UHL Maternity Improvement Journey

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Trust Board paper C

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
Noting	For noting without the need for discussion	x

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)	22.03.21	W&C improvement journey
Executive Board		
Trust Board Committee		
Trust Board		

Executive Summary

Context

This paper is to inform Trust Board of the improvements within the maternity service in the past year. In conjunction with a power point presentation it describes safety improvements, involvement and co-production with service users, and our journey towards achievements of Better Births Transformation.

Questions

1. What Improvements have been achieved aligned to the national Maternity Agenda
2. What are the service changes and opportunities associated with the maternity transformation programme

Conclusion

1. The maternity transformation programme was created to implement the vision from the better births report (2016) and deliver on the national ambition to halve the number of stillbirths neonatal deaths and brain injuries. A national maternity safety improvement programme-maternity and Neonatal Safety Collaborative, was developed to teach and develop teams from Trusts in QI methodology and take on a quality improvement project to implement and embed change in maternity and neonatal services and improve safety and outcomes. UHL team were

wave 3 and therefore in the third year of the programme completing the project in March 2020 the project and achievements are described in the PowerPoint presentation

2. A recommendation from the Better Births report in 2016 was to achieve 75% of a continuity model of care for women in maternity services by 2024. Within the 75% it is required to have a further 75% of women been of black and Asian ethnic groups and vulnerable women. The maternity service in UHL has a robust action plan of Continuity of carer but successfully launched the Lotus team in September 2020, the midwives case hold and provide antenatal, intrapartum and postnatal care for a co-hort of women from a GP practice in the city, the women are all from a BAME background, the GP's have been extremely supportive and the team are receiving excellent feedback, the team lead and matron have presented the success on a national continuity of care platform.

   The Maternity Voice partnership in LLR has been in place for over two years, it is chaired by users of the services, throughout the past year the members have significantly helped and advised in a number of ways, they provide support for producing information, we feedback patient experience to comments to the MVP so they can advise on how to improve services and the chairs will discuss with us if any members have not had they experience they would have liked so the service can address this. The MVP have also worked with us on senior leadership interviews and reconfiguration.
   The safety champion role within maternity has expanded over the last 3 years and the maternity safety champion midwife and obstetrician work closely with the Board level safety champion and executive sponsor for maternity to listen to staff and women regarding safety concerns and try and address or escalate these. They attend the safety champion meetings and local learning events in the region to report on their roles and safety projects.

3. **<u>Summary</u>**

The improvement journey has continued for Leicester maternity services throughout the pandemic, the achievements and opportunities will continue to drive improvements, continued engagement with the MVP and users of the service is crucial. Engagement and wellbeing of staff is key to making improvements to the services and continued development of forums, engagement sessions and insitu simulation scenarios will enhance the communications already in place.

Through the NHS Resolution safety standards described in the CNST document assurance is provided internally and externally that the service is fully engaged with the safety agenda. The Trust has a robust wellbeing strategy which Maternity services communicate to staff in a number of ways, alongside this the Professional Midwifery advocates are on hand to offer restorative supervision and support if needed.

Input Sought

We would welcome the Trust Board's input regarding any comments or advice to further improve maternity services or further information or evidence the Board may require.

For Reference

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures [Not applicable]
Improved Cancer pathways [Not applicable]
Streamlined emergency care [No]
Better care pathways [Yes]
Ward accreditation [Yes]

2. Supporting priorities:

People strategy implementation [Not applicable]
Investment in sustainable Estate and reconfiguration [Not applicable]
e-Hospital [Not applicable]
Embedded research, training and education [Not applicable]
Embed innovation in recovery and renewal [Not applicable]
Sustainable finances [Not applicable]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)?
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required
- How did the outcome of the EIA influence your Patient and Public Involvement ?
- If an EIA was not carried out, what was the rationale for this decision?

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	Select (X)	Risk Description:
Strategic: Does this link to a ***Principal Risk*** on the BAF?		
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None		

5. Scheduled date for the **next paper** on this topic: [date] or [TBC]

6. Executive Summaries should not exceed **5 sides** [My paper does comply]

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

UHL Maternity Improvement Journey

#hello my name is...

Elaine Broughton
Head of Midwifery
Kerry Williams
Deputy Head of Midwifery

One team shared values

Outline

- National agenda
- UHL MatNeo safety improvement project
- Co-production in action
- Safety champion

