Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:** 1 February 2024	
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 of Directors 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
- Maternity Assurance Committee
- Quality Committee

Acronyms

- Baby Friendly Initiative (BFI)
- Care Quality Commission (CQC)
- Local Maternity and Neonatal System (LMNS)
- Maternity and Neonatal Safety Champion (MNSC)
- Maternity and Neonatal Voice Champion (MNVP)
- Perinatal Culture and Leadership programme (PCLP)
- Saving Babies' Lives Care Bundle (SBLCB)

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 January 2024

1.Service User Voice

In January 2024 we saw the re-launch, following the COVID-19 lockdown, of birthing partners staying overnight on the Maternity Ward. This has been a co-production project, working with the MNVP and the LMNS to respond to CQC Maternity Survey results in 2022, where birthing people wanted to have their partner with them overnight. The working group secured funding for recliner chairs that pull out to beds for every room on the birthing unit and maternity ward. The MNVP have carried out further scoping of service user's thoughts through their networks and the feedback was that birthing people wanted their significant support person to be able to stay overnight if they wished.

We now have a co-produced a guideline with the MNVP and a volunteer has written a leaflet for families to explain the option. We are planning an official celebratory launch with the MNVP on the 30th of January 2024.

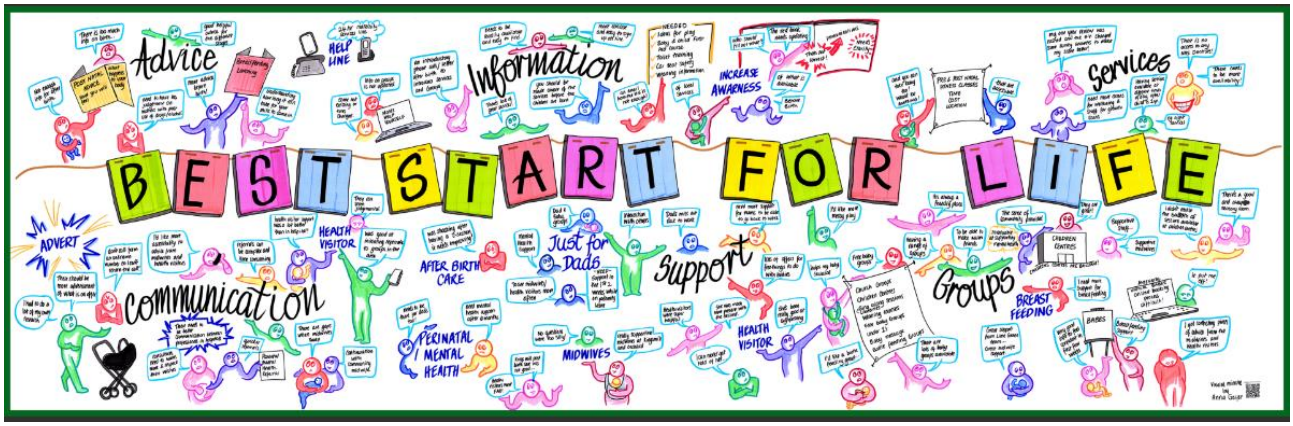
Following the Best Start Event, reported in the November MNSC paper, the below infographic was shared with the team as part of the feedback following the event, areas for celebration have been shared but equally the points raised to address will be actioned through the MNSC meeting.

To celebrate:

"Great support from the Lime Green Team and Community Midwife"
"Really supportive Midwives at Kings Mill and Orchard (Medical Practice)"
"No question was ever too silly"

To address:

"Too much information on birth and not enough on postnatal"
"Better communication between professionals at the hospital"
"Don't call from unknown call numbers"
"Introductory phone call/ letter after birth to introduce services and groups"



2.Staff Engagement

The planned MNSC walk round took place on the 9th of January 2024. Staff reported the high activity and the challenges this presented particularly around the triage environment. The MNSC walked the patient journey through with the team to understand fully the estates challenges. Whilst this is phase 2 of the triage implementation this may need to be brought forward. Areas within the division where also explored for potential of a move and the MNSC have taken this away as an action to progress.

The revised format of the Maternity Forum started on the 11th of January 2024 following feedback from previous forums in 2023. Due to the Trust position on mask wearing, this session had to return to teams only, but high attendance was noted particularly from members of the team who have not joined before. The Director of Midwifery provided the team with an update from previous meetings and reinforced the communication channels within the Division and wider Trust.

