Annex: Role descriptor for the non-exec board safety champion

In line with recommendations from the Ockenden Review, the board-level safety champion role should be supported by a non-executive director. In trusts where this role is currently being undertaken by an exec lead, a non-exec must now be appointed in addition and the two should work together to ensure a seamless leadership function.

The role of the trust board safety champion is to act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, LMS leads, the Regional Chief Midwife and Lead Obstetrician and the Trust board to understand, communicate and champion learning, challenges and successes. Published guidance sets these responsibilities out in detail. The non -executive will act as a support to the Board Perinatal Safety Champion by:

- bringing a degree of independent, supportive challenge to the oversight of maternity services
- ensuring that they are resourced to carry out their role
- challenging the board to reflect on the quality and safety of its maternity services
- ensuring that the views and experiences of patients and staff are heard

Together the non-executive and the board-level safety champion should:

- adopt a curious approach to understanding quality and safety of services
- jointly, with frontline safety champions, draw on a range of intelligence sources to review outcomes, including staff and user feedback to fully understand the services they champion
- update the Trust Board **on a monthly basis** from January 2021, on issues requiring board-level action.

- The Board should be updated using a board level dashboard (see Annex x) which includes as a minimum:

    - All maternity and neonatal Serious Incidents
    - Incidents graded as moderate harm or higher
    - Trust position in meeting national ambition trajectories for stillbirth, brain injury, maternal mortality, neonatal mortality and preterm birth rates; implementation rates of SBLCBv2 and Continuity of Carer
    - safe staffing levels
    - correspondence or concerns raised by the Regional Chief Midwife and Lead Obstetrician, Coroners, Deaneries, national bodies including NHS Resolution, CQC, HSIB or the Invited Review process

- ensuring that Duty of Candour is upheld and that locally undertaken SI investigations meet national standards for review
- ensuring themes and learning from SI investigations, Never Events, Invited Reviews and concerns raised by external parties, including service users, are implemented, audited for efficacy and monitored at board level ensuring accountability for actions being undertaken
- providing oversight and appropriate challenge in relation to evidence for the CNST maternity incentive scheme safety actions
- ensuring that learning as well as improvement activity is are shared with the LMS, Regional Chief Midwife and Lead Obstetrician and Patient Safety Networks as part of revised oversight and governance structures.

Enablers to achieving these priorities include:

- Protected time to undertake the Board Maternity Safety Champion role
- Together with your MVP lead, non-exec and Board safety champion, undertaking an assessment of the safety of your services using the Maternity Safety Self-Assessment Tool
- Taking into account locally undertaken culture surveys, working with service users and the wider clinical team to develop a common vision for safety
- Meeting monthly with midwifery, obstetric and neonatal safety champions to fully understand relevant insights, barriers and successes which need reflecting at board level
- Acting as a key point of contact for the clinical triumvirate, national organisations, the Regional Chief Midwife and Lead Obstetrician and LMS lead to address identified issues

- Engaging with leaders in other parts of the organisation responsible for safety and improvement to ensure alignment of safety initiatives.
- Supporting improvement initiatives that require both maternity and neonatal collaboration
- Setting out clearly and publicly how the Trust is working to improve the safety of perinatal services – including those relating to service user feedback