### DEVELOPING THE NATIONAL MATERNITY SAFETY NETWORK

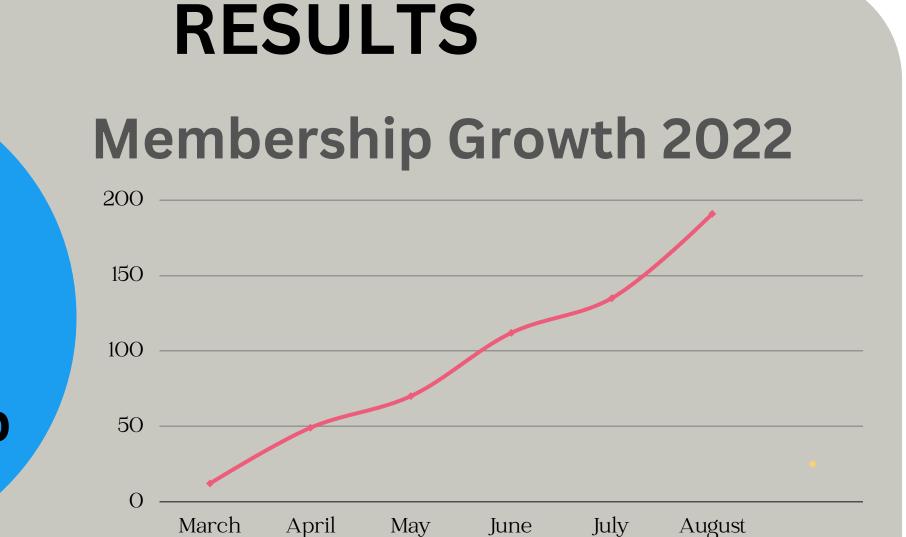
Est. March 2022

Charlene Cole, RM, PhD, Ockenden and CNST Lead Midwife

#### **BACKGROUND & OBJECTIVES**

 New in post, recognised a need for **COLLABORATION** to discuss safety issues, including the Ockenden Report and the Maternity Incentive Scheme safety actions

Current membership



 Used social media to canvas opinion and form the intial group and **COMMUNICATE** dates and information

 Safe forum to share INNOVATION used in other Trusts to improve safety and talk through any problems and queries

 Open to everyone including service users (members of the public), important to LISTEN to other's experiences to shape our maternity safety agenda

#### **MEMBERSHIP BY SECTOR**

organisations represented

August

**Service User** 

**Midwives** 

Researchers

**Obstetricians** 

**Patient Safety** 

**NHS England** 

NHS Improvement



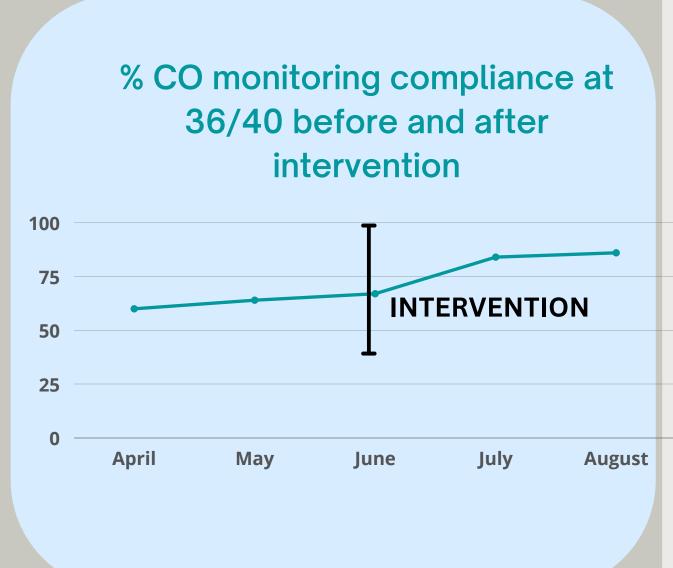
Smoking is an important modifiable risk factor for stillbirth and measuring CO antenatally has been shown to encourage women to stop smoking (Flenady et al. 2011), (NHS England 2019)

meetings held so far

#### **ACHIEVEMENTS TO DATE**

 Quality improvement project discussed at the forum showed that measuring carbon monoxide (CO)each at antenatal appointment increased measurement at 36 week's gestation

 Implementing this in our Trust showed a significant increase in compliance (all women should have their CO measured at 36/40 gestation)



 Meeting with NHSE Clinical Director for Maternity & Women's Health, as direct result of group discussions: asked to form Midwifery Clinical Reference Group to advise NHSE.

#### REFERENCES

1. Stillbirths: the way forward in high-income countries, The Lancet, Volume 377, Issue 9778, 2011, Pages 1703-1717, ISSN 0140-6736, Vicki Flenady, Philippa Middleton, Gordon C Smith, Wes Duke, Jan Jaap Erwich, T Yee Khong, Jim Neilson, Majid Ezzati, Laura Koopmans, David Ellwood, Ruth Fretts, J Frederik Frøen

2. www.saving-babies-lives-care-bundle-versiontwo-v5.pdf (england.nhs.uk) (last accessed 21st September 2022)

ju carr @jucarr15 · 27 May Replying to @charlMidwife and @howlett\_leanne It really has prompted so much thought, as a service user I've experienced a lot of trauma relating mainly to staff lack of understanding around genuine informed consent, I feel I saw a bigger picture today & came away understanding some of the complexities. Many ideas forming 🙏



Nicky Galdeano = liked 3 of your Tweets

What a great meeting 😩 👌 @charlMidwife 43 members, great discussions and opportunities to ensure learning and compliance is achieved Simple @helenh49 @DOckendenLtd @sallyONeill4 pic.twitter.com/8DTthqmVwF

charlene.cole@uhcw.nhs.uk



@CharlMidwife



02476 967396





Client Empowerment In the Induction of Labour Journey – A Novel Approach

Mirza, M, Falvey-Browne C, Solly S, Parmar S, Dwase M, Gomoh, M, Khan F, Latham S, Velauthar L <sup>1</sup> Maternity Unit, Newham University Hospital, BartsHealth London UK





Virtual education session for women and their family, in the comfort of their own home – a new way of empowering women on induction of labour

"I did not think my induction would take four days " -**ST May 2021** 

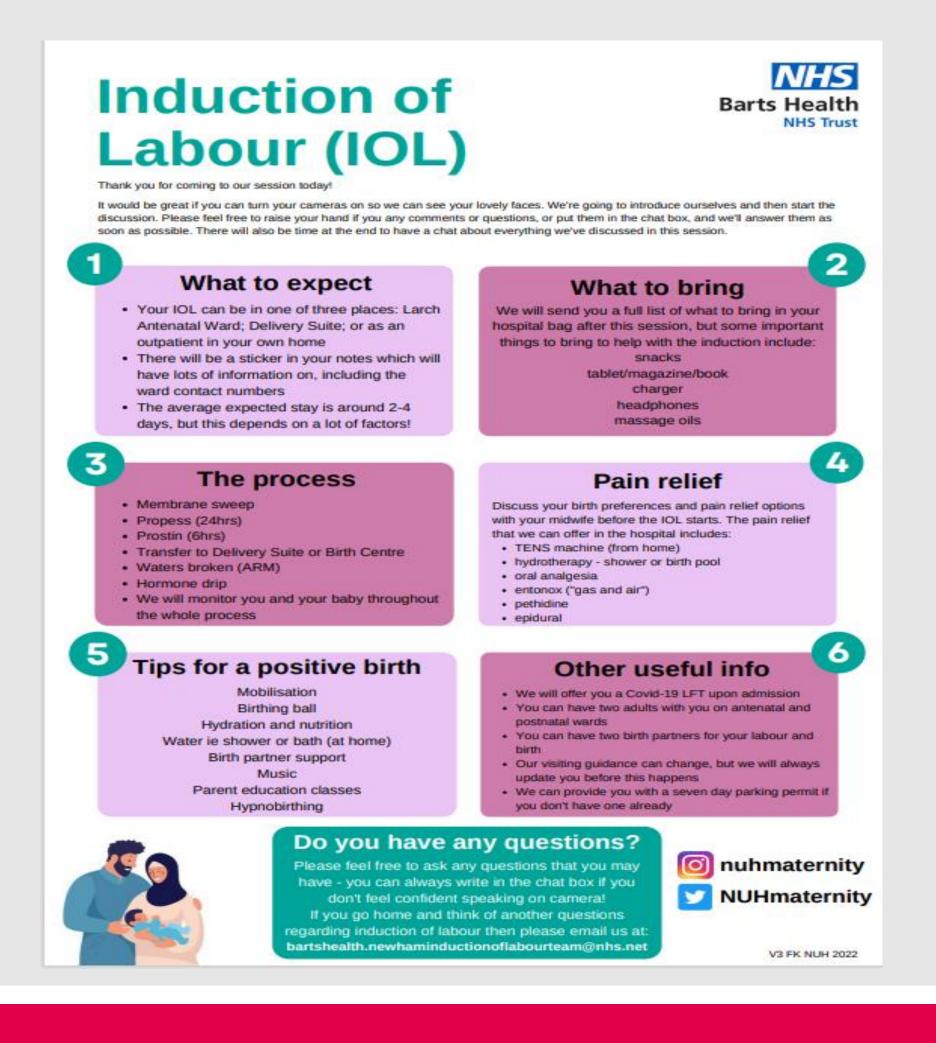
I have been booked for an Induction of Labour (IOL) BATTS HEATHS				
	My induction of labour has been booked:			
	on(date)			
	at(time)			
	by Midwife / Doctor(name)			
	because(reason)			
	My induction of labour will take place on:			
> 9	Larch Antenatal Ward Zone 4, Ground Floor 0207 363 8192  Delivery Suite Zone 4, First Floor 0207 363 8137  Outpatient Zone 4, Ground Floor 0207 363 8765			
	If you have any questions about your appointment, please speak to your midwife or doctor.			
Do you want more information about induction of labour? Do you want some helpful tips on how to achieve a positive birth experience?				
Newham Maternity holds a virtual induction of labour education session every Wednesday from 10am - 11am on Zoom				
Email <u>bartshealth.newhaminductionoflabourteam@nhs.net</u> to get booked in!  Please include your name, date of birth & preferred language				
	We look forward to seeing you on Wednesday!			

