UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 23 JULY 2020

Title:	**ANNUAL MATERNITY SAFETY & EVIDENCE REPORT**
Responsible Director:	**Lisa Stalley-Green, Chief Nurse**
Contact:	**Alison Talbot, Director Of Midwifery**

Purpose:	To give an overview to the BOARD OF DIRECTORS of key aspects of maternity safety and quality improvements. In particular, highlight the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (NHS resolution 2020) and provide the board with evidence towards achieving the ten maternity safety actions.
Confidentiality Level & Reason:	None
Board Assurance Framework Ref: / Strategy Implementation Plan Ref:	BAF - SR3/18 - Prolonged and/or substantial failure to meet operational performance targets BAF - SR6/18 - Material breach of clinical and other legal standards leading to regulatory action SIP - #3 Provide the highest quality of care to patients through a comprehensive quality improvement programme SIP - #4 Meet regulatory requirements and operational performance standards, in line with agreed trajectories
Key Issues Summary:	• If the Trust achieves the CNST maternity incentive scheme 10 safety actions they will be entitled to recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of unallocated funds. • The Maternity Services at the Trust have implemented a number of improvements in safety and quality.
Recommendations:	The BOARD OF DIRECTORS is asked to: 1. The board is invited to note the contents of the report and approve the 2020 CNST actions and supporting evidence.

Signed: Lisa Stalley-Green	**Date:** 13 JULY 2020

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BOARD OF DIRECTORS

Thursday 23 July 2020

ANNUAL MATERNITY SAFETY & EVIDENCE REPORT

PRESENTED BY CHIEF NURSE

Purpose

The purpose of this report is to give an overview of key aspects of maternity safety and quality improvements and in particular, highlight the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (NHS resolution 2020) and provide the board with evidence towards achieving the ten maternity safety actions.

Background and Links to Previous Papers

To compliment the suite of improvement opportunities within maternity in response to the Department of Health national ambition to reduce stillbirths, neonatal deaths and intrapartum brain injury by 20% by 2020, and by a further 50% by 2025 the team have developed a safety improvement plan as recommended by national publications 'Spotlight on Maternity' and 'Safer Maternity Care' (2016). The aim of the bespoke maternity safety improvement plan is to integrate existing and new plans into one place. A follow on national publication, Safer Maternity Care, Progress and Next Steps (2017) outlined an incentive to further support the implementation of best practice to improve safety led by NHS Resolution. (Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme).

Actions arising from the CNST safety actions (2019) are included in the improvement plan for University Hospitals Birmingham and subsequently recommendations from MBBRACE (2018).

The Maternity Safety Improvement Plan and CNST safety actions are due to be shared at the Trusts Care Quality Group on July 21st 2020 and updated plans are scheduled to be presented quarterly.

1. Executive Summary

Spotlight on Maternity (2016) and Safer Maternity Care (2017) were published by the Department of Health in 2016. Both documents aim to improve the quality of care within Maternity and Neonatal Services and support the national ambition of the Department of Health to reduce the rate of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 50% by 2030; refining the care through focus on teams, leadership, data, innovation, learning and best practice. Safer Maternity Care Progress and Next Steps (2017) brought forward the expected date of the planned improvements by 5 years to 2025.
UHB are fully committed to the national ambition and are participating in all of the recommended national projects. These projects include Saving Babies Lives

Care Bundle introduced by NHS England, Each baby counts, RCOG, MBRRACE UK, Perinatal Mortality Review Tool (PMRT), National Maternity and Neonatal Health Safety Collaborative and fully subscribe to the Maternity Data Set project.

NHS Resolution is operating a third year of the CNST maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. As in year one and two, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

As in year one and two, the scheme incentivises ten maternity safety actions that reinforce best practice to ensure that we are meeting the recommendations and working towards the national ambition. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

2.0 Maternity Safety Improvement plan (Spotlight on maternity and Safer Maternity Care 2016)

A bespoke Maternity Safety Improvement Plan, as recommended by Spotlight on Maternity and Safer Maternity Care, is regularly monitored and updated, and is provided in Appendix 4.

3.0 Saving Babies Lives Care Bundle

The Saving Babies Lives Care Bundle V1 (2016) contained 4 elements which when implemented were recognised to have a significant positive impact on perinatal mortality.

- Reducing smoking in pregnancy
- Risk assessment and surveillance for fetal growth restriction
- Raising awareness of reduced fetal movements
- Effective fetal monitoring during labour

In May 2019 Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality was launched with an additional element that if achieved will improve long term outcomes for babies and their families.

- Reducing Preterm Birth

The maternity units of University Hospitals Birmingham NHS Foundation Trust (UHB) adopted the SBLCB from its inception in 2016. (UHB) had 9700 births in 2019, maternity services are provided at all three hospital sites Netherbrook Birth Centre; Solihull Hospital (SOL) is a Standalone Midwifery Led Unit and cares for low risk women of 37 weeks gestation and above. Good Hope Hospital (GHH) provides a level 1 neonatal service and therefore does not provide long term care for neonates less than 34 weeks of age. This site offers women the following options: midwifery led care, consultant led care and shared care. Birmingham Heartlands Hospital (BHH) has a neonatal intensive care unit that provides level 3 neonatal services. This site also offers midwifery led care in a designated alongside midwifery led unit; consultant led care and shared care.

Each hospital serves a unique and diverse population due to the demographic location of each hospital. The population around BHH is also very diverse, many of whom do not speak English and a significant number come from some of the most deprived areas in England (Department for Communities and Local Government 2014). Whereas SOL and GHH tend to serve a more affluent population, however there are still pockets of deprivation within these areas. The latest MBRACE perinatal mortality rate released in 2019 revealed that the stillbirth rate, neonatal mortality rate, and extended perinatal mortality rate was higher than the national average.

