Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Update	**Date:** 19th June 2021	
Prepared By:	Julie Hogg, Chief Nurse		
Approved By:	Julie Hogg, Chief Nurse		
Presented By:	Julie Hogg, Executive Board Safety Champion & Clare Ward, Non-executive Board safety champion		

Purpose		
To update the board on our progress as maternity and neonatal safety champions	**Approval**	
	Assurance	**x**
	Update	**x**
	Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
x	**X**	**X**	**x**	

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		x		

Risks/Issues	
Financial	
Patient Impact	**X**
Staff Impact	**X**
Services	**X**
Reputational	**X**

Committees/groups where this item has been presented before

None

Executive Summary

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, local champions 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.

This report provides highlights of our work over the last month.

1. Saving Babies Lives Care Bundle v2

The Saving Babies Lives Care Bundles 2 provides detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice:

- Reducing smoking in pregnancy
- Risk assessment, prevention and surveillance of pregnancies at risk of fetal
- growth restriction (FGR)
- Raising awareness of reduced fetal movement (RFM)
- Effective fetal monitoring during labour
- Reducing preterm birth

SFH has continued to monitor its compliance with all elements of the Saving Babies' Lives Care Bundle v2. On-going progress is reported externally quarterly to NHSE via the Midlands Maternity Clinical Network (MCN). Within Safety Action 6 of the Maternity Incentive Scheme, process and outcome measures regarding compliance have been validated. The Trust are now able to declare full compliance to this care bundle following a review by the MCN and CCG.

2. Continuity of Carer

The term 'continuity of carer' describes consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour and the postnatal period (NHS England 2017). Women who receive midwifery-led continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth and report significantly improved experience of care across a range of measures (Sandall et al 2016). Pre-term birth is a key risk factor for neonatal mortality. Continuity of carer can significantly improve outcomes for women from ethnic minorities and those living in deprived areas (Rayment-Jones et al 2015, Homer et al 2017 in RCM 2018).

There are significant and widening health inequalities in maternity care. When compared to babies of White ethnicity: Black/Black British babies have a 121% increased risk for stillbirth and 50% increased risk for neonatal death and the gap has been widening since 2013; Asian/Asian British babies have a 66% increased risk of neonatal mortality and this risk is rising and an increased risk of stillbirth of around 55%. Babies born to mothers in the most deprived quintile have a 30% increased risk neonatal mortality and the gap between the most deprived and the least deprived quintiles is widening.

At SFH Trust we currently have two Continuity of Carer teams that have been running for the past year as a pilot. To reflect the most high risk groups in our geographical areas and from our data, these teams are based in the Mansfield and Ashfield areas as these are the areas with highest social deprivation. In May 2021 there were 19% of our women booked on a continuity of carer pathway of which 5.3% were BAME with 6% of all women who gave birth in May 2021 receiving Continuity of Care in labour.

The Trust's Consultant Midwife continues to support Maternity Transformation. She has reviewed the outcomes of the pilot and has provided the next steps in this area of Transformation, these are included in Appendix 1 and 2 for board oversight.

3. Board Safety Champion Walkarounds

The monthly board safety champion walkarounds have continued with widening participation from the multi-professional teams. The team raised a new concern this month in regards to safe staffing. This is being addressed by a multi-professional working group, who are currently reviewing the Birthrate plus data against current establishment within the division. Whilst the review is being undertaken steps to mitigate have been taken and whilst this is an issue no immediate patient safety risks have been identified and outcomes remain good.

4. UK Obstetric Surveillance System (UKOSS)/ Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE)

The SFH perinatal mortality and morbidity cases for benchmarking against the UKOSS and MBRRACE guidance were reviewed. Local data although small numbers of BAME women (around 2-4% of overall pregnant population) demonstrated no women within the perinatal mortality and morbidity cases. Whilst no further actions are required at present, this data is reviewed regularly as part of normal governance processes and within the outlined action plan enclosed in Appendix 2.

An infographic has been designed for shared learning within the Maternity Service, see Appendix 3, which reflects and outlines the data for SFH.

5. Ockenden Report and NHS Resolution

Progress continues to ensure compliance with recommendations from the Ockenden report and the NHS Resolution standards. A maternity assurance committee, chaired by the Chief Nurse has been established to scrutinise the Trust's submission. The committee have now signed off the safety actions which are externally validated. Safety actions which require internal sign off have been externally audited by 360 assurance. Following the evidence submission these final safety actions have been now signed off as complete. The Division will now complete the Board Decelerations forms for the final submission dates.

The submission deadline for the Ockenden evidence has now been extended until the 30th of June for the Local Maternity and Neonatal System to sign off.

6. External reporting

The Maternity Governance team have received the monthly review from the Healthcare Safety Investigation Branch (HSIB) confirming that there are currently no active cases. Further to this SFH have no SI to report this month and therefore there are no requirements to share with the Maternity Assurance Committee.

