Report from the UK Neonatal Partnership Board

National Reviews of Maternity and Neonatal Care: Supporting the perinatal team to implement recommendations related to Neonatal Care

Neonatal Partnership Board, May 2023

The Neonatal Partnership Board is a forum of the following organisations leading on national maternity, neonatal and perinatal programmes.

Bliss
British Association of Perinatal Medicine (BAPM)
Confidential Enquiry into Maternal Deaths (CEMD)
Institute for Health Visiting (IHV)
MBRRACE-UK
Neonatal Clinical Reference Group (CRG)
National Maternity and Perinatal Audit (NMPA)
National Neonatal Audit Programme (NNAP)
National Neonatal Network Directors Forum
National Neonatal Research Database (NNRD)
Neonatal Nurses Association (NNA)
Neonatal and Paediatric Pharmacists Group (NPPG)
NHS England/NHS Improvement
Northern Ireland Neonatal Network
Royal College of Midwives (RCM)
Royal College of Obstetricians and Gynaecologists (RCOG)
Royal College of Paediatrics and Child Health (RCPCH)
Scottish Government
Scottish Neonatal Nurses' Group (SNNG)
Tommy's
Welsh Government

The Board is Chaired by Dr Helen Mactier, who recently retired after 20 years as a consultant neonatologist at the Princess Royal Maternity in Glasgow. Dr Mactier is an Honorary Senior Research Fellow within Medicine at the University of Glasgow and the immediate-past President of the British Association of Perinatal Medicine.

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Foreword

As Chair of the Neonatal Partnership Board it is my privilege to present this Report on behalf of all the members of the Board. Understanding and implementing the many recommendations from recent Reviews of Maternity and Neonatal care is challenging, particularly in the wake of a pandemic and with a tired and depleted workforce, but there are some changes which can be made relatively easily and without additional resource. Most importantly we must take time to acknowledge that neonatal care in the UK can be world class, particularly if we practise within multidisciplinary teams full of kindness and respect. Every single member of the perinatal team has the power to make a real difference to families.

Helen Mactier

Background

The Neonatal Partnership Board (NPB) (previously the Neonatal Programme Board) was established by the Royal College of Paediatrics and Child Health (RCPCH) as an independent forum whose members have current "hands on" experience of perinatal care as well as roles in setting the strategic agenda for neonatal care in the UK.

Having discussed the recent Reviews of Maternity and Neonatal care including Cwm Taf Morgannwg, Shrewsbury and Telford and East Kent [1, 2, 3] the NPB offers this guidance to help local and network perinatal teams in implementing the recommendations.

We are aware that much work is presently underway at national level and that many teams have already acted on some or all of the recommendations; this guidance is not intended to replace any of this work, but rather to add practical guidance for neonatal units (NNUs) and network teams. Common themes from the three Reviews are reflected in the recently published NHS England "*Three year delivery plan for maternity and neonatal services*" [4] ; these apply equally across the entire UK:

1. Family experience

- The importance of compassion and listening to families
- Parental partnership in care
- Implementation of neonatal transitional care (NTC) within maternity and neonatal services

2. Neonatal workforce

- Workforce planning and sustainability
- Professionalism/standards of behaviour including oversight and direction of clinicians
- Support for trainees

3. Safety and Learning

- Multidisciplinary teamworking and training including shared learning
- Working together towards common goals

4. Governance, assurance and accountability

- Timeliness and transparency of incident investigations including shared learning
- Monitoring safe performance with valid outcome measures capable of differentiating signal from noise in a timely manner

1. Family Experience

Compassion and listening to families:

These aspects of provision of maternity and neonatal care comprise the basic tenets of all patient care and ***should not per se require any additional resource***. In a system which is currently over-stretched it can, however, be easy for tired, stressed professionals to feel that the demands of a multitude of tasks do not allow the additional time needed to listen properly to the patient and/or their family.

- Showing compassion and listening to patients and families must be:
  - embedded in team culture and practised by everyone, with senior professionals leading from the top.
  - an integral part of on-going appraisal for all perinatal staff.
- Team culture within neonatal and maternity units must encourage any deviation from this behaviour to be called out and feelings of empowerment explored as part of routine appraisal.

The key issue is modelling "kind behaviour" within clinical teams and displaying in our day-to-day interactions with colleagues, as well as with patients and their families, the attitudes that we all seek to receive when we experience care [5].

Parental partnership in care:

The importance of parental partnership in care within all neonatal and maternity settings is underpinned by a wealth of evidence [6, 7]. Family-integrated care (FiCare) should be considered the gold standard, but even in neonatal units where FiCare is not yet fully implemented, it is essential that families are always placed at the centre of their baby's care.

