

# Jessop Wing Maternity Services

Chris Morley, Chief Nurse

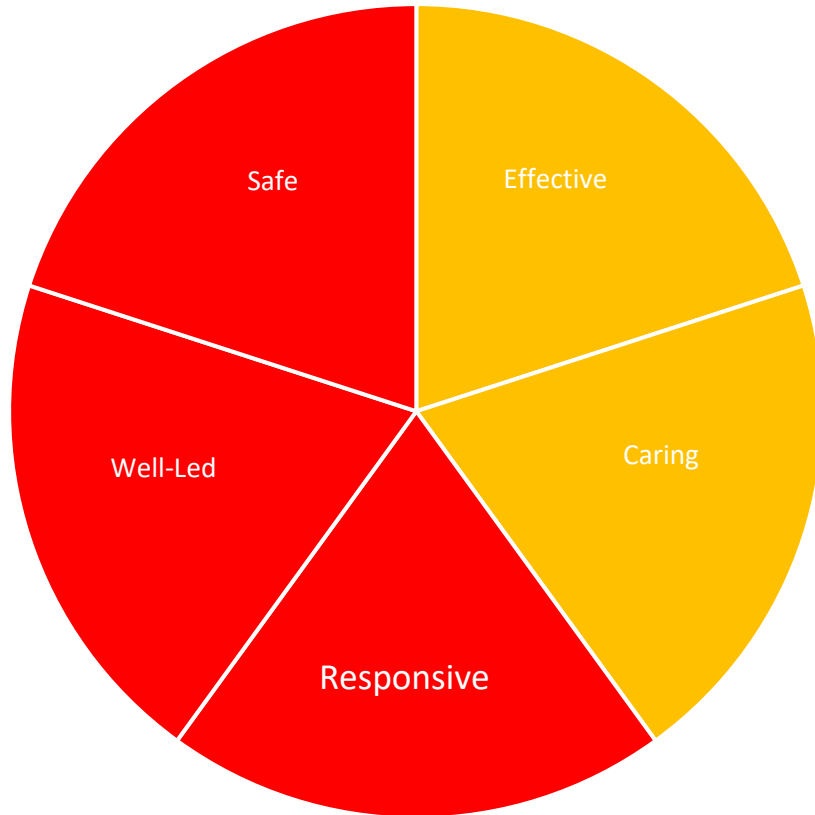
Laura Rumsey, Midwifery Director

Angie Legge, Quality Director

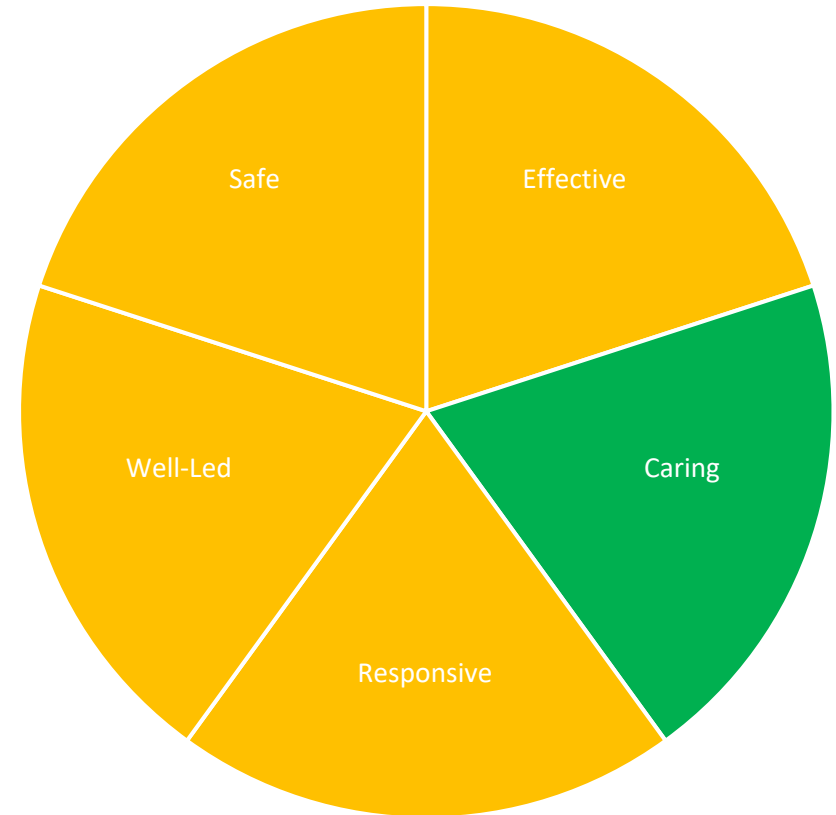


# Context

2021



2022



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# Well –Led: Stable & Established Triumvirate



