NHS Improvement

A guide to support maternity safety champions

February 2018

collaboration trust respect innovation courage compassion

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

1. Foreword

There has never been a safer time to have a baby in England. The stillbirth and neonatal mortality rate has fallen by a fifth in the last decade. Safety is a 'golden thread' running through the whole maternity transformation programme and implementing Better Births[1] is a key element in how we will deliver the Secretary of State's ambition and make our maternity services among the safest in the world.

The *Safer maternity care* action plan[2] made the case for strong leaders at every level of the system; working across regional, organisational or service boundaries to promote the professional cultures needed to deliver better care. Safety champions will play a central role in ensuring that mothers and babies continue to receive the safest care possible by adopting best practice.

Anecdotal evidence from maternity providers that have successfully implemented the Saving Babies' Lives Care Bundle[3] is that they have significantly reduced stillbirths. There is unwarranted variation in care and outcomes that implementing current best practice will address. Leadership is key to this and safety champions will be central in driving down variation.

Everyone − from Each Baby Counts lead reporters, maternal and neonatal health safety collaborative board-level executive sponsors and improvement leads through to safety champions in clinical networks − will work towards a safer maternity system by using their collective insights and skills to deliver and embed improvements, through evidence-based improvement science. Maternity safety commissioners will play a key role in encouraging peer learning and review.

The outcomes of this work will improve the care for all mothers and babies. This will include an improved understanding of safety science, strong mechanisms for sharing learning from harm as well as improvements in clinical outcomes such as fewer stillbirths, a reduction in women smoking during pregnancy and improved management of complex cases.

[1] www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/
[2] www.gov.uk/government/publications/safer-maternity-care
[3] www.england.nhs.uk/mat-transformation/saving-babies/

As maternity safety champions − you are the ambassadors for this work. In whichever role and at whatever level, this is a fantastic opportunity to play a full part in improving our maternity services. Your leadership will be central to making sure it is a success and we hope this guide will enable you to play your part in full.

Matthew Jolly

National Clinical Director for Maternity and Women's Health, NHS England

National Champion for Maternity Safety

Jacqueline Dunkley-Bent

Head of Maternity, Children and Young People, NHS England

National Champion for Maternity Safety

2. How to use this guide

This guide will enable, support and empower you as a maternity safety champion, whether at frontline, trust board or regional level. It is not exhaustive − you are likely to want to develop and grow your role in response to specific intelligence and safety priorities. However, we outline broad role descriptions and responsibilities for you to use and share, recognising that these will develop as your role embeds. We also explain how you might seek out existing safety initiatives and improvements to provide leadership and support to your teams.

The guide suggests a means of optimising effective sharing of information between individuals in trusts whose roles provide insights into areas where local safety needs might be addressed locally. Strong, cohesive relationships at the frontline between all those leading maternity and neonatal safety initiatives will enable insights from local intelligence coupled with recommendations from national reports to form the basis on which safety improvements are made locally, regionally and through your local maternity system (LMS).

You can find up-to-date information and contact details on the maternity and neonatal area of our improvement hub, and we would encourage you to use the hub and the nhsi.maternitysafetychampions@nhs.net email address to let us know what you are doing and how we can support you.

3. Context

In November 2015 the Secretary of State for Health announced a national ambition to halve the rates of stillbirths, maternal and neonatal deaths and brain injuries that occur during or soon after birth by 2030; a timeframe subsequently revised to 2025.[4] In autumn 2016 the *Safer maternity care: Next steps towards the national maternity ambition*[5] developed the maternity safety movement further, including a strong focus on leadership.

Two national maternity safety champions, Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent, lead by working across professional groups and system boundaries to maintain the emphasis on high quality, safe maternity care for women and newborns. They promote learning and innovation, seeking out best practice and sharing it across the system.

As part of *Safer maternity care*, maternity clinical networks were asked to designate a maternity safety champion as local quality improvement adviser, coach and conduit for sharing learning from national and international research and from local investigations or initiatives. The role includes fostering relationships between maternity clinical networks and neonatal operational delivery networks.