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

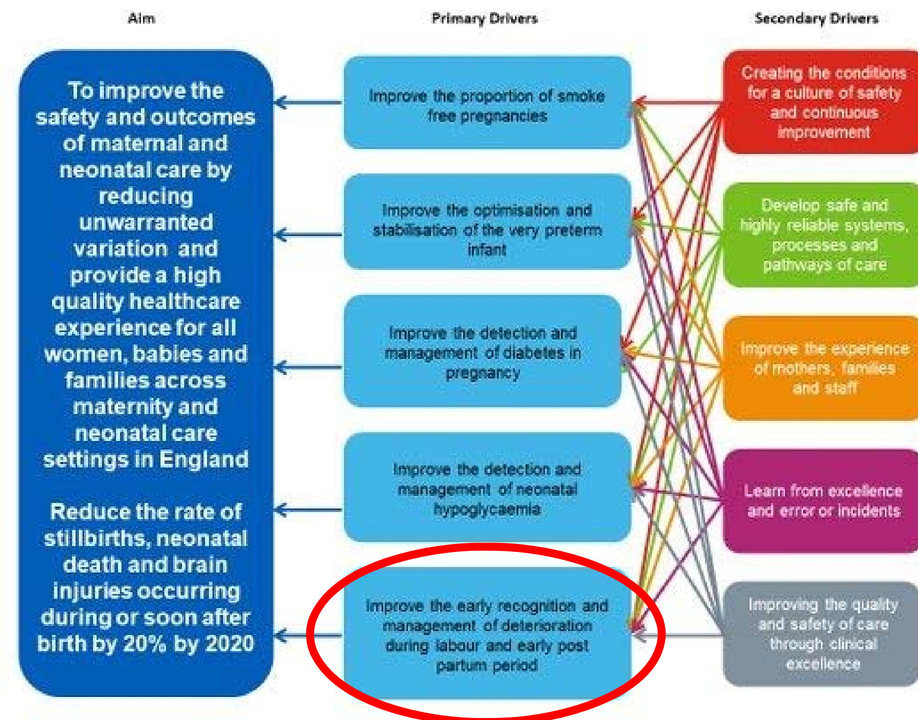
National Agenda

- Better births report 2016
- Maternity transformation programme
  - MatNeoSIP
  - Maternity voices partnership (MVP)
  - Maternity safety champions

One team shared values

MatNeo project

- Improve safety & outcomes
- 5 primary drivers
- Focus on excellence
  - Prevention
  - Recognition
  - Response



Project plan

- Implement safety huddles
- Improve fresh eyes compliance
- Introduce intrapartum risk assessment
- Implement physiological interpretation of CTG

Fresh Eyes

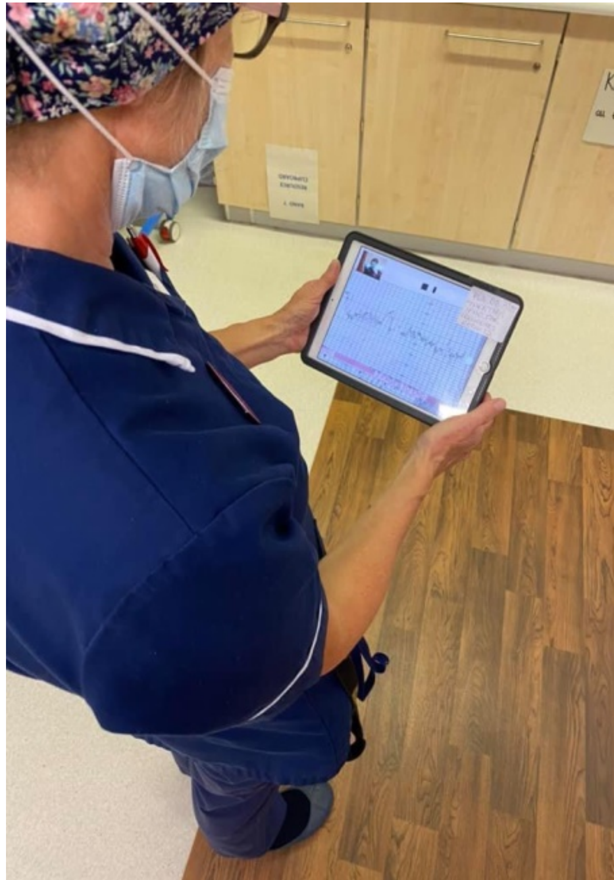
FRESH EYE COMPLIANCE LGH

% OF COMPLIANCE

100
90
80
70
60
50
40
30
20
10
0

Goal

Mar-19
Apr-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Jan-21
Feb-21



Bathroom
Toilet

Intrapartum Risk Assessment

INTRAPARTUM RISK ASSESSMENT LGH

% OF COMPLIANCE

120
100
80
60
40
20
0

Goal
Median

Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21

Coproduction in action

- MVP
  - Devised infographic for women
  - Review our patient information leaflets
  - Involved in maternity visiting policies
  - Facilitate focus groups for leadership recruitment
  - Attend quality board
  - Development of BAME dashboard
  - Reconfiguration

Baby and me

NHS University Hospitals of Leicester NHS Trust

If you are from a Black, Asian or Minority Ethnic (BAME) community, you are not more likely to contract COVID-19, however your symptoms may be more severe and you may feel sicker.

