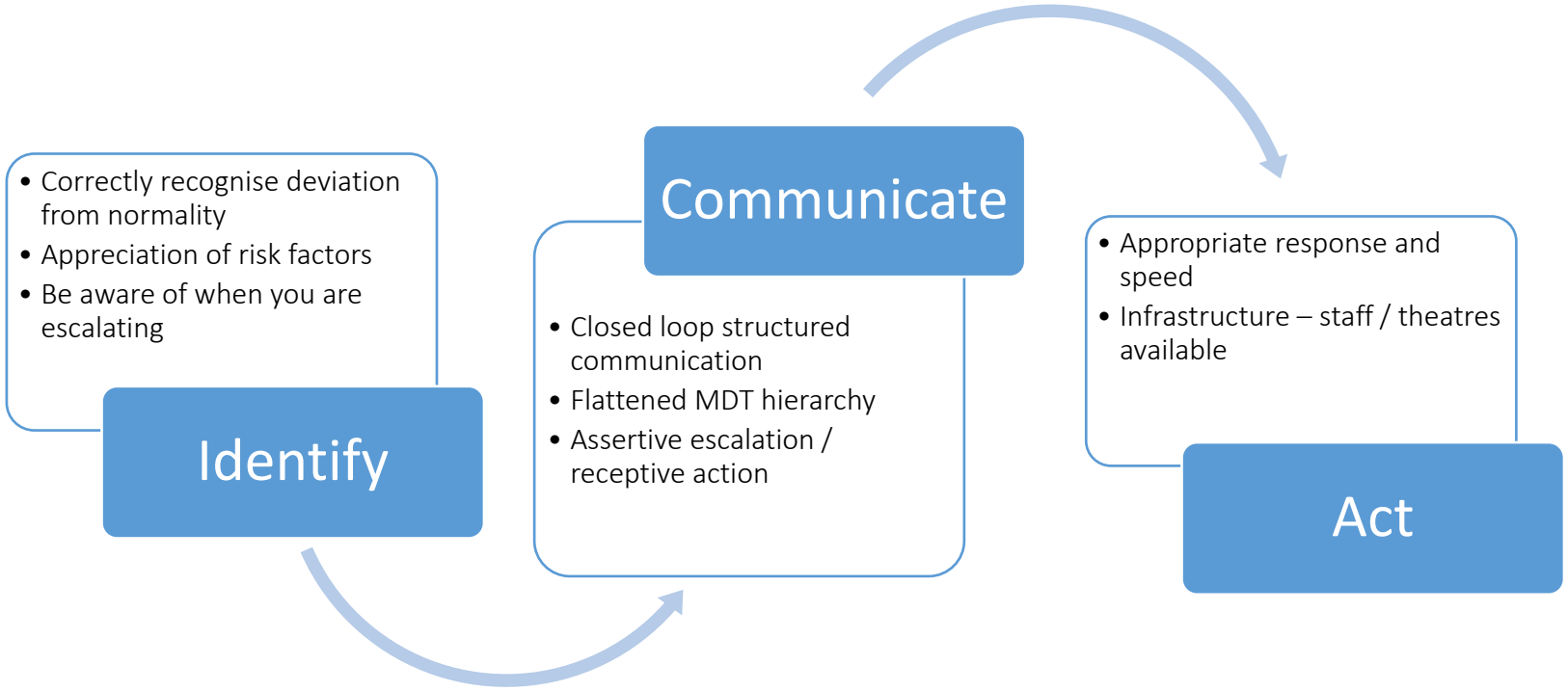


each baby counts
learn & support

Understanding *clinical* escalation:

*'Escalation is **safety critical communication** to achieve a **timely** senior **response** for a **complication or evolving clinical situation**'*

Right person, Right place, Right Response, Right time?



Quality Improvement Process

each baby counts + learn & support

Diagnostic phase

- Identify what needs to change (review serious incident forms, observation of practice)
- Exploring barriers and facilitators of the desired behaviours (interviews or focus groups with staff)
- How often is the behaviour happening/not happening, team views on the reasons why using the COM-B model

Spanned covid-19 pandemic

Design phase

- Developing impactful interventions to support/enable practice change
- Targeting the factors known to hinder and/or facilitate the change
- Interventions co-developed with staff to ensure buy-in
- Consultations with women
- Develop any training materials/resources required for roll-out

Nov 2020-Feb 2021

Implementation

- Put the agreed intervention{s) into place following agreement from the whole team
- Deliver any training required to teams to carry out the desired behaviours
- Baseline questionnaire with all staff prior to roll out
- Repeat questionnaire following period of implementation (e.g. after 3 months)
- Qualitative interviews/focus groups with selected staff to further explore the implementation of the intervention

March 2021-September 2021

Evaluation

Ongoing throughout. All contained in final report on RCOG website

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learn & support

Change ideas and change methodology

Campaign: Identify - Communicate - Act (Response)

IDENTIFY –

Team of the shift: Use checklist for setting up team of the shift – with visuals and prompts.

Knowledge and skills: Develop educational material re knowledge, tools, escalation process: increasing conscious awareness

COMMUNICATE -Use concise, safety critical language to communicate concerns and SBAR.

Begin conversation with:

"I need advice"

" I need to inform"

"I need a response"

ACT (AND RESPOND) - Teach or Treat

Respond kindly, quickly and appropriately using

TEACH "Tell me what you think and why, I'll do the same so we can discuss"

or

TREAT "Lets take action to the clinical escalation"

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Overall Aim: To Improve Clinical Escalation

To reduce delays in escalation by improving the response escalation and action taken
To standardise the use of safety critical language
To reduce feelings of hierarchy, creating a supportive environment which empowers staff of all levels to speak up when they identify deterioration or a potential mistake
To promote a culture of respect, kindness and civility amongst staff members, normalising positive feedback and saying thank you to each other
To improve the ways in which we listen to women

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Interventions Developed and Tested Using QI Methodology

Teach or Treat
Learning conversations

AID
Safety critical language

TOS
Promoting excellence in team working

All aim to improve clinical escalation, psychological safety for staff, and provide a structured way of improving communication and behaviour change.

Team of the Shift

- Standardises a multidisciplinary team huddle at the start of every shift to promote optimal teamwork.
- Huge variation around the country.
- Emails, proformas, posters, business cards used to promote its use
- Promotes positive workplace culture and behavioural norms – every huddle follows the same format

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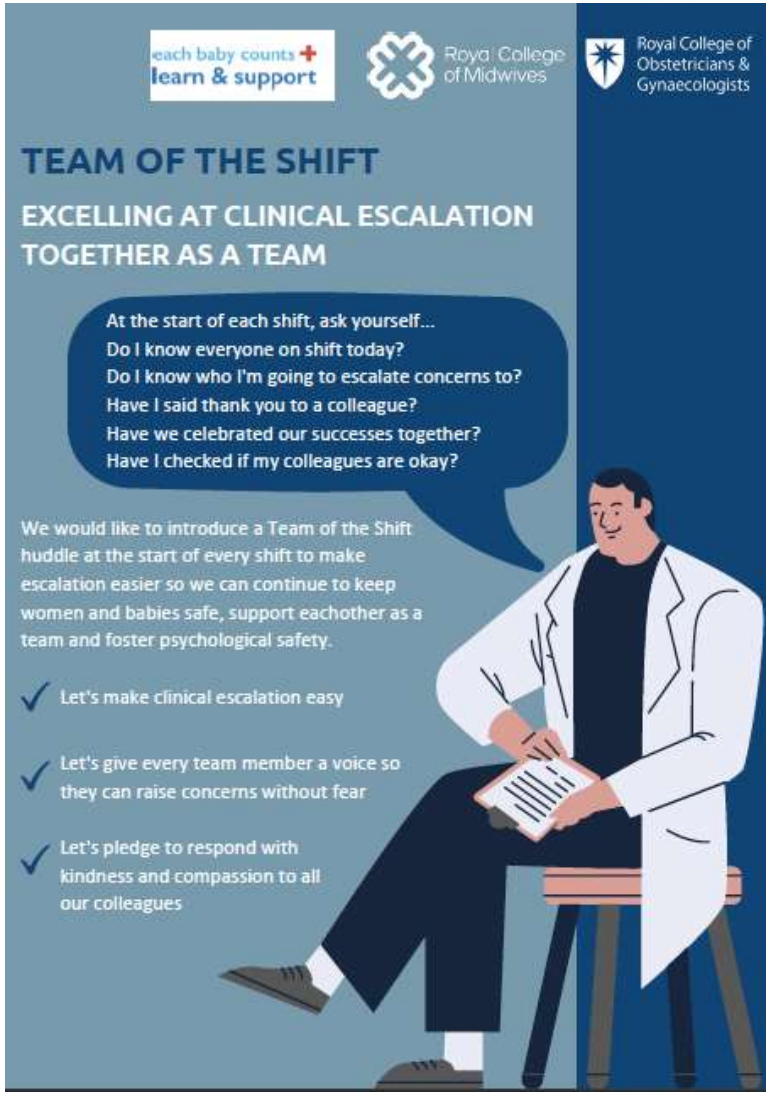