The Midwives shared up coming events, such as the Royal College of Midwives annual general meeting, newly appointed team members and updates around the QI work for Induction of Labour and Aromatherapy. Our Maternity Clinical Support Trainer also update of the progress of the Maternity Support Worker Transformation.

3.Governance Summary

Three Year Maternity and Neonatal Plan:

The Maternity Safety Team continued to work with the LMNS at looking at the planned workbook activities and how this can embed into the current work the division is undertaking. Key deliverable have been identified, such as the BFI status for Maternity and Neonatal services, and are on track for the 2027 deadlines.

Ockenden:

We have received the annual Ockenden insight visit report from our visit in October, the action plan is in place and discussed through the MNSC meetings. The visit findings supported the self-assessment completed by the Trusts. Area's have been identified from the visit to strengthen the embedding of the immediate and essential actions; these are included within the action plan and focus on bereavement resources across the system.

NHSR:

The Year 5 submission for full compliance has now been approved through Trust Board on the 4th of January 2024 and Executive Partners on the 16th of January 2024. The final submission will be made to NHSR for the deadline of the 2nd of February 2024.

Saving Babies Lives:

SFH has continued to monitor its compliance with all elements of the Saving Babies' Lives Care Bundle (SBLCB) in version 2 and following the uploaded evidence submitted to the regional teams we have received confirmation that we have achieved the agreed over 70% of compliance for version 3 (SFH currently at 87%). Work continues to ensure that we aim for full compliance within the agreed time thresholds.

CQC:

Following the “Good” rating from the planned 3-day visit from the Care Quality Commission (CQC) the evidence has been rated as “green” through the QC, further is needed for these actions to become embedded. The “Must-Do” progress will be tracked through the MNSC. The Trust Mandatory training remains above the 90% threshold and a standardised triage system is in place, this continues to have support from a task and finish group to ensure this becomes embedded.

4. Quality Improvement

In January the SFH Improvement Faculty presented the SFH MatNeoSIP team with an ambassador award. The Mat/ Neo SIP team support the works from the national Maternity and Neonatal Safety Improvement Programme (MatNeoSIP). This programme is led by the National Patient Safety team and covers all maternity and neonatal services across England. It continues to be supported by 15 regionally based Patient Safety Collaboratives.

The programme aims to:

Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high-quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England contribute to the national ambition, set out in Better Births of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 50% by 2025.

The nomination noted that the *“Maternity and Neonatal Services Team have implemented a wide range of improvement projects and are the recipients of our third Improvement Ambassador Award”.*

5.Safety Culture

The planned work of debriefing is now in its second week and staff have engaged openly with the conversations. A written letter has been sent from both the organisational delivery lead and the triumvirate to support the plans moving forward with the feedback to the MNSC.

The planned debriefing feeds back into the wider work around the national Perinatal Culture and Leadership Programme (PCLP). Hosted by NHS England the PCLP is designed to support the teams to create and craft the conditions for a positive culture of safety and continuous improvement. This will have a positive impact on the experiences of women, families and babies and enable a more collaborative, supportive workplace for you and your wider teams. The PCLP also aims to enable psychologically safe working environments and develop compassionate leadership to make work a better place to be.

