Board of Directors Meeting - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Update July 2022	**Date:**		
Prepared By:	Maternity and Neonatal Safety Champions and Monthly Maternity Update			
Approved By:	Philip Bolton, Chief Nurse			
Presented By:	Paula Shore, Director of Midwifery, Philip Bolton, 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 and updates of key activity this month			**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				
Contents reviewed and discussed through the Maternity and Neonatal Safety Champions Meeting June 2022				

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 and a request to note and sign off the action plan provided within point 5 and at the end of report.

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

1. **Service User Voice**

   Our Parent Voice representative attended the meeting and updated around her work for this month, including speaking with Maternity Ward, Pregnancy Day Care and Newark Women's Centre. New issues that arose were around the antenatal capacity at Newark, particularly that they do not currently have a five-day antenatal clinic service. This can cause problems with women requiring appointment over at KMH especially when reliant on transport. A further issue raised was around the availability of information leaflets in multiple languages. Both these points have been actioned and will be monitored through the MNSC meeting to ensure they are resolved.

   An area raised in previous service user updates and also noted as a theme within complaints is infant feeding support for women who have undergone a caesarean section. A meeting has been held with the Parent Voice Rep, Infant Feeding Lead, Director of Midwifery and Ward Leader and actions taken to address these concerns raised.

2. **Staff Engagement**

   MNSC Walk round

   The MNSC Walk Round was completed on the 7th June 2022. This was Phil Bolton's first opportunity as Board Level Safety Champion to complete this walk round and after speaking with the teams the below points were identified:

   - Noticeable increased activity and the impact this is having on both the estates and recourses available across the areas visited (NICU, Birthing Unit, Maternity Ward and Antenatal Outpatients).
   - Impact of not having a dedicated elective Caesarean list on the birthing unit activity
   - More positively staff spoke about the increased staffing levels and that this had helped them manage the described increased activity.

   Maternity Forum

   The forum occurred on the 26th of June, chaired by Robin Binks and attended by Paul Robinson. Updates were provided by the Director of Midwifery, Recruitment and Retention Lead Midwife and Matron for Maternity Governance.

   Discussions were had around the extension of the bank rates and confirmation was given that these had been extended until the 5th of July 2022 to allow for a system wide consultation. A Community Midwife, based at Newark, commented on the value of the new supported preceptorship programme noting that due to the support they have noticed how confident and prepared the preceptorship Midwives are currently. She further noted that this has boosted Newark Community Team in that the current preceptor has decided to join the team at the end of preceptorship programme due to the positive experience and exposure to Community which was previously not within the package. Paul Robinson noted that he was over at Newark the following day and would come and speak with the team at Sherwood Women's Centre.

3. Governance

We have worked with the current interim MVP Chair on the final immediate and essential action (IEA) requiring completion at SFH which is around the gap analysis of the associated website. This analysis has now been completed and we are working on the co-produced action plan to ensure the required improvements. This takes the percentage compliance for IEA 7 from 71% to 86%. Our newly appointed Digital Midwife is working on the final aspect with the MVP chair.

We are also working towards the peer assessed completion of the final 5 of the 15 IEA's produced from the final Ockenden 2 report. These will be taken through the MAC and then to public board in August.

As part of the Maternity Incentive Scheme (MIS) Year 4 our Neonatal Safety Champions outlined the actions required around Avoiding Term Admission to Neonatal Units (ATAIN). This is outlined in more depth in this month's feature. Identified champions will support the action plan from the quarterly audit and how this is shared with the LMNS and ICS quality surveillance meeting each quarter.

4. Quality Improvement Approach

Work continues as part of the Maternity and Neonatal Safety Improvement Programme (Mat/NeoSIP) focusing on the delivery of the improvement work aligned to the Mat/NeoSIP. MDT members across both Maternity and Neonatal services, East Midlands Maternity & Neonatal Safety Network Event on the 9th of June and learning will be shared through the teams.

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 in Q2 this year.

For information, the SCORE survey is an anonymous, online tool that can be used to gain insight into a team's safety culture to help the team identify strengths and weaknesses and start to drive genuine improvement. SCORE provides a cultural overview, and more detail in particular areas, such as communication and staff burn out, which featured as a theme within this year's staff survey findings for W&C.

A further element of the safety culture provided by the MIS Year 4, requiring sign off by the 29th of July, is the monitoring of the compliance of Obstetric Consultant attendance for clinical situations outlined within both the RCOG document and our SOP for the Responsibilities of the On Call Consultant for the Obstetrics and Gynaecology (V1.0, Sept 2021).