Team of the Shift - Aims

- Identify all the staff on shift that day, including job role and length of shift
- Identify the team leaders, including those who will be escalated to
- Flatten hierarchies by giving everyone a voice and encouraging first name introductions
- Support staff by creating psychological safety, encouraging them to raise concerns and speak up
- Identify anyone in the team who may need additional support that day
- Identify learning needs for trainees and students
- Create a positive workplace culture by thanking staff and celebrating successes
- Foster a culture of kindness and civility
- Eliminate cultures of criticism, including “toxic handovers”
- Foster a sense of teamwork, mutual respect, and create a shared mental model of the team’s workload, priorities, and potential challenges that shift

Team of the Shift– Evaluated Benefits

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- Easy to implement and sustain
- It opens discussions around creating psychological safety “learning to make time to introduce people to one another and talk about escalation to in turn creates safer shifts”.
- Impacts positively on staff during a time of high workload and low morale
- Makes escalation more efficient
- Builds trust, respect, and a sense of unity.
- Identifies individual needs within the team to plan areas of support as well as providing a positive and supportive way to start a shift.
- Empowers junior staff
- Introductions were noted as particularly helpful to avoid confusion and improve safety on the unit.

AID – Advice, Inform, Do

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each baby counts
learn & support

Advice, Inform, Do:

AID is as a clear and simple communication tool which initiates escalation conversations using 3 simple phrases:

- **“I am asking you for Advice”,**
- **“I am Informing you” and**
- **“I need you to Do…”**

It is designed to precede the commonly used SBAR (situation, background, assessment, recommendation)

It can also be used “in reverse” – ie if it is unclear what response the person escalating is looking for, the clinician being escalated to can ask the following:

- **“Are you asking me for Advice”,**
- **“Are you Informing me”,**
- **“Do you need me to DO something / what would you like me to DO”?**

It is not expected that clinicians force these exact phrases into conversations, but that the principles of “ADVICE, INFORM, DO” are used as a framework when escalating.

Aims / Use

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- Clearly identify when escalation is taking place
- Elicit a time critical response, reducing delays
- Help prioritisation for clinicians who may receive multiple escalations within any given shift (band 7 midwifery co-ordinators, consultants)
- Empower junior staff

Used…..

- At the outset of all escalation conversations between ALL members of the MDT
- Particularly helpful when escalating to non resident clinicians (usually consultants) and during periods of high activity

Evaluated Benefits of AID

- Simple, empowering, works as a safety net – therefore well received, particularly by the people being escalated to.
- Streamlines communication and creates escalation awareness
- Improves responses and decision making
- Improves communication and teamwork
- Flattens hierarchies

Teach or Treat

‘Teach or treat’ is a communication process which enables team members to explore their colleagues clinical decision-making process in a respectful dialogue that encourages people to reflect on their own decision-making process. It can help solve disagreements by empowering staff and improving their relationships.

It promotes a collaborative understanding about the unravelling clinical situation, learning and understanding from everyone’s perspectives, and encourages respect for the opinion of others.

Aims of Teach or Treat:

- Promote respectful conversations between staff members so that junior members of the team are not afraid to be unsure, be wrong, or escalate concerns.
- Promote shared understanding of a clinical situations from different clinicians' perspectives
- Put the woman at the heart of the decision making and information giving
- Identify when escalation has taken place
- Promote a flattened hierarchy, a culture of learning and of mutual respect
- Empower all members of the team to respectfully challenge if they think another member may be making a mistake

When is it used?

- When implemented in units around the country, it was most widely used when interpreting CTGs. However, it can be used in any clinical situation.
- On ward rounds
- When performing “fresh eyes” if there is disagreement between the two clinicians
- When escalating clinical concerns
- In CTG / intrapartum care teaching

Benefits of Teach or Treat:

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- Widely accepted as a positive intervention “it makes you really think about your behaviours and actions, and promotes you to have better conversations”
- It improves multi-disciplinary relationships
- It makes staff feel safe
- It flattens hierarchies and empowers junior staff
- It promotes staff to reflect on their decisions and create collaborative care plans
- Women who witnessed the conversations received reassurance and better understandings of their own situation, whilst describing the conversations as respectful.

Challenges of Change

Time, change fatigue

Low morale

Cynicism

Some staff groups more hesitant than others

BUT –

Interventions are designed to be simple

Staff feel safer therefore highly acceptable

Overall package leads to a more positive workplace culture

What Have We Learnt?

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- The impact of local diagnostics
- Maternity units across the country have more in common than they realise
- The impact of human factors and safety thinking underpinning interventions
- The impact of "campaign methodology"
- Break large ambitions into small, manageable projects
- The importance of the "bottom up" approach
- Measure improvement and celebrate successes
- Cake is a key safety intervention in maternity – we need to look after our staff

And Finally…..

- The human side to all this work
- A big team of dedicated professionals who really want to make a difference
- A LOT of cakes baked
- During the most challenging time of people's lives

THANK YOU to an inspiring group of people

Royal College of Midwives

each baby counts + learn & support

Royal College of Obstetricians & Gynaecologists

Thank you

ebc_learnandsupport@rcog.org.uk

Enabling maternity teams to work safely

Royal College of Obstetricians and Gynaecologists, 10-18 Union Street, London SE1 1SZ

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National Patient Safety Improvement Programmes

NHS

Maternity and Neonatal

Optimisation and stabilisation of the preterm infant

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Northern Neonatal Network

North East and North Cumbria Local Maternity System

Led by:

NHS England
NHS Improvement

National Patient Safety Improvement Programmes

Maternity and Neonatal

National Overview

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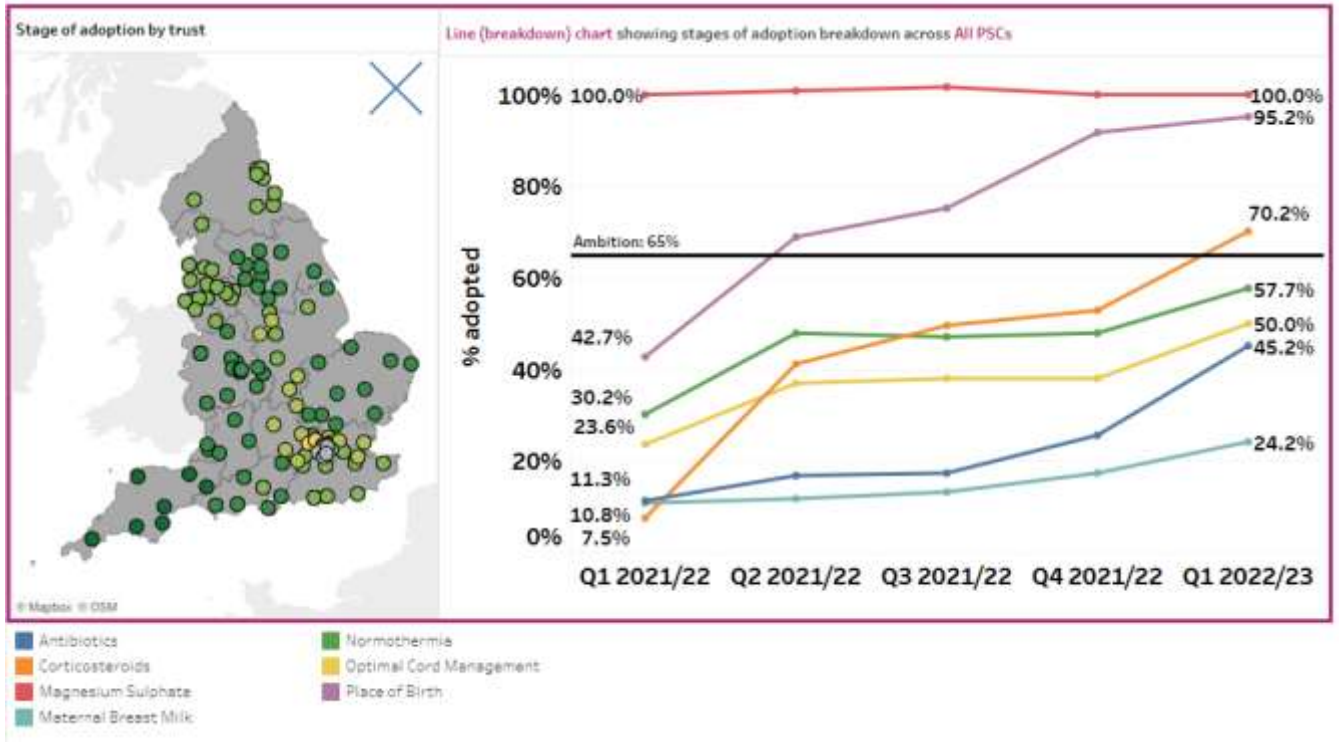
National Overview

