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:** 2 February 2023	
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.

Summary of Maternity and Neonatal Safety Champion (MNSC) work for December 2022

1.Service User Voice

Due to operational pressures the meeting was conducted by a virtually review of the agenda. As part of the agenda the below wordal was shared by our Parent Voice Champion Sarah who is pulling together an annual report. This wordal has been performed from her first 9 months in post after 186 contacts with women and their families. Once the annual report is available this will be presented to through the safety champion forums and meetings, alongside being shared with the teams.

2.Staff Engagement

The MNSC Walk Round was completed on the 19th of December 2002. Staff spoke about and was visible the change in activity however they noted the position of the Trust in regard to the critical incident and how this has impacts on the services. Similar themes to previous walk round have been report around the increased activity and the issues around the estates as to how this is impacting on the daily activity.

The maternity forum was cancelled due to ongoing Trust wide pressures this month and is rescheduled for January.

3.Governance
Ockenden:

The National team are currently out for consultation for a single delivery plan which is understood that the findings from the Ockenden and Kirkup Report being combined under a singular assurance framework due Easter 2023.

Through the LMNS Ockenden Assurance Meeting, we are working on the three elements of the East Kent Report to focus on as a system until the single oversight framework is available, once

the details have been finalised these will be reviewed through both the MNSC meeting and MAC. Attendance from SFH 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, now the digital system has been implemented this has now been prioritised.

NHSR:

The divisional working group continues to work on the delivery of the scheme, meeting fortnightly with the last meeting planned in January for this year's submission. No risks have been identified since the reporting deadline for the 5th of December has closed and the safety actions are being prepared for the review through MAC. The final presentation to Trust Board has been prepared and listed for review through the MAC, QC and LMNS Executive Partnership Meeting.

Saving Babies Lives:

The Saving Babies Lives Care Bundle 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

Version 3 of the care bundle will be launched this year adding an additional element focusing on diabetes. Due to the reporting and training requirements divisional we are looking at a role which will support the delivery of this as part of the maternity safety team.

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, LMNS and ICB. The quarterly paper will be delayed until the next agenda due to the data release dates.

CQC:

On the 22nd of November 2022 we had a 3-day visit from the Care Quality Commission (CQC). This was part of the national planned review of all Maternity Services across England following the recommendation from the Ockenden Report. We have received the draft report and are responding to this within the allocated timeframes, once the report is final this will be shared with the teams.

4. Quality Improvement

On the 11th of January 2023 the CQC released the result of the 2022 national Maternity Survey. Women and other pregnant people who gave birth between 1 and 28 February 2022 (and January if a trust did not have a minimum of 300 eligible births in February) were invited to take part in the survey. Fieldwork took place between April and August 2022. Responses were received from 20,927 women and people who had recently given birth. This was a response rate of 46.5%.

At a national level the 2022 maternity survey shows that people's experiences of care have deteriorated in the last 5 years. Trend analysis was carried out on 26 evaluative questions on data from between 2017 and 2022. Of these questions, 1 showed a statistically significant upward trend, 4 showed no change and 21 showed a statistically significant downward trend. Furthermore, of the 21 questions with downwards trends, results for 2022 were at the lowest point for the 5-year period in 10 cases.

Results for 18 of these questions declined during the height of the pandemic (2021). Out of the 18 questions that saw a large decline in experience in 2021, 5 have seen a further decline in 2022 and 6 have stayed level with 2021 results. This indicates that some experiences of maternity services haven’t yet recovered to pre-pandemic levels including care during labour and birth and postnatal care at home and in hospital.

At SFH we have reviewed our data and a detailed response and action plan will be brought through the MNSC to Board.

5.Safety Culture

The planned delivery for the SCORE survey has commenced for Q4 2022/23 with a slight delay due to the critical incident. This will be used to provide a local quality improvement plan, triangulating the PTE and staff survey findings.