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 December 2024
Prepared By:	Sarah Ayre Head of Midwifery, Rachael Giles Deputy Divisional Director of Nursing, Women's, and Children's Division		
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**	**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	Insufficient financial resources available to support the delivery of services.	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	**X**
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
- Divisional Governance Meeting
- Maternity and Gynaecology Clinical Governance
- Paediatric Clinical Governance
- Service Line
- DPR
- Perinatal Forum (formally Maternity Forum)
- Divisional People Committee
- Senior Management Team weekly meeting

Acronyms

- BAPM British Association of Perinatal Medicine
- CQC Care Quality Committee
- EMNODN East Midlands Neonatal Operational Delivery
- HoM Head of Midwifery
- LMNS Local Maternity and Neonatal System (LMNS)
- MNSC Maternity and Neonatal Safety Champion
- MNVP Maternity and Neonatal Voice Champion
- NICU Neonatal Intensive Care Unit
- PAC Perinatal Assurance Committee
- MSW Maternity Support Workers

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 October 2024

1. Service User Voice

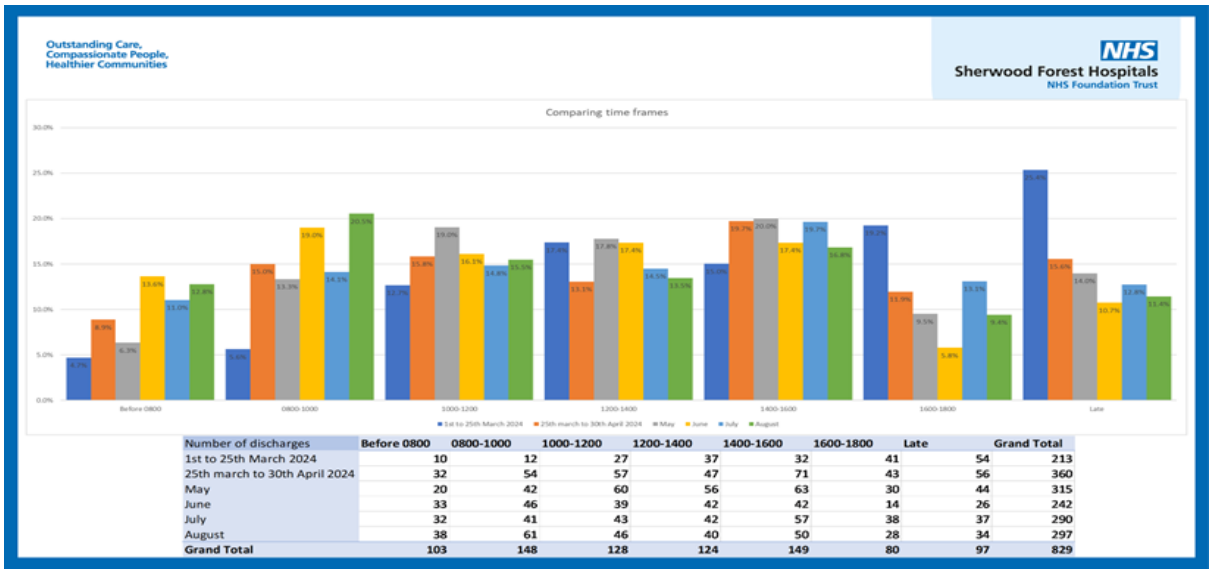
MNVP

On 27th September 2024 we welcomed the MNVP team to our Kings Mill Hospital maternity site for the 15 Steps service user initiative. We have now received the formal feedback and will be welcoming the team back in the New Year to demonstrate the improvements made in support of the areas highlighted. This action plan is available for your perusal on request.

Journey Home

Improvements in discharge home pathways have been initiated, through ensuring a dedicated midwife is available across each day shift to facilitate and prioritise pathways home on our Maternity Ward. This role commenced in March 2024 and the data below will now support the business case to embed this role permanently within our Maternity Ward establishments.