This monitoring process has been embedded within the weekly local level governance meeting (Trigger meeting) noting that the cases reviewed through this meeting are the higher-level clinical incidents, with a higher proportion meeting the criteria for the Consultant attendance.

For this month's review, all cases which met the criteria had been appropriately attend and/ or Consultant attendance had been requested. The actions, extract below, taken from this meeting was to recirculate a list to remind all staff and update to meeting's notes to incorporate this needed review.

Consultant Attendance review action log

Action	Action Lead/When	Update	RAG
Re-circulate list/poster of when a Consultant should be called	Matron for Maternity Governance (July 22)		
Update Trigger meeting minutes to include Consultant review	Clinical Governance Midwife (July 22)		

2. Monthly Feature- Avoiding Term Admissions to the Neonatal Unit and Neonatal Transitional Care

The NHS England programme of Avoiding Term Admissions to the Neonatal Unit (ATAIN) main aim is to reduce harm leading to avoidable admissions to neonatal units for babies born at or after 37 weeks. In 2016, Better Births set out a 5 year forward vision for NHS Maternity Services which is to be realised through Local Maternity and Neonatal Systems (LMNS). There is overwhelming evidence that separating mother and baby at or soon after birth can affect the positive development of the mother-child attachment process and adversely affect maternal perinatal mental health. Preventing separation except for compelling medical indications is essential in providing safe maternity services. Neonatal Transitional Care (NTC) supports resident mothers as primary care providers for their babies with care requirements in excess of normal newborn care, but who do not require to be in a neonatal unit. Implementation of NTC has the potential to prevent thousands of admissions annually to UK neonatal units, and also to provide additional support for small and/or late preterm babies and their families.

At Sherwood Forest Hospitals Trust we have an established and robust ATAIN and NTC working group which has met monthly since 2015 and 2019 respectively, to review all term cases, identifying the avoidable cases and subsequent learning. This meeting, which is attended by MDT colleagues from both Maternity and Neonatal services, produces both quarterly and annual audits, reports and action plans. Below is the action plan and will be overseen by the MNSC meeting.

Action Plan for Q1 2022-23 ATAIN and Neonatal Transitional Care (extract taken from ATAIN & NTC report)

Action	In Place	By Who	By When	Evidence	RAG
Monthly review of Term admissions to NICU – multidisciplinary meeting with named Obstetrician, Neonatologists, Midwifery and Nursing leads.	Established monthly meetings started 2015	MDT Core members Neonatal and Obstetric Consultant	On going	TOR ATAIN ToR May 22.docx **ATAIN-CASE-NOTE-REVIEW-PROFORMA**	Green
Specific areas of ATAIN plan to highlight actions undertaken and success criteria established:					
1) Respiratory Distress Syndrome	Review through TC working group and support zero separations Timing of EL LSCS timings Review of SROM cases and timings of antibiotics- sharing any learning.	Labour Ward Forum/ Transitional care working group	On-going		Green

2) Bilious Vomit	Current pathway- babies require transfer from NICU to external terms. We are reviewing this area to ensure as minimal separation as possible and learning from cases with concern	Transitional Care Working Group	On-going		
3) HIE 1-3	Case review to be performed to look at cases of 1&2 together (HIE 3 excluded as reviewed externally as part of HSIB criteria noting no HIE 3 since 2019) for learning.		Oct 2022		
Share learning from Term admissions and NTC review meetings.	Cases reviewed wherever applicable are then presented at the perinatal mortality and morbidity meeting for learning. If immediate actions are required then a LIPS or LIMS are produced and escalated to the neonatal when required. Other learning shared through unit news letters	Clinical Governance Midwife and Lead Neonatologist	On going	Example from MuM's Newsletter **Autumn Winter 2021.pdf**	
Meet with ODN lead to shared service development plans for LNU activity including transitional care pathways – Peer review meeting.	Peer review meeting led by ODN	Matron, Ward leader, NICU HoS and Governance lead.	On going		
Monitoring of on-going QI projects to reduce term admissions to LNU – outreach CQUIN work and evidence, term admissions data.	Term admissions work is in place and on-going with monthly meetings and annual report. Outreach CQUIN data collected monthly to review NICU admissions and appropriate discharges.	CQUIN lead, NICU ward leader.	On going		
Transitional Care Working Group	Continue established meetings feeding into to appropriate governance meeting and escalating as required following presentation of monthly audits.	Neonatal Ward Leader and Maternity Ward leader.	On going	Audit example **NTC Dashboard_Jan-Mar**	