Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

The Maternity service has achieved the Saving babies lives care bundle surveys for 2022 and submitted a compliant survey 7 to the LMNS 02/11/22 and have received confirmation from the national team.

Copy of Survey 7 - RAG for RAE.xlsx

To achieve the MSDS SBLv2 requirements the service has a MSDS action plan in place which has been approved by the LMS and BTHFT Trust Board.

SBL requirements for The maternity incentive scheme

Element 1- process indicators

A. **Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.**

B. **Percentage of women where CO measurement at 36 weeks is recorded.**

If the provider Trust is unable to record these data on their maternity information system an audit of 60 consecutive cases would be acceptable evidence to demonstrate >80% of women having a CO measurement recorded at 36 weeks. The denominator for the audit should be 60 consecutive women at 36 weeks gestation, whereas the denominator for the electronic audit would be the total number of women at 36 weeks gestation. In addition to this, the audit should be accompanied by a brief description of the stop smoking strategy within the Trust and any plans for improvement.

CO at 36wk audit 2022.docx

86% (51) of the women reviewed had CO monitoring performed at the 36week appointment

To achieve the MSDS SBLv2 requirements the service has a MSDS action plan in place which has been approved by the LMS and BTHFT Trust Board. Work on this plan is ongoing and reporting figures are currently not available for review. The trust believe that at submission deadline for the maternity incentive scheme year 4 the data will be available.

Maternity services are currently implementing a Smokefree pregnancy model in line with Long term plan recommendations and are on track to deliver all recommendations as set out by the WY ICS programme .

A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

Copy of WY ICS Prevention Programm

As additional evidence the trust must:

1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric.

To achieve the MSDS SBLv2 requirements the service has a MSDS action plan in place which has been approved by the LMS and BTHFT Trust Board. Work on this plan is ongoing and reporting figures are currently not available for review. The trust believe that at submission deadline for the maternity incentive scheme year 4 the data will be available.

2) Have a referral pathway to smoking cessation services (in house or external).

Helping-Women-to-Quit-Smoking-in-Preg

3) Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service.

CO over 4 referral audit - dec 2022.docx

4) Have generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period:

   · Percentage of women with a CO measurement ≥4ppm at booking.

To achieve the MSDS SBLv2 requirements the service has a MSDS action plan in place which has been approved by the LMS and BTHFT Trust Board. Work on this plan is ongoing and reporting figures are currently not available for review. The trust believe that at submission deadline for the maternity incentive scheme year 4 the data will be available.

   · Percentage of women with a CO measurement ≥4ppm at 36 weeks.

CO at 36wk audit 2022.docx

   · Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment.

To achieve the MSDS SBLv2 requirements the service has a MSDS action plan in place which has been approved by the LMS and BTHFT Trust Board. Work on this plan is ongoing and reporting figures are currently not available for review. The trust believe that at submission deadline for the maternity incentive scheme year 4 the data will be available.

Element 2 – process indicators

1) **Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan (e.g. Appendix D of the SBLCBv2).**


FGR at booking and 20 week scan.docx

Of the 40 cases reviewed 95% (38) were risk assessed at booking for FGR. At 20 week scan only 38 of the cases were eligible, due to pregnancy loss. Of the eligible cases 97.5% (37) underwent further risk assessment for FGR as outlines in local and national guidelines.

If there is a delay in the provider Trust Maternity Information System's ability to record these data at the time of submission an in house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records should have been undertaken to assess compliance with this indicator.

In addition the Trust board should specifically confirm that within their organisation:

1) Women with a BMI>35 kg/m^2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards


BMI- uss audit 2022.docx

2) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation


FGR high risk UAD by 24 completed weeks g

Of all the eligible high risk bookings 100% (29) had received a uterine artery before 24 completed weeks gestation as per local and national guidance.

3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.

Within the trust babies born <3rd centile >37+6 are also subject to review in a multi- disciplinary team meeting. The objectives of the team is to find learning from review and share its findings. This is done in a variety of ways. Such as lessons learnt. SBL bitesize and individual case review.

Talk About-assessment of fetal g

FGR meeting terms of reference.doc

This information is also available via local maternity dashboard

ACTIVITY INDICATORS	Definition	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Small for Gestational Age (SGA)/Fetal Growth Restriction (FGR)										
38 weeks and over	Babies born of a gestation 38 weeks and over	326	326	301	303	369	367	397	286	
Below 3rd Centile	Below 3rd Centile	14	12	14	6	7	12	10	8	
% of babies below 3rd Centile	**Calculation**	4.29%	3.68%	4.65%	1.98%	1.90%	3.27%	2.52%	2.80%	
40 weeks and over	Babies born of a gestation 40 weeks and over	152	124	124	126	163	154	171	88	
Below 10th Centile	Below 10th Centile born 40 weeks and over	17	16	18	9	10	12	20	8	
% of babies below 10th Centile	**Calculation**	11.18%	12.90%	14.52%	7.14%	6.13%	7.79%	11.70%	9.09%	
Number of missed below 3rd Centile	Number of babies born 38 weeks and over - missed FGA	14	9	12	5	6	9	9	6	
Number of missed below 10th Centile	Number of babies born 40 weeks and over - missed SGA	14	14	15	8	8	8	18	8	

4) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT).

