The maternity safety landscape – 2020 priorities

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NHS England and NHS Improvement

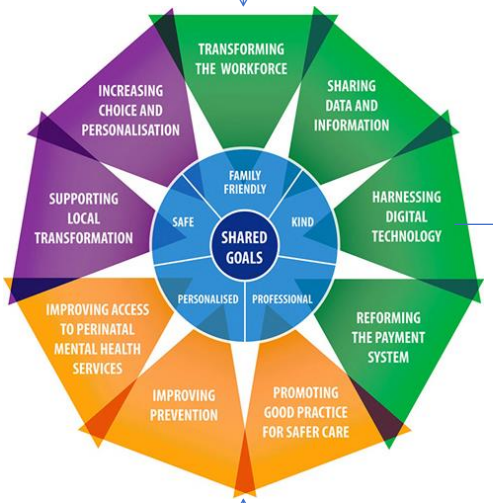
Context – the safety workstream

6/28 Recommendations from Better Births

2016 – Safer Maternity Care Action Plan – 11 actions

2017 – Progress and next steps – 9 actions

Overseen by the Maternity Transformation Programme Board



10 workstreams Safety as a Golden Thread Through out the programme

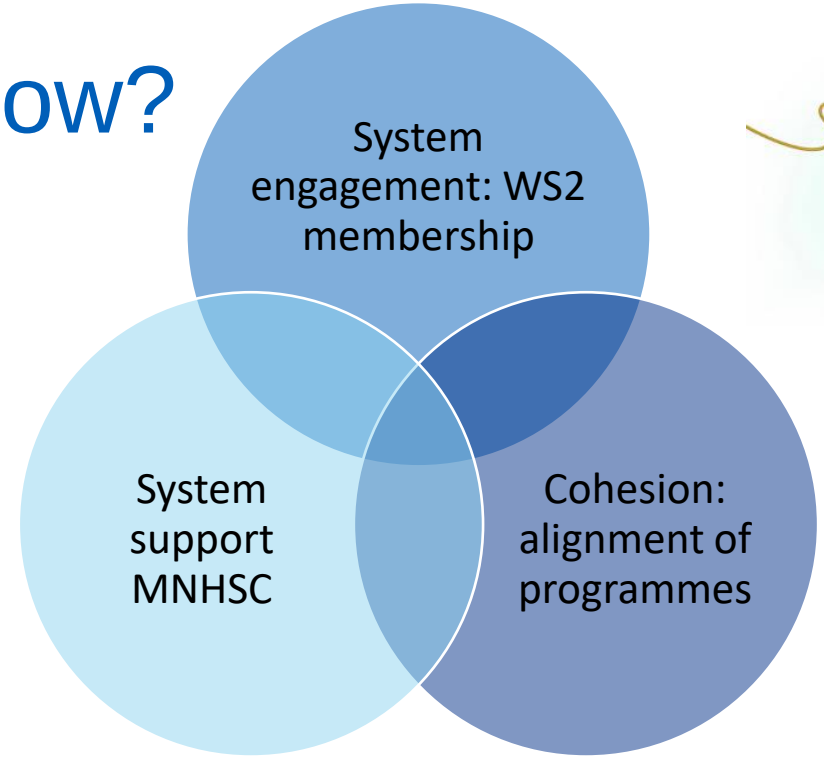
Delivery challenged and supported by the Stakeholder Council

Safety workstream aims

Make measurable improvements in safety outcomes for women, their newborn babies and families in maternity and neonatal services, as set out in Better Births

Deliver the Government's national ambition to halve the 2010 rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries in babies by 2025, with a 20% reduction by 2020

How?



