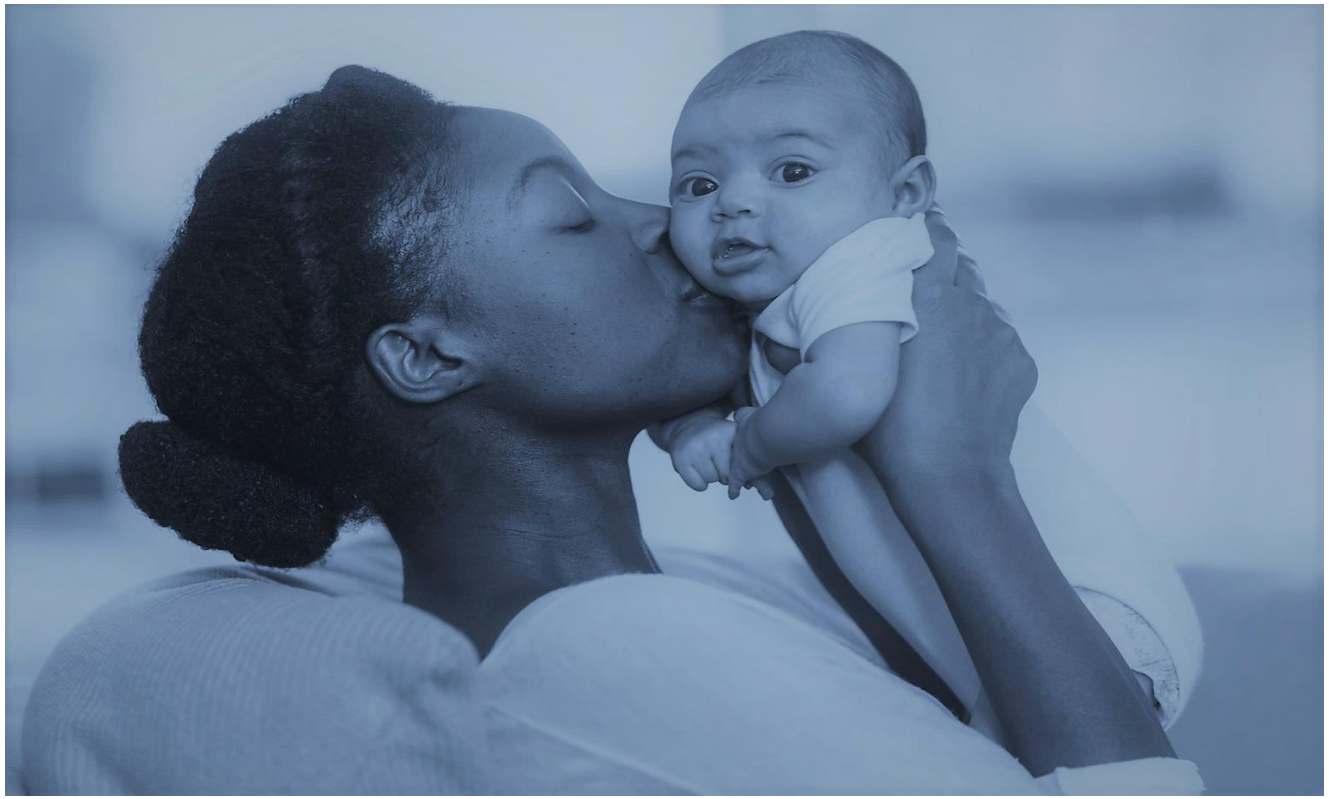
Maternity and Neonatal Safety Champions Toolkit September 2020



- National Maternity Safety Ambition
- Role of the Safety Champion
- How to support Safer maternity care
- National support offer
- Further resources

NHS England and NHS Improvement

Welcome

This toolkit is designed to be a helpful resource to enable support and empower you as a maternity or neonatal safety champion.

Maternity safety champions work at every level – trust, regional and national and across regional, organisational and service boundaries.

They develop strong partnerships, can promote the professional cultures needed to deliver better care and play a central role in ensuring that mothers and babies continue to receive the safest care possible by adopting best practice.

Useful publications supporting this work include *Better Births*, *Safer Maternity Care: Next steps towards the national maternity ambition* and *Safer Maternity Care: Progress and Next Steps, Transforming Perinatal Safety resource pack, Safety Champions Guidance*

How to use this guide

- This guide is an interactive toolkit made up of five key areas. Each of these areas can be accessed at any time from the main menu.
- There is a button to return to the main menu at the end of every section to make it easier to navigate.
- The Toolkit can be accessed as and when required, enabling you to rapidly access the content you need.
- You may notice that some of the links are directed to the Maternity Transformation Hub which you will need to register for access. All Trust Safety Champions can request access to the hub.
- This toolkit will enable, support and empower you as a safety champion, whether at frontline, trust board or regional level. It is not exhaustive − you are likely to want to develop and grow your role in response to specific intelligence and safety priorities.

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National Maternity Safety Ambition

➔National policy drivers
➔National safety ambition
➔Safety priorities
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Role of Maternity and Neonatal Safety Champions

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➔Role of the safety champions
➔National maternity and neonatal safety champions
➔Safety Champions at Local Maternity System level
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➔Frontline safety champions (Maternity, obstetric and neonatal)

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➔A parent's view
➔Safety Champions and co-production/MVPs
➔Choice and personalised care

National Support Offer

➔Links to national support resources
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Further Resources

Further resources to support the role of the Safety Champion

The journey towards a national safety ambition

This section covers:

Policy drivers

‘Halve it’ campaign

Safety Priorities

Insight, Involvement, Improvement

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Responsibility for safety…

“The prime responsibility for ensuring the safety of clinical services rests with the clinicians who provide them...