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)	Comparison to the average for similar Trusts & Health Boards
Stillbirth	39	3.99	3.86 (3.22 to 4.54)	Up to 5% higher or up to 5% lower
Neonatal	23	2.36	2.45 (1.64 to 3.50)	More than 5% higher
Extended perinatal	62	6.34	6.25 (5.45 to 7.67)	Up to 5% higher or up to 5% lower

3.1 University Hospitals Birmingham NHS Foundation Trust Compliance with Saving Babies Lives Care Bundle Version 2

Element	Action	Compliance level
Element 1	Reducing Smoking in Pregnancy	
Element 2	Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction	
Element 3	Raising Awareness of Reduced Fetal Movements	
Element 4	Effective Fetal Monitoring	
Element 5	Reducing Preterm Births	

A quarterly report is produced and shared at Divisional meetings to enable the wider multiprofessional teams to understand our performance against the national ambition, this report now includes outcome indicators compliance. The report is distributed to all maternity staff and ensures that the multiprofessional teams have knowledge of and are fully engaged in objectives to reduce perinatal morbidity.

Element 1 Reducing Smoking in Pregnancy

Due to the current COVID 19 pandemic, CO monitoring has been suspended as this is an aerosol generating procedure. This has meant that women who have high levels of CO are not identified. Therefore the current recommendation from UHB is that all women who smoke should be referred to smoking cessation services.

Face to face Very Brief Advise (VBA) training has also been suspended and staff have been directed to complete the online Smoking in Pregnancy Challenge Group training. Smoking Cessation leads were also appointed in March 2020, however they have not been able to start duties as yet due to the current pandemic. A date is now being agreed for the leads to commence.

Element 2 Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction

The 28/40 week ultrasound was briefly suspended due to COVID-19 however this has now been reinstated. A recent audit of 215 cases of small for gestational age babies (SGA) found that only 45% of SGA babies were detected antenatally. To assist with drilling down further into the causes for these missed cases, particularly <3rd centile from July 2020 the Trust has adopted the Perinatal Institute SGA audit tool that will allow the teams to input data with the result that themes and action plans can be generated to identify causes to then implement strategies to improve the Trusts detection rate.

Another initiative to meet this element is the implementation of a dedicated SGA clinic which will start in August 2020.

Element 3 Raising awareness of reduced fetal movements

The Trust currently audits 160 records per month for compliance with distribution of reduced fetal moment's leaflets. Alerted fetal movements in pregnancy have been identified as a potential sign of impending poor pregnancy outcomes.

To support the audits we have appointed a band 6 audit midwife and Band 3 SBLCB administrator to support the level of work needed to meet our objectives. To ensure that women are accessing literature on RFM the electronic maternity records BadgerNet have now released the BadgerNet App whereby women can access leaflets in 27 languages via their phone or tablets.

Element 4 Effective fetal monitoring during labour

Face to face fetal monitoring training and competency testing was suspended during COVID 19. This is now gradually being reintroduced; however there will be a substantial backlog in the number of staff members who require training.

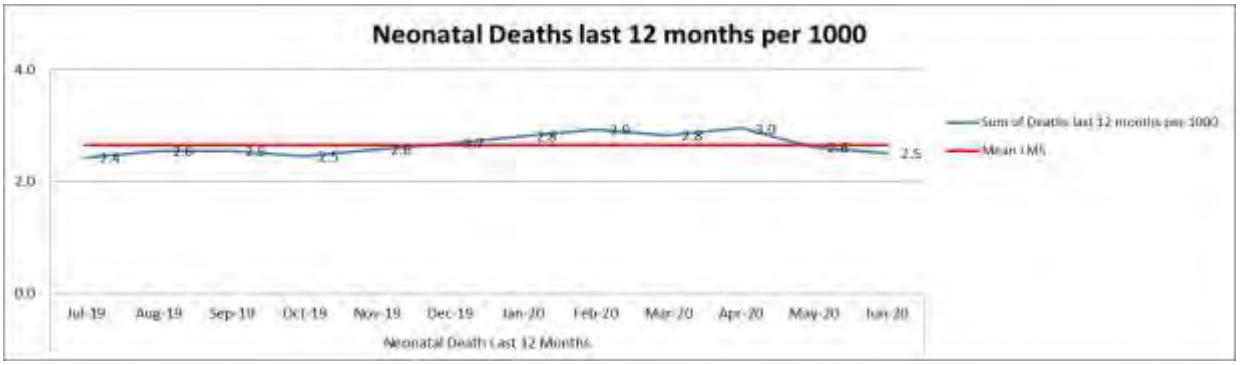
Staff are now being requested to complete the online learning package on fetal monitoring provided by the Electronic Library For Health. Once staff have completed this training they will be invited to face to face competency testing. The Trust have also recently appointed a Fetal Surveillance Midwife to assist with the implementation and monitoring of this element. The practice development team have submitted detailed plans of how they will achieve the training requirements of this element which involve working with our local maternity system colleagues at Birmingham Women's Hospital.

Element 5 Reducing Preterm Births

Ensuring that there is reduced mortality and morbidity of neonates born prior to 34/40 has been the latest addition to the care bundle. Currently this element has not been affected by the COVID pandemic. The PReCePT programme which supported this element has now come to an end and the maternity units have taken ownership of its objectives.

To Support this element, the LMS developed a 27/40 preterm pathway to ensure that women could be transferred to the most appropriate unit for their baby's needs; this has been a success and enhanced communication within the LMS.

The commitment to the implementation of the SBLCB is beginning to show some success which equates with more mothers returning home with their healthy babies as demonstrated in the graphs below.



Currently compliance with the bundle sits at Amber, predominately due to the recent pandemic. However the teams have additional support, are engaging in new ways of working and implementing new initiatives to ensure that even with limited appointments and reduced face to face contacts with women the Trust can still meet the SBLCB objectives.

4. CNST Maternity Incentive Scheme

NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. As in year two, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

As in year two, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

This document provides guidance on the safety actions for year three of the maternity incentive scheme.