#### Introduction

- Establishing a new platform to educate women and families on understading the process of IOL
- One on one interaction between women and health care professionals

#### Methods

- Maternity Unit of Newham University Hospital in East London
- Nearly 6000 deliveries per annum
- Highly diverse, 50% ethnic population
- Poor women's experience captured; 40% of women stating unfamiliarity with IOL process



#### Results

- Launch of novel, weekly, multilinguistic education session for women and families in 2021
- Offered in English, Urdu, Gujrati, Hindi and Punjabi
- >150 participants
- "Better prepared for IOL" FB Aug 2021, "Thank you for such useful information – AK Dec



There was a QI programme which introduced virtual zoom classes to prepare women for induction of labour (CQC, June 2021)

One of our many initiaitive taken to engage women and families and empower them regarding their care

Our Values

We will work together towards our vision and show that WeCare.



**ACCOUNTABLE** 



RESPECTFUL

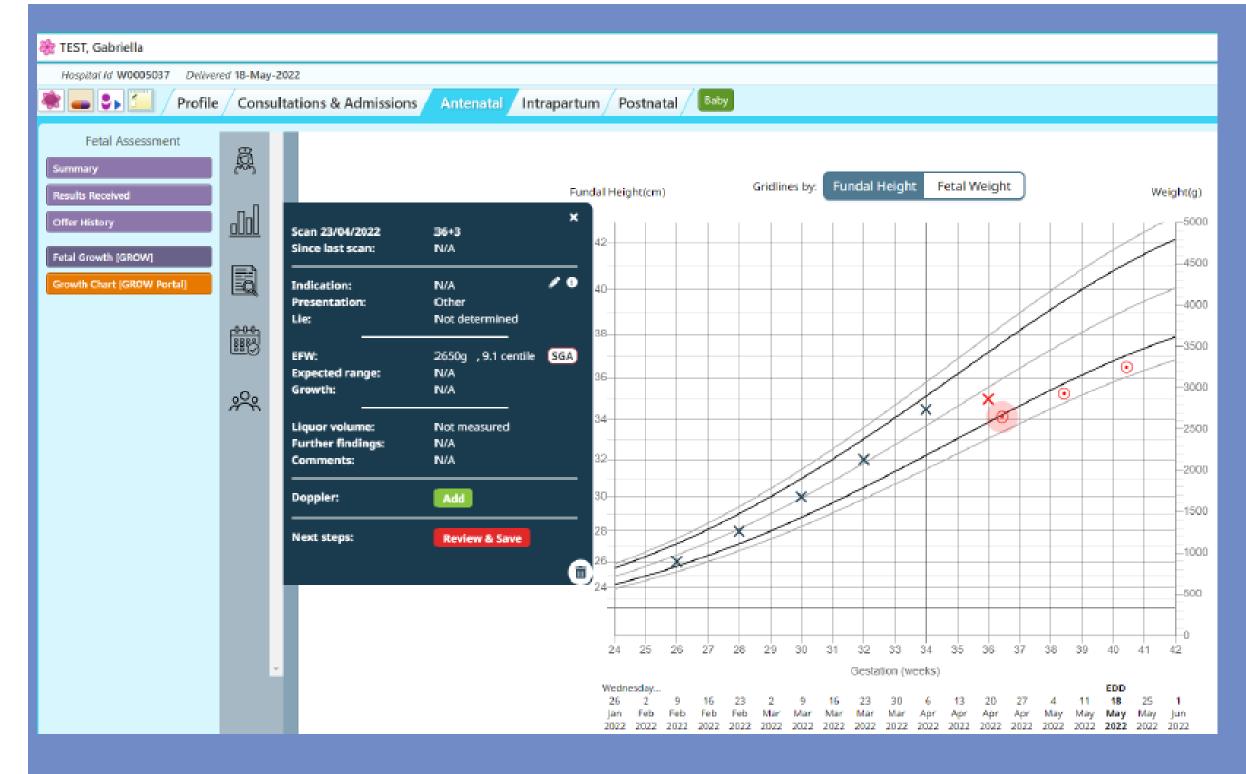






# Implementing Integrated Electronic Growth Charts To Improve Pregnancy Outcomes For Women And Babies

Cousineau G, Ford A, Clement-Jones M Maternity, Liverpool Women's NHS Foundation Trust, Liverpool, England



The GROW 2.0 electronic chart integrated into the K2 Athena EPR highlighing abnormal symphysis-fundal height and estimated fetal weight measurements. These measurements have integrated and auomatically plotted from K2, CRIS and Viewpoint.

#### Conclusion

- •In June 2022, integration between the Trust's imaging system (CRIS), K2 Athena and Pl's GROW 2.0 system was launched, the first of its kind.
- •Clinician's can access the PI GROW 2.0 software from within K2 Athena, ensuring clinical assessment and decision-making is **standardised** and **digitally supported**.
- •Improved patient safety and outcomes by **reducing the risk of human error** which may increase
  detection of babies affected by fetal growth
  restriction.
- •Additional benefits including saved clinician time, end-user satisfaction, and improved data quality have also been recognised.

#### Introduction

- In January 2021, Liverpool Women's launched K2 Athena, the Trust's first **end-to-end Electronic Patient Record** (EPR) system.
- Perinatal Institute (PI) growth chart became the sole paper document that women carried throughout their pregnancy, which posed numerous risks.
- Whilst the stand-alone PI GROW 2.0 software was a viable option, it was recognised that introducing an addition system could cause clinician fatigue through duplication of documentation and multiple systems.
- An integrated digital solution was required to improve patient safety and outcomes.

#### Risks of the Paper GROW Chart

- Inaccurate plotting of Symphysis Fundal Height (SFH) and Estimated Fetal Weight (EFW).
- Misplaced and forgotten charts.
- Time consuming process for generating the paper chart with manual and duplicated data entry.
- Lack of compliance with generating chart at dating scan.
- Clinical judgement subjective and not standardised.
- No prompts to act on abnormal measurements.
- **Inability** to generate birthweight centiles without the growth chart

#### Results

The new GROW 2.0 gives me reassurance that the women and babies in my care have a more robust system in place to monitor fetal wellbeing and development. The precision plotting ensures that I am truly confident in the accuracy of my documented measurements, and my clinical judgement is supported by the system prompting me to act.

- Anna Jones, Community Midwife

- FH and EFW are automatically plotted.
- Women no longer responsible for carrying paper chart.
- Generated automatically using key booking information and EDD.
- Can be accessed within the EPR at any time remotely.
- Plots indicative of slow, static or accelerated growth, in addition to SGA and FGR, are highlighted in red.
- Birth weight centiles automatically generated.



Previous birth weight centiles are pulled through from the booking information and highlighted if FGR/SGA.

#### What's next...

- Assess the impact of the integrated electronic growth charts on clinical safety and patient outcomes.
- Facilitate sharing agreements between Liverpool Women's Hospital and other Trusts.
- Integration between the K2 and Perinatal Institute patient portals.

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Local Maternity and Neonatal System

Ask a Midwife (AAM) Service

NHS Resolution Poster Competition - Nov 2022

Hull University
Teaching Hospitals
NHS Trust

The AAM social media messaging service helps women, birthing people and their families make informed decisions about their maternity care, empowering them to ask the questions and get the answers they need from midwifery professionals in a timely and supportive manner.

#### **Background**

AAM started in response to the COVID-19 pandemic in March 2020 in a time of significant increased pressure on the system, and HUTH played a pivotal role in the initial stages.

It was really important that the LMNS found a different way of communicating with women, birthing people and their families to:

- 1. keep up with the rapidly changing situation
- 2. reassure them about concerns
- 3. highlight any messages around how maternity services were being delivered which they might need to know during their pregnancy or labour.