The prime responsibility for ensuring that they provide safe services, and that the warning signs of departure from standards are picked up and acted upon, lies with the Trust, the body statutorily responsible for those services.”

Dr. Bill Kirkup

The journey to a national maternity safety ambition

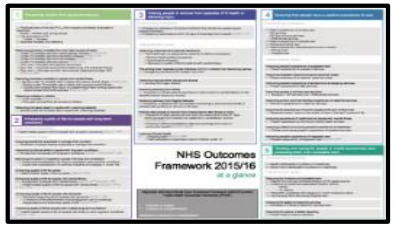
2014
Five Year Forward View

2015 – National Ambition

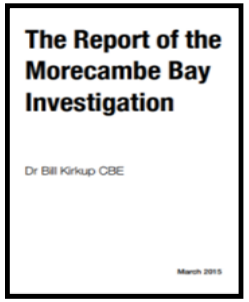
2016 – Safer Maternity Care Action Plan

2019 - Implementing the Neonatal Critical care review Recommendations

2010 - NHS Mandate & Outcomes Framework



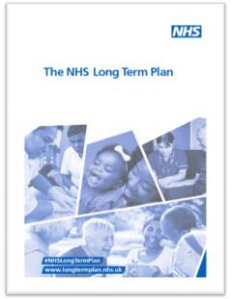
2015 – Kirkup Report



2016 – Better Births

2017 – Progress and next steps

2019 - Long term Plan



National maternity safety ambition

‘Halve it’ campaign

Our Collective aim is to make measurable improvements in safety outcomes for women, their babies and families in maternity in neonatal services, as set out in Better Births in 2016.

This includes halving the rate of stillbirths, neonatal deaths, intrapartum brain injuries and maternal deaths by 2025 (2010 baseline), with a 20% reduction by 2020. Also, reducing pre-term births by 25% (2015 baseline) by 2025 by reducing the pre-term birth rate from 8% to 6%.

Local Maternity Systems and Provider organisations have been undertaking a range of safety interventions and should continue to throughout the Long Term Plan (LTP) period, in order to meet the safety ambitions.

The safest maternity and neonatal services in the world

Safety is a ‘golden thread’ running through the Maternity Transformation Programme (MTP). The MTP is responsible for implementing Better Births and the mechanism through which we are delivering the government’s ambition to make our maternity and neonatal services the safest in the world.

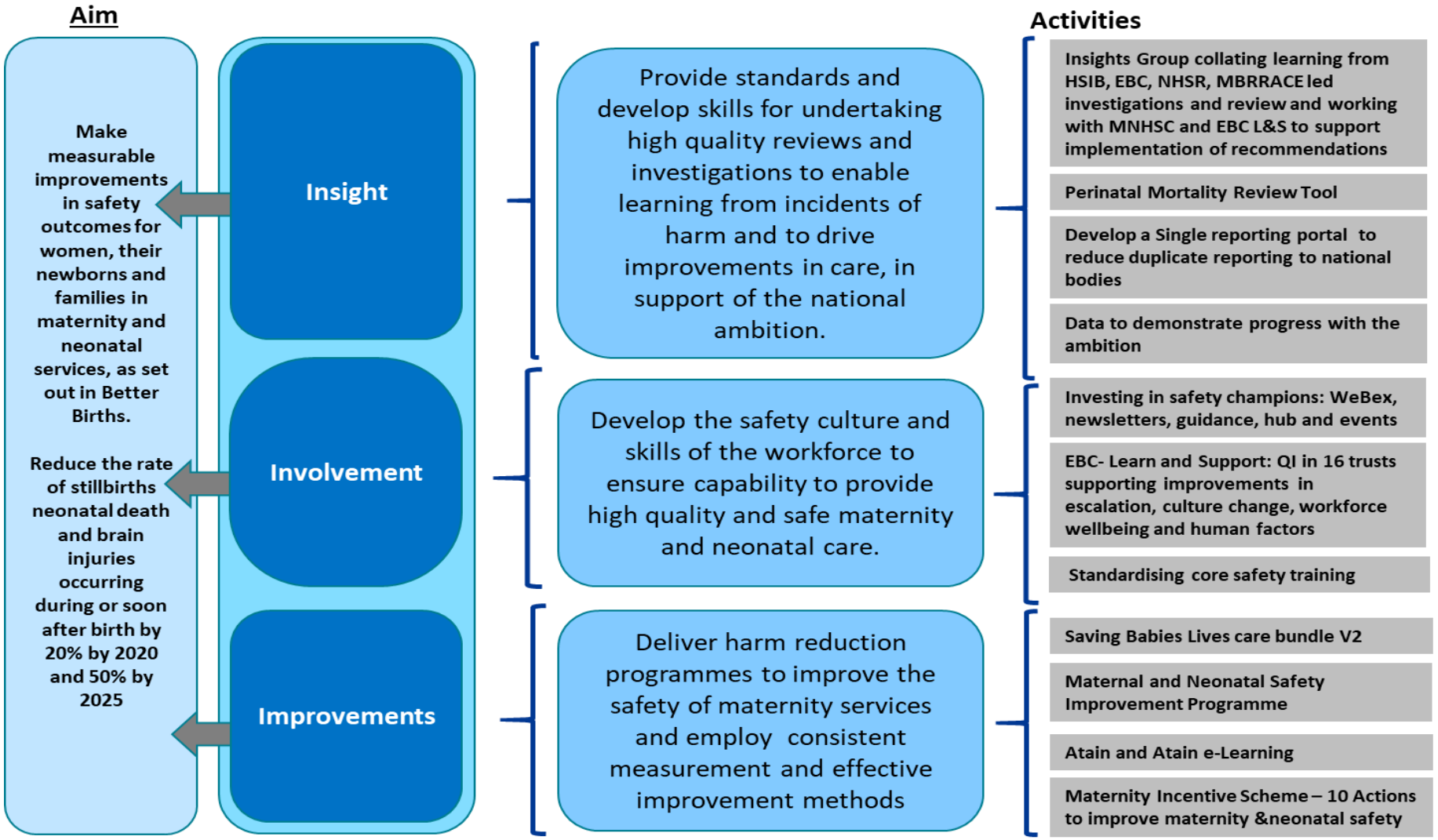
The Safer maternity care action plan and the 2017 revised action plan made the case for strong leaders at every level of the system to promote the professional cultures needed to deliver better care. As Safety Champions, you play a central role in ensuring that mothers and babies receive the safest care possible by adopting best practice, with a particular focus on improving outcomes for mothers and their babies from Black, Asian and Minority ethnic backgrounds drawing on insights from the SARS-Covid UKOSS report and the MBRRACE-UK report.