4.1 Maternity Incentive Scheme Year Three: conditions

In order to be eligible for payment under the scheme, trusts must submit their completed Board declaration form to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on Thursday 17 September 2020 and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions
- The Board declaration form must be signed and dated by the trust chief executive to confirm that:
- The Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
- The content of the Board declaration form has been discussed with the commissioner(s) of the trust's maternity services.
- The Board must give their permission to the chief executive to sign the Board declaration form prior to submission to NHS Resolution.

Please note that it is likely that the deadline for declaration will be extended.

4.2 Evidence for Submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the trust Board only, and will not be reviewed by NHS Resolution.
- Trust submissions will be subject to a range of external verification points, these include cross checking with: MBRRACE-UK data (Safety action 1), NHS Digital regarding submission to the Maternity Services Data Set (Safety action 2), and against the National Neonatal Research Database (NNRD) for number of qualifying incidents reportable to the Early Notification scheme (Safety action 10)
- Trust submissions will also be sense checked with the Care Quality Commission (CQC).

For trusts who have not met all ten maternity actions

Trusts that have not achieved all ten actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such trusts must submit an action plan together with the Board declaration form by 12 noon on Thursday 17 September 2020 to NHS Resolution (MIS@resolution.nhs.uk). The action plan must be specific to the action(s) not achieved by the trust and must take the format of the template .Action plans should not be submitted for achieved safety actions.

NHSR have stated in recognition of the current pressure on the NHS and maternity services in response to COVID-19, reporting requirements have been temporarily put on hold and revised timescales should be received in late July 2020.

4.3 10 Safety Actions

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Safety action 3: Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version 2?

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Safety action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Safety action 10: Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?

Evidence required to be shared at July 2020 Board of Directors is included as appendices:

- Quarterly report that includes details of the deaths reviewed using the perinatal mortality review tool (appendix 1)
- Action plan for Avoiding Term Admissions into neonatal units (appendix 2)
- Progress report in meeting the Continuity of Care action plan (appendix 3)
- Safety Improvement Plan (appendix 4)
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5. Governance

The Maternity Safety Improvement plan which incorporates the CNST maternity safety actions, Saving Babies Lives actions and actions from the perinatal mortality reviews is to be shared at the Trusts Care Quality Committee on a quarterly basis.

Our Board level safety champion attends a Maternity Safety Production board meeting fortnightly where safety outcomes including stillbirths, neonatal deaths, admissions to the neonatal unit for hypoxic ischaemic encephalopathy, massive obstetric haemorrhage and CTG compliance are discussed. This ensures that board members are cited on patient safety events within maternity

and also gives all levels of staff the opportunity to raise any concerns that they have directly with the maternity safety champions and the board level safety champions. Attendance records for this meeting are kept.

UHB took part in the National Maternity and Neonatal Safety Improvement Collaborative (MATNEO) Wave 2 in 2017. The Local Improvement Team led on 4 Key projects (neonatal hypoglycaemia, Learning from excellence and the Category 1 caesarean section pathway). A Safety Culture Survey (SCORE) was also undertaken within the unit with completion by a large number of maternity and neonatal staff. The results from the culture survey have not been used widely, however as there have been many changes since this took place the team are planning to re do this survey over the next few months. As some of the MATNEO team have left the organisation, a new team has been formed to reenergize this piece of work.

6. Recommendations

The board is invited to note the contents of the report and approve the 2020 CNST actions and supporting evidence.

For the purpose of meeting the required standards the Board is requested to formally acknowledge and minute that the following evidence has been provided:

- Action plan for Avoiding term admissions into neonatal units (ATAIN)
- Perinatal mortality Review Tool (PMRT) report
- Progress in meeting the Continuity of Carer pathway
- Board support for the safety improvement plan
- Trust Board level consideration of how the organisation is complying with the Saving Babies Lives Care Bundle V2

Maternity Safety is reported to Care Quality Group on a monthly basis.

A further compliance and strategic update will be brought forward to Board of Directors in October 2020.

Lisa Stalley-Green
Chief Nurse
July 2020

Appendix 1

Perinatal Mortality Review Tool (PMRT)

Background

A collaboration led by MBBRACE UK was appointed by the Healthcare Quality Improvement Partnership (HQIP) to develop and establish a national standardised Perinatal Mortality Review Tool (PMRT) building on the work of the DH/Sands Perinatal Mortality Review 'Task and Finish Group'. The PMRT has been designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'.

The aim of the PMRT programme is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. The tool supports:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process.
- A structured process of review, learning, reporting and actions to improve future care.
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided.
- Production of a report for parents which includes a meaningful, plain explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented.
- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable.
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews.
- Parents whose baby has died have the greatest interest of all in the review of heir baby's death. Alongside the national annual reports a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.

Reviews

The Perinatal mortality review tool was implemented in April 2018 at University Hospitals Birmigham. For the purposes of providing evidence for the CNST safety action 1, data from the 12th December 2019 to 29th February 2020 is included below.

The numbers and causes are outlined below:

	Number	Causes
Stillbirths and late fetal losses	14	Cord prolapse/Multiple congenital anomalies/Uterine rupture/Growth restriction
Neonatal deaths	8	Prematurity/Extreme prematurity/Congenital anomalies

- 100% of deaths suitable for review were started within 4 months of the death.
- 93% of deaths suitable for review were completed within 4 months of the death.
- In 100% of deaths parental perspectives were sought.

Actions that have come out of the reviews are included below:

- Review of process when women move from low risk to high risk during intrapartum care.
- Review of process for calling neonatal team to cat 1 sections and seniority of attending doctor.
- New pathway for unbooked women attending triage.
- Communication in relation to management of reduced or no fetal movements and consistent message to women to come in straight away.
- Reminder to all staff ensuring routine enquiry re domestic abuse at booking and antenatally and subsequent audit.

It must be noted that these actions are from the entire reviews and not necessarily contributory factors.

Plans are in place to hold joint reviews across the Local Maternity System to provide external input and challenge.

