National Patient Safety Improvement Programmes

NHS

Maternity and Neonatal

Maternity and Neonatal Safety Improvement Network (MatNeoSIP) Event

Wednesday 14th December 2022, 13:00- 16:00

@AHSN_NENC

ahsn-nenc.org.uk

Delivered by:

North East and North Cumbria
Patient Safety Collaborative

The AHSN Network

Maternity Clinical Network North East and North Cumbria

Northern Neonatal Network

North East and North Cumbria Local Maternity and Neonatal System

Led by:

NHS England
NHS Improvement

House Keeping

- Please ensure your microphone and video are turned off during the session unless asked otherwise. This is to help with the streaming of the session.
- If you need to take a break, please feel free to drop off the call at any time and re-join.
- Live captions are available if required.
- This event will be recorded and photographs may be taken.
- Please ask any questions you have through the chat facility. We will try to address questions during the event, but if we don't manage to do this we will follow up after the event.
- If you can't see the chat please email your question/s to gemma.todd@ahsn-nenc.org.uk
- Speaker presentations and the recording will be circulated following the event.

National Patient Safety Improvement Programmes

NHS

Maternity and Neonatal

Welcome

@AHSN_NENC

ahsn-nenc.org.uk

Delivered by:

North East and North Cumbria
Patient Safety Collaborative

The AHSN Network

Maternity Clinical Network North East and North Cumbria

Northern Neonatal Network

North East and North Cumbria Local Maternity and Neonatal System

Led by:

NHS England
NHS Improvement

Agenda (previously circulated)

Timings (approximate)	Agenda Item	Speaker
13:05	MatNeoSIP National Overview	Charlie Merrick Senior Improvement Manager – Patient Safety Improvement Team NHSE/I
13:25	MatNeoSIP Regional Overview	Julia Wood MatNeoSIP Lead – NENC Patient Safety Collaborative
13:40	Patient Safety Incident Response Framework (PSIRF)	Wendy Halliburton Patient Safety Lead Academic Health Science Network for NENC
14:00	Human Milk and Brain Development in the Preterm Infant	Professor Nick Embleton Consultant Neonatal Paediatrician and Professor of Neonatal Medicine The Newcastle upon Tyne Hospitals NHS Trust
14:30	Break	
14:40	Supporting Provision of Maternal Breast Milk – moving forward from the first 24 hours	Ros Nunn Infant Feeding and Maternal Healthy Weight Co-ordinator Public Health prevention in Maternity, NENC Integrated Care System North East Regional Lead – National Infant Feeding Network (NIFN)
15:10	Preterm Birth Clinics	Dr Gareth Waring Consultant in Obstetrics The Newcastle upon Tyne Hospitals NHS FT
15:30	Break	
15:35	Quality Improvement Session: Involving women and families in improvement using the Coalition for Personalised Care Co-Production Model	Julia Wood
16:00	Close	

House Keeping

- Please ensure your microphone and video are turned off during the session unless asked otherwise. This is to help with the streaming of the session.
- If you need to take a break, please feel free to drop off the call at any time and re-join.
- Live captions are available if required.
- This event will be recorded and photographs may be taken.
- Please ask any questions you have through the chat facility. We will try to address questions during the event, but if we don't manage to do this we will follow up after the event.
- If you can't see the chat please email your question/s to gemma.todd@ahsn-nenc.org.uk
- Speaker presentations and the recording will be circulated following the event.

National Patient Safety Improvement Programmes

Maternity and Neonatal

National Overview

Charlie Merrick, Senior Improvement Manager – Patient Safety Improvement Team
NHS England and NHS Improvement

@AHSN_NENC

ahsn-nenc.org.uk

Delivered by:

North East and North Cumbria
Patient Safety Collaborative

The AHSN Network

Maternity Clinical Network North East and North Cumbria

Northern Neonatal Network

North East and North Cumbria Local Maternity and Neonatal System

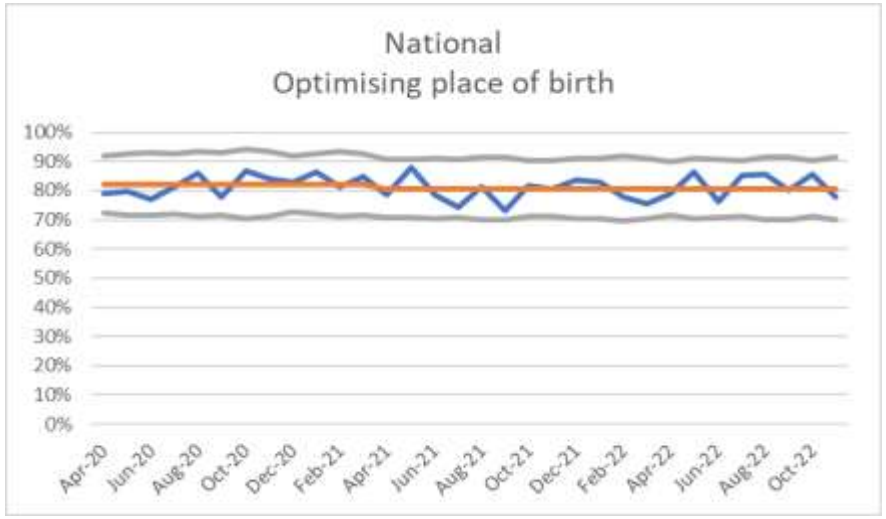
Led by:

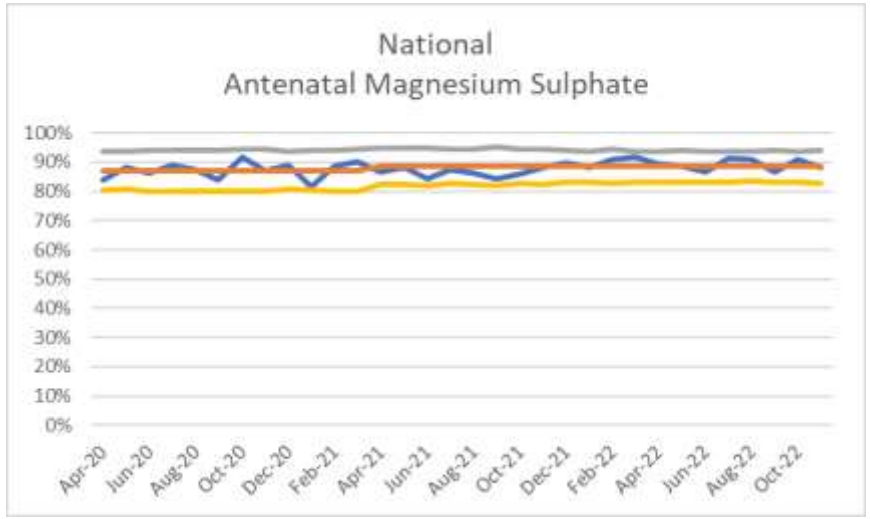
NHS England
NHS Improvement

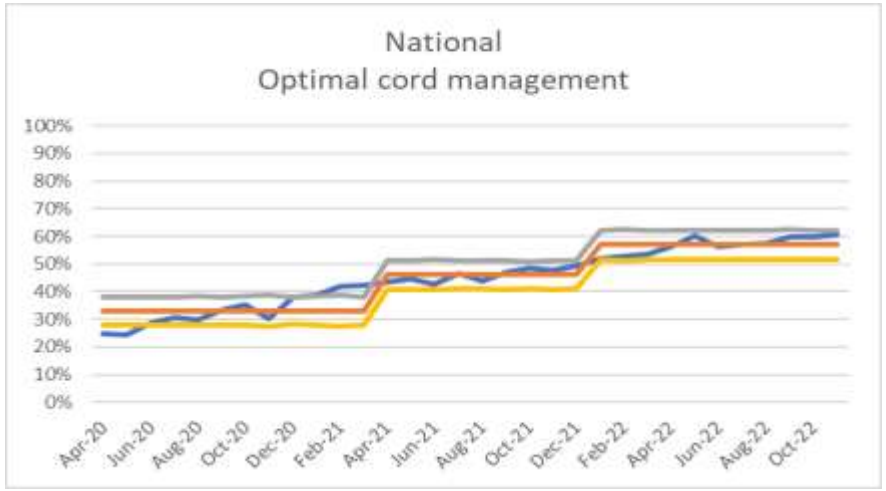
National overview

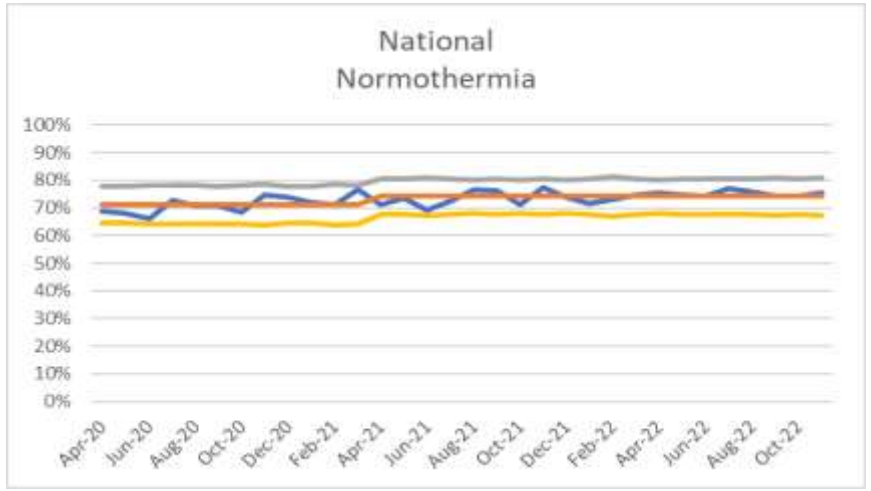
- Significant improvement in Preterm Optimisation Pathway 5/7 measures
- National Dashboard
- Economic framework
- Action Learning Sets
- Saving Babies Lives V3
- 3 NIHR Evaluations been agreed

National dashboard









Optimal Cord Management

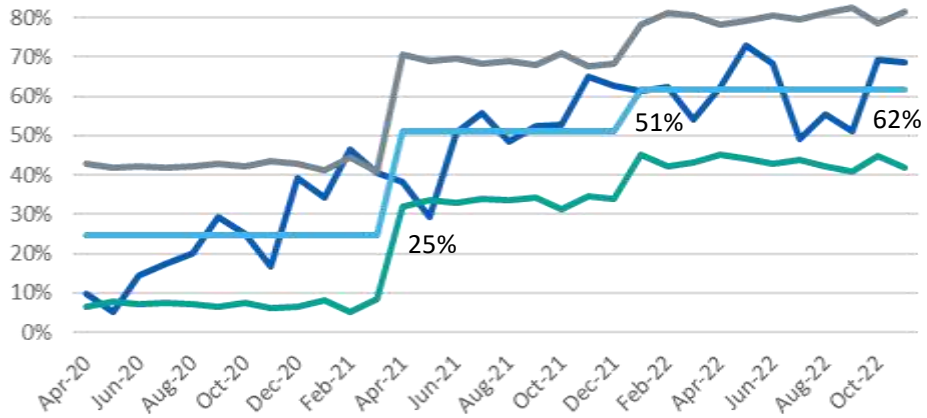
National Average
57% (Increase 23.9%)
Variation 33.1% - 74.8%
7 PSC's above the national average

ALL 15 PSCs have improved from baseline

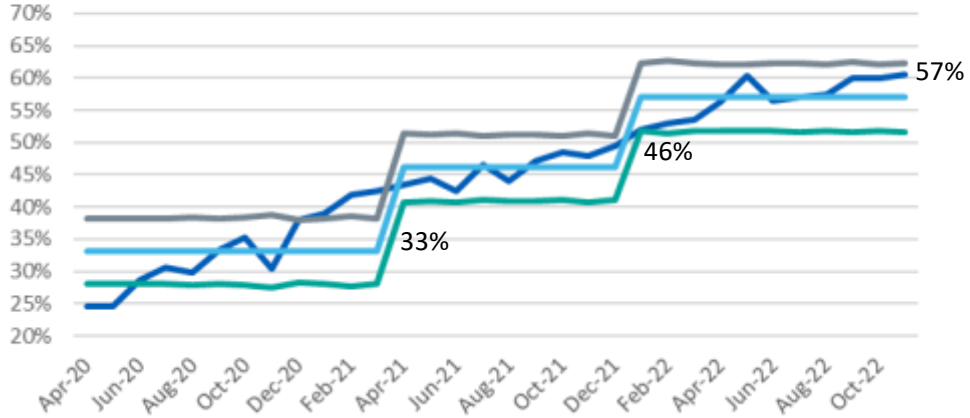
NENC
Has the greatest improvement
24.8% to 61.7%
increase 37%

South West and West of England
have the highest level of reliability
74.8% and 71.9%