The service routinely averages in excess of 800 queries per month. Our recent AAM survey told us that users value the convenience of interactions through social media and the fact that they are getting evidence-based advice and information from an actual midwife when they really need it! Our testimonials speak for themselves!

#### **AAM Messages Sept 2021 to Aug 2022**

	Messages	Referrals	%
HUTH	5,164	307	5.90
NLaG	2,624	144	5.49
YSTHFT	2,006	97	4.83
Total	9,794	548	5.60

Thank you - this service is one of the best services that any new mother or parent could ask for.

You ladies all do a wonderful job and we appreciate all the lovely care!

Thank you very much for providing such a great way of communicating throughout my pregnancy.

#### ent r. nank you very much

#### **How it works**

AAM is delivered using social media platforms and co-ordinated centrally by the LMNS to ensure consistency of delivery and messages around the system. It is staffed by Trust midwives who have a dual role in supporting the AAM service on a part-time basis alongside their clinical work. HUTH continues to be the lead LMNS Trust in respect of the service.

If people have questions about pregnancy, birthing options, or the care of a newborn baby, they can access the service as follows:

- York & Scarborough yorkandscarboroughbumps2babies
- Hull & East Riding heynhswc / askamidwifehuth
- North & North East Lincolnshire nlagmaternity email: hny.lms@nhs.net

The service also allows the LMNS to give key public health and other messages/updates in a timely and responsive manner. This has included communications around COVID-19 updates, vaccinations, 6-8 week GP checks, ICON, Vitamin D, perinatal mental health, choice and personalised care, postnatal care including infant feeding and maternity unit updates.

We promote AAM through our Maternity Voices Partnership Groups; with printed postcards which are distributed in maternity settings, Children's Centres etc..; through direct referral by midwives; and attendance at community events.





#### **Going forward**

The service has expanded significantly since March 2020, and we know that it will continue to grow and improve with the implementation of our new LMNS shared maternity IT system; and increased use of Instagram.

AAM will be commencing face to face outreach/factory visits to our most vulnerable women and families, including those whose first language isn't English, to ensure equity of access and promotion of the service, this will be enabled using translation apps.

#### Impact on our hospitals

LMNS Trusts have collaborated to release midwives to support the service, and this has facilitated shared learning, quality improvement, and helped identify gaps in services - all in a very cost effective, individualised and friendly way. The AAM lead is a HUTH community midwife.

The service consistently diverts workload away from clinical areas and AAM staff have implemented quality improvement measures to streamline referral processes and make access to care much quicker for some. AAM is able to refer women and babies to other health professionals (over 90% of queries can be answered immediately) and support organisations and agencies where required, and this reduces workload for hospital midwives.





### Making decisions about your care



When you need to make a decision about your care the law says that your doctor or midwife should give you all the information you need to help you make a decision that is right for you. This is **informed consent.** 

### You must be given clear and factual information

Risks should be given in a format that makes sense to you. Where possible, the risk should be given as a probability or a percentage figure eg. 1 in 100 or 1%



If you are only told that a risk doubles or increases, ask what the actual risk is.

You could ask your midwife or doctor to discuss how good the evidence is.

You may be given a leaflet or webpage to read. You should always have the opportunity to ask questions and discuss your thoughts and feelings.

#### BRAIN can help you ask questions

B = what are the benefits?
R = what are the risks?
A = what are the alternatives?
I = what does your intuition or your gut feeling tell you?
N = what happens if we do nothing for now? Can we wait and take some time to think?



The BRAIN acronym helps you have conversations that will support you to make a decision.

#### You can say no

One of your options is to decline recommended care

Your midwife or doctor will respect your decision and work with you to create a personalised care and support plan.







### You need to be told the risks and benefits of every option

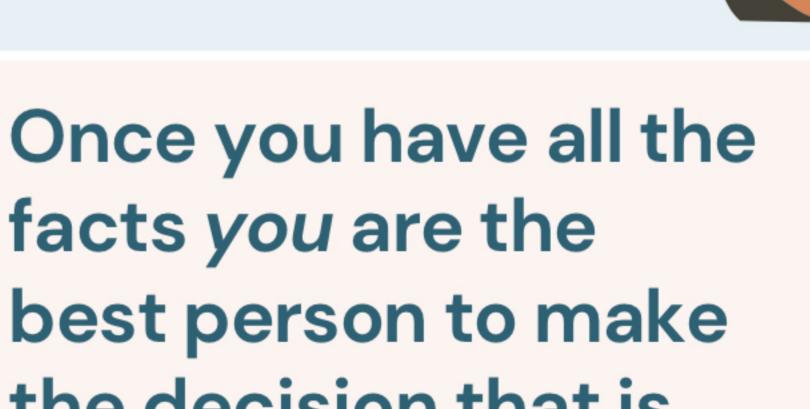
This must include the risks of the care your doctor or midwife is recommending.

If you haven't been told the risks and benefits of each option, then ask your doctor or midwife for more information.

# It is not OK to feel pressured or guilted into making a decision

Doctors and midwives should use factual information and they should not use "coercive language". This means it is not OK for you to feel pushed towards making a particular decision.





the decision that is right for you

Everyone is different. Your previous history and your personal circumstances will influence your decision.

Your doctors and midwives will look after you, whatever you decide.



# Quality Improvement and communications - A shared strategy

Vassell M<sup>1</sup>, Clifford-Turner C<sup>2</sup>, MacCormack T<sup>3</sup>

<sup>1</sup>King's College Hospital NHS Foundation Trust, Women's Care Group, London, United Kingdom



Clare Clifford-Turner, Speclialist Midwife for Communications

#### **Specialist Midwife for Communications**

This role was initiated by the Director of Midwifery, Tracey MacCormack to report into the Lead Midwife for Governance, Maxine Vassell, and was newly created and recruited into in July 2022.

The midwife to pilot this is Clare Clifford-Turner, whose remit is to champion effective communication to strengthen collaboration and safety across multidisciplinary team within the Women's Care Group.

Key to the role is to act as a **central point of contact for communications**, **lead on commulcations projects**, and **liaise externally with the Maternity Voices Partnership**. Clare co-ordinates maternity content on social media, production of a video tour of the maternity unit, and building key relationships with stakeholders within the Trust and externally to increase positive service user and staff engagement.

## Internal communications Maternity Council

Elections were held in November, Dawn Litchmore and Claire Ceuppens will take position of the Chairs.

Staff in Band 2-6 are encouraged to attend the next huddle to feedback ideas into maternity transformation plans. Clare will present this at Maternity Governance in December 2022.

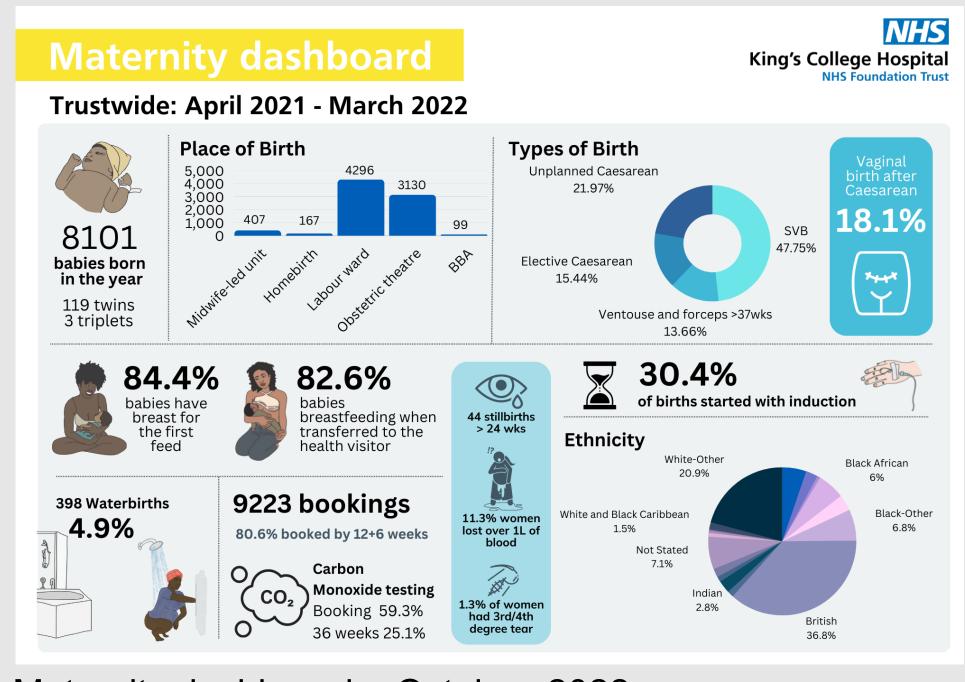
#### **Microsoft Teams**

The Maternity and Gynaecology private group for staff working within the Women's Care group now has 849 members. 315 are active users and 535 are inactive. Work is underway to increase engagement.