National picture A&S measures

Data Dashboard

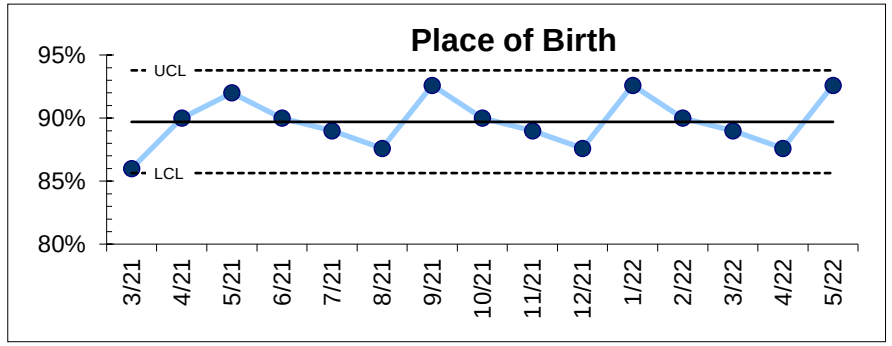
Economic Framework

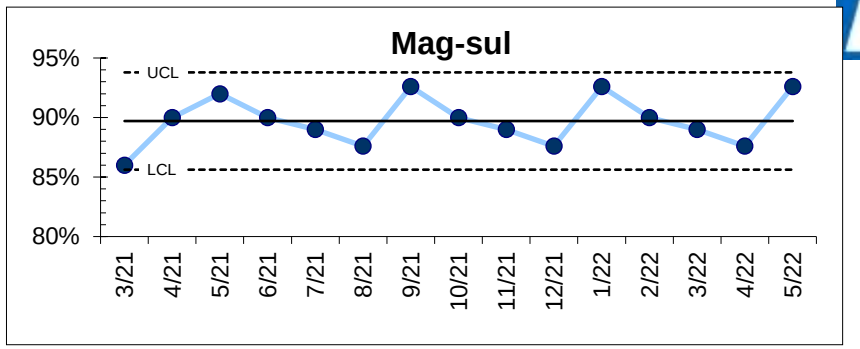


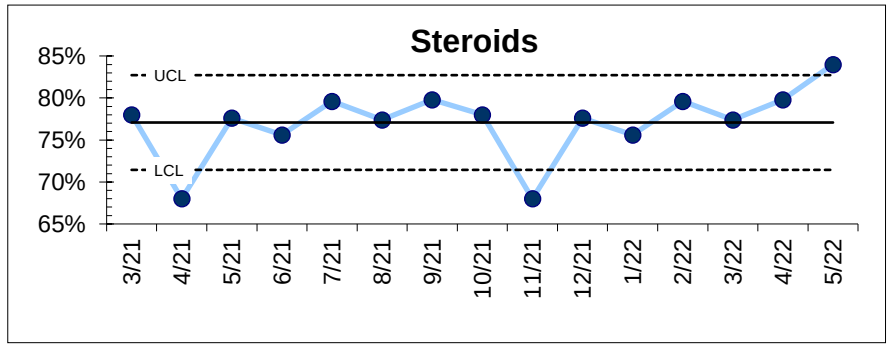
Data Dashboard

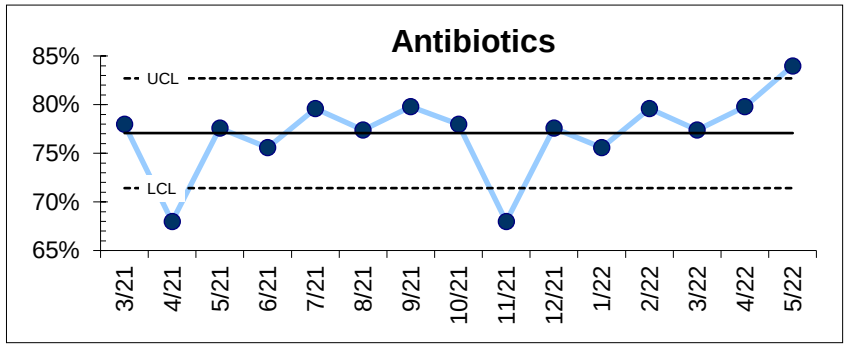
> National / Regional / PSC / ICS
> Process level data
> Aggregate and Composite
> Outcomes
> Economic / cost effective measures
> Comparative measure