Appendix 2

ATAIN (Avoiding Term Admissions into Neonatal units) July 2020 update

1. Local and National reviews of all anticipated Term Admissions to NNU

Work continues to support the compliance for the Saving Babies Lives (SBL) care bundle V2 (NHSE 2016). Reduced fetal movement (RFM) leaflets are now available in 27 languages, and can be accessed via the maternity app. Collaborative work is also underway with the Maternity Voices Partnership to understand how women perceive RFM. LMS funding has now been agreed for smoking cessation roles. Co2 monitor training is now in progress, though Co2 monitoring has been temporarily suspended during the Covid-19 Pandemic.

2. Transitional Care (T.C)

A transitional care (T.C) policy exists for both GHH and BHH, though the TC provision at GHH is currently under review. A multi professional group have met and agreed wider criteria for TC provision. This will include babies requiring naso –gastro (NG) tube feeding. The revised pathway is written and is currently being circulated for comments. A training implementation plan has also been developed, ready for launch when this pathway is approved.

The Kaiser Permanente Sepsis Risk Calculator (KP-SRC) is awaiting trust sign off before being implemented. This care pathway aims to implement the use of the Sepsis Risk Calculator (SRC) for risk assessment and management of early onset sepsis (EOS). The algorithm uses maternal and baby factors to work out risk of neonatal infection in the first 12 hours of life for that baby, at that time and then recommends management depending on baby's wellness. Regional data suggests that the pathway has reduced the use of antibiotics by 50%, without missing additional cases of true sepsis. This has also resulted in a 20% reduction in bed hours.

3. Hypoglycaemia

All actions from the current action plan are completed.

4. Respiratory symptoms

All actions from the current action plan are completed. In addition the Term care bundle was successfully launched in June 2020. This care pathway outlines a small set of practices, that when performed collectively, reliably and continuously can improve patient outcomes and prevent admission of term babies (≥37 weeks) to the neonatal unit.

The new 'Facilitating Skin to Skin in Theatre' training module is now available on Moodle. The core part of the module contains a training video, and a short assessment. Both of these cover the trust guideline (Skin to Skin Contact in Maternity), the manual handling and general risk assessment for safe skin to skin in theatre and during lateral transfer. This training is designed to support all members of the multi-professional team that may be involved in supporting skin to skin in theatre including, Anaesthetic and Midwifery staff.

5. Jaundice

All actions from the current action plan are completed.

6. Asphyxia

All actions from the current action plan are completed. In addition, the team have completed a fetal monitoring training GAP analysis, to help review the current provision of the current CTG training package. This will ensure that all training meets the requirements of safety action 8, for CNST 2020. The current training provision includes a competency assessment for all staff, which is clearly outlined in a competency assessment procedure document. This document will require CCG approval to support safety action 8, of the CNST incentive scheme 2020. The team will also need to develop an Anaesthetic and Neonatal training action plan to support this element of CNST.

7. Circulate the Alert

The maternity and neonatal teams will be redeveloping their ATAIN action plan this month to reflect the requirements of the safety action 3, of the CNST incentive scheme and the Saving Babies Lives Care Bundle (Version 2). The latest Trust data from June 2020 shows that the avoidable term admission rate fell below the national ambition of 5% at both Good Hope hospital (fig.1) and Birmingham Heartlands hospital (fig.2) for the first time since 2017. All term admissions and any immediate learning are discussed at the monthly safety champions production board meetings.

Fig.1 Term to NNU rates for GHH

UHB NHS Trust Term to NNU rates for GHH 2017 - 2020

ATAIN	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020
Total term admissions	54	56	37	41	45	60	44	56	43	49	38	45	51	30
Cong Abn	1	0	3	2	3	5	1	2	1	2	1	0	1	0
unexpected admissions	53	56	34	39	42	55	43	54	42	47	37	45	50	30
														2
Live Births	863	909	838	743	723	775	778	747	642	724	767	711	669	701
Term live births	797	850	776	680	660	707	710	696	586	668	712	666	612	651
Term adm rate/ term live births %			4.7								5.3			4.6
Unexpected term adm rate %			4.4	5.7							5.1			4.6

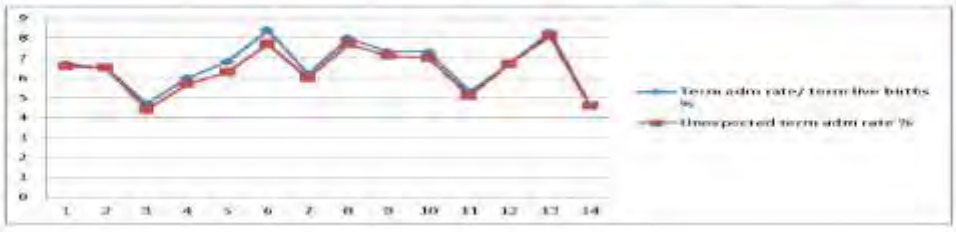
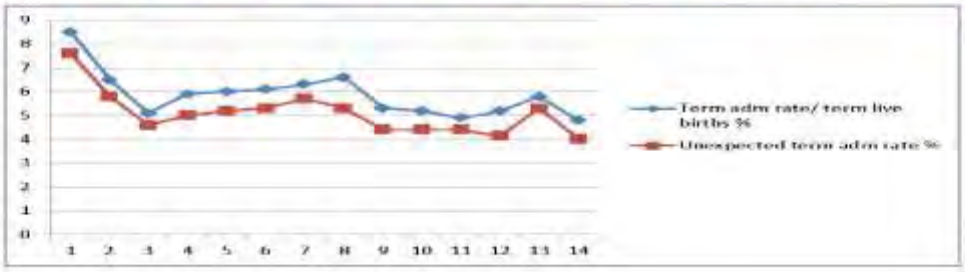