#### Infographics

This 2021-2022 financial year data developed into an infographic for a presentation during the Ockenden Assurance Visit, October 2022

Staff can access this and other data about the service and performance via the MS Teams group.



Maternity dashboard – October, 2022

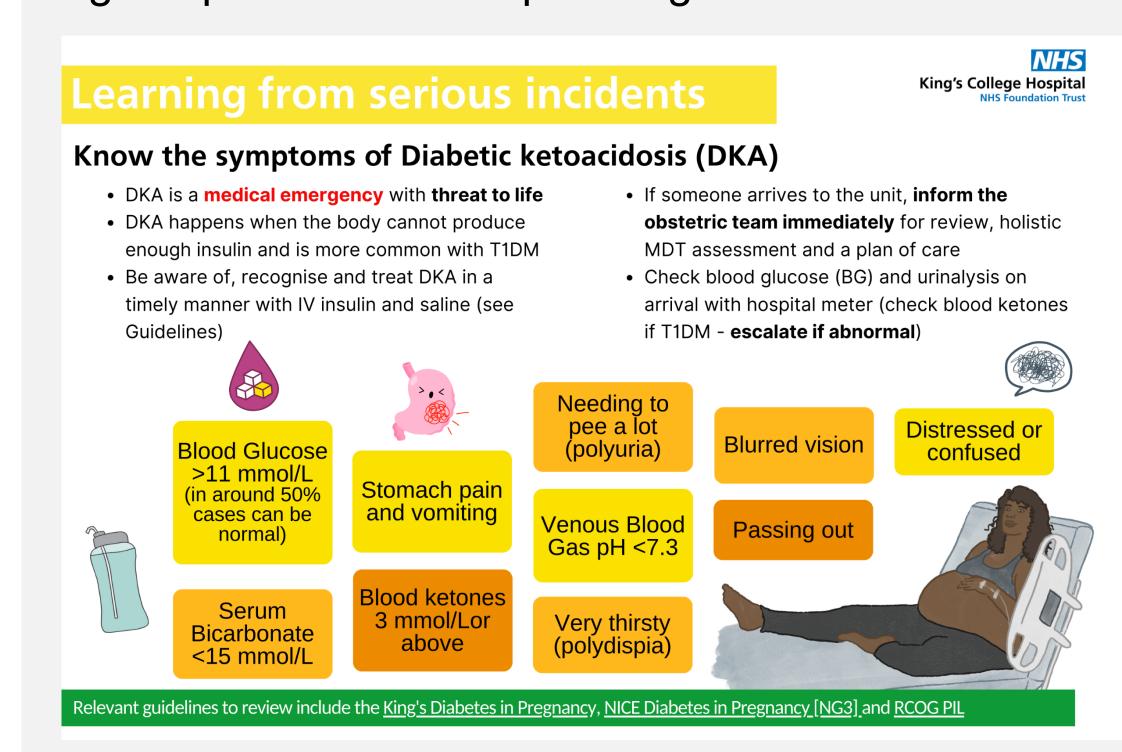
#### **External communications**

The communications midwife has key relationships with the Maternity Voices Partnership (MVP)

Resources have also has shared with external agencies, including HSIB (see below) and midwives in similar roles at other NHS Trusts.

### Safety notice published in HSIB newsletter

This poster was produced to support staff in the rapid recognition of Diabetic Ketoacidosis (DKA) as an emergency that requires urgent medical attention. It will be featured as an example of good practice in the upcoming HSIB newsletter.



Internal safety notice – November, 2022



The online parent education workshops, overseen by Clare, were shortlisted for a HSJ Award. Social media engagment increased during the gala.

NHS ge Hospital



E-mail: maxine.vassell@nhs.net
Phone: 0203 299 8342
Web: www.kch.nhs.uk/service/a-z/maternity







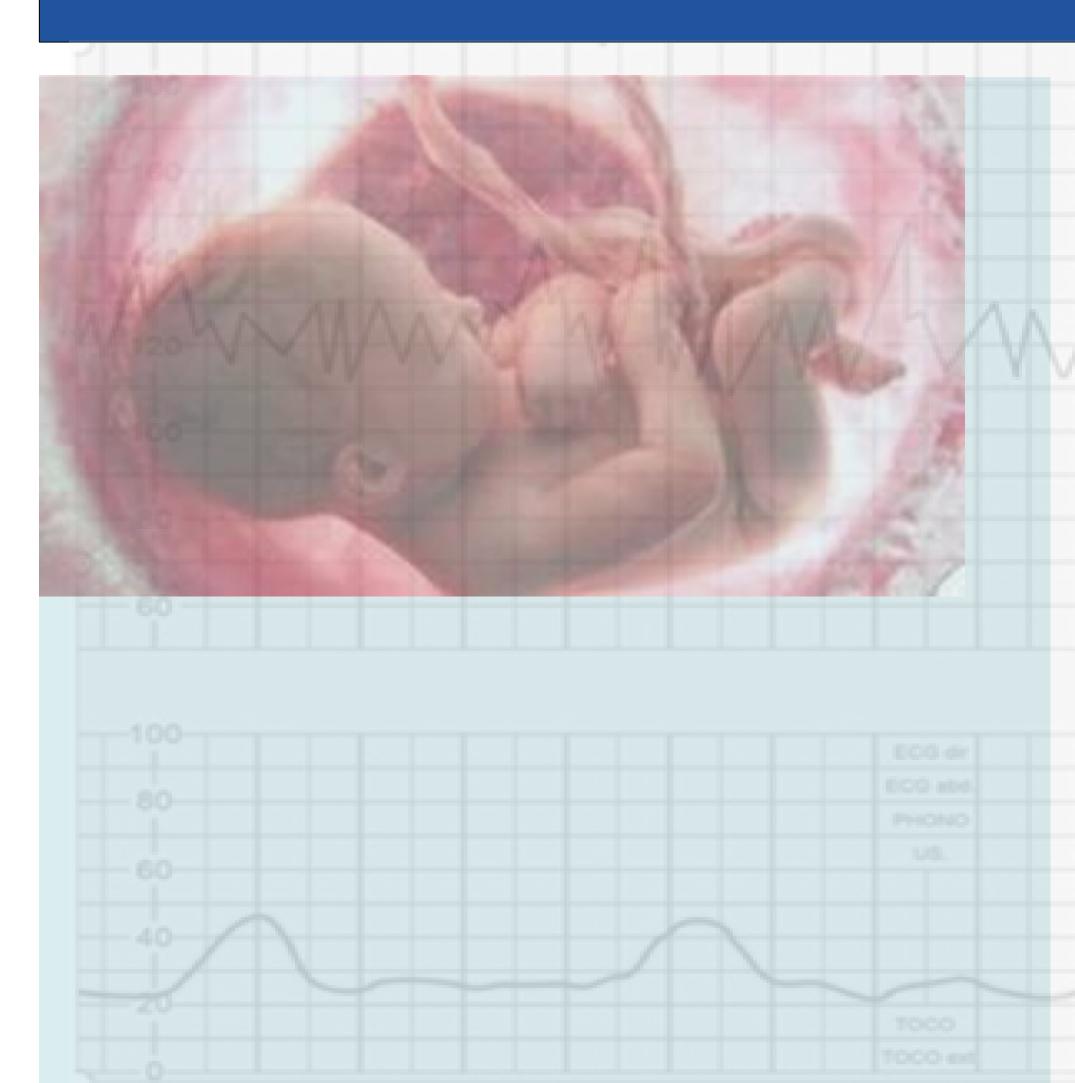
4th Floor, Golden Jubilee Wing • SE5 9RS

# Reducing poor perinatal outcome by improving cardio- tocograph interpretation in labour

Jones Charles C<sup>1</sup>, Perkins D<sup>2</sup>, Scott S.<sup>3</sup>

<sup>1</sup>Director of Midwifery 2Practice Development Midwife, 3Fetal Monitoring Midwife

Walsall Healthcare NHS Trust, Women's' and Children's Department West Midlands, England



Misinterpretation of the fetal heart via Cardio-tocograph(CTG) is a leading cause of perinatal morbidity and mortality. This can lead to separation of mother and baby for lengthy periods and have a lasting impact on families.

During the period January -October 2021 Walsall Heathcare Trust (WHT) experinced an increase in the number of babies requiring cooling at birth. To address the concern the multiprofessional team met and developed a multifaceted approach to improve this. The outcome was that WHT reduced the number of babies requiring cooling by 70%, from 10 babies to 3 January –October 2022.

\*no babies went for cooling November and December 2021

#### Introduction

Walsall Healthcare NHS Trust has approximately 3700 births per year and a Level 2 neonatal unit. The Trust employs 178 Midwives and 13 Obstetricans/ 6 trainees. There is a national ambition to have a 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025. This work part of WHT journey towards achieving this goal.

#### **AIM**

- 1. Illustrate the measures taken to reduce perinatal morbidity in early neonatal period.
- 2. Reduce the seperation of mother and baby.