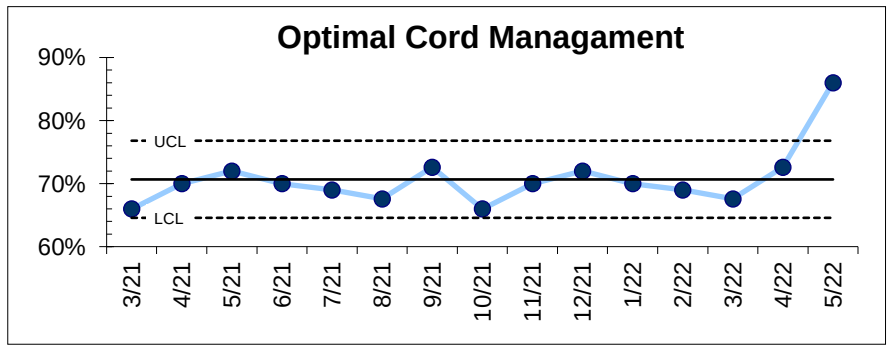
Process level data

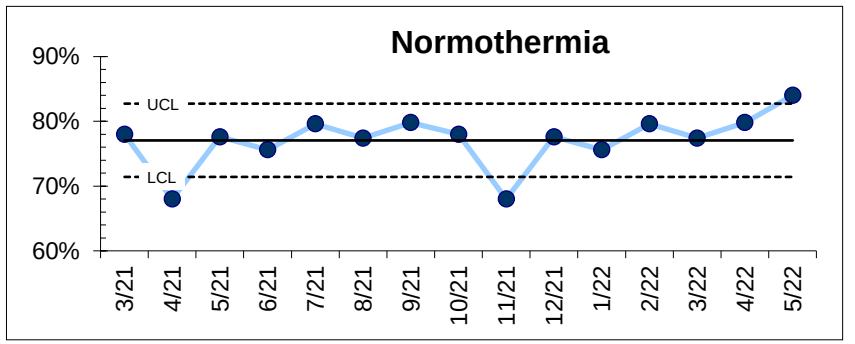


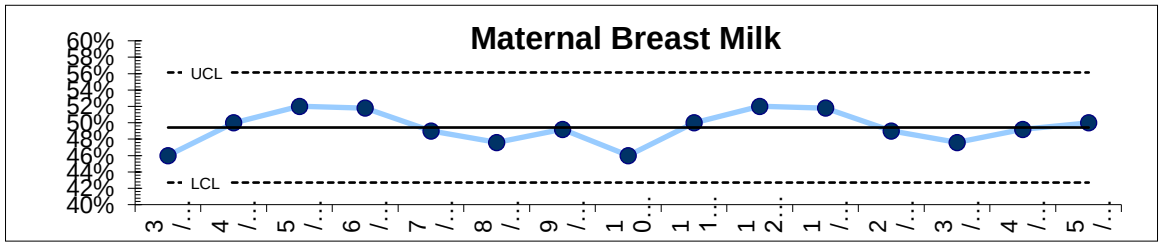




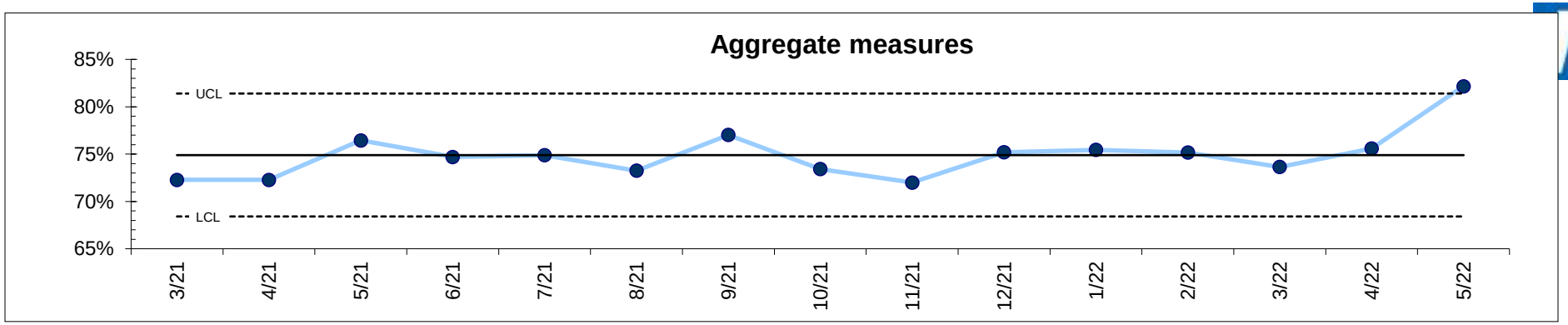


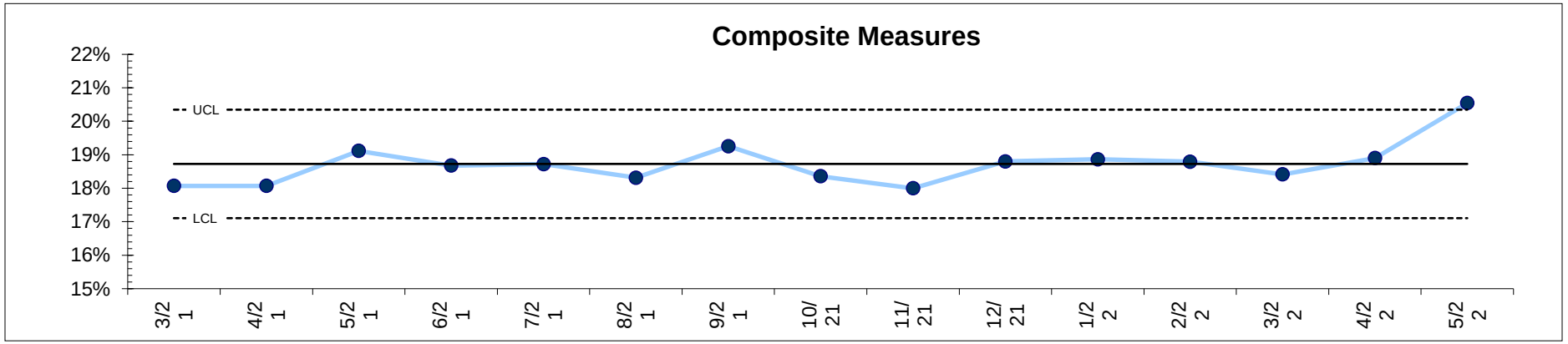


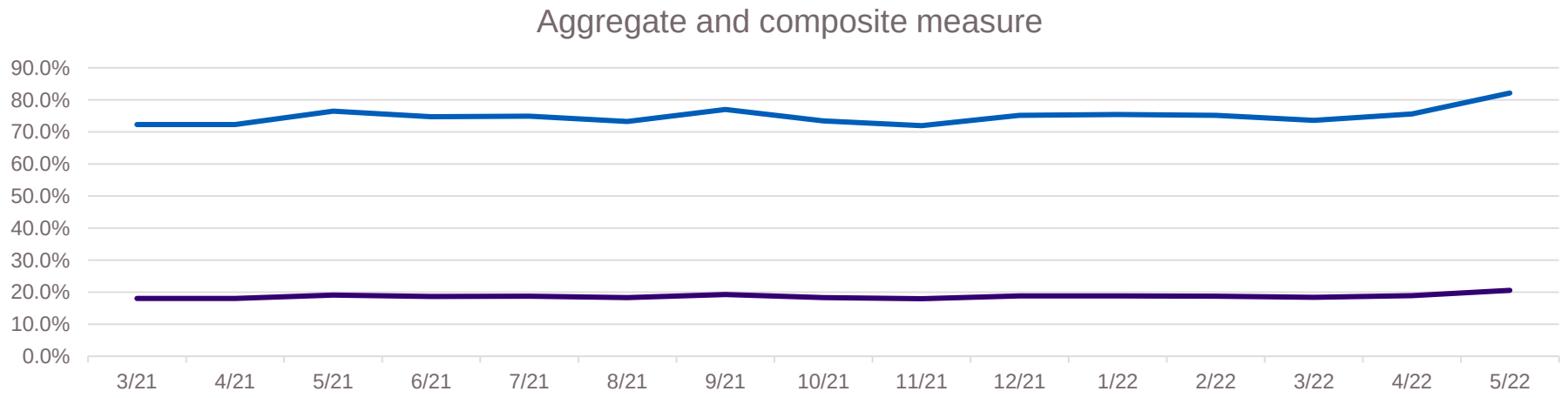




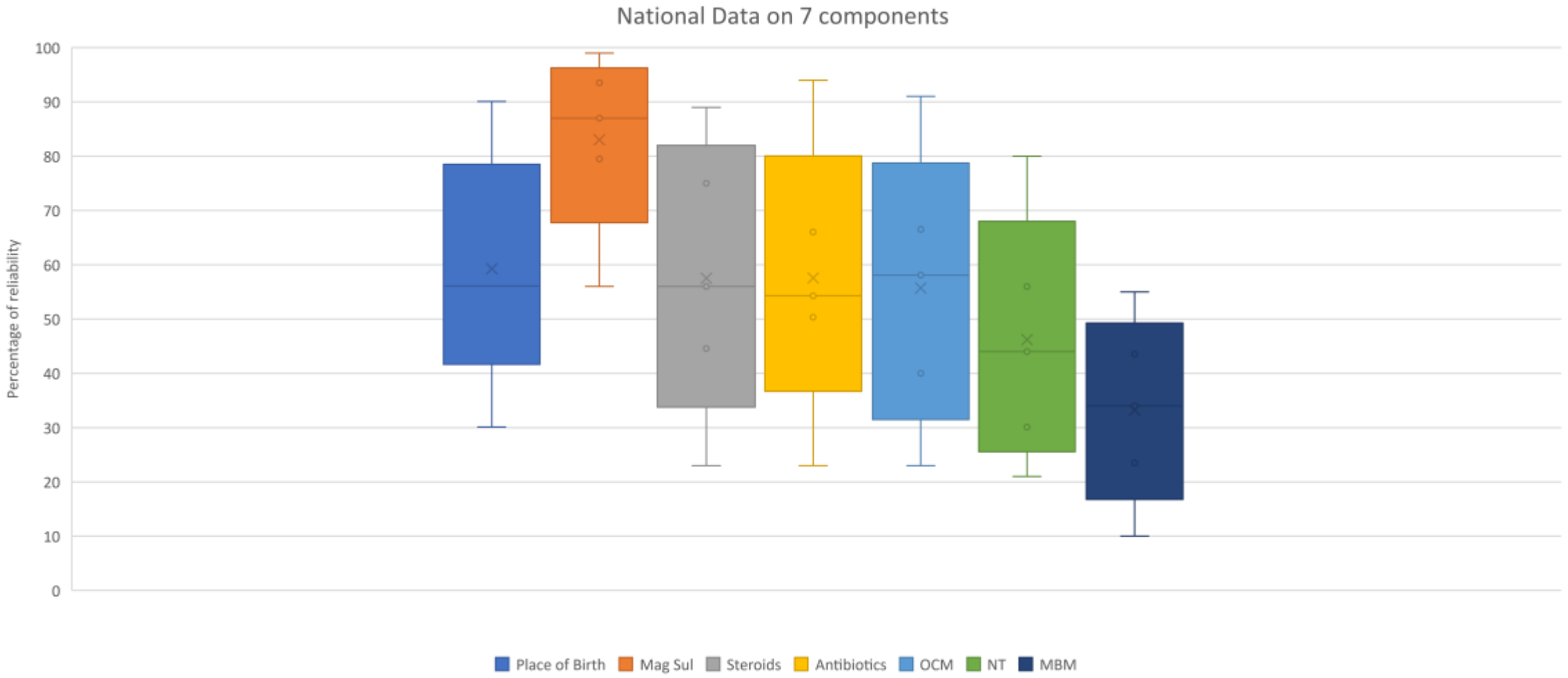
Additional Measures







Box and whisker



National Patient Safety
