Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Update	**Date:** 3rd March 2022	
Prepared By:	Paula Shore, Divisional Head of Nursing and Midwifery		
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.

Update on Mandated Maternity and Neonatal Safety Champion (MNSC) work for January 2022

1. Service User Voice

   To help support and strengthen the current Professional Midwifery Advocacy (PMA) service two full time PMA's have been recruited, the planned re-launch of the service on the 3rd of January 2022 was paused to allow for the PMA's to support the clinical rota. The revised date of the 7th of February 2022 has been met and these individuals are now in post.

   Following a review of the current risk of the Nottinghamshire Maternity Voice Partnerships (MVP). The MNSC proposed that SFH will look to recruit a service user representative to help strengthen to Ockenden return, this process has been completed and the individual will join the service on 7th March 2022. Please see this month's feature for further details.

2. Staff Engagement

   The MNSC Walk Round was completed on the 12th of January 2022 with the key issues escalated being around the impact of both the abatement changes and mandatory vaccination on the staffing. Colleagues were reassured that any necessary actions have been taken and all individuals are being supported. These themes were reflected at the Maternity Forum on the 17th of January. All discussion and subsequent actions are captured and shared out within the Maternity Matters newsletter which is distributed to all colleagues.

3. Governance

   Due to the increasing staffing and clinical pressures of Omicron during December, a joint position statement from NHSI/E mandated that all reporting for the Maternity Incentive Scheme cease for a three-month period. This included all activities around Ockenden, Saving Babies Lives and Continuity of Carer. The teams allocated the safety actions have continued with the on-going work and monitoring. The working group has been re-established and is awaiting the revised guidance.

   NHSR have confirmed our full compliance with the 10 safety actions for year 3 as signed off by the board of directors in 2021. This is excellent news for the service and provides a significant rebate to reinvest in the service.

4. Quality Improvement Approach

   Work continues on the Maternity and Neonatal Safety Improvement Programme, January saw the return of the regional events, specifically focusing on the prevention of pre-term birth. The early implementor site work, featured in our update last month, continues to gather strength. Supportive training measures are underway through mandatory and ad hoc sessions for all Maternity staff.

5. Safety Culture

   The executive team have approved procurement of the SCORE safety survey. The quality improvement team are planning the roll out across the maternity service and associated actions.

2. Monthly Feature - Service User Voice

The aim of Nottingham and Nottinghamshire Maternity Voices Partnership (MVP) is multidisciplinary in nature, bringing together representatives from organisations involved in maternity care and local women and their families. MVP's are independent NHS working groups that aim to review and improve maternity services by putting the experiences of women, birthing people and their families, actively seeking out and supporting the views of local people on how care during pregnancy, labour and birth, and after birth should look.

Unfortunately since September 2021 the Nottingham and Nottinghamshire MVP has been without a chair, despite two rounds of recruitment. This has significantly impacted upon the resource and engagement to a point the LMNS have raised this as a risk to the system. The MVP is a critical service for strengthening the links between SFH and the women and families using our services.

The Ockenden Report (2020) noted that it is *"imperative that family voices are strongly and effectively represented in each LMNS through the Maternity Voices Partnerships."* This led to the creation of an immediate and essential action specifically for listening to women and their families (IEA2).

At SFH we have been able to provide evidence for MIS Year 3 but through MNSC meeting we have discussed the concerns, moving in relation to strengthening the Ockenden evidence and the ask of the MIS Year 4, noting the risks within the MVP. Following a discussion, the below points have been actioned with immediate effect:

- Continued MDT attendance at the MVP Board (Consultant Midwife, Obstetric Consultant, PMA's and peer representative once appointed).

- Continued engagement through supporting workstreams namely, Equality, Public Health and Transformation.

- SFH to recruit Peer Representation to engage with women and their families, SFH team and MVP.

- To support compliance towards supporting the Ockenden immediate and essential actions, the LMNS has been awarded funding for Trust's to utilise. A bid was submitted and has been successful for SFH to utilise this for the Peer Representative for renumeration. We conducted informal interviews in February 2022 and Sarah Seddon has been appointed. She will commence on 7th March 2022. The job plan for this role is being drafted with the first activities to be related around:

- Co-production within the Maternity strategy and quality improvement plan

- MDT quality review- 15 steps quarterly

- Review current service user feedback mechanisms

This progress of this will be reviewed through the MNSC meetings and any concerns escalated to Maternity Assurance Committee.

Appendices

Appendix 1- Supporting Narrative on Mandated MNSC Activity

Service User Voice

PMA background information

The PMA is a new and fundamental leadership and advocacy role designed to deploy the A-EQUIP model. The role supports staff through a continuous improvement process that aims to build personal and professional resilience, enhance quality of care and support preparedness for professional revalidation.

The PMA role descriptor and the PMA competency framework involves:

● Deployment of the A-EQUIP model
● Supporting and developing the advocacy role of midwives
● Supporting and guiding midwives through actions that will be of benefit to women and their families
● Providing support and feedback to develop, progress and strengthen the capabilities of the midwifery workforce

The A-EQUIP model works for women in three ways:

● Advocating for women
● Providing direct support for women within a restorative approach
● Undertaking quality improvement in collaboration with women.

The model has been designed to provide all midwives via PMAs with the skills and knowledge to be able to advocate confidently for women. It also provides the flexibility for PMAs to continue to offer direct support to women if the maternity provider chooses this approach. PMAs can also use the specialist knowledge gleaned from their PMA role to contribute to making service improvements through their local Maternity Voices Partnership

Staff Engagement

Every Trust in England has named midwifery, obstetric, neonatal and board level maternity safety champions responsible for working closely with their clinical network and LMS leads to champion safety at frontline and system level. Each Trust should have developed a local pathway which describes how frontline midwifery, neonatal, obstetric and board safety champions share safety intelligence from floor to board and through the LMS and Maternity and Neonatal Patient Safety Networks.

Maternity and neonatal safety champions are responsible for:

- Supporting the provision of a seamless multidisciplinary perinatal service responsive to the needs of women, babies and their families
- Supporting implementation of the Neonatal Critical Care Review recommendations
- Supporting board safety champions to represent the safety needs of their services at board level
- Building the maternity and neonatal safety movement locally to prioritise improvement activities and adopt best practice within the organisation.
- Ensuring safe delivery of care provision with appropriate protection for staff, women and their families in light of the COVID-19 pandemic

As part of staff engagement at SFH we ensure the monthly MNSC walk round and midwifery forum, which is supported by the publication of the “Midwifery Matters” article details any issues raised and subsequent action plans.

Governance

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.

Ockenden and Maternity Incentive Scheme Update

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 has now been submitted for 2020-21, awaiting review. This release has been delayed and is now due end of October 2021. The standards for 2021-22 have been released and the working group are supporting these

actions. Again it is anticipated that due to the on-going pandemic and recent increased pressures that the reporting timeframes and requirements will be amended, this will be noted within subsequent papers.

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.

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 ongoing 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