Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Update	**Date:** 2nd December 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. Within Safety Action 6 of the Maternity Incentive Scheme, process and outcome measures regarding compliance have been validated. SFH are continuing to work towards compliance and are being supported through action plan, 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. Initial risk specifically around safety action 8 has been escalated regionally in regards to the timeframes for MDT training. The reviewed standards have are now available at Trust level and the working group are working towards these.

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 *"Delivering Midwifery Continuity of Carer at full scale: Guidance on planning, implementation and monitoring 2021/22"* was published by NHS England on the 21st of October with revised time frames for reporting. These timeframes, as below, have been mapped against the key maternity meetings with the revised plan to be submitted to Board on the 30th of December 2021 for review on the 6th January 2022.

What	When	KLoE	How will this be assured?
Submission and agreement of plans	January 2022 (submission) Q4 (assurance)	Has the plan been signed off by the trust board and subsequently the regional maternity board?	Q3 regional LMS assurance
Delivery against plans: building blocks	Quarterly from Q4 2021	Is the LMS on track against stated deliverables and milestones?	Quarterly regional assurance (RAG rating)
Delivery against plans: provision	Quarterly from Q4 2021	Is the current level of provision on track against the planned phased implementation?	Quarterly regional assurance (latest data on level of provision)
Workforce capacity surveys	October 2021 and March 2022 and on-going until providers are reporting provision on MSDS	What is the current establishment and caseload of MCoC teams?	Survey of maternity providers across England
Placing most Black, Asian and Mixed ethnicity women and women from deprived neighbourhoods onto MCoC pathways	March 2022	Rate eligible women reaching 29 weeks gestation in March are placed on MCoC pathways (>51%)	Analysis of rates of placements using MSDS data

Continuity of Carer Performance – September 2021

The revised "Delivering Midwifery Continuity of Carer at full scale: Guidance on planning, implementation and monitoring 2021/22" has a clear message that Trust are to work towards the building blocks to support the re-implementation of MCoC and that there are no reporting requirements until Trust have these building blocks in place.

In line with this we will cease formal reporting and re-focus upon the building blocks as outlined with the proposed paper due for sign off in January 2022.

Board Safety Champion Walk around and Midwifery Forum

The monthly board safety champion walk rounds have continued with widening participation from the multi-professional teams and areas within Maternity. This is further reflected through the Midwifery Forum, chaired by the Chief Nurse. Both received positive comments from staff in regards to the improvements with safe staffing levels and support from the Senior Leadership Team. Raised at Midwifery Forum was the case of a woman who we were not able to facilitate her homebirth but how she had a positive experience from the individualised plan made. This has been prepared for presentation at Trust Board as a patient story for December 2021.

3. 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 national benchmarking of this review has been completed and was returned to the trust on the 21st of October. We had the opportunity to appeal the view of our compliance with the recommendations. The outcome was supported and reflects the SFH self-assessment. Work continues to strength the areas rated as amber.

The Board declaration form for NHS Resolution was submitted for 2020-21 and remains waiting review. This release has been delayed and is now due end of November 2021. The standards for 2021-22 have been released and the working group are supporting these actions. National push back has been raised around the reporting timeframes, these have not been released and the working group are reviewing these.

4. 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 reported one case externally to the CCG via STEIS. This is case is currently a Divisional Investigation led by Maternity with support from Urgent and Emergency Care.

5. National Maternity team visit

On the 22nd November we hosted a visit from Professor Jacqueline Dunkley–Bent, Chief Midwifery Officer for England, Sasha Wells-Munro, Deputy Chief Midwifery Officer for England, Janet Driver, Regional Chief Midwife and Professor Donald Peebles, National Maternity Advisor – Obstetrics. The visit was part of a programme of visits across all maternity services in England to share the updated maternity self-assessment tool. The team also spent time with the divisional triumvirate in the maternity service. Feedback was very positive from the team.

In addition Ruth Nanthwambe, Sherwood Birthing Unit Ward Leader received a silver Chief Midwifery Officer award to recognise her contribution to midwifery services at SFH.