Improvement Programmes

NHS England

Maternity and Neonatal

Economic Framework

@PTSafetyNHS / @MatNeoSIP

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Northern Neonatal Network

North East and North Cumbria Local Maternity System

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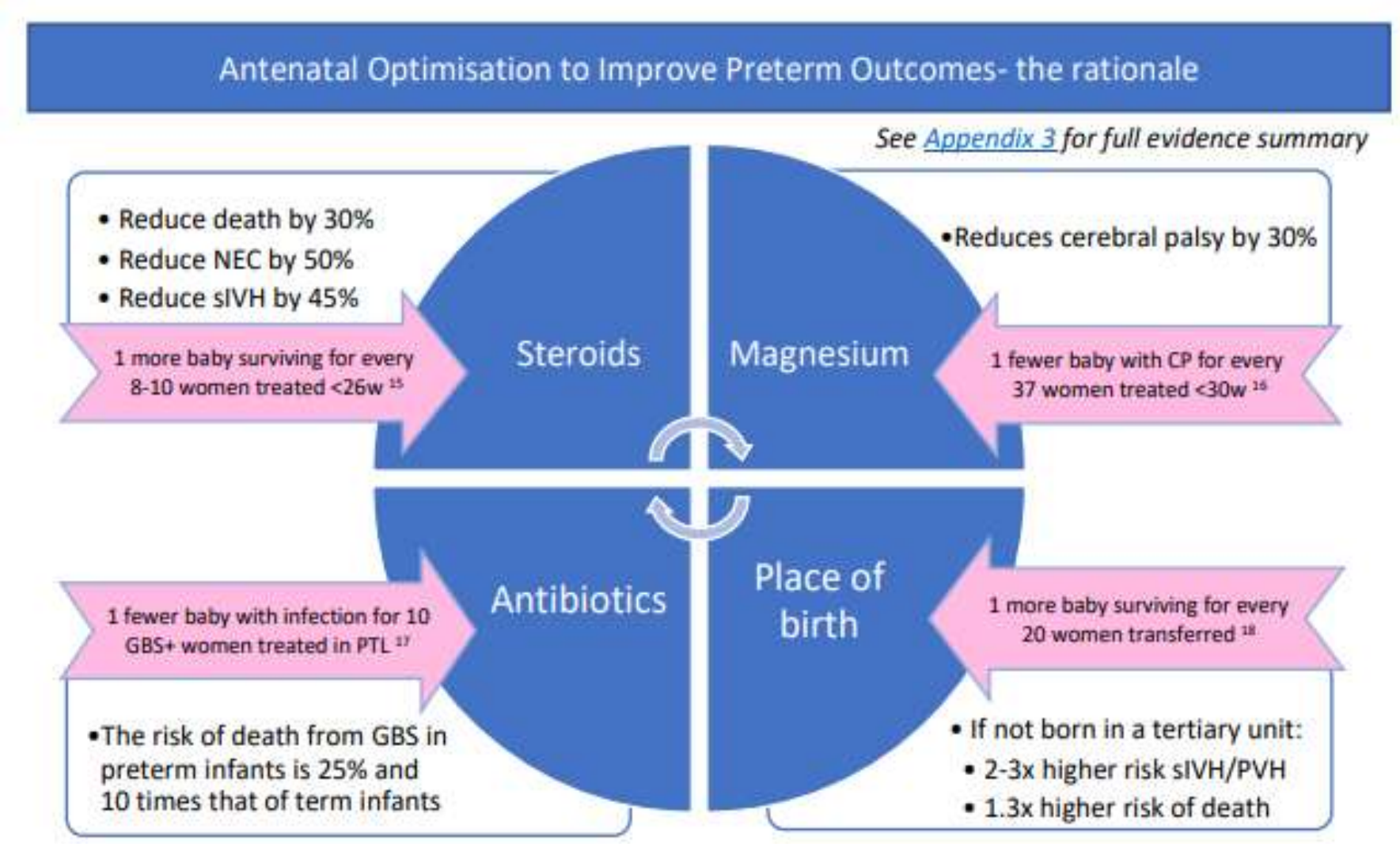
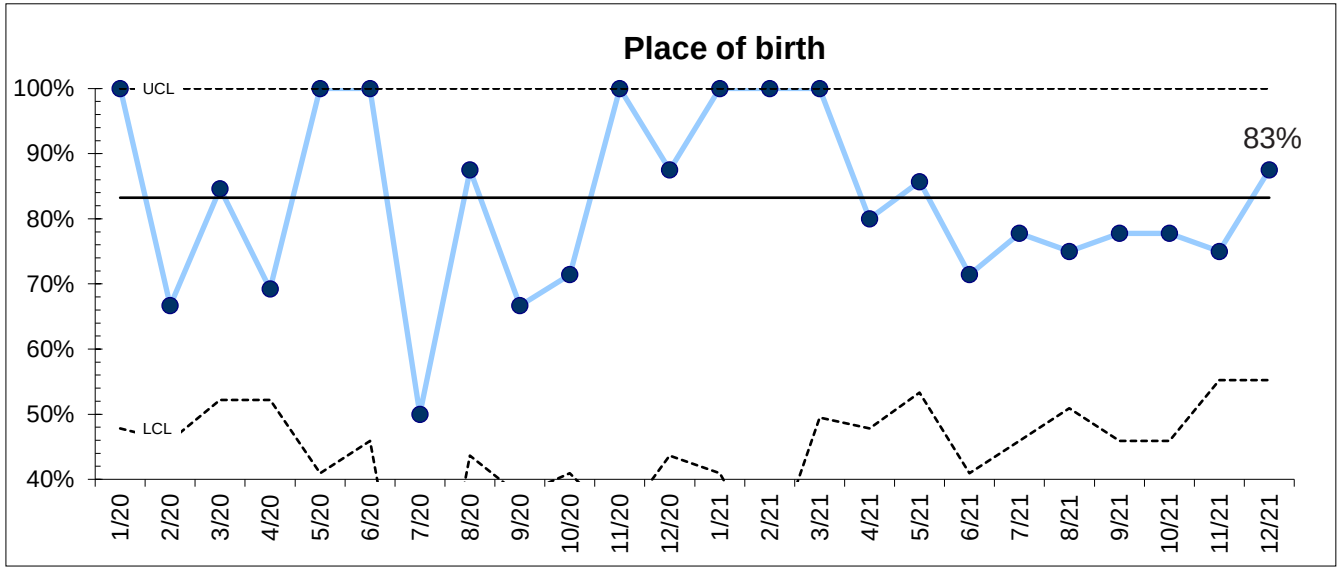
What is it

