

# Sherwood Forest Hospitals NHS Trust

Maternity Services – Overview findings of Regional and System Insight Visit 4th October 2022

NHS England and NHS Improvement



## Visit Purpose



An Insight visit to SFH NHS Trust maternity services was completed on the 4<sup>th</sup> October 2022.

The purpose of the visits was to provide assurance against the 7 immediate and essential actions from the Ockenden report. The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were embedded in practice.

Conversations were held with members of the senior leadership team and many front line staff ranging in job roles. Emerging themes from conversations were organised under the immediate and essential actions headings

- 1. Enhanced Safety
- 2. Listening to Women & Families
- 3. Staff Training and Working Together
- 4. Managing Complex Pregnancy

- 5. Risk Assessment Throughout Pregnancy
- 6. Monitoring Fetal Well-Being
- 7. Informed Consent
- 8. Workforce Planning and Guidelines

Insight Visit Team members: Midlands Perinatal Team ;Sandra Smith Deputy Regional Midwife Midlands Perinatal Team; Chantal Knight Regional Governance and Assurance Lead Midwife; Natalie Whyte Regional MVP Midlands Perinatal Team; Joanna Morris Interim Head of Quality; Marie Teale Senior Project Manager Nottinghamshire LMNS ICB

## Key Headlines Points for Celebration



- Supportive, open and honest organisation with a shared understanding of issues at all levels and strong culture of escalation.
  - Loyal staff with access to career development and progression, who genuinely enjoy working at the unit
- Experienced senior leadership team with clear executive and NED visibility
- Wide range of specialist midwife roles in place with knowledgeable, enthusiastic and inspiring staff in post
- Good engagement with the executive team and safety champions demonstrating close links to Parents Representative
- A strong Parents Representative employed on temporary basis who is able provide robust user feedback
  - maximising the potential to reach minority groups
  - Links closely with all staff groups and senior leadership team

#### Key Headlines Points for Consideration

4



- Strengthen audit plan to incorporate <u>all</u> Ockenden actions frequently and regularly reported throughout the division.
  - Ensure staff are aware of audit results and Ockenden requirements using a variety of communication pathways including information boards in clinical areas, social media and training study days
- Over reliance on small number of key obstetricians for multiple roles risk if absences occur with need to support antenatal clinic capacity following increase in bookings from NUH
  - Review and increase the obstetric workforce to take this into account
  - Review and share PA allocation for important and essential additional obstetric roles including; governance lead; SBLCBv2 lead, audit lead, guideline lead, PMRT lead, fetal monitoring lead
- PMRT meetings should be coordinated by the governance team
  - currently led by the bereavement midwife, could lead to conflict of interest
  - all cases should be reviewed by external MDT
- Progress work to revisit the Birthrate + assessment
  - ensure the operational challenging increase in bookings from NUH and medical complexity of women are taken into account for recruitment of midwives

# Summary of Insight Visit Review of Ockenden IEAs Status



IEA	i	ii	iii	iv	V	vi	vii	viii
1) Enhanced safety								
2) Listening to women and families	N/A	N/A						
3) Staff training and working together								
4) Managing complex pregnancy								
5) Risk assessment throughout pregnancy								
6) Monitoring fetal well-being		*			*			
7) Informed consent								
Workforce Planning								
Guidelines								

<sup>5</sup> A 38 remains amber whilst not fully SBLCBv2 compliant

## **IEA1** Enhanced Safety

- NHS
- Points for Celebration IEA1 RAG Clear Perinatal Clinical Quality Surveillance Model in place Q1 -All SI cases have external review **Dashboards** Good internal review of PMRT cases including HSIB colleagues to fully discuss Q2 – External review of SIs cases if required Q3 - SIs to 100% of HSIB cases are reported and 95% + cases for PMRT are commenced in **Board/LMNS** the timescale required Q4 - PMRT Points for Consideration Q5 - MSDS • Work towards external review for <u>all</u> PMRT case - consider grouping cases into Q6 - HSIB thematic reviews for external clinical opinion e.g. congenital abnormality and severe Q7 - PCQSM • This will assist with workload requirement e.g. congenital abnormality and severe prematurity Q8 - SIs to Board/LMNS

prematurity

# IEA2 Listening to Women & Families



Points for Celebration		
Posters with details of all maternity safety champions were visible in clinical areas		RAG
<ul> <li>A strong Parents Representative has been employed on a short term basis who is able provide robust user feedback</li> <li>maximising the potential to reach minority groups</li> <li>Links closely with all staff groups and senior leadership team</li> </ul>		N/A
		N/A
Points for Consideration		
<ul> <li>PMRT meetings should be coordinated by the governance team</li> <li>currently led by the bereavement midwife, could lead to conflict of interest</li> <li>all cases should be reviewed by external MDT</li> </ul>		
<ul> <li>PMRT cases have MDT review and are taken for external review - consider grouping cases into thematic reviews for external clinical opinion e.g. congenital abnormality and severe prematurity</li> <li>this would assist with workload for this requirement</li> </ul>		
<ul> <li>Support parent representative with longer term post to continue the excellent <sup>7</sup> work underway</li> </ul>	Q16 – NED	

# IEA3 Staff Training and Working Together

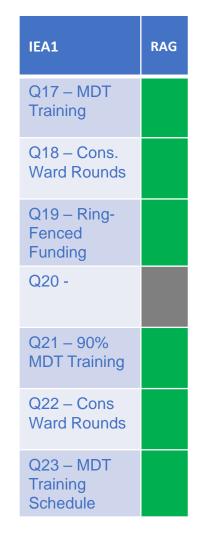
## Points for Celebration

- Achieved the required standard for MDT training
- Comprehensive understanding of training data and training compliance rates
- At least twice daily consultant ward rounds are well embedded and feedback from staff is positive and supportive