2021 SB's including PMRT findings.pptx

Preventable Perinatal Deaths 202

Stillbirths and the PMRT.pptx

The PMRT overview with most of the statistics was presented at department clinical governance in February 2022. Preventable deaths was presented in joint governance meeting May 2022. Stillbirths and PMRT was presented to the clinical outcomes group October 2022.

5) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network.

Multiple-Pregnancy-S
canning-Guideline.doc

They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care.

FGR highlight report
jan-june 2022.pptx

Further review is undertaken on a monthly basis as described within element 2 process indicators and the MDT review team are currently undergoing review regarding membership and objectives. There has been some delay in larger scale reviews as predicted by NHSR.

Element 3 – process indicators

A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy.

tommy's leaflet audit
dec 2022.docx

Patient information from November deliveries was used which amounted to 412 women, the report identified two options as evidence of providing the Tommy's patient information leaflet, they were : Tommy's RFM leaflet provided, Tommy's RFM leaflet Language. None compliance was identified as: No Mapping Of Leaflet to Pregnancy ID. 10% (42) of the women reviewed had no mapping of leaflet to pregnancy ID. With 90% (370) having received the leaflet.

All women receive the Tommy's reduced fetal movement information within their booking packs and following conversations with community staff current practice is to discuss this during a later antenatal appointment. There appears to be some discrepancy regarding how midwives document this as it was communicated that as some feel that as they didn't provide the leaflet they just discuss it that they would document discussed as appose to provided and therefore amount to the report identifying that no leaflet could be mapped to the pregnancy ID.

B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation).

CCTG - rfm audit dec 2022.docx

The results that all eligible women that attend with RFM being offered and accepting a Cctg is excellent and in line with local and national guidance. BTHFT procurement of further Cctg machines has massively helped us to be able to continue to achieve this.

- All 100% of the women reviewed received a Cctg on admission with RFM
- 80% (16) of the women reviewed had a fetal movement checklist/ assessment completed
- There were no issues identified in management following assessment

Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators.

A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.

If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

Implementation of patient electronic records has provided many new challenges with data collection and systematic documentation. The trust has employed Data quality midwives to assist.

Element four

There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness.

The Trust board should specifically confirm that within their organization 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above.

BTHFT used the K2 perinatal training programme for staff training and competency assessment in relation to fetal surveillance compliance figures:

Midwives = 94.6%

Consultants = 85%

All other doctors = 90%

Overall compliance = 94%

MDT training in relation to human factors, escalation and situational awareness is covered via maternity prompt training. Staff training in the use of CTG monitors will be covered in the face to face fetal surveillance day and compliance on labour ward is currently 80%

In 2022 we will move forward with face to face MDT fetal surveillance training and Each baby counts learn and support.

Talk About-
Maternity Safety-May

fetal wellbeing study
day agenda.pptx

<u>Element five – process indicators</u>

A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.

B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.

C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.

D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).

If there is a delay in the provider Trust MIS's ability to record these data then an audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators.

perinatal optimisation
dec 2022.docx

- Of the cases reviewed 73% (30) women received antenatal steroids however only 39% (16) women received a full course of antenatal steroids, 81% (13) of the full course administrations were within 7 days of birth. Of the 16 cases that received antenatal steroids 3 (19%) of the births occurred more than 7 days after administration.

- Of the cases reviewed there were 18 women that were eligible for Mgso4, 67% (12) of those eligible received mgso4.

- Bradford teaching hospital NHS trust neonatal unit are a level 3 Neonatal intensive care unit.

Nearly a third 27.5% (11) of the women reviewed gave birth within an hour of attending the unit and following review by the preterm birth MDT it was felt that there were only 2 missed opportunities to diagnose preterm labour before this admission.