NHS

Department of Health & Social Care

Neonatal CRG

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

each baby COUNTS

HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

PMRT
Supporting high quality local perinatal reviews

Royal College of Obstetricians & Gynaecologists

THE ROYAL COLLEGE OF MIDWIVES

CareQuality Commission

Public Health England

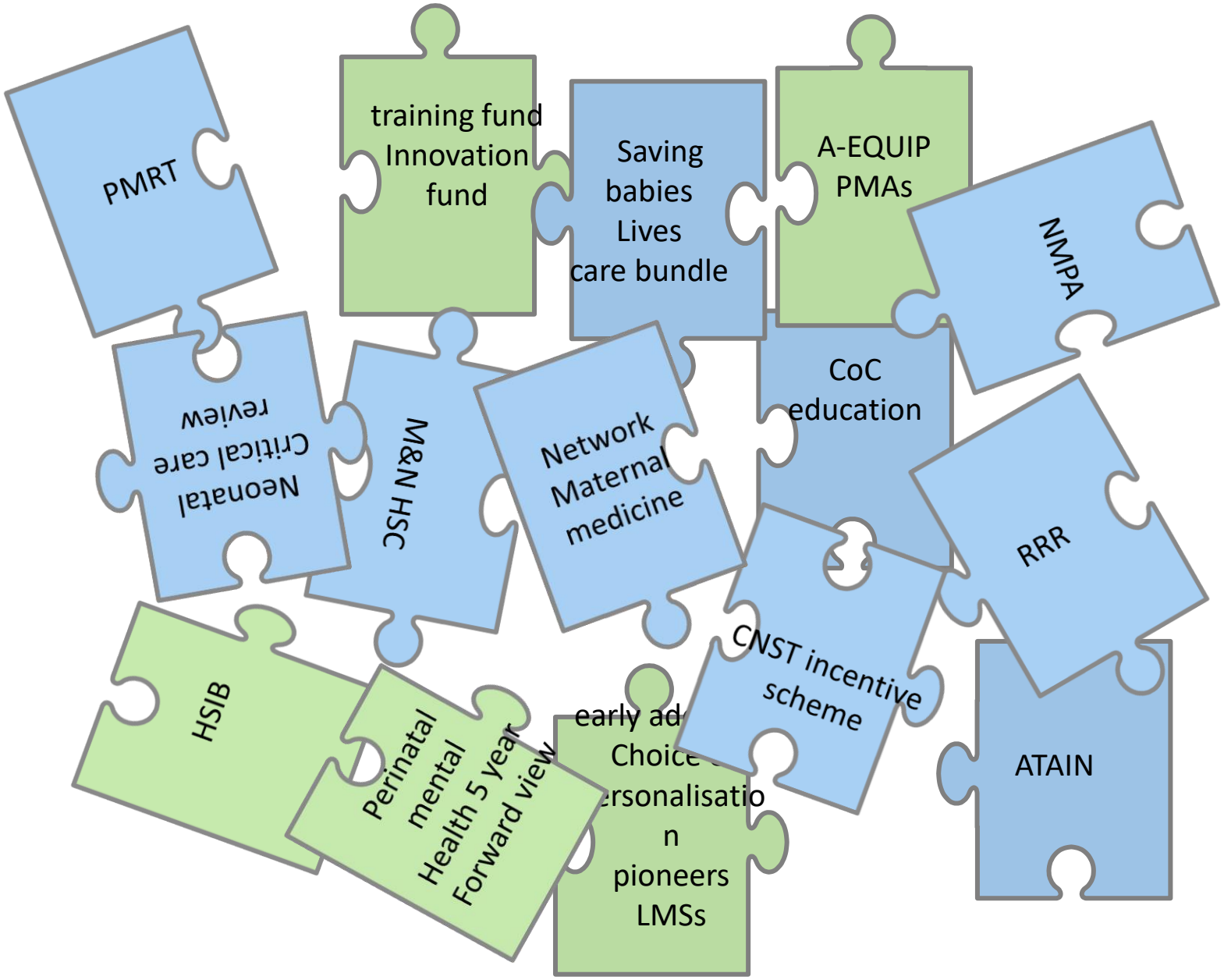
NHS England

NHS Resolution

CfSB
Campaign for Safer Births

Twitter: @CfSaferBirths
Fb: campaignforsaferbirths

Multiple Initiatives



Key Maternity Safety Priorities

Aim

Make measurable improvements in safety outcomes for women, their newborns and families in maternity and neonatal services, as set out in Better Births.

Reduce the rate of stillbirths neonatal death and brain injuries occurring during or soon after birth by 20% by 2020 and 50% by 2025

Insight

Provide standards and develop skills for undertaking high quality reviews and investigations to enable learning from incidents of harm and to drive improvements in care, in support of the national ambition.

Involvement

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

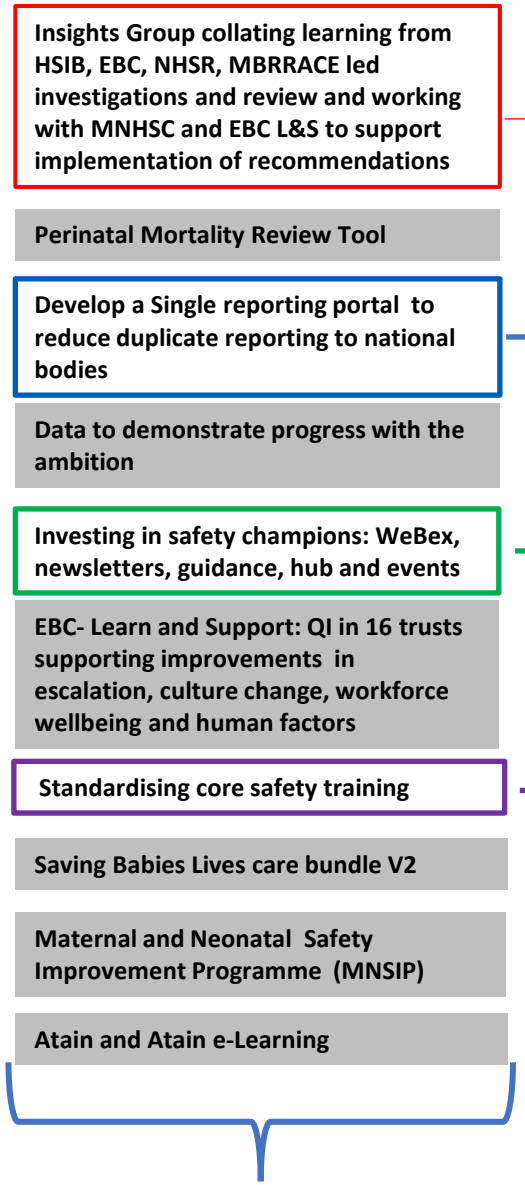
Improvements

Deliver harm reduction programmes to improve the safety of maternity services and employ consistent measurement and effective improvement methods

