Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:**	16th September 2024
Prepared By:	Sarah Ayre Head of Midwifery, Women and Childrens		
Approved By:	Phillip Bolton, Executive Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery/Divisional Director of Nursing, Women and Childrens, Phillip Bolton, Executive 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	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community
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 items have been presented before

- Nursing and Midwifery AHP Committee
- Perinatal Assurance Committee (PAC)
- Divisional Governance Meeting
- Maternity and Gynaecology Clinical Governance
- Paediatric Clinical Governance
- Service Line
- DPR
- Perinatal Forum
- Divisional People Committee
- Senior Management Team weekly meeting

Acronyms

- Maternity and Neonatal Safety Champion (MNSC)
- Maternity and Neonatal Voice Champion (MNVP)
- Perinatal Assurance Committee (PAC)
- Care Quality Commission (CQC)
- Local Maternity and Neonatal System (LMNS)

Executive Summary
The role of the maternity and neonatal safety champions is to support the regional and national Safety Champions as local champions for delivering safer outcomes for pregnant women, birthing individuals, and their babies. At provider level, local safety champions should: • Build the maternity and neonatal safety movement in your service locally, working with your clinical network safety champions, 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 perinatal team working to deliver safe, personalised care. • act as a conduit to share learning and best practice from national and international research and local investigations and 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 August 2024

1. Service User Voice

A key focus in August for Maternity service user feedback has been communication, particularly in terms of how midwives and doctors explain details of care to women and birthing individuals to ensure they are able to make an informed choice. Our MNVP have been collaborating with staff on setting and managing realistic expectations for service users; for example, in the antenatal period, how often they will see a midwife, in addition to information on postnatal care when on the ward and what to expect around receiving pain medication, mealtimes and mobilising post a theatre admission. The MNVP are also working on how we can best ensure consistent messaging across the MDT – however we recognise this is nationally acknowledged as an issue in service user feedback.

Neonatal feedback has also been predominantly positive. There has been a theme again around communication. One parent did comment that in a conversation about discharge, she did not like the phrase "don't want to set you up to fail." Whilst she understood the sentiment and knew it was not meant with any negative intent, she felt it was insulting and implied the parents were not competent to take their babies home even though they had gone through all the necessary 'training'.

Overall feedback through August has been positive especially surrounding breast/chest feeding and midwives on the wards in terms of 'bedside manner.'

On 27th September we are pleased to be welcoming the MNVP team to our Kingsmill Hospital maternity site for the 15 Steps service user initiative.

Clare and Tara	Manda and Volunteer	Emma and SFH personnel
Transitional care	Bereavement suite	Neonatal unit
Postnatal unit	Labour suite	Antenatal ward
Clinics/antenatal appointments	Triage	

On the day the MNVP will provide face to face feedback, and they will also submit a detailed written report. This will be presented at the MNVP board meeting in October and at the MNSC meeting in November. We will work together to agree any actions and later in the year the MNVP team will organise a follow-up meeting to assess progress.

2. Staff Engagement

The planned monthly MNSC Safety Champions Walk around took place on Thursday 12th September 2024. In support of our new Non-Executive Director (NED) for Women and Childrens, Neil McDonald's (NM) request to observe and understand the pregnancy journey as experienced by our service users, this month's focus was community and specialist midwifery.

NM and Paula Shore (PS), Director of Midwifery and Divisional Director of Nursing (DoM/DDN) spoke with staff from the service, and they outlined area's which they are proud off, particularly the homebirth service and the continuity they can provide all women during the antenatal and postnatal period. They also spoke the challenges they face with estates within community, notable the eviction of midwifery services from GP practices. They spoke about the main concerns around ensuring that women, especially those with a high deprivation index, can access midwifery services. NM and PS took an action away to look at offers for transport and engagement with GP services.

The next walkaround is planned for Tuesday 8th October and will focus on our antenatal ward and induction of labour care.

The monthly Maternity Forum took place on 19th September 2024. PS has provided the following overview:

This monthly meeting was attended by members of staff across the service who took the opportunity to welcome Nicole Bulley our new Intrapartum Matron who has started an 18-month secondment with SFH on the 16th of September 2024. We spoke about the actions from previous meetings, a parking update around the planned works was provided to the teams, which has been raised as an ongoing issue. We also spoke about the revised plan for staff support, following listening to the teams and how this model will look moving forward.