North East and North Cumbria
Optimal cord management



National
Optimal cord management



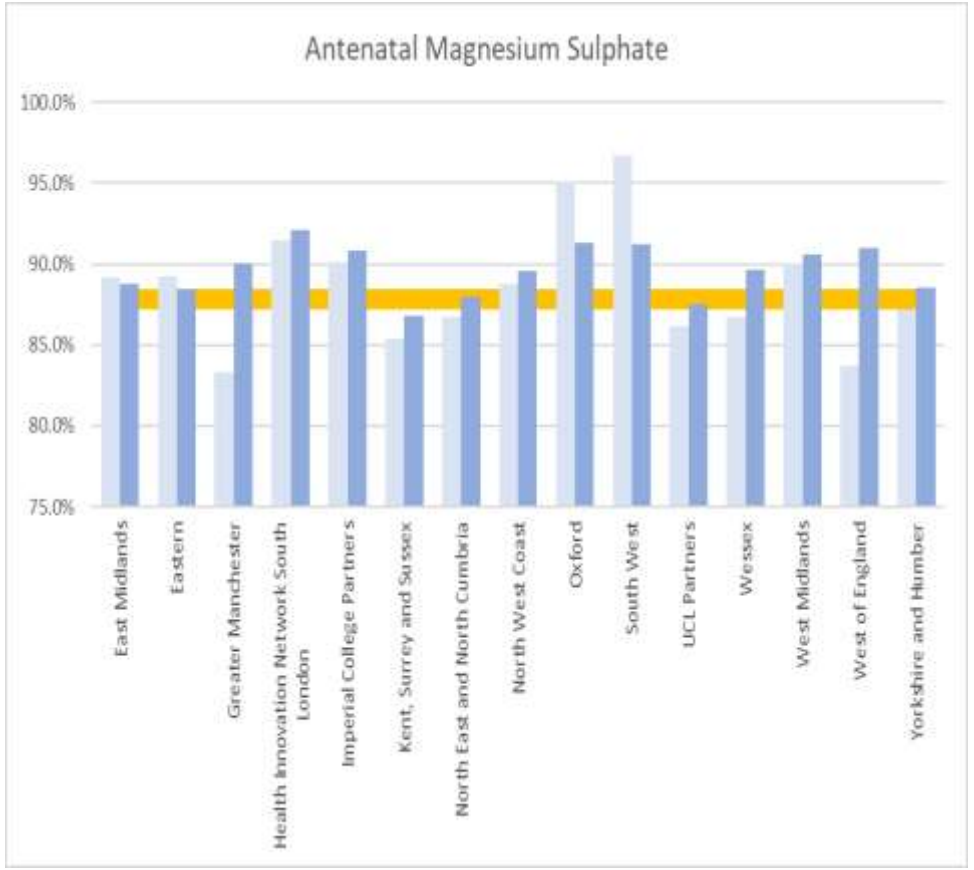
Dashboard analytic examples

199

7393 women giving birth at less than 30 weeks of gestation received magnesium sulphate within the 24 hours prior to birth. This potentially means that 199 babies will not develop celebral palsy.

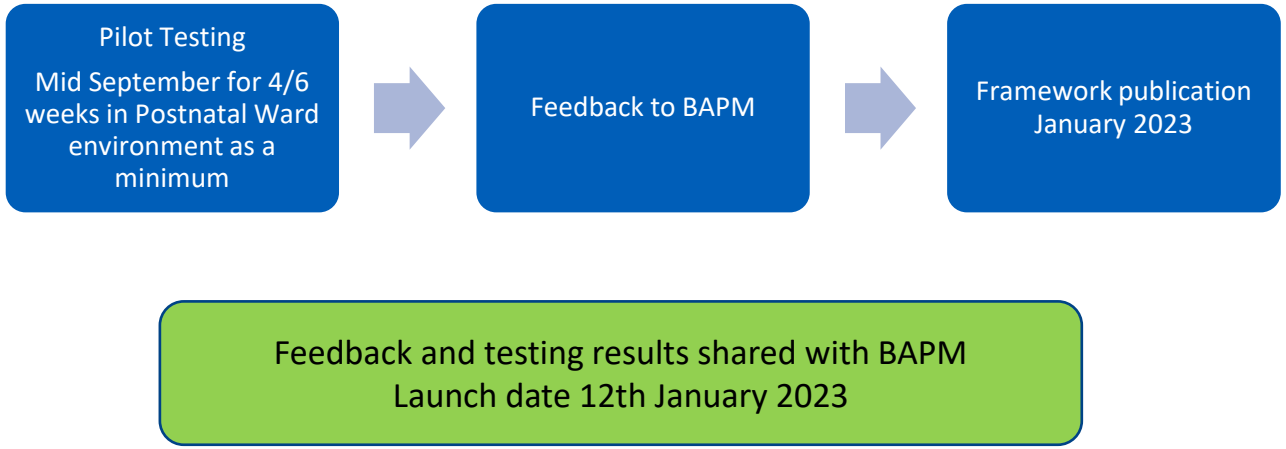
228 - 381

Between 228 and 381 babies born at less than 34 weeks gestational age potentially survived because their umbilical cord was clamped at or after one minute after birth.

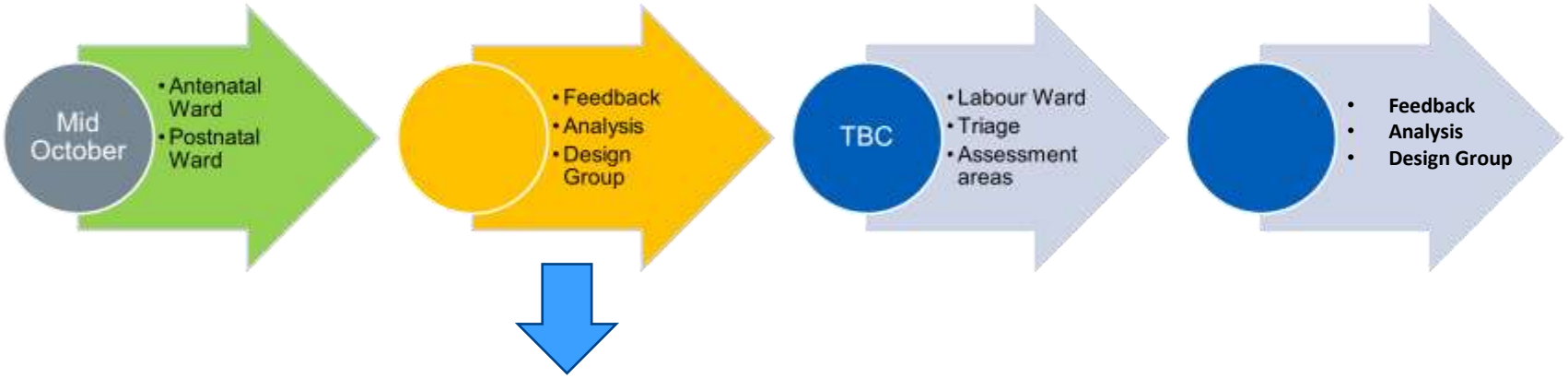


Deterioration update – NHS England and NHS Improvement

NEWTT2


Pilot Testing
Mid September for 4/6 weeks in Postnatal Ward environment as a minimum
Feedback to BAPM
Framework publication January 2023
Feedback and testing results shared with BAPM
Launch date 12th January 2023

MEWS



- 13 organisation from 20 originally
- Timeframe extension

IMPLEMENTATION STRATEGY
- Drawing up plans currently
- Organisations that want to progress to this phase need to be understood

Updates

NIHR Evaluation
Approved
eMEWS

TRAINING: MEWS
HEE approved
Completion early 2023

DIGITAL
Discussions re how the digitalisation will be supported are ongoing but with hopeful update early 2023

National Patient Safety Improvement Programmes

Maternity and Neonatal

MatNeoSIP Regional Overview

Julia Wood
MatNeoSIP Lead – NENC
Academic Health Science Network NENC

@AHSN_NENC

ahsn-nenc.org.uk

Delivered by:

North East and North Cumbria
Patient Safety Collaborative

TheAHSNNetwork

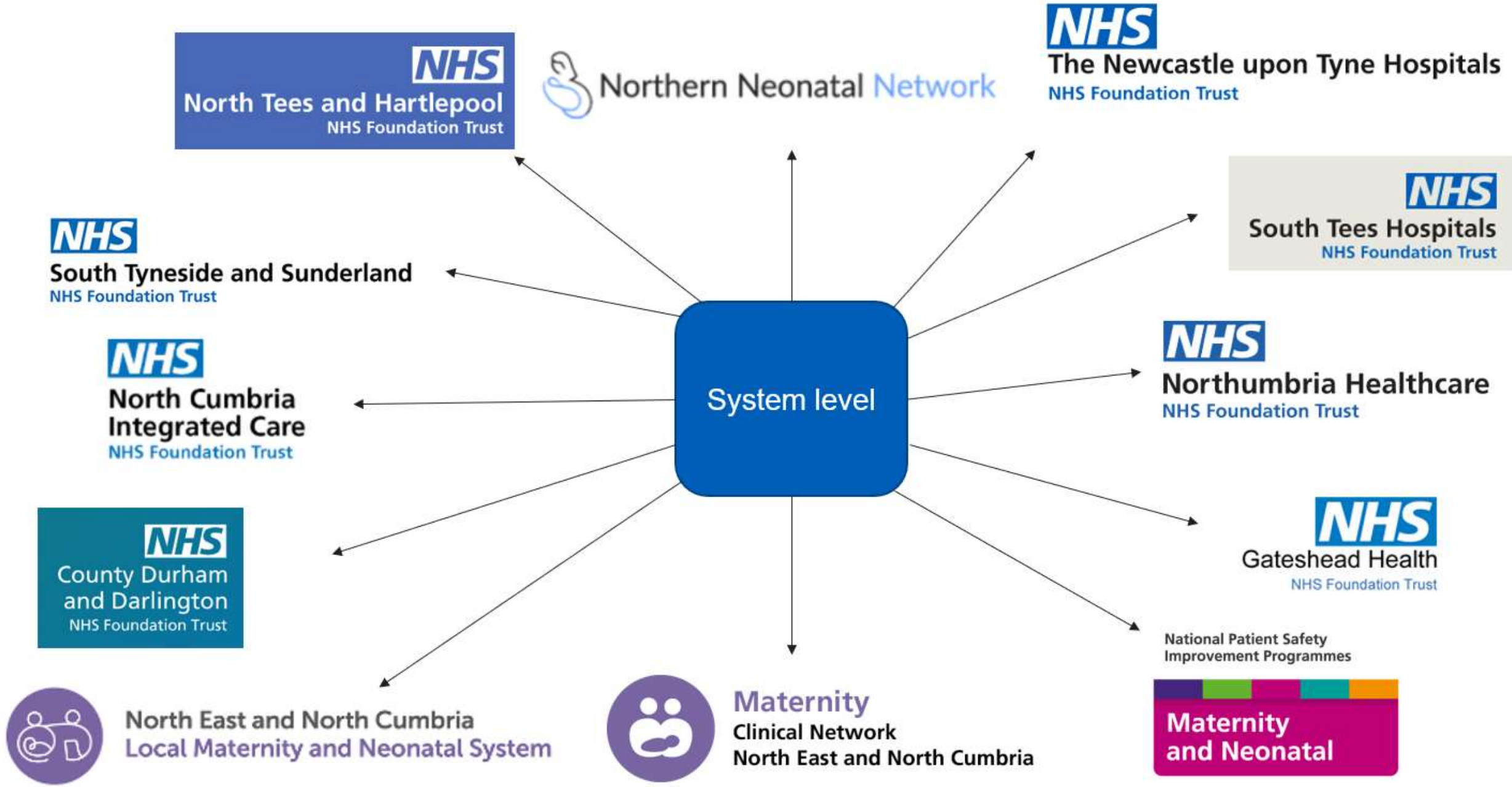
Maternity Clinical Network North East and North Cumbria

Northern Neonatal Network

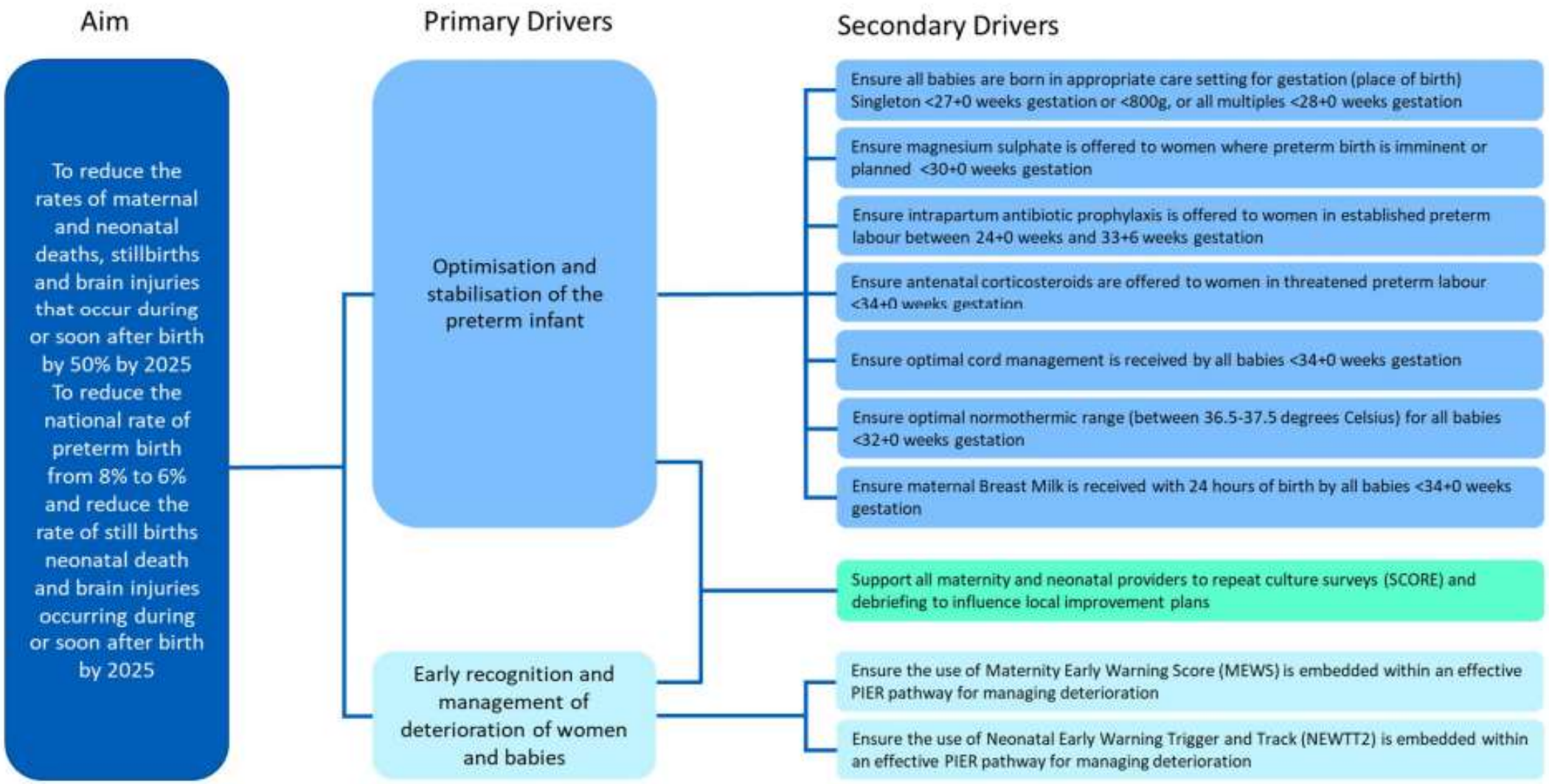
North East and North Cumbria Local Maternity and Neonatal System

