Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Update May 2022	**Date: 09/06/2022**	
Prepared By:	Paula Shore, Divisional Head of Nursing and Midwifery		
Approved By:	Robin Binks, Deputy Chief Nurse		
Presented By:	Phil Bolton, 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 month.

Update on Mandated Maternity and Neonatal Safety Champion (MNSC) work for April 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 is further planned to present at this month's board regarding her journey.

2. Staff Engagement

   The MNSC Walk Round was completed on 5th April 2022. Positive feedback was received, and thanks was given to Julie Hogg on her last walk round from the Maternity team. The Maternity Forum occurred on 21st April, chaired by Robin Binks. Updates were provided on the raised bright sparks idea regarding the lanyards and how this idea might be replicated Trust wide. 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 31st 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 was lifted on 6th May 2022, the divisional working group has been relaunched to help the delivery of the scheme.

4. Quality Improvement Approach

   Work continues within Maternity and Neonatal Safety Improvement Programme, looking at the 2022-23 improvement plan with a focus on pre-term birth. A team from SFH will be attending the planned QI Mat/Neo Safety Network event on 8th June 2022.

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. The aim is to survey in August 2022.

2. Monthly Feature- Maternity and Neonatal Safety Collaborative

The Maternity, Neonatal Safety Improvement Programme (MatNeoSIP), was renamed following the launch of the NHS Patient Safety Strategy in July 2019. It was previously known as the Maternal and Neonatal Health Safety Collaborative.

MatNeoSIP is led by the National Patient Safety team and covers all maternity and neonatal services across England. It continues to be supported by 15 regionally-based Patient Safety Collaboratives.

The programme aims to:

- Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high-quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England.
- Contribute to the national ambition, set out in Better Births of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 50% by 2025.

To aid the delivery of the programme, the East Midlands Academic Health Science Network Patient Safety Collaborative (EMASHN PSC) are commissioned to support. This offer includes the below:

- Build on the MatNeo Safety Network
- System leadership for safety improvement
- Support and scale up improvement activities
- Support measurement: baseline data and outcomes
- Share lessons and best practice
- Embed and support MatNeoSIP priorities
- Support clinical improvement advisor role in the safety network

The SFH improvement plan will focus upon the primary driver of optimisation and stabilisation of the preterm infant (appendix 1). The national ask is to focus on this driver noting the national launch of MEWS and NEWTT in Q3 2022-23. SFH are assessing the baseline data in or der to inform the plan. This will be presented and monitored through MAC.

Appendix 1

Maternity and Neonatal Safety Improvement 2022.23