- Outline
- Purpose
- Why
- Problem
- Background

British Association Perinatal Medicine



Place of Birth

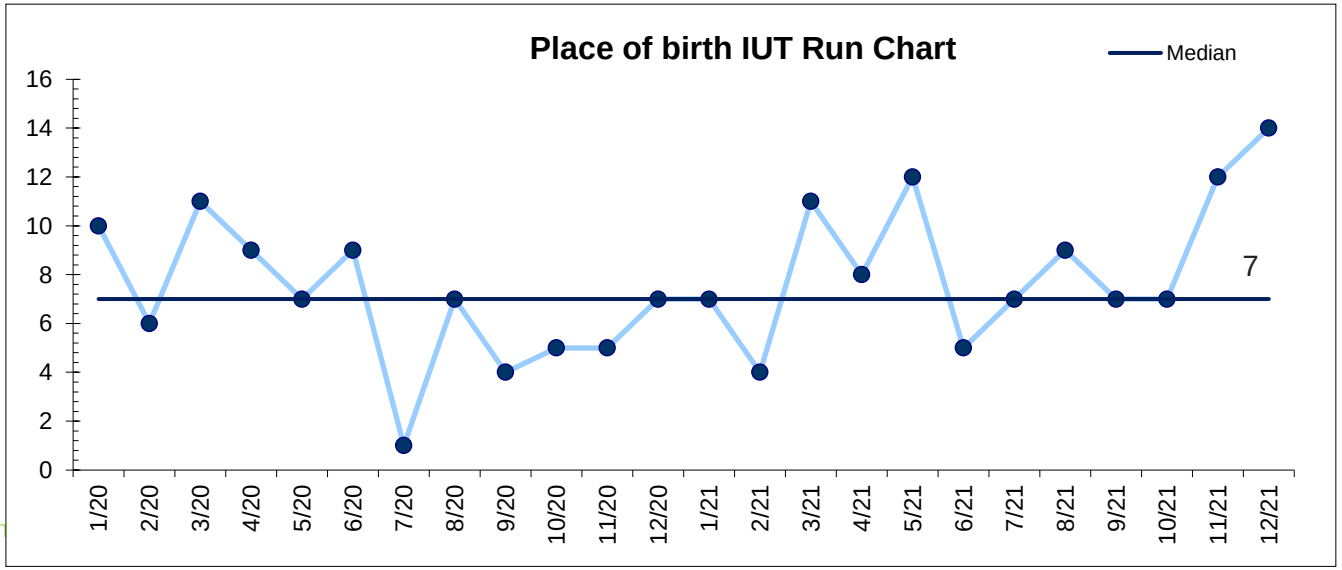


Place of birth

Delivered in appropriate care setting for gestation

1 more baby surviving for every 20 women transferred, born in correct place.

Reliably delivered 83%



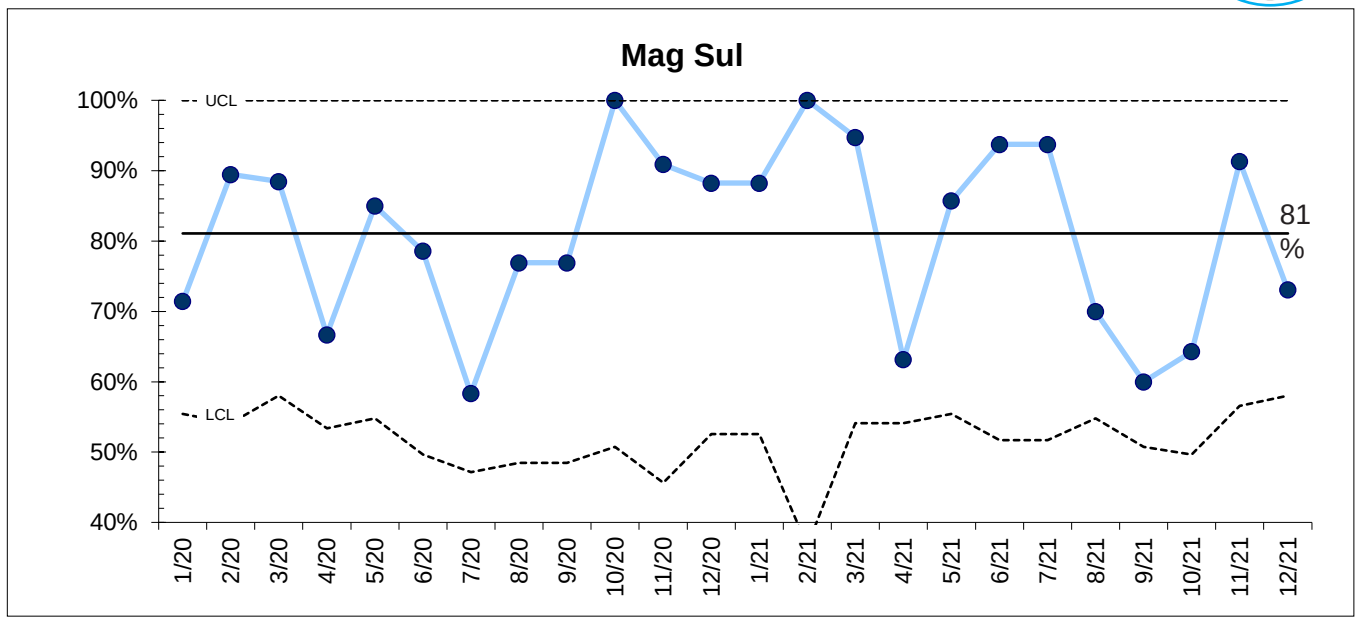
In-Utero transfers

N=184 eligible babies born in right place / transferred over two years

184 / 20 = 9 more babies surviving over two years

Median 7 babies born / transferred to right place each month

Magnesium Sulphate

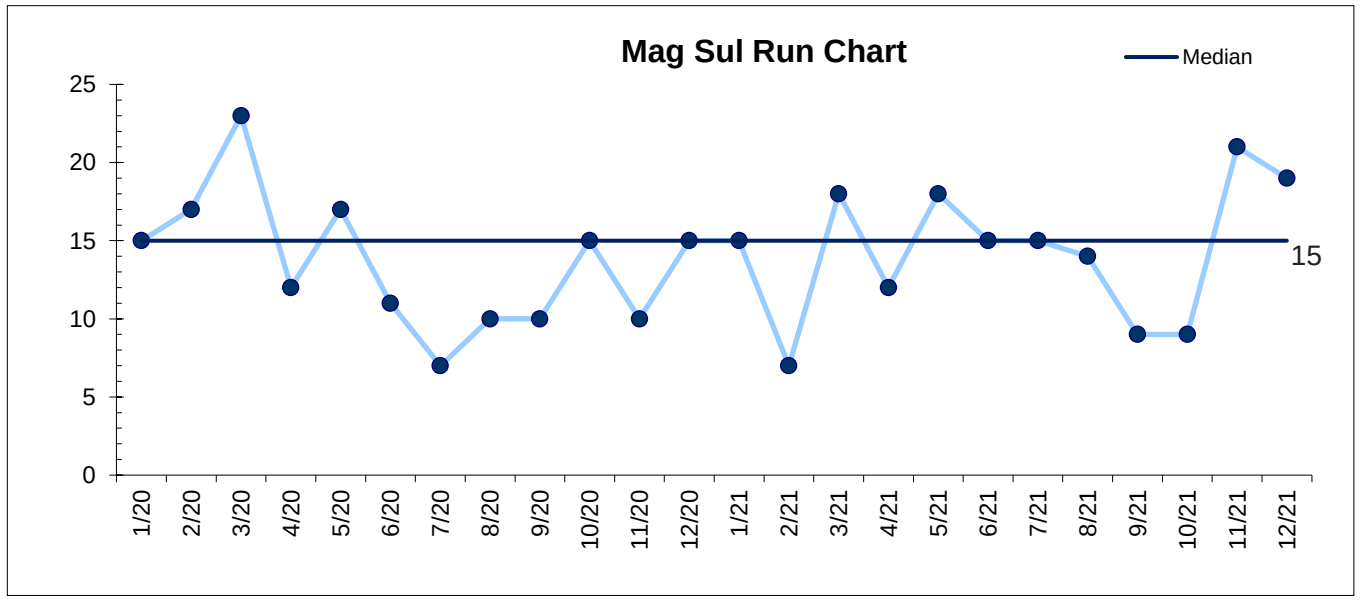


Reduces cerebral palsy by 30%

1 fewer baby with cerebral palsy for every 37 women treated.

