The Shrewsbury and Telford Hospital NHS Trust

Women & Children's Care Group Maternity Learning

Adam Gornall – Consultant Fetomaternal Medicine & Maternity Clinical Director

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SaTH mortality and morbidity – the facts

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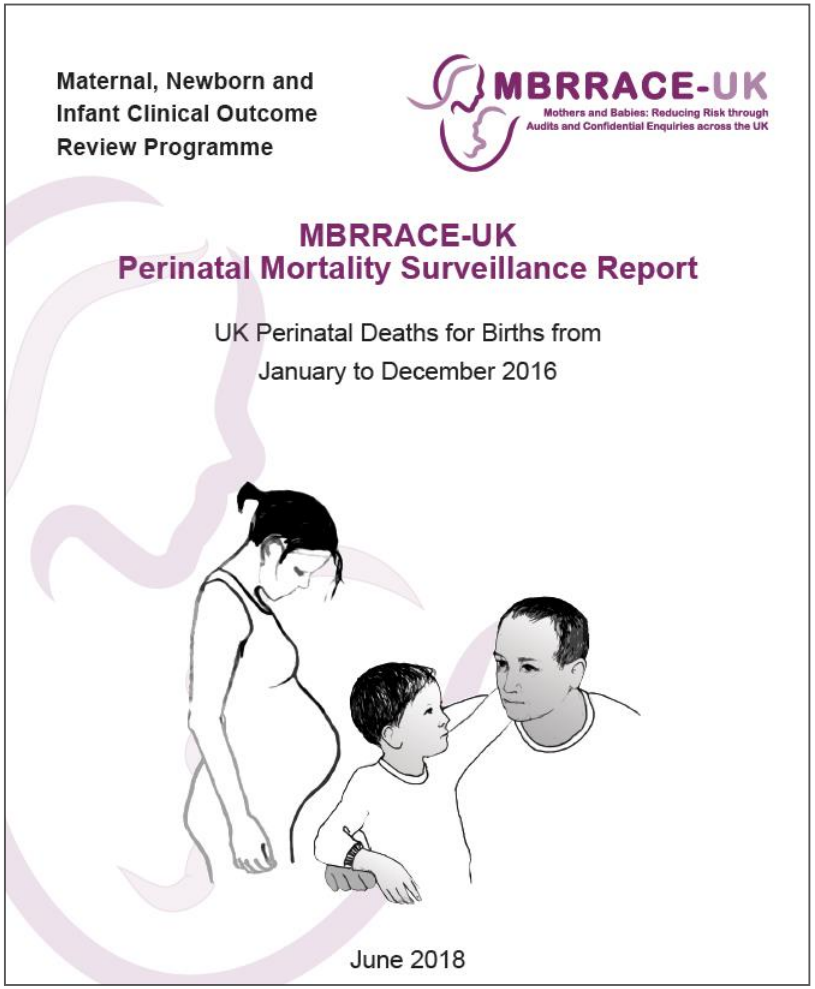
Perinatal mortality (PNM)



- Stillbirths from 24 weeks gestation (excluding termination of pregnancy) but including lethal congenital anomalies
- Neonatal deaths up to 28 days after delivery, born in SaTH, including lethal congenital anomalies

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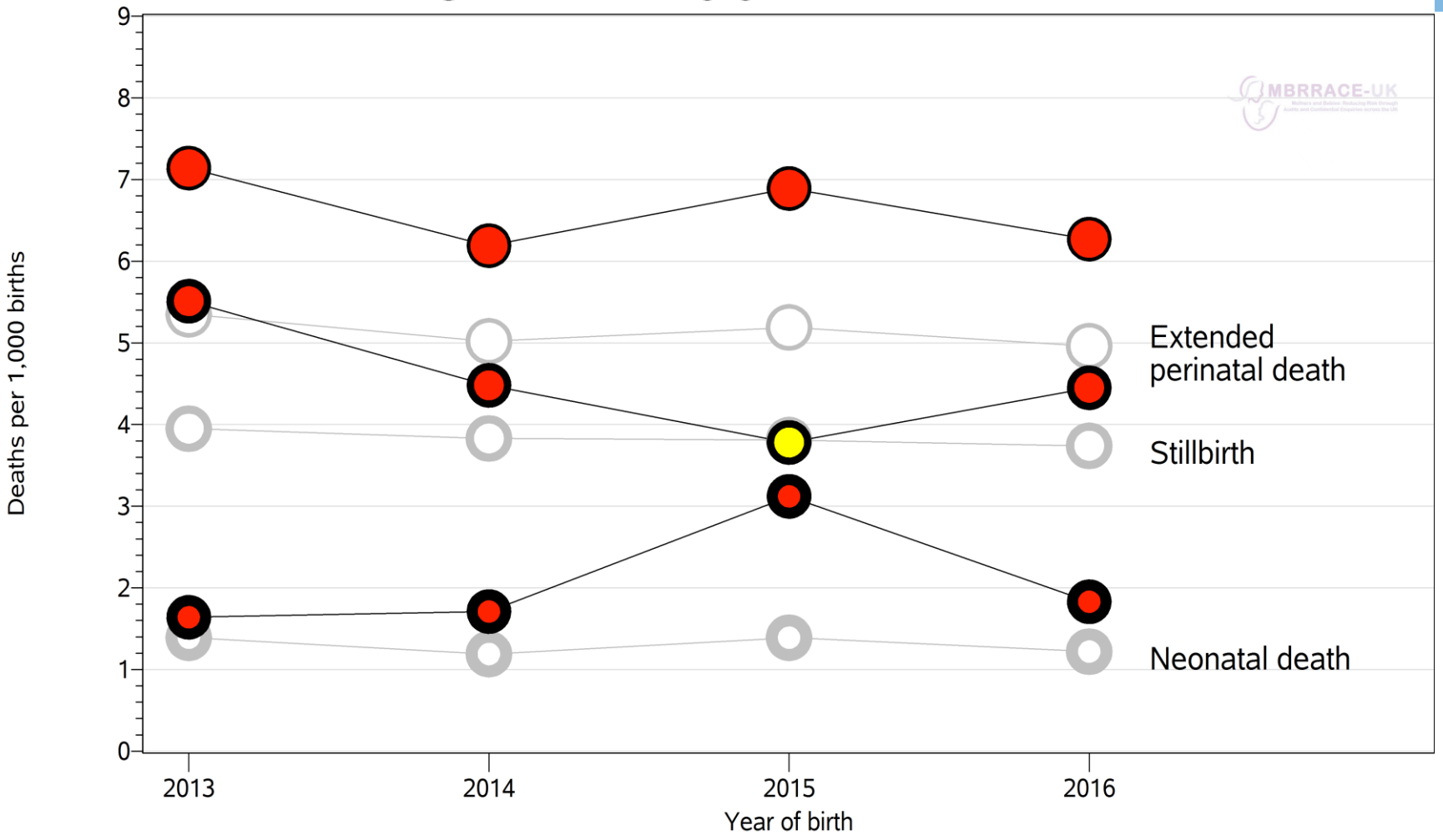
PNM definitions

- **Stillbirth** A baby delivered at or after 24+0 weeks gestational age showing no signs of life, irrespective of when the death occurred
- **Neonatal death** A liveborn baby (born at 20+0 weeks gestational age or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available), who died before 28 completed days after birth
- **Extended perinatal death** A stillbirth or neonatal death

Crude mortality rates for babies born at 24 weeks gestational age or later by year of birth



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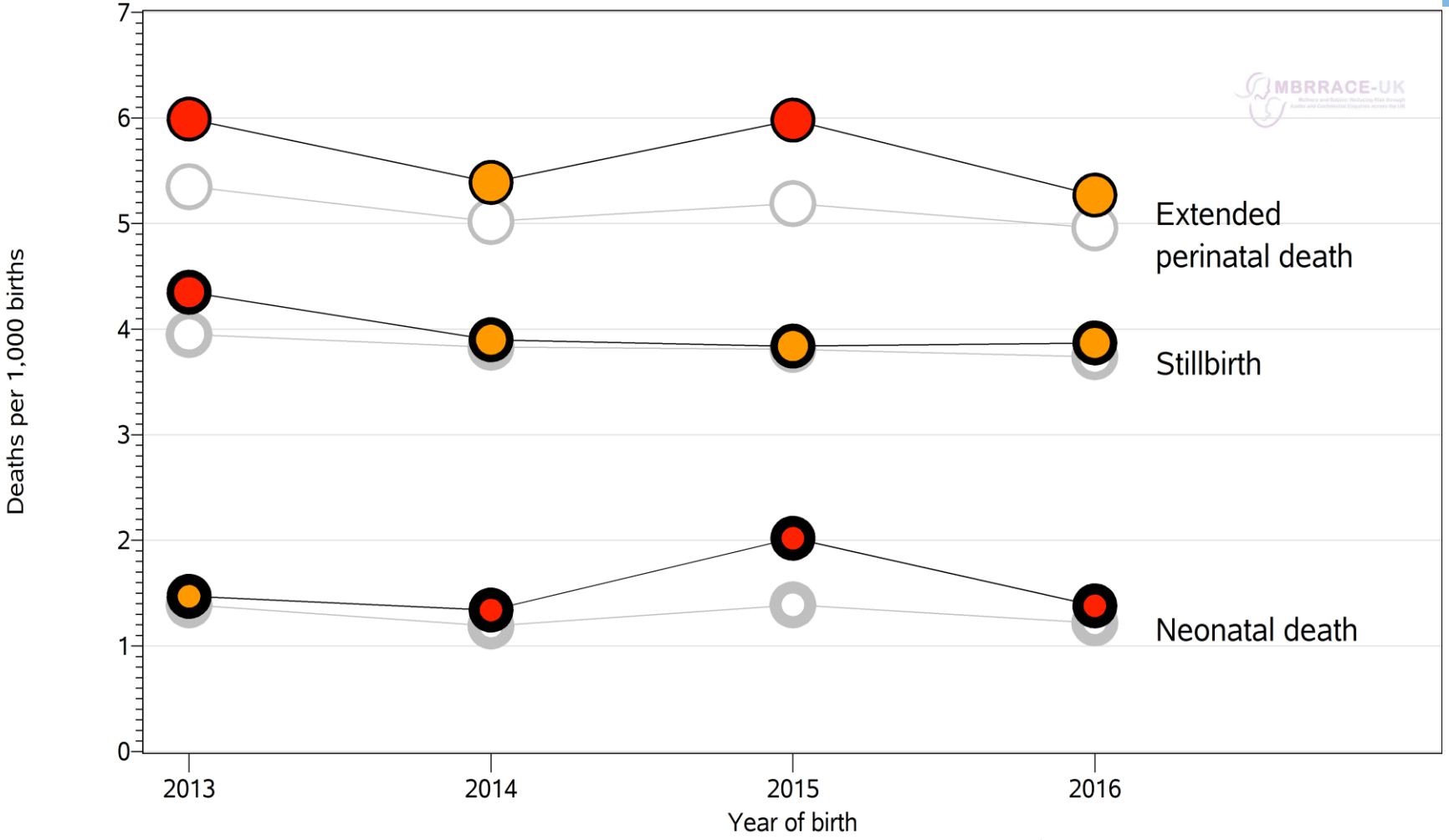
Stabilised & adjusted mortality rates for babies born at 24 weeks gestational age or later by year of birth



