Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:** 20th March 2024	
Prepared By:	Paula Shore, Director of Midwifery and Divisional Director of Nursing for Women and Childrens.		
Approved By:	Phillip Bolton, Executive Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery and Divisional Director of Nursing for Women and Childrens.		

Purpose		
To update the board on the progress of the 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**	**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

- Maternity Assurance Committee 28/04/2024

Acronyms

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

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 March 2024

1.Service User Voice

In March the Maternity and Neonatal teams implemented a key action against areas of feedback from service users from recent surveys, walk rounds and complaints, this being partners staying overnight.

We have listened to and acted on feedback from new families about how their birthing experience could be improved and as a result, 47 recliners – one for every room and bay on the post-natal ward – have been provided thanks to equal funding from Sherwood Forest Hospitals Charity and Nottingham and Nottinghamshire Local Maternity and Neonatal System (LMNS).

The MNSC spent time talking to women and their families about the impact this has had on their experience and some of this experience was captured by our Communication team, as below.

Holly Fishwick and her husband Matthew were delighted that he was able to stay overnight following the birth of their son Cove. Matthew, who lives in Clipstone, said:

“This has made our lives a lot easier. I can’t imagine what it would have been like having to go home at night.

“The chair fully reclines into a flat bed and is really comfortable, meaning I’m well rested. I can bond with Cove, change nappies, and do simple things to support Holly, like refill her water bottle. Without the extra support of having me here, I don’t think Holly would still be breastfeeding, which is something she really wanted to do.”

2.Staff Engagement

The planned MNSC walk round took place on the 6th of March 2024. The MNSC, as mentioned previously, spent time on the Maternity Ward to talk to families and staff about the impact of birth partners staying overnight.

The champions spent further time on the Neonatal unit speaking to staff about the upcoming Neonatal Peer review and families about their reflections of the time they spent on the unit. An action was taken regarding the provision of hot meals, out of working hours, for the families on the unit. Whilst families reported that they were able to access cold food and had facilities for warming their own food, out of working hours hot meal provision is not available.

On the 14th of March the revised Maternity Forum was held. The forum focused upon the recent staff survey findings, which for maternity showed an improved position on last year's results and when cross reference against the culture survey findings a focus for improvement will be made on three key themes. These themes are highlighted below in the safety culture section (5). Staff spoke positively about the changes within the structures and revised portfolios of the senior leadership team since the new Head of Midwifery post commenced. An action taken from this meeting was to learn more about the changes within the senior leadership team and focused communication will commence next month.

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 deliverables have been identified, and the Trust are working through individual plans. A focus this month is around listening to women, and we are currently looking at the service user voice and the new structure of the Maternity and Neonatal Voice Partnership.

Ockenden:

The action plans continue through following the annual Ockenden insight visit report from our visit in October 2023. 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, progress has been made as a system around the bereavement provision, notable with the counselling support available for families as a system.

NHSR:

The Year 5 submission for full compliance has been submitted to NHSR for the deadline of the 2nd of February 2024. We are awaiting the results and the Year 6 MIS is due for release in April 2024. Provision letters have been provide to organisations to outline some key changes within the safety actions and revised timeframes.

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

A second key area for improvement, identified as a theme through incident review, as a Trust and a System was support for Women when English is not their first language. Following a successful launch event, Maternity services are now utilising the new translator app CardMedic.

Interpreting Services are a vital function within the Trust that allows all of our non-English speaking, and hearing impaired, patients access to fair and equitable care. CardMedic is five times faster than an interpreter, which provides pre-scripted multi-lingual clinical dialog, on-demand as digital flashcards. Whilst this is app is not to replace face to face translation in times when information and support is needed rapidly the app will be utilised.

CardMedic hosts an A-Z library of scripts written by clinical experts that succinctly replicate common clinical conversations. Caregivers choose the topic and display the screen to the patient to guide the clinical interaction. The content can be flexed to 49 languages, sign language videos, 'easy read', or read-aloud.

5.Safety Culture

With the completion of the debriefing for the cultural survey completed and the findings of the national staff survey released, as below, the newly formed perinatal culture team are leading on the action plan for the year. The focus will be around three key themes from the review, these being communication, leadership and health and well-being. Each service line will now focus upon what key actions are needed to support these themes and will be monitored through the People Committee.