Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

All reports MUST have a cover sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:** October 2022	
Prepared By:	Paula Shore, Director of Midwifery/ Head of Nursing		
Approved By:	Phil Bolton, Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery/ Head of Nursing, Phil Bolton, Chief Nurse		

Purpose		
To update the Board of Directors 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**	

Identify which principal risk this report relates to:		
PR1	Significant deterioration in standards of safety and care	**X**
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Failure to achieve the Trust's financial strategy	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Maternity and Neonatal Safety Champions Meeting

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 September 2022

1. Service User Voice

Our Parent's Voice Representative has provided an update to the activity within her role, following listening events both with the hospital and community the below details were provided.

Some of the themes which keep coming up are:

- Kindness/compassion in bucketloads – staff are always willing to help & nothing is too much trouble
- Staff really listening to women and understanding what they need
- Everything really clearly explained during labour
- Women/birthing people feel safe
- Individual needs are taken into account & communication is excellent between staff and service users.

Some of the key suggestions for improvement that our women are asking for are:

- More information on the induction process
- Improved communication between different professionals – i.e. awareness of all information that is documented so that everyone is giving the same message
- More information on what to expect at the different appointments / scans and what the purpose of these are
- Careful use of language and clarity about when there is a choice

These comments are provided to the teams and actions are monitored through the MNSC meetings.

2. Staff Engagement

The MNSC Walk Round was completed on Tuesday 6th October 2022. Feedback on the day was positive particularly around the support despite the constant challenges.

The Maternity Forum which was due to be held on the 29 September 2022 had to be cancelled on the day due to high clinical activity. Any action updates have been sent out to the team with an apology from the Director of Midwifery.

Our Freedom to Speak up Champions have produced some focused communication for October.

You said- we did feedback:

An action taken from both the recent walk round and forum was around Antenatal Clinic capacity with a specific focus on the Diabetic Clinic. Given the concern and the impact this was taken a separate action from the overarching paper around the impact of the increasing birth rate. Working with colleagues from both Diagnostic and Outpatients and the Medical Division we have managed to obtain an additional session for Wednesday morning creating an additional 10 scan and clinical appointments to ease the pressures on the full day Tuesday clinic. This has been reported back to the team outside of the forum due to this being cancelled.

3. Governance

Ockenden: out of the final 5, 14 have been peer reviewed and
we are awaiting the final IEA which relates to Anaesthetic, which we have not progressed due to clinical commitments and reviewing the Maternity Incentive Scheme evidence through MAC to ensure the submission deadline is met. There remains no national reporting plan yet for the final 15 IEA's.

The LMNS quarterly panel met on the 21st of September 2022, in which our gap analysis submitted was approved taken the compliance of IEA 7 up to 91%. As this is approved, we can now start the work around the action plan for this analysis. We are further working on as both an organisation and a system on how we can sustain some of the actions.

Final plans have been made for the Ockenden Quality Insight Visit on the 4th of October which will be performed by the regional team as part of one their recommendations from the report.

NHSR: Due to the challenges, the weekly meeting continues with the additional business support. During a conference in October, it was announced that the safety actions and submissions are under revision. We are continuing to work to the current deadlines until clarity is provided.

4. Quality Improvement Approach

The Maternity and Neonatal SIP programme has been re-energised with the focus around the optimisation and stabilisation of the pre-term infant. The team, led by the Consultant Midwives contains colleagues from both neonatal and maternity services. After reviewing the baseline data the team will provide an improvement plan which will be monitored through the MNSC meeting.

5. Safety Culture

The Pathway to Excellence Survey is now live and all staff have been encouraged to engage. The SCORE survey has been delayed until Q4 2022/23 but will be using the previous results to provide a local quality improvement plan which will be signed off through the MNSC meeting in November. We currently have the national staff survey live which all colleagues are being supported around engaging