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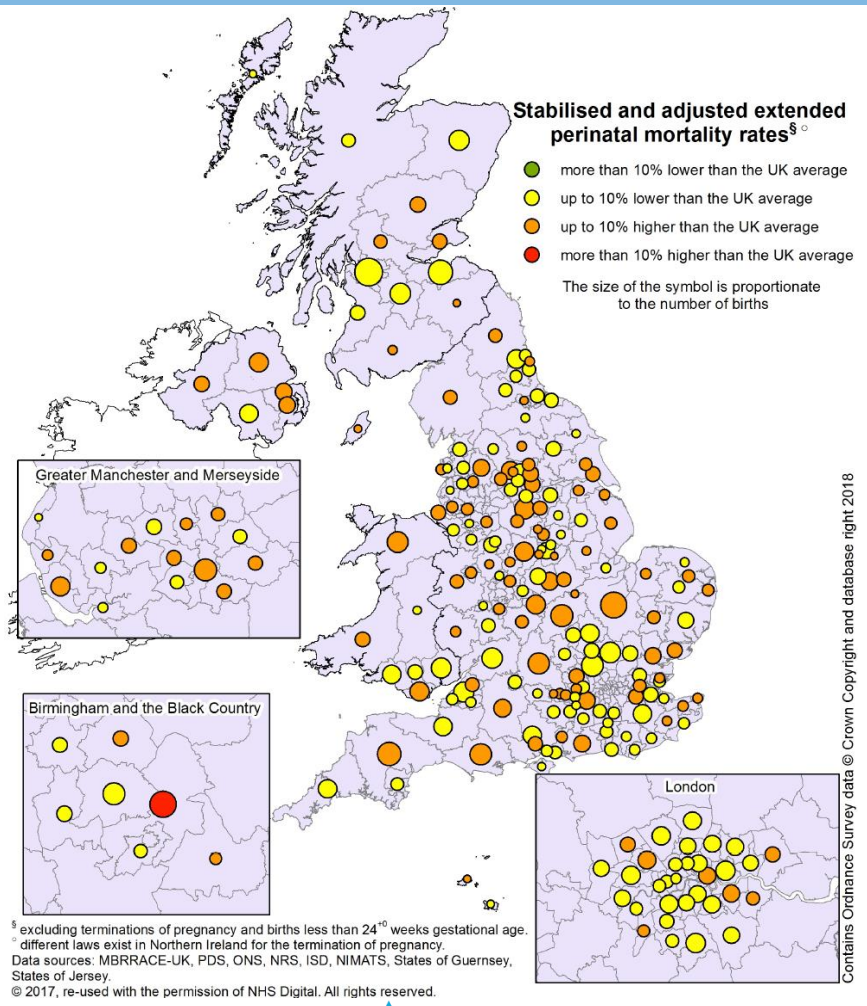
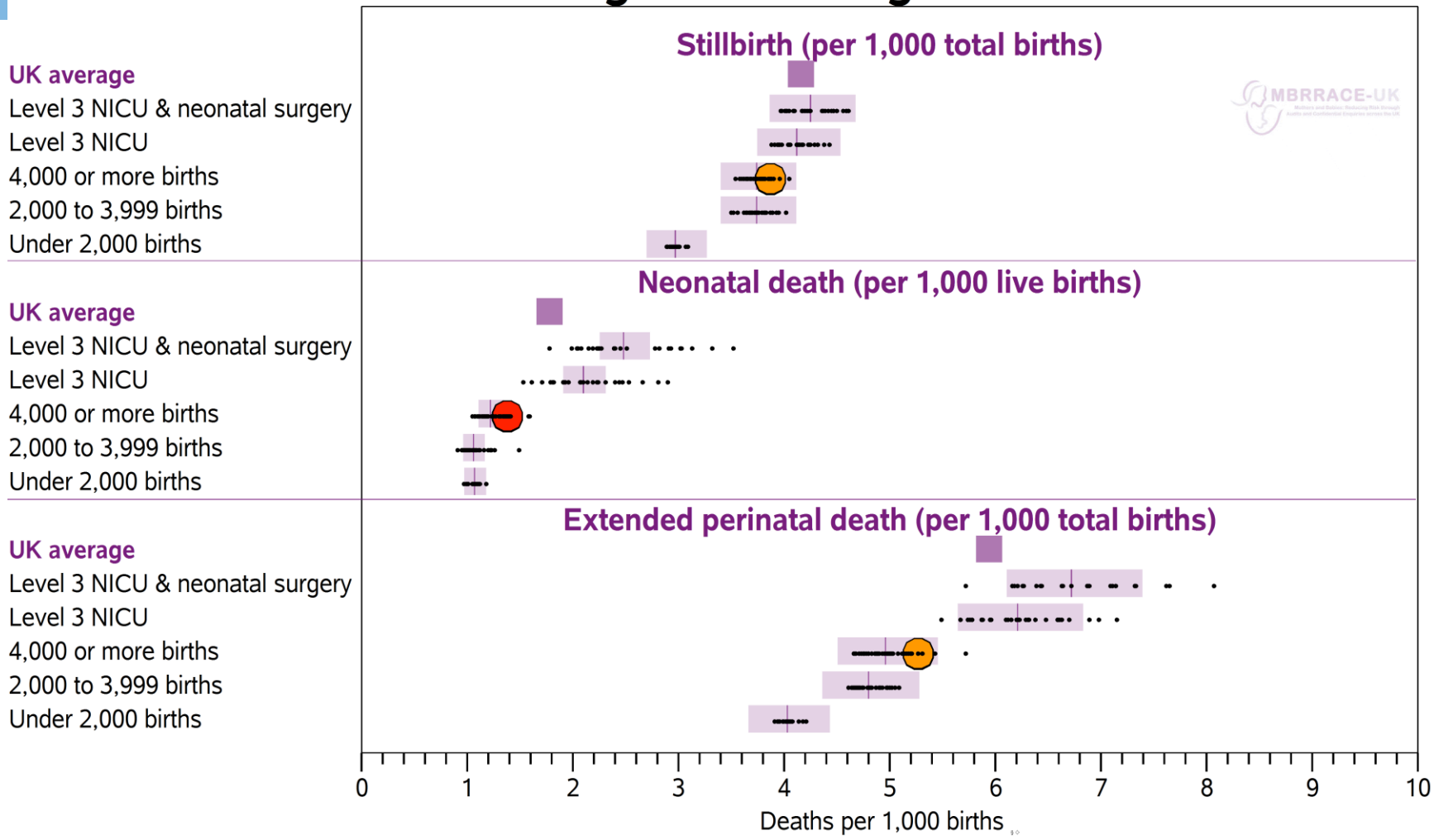
Stabilised and adjusted PNM rate by CCG 2016

- Stabilisation is designed to take account of some of the random variation inherent in this type of data and adjustment takes account of some of the factors known to affect perinatal mortality rates in particular populations, e.g. the level of social deprivation.



Stabilised & adjusted mortality rates for babies born in 2016 at 24 weeks gestational age or later



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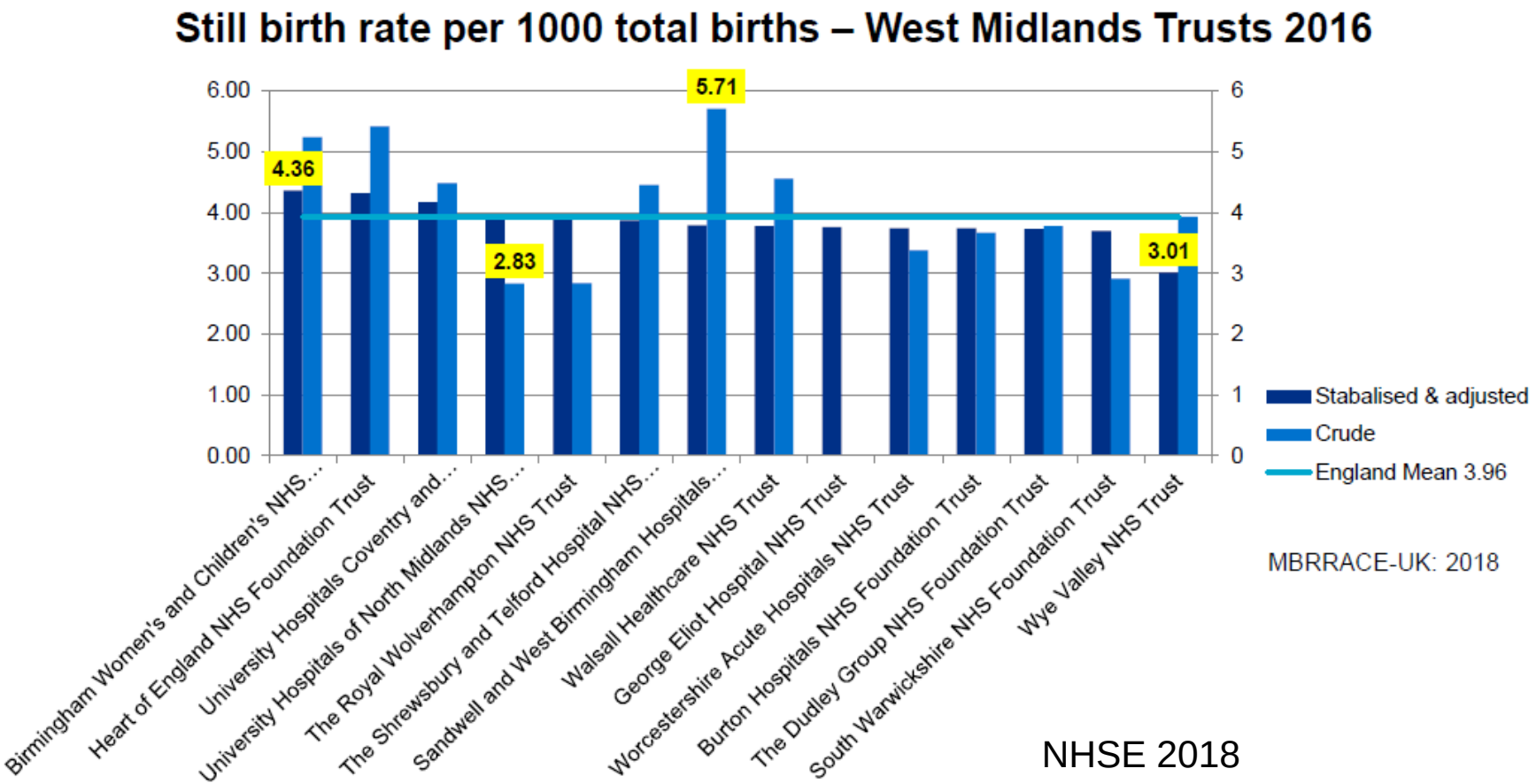
PNM rate in the West Midlands



NHSE 2018

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National initiatives to reduce mortality and morbidity

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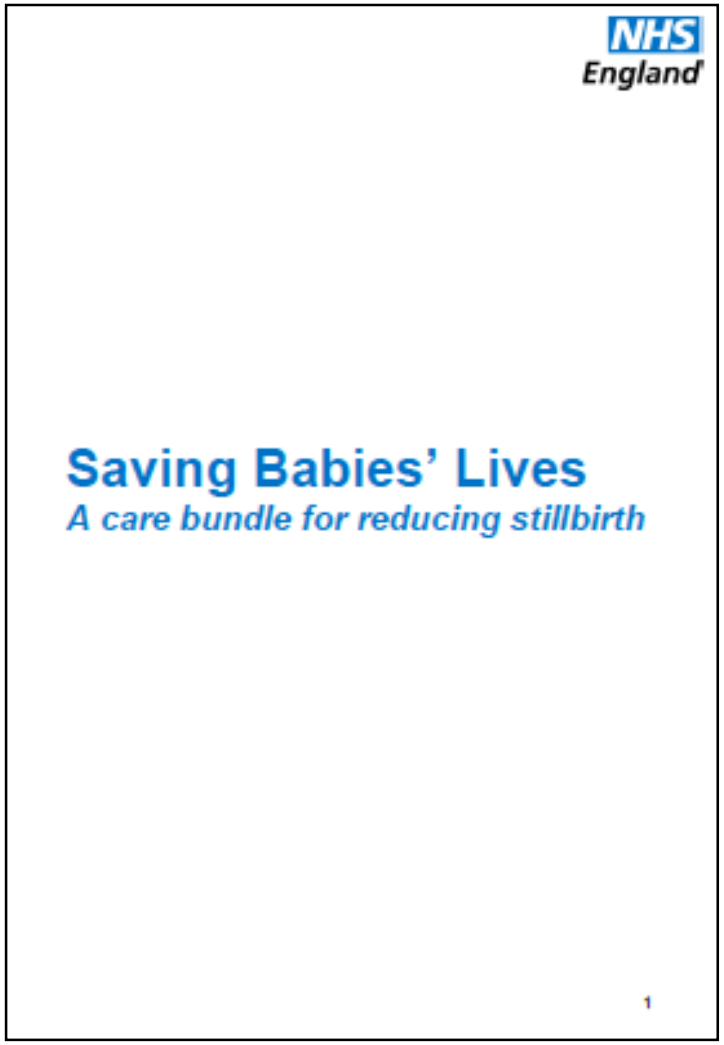
Saving Babies Lives – NHSE 2016