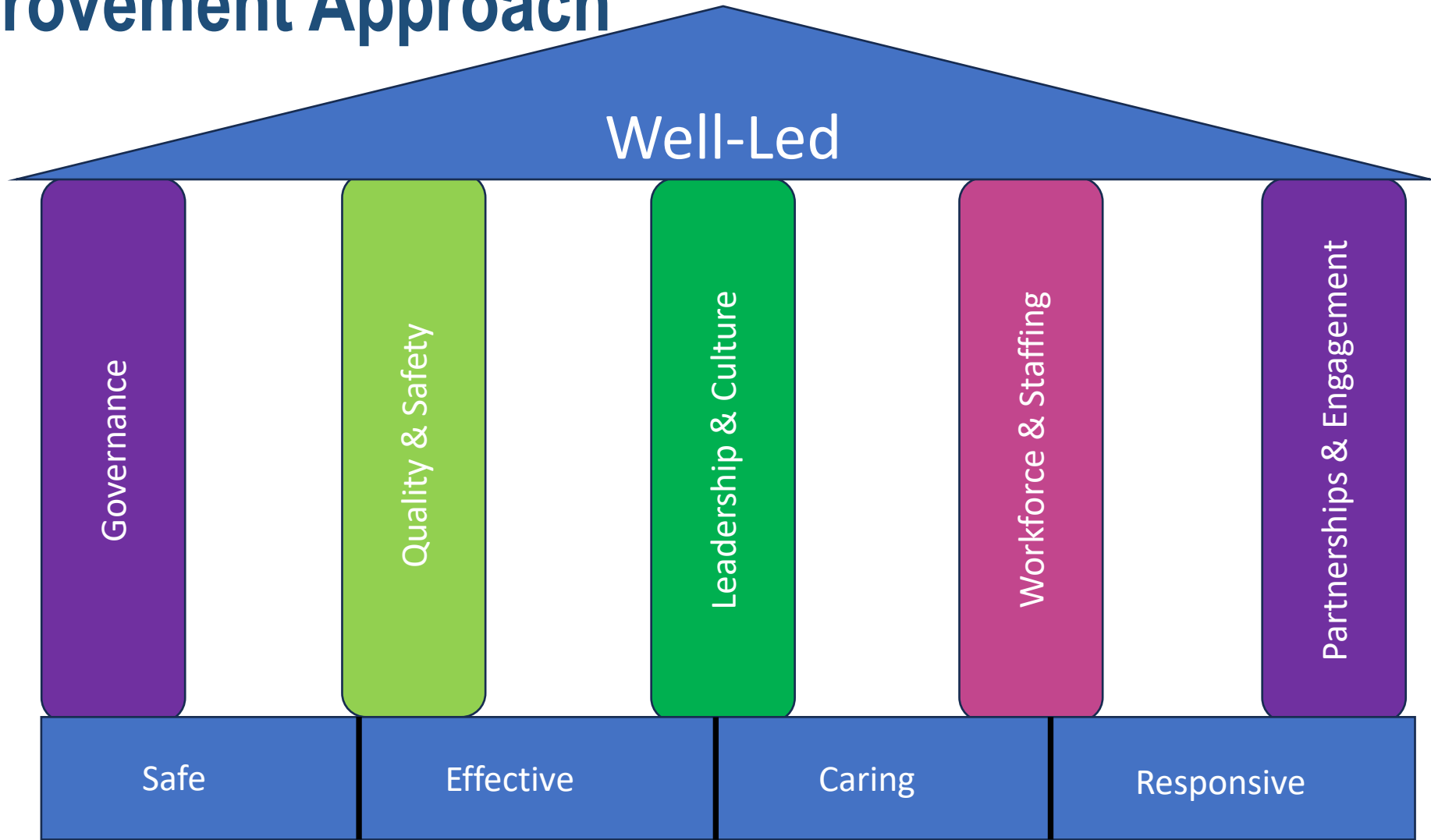
**Triumvirate:**  
Clinical Director: Mr Andrea Galimberti  
Director of Midwifery: Laura Rumsey  
Operations Director: Sue Gregory



**New Leadership Roles:**  
Fetal Surveillance Matron  
Cultural Safety Midwife  
Education and Development Matron  
Pastoral Support Midwife  
Digital Midwife



# Improvement Approach



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# JESSOP WING MATERNITY IMPROVEMENT PROGRAMME

## Governance

- Robust risk management
- Appropriate Datix/Incident reporting
- Duty of Candour processes
- Investigative processes
- Governance team structure and function
- Risk review process
- Governance structure & reporting
- Floor to board reporting
- Visibility of information flows
- Family liaison and engagement
- Clinical effectiveness
- Training and education
- Sharing of learning
- Board level safety champions
- Saving Babies Lives Care Bundle v2

CQC Must Do: 43, 44, 45, 49, 52

CQC Well-Led, Safe, Effective

Ockenden 1,2,3,4,5,9,14,18.

CNST: 1,3,4,5,6,7,8,9,10

Saving Babies Lives v2

## Quality & Safety

- A culture of safety
- Capacity and demand matching
- Communication
- Non-critical quality improvement projects
- National Maternity Transformation Programme
- Risk assessments
- Safety Training
- CQC preparedness
- Safety benchmarking
- Emergency Equipment
- Infection prevention and control
- Prescription of medication

HSIB/Other

CQC Must Do: 50, 51, 53, 54, 55, S29a: 2.4, 2.5, 12(6)d.

CQC Well-Led, Safe, Effective, Responsive

Ockenden: all immediate and essential and local actions

CNST: 1,6,7,9

All workstreams aim to review and improve or implement the themes described.

Priority Actions are CQC or regulatory must-dos & will be updated Quarterly

## Leadership

- Roles & responsibilities of the Senior Midwifery Team
- Effective appraisal processes
- Development packs for all Band 7 and above midwives
- Leadership Development - coaching and leadership training
- Triumvirate Leadership development
- Clinical shifts for managerial staff
- Improved meeting and communication structures

CNST: 3,4,5,8,9

HSIB/Other

CQC Well-Led, Action Plan 2.1b

## Workforce & Staffing

- Midwifery Establishment
- Monitoring and Reporting of midwifery establishment
- Neonatal workforce
- Medical workforce
- MDT training
- Workforce well-being

HSIB/Other

CQC Must Do: 47, 48 S29a), 3a, 4.1 18b, 18(2) a

CQC Safe, Effective

Ockenden 1,3,7

## Partnerships & Engagement

- Maternity Voices Partnership working
- Effective staff engagement -& ensuring staff feel they have a voice
- Maternity Star Awards
- Communication strategy
- Cultural development work - NHSE/I Civility & Respect Toolkit
- Trust Proud Behaviours Programme and Maternity House Rules (Behaviour Charter)
- Psychological safety

HSIB/Other

CQC Well-Led

CQC Must Do: S29a) 8.3

Ockenden 1,4,7

CNST: 7,8

# Environment

## Phase 1

- Level 1 entrance, communal areas and amenities
- Maternity Assessment Centre (MAC) – New build

## Phase 2

- Labour Suite / Maternity Assessment Centre Entrance, Reception, waiting areas and amenities

## Phase 3

- Maternity Assessment Centre Clinical Rooms (Renovation and upgrade of existing footprint)

Phase 2 and 3 to be completed April 2024

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# Environment – Phase 1

Refurbishment of the Level 1 area:

- Updated & Improved signage
- Redecoration new flooring
- Updated toilet, baby change and feeding facilities
- Colour coded entrances to outpatient areas to aid patient navigation

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# Maternity Assessment Centre (MAC) Phase 1

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CQC 2022: “The triage area had been restructured since the October 2021 inspection.”...  
“we saw rooms designated for women waiting for triage and clinical assessment”....  
“There was an electronic system in place which showed the waiting area on a screen for staff to monitor. This allowed staff to reserve chairs in the triage area for women who had telephoned the labour ward prior to attending”



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# Workforce: Returning Experienced Midwives



I came back to the Jessop Wing as I felt ready for career progression, and I felt this was where I would be most supported to succeed. I have already witnessed how far the unit had progressed.  
Kelly, Lead Midwife



I returned to Jessop Wing as I was aware of improvements and I really missed the diversity Sheffield offers from both my colleagues and the women and babies we provide care to.  
Kate, Pastoral Support Midwife



I returned to Jessop Wing and I now feel much more supported. Staffing levels have also improved significantly.  
Hayley, Senior Midwife.