Activities

- **Insights Group collating learning from HSIB, EBC, NHSR, MBRRACE led investigations and review and working with MNHSC and EBC L&S to support implementation of recommendations**
- **Perinatal Mortality Review Tool**
- **Develop a Single reporting portal to reduce duplicate reporting to national bodies**
- **Data to demonstrate progress with the ambition**
- **Investing in safety champions: WeBex, newsletters, guidance, hub and events**
- **EBC- Learn and Support: QI in 16 trusts supporting improvements in escalation, culture change, workforce wellbeing and human factors**
- **Standardising core safety training**
- **Saving Babies Lives care bundle V2**
- **Maternal and Neonatal Health safety Collaborative**
- **Atain and Atain e-Learning**
- **Maternity Incentive Scheme – 10 Actions to improve maternity &neonatal safety**

The Safety Programme - 2020



1. CREATED SMART recommendations
2. Collate insights and map activity
3. Consider how action results from learning

Single Notification Portal through which incidents meeting EBC criteria can be reported

Guidance, SC hub, newsletters, events;
How To guides; CMO visits; involvement in and findings from inspections, communications and reviews from outside organisations

6-8 core safety training requirements nationally

Take forward Stakeholder Council feedback

Understand escalation processes relating to maternity and neonatal services:

- National and regional processes
- Hearing from users, staff

Maternity Incentive Scheme – 10 Actions to improve maternity &neonatal safety

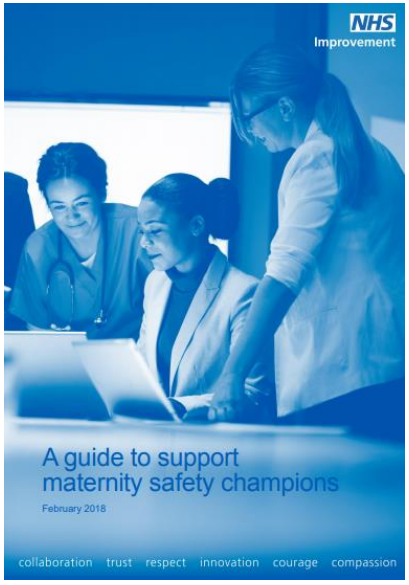
Insights

- ✓ Systematic, MDT, high quality reviews
- ✓ Active communication with parents
- ✓ A structured process of review, learning, reporting and actions to improve future care
- ✓ Coming to a clear understanding of why each baby died

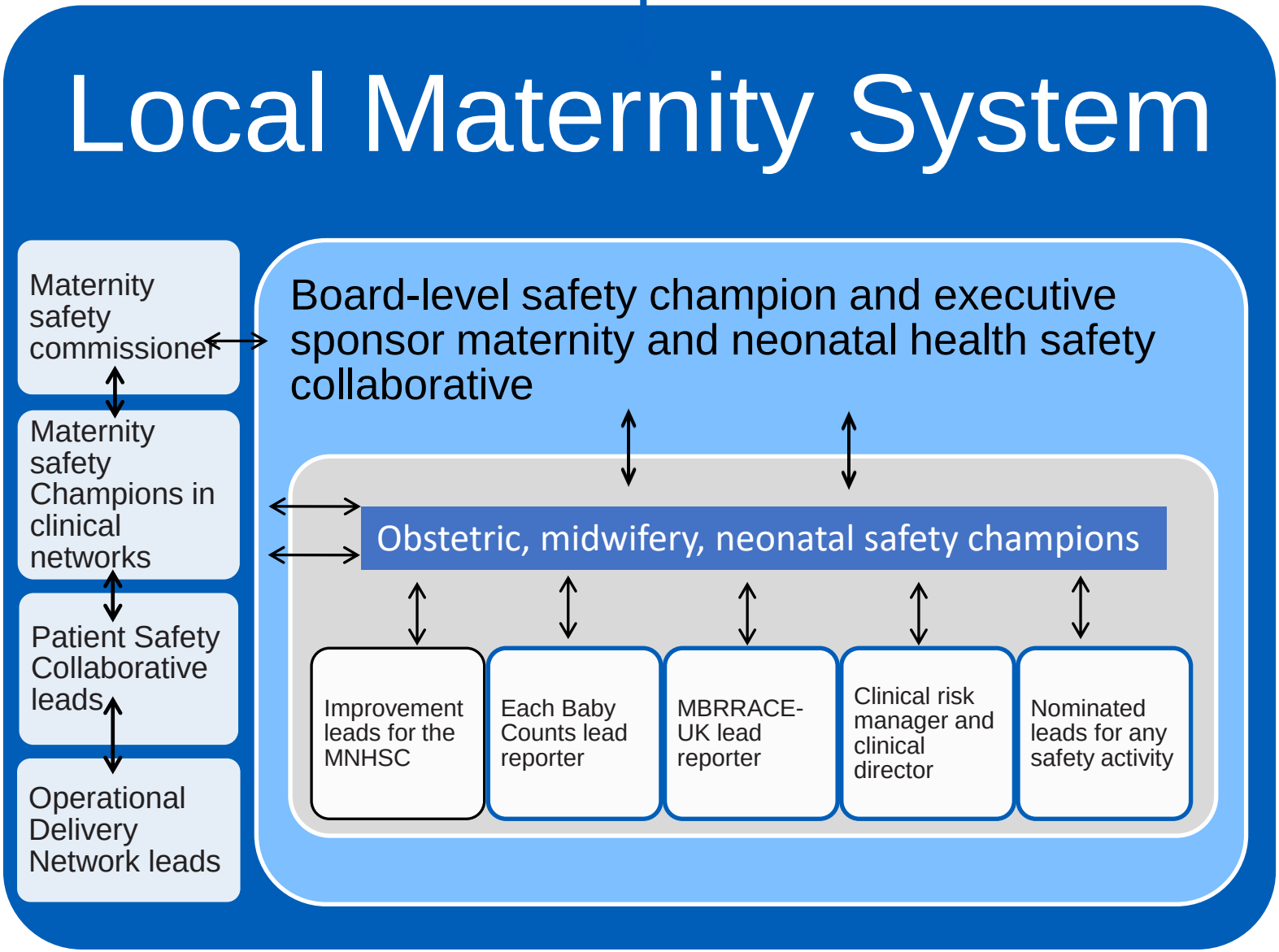
- ➢ General developments in line with user requests
- ➢ Working with National Child Mortality Database to de-duplication effort providing data to NCMD and CDOPs.
- ➢ Working with NHSE/I on the development of a single reporting portal
- ➢ Improving parent engagement materials to support improved action plan development following the outcome of reviews.