At provider level, to promote unfettered communication from 'floor-to-board', the *Safer maternity care* action plan set out the need for a board-level maternity safety champion to ensure a board-level focus on improving safety and outcomes as part of improving maternity services. The executive sponsor for the maternal and neonatal health safety collaborative will ideally also undertake the role of the maternity safety champion, ensuring that safety in its broadest sense is a priority item at board meetings, with the board taking action where needed as well as regularly monitoring quality and safety outcomes.

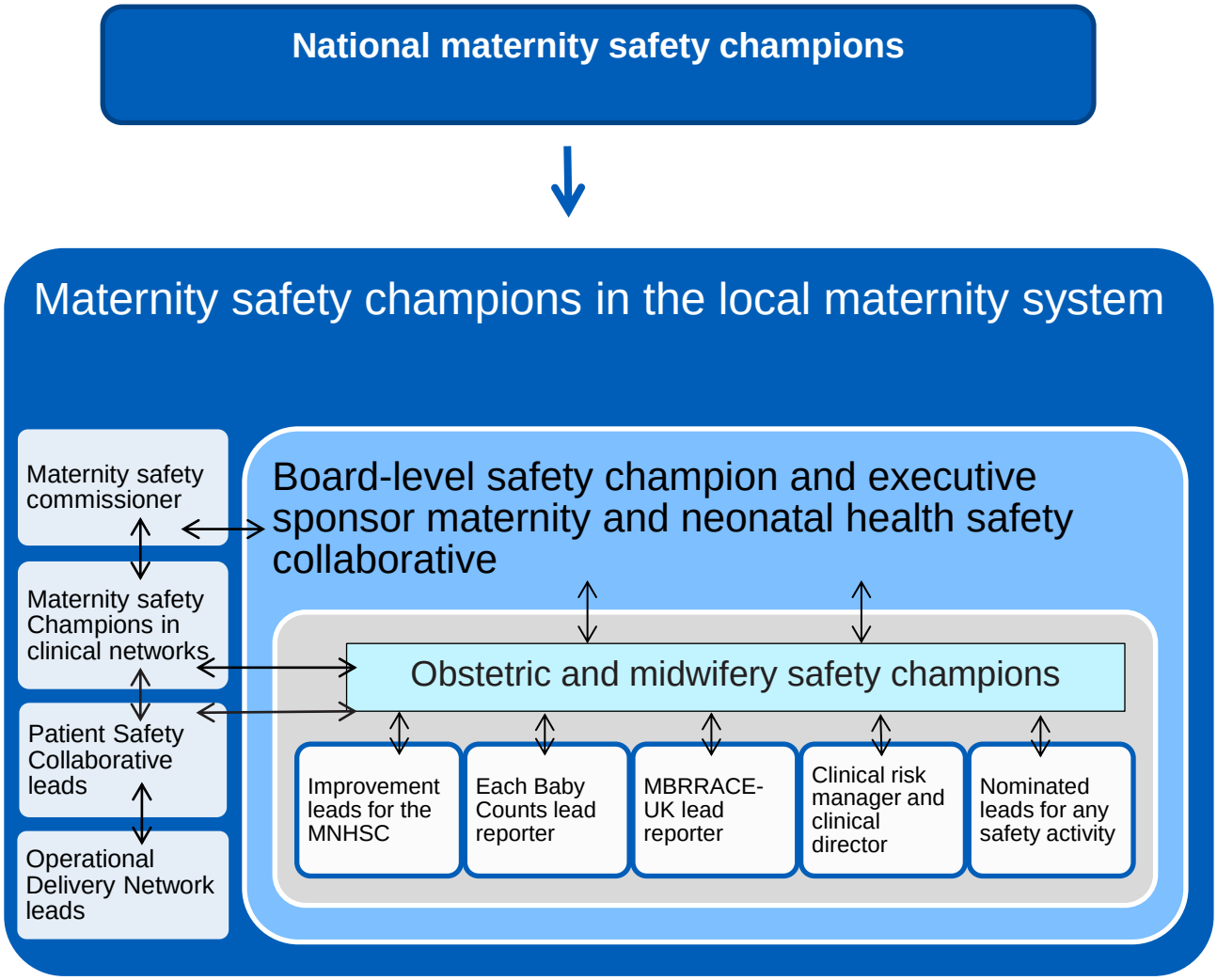
At frontline level, every maternity provider is expected to nominate an obstetrician and a midwife who are jointly responsible for championing maternity safety locally, making appropriate links with the board, the local maternity clinical network and the maternal and neonatal health safety collaborative in their region.