I returned to Jessop Wing where I had worked previously for 15 years to undertake the position Matron for Education & Development, a role I love. I feel very blessed to have returned to a Trust with strong leadership and direction.  
Alison, Matron, Education & Development

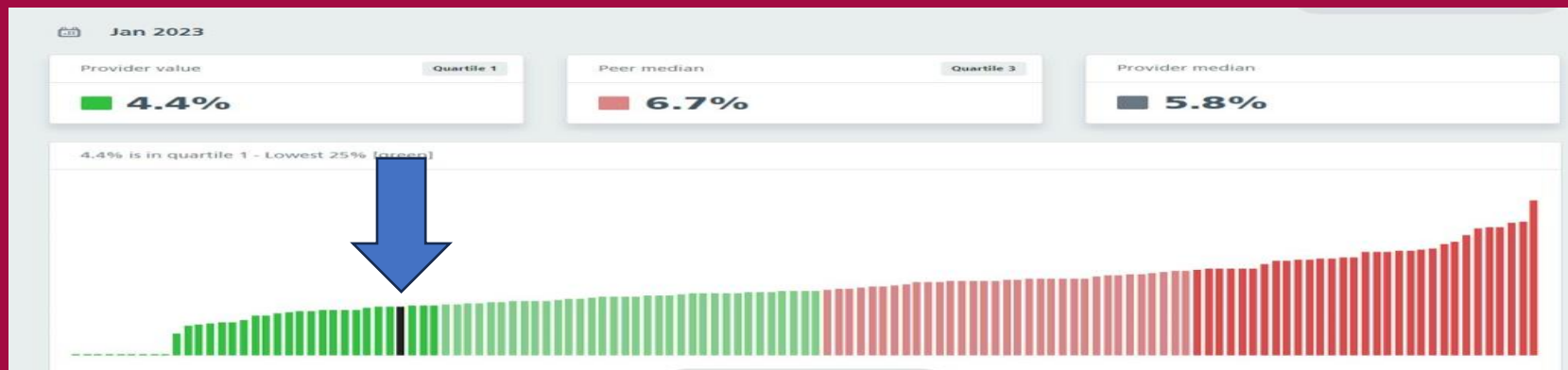
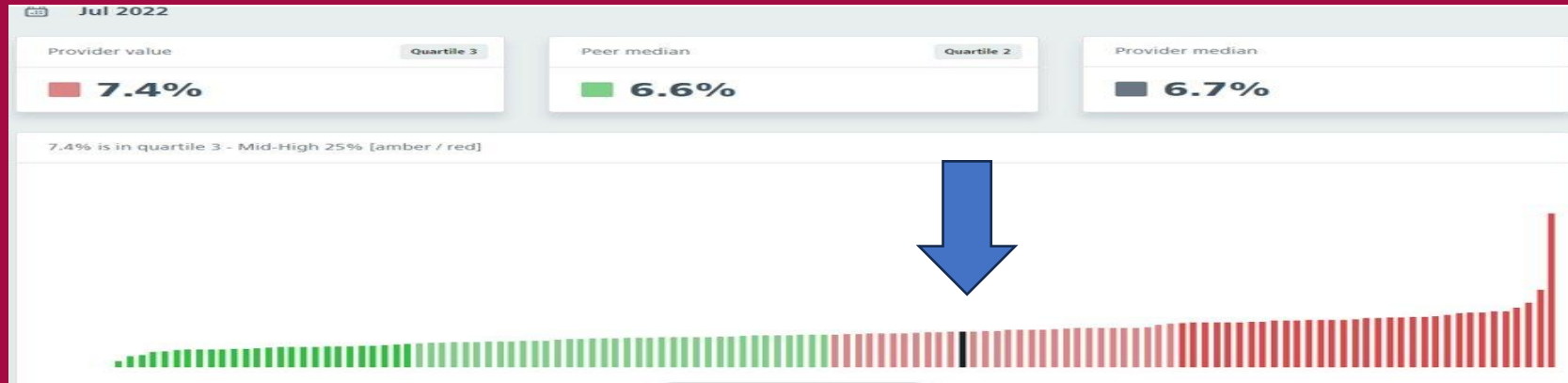


# Maternity Workforce

- 24 early career midwives starting October
- 3 Internationally Educated midwives from September to December (10 in total)
- Maternity skill mix to include Registered Nurses to support postnatal care (under midwifery supervision)
- NHS England funded Registered Nurse to Registered Midwife Masters, 20 month course- 5 students commenced 2023,( further 10 students planned-March 2024)
- Midwifery Degree Apprenticeship, 40 month course –3 students 2023.
- 10 Maternity Support Worker apprentices graduate January 2024
- Strategies to support retention & rolling recruitment programme



# Workforce: Midwife Retention Improvements



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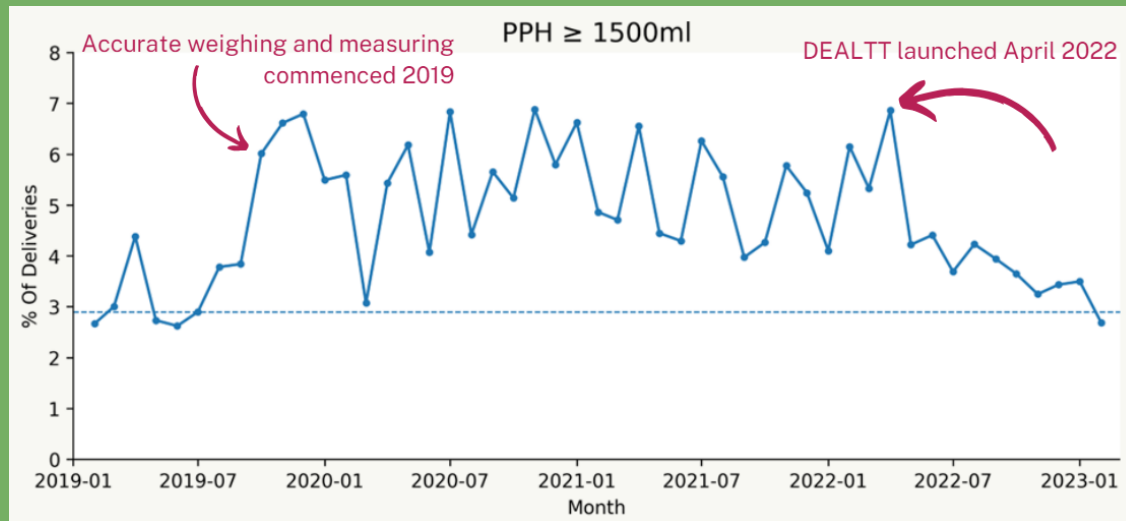
# Quality Improvements

