Board of Directors Meeting in Public - Cover Sheet and report

Subject:	Maternity and Neonatal Safety Champions Report	**Date:**	6 June 2024
Prepared By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing for Women and Childrens.		
Approved By:	Phillip Bolton, Executive Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing for Women and Childrens, Phillip 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	
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

- Care Quality Commission (CQC)
- Data Sharing Agreement (DSA)
- Induction of Labour (IOL)
- Local Maternity and Neonatal System (LMNS)
- Maternity and Neonatal Safety Champion (MNSC)
- Maternity and Neonatal Voice Champion (MNVP)
- Maternity Assurance Committee (MAC)
- Newborn and Infant Physical Examination – (NIPE)

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 May 2024

1.Service User Voice
This month has seen the MNSC reviewing the updated CQC annual maternal survey action plan. All actions have progressed with some, such as birthing partners staying overnight, now being completed. On the monthly MVP walk round, our MVP representative Emma collated the below responses regarding partners staying overnight:

Positives

"It's really good to be able to stay together. For supporting my partner it's good as it can be very stressful at times".

"It's a good thing as I don't have to keep asking the staff for support all the time. For things like moving around and help with the baby."

"It's helpful for someone else to be there and move the baby around, just having another person there to support me with everything. Nice to have my Mum stay with me."

"I had a traumatic birth so I was glad he could stay with me as my friend's partners before had to leave nearly straight away when they had their baby here, a while ago. Good to have him there to help with looking after baby, moving him around and nappies/feeding. I haven't needed to ask for as much help from Midwives as I would have if he wasn't here."

Negatives

"The chairs are not comfortable at all for sleeping."

"It would be good to get a pillow and blanket on the chair for my partner. We had asked the staff, but they didn't bring one, but we understand they are busy."

The feedback has been provided to the Ward Leader to review.

The senior leaders within Maternity are supporting the interviews for an engagement role within the revised MVP structure for SFH. Onsite we have also created a role for a senior advocate onsite to support the ask in the revised year 6 version of the Maternity Incentive Scheme.

2.Staff Engagement
The planned MNSC walk round took place on 10 May 2024. The MNSC spoke with staff on the birthing unit about the revised break system; the "10 at 10" followed by an hour break later in the day which all reported was working better in that they were able to take a full break. This was

supported in the reduction of staff reporting missed breaks and TOIL allowance. The Maternity ward had reported the positive impact that the pilot of the transfer home and NIPE shift midwife was having and due to this the senior leadership was looking at how this could become embedded.

The team also reported the difficulty in obtaining, due to the increased volume of discharges, pre-packed medication to take home. The MNSC took an action away to raise this. To update, the pharmacy team are currently reviewing this with the ward leader for a resolution with a wider risk already existing on the risk register as to the divisional cover for women and children's.

On 20 May 2024, the Maternity Forum was held. Chaired by the Chief Nurse and attended this month by the Interim Chief Executive Officer, the meeting was well attended by divisional colleagues. Updates were received regarding actions from previous meeting around car parking and support for specialist teams.

A current issue highlighted this month and discussed, was the support provided to staff who are involved within the coronal process. The Director of Midwifery spoke about the current package of support, which is offered to all staff, whilst recognising that not all staff would require or want the same support. The need for clear signposting is needed. Whilst this offer of support is infrequent it will need formalising, initially within midwifery, but also needs wider organisational consideration, which the MNSC have asked the governance teams to lead on.

3.Governance Summary

Three Year Maternity and Neonatal Plan:
The Maternity Safety Team continue to work with the LMNS, now the Three-Year plan is in its second year regarding how we can evidence the progress so far and what needs to be prioritised moving into the third year. It is also a good point of celebration with the teams to show how much has been achieved in the first half of the plan.

Ockenden:
The action plans continue to be worked through following the annual Ockenden insight report from our visit in October 2023. The visit findings supported the self-assessment completed by the Trust. Areas have been identified from the report to strengthen the embedding of the immediate and essential actions. Progress has been made as a system around the bereavement provision, with the counselling support available for families as a system, which is a feature of the Three-Year plan. Discussions are being held with the LMNS as to the future of insight visits.