[4] www.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf
[5] www.gov.uk/government/publications/safer-maternity-care

We suggest you read the following sections on the roles, responsibilities, relationships and suggested activities of maternity safety champions at different levels and across different parts of the system to get a good understanding and awareness of the interface between roles. This will help you agree, locally and through your local maternity system (LMS), how to work together to share safety messages and learning.

Figure 1 below describes how champions could work together to ensure safety intelligence is used from floor-to-board and through the LMS. Local transformation plans should include clear plans for addressing locally identified safety and improvement needs. Developing cohesive mechanisms for sharing information will help enable this.

Figure 1: Maternity safety champion roles working together



Note: Maternity and neonatal health safety collaborative (MNHSC)

4. Provider maternity safety champions

Safer maternity care called on maternity providers to designate and empower three individuals to champion maternity safety in their organisation: a board-level maternity champion as well as one obstetrician and one midwife to be jointly responsible at unit level. The board-level maternity safety champion (who could be a non-executive director) will act as a conduit between the board and the obstetric and midwifery champions.

The role of the maternity provider safety champions is to support the regional and national maternity safety champions as local champions for delivering safer outcomes for pregnant women and babies.

At provider level, having taken on the role of local champion you should:

- build the maternity safety movement in your service locally, working with your maternity clinical network safety champion and continuing to build the momentum generated by the maternity transformation programme (MTP) and the national ambition
- provide visible organisational leadership and act as a change agent among health professionals and the wider maternity team working to deliver safe, personalised maternity care
- act as a conduit to share learning and best practice from national and international research and local investigations or initiatives within your organisation.

Board-level champions

- Work with your obstetric and midwifery champions, head of midwifery and clinical director for maternity to ensure maternity issues are communicated and championed at board level.
- Work with your executive sponsor for the maternal and neonatal health safety collaborative to address the needs of staff and support local quality improvement work.

- Regularly monitor safety and outcomes in maternity services drawing on data from:
  - MBRRACE-UK reports
  - National Maternity and Perinatal Audit reports
  - Friends and Family Test
  - CQC 2017 maternity survey
- Ensure you meet standards required for effective data quality and coverage, as defined by NHS Digital in the new data quality standard
- Ensure your board receives regular updates on issues requiring board-level action such as stillbirth rates, progress with implementing the Saving Babies' Lives care bundle; learning identified from cases meeting the Each Baby Counts criteria and Serious Incident investigations. Ensure that appropriate actions to address the findings are implemented and monitored at board level to ensure the required improvements are made.
- Ensure your unit is robustly following national guidelines and where outcomes demonstrate that your unit is an outlier, ensure the use of audit and investigation to inform where improvements are needed and whether more training is required.
- Where your unit is identified as an outlier carry out in-depth review to ensure contributory factors are understood; appropriate action undertaken and results monitored closely. Be mindful that changes made do not lead to unintended consequences.
- Ensure your board receives updates relating to maternity successes.
- Ensure staff in maternity and neonatal services are getting all the training, support and resources they need and promote a culture of multidisciplinary team-working with joint training, briefings and handovers.
- Ensure your senior leaders are visible to, learning from and open to feedback from those providing and receiving care.
- Lead and proactively respond to specific requests made as a result of national maternity safety initiatives, eg ensuring that Serious Incident investigations are carried out in line with national guidance, involving parents and with external representation.
- Ensure your organisation shares local learning with the LMS, and is engaged in designing and delivering the local maternity transformation plan, including ensuring it has the right focus on safety.

