Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Update	**Date:** Thursday 3rd June 2021	
Prepared By:	Julie Hogg, Chief Nurse		
Approved By:	Julie Hogg, Chief Nurse		
Presented By:	Julie Hogg, Executive Board Safety Champion & Clare Ward, Non-executive Board safety champion		

Purpose		
To update the board on our progress as maternity and neonatal safety champions	**Approval**	
	Assurance	**x**
	Update	**x**
	Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
x	**X**	**X**	**x**	

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		x		

Risks/Issues	
Financial	
Patient Impact	**x**
Staff Impact	**X**
Services	**x**
Reputational	**x**

Committees/groups where this item has been presented before

None

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 (MTP) 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 3 months.

1. Saving Babies Lives Care Bundle v2

The Saving Babies Lives Care Bundles 2 provides detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice:

- Reducing smoking in pregnancy
- Risk assessment, prevention and surveillance of pregnancies at risk of fetal
- growth restriction (FGR)
- Raising awareness of reduced fetal movement (RFM)
- Effective fetal monitoring during labour
- Reducing preterm birth

SFH has continued to monitor its compliance with all elements of the Saving Babies' Lives Care Bundle v2. On-going progress is reported externally quarterly to NHSE via the Midlands Clinical Network. Within Safety Action 6 of the Maternity Incentive Scheme, process and outcome measures regarding compliance have been validated. It is anticipated that we will be able to declare full compliance by July 2021 after a consistently improving trajectory since the launch of the Care Bundle in April 2019.

2. Continuity of Carer

The government's ambition is, by 2025, to halve rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth and to reduce preterm births from 8% to 6% (DHSC 2017). In order to achieve the government's ambition and reduce health inequalities, it is important to target those groups in the population most at risk.

There are significant and widening health inequalities in maternity care. When compared to babies of White ethnicity: Black/Black British babies have a 121% increased risk for stillbirth and 50% increased risk for neonatal death and the gap has been widening since 2013; Asian/Asian British babies have a 66% increased risk of neonatal mortality and this risk is rising and an increased risk of stillbirth of around 55%. Babies born to mothers in the most deprived quintile have a 30% increased risk neonatal mortality and the gap between the most deprived and the least deprived quintiles is widening. Draper et al 2018.

The term 'continuity of carer' describes consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour and the postnatal period (NHS England 2017). Women who receive midwifery-led continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth and report significantly improved experience of care across a range of measures (Sandall et al 2016). Pre-term birth is a key risk factor for neonatal mortality.

Continuity of carer can significantly improve outcomes for women from ethnic minorities and those living in deprived areas (Rayment-Jones et al 2015, Homer et al 2017 in RCM 2018).

At Sherwood Forest Hospitals NHS Trust we currently have two Continuity of Carer teams that have been running for the past year as a pilot. To reflect the most high risk groups in our geographical areas these teams are based in the Mansfield and Ashfield areas as these are the areas with highest social deprivation. In April 2021 there were 19% of our women booked on a continuity of carer pathway of which 5.3% were BAME (This is reflective of the BAME percentage in our general pregnant population). 6% of all women who gave birth in April 2021 received Continuity of Care in labour.

The Trust has recently employed a Consultant Midwife to support Maternity Transformation and she will be reviewing the outcome of the pilot and supporting the next steps in this area of Transformation. The continuity of carer action plan is included in Appendix 1.

3. Board Safety Champion Walkarounds

The monthly board safety champion walkarounds have continued with widening participation from the multi-professional teams. The team continue voice frustrations about infrastructure and processes. No immediate patient safety risks have been raised. May's publication of maternity matters is included in Appendix 2.

4. UK Obstetric Surveillance System (UKOSS)/ Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE)

The SFH perinatal mortality and morbidity cases for benchmarking against the UKOSS and MBRRACE guidance were reviewed. Local data although small numbers of BAME women (around 2-4% of overall pregnant population) demonstrated none affected in the perinatal mortality and morbidity cases. 61% of BAME women were booked onto a continuity pathway at end March 21, receiving targeted support as proposed in the letter referred to in NHSR Safety Action 9. No further actions required at present, this data is reviewed regularly as part of normal governance processes.

An overview has been provided for shared learning within the Maternity Services, see Appendix 3, to reflect and outline the data for SFH.

5. Ockenden Report and NHS Resolution

Progress continues to ensure compliance with recommendations from the Ockenden report and the NHS Resolution standards. A maternity assurance committee chaired by the Chief Nurse has and reporting to the Quality Committee has been established to scrutinise the Trust's submission. The Local Maternity and Neonatal System will sign off our Ockenden evidence in mid June 2021. We will return to board with our NHS Resolution submission in July 2021.