- Standardised Telephone Triage training for midwives
- BSOTS (Birmingham Specific Obstetric Triage System)
  - Monthly audit of Maternity Assessment Centre waiting times against BSOTS standards
- Consultant of the Week
  - Daily review of all antenatal women and women attending Antenatal Day Assessment Unit & Maternity Assessment Centre
  - Twice daily review and risk assessment of women awaiting induction of labour



# Quality Improvements Post Partum Haemorrhage (PPH)

- DEALTT (April 2022)
  - PPH rates reduced



## DEALTT with PPH

Deltoid injection for 3<sup>rd</sup> stage management



Early escalation for help - Loss > 500mls



Accurate immediate weighing



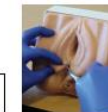
Leader with helicopter oversight



Tranexamic Acid - 1000mg / 10mls

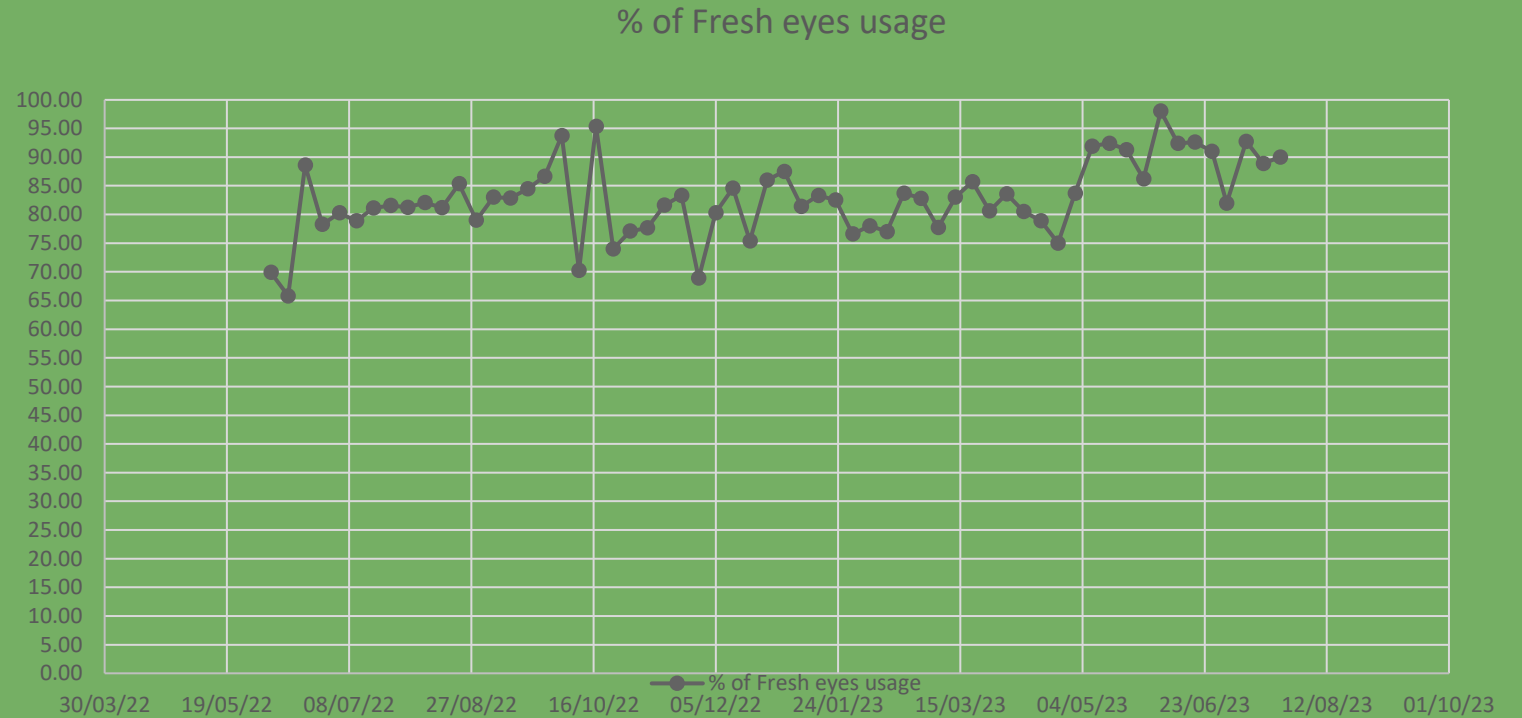


Trauma – recognition and early suturing



# Quality Improvements Fetal Surveillance

- Monthly compliance audit of Fresh Eyes assessments in labour.
- 7.5 hours annual mandatory Fetal Surveillance training for the Multi-Disciplinary Team