Significantly, please note discharges home before 10am have risen to 61 discharges in August 2024 in comparison to only 12 in March 2024 as demonstrated in the graph below:



Number of discharges	Before 0800	0800-1000	1000-1200	1200-1400	1400-1600	1600-1800	Late	Grand Total
1st to 25th March 2024	10	12	27	37	32	41	54	213
25th march to 30th April 2024	32	54	57	47	71	43	56	360
May	20	42	60	56	63	30	44	315
June	33	46	39	42	42	14	26	242
July	32	41	43	42	57	38	37	290
August	38	61	46	40	50	28	34	297
Grand Total	103	148	128	124	149	80	97	829

Friends and Family Test (FFT)

In October 2024, 50 of a possible 309 service users took time to complete the FFT about the care they received in the Sherwood Birthing Unit. This is recorded as a 16% response rate: 40 recorded care as very good and 6 as good. 1 stated poor and another stated very poor.

Hospital Site Details			Total responses received via each mode of collection								
Divisions	Hospital Site name	Ward Name	1 - Very good	2 - Good	3 - Neither good nor poor	4 - Poor	5 - Very poor	6 - Don't know	Total number of people eligible to respond	Total number of responses for each Ward	Response Rate for each Ward
Womens and Childrens	Kings Mill Hospital	Antenatal Clinic (Touch Point 1)	9	0	0	2	1	0	305	12	4%
Womens and Childrens	Kings Mill Hospital	Community Midwives (Postnatal) (Touch Point 4)	8	0	0	0	1	0	315	9	3%
Womens and Childrens	Kings Mill Hospital	Maternity Ward (Touch Point 3)	43	13	1	1	3	0	315	61	19%
Womens and Childrens	Kings Mill Hospital	Obstetrics	18	7	1	3	1	0	1285	30	2%
Womens and Childrens	Kings Mill Hospital	Sherwood Birthing Unit (Touch Point 2)	40	6	2	1	1	0	309	50	16%
Womens and Childrens	Newark Hospital	Antenatal Clinic (Touch Point 1)	1	0	0	0	0	0	34	1	3%
Womens and Childrens	Newark Hospital	Midwifery Services	0	1	0	0	0	0	79	1	1%
Womens and Childrens	Newark Hospital	Obstetrics	2	1	0	0	0	0	147	3	2%

Ward Sisters alongside support from the housekeepers will be working towards an improved response rate and we will work closely with our MNVP colleagues to best understand how this can be achieved and maintained.

Complaints

One complaint was received by email via PALS in October 2024. The theme was lack of communication from our Obstetric Consultant regarding a treatment plan and concerns regarding the discharge process. This complaint has been allocated for investigation with response due by the end of December 2024**.**

Compliments

We have received several compliments during October 2024, via several sources including through our Professional Midwifery Advocate Julia Andrews and via emails direct to HoM Sarah Ayre, as per below, shared with consent:

Feedback RE Maternity Ward

TB Taylor Blower<taylorblower@gmail.com>

To: AYRE, Sarah (SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST) Sat 16/11/2024 19:25

You don't often get email from taylorblower@gmail.com. Learn why this is important

This message originated from outside of NHSmail. Please do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Sarah,

I'm writing to provide a review of the maternity services I received in the last two weeks welcoming our son Charlie Nightingale into the world on 6th November 2024.

I particularly wanted to outline the outstanding care I received leading up to the birth in Triage with the midwives and Dr's looking after me as in the last two weeks of my pregnancy my blood pressure spiked significantly and is still something I'm suffering with now post partum.

I've recently been discharged from the maternity ward after a second admission following the birth and both times have been looked after by a midwife named Ellie Roache. Ellie thoroughly looked after us on both admissions and understood our desire to be discharged and particularly managed in community for my BP, with being new parents and also with me expressing that extended stays in hospital has a negative impact on my BP overall which reflected why it was getting worse. It did feel like on most other occasions the level of care provided by the midwives on the ward differed significantly, with Ellie being a prime example of what outstanding maternity care should be like.

I wanted to write this feedback to highlight both the triage staff and Ellie on the maternity ward for their outstanding commitment to the care I received whilst in King's Mill and I hope if I ever did have another baby in the future I would recieve such outstanding care again.