Involvement

Safety Champions
– Ambassadors for Safety



Maternity safety champions in the LMS



Involvement – supporting safety champions

- Safety champion hub with published guidance - supporting safety initiatives
- Refreshed ‘How To’ guides imminent
- Bi-monthly themed WeBex’s
- Bi-monthly newsletters – curation of safety messages
- Co-ordinate messages through a single email channel
- Safety events/conferences
- Involvement in CMO visits, IR processes, CQC

Involvement

each baby counts +

learn & support

16 Trusts

Led by RCOG and RCM

Aligned to MNHSC

Improvements

Saving Babies Lives Care Bundle V2

1. Reducing smoking in pregnancy

CO testing for all women at booking ; test through pregnancy as appropriate; identification of smokers and referral for support; all staff to be trained in VBA

2. Risk assessment and surveillance for fetal growth restriction – focus on high risk identified at booking ; focus on training staff in symphysis fundal measurement , publication of detection rates and reviews of missed cases

3. Raising awareness of reduced fetal movement – Raise awareness amongst pregnant women; best evidence protocols in place ; evaluate compliance with national best practice

4. Effective fetal monitoring during labour – CTG competency and Buddy system; principles for training packages ;standardised risk assessment tool; regular CTG reviews; fetal monitoring lead ;

5. Reducing Pre Term Birth - new element – Focus on prediction, prevention and preparation

Saving Babies Lives Care Bundle V2

- Over 2019/20 HEE have provided funding for LMS's via a bidding process for targeted training resources

- A specialised e- learning module for each element of SBLCB V2 has been developed (available Feb 2020) to support implementation.

- Full implementation is incentivised through the MIS

- All maternity providers are already implementing the care bundle and this is tracked through a national survey.

Saving Babies Lives Care Bundle V2 (Oct 2019)

Percentage of providers implementing all activities by element:

- Element 1- Reducing Smoking in Pregnancy 70%
- Element 2- Detecting Fetal Growth Restriction 34%
- Element 3- Raising Awareness of Reduced Fetal Movement – 88%
- Element 4- Improving Effective Fetal Monitoring in Labour – 35%
- Element 5 – Reducing Pre Term Birth – 32%

Percentage of providers implementing at least one activity by element:

- Element 1- Reducing Smoking in Pregnancy 98%
- Element 2- Detecting Fetal Growth Restriction 100%
- Element 3- Raising Awareness of Reduced Fetal Movement – 100%
- Element 4- Improving Effective Fetal Monitoring in Labour – 100%
- Element 5 – Reducing Pre Term Birth – 100%

Avoiding harm leading to Term Admissions Into Neonatal Units

atain
Changing practice to keep mother & baby together

Respiratory

Chairs

Dr Sandy Calvert (N)
Dr Kate Harding (M)

Priorities
V = completed

- ✓ Data analysis to understand contributory factors:
  - ➢ Elective c/s <39 weeks
  - ➢ Role of hypothermia
  - ➢ Role of steroids
- ✓ Improve education training for all staff
- ✓ Parent information on recognising the sick newborn

Publish findings

Asphyxia

Chairs

Dr Debbie Derbyshire (N)
Dr Sheila McPhail (M)

Priorities
V = completed

- V Develop a MDT leadership training programme for labour ward leaders to include Board level lead and delivery of a QI programme

Jaundice

Chairs

Dr Janet Rennie (N)
Stephanie Michaelides (M)

Priorities
V = completed

- ✓ Data analysis to understand contributory factors to admission
- ✓ Thematic review of litigation claims
- ✓ Promote increased use of TcB
- ✓ NICE guidance for detection and management of jaundiced babies
- ✓ Improve education and training
- ✓ Parent involvement and information in recognising sick newborn
- ✓ Publish

Scope practice on management of jaundice

Hypogl...

