Board of Directors Meeting

Subject:	Maternity and Neonatal Safety Champions Update	**Date:** 7th 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. 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.

1. 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.

   On the 7th of March we welcomed Sarah, our service user representative, who is supporting and ensuring that the maternal voices are heard within our services. Following an induction to the area, Sarah initial work plan is to perform a “walking of the patch”, support the Ockenden requests and the CQC survey findings.

2. Staff Engagement

   The MNSC Walk Round was completed on the 14th of March 2022 which was positive with staffing reported as being improved. Areas around antenatal clinic messaging system had been raised and actions taken. Colleagues were reassured that any necessary actions have been taken from previous walk rounds. The Maternity Forum on the 21st of March reflect this feel and discussion were made around the recent appointment (Deputy Head of Midwifery) and the subsequent plans of the coming months. All discussion and subsequent actions are captured and shared out within the Maternity Matters newsletter which is distributed to all colleagues.

   Further in staff engagement, highlighted in this month feature, is new role of the Recruitment and Retention (R&R) Lead Midwife post.

3. Governance

   Due to the increasing staffing and clinical pressures of Omicron during December, a joint position statement from NHSI/E mandated that all reporting for the Maternity Incentive Scheme cease for a three-month period. We have had some communication that this is due to recommence Mid-April 2022.

   NHSR have confirmed our full compliance with the 10 safety actions for year 3 as signed off by the board of directors in 2021. This is excellent news for the service and provides a significant rebate to reinvest in the service.

   Due on the 30th of March 2022 is part 2 of the Ockenden Report and our teams will be briefed in preparation.

4. Quality Improvement Approach

   Work continues on the Maternity and Neonatal Safety Improvement Programme, the regional events continue, specifically focusing on the prevention of pre-term birth. The early implementor site work, featured in our update previously, continues to gather strength. Supportive training measures are underway through mandatory and ad hoc sessions for all Maternity staff.

2. Monthly Feature – Recruitment and Retention Lead Midwife Role

This role, funding by NHSEI for 12 months, aims to offer individualised supportive interventions related to student, early career retention, late career progression and retire and return flexibility, based on local data and insights, including learning, career advice and pastoral care.

NHSEI recognise that there will be a variety of existing models of support and the aim of this resource is to complement or strengthen these to meet the objectives below. This role needs to clearly demonstrate added value beyond current establishment.

Objectives:

1. Provide individualised situated support in clinical environment for students, return to practice learners and early career midwives

– Develop mechanisms for identifying and addressing individual needs
– Provide, or signpost to, resources that will promote job satisfaction and retention across multiple domains including those related to pastoral care, learning support and career development.

2. Assimilate and analyse local data, research and intelligence to target interventions.

3. Seek out new and innovative solutions to enhance programme outcomes and/or reinvigorate approaches that have demonstrated value and impact in the past.

4. Monitor impact of interventions on a range of staff experience indicators including local leaver rates.

5. Act as direct link between the director of midwifery/head of midwifery/chief nurse and students, return to practice learners and early career midwives to inform enhancements in learner and staff experience.

6. Work collaboratively with the regional retention teams to inform and evaluate national retention offer for midwives.

7. Participate in learning activities locally and nationally to enhance the overall objectives of the programme.

Delayed initially due to COVID-19 and staffing pressies, our R&R Lead Midwife started in post on the 7th of February with a clear job plan to address the above 7 points. We will be monitoring and collating local data as the impacts of the role, which will be tracked through the MNSC meeting. Over February each preceptorship midwife has had a one-to-one conversation with the R&R midwife are the agreed actions she has taken following these meetings. These have been shared at the MNSC meeting and Midwifery Forum in March 2022.

Action plan:

Action number	Action	By Whom/ When	Updates	Action RAG rating
1	Matron team to ensure ward leaders authorise annual leave in a timely manner	Matron for Inpatient Services		
2	Matron team around roster practice, specifically consideration for weekend working	Matron for Inpatient Services		
3	PDM Team to streamline Preceptorship paperwork	PDM Midwives	Action underway- update next month	
4	PDM Team to look at booking in all study days (Calculation test, IV Study day, IV Cannulation) prior to induction for the new starters	PDM Midwives	Action underway- update next month	
5	PDM Team to review why new starters need to be signed off by a 'buddy' for core midwifery skills	PDM Midwives	Action underway- update next month	
6	Pursue 'Bright Sparks' Team regarding lanyards	R&R Lead Midwife	Action underway- update next month	

Appendices

Appendix 1- Supporting Narrative on Mandated MNSC Activity

Governance

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 fatal 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 Maternity Clinical Network. Within Safety Action 6 of the Maternity Incentive Scheme, process and outcome measures regarding compliance have been validated. SFH are continuing to work towards compliance and are being supported through action plan, drafted by the service director, and supported by the MCN and CCG. The NHSR year 4 was released on the 8th of August 2021. SFH have re-instated the divisional working group. Initial risk specifically around safety action 8 has been escalated regionally regarding the timeframes for MDT training. The reviewed standards have are now available at Trust level and the working group are working towards these.