Thank you
Taylor Nightingale

Compliments are shared with staff individually, if named, via email and with the MDT through HoM update emails monthly. We also post with the consent of the families on our Facebook SFH Maternity Staff page. As part of feedback from staff requesting a more open way to share positivity, they are leading on creating a positivity board in the corridor between SBU and the Maternity Ward and will share this information here also from January 2025.

2. Staff Engagement

The planned monthly MNSC walk round took place on Thursday 14th November 2024. In support of our new Non-Executive Director (NED) for Women and Childrens Neil McDonald's request, to observe and understand the pregnancy journey as experienced by our service users, this month's focus was on Ward 25 and NICU. The teams have received positive feedback in terms of the information boards providing assurance and information for both staff and families.

As part of the Neonatal peer review and also to support the staffing model within the NICU, we have the support of our Chief Nurse and Non-Exec Director to complete a feasibility study to see how we explore making this happen. This involves removing a wall between room 1 and 2 on NICU to open the area. Options currently being considered and reviewed.

The next MNSC walk round is planned for Tuesday 3rd December 2024.

Due to activity and adverse weather conditions, the Maternity Forum was cancelled on Tuesday 19th November 2024. The next Maternity Forum is planned for 09.00 on 17th December 2024.

You Said We Did

Maternity launched its Staff Council on 23rd October 2024. Representatives from the Staff Council will attend the Maternity Forum monthly commencing in December 2024, to strengthen the staff voice direct to our Trust Executives and will ensure an open and transparent approach to Ward to Board to Ward communication; a frequent request of our staff.

Celebrating Success

On Monday 18th November Maternity Services were pleased to welcome Regional Chief Midwifery Officer Gaynor Armstrong into our Unit.

Gaynor attended to present the Chief Midwifery Officer award to Jodie Prest, Maternity Clinical Support Trainer. Jodie was nominated for the award by Consultant Midwife Gemma Boyd for her dedication and commitment to ensuring the very best care of our women and birthing individuals and their families, through training and developing our band 2 and 3 workforce. Jodie has repeatedly gone the extra mile to ensure she supports and nurtures our teams, demonstrating core Trust values in all she does. Jodie has led in maternity, and it has been a joy to watch her develop within the MSW Clinical Support Trainer role. She has demonstrated that given the right tools and opportunity that MSWs are great forces for change and improvement, influencing senior leaders and being an advocate for her role

Maternity Support Worker Celebration Day – Monday 25th November
The lead up to the Maternity Support Worker celebration day was marked with a week of tea trolley visits from Monday 18th November 2024. These daily visits were hosted by our senior team, leading to an internal awards ceremony.

The focus of the celebration day was on recognising the vital and varied roles the MSW's undertake across our Maternity Services.

On Monday 25th November 2024, we hosted brunch for the team and were fortunate enough to welcome Chief Nurse Phil Bolton and Director of People Rob Simcox, alongside our Director of Midwifery Paula Shore, to present varying awards to our MSWs.
Many staff took time to vote across the categories. Certificates and small prizes were awarded to the winners, with each MSW receiving a token of appreciation from the Senior Leadership Team.