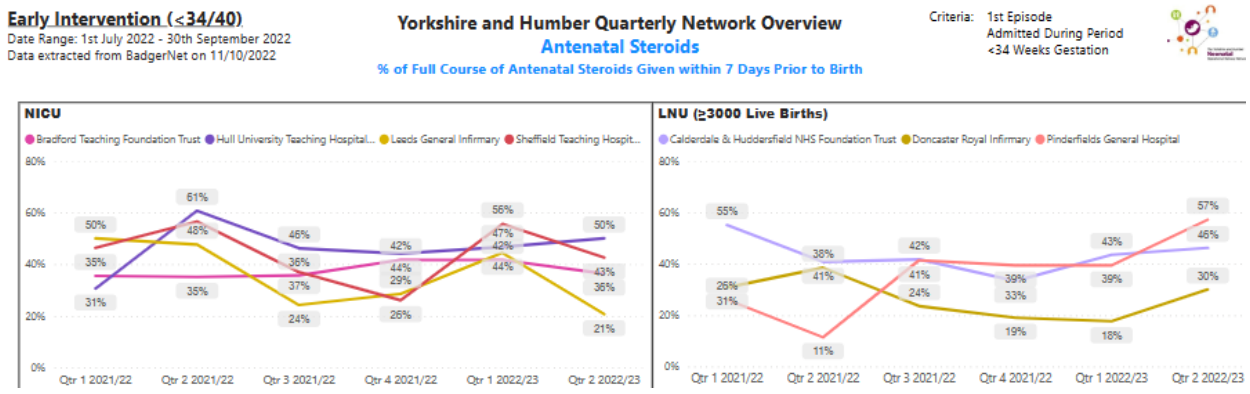
The Trust board should receive data from the organisation's Maternity Information System evidencing 80% compliance with process indicators A, C and D. The percentage for process indicator B should be as low as possible and can be reported as the proportion.

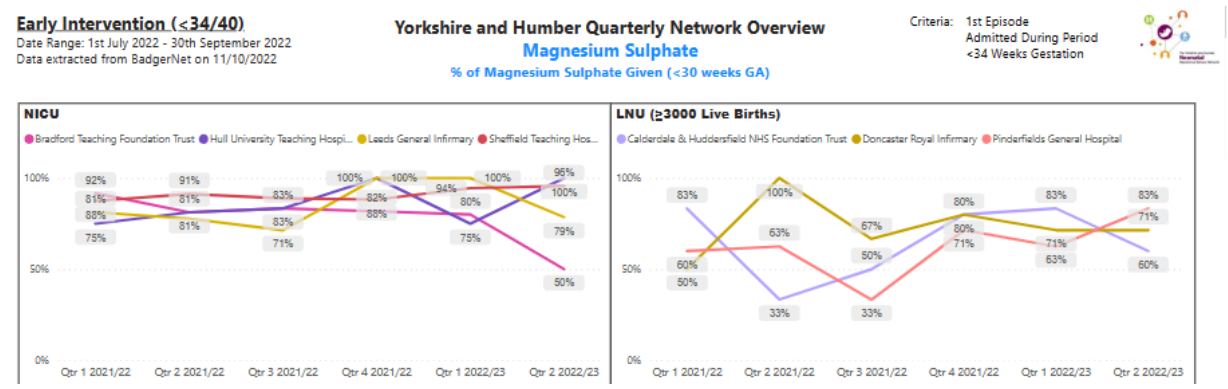
A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must have an action plan for achieving >80%.

Bradford teaching hospital NHS trust have adopted local LMNS preterm guidelines and have a preterm birth clinic now established to give us a greater emphasis on the recommendations of the saving babies lives care bundle and other national drivers in relation to focusing on reducing spontaneous preterm birth via prediction, prevention, and optimisation of care when preterm birth is imminent.

W-Yorks-LMS-preter
m-birth-guideline-for-

Several QI projects have been completed and are in planning to address the finding of our monthly preterm reviews, the results of this audit and national data shared by the Yorkshire and Humber neonatal ODN.





Information and education regarding findings is shared locally via preterm spotlights, tea trolley education events, lessons learnt and saving babies lives bitesize.


preterm spotlight August 2022.pptx


preterm spotlight march 2022.pptx


Talk About-Maternity Safety-May


SBL bitesize july 2022..pub


SBL bitesize march 2022..pub


Organisational Learning- Think prem


cord clamping.completed.p

In addition maternity and neonatal services will continue to work closely together as the preterm birth MDT continue involvement with the WY & H LMNS preterm birth steering group and MatNeo Sip.

They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. (Best practice would be to also appoint a dedicated Lead Midwife.

Preterm Lead consultants are Padma Munjuluri and Tom Pettinger. Katy Newton was appointed as a preterm midwife in 2022.

Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice.


W-Yorks-LMS-preterm-birth-guideline-for-

BTHFT have a preterm prevention which runs on alternate Thursdays with the preterm lead consultants

An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway. The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local CCGs following advice from the Clinical Network.


PTB risk assessment & stratification audit.

- 95% (38) of the women assessed had a preterm birth assessment completed at booking
- 5% (2) women were identified as at intermediate risk
- 100% (2) of the women identified as at intermediate risk were referred to the preterm birth clinic.

Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network.

Multiple-Pregnancies-Antenatal-and-Intrap