NEONATAL Parent Voices
Working in Partnership to Improve Neonatal Services

NHS United Lincolnshire Hospitals NHS Trust

Excellence in rural healthcare

Better Births Lincolnshire

Neonatal Pathway

Neonatal Work Stream Plan 4 –
Reducing mortality, improving safety and quality

Lead professionals – Julie Buteel (Maternity Matron), Emma Upjohn (Maternity Matron), Karen Ludkins (Midwife), Olivia Maxwell (Midwife), Jane Hauton (Governance Manager), Helen Chaplin (ANNP).

"Safer care with professionals working together across boundaries to ensure rapid referral , and access to the right care in the right place, leadership for a safety culture within and across organisations, and investigation, honesty and learning when things go wrong".

Standard	Reports and documents to support standard	Actions required	Evidence gathered to support standard and workstream plan	Completion date and RAG score Key: Blue complete. Green – on Track, Amber commenced – not reaching timescale, Red – not started timescale passed.
6.0 Improve the experience of mothers, families and staff. 6.1 Reduced rates of still birth, neonatal death, maternal death and brain injury during birth by 20% and are on track to make a 50% reduction by 2025	MBRRACE-UK%20Maternal%20Report%2(Maternity and neonatal NHS Improv Midlands Perinatal Mortality Surveillance	Develop the baseline and trajectory and measure neonatal death and brain injury during birth. Data evidence for neonatal work stream meetings (neonatal network collecting data).	Safety Improvement Plan Dec 19.docx **ULHT Safety Improvement plan in place** **Neonatal service operational**	

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6.2 Reduction of parent complaints		Feedback from parents in place and monitored. Feedback also sent to Neonatal parent voices. "Safety and your baby" education sessions for neonatal families in preparation for home, including resuscitation training.	**plan in place**	**Needs to commence**
6.3 Professionals should work together		Evidence of multiprofessional neonatal	**Within ULHT safety plan**	**Needs to**

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in a multi-professional team in the interests of the woman and her baby, seeking to keep them as safe as possible. Time should be made for multi-professional training, its uptake should be monitored and impact evaluated.		simulation training		**commence**
6.4 Keep mother and baby together- Antibiotics, cannulation and other necessary procedures to be undertaken where mother and baby reside. 7		8 Explore midwifery competencies and neonatal midwifery collaboration to support BAPM transitional care model.		

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8.2 Maternity dashboard will demonstrate improvements.		Consider a local neonatal dashboard to be embedded into plan. With the following evident on dashboard and available for neonatal work stream meeting.: Reduction of neonatal admissions for: ○ Hypoglycaemia Hypothermia ○ Jaundice ○ Respiratory problems ○ Perinatal asphyxia ○ Neonatal deaths ○ Cases of severe brain injury in	**Within ULHT safety plan**	**Completed**

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Safety champions will be ambassadors		babies ○ 2yr follow up Named neonatal safety champion.		
8.3 Creating the conditions for a culture of safety and continuous improvement.	Safety collaborative meetings	Feedback from safety collaborative meetings at neonatal ward level and evidence of progression. Evidence of regular attendance at EMODN Clinical Governance group and Mortality Steering group meetings.		
8.4 Learn from excellence and error or incidents. Lessons learned and shared. Demonstration that where serious incidents occur there are processes where the system can reflect, put	Risk management team in place	Are investigating and learning from incidents and sharing this learning through the Local Maternity System, Neonatal Governance and Neonatal network governance .		**Need risk report**

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in interventions and improve quality, family experience and minimise reoccurrence through shared learning.		Neonatal risk report available for neonatal work stream meetings.		
8.5 Improving the quality and safety of care through Clinical Excellence		Evidence of neonatal research and audit		

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4.6 Element 5 Saving Babies lives care bundle **Stillbirth and Neonatal death** Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented. Optimise place of birth – **women at imminent risk of preterm birth should be transfered to a unit with appropriate and available neonatal cot facilities when safe to do so and as agreed by the relevant neonatal Operational Delivery Network (ODN).**	PDF saving-babies-lives-care-bundle-version-tv Neonatal network care pathways in place. PDF 2016 09 27 TPN Care Pathway 2016 FINAL	Audit in place for Element 5 Saving Babies lives care bundle and results available for neonatal work stream meeting. Need Intrauterine transfer (IUT) data and babies born outside the network pathway and reasons why.	**Within ULHT safety plan**	

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Antenatal corticosteroids to be offered to women between 24+0 and 33+6 weeks, optimally at 48 hours before a planned birth. A steroid-to-birth interval of greater than seven days should be avoided if possible.	neonatal-specialist-care-pdf-5829606675 Transfers-of-premature-and-sick-babies.p	Ensure the neonatal team are involved when a preterm birth is anticipated, so that they have time to discuss options with parents prior to birth and if transfer out is required. Data for neonatal workstream To embed data into this work stream plan.		

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Magnesium sulphate to be offered to women between 24+0 and 29+6 weeks of pregnancy, and considered for women between 30+0 and 33+6 weeks of pregnancy, who are in established labour or are having a planned preterm birth within 24 hours. Evidence of the Precept trial has improved outcomes and reduced preterm labour	https://www.weahsn.net/our-work/transforming-services-and-systems/precept/	Neonatal representative and neonatal voice at East midlands maternity network preterm working group. Training to display 100% compliance ULHT to embed the appropriate use of magnesium sulphate and audit its effectiveness. Work with the neonatal work stream of transformation to gain assurance of progress and improvement Reports of improvements and		

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For women between 23 and 24 weeks of gestation, a multidisciplinary discussion should be held before birth between the neonatologist, obstetrician and the parents about the decision to resuscitate the baby. If resuscitation is agreed to be attempted, women should be offered magnesium sulphate and steroids timed according to the above recommended intervals to birth.	 Neonatal-Critical-Car e-Transformation-Pro	potential challenges to go through governance channels and escalated to the LMNS		

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Redesign and improve the safety and effectiveness of services and experience of families in line with current Neonatal Critical care Transformation Programme asks.	Implementing-the-Recommendations-of-th	Report recommendations.		