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:**	7 November 2024
Prepared By:	Sarah Ayre Head of Midwifery, Women and Childrens		
Approved By:	Phillip Bolton, Executive Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery/Divisional Director of Nursing, Women and Childrens, Phillip 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**	**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 (PAC)
- Divisional Governance Meeting
- Maternity and Gynaecology Clinical Governance
- Paediatric Clinical Governance
- Service Line
- DPR
- Perinatal Forum
- Divisional People Committee
- Senior Management Team weekly meeting

Acronyms

- Birmingham Symptom Specific Obstetric Triage System (BSOTS)
- Care Quality Commission (CQC)
- Domestic Violence (DV)
- Fetal Alcohol Spectrum Disorder (FASD)
- Induction of Labour (IOL)

- Local Maternity and Neonatal System (LMNS)
- Maternity and Neonatal Safety Champion (MNSC)
- Maternity and Neonatal Voice Champion (MNVP)
- Perinatal Assurance Committee (PAC)
- Pregnancy Day Care (PDC)
- Sherwood Birthing Unit (SBU)
- Transitional Care (TC)

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 September/October 2024

1. Service User Voice

On 27th September 2024 we welcomed the MNVP team to our Kings Mill Hospital maternity site for the 15 Steps service user initiative. We await their formal feedback, however, initial feedback provided on the day by the MNVP is reported by the Deputy Head of Midwifery as per below:

Postnatal Ward / Transitional Care
All staff were welcoming, kind and appeared happy. Atmosphere was calm and peaceful. Lack of a leaflet explaining TC care to mums. Signage around TC needs to have some additional languages added (talked about some QR codes added to posters) Postnatal ward needs more 'You said, we did' type of posters etc to share changes with families. Lack of poster showing staff so visitors can understand the uniform for each member of staff.

Antenatal Clinic / Pregnancy Day Care
All staff were welcoming, kind and appeared happy. Atmosphere was calm and peaceful. The signage about waiting time in clinic had nothing written in the 'minutes wait 'section. If there is no wait, can we write '0'. Only noted domestic violence information for patients and visitors in one toilet through whole of Maternity Unit. Need to frost the glass wall between the scan waiting area and corridor (from a previous visit following a woman stating she felt she was being watched walking up to quiet room after a poor outcome.)

Bereavement Suite
Acknowledged this is an excellent facility for our families. Please can a selection of the leaflets that are outside the door be put into a folder and available in the room. Can we source a new sofa bed as very poor condition. Can we look at some books about loss if there are not any for visiting siblings.
SBU/ Triage