Our ambition for personalising care is interwoven with safety. Personalisation is based on a robust and continued assessment of a woman’s circumstances and choices based on a relationship of trust between the woman and her clinicians and is a vital prerequisite for safe care.

Everyone: lead reporters, maternal and neonatal safety improvement programme board-level sponsors and improvement leads; frontline teams and safety champions are working towards a safer maternity system by using their collective insights and skills to deliver and embed improvements.

As Safety Champions, you are the ambassadors for this work , your leadership is central to its success – this toolkit will guide you to play your part in making maternity services one of the safest in the world

Aims and activities of the Maternity Transformation Programme Safety Workstream – 'at a glance'



Insights

Our goal is to provide standards and to develop skills for undertaking high quality investigations. This will enable learning from incidents of harm and drive improvements in care, in support of the national ambition.

We will do this by:

- ➔ Publishing standards for maternity investigation as part of the new Patient Safety Incident Response Framework
- ➔ Publishing data to demonstrate progress with the national ambition
- ➔ Using the MatNeoSIP to share new insights and work with stakeholders to respond to key recommendations and safety concerns identified by national organisations
- ➔ Promoting and incentivising the use of the Perinatal Mortality Review Tool (PMRT) to support standardised, systematic, multidisciplinary, high quality reviews
- ➔ Collating learning from the Healthcare Safety Investigation Branch (HSIB) maternity investigations, Each Baby Counts (EBC), NHS Resolutions Early Notification Scheme and MBRRACE-UK led investigations and reviews through a new Insights Group to share learning, emerging evidence and act on safety concerns
- ➔ Testing the feasibility of a single reporting portal to reduce the burden of duplicate reporting to national bodies

Involvement

We aim to develop the safety culture and skills of the workforce to ensure capability to provide high quality and safe maternity and neonatal care.

We will do this by:

- ➔ Investing in safety champions by continuing our themed online seminars; publishing regular, relevant safety news items in our safety champion newsletter; signposting to existing guidance to support you in your role; updating our existing safety champions hub with useful resources, engaging with you as safety champions as part of regional and national events.
- ➔ Developing a multi-disciplinary clinical leaders' group to support MatNeoSIP with the leadership, capacity and capability of improvement through the networks.
- ➔ MatNeoSIP will also offer a further safety culture survey (SCORE) to all maternity and neonatal care providers, and through the Patient Safety Networks will provide support to utilise cultural insights to inform local quality improvement plans.
- ➔ Working with 16 trusts as part of Each Baby Counts + Learn and Support using quality improvement methodology to drive improvements in escalation, culture change, workforce wellbeing and human factors. Building the clinical leadership, safety thinking and quality improvement of 16 NHS maternity professionals, EBC L&S will facilitate and evaluate a structured quality improvement process using behavioural science to improve clinical escalation in intrapartum settings.
- ➔ Standardising core safety training

Improvements

We will deliver harm reduction programmes to improve the safety of maternity services and employ consistent measurement and effective improvement methods.

We will do this by:

- ➔ Supporting the implementation of Saving Babies' Lives care bundle v2
- ➔ Through the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) - supporting LMS's via Patient Safety Networks to test interventions where there is a strong evidence base; reduce unwarranted variation in outcomes and care experiences; and support providers to build the capability to improve and sustain change over time.
- ➔ Incentivising safer practice focusing on ten criteria, including Maternity Transformation Programme initiatives through the CNST Maternity Incentive Scheme (MIS)
- ➔ Continuing to support implementation of Continuity of Carer and to identify interventions which address inequalities drawing on insights from the SARS-Covid UKOSS report and the MBRRACE-UK report.
- ➔ Promoting personalised care being safe care – implementation of personalised care and support plans for every woman
- ➔ Supporting activity which optimises Maternal mental health and reduces the impact of trauma
- ➔ Supporting implementation of the Neonatal Critical Care Transformation Plan

The role of the maternity and neonatal safety champion

This section covers an introduction to:

Our national maternity and neonatal safety champions

The role of the clinical network safety champion

Key activities and responsibilities of the trust board safety champion

A parent's view – my challenge to board level safety champions

The role of the frontline safety champion (maternity, obstetric and neonatal)

Who are your safety champions?