3. Quality and Safety

Risk

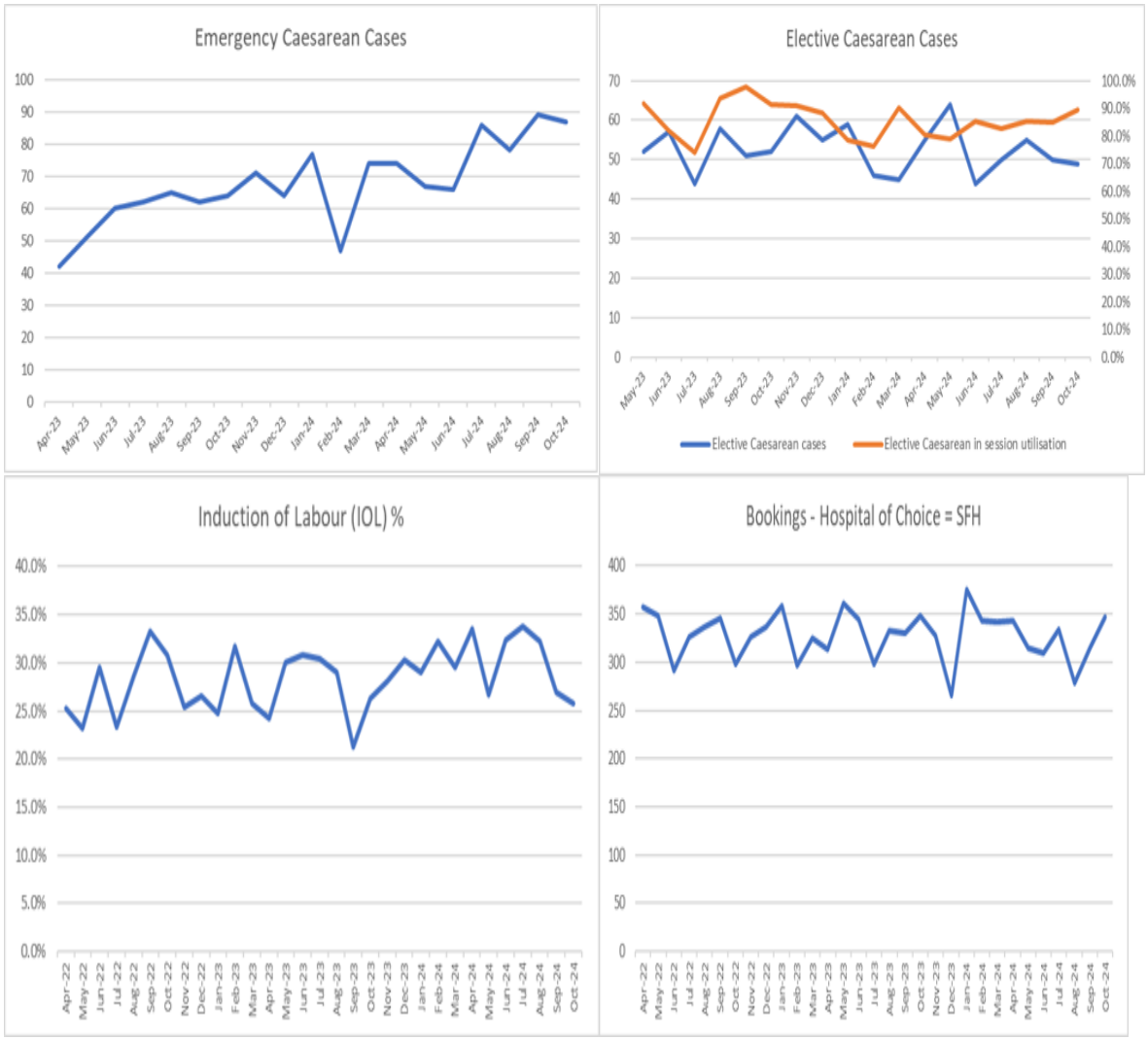
An improved process around managing and reviewing the Divisional Risk register commenced in November 2024. This focused Risk meeting will review the register with key stakeholder's, chaired by Quality Governance Facilitator – Women's and Children's Division Jenny Aldred. Owners will be required to attend to provide updates on actions, and any escalations will be made to Divisional Governance.

Quality Improvement

Maternity

Planned Care Lead Midwife interviews are booked for early December 2024 with a good external response rate to the advert. An Elective Caesarean Pathway Review Group is scheduled to commence on 2nd December 2024 with support from Deputy General Manager Lisa Walker and including Theatre and Anaesthetic colleagues. The aim is to assess movement of elective obstetric theatre cases to the main theatres with consideration to bring elective obstetric cases through the Trust's Planned Care Steering Group.

The data we collect monthly through our dashboard will support the approach taken to embed quality improvements in planned care; such as noted below.