- ✓ Data analysis to un... factors to admission
- ✓ Scope practice on detection an... management of hypoglycaemia
- ✓ Thematic review of litigation claims
- ✓ Publish
- ✓ Education and training - all staff
- ✓ Parent information on recognising the sick newborn

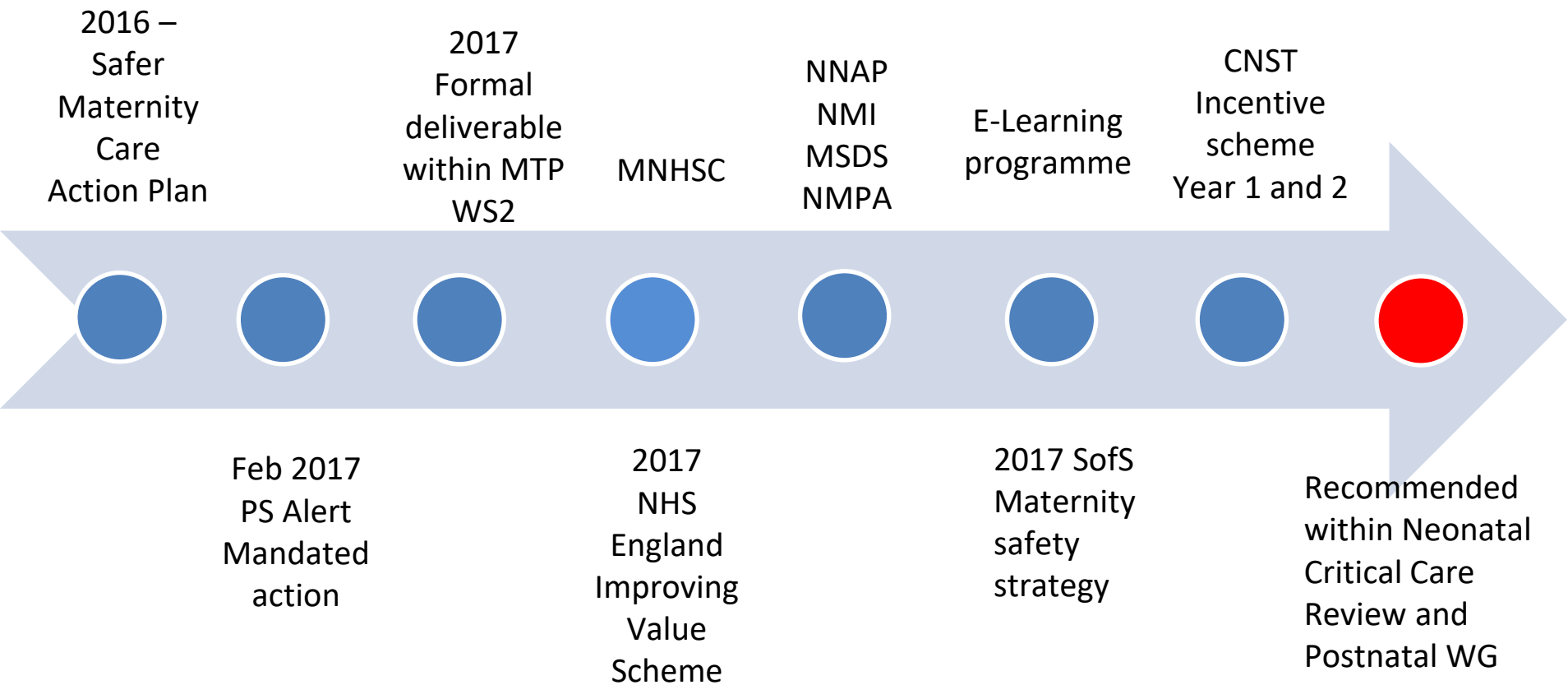
Develop a framework for identification and management of neonatal hypoglycaemia