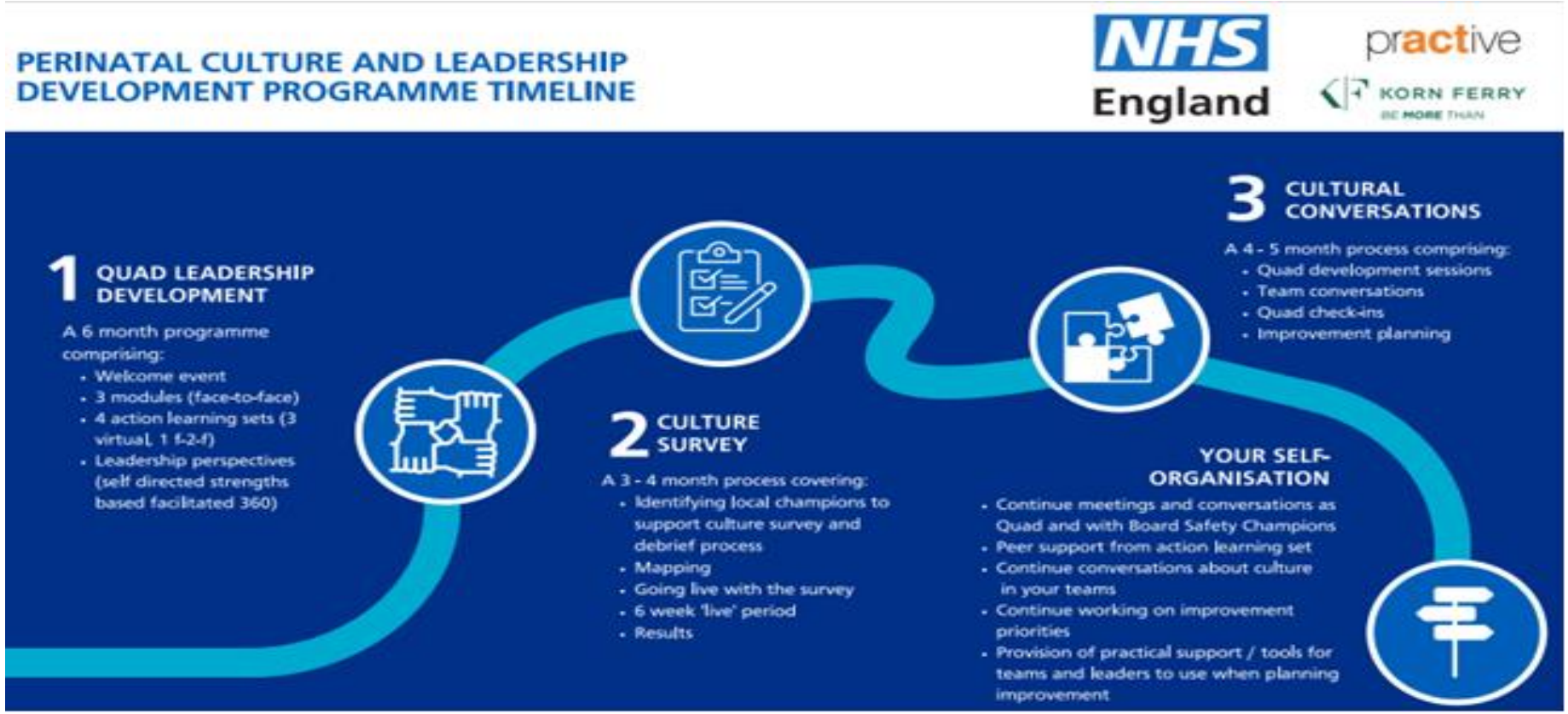
The PCLP supports the:

*National ambition – To halve the number of stillbirths, neonatal and maternal deaths and brain injuries by 2025, by equipping senior perinatal leaders to create the conditions for a culture of openness, safety and continuous quality improvement through positive, inclusive and compassionate leadership.

*Three-year delivery plan for maternity and neonatal services – The plan sets out that by April 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership, including a diagnosis of local culture and practical support to nurture culture and leadership.

*Ockenden and Kirkup reports – The PCLP addresses themes of flawed teamworking; pulling in different directions, a lack of compassionate care and the importance of fostering a culture of learning and transparency. It emphasises the value of training together as a team, with a focus on relational aspects of the maternity and neonatal team dynamic, with compassion being at the centre.

The below infographic outlines the progress through the programme, as SFH have recently conducted a culture survey, this can be utilised for the second stage and Quad will now start looking into the third stage.


PERINATAL CULTURE AND LEADERSHIP DEVELOPMENT PROGRAMME TIMELINE
NHS England
practive
KORN FERRY
1 QUAD LEADERSHIP DEVELOPMENT
A 6 month programme comprising:
• Welcome event
• 3 modules (face-to-face)
• 4 action learning sets (3 virtual, 1 f-2-f)
• Leadership perspectives (self directed strengths based facilitated 360)
2 CULTURE SURVEY
A 3 - 4 month process covering:
• Identifying local champions to support culture survey and debrief process
• Mapping
• Going live with the survey
• 6 week 'live' period
• Results
3 CULTURAL CONVERSATIONS
A 4 - 5 month process comprising:
• Quad development sessions
• Team conversations
• Quad check-ins
• Improvement planning
YOUR SELF-ORGANISATION
• Continue meetings and conversations as Quad and with Board Safety Champions
• Peer support from action learning set
• Continue conversations about culture in your teams
• Continue working on improvement priorities
• Provision of practical support / tools for teams and leaders to use when planning improvement