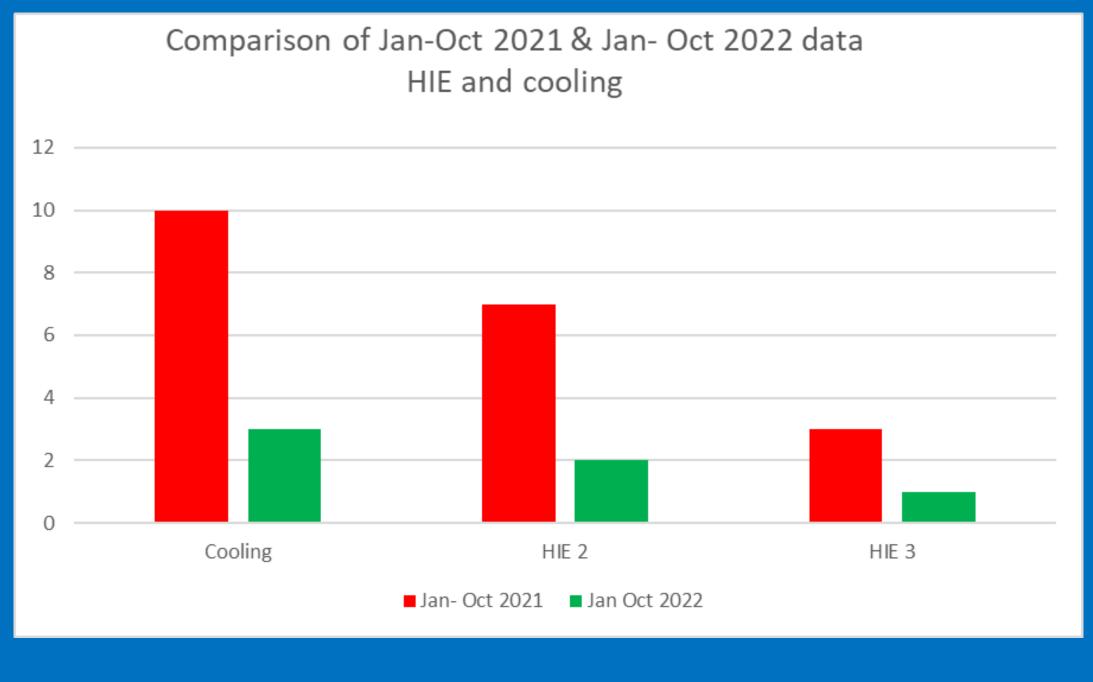


#### Results

Staff who undertook the new methods of CTG training and awareness valued the input and evaluated it well



Fetal outcomes improved significantly 10 babies underwent cooling in 2021 compared to 3 babies in 2022. Also 10 babies had grade HIE 2-3 in 2021 compared to 3 in 2022. This resulted in 1872hrs of mother and baby separation in 2021 compared to 744hrs in 2022



Hospital/University Wallsall Healthcare NHS Trust Name Karen Scot

**Title • Fetal Monitoring Midwife** 

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E-mail: karen.scott59@nhs.net Phone: 01922 721172 ext 7546

Web:

https://www.walsallhealthcare.nhs.uk



# Reduction in Post Partum Haemorrhage >1500mls GHNHSFT 2022

- Dr Leanne McDermott

#### **References:**

Begley et al (2109) Active versus expectant management for women in the third stage of labour Cochrane review NICE (2017) Intrapartum care for healthy women and babies available at: <a href="https://www.nice.org.uk/guidance/cg190">https://www.nice.org.uk/guidance/cg190</a> chapter/Recommendations

NICE (2021) Care in the Third Stage of Labour available at: https://pathways.nice.org.uk/pathways/intrapartum-care/care-in-third-stage-of-labour

WHO (2013) Active Management of the Third Stage available at:

http://apps.who.int/iris/bitstream/handle/10665/119831/WHO\_RHR\_14.18\_eng.pdf;jsessionid=CDAB49331CA7B0FF00B24535B4B012B?sequence=1

#### Introduction

Post Partum Haemorrhage is a major cause of maternal morbidity and is the second leading cause of direct maternal death in the UK.

There are regional variations in PPH rate due to inconsistencies with estimating blood loss and data reporting but severe haemorrhage is estimated to complicate between 1-5% of deliveries.

The Women and Children's Division were persistently required to 'exception report' a PPH rate >1500mL which resided above the Trust <4% target.

#### Aim

To consistently achieve a reduction in Post Partum Haemorrhage >1500ml at GHNHSFT to below 4%

#### Key Areas of Focus and Evidence Base

#### UTEROTONICS

- Administer with delivery of anterior shoulder (in women choosing active Mx)
- Delayed cord clamping does not mean delayed administration (including at LSCS)
- Remember IM Syntometrine for trials

**Context for recommendation:** ~50% of midwives (and anaesthetists) surveyed at GRH delayed administration of oxytocin until clamping of cord

Anecdotal evidence that GRH has drifted towards a practice 'norm' of IV syntocinon being given at trials of vaginal birth in theatre rather than syntometrine

#### **AVOID PROLONGED SECOND STAGE**

- Obstetric review if unable to define foetal position when a VE is undertaken at full dilatation
- Decision regarding passive descent made in conjunction with obstetrician
- Think holistically
  - why are there no urges to push or signs of progress?
  - why am I unable to define position; is there malposition or obstruction?

Context for recommendation: Median length of 2nd stage for PPH following vaginal birth: 3hr 29 (GRH PPH audit 2021)

A recent survey asking obstetric trainees to compare practice within the Severn Deanery found the theme of a prolonged second stage (and accepted 2 hr passive descent) as a potential reason for a high PPH rate

#### THIRD STAGE

Expansion of criteria for PPH bundle

- Consider for: all prolonged labours (1st stage >12hr, 2nd stage>2hr)
  - all women where syntocinon is used to augment labour
  - BMI<18
- Additional HCP (Midwife or HCA) for all OVDs in the room to improve efficiency of perineal suturing

**Context for recommendation:** Perineal trauma following vaginal births is our most common cause of PPH 100% of obstetric trainees felt their efficiency of perineal suturing would be improved if they had assistance...this is what happens in other units

Local HSIB safety recommendation highlights the importance of appreciating blood loss as a % of circulating volume rather than volume of blood lost alone i.e. women with BMI <18 have less ability to compensate

#### **Next Steps**

Development of a new Obstetric Haemorrhage proforma which:

- Is a combined linear PPH management algorithm and documentation tool
- Aims to promote real time weighing of blood loss
- Will reduce documentation! It has space for timings so no need to duplicate in notes

PPH code red process video:

Code red process –simplified

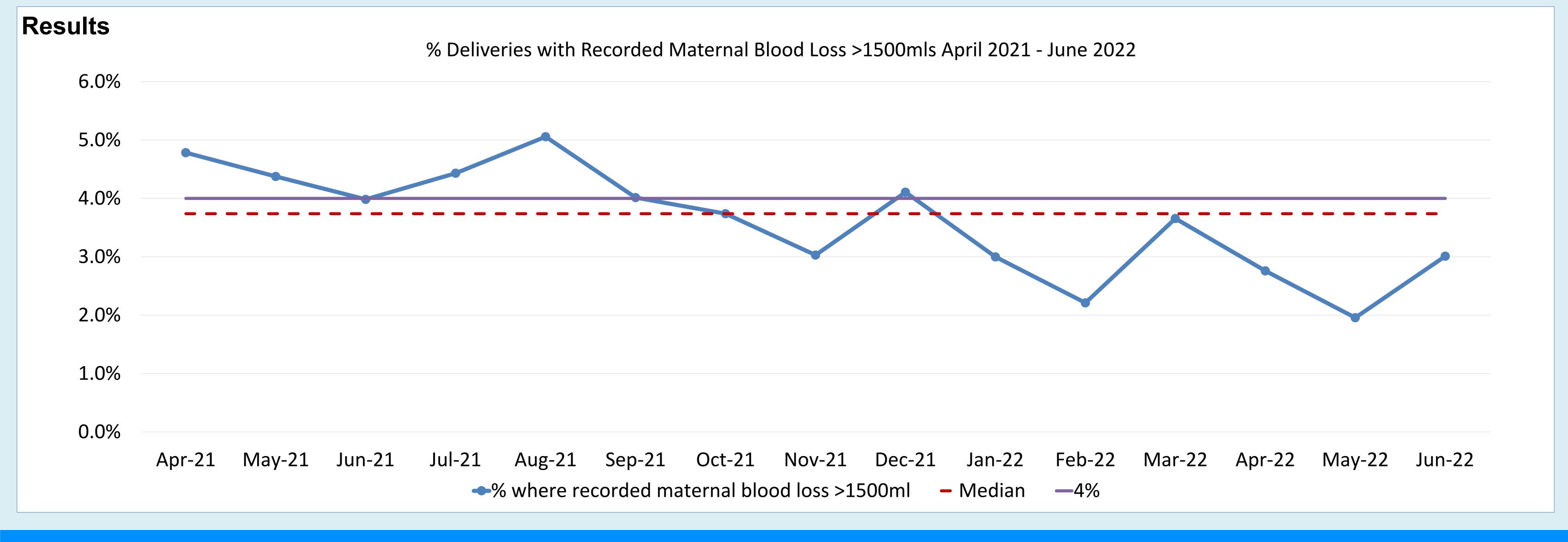
Aim to improve our perinatal anaemia management

- A recent audit of cell salvage use at GRH showed 10-12% of women were anaemic <110 prior to delivery</li>
- Move towards treating iron deficiency before women become anaemic
- Severe anaemia impacts of foetal growth, rates of LSCS, PPH and breastfeeding

Continuation of monthly PPH risk meetings and drive to improve dissemination of learning

#### Data collection

- Align data collection with national dashboard i.e.
   1500ml inclusive and above
- Aim to review all PPH >500ml



### Sharing Lessons Learnt From Maternity Never Event Incidents at BHRUT NHS Trust

Burrell C. Kropiwnicka Z.

