Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Update March 2022	**Date:** 24th April 2022	
Prepared By:	Paula Shore, Divisional Head of Nursing and Midwifery		
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.

This report provides highlights of our work over the last month in relation to:

- The service user voice
- Staff engagement
- Governance
- Quality improvement
- Safety culture

Our monthly focus is on the professional midwifery advocate service. Board is asked to note the updates on these key pieces of work.

Update on Mandated Maternity and Neonatal Safety Champion (MNSC) work for March 2022

1. Service User Voice

   The Professional Midwifery Advocacy (PMA) service continues to provide services to both our women and their families, through the birth outside of guidance, birth after thoughts clinic and to staff through open clinics and planned clinical restorative supervision sessions.

   Sarah, our service user representative, is continuing to support and ensure that the maternal voices are heard within our services. We have completed our first 'walk of the patch', details as provided within the feature. Sarah will be sharing her own bereavement journey and her reflections on the Ockenden report during this board meeting.

2. Staff Engagement

   The MNSC Walk Round was completed on the 14th of March 2022. Positive feedback was received from the teams and colleagues were reassured that any necessary actions have been taken from previous walk rounds.

   The Maternity Forum occurred on the 21st of March, chaired by Robin Binks. Positive feedback was provided around several ideas to improve colleague experience such as the purchase of lanyards that identify individuals' roles. These have been progressed divisionally. A colleague raised concerns about birthing partners not being allowed into triage, discussion was had around the difficulties with this due to space and social distancing. It was reiterated by Paula Shore that anyone who requires an individualised support plan then we can accommodate these. Teams were reminded of the importance of personalised care and support plans. All discussion and subsequent actions are captured and shared out within the Maternity Matters newsletter which is distributed to all colleagues.

3. Governance

   The final Ockenden Report was released on the 31st of March, outlining 15 additional immediate and essential actions to be taken by all Trusts, a separate paper will be presented as to the current position and plans for SFH.

   NHSR have confirmed our full compliance with the 10 safety actions for year 3 as signed off by the board of directors in 2021. The Year 4 pause remains and the teams across the division continue to work on the minimum reporting requirements.

4. Quality Improvement Approach

   Work continues on the Maternity and Neonatal Safety Improvement Programme, and our smoking cessation team are due to present at the next regional meeting.

5. Safety Culture

   The executive team have approved procurement of the SCORE safety survey. The quality improvement team are planning the roll out across the maternity service and associated actions.

2. Monthly Feature- Service User Representative and Professional Midwifery Advocates

As outline above, Sarah completed her first walk of the patch this month, providing the below feedback to the MNSC meeting:

I just wanted to let you know how overwhelmingly positive the feedback was today from the ladies who I listened to. I spoke with 11 women and one partner today and the key themes coming out were: 'amazing experience', 'partners involved', 'brilliant' 'staff going above & beyond', 'supportive', 'caring', 'helpful', 'positive', 'listened to' which was just lovely to hear and I will make sure I feed it back to people.

- A couple of specific examples which jumped out at me from today that I wanted to make you aware of:

- One lady, who was a first-time mum:

  "Before I came into hospital, I was really scared of midwives – some of the things which I have read in the news made me afraid of midwives and of what the birth would be like. But there was no need for me to feel frightened- it was the best experience ever".

  I think it's really important to acknowledge how the Ockenden report and the NUH review and the way that they are reported in the media can affect families, their birth choices and how they feel about coming into hospital & accessing services…… I know that you already try to put things in place to support staff who may be affected by these reports but is there something specific for women/birthing people/families? Is there more we can do to put them at ease – even just acknowledging these reports on Trust social media & sharing a contact number for anyone who is booked here who has concerns which they would like to talk through?

- Another first-time mum:

  "All the information given to us from Drs is at a time when our partners aren't on the ward so then I have to relay it to my partner, which I find really hard because I'm not a healthcare professional and he then has questions which I can't answer"

  Is there anything which can be quickly implemented to resolve this kind of issue – e.g. if a woman would like her partner to listen in when a Dr is explaining things, could they join the conversation on speaker-phone or Facetime?

All the above comments and recommendations have been noted and actions taken through MNSC and relevant divisional meetings for action.

Our Professional Midwifery Advocacy (PMA) provided a further breakdown, see infographic below, as to their activities since the launch on the 6th of February. Again, the delivery issues have been noted and are being monitored. The main risk remains attendance at restorative clinical supervision.

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PMA Maternity Safety Champions Update: APRIL 2022

*Figures since PMA Launch

Birth Afterthoughs(21)

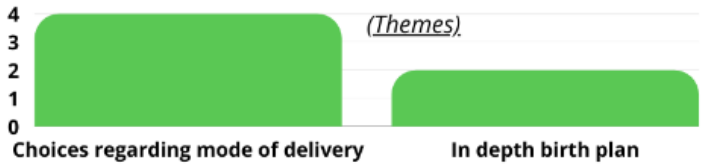
Key actions completed

- 21 Birth afterthoughts (2hr sessions) ^from 9

Key actions Planned

- Receive feedback on all birth afterthoughts sessions
- Communications to approve letters/informing women how to self refer (signpost)
- Setting up birth afterthoughts clinics x2 per week

Birth Options (6)



Key actions completed

- 6 women access birth options (on going) ^ from 2
- Poster/email sent to all consultants about this service & how to refer

Key actions Planned

- Receive feedback on all birth options sessions
- Communications to approve letters/informing women how to self refer
- Setting up birth options clinics x1 per week
- Complete guideline 'personalised women centred care: shared decision making'

RCS - Individual and group (29)

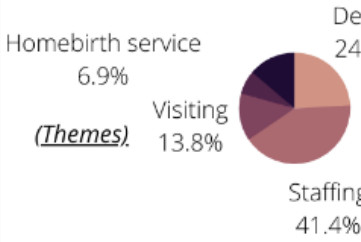
Key actions completed

- List collated to invite midwives for individual RCS
- Working with governance to support midwives involved in incidences
- Monthly reflect and learn sessions with early career midwives

Key actions Planned

- Invite midwives for individual RCS from April
- Offer TOIL to midwives attending RCS in their own time
- Invite midwives for individual RCS from April
- Offer TOIL to midwives attending RCS in their own time

FFT



Key actions completed

- Indentifying themes

Key actions Planned

- Improve quantity FFT feedback
- Share feedback with shared governance council- ideas for improvement

Delivery risks: Too early to comment

Delivery issue: Releasing staff for RCS sessions, uptake of RCS, implementing new guideline into practice