## Points for Consideration

• The upcoming implementation of a bespoke maternity EPR will assist in robust recording of the consultant ward round occurrences for evidence of continuing compliance





## IEA4 Managing Complex Pregnancy

#### **Points for Celebration**

- All women who were classified as high risk pregnancies were allocated a named consultant
- Maternal Medicine Network pathways are in place

#### Points for Consideration

- Two divergences are in place for SBLCBv2 with actions in place to address the non compliance
  - Continue to progress at pace UtAD training and the care pathway of women with a BMI of >35 to conform with national requirements

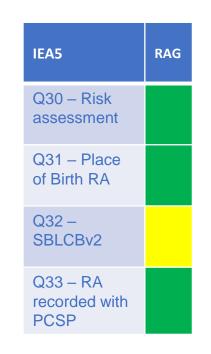


IEA4	RAG
Q24 – MMC Criteria	
Q25 – Named Consultant	
Q26 – Complex Pregnancies	
Q27 – SBLCBv2	
Q28 – Named Cons/Audit	
Q29 – MMC	

### IEA5 Risk Assessment Throughout Pregnancy

#### Points for Celebration

- Antidotally antenatal risk assessment is carried out at every contact with evidence confirming compliance
- Review of incidents looks at care pathways and antenatal risk assessment compliance
- Points for Consideration
- Two divergences are in place for SBLCBv2 with actions in place to address the non compliance
  - Continue to progress at pace UtAD training and the care pathway of women with a BMI of >35 to conform with national requirements
- The upcoming implementation of a bespoke maternity EPR will assist in robust recording of the antenatal risk assessment occurrences and interactive PCSP for evidence of continuing compliance





# **IEA6** Monitoring Fetal Well-Being

#### Points for Celebration

- Fetal wellbeing leads in post with clinical expertise
- Achieved the required standard for MDT training
- Comprehensive understanding of training data and training compliance rates

#### Points for Consideration

- Two divergences are in place for SBLCBv2 with actions in place to address the non compliance
  - Continue to progress at pace UtAD training and the care pathway of women with a BMI of >35 to confirm with national requirements
- \*Q35 & 38 remains amber whilst not fully SBLCBv2 compliant

IEA6	RAG
Q34 – Leads in post	
Q35 – Leads expertise	*
Q36 – SBLCBv2	
Q37 – 90% MDT Training	
Q38 – Leads in post	*

# **IEA7 Informed Consent**

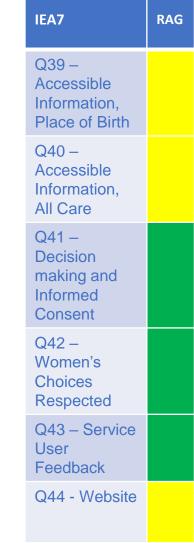
Points for Celebration

- A strong Parents Representative has been employed on a short term basis who is able provide robust user feedback
  - maximising the potential to reach minority groups
  - Links closely with all staff groups and senior leadership team
- Reinstatement of Homebirth services is welcomed to provide choice for women in place of birth

#### Points for Consideration

- Consider reviewing the existing forward audit plan to ensure the evidence demonstrates that women's choices have been respected, informed choice has been given and accessible information in all formats is available
- lack of patient information regarding choice of birth on trust website impacting on informed choice process.
  - trust website function converts english into other languages does not convert leaflets into the relevant language.
  - ensure the website can give service users access to pathways of care in any language required and capability of providing information for women
  - 12 | and their families who have auditory and visual impairments





## Workforce Planning & Guidelines

Points for celebration

- Visible leadership from director of midwifery and triumvirate in place, meeting weekly to discuss current concerns and solutions
- New dedicated retention midwife in post and already demonstrating ability to support staff to stay in post
- Wide range of specialist midwife roles in place who were extremely knowledgeable, enthusiastic and inspiring staff in post
- Coherent matron team who work well together

#### Points for consideration

- There is an over reliance on a small number of key obstetricians for multiple roles which is a risk if any absences occur and additionally to support antenatal clinic capacity with the increase in bookings from NUH
  - Review and increase the obstetric workforce to take this into account
  - Review and share the PA allocation for important and essential additional obstetric roles including; governance Lead; SBLCBv2 lead, audit Lead, guideline Lead, PMRT Lead, fetal monitoring lead
- Continue the plan to recruit a Head of Nursing to support the DOM for Children's and Neonates workload



WFP & G	RAG
Q45 – Clinical Workforce Planning	
Q46 – Midwifery Workforce Planning	
Q47 – D/HoM Accountable to Exec Dir	
Q48 – Strengthening Midwifery Leadership	
Q49 - Guidelines	

#### **Additional Celebration Points**



- Effective induction of labour pathway in place keeping delays to a minimum
- Excellent Blood spot screening QI project –improving the screening pathway and experience of women and babies
- Introduction of the Each Baby Counts Escalation Tool to improve safety and support staff in structured conversations
- Listening event has been undertaken to hear the voices of obstetric trainees and plan solutions following concerns raised in HEE survey

#### **Additional Points for Consideration**

- Progress the work underway to fully implement BSOTS when staffing allows
  - continue to monitor outcome data and ability to achieve timely assessment in triage

## Offers of Support to Trust



• Link SFH Digital lead Midwife with other Trusts using Badgernet

The visiting team would like to express thanks to all the staff who on the day of the visit were very welcoming in sharing their thoughts regarding the maternity services.