Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Update	**Date:** 23rd August 2021	
Prepared By:	Paula Shore, Head of Midwifery, Lisa Gowan, Divisional General Manager & 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.

Following the submission to the MCN and CCG, a request has arrived in regards to the action plan for achieving the compliance in two outlined areas for which SFH has prior agreed deviation from. The Service Director is pulling together a plan to remove the need for deviations.

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 (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 revised action plan has now been completed and plans for engagement have commenced prior to the launch of the next teams.

Continuity of Carer Performance – July 2021

In July 2021 there were 18% of our women booked on a continuity of carer pathway with 0% receiving MCoC during the intrapartum period. This is an anticipated reduction due to the pause in the roll out of team midwifery whilst the team explore models to provide intrapartum continuity whilst ensuring work-life balance for colleagues providing it. Following the review of the pilot it is anticipated that the new model will be integrate workforce from both from community and acute midwifery services. The Trust's Consultant Midwife continues to lead maternity transformation.

Continuity of Carer Trajectory

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 alongside progress with our action tracker.

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

Board should 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. It should also be noted that whilst we have an internal trajectory, there is no national mandate to provide performance information.

3. Board Safety Champion Walk around

The monthly board safety champion walk rounds have continued with widening participation from the multi-professional teams and areas within Maternity. The teams previous concerns raised around staffing have been further addressed by the Chief Nurse via a second virtual Maternity Forum. Positive feedback has been received in response to our plans to increase staffing and the role of the registered nurse within maternity.

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 have identified areas within maternity that require strengthening of the evidence and actions have been taken to support this, continued uploads to the portal are being made as requested by the LMNS. The Board declaration form for NHS Resolution has now been submitted for 2020-21 and is awaiting review national review. NHSR year 4 requirements have now been received and the team are developing a plan to ensure compliance. We will update on this at October board.

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 to report this month and therefore there are no requirements to share with the Maternity Assurance Committee and Local Maternity and Neonatal System.

6. Maternity Assurance Programme

Following the board of directors meeting in July and a discussion relating to heightened scrutiny of maternity services nationally and locally; the execs were asked to review our approach to board assurance for maternity.

One of the ways boards can feel assured rather than just reassured is by adopting a triangulated assurance approach. This is about not just relying on what is written, but also by observing and listening to how the organisation is operating.

The divisional leadership team and maternity safety champions have developed the following approach; which has been approved by the executive team.

Data and information

a. Thematic review of SI's over last 10 years with recommendations led by the governance team at SFH
b. Thematic review of legal cases over last 10 year with recommendations led by the legal team
c. Thematic review of complaints over 3 years with recommendations led by the Head of Patient Experience at SFH and the maternity voices partnership (MVP)
d. Perinatal surveillance scorecard reviewed monthly at BoD
e. Bimonthly review of incidents and SI's at BoD
f. Monthly maternity assurance committee with exec led review of safety, women's experience, colleagues experience, maternity audit programme and progress with national maternity programmes.

2. **People**
   a. Safety champions walk around
   b. Safety culture survey
   c. Monthly executive led maternity forum
   d. Establishment of shared governance council in maternity

3. **Observe**

a. Annual peer review of maternity services adopting CQC framework– provider to be determined by regional CN / CM
b. SFH to peer review another maternity service adopting the same approach
c. Monthly 15 steps review of maternity led by governors / MVP
d. Review of all inadequate reports for maternity with action plan
e. Leadership rounds by the divisional team

The programme will be led by the divisional leadership team and overseen by the maternity assurance committee reporting in Quality Committee.