Education and training working group

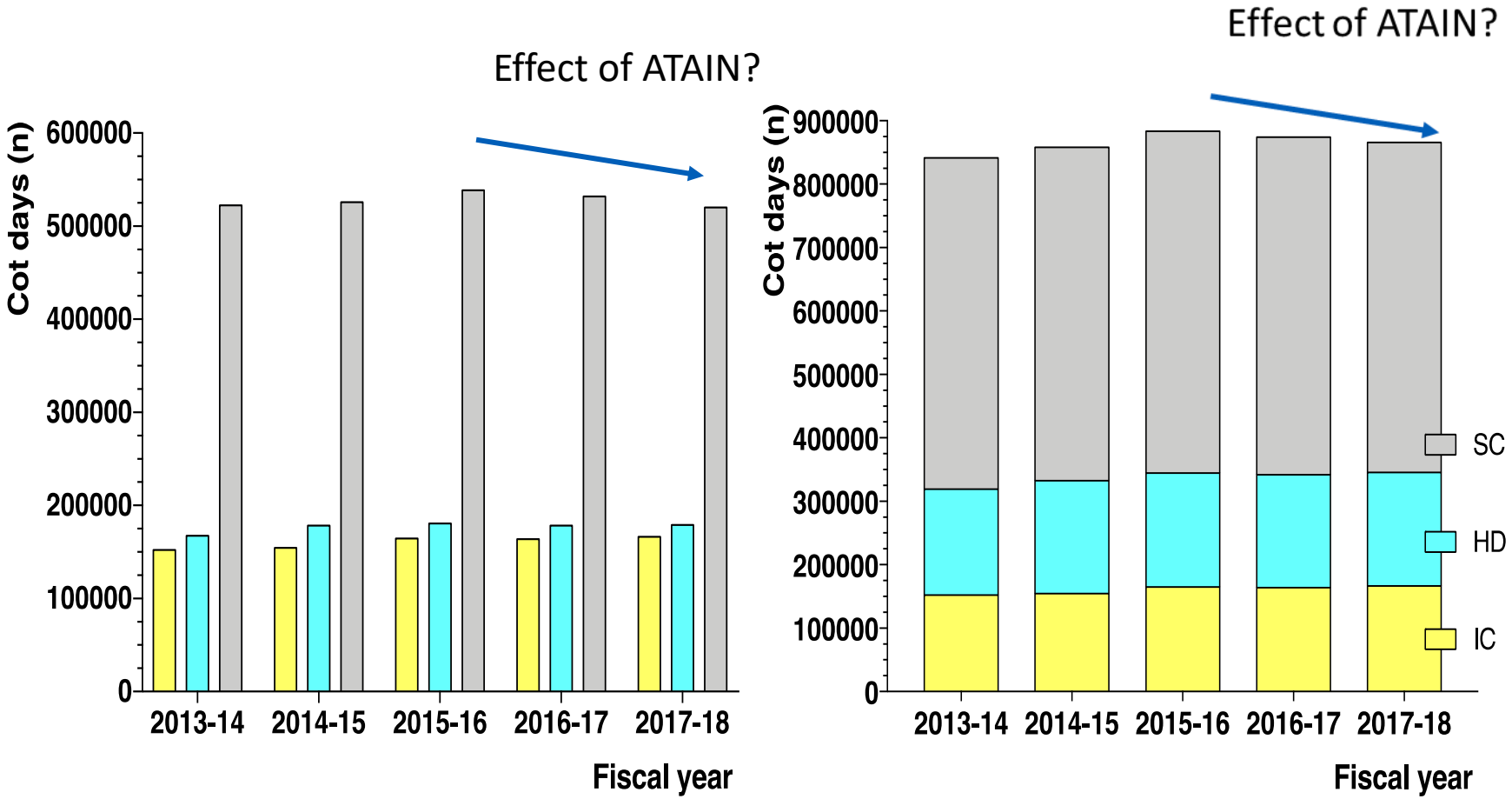
Parent information working group

IDENTIFICATION OF COMMON THEMES

Improvements - Atain



Neonatal activity – 13/14 – 17/18 - national



Intensive care (IC) rising by 3613 days per year;
High Dependency care (HD) rising by 2968 days per year;
Special care (SC) static

Improvements

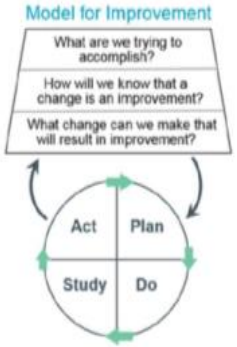
Maternal and neonatal health safety collaborative

A three-year programme to support improvement in the quality and safety of maternity and neonatal units across England

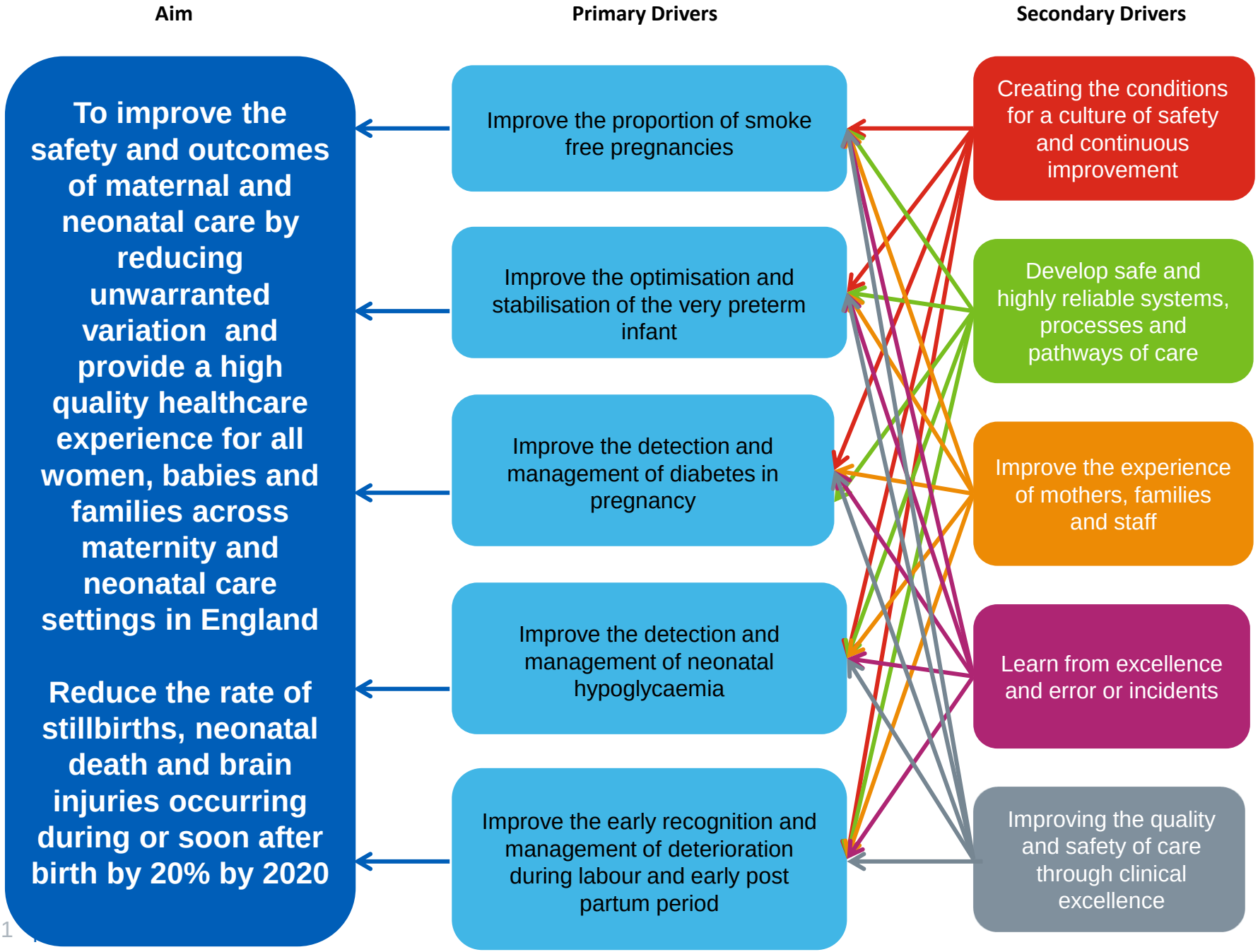
Maternity and neonatal Quality Improvement programme