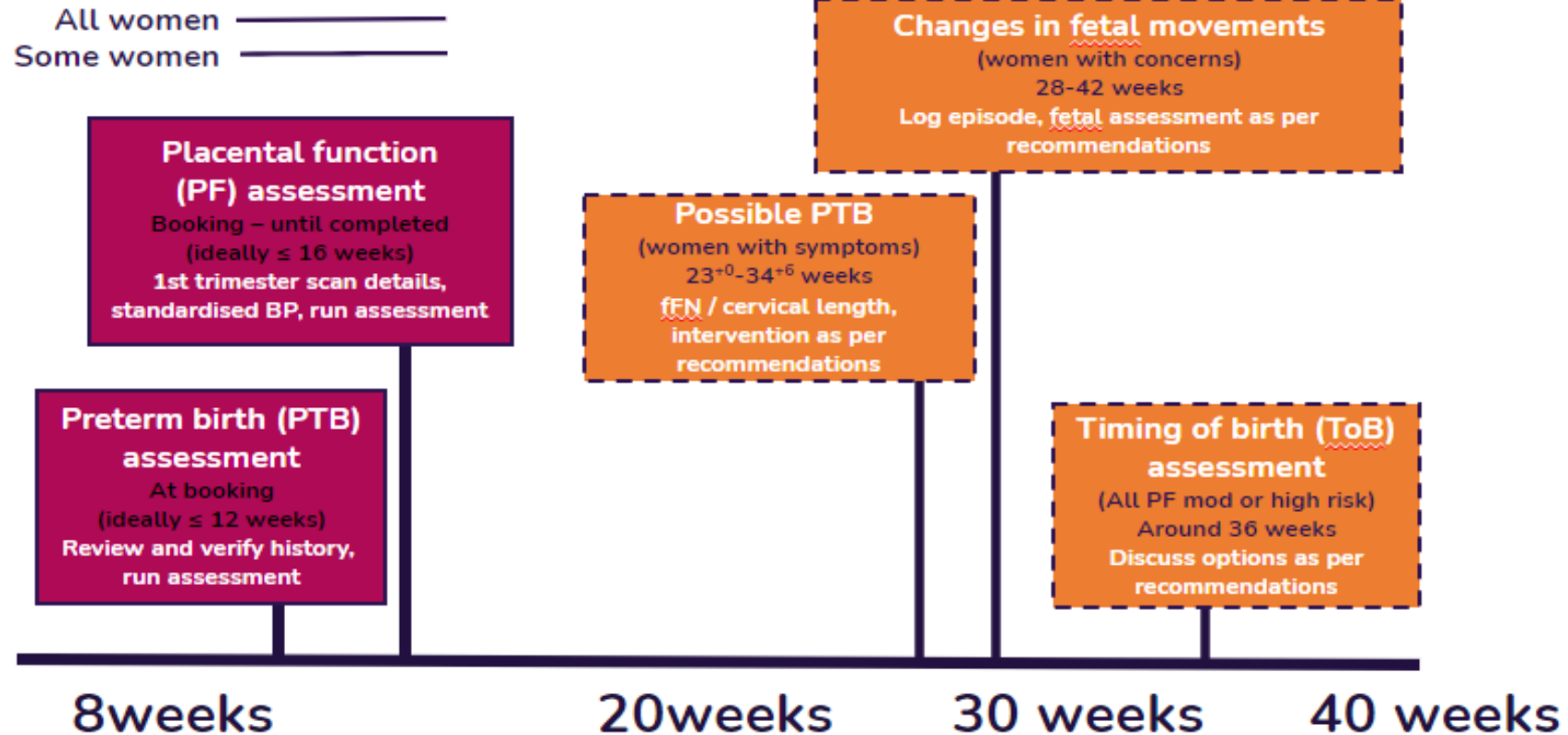




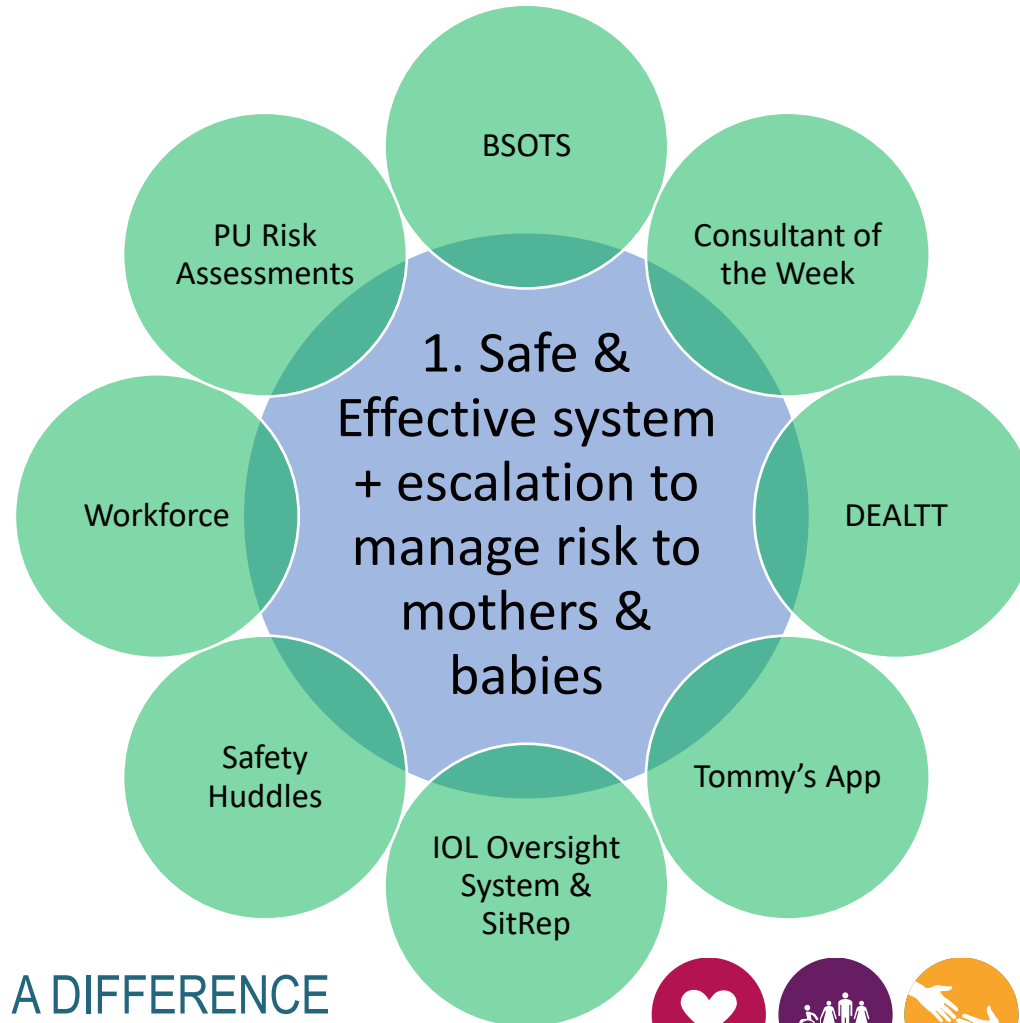
# Quality Improvements – Tommy's App

## Tommy's Clinical Decision Support

Tommy's  
National Centre for  
Maternity Improvement

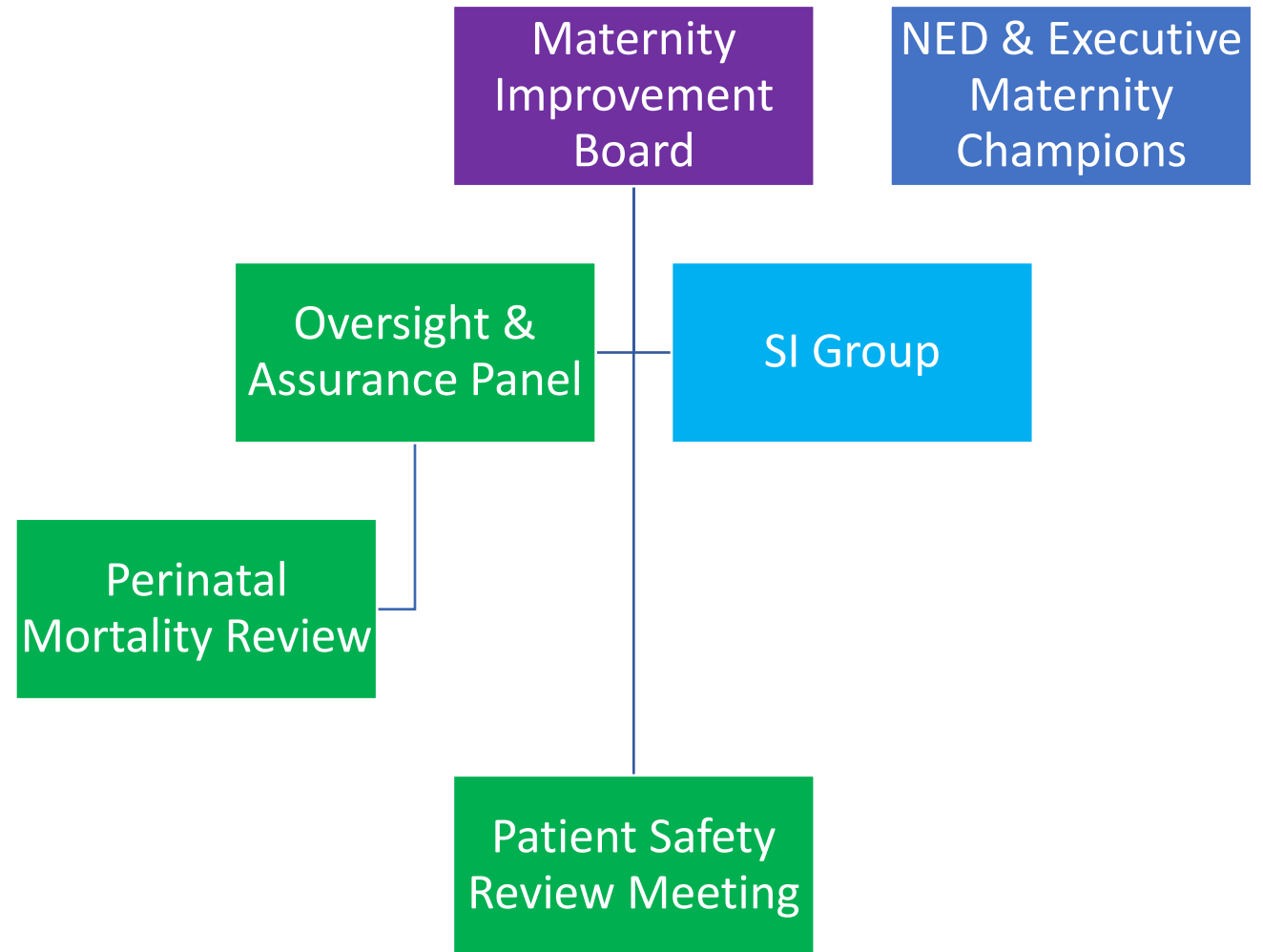


# Addressing CQC findings Managing Risk



# Addressing CQC findings Good Governance

- Robust review of Risk Register
- Serious Incident (SI) process
- SI Backlog removed
- Healthcare Safety Investigation Bureau (HSIB) Learning addressed



# Addressing CQC findings

## Training

At the time of the 2021 CQC review, our inspection found that only 73% of midwifery staff had completed mandatory training, that training had been suspended between March and July 2020 and had been moved to virtual training.

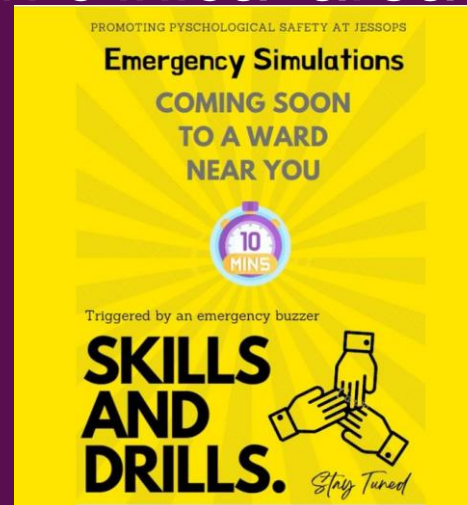
- CQC 2022

“The mandatory training was comprehensive and met the needs of women and staff. At the time of this inspection, there was evidence that face-to-face multidisciplinary (MDT) training had re-commenced which was in line with best practice guidance.”



# Training / Learning

- Fetal Monitoring training
- Practical Obstetric Multi-Professional Training emergency drills
- Newborn Life Support training
- Live simulations in clinical areas



All MDT Training  
incorporates  
learning from  
incidents



# Learning

- Tea Trolley Learning & Teaching
- Safety Message of the Week (SMOW)
- Patient Safety Review newsletters
- HSIB Quarterly newsletter
- Incorporating learning into training



- Learning Noticeboards
- Safety Huddles
- Emails
- MDT closed Facebook learning platform

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# Learning

- Learning Forums

Obstetrics & Neonatology

Sheffield Teaching Hospitals NHS Foundation Trust

## Maternity Learning Forum

### Preterm Birth Optimisation


Dr Elizabeth Pilling  
Consultant Neonatologist

Dr Tamara Williams  
Consultant Neonatologist

Dr Vicky Stern  
Consultant Obstetrician

Microsoft Teams!

