The Shrewsbury and Telford Hospital NHS Trust

Standard Operating Procedure (SOP)

SOP Title	Maternity Safety Huddles		
SOP Number	049		
Care Group	Women and Children's		
Version Number	2		
Effective Date	15th May 2025	Review Date	May 2028
Author	Jacqui Bolton, Deputy Head of Midwifery		
Approved by	Maternity Governance		
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Distribution	All Maternity Areas		
Location	Maternity Services		

Document Control				
Version	Date	Author	Status	Comments
1	28/5/2020	Deputy Head of Midwifery & Guideline Midwife	New	Standardised process for maternity safety huddles
2	15/05/2025	Deputy Head of Midwifery	Full review	

SOP Objectives	• To describe the standard process of safety huddles held within maternity • To standardise the huddle process for each maternity area • To define safety huddles that occur within maternity (ward/unit huddle and management huddles)
Scope	Safer Maternity Care is an action plan setting out the vision for making NHS maternity services some of the safest in the world, by achieving a national ambition to halve the rates of stillbirths, neonatal deaths, brain injuries that occur during or soon after birth and maternal deaths, by 2025. W&C undertook the Patient Safety Value Stream (Virginia Mason Institute) #5Patient Safety. This included Rapid Process Improvement Week (RPIW) for Safety Huddles and Datix Incident Reporting. Safety Huddles were standardised across all areas of Maternity which included feedback to staff regarding immediate lessons from incidents. The Safety Huddles are in addition to currently established Delivery Suite handovers and Delivery Suite board and ward rounds
Performance Measures	Monitored as part of the clinical audit and governance process currently a weekly audit
References	NHS Improvement (2019) Implementing handovers and huddles: a framework for practice in maternity units.

Number	Brief	Responsibility
1	**Introduction** Huddles in Maternity are short briefings where key members of staff come together to share clinical information, review events and plan for the day ahead across service, while maintaining individual clinical responsibility. In order to deliver an effective huddle, there should be a focus on: Share key general information to increase all team members' situational awareness (e.g delivery suite/MLU capacity, any complex safeguarding cases) • Improve patient flow (e.g. postnatal capacity) • Identify patient safety concerns (incidents, Red Flags identified, acuity) including staffing. • Delay in progressing Induction of Labour eg ARM Factors to consider in order to increase safety awareness • Non-judgemental environment • Everyone has the opportunity to contribute • All points of view are respected • Overseen by the designated shift co-ordinator or ward manager but led by any member of staff • All ward staff invited to attend, including non-clinical • Happens at the same time and place • All staff arrive on time • Is kept to time brief and follow a set agenda • The expectation for attendance is set • It is kept factual • Delivered in an environment free from disruptions and distractions	
2	**Ward/Unit department huddles** Ensure template Agenda is utilised – **see Appendix 1** each department to populate relevant agenda items as this may vary, however, the paperwork and number of agenda items are standardised. This will include timing of Huddles. As a minimum a daily huddle will be completed (unless otherwise stated by the Department e.g. outpatients closed on weekends and bank holidays) **Attendees** All available staff to attend unless providing time critical clinical care 1. Huddle lead to follow department agenda. 2. Complete Safety Huddle Record (**Appendix 2**) to ensure staff attendance is captured and follow up with any staff unable to attend (community areas may be to dial in other teams when separate from the main base e.g. Wrekin MLU main unit with Market Drayton as a satellite community base). **3.** Huddle lead to maintain attendance sheet and record of agenda in Huddle Folder (staff who have been absent from the department will be directed to review the Huddle Folder).	**Ward Manager** **Attendees** **Huddle Lead**
3	**Management Huddles** There is an allocated Manager of the Day (MOTD) to lead the Management huddle and has operational oversight of the unit.	