<sup>1</sup>Barking, Havering and Redbridge University Teaching Hospital



This poster analyses BHRUT Never Events - 4 Case Series (2015-2021), reviewing one case in detail, incorporating maternal views and disseminating lessons learnt across North East London NELMS to improve patient safety locally & regionally.

### THIS POSTER LOOKS AT MEASURES TO REDUCE NEVER EVENTS AND IMPROVE PATIENT SAFETY

1.Improve staff education locally (BHRUT) and regionally (London) (2022):

Introduce first BHRUT Never Event E Learning Package and modify Midwifery Perineal Repair Induction Package;

Introduce North East London LMS Regional Teaching - Never Event Workshops (May 2022 & Dec 2022).

- 2. Standardize swab counting technique and SOP guideline in maternity theatres and main theatres.
- 3 Alert System: reiterate the pink wristband and sticker require signature at swab removal
- 4 Empower women to ask about swab removal before discharge.

#### Introduction

Never Events are serious incidents that are entirely preventable because guidance or safety recommendations are available.

April 2022 - August 2022, there were 168 Never Events reported to NHS England. Retained vaginal swabs is the commonest Never Event in maternity – 14 cases (8%).

#### Method

Retrospective case reviews.

#### **NEVER EVENT - CASE 3**

A young multiparous mother had a low risk pregnancy and spontaneous labour at 39+4 /40 The mother had forceps delivery in theatre, with shoulder dystocia and postpartum haemorrhage of 1.7 litres and 3<sup>rd</sup> degree tear.

Vaginal swabs were inserted per vaginum but there was no verbal or written communication on the theatre white board. The theatre surgical team shift finished and handed over before the surgery was completed. The outgoing day team and incoming night team had verbal **HANDOVER** but no direct vision of the missing swab, but the final WHO checklist was signed as complete.

The mother developed sepsis requiring Antibiotics before discharge. She self-referred to hospital three times, receiving further Antibiotics. At episiotomy repair (day 37), the retained vaginal swab was discovered.

### BHRUT NEVER EVENT CASE SERIES CASE 1 – Jan 2015

**Key factors**: busy labour ward, poor communication and poor documentation. Case of retained tampon after ventouse delivery, perineal repair, and suboptimal **HANDOVER**.

#### **CASE 2 – May 2019**

**Key factors**: busy labour ward, poor documentation and guideline deviation. Case involved a vaginal swab intentionally left in situ after ventouse delivery and perineal tear repair with verbal **HANDOVER** only without alert sticker.

#### **CASE 3 – June 2020**

**Key factors**: busy labour ward, poor communication and inadequate documentation. Case of retained vaginal swab after forceps delivery, with shoulder dystocia and 3rd degree perineal tear. Theatre staff had completed **HANDOVER** prior to completion of the surgery.

#### **Patient Prospective – Quote**

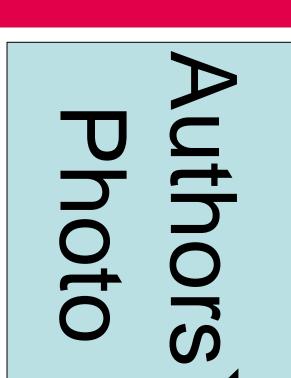
"I would like to know why I had seen 4 different doctors and who had checked my stiches... but they didn't notice that I had a swab left inside of me'

#### **CASE 4 – October 2021**

**Key factors**: busy labour ward, guideline deviation and human factors. Case of retained anal pad after a ventouse delivery at the **HANDOVER**. There was no formal count in/out system or documentation of anal pads.

With the introduction of PSIF Investigation, there is optimism to investigate SI cases and disseminate lessons learnt in a more timely manner.

Barking, Havering and Redbridge University Teaching Hospital
Burrell, Celia
Consultant Obstetrician Celia.Burrell@nhs.net
Maternity Department







# The journey following a neonatal death at Hampshire Hospitals Foundation Trust (HHFT)

Hunt, C. Barrio, K. Nash, A.



Excellence in care and support provision for both woman and staff following an unavoidable neonatal death.

At HHFT, a dedicated PMRT midwife works collaboratively with families, Bereavement Midwives, Maternity Risk & Governance team, Professional Midwifery Advocates (PMA), and the wider multidisciplinary team to ensure every case has a robust review, families voices are heard, and lessons learnt.

#### Neonatal death occurs

#### Clinical care

Care provided by midwives, obstetricians and paediatricians.

Specialist Bereavement midwives visit family - allocated as key contact.

#### Staff support

Hot debrief
PMA-led Team Safety Debrief with TRiM
Referral for counselling (Health Assured)
Practice Development Midwives
Specific Chaplaincy service

#### Bereavement follow-up

Bereavement Midwife: phone/in person support
SANDS Befriender
Bereavement Counselling
Links with local hospice

Rainbow Clinic

#### **PMRT**

Written info provided

Dedicated PMRT email address

Panel review attended by external experts

Copy of report to parents

#### **Risk & Governance**

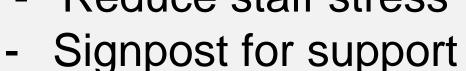
Family contacted by Duty Of Candour lead Case presented at Incident Review Meeting, reviewed by MDT

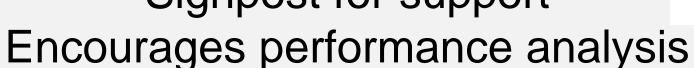
#### Learning

MQuEST
Safety Bulletins
Daily Safety Huddles
Theme of the Week

#### Impact

- ✓ Compassionate, woman centred care
- ✓ Key contact: avoid communication breakdowns
  - ✓ Debriefing benefits:- Reduce staff stress





- Positively impacts MDT relations
- Identifies communication & equipment issues
  - Encourages reflection
- Improves future performance & patient safety
- ✓ Increased wellbeing, resilience & satisfaction at work









- ✓ Ensure families receive **ongoing support** in the weeks/months following a loss
  - ✓ Future pregnancies offered Rainbow clinic = lower anxiety scores, improved outcomes



- ✓ Provides families with opportunity to ask questions and feed back through various communication methods = improved engagement.
- ✓ Understanding of process involved, reassurance that loss being taken seriously



#### **Duty of Candour**

✓ Parents feel involved in review process
 ✓ Unbiased, multidisciplinary review of care, learning identified



- ✓ Learning identified is disseminated to wider team ("shop floor" staff)
  - ✓ Improvements in safety and quality of care