Four part care bundle

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

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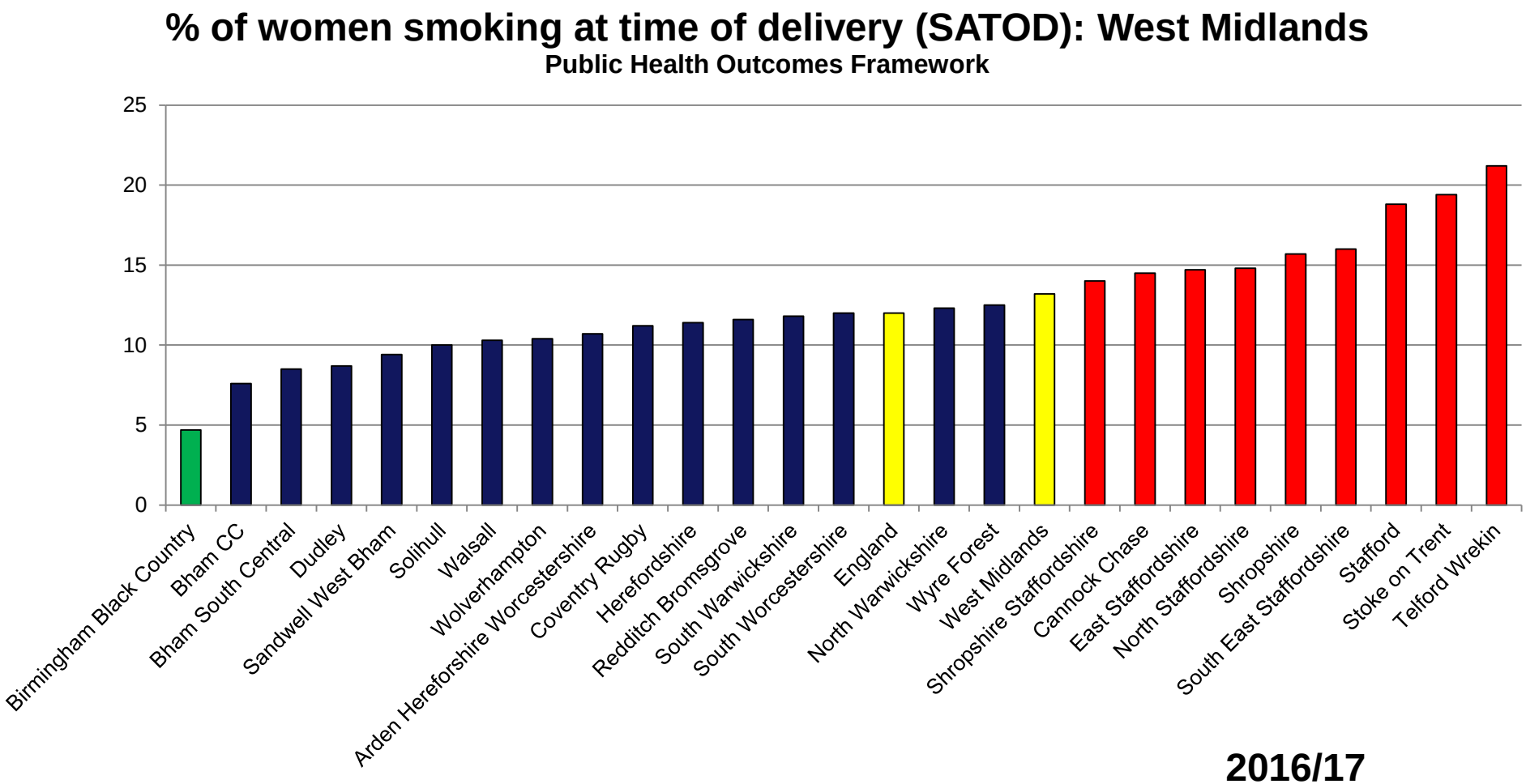
Saving Babies Lives – NHSE 2016

- All Trusts are required to have fully implemented the Care Bundle by March 2019
- Nationally the Care Bundle has been completed by 31% of Trusts
- SaTH achieved completion of the care bundle in May 2018
- Ongoing audit to assess impact

Reducing smoking in pregnancy



2016/17

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Reducing smoking in pregnancy

- **Reducing smoking with public health midwife post**
  - With initail support from T&W CCG and ongoing support from T&W council SaTH have employed a public health midwife with a specific role to reduce smoking in pregnancy. Commenced 12 months ago
- **Universal carbon monoxide screening for all women at booking**
  - Currently in place
  - Plan to check CO in all women at every visit
- **Money boxes to remind our pregnant mother not to smoke**
  - To encourage women to stop smoking we have been working with our local maternity system to design and provide ‘money boxes’ – they will have room for a scan picture and will show a simple message to encourage women to save the money that they would otherwise have spent on cigarettes

Reducing smoking in pregnancy

- **Maternity and Neonatal Health Safety Collaborative** (NHSI Matneo)
- All Trusts in UK involved in the collaborative
- SaTH in Wave 2 of 3 annual waves
- Commenced in March 2018
- Reduction of smoking in pregnancy chosen project

NHS Improvement

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Reducing smoking in pregnancy

- Smoking at time of delivery for both CCGs 2018/19
  - Trustwide 15.6%
  - Telford and Wrekin 18.4%
  - Shropshire 13.6%

- National rate 12% in 2016/17

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Risk assessment and surveillance for fetal growth restriction

- 2 more whole equivalent sonographer midwives appointed by SaTH since May 2018
  - serial scans for all women at risk of FGR in line with RCOG recommendations
- Training for staff from SaTH at the Perinatal Institute
- Implementation of GAP programme
- Ongoing audit of growth restricted cases
  - early data shows an over representation of small babies in the Shropshire population

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Raising awareness of reduced fetal movement

- Fetal movements bracelet
  - along with the LMS developed a bracelet to enable women to monitor their babies movements, this will be made available to all of our women
- Raising awareness of reduced fetal movements
  - we are nearing the end of our competition to re-design the front cover of our maternity hand held records, the image will encourage women to keep an eye on their babies movements and to give a clear message that 'healthy babies don't stop moving'
- Mama wallets

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Effective fetal monitoring during labour

- Nationally heart rate monitoring (CTG) is recognised to be a significant contributor to perinatal mortality
- Successful Sign up to Safety bid in 2015 through NHSLA
- SaTH CTG training
  - K2 training software
  - Annual update within PROMPT study day
  - Twice weekly face to face CTG training meetings
  - Enhanced training for Delivery Suite Coordinators
  - Human factors training
- Fresh eyes
- Investment in hardware and software
- Along with the WM maternity network we are looking at a network wide competency assessment for all midwives in the region

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Each baby counts - RCOG

- All stillbirths, neonatal deaths and brain injuries occurring during term labour in 2015
- Published by RCOG in 2017 based upon cases from 2015
- The key finding – that for many of the babies reported to Each Baby Counts, different care might have resulted in a different outcome

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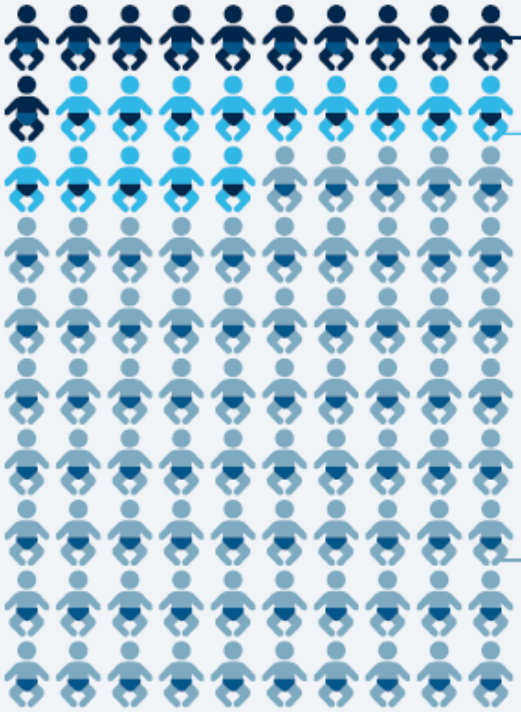
How many babies?

1136
BABIES IN 2015

The total number of babies fulfilling the "Each Baby Counts" criteria in 2015 was **1136**.

Of these:



11% Intrapartum stillbirths
126 babies

14% Early neonatal deaths
156 babies

75% Severe brain injuries
854 babies

Note: These categories are mutually exclusive. Babies with a severe brain injury who died within the first 7 days of life are classified as early neonatal deaths.

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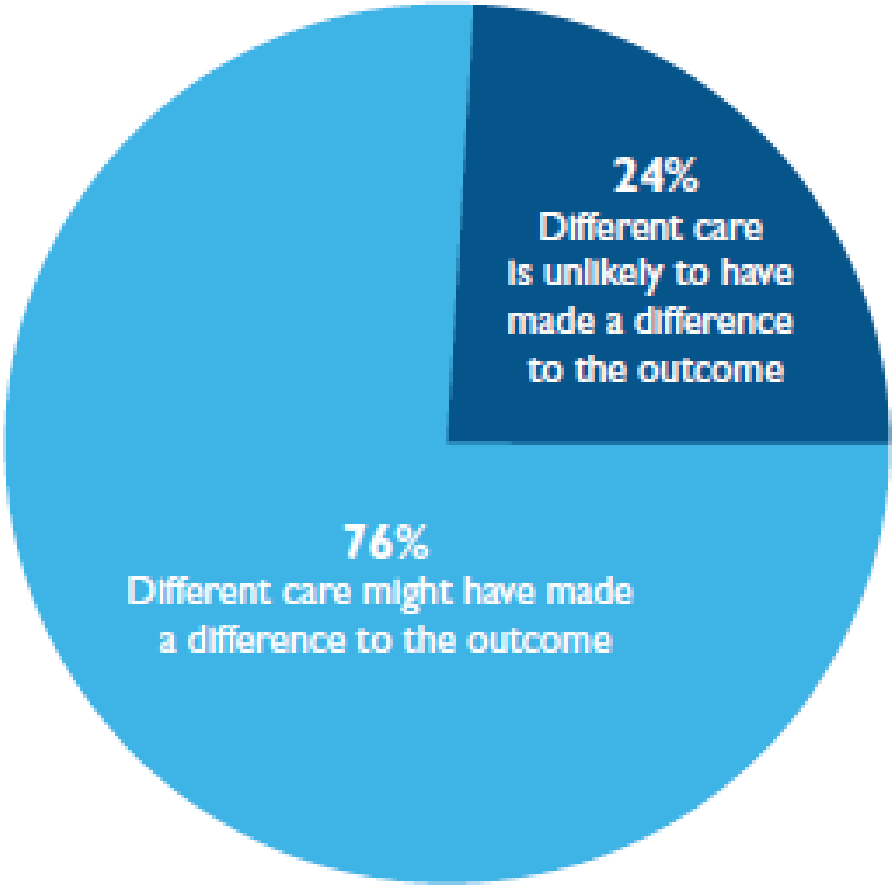
Each baby counts - RCOG



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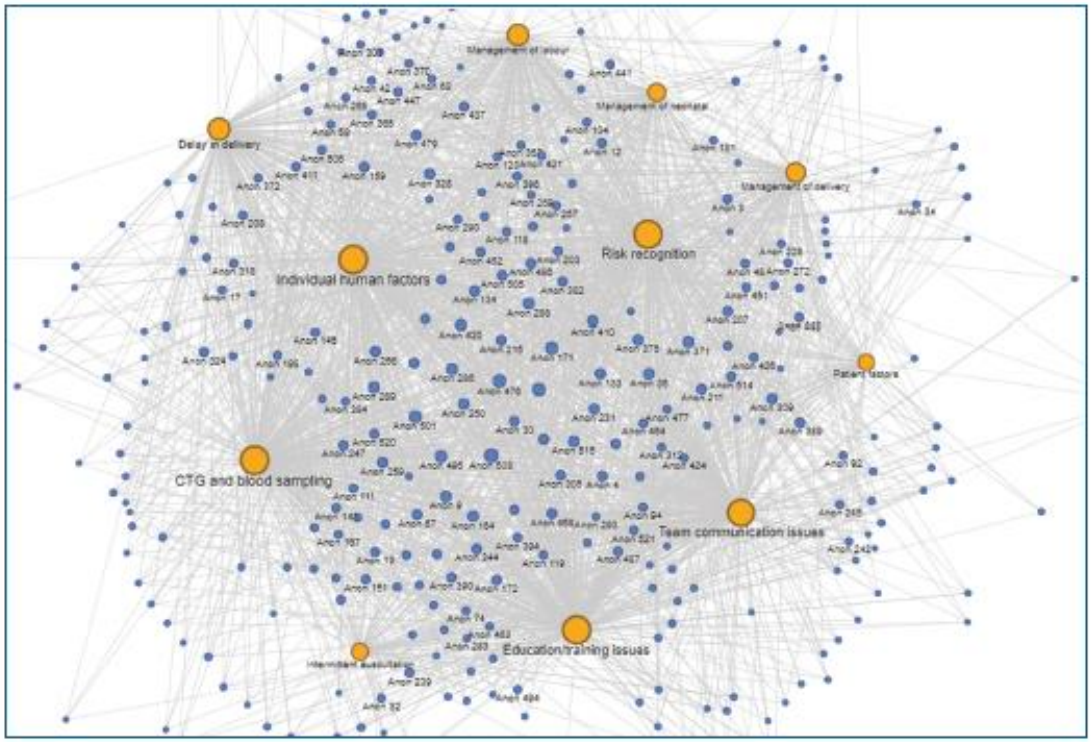
Key recommendations for care

- Risk assessment
- CTG analysis
- Human factors
- Education and training



Risk assessment in SaTH

- Assessment and quantification of risk on Delivery Suite since 2012
- Assessment of risk in antenatal period – work with maternity network in 2016
- SaTH Maternity triage using the CQC commended Birmingham BSOTS model since 2016