Appendix 1 Midwifery Continuity of Care (CoC) Action Plan

Recommendations	Action	In Place	By Who	By When	Evidence	RAG
Co-design a plan by July 2021 with local midwives, obstetricians and service users for implementation of continuity of carer teams in compliance with national principles and standards, and phased alongside the fulfilment of required staffing levels. This plan should also take into account the need for maternity staff to be supported to recover from the challenges of the pandemic.  Maternity planning guidance submission	1) Empower existing teams to create new models of working	Series of workshops facilitated by Consultant Midwife	GB/LF/MJ/LB	June 2021	Minutes of meetings	
	2) Gather data from existing teams around current experiences	Facilitated conversations at team meetings and 1-2-1s with team members	GB	May 2021	Themes log	
		1-2-1s with exiting team members	GB	June 2021	Themes log	
	3) Gather data from all staff around staff experience	AMat survey launched. Data reviewed weekly and themes shared monthly with all staff via teams meeting and email.	GB/AF	Ongoing	 AMat survey response overview.dc	
		Themes shared with MSLT monthly in face to face meeting	GB	Ongoing		
		Themes shared at Maternity Transformation Board	GB/AF	Ongoing	Minutes of meeting	
	4) Increase midwifery establishment	Revised job description/recruitment	RS/MSLT	May 2021	21 midwives appointed	

		brochure/ Recruitment	LB			
		Recruitment for Band 6 midwives –presently on Trac	LB/PS	June 2021		
	5) Facilitate CoC teams to focus on delivering continuity to the women booked within their team	Secondment opportunity for acute midwives to work in community for 6 months to support community staffing and develop skills of acute midwives	PS/LB	June 2021	Appointment of seconded midwives	
	6) Evaluate current model of CoC	Evaluation report of pilot of CoC teams for presentation at Maternity Transformation Group	LF/MJ/GB	June 2021	Report	
	7) Scope existing models of delivering CoC in other Trusts	Meetings with other HoM/Consultant Midwives to share experiences of launching and sustaining CoC	GB to lead	April-July 2021	Overview of other Trusts document	
	8) Engage with staff across whole service to develop plan of models of CoC	1) CoC working party with representation from all areas and disciplines that reports	GB/AF	Commence July 2021	Minutes of meetings/action log	
		2) Maternity Hub to support engagement set	GB/AF			

		up in maternity unit				
		3) Regular CoC update MS teams meetings/comms across maternity to share information	GB to lead/LB/MJ /LB	By end of July 2021		
		4) Develop options appraisal of models within the CoC working group for discussion at Maternity Transformation meeting	GB/PC/LG/JH	August 2021	Paper to Maternity Transformation group	
	9) Ensure Trust oversight of CoC	Ensure mechanisms in place around decision making and assurance to Board	All	From June 2021	SFH Governance Structure for CoC.doc	

Appendix 2 Action plan for increasing number of women who identify as being from a BAME background booked onto Continuity of Carer pathway

Recommendations	Action	In Place	By Who	By When	Evidence	RAG
Prioritise those most likely to experience poorer outcomes first, including ensuring most women from Black, Asian and mixed ethnicity backgrounds and also from the most deprived areas are placed by on a continuity of carer pathway by March 2022.	1) Understanding our population	Postcode review of our BAME population	Name	June 2021	Maternity BAME Postcode spread.pdf	
		Review of morbidity and mortality data and evaluate risks for BAME women	PS	March 2021		
		Engage with MVP to support interview and focus groups with women who have identified as from a BAME background and have recently accessed maternity are at SFH	MVP/GB	July 2021	KMH_001099_MM_Data_Infographic_SFH. Report of data collected	
		Identify women accessing inpatient care and gain consent for follow up phone call to feedback around their experience of care	GB/MW	August 2021	Report of data collected	
	2) Engage staff	Identify midwife with special interest in empowering and	GB	June 2021		

		supporting gold standard of care for women who have identified as being from a BAME background and give protected time				
	3) Understanding national position	1) Scope out how other units are facilitating continuity of care for women who identifiy as being from a BAME background via consultant midwife network and closed social media pages	GB	June 2021		
	4) Education and strengthening cultural competency of staff	1) Meeting to discuss with Cultural Liaison Midwife from Bolton Hospital and founder of Association for South Asian Midwives (ASAM) around evidence base for training	GB	July 2021		
		2) Scope national offer of training around unconscious bias and cultural	GB/MW	July 2021	Options appraisal	

		competency and how we could incorporate this into our current training.				
	5) Increase number of women from general population booked onto CoC pathway	Maternity Transformation	All	Ongoing	Continuity of Carer action plan.docx	

Appendix 3 SFH Mortality and Morbidity Data 2020-21