Monday 19th June 2023  
13:30-14:30



Sheffield Teaching Hospitals NHS Foundation Trust

The Jessop Wing

## QUALITY IMPROVEMENT CONFERENCE

JESSOP WING  
SEPTEMBER 1ST 2023

13:30 - Nibbles  
14:00-16:00 - Presentations

JOIN US AS WE SHOWCASE SOME OF THE FANTASTIC WORK THAT STAFF ACROSS THE MATERNITY AND NEONATAL SERVICES HAVE WORKED SO HARD ON IN THE LAST 24 MONTHS.



CHRISTMAS CTG MEETING

Friday 16th December  
Level 4 Lecture Theatre  
Jessop Wing  
1500-1600

All Welcome

Mince Pies  
Warm Drinks  
& Cookies



### Uterine Hyperstimulation

Occurs in 12-16% of women during labour - caused by overstimulation of the uterus. These responses are twice as likely to be admitted to NICU.

Reduces ability of the fetus to maintain central oxygen saturation.

Irregular use of oxytocin was a contributory factor in 68.5% of medicine legal claims.

UK & NIOS - approx. 20% of poor neonatal outcomes were due to UK and augmentation misuse.

MIIRACE - hyperstimulation from OX was frequently identified in women who had died from foetal death and foetal brain damage.

Management


Intrauterine resuscitation

Stop Oxytocin

Consider A&A Escalate to 2nd Line Resuscitation if necessary

Termination

Signs of fetal improvement may be anticipated in 2-3 hours	In certain circumstances a decision may be appropriate	Not appropriate if underlying cause is placental or chromosomal	Increase risk of PHN if threatened
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### Prolonged deceleration...What's the risk?

Is this reversible?

Yes the CTG normalised by 15 mins

Exclude reversible causes

Exclude non-reversible causes

Consider if fetal compromise, severe hypoxia, severe acidemia, severe hypotension

Exclude if rapid

Remember 90% will recover by 6 mins, 95% by 15 mins if provoked by a normal CTG and no non-reversible cause



### Joint Obstetric Morbidity and Mortality Reviews - 2023

7th February - 13:30-14:30 - Obs/Neonatal

15th March - 08:00-10:00 - Obs/Anaesthetics

20th April - 13:30 - 14:30 - Obs/Neonatal

19th May - 08:00-10:00 - Obs/Midwifery

19th June - 13:30-14:30 - Obs/Anaesthetics

11th July - 08:00-10:00 - Obs/Midwifery

5th October 08:00-10:00 - Obs/Anaesthetics

10th November - 13:30-14:30 - Obs/Neonatal

14th December 08:00 - 10:00 - Obs/Anaesthetics

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# Listening to our staff

Maternity Safety  
Champions

Freedom to Speak  
Up Guardians &  
Champions

Triumvirate  
Pledge

Professional  
Midwifery  
Advocate Sessions

What  
Matters to  
You?

Human  
Factors  
Training

Monthly Directorate  
Briefings and  
Feedback

Perinatal  
Culture Leadership  
SCORE Survey

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# Our PROUD Behaviours Patients, visitors & staff

How we behave towards each other can affect the experiences of patients, visitors and staff and impact our ability to provide the best care possible. The PROUD to Work Together behaviours have been created in partnership with patient representatives, community groups and staff members to set out what you can expect from us and what we expect from you as patients and visitors.



**Respect:** Be kind, respectful to everyone and value diversity

**You can expect us to...**

Listen and show compassion towards your needs and choices.

Treat everyone fairly and with respect, and value and celebrate differences positively.

Be open and honest about your care, and say sorry when things don't go as planned.

**We need you to...**

Be considerate to all patients and staff.

Do the same as us in treating everyone fairly and with respect, and value and celebrate differences positively.

Never intimidate anyone or be aggressive.



**Unity:** Work in partnership and value the roles of others

**You can expect us to...**

Work effectively with you and other staff members to offer the best care for you.

Listen to and acknowledge your concerns.

Pay attention to your needs.

**We need you to...**

Work with us to help provide you with high quality care including letting us know about any concerns you have.

Understand staff are working in the interests of all patients.

Ensure your behaviours are PROUD towards everyone regardless of their role.



**Patient First:** Ensure that the people we serve are at the heart of all that we do

**You can expect us to...**

Introduce ourselves and our role and say 'hello' in a friendly manner.

Show kindness and care to patients, and those accompanying you.

Treat you with respect, and discuss your care with you.

**We need you to...**

Be polite and kind to all members of staff and other patients.

Understand that staff will make decisions based on the needs of all patients.

Be as open as possible about information that will help us to provide you with the best care.



**Ownership:** Celebrate our successes, learn continuously and ensure we improve

**You can expect us to...**

Have our ID badges visible at all times and dress in line with the dress code policy.

Prioritise the health and wellbeing of patients and staff.

Learn from mistakes and feedback.

**We need you to...**

Let us know if you have any needs for your appointment, such as an interpreter or someone to support you.

Take responsibility for your actions and behaviour in any environment where you receive care from us.

Give us feedback on your experiences of receiving care.



**Delivery:** Be efficient, effective and accountable for our actions

**You can expect us to...**

Communicate clearly with you, your relatives, and others who are with you.

Take reasonable steps to meet your needs and expectations.

Prioritise your safety at all times.

**We need you to...**

Arrive at your appointment time and ensure you follow advice about any preparation needed.

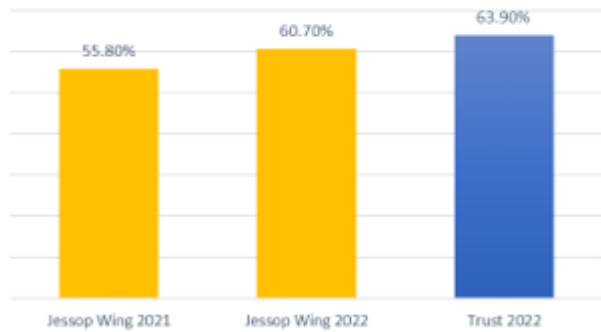
Let us know if you can't attend your appointment or are going to be late, so we can make the best use of resources.

Follow instructions that are there to protect patient safety.



