Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:**	1 August 2024
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Approved By:	Philip Bolton, Executive Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing for Women and Childrens, Philip Bolton, Executive Chief Nurse		

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	X
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 items have been presented before

- Nursing and Midwifery AHP Committee
- Maternity Assurance Committee

Acronyms

- Maternity and Neonatal Safety Champion (MNSC)
- Maternity Voice Champion (MVP)
- Care Quality Commission (CQC)
- Local Maternity and Neonatal System (LMNS)
- Saving Babies Lives Care Bundle (SBLCB)

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.

Apology

As Maternity and Neonatal Safety Champions we would like to offer our deepest condolences to the families of Baby Arlo Lambert and Baby Theodore Bradley. In both cases, areas of care have been identified that could and should have been better and for this we are truly sorry.

We are committed as safety champions to ensure that improvements are made in the areas of care as identified by His Majesty's Coroners Miss L Bower and Dr E Didcock.

We will closely monitor the action plans, provide support for the resource required and challenge, when needed. We want to assure both families that we have taken the learning to improve and inform our future practice.

Summary of Maternity and Neonatal Safety Champion (MNSC) work for July 2024

1.Service User Voice

On the 18th of July 2024, as part of the planned MVP Trust Update meeting, we had the opportunity to meet with our new MVP Volunteer for SFH. Emma has been through a recruitment process and training now and is looking forward to spending time at the organisation.

A key deliverable this month from the MVP and the Trust has been through the MVP identifying that nationally the free text report for the annual CQC survey had been made available but neither SFH or NUH had access to this. Through joint working this has now been made available and the team leading on the survey feedback will now build these comments into the action plan.

2.Staff Engagement

The planned MNSC walk round, and Maternity Forum took place on the 11th of July 2024. The MNSC spoke with colleagues across the MDT with a key theme from all staff being the reflections following a recent coronal case.

As part of the walk round, open, and honest discussion were held into the case and subsequent actions with assurance from the teams regarding the culture elements outlined. As MNSC we will be closely cited to the action plan for the Regulation 28 report, which we will ensure is cascaded to all staff.

The forum later that day further provided the opportunity for open and honest feedback, which was provided. Actions were taken away by the Director of Midwifery which strengthened the current immediate actions in place following the Coronal case and information shared at that inquest.

3.Governance Summary

Three Year Maternity and Neonatal Plan:
The Maternity Safety Team continue to work with the LMNS, the first joint meeting with NUH and the LMNS was held at the end of June 2024 from which a template has been developed. We are working through this template but from the initial review we can provide assurance for the majority of this template. Escalation will be made to the MNSC regarding any areas that may be potential risk.

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. This is being progressed now through the systems Transformation Committee.

The request from the independent maternity review at Nottingham regarding a data sharing agreement (DSA), has been presented to the Digital Committee and now requires progressing to the Information Governance Board, due to be held in July 2024. Until the DAS has been approved any request are being taken through the access to health records for review.

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.

Several national changes have been communicated and the team have updated their work plan accordingly. Presented to the MNSC is the risk around the Transitional Care staffing, an action plan will be drafted to support the submission for this year.

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.

Key area of focus is to support the newest element within the version 3 of the bundle which focuses upon the diabetes service.

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. The triage task and finish group continue to present through the MNSC meeting.

A revised peer review programme has commenced, initial in maternity to review set areas which would be incorporated within the CQC programme.

4. Quality Improvement
Colleagues in our Neonatal Unit are celebrating after they were awarded the prestigious Baby Friendly Award by the UNICEF UK Baby Friendly Initiative. Following an extremely competitive application process, the neonatal unit was one of 18 from across the UK to be selected for the initiative and was very lucky to

receive a range of support and opportunities over a three-year period to achieve their accreditation by 2024. Achieving this status is a key deliverable for the three-year plan, which we have reached before the target of 2027.

The Baby Friendly Initiative is a global programme which aims to transform healthcare for babies, their mothers, and families as part of a wider global partnership between UNICEF and the World Health Organization (WHO). In the UK, the Baby Friendly Initiative works with public services to better support families with feeding and developing close, loving relationships to ensure that all babies get the best possible start in life. The award is given to health facilities/hospitals/universities after an assessment by a UNICEF UK team has shown that recognised best practice standards are in place.

The award comes after the unit achieved their stage three Baby Friendly Accreditation just two years after the starting their baby friendly journey. The team have worked extremely hard to achieve all three stages of the accreditation process in a short period of time after initially receiving their certificate of commitment in April 2022, then going on to achieve stage one in July 2022 and stage two in late 2023.

5.Safety Culture

As part of the perinatal cultural workplan, drawing on the three themes of communication, leadership and health and wellbeing. Significant progress has been made towards the “You Said- Together We Did” campaign across the services, within a plan discussed at the Divisional People Committee as to how this is communicated widely.

Another element which will be incorporated into the Perinatal Quad Cultural work is the issues raised following the recent Coroners inquest, as part of the immediate action an anonymous survey will be circulated to review the concerns report by individuals during the inquest to understand if these are wider issues. These focus on the enhanced rate of pay and night working.