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:**	22nd April 2024
Prepared By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing for Women and Childrens		
Approved By:	Phil Bolton, Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing for Women and Childrens		

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	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 this item has been presented before

- Nursing and Midwifery AHP Committee
- Maternity Assurance Committee

Acronyms

- Maternity and Neonatal Safety Champion (MNSC)
- Maternity and Neonatal Voice Champion (MNVP)
- Care Quality Commission (CQC)
- Local Maternity and Neonatal System (LMNS)
- PROMPT - PRactical Obstetric Multi-Professional Training

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 April 2024

1.Service User Voice

A focus this month presented to the MNSC focused on the provision of pain relief during and after birth at SFH. The recent CQC Maternity Survey highlighted the need to address our service-user experiences of pain control. The Parent Voice champion carried out a listening event on the maternity ward and via the MVP volunteer networks to try to gain a wide range of viewpoints across diverse members of our local population.

An antenatal class was also observed as these were paused during Covid and were re-instated after the CQC survey was carried out (full report of this observation available separately as it covers the entire class and not just the section on pain relief). 25 women and birthing people gave their opinions about their pain relief during and after birth and the full themes log is attached, which contains greater detail of individual conversations. People were not pushed to discuss any aspect of their pain relief but instead were asked to share their experiences relating to pain relief.

Description of conversation	Number of people (percentage of all people)
People who said they were offered pain relief in a timely manner	**11 (44%)**
People who said they were not offered pain relief in a timely manner	**10 (40%)**
People who felt they understood all the options for pain relief and could make an informed choice	**14 (56%)**
People who felt they did not understand all the options for pain relief and could not make an informed choice	**5 (20%)**
People who described feeling 'judged' about their choices or felt their choice was taken away from them	**6 (24%)**

Suggested recommendations and updates from the report author following the review.

The following recommendations are suggested for discussion and consideration, depending on resources available and current priorities within the service:

1. Carry out an advertising campaign for the SFH antenatal classes to increase awareness, especially in our more deprived communities:

    •include physically going out to community groups, religious groups, charities, baby groups
    • include digital information and paper leaflets
    • include information in multiple languages

2. Secure funding and staffing to increase choice of day / time and location of antenatal classes to ensure they are accessible for all.

3. (NB: Action already ongoing): Continue the new PROMPT training which includes a session on compassionate communication / being person centred / informed consent and continue to prioritise this as having equal value to clinical expertise.

4. Review in more detail the barriers that exist on the post-natal ward regarding timely access to pain relief, inconsistencies in regularly checking how someone's pain is and staff ability to give more (personalised) information about pain relief options.

5. (NB: This has already been actioned at the time of writing): ensure that information about pain relief options is easily accessible on the SFH maternity public-facing website.

The ongoing monitoring will be cited at maternity governance with any escalation to the MNSC meeting.

2.Staff Engagement

The planned MNSC walk round took place on the 9th of April 2024, following the visit from the Labour leader Keir Starmer and Shadow Health Secretary Wes Streeting. Whilst the activity remained high on the MNSC walk round, staff reflected the positive changes around the staffing which was supporting these higher periods of activity. The teams reflected on the walk round and though the forum regarding the increase in women who chose to have services at SFH that are out of the traditional areas in which sit within the hospital's areas. This has been raised at the MNSC meeting and whilst the work has focused on the retrospective view of postcode analysis the establishment of an "out of area clinic" based at SFH will allow for a more proactive way to manage and plan care given the tangible changes in numbers.

As mentioned on the 8th of April 2024, the MNSC led the visit with the Labour Leader and Shadow Health Secretary spending time speaking to women, birthing people, and families on the maternity ward. The visit was positively received by the staff, women, birthing people, and their families and allowed for discussion around the complexities within maternity and neonatal services.

On the 11th of April 2024 the Maternity Forum was held. Chaired by the Chief Nurse and led this month by the new Head of Midwifery, the teams discussed the changes, following the feedback from the staff and culture survey that are place. The teams also discussed the priority plans for the year, update from the triage working group and workforce planning.

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. The planned focus on the MNVP restructure has been supported and now progressing the focus will now be upon equity within the system.

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 which is a feature of the Three-Year plan.

NHSR:
The Year 5 submission for full compliance has been submitted to NHSR for the deadline of the 2nd of February 2024. We have now received the confirmation that our submission has been successful, and the rebate granted. The Year 6 compliance has now been released and the task and finish group has reinstated to support the submission.

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
The Perinatal Pelvic Health Service (PPHS) for Nottinghamshire official launched at the beginning of April 2024.

The establishment of Perinatal Pelvic Health Service (PPHS) nationwide is a huge step forward to providing women with the knowledge and support that they require through the antenatal and postnatal period, and an open door beyond the immediate postnatal period to receive the specialist physiotherapy that they need when they develop symptoms that impact on their quality of life.

Further, it will change the dialogue for women from confusion about when and where to get help and what to tolerate as 'normal' to an expectation of specialist care to optimise their perinatal experience and minimise their future pelvic floor problems.

As a system the Nottinghamshire LMNS have supported the PPHS and now has in place a team including Maternity Commissioning, Clinical Lead Physiotherapist, Obstetrics and Gynaecology leads and key stakeholders from both organisations to support the work outlined within the long-term plan.

To allow time for embedding and actions, the PPHS plan to present their findings, plans and any QI work to the MNSC in July 2024.

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 perinatal quad verbally updated their progress against the national programme and plans to present a report to the MNSC monthly.