Fig.2 Term to NNU rates for BHH

UHB NHS Trust Term to NNU rates for BHH 2017 – 2020

ATAIN:	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020
Total term admissions	116	91	78	87	81	88	92	94	71	71	75	70	70	64
Cong Abs	12	10	8	13	11	11	8	18	17	10	8	14	5	11
unexpected admissions	104	81	70	74	70	77	84	76	59	61	67	56	65	53
live Births	1502	1536	1609	1594	1484	1616	1609	1570	1484	1528	1582	1517	1355	1481
Term live births	1365	1398	1526	1460	1343	1436	1457	1418	1324	1368	1505	1350	1206	1317
Term adm rate/ term live births %	[illegible]	[illegible]	5.1	5.9	[illegible]	[illegible]	[illegible]	[illegible]	5.3	5.2	[illegible]	[illegible]	5.8	[illegible]
Unexpected term adm rate %	[illegible]	5.8	[illegible]	[illegible]	5.2	5.3	5.7	5.3	[illegible]	[illegible]	[illegible]	[illegible]	5.3	[illegible]



Appendix 3

Continuity of Care – Progress report July 2020

"Better Births: improving outcomes of maternity services in England – A five year view of Maternity Services" was published on 22 February 2016. This was followed by a Cochrane review both recommending that providing a continuity of carer model to pregnant women improves clinical outcomes ensuring care is safe, clinically effective and affords a good experience for women and their families as well as midwives. Findings include that women who receive continuity of carer are:

- 16% less likely to lose their baby at any stage of pregnancy
- 19% less likely to lose their baby before 24 weeks
- 24% less likely to experience pre-term birth
- 15% less likely to have regional anaesthesia
- 16% less likely to have an episiotomy
- 10% less likely to have an instrumental delivery

This makes a compelling case for change to the current model of care as continuity of carer will improve physical and psycho-social well-being in both short and long term trajectories for women and families. The aspiration is that this model of care is available to most women; care cannot be given in a piecemeal fashion, but needs to be a total service approach in order to be successful.

The previous national target of providing 51% continuity of care throughout all three elements of pregnancy and the postnatal period by March 2021 has been changed in light of the Covid pandemic to 35% by March 2021. Our action plan provides evidence of the Trust working towards this target. To reach this target requires a system change in the way that midwives are working to ensure that women are cared for in the antenatal, labour and postnatal period by a small team of midwives known to them. This requires midwives to be on call regularly.

All of the teams across the Local Maternity System are named after inspirational women. Team Nightingale, our first continuity team was launched on 15th June 2020 and are steadily increasing their caseloads. This team is based geographically in Erdington as this is a known area for high perinatal mortality.

Team McCall is in progress which will look after our vulnerable teenagers and is hoping to go live in August 2020. The teenagers currently pregnant and set to receive all three elements of care within UHB have been mapped and the three areas of higher concentration have been identified as Chelmsley Wood, Erdington and Highfield. A baseline audit is in process and work around the estimated total bookings has been identified that the team should comfortably be able to look after all teenagers 18 years and under along with some of the most vulnerable 19 year olds. These two teams will provide approximately 7% of full continuity.

Further teams are currently being scoped and a variety of different models being considered as it is recognised that some of our high risk complex women have the majority of care in the hospital as opposed to with their community midwife.

Barriers to moving forward are staff engagement. Staff have reported that they don't want to work in these models for a variety of different reasons, the main one not wanting or being able to do on calls.

Another barrier is the disparity across the Local Maternity System on calls payments. BWCH currently follow agenda for change and UHB have a different system. This has been discussed with our Board Safety Champion and further discussions with HR are taking place. This is creating a risk to delivery of this national recommendation.

Appendix 4

Gap analysis with Spotlight on Maternity (2016), Safer Maternity care (2016)
and the
Confidential Enquiry into Maternal Deaths and Perinatal Deaths (MBRACE)
Safety Improvement Plan

Introduction

Spotlight on Maternity (SOM) and Safer Maternity Care (SMC) were published by the Department of Health in 2016. Both documents aim to improve the quality of care within Maternity and Neonatal Services and support the national ambition of the Department of Health to reduce the rate of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 50% by 2030; refining the care through focus on teams, leadership, data, innovation, learning and best practice. Safer Maternity Care, The National Maternity Safety Strategy - Progress and Next Steps was produced in November 2017 bringing forward the expected date of the reductions by 5 years to 2025.

University Hospitals Birmingham NHS Trust are totally committed to the national ambition and are taking part in all of the recommended national projects. These projects include Saving Babies Lives Care Bundle introduced by NHS England, Each baby counts, RCOG, MBRRACE UK, Perinatal Mortality Review tool, Avoiding Term Admission to the NNU, Maternity and neonatal health safety collaborative and fully subscribe to the Maternity Data set project.

Key Factors outlined within both of these documents are outlined below:

1. **Focus on leadership**: Create strong leadership for maternity systems at every level.
   Building strong leadership in maternity services by:
   - Ensuring a board-level focus on safety in maternity.
   - Setting up your maternity team to ensure a focus on safety.
   - Developing a bespoke Safety Improvement Plan for maternity.

2. **Focus on learning and best practice**: Identify and share best practice and learn from investigations.
   Sharing progress and lessons learnt across the system by:
   - Sharing your Safety Improvement Plan and progress publically.
   - Sharing what you are learning so that others can benefit.

- Helping create a national picture by contributing to the Governments annual report.

3. **Focus on teams**: Prioritise and invest in the capability and skills of the maternity workforce and promote effective multi–professional working.
   Building capability and skills for all maternity staff by:
   - Improving communication within and across teams.
   - Ensuring that all maternity staff complete and implement MDT training.

4. **Focus on data**: Improve data collection and linkages between maternity and other clinical data sets to enable benchmarking and drive a continuous focus on prevention and quality.
   Improving data capture and knowledge in maternity services by:
   - Improving the collection and reporting of high quality data to national data collections.
   - Ensuring that your service follows national guidelines for patient safety reporting.

5. **Focus on innovation**: Create space for accelerated improvement and innovation at local level.

6. **Focus on early detection of the risks associated with perinatal mental illness by** :
   - Ensuring that all staff that work in the maternity services are trained to identify the risks and symptoms of mild to severe perinatal mental illness.
   - Ensuring that all staff that work in maternity services are aware of the local perinatal mental health pathways in care.

