Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:** 4 January 2024	
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 December 2023

1.Service User Voice

During December 2023, our MVP volunteers has focused upon pain relief as part of the monthly walk rounds, following national findings from maternity surveys. Whilst the team focused on pain relief (choices, information given, availability, any concerns) subsequent feedback came in the form of the recently reinstated and revised and face to face antenatal education. Below are the comments that have been shared with the Community Midwives involved.

"The antenatal class was brilliant – so valuable and really balanced. I felt that I was given all the options and the benefits and risks of each and that I could choose what was best for me. I was so impressed by the balance and the fact that no one was pushing a particular agenda."

"I can still remember them talking about the ladder of pain relief – it was so good, and they made it easy to understand."

"The antenatal class was so good, but I found out about it a bit late from Badgernotes. They should put up more posters to make it easier for people to find out about these classes as I'd recommend them for everyone."

"I felt so empowered afterwards – I knew what my options were."

As part of the wider service users voice action plan, an additional action has been added regarding the information available and the accessibility of this.

For January 2023 we have started work on the co-produced action plan for the currently embargoed annual CQC Maternity Feedback survey, due for release in February.

2.Staff Engagement

The planned MNSC walk round, due to operational pressures and planned leave is due to take place on the 21st December 2023. Due to the high activity in November and December 2023 many of the senior leadership team have been supporting clinical activity and have supported the teams.

The previous action taken by the senior leadership team to support divisional colleagues with a safety huddle is now into the first month and is becoming embedded into daily practice. Evaluation and refinement have been undertaken.

Due to operational pressures the forum was stood down on the 8th December 2023, the planned re-launch in the new year of the hybrid meeting is in place. The aim is to have the meeting in a centrally located area so that clinical staff can join whilst maintaining the hybrid format for staff who work remotely within the community.

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. Key deliverable have been identified, such as the BFI status for Maternity and Neonatal services and are on track for the 2027 deadlines.

Ockenden:

We have received the annual Ockenden insight visit report from our visit in October 2023, the action plan is in place and discussed through the MNSC meetings. The visit findings supported the self-assessment completed by the Trusts. Area's have been identified from the visit to strengthen the embedding of the immediate and essential actions; these are included within the action plan and focus on bereavement resources across the system.

NHSR:

The evidence review has concluded through the MAC meetings, following a presentation of evidence of all 10 Safety Actions (SA). Assurance has been provided through both the externally validated (SA 1, 2, 6 and 10) and the remaining which whilst internally validated has been through a robust process to provide assurance.

The final presentation will be presented to both Trust Board and LMNS Executive Partners in January 2024 for final sign off in preparation for submission in February 2024.

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 in January 2024 for sign off.

4. Quality Improvement

Planned for discussion at the MNSC December meeting is the points for reflection and celebration within this years' service user voice action plan, as detailed below.

New IOL leaflet and also IOL pathway poster supporting women to make informed choices throughout their IOL process.

Supporting choice, addressing unconscious bias and civility workshops on PROMPT this year, which has evaluated very positively and been taken on by the CMO as a good practice example.

Birth Options and Birth Afterthoughts clinics established.

Cultural Safety Training

Plan to pilot a 16-week personalisation appointment in February.

Example of PMA leaflets for families.

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. Debriefing has commenced and two out of the five areas have been completed, with the further progressing in January 2024