Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Update	**Date:** 29th September 2021	
Prepared By:	Paula Shore, Interim Head of Midwifery & 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. Within Safety Action 6 of the Maternity Incentive Scheme, process and outcome measures regarding compliance have been validated.

SFH had derogation for one of the standards in year 3 so are continuing to work towards compliance and are being supported through the action plan which has been drafted by the service director and supported by the MCN and CCG. The NHSR year 4 was released on the 8th of August 2021. SFH have re-instated the divisional working group.

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 the tests of change are being launched on the 27th September 2021.

Continuity of Carer Performance – August 2021

In August 2021 there were 21% of women booked on a continuity of carer pathway with 0% receiving MCoC during the intrapartum period. As agreed by board the pilot has been paused and whilst the team to continue to provide antenatal and postnatal continuity, continuity of carer for intrapartum care is not mandated. The new model, following the review of the pilot will be

integrated utilising the workforce both from community and acute midwifery services. The Trust's Consultant Midwife continues to support Maternity Transformation.

Continuity of Carer Trajectory

In response to the discussion at June 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 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. In fact, the recently publicised Health Select Committee paper has recommended that the requirement to submit a MCoC plan by 31 July 2021 be delayed, we have yet to receive any further updates nationally.

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 facilitating a Maternity Forum and positive feedback has been provided in regards to the attempts being made to increase staffing and the role of the registered nurse within maternity. It should be noted though the staffing position remains a concern both at SFH and nationally.

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. Feedback from the national team on the evidence submitted has been delayed and at the time of writing this report remains outstanding.

The Board declaration form for NHS Resolution was submitted for 2020-21 and we continue to await review. This release has been delayed and is now due end of October 2021. The standards for 2021-22 are expected to be realised at the beginning of August 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 SI to report this month and therefore there are no requirements to share with the Maternity Assurance Committee and Local Maternity and Neonatal System