Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:** 5 October 2023	
Prepared By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing W&C		
Approved By:	Phil Bolton,Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing W&C and Phil Bolton,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	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
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	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

- Quality Committee 03/10/2023

Acronyms

CQC- Care Quality Commission
IEA – Immediate and Essential Actions
LMNS- Local Maternity and Neonatal System
MNSC-Maternity and Neonatal Safety Champion

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:

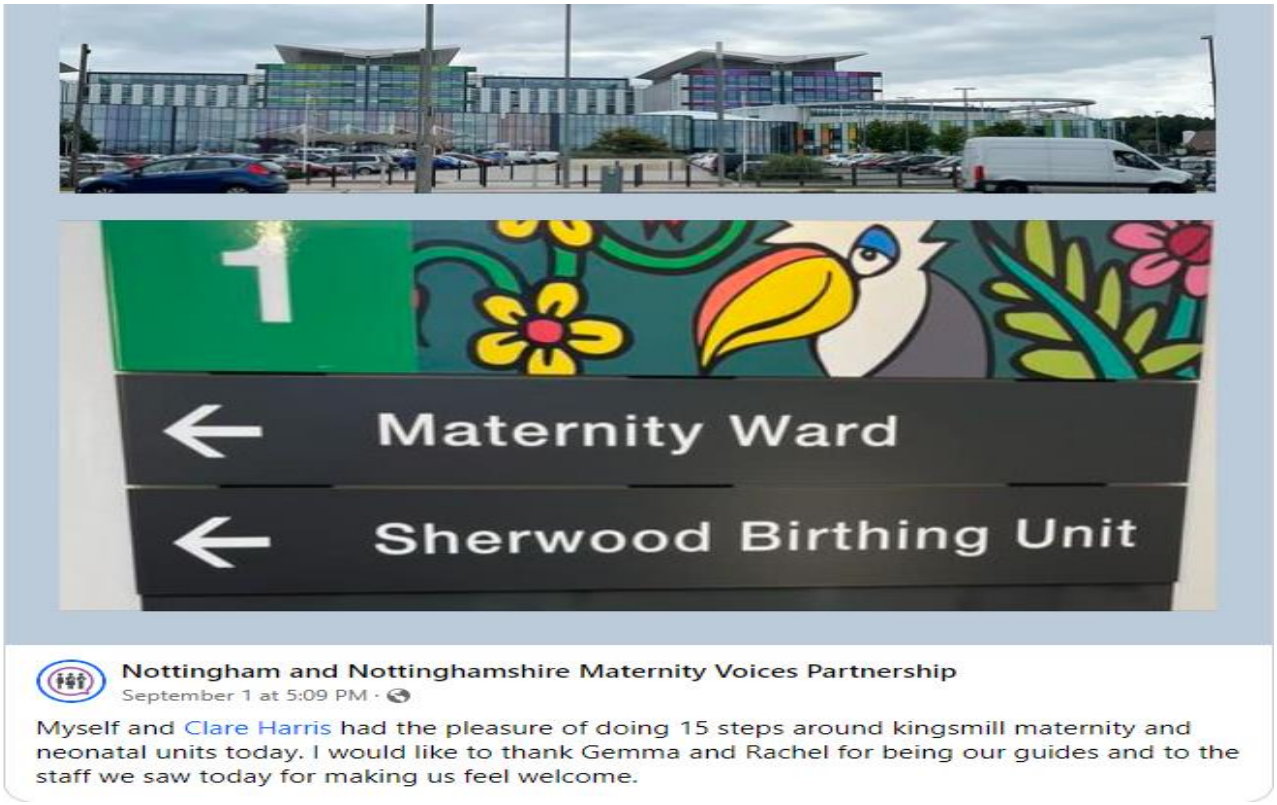
- build the maternity safety movement in your service locally, working with your maternity clinical network safety champion and continuing to build the momentum generated by the maternity transformation programme and the national ambition
- provide visible organisational leadership and act as a change 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 September 2023

1.Service User Voice

At the beginning of September our newly appointed Neonatal Voice Chair, Clare Harris, and the Maternity Voice Chair Amanda Doughty completed 15 steps walk round of both the Neonatal and Maternity Unit. Key actions were taken around the signage and language used to describe the neonatal unit across the Trust. Further feedback will be provided from the written follow up report.