CTG analysis in SaTH

- Nationally heart rate monitoring (CTG) is recognised to be a significant contributor to perinatal mortality
- Successful Sign up to Safety bid in 2015 through NHSLA
- SaTH CTG training since 2016
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Human factors in SaTH

- Collective Leadership courses in conjunction with BPP University in 2015
- Continued in 2016 with the NHSLA Sign up to Safety funding
- Provided to all midwives in 2017 as part of annual update
- Incorporated into PROMPT skills training in 2018

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Human factors in SaTH

- Enhanced handover of care using SBAR
- Safety huddles implemented as a result of our work with Virginia Mason
- Twice daily safety huddles give chance for all staff in each ward or area to ‘stop’, come together, discuss plans of care, immediate risks or good practice to share widely
- Management safety huddle every day

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Education and training in SaTH

- Successful Health Education England bid in 2017
- Development of a Training Faculty within maternity
- Delivery of multidisciplinary PROMPT skills training for members of staff annually
- Delivery of ROBUST assisted delivery training for all doctors

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Education and training in SaTH

- Neonatal stabilisation training for midwives (MIST course) developed in SaTH and now being developed nationally
- Further human factors training for neonatal team planned

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Mortality and morbidity results

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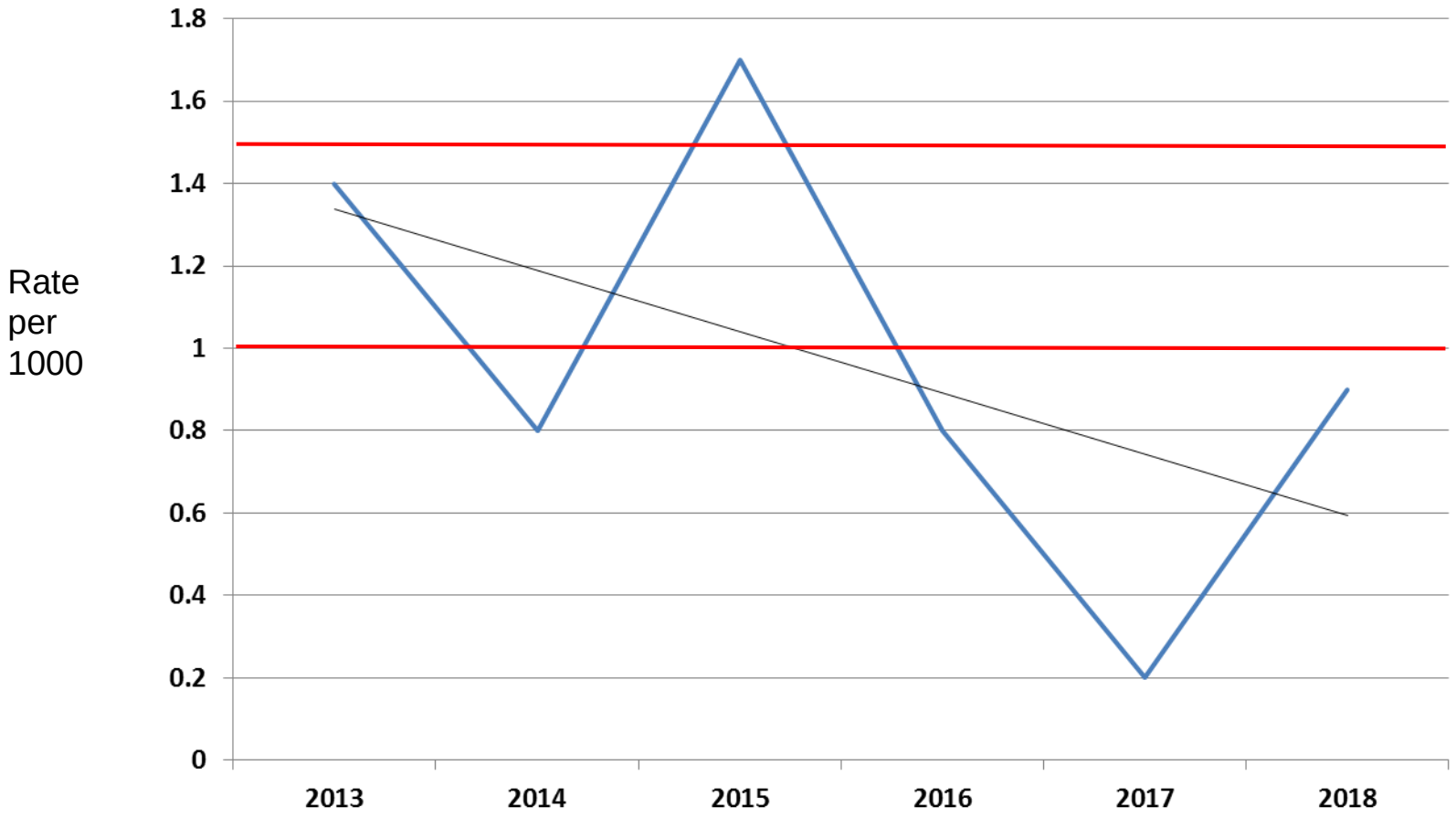
Neonatal cooling rates in SaTH (to end Sept 2018)



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Get it right first time GIRFT 2015/2016

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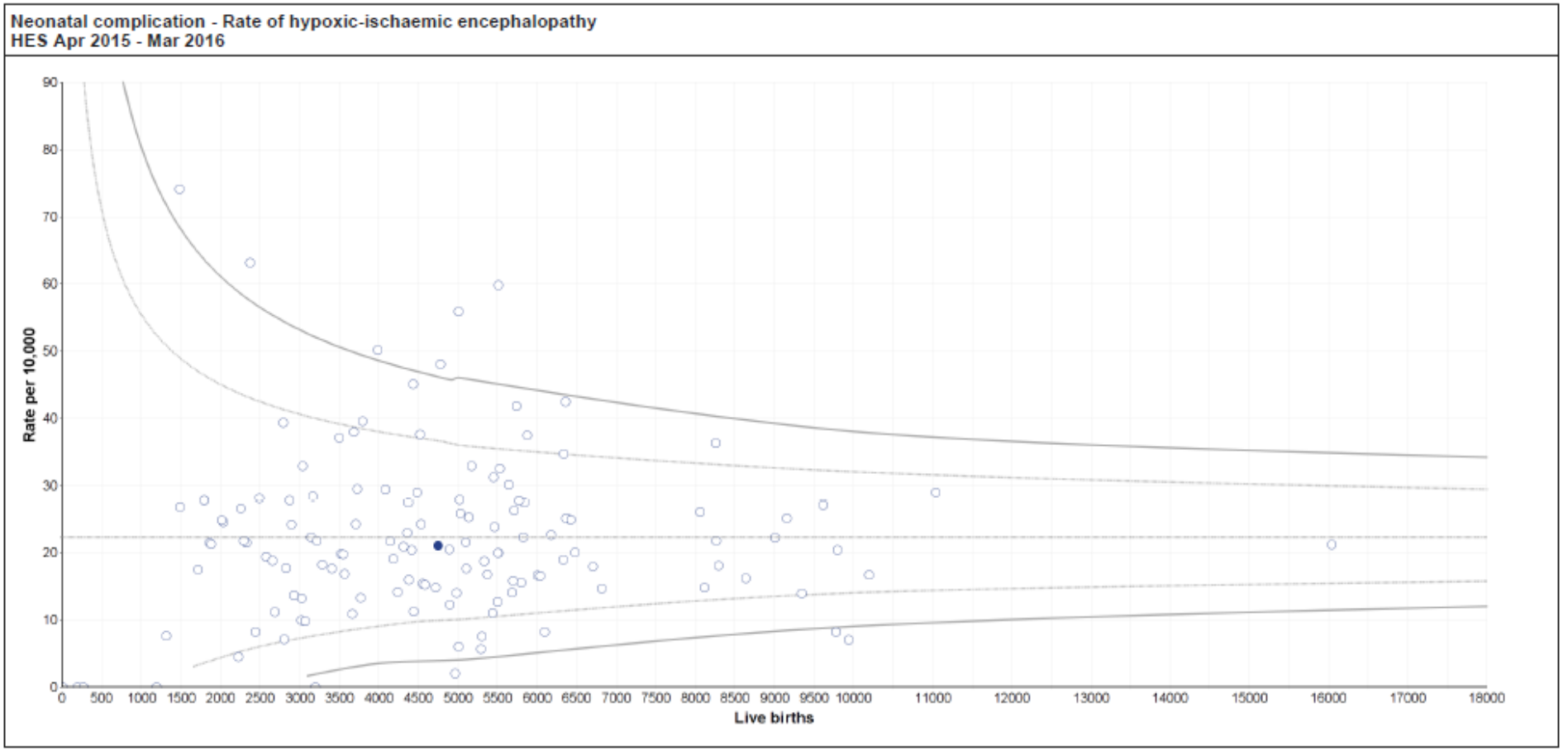
6.32 Neonatal complication - Rate of hypoxic-ischaemic encephalopathy



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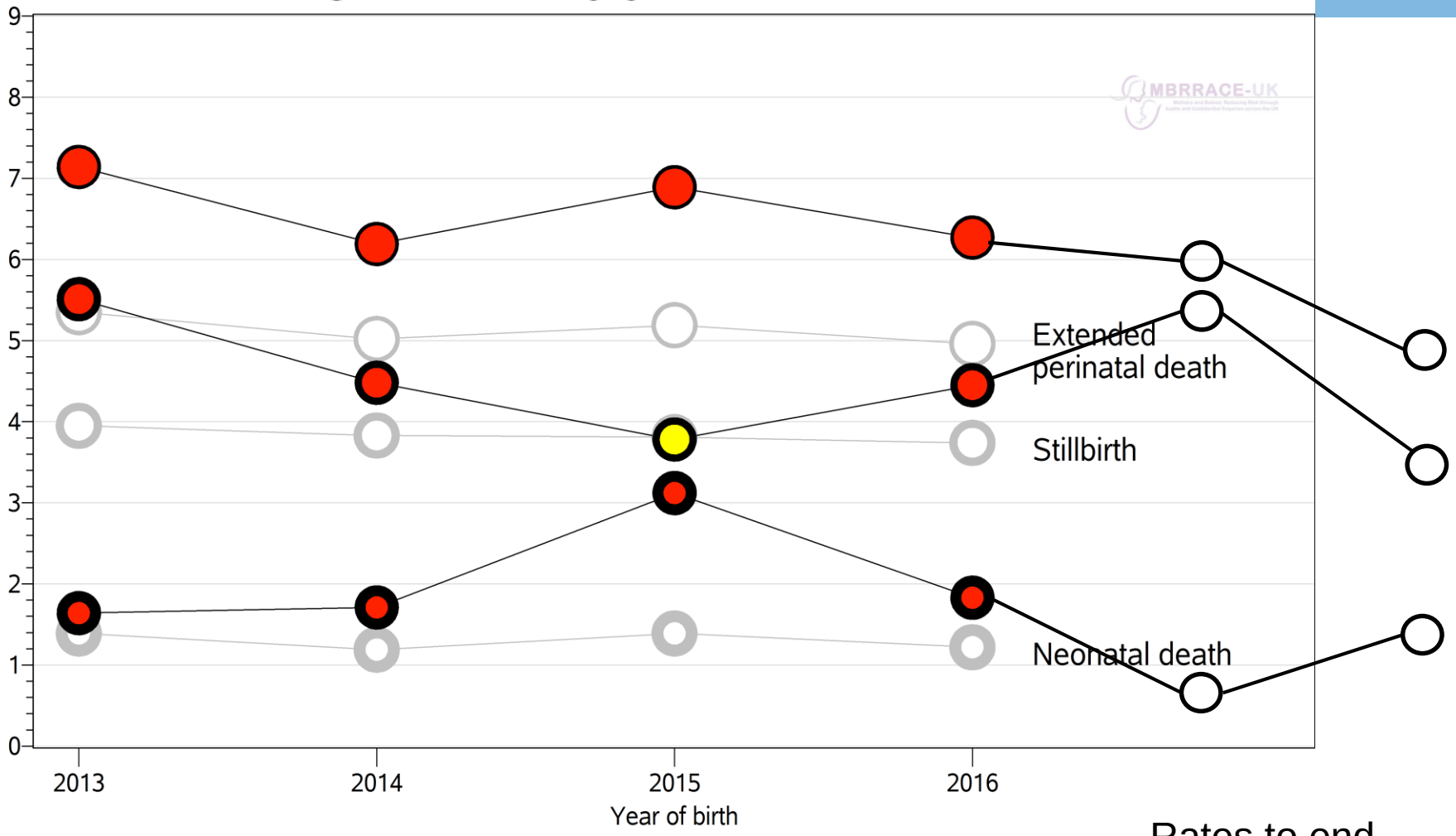
Crude mortality rates for babies born at 24 weeks gestational age or later by year of birth



