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:**	5 September 2024
Prepared By:	Sarah Ayre Head of Midwifery, Women and Childrens		
Approved By:	Philip Bolton, Executive Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery/Divisional Director of Nursing, Women and Childrens, Philip 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	**X**
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

- Divisional Governance Meeting
- Maternity and Gynaecology Clinical Governance
- Paediatric Clinical Governance
- Service Line
- DPR
- Maternity Forum
- Divisional People Committee
- Senior Management Team weekly meeting

Acronyms

- APH - Antepartum Haemorrhage Intrapartum Haemorrhage (IPH),
- BSOTS - Birmingham Symptom Specific Obstetric Triage System
- CQC - Care Quality Commission
- IPH - Intrapartum Haemorrhage (IPH),
- KLOE – Key lines of enquiry
- LMNS - Local Maternity and Neonatal System
- MIS – Maternity Incentive Scheme
- MNSC - Maternity and Neonatal Safety Champion

- MNSI - Maternity and Newborn Safety Investigations
- MNVP - Maternity and Neonatal Voice Champion
- RSV - Respiratory syncytial virus
- SBLCB – Saving Babies Lives Care Bundle

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 deliverable in July 2024, as reported, was the MNVP identifying that nationally the free text report for the annual CQC survey from February 2023 had been made available. Through joint working this report was made available to the team and they are now leading on the survey feedback, building the comments into an action plan. 300 women were invited to participate and 116 completed the survey, which is a 39% return rate. Some of the free text received from our service users:

"I repeatedly asked for an epidural and was ignored multiple times."

"I was made aware by every member of staff how short staffed the department was which made me feel unsafe"

"I found the most difficult aspect after birth was trying to breastfeed my baby and think that if I had received more information before the birth, I would have been better prepared at how hard breastfeeding can be"

"I was asked to come in for growth scan I was told it was most likely I'd be induced I never got told any information about the induction until the week before I wasn't very happy with that service."

Most Sherwood Forest Hospitals NHS Foundation Trust's scores are in the intermediate-60% range of all Trusts surveyed by IQVIA. There are 9 scores in the top-20% range, which appear mainly in the antenatal and postnatal care at home sections. There are 9 scores in the lower-20% range, which are mainly in the labour and birth section.

Nearly all responses showed very little statistical change from the previous year (2022). It is important to remember that our women and birthing people were surveyed in February 2023 and many of the actions from the previous year's responses had not been fully implemented due to the publication of the previous year's report only being released in November 2022. Many of the recommendations made in that report were addressed in last year's action plan and this work continues with improvements likely to be reflected in the survey results for 2024, anticipated mid-2025.

The current action plan will be presented by Consultant Midwife Gemma Boyd in collaboration with our MNVP Leads at September's MNSC meeting and is overseen by Sarah Ayre, Head of Midwifery through Maternity and Gynaecology Clinical Governance (monthly), Maternity and Neonatal Safety Champions (every other month) and the LMNS Patient Safety and Quality Group (quarterly). The report has also been shared openly with our multi-disciplinary staff for awareness.

2. Staff Engagement

The planned MNSC walk round was undertaken on Tuesday the 6th of August 2024 introducing and welcoming the new Non-Executive Director (NED) for Women and Childrens Neil McDonald.

Neil has lived in Nottinghamshire since 1999 and joined the Trust Board as a Non-Executive Director in December 2023. He has 38 years' experience in the rail industry, having started out as an engineering apprentice. After 27 years in engineering, he moved into general management as Managing Director of the Industrial Business Unit of EWS Railways/DeutscheBahn, followed by a period as Head of Sales. In 2015, he became the Chief Operating Officer of the first heavy haul Railway in the UAE, a joint venture between DB and Etihad Rail. For five years, he was a Non-Executive Director of the Railway Safety and Standards Board, representing freight members. Since 2018, he has been a member of the Board of Governors for West Nottinghamshire College where has been a member of the Senior Postholder and Governance Committee and Chair of the Audit Committee. He has an MBA from Nottingham Trent University and brings 20 years' executive management experience to the Trust Board.

As part of the planned walkaround, Neil has asked that we spend time over the coming months introducing him to the pregnancy journey, with this month's focus being Antenatal and Outpatients Clinic. Claire Allison, the Matron for Antenatal and Outpatients, spent time talking Neil through the journey in outpatients and highlighted the service and current changes including the national RSV programme which is due to go live at SFH at the beginning of September 2024. Claire highlighted the estates issues that the teams are currently facing in the department and the MNSC were able to support with some immediate resolutions, and support with the ongoing review into the planned outpatient transformation.

The MNSC were able to speak with some staff members, whilst it was clearly a busy session the staff reflected that they loved working at SFH, with one member of staff moving into a significant period of long service. This positive feedback was further echoed across the teams and families using the service that morning.

