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 & Neonatal Safety Champions Report			Date: 6th July 2022	
Prepared By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing for W&C				
Approved By:	Phil Bolton, Chief Nurse				
Presented By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing for W&C, 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					
Provide outstanding care in the best place at the right time	Improve health and wellbeing within our communities	Empower and support our people to be the best they can be.	To continuously learn and improve	Sustainable use of resource and estate	Work collaboratively with partners in the community
X	**X**	**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

- Nursing and Midwifery AHP Committee 24/05/2023
- Maternity Assurance Committee 26/05/2023

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 June 2023

1.Service User Voice

We have had feedback this month rom the below engagement session and the PMA team have incorporated the feedback into the action plan developed from the “What good looks like” in Maternity Services Report.

Sarah Seddon has also started in her new role within the LMNS as Maternity and Neonatal Independent Senior Advocate supporting birthing people and their families at SFH. We are continuing to support and engagement with her and this key role at SFH.

2.Staff Engagement

The planned MNSC walk round happened on the 6th of June visiting NICU, the birthing unit and the newly re-launched triage area. We spoke with staff involved in the triage re-launch and all had reported positive launch day. Whilst it was early days the team were happy with the feedback mechanisms in place is needed and how the project plan had helped. We also spoke with some further colleagues across the team in regards the elective caesarean lists. Since the launch back in May they reported variety, especially with the start times, depending upon the team that day. The MNSC took an action to feed this back to the working group that supported the launch of this list and will await the plan.

The Maternity Forum ran on the 5th of June 2023, with colleagues joining from all areas across the division. We updated on previous actions around car parking and the enhanced rates on bank shifts. We further reported on the Successful Midwifery Recruitment Day on the 12th of May and subsequent interviews. Moving forward we are looking at, with support from HR and OH, to on the day recruitment. Staff also spoke proudly about the nominations for the upcoming Staff Excellence Awards, we have nominations for Specialist Healthcare Individual (Jodie Prest), MDT of the year (Maternity and Badgernet Team). Action's taken away from the session came from colleagues at Newark who feedback in regard to an issue with a clinic room and trolley space and how as team leaders do the communicate widely within the teams. An update in regard to these actions will be provided at the next meeting.

3.Governance Summary

Three Year Maternity and Neonatal Plan:

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

As a system we have looked at how to address, understanding the local data and demand and have provisional proposed an initial focus upon two key priority areas, which are aligned to the ICS Integrated Care Strategy commitments:

1. Embedding the voice of women, birthing people and families – and ensuring key learning from service users is the main driver in transforming our maternity and neonatal services. This includes but is not limited to development of MVP and NVP

2. Equity as the lens through which we view all areas of the LMNS – ensuring equity across our services and local population, with a focus on experience as well as outcomes, looking at localized data for Nottingham and Nottinghamshire.

Further technical guidance has been provided on the 31st of May and the team are working through how these will help to deliver the plan.

Ockenden:

The outstanding action required for full compliance for the initial 7 IEA's focuses on a co-produced action plan was approved at the panel meeting and we have now 100% compliance for Ockenden initial 7IEA. 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**.**

NHSE have confirmed that the system is not required to report compliance against Ockenden II. However, NHSE have suggested local Trust actions plans are developed and progressed to deliver the IEAs set out in Ockenden II. SFH completed this work and have been advised to review their delivery plans.

We have a planned Ockenden Oversight visit for October 2023, the team are collating evidence to support the embedding of the 7IEA's and a report is viewed at the MNSC quarterly.

NHSR:

Following a bid from SFH, we have been successful, the amount has now been received and this will support the delivery of year 5 MIS. Year 5 of the MIS was launched on the 31st of May, with a submission date of the 2nd of February 2024. The team have re-instated the working groups and the proposed timelines and governance plan will be presented at the July MNSC and Maternity Assurance Committee meetings.

Saving Babies Lives:

On the 26th of June we have an on sight from NHSE. Following the success of the Phoenix Team, our Tobacco Dependency Team, work from the early implementer site for the NHS LTP maternity model. The have approached a family who are willing to be part of a film that is to sit alongside the launch of the maternity Saving Babies Lives care bundle v3.