- Ensure your organisation sets out clearly and publicly how it is working to improve the safety of maternity services, regularly updating on progress.

David Booth, board-level safety champion at Norfolk and Norwich University Hospitals NHS Foundation Trust, on enhancing information technology (IT) support for community midwifery teams through effective working partnerships between the frontline and board.

"Community midwifery in this region covers some densely populated urban areas and many widely dispersed smaller populations spread over a large rural geographical area. The physical distance from the acute hospital environment poses specific challenges to timely communication and access. We recognised over a long time period the risks to patient safety, including delay in access to blood results, limited access to current guidance, less responsive communication and increased difficulties in completing mandatory training.

Provision of up-to-date IT solutions was prohibitively expensive.

In having a maternity champion at board level, we were able to bring together disparate threads of activity including high level changes in IT contracts in the trust, changes in the use of charitable funds and a trust commitment to fund matching to make the case for provision of up-to-date mobile computing for a large workforce.

Presence on the board allowed the case to be made directly and with credibility for a high cost investment in patient safety and patient experience."

Midwifery and obstetric champions

Jointly:

- Champion maternity safety in your organisation and contribute to the implementation of your locally developed safety improvement plan.

- Ensure there are appropriate links to your board-level champion, your local maternity system, your local maternity clinical network and the maternal and neonatal health quality improvement programme in your region.

Provider-level champions: suggested activities

Your local knowledge and expertise will help you lead safety improvement in your organisations. Here are some suggested activities.

- Make links with your regional maternity clinical network safety champions and your LMS, working across your locality to share learning, support collaborative improvement efforts and ensure a focus on safety.
- Lead on or support your organisation's participants in the maternal and neonatal health safety collaborative, including by attending regional and national meetings and events and providing leadership and support for quality improvement work on the ground.
- Make links with the executive sponsor (where different from your board-level champion), improvement manager and patient safety collaborative leads for the maternal and neonatal health safety collaborative to ensure clear understanding of your local improvement initiatives and maintain a coherent and supportive approach to local safety improvements.
- Work with service users to address identified needs, particularly in the redesign of new services.
- Make links with your local risk manager and governance leads as well as lead reporters for MBRRACE-UK, Each Baby Counts, the early notification scheme and those leading other local improvement initiatives such as the 'Caring for You' campaign (see 'Champion, improvement and lead roles in maternity'). Ensure their insights along with findings and recommendations from local, regional and national Serious Incident reviews are considered.
- Use these insights to inform local maternity safety priorities, co-ordinating trust-wide efforts thereby ensuring a common set of objectives. Board-level agreement and sign off of the agreed objectives would provide assurance that efforts are focused appropriately. Ensure local priorities are aligned with the strategic priorities of the LMS, clinical network, operational delivery network, region and maternity transformation programme.
- Provide regular safety-specific communications through your professional networks, referring back to the ambition and the specific deliverables in the

national *Safer maternity care* action plan. Materials from the national and regional level champions could help you with this.

- Work with your local neonatal operational delivery network to promote links between neonatal and maternity services and to support shared aims.

Emma MacKay, midwifery champion at Norfolk and Norwich University Hospitals NHS Foundation Trust, worked closely with her team to carry out a survey looking at staff concerns about safety in the delivery suite, which led to implementing human factors training.

Two main points came from the survey:

- team working was not felt to be good – shifts of midwives and the doctors they worked with were not working effectively together with the potential to impact on patient safety
- staff didn't always feel confident to submit clinical incident forms or escalate issues of safety – they felt that their reports would reflect badly on them or that their staff record would be adversely affected.

This concern for safety was one factor which generated a successful bid for resources from a maternity safety training fund – it was decided to invest in human factors training that would be ongoing (ie not a one-off) and would establish a culture across delivery suite, NICU [neonatal intensive care unit] and obstetric theatres.

This initiative was presented and discussed at executive level and then presented at board level to assess as an initiative that could be rolled out trust wide. The board recognised the value of this training and there is support for it to continue and to be spread throughout the trust.