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National maternity and neonatal safety champions

Matthew Jolly
National Clinical Director for Maternity and Women's Health

Professor Jacqueline Dunkley-Bent
Chief Midwifery Officer

As national maternity safety champions, Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent lead the maternity safety movement by working across professional groups and system boundaries to maintain the emphasis on high quality, safe maternity care for women and their babies.

Who are your Safety Champions?

National Maternity Safety Champions
Professor Jacqui Dunkley-Bent & Dr Matthew Jolly
nhsi.maternitysafetychampions@nhs.ne

Clinical Network Safety Champion is:
Name and contact details here

Insert photo

Your Trust Board level Safety Champion is:
Name and contact details here

Insert photo

Your Midwifery Safety Champion is:
Name and contact details here

Insert Photo

Your Obstetric Safety Champion is:
Name and contact details here

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Your Neonatal Safety Champion is:
Name and contact details here

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Role of the Safety Champions

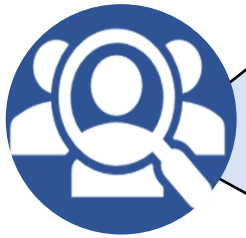
As an ‘ambassador for safety’ what difference can you make?

- Effective relationships
- Strong leadership and
- Robust governance processes

are the foundations of
SAFE SERVICES.

This section sets out key responsibilities for regional, board level and frontline safety champions, including links to relevant chapters in the ‘Transforming Perinatal Safety’ resource pack.

Key responsibilities for the clinical network safety champion



Develop strong working relationships with trust-level board and frontline safety champions through local network forums.

Foster collaborative working relationships with maternity and neonatal care providers, operational delivery networks, clinical commissioning groups and maternity voice partnerships across the network to develop care pathways that are responsive to the needs of your local population.

Draw on insights from provider and LMS colleagues and act as a regional conduit for sharing learning and best practice

Build on the maternity safety movement regionally, leading the focus on maternity safety

Provide visible leadership and act as a change agent among maternity and neonatal services and the health professionals and commissioners working to deliver those services in your network trusts

Act in partnership with patient safety collaboratives adviser and coach to support improvement activities including participation in the Maternity and Neonatal Safety Improvement Programme

Key contacts

- ➔ Maternity Voices Partnership User Chair
- ➔ Board level maternity safety champions
- ➔ Regional Chief Midwife
- ➔ Regional Lead obstetrician
- ➔ Local Improvement lead for MatNeo SIP
- ➔ Operational Delivery Network leads
- ➔ Lead commissioner for safety in LMS
- ➔ National Maternity safety Champions
- ➔ Maternity Transformation programme leads

Further information and detail is set out in ‘Transforming Perinatal Safety’ resource pack

Key roles and responsibilities of the Board level Safety Champion

Your role is to provide proactive board level leadership to ensure that:

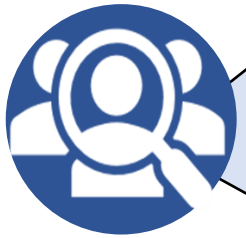
- ✔ High quality clinical care
- ✔ Maternity and neonatal service and facilities
- ✔ Workforce numbers
- ✔ Learning and training systems and
- ✔ Effective team working

are all in place

- ✓ **Oversee effective learning from incidents**
- ✓ Share learning as well as successes within and beyond your own trust
- ✓ Promote authentic engagement with service users who access maternity services
- ✓ **Act upon their feedback to help deliver services which are some of the best in the world**

The Board Safety Champion is ideally a non-executive director and the same individual providing executive sponsorship for the MatNeoSIP, acting as a conduit between the Trust board and frontline safety champions.

Key roles and responsibilities of the Board safety champion



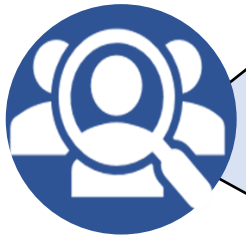
- ➔Engage with staff and service users to determine views on safety and staff satisfaction through walkabouts, audit, investigation and user feedback
- ➔Review the quality of investigation reports and ensure they meet national standards;
- ➔Ensure Duty of Candour is upheld
- ➔Address recommendations from investigation findings; provide leadership and oversight for improvement
- ➔Ensure services are following national guidelines
- ➔ Oversee reviews and audit if the Trust is identified as an outlier
- ➔Ensure standards for effective data quality and coverage, as defined by NHS Digital in the new data quality standards are being met

Key contacts

- ➔ Maternity Voices Partnership User Chair
- ➔ Board level maternity safety champion
- ➔ Regional Chief Midwife
- ➔ Regional Lead obstetrician
- ➔ Local Improvement lead for MatNeo SIP
- ➔ Operational Delivery Network leads
- ➔ Lead commissioner for safety in LMS
- ➔ Maternity Transformation programme leads
- ➔ National Maternity Safety Champions