### The User Experience (UX) Initiative

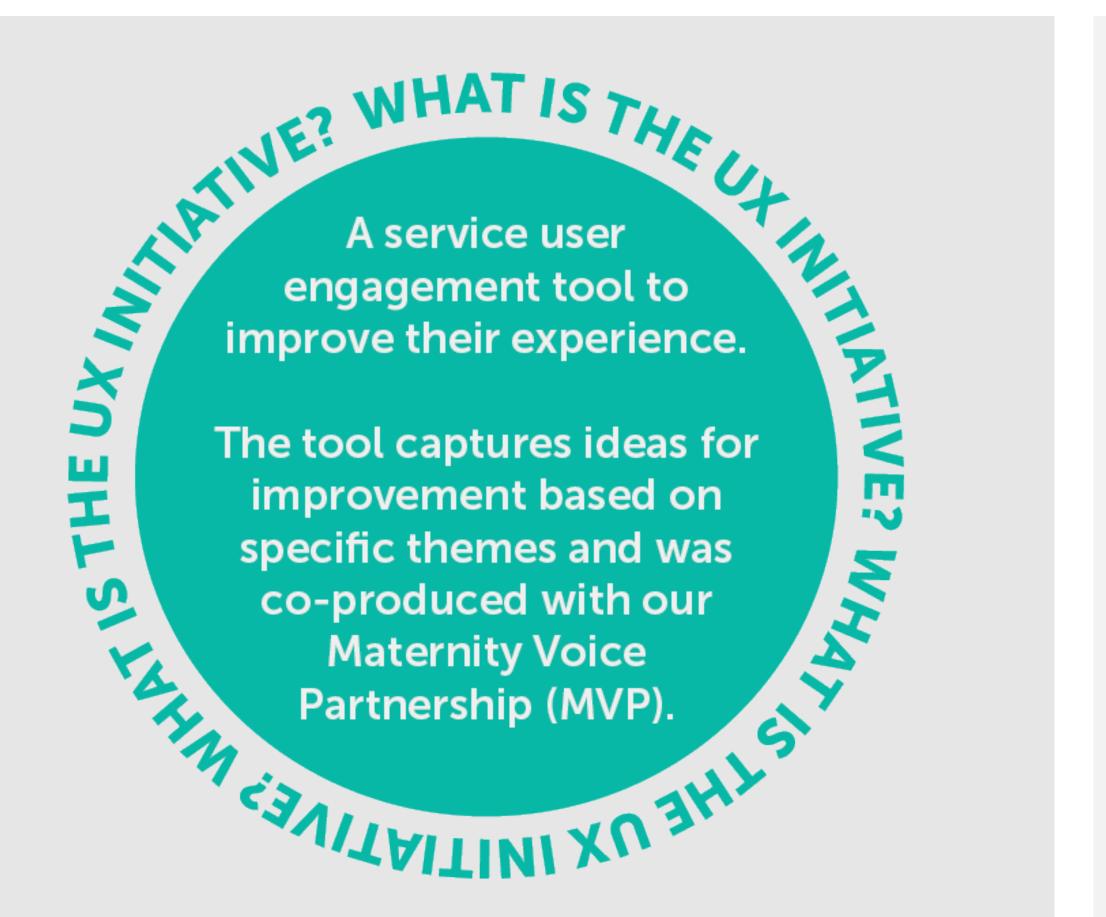
Hon M<sup>1</sup>, Knill C<sup>2</sup>, Eagleton C<sup>3</sup>, Evans E<sup>4</sup>

<sup>123</sup> The Shrewsbury and Telford Hospital NHS Trust <sup>4</sup> Shropshire Telford and Wrekin Maternity Voices Partnership

The Shrewsbury and Telford NHS Trust has received two Independent Reviews of maternity services in the past 18 months. The first Ockenden report was published in December 2020, and the final Ockenden report, in March 2022. The reports contain 210 actions in total for the Trust to implement without delay.

These reports highlight significant failings at the Trust's maternity services and the impact this has had, and continues to have, on the families concerned. This must never happen again and the Trust must learn from its failings and address them without delay. The Chief Executive has apologised unreservedly to the families involved and has committed that the Trust will learn from their experiences. Improvement work is underway with the aim of ensuring the highest standards of maternity care and rebuilding the confidence and Trust of the community. The Trust must continue to implement actions contained in the first report, along with all new actions from the final report.

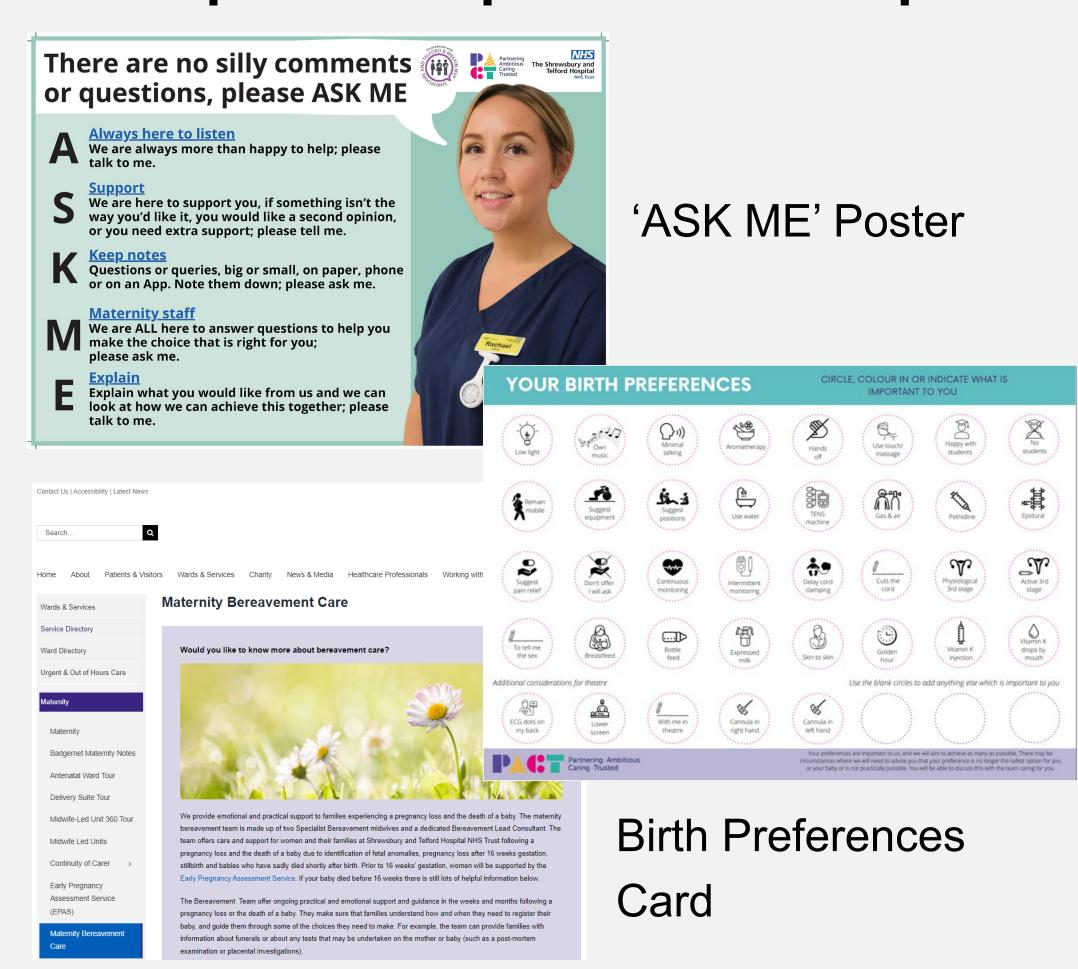
On 08.11.22, 123/210 actions have been delivered.



#### **How the Process Works:**

- 1. A theme is selected and MVP and SaTH promoted on Twitter, Facebook and Instagram to obtain UX cards.
- 2. UX cards are obtained through a digital feedback form and a UX card making workshop is conducted.
- 3. A UX workshop is conducted. Actions are then created and MoSCoW prioritised (Must have, Should have, Could have and Won't have).
- 4. The UX Team then deliver on the improvement actions.
- 5. Improvements are delivered and fed back via social media to service users, to show their voices are being heard.

#### **Examples of Improvement Outputs**



Bereavement Section on Our Website

#### **Conclusion & Next Steps:**

The UX Initiative to become part of 'business as usual' at SaTH Maternity Services, this is an initiative also being adopted by other departments.

The UX system was co-produced with the MVP as part of the Maternity Transformation Programme (MTP) under the communications and engagement workstream, and has been successfully running for 16 months now.

The system is based on Agile Project Management 'user story' concept.

A toolkit has been created and copyright are being arranged to share with other Trusts around the country.

The Shrewsbury and Telford Hospital NHS Trust
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# Traumatic Events in the Perinatal Setting: Supporting the Second Victim

King R<sup>1</sup>, Frayne E<sup>1</sup>, Owen J<sup>1</sup>

¹Great Western Hospitals NHS Foundation Trust, Swindon, UK



A study by Waterman et. al. (2007)<sup>9</sup> found almost 50% of clinicians will experience the impact as a second victim at least one time in their career.

Health care professionals are more commonly exposed to potentially traumatic events than individuals in other professions<sup>2</sup>. Obtaining timely support in an emphatic, confidential, non-judgmental environment is vital in helping prevent long-term emotional consequences, including post-traumatic stress disorder (PTSD)<sup>3</sup>.

The Perinatal Support Services (PSS) team within Perinatal services at Great Western Hospitals NHS Foundation Trust have led an initiative in supporting staff who have been involved in an adverse clinical event.

Staff feedback so far indicates the service has been 'revolutionary' in how staff are supported following an event and are extremely supportive of continuing to roll it out within the Trust.

#### Introduction

An increasing body of research demonstrates the effect traumatic events in the perinatal setting has on members of staff, often referred to as the 'second victim.'<sup>4</sup>

Each second victim will have unique perspectives, needs, and emotions related to the event, with both physiological and psychological symptoms manifesting themselves in varying timelines following the event.

Wu (2000)<sup>5</sup> devised the term 'second victims' in relation to the trauma often experienced by the clinicians involved in adverse events and the negative impact it can have on both their professional and personal life. In extreme cases, second victims have died by suicide as a result of the impact of an adverse event<sup>6</sup> which is of significant concern.