Led by:

NHS England
NHS Improvement


NHS
North Tees and Hartlepool
NHS Foundation Trust
Northern Neonatal Network
NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust
NHS
South Tees Hospitals
NHS Foundation Trust
NHS
South Tyneside and Sunderland
NHS Foundation Trust
NHS
North Cumbria
Integrated Care
NHS Foundation Trust
System level
NHS
Northumbria Healthcare
NHS Foundation Trust
NHS
County Durham
and Darlington
NHS Foundation Trust
NHS
Gateshead Health
NHS Foundation Trust
National Patient Safety
Improvement Programmes
North East and North Cumbria
Local Maternity and Neonatal System
Maternity
Clinical Network
North East and North Cumbria
Maternity
and Neonatal

MatNeoSIP Specification from April 2022



FutureNHS

Regional Hub

- [MatNeoSIP Patient Safety Network for North East and North Cumbria - FutureNHS Collaboration Platform]

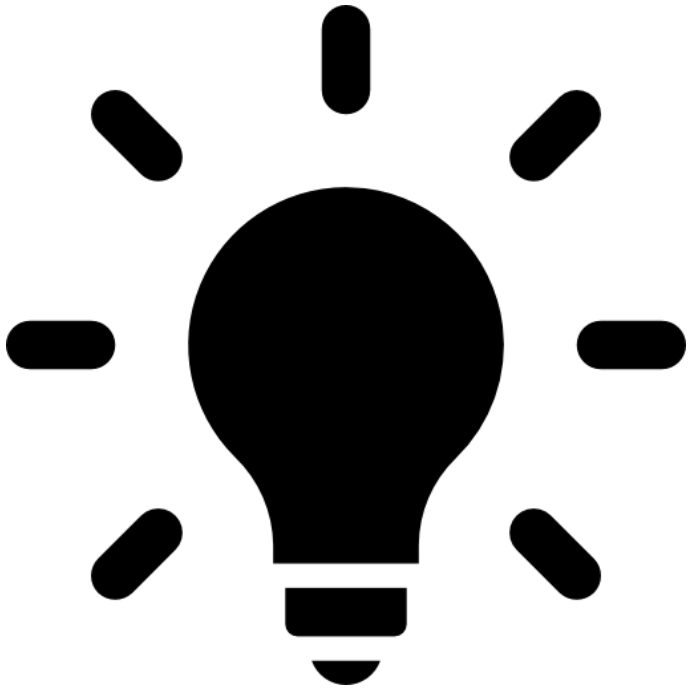
National Hub

- [Maternity and Neonatal Safety Improvement Programme - FutureNHS Collaboration Platform]

Considerable information on both

Need to register with FutureNHS to join

Quality Improvement Bitesized Training



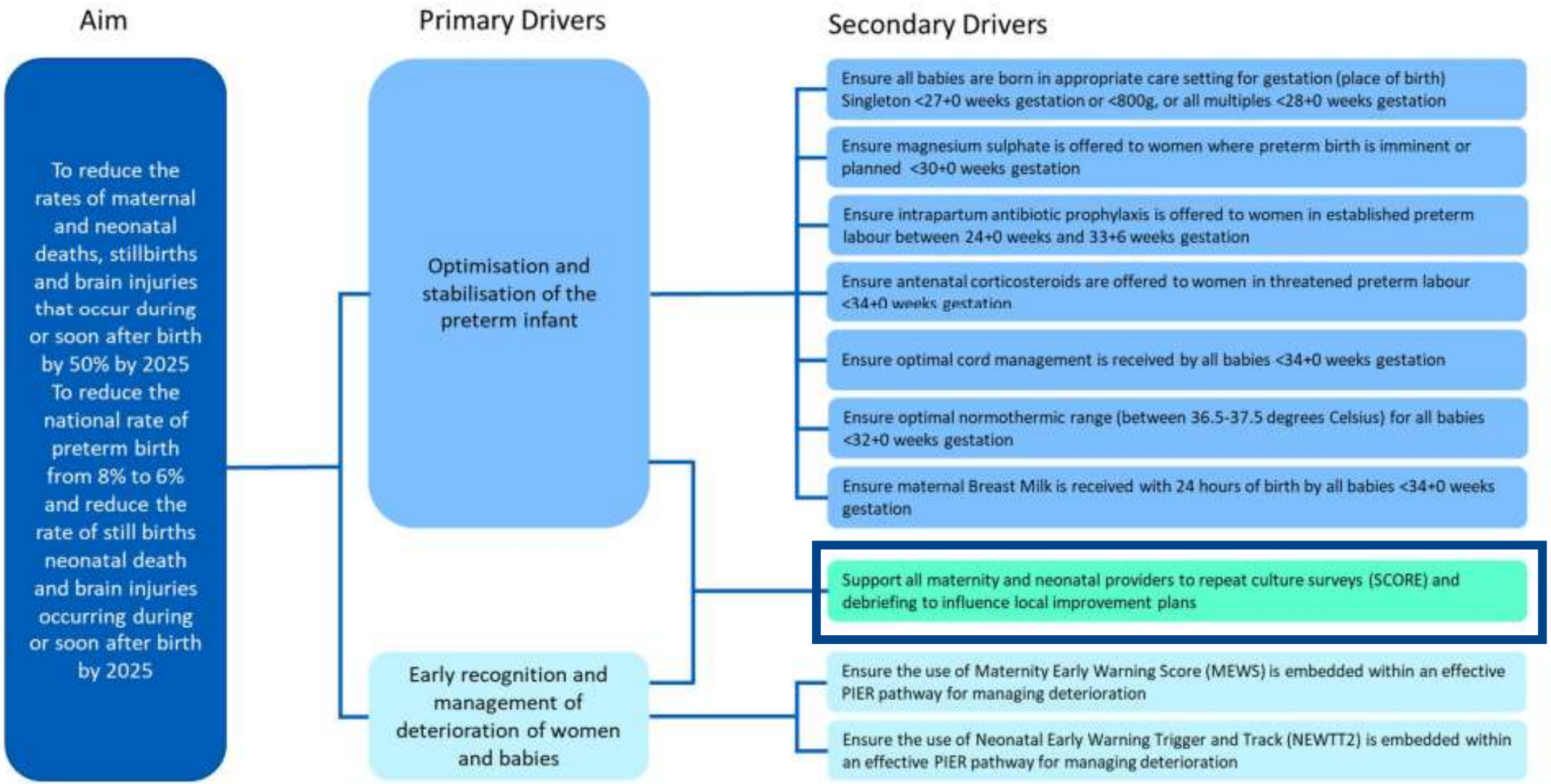
MatNeoSIP - YouTube

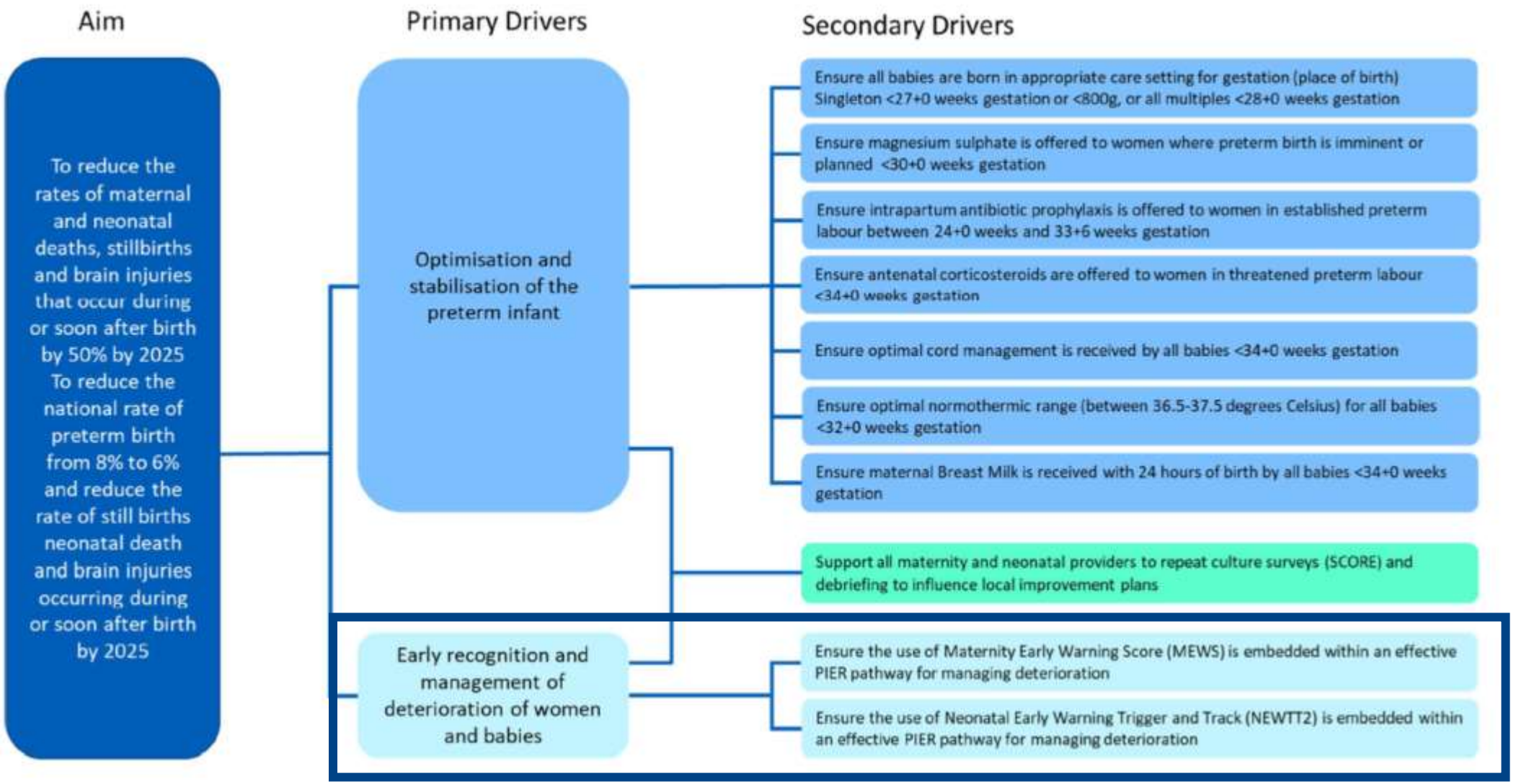
Next event: 14th March 9.30 – 12.30

[Maternity and Neonatal Safety Improvement Network (MatNeoSIP) Event Registration, Tue 14 Mar 2023 at 09:30 | Eventbrite]