Key relationships at provider level

As the maternity safety champion role develops so will the range of local and regional stakeholders. As a minimum, stakeholders and key contacts for trust maternity safety champions are likely to include:

- LMS leads
- maternity and neonatal health safety collaborative executive sponsors at board level (where different from the maternity safety board champion)
- local midwifery and obstetric champions
- clinical risk manager and relevant leads for local safety improvement programmes, eg Each Baby Counts, NHS Improvement maternity safety leads or MBRRACE-UK lead reporters.

5. Regional maternity safety champions

Safer maternity care calls for maternity clinical networks to designate regional maternity safety champions to support the national maternity safety champions to deliver safer outcomes for pregnant women and babies.

Your role as a regional maternity safety champion is to support the national maternity safety champions by:

- building the maternity safety movement regionally, spearheading the focus on maternity safety and continuing to build the momentum generated by the maternity transformation programme and the national ambition
- providing visible leadership and acting as a change agent among maternity services and the health professionals and commissioners working to deliver those services in your network trusts
- acting as a regional conduit for sharing learning and best practice arising from national and international research and local investigations or initiatives
- making appropriate links with and acting as a regional conduit for safety-specific messages, sharing learning between trust-level board and maternity safety champions and the national maternity safety champions through the maternity clinical network monthly forum
- acting in partnership with patient safety collaboratives as a regional quality adviser and coach to support improvement activities including participation in the maternity and neonatal health safety collaborative
- fostering collaborative working with maternity and neonatal care providers, operational delivery networks, clinical commissioning groups and maternity voice partnerships across the region to develop care pathways that are responsive to the needs of your local population with a focus on outcomes-based commissioning.

Regional safety champions: suggested activities

Your knowledge and expertise will help you lead safety improvement in your area but here are some suggested activities that will support our shared endeavour:

- Make links with your trust-level maternity clinical network safety champions and work across your locality with colleagues in relevant organisations to support collaborative improvement efforts.
- Understand who is doing what at each trust in your region, maintaining contacts and a network, supporting communication of effort and activities, encouraging peer learning and review, and acting as a conduit for identifying reciprocal support arrangements for improvement work, incident investigation expertise and other safety-related activities.
- Lead on and support your region's participants in the maternal and neonatal health safety collaborative, including by attending regional and national meetings and events and providing leadership and support for quality improvement work on the ground.
- Provide regular safety-specific communications via your professional networks, including the trust-level champions, referring back to the ambition and the specific deliverables in the national *Safer maternity care* action plan. National-level champions will share materials to help with this.
- Work with local neonatal operational delivery networks to promote links between neonatal and maternity services and support our shared aims.

Key relationships at regional level

As the maternity safety champion role develops, the range of stakeholders you collaborate with will also increase. As a minimum, your stakeholders and key contacts are likely to include:

- board-level maternity safety champion and/or maternal and neonatal health safety collaborative executive sponsor in each trust in the clinical network
- improvement leads for the health safety collaborative
- operational delivery network (neonatal network) leads
- Maternity Voice Partnerships
- lead commissioner for maternity safety in your LMS.

6. National maternity safety champions

The champions for the national maternity safety ambition are expected to:

- build the maternity safety movement in the NHS nationally, spearheading the focus on maternity safety and continuing to build the momentum generated by the maternity transformation programme and the national ambition
- provide visible leadership and act as a change agent among maternity services and the health professionals and commissioners delivering those services
- make links with regional champions as set out in *Safer maternity care*, and through them to the board-level and obstetric and midwifery leads in each maternity trust
- promote learning and innovation, seeking out best practice and sharing it across the system
- provide regular safety-specific communications through professional networks, speaking events, social media and other opportunities, referring back to the ambition and the specific deliverables in the *Safer maternity care* action plan.

As leaders in the maternity transformation programme the national champions are also expected to:

- provide regular advice to ministers and Department of Health and Social Care (DHSC) officials to support delivery of the national maternity ambition and the maternity safety work programme including attending the Secretary of State's care meetings and other ministerial meetings as required
- look across all workstreams of the maternity transformation programme, proactively identifying, formally raising and, where relevant, taking action on links, opportunities and interdependencies between the safety workstream and the other workstreams, thereby contributing to the 'golden thread' of safety that runs through the programme.