Further information and detail is set out in ‘Transforming Perinatal Safety’ resource pack

Suggested activities to promote communication from ‘Floor to Board’



Undertake regular safety huddles

Lead a weekly safety ward round

Review and disseminate the national safety Champions newsletter

Consider implementing a local safety newsletter/update

Participate in developing an action plan to support findings from your local SCORE culture survey

Implement a monthly safety ‘shout out’ with focus topic

Undertake a monthly board champion feedback session

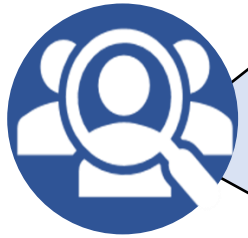
Share actions from the feedback sessions through a ‘You said, we did’ staff noticeboard, updated monthly

Prioritise direct contact with safety champions via phone/face to face/email

- ➔ Bi-monthly meetings with frontline safety champions to enable escalation of locally identified issues and share successes
- ➔ Engage with Trust representatives of the National Clinical Improvement Leaders Group (where relevant)
- ➔ Quarterly national improvement network meeting
- ➔ Quality reviews e.g. 15 steps
- ➔ Quarterly Board level update
- ➔ Attendance at key monthly directorate meetings
- ➔ Engage and involve service user e.g. MVP contact
- ➔ Drive the ambition for every woman to have a personalised care and support plan
- ➔ Attend and contribute to annual or bi-annual trust-wide safety learning events or patient safety conference
- ➔ Participate in National Learning Events and/or MatNeoSIP WebEx’s
- ➔ Draw on the CNST MIS Webinars to fully understand and implement the requirements of each safety action

Further information and detail is set out in ‘Transforming Perinatal Safety’ resource pack

Tools and resources for Board Safety Champions



Draw on:

- ➔ Findings from locally undertaken assessment using the NHSE&I Maternity Self Assessment Tool
- ➔ Findings from the local SCORE Culture Survey
- ➔ Activity to fulfil NHS Resolution Maternity Incentive Scheme – 10 Safety Actions
- ➔ The Board level chapter of 'Transforming Perinatal Safety'
- ➔ Trust Quality Improvement Plan
- ➔ Local Maternity Safety Strategy
- ➔ Local Maternity Risk Management Strategy
- ➔ Local Governance Framework
- ➔ Trust Board Assurance Framework
- ➔ Personalised Care and Support Plans guidance
- ➔ Trust level reports and findings from

Insights from local leaders

- ➔ Maternity Voices Partnership lead
- ➔ Safety champions in the Maternity Clinical Network, Leads from the LMS, Neonatal ODN and MatNeoSIP
- ➔ Trust Quality Improvement Leads
- ➔ Trust Executive sponsor for the MatNeoSIP

Relationships

Work with your obstetric, midwifery and neonatal safety champions, leads for the MatNeoSIP programme, Head of Midwifery and Clinical Directors to ensure maternity and neonatal issues are communicated and championed at board level.

Regularly monitor safety and outcomes in maternity and neonatal services drawing on data from:

- ✓ NHS Digital dashboard
- ✓ MBRRACE-UK reports
- ✓ HSIB reports
- ✓ Local SI investigation findings
- ✓ National Maternity and Perinatal Audit reports
- ✓ Friends and Family Test
- ✓ CQC maternity survey

Further information and detail is set out in 'Transforming Perinatal Safety' resource pack