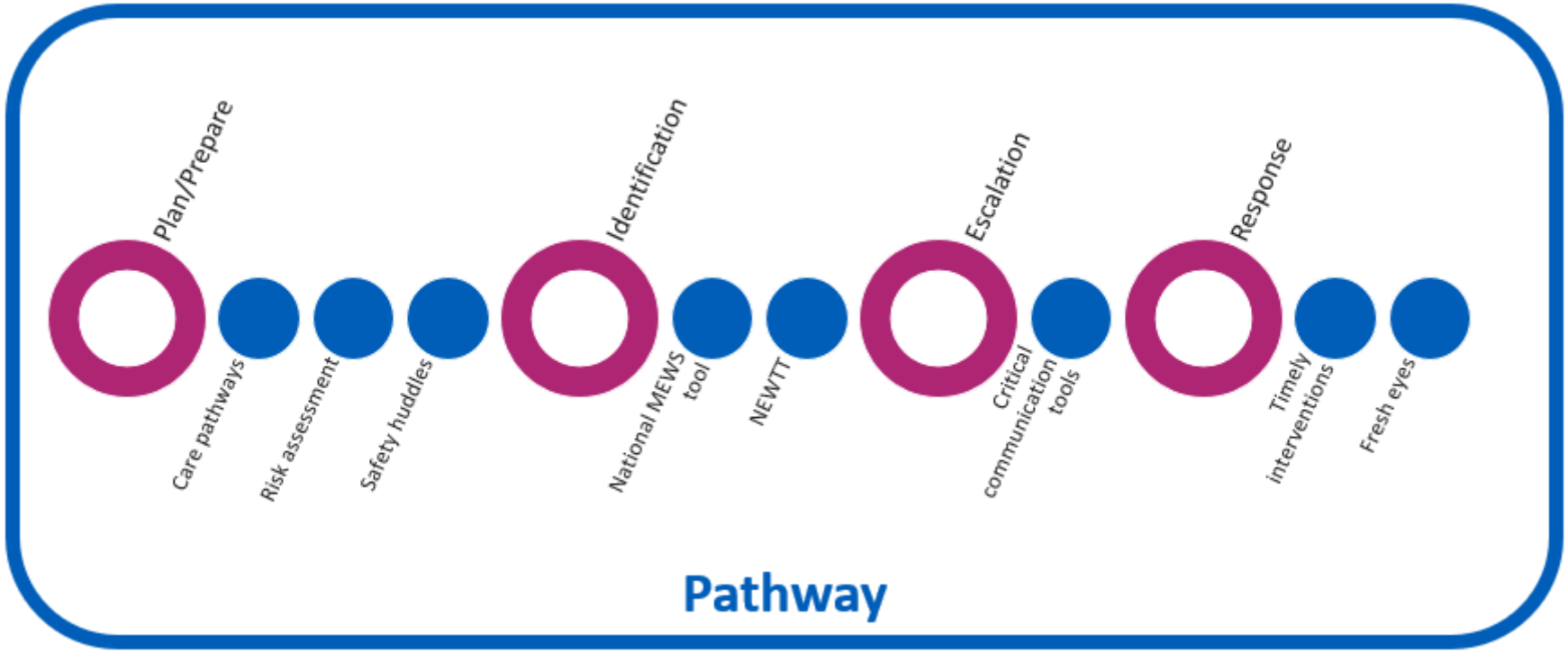
Get involved

julia.wood@ahsn-nenc.org.uk


Aim
Primary Drivers
Secondary Drivers
To reduce the rates of maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth by 50% by 2025
To reduce the national rate of preterm birth from 8% to 6% and reduce the rate of still births neonatal death and brain injuries occurring during or soon after birth by 2025
Optimisation and stabilisation of the preterm infant
Early recognition and management of deterioration of women and babies
Ensure all babies are born in appropriate care setting for gestation (place of birth) Singleton <27+0 weeks gestation or <800g, or all multiples <28+0 weeks gestation
Ensure magnesium sulphate is offered to women where preterm birth is imminent or planned <30+0 weeks gestation
Ensure intrapartum antibiotic prophylaxis is offered to women in established preterm labour between 24+0 weeks and 33+6 weeks gestation
Ensure antenatal corticosteroids are offered to women in threatened preterm labour <34+0 weeks gestation
Ensure optimal cord management is received by all babies <34+0 weeks gestation
Ensure optimal normothermic range (between 36.5-37.5 degrees Celsius) for all babies <32+0 weeks gestation
Ensure maternal Breast Milk is received with 24 hours of birth by all babies <34+0 weeks gestation
Support all maternity and neonatal providers to repeat culture surveys (SCORE) and debriefing to influence local improvement plans
Ensure the use of Maternity Early Warning Score (MEWS) is embedded within an effective PIER pathway for managing deterioration
Ensure the use of Neonatal Early Warning Trigger and Track (NEWTT2) is embedded within an effective PIER pathway for managing deterioration


Aim
Primary Drivers
Secondary Drivers
To reduce the rates of maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth by 50% by 2025
To reduce the national rate of preterm birth from 8% to 6% and reduce the rate of still births neonatal death and brain injuries occurring during or soon after birth by 2025
Optimisation and stabilisation of the preterm infant
Ensure all babies are born in appropriate care setting for gestation (place of birth) Singleton <27+0 weeks gestation or <800g, or all multiples <28+0 weeks gestation
Ensure magnesium sulphate is offered to women where preterm birth is imminent or planned <30+0 weeks gestation
Ensure intrapartum antibiotic prophylaxis is offered to women in established preterm labour between 24+0 weeks and 33+6 weeks gestation
Ensure antenatal corticosteroids are offered to women in threatened preterm labour <34+0 weeks gestation
Ensure optimal cord management is received by all babies <34+0 weeks gestation
Ensure optimal normothermic range (between 36.5-37.5 degrees Celsius) for all babies <32+0 weeks gestation
Ensure maternal Breast Milk is received with 24 hours of birth by all babies <34+0 weeks gestation
Support all maternity and neonatal providers to repeat culture surveys (SCORE) and debriefing to influence local improvement plans
Early recognition and management of deterioration of women and babies
Ensure the use of Maternity Early Warning Score (MEWS) is embedded within an effective PIER pathway for managing deterioration
Ensure the use of Neonatal Early Warning Trigger and Track (NEWTT2) is embedded within an effective PIER pathway for managing deterioration

National approach to deterioration

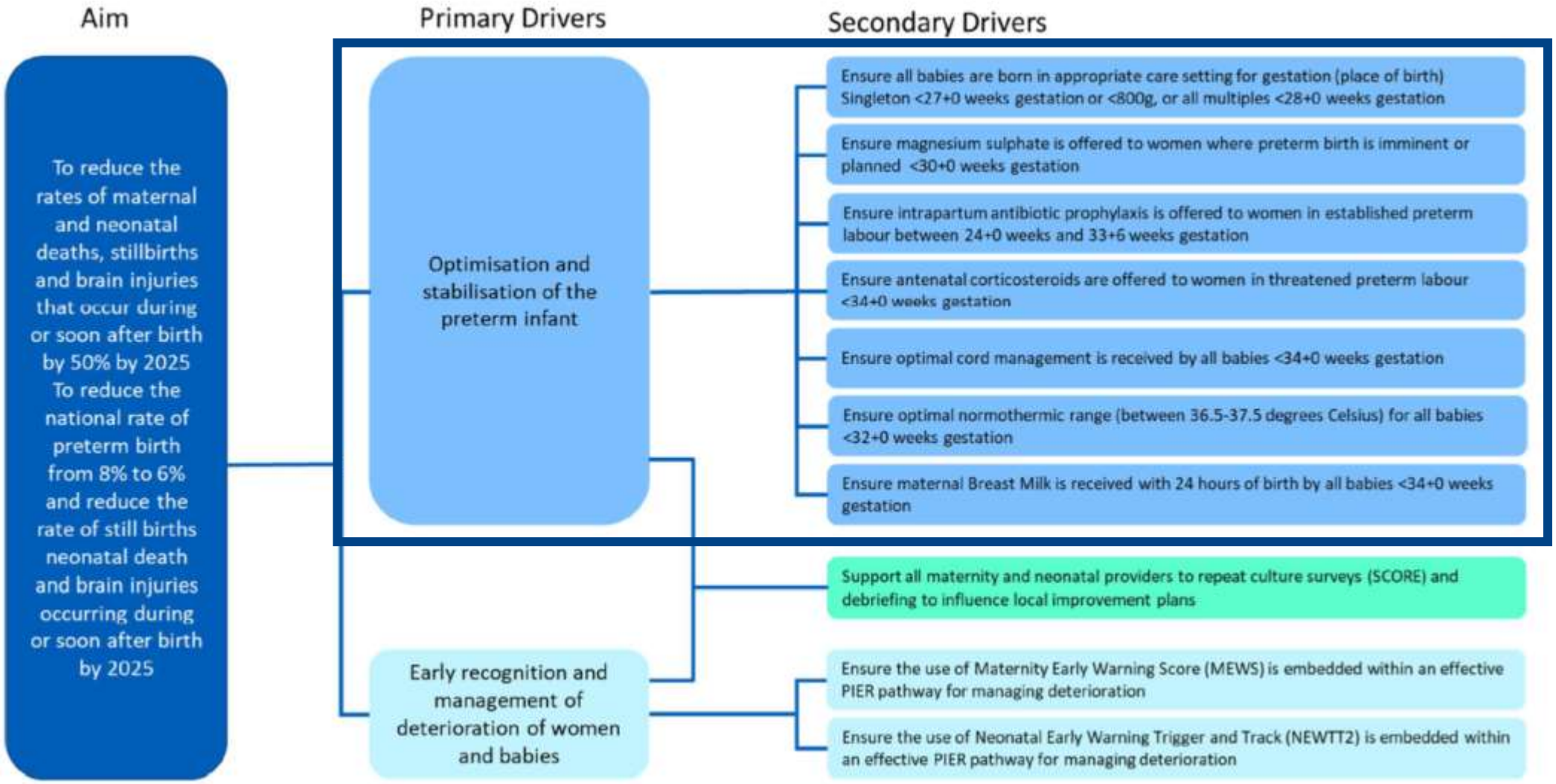


Early recognition and management of deterioration in women and babies

Tools used to support the identification of deterioration in women and babies

- National MEWS (Maternity Early Warning Score)
- NEWTT2 (Newborn Early Trigger and Track)

- Good engagement for testing across our region:
  - South Tees Hospitals NHS FT
  - The Newcastle Hospitals NHS FT
  - North Tees and Hartlepool NHS FT
  - plus Gateshead Health NHS Trust involved in Phase 1 testing for NEWTT2


Aim
Primary Drivers
Secondary Drivers
To reduce the rates of maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth by 50% by 2025
To reduce the national rate of preterm birth from 8% to 6% and reduce the rate of still births neonatal death and brain injuries occurring during or soon after birth by 2025
Optimisation and stabilisation of the preterm infant
Ensure all babies are born in appropriate care setting for gestation (place of birth) Singleton <27+0 weeks gestation or <800g, or all multiples <28+0 weeks gestation
Ensure magnesium sulphate is offered to women where preterm birth is imminent or planned <30+0 weeks gestation
Ensure intrapartum antibiotic prophylaxis is offered to women in established preterm labour between 24+0 weeks and 33+6 weeks gestation
Ensure antenatal corticosteroids are offered to women in threatened preterm labour <34+0 weeks gestation
Ensure optimal cord management is received by all babies <34+0 weeks gestation
Ensure optimal normothermic range (between 36.5-37.5 degrees Celsius) for all babies <32+0 weeks gestation
Ensure maternal Breast Milk is received with 24 hours of birth by all babies <34+0 weeks gestation
Support all maternity and neonatal providers to repeat culture surveys (SCORE) and debriefing to influence local improvement plans
Early recognition and management of deterioration of women and babies
Ensure the use of Maternity Early Warning Score (MEWS) is embedded within an effective PIER pathway for managing deterioration
Ensure the use of Neonatal Early Warning Trigger and Track (NEWTT2) is embedded within an effective PIER pathway for managing deterioration

Place of birth
Gest <27 weeks or <800g or multiples <28 weeks

WHY?
Extreme preterm birth in a tertiary unit setting significantly improves survival and neurodevelopmental outcomes

- April 20 – June 21 (15 months)
  - 118 eligible babies
  - 101 born in a NICU
  - 86% born in a NICU
- July 21 – Sept 22 (15 months)
  - 145 eligible babies
  - 122 born in a NICU
  - 84% born in a NICU
- % is lower for July 21 – Sept 22
  but numbers are higher
  (21 more babies born in a NICU)

Place of birth
Gest <30 weeks or <1250g

WHY?
Extreme preterm birth in a tertiary unit setting significantly improves survival and neurodevelopmental outcomes

- April 21 – March 22 **(12 months)**
  - 235 eligible babies
  - 191 born in a NICU
  - 81% born in a NICU

- Apr 22 – Sept 22 **(6 months)**
  - 115 eligible babies
  - 98 born in a NICU
  - 85% born in a NICU

Magnesium Sulphate
Gest <30 weeks within 24 hours

WHY?
The use of magnesium sulphate within 24 hours prior to birth significantly reduces the risk of cerebral palsy
(1 fewer baby with cerebral palsy for every 37 women treated < 30 w)

- Apr 20 – June 21 (15 months)
  - 232 babies eligible
  - 192 babies reported as receiving MagSulph
  - 83%
- July 21 – Sept 22 (15 months)
  - 246 babies eligible
  - 195 babies reported as receiving MagSulph
  - 79%
- 14 more eligible babies were born between July 21 – Sept 22 than in the previous 15 months
- 3 more babies were given MagSulph between July 21 – Sept 22 than in the previous 15 months
- 10 less babies with cerebral palsy over the last 30 months

Intrapartum Antibiotics (24+0 – 33+6 weeks, at least one dose)

WHY?
The use of antibiotics 4 hours before birth significantly improves survival outcomes by reducing the risk of Group B Streptococcus sepsis

- April 20 – June 21 (15 months)
  - 700 eligible babies
  - 165 reported as receiving antibiotics
  - 24%
- July 21 – Sept 22 (15 months)
  - 812 eligible babies
  - 225 reported as receiving antibiotics
  - 28%
- 60 more babies reported as receiving at least one dose of antibiotics between July 21 - Sept 22 than in the previous 15 months

clevermed

Intrapartum Antibiotics (24+0 – 33+6 weeks, at least one dose within 4 hours)

WHY?
The use of antibiotics 4 hours before birth significantly improves survival outcomes by reducing the risk of Group B Streptococcus sepsis

clevermed

- Only 10 months data available (**Dec 21 – Sept 22)**
  - 507 eligible babies
  - 40 reported as receiving antibiotics
  - 8%

- This means that on average each month **51** babies are eligible but only **4** are reported as receiving antibiotics within 4 hours

Antenatal Steroids (<34 weeks, any dose)