NHS Improvement

- 3 year national QI programme
- 136 trusts with maternity units
- Multidisciplinary and each trust will need to identify minimum of 3 key representatives - obstetrician, midwife, senior manager
- Supported by effective regional communities of practice
- Develop QI capability at every level of maternity systems
- Steering group to provide oversight and direction with support from an advisory faculty and programme delivery team



Programme support to maternity units


Aim
Primary Drivers
Secondary Drivers
To improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England
Reduce the rate of stillbirths, neonatal death and brain injuries occurring during or soon after birth by 20% by 2020
Improve the proportion of smoke free pregnancies
Improve the optimisation and stabilisation of the very preterm infant
Improve the detection and management of diabetes in pregnancy
Improve the detection and management of neonatal hypoglycaemia
Improve the early recognition and management of deterioration during labour and early post partum period
Creating the conditions for a culture of safety and continuous improvement
Develop safe and highly reliable systems, processes and pathways of care
Improve the experience of mothers, families and staff
Learn from excellence and error or incidents
Improving the quality and safety of care through clinical excellence

A new PIER Framework for safety

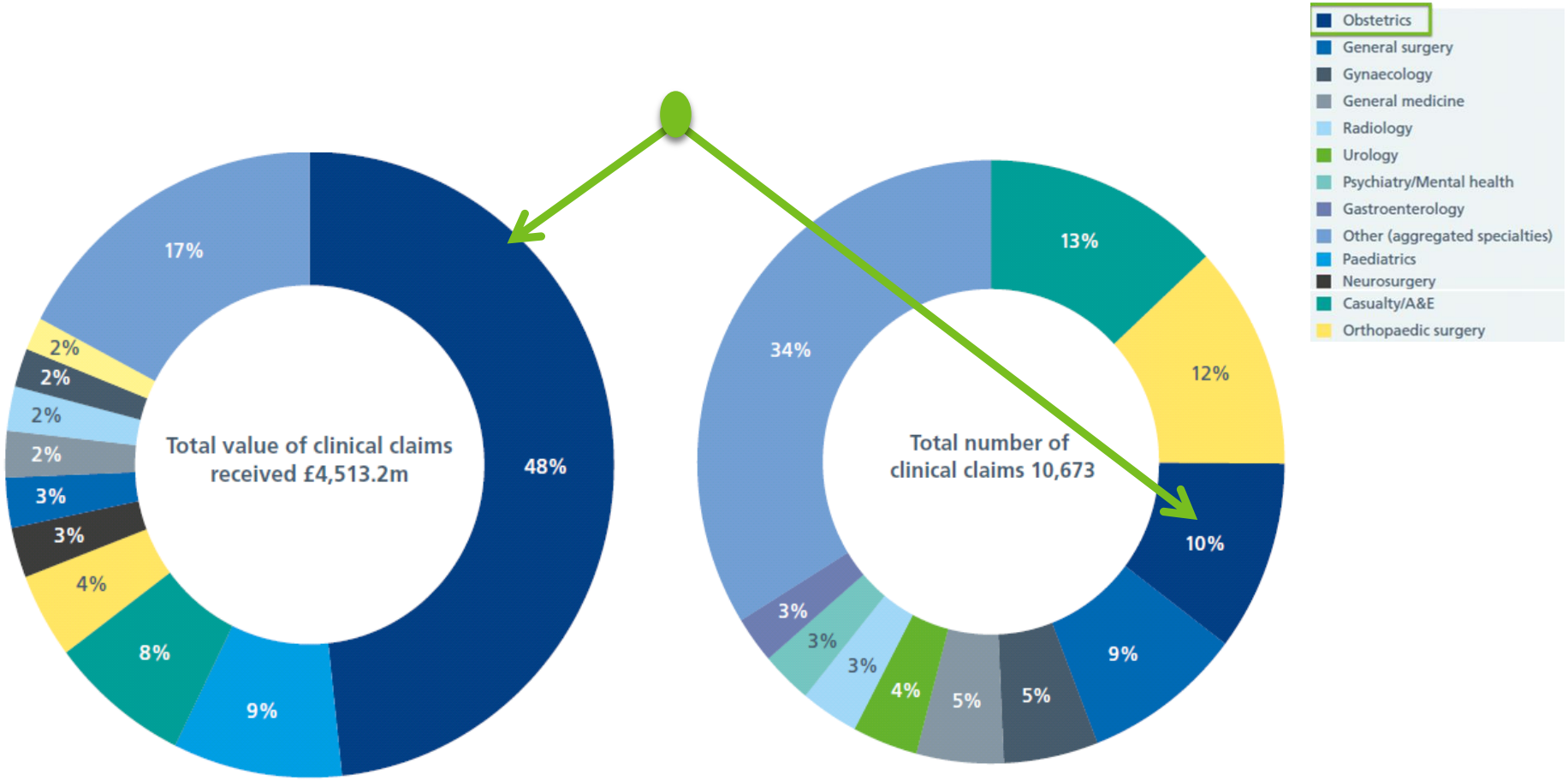
Prevention - interventions that will help monitor or reduce individual risk