The current average amount of Cerebral palsy paid out from NHS Resolution is £10.8M

Reliably delivered 81%



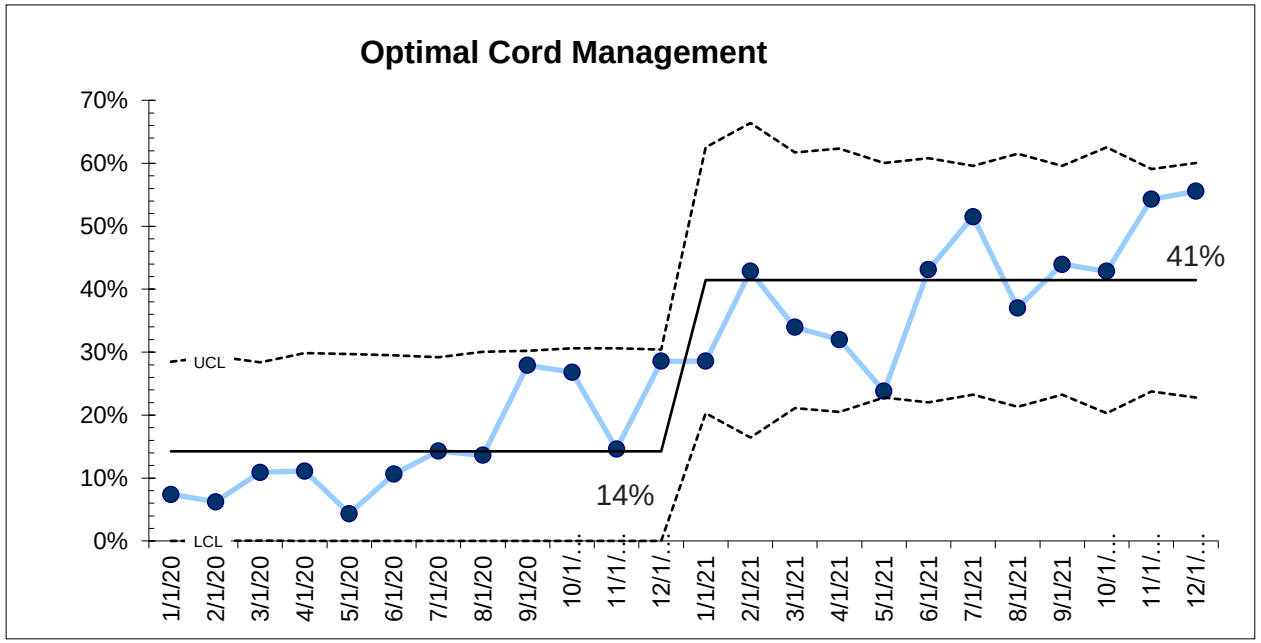
N=334 eligible babies received magnesium-sulphate over two years

334 / 37 = 9 babies avoided cerebral palsy

Average litigation pay out for Cerebral palsy is £10.8m

Median number of 15 babies a month receiving mag-sul

Optimal Cord Management

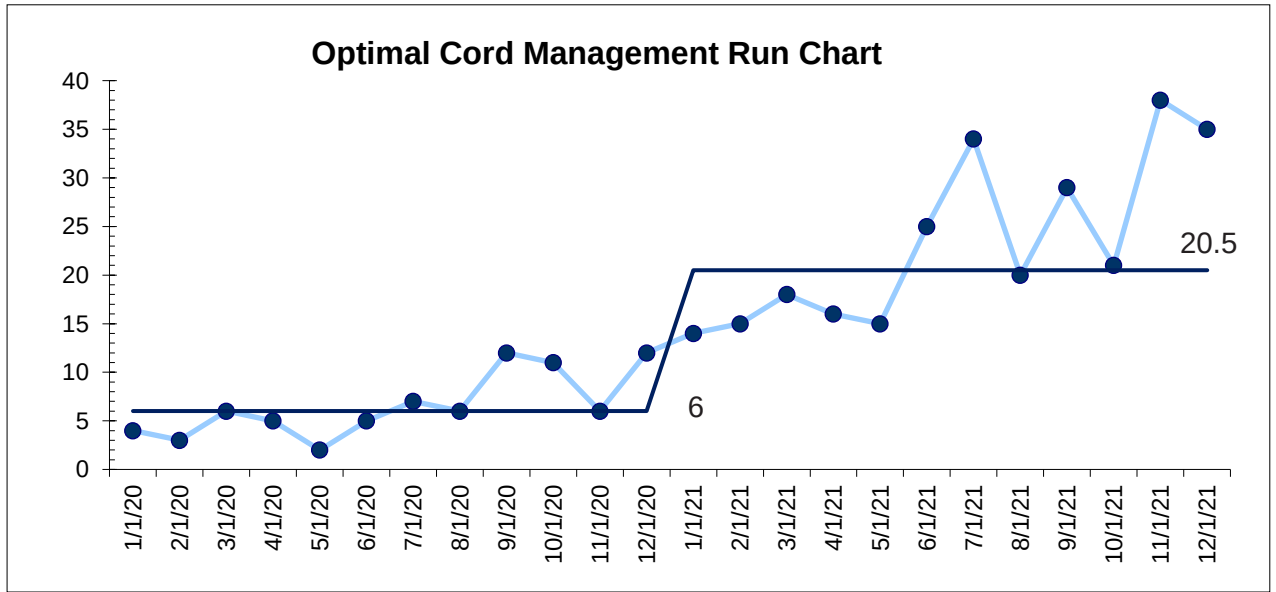


[Optimal Cord Management]

Optimal Cord management reduces death in preterm babies by nearly a third.

The number of babies needing to receive OCM to prevent a death is around 30-50 overall and may be as low as 20 in the least mature babies.

Baseline of 14% to now 41%, Increase of 27%



N=359 eligible babies received OCM over two years
359 / 30 = 12
359 / 50 = 7
The range is between 7 -12 more babies surviving.

Difference compared to the improvements made (20.5 - 6) = 14.5 *
12 = 174 / 50 = 3
174 / 30 = 5

The range is between 3 - 5 more babies surviving.

Summary

9 more babies surviving

9 babies avoided cerebral palsy.

Estimated saving of £10M per case

Our range is between 7 – 12 babies over 2 years survived

Improvements have resulted in range of 3 – 5 more babies surviving

2 Years

Total of 16 - 21 more babies surviving
9 fewer cerebral palsy cases with an estimated cost saving of £10M per case

Compared to no improvements made and
Total of 13-16 babies surviving
9 fewer cerebral palsy cases with an estimated cost saving of £10M per case

Next steps

- LOS data
- Test the framework
- Support with any publications or abstracts
- Help display and articulate outcomes

National Patient Safety Improvement Programmes

Maternity and Neonatal

Regional Overview

Julia Wood, MatNeoSIP Lead - NENC
Patient Safety Collaborative NENC

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NENC overview

- Need to look at this work as a pathway of care for each baby
- Some areas need more focus than others
- Optimal Cord Management and Normothermia Collaborative
- Antibiotics, steroids and maternal breast milk
  - Data pulled nationally from Neonatal BadgerNet
  - Not always recorded
- Data packs – not on the list, let me know
- Trust specific work

Get involved

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National Patient Safety Improvement Programmes

Maternity and Neonatal

NHS

NENC LMNS Ockenden Insight Visits

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NENC LMNS Ockenden Insight Visits 2022

North East and North Cumbria
Local Maternity and Neonatal System

North East and North Cumbria
Local Maternity and Neonatal System

Background

The former Secretary of State for Health and Social Care instructed NHS Improvement in 2017 to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

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The national team requested the regional maternity teams to conduct Ockenden Insight Visits; to be completed by September 2022, based on the initial report December 2020.

North East and North Cumbria
Local Maternity and Neonatal System

Objectives

To provide a thematic review following the Ockenden first report Insight Visits to review good practice, and areas for improvement and identify where regional support may be required

To summarise the key areas of good practice and key issues for improvement in maternity services within the North East and North Yorkshire

To enable more focused and targeted support from Integrated Care System (ICS), Local Maternity and Neonatal System (LMNS) and regional maternity team.

North East and North Cumbria
Local Maternity and Neonatal System

NENC LMNS Overview

Main themes from visits:

- Lack of understanding how the NENC LMNS reviews Serious Incidents
- Strengthen role of NED & Safety Champion
- Board Oversight
- Strengthen external review process
- HoMs do not always have direct access to Trust Executive Board
- Robust audit processes required within some Provider Trusts
- MVP profile within some Trusts needs to be improved e.g. regular meetings with triumvirate, governance processes, complaints and coproduction
- Training – improve training for Anaesthetists / no practice development midwife in post in some Trusts
- Workforce plans differ greatly across the LMNS
- Process to review guidelines within Trusts need to be in place

North East and North Cumbria
Local Maternity and Neonatal System

Summary of how the NENC LMNS position has changed between Dec 2021 and August 2022

North East and North Cumbria
Local Maternity and Neonatal System

North East & Yorkshire Regional Recommendations

- Monitor progress monthly, amend RAG ratings accordingly, report through Governance processes up to Trust Board and LMNS/ICS until full compliance achieved. (Regional Heat Map)
-
- Maternity services to continue to improve staff knowledge of Ockenden interim report (December 2020) and final report (March 2022).
-
- Continue to benchmark compliance against the interim report, whilst awaiting National guidance for the final Ockenden report (March 2022) and East Kent report (Sept 2022).
-
- Include MVP colleagues in true co-production of their maternity services. MVP chairs are instrumental in capturing user feedback and must be supported to enable them to deliver their workplans

North East and North Cumbria
Local Maternity and Neonatal System

NENC LMNS Next Steps

The LMNS will use the 8 Providers Trust reports to undertake a further analysis of the areas that require improvement across the North East and North Cumbria. An action plan will be drawn up and this will be used to facilitate discussions within the LMNS and the Regional Maternity Transformation Team to prioritise how specific areas of improvement are going to be addressed.