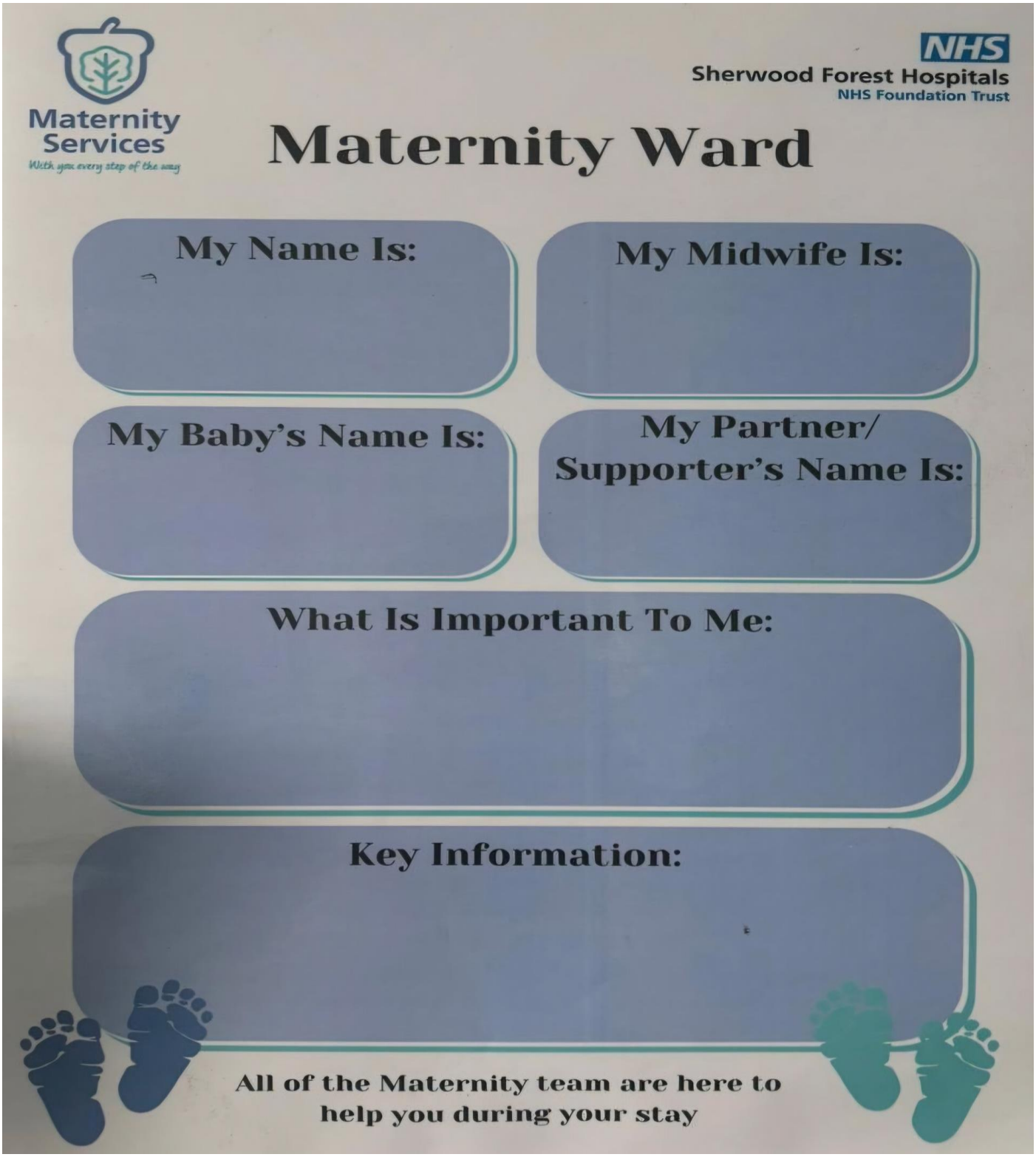
All staff were welcoming, smiling, and stopped to talk. Partners felt involved in the care. No information on walls in SBU for women re: breastfeeding. Also need to think about different languages again on information. The new board on SBU is blank. No drinking water for women in triage waiting area/could also put up a sign saying available on request? Found a leaflet about FASD that did not explain the acronym on the leaflet. The BSOTS notice board not very well set out, no information about a red patient which may explain to women why there is a wait on times. Information too low down to appear important / to be read. No leaflets around for women to read while waiting. Could put signs up reminding women how to access leaflets on Badgernet.

NNU
Minimal info in other languages. Information about card medic not up in the area. The general route into the

The Divisional SLT have been able to address most actions since receiving the informal feedback and will provide assurance against the formal feedback once received. The next MNSC meeting is planned for 30th December 2024.

You Said We Did

Our MNVP have been collaborating with maternity staff on setting and managing realistic expectations for service users; focusing in September on information around postnatal care when on the ward and what to expect around receiving pain medication, mealtimes, and mobilising post theatre admission. As part of this work the ward have implemented new notice boards at the bedside as per the picture below:



Utilisation and the impact of these boards on service user experience will be audited by Ward Leads and presented at MNSC meeting in December 2024.

Neonatal Services feedback remains predominantly positive with no specific escalations received for September.

On 2nd October 2024 our MNVP provided an updated focused work plan for 2024-2026 based around 2 clear objectives; Listening to the voices of women and families and working with Maternity & Neonatal Service Providers.

Our Consultant Midwife, Deputy Director of Nursing and Head of Midwifery will ensure collaboration and support for this plan and any escalation/highlights will continue to be presented via our MNSC meeting.

2. Staff Engagement
The planned monthly MNSC Safety Champions Walk around took place on Tuesday 8th October 2024. In support of our new Non-Executive Director 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 is starting the journey through our varied intrapartum care services.

Neil McDonald, Phil Bolton Chief Nurse and Paula Shore, Director of Midwifery and Divisional Director of Nursing, also welcoming Matt Warrilow back to work, spent time talking to the teams who support the Induction of Labour, Triage and Birthing services to understand the process, but also asked 'what it is like to work in these areas'.