We also took the time to acknowledge the recent Excellence Awards from our staff across the division who received nominations to the Lotus and Bereavement Teams who won their categories. We had an update from the Infant Feeding Lead, Consultant Midwife, Recruitment and Retention Lead Midwife and Induction of Labour Lead Midwife. All discussed the progress within their roles and the Induction of Labour Lead Midwife plans to present the quality improvement work at the upcoming Celebrating Excellence Event on the 16th of October 2024.

The next Maternity Forum is planned for the 25th of October 2024.

3. Governance Summary

We currently have two live risks associated to Triage scoring 12, and these are held by Head of Midwifery Sarah Ayre (SA) with a review date for 18th October 2024. An full update will be provided at the November meeting.

ID	Handler	Division	Risk title:	Opened	Closed date	Risk Type	Approval status	Risk Subtype	Rating (current)	Review date
2893	Sarah Ayre	Women and Children's Division	BSOTS triage system has not been fully embedded within Maternity Triage.	28/03/2024		Patient harm	Service level risk	Modify - take action to improve control of the risk	12	18/10/2024
2892	Sarah Ayre	Women and Children's Division	Maternity Triage Telephone Service	25/03/2024		Patient harm	Service level risk	Modify - take action to improve control of the risk	12	18/10/2024

Risk 2893 Embedding BSOTS

Currently our Digital Lead Midwife Nicola Armstrong (NA) is leading on data quality analysis pulled from Badgernet to ensure we can evidence the impact of embedding BSOTS.

Risk 2892 Maternity Telephone Triage Service

Current focus is on ensuring all calls into Triage are recorded. This facility should be live by the end of September.

Three Year Maternity and Neonatal Delivery Plan (March 2023):

The Maternity Team continue to collaborate with the LMNS on the 4 main themes and the 12 objectives of the delivery plan:

Theme 1: Listening to and working with women and families with compassion
- Objective 1: Care that is personalised
- Objective 2: Improve equity for mothers and babies
- Objective 3: Work with service users to improve care

Theme 2: Growing, retaining, and supporting our workforce
- Objective 4: Grow our workforce
- Objective 5: Value and retain our workforce
- Objective 6: Invest in skills

Theme 3: Developing and sustaining a culture of safety, learning, and support
- Objective 7: Develop a positive safety culture
- Objective 8: Learning and improving
- Objective 9: Support and oversight

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care
- Objective 10: Standards to ensure best practice
- Objective 11: Data to inform learning
- Objective 12: Make better use of digital technology in maternity and neonatal Services

The current focus as a system is the 7 day a week bereavement care provision, specifically with the counselling support available for families. For us at SFH this includes the introduction and development of the Rainbow Clinics in collaboration with Consultant Obstetrician Ms Alicia Hills and our award-winning Bereavement Midwives, Louise Heath (LH) and Amy Dewar (AD). This follows the nationally accredited model developed in Manchester. The team will be visiting the Manchester clinic in December 2024 and currently propose a joint approach to support families at appointments offering continuity to the families.

The Rainbow Clinic

This is a specialist service for women and their families in a pregnancy following a stillbirth or neonatal death. Becoming pregnant after a stillbirth is an incredibly daunting prospect. Around half of all stillbirths are unexplained, leaving parents feeling powerless in a following pregnancy to stop it happening again. The standard of care given to women who have suffered a stillbirth varies across the country, often with no continuity of care. Parents have to endure the distress of having to explain their previous loss to health professionals over and over again.

Ockenden:

The report received following our annual Ockenden visit in October 2023 forms the basis of the robust action plan currently overseen by Head of Midwifery SA. The visit findings supported the self-assessment completed by the Trust. Area's have been identified from the visit to strengthen the embedding of the immediate and essential actions however, important to note the continuing progress as a system around bereavement care provision, specifically with the counselling support. This is being progressed now through the systems Transformation Committee attended by Head of Midwifery SA.