# Staff Survey

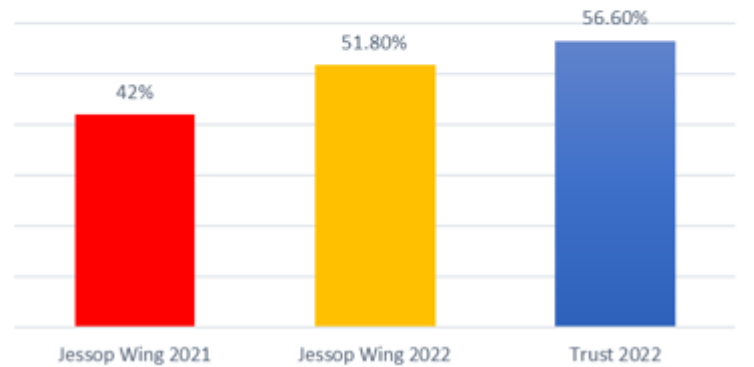
## Effective team working



## How you feel about your work



## Ability to carry out improvements in your area



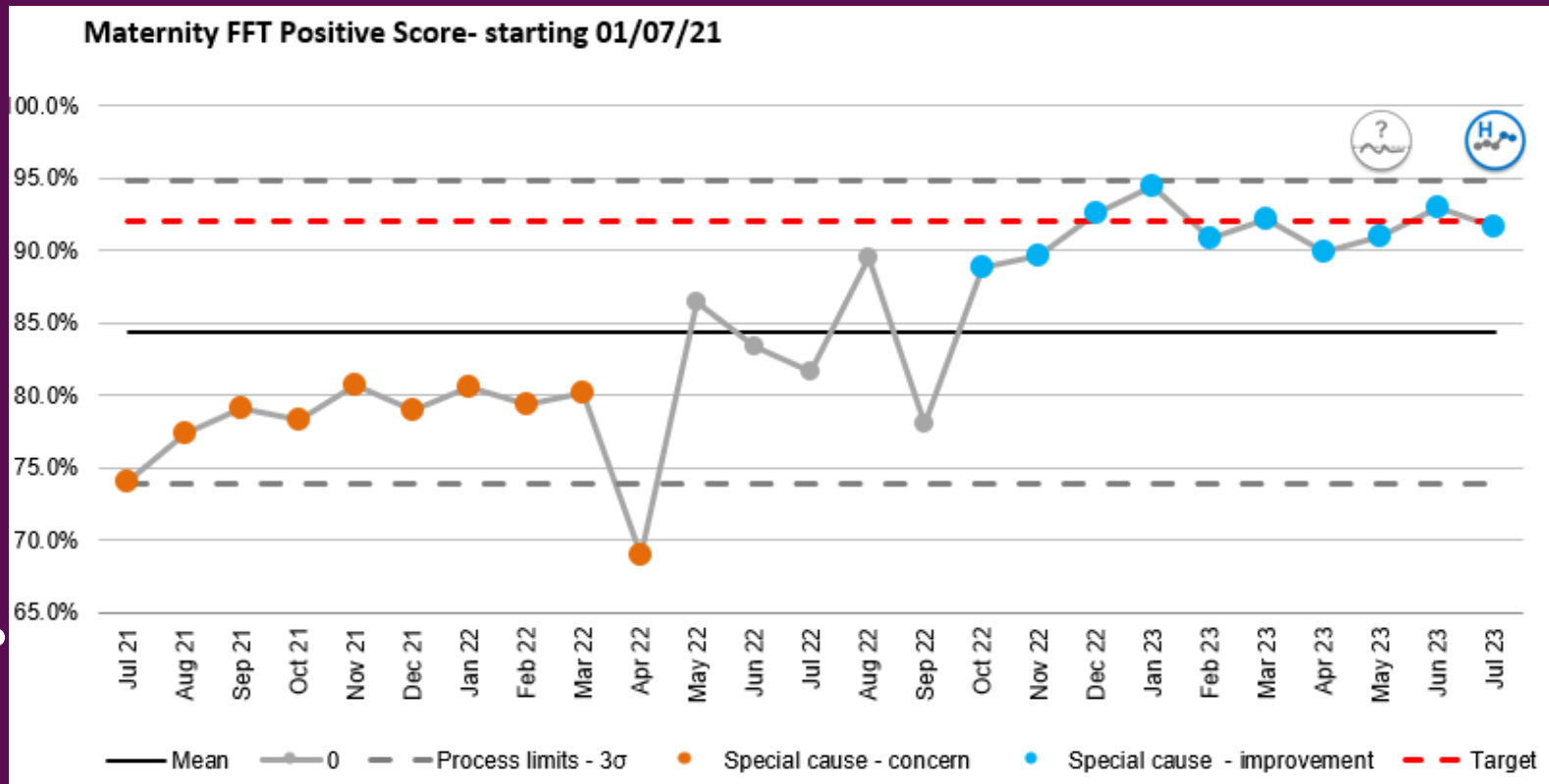
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# Feedback from Women & Families

- Friends & Families Test







Sheffield Maternity & Neonatal Voices Partnership Meeting

Israac Somali Community Centre

Friday 17<sup>th</sup> March



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Sheffield Maternity & Neonatal Voices Partnership

Community Iftar,  
Darnall

Sunday 27<sup>th</sup> March



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# Reducing Health Inequalities



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Co-production of Maternity & Neonatal Services in collaboration with Service Users

Cultural Safety Mandatory Training

Cultural Safety Midwife

Workforce Race Equality Standard 2023 data

- Recommendations from National & Local reports:
- Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE)
    - 5XMore
    - Invisible
    - Birthrights
  - Jessop Wing Maternity Services NHS Equality Delivery System 2022 (EDS22) peer review
  - SY&B LMNS Equity & Equality 5 Year Plan

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# Reducing Health Inequalities

- Facilitating use of translation services & auditing
- Introduction of 'languages needs assessment tool'
- Development of a Female Genital Mutilation (FGM) care package
- Chairing a Cultural Safety Forum for women and agencies across Sheffield
- MNVP 12 month funded workplan to co-produce maternity and neonatal services
- Listening to communities ....



# Where would we be now?



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# Summary

- Significant improvement work
  - ✓ Leadership
  - ✓ Environment
  - ✓ Processes
  - ✓ Training & Learning
  - ✓ Workforce recruitment and retention
- Better outcomes
  - ✓ Women and Family experience
  - ✓ Staff feedback

# Any Questions

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