- All NNUs should seek to comply with Bliss Baby Charter [8] as well as UNICEF Baby Friendly Initiative [9], utilising the need to implement the Reviews' recommendations as a catalyst for additional resource including staff training and family facilities. Remember that small improvements may make a huge difference to families.

Implementation of neonatal transitional care (NTC) within all maternity and neonatal services:

NTC is well established in many maternity and neonatal services in the UK but there remain barriers, both real and perceived. NTC should be considered a service, rather than a place, with various effective models [10]. NTC improves mother and infant attachment and helps to achieve the national aim of reducing mother/baby separation [11,12]. NTC reduces NNU admissions but is likely to incur increased (low dependency) maternity length of stay; overall, provision of NTC should be cost neutral.

- Reduction in maternal/infant separation should be prioritised.
- There must be reduced "silo working" with joint review of maternal and neonatal capacity

which considers the need for mothers and babies to be cared for together, supports collaboration between maternity and neonatal services and allows more flexibility in working practices.
- We strongly recommend that development of neonatal outreach services should accompany NTC, to further reduce neonatal unit length of stay and facilitate attachment [13].

2. Neonatal workforce

Workforce planning and sustainability:

We are critically short of all professionals, including (but not exclusively) nurses, allied health professionals, pharmacists, psychological professionals and doctors within neonatal services. This problem is not new and reflects decades of under investment in the NHS's most precious resource, its people. The solution lies in recruitment of motivated persons to what is perceived as a rewarding and fulfilling career. This will, however, take time. In the short term, while we need to describe and acknowledge the extent of staffing shortfall and accelerate recruitment and training, we must also do everything possible to retain existing staff. Staff are more likely to be retained within a service which makes them feel valued and in control of their destiny. Maternity and neonatal services by and large have a compassionate and dedicated workforce, which partially explains why it has taken so long to reach crisis point. Improving team culture will help but is not the full solution.

- Allied health professionals, neonatal pharmacists and accredited psychological professionals with specialist expertise in neonatology are an integral part of the neonatal multidisciplinary team and must be included in staffing models with adequate resourcing[14].
- Pending recruitment and training of additional staff, we need urgently to look at ways of safely reassigning some of the tasks currently unnecessarily undertaken by highly trained persons. Examples of good practice exist up and down the country, including ancillary staff/nursery nurses in NTC undertaking roles previously confined to junior doctors and/or registered nurses; these must be shared.
- We need more innovative staffing models, recognising that different work patterns will be more suited to individuals at differing stages in their career. The role of the professional nurse advocate should be encouraged [15].
- The issue of NHS consultant pension tax liability has recently been addressed; NHS providers should support the return and retention of skilled consultants as part of local workforce planning, including the appointment of fixed term roles for more than one year.

Professionalism/standards of behaviour including oversight and direction of clinicians:

The NPB strongly agrees that we should expect the highest standards of behaviour from all staff working within neonatal services. We note that difficult behaviours exist; this must be dealt with promptly and efficiently or attempts to improve multidisciplinary team working will be eroded. Simply tolerating difficult and disruptive character traits is no longer acceptable.

- We call upon the Royal Colleges, both medical and nursing, other professional bodies and employers to agree accepted standards of behaviour and to support employers and regulators in enforcing these standards.
- Psychological safety and models of challenge to behaviour must be taught to the entire

perinatal team and accepted as normal practice.

Looking after our trainee doctors:

The NPB notes the current high dropout rate of medical trainees and urges the Royal Colleges and employers to seek to address trainee doctor concerns, specifically in relation to working hours, flexibility of annual leave and protected training time. Improved team culture within neonatal services will help to improve trainee retention.

- Trainees should be actively involved both in activities to build better teams and in rota design.

3. Safety and learning

Multidisciplinary teamworking and training, including shared learning:

There is a plethora of data to support the benefits of good team culture within all healthcare services [16]. The RCPCH Progress curriculum embeds multidisciplinary working throughout the syllabus as do many postgraduate teaching programmes but full implementation at ward level requires a multidisciplinary team culture within services, headed by local champions. This will not be achieved by a simple "box ticking" exercise, (e.g. presence or absence of formal handover, evening consultant ward rounds, attendance at teaching sessions) but requires full buy-in from all clinicians, regardless of seniority. Good multidisciplinary team culture within a NNU may not be recognised as such, but will be reflected in good outcomes, lower sickness absence and better retention of staff. Similarly, failure to recognise that a poor multidisciplinary team culture is contributing to serious adverse events, disgruntled trainees and early retirement of senior staff is detrimental and unfortunately common.