NHSR:

The Task and Finish group for the Maternity Incentive Scheme (MIS) Year 6 is now established, meeting fortnightly to work through the evidence upload needed to meet each of the 10 Safety Actions. Each action has been allocated a nominated individual who is required to present evidence and escalate any concerns around challenges faced in achieving within the agreed monitoring period. The group is chaired by Speciality General Manager Sam Cole (SC) and in collaboration with Operations Manager Jess Devlin (JD). Several national changes have been communicated since year 5 and the team have updated their work plan accordingly.

In brief the safety actions are:

SA1 Perinatal Mortality Review Tool
SA2 Maternity Services Data Set
SA3 Transitional Care
SA4 Workforce – medical
SA5 Workforce – midwifery
SA6 SBLCBV3
SA7 Service User
SA8 Training
SA9 Board assurance
SA10 Maternity and Newborn Safety Investigations (MNSI) programme and NHS Resolution's Early Notification (EN) Scheme

Currently all actions are assessed as AMBER which is defined as 'on target with evidence to be submitted and reviewed.'

CQC:

Following the "Good" rating from the planned 3-day visit from the Care Quality Commission (CQC) in early 2020, the evidence submitted has been rated as "green" through the QC. It is noted however that further work is needed for these actions to become embedded, and a clear action plan is being reviewed and overseen by Head of Midwifery SA and Quality and Safety Lead Midwife Hannah Lewis (HL): The "Must-Do" progress will be tracked through Perinatal Assurance Committee.

In support of ensuring we are progressing, a revised peer review programme has commenced, initially across our acute areas within maternity to review the CQC programme; a current focus on infection prevention and control across the Maternity Ward is being overseen by Matron Melanie Johnson (MJ) with escalation to MNSC.

The first Peer Review took place on Wednesday 11th September 2024 and feedback will be shared with a robust response to any actions required for the next MNSC Maternity focused meeting in November.

4. Quality Improvement

Divisional Strategy

Next steps: review of our key objectives and ambitions, benchmarking progress is underway and being overseen via the senior triumvirate at our weekly Senior Management Team (SMT) meeting.

Maternity

New Matron for Intrapartum Services commenced in post on 16th September, and we would like to formally welcome her to the team. Nicole Bulley is an external recruit joining us from Chesterfield.

Antepartum Haemorrhage (APH) and Intrapartum Haemorrhage (IPH) – we have participated in a system wide meeting, supported by the regional Midwifery, Obstetric and QI team alongside MNSI and the Health Innovation Network. This group is reviewing the evidence around APH and IPH to plan an evidence-based approach to the assessment and management of APH/IPH noting the concerns that have been raised on both sites and seen as a theme through our recent coronial cases.

The work on APH and ensuring situational awareness and appropriate clinical care by all staff from the point of a call into Triage and attendance at the Unit, has been the focus following the PFD notices. The APH Guideline has been updated, ratified, and shared with the MDT. The main amendment is noted below:

Neonatal

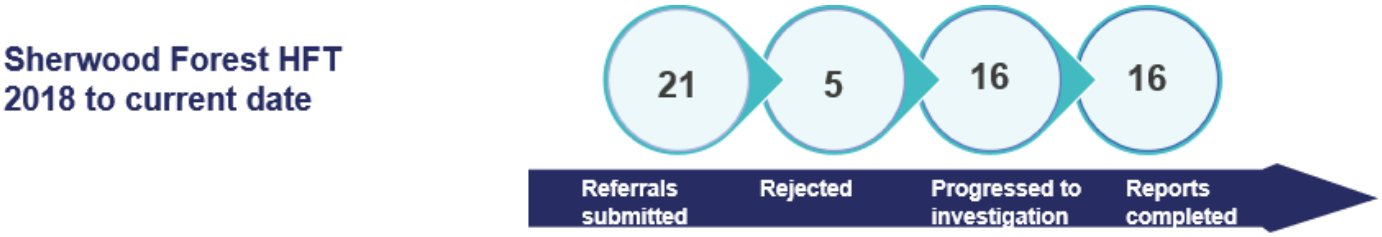
New Matron for Children and Young People commenced in post at the end of August, and we would like to formally welcome her to the team. Matron Sarah Jenkins is an internal appoint coming from Ward 25.