WHY?
The use of antenatal steroids significantly improves survival by reducing the risk of preterm lung disease, brain haemorrhage, necrotising enterocolitis (NEC) and sepsis

- April 20 – June 21 (15 months)
  - 703 eligible babies
  - 620 reported as receiving steroids
  - 88%
- July 21 – Sept 22 (15 months)
  - 821 eligible babies
  - 685 reported as receiving steroids
  - 83%
- Percent is lower from July 21 – Sept 22 when compared to the previous 15 months, but:
  - 118 more eligible babies
  - 65 more babies reported as receiving steroids

Antenatal Steroids (<34 weeks, full course within 1 week)

WHY?
The use of antenatal steroids significantly improves survival by reducing the risk of preterm lung disease, brain haemorrhage, necrotising enterocolitis (NEC) and sepsis

clevermed

- Only 10 months data available (Dec 21 – Sept 22)
  - 516 eligible babies
  - 142 reported as receiving steroids
  - 28%

- This means that on average each month **52** babies are eligible but only **14** reported as receiving steroids

Optimal Cord Management (<34 weeks)

WHY?
Number of babies needing to receive OCM to prevent a death is around 30 – 50 and may be as low as 20 in the least mature babies

- Apr 20 – June 21 (15 months)
  - 706 babies eligible
  - 169 babies reported as having OCM
  - 24%
- July 21 – Sept 22 (15 months)
  - 828 babies eligible
  - 430 babies reported as having OCM
  - 52%
- 122 more eligible babies were born in July 21 – Sept 22 than in the previous 15 months
- 261 more babies had OCM from July 21 – Sept 22 than in the previous 15 months

- April 20 – June 21:
  - 30 = 5 babies (round down)
  - 50 = 3 babies (round down)
- July 21 – Sept 22:
  - 30 = 14 babies (round down)
  - 50 = 8 babies (round down)
- 11 – 19 deaths prevented over the past 30 months
- There has been an increase of between 5 – 9 deaths prevented in the last 15 months

Temperature 36.5 and 37.5 degrees Celsius
(<34 weeks, includes those where temperature was not recorded within 1 hr)

WHY?
Early hypothermia (<36.5 degrees Celsius) increases the risk of mortality and brain haemorrhage, necrotising enterocolitis (NEC) and sepsis. Emerging evidence links hyperthermia (>38 degrees Celsius) to adverse outcomes

- Apr 20 – June 21 (15 months)
  - 706 babies eligible
  - 454 babies had a temperature recorded between 36.5 and 37.5 degrees Celsius
  - 64%
- July 21 – Sept 22 (15 months)
  - 822 babies eligible
  - 575 babies had a temperature recorded between 36.5 and 37.5 degrees Celsius
  - 70%
- 116 more eligible babies were born in July 21 – Sept 22 than in the previous 15 months
- 121 more babies had a temperature of 36.5 – 37.5 degrees Celsius reported from July 21 – Sept 22 than in the previous 15 months

Maternal Breast Milk
(<34 weeks, within 24 hours of birth)

WHY?
MBM significantly improves survival by reducing the risk of sepsis and necrotising enterocolitis (NEC)

clevermed

- **Jan 22- Sept 22** (only 9 months data available)
  - 454 babies eligible
  - 46 reported as being given MBM
  - 10%

- Average **50** babies eligible per month and only **5** of those reported as receiving MBM

Data packs


NHS
National Patient Safety Improvement Programmes
North East Quality Observatory Service
Maternity and Neonatal
Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) for NENC
Preterm Perinatal Optimisation Care Pathway/Bundle
Measures: Regional Overview
Data: May 21 – October 22
@NatPatSIP / @MatNeoSIP
www.improvement.nhs.uk
Delivered by:
TheAHSNNetwork
North East and North Cumbria Patient Safety Collaborative
Led by:
NHS England
NHS Improvement


THANK
YOU

National Patient Safety Improvement Programmes

Maternity and Neonatal

MatNeo & the Patient Safety Incident Response Framework (PSIRF)

Wendy Halliburton, Patient Safety Lead / System Safety Work Stream Lead

@AHSN_NENC

ahsn-nenc.org.uk

Delivered by:

North East and North Cumbria
Patient Safety Collaborative

The AHSN Network

Maternity Clinical Network North East and North Cumbria

Northern Neonatal Network

North East and North Cumbria Local Maternity and Neonatal System

Led by:

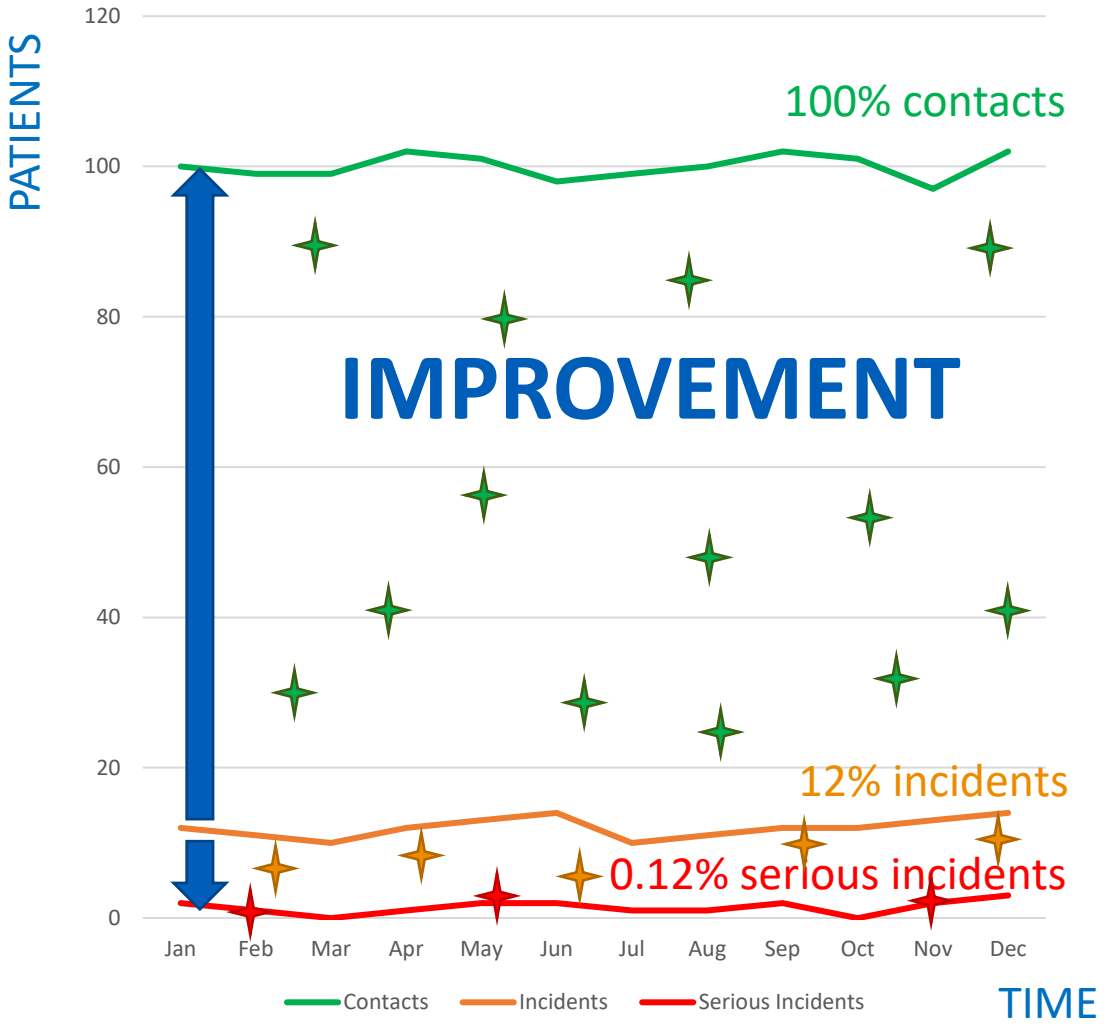
NHS England
NHS Improvement

PSIRF in 5 minutes……

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents **for the purpose of learning and improving patient safety.**

Introducing the Patient Safety Incident Response Framework (PSIRF): A framework for learning - YouTube

WHAT WENT WELL



	INSIGHT		INVOLVEMENT	
	Criteria for investigation	Investigation methodology	Timescale	Investigators
PSIRF	Trends Local risk Learning LFPSE - Incidents - Outcomes - Risk - Good practice	Systems PSII After Action Review Hot debriefs Medical Examiners M&Ms SJRs PMRT	Negotiated with patients and families	Patient Safety Specialist Patient Safety Partners National syllabus ↑ Patients ↑ Staff
TRUST	All	Root Cause Analysis	28 days	Clinicians
SIF	Level of harm	Root Cause Analysis	60 days	Clinicians

WHAT WENT WRONG

PSIRF vs Serious Incident Framework

- Serious Incident Framework → response to a **serious** incident
- PSIRF → responses to **all** incidents or events
- The response is based on the potential for **learning** (not harm)
- Each Trust develops a PSIRP (plan) to identify their local priorities, areas of risk and learning response for each ‘type’ of incident – signed off by ICB
- Some incident types will still require a formal investigation (national requirement)

National learning response methods include:

- Patient Safety Incident Investigation (PSII)
- MDT review
- Swarm huddle
- After action review

National event response requirements (1)

Event	Action required
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria)	Locally-led PSII
Deaths of patients detained under the Mental Health Act (1983) or where Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally-led PSII
Incidents meeting the Never Events Criteria (2018) or its replacement	Locally-led PSII
Mental health-related homicides	Referred to NHS regional independent investigation team (RIIT)
Maternity and neonatal incidents meeting HSIB criteria or Special Healthcare Authority (SpHA) criteria when in place	**Refer to HSIB or SpHA for independent PSII**
Child deaths	Refer for Child Death Overview Panel (CDOP) Locally led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel

National event response requirements (2)

Event	Action required
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this
Incidents in NHS screening programme	Refer to local screening quality assurance service for consideration of locally-led learning response
Safeguarding incidents in which - Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse / violence - Adults (over 18 years old) are in receipt of care and support needs from their local authority - The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse / violence	Refer to local authority safeguarding lead
Deaths in custody (e.g. police custody, in prison, etc) where health provision in delivered by the NHS	Refer to the Prison and Probation Ombudsman or Independent Office for Police Conduct
Domestic homicide	Police and Community Safety Partnership will determine requirement for Domestic Homicide Review (DHR)

Patient Safety Incident Investigations (PSII) or review?

Incidents requiring referral to HSIB → independent PSII

- Intrapartum still birth
- Early neonatal death (0-6 days)
- Potential severe brain injury diagnosed within first 7 days
- Maternal deaths – whilst pregnant or within 42 days (related to the pregnancy)

Incidents NOT requiring referral to HSIB → include in Trust plan

- Consider known incident types, areas of risk or safety concerns
- Consider response to new / emerging issues
- Select appropriate learning response method for each type of incident
- Focus on understanding how to reduce risk of future incidents

A Just Culture approach to reviews?

PSIRF standards

15.1 Responses are conducted for the sole purpose of learning and identifying improvements that reduce the risk and / or prevent or significantly reduce recurrence

15.2 Responses are **insulated from remits that seek to determine avoidability / preventability / predictability;** legal liability; blame; professional conduct / competence / fitness to practice; criminality or cause of death.

Perinatal Mortality Review Tool (PMRT)

The third type of questions support the review of the care and involve consideration of the care provided and broadly ask the review group to consider whether the local care provided was appropriate in the circumstances and met existing national or local guidelines and standards where they exist. These questions require the review group to make **judgements about the quality of care provided.**

The review group are asked to consider and **grade the quality of care provided**.

Ockenden – Essential actions

4. Clinical governance – leadership

- **Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services**
- All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement

Ockenden – Essential actions

5. Clinical governance – incident investigations and complaints

- All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.
- Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.
- Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.
- **Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.**
- **All trusts must ensure that complaints which meet SI threshold must be investigated as such**.
- All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.
- Complaints themes and trends must be monitored by the maternity governance team.

National Patient Safety Improvement Programmes

Maternity and Neonatal

Human Milk and Brain Development in the Preterm Infant

Professor Nick Embleton
Consultant Neonatal Paediatrician and Professor of Neonatal Medicine
The Newcastle upon Tyne Hospitals NHS Trust

@AHSN_NENC

ahsn-nenc.org.uk

Delivered by:

North East and North Cumbria
Patient Safety Collaborative

The AHSN Network

Maternity Clinical Network North East and North Cumbria

Northern Neonatal Network

North East and North Cumbria Local Maternity and Neonatal System

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Newcastle University

Led by:

NHS England
NHS Improvement


TAKE
a
break

National Patient Safety Improvement Programmes

NHS

Maternity and Neonatal

Supporting provision of maternal breastmilk: moving forward from the first 24 hours

Ros Nunn, Infant Feeding and Maternal Healthy Weight Co-Ordinator Public Health Prevention in Maternity, NENC Integrated Care System
North East Regional Lead – National Infant Feeding Network (NIFN)

@AHSN_NENC

ahsn-nenc.org.uk

Delivered by:

North East and North Cumbria **Patient Safety Collaborative**

The AHSN Network

Maternity Clinical Network North East and North Cumbria

Northern Neonatal Network

North East and North Cumbria Local Maternity and Neonatal System

ICS Integrated Care System

Led by:

NHS England
NHS Improvement

Overview

- Current data
- What has been achieved towards UNICEF BFI accreditation in Neonatal care
- Impact of practice in first 24 hours on breastmilk supply
- Supporting continued breastmilk production and provision
- Implementing best practice

Drivers and Targets - Breastfeeding

- Better Births (2016), Maternity Transformation Programme, NHS Long Term Plan (2019) Neonatal Critical Care Review (2020) , LMNS “must do’s”
- Joint Northern Neonatal Network and LMNS UNICEF Baby Friendly NENC project.