Identify – prompt recognition of deterioration through the reliable monitoring, identification and assessment

Escalate - reliable escalation and communication using a ‘common language’ with high quality, structured communication

Respond - timely response and review by senior clinicians, reliable activation of clinical interventions and monitoring.

Maternity litigation claims



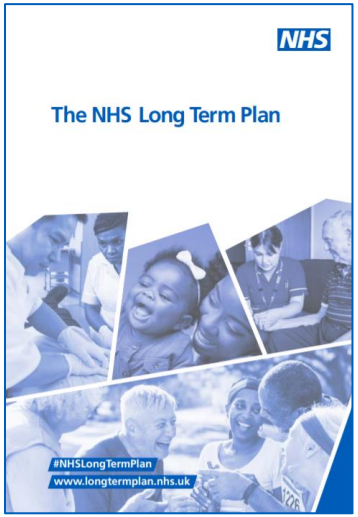
(Source: NHS Resolution Annual report and accounts 2017/18)

Improvements – Maternity Incentive Scheme

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	
2	Are you submitting data to the Maternity Services Data Set to the required standard?	
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	

Neonatal Critical Care Review

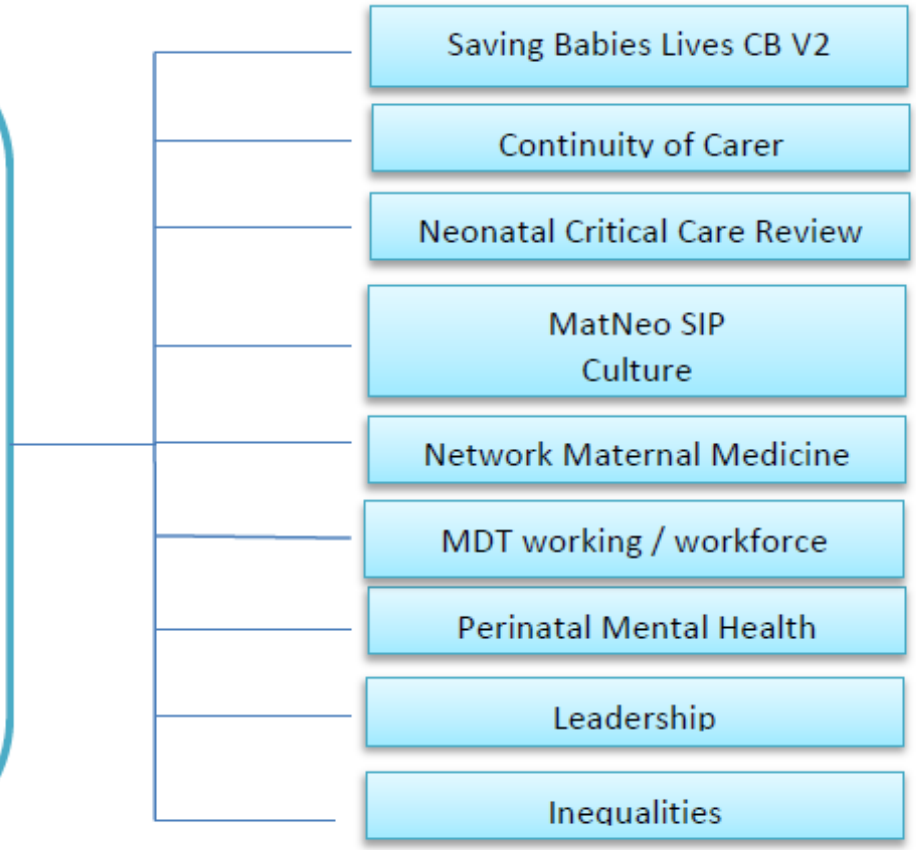
- Commissioned by NHS England in response to issues identified in *Better Births*
- Led by Neonatal Critical Care CRG within Specialised Commissioning
- NCCR Action Plan identifies 10 actions under the following themes:
  - Aligning capacity
  - Developing the expert neonatal workforce
  - Enhancing the experience of families
  - Making it happen
- Action plan published in December 2019 with early milestones in March 2020
- Vital roles for local and regional groups to work together to transform neonatal services



Key initiatives going forward

Make measurable improvements in safety outcomes for women, their newborns and families in maternity and neonatal services, as set out in Better Births.

Reduce the rate of stillbirths neonatal death and brain injuries occurring during or soon after birth by 20% by 2020 and 50% by 2025



Since 2010 there has been a 21% fall in the stillbirth rate up to 2018
4.6% fall in the rate of all neonatal deaths up to 2017
a 14% reduction in the triennial matenal mortality rate up to 2015-17.
The rate of serious brain injuries fell from 5.4 per 1000 in 2014 to 5.1 per 1000 births in 2017, having previously increased from 4.9 in 2012.

Thank you

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