Transitional Care (safety action 3) – Task and Finish group to be launched to support embedding of the service, relaunch of SOP and staff roles and responsibilities. Collaboration across Maternity and Neonatal leadership team to undertake the work streams identified. Update on plan and progress to be shared at MNSC meeting in October.

5.Safety Culture

On Thursday 12th September we were pleased to welcome MNSI to the Trust for their Quarterly Review Meeting (QRM). The meeting was hosted by Quality and Safety Lead Midwife HL and attended by 15 MDT staff. The purpose of the QRM is to encourage an open and JUST culture around learning from incidents and to ensure all staff are afforded an opportunity to contribute.

We noted:



Overview of all referred cases

Number of referrals	Number of cases rejected	Number of completed investigations	Number of live investigations
21	5- Duplicate- 1 Lack of family consent- 1 Did not meet criteria- 3	16	0

	2019	2020	2021	2022	2023	2024
IPSB	0	1	0	0	3	0
NND	0	3	0	2	1	1
HIE/Cooling	0	2	0	0	0	2
MD	2	0	3	0	1	0
Total	2	6	3	2	5	3

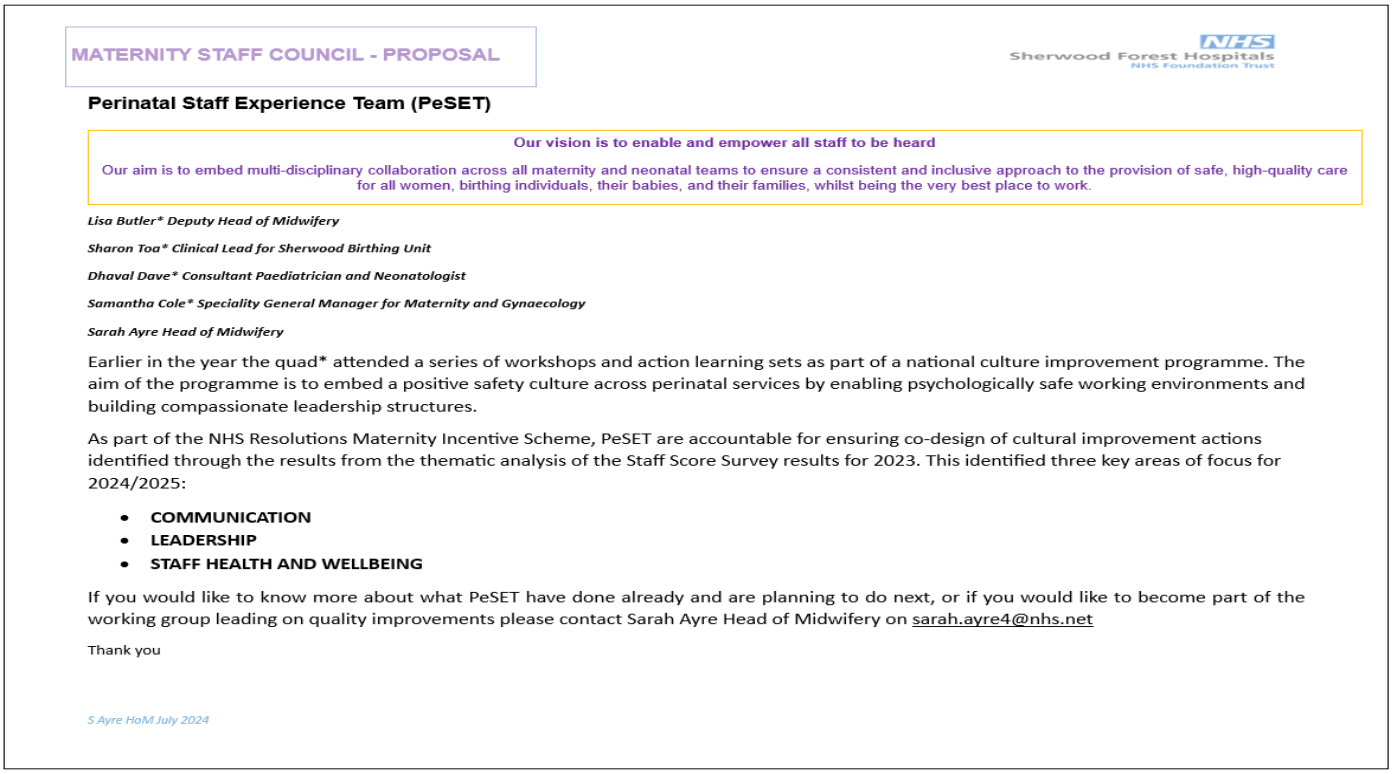
5

Overall, the QRM presented an opportunity for some insightful discussion around key national findings and an opportunity for our staff to discuss learning.