Developing a bespoke Safety Improvement Plan for maternity

Every Trust is required to develop a bespoke Maternity Safety Improvement Plan which brings together existing and new plans into one place.

A Safety Improvement Plan is a document which sets out the organisation's plans for the next three to five years in relation to quality and safety.

There are several benefits of a bespoke maternity Safety Improvement Plan:
- It helps the staff in the organisation to be clear about what they want to achieve and when they want to achieve it by.

- It enables all the current work on quality and safety in maternity to be collated in a single place which is easily accessible.
- It can be discussed with the organisation's leadership team or Board.
- It can be used as evidence for anyone who wishes to find out what the organisation is doing to improve the safety of maternity care.

Recommendations from Spotlight on Maternity (SOM), Safer Maternity Care (SMC)
and the
Confidential Enquiry into Maternal Deaths and Perinatal Deaths (MBRACE)
Gap analysis and action plan for UHB

Focus on Leadership

Reports	Action No.	Recommendation	Met	Actions required	Target Date	Person Responsible	Comments
SOM & SMC	1.0	Board level Maternity Champion appointed. Local champions to meet with Board level champion bi - monthly	Yes			Alison Talbot Amit Chaudhuri	Lisa Staley Green – Executive Chief Nurse appointed as Board level Maternity Champion. Midwifery Neonatal leads also identified. Local champions identified and this information is displayed in the clinical areas. Bi monthly meetings set up on each site. Monthly strategic Maternity and neonatal safety improvement group
	1.1	Organisation should provide the opportunity for the CSL and DOM to present regularly to the board.	Yes			Alison Talbot Amit Chaudhuri	Safety Board meetings take place at GHH and BHH monthly
	1.2	Organisation should create a specific work stream for maternity within their existing sign up to safety team				Alison Talbot	Top work with the corporate quality and safety team

	1.3	Maternity safety improvement plan needs to fit into the organisations wider plan.	Yes			Alison Talbot Amit Chaudhuri	Gap analysis completed and Maternity safety action plan written. To be shared monthly at the Strategic Maternity and Neonatal Safety Improvement Group
SOM & SMC	1.4	Maternity Safety Champion appointed in Maternity Clinical Networks.	Yes			Alison Talbot Amit Chaudhuri	Board level safety champion Lisa Staley Green – UHB Executive Chief Nurse
SMC	1.5	Trusts will have one obstetrician and one midwife jointly responsible for championing maternity safety in their organisation.	Yes			Alison Talbot Amit Chaudhuri	Alison Talbot Divisional Director of Midwifery and Amit Chaudhuri Clinical Service Lead for Obstetrics will lead maternity safety at UHB NHS Trust
SOM	1.6	Bespoke Maternity Safety Improvement Plan agreed and made public.	Partial	First draft written – awaiting approval and sign off	August 2020	Natasha Stringer	Maternity Safety Improvement Plan is completed. To be circulated and available for all to view.
	1.7	Working collaboratively with our educational partners and involving them in the improvement plan.	Partial		February 2021	Natasha Stringer	Collaborate with the local Maternity & Neonatal Programme Lead & Quality Improvement and Human Factors Facilitator at West Midlands Patient Safety Collaborative - Ann Abbassi to help build QI capability for improvement

	1.8	Ensuring appropriate staffing levels in line with the birth-rate plus assessment.	Partial	Implementation of the live acuity tool at UHB	November 2020	Alison Talbot	Birth-Rate Plus acuity tool commissioned and is now live (Q1 2020/21) Full workforce assessment to start in August 2020
	1.9	Public statement to be put on the Maternity and Trust website demonstrating commitment to contributing to the National ambition	No	Link up with the Trust comms team to help facilitate	September 2020	Natasha Stringer Karen Stephenson	
	2.0	Develop safety champions across the MDT workforce and outline the roles and responsibilities of the team	Yes	Photo boards to be displayed identifying safety champions	March 2020	Alison Talbot Natasha Stringer Karen Stephenson Amit Chaudhuri Pinki Surana	MDT Safety champions appointed. Safety champion's pathway circulated to appointed champions and all staff.
	2.1	Develop a communications plan for how we will share the safety improvement plan with staff and the public and share progress periodically.	Partial		April 2020	Natasha Stringer Karen Stephenson	To develop a comms strategy for communicating safety improvement plan progress.
	2.2	Ensure Labour ward coordinators become supernumerary in line with safe staffing levels.	Yes		March 2020	Alison Talbot Jade Hellier Ella Vitue	Labour ward coordinators supernumerary
	2.3	Conduct a patient safety culture survey	No	SCORE survey to be completed in 2020. Introduction of cultural barometer tool	October 2020	Natasha Stringer Joselle Wright Amit Chaudhuri Pinki Surana Sarah Moxon	Plans in place with the MAT NEO leads

	2.4	Introduction of a new post band 7 – clinical preceptor support midwife to support the clinical implementation of the improvement plan.				Alison Talbot Natasha Stringer	
Focus on learning and best practice							
SMC	3.0	NHS England have published Version 2 of the Saving Babies' Lives care bundle for use by maternity commissioners and providers	Partial	Work continues to improve outcomes linked to the 5 domains; • Smoking in pregnancy • Reduced fetal movements • Pre-term birth • Fetal monitoring in labour • Detection and management of FGR	Ongoing	Joselle Wright Shalini Patni Malar Malarselvi	Action plan developed in response to monthly audits. Fetal monitoring midwife appointed. Staff awareness day hosted. Staff attending CTG masterclass. RFM leaflets now available in 27 languages, and can be accessed via the maternity app. LMS funding agreed for smoking cessation roles. Co2 training in progress. Collaborative work with the MVP to understand how