In September 2024, we reported a 17.9% vaginal birth rate after a previous caesarean section. This has improved to 33.3% in October.

Maternity Strategy

The Maternity Strategy for the Senior Leadership Team (SLT) in 2025 will focus on ***clinical excellence and professional standards***. This will include a work stream that will focus on mobility in labour, pain relief options and birthing environment and will involve collaboration with our MNVP, our staff, and will welcome support and learning from our neighbouring units.

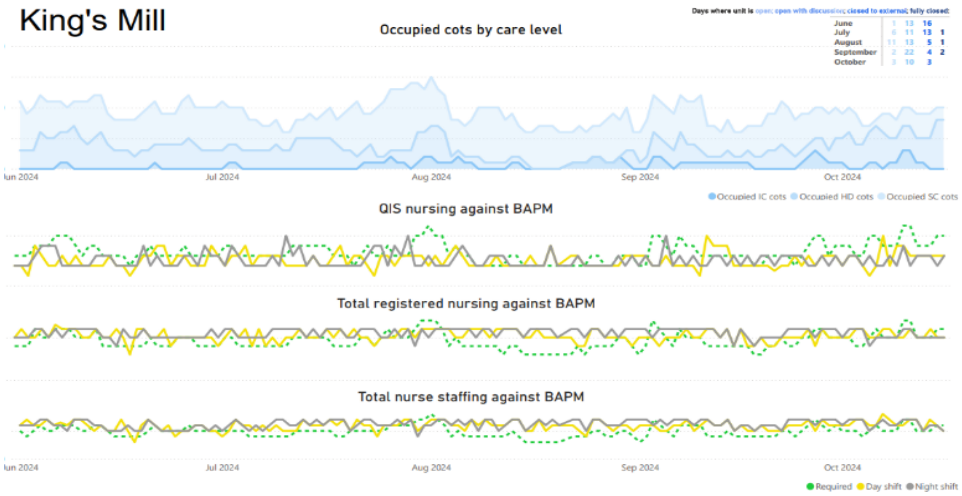
We will also have a focus in 2025 on caring for our leaders and will be working through various mechanisms to support work/life balance. Recent studies of organisational culture and patient safety, emphasise the role of senior leadership. Effective leaders show active engagement with service users and staff, and this has a bearing on safer care. By fostering an environment of psychological safety that encourages others to feel safe communicating issues and speaking up with concerns, we aim to promote and embed a positive organisational climate which will contribute to higher job satisfaction among our SLT, decrease burnout and overall embed a culture of safety

Neonatal update
NICU Home care service:

An SLA is in place with NUH to provide a 7-day service and home phototherapy. The home care team will increase to 4 wte at SFH and network working. The new posts have been successfully recruited to and the staff will be starting in January 2025. The SFH current team will TUPE over on 25th January 2025.

QIS in NNU – BAPM compliance 70%

- We currently have 60.67% of NICU workforce QIS trained.
- By Spring 2025 x2 more staff will be QIS trained, resulting in 65.8%
- By Oct 2025another x4 staff should be trained, resulting in 75.6%



Currently the unit has approximately 7 wte QIS nurse gaps in post, measured against the budgeted establishment. This is partly offset by the over establishment of non-QIS nurses who are expected to complete the QIS training to reduce the gap. The overall gap is 3 wte. These posts are on Trac for recruitment.

Neonatal transition Care service:
The unit has successfully recruited to the band 3 senior support worker role and staff are currently undergoing training and induction. Recruitment of nurses has been successful. The lead nurse has returned to work and is reviewing the SOP and service compliance. This will be reported to the division to identify and support any gaps and ensure we are meeting the MIS Year 6 Safety Action 3.

Network Peer review:
East Midlands Neonatal Operational Delivery Network (EMNODN) undertook a biannual peer review on 24th May 2024. The report was received by the Trust on 4th November 2024. The delay in receipt of the report was acknowledged but we were provided with verbal feedback post review:

- Undertake a risk assessment and develop a business case to increase AHP, psychology and pharmacy funding to meet national recommendations.
- Consider reconfiguration of the unit layout by utilising the cubicles for ITU patients to ensure safe staffing in the cubicle area.