2.Staff Engagement

On the 5th of September the MNSC planned walk round and Maternity Forum were conducted. Feedback provided assurance around increased staffing levels and support for the preceptorship Midwives. Further feedback was provided around the elective caesarean section list and how this was improving the woman's journey, but further feedback and work was required to ensure that this becomes embedded.

Staff spoke passionately about the homebirth service and how since the re-launch in September last year this has gained strength due to the passion of the community teams. The team also reported the positive feedback from the revised antenatal education sessions, with the ask of support from the MNSC around finding a more suitable venue due to its success!

The team also updated the MNSC that the vaccination registered nurse is now in post and is awaiting the delivery of both the flu and COVID-19 vaccines to commence the plan annual vaccination programme offer to any pregnant woman attend at SFH.

3.Governance Summary

Three Year Maternity and Neonatal Plan:
Key members of the Maternity Safety Team attended the planned regional workshop to look at how to progress the bespoke workbook. Updates from this workshop will be brought through the MNSC and MAC meeting.

Ockenden:
Due to the industrial action planned on the 4th of October, the planned annual Ockenden Visit has been re-arranged for the 9th of October. All evidence uploads have been completed have been completed prior and we are now making arrangements for the visit. Clear direction has now been provided by the systems that once completed we will not be asked to formally report on the Ockenden IEA's but focus upon the workbook, provided from the Three-Year Plan, in which these actions are captured.

NHSR:
Discussed at the MNSC meeting was the progress of the NHSR Year 5 task and finish group. All the deadlines to date have been met and the evidence collection in underway. NHSR have issued a revised document which has been factored into the plan for delivery at SFH. Regional escalation has been made around safety action 6 and 8, specifically around element 2 of saving babies lives and MDT training. We are awaiting a response.

Saving Babies Lives:
SFH has continued to monitor its compliance with all elements of the Saving Babies' Lives Care Bundle (SBLCB) v2 through reviewing evidence to support the elements in preparation for the national upload due at the end of September. In addition to this our Phoenix Team prevention film is now live on the NHSE website, link as below. They were approached following the success of the smoke free pregnancy work the team have undertaken.

https://www.england.nhs.uk/ourwork/prevention/tobacco-dependency-programme/

Tobacco treatment services are being rolled out across a range of NHS settings. The following films show how the Phoenix Team at the Kings Mill hospital, which is part of the Sherwood Forest Hospitals NHS Foundations Trust, developed its service to assist pregnant women to get the real time support to quit.

Saving Babies Lives – Kings Mill Hospital

CQC:
Following the “Good” rating from the planned 3-day visit from the Care Quality Commission (CQC) an action plan has bee approved by the Quality Committee on the 13th of April 2023.

Work to complete the two “must-do” actions has been completed and the plan is to present this to the Quality Committee on the 3rd of October 2023.

A focus has now move on the “should do” actions, and a subsequent action plan will be cited at MNSC and MAC in the subsequent months. These “should do” actions are:

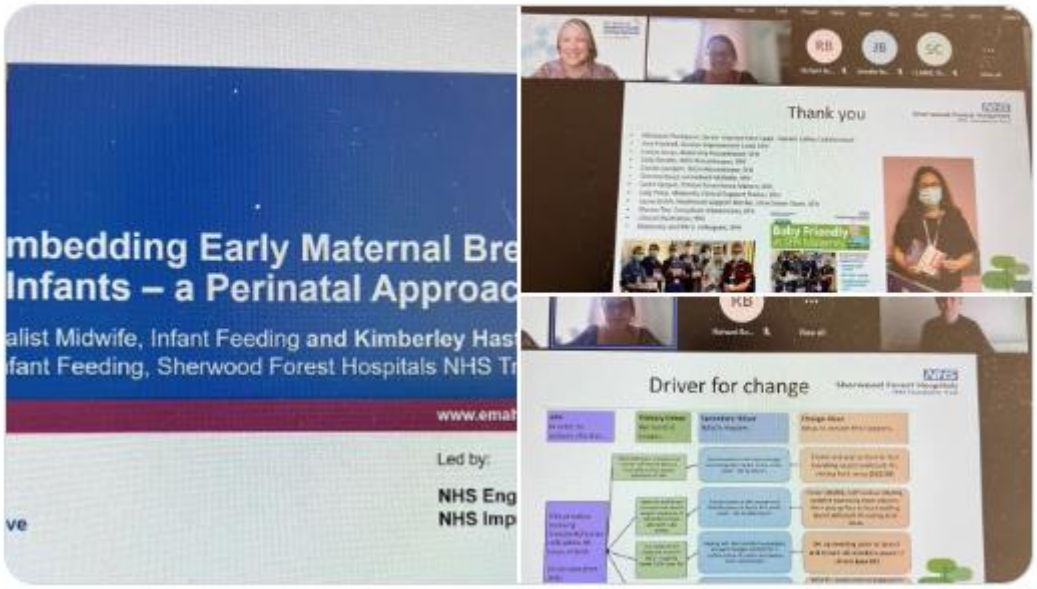
> The trust should ensure all medicines are stored safely and appropriately in line with trust policy.
>
> The trust should continue to implement their new electronic system. To support auditing the quality of the service. When issues are identified from audits action is taken further auditing cycles are undertaken to demonstrate if improvements and changes in practice have improved patient outcomes and improved practice.
>
> Leaders should continue to implement improvements to how they effectively communicate any changes in service provision with staff.