							women perceive RFM.
	3.1	Development of a learning and development action plan for the whole MDT.	Partial	Action plan developed TNA to be ratified and include MDT		Natasha stringer Adele Causer Samantha Busby Tammy Martin Pinki Surana Ajit Bhat Amit Chaudhuri	Action plan developed to ensure all elements of safety action 8 for the 2020 NHSR Maternity Incentive Scheme.
SMC	3.2	Work to reduce term admissions to SCBU	Partial	Progression through the Trust's ATAIN action plan	Ongoing	Katherine Barber Natasha Stringer Pinki Surana	UHB ATAIN action plan
SMC	3.4	A package of publications and resources will be available for maternity and neonatal teams to support them to provide safer care and avoid unnecessary separation of mother and baby.	Yes	Plan to ensure Neonatal staffs have access to ATAIN e-Learning package. ATAIN newsletter to be developed and circulated.	June 2020	Katherine Barber Natasha Stringer Pinki Surana	ATAIN e-Learning package added to the Midwifery mandatory training schedule. ATAIN updates shared via the Bi-monthly safety production board meetings Updated ATAIN action plan to be developed
SMC	3.5	Promoting best practice in whooping cough and flu immunisation	Partial	Whooping cough and Flu vaccine clinics developed to try and increase administration rates	Ongoing	Joan Lilburn	

SOM	3.7	All staff trained to identify the risks and symptoms of mild to severe perinatal mental illness and are aware of the local pathway for perinatal mental health	Partial	Perinatal Mental Health guideline is currently being reviewed. Once ratified and live we will be fully compliant.	Ongoing	Jo Smith Michelle Richardson Tracey Tolley Vicky Brennan	All midwives receive Level 3 mandatory training which includes perinatal mental health and the staff have access to all the local UHB pathway within the guideline once completed. This revised guideline has now been signed off ops meeting 12.06.2020 corporate governance question regarding content-amendment to be made by author by 25.06.2020 then for corporate
	3.8	Review of the use of safety briefings and shift handovers in order to improve communication	Partial	Daily capacity huddle at midday on delivery suite	Ongoing	Ella Vitue Jade Hellier Maggie Coleman Suzanne Wilson	Daily Team brief now takes place at 7.30&19.30 at GHH/BHH. Safety huddle has commenced on 17.2.20 between anaesthetic, neonatal, obstetric and midwifery staff 2 MDT teams to RCOG / RCM labour ward leaders event in Sept 2020 and project around handovers to be undertaken

	3.9	Share learning and best practice across our network at LMS meetings	Yes I	Maternity dash board SBL V2 and ATAIN reported to LMS board (monthly)		Alison Talbot Amit Chaudhuri Natasha Stringer	
	4.0	Continue implementing the Saving babies lives care bundles	Partial	SBL V2 action plan developed	Ongoing	Shalini Patni Mani Malarselvi Jo Wright	
Focus on teams							
SOM & SMC	5.0	Learning and development plan in place for entire multi-disciplinary team.	Partial	GAP analysis completed to identify actions to help meet the requirements of safety action 8 for CNST 2020. Action plan developed, which includes revised 1 day fetal monitoring training		Samantha Busby Adele Causer Rhoda Flynn Tammy Martin	1. Session plan for new fetal monitoring day written. 2. Competency Assessment document requires CCG approval. 3. Anaesthetic and Neonatal training action plan needs developing
SOM & SMC	5.1	The maternity team to attend maternity safety training with funding allocated from the Maternity Safety Training Fund.	Yes				UHB Maternity safety training fund (HEE) final spend plan.
SOM & SMC	5.2	MDT labour ward team to take part in the RCOG / RCM labour ward leaders project	Partial	Funding agreed and teams to be identified to attend this training	September 2020	Ella Vitue Jade Hellier Irshad Ahmed Hesham Ghoneimy	Plans to attend in September 2020

Focus on Data							
SOM & SMC	6.0	Trust is reporting to Maternity Services Dataset and other key data sets such as MBRRACE-UK, the Royal College of Obstetricians and Gynaecologists' Each Baby Counts programme, the National Neonatal Dataset and the new National Maternity and Perinatal Audit.	Yes			Claire Jennings Pinki Surana Karen McGuigan Natasha Kaba	
SOM & SMC	6.1	Maternity and neonatal teams are using the Standardised Perinatal Mortality Review Tool to review and share learning from every stillbirth and neonatal death, when it is available.	Yes		Ongoing	Shalini Patni Mani Malarselvi Clare Beesley	2 panels meet and review all cases that meet the criteria for PMRT.
SMC	6.2	Maternity team is using national indicators dashboard to track their outcomes over time and benchmark against other organisations in their local maternity system and across the region.	Yes		Ongoing	Claire Jennings Kath Barber	
Focus on Innovation							
SMC	7.0	Continuation of the National Maternal and Neonatal Safety Collaborative.	Partial	Plans under way to re-invigorate the group. Multi professional involvement invited. More staff to receive QI	September 2020	Joselle Wright Natasha Stringer Hayley Butler	6 staff attended Wave 1 of the National Maternity and New born Safety Collaborative (MATNEOQI). CILG national group - The Trust is represented in this group.

Focus on detection of the risks associated with perinatal mental health							
SOM	8.0	Training for all staff in the detection of the risks should be reviewed to ensure that it is fit for purpose	Partial	Perinatal Mental Health guideline is currently being reviewed. Once ratified and live we will be fully compliant.	September 2020	Jo Smith Natalie Rossiter	All midwives receive Level 3 mandatory training which includes perinatal mental health and the staff have access to all the local UHB pathway within the guideline once completed
	8.1	Ensure all staff are aware of the local perinatal pathways of care	Partial	Perinatal Mental Health guideline is currently being reviewed. Once ratified and live we will be fully compliant.	September 2020	Jo Smith Natalie Rossiter	All midwives receive Level 3 mandatory training which includes perinatal mental health and the staff have access to all the local UHB pathway within the guideline once completed

Focus on MBRRACE UK: Saving Lives, Improving Mothers' Care 2019							
Improving care of women with cardiovascular disease							
Saving Lives, Improving Mothers' Care 2018	9.0	Repeated presentation with pain and/or pain requiring opiates should be considered a 'red flag' and warrant a thorough assessment of the woman to establish the cause. Pain severe enough to prevent a woman caring for her baby represents a similar 'red flag'	Partial	Partially reflected in the current guidance		Irshad Ahmed Natalie Rossiter	Update 25.06.2020 current guidance CG692 '*Cardiac Disease in Pregnancy and Labour'* under review

