Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:** 3 August 2023	
Prepared By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing W&C		
Approved By:	Phil Bolton,Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing W&C and 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 well-being within our communities	Empower and support our people to be the best they can be	To continuously learn and improve	Sustainable use of resources and estate	Work collaboratively with partners in the community
X	**X**	**X**	**X**		

Principal Risk		
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 27/06/2023
- Maternity Assurance Committee 27/07/2023

Acronyms

MNSC-Maternity and Neonatal Safety Champion
Maternity Voice Champion (MVP)
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 July 2023

1.Service User Voice

July has seen the start of our new Maternity Voice Champion (MVP) volunteer Emma. As part of the "*Walk the Patch*" this month, Emma had her orientation to Acute Maternity areas. To support the ongoing work around the experience of birthing people undergoing an elective caesarean section, Emma spent time obtaining feedback from birthing people who have used this service.

Emma spoke with five women in total, the positives they shared about their care were as below;

> Very happy with care. Felt preparation was good. Happy the day of the caesarean was confirmed and kept.
>
> Really positive. Very impressed with support from midwife.
>
> Happy with support and care. Feels everything is being done that can be.
>
> Positive about all care. Had understood everything that was happening and happy with everything.
>
> Very happy with care. Felt everything went well and to plan.

Emma also explored what we could have done to make the experience better, as detailed below. The below themed points around communication and timing of discharge will be actioned through the Postnatal Forum.

> Two previous experiences of delay in discharge and worried this might happen again.
>
> Partner was not able to stay and wasn't aware that this was the case as had previously been in a side room so had partner stay with last baby.
>
> Awaiting discharge but unsure when that will be.
>
> Wasn't aware of changes to visiting and thought it was only 2 visitors. (ward manager spoke to women to explain visiting immediately following the feedback)
>
> Wasn't aware when discharge would be.

2.Staff Engagement

The planned MNSC walk round happened on the 4th of July visiting the Neonatal Unit, Sherwood Birthing Unit and the Maternity Ward. We were joined this month by our new Divisional General Manager, Matthew Warrilow, this month. Staff reported that activity was high although the staffing levels supported this. We spoke further to staff about the recent Digital walk round and the issues flagged by the team and what the Digital Transformation Unit are doing to address these.

The Maternity Forum ran on the 3rd of July 2023, with colleagues joining from all areas across the division. Staff were looking forward to the upcoming Staff Excellence Awards (5th of July) as many across the Division had received nominations. The team were updated on the up-and-coming plans for the noted increased in maternity leave and how the Senior Leadership Team had plans in place to support this. An update was also provided into the progress of the Entonox Report, in that

a Trust Wide Task and Finish Group had been set up to support the response and that an email explain the report and actions would be sent to all staff soon.

3. Governance Summary

Three Year Maternity and Neonatal Plan:

Further to the previous updates, the governance team have met with colleagues from the LMNS to look at the approach to the below priorities, with a request that each site now looks at their data/ information as to how these will be prioritised.

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.

Ockenden:

We have started the preparations for the planned Ockenden Oversight visit for October 2023, the team are continuing to collate the evidence to support the embedding of the 7IEA's. This report is viewed at the MNSC quarterly.

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.

NHSR:

The NHSR Year 5 task and finish group is underway, with the named safety action leads meeting fortnightly. A mapping exercise has been undertaken to plan the evidence review through the extended Maternity Assurance Committee meeting in Q3 prior to the final submission in February 2024. This fortnightly meeting produces a flash report which is cited through MNSC, MAC and onwards to Quality Committee.

Saving Babies Lives:

NHSE visited the Trust on the 26th of June to film the work of the Tobacco Dependency Team, our early implementer site for the NHS LTP maternity model. They filmed staff and a family as part of the national launch for Saving Babies Lives care bundle v3 as a good case example.

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. For the training year 2023-24 the completion rate remains at 91.8%, above the Trust target.

The second "Must do" relates to triage, which live re-launched on the 5th of June, work continues to embed this change.

4. Quality Improvement

As part of the national Maternity and Neonatal Safety Improvement Programme work and outlined in previous papers, we have had a drive around specific target areas. An update shared through the safety champions meeting is the early breast milk data for July, which showed an improvement with 87.5% of babies born before 34 weeks receiving breast milk within 24 hours of birth (previous rates outlined remained around 30%). This has been achieved through the below actions and will be monitored through the MNSC.