A parent's view: my challenge to board level safety champions

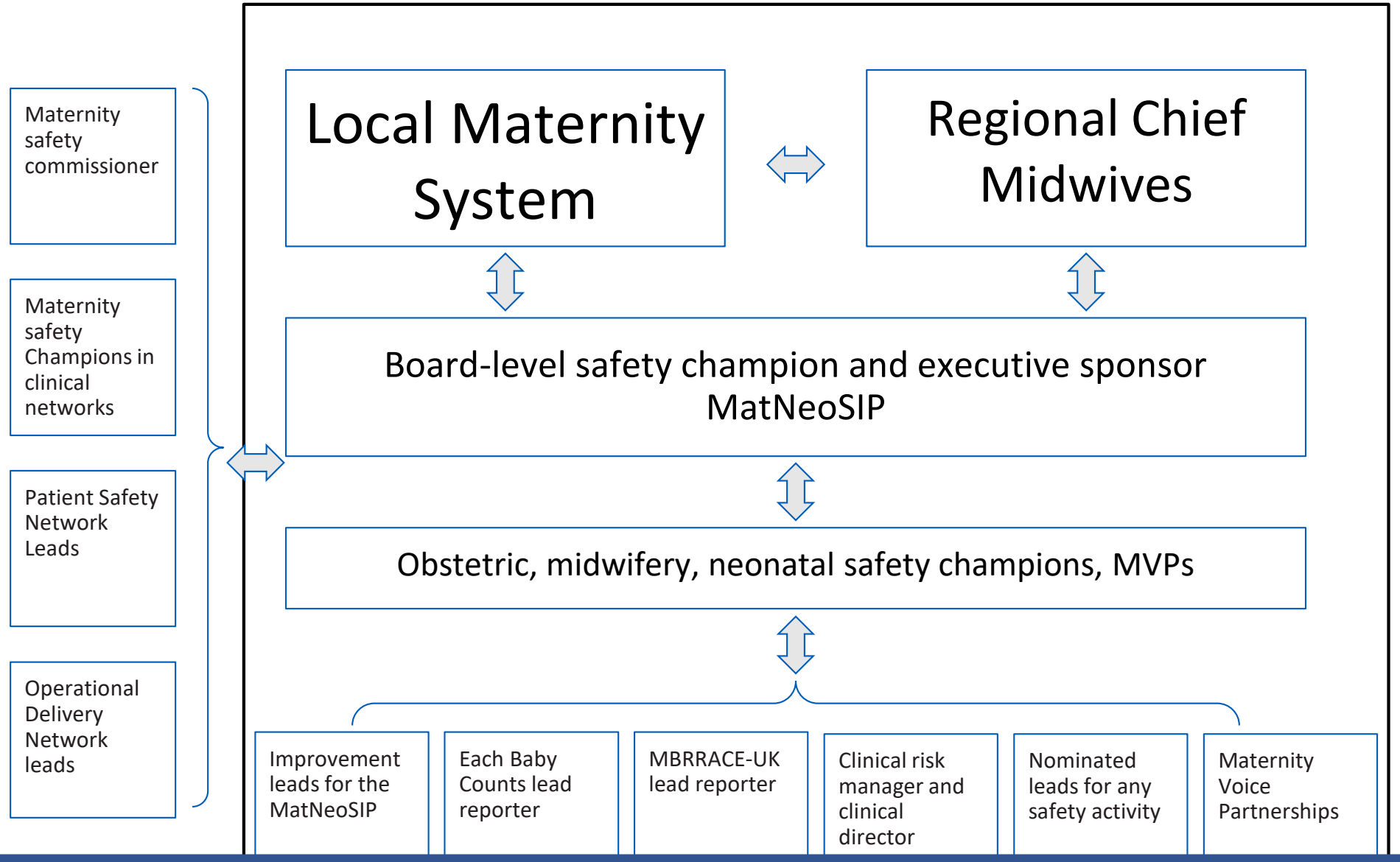
Nicky Lyon, Campaign for Safer Births and User Co-Chair of the National Maternity Safety Workstream, asks the following questions for Board level safety champions:

HOW DO YOU KNOW…

- ➔ If your unit is delivering the safest care possible?
- ➔ Do you read feedback and comments from parents? What changes have you made in response?
- ➔ Is your unit following all current guidelines? Are they documented, trained and audited?
- ➔ Have you checked that the staff in your unit have all the resources, training and support they need to do their job well?
- ➔ Is the MDT training developed in your trust with joint training briefings and handovers?
- ➔ Are you investigating all SI's and perinatal deaths robustly with external representation and invited parental input?
- ➔ Do you know how many stillbirths there have been in your unit? How many occurred in labour? How many SI's?
- ➔ Have you briefed the Board on maternity safety and the activity you would like to undertake to improve further?

Find out more: A parent's view: my challenge to board-level maternity safety champions

The role of safety champions in local oversight for safety



Further information and detail is set out in 'Transforming Perinatal Safety' resource pack

Key responsibilities of frontline safety champions (Maternity, Obstetric and Neonatal)

- ➔ Support the provision of a seamless multidisciplinary *perinatal service,* sharing successes, learning and best practice between maternity and neonatal services
- ➔ Working with your MVP leads identify, develop and implement pathways that respond to the needs of women, babies and their families.
- ➔ Understand the synergies between personalised care and safe care and promote these principles.
- ➔ Work with your Board level and maternity and obstetric safety champions to support implementation of the Neonatal Critical Care Review recommendations
- ➔ Support your Board Level Safety Champion to represent the needs of your service by clearly articulating barriers to achieving safe and personalised care
- ➔ Share progress with agreed action plans on all improvement initiatives with the board and your Local Maternity System and operational delivery network leads
- ➔ Develop strong working relationships with and draw insights from those leading all safety improvement related activity (e.g. your risk manager, lead reporters, MatNeoSIP and EBC L&S improvement leads)

Further information and detail is set out in 'Transforming Perinatal Safety' resource pack

Key responsibilities of frontline safety champions (Maternity, Obstetric and Neonatal)

Update the board safety champion on issues requiring board-level action e.g. trust position in meeting the national ambition trajectories including:

- ➔ stillbirth rate, brain injury rates, maternal mortality and neonatal mortality rates
- ➔ Implementation of SBLCBv2
- ➔ Implementation of CoC to meet national trajectories
- ➔ learning from Each Baby Counts cases and Serious Incident investigations, and ensuring appropriate actions are implemented and monitored at board level
- ➔ MBRRACE perinatal mortality status
- ➔ CNST Maternity Incentive Scheme
- ➔ Ensuring the Trust meets the standards required for effective data quality, using this to inform future improvement activity
- ➔ Acting as a point of organisational contact for the National Maternity Team
- ➔ Work with local specialist perinatal mental health teams for consultancy, supervision and joint-care planning for women experiencing mental health difficulties

Further information and detail is set out in 'Transforming Perinatal Safety' resource pack

Safety Champions role in supporting safer maternity care

This section covers:

Safety champions and co-production/ working with Maternity Voices Partnerships

The role of the safety champion in achieving equity

Key questions for safety champions – challenge yourselves

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Maternity and Neonatal Safety Champions supporting co-production with Maternity Voices Partnerships

Board and frontline safety champions should work together with their Maternity Voices Partnership service user chair to co-develop plans, ensuring that options continue to be on the basis of a personalised risk assessment and package of care agreed with each woman based on options available at the time.