- Neonatal and maternity services must reflect upon the team culture within their units; this should be incorporated within existing appraisal systems for both medical and nursing staff. Trainees and student nurses, often with experience in more than one NNU, may have much to offer in terms of insight, but translating this knowledge into progress will require that the whole team (including the most senior members) is willing to learn. The Networks also have a role to play in helping to highlight where teamworking needs improvement.
- The British Association of Perinatal Medicine (BAPM) has published a toolkit to support delivery of the Perinatal Optimisation Pathway developed in conjunction with the Maternal and Neonatal Safety Improvement Programmes [17,18,19]. Many aspects of this resource are common to all aspects of team working within neonatal and maternity services.
- All NNUs' teaching programmes must include multidisciplinary sessions which encompass antenatal counselling, perinatal optimisation, labour ward emergencies and early postnatal care of both mother and baby. Badging existing training courses as "perinatal", rather than "maternity" or "neonatal" is a simple first step to help foster team culture and multidisciplinary training.
- The crucial importance of human factors in all training resources must not be forgotten.
- Shortage of resources to facilitate reflection and learning, including staff shortages will be challenging, but that should not deter all NNUs striving for excellent team culture.

Working together towards common goals:

One of the headline issues in the Ockenden Report [2] involved inter-professional conflict regarding mode of delivery, but there are many other situations within maternity and neonatal care where professionals may hold, or be perceived to hold, differing opinions around best practice. While the "goal" of maternity and neonatal care might always be deemed to be a healthy mother and baby, professionals must all recognise that the route towards that goal should be navigated with care, ensuring that families are given consistent, safe information on which to base decisions.

- Solutions lie in effective multidisciplinary teamworking and training as well as shared learning.
- Adherence to existing national guidance must be strongly encouraged by Networks, with justification of any deviation. National guidelines for neonatal care would help to ensure consistency of practice in addition to saving many hours of work in writing and agreeing local/network guidance and there should be national unity in addressing evidence gaps in research prioritisation.
- Think about how well you liaise with your obstetric and/or neonatal colleagues; do you currently have joint teaching sessions, and are they well attended? We have much to learn from each other.

4. Governance, Assurance and accountability

Timeliness and transparency of incident investigations, including shared learning:

Systems exist to support multi-professional investigation of serious incidents, but the process is time consuming and requires external input to ensure transparency.

- All NNUs must have a named lead for Serious Incident Review (SIR) with designated time to liaise closely with obstetric and maternity colleagues. ***All*** neonatal consultants must have designated time in their job plan and appropriate training to engage in perinatal mortality review (PMR) with consistency across the UK as to whether this activity is designated Direct Clinical Care (DCC) or Supporting Professional Activity (SPA). The NPB recommends that this work be designated as DCC. Sharing of SIR findings must be encouraged and supported, both locally and nationally.
- The roles of both executive and non-executive safety champions must be supported [18,19] and a National Neonatal Safety Champion appointed.

Monitoring safe performance with valid outcome measures capable of differentiating signal from noise in a timely manner:

Neonatal data collection in the UK is world-leading, with a well-established national clinical audit process [20] and all NHS NNUs in England, Scotland, Wales and the Isle of Man contributing to a national neonatal database. We do, however, need more timely data reporting.

- There must be support and encouragement for all NNU professionals inputting accurate

data; an appropriately resourced designated data lead in each neonatal unit with ultimate responsibility for timely submission of data is essential. Consideration should be given to extending the role of digital midwives to neonatal services [21].

- There should be close linkage between maternity and neonatal datasets and as new electronic patient records are developed it is essential that they are compatible, to avoid unnecessary duplication of data entry.
- We applaud the recent creation of an NHS England Neonatal Outcomes group [22] and encourage all professional bodies to work together to support timely and easily understood reporting of data which does not shy from identifying potential outliers. National mechanisms should flag and swiftly escalate maternity and neonatal units of concern.

Conclusions:

The common thread running through many of the recommendations of the recent Reviews is the importance of multi-professional teamworking and good team culture within both neonatal and maternity services. All clinicians must acknowledge the importance of multidisciplinary team working and be helped where necessary to recognise that in some maternity and neonatal units in the UK, a suboptimal or even dysfunctional multidisciplinary team structure exists. Only by recognising the presence of a problem can solutions be employed to effect positive change. Teamworking is closely allied to practising with compassion and good listening skills, the importance of which requires formal acknowledgement from, and example setting by, leaders within the NHS.

We strongly support BAPM's call for a National Neonatal Safety Champion to complement the excellent work of the National Obstetric and Maternity Safety Champions. ***Their first task should be to identify those neonatal units which have embedded good multidisciplinary teamworking and then share this knowledge.***

Above all, all members of the perinatal team must acknowledge the positive features of our services and learn and be supported to show respect and compassion at all times, both for the babies and families in our care and (just as importantly) for each other.

Despite many challenges, neonatal services in the UK are among the best in the world, with a skilled and dedicated, albeit currently very overstretched, workforce.

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