Rates to end Sept 2018

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SaTH crude PNM rates for 2018 at end Sept

- Stillbirth 3.5/1000
- Neonatal death 1.4/1000
- Perinatal mortality rate 4.9/1000

- National PNM rate 2016 5.1/1000

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ATAIN - term admissions

- Overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child
- Reducing admission of full term babies to neonatal units
- Over 20% of admissions of full term babies to neonatal units could be avoided
- National target of 6%

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ATAIN - term admissions

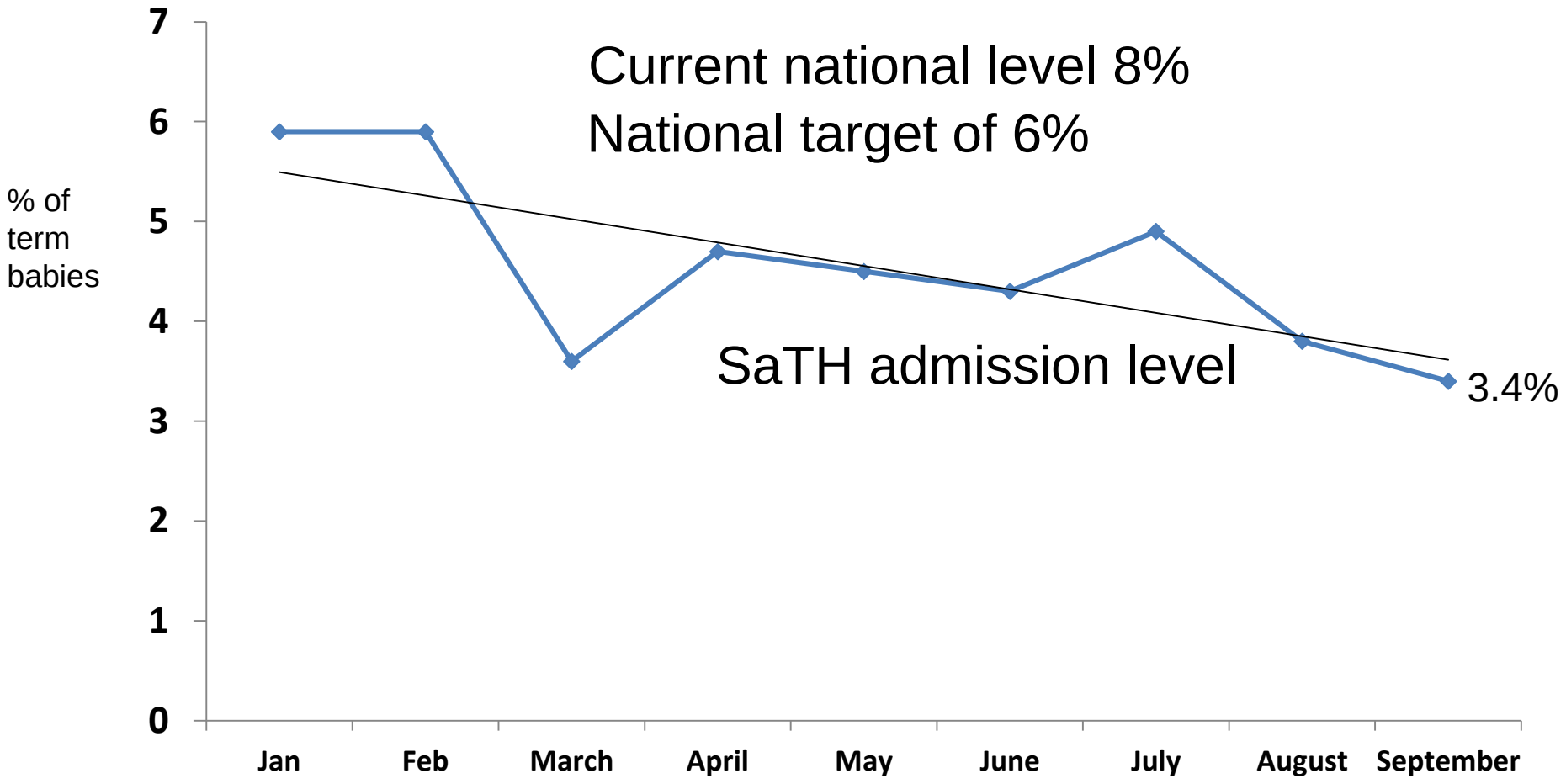
Main areas that reduce term admissions

- Breathing problems
- Getting cold
- Low blood sugars
- Jaundice
- Reducing asphyxia in labour

ATAIN - term admissions for SaTH

- **Red hats for babies at risk**
  - We have implemented a really striking way to alert staff to babies who are at risk of admission to the neonatal unit – all babies at risk will wear red hats – women (and possibly men…) all over Shropshire have been busy knitting them for us – bags and bags of red hats!

ATAIN - term admissions for SaTH



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Investigations and sharing learning from incidents

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Investigations and sharing learning from incidents

- External RCA investigator training in 2017
- New appointments of Risk Midwife and Risk Consultant
- Increasing use of external investigators
- Working on a consistent external approach along with neighbouring LMS

Investigations and sharing learning from incidents

- Weekly risk review meetings since 2017
- Improved governance process for sharing learning
  - Governance feedback meetings
  - Staff huddles

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Perinatal Mortality Review Tool (PMRT)

- Using since January 2018
- Launched by MBRRACE
- National tool
- All stillbirths and neonatal deaths in SaTH
- Structured assessment
- Awaiting key themes for 2018

Healthcare Special Investigations Branch (HSIB)

- Go live at SaTH for support in November 2018
  - national programme whereby ALL trusts' maternity services will have all of their major investigations carried out by an independent body

HSIB

HEALTHCARE SAFETY INVESTIGATION BRANCH

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National audit

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NMPA

National Maternity and Perinatal Audit

Clinical report 2017 - revised version

Based on births in NHS maternity services
between 1st April 2015 and 31st March 2016

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Obstetrics and Gynaecology Review

Shrewsbury and Telford Hospital NHS Trust

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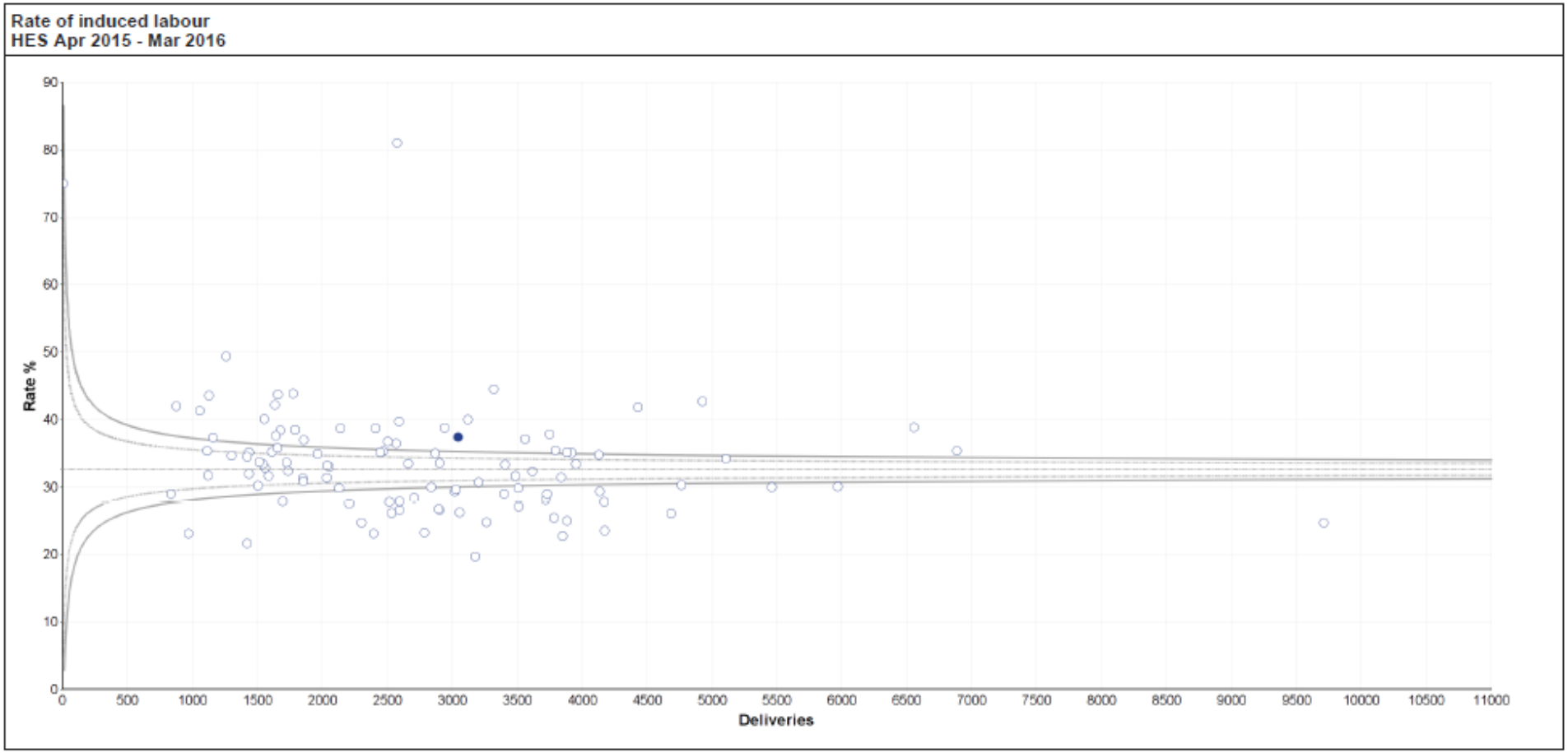
6.8 Rate of induced labour



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GIRFT - SVD

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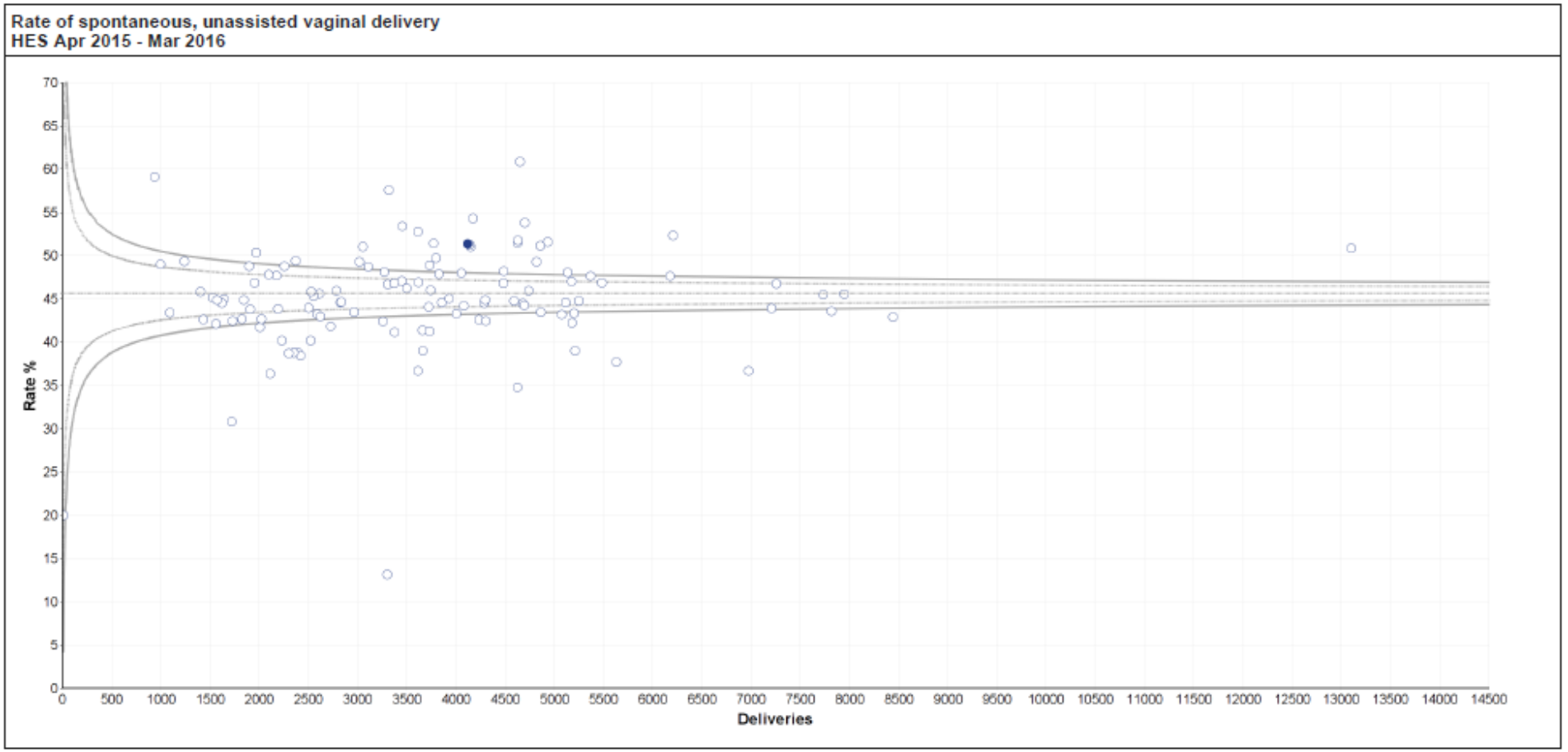
6.4 Rate of spontaneous, unassisted vaginal delivery