A request has come through from the independent maternity review at Nottingham regarding a data sharing agreement (DSA), due to the nature of the digital records shared between the system. Whilst this is taken through the internal digital governance process, any requests are being taken through the Access to Health records for review. The DSA will be required as it is anticipated, with the expansion of the review to include any antenatal patients, that more records will need to be shared from SFH.

NHSR:
The task and finish group for the year 6 Maternity Incentive Scheme is established now and meeting fortnightly to work through the evidence upload needed. A risk has been identified regarding safety action one and the need for the service user voice at the perinatal mortality review meetings. A local action plan is in place, with the establishment of the senior advocate role, until further clarity is provided.

Saving Babies Lives:
SFH has continued to monitor its compliance with all elements of the Saving Babies' Lives Care Bundle (SBLCB) in version 2. 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 Quality Committee. Further work is needed for these actions to become embedded. The "Must-Do" progress will be tracked through the MNSC. The Trust Mandatory training compliance remains above the 90% threshold and a standardised triage system is in place. The triage task and finish group presented an update through the Maternity and Neonatal Safety Champion meeting where significant progress has been made around the digital workstream, involving the telephone waiting and recording systems.

4. Quality Improvement
Induction of Labour (IOL) is the most performed obstetric intervention and is recommended to women when it is assessed that the outcome of the pregnancy will be improved if it is artificially interrupted rather than being left to follow its natural course. Whilst rates at SFHT have remained around the national standard, experientially women have reported, through various feedback mechanisms, issues around the process. Following this, a review of the pathways has taken place, supporting a midwife to focus upon IOL and adopting QI methodology to launch the non-medical induction of labour pathway.

After a period of wide consultation, review and establishment of the pathway and guidance the launch date for the use of foley catheters in the induction of labour is due to go live. This will support the experience of women undergoing IOL and the next steps in moving towards an outpatient IOL pathway. The MNSC have been updated on the progress and the lead midwife will be working with the MNVP to ensure we capture the service user feedback to help shape the service.

Below shows the countdown information shared with the teams, following education from the champions. A revised leaflet has been co-produced and is available on the trust intranet in multiple languages and on Badgernet.

5.Safety Culture

As part of the perinatal cultural work, areas are having a focus upon the three themes identified through the staff survey findings, these being communication, leadership and health and wellbeing. An example of this is detailed below and noted earlier with the walkaround is the “You said, The family voiced, We did” communication.

You said,

More Core team members of staff were needed.

The core team feels disjointed and not working together.

The family voiced,

They wanted to know who their midwife was and see key updates.
Please see the family info board for each bedside coming soon.

Maternity Ward

My Name Is:

My Midwife Is:

My Baby's Name Is:

My Partner/ Supporter's Name Is:

What Is Important To Me:

Key Information:

We did....

We have successfully recruited Kim Passey and Emma Thompson to the core team and retained the existing team.

We have arranged our first core team meeting on the 30/5/24 to start looking at our priorities and working together as a team.

You said,

Getting a NIPE completed in a timely manner was a big issue, especially at a weekend. This is impacting on the transfer home and patient experience.

The family voiced,

Unnecessary waits and long delays in transfer home.

We did....

A transfer home midwife will now be on duty Monday – Saturday, 8am until 5pm.

A NIPE Midwife will be on Friday – Monday 9:30am – 1:30pm.

(Subject to shifts being picked up)

The impact from these roles will be audited for the month of May 24 and support a permanent job role/plan being developed within establishment moving forward.

Please see the email sent for further details.

Thank you!

We cannot express how grateful we are to have had Claire Ward as our Non-Executive Director Maternity and Neonatal Safety Champion for the last five years. To have had Claire within this role has meant so much to our colleagues across Maternity and Neonatal services, her support and championing has been appreciated by all and we know that she will miss the smallest patients within the organisation. Whilst it is sad to say goodbye, we all wish her well in her new role and hope that we will cross paths again in the future.

We have circulated the job description for the Non-Executive Director role for the Maternity and Neonatal Safety Champion as we will need to appoint into the role.