It was clear to the MNSC how increased activity and complexity was impacting staff and they noted the proposed solutions in place to support, such as the Elective Caesarean Sections List moving away from SBU to general theatres whilst also introducing outpatient IOL via PDC. The team also spoke about ideas they had within their own areas to make changes which could positively impact capacity and flow, alongside quality and safety and improve staff experience. The MNSC spoke with staff about the support needed for these changes and took away an action to work with colleagues from the Estates team around shared areas, particularly on SBU, to look at potential alternative provision for storage space.

The next MNSC walk round is planned for the 5th of November 2024 and will focus more specifically on our elective section pathway.

The Maternity Forum held in September mostly highlighted the continued low morale of our midwives and support workers following the impact of the two PFDs received earlier this year. Identifying and accessing the correct support for individuals and ensuring we listen remains a key priority of all leaders within Maternity.

The next Maternity Forum is planned for 19th November 2024. Maternity launched its very first Staff Council on 23rd October. Organised and supported by our MDT staff, representatives will attend monthly at the Maternity Forum to strengthen 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 for many months.

Staff Voice - Round up
In acknowledgement of the various and multiple approaches to staff engagement and improving staff experience, Consultant Midwife Gemma Boyd has designed an overall action log. As this document has embedded evidence, we are unable to share during the normal channels with Board of Directors, but this document can be shared if requested.

This document helps shape our SLT priorities and next steps and is reviewed monthly at the SLT meeting chaired by the Head of Midwifery.

3. Quality and Safety

Risk
An improved process around managing and reviewing the Maternity Risk register will commence from November 2024. A focused Risk meeting will commence to review the register with key stakeholder's, chaired by the Quality and Safety Lead Midwife and her team. Owners will be required to attend to provide updates on actions, and escalations will be made to Divisional Governance. A robust highlight report from this meeting will be presented at Service Line, MNSC and PAC meetings.

Quality Improvement
Maternity
Divisional Strategy Next steps: Review of our key objectives and ambitions for 25/27 is underway, benchmarking progress and being overseen via the senior triumvirate at our weekly Senior Management Team (SMT) meeting.

Planned Care Lead Midwife: Recruitment into this new role to support developments and improvements in our elective care pathways and outpatient inductions is in progress.

Neonatal
Transitional Care (MIS Yr. 6, Safety Action 3) – Task and Finish group to be launched to support embedding of the service, relaunch of SOP and staff roles and responsibilities. Workforce review completed. Collaboration across Maternity and Neonatal leadership team to undertake the work streams identified.

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 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 Quad have formed Perinatal Staff Experience Team (PeSET) with support from the Head of Midwifery. Once the next stage has been completed by Kornferry, objectives can be agreed and next steps formed into an action plan, which will be shared through MNSC meeting and escalations made at PAC.

CQC Action Plan
The Should Do Action plan based on the CQC visit 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. The Quality and Safety Lead Midwife has oversight for this action plan.

Peer Review Action Plan
Maternity Services Peer review was undertaken in September 2024. It identified both good practices and areas for improvement. The main report will be shared once the Peer Review Team have completed a full review of the documents provided as part of the request for information. Once received and actions agreed, the plan will be presented though MNSC and PAC for oversight and assurance.

Three Year Maternity and Neonatal Delivery Plan:
We continue to collaborate with the LMNS on the 4 main themes and the 12 objectives of the delivery plan. This document presents the 3-year delivery plan's technical guidance and will shape the oversight and assurance that we meet all aspects of the delivery plan. The mapping process against this plan is currently being overseen by the Head of Midwifery. Once the LMNS formally request evidence and assurance, we will fix an agenda item at Perinatal Assurance Committee to share our status against the plan.

NHSR
The Task and Finish group for the Maternity Incentive Scheme (MIS) Year 6 is now established, meeting fortnightly to work through the evidence upload needed to meet each of the 10 Safety Actions, chaired by the Speciality General Manager in collaboration with the Operations Manager. Currently all actions 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, important to note the continuing progress as a system around bereavement care provision, specifically with the counselling support. This is being progressed now through the systems Transformation Committee attended by the Head of Midwifery and Consultant Midwife.

CQC National Survey
Conducted in February 2023, some of the free text received is noted below prepared by the Consultant Midwife. Our action plan is overseen by our Consultant Midwife, 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. Our Consultant Midwife is working with 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. The full report can be accessed as follows. https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports/maternal-report-2020-2022

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