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Introduction

Safety is a fundamental thread running through the Maternity Transformation Programme (MTP) and as outlined in Better Births [1] and The Safer maternity care action plan [2] there is a case for strong leaders at every level of the system to promote the professional cultures needed to deliver better care. Every provider is expected to have a representative from maternity and neonatal services who are jointly responsible for championing maternity & neonatal safety locally with a route to escalate to Trust Executive Board.

Purpose

The role of the local neonatal safety champions is to ensure that babies receive the safest care possible by adopting best evidence-based practice and ensuring care is centralised around the baby and family. The maternity and neonatal champions should be the ambassadors for this work and their leadership is central to its success. Within the North West Neonatal Operational Delivery Network (NWNODN), it is an expectation that all Trusts providing Neonatal care will ensure that the Neonatal safety Champion is supported in their role. This guideline seeks to support both the Neonatal Safety Champions themselves in fulfilling this vital role and the Provider services to support and act upon Champions recommendations.

Responsibilities of the Safety Champions

The key responsibilities for maternity and neonatal safety champions can be found in The Maternity and Neonatal Champion Toolkit [3]. In order to support Neonatal Safety Champions in the North West these have been utilised to develop guidance on the expectation of their role as set out below.

1. Support the provision of a seamless multidisciplinary perinatal service, sharing successes, learning and best practice between maternity and neonatal services by:
   - Ensuring Neonatal Team are aware of your role and its remit
   - Ensuring that within your service there are joint meetings (at least bi-monthly) of the Maternity and Neonatal Champions to enable escalation of locally identified issues and to share successes
   - Providing a quarterly update to the Board level safety champion (covering at a minimum all areas outlined in Appendix 1)
   - Participating in National Learning Events and/or MatNeoSIP WebEx's
   - Drawing on the CNST MIS Webinars to fully understand and implement the requirements of each safety action.
   - Accessing the weekly NWNODN Bulletin to ensure awareness of current National and NWNODN newsand ensure this is shared within their service
   - Working with the NWNODN Care Coordinator and the Parent Advisory Groups (PAG) to identify, develop and implement pathways that respond to the needs of women,

[1] national-maternity-review-report.pdf (england.nhs.uk)

[2] Safer Maternity Care: Next steps towards the national maternity ambition (publishing.service.gov.uk)

[3] Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk)

babies and their families. Understand the synergies between personalised care and safe care and promote these principles.

2. Work with your Board level and maternity and obstetric safety champions to support implementation of the Neonatal Critical Care Review recommendations. This involves:
   - Attendance at NWNODN meetings in relation to NCCR [4]
   - Ensure Board are briefed on services adherence to NCCR standards
   - Work with NWNODN on QI projects to improve NCCR matrix
   - Ensure PMRT [5] is utilised for appropriate mortality reviews and are completed as per standards. Trust Board should have a view of the maternity and neonatal services achievement of PMRT standards utilising the PMRT system Trust reports to provide evidence of this and to cross check completion.
   - Ensuring LNU services undertake an MDT review of all deliveries less than 27-week infants and a summary of lessons learnt and actions required to ensure infants are born in the right place is reported to their board.

3. Support your Board Level Safety Champion to represent the needs of your service by clearly articulating barriers to achieving safe and personalised care
   - Ensure at least quarterly updates completed as in appendix 1

4. Share progress with agreed action plans on all improvement initiatives with the board, your Local Maternity System and the NWNODN leads
   - Provide oversight of safety incidents and lessons learnt monitoring outcomes in relation to neonatal death and neonatal brain injury
   - Awareness of local parental feedback and action plans in response to this
   - Utilise national and regional information to gain insight into the performance of local services in comparison to other similar service, such as NNAP and the NWNODN quarterly dashboards, to focus local QI work.

5. 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)
   - Overview of clinical incidents and themes with learning and actions
   - Ensure provider attendance at and awareness of issues raised at NWNODN CEG
   - Maintain awareness of the service risk register and key activities required to reduce any risks with mitigation

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[4] NHS England » Implementing the Recommendations of the Neonatal Critical Care Transformation Review

[5] Perinatal Mortality Review Tool | NPEU (ox.ac.uk)

Appendix 1

(Trust) Neonatal Safety Champion : Brief for (Trust) Board Safety Champion

Top 3 Safety Concerns:

1

2

3

Safety Measure	Metrics	Evidence/Action/Comments
Care outside service specification	No /%	Key themes and Learning Detail of actions required Specific requirement from Board if applicable
Exceptions as per local and network reporting <27/40 in LNU <28/40 multiple in LNU <32/40 in SCU Cooling in LNU ICU in LNU >48hrs >44/40 on NNU		
Neonatal mortality rates	Y/N - Number	Comments regarding mortality figures/trends Themes Identified from all reviews Issues associated with PMRT (if any) Specific requirement from Board if applicable
Mortality Rate per 1000 (previous 4 quarters) Mortality reviews completed locally for all deaths? **CNST Maternity Incentive Scheme** **Safety action 1**: • Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Number eligible for PMRT review		

Number with complete PMRT review		
Clinical Incidents	Number	Themes identified from incidents Areas of learning/action plans in place Specific requirement from Board if applicable
Number of incidents entered locally and trends (last 4 quarters) Number of Serious Incident investigations Never Events since last report		
Workforce	Vacancies	Notes on current workforce gaps to BAPM standards Vacancy rates and detail of workforce planning as per CNST action plan Specific requirement from Board if applicable
CNST Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? For Medical and Nurse staffing? NCCR – Actions 3,4,5 – Nursing /Medical AHP **Nursing workforce** **Medical Workforce** **AHP workforce**		
Activity, Capacity and Demand		Progress against CNST action plan Evidence of engagement in NCCR capacity review Evidence of review of unit closures and impact on local population Specific requirement from Board if applicable
CNST Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Term Admission rate	

NCCR[6] Action 1: Review and invest in neonatal capacity How does Trust do against standards for activity described in the NCCR:	N/A	
Unit closures over 24 hours Closures to external neonatal admission Closure to all neonatal admissions	Number of 24 hr closures	
Parental Involvement	Feedback rates vs discharges	Parent feedback themes and how these have fed into actions Details of family complaints and learning Specific requirement from Board if applicable
NCCR Action 6: Develop and invest in support for parents. NNAP Measures not met Complaints and feedback		
Adherence to National Standards	NWNODN Flags	Details of flags raised by NWNODN and actions taken Specific requirement from Board if applicable
Number of flags on NWNODN dashboard and action plan to meet standard.		

[6] Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk)