Board of Directors Meeting in Public - Cover Sheet

All reports MUST have a cover sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:** 2 March 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.

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

1.Service User Voice

Discussed through the MNSC meeting in January was the "*Whose shoes"*® Home Birth Workshop.

The aim of the workshop was to facilitate the participation of multiple stakeholders, especially maternity service users, to contribute to informing both maternity service provider and commissioner actions that could support the development and redesign of home birth services locally.

Attended by a wide range of participants, 64 in total including Maternity service users, clinicians, commissioners, universities and private midwife/doulas.

A total of five recommendations were made on the day, these being:

Recommendation 1: To establish a model of care that will provide a reliable and sustainable home birth service that is available 24/7/365 to all women who request a home birth in Nottingham and Nottinghamshire.

Recommendation 2: To increase the skills and confidence of service providers and their staff to deliver a safe and supportive home birth service.

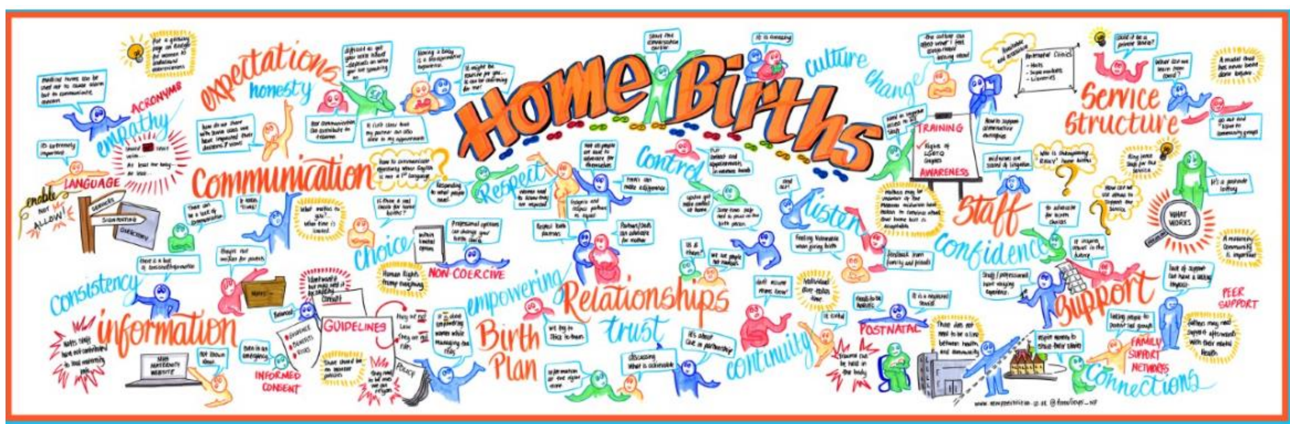
Recommendation 3: That maternity services in Nottingham and Nottinghamshire hold further engagement events with service-users whose voices are seldomly heard or easily ignored. In doing so, working towards culturally competent maternity services that empower people from all parts of the community to feel welcome and valued.

Recommendation 4: To improve how staff can listen and advocate for choice. Ensuring choice of place of birth is communicated to service-users using the principles of informed decision making that take account of up-to-date evidence and personalising this to each service-user.

Recommendation 5: To create a suite of information and resources to share with women and families about home births, which will share the facts and promote the new service.

The next steps are for service-leaders and commissioners to set up task-and-finish groups aimed at working towards bringing the recommendations to life, with support through the LMNS>

SFH were able to share the recent learning around the re-instatement of our homebirth service and will be a key part of the task and finish group



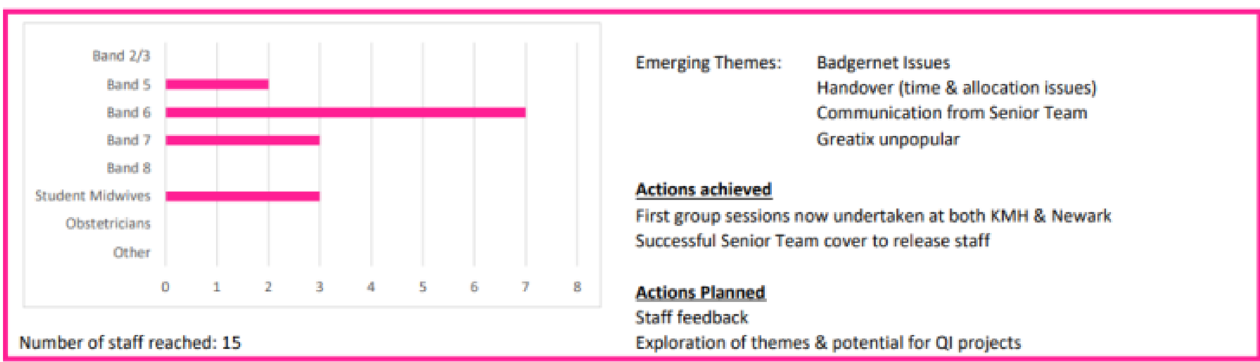
2.Staff Engagement

The MNSC Walk Round was completed on the 31st of January 2023. Staff continued to speak about the change in acuity and the positive impact this was making on the team. The MNSC spoke with staff about the recent implementation of Badgernet in November 2022. All staff within the antenatal and postnatal settings reflected how this has made a significant positive impact within their working areas. Conflicting feedback was provided for the intrapartum setting. The Digital Support Unit have planned engagement session throughout February to review with the team and the feedback/ themes from this will be cited through MNSC.