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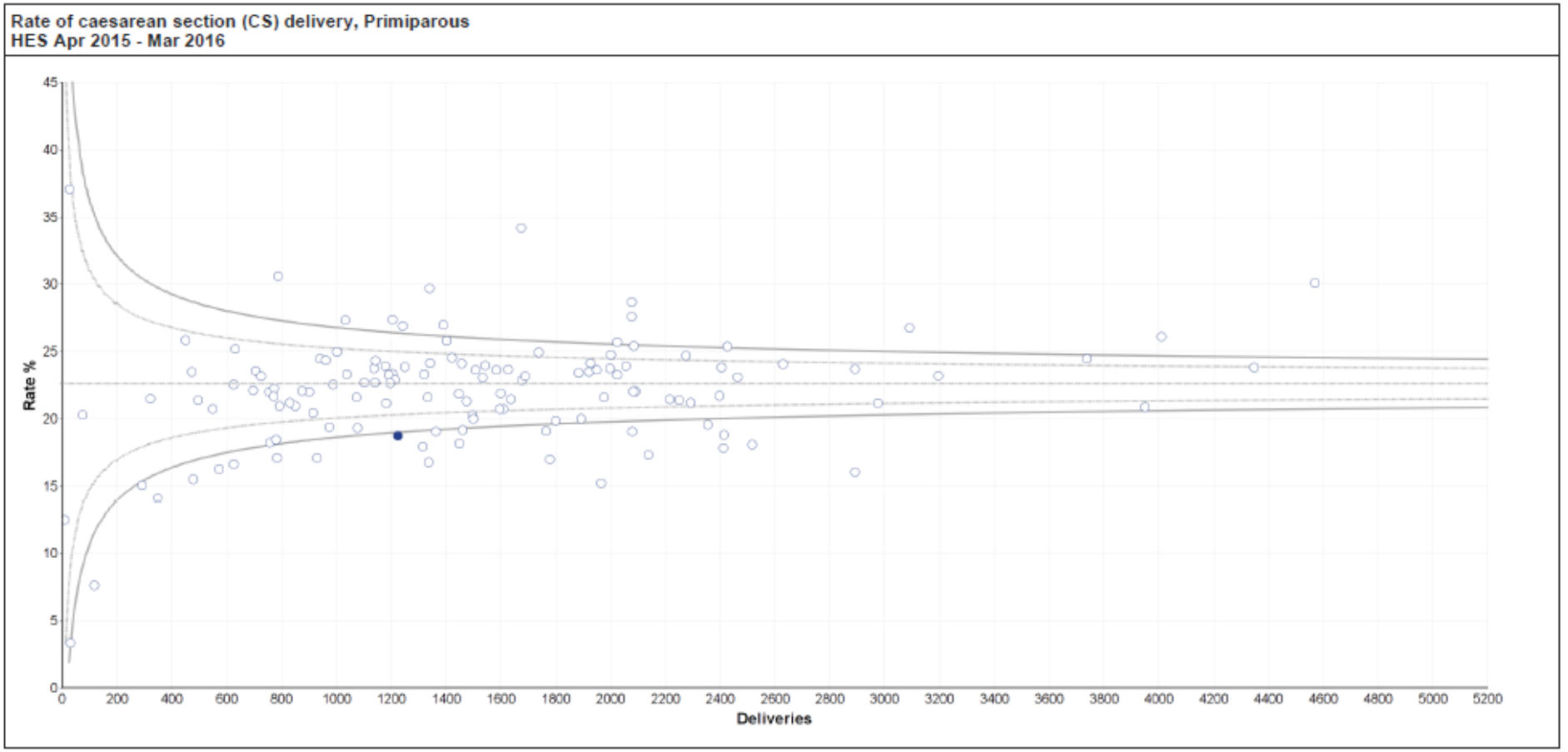
GIRFT - CS

6.16 Rate of caesarean section (CS) delivery, Primiparous



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GIRFT - CS

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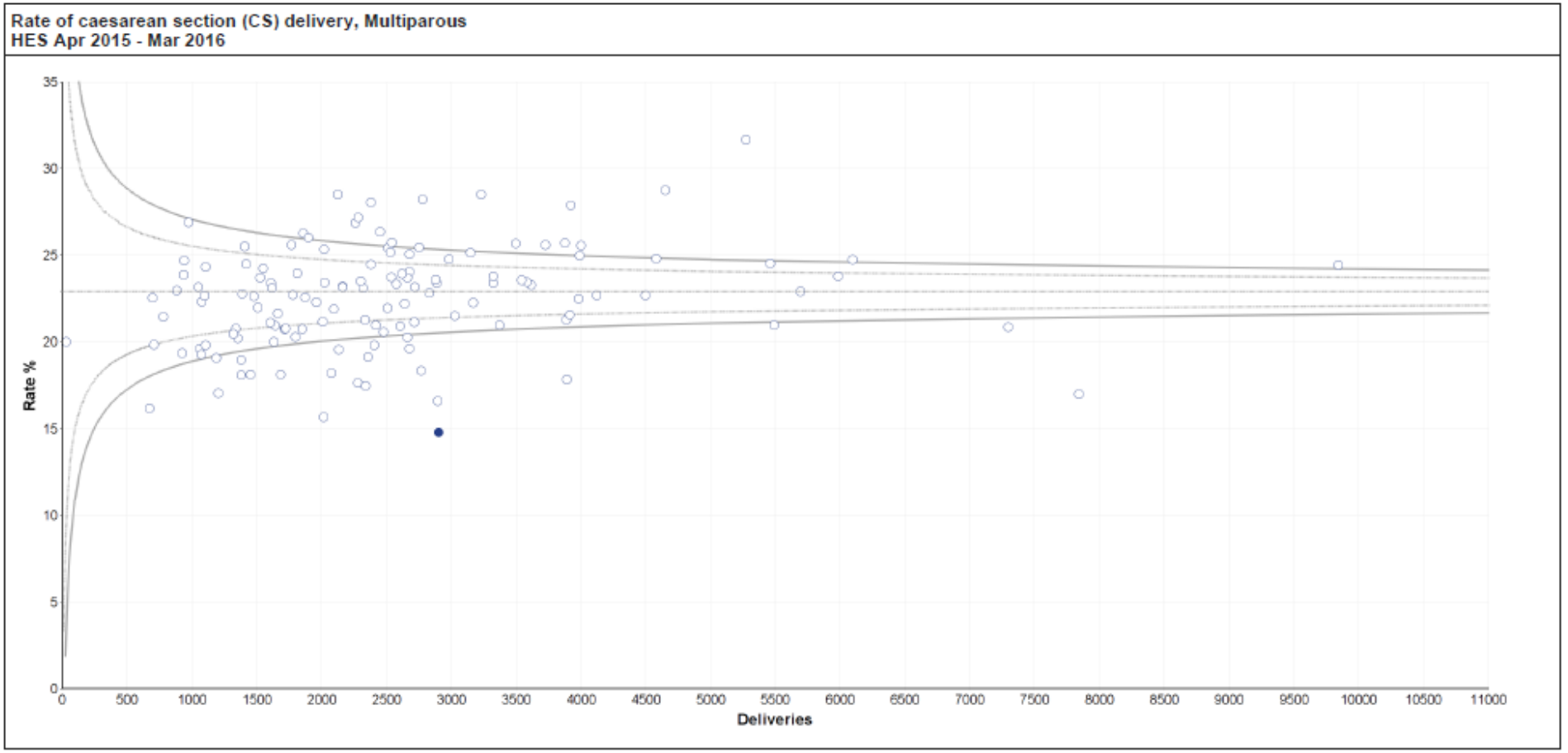
6.18 Rate of caesarean section (CS) delivery, Multiparous



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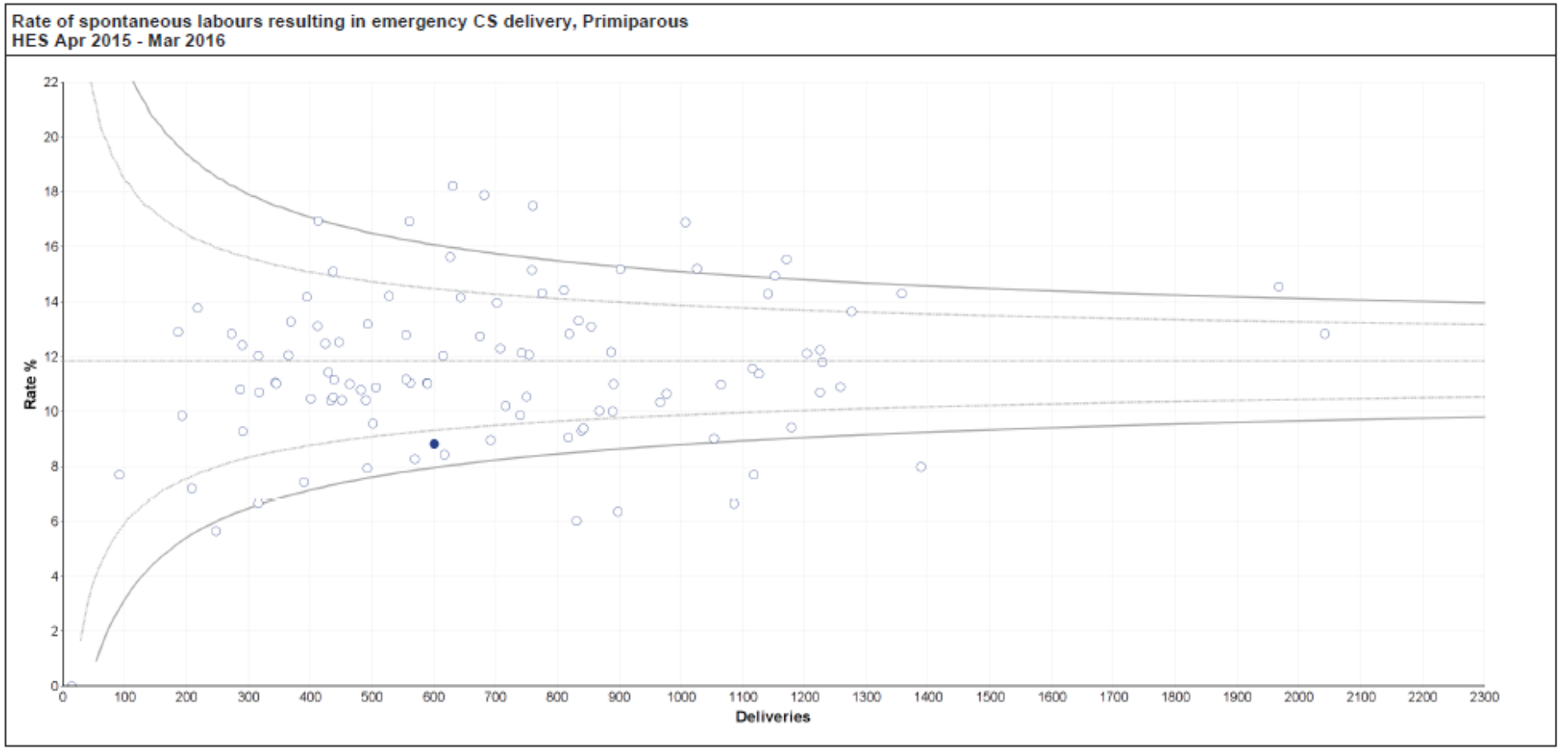
GIRFT - CS