NHSE Perinatal Culture and Leadership Programme

With the aim of nurturing and growing our safety culture, enabling psychologically safe working environments, whilst continuing to build compassionate leadership, 4 of our senior leaders attend a series of workshops and action learning sets as part of a national programme focused on Cultural Safety led by NHSE. This has provided dedicated time for them to work and learn together, and embed a wider culture programme around ensuring staff voices are heard, that issues impacting the delivery of high quality and safe care are addressed openly whilst also ensuring senior leaders are accountable and active in influencing and embedding change.

The objectives identified by the team have a wider, long-term perspective but has both short and long term aims to improve our safety culture. The next step for this work is captured in the poster below:



MATERNITY STAFF COUNCIL - PROPOSAL

Sherwood Forest Hospitals NHS Foundation Trust

Perinatal Staff Experience Team (PeSET)

Our vision is to enable and empower all staff to be heard

Our aim is to embed multi-disciplinary collaboration across all maternity and neonatal teams to ensure a consistent and inclusive approach to the provision of safe, high-quality care for all women, birthing individuals, their babies, and their families, whilst being the very best place to work.

Lisa Butler Deputy Head of Midwifery*

Sharon Toa Clinical Lead for Sherwood Birthing Unit*

Dhaval Dave Consultant Paediatrician and Neonatologist*

Samantha Cole Speciality General Manager for Maternity and Gynaecology*

Sarah Ayre Head of Midwifery

Earlier in the year the quad* attended a series of workshops and action learning sets as part of a national culture improvement programme. The aim of the programme is to embed a positive safety culture across perinatal services by enabling psychologically safe working environments and building compassionate leadership structures.

As part of the NHS Resolutions Maternity Incentive Scheme, PeSET are accountable for ensuring co-design of cultural improvement actions identified through the results from the thematic analysis of the Staff Score Survey results for 2023. This identified three key areas of focus for 2024/2025:

- **COMMUNICATION**
- **LEADERSHIP**
- **STAFF HEALTH AND WELLBEING**

If you would like to know more about what PeSET have done already and are planning to do next, or if you would like to become part of the working group leading on quality improvements please contact Sarah Ayre Head of Midwifery on sarah.ayre4@nhs.net

Thank you

S Ayre HoM July 2024

The first action for PeSET is to embed Tree Teams. This work will commence in September and an initial update will be provided to MNSC in November. From each of the smaller teams volunteers will form the Staff Council.

6. LMNS

On 30th July Sarah Pemberton (SP) Head of Quality for Maternity & LMNS lead midwife and Marie Teale (MT) Deputy Head of Maternity Commissioning visited our Maternity Service at SFH. The key aim of their visit was to introduce themselves to the maternity staff on duty with a forward plan to undertake a regular programme of visits to the unit, to ensure our team become familiar with the LMNS team and its function.

They spoke to staff about how they are supported following incidents at work and if they feel comfortable in seeking support and raising concerns through the maternity team or through freedom to speak up (FTSU) guardians. Also, as the ICS have recently funded a larger Maternity and Neonatal Voices Partnership (MNVP) team through the LMNS they established what knowledge the staff had about MNVP with the aim of developing the MNVP workplan for 2025/2026. Finally, they spoke to staff about the implementation of BSOT's (Birmingham Symptom Specific Obstetric Triage System) in Triage.

Their report was received Mid-September and can be accessed below:

SFHT Maternity Quality LMNS visit Ju

In summary the feedback was positive from both staff and women however some key areas of focus were confirmed, and this is around staff support and staff knowledge of the function of our MNVP.