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:** May 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 17/04/2023
- Maternity Assurance Committee 25/04/2023

Acronyms

- MNSC-Maternity and Neonatal Safety Champion
- CQC- Care Quality Commission
- LMNS- Local Maternity and Neonatal System

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 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.

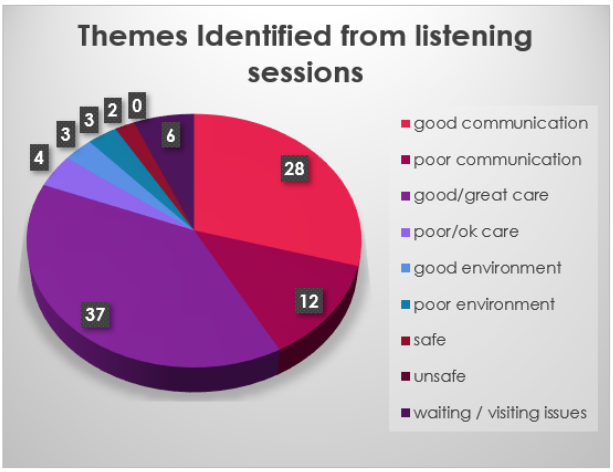
Summary of Maternity and Neonatal Safety Champion (MNSC) work for April 2022

1.Service User Voice

The previously discussed What Good Maternity Care Looks Like report now has a clear action plan, which has also taken into consideration the CQC Maternity Survey from February 2023. This will be reviewed through MNSC and cited at Maternity Assurance Committee.

Below are the flash reports which featured the activity of our Maternity Parent Voice Champion, actions have been taken against the areas identified, and this will be led by the MNSC

MATERNITY PARENT VOICE CHAMPION FLASH REPORT (FEB-MAR 2023)



Communication continues to be the one thing that makes the most difference to experience of care

Number of parents listened to = 40

Locations of listening sessions

- Maternity ward (KMH)
- Antenatal Clinic (Newark)
- Polish Village, Newark
- Phone calls to women/birthing people who accessed birth options/birth afterthoughts sessions

Additional work undertaken

- Report completed and shared summarizing thematic review of 9 months of feedback (186 conversations)
- Parent voice on PMA interview panel
- Ockenden learning event
- Ockenden subgroup IEA7 (Informed consent)
- Delivery suite environment working group
- LMNS bereavement workstream

MATERNITY PARENT VOICE CHAMPION FLASH REPORT (FEB-MAR 2023)

New issues to refer to Maternity Safety Champions for action:

- ***Communication continues to be the thing that makes the most difference to peoples' experience of care. Specific poor experiences included:***
  - Questions about induction not answered
  - Electronically recorded birth plan 'lost'
  - Inconsistent information given
  - Information not passed from delivery suite to ward
  - Inaccurate documentation in notes
  - Rudeness
  - Staff promised to come back after10 minutes, but no one returned
  - Notes lost
  - Results not available when promised

Next steps:

- PS/GB to agree final action plan following on from thematic review which will be monitored through Maternity Safety Champions
- Independent Senior Advocate role likely to commence May or June 2023 – MVP to take on some roles previously covered by the Maternity Parent Voice Champion
- Monthly community listening clinics to continue with PMA, focussing on 'harder to reach' groups
- Continue 'walking the patch' to listen to families at KMH and Newark
- Involvement in MVP workstreams and LMNS Bereavement care workstream

2.Staff Engagement

The MNSC Walk Round has been rescheduled and will take place following the publication of this paper on the 25th of April 2023, due to the on-going industrial action. An update will be provided within the next MNSC paper. The Division have continued to ensure the Senior Leadership Team (SLT) visibility through walk rounds and open meetings.

The Maternity Forum for April was cancelled due to the ongoing industrial action. The next scheduled forum is on the 9th of May 2023 again the SLT have supported through increased visibility within Division and post reaffirming staff on the ways to escalate to the SLT.

3.Governance Summary

Ockenden:
The anticipated Single Delivery Plan was launched on the 31st of March, following a delay and title change as the "Three Year Delivery Plan for Maternity and Neonatal Services (NHSE, 2023). The plan focuses upon four key themes:

1. Listening to and working with women and families with compassion
2. Growing, retaining and supporting our workforce
3. Developing and sustaining a culture of safety, learning and support
4. Standards and structures that underpin safer more personalised and more equitable care

Within the plan there is no measures as to how organisations will report against, following a meeting with the Regional Midwifery team this responsibility will sit with the LMNS. This meeting is to be arranged to look at the system focus and measures.

The outstanding action required for full compliance for the initial 7 IEA's focuses on a co-produced action plan which has been completed and listed for the quarterly panel review on the 20th of April. If this is signed off as complete, then we will have full compliance. We will continue with our monthly local level meeting which will feed into the LMNS as to the assurance of the embedding on the 7 IEAS.

NHSR:
Following a bid from SFH, we have been successful, and the amount returned is yet to be confirmed. The year 5 of the Maternity Incentive Scheme has yet to be launched nationally but is anticipated the announced in Q1 2023/24 to date has yet to be released.

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. Discussed at MNSC and shared as part of the reading room is the monthly data for the SBLCB taken from Badgernet, which is showing an improving position and is being used for governance papers through division. We remain on track for the compliance for the two areas who currently have agreed divergence against with support from both the LMNS and regional team.

CQC:
Following the "Good" rating from the planned 3-day visit from the Care Quality Commission (CQC) an action plan has bee approved by the Quality Committee on the 13th of April 2023 and the two "Must do" actions are progressing. The progress of these and the commencing of the "Should do" actions will be discussed through Maternity Assurance Committee.

4. Quality Improvement

The teams have sent out clear communication across the division regarding the programmes of work underway as part of the Maternity and Neonatal Safety Improvement Programme. The posters are displayed within the clinical areas and have been shared via email and social media platforms.

Example of the social media post.

5.Safety Culture

Due to resource challenges within the organisational development team the start of the culture survey has been delayed until Q1 2023/24. We are maintaining communication and are supporting the team to progress this.