	Each ward/unit department provides a summary of capacity, staffing and identify any significant or potential safety or patient flow concerns for the department for the commencing week, including a review of planned homebirth's expected across the County and MLU/community on calls. The Birthrate® Acuity Tool will be utilised by delivery suite to aid assessment of capacity and flow. Management huddles take place at 9:15 and 15:15 Monday to Friday. The need for additional huddles is agreed when bed capacity and acuity is challenged. Maternity Sit Rep for Regional reporting is based on the morning huddle this is submitted online by allocated MOTD (link here). Maternity Daily Sit Rep reporting is based on Escalation Policy & Operational Pressures Escalation Levels Maternity Framework. The Huddle Board is a static wall mounted board and standard agenda items are reviewed (**Appendix 3**) **Attendees (to include where possible)** Manager of the Day, Ward Managers or representative from the ward/unit department, Director of Midwifery, Deputy Head of Midwifery or Matron(s) and a Specialist Representative, W&C Manager on call (PM) and Neonatal Representative. 1. Held at a minimum daily within a specified time (excluding weekends and Bank Holidays) – huddle sheet is completed by the allocated MOTD at weekends 2. MOTD is the huddle lead 3. Dial in any other departments off site 4. MOTD to complete Huddle Board (to include attendance) and agree any plans where issues are raised which will include escalation if required. A further Management huddle may be required where capacity or staffing issues have been identified to re-evaluate plans prior commencement of W&C Manager on call. 5. MOTD will also complete the management huddle sheet (**Appendix 4)** for each huddle. 6. W&C Admin Team circulate the completed Huddle Sheets (two per day) 7. MOTD completes a Maternity Status following the 15:15 huddle highlighting any issues eg staffing, complex cases, bed capacity, this is circulated to the oncoming W&C Manager on call, Delivery suite co-ordinator allocated for the night shift, DOM, HOM and Divisional Director,	**Attendees** **MOTD**

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Maternity Safety Huddle Agenda Template

Department/Ward_____ Time held_____

	Item	To include	Actions
1	Lessons Learned	• Serious Incident's and any feedback. • Lessons and themes from Datix • Any High Risk Case Review/Never Events	Review feedback add copy to huddle folder
2	Safety Critical Memos	Safety Critical Memos issued	Review add copy to huddle folder
3	Equipment Checklists	• Equipment issues • Resuscitaire checks • Ward/Department Environmental Checks	Identify individual(s) responsible/ confirm completed
4	Immediate Safety Concerns	• Staffing • Acuity • Complex clinical care or social care cases	Escalate where necessary involve MDT/SMT

Safety Huddle Record

W/C:……/……/…… **Location:…….**

	Attendees	Memos/Datix	Comments
Mon			
Tues			
Wed			
Thurs			
Fri			
Sat			
Sun			

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Maternity Management Safety Huddle Agenda Template

	Item	To include	Actions
1	Staffing and acuity	Ward/unit representative to highlight any acuity issues Current or future staffing issues Short fall in staffing or on call rota	Ensure plan recorded on huddle board
2	Safety Critical Incidents	SIs/HRCR/Never Events in last 24 hours or since last huddle	Ensure any immediate action required and recorded on huddle board
3	Forward Planning	Ward/unit representative to highlight any issues related to acuity/staffing or complex patient needs	Ensure plan recorded on huddle board
4	Critical Updates	Events that may affect W&C or Trustwide	Ensure any immediate action required and recorded on huddle board

Appendix 4 – Management Safety Huddle Record & Attendance Sheet

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Senior Management Daily Huddle	Date Time	In attendance	
Antenatal ward			
Postnatal Ward			
Delivery Suite			Acuity
Triage			

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Our Vision: To provide excellent care for the communities we serve

Wrekin MLU					Acuity
Community Areas RSH Oswestry B'North Ludlow Whitchurch Mkt Drayton					
Outpatient/USS					
DAU					
NNU					Acuity
ON call HB	RSH	Wrekin	Rose	Violet	
Safeguarding Issues					

Datix/Incidents **(Please Datix when below staffing)**	**INCIDENT NO: GRADING: ASSIGNED TO:**
For sharing and learning- last 24 hours.	Stillbirth* 0 Intrapartum Stillbirth - 0 Maternal admission to ITU * 0 Neonatal Admission requiring intubation - 0 Any Obstetric Emergency e.g. eclamptic fit (State the emergency) 0 Never event 0 MLBU Closures 0 Homebirth Closures Yes /No Any event resulting in harm to a mother, baby or staff member * Yes /No CoC or Community called in for escalation Yes/No ***If any of the following have occurred- immediate escalation to the DHOM, HOM and Clinical director must occur**
AOB	

Staffing required across inpatient maternity areas template = **Total template staffing Inpatient area at huddle time =** **Deployment of staff required** **Yes No**	**Actions required** **Reactive huddle required.**