The next walkaround is planned for 2.00pm on Thursday 12th September 2024 and we will be looking at how Neil can meet and engage with our community and specialist midwifery and nursing teams and families that receive care from these teams.

The monthly Maternity Forum took place, on 15th August 2024. The Forum was well attended by the multi-disciplinary workforce despite increased acuity and operational challenges. Paula Shore, DoM/DDN has provided the following overview:

On the 15th of August we held the monthly Maternity Forum. Chaired by the Chief Nurse and attend by the Chief Executive Officer, open conversation was had around the actions taken following the recent Coroners cases. Staff felt that through open conversations that they understood why the actions were needed. Staff also reflected that the activity felt higher than normal, for an August. Upon reflection, whilst forward looking the activity planned is average it feels that there is a sustained increase in the acuity. This has been identified by the Head of Midwifery who is looking at how as an MDT we could prioritise the workload differently and how we can build this change into this year's establishment review. We also reflected the positive news around this month's Daisy award that was presented to Jess Rawson and the number of nominations and short listing for Staff Excellence Awards that we have received within Maternity Services.

3. Governance Summary

Three Year Maternity and Neonatal Plan:
The Maternity Team continue to collaborate with the LMNS. The first joint meeting with Nottinghamshire University Hospitals, hosted and chaired by the LMNS, was held at the end of June 2024 from which a template has been developed to track agreed actions against the plan and ensure system oversight. It was

acknowledged by the Chair that neonatal collaboration going forward across the system would be strengthened to ensure a perinatal approach to all work streams.

Our senior team are working together to appraise the template in detail and this work is led by Consultant Midwife Gemma Boyd. The initial review of the template has provided assurance to the divisional senior triumvirate of compliance with the main areas however escalation will be made via MNSC meeting in September regarding any areas that may be a potential risk, with a robust plan and trajectory for addressing compliance, overseen by Head of Midwifery, Sarah Ayre.

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 Sarah Ayre. The visit findings supported the self-assessment completed by the Trusts. Areas 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 available for families as a system which is a feature of the Three-Year plan. This is being progressed now through the systems Transformation Committee attended by Head of Midwifery, Sarah Ayre.

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. 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 to
NHS Resolution's Early Notification (EN) Scheme

Midwifery Workforce (Safety Action 5):
Head of Midwifery Sarah Ayre is currently working closely with the Health Roster Team, Matrons and team leads to review availability of staff in post, secondments, flexible working patterns, study leave and management days to ensure safe staffing initiatives. The team are revisiting use of software functions such as auto roster and roster analyser to ensure robust planning. Alongside this is a review and relaunch of the Division's escalation policy, OPEL status management and Bronze on Call support, led by Deputy Head of Midwifery Lisa Butler.

Saving Babies Lives (Safety Action 6):
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. Key area of focus is to support the newest element within the version 3 of the bundle which focuses upon the diabetes service. We have recently recruited a further specialist Midwife and are reviewing current caseloads against national trend of an increase in women and birthing individuals in pregnancy managing diabetes.

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 Quality Committee. 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 Sarah Ayre. The “Must-Do” progress will be tracked through the MNSC. These include Trust Mandatory training, which continues to remain above the 90% threshold, and a standardised triage system: Birmingham Symptom Specific Obstetric Triage System (BSOTS).

The Triage task and finish group, chaired by Divisional Manager Matthew Warrilow, continues to escalate through the MNSC meeting and this work is split into 5 main work streams and is benchmarked against the Royal College of Obstetricians and Gynaecologists (RCOG) Good Practice Paper on Maternity Triage. (Appendix 1)

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 with escalation to MNSC. This includes weekly walkarounds by Head of Midwifery Sarah Ayre and visits by the senior leadership team over night and at weekends to support staff engagement. An action log has been drafted to capture all small works, equipment and signage issues that need addressing and a review of the risk register is planned for September 2024.

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
In terms of 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. We have met twice and asked the academic team supporting us to investigate the literature with the search terms, IPH and APH. We are re-grouping at the beginning of September 2024 to look at the next steps following the literature review.

Neonatal
Transitional Care (safety action 3). A 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 2024.

Urgent review underway to evaluate the MIS Year 6 technical advice for this safety action to ascertain evidence available to ensure compliance, overseen by Rachael Giles, Deputy Divisional Director Nursing.

5.Safety Culture

As part of the perinatal cultural workplan, drawing on the three themes identified, a focused action plan drawing all current work streams together is being devised by Consultant Midwife Gemma Boyd. This action plan will sit within the CQC’s 5 key lines of enquiry (KLOE) and will ensure a focus on communication, leadership and health and wellbeing.

Additionally, following staff feedback, a further element which will be incorporated into the culture plan work is the issues raised following the recent Coroners inquests; this will include how we organise and provide support both for professional learning and personal wellbeing