Some key relationships at national level

7. Champion, improvement and lead roles in maternity

There are a range of ‘champion’, ‘improvement lead’ and ‘lead reporter’ roles supporting one or more of the safety initiatives in maternity and neonatal services. These include lead reporters for the Royal College of Obstetricians and Gynaecologists ‘Each Baby Counts’ programme and MBRRACE-UK confidential enquiries, the NHS Resolution-led early notification scheme, the TAMBA project and the Royal College of Midwives ‘Caring for You’ initiative.

We outline below the roles of leads or champions in some of those initiatives. Establishing relationships with those them will help local teams work together to optimise sharing and learning from related initiatives.

Each Baby Counts

Each Baby Counts (EBC) lead reporters are responsible for reporting, via the online reporting platform, all babies meeting the EBC eligibility criteria (see below in the early notification scheme) born under the care of their trust/health board, including home births.

They are asked to complete the initial report to Each Baby Counts within five working days of the date of the incident using information available in the maternal and/or baby case notes and discharge summary. As soon as the local investigation is complete, the final sections of the report should be completed using the investigation report and an anonymised version of the investigation.

If there is more than one lead reporter in a trust/health board, the EBC team asks that a system for reporting cases is agreed and implemented: for example one person reports all deaths and the other reports all severe brain injuries or one lead reporter is responsible for reporting all babies born in each site/unit.

Early notification scheme

The lead reporter for the early notification scheme must report all maternity incidents meeting the below definition to NHS Resolution within 30 days of the

incident occurring. Criteria for reporting follow those of Each Baby Counts so the cases are already identified in the system.

Eligible babies include those born at term (≥37 completed weeks of gestation), following labour, who had a severe brain injury diagnosed in the first seven days of life. These are any babies with one or more of the following:

- grade 3 hypoxic ischaemic encephalopathy
- actively therapeutically cooled
- all three of the following signs: decreased central tone, comatose, seizures of any kind.

Reports are sent to NHS Resolution through the legal services departments. The lead reporter should liaise with the maternity team and submit the following documents to NHS Resolution:

- early notification form completed in full
- copies of the relevant maternity and neonatal clinical notes, including the cardiotocograph traces
- copies of initial Duty of Candour letter, 72-hour report and any other available investigation documents.

Executive sponsors for the maternal and neonatal health safety collaborative

The three-year maternal and neonatal health safety collaborative led by NHS Improvement involves all maternity trusts in England and includes board-level executive sponsors and improvement managers. There are three waves to the programme, every 12 months from March 2017, with 45 trusts taking part in each wave.

The executive sponsor (who should ideally be the same person as the board-level maternity safety champion) for the maternal and neonatal health safety collaborative should:

- champion the ambitions of the collaborative at board level, ensuring appropriate resources (including capacity) are available to support the improvement leads in delivering local improvement projects, attending

learning events and engaging with relevant networks and the collaborative communities of practice

- contribute to the developing ‘learning system’ and ensure that improvement learning is disseminated and shared across the organisation and where relevant, the wider system, including on a national platform
- support and contribute to the national learning sets of the collaborative and actively take part where there are development opportunities for board-level champions
- support the improvement leads to overcome any organisational issues or barriers that may prevent projects from progressing.
- act as the first point of organisational contact for the central programme team if there are issues with team engagement or improvement progress
- engage with the maternity safety champions and other parts of the organisation responsible for improvement to ensure the work of the improvement leads is aligned.

Local improvement leads for the maternal and neonatal health safety

Among other things the local improvement leads for the collaborative need to:

- help the organisation define a clear ambition for its maternal and neonatal improvement with a set of measurable aims for each project; providing overall co-ordination and facilitation of the quality improvement work
- be the main point of contact for the collaborative central programme team and the patient safety collaborative team
- be an active member, contributing to the developing ‘learning system’ and ensuring that improvement learning is disseminated and shared across the organisation and wider system, including on a national platform
- work with colleagues to ensure that there is a plan to build improvement capability and embed quality improvement methodologies into business as usual
- work with senior leadership, maternity safety champions and the nominated maternity board-level safety champion (executive sponsor for the maternal and neonatal health safety collaborative), to update on progress and to get support around the implementation and promotion of the projects

- work with women and their families to help develop safe and high quality pathways.