Saving Lives, Improving Mothers' Care 2016	9.1	A raised respiratory rate, chest pain, persistent tachycardia and orthopnoea are important signs and symptoms of cardiac disease which should always be fully investigated. The emphasis should be on making a diagnosis, not simply excluding a diagnosis	Partial	Current guidance '*Cardiac Disease in Pregnancy and Labour'* was due for review 2016		Irshad Ahmed Natalie Rossiter	Update 25.06.2020 current guidance CG692 '*Cardiac Disease in Pregnancy and Labour'* under review
ESC syncope guideline 2018	9.2	Syncope during exercise can suggest a cardiac origin, and should prompt cardiac evaluation	No	Current guidance '*Cardiac Disease in Pregnancy and Labour'* was due for review 2016	September 2020	Irshad Ahmed Natalie Rossiter	Update 25.06.2020 current guidance CG692 '*Cardiac Disease in Pregnancy and Labour'* under review
ESC cardiovascular diseases in pregnancy guideline 2018	9.3	ECG and measurement of troponin levels are recommended when a pregnant woman has chest pain. Echocardiography is recommended in any pregnant patient with unexplained or new cardiovascular signs or symptoms	Yes	Reflected in current guidance		Irshad Ahmed	
UK Resuscitation Council guidelines 2015	9.4	Following resuscitation from an arrest with a likely cardiac cause, coronary angiography ± percutaneous coronary intervention is the appropriate initial diagnostic investigation	Yes	Reflected in current guidance		Irshad Ahmed	
ESC cardiovascular diseases in pregnancy guideline 2018	9.5	Electrical cardioversion is safe in all phases of pregnancy. Immediate electrical cardioversion is recommended for any woman with a tachycardia with haemodynamic instability and for pre-excited atrial fibrillation	No	Current guidance '*Cardiac Disease in Pregnancy and Labour'* was due for review 2016	September 2020	Irshad Ahmed Natalie Rossiter	Update 25.06.2020 current guidance CG692 '*Cardiac Disease in Pregnancy and Labour'* under review
UK Medical Eligibility Criteria for Contraceptive Use 2016	9.6	Clear guidance on contraceptive choices for women with cardiac disease is available and should be consulted	Yes	Reflected in current guidance		Irshad Ahmed	

Improving care of women with pre-eclampsia and related hypertensive disorders of pregnancy							
NICE NG133	11.0	Advise women at high risk of pre-eclampsia, or with more than one moderate risk factor for pre-eclampsia, to take 75-150 mg of aspirin daily from 12 weeks until the birth of the baby	Yes			Pallavi Karkhanis	Outlined in the Trust Guideline ***Use of Aspirin in prevention of pre-eclampsia in pregnancy***
NICE NG133	11.1	Offer pharmacological treatment to women if blood pressure remains above 140/90 mmHg. Aim for a target blood pressure of 135/85 mmHg or less once on hypertensive treatment	Yes			Vibha Giri	Outlined in the Trust Guideline *Pathway for Gestational Hypertension & Chronic Hypertension in pregnancy*
NICE NG133	11.2	In women with severe hypertension (blood pressure of 160/110 mmHg or more) offer pharmacological treatment to all women and measure blood pressure every 15-30 minutes until BP is less than 160/110	No	Ensure new guideline reflects MBRACE recommendation		Vibha Giri Natalie Rossiter	Awaiting Trust approval of the Guideline *Severe hypertension, pre-eclampsia and eclampsia*
NICE NG133	11.3	In women with gestational hypertension who have given birth, measure blood pressure: • daily for the first 2 days after birth • at least once between day 3 and day 5 after birth • as clinically indicated if antihypertensive treatment is changed after birth	Yes			Vibha Giri	Outlined in the Trust Guideline *Pathway for Gestational Hypertension & Chronic Hypertension in pregnancy*
NICE NG133	11.4	In women with gestational hypertension who have given birth: • continue antihypertensive treatment if [it was] required • advise women that the duration of their postnatal antihypertensive treatment will usually be similar to the duration of their antenatal treatment	Partial	Ensure new guideline reflects MBRACE recommendation	September 2020	Vibha Giri Natalie Rossiter	Some of this guidance Outlined in the Trust Guideline *Pathway for Gestational Hypertension & Chronic Hypertension in pregnancy.*

		(but may be longer) • reduce antihypertensive treatment if their blood pressure falls below 130/80 mmHg					
Prevention and management of accidents in pregnancy or postpartum							
RCOG green-top guideline 56	13.0	From 20 weeks of gestation onwards, the pressure of the gravid uterus must be relieved from the inferior vena cava and aorta during maternal resuscitation	Yes			Samantha Busby Adele Causer Rhoda Flynn	This is taught to all staff on the annual mandatory maternity specific BLS training
Messages for Maternal Critical Care							
Care of the critically ill woman in childbirth 2018	14.0	The route of escalation to critical care services should be clearly defined, and include multidisciplinary discussion	Yes	Clear pathway in place for women needing critical care			
RCOG Green-top guideline 64b	14.1	Where sepsis is present the source should actively be sought with appropriate imaging and consideration given to whether surgical or radiological-guided drainage is required	Yes	Sepsis pathway in place			
Key findings – Health inequalities for women from BAME backgrounds							
	15.0	There remains a five-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to white women, emphasising the need for a continued focus on action to address these disparities	Partial		September 2020	Alison Talbot Amit Chaudhuri Joselle Wright	1. RFM leaflets now available in 27 languages. 2. Kicks count leaflets available in 7 languages. 3. During recent Covid pandemic. Maternity COVID-19 Surveillance Pathway written that outlined the process for identification

							and surveillance for women who are suspected and confirmed COVID-19 cases. BAME working group as part of LMS