THE BABY FRIENDLY INITIATIVE

unicef UNITED KINGDOM

Externally assessed evidence-based standards which encompass the holistic care of families related to building close relationships, feeding and supporting parents to be partners - improving outcomes for the most vulnerable babies.

All maternity units accredited to UNICEF BFI stage 2 by 2020

All maternity units and Neonatal units fully UNICEF BFI accredited by 2025

Breastmilk provision in Neonatal Units - UNICEF BFI data requirements - Neonatal

	% by Trust - January 2022 – October 2022									
	RVI	JCUH	SRH	UHNT	QEH	UHND	DMH	CL	WCI	NSECH
Mothers expressing breastmilk during 1st 24 hours of baby's admission	11.80	51.20	4.60	3.90	0.70	20.40	42	9.20	20.40	4.80
Babies receiving human milk in 1st 24 hours of admission	20.30	39	6.50	4.90	0.40	19.40	40.80	13.10	18.40	4.80
Babies receiving human milk on discharge	49.60	42.30	8.20	10.70	0	28.10	44.30	26.40	16	7.60
Mothers expressing breast milk at baby's discharge	42	31.80	7.50	6.80	0	17.60	39.50	15.30	14	2.80
Mothers breastfeeding their baby at discharge	36	17.60	3.30	9.70	0	11.90	22.80	20.10	15	5.90

Badgernet Data - all babies (Nov 2021 - Oct 2022)

2333 admissions

417 (17.9%) received breastmilk in first 24 hours

To reach 50% - 750 more babies per year

That's only - 1 more baby a week in level 1 and 2 babies a week in Level 3

3162 discharges (with repeats)

1292 (40.9%) receiving breastmilk on discharge

To reach 50% - 289 more babies per year

That's only - 2 babies a month in level 1 and 4 babies a month in level 3

- Improved data input + practice changes = success
- Audit - if colostrum isn't given what is the reason

UNICEF Baby Friendly Initiative – best practice standards (inclusive of all admissions)

1. Support parents to have close and loving relationships with their babies
2. Enable babies to receive breastmilk and to breastfeed when possible
3. Value parents as partners in care

Aim

Certificate of commitment end of 2021

Stage1 - Easter 2022

Stage 2 - Summer 2023

Stage 3 - 2025

STAGE 1: BUILDING A FIRM FOUNDATION

1. Have written policies and guidelines to support the standards
2. Plan an education programme that will allow staff to implement the standards according to their role
3. Have processes for implementing, auditing and evaluating the standards
4. Ensure that there is no promotion of breastmilk substitutes, bottles, teats or dummies in any part of the facility or by any of the staff.

STAGE 2: AN EDUCATED WORKFORCE

1. Educate staff to implement the standards according to their role and the service provided.

STAGE 3: PARENTS' EXPERIENCES OF NEONATAL UNITS

1. Support parents to have a close and loving relationship with their baby
2. Enable babies to receive breastmilk and to breastfeed when possible
3. Value parents as partners in care.

Challenges when babies born too soon

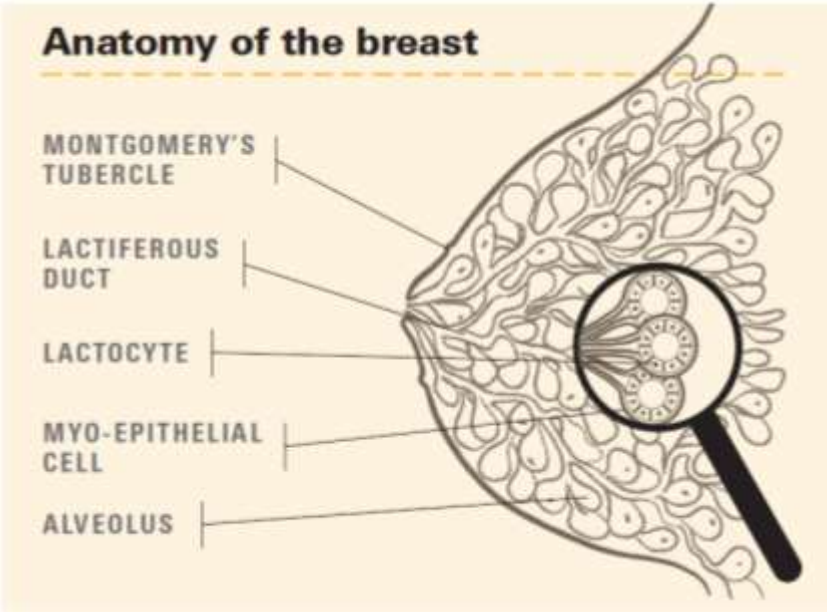
- Immature breast development
- Mother and baby separated at birth
- Baby not able to feed
- Mother’s anxiety over baby’s condition
- Mother may be unwell
- Support to establish and maintain breastmilk supply
- Culture of mothers sleep and rest following birth

Stages of lactation

- **Lactogenesis 1** – Breast development and colostrum production from approx. 16 weeks gestation

- **Lactogenesis 2** – Onset of copious milk secretion occurring between 32 and 96 hours after birth

- **Lactogenesis 3** – Maintenance of milk production



After birth

- Oestrogen and progesterone levels drop
- Prolactin and oxytocin levels rise in response to touch, smell and sight of baby
- Baby begins spontaneous breast seeking behaviour
- Mothering behaviours initiated

Teamwork

Prolactin

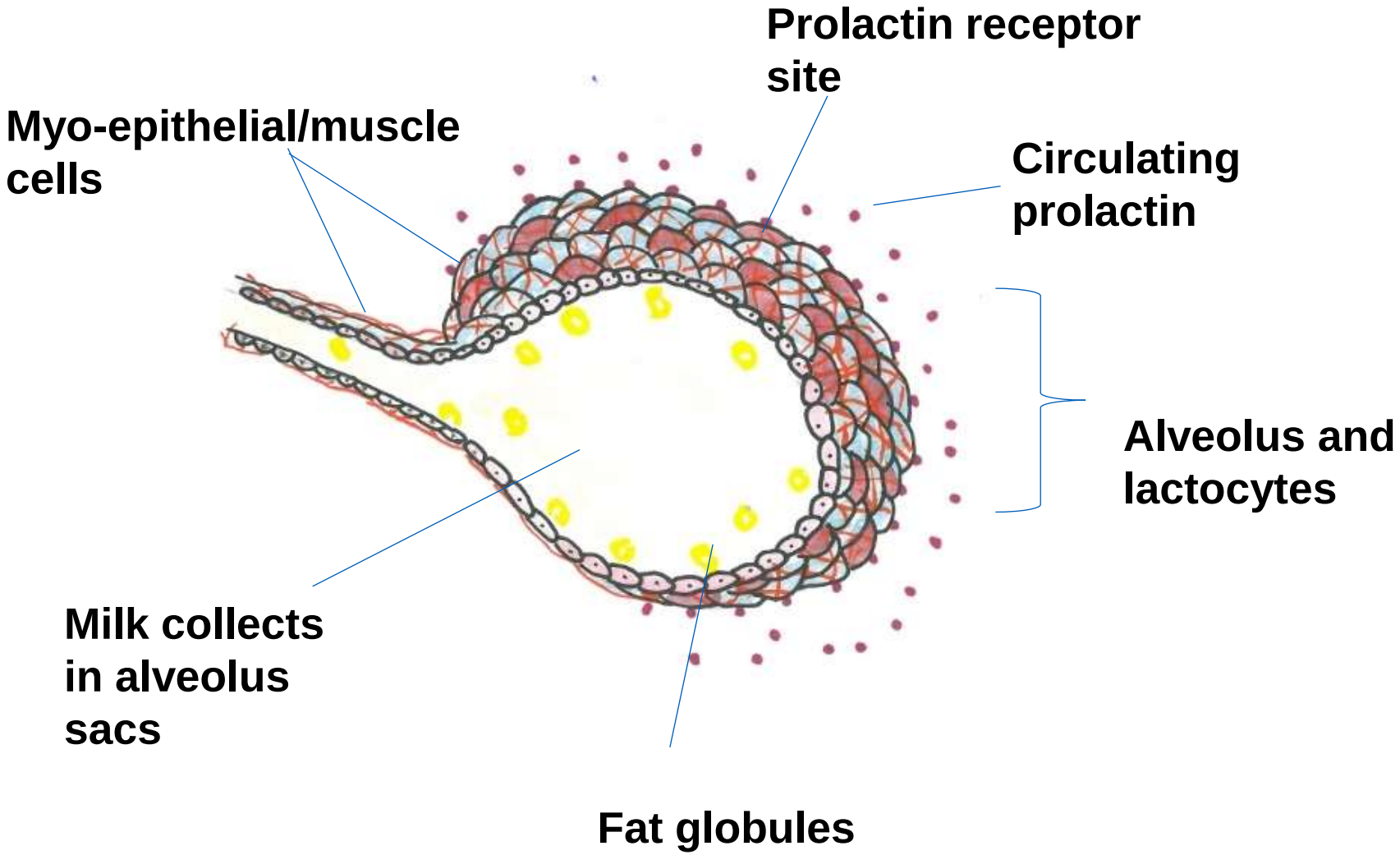
- Responsible for **milk production**
- Responsive to touch and stimulation
- Levels higher at night
- Frequent contact/feeds sets up long term production

Oxytocin

- Responsible for **milk delivery**
- Acts on muscle cells in pulsatile action
- Levels higher when baby is near
- Stress can temporarily delay ‘let down’

Together they stimulate instinctive mothering behaviours and provide the basis for close and loving relationships to thrive.

The prolactin receptor theory



Oxytocin: The love hormone

- Works on our feelings and emotions
- Lowers blood pressure and improves sleep
- Reduces stress levels by ‘taking on’ cortisol
- Reduces pain sensitivity
- Boosts our immune system

Some evidence that synthetic oxytocin can negatively impact on normal production

For sick or preterm babies

Skin-to-skin contact at birth if possible – delivery room cuddles

Hand express **within 2 hours** of birth (collaboration between Neonatal and maternity)

Express at least **8 times (preferably 8-10)** in 24 hours, including at night

Combine hand and pump as volume increases

Keeping it going

- Spend time with baby
- Skin contact / kangaroo care
- Breast massage
- High quality breast pump
- Double pumping
- Funnel size

Keep checking in on mum to see how expressing is going and remind her how amazing it is that she is doing this for her baby

Aim high!

But how high???

Supporting early breastfeeding in Practice

- Antenatal conversation
- Antenatal colostrum collection -hand expression -colostrum packs
- Continued staff education and clinical skills reviews
- Joint working with maternity/Neonatal
- Buccal colostrum guidance / mouthcare
- Expression checklists
- Transition to breastfeeding
- Feeding plans
- Maximising and valuing breastmilk
- Alter timings if required
- Full access

Expressing assessment form

If any responses in the right hand column are ticked refer to specialist practitioner. Any additional concerns should be followed up as needed. Please date and sign when you have completed the assessments.

Mother's name:	*Baby's name:* *Date of birth:*	*Date of assessment:*				*Birth weight:* *Gestation:*				
What to observe/ask about	**Answer indicating effective expressing**	✓	✓	✓	✓	**Answer suggestive of a problem**	✓	✓	✓	✓
Frequency of expression	At least 8-10 times in 24 hours including once during the night.					Fewer than 8 times. Leaving out the night expression.				
Timings of expressions	Timings work around her lifestyle – if cluster expressing, no gaps of longer than 4 hours (daytime) and 6 hours (night time)					Frequent long gaps between expressions. Difficulty 'fitting in' 8 expressions in 24 hours.				
Stimulating milk ejection	Uses breast massage, relaxation, skin contact and/or being close to baby. Photos or items of baby clothing to help stimulate oxytocin.					Difficulty eliciting a milk ejection reflex. Stressed and anxious.				
*Hand expression	*Confident with technique. Appropriate leaflet/information provided.					*Poor technique observed. Mother not confident.				
Using a breast pump	Access to electric pump. Effective technique including suction settings, correct breast shield fit. Double pumping (or switching breasts) to ensure good breast drainage. Uses massage and/or breast compression to increase flow.					Concern about technique. Suction setting too high/low, restricting expression length, breast shield too small/large.				
Breast condition	Mother reports breast fullness prior to expression which softens following expression. No red areas or nipple trauma.					Breasts hard and painful to touch. Evidence of friction or trauma to nipple.				
Milk flow	Good milk flow. Breasts feel soft after expression.					Milk flow delayed and slow. Breasts remain full after expression.				
Milk volumes	Gradual increases in 24 hr volume at each assessment.					Milk volumes slow to increase or are decreasing at each assessment.				

