Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Update	Date: 26th July 2021	
Prepared By:	Paula Shore, Interim Head of Midwifery & Lisa Gowan, Divisional General Manager		
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. 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 and the NHSR submission has been submitted to confirm this.

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 we currently have two Continuity of Carer (MCoC) 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. The pilot has now concluded and outcomes are under review. Initial findings demonstrate similar themes to those described in the recent publication from the Healthcare Select Committee (July 2021).

The on-going development of the MCoC plan will reflect both the local and national findings to ensure we have a sustainable model that is responsive to the needs of women and their babies.

Continuity of Carer Performance – June 2021

In June 2021 there were 21% of our women booked on a continuity of carer pathway with 1.1% receiving MCoC during the intrapartum period. 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

In response to the discussion at July Trust Board meeting, the maternity service has produced the below trajectory for offering MCoC. This will be monitored and reported to Trust Board on a quarterly basis

QUARTER	% Agreed Performance	%Actual Performance
Quarter 1	20%	22%
Quarter 2	22%	
Quarter 3	24%	
Quarter 4	26%	

Board may note that the trajectory is not ambitious given we have exceed our plan in quarter 1, however the review of the pilot demonstrates significant adaptations are required to the current model to achieve sustainability. Board should also note that the evolvement of the care model alongside the current vacancies could compromise the compliance around these trajectories but a narrative will be provided at the time to explain the position. Whilst we have an internal trajectory at SFH as we are committed to the model, there is no national mandate to provide performance information. In fact, the recently publicised Healthcare Select Committee paper has recommended that the requirement to submit a MCoC plan by 31 July 2021 be delayed.

3. Board Safety Champion Walk rounds

The monthly board safety champion walk rounds have continued with widening participation from the multi-professional teams. The teams previous concerns raised around staffing have been further addressed by the Chief Nurse facilitating a Maternity Forum, allowing for more of the team to join virtually. Further concerns were raised around the staffing levels and plans have been put in place to address the concerns expressed (appendix 2).

The monthly safety champion walk round was conducted on the 20th July, with staff reporting tangible benefits from this plan. The plan will be monitored via the executive led Maternity Assurance Committee.

4. Ockenden Report and NHS Resolution

The Ockenden initial submission was completed on the 30th June 2021. Progress continues to ensure compliance with recommendations from the Ockenden report. We will report progress to board in relation to these at the end of quarter 2 following board approval of our plan.

The Board declaration form for NHS Resolution has now been submitted for 2020-21 and is awaiting external review. The standards for 2021-22 are expected to be released in quarter 3 and preparations are being made in readiness for these.

5. 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 serious incidents (SI) to report this month and therefore there are no requirements to share with the Maternity Assurance Committee and Local Maternity and Neonatal System. One SI case has been closed on STEIS this month; this will be shared through MAC and the LMNS SI panel. This will feature on the Boards SI update paper.

There have been no maternity related CQC enquires.

6. Health Select Committee – State of Maternity Services; conclusions and recommendations

a. Supporting Maternity Services and Staff to Deliver Safe Maternity Care

The Expert Panel overall rated progress towards safe staffing as 'Requires Improvement'. Appropriate staffing levels are a prerequisite for safe care, and a robust and credible tool to establish safe staffing levels for obstetricians is needed. We were pleased that following our evidence session, the Department has committed to fund the Royal College of Obstetricians and Gynaecologists to develop a tool that trusts can use to calculate obstetrician workforce requirements that will be in place by autumn 2021. This work should also enable trusts to calculate anaesthetist workforce requirements within maternity services. We will contact the Department and RCOG for the outcome of this work in October 2021.

With 8 out of 10 midwives reporting that they did not have enough staff on their shift to provide a safe service, it is clear that urgent action is needed to address staffing shortfalls in maternity services. Evidence submitted to our inquiry estimates that as a minimum, there need to be 496 more obstetricians and 1,932 more midwives. While we welcome the recent increase in funding for the maternity workforce, when the staffing requirements of the wider maternity team are taken into account–including anaesthetists to provide timely pain relief which is a key component of safe and personalised care - a further funding commitment from NHS England and Improvement and the Department will be required to deliver the safe staffing levels expectant mothers should receive.

b. Learning from Patient Safety Incidents

Involving families in a compassionate manner is a crucial part of the investigation process. Too often, maternity investigations have failed to do this in a meaningful way. Families must be confident that their voices are heard and that lessons have been learnt to prevent the tragedy they have endured being repeated. We welcome the independent nature of HSIB investigations and believe that HSIB has taken considerable steps to improve family engagement in investigations. However, it is important that they continue to pursue improvements in this area to ensure all investigations are informed by the experience of families.