#### **Staff Support Service**

In order to better support staff following a traumatic event, PSS at the Trust have developed a staff support service, primarily based on the Trauma Risk Management (TRiM) system.

TRiM is based on 'watchful waiting', that means keeping a watchful eye on individuals who have been exposed to a traumatic event.

#### **Methods Used**

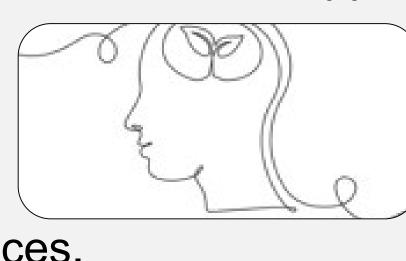
Based on feedback from staff who stated they value the opportunity to come together as a team

for a reflective debrief meeting following an adverse event, the PSS team have modified the TRiM framework to include the reflective debrief meeting.

REFLECT RETHINK REVISE

In addition, signposting to other forms of support is also shared with staff.

This includes; information leaflets, Trust employee support details and local psychological support services.



#### Results

Due to the recent introduction of this staff support service, limited data is available to assess outcomes. Feedback from a Neonatal nurse stated: "A debrief following a traumatic incident is very useful for many reasons. It's a neutral environment where you can express your feelings, seek reassurance but also to realise you aren't alone and even senior team members who seem calm and coping have the same anxieties."

#### References:

<sup>2</sup> Scott, Z., O'Curry, S., Mastroyannopoulou, K., 2022. The impact and experience of debriefing for clinical staff following traumatic events in clinical settings: A systematic review. *Journal of Traumatic Stress*, 35(1), pp.278-287

<sup>3</sup> Baas, M.A.M., Scheepstra, K.W.F., Stramrood, C.A.I., Evers, R., Dijksman, L.M., van Pampus, M.G, 2018. Work-related adverse events leaving their mark: a cross-sectional study among Dutch gynecologists. *BMC Psychiatry,* 18(1):73

<sup>4</sup>Leinweber, J. and Rowe, H.J., 2010. The costs of 'being with the woman': secondary traumatic stress in midwifery. *Midwifery*, 26, pp.76-87

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<sup>6</sup> Strobl, J., Panesar, S., Carson-Stevens, A., Mcildowie, B., Ward, H., Cross, H. and Madhok, R., 2014. *Suicide by clinicians involved in serious incidents in the NHS: a situational analysis'* [pdf] Available at: https://www.bapio.co.uk/wp-content/uploads/2020/09/FINAL-REPORT-Suicides-by-cliniciansinvolved-in-SIs-in-the-NHS.pdf.

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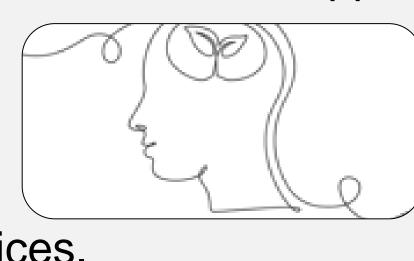
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cliniciansinvolved-in-SIs-in-the-NHS.pdf.

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# London Ambulance Service NHS Trust

# Building a world-class ambulance service for a world-class city ON PHONE ON PHONE ON PHONE

#### Work Together, Train Together

Evaluation of a collaborative maternity training programme involving ambulance clinicians and midwives in London.

#### Aimée Humphreys and Camella Main

Maternity Team, Clinical Directorate, London Ambulance Service NHS Trust Londamb.maternity.team@nhs.net



Ambulance clinicians from North Central London and midwives from Whittington, Royal Free and North Middlesex NHS Trusts at Friern Barnet Ambulance Station Joint Training.

Multidisciplinary simulation training between midwives and ambulance clinicians is likely to increase confidence of professionals providing pre-hospital maternity care.

Multidisciplinary simulation training is evidenced to improve maternal and neonatal outcomes (1). A key recommendation from the recent Ockenden report (2) is for staff who work together to train together. On occasion, midwives and ambulance clinicians are required to work together in emergency situations.

Use of a joint simulation training programme could benefit patient safety in pre-hospital maternity care across the UK.

#### Introduction

The London Ambulance service receives an average of 1,200 maternity related emergency calls a month. The majority of these calls result in an ambulance resource being dispatched with emergency conveyance to hospital occurring in 67% of cases.

Ambulance clinicians include registrants and non-registrants who have a variety of skill levels. A collaborative education programme was designed involving midwives and ambulance clinicians of all grades undertaking simulation-based training in obstetric emergencies.

#### Aims

The aim was to increase clincians' confidence in providing pre-hospital maternity care. This in turn is anticipated to improve patient safety and improve working relationships between professional groups.

#### Methods

Community midwives from four maternity units in the London region were invited to participate in the pilot training events with ambulance clinicians from London Ambulance Service. Directly following the training event an anonymised survey was completed by the 49 ambulance clinicians who attended the training.



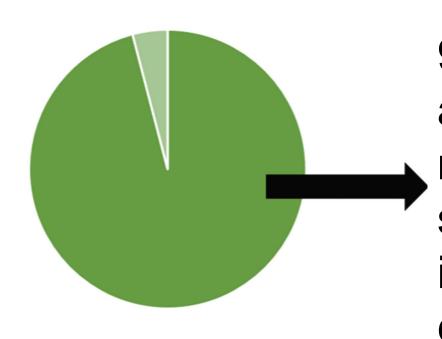


(Left to right)
Aimée Humphreys
BSc RM, Practice
Development
Midwife
Camella Main BSc
RM, Practice Lead
Midwife

# 1. Bogne kamdem valery, Daelemans C, Englert Y, Morin F, Sansregret A. Using simulation team training with human's factors components in obstetrics to improve patient outcome: A review of the literature. European Journal of Obstetrics & Gynecology and Reproductive Biology. 2021;260:159–65. 2. Ockenden Review: Summary of findings, conclusions and essential actions [Internet]. GOV.UK. [cited 2022Nov18]. Available from: https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions

#### Results

The survey showed an increased confidence level in ambulance clinicians who attended the event.



95.2% of attending ambulance clinicians reported feeling significantly more confident in their role at maternity calls following the training

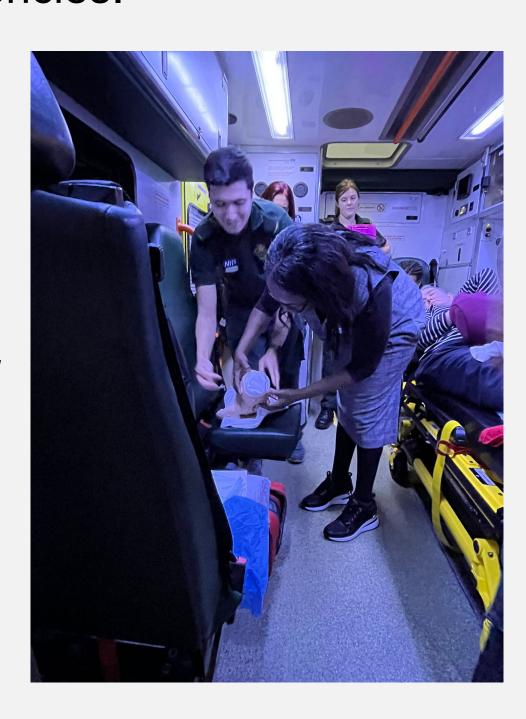
Qualitative data was collected to understand the perception of clinicians of the impact of training on future practice.

The key themes were improved civility and communication between professional groups and increased knowledge of the roles within the multidisciplinary team when managing prehospital obstetric emergencies.

'It will help my communication with midwives on scene. I feel more confident to step in and offer to help, or to ask colleagues for support.' - Paramedic attendee

(Right) Ambulance clinicians

(Right) Ambulance clinicians and midwives participating in a Newborn Life Support live scenario in an LAS event ambulance



The LAS Maternity Joint Training programme will continue next year with more maternity teams and ambulance clincians from across London. Further research is required to explore impact on health outcomes.

#### Reduced waiting time for maternity debrief appointments at East Sussex Healthcare Trust.

Specialist debrief midwives have reduced the waiting time for maternity debrief from 20-52 weeks to 3-12 weeks.

This has been achieved by providing a full-time debriefing service. To avoid delay the debrief midwives see all referred women and people initially even if they require consultant input. Once the debrief has taken place we then refer on to the appropriate consultant for an additional joint debrief or follow up as needed.

We offer priority appointments by 3-5 weeks of referral, to women and people who are undergoing psychological treatment or who are pregnant, to protect their emotional wellbeing and safety.

To optimise efficiency, we document a short note on our shared computer system following debrief, rather than sending detailed letters as before.

We plan to create a self-referral portal via East Sussex
Healthcare Trust maternity page enabling women and
people to refer if they choose to and when they feel ready.
We are co-producing a debrief evaluation tool with the
Maternity Voices Partnership.