Hand expression may not need to be reviewed every time

If milk production falters

A drop in production commonly coincides with a setback in the baby's progress

- Check expression technique and frequency
- Kangaroo care
- Increase frequency and duration of expression
- Relaxation techniques
- Prolactin enhancers
- Build mother's confidence

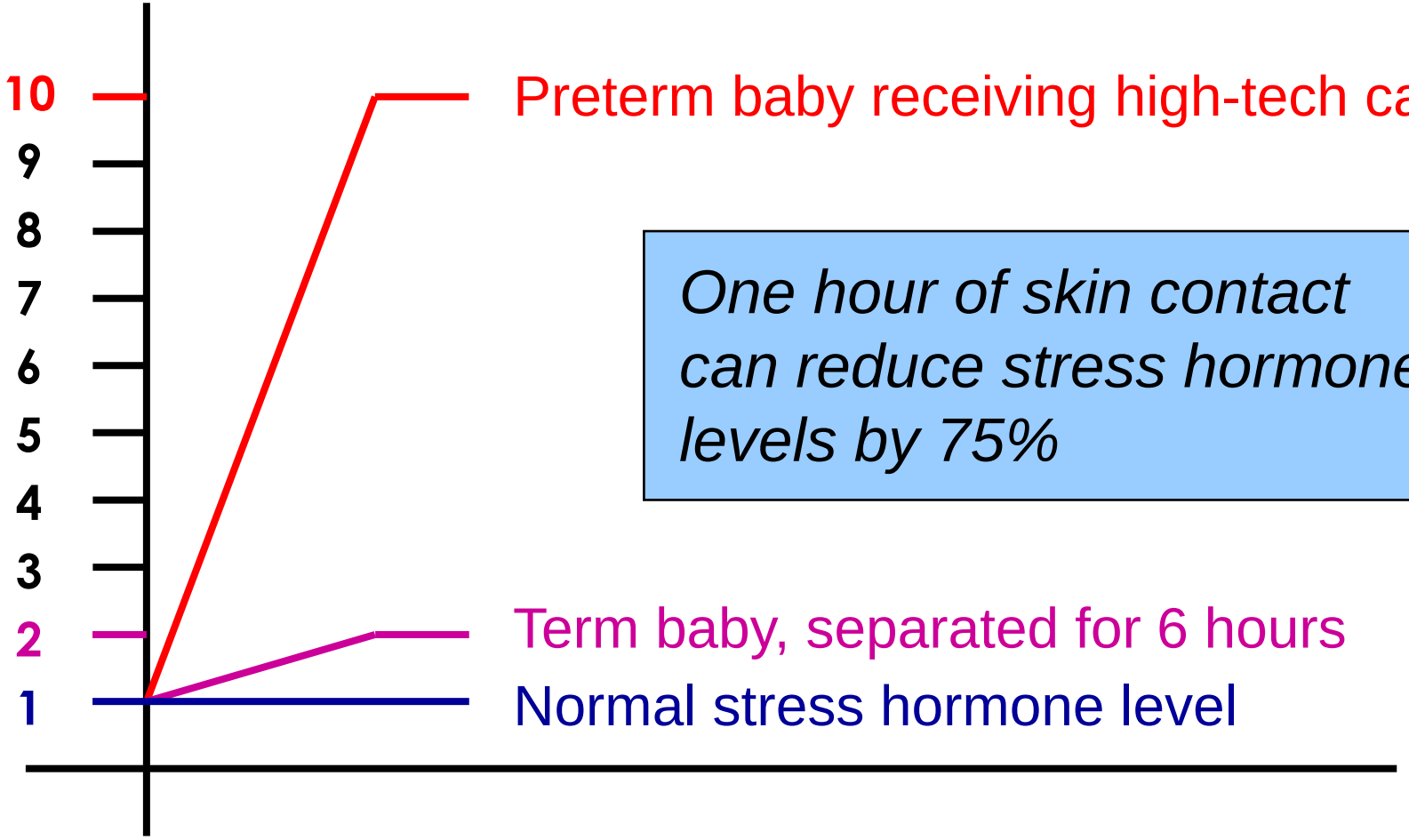
Skin-to-skin contact (KMC)

Share the love!

% of babies receiving Skin to skin contact during stay on NNU

Trust	<28 weeks		28-31 weeks		32-36 weeks		37+ weeks	
	Sept 2021	Jan – Oct 2023	Sept 2021	Jan – Oct 2023	Sept 2021	Jan – Oct 2023	Sept 2021	Jan – Oct 2023
RVI	52.9	43.75	47.5	57.89	20.49	26.79	9.5	17.95
JCUH	85.1	67.21	73.17	91.18	42.85	60	35.8	39.85
SRH	0	0	0	0	0	0	0	1
UHNT	33 (3)	35.71 (14)	20 (10)	50 (28)	36.6	37.68	29.6	27.66
QEH	28.5 (5)	20 (5)	75 (4)	52.85 (13)	43.75	31.91	35.7	27.78
UHND	0 (4)	35.71 (14)	60 (15)	57.58 (33)	48.64	44	14.9	25.2
DMH	50 (2)	0 (2)	100 (11)	50 (18)	64.5	56.06	25.4	35
NSECH	33 (6)	77.78 (9)	85.71 (14)	74.36 (39)	60	66.67	39.21	48.65
CL	- (0)	40 (5)	14.28 (14)	50 (18)	61.5	50	38.7	36.23
WCL	50 (4)	33.3 (3)	50 (6)	53.33 (15)	33	31.71	13.7	7.69

Separation and stress



One hour of skin contact can reduce stress hormone levels by 75%

What may prevent skin-to-skin contact from taking place more often?

Unit progress

Trust	Progression Stage	Champion protected hours	Baseline audit	Training	Projects in place / interventions Parents as partners in care
CDDFT	Cert of commitment Stage 1 application for March 2023. Stage 2 planned by end of 2023	not currently in place.	Complete	Training commenced 60% of staff to be fully compliant by March 2023	Data improvement Expression packs in place Buccal colostrum guideline Collaborative working with maternity Parent access to food/drink
JCUH	Stage 1 Stage 2 planned by end of 2023	6 hours band 6 extra paid hours when required	Complete	All staff by April 2023 due to staffing and pressures may be delayed.	Data improvement achieved through IF champion comms and stickers on all computers. Skin to skin audits ongoing Expression packs Parent access to food/drink Golden drops cards
UHNT	Cert of commitment Stage 1 for submission by April 2023	Protected time confirmed from January 2023 for champion.	To commence Jan 2023	Stand-alone training to commence March/April 2023	Parent access to food/drink Expression packs
NCIC	Cert of commitment Stage 1 TBA	not currently in place	Plan to be put in place	Plan to be put in place	Expressing packs Fold out beds available Recliners next to each cot Access own milk

Unit progress

Trust	Progression Stage	Champion protected hours	Baseline audit	Training	Projects in place / interventions Parents as partners in care
RVI	Full accreditation achieved January 2022	1x Band 7 -25hours/week and 1x band 6, 24 hours/ week.	Baseline N/A Annual audit for submission January 2023.	Training remains a challenge due to high staffing numbers and turn over.	Colostrum prescribed (milk as Medicine)
QEH	Cert of commitment Stage 1 for submission by April 2023	Not currently in place	Complete	Start date TBC and curriculum completed	
NSECH	Stage 1 Stage 2 date TBA	As part of ANNP role	Complete	In place Expected date of completion: mid 2023	Recliners next to each cot Parent access to food/drink
SRH	Stage 1 Stage 2 date TBA	Band 6 / 29 hours	Complete	Commenced	Access own milk

NENC approach

- NENC Neonatal infant feeding network
- Collaboration for development of action plans
- Curriculum planning support – sharing of lesson plans/materials etc
- Audit support linked to Ficare and Neonatal service user experience feedback and surveys
- Care Co-Ordinator support

What we do now lasts a lifetime

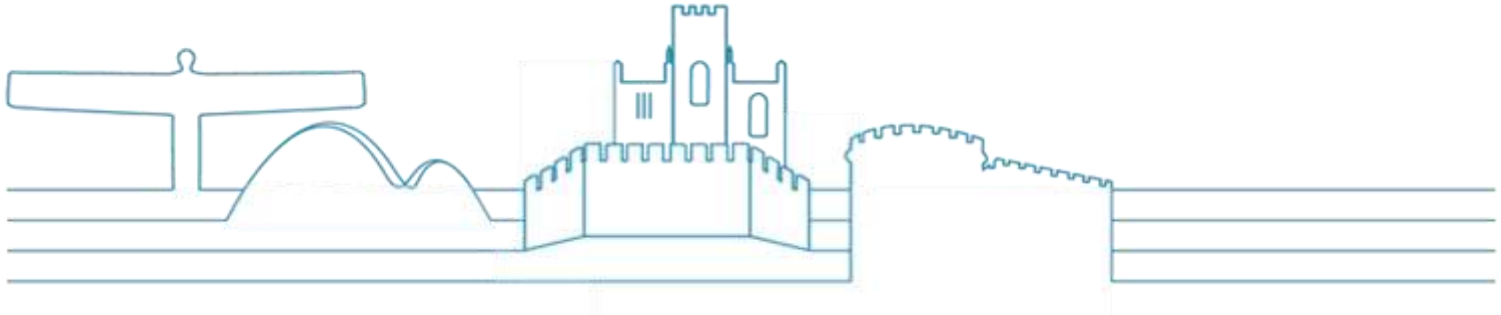
THE BABY FRIENDLY INITIATIVE

unicef UNITED KINGDOM

Contact details

rnunnrnunn@nhs.net

07807812390270



National Patient Safety Improvement Programmes

Maternity and Neonatal

NHS

Preterm Birth Clinics

Gareth Waring
Consultant in Obstetrics
The Newcastle upon Tyne Hospitals NHS FT

@AHSN_NENC

ahsn-nenc.org.uk

Delivered by:

North East and North Cumbria
Patient Safety Collaborative

The AHSN Network

Maternity Clinical Network North East and North Cumbria

Northern Neonatal Network

North East and North Cumbria Local Maternity and Neonatal System

NHS The Newcastle upon Tyne Hospitals NHS Foundation Trust

Led by:

NHS England
NHS Improvement


TAKE
a
break

National Patient Safety Improvement Programmes

NHS

Maternity and Neonatal

Involving women and families in improvement using the Coalition for Personalised Care Co-Production Model

Julia Wood
MatNeoSIP Lead – NENC
Academic Health Science Network NENC

@AHSN_NENC

ahsn-nenc.org.uk

Delivered by:

North East and North Cumbria
Patient Safety Collaborative

TheAHSNNetwork

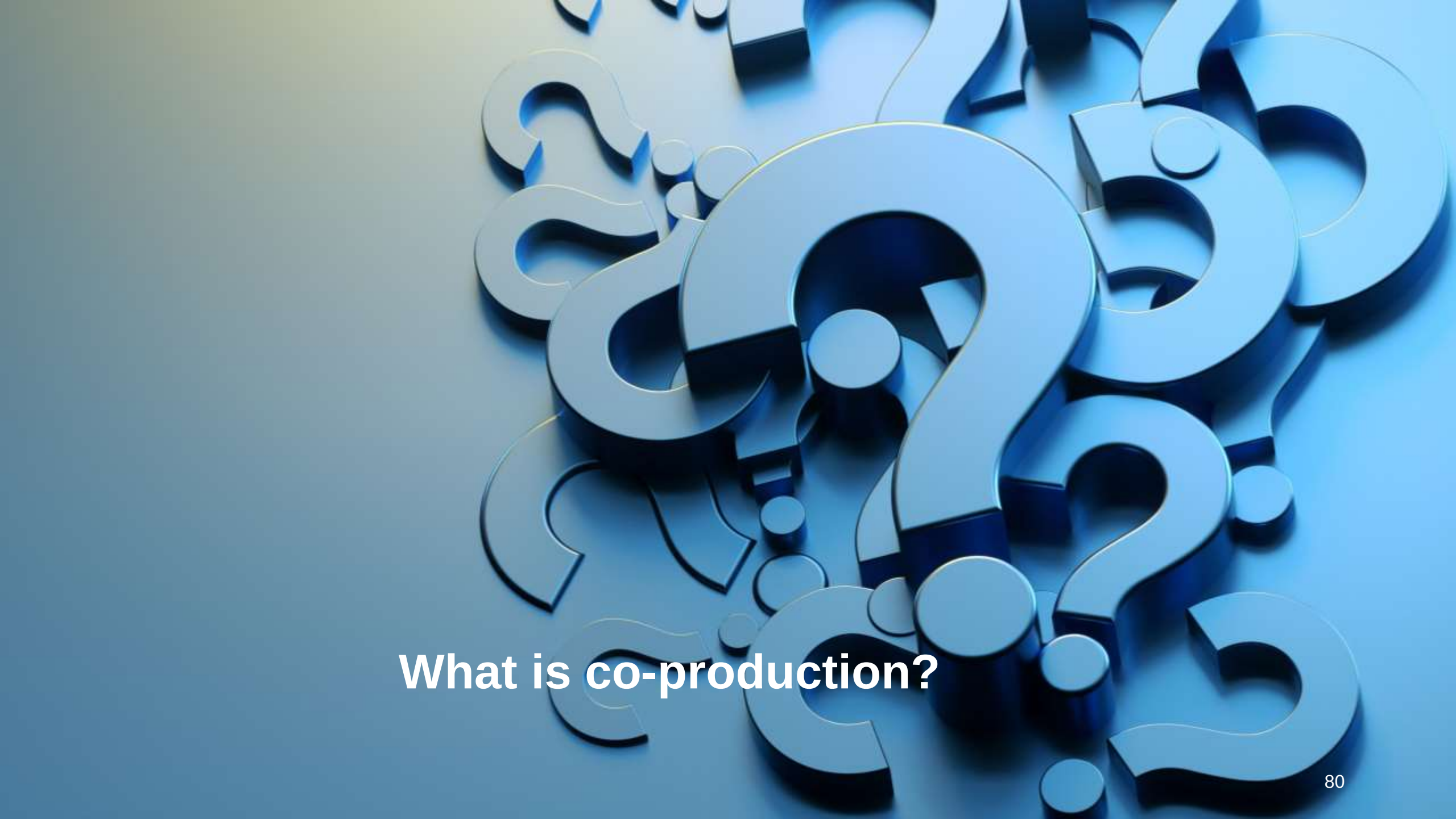
Maternity Clinical Network North East and North Cumbria