We believe that HSIB's ability to take a broad and independent view of the services and factors contributing to maternity incidents is a valuable step in the right direction to learning from maternity incidents. It is essential that an independent, standardised method of investigating the most serious incidents is maintained. However, there is still work to be done to improve the timeliness of investigations and the relationship between HSIB and trusts to ensure there is local ownership of recommendations made and investigations maximise learning at the local level. That relationship should not be confined to senior management; all members of the team, and in particular junior members of the clinical team, should be able to engage with an investigation in a manner which increases learning and the implementation of recommendations. Trusts should also improve local

and regional sharing of key learning's particularly through Local Maternity Systems (LMS).

It is clear to us that in its current form the clinical negligence process is failing to meet its objectives for both families and the healthcare system. Too often families are not provided with the appropriate, timely and compassionate support they deserve. For those delivering maternity care, the adversarial nature of litigation promotes a culture of blame instead of learning after a patient safety incident. Alternative approaches are already in place in other countries where the use of a threshold of 'avoidability' rather than 'negligence' to award compensation has helped to tackle the debilitating culture of blame, accelerate learning and provide timely support to patients and their families. We believe that adopting such an approach is an essential next step in shifting the culture in maternity services away from blame to one of learning.

c. Providing Safe and Personalised Care for All Mothers and Babies

England remains a largely safe place to give birth and efforts to increase the safety of maternity services have led to further improvements. However, the Expert Panel overall rated the Government's progress on maternity safety outcomes as 'Requires Improvement'. The Expert Panel highlighted that the Government's commitment to halve the rate of stillbirths, neonatal deaths, brain injuries and maternal deaths is not currently achieving equitable outcomes, with women and babies from minority ethnic and socio-economically deprived backgrounds at greater risk when compared to their white or less deprived peers. We acknowledge the positive steps the Department and NHS England and Improvement have taken, including the commitment to continuity of carer for 75% of women from Black, Asian and minority ethnic groups. We support the principles of the continuity of carer model but conclude that further work is required to ensure it can be implemented in a sustainable manner. The Expert Panel overall rated progress towards delivering continuity of carer as 'Requires Improvement'. Continuity of carer alone is also unlikely to resolve the deep seated and long-standing inequalities persisting in maternal and neonatal outcomes.

The Expert Panel overall rated the Government's progress towards providing personalised care as 'Inadequate'. We believe that personalisation must go hand in hand with safety and women must be fully and impartially informed about the safety risks associated with all birthing options. Women should also be provided with clear information about the likelihood of interventions.

The committee made a number of recommendations for the government, NHSEI and providers. The team are working through these to ensure these are rapidly adopted at SFH.

Appendix 1 Midwifery Continuity of Care (CoC) Revised Action Plan

High level principles:- 1) The plan should take into account the need for maternity staff to be supported to recover from the challenges of the pandemic 2) The plan is co-designed by service users, obstetricians and local midwives						
Recommendations	Action	In Place	By Who	By When	Evidence	RAG
Increase midwifery establishment in line with BR+ recommendations	Revised job description/recruitment brochure	Interview dates agreed	RS/MSLT	May 2021	21 midwives offered positions – mainly B5 offered	
	Recruitment for Band 6 midwives –presently on Trac		LB/PS	June 2021		
	Secondment opportunity for acute midwives to work in community for 6 months to support community staffing and develop skills of acute midwives		LB/PS	June 2021	Appointment of seconded midwives completed	
Evaluate current model of CoC	Evaluation report of pilot of CoC teams for presentation at Maternity Transformation Group	Facilitate CoC teams to focus on delivering continuity to the women booked within their team	GB/LB	May 21	Presentation to MTG on 19/5/21 Discontinue pilot of CoC in current model Evaluation of MCoC pilot.docx	

Respond to staff concerns around current CoC model	Explore moving existing CoC teams redeployed into traditional midwifery or acute	One CoC team to remain in place	GB/LB	June 21		
Engage with staff across whole service to develop plan of future models of CoC	Staff engagement to disseminate changes including email, closed social media, teams meetings, face to face meetings, 1-2-1 meetings and walk rounds	Maternity Hub to support engagement set up in maternity unit Regular CoC update MS teams meetings/comms across maternity to share information	LF/MJ/GB	July 21		
Scope existing models of delivering CoC in other Trusts	Meetings with other HoM/Consultant Midwives to share experiences of launching and sustaining CoC		LF/MJ/GB	June 21		
	CoC working party with representation from all areas and disciplines established		LF/MJ/GB	July 21	ToR to be reviewed at Maternity Transformation Group Highlight report to be presented at MTG	

					SFH Governance Structure for CoC.doc	
Develop options appraisal of models within the CoC working group for discussion at Maternity Transformation meeting	Engage with staff across whole service to develop plan of models of CoC		GB	Ongoing		
Ensure Trust oversight of CoC	Highlight report agreed at MTG that is shared at MAC on a monthly basis		PS/GB	Ongoing		

RAG Key

	Delayed
	Update Required
	On Track
	Completed