Together MVP's should aim to understand their population profile and offer services which truly reflect their needs with a focus on improving outcomes women with health inequalities and those from disadvantaged backgrounds.

Your MVP should be funded, the user chair should be represented on the LMSs and both board and frontline safety champions should work with the MVP user chair to ensure co-production is embedded in all safety improvement work.

More information on this can be found in 'Transforming Perinatal Safety' resource pack.

Achieving equity

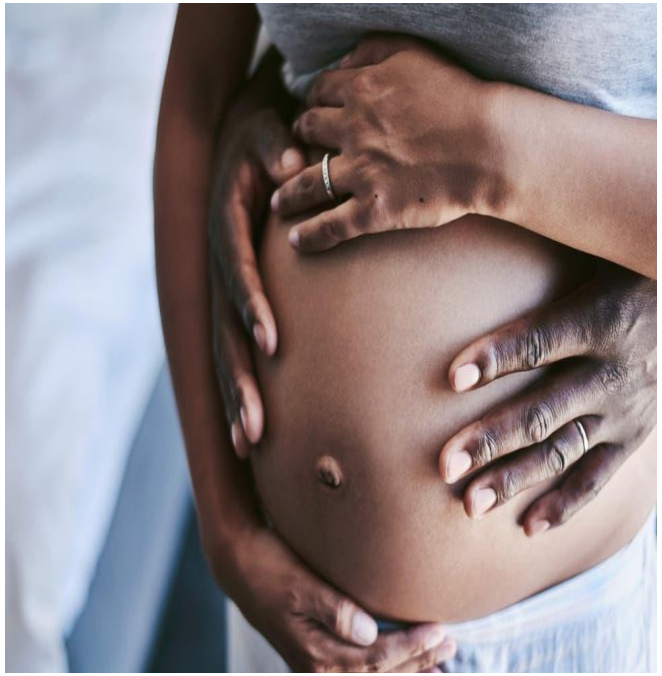
To achieve the 'halve it' ambition, we need to improve care for populations most at risk of poor outcomes and Safety Champions can help to drive this. The NHS also has a legal duty to reduce inequalities through the NHS Constitution and Health & Social Care Act 2012.

Whilst **mortality rates are reducing for the population overall**, stark health inequalities persist (MBRRACE-UK 2019):

- ➔ **Maternal mortality** is 5 times higher for Black women, 3 times higher for mixed ethnicity & twice as high for Asian women than white women;
- ➔ **Stillbirth rates** are twice as high for Black & Asian babies and 1.5 times higher for babies born to mothers living in the most deprived areas
- ➔ **Neonatal death rates** are increasing for Black and Asian babies (x1.7) . The rate for babies born to mothers in the most deprived areas is x1.2.

Safety Champions role in achieving equity

The 2020 **UKOSS** study 'Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK' showed that 55% of pregnant women admitted to hospital with **COVID-19** were from a BAME background. The risk is 8 times higher for Black women and 4 times higher for Asian women.



Keys to improvement:

- ➔ Implement the 4 actions set out in 'Perinatal support for BAME women during the COVID-19 Pandemic' (NHSE/I publications approval reference: 001599)
- ➔ Implement 'Four actions to achieve equity in maternity outcomes' published on the Local Transformation Hub.

Personalised care has a positive impact on health inequalities, taking account of the wider context of people's lives, with people from lower socio-economic groups able to benefit the most from personalised care1. (ref: Universal Personalised Care: Implementing the Comprehensive Model)

Continuity of Carer can significantly improve outcomes for ethnic minority women and those living in deprived areas – support the establishment of Continuity teams in locations with the highest levels of deprivation and the highest proportion of black and/or Asian women.

Safety champions – ask each other:

- ➔ How do you maintain oversight of safety incidents and monitor outcomes in relation to stillbirth, neonatal death, neonatal brain injury and maternal mortality?
- ➔ How are you balancing the response to COVID-19 with the continuing need to manage obstetric risk?
- ➔ How do you coordinate service changes via your Local Maternity System, Clinical Network and your Regional Chief Midwife?
- ➔ What are you doing to achieve a thorough understanding of the safety of your local maternity and neonatal services?
- ➔ How does your role integrate with internal governance and learning processes?
- ➔ How do you ensure your board is appraised of maternity safety?
- ➔ What are you doing to maximise your impact in your unit?
- ➔ Have you evaluated your role and its impact?
- ➔ What role are you playing as a catalyst for rapid learning?
- ➔ Do your maternity and neonatal teams have a good understanding of your role?

Safety Champions – ask yourselves:

- How am I supporting my fellow midwifery, obstetric and neonatal safety champions in their roles?
- How do I ensure that the board safety champion receives updates relating to maternity and neonatal successes?
- How do I know our services are safe?
- What am I doing to ensure the Trust board is receiving regular updates on issues requiring board-level action such as stillbirth rates, implementation of the Saving Babies' Lives care bundle and that learning from adverse incidents is being implemented?
- How do I know whether our services are following national guidelines?
- How do I ensure that our staff in maternity and neonatal services are getting all the training, support and resources they need and promote a culture of multidisciplinary team-working with joint training, briefings and handovers?
- Am I visible enough to our maternity and neonatal teams?
- What change has come about based on feedback from staff who are providing care and from those receiving care in maternity services?

