Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:** 7 December 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

- Induction of labour (IOL)
- Maternity and Neonatal Safety Champion (MNSC)
- Maternity Voice Champion (MVP)
- 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 November 2023

1.Service User Voice

Emma, the MVP volunteer for SFH has worked with the Induction of Labour (IOL) lead Midwife this month to look at progressing the actions identified through service users' feedback. This work has focused upon the information provided as part of the IOL process and

Teams from Maternity and Neonates attended the Baby Week Celebration event at a local Leisure Centre supporting Mum's within our areas with children under 5 to attend engaging in free activities and speaking to key services within child health.

2.Staff Engagement

The MNSC planned walk round was conducted on 7 November 2023. The activity has remained high but evidence of the additional LSCS and staffing levels to support this had eased the pressure. All teams reported the higher activity and the difficulties which have led to the suspension of services.

The senior leadership team took away an action away to look at how to support the division with these challenges. The outcome was that now all areas within division attend a safety huddle three times a day, prior to the Trust's bed meetings, to discuss activity, safety and any escalations. We have run this now for two weeks and initial feedback has been positive.

The Maternity Forum was held on 3rd November 2023. With the members that joined, we continued to discuss 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.

On 23 November 2023, the Trust received a visit from Dame Ruth May, Chief Nursing Officer and Kate Brintworth, Chief Midwifery Officer for England. This visit provided a great opportunity for all the team to meet and showcase their MNSC work to Ruth and Kate.

The team received very positive feedback from Kate Brintworth following the visit which is detailed below

I just wanted to write on behalf of Ruth and I and say thank-you to you and all the team for such a fantastic visit on Thursday. We felt so inspired by so many things that the maternity team are doing, and have been telling everyone about how your PROMPT training is rooted in human factors, about your brilliant PMA Julia Andrews and the work on choice you are doing and the focus on inequalities for everyone in the team – I really need to see that business case to help others achieve the same.

Everyone we met was so enthused by their work and proud of their team and the successes which you are clearly achieving by working together. Thank-you to everyone who showed us round, especially Paula and she can tell Melanie that I have read her document from cover to cover – I always enjoy reading homebirth stats and learnt a new thing about a 'fuddle in a field'. A new one on me (!) but again with that precious focus on caring on one another. I am very grateful Melanie took the time.

Thank-you for all the time and energy that went into making us feel welcome and for the care your team gives every day.

Please do pass this on to the team.

Very best wishes

Kate and Ruth

3.Governance Summary

Three Year Maternity and Neonatal Plan:

The Maternity Safety Team continued to work with the LMNS at looking at the planned workbook activities and how this can embed into the current work the division is undertaking.

Ockenden:
We have received the annual Ockenden insight visit report from our visit in October. The report is very positive and supports the team's self-assessment against the initial 7 IEA from the report. The have suggested areas for consideration and the team are looking at an action plan which will be tracked through the MNSC meetings.

NHSR:
The evidence review continues through the MAC meetings this month, all safety actions remain on track, noting that following escalations around SA8 the guidance has been revised around training standards. This was following escalation due to the industrial action and the pressure that it has placed on MDT training.

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 has been completed and will be presented at the next Patient Safety Committee meeting for sign off.

4. Quality Improvement

Aligning to the World Prematurity Day, on the 17th November the Neonatal teams celebrated obtaining stage 2 of the Baby Friendly Initiative accreditation. The unit is only one of a few nationally that have achieved this stage, prior to full accreditation, before the outlined target set by the Three-Year Plan of all Maternity and Neonatal Units achieving the standard for BFI by March 2027.

5.Safety Culture

Divisional colleagues have worked with organisational development to support the debriefing following the release of the score survey. This plan has had to be revised from the original due to operational pressures. Once the debriefing has been completed an action plan will be addressed through the MNSC meetings.