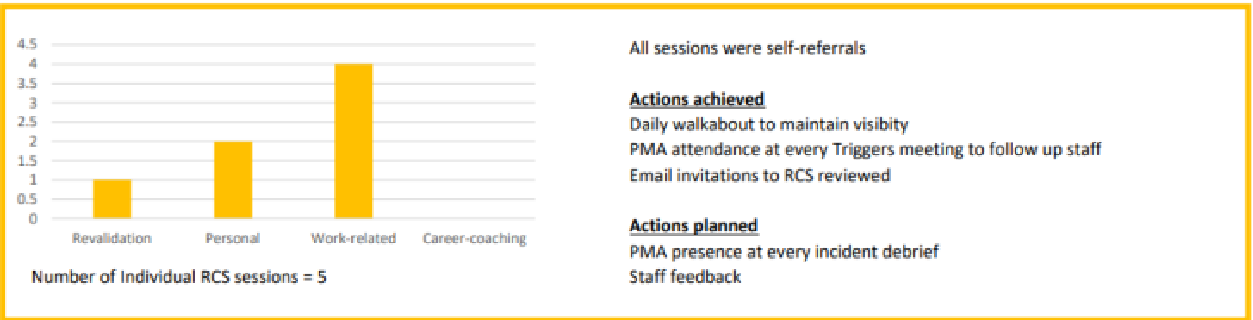
The maternity forum was cancelled due to ongoing Trust wide pressures this month and is rescheduled for February.

Shared as part of the Professional Midwifery Advocate Bi-Monthly Flash report was the details around both the Individual and group restorative clinical supervision sessions. The group session were newly launched in December and the thematic feedback has been shared with the senior leadership team.

Staff Group Restorative Clinical Supervision (RCS) / Decompression Session:



Staff Individual Restorative Clinical Supervision (RCS):



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 with the Digital Midwife reviewing. At the monthly Ockenden meeting with the LMNS the discussion was had around the finance for 2023/24 with the anticipation that this information surrounding this will be released imminently.

NHSR:

A change in the position has been escalated to the Executive Team and Board due to an error noted within Safety Action 1 part A surrounding the timeframe for reporting of the surveillance form. Following consultation with NHSR the advice given was to report no compliance for this element with a supporting action plan. This has been drafted in preparation for submission on the 2nd of February 2023.

Saving Babies Lives:

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.

Discussed at MNSC and shared as part of the reading room is the quarterly data for the SBLCB taken from Badgernet. Noting that we have data transfer still outstanding this quarter due to the legacy system.

For this quarter the improvements are outlined below in the Mat/Neo SIP actions taken in this month with the specific focus on Element 5.

CQC:

Following the planned 3-day visit from the Care Quality Commission (CQC) on the 22nd of November 2022 the final report was released on the 22nd of February 2023 with the Maternity Services rating of this service stayed the same (Good).

The CQC rated the services good because:

- The service had enough staff to care for women and keep them safe. Staff had training in key skills, and worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well.
- The service controlled infection risk well. Staff assessed risk to women, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well and supported staff to develop their skills. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued.
- They focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services. People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services continually.
- The CQC further identified areas for improvement under the safe domain, noted below, from which an action plan will be drafted and monitored through Maternity Assurance and Quality Committee.

- Leaders recognised they needed to make improvements regarding how they communicated with staff when making changes to their vision and plans for the future of the service.
- Not all staff had completed mandatory training. Staff did not always document effectively in triage to enable appropriate prioritisation and audit. Information systems were in their infancy and needed to be embedded into practice to support service improvement.

4. Quality Improvement

Below tabled are the updates from the Maternity and Neonatal Service Improvement Programme (Mat/Neo SIP).The work surrounding the maternal early breastmilk, which was promoted through Twitter, has been picked up by the national Mat/Neo SIP team as a case study for excellence**.**

Item No.	Actions this month	Date
Birth in Right Place and AN antibiotic use Driver Diagram Template -peri-prem	• Scoped Peri-prem passports from other areas • Adapted peri-prem passport to SFH • Printed peri-prem passports and currently being given out in preterm clinic • Plan to audit in 8 weeks to see if being used effectively	4/2/23
Antenatal Steroid use	• Data collection and review of audit identified overuse of steroids • Current tests to diagnose preterm labour unreliable therefore steroids given to most women who present with signs of pre term labour • Fetal fibronectin testing to be introduced. Equipment purchased. • Plan to roll out training for staff on tetal fibronectin testing	4/2/23
Optimal cord management Driver Diagram Template - delayed cc	• Awaiting data on existing duration of cord clamping • Scoping of products to support delayed cord clamping for premature babies • Secured funding for Neosuit	4/2/23
Maternal early breastmilk Driver Diagram matneosip -early brea	• Comms for early colostrum created. Posters and leaflets read yto be put up in clinical areas • Continually audit of data, though challenges in capturing all breastmilk given ie if for mouthcare • Tea trolly training planned • Colostrum kits ready and being given out in preterm clinic	4/2/23
Thermoregulation Driver Diagram -normothermia.pptx	• Cue cards made and put on every resusitaire on SBU and every cot in NICU • Posters created and social media posts • Introduced continuous probes • Training for staff on using probes	4/2/23

	• Plan to include checking probe as part of checklist when checking equipment • Continual audit of data. 26 week twins admitted that had normal temperature range this week. • Recognition and reward plans for staff who cared for babies that had normal temperatures.	

5.Safety Culture

The planed delivery for the SCORE survey commenced in the beginning of March 2023. This will be used to provide a local quality improvement plan, triangulating the PTE and staff survey findings.