National support offer

This section covers:

Links to national support resources

Safety champions role in the Clinical Negligence Scheme for Trusts

The Maternity Safety Self Assessment Tool

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Our support offer

Safety newsletters (subscribe via email below)

Safety Champion Events (subscribe via email below)

Safety Champion Hub

MTP Local Transformation Hub

Transforming Perinatal Safety resource pack

nhsi.maternitysafetychampions@nhs.net

Our support offer

Maternity Services System Learning: self assessment tool

This tool has been designed for Trusts to self – assess whether their operational service delivery meets national standards, guidance and regulatory requirements. We encourage all maternity services to undertake a self assessment using the tool.

The philosophy is one of promoting a positive leadership and safety culture.

e.g. Do your trust board meetings reflect check and challenge on maternity and neonatal services from your board level safety champion?

Do your safety champions lead quality reviews, e.g.15 Steps?

HoMs, DoMs and CD's: Complete your self assessment share results with your safety champions and address any gaps

CNST Maternity Incentive Scheme and Safety Champions

- The CNST Maternity Incentive Scheme incentivises ten maternity safety actions
- Trusts that can demonstrate they have achieved all of the ten safety actions recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds
- Trusts that do not meet the ten-out-of-ten threshold do not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund
- Specific action related to Safety Champions is detailed in Safety Action 9
- NHS Resolution have strengthened the conditions of the scheme and champions should familiarise themselves with the changes, supported by a series of webinars to complement Trusts preparation for year 3 of the maternity incentive scheme

CNST Safety Action 9 – Can you demonstrate that the trust safety champions are meeting bi-monthly with board level champions to escalate locally identified issues?

Safety Champions role and CNST

The Board level maternity safety champion will act as a conduit between the board and the obstetric and midwifery champions. You are expected to work with your obstetric and midwifery champions, head/director of midwifery and clinical director for maternity to ensure maternity issues are communicated and championed at board level and evidence that you work with the team to ensure that the Maternity Incentive Scheme safety actions are achieved and embedded.

Trusts are asked to declare whether they meet all ten actions based on evidence sent to their board in line with MIS guidance and to discuss this with commissioners of the maternity services.

MIS Ratification Process

- ➔ Transparency published on the website
- ➔ Automatic request to review previous years submissions
- ➔ Repay MIS contribution and any surplus monies
- ➔ Action plan in place
- ➔ Implementation by board level safety champions of monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues
- ➔ Inclusion of neonatal staff
- ➔ Evidence of opportunities to discuss safety concerns and visibility to clinical staff

Maternity safety resources

Following the letter of 14 December 2020 in response to the Ockenden Report we have published supporting documentation and resources referred to in the letter:

- Implementing a revised perinatal quality surveillance model
- Core Competency Framework
- Transforming Perinatal Safety
- Non-executive role descriptor
- Board measures

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Further resources

Safety Champions Guidance
Safety Champions Resource Hub
Maternity Self-Assessment Tool
Parent's View Blog
CNST Maternity Incentive Scheme
Implementing the Recommendations of the NCCR
SBLCBv2
Atain
LMS Guidance
Continuity of Carer Guidance
LTP Implementation Guidance
Each Baby Counts Learn + Support
BAPM Toolkit for Antenatal Optimisation
MatNeoSIP – Measuring Safety Culture
Bringing Lean to Life
A Simple Guide to Quality Improvement
Trauma-Informed Care in Maternity and Perinatal Mental Health Services Webinar

If you have any queries regarding these or other resources please contact:

Nhsi.maternitysafetychampions@nhs.net

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COVID-19 Pandemic Resources

Specialty Guide on Intrapartum Maternity Care

RCOG Coronavirus in Pregnancy Guidance

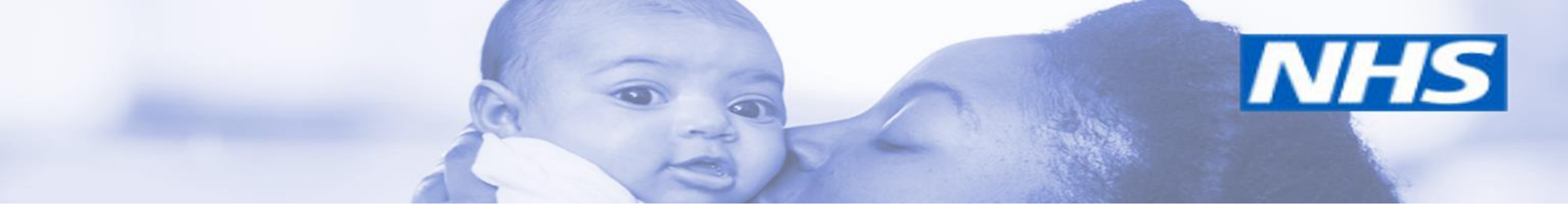
Saving Babies' Lives Care Bundle v2 Guidance

NHS England and NHS Improvement Specialty Guides

RCM Coronavirus Guidance

RCPCH Coronavirus Guidance

Coronavirus Infection Prevention and Control



Feedback

If you would like to provide feedback on this toolkit, please email

nhsi.maternitysafetychampions@nhs.net

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