Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet template and Guidance for all governance meetings

All reports MUST have a cover sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:** December 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 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**	

Identify which principal risk this report relates to:		
PR1	Significant deterioration in standards of safety and care	
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 October 2022

1.Service User Voice

During the monthly MNSC walk round for October our Non-Executive and Board Level Safety Champion, Claire Wood and Phil Bolton Executive Chief Nurse had the opportunity to present the Midwifery Team with their Staff Excellence Award- The Peoples Award.

This year the Midwifery Team and many individuals within it received a significantly high number of nominations from our Women and their Families, some are outlined below.

"For going above and beyond expectations at every single midwife appointment both antenatally and postnatally. For making me feel so at ease and making everything so much easier during what I thought was going to be a difficult time."

"She deserves this award as she helped us deliver our baby girl. After a difficult pregnancy and a horrible induction, she took all this on board, and she made it the best experience. She kept calm and respected all my wishes".

"Any family who has the privilege of having this dream team care for them at one of the most precious and life changing times of their life is very lucky indeed. They will forever be special to my family, as I'm sure they are to so many other families"

2.Staff Engagement

In addition to the above presentation the team highlighted the increased pressures that they were experiencing from the increased activity. The MNSC outlined the actions being taken within the Maternity services but agreed to look at the ways this can be communicated more widely within the teams.

October's Maternity Forum was cancelled due to high activity. However, on the 10th of October the inaugural Maternity Support Worker (MSW) Forum was held, which was attended by the Director of Midwifery. This forum aims to help support the MSW workforce development and ensuring that their voice is heard as part of the MDT Maternity team.

As part of the Freedom to Speak up Month in October, Shirley Higginbotham Executive Director Corporate Affairs performed walk rounds within Maternity Services, speaking with staff and discussing the different avenues and processes available to staff for speaking up and highlighting the Freedom to Speak up Champions available within Maternity services.

3.Governance

The National maternity team are currently out for consultation on the creation of a single delivery plan which it is believed will combine the findings from the Ockenden and Kirk up Reports into a singular assurance framework (Maternity SOF). It is anticipated that this framework will be released in early 2023.

The findings of the East Kent Report released last month are provided to Board in a separate summary paper outlining the position of SFH, which will be shared with the LMNS.

Ockenden:

The action plan, taken from the findings from of the Regional Quality Insight Visit, have been presented both internally and to the LMNS Executive Partners. This action plan will be monitored through the MNSC meeting.

Attendance continues at both the monthly and quarterly Ockenden Assurance Panel. The outstanding action required for full compliance sits with the development of the website at SFH. This has been taken through the Digital Transformation Unit, which will mobilise once the go live of the new digital system has launched. An additional note from the regional team was to review and provide timeframes for the work to complete the agreed divergence work in regard to the SBLCB, this is underway with support from the sonography team.

NHSR:

The divisional working group continues to focus on the delivery of the scheme, meeting fortnightly to review the progress and upload progress to the shared portal. The revised timeframes have been presented through the MNSC and MAC and approved.

Following the risk raised last month we now have an interim agency manager supporting the delivery programme who started in September 2022. 360 Assurance have commenced external validation process on 4 of the 10 safety actions, noting this was an initial review with no recommendations. The highest risk area of Safety Action 8 has had a positive report this month in that four of the five training scores have reached over the 90% of staff groups trained, with the final element completed at the end of November 22.

4.Quality Improvement Approach

The early implementor site work around smoke-free pregnancy continues to gain momentum and was presented at the LMNS Executive Partners Meeting. The Divisional workgroup focusing upon the Mat/Neo work of the optimisation and the stabilisation of the pre-term infant have finalised the neonatal peri-prem passport which has been shared with our LMNS colleagues to look at a system passport for the babies born between 23- 33+6 weeks gestation.

5.Safety Culture

The Pathway to Excellence Survey has closed and we are awaiting the feedback from this survey. The staff survey is now live and staff are being encouraged to complete. These findings, along with the planned SCORE survey in Q4 2022/23 will be used to provide a local quality improvement plans.