6.20 Rate of spontaneous labours resulting in emergency CS delivery, Primiparous



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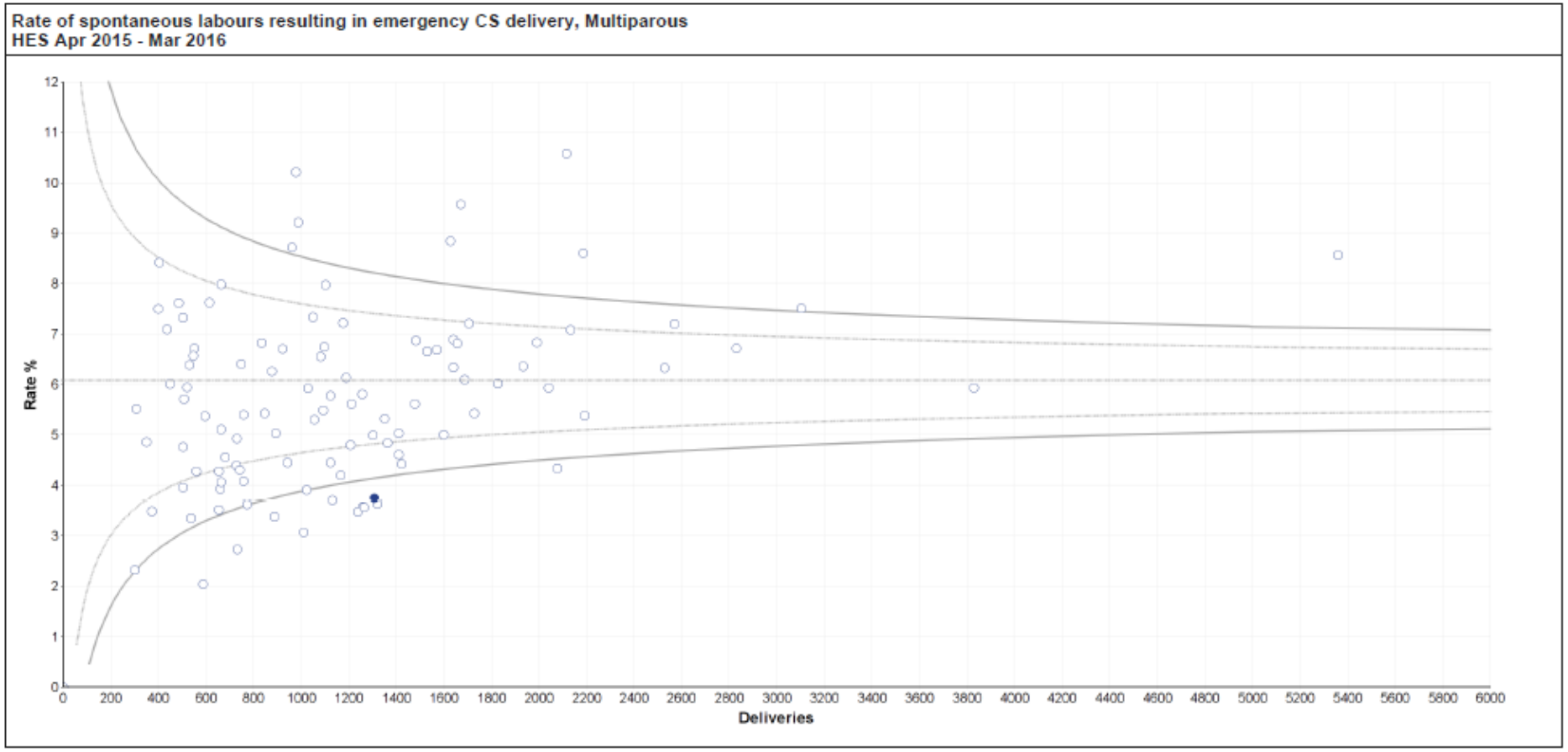
GIRFT - CS

6.22 Rate of spontaneous labours resulting in emergency CS delivery, Multiparous



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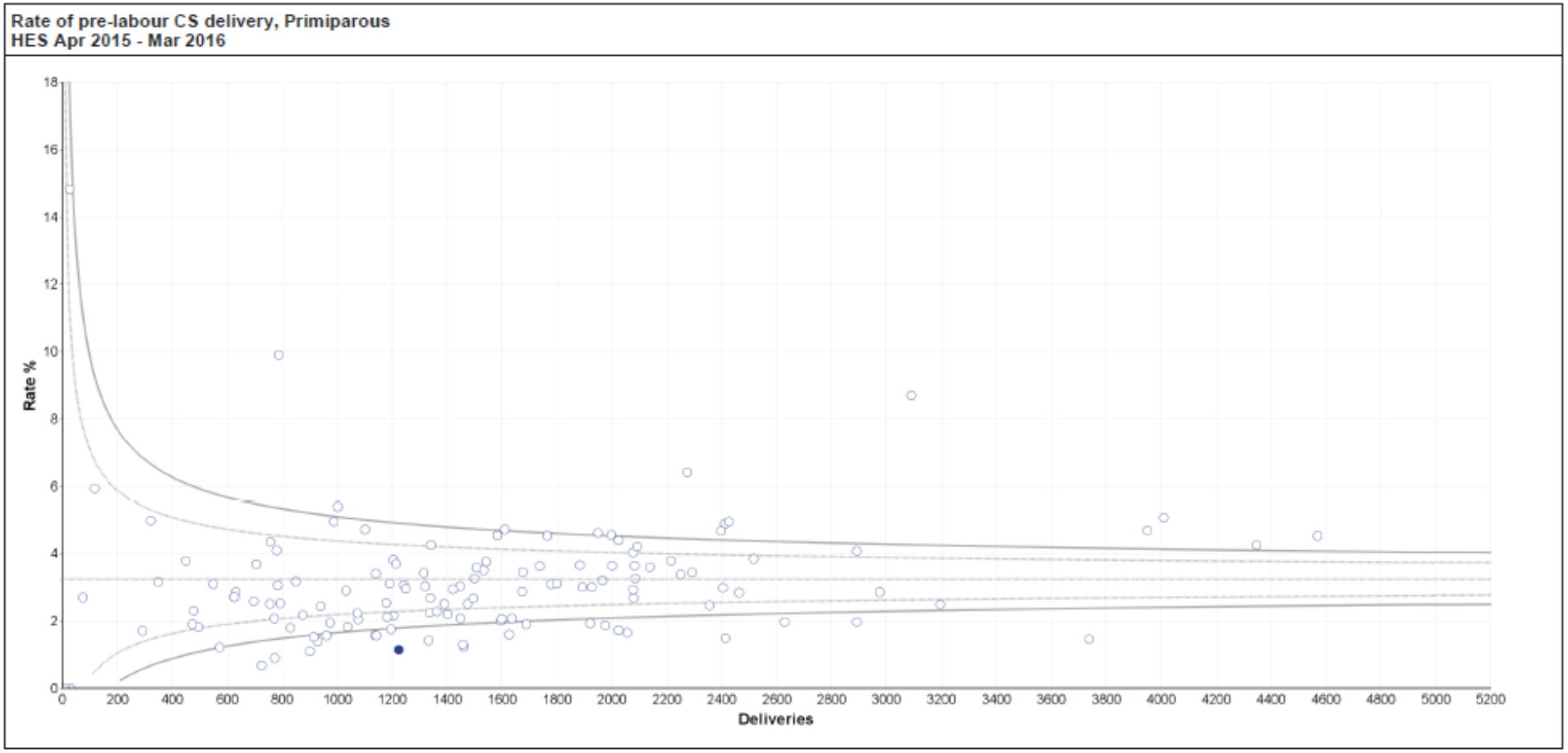
GIRFT - CS

GETTING IT RIGHT FIRST TIME

6.24 Rate of pre-labour CS delivery, Primiparous



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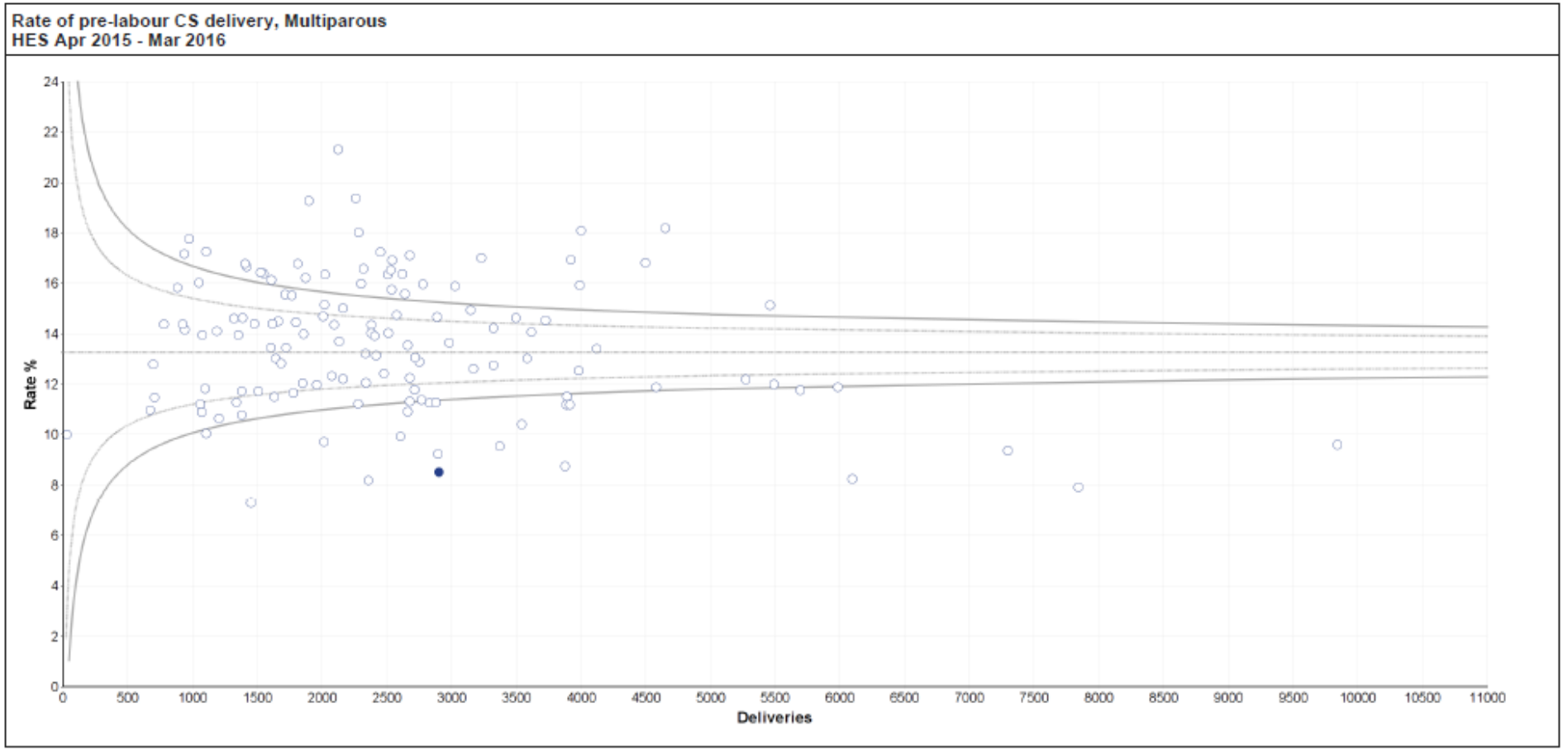
GIRFT - CS

GETTING IT RIGHT FIRST TIME

6.26 Rate of pre-labour CS delivery, Multiparous



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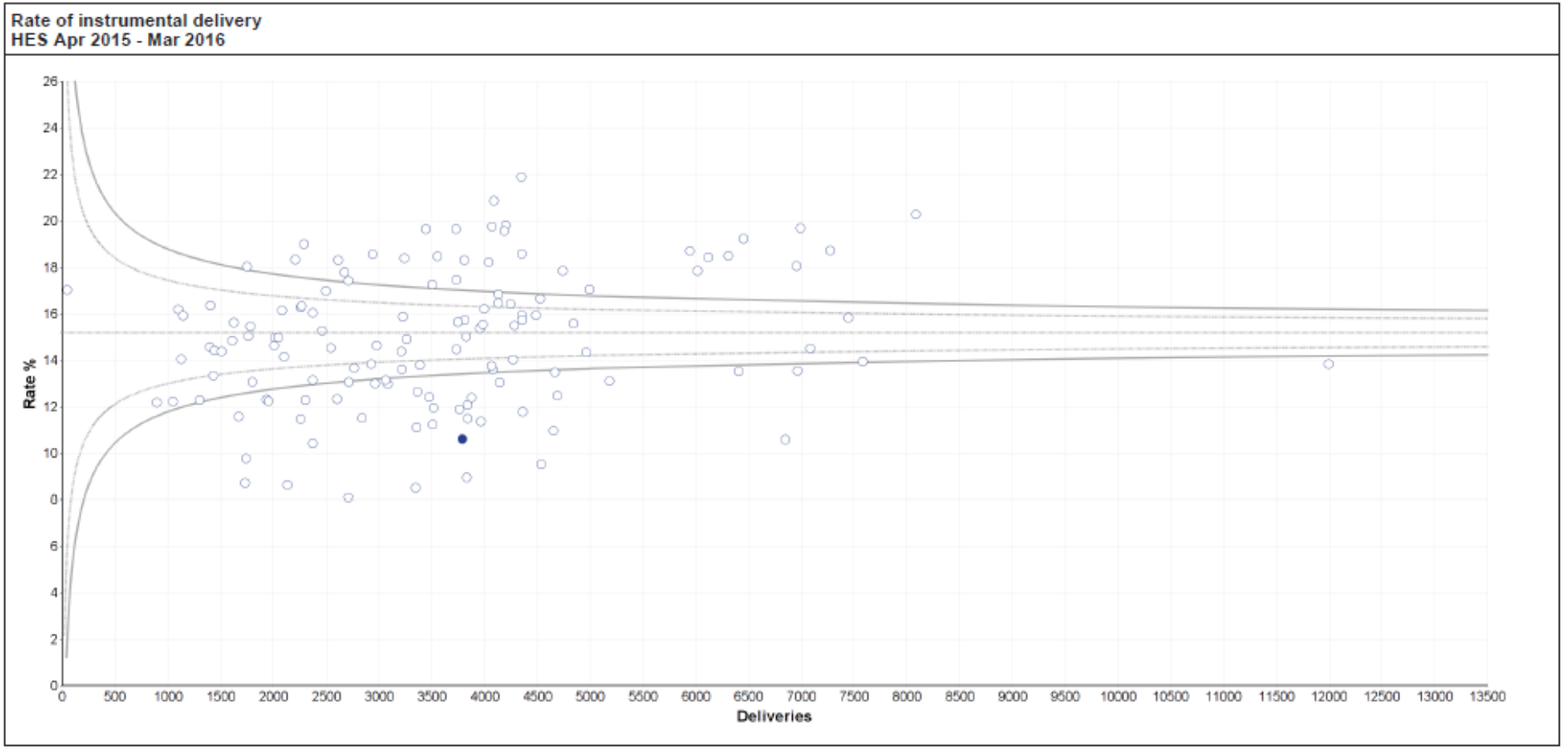
GIRFT - ID