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National Patient Safety Improvement Programmes

Maternity and Neonatal

Problem solving tools and techniques

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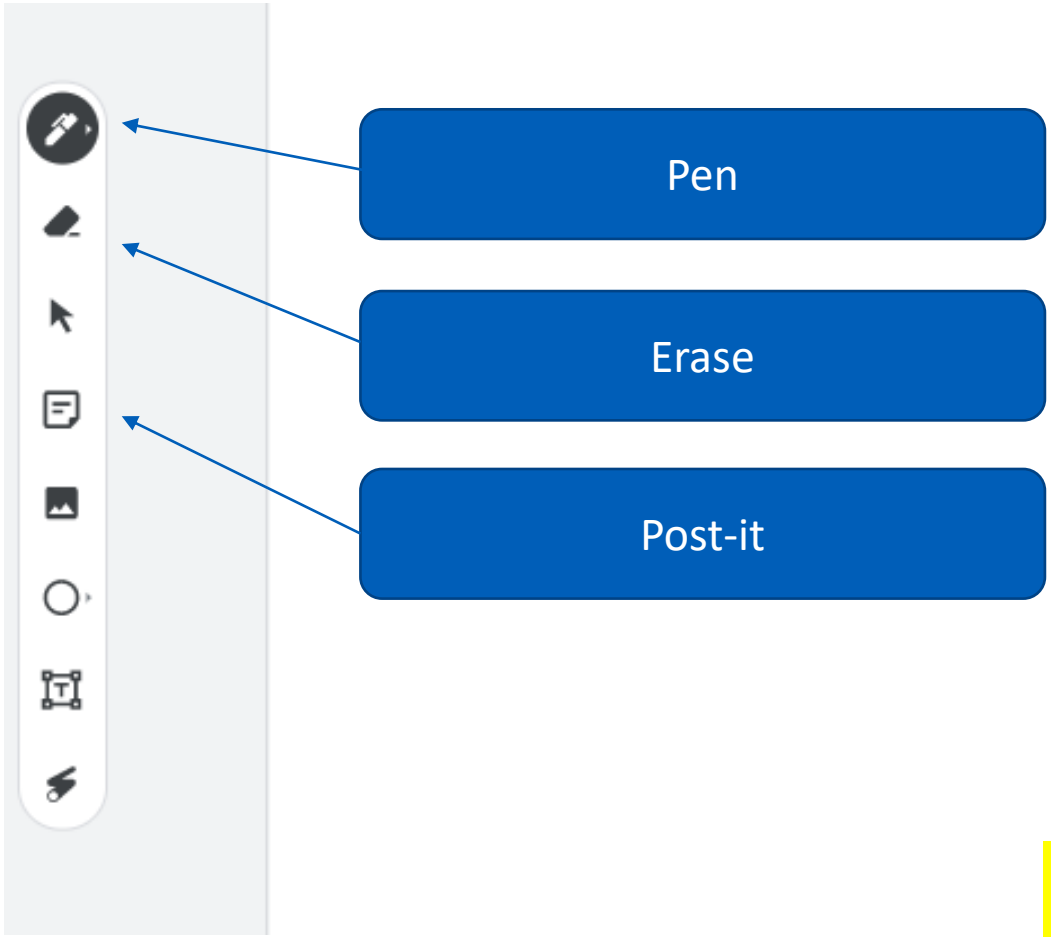
Problem Solving

- Techniques you are more likely not to have come across before
- Problem solving is more challenging virtually – see how it works!
- TRIZ
- Weighted voting

Test Jamboard



Let’s try it

TRIZ

- TRIZ is the Russian acronym for the Theory of Inventive Problem Solving

- Purpose of the tool is to:
  - make it possible to speak the unspeakable and get skeletons out of the closet
  - make a space for innovation
  - builds trust by people acting together to remove barriers

- Safe example

- Maximum 50 users

Problem:
Across the region we are not reaching the national ambition of 95% of all babies <34 weeks being recorded as having a temperature within the optimal range of 36.5 – 37.5 degrees Celsius. Current average is 71%.

Let's try it

TRIZ face-to-face

- Groups of 4 – 7
- Identify the problem
- Each person to individually reflect on why it is a problem
- Then do the same in groups of two
- Then in groups of four
- Write all ideas on separate sticky notes, put on the wall or on flipchart paper, and group into themes if necessary
-
- Then, again go through the process to develop a list highlighting all the current actions what you do that resembles ones from the first list
- Then, again go through the process to identify which of these actions you will stop doing
- Try is for antibiotics, steroids and maternal breast milk! I'll help!

Weighted voting

Use for problem solving or generating ideas

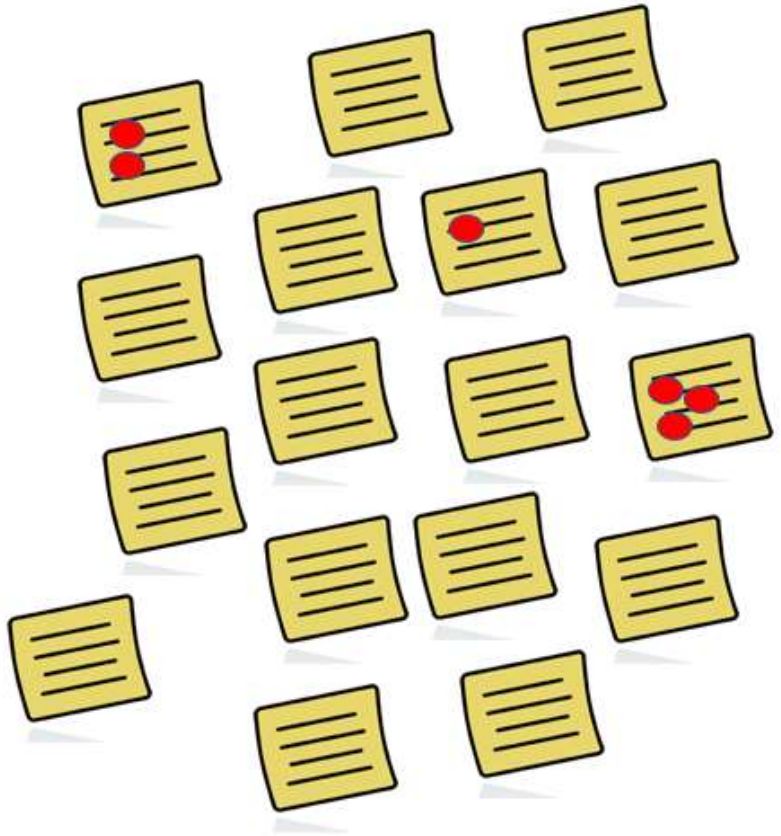
Scenario

It cannot be decided what to do for your work Christmas party and it is beginning to cause tension

Let’s try it

Weighted voting face-to-face

- Individually people write on individual sticky notes the causes for a problem or the options for a solution
- Place all sticky notes onto the wall or flipchart paper, grouping them into themes where appropriate
- Give everyone five dots to ‘spend’
  - They can spend them all on one cause/option, and if they do they would place all five dots on the one sticky note
  - They may want to spend it on a number of causes/options, such as two dots on one, two dots on another, and one on another



National Patient Safety Improvement Programmes

NHS

Maternity and Neonatal

Final Comments

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North East and North Cumbria
Patient Safety Collaborative

The AHSN Network

Maternity and Perinatal Mental Health Clinical Networks North East and North Cumbria

Northern Neonatal Network

North East and North Cumbria Local Maternity System

Led by:

NHS England
NHS Improvement