

## Board of Directors Meeting in Public - Cover Sheet

<b>Subject:</b>	Maternity and Neonatal Safety Champions Report	<b>Date:</b> 7 March 2024			
<b>Prepared By:</b>	Paula Shore, Director of Midwifery/ Divisional Director of Nursing for W&C				
<b>Approved By:</b>	Phil Bolton, Chief Nurse				
<b>Presented By:</b>	Paula Shore, Director of Midwifery/ Divisional Director of Nursing for W&C. Phil Bolton, Chief Nurse				
<b>Purpose</b>					
To update the Board of Directors on our progress as maternity and neonatal safety champions		<b>Approval</b>			
		<b>Assurance</b>	<b>X</b>		
		<b>Update</b>	<b>X</b>		
		<b>Consider</b>			
<b>Strategic Objectives</b>					
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
<b>X</b>	<b>X</b>		<b>X</b>		<b>X</b>
<b>Principal Risk</b>					
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				
<b>Committees/groups where this item has been presented before</b>					
<ul style="list-style-type: none"> <li>Maternity and Neonatal Safety Champions meeting – 01.03.24</li> </ul>					
<b>Acronyms</b>					
<ul style="list-style-type: none"> <li>Maternity and Neonatal Safety Champion (MNSC)</li> <li>Maternity Voice Champion (MVP)</li> <li>Care Quality Commission (CQC)</li> <li>Local Maternity and Neonatal System (LMNS)</li> </ul>					
<b>Executive Summary</b>					
<p>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:</p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>act as a conduit to share learning and best practice from national and international research and local investigations or initiatives within your organisation.</li> </ul>					
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

February saw the national release of the annual CQC Maternity survey results. The CQC Maternity Survey is sent to all women and birthing people who were aged 16 and had their baby at Sherwood Forest Hospitals in February 2023. 300 women were invited to participate and 116 completed the survey., which is a 39% return rate.

Nearly all responses showed very little statistical change from last year.

The majority of 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.

The area where are results are better than most other Trusts are in our support of birthing people's mental health with 92.7% of respondents saying they were given enough support with their mental health and 90.2 % of respondents were asked about their mental health at antenatal appointments. This was mirrored in the postnatal period, with 77.6% of respondents being given information about any changes you might experience to your mental health after having a baby and 89.9% of birthing people were told what support was available to them should they experience any changes to their mental health.

The response to 'Was your partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital?' has showed the biggest increase in satisfaction. We will expect this score to rise next year even more as we have listened to families and worked with our MNVP and our charitable funds and now have a recliner chair in every room and bay on the birthing unit and on the ward, so partners or supporters are able to stay comfortably.

The areas in which the questions scored in the lower-20% range, mainly focused around labour and birth and have a clear action plan, detailed below.

### Our care could be even better if.....

*'If you raised concerns during labour and birth, were these taken seriously'* is a question where we did not score as highly as other Trusts.

### Actions to address

- Training for all doctors, midwives and maternity support workers last year was delivered focusing on listening to women, supporting choices and addressing unconscious bias
- A more in depth 2-day cultural safety training is now mandatory for all midwives and MSWs and has been running since September 2023.

*'Before you were induced, were you given appropriate information and advice on the risks of induction of labour?'* also had a reduced score from 73% to 50%.

### Actions to address

- Induction of Labour Lead Midwife who has been working this year to improve the service. In partnership with our Professional Midwifery Advocate and the MNVP, we have developed a new leaflet that is available on badgernotes and the website that helps families make informed decisions around induction of labour.

- Poster to go on the wall of every induction of labour room that outlines the options available at every stage of the process.

A new question that we could improve on *‘Do you think your healthcare professionals did everything they could to help you manage your pain?’*

#### **Actions to address**

- Currently seeking feedback from service users via MNVP social media and 1-2-1 conversations with postnatal women on the ward with MNVP volunteer to deep dive into this area and understand better the actions we can take to address this.
- We have relaunched our face-to-face antenatal education classes this year and our MNVP volunteers have observed the sessions around pain relief to n feedback around the level and depth of information we share.
- We are planning to offer a more choice for pain relief option for birthing people who are being induced or are in early labour, recognising this can be a particularly challenging time for getting pain relief right.

The question with the biggest decrease was *‘During evening, nights and weekends and you needed advice about feeding your baby, were you able to get it?’*

#### **Actions to address**

- Updated out antenatal education and contact details so birthing people know who to contact out of hours.
- Developing pathway for ensuring when birthing people call for advice out of hours, we can signpost them to the right service
- Relaunched our Maternity website with lots of feeding support information and contacts.

The report has several recommendations included in it and we are currently working closely with our teams and our birthing people to implement these.

## **2. Staff Engagement**

The planned MNSC walk round took place on the 6<sup>th</sup> of February 2024. Staff reflected on the positive changes to the team and activity. The MNSC caught up with the Lead Midwife for Recruitment and Retention and discussed the positive workforce plans for 2024/2025. The MNSC also spoke to the teams and families on the Neonatal Unit and the complexities of discharge planning on the unit and how the wider Trust teams can support.

On the 15<sup>th</sup> of February 2024 the revised Maternity Forum was held. The teams met the new Head of Midwifery, Sarah Ayre, who started on the 5<sup>th</sup> of February 2024. The teams welcomed Sarah and updated through actions that have been taken from previous meetings, these included the ongoing work around recruitment and student support.

### 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, and the Trust are working through individual plans.

#### 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; these are included within the action plan and focus on bereavement resources across the system.

#### NHSR:

The Year 5 submission for full compliance has been submitted to NHSR for the deadline of the 2<sup>nd</sup> of February 2024. We are awaiting the results and the Year 6 MIS is due for release in April 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

On the 12<sup>th</sup> of February 2024, pulling together the actions from the initial Ockenden immediate and essentials actions and feedback from our service users, the Maternity landing page for the Trust internet was relaunched. The Maternity and communication team leading the project, supported by the chairs of the MVP and NVP attended the live launch event and celebratory packs were given to all babies born that day. The ongoing management and updating will remain under the responsibility of the Digital Midwife with support from the wider teams.



On the 26<sup>th</sup> of February 2024 the Aromatherapy service was re-launched following consultation against the national guidance and was supported by our service users.



## 5. Safety Culture

The debriefing has been completed now, with the support of the organisational development team, and the key themes are to be presented to the divisional leadership team via the People Board. The perinatal quad team, outlined within the last paper, will be utilised as the key drivers to support the action plan from the survey.