6.6 Rate of instrumental delivery



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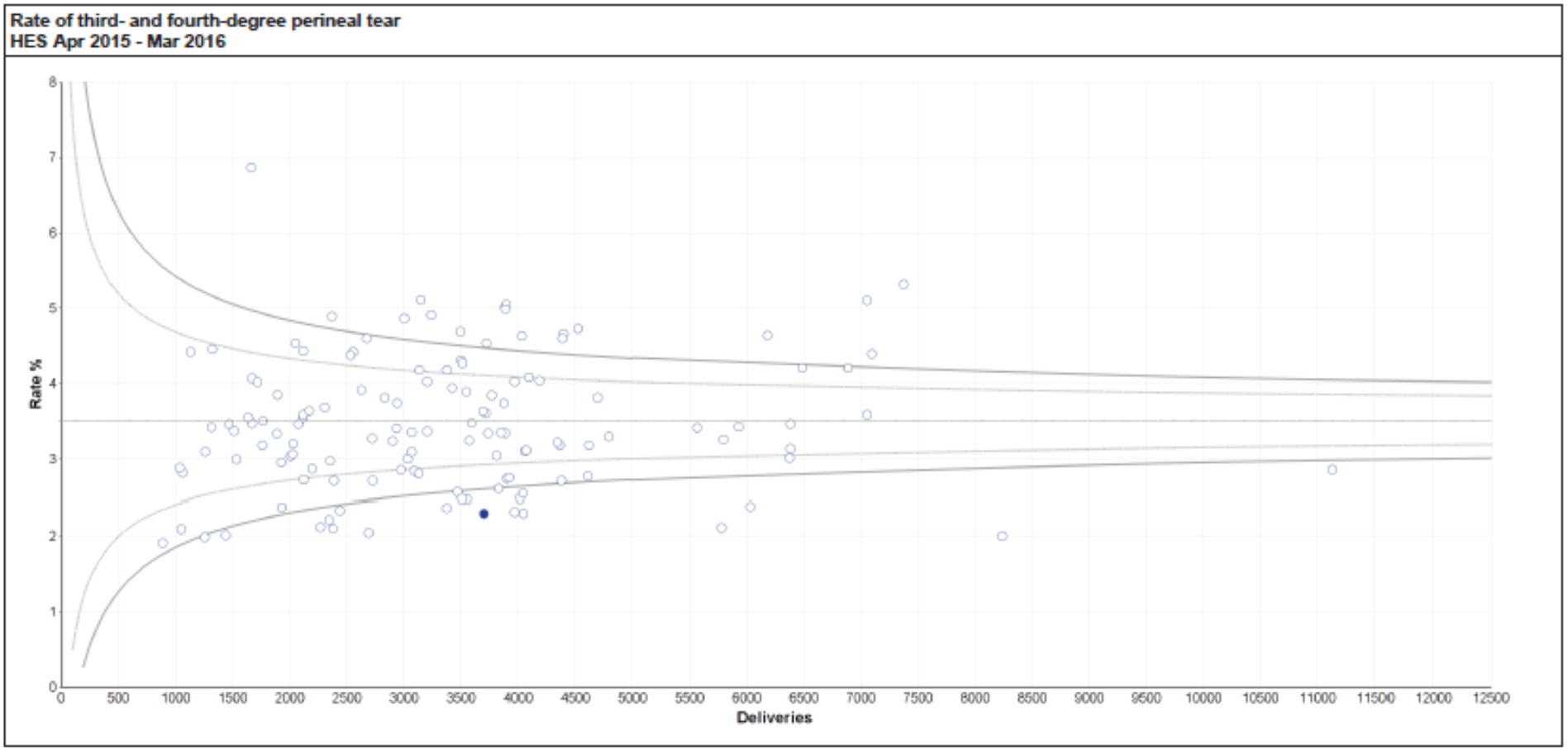
GIRFT – Perineal trauma

GETTING IT RIGHT FIRST TIME

6.14 Rate of third- and fourth-degree perineal tear



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NMPA - haemorrhage

The Princess Royal, Telford
Shrewsbury and Telford Hospital NHS Trust
National Maternity and Perinatal Audit

HQIP Healthcare Quality Improvement Partnership

3130 cases	Case-mix adjusted proportion of women with severe post partum haemorrhage of greater than or equal to 1500 ml	Safe	1.32%*	2.70%	N/A	 Better than expected

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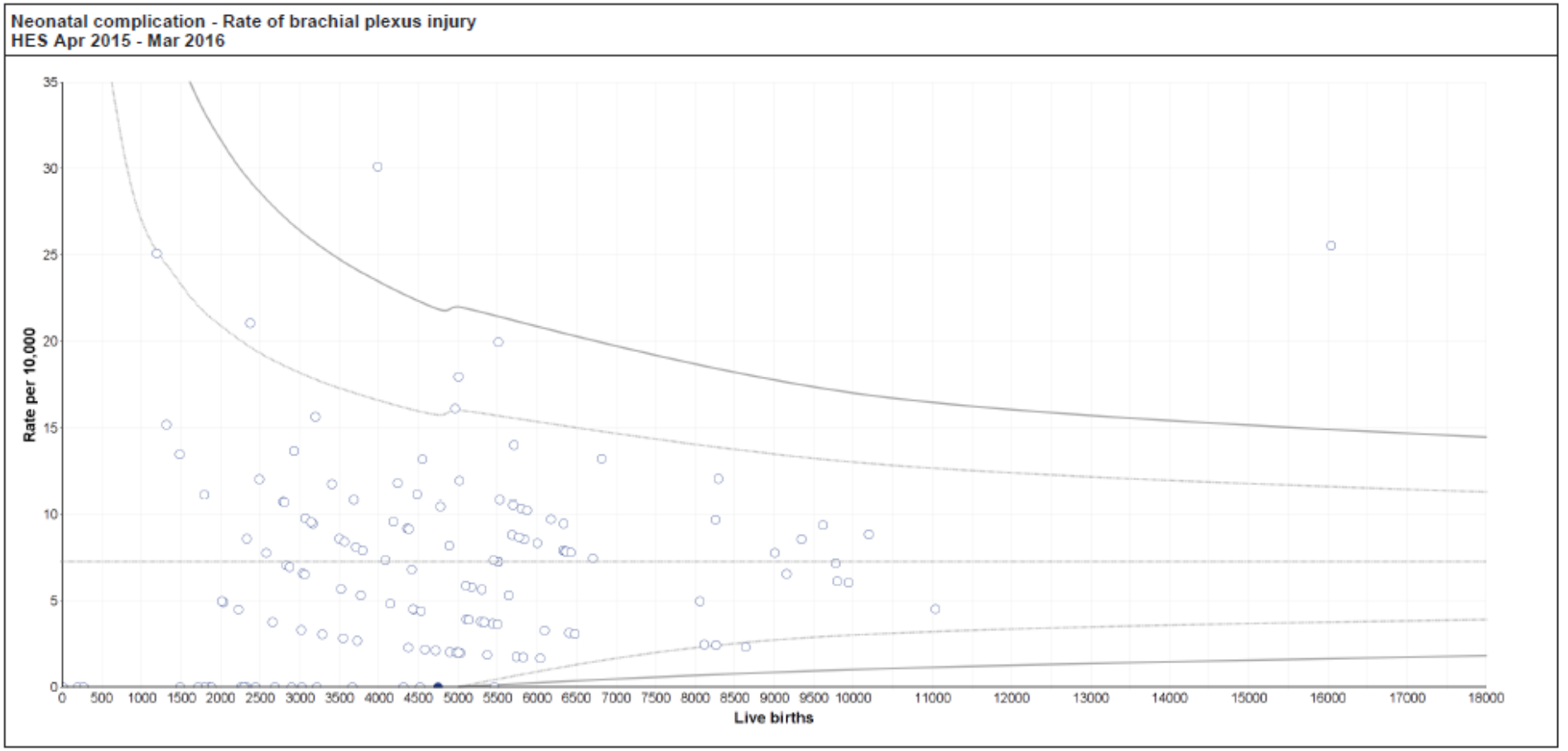
GIRFT – brachial plexus injury

GETTING IT RIGHT FIRST TIME

6.33 Neonatal complication - Rate of brachial plexus injury



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CQC Maternity Survey 2018 – labour and birth

- **Advice at the start of labour**
  Receiving **appropriate advice and support** — 9.3/10 About the same

- **Moving during labour**
  Being able to **move around** and choose the most comfortable position **during labour** — 8.1/10 About the same

- **Skin to skin contact**
  Having **skin to skin contact** with the baby **shortly after birth** — 9.3/10 About the same

- **Partner involvement**
  Partners being involved as much as **they** wanted — 9.6/10 About the same

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CQC Maternity Survey 2018 – staff during labour and birth

- **Staff introduction**
  Staff **introducing** themselves before examination or treatment
  9.3/10
  About the same

- **Being left alone**
  Not being left alone by midwives or doctors **at a time when it worried them**
  8.2/10
  About the same

- **Raising concerns**
  Concerns being **taken seriously** once raised
  9.0/10
  Better

- **Attention during labour**
  If attention was needed **during labour and birth,** a member of staff helped them within a **reasonable amount of time**
  9.1/10
  About the same

CQC Maternity Survey 2018 – staff during labour and birth

•	**Clear communication** Being **spoken to** during labour and birth, in a way they could **understand**	Better
•	**Involvement in decisions** Being **involved** enough in **decisions** about their care during labour and birth	8.8/10 About the same
•	**Respect and dignity** Being treated with **respect and dignity** during labour and birth	9.7/10 Better
•	**Confidence and trust** Having **confidence and trust** in the **staff** caring for them during labour and birth	8.9/10 About the same

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CQC Maternity Survey 2018 – care in hospital after the birth

- **Length of hospital stay**
  Feeling the **stay in hospital** after the birth was the **right amount of time** — 8.1/10, Better
- **Delay in discharge**
  Discharge from hospital being **delayed** — 7.1/10, Better
- **Reasonable response time after birth**
  If attention was needed **after the birth**, a member of staff helped within a **reasonable amount of time** — 8.2/10, About the same
- **Information and explanations**
  Receiving the **information and explanations** they needed after the birth — 8.3/10, About the same

CQC Maternity Survey 2018 – care in hospital after the birth

- **Kind and understanding care**
  Being treated with **kindness and understanding** by **staff** after the birth — 9.0/10, About the same
- **Partner length of stay**
  That their **partner who was involved in their care** was able to **stay with them as much as they wanted** — 5.8/10, About the same
- **Cleanliness of room or ward**
  Thinking the hospital room or ward was **clean** — 9.5/10, Better

The Shrewsbury and Telford Hospital NHS Trust

Summary

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What have we learned?

- Challenges within the community
- Mortality that is comparable for the WM region
- Cooling rates and term admission rates falling
- Already embedded actions that align with national drivers
- Appropriate intervention
- Low harm
- High satisfaction

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What have we learned?

- Recognition that in individual circumstances things do go wrong
- We own the problem (now supported by HSIB)
- We are responsible for learning and continued improvement
- System wide improvement is required

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Thank you

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