- Develop a business case to expand the ANNP team with a clear job outline.
- 3D tour NICU ready for review December 24 and should hopefully be launched in the new year.

As part of the perinatal work on staff culture and support from the QUAD work, NICU are now being involved in the engagement starting with cultural conversations with staff throughout December.

Celebration World Prematurity Day:

On Sunday 17th November 2024 SFH celebrated World Prematurity Day with our staff, families, and Mansfield Town Football club members. The team held an information stall in the main reception and a raffle, along with the little miracles lantern walk around the reservoir.

4. Safety Culture
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 attended a series of workshops and action learning sets, over the last 12 months, as part of a national programme focused on Cultural Safety led by NHSE.
We are now engaging with an external agency, Kornferry, to process our SCORE survey results and benchmark our actions, to date, against desired outcomes.

As part of our approach to addressing the SCORE survey themes, the original Quad have formed PeSET with support from the Head of Midwifery, Sarah Ayre. In November 2024 we met with Kornferry and have agreed next steps are to widen the group to include Neonatal colleagues Rachael Giles and Sarah Jenkins.

Kornferry are commissioned by NHSE throughout December 2024 to undertake 4 cultural conversation sessions with staff across the MDT and then a thematic analysis of responses will share next steps for PeSET. We will continue to update and provide assurance on the impact of our initiatives through PAC.

CQC Action Plan
The Should Do Action plan based on the CQC visit in 2023 has been completed and embedded. However, we will continue to monitor success and additional actions through the peer review process, and further action plans will be presented through PAC. Quality and Safety Lead Midwife Hannah Lewis has oversight for this action plan.

Three Year Maternity and Neonatal Delivery Plan:
We continue to collaborate with the LMNS on the 4 main themes and 12 objectives of the 3-year delivery plan. The collaborative LMNS mapping process against this plan is currently being overseen by Sarah Ayre, Head of Midwifery for SFH. Once the LMNS formally request evidence and assurance, we will fix an agenda item at PAC to share our status against the plan.

NHSR
The Task and Finish group for the Maternity Incentive Scheme (MIS) Year 6 meets fortnightly to work through the evidence upload needed to meet each of the 10 Safety Actions, chaired by Speciality General Manager Sam Cole in collaboration with Operations Manager Jess Devlin. Currently 2 of the safety actions have been presented for sign off at PAC – SA2 and SA4 and the remaining 8 are assessed as AMBER which is defined as ‘on target with evidence to be submitted and reviewed.
Ockenden

The report received following our annual Ockenden visit in October 2023 forms the basis of the robust action plan embedded within Maternity. The visit's 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, it is important to note the continuing progress as a system around bereavement care provision, specifically with the counselling support.

The plan is to revisit the maternity self-assessment tool created by NHSE in July 2021, in 2025 to benchmark progress. This will be undertaken by Head of Midwifery Sarah Ayre and Consultant Midwife Gemma Boyd and presented at PAC in February 2025. The National Maternity Self- Assessment Tool provides support to all Trusts seeking to improve their maternity service rating from 'requires improvement' to 'good,' as well as a supporting tool to support Trusts looking to benchmark their services against national standards and best practice guidance

CQC National Survey
Conducted in February 2023 - Our action plan is overseen by Consultant Midwife Gemma Boyd, and we remain in an active phase of embedding quality improvements, as reported.

Conducted in 2024 - It is noted that women and birthing individuals were asked for the first time within the national CQC survey about the care received by their GPs and the 6–8-week routine postnatal appointment. Consultant Midwife Gemma Boyd is working with Jen Mosslangfield from the LMNS to discuss how we can collaborate, share, and assure these actions that sit in primary care. The results and free text are currently embargoed and so further updates, and our action plan will be shared though PAC once we can share all information.

MBRRACE-UK:
Saving Lives, Improving Mothers' Care 2024 - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22 full report is available on request.

Quality and Safety Lead Midwife Hannah Lewis is currently benchmarking against the report and her updates will be shared via PAC once completed.