Lead reporters for MBRRACE-UK

MBRRACE-UK lead reporters are responsible for reporting all maternal deaths and all perinatal deaths occurring in the care of their trust/health board, including any deaths occurring at a home birth.

For maternal deaths reporters are asked to contact the MBRRACE-UK office in Oxford by telephone within five working days of the death to notify the death and then to send a copy of the complete set of notes as soon as possible.

For perinatal deaths they are asked to report all perinatal deaths via the MBRRACE-UK online reporting system, starting the report within five working days of the death. The data collection for each case should be completed as soon as all the relevant information is available, including the results of the post-mortem report if there was a post-mortem.

The MBRRACE-UK system dashboard, which is specific to each trust/health board and only visible to staff from that organisation, shows the cases that have been reported and completed and those that have been reported but for which the data collection is not yet complete.

Maternity safety commissioners

Safer maternity care: next steps towards the national maternity ambition describes the need for the right leadership in commissioning maternity and neonatal services. Each LMS should appoint a lead commissioner for maternity safety who will champion effective commissioning of maternity services and hold providers to account for improving outcomes.

NHS England has produced a resource pack for commissioning safer maternity services for local maternity systems[6] which provides more detail.

[6] www.england.nhs.uk/wp-content/uploads/2017/03/nhs-guidance-maternity-services-v1.pdf

Establishing a coherent approach at trust level

The roles described above make a significant contribution to maternity and neonatal safety and improvement and it is imperative that links are established between these team members and midwifery and obstetric champions at trust level. In many trusts the same person may have responsibility for some or all of these lead roles and local arrangements need to ensure co-ordination of messages, planned actions and recommendations.

Regular meetings between the relevant leads and board-level safety champion are necessary to ensure a coherent and well-informed local and regional safety agenda. This should support a two-way communication channel between 'floor and board' to share information, action plans and progress and highlight issues for the board.

These meetings should take place a minimum of every two months, supported by appropriate governance including a record of minutes and discussions. By doing this, your trust will be meeting one of the 10 criteria in the 2018/2019 Clinical Negligence Scheme for Trusts incentivisation scheme.[7]

The expectation of the scheme is that trusts will be able to demonstrate the required progress against all 10 of the actions to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of their maternity premia). Trusts will be expected to provide a report to their board demonstrating evidence of progress against each of the 10 actions.

[7] www.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

8. Communicating

Improvement Hub

Our Improvement Hub helps providers and users to access improvement tools, resources and ideas from across the health sector. It can be used to collaborate and explore ideas with colleagues, share improvement stories, including lessons learned and successes as well as identified improvement resources.

The hub has a 'maternity and neonatal' section which links to a range of improvement resources, the collaborative and other programmes. You can also upload resources and take part in the discussion forum from the page.

Summary of maternity safety activity

We have collated a summary of all nationally led maternity safety activity across England which will be housed on the hub. We will update it regularly as new initiatives emerge so look here to make sense of the range of work and who is responsibility for current activity.

Maternity safety champions – keeping in touch

To target relevant communications to the appropriate champions, we need a robust way to identify named champions at every level.

We have collated a list of identified champions in every trust and region. If these change, to ensure we always hold up-to-date information, please update us by sending the new named contacts to nhsi.maternitysafetychampions@nhs.net

Your roles are vital for improving maternity safety so you can expect to receive invitations to relevant events and be asked your views; system leaders may also want to share specific information with you. We will use the nhsi.maternitysafetychampions@nhs.net email address to co-ordinate communications so that you do not receive emails from several sources.

We look forward to working with you to drive safety improvements in maternity and neonatal services. Thank you for championing this role.

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