Northern Neonatal Network

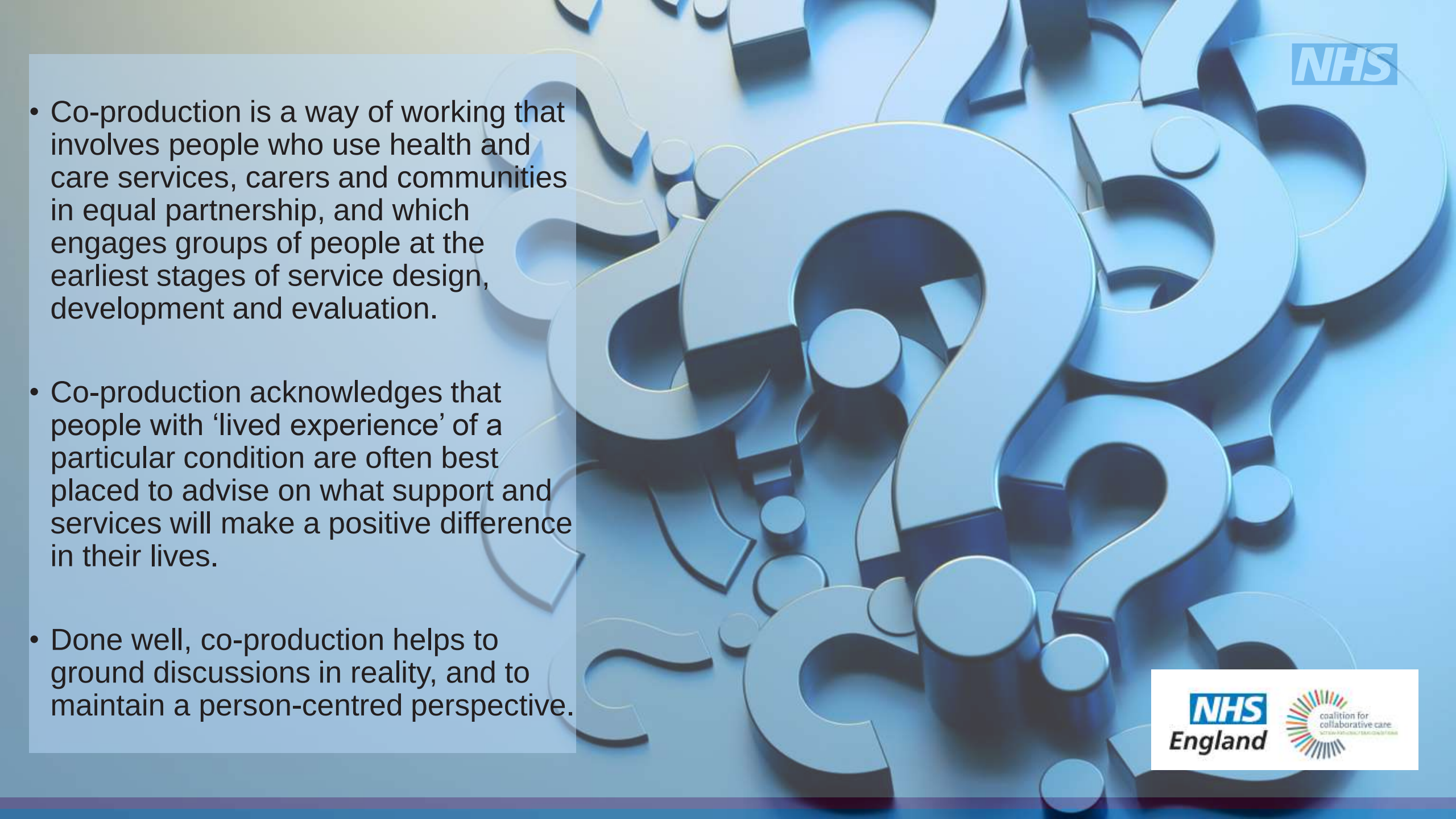
North East and North Cumbria Local Maternity and Neonatal System

Led by:

NHS England
NHS Improvement



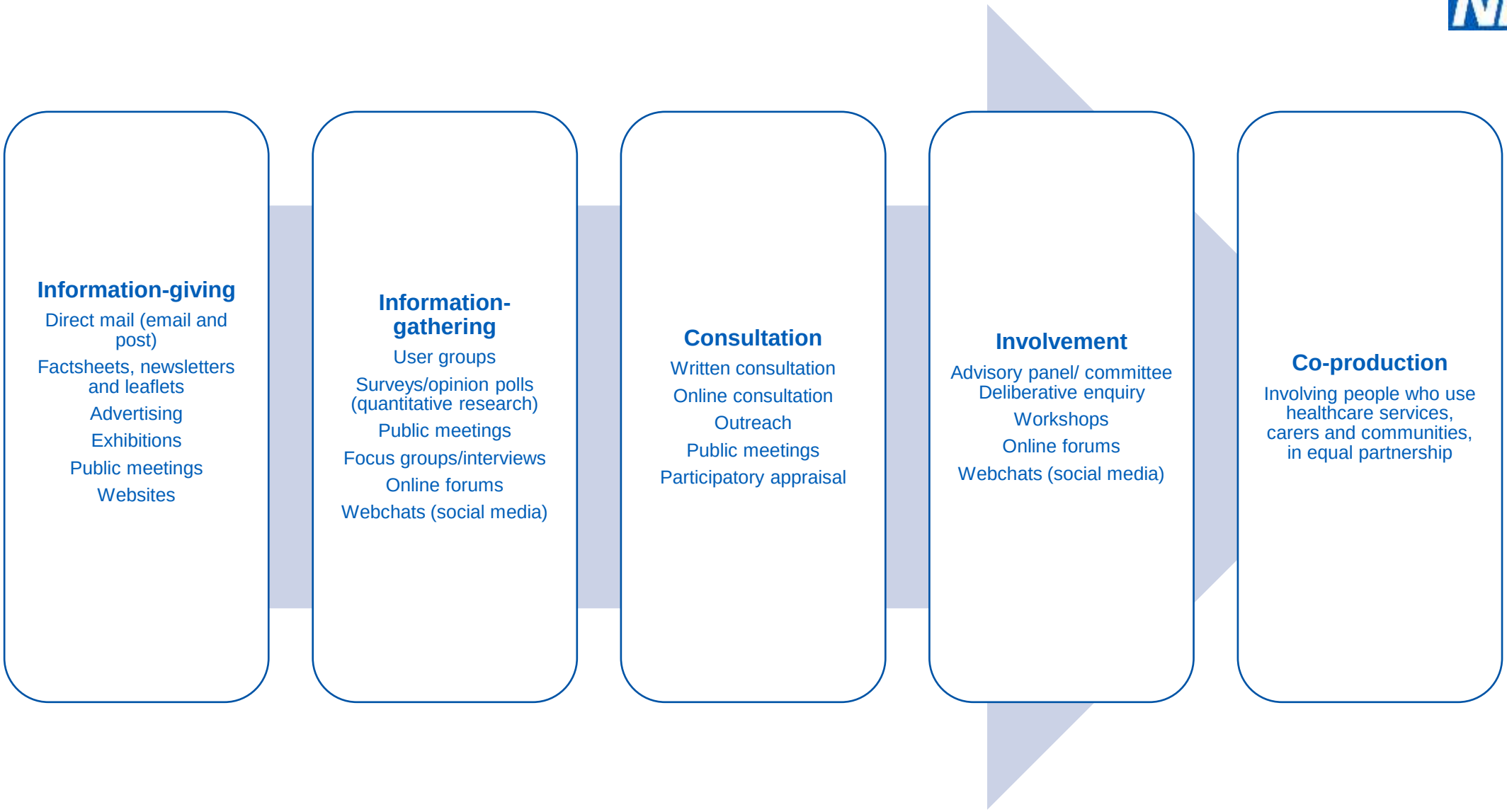
What is co-production?



- Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership, and which engages groups of people at the earliest stages of service design, development and evaluation.

- Co-production acknowledges that people with ‘lived experience’ of a particular condition are often best placed to advise on what support and services will make a positive difference in their lives.

- Done well, co-production helps to ground discussions in reality, and to maintain a person-centred perspective.

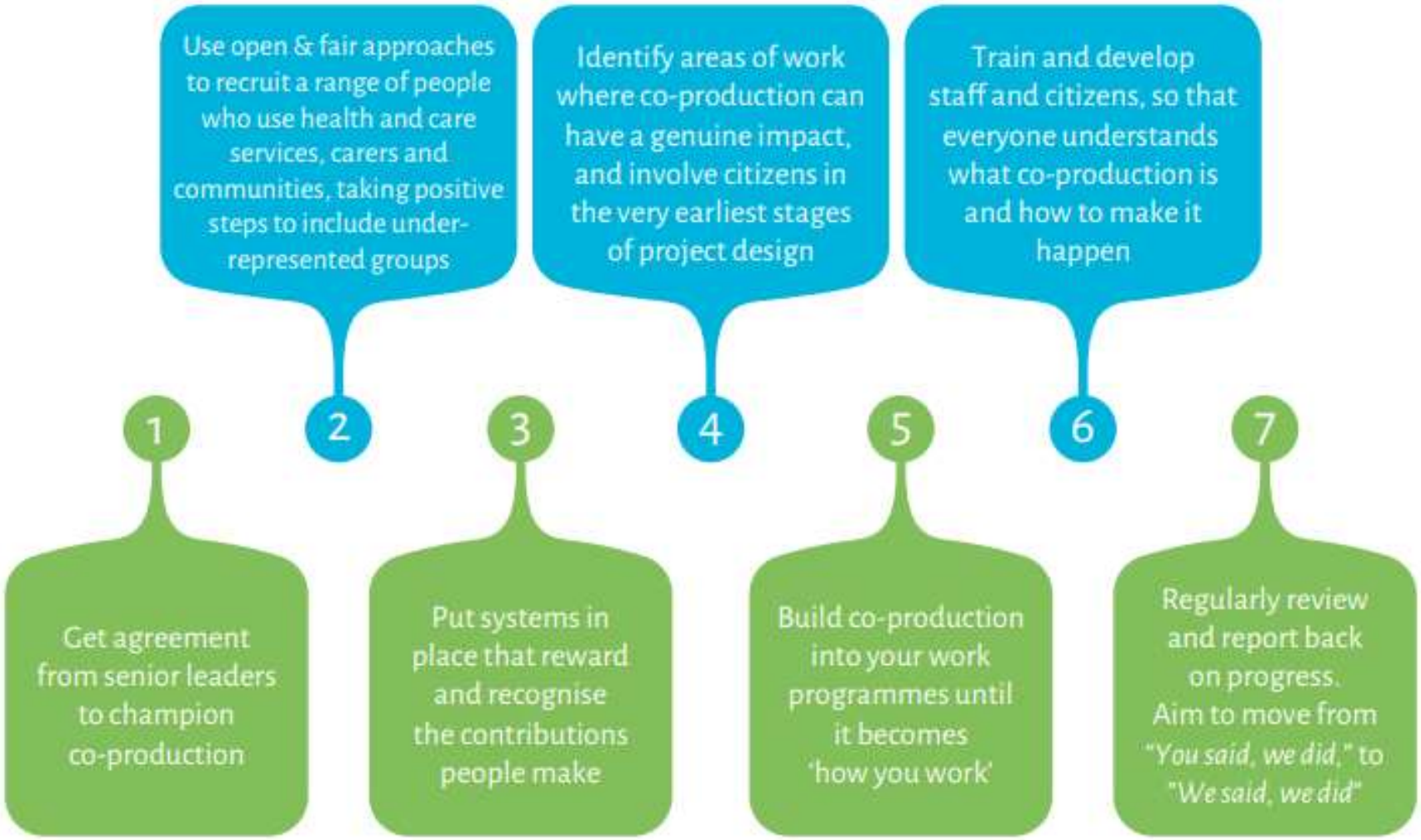

Information-giving
Direct mail (email and post)
Factsheets, newsletters and leaflets
Advertising
Exhibitions
Public meetings
Websites
Information-gathering
User groups
Surveys/opinion polls (quantitative research)
Public meetings
Focus groups/interviews
Online forums
Webchats (social media)
Consultation
Written consultation
Online consultation
Outreach
Public meetings
Participatory appraisal
Involvement
Advisory panel/ committee Deliberative enquiry
Workshops
Online forums
Webchats (social media)
Co-production
Involving people who use healthcare services, carers and communities, in equal partnership

Values and behaviours

For co-production to become part of the way we work, we will create a culture where the following values and behaviours are the norm:

How to do it?

Seven practical steps to make co-production happen in reality:



What is your experience? Is this approach possible?


THANK
YOU

National Patient Safety Improvement Programmes

Maternity and Neonatal

NHS

Final Comments

Julia Wood
MatNeoSIP Lead – NENC
Academic Health Science Network NENC

@AHSN_NENC

ahsn-nenc.org.uk

Delivered by:

North East and North Cumbria
Patient Safety Collaborative

The AHSN Network

Maternity Clinical Network North East and North Cumbria

Northern Neonatal Network

North East and North Cumbria Local Maternity and Neonatal System

Led by:

NHS England
NHS Improvement