Discuss colostrum collecting with anyone with a chance of preterm birth in ANC, PDC and Community

Offer colostrum packs to parent in the IOL suite or on the ward

Facilitate hand expressing within 2 hours of birth on SBU

Ensure packs are readily made up

5.Safety Culture

We now commenced the first wave of the culture survey; the survey is live and we are awaiting the results. Plans are in place for the debriefing element.

In addition to this the Division Quadrumvirate are also booked onto the Perinatal Culture and Leadership 'Quad' Programme in Q3 this year. This initial introductory meeting has occurred, and we are in a strong position, given the current culture work and plans as these feature as part of the programme.

Appendix One

NHSR Maternity Incentive Scheme year 5 – Flash Report @ 10/07/2023

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Reporting to: Divisional Triumvirate Meeting / Maternity Assurance Committee / Service Line	**Operational Lead: Samantha Cole**
Report Date: 10th July 2023	**Clinical Leads: Paula Shore / Srini Vindla**
Completed by: Samantha Cole	**DGM: Matt Warrilow**

Key Actions Completed

- Safety action leads and teams established
- All initial meetings held working through guidance and identifying any gaps / concerns
- Futures platform created and evidence folders created
- Safety action compliance tracker shared with MAC 28th June 2023 and at Safety Champions on 4th July 2023
- First fortnightly drop in session with leads held 6th July 2023
- Requested clarification on safety action 3 regarding babies to include part c
- Requested clarification on safety action 10 to confirm HSIB / MNSI / CQC are one entity
- Agreed MAC dates to go through evidence for each safety action
- Extended MAC sessions

Next actions to be completed

General

- Safety action leads to arrange separate meetings with teams to start evidence collection / planning / setting actions to progress
- Review of futures interaction and evidence gathering at each fortnightly catch up

Safety Action specific

- SA1 – SC to add deadline dates/RAG within PMRT tracker on each timeframes to aid timely data collection
- SA2 – Team to do a 'dummy' run checking CQIMs / ethnic category collection following July's MSDS submission to highlight any potential DQ issues that can be addressed in advance of Octobers submission
- SA3 – Team to work on an action plan to implement TC Pathway to go to MAC August/Sept, also reviewing policies
- SA4 – SC to be given access to CLW rota to evidence adherence to Anaesthetic medical workforce. Sc to contact SR regarding Neonatal workforce evidence
- SA5 – LB to look at plan to address the findings of the table top exercise of BirthRate+
- SA6 – SS to request that RN ensures that the SBLCBv3 national tracker wording matches to NHSR ask
- SA7 – SC to contact MVNP for evidence relating to establishment, infrastructure and funding.
- SA8 – SC to upload TNA plans to futures. Team to work through local training plan for implementation of V2 of core competency framework. Plan for adhoc emergency scenario to be conducted
- SA9 – PS to gain evidence that non-exec and exec safety champions have registered on dedicated Futures workspace by 1st August 2023 (was 1st July 2023 in original guidance)
- SA10 – SS to prepare templates to collect qualifying cases

NHSR Maternity Incentive Scheme Compliance Tracker

SA1	Safety Action Name	Safety Action ask	SA Teams	Tracking RAG Rating position by month							
				May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
1	Perinatal Mortality	Are you using the National Perinatal Mortality Review tool to review perinatal deaths to the required standard?	Sarah Sajant/Louise Heath/Amy Dewar/Hannah Lewis								
2	MSDS	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Lisa Butler/Matt Vake								
3	Transitional care services	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Rhian Cope/Kelly Marie McMeo/Rachael Giles/Lynsey Lord/Tilly Paul/Mohammad								
4	Clinical Workforce	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Susie Al-Samarai/Simon Rhodes/Sarah Hennell								
5	Midwifery Workforce	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Paula Shore/Lisa Butler								
6	Saving Babies Lives	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies Lives Care Bundle Version Three?	Sarah Sajant/Ruth Nambambe/Claire Allison/Natalie Pottst/Sophie Cave/Hannah Lewis								
7	Listening & coproduction	Listen to Women, parents and families using Maternity and Neonatal services and coproduce services with users	Gemma Boyd/Julia Andrew								
8	Training	Can you evidence the following 3 elements (in the SA breakdown) of local training plans and 'in-house', one day multi professional training?	Lisa Butler/Page Eastwood/Natalie Pottst/Julie Vizard								
9	Board Assurance	Can you demonstrate that there are robust processes in place to provide assurance to the Board on Maternity and Neonatal safety and quality issues?	Paula Shore								
10	HSIB/MNSI Early notification	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolutions' early Notification (EN) scheme?	Sarah Sajant/Hannah Lewis								