SFH has continued to monitor its compliance with all elements of the Saving Babies' Lives Care Bundle (SBLCB) 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.

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. The "must do" action for mandatory training has been completed for the training year 2022/23 with the Trust Mandatory training meeting the planned trajectory of 91% (Trust target 90%). Subsequent planning has been applied to the 2023/24 training year and a clear trajectory, which is monitored through governance.

The second "Must do" relates to triage, which live re-launched on the 5th of June and features below.

4. Quality Improvement

On the 5th of June we re-launched the Maternity Triage. The Birmingham Symptom Specific Obstetric Triage System (BSOTS) was developed by clinicians and researchers from Birmingham Women's Hospital and University of Birmingham. It was led by Dr Nina Johns (Consultant Obstetrician and Clinical Lead of Delivery Suite, Birmingham Women's Hospital) and Professor Sara Kenyon (Professor of Evidence Based Maternity Care, University of Birmingham).

BSOTS is a maternity triage system, which improves the safety of mothers, babies, and the management of the department. It consists of a prompt and brief assessment (triage) of women when they present with unexpected problems or concerns, and then a standardised way of determining the clinical urgency in which they need to be seen.

Women found to have a lower clinical priority can be sat back in the waiting room, thus improving the pathway, and the standardised assessment and excellent inter-rator reliability means variation in the clinical urgency of women between midwives is minimal. The shared language between health care professionals supports clear communication. The system can be amended to personalise it to individual maternity units but the principle that the assessment is a triage (i.e., both prompt and brief) and the algorithms (which are used to define the women's clinical priority)

cannot be changed. A QI project has managed the re-launched and key performance indicators identified for monitoring and future presentation.

Examples of social media posts:

Launch of maternity triage system

Posted Wednesday, June 7, 2023 12:41 PM

We've launched a new maternity triage system for anyone who has pregnancy-related concerns.

Our triage midwives aim to review and assess people within 15 minutes of arrival at a new waiting area at the Sherwood Birthing Unit at King's Mill Hospital. Care will be prioritised based on the urgency of your symptoms and you will be told if you will be seen immediately, within 15 minutes, within one hour, or within four hours.

The midwife will inform you if any tests need to be done and when and if you need to see a doctor.

This system has been developed in response to national guidance and recommendations, including from the Care Quality Commission (CQC), as well as feedback from service users about waiting times and the quality of the triage journey.

If you have any concerns during your pregnancy or after baby arrives, contact our midwives 24/7 on 01623 676170. Save this number in your phone!

If you have any concerns, always call - never leave any concerns until the next day. Our midwives are here to talk to you and direct you to the support you need 24 hours a day, every day of the year.

This could include:

- Your unborn baby moving less than usual at any gestation.
- You think your waters have broken.
- You have a high temperature/rapid heart rate or feel unwell (pregnancy or postnatal).
- Any bleeding from the vagina if pregnant or unusually heavy bleeding and/or clots if postnatal.
- Abdominal (upper or lower tummy) pain.
- Anything that concerns you and you need reassurance/advice/check.

If you do attend our Maternity Triage, please let our midwives know what you think about the new system.

5.Safety Culture

We now commenced the first wave of the culture survey, and the teams have worked on a communication plan. Further key dates are below;

Survey launch 19th June

Survey close 7th July

Results available 24th July

Once the results are available, we will present the to the MNSC.

In addition to this the Division Quadrumvirate are also booked onto the Perinatal Culture and Leadership 'Quad' Programme in Q3 this year. This is a modular programme, facilitated by NHSE, which provides opportunities for organisations to understand their own culture using evidence-based tools, develop tailored leadership strategies for developing compassionate, inclusive and collective leadership and deliver culture change. The national aim is for Trust's to better understand the culture within their maternity and neonatal services has been received and that any support required of the Board has been identified. Once completed, an action plan will produce an action plan which will be cited through and supported by the MNSC.