4. Quality Improvement

In September we have celebrated the Lime Green Infant Feeding Team (LGT) 10th Anniversary at SFH. Our (LGT) offer focused feeding support both in the hospital and home setting. A key part of the celebrations was a display of the feedback from our women, birthing people, and their families.

The Infant Feeding Leads for Maternity and Neonatal also presented the early breast milk QI project at the East Midlands Maternity and Neonatal Safety Improvement Programme Event which received positive feedback from across the region.

Today @KimHastings88 and I presented our early breast/chestmilk project @EM_AHSN - we reflected on the last 2 years, + had chance to thank colleagues who have made increased rates + good outcomes possible - as host @AlmaGallagher15 said it's about relationships & little wins



5.Safety Culture

The score survey is now closed for Maternity and Neonatal services, we are still awaiting the results, the feedback will be brought to the MNSC.

As part of the safety culture update, this month we have included the ongoing working around the addressing inequalities within Maternity Services, and the below flash report provides the current update as to the progress.

Addressing Health Inequalities in Maternity Care at SFHFT

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Reporting to: Quality Committee	
Report Date: September	**Completed by: Gemma Boyd – Consultant Midwife**

Key Actions Completed	Key Actions Planned
• Cultural Safety in maternity care Interactive workshop delivered as part of mandatory training to all midwives, MSWs. Obstetricians and Obstetrics Anaesthetists • MDT Cultural competency and safety 2 day training attended by 24 maternity staff in June 22. • 25 members of MDT team became cultural safety champions and supported embedding of training into practice • 12 maternity staff trained to deliver cultural safety training • Consultant Midwife worked closely with LMNS to develop Maternity Equity and Equality Strategy for Nottingham and Nottinghamshire • Active participation with LMNS Health Inequalities working group and identified key priorities to address • Phoenix team – in house tobacco dependency treatment service reduced smoking at delivery from 18.4% to 14.1% between Dec 2021-March 2023 • 121 smokefree babies birthed to referred families in 2022 • LMNS funded pilot incentive scheme achieved 83.3% whole smokefree pregnancy rate n42 • Consultant Midwife represents SFH at national Maternity EDI midwives network to learn from and share best practice nationally • NTU evaluation highlighted life changing outcomes for people who participated in our incentive scheme • Active participation with LMNS Interpreter Services working group scoping piloting options for improved interpreter services • Strong SFH representation in the MVP led BAME working group and have worked with MVP to embed recommendations	• 2 day cultural safety training for all Midwives and MSWs over 3 years. First cohort in October with view to develop action log from staff pledges and to evaluate impact of training to measure behaviour changes. • SFH personalisation and health inequality group established to move forward with actions identified within LMNS • Actively involved in LMNS funded social prescribers pilot. Phase 1 in Nottingham City 2023/24 with view that phase 2 would include SFH. • LMNS on business case to pilot CardMedic interpreter support • Development of LMNS hosted Health Inequalities Dashboard • To add ethnicity and language spoken to LMNS dashboard • Ensuring the images on our website reflect the diversity of our staff and population • Working with LMNS to secure antenatal education and ensure all leaflets and information is available in multiple languages

Delivery Issues	Delivery Risks
• Delay to meetings and training due to ongoing industrial action	• Funding for the inequalities workstream sits within the LMNS non-recurrently