Keeping you and baby safe

clean your hands / regularly use sanitiser

cough or sneeze into a tissue or your bent elbow

avoid touching your eyes, nose and mouth

wear a mask or face covering in public spaces

keep a distance of 2 metres from people outside your household

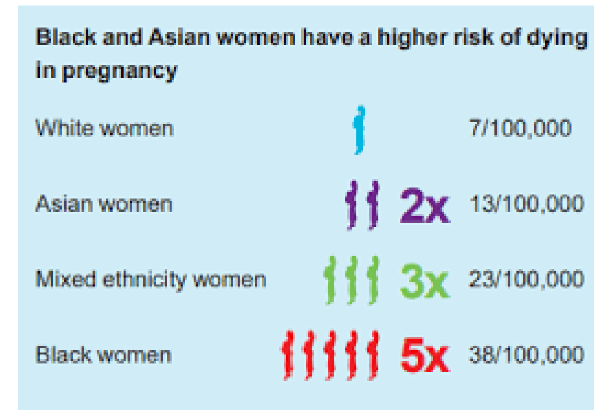
call your midwife if you are worried

If you have a fever, cough, loss of taste or smell please call 111.
To book your COVID-19 test call 119.

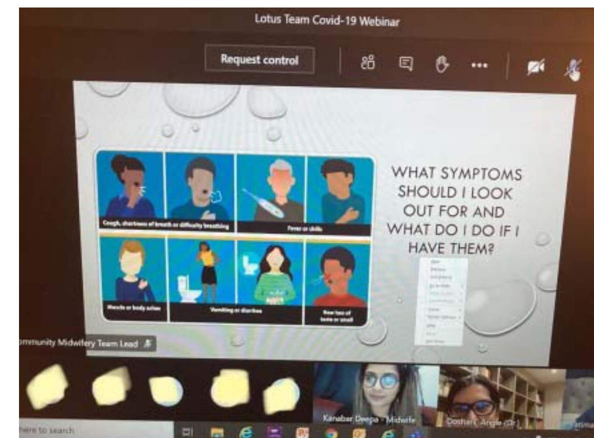
If you have any concerns, please call the Maternity Assessment Unit
Leicester Royal Infirmary: 01162586312
Leicester General Hospital: 01162584808
Community Midwives Office: 01162584834

Lotus Continuity team

- Case holding team



- Webinar in 3 languages



Maternity Safety Champions

- Trust board safety champion – Vicky Bailey
- Midwifery safety champion – Sarah Blackwell
- Obstetric safety champion – Chandrima Roy
- Neonatal safety champion – Cara Hobby
  - Facilitate monthly feedback sessions with staff
  - Foster 'you said we did' approach
  - Attend national/local learning events
  - Attend quality & safety board
  - Review Continuity of carer action plan

MATERNITY SAFETY NEWS

MARCH 2021 (FEB STATS)

COMPLIMENT THEMES

- FRIENDLY/HELPFUL
- FEELING SAFE & SUPPORTED
- TOOK TIME TO LISTEN
- GREAT CARE
- CARING

DATIX TOP 3 THEMES

- LABOUR OR DELIVERY
- SIMPLE COMPLICATION OF TREATMENT (SHOULDER DYSTOCIA/PPH ETC)
- UNEXPECTED ADMISSION TO NNU

COMPLAINT THEMES

- NOT BEING LISTENED TO
- STAFF ATTITUDE
- NOISE
- STAFFING
- VISITING
- POOR COMMUNICATION

INCIDENT THEMES

- MISSED ALERT STICKER IN NOTES
- LACK OF AN CARE
- MISLABELLING OF SAMPLES
- GDPR BREACHES (WRONG NOTES FILED)
- MOH

GUIDELINES - NEW & UPDATES

- WATERBIRTH GUIDELINE
- MAU GUIDELINE - INCLUDES BSOTS/LATENT PHASE LABOUR
- FETAL SURVEILLANCE
- ULTRASOUND GUIDELINE

TRAINING COMPLIANCE

- MOT - MW 94% CONS 100% ANAESTH CONS 100%
- FETAL MONITORING - MW 94% CONS 95%
- SAVING BABIES LIVES - 95%

PLEASE CHECK YOUR DASHBOARD AND REMEMBER THE FOLLOWING ALSO:

- MEDICINES MANAGEMENT
- VTE

SAFETY CHAMPION FEEDBACK
YOU SAID - WE DID

Maternity Safety Staff Feedback

Safety Concerns Raised in January 2021

YOU SAID	YOU SAID	YOU SAID	YOU SAID
Issues with MAU Telephones	Are we to start swabbing partners?		
WE DID	WE DID	WE DID	WE DID

INTERESTING STATS

699 BIRTHS

LOWEST NUMBER OF BIRTHS IN ALMOST 6 YEARS!!

HIGHEST BREAST FEEDING INITIATION IN 8 MONTHS

NO SERIOUS INCIDENTS

AROUND 1:3 WOMEN HAD A LSCS

ALL WOMEN RECEIVED 1:1 CARE IN LABOUR

One team shared values

Conclusion

- National agenda
- UHL MatNeo safety improvement project
- Co-production in action
- Safety champion

Future developments

- 2 joint QI projects with NNU
- Roll out our continuity of care action plan
- Drive digital transformation
- Assessment and accreditation

THANK YOU

Any Questions?