Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:** 3 November 2023	
Prepared By:	Paula Shore, Director of Midwifery/ Divisional Director of Nursing for W&C		
Approved By:	Phil Bolton, Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery/ Divisional Director of Nursing for W&C. Phil Bolton, Chief Nurse		

Purpose		
To update the Board of Directors 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

- Nursing and Midwifery AHP Committee
- Maternity Assurance Committee
- Quality Committee

Acronyms

- Maternity and Neonatal Safety Champion (MNSC)
- Maternity Voice Champion (MVP)
- Maternity Assurance Committee (MAC)
- Care Quality Commission (CQC)
- Local Maternity and Neonatal System (LMNS)

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 October 2023

1. Service User Voice

Work from the service user voice representative from both Maternity and Neonates has focus on looking at the delivery plan and model for the next year, ensuring that this plan has been co-produced.

The proposed plan and funding streams will be presented to the Executive Partners meeting in November.

The MVP has further supported the engagement work around induction of labour, a theme which appeared within the CQC Maternity Survey 2022/23 and Walk the Patch from the MVP. The detail of this will feature within next month's MNSC update.

2. Staff Engagement

On the 3rd of September the MNSC planned walk round. The higher activity was felt and reported on by all the team, but assurance was provided around the staffing levels to support it.

The MNSC spoke with some of the early career Midwives who had newly started and student Midwives, on the shortened MSc Programme, who are due to qualify in January 2024. All reported that they were looking forward to joining the team and had already had contact with the R&R Midwife.

Maternity Forum was conducted on the 4th of October. With the members that joined, a discussion was held around reforming the forum. The outcome was that the meeting will become hybrid so that colleagues can continue to join via MS Teams but through holding the opportunity for face-to-face engagement within a clinical area. Feedback was given around the actions from the previous meeting, specifically regarding the venue for the antenatal education and log design for Maternity.

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, we are still awaiting the updates to the workbook **from the system.**

Ockenden:

The annual Ockenden insight visit was conducted on the 9th of October. The agenda for the day included opportunities from the visiting to panel to speak with both staff across all levels and service users. The initial feedback provided was very positive around the culture and embedding of the initial Ockenden immediate and essential actions. We have yet to receive formal feedback, once provided this will be reviewed through the MNSC for action.

NHSR:

Through the MAC this month we have started to present the evidence, as discussed through the MNSC meeting, for compliance against the Year 5 Maternity Incentive Scheme. Safety actions 2, 5 and 7 have been presented and approved as compliant.

Saving Babies Lives:

SFH has continued to monitor its compliance with all elements of the Saving Babies' Lives Care Bundle (SBLCB) in version 2 and following the uploaded evidence submitted to the regional teams we have received confirmation that we have achieved the agreed over 70% of compliance for version 3. Work continues to ensure that we aim for full compliance within the agreed time thresholds.

CQC:

Following the "Good" rating from the planned 3-day visit from the Care Quality Commission (CQC) the evidence has been rated as "green" through the QC, further is needed for these actions to become embedded. The "Must-Do" progress will be tracked through the MNSC.

The focus has 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.

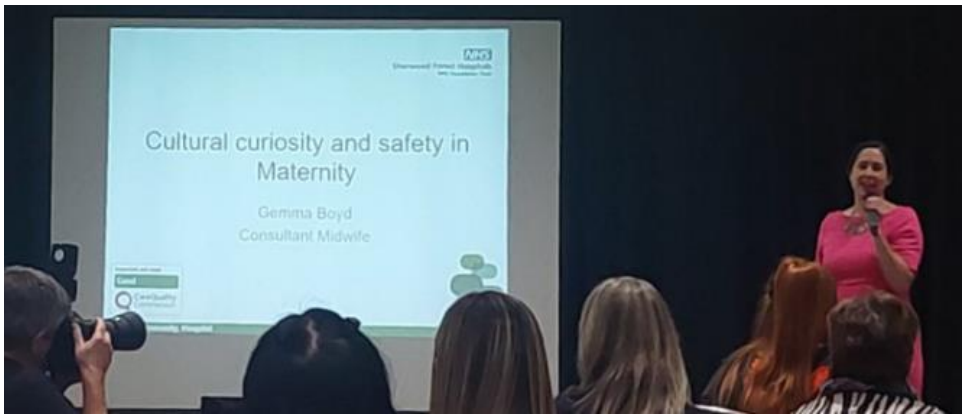
The trust should continue to implement their new electronic system. To support auditing the quality of the service. When issues are identified from audits action is taken further auditing cycles are undertaken to demonstrate if improvements and changes in practice have improved patient outcomes and improved practice.

Leaders should continue to implement improvements to how they effectively communicate any changes in service provision with staff.

At the MNSC meeting this month we reviewed the action plan and approved.

4. Quality Improvement

On the 13th of October, the teams were able to celebrate the work that they have supported over the last year at the Trust's Celebrating Excellence Event. Both the Maternity and Neonatal team presented their work around Cultural Safety and Neonatal Baby Friendly Initiative at the event sharing the key work and futures plans.



5.Safety Culture

Following on from last month's focus on the Equity and Equality work, this month saw the first two-day training in Cultural Safety. This new mandatory training is being rolled out across maternity services for the next three years, with the focus of the days listening to parents lived experiences, drafting action to reduce inequalities and ends with collective support for the group.