Agenda Item No. 15

The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (PUBLIC)

RESPONSIBLE DIRECTOR:	REPORT FOR:		IMPACT ON BUSINESS:		
	Decision		High	Med	Low
Libby McManus	Consideration	✓	✓		
	Information				
LEAD MANAGER:	**REPORT TYPE:**		**BAF REFERENCES & RAG:**		
Kathryn Owens	Strategic				
	Operational	✓			
	Governance				
	IMPLICATIONS:		**RELATED WORK: (PREVIOUS PAPERS TO BOARD/COMMITTEE)**		
	Patient Care/Safety/ Experience	✓			
	Finance				
	Workforce				
	Policy				
PEER ASSIST (inc. clinical engagement):	**PEER REVIEW:**				
CQC Domain: (safe, caring, effective, responsive, well-led, use of resources)					

Meeting Date: **04 February 2020**

Report Title: **Maternity Transformation Programme**

PURPOSE:

Better Births, the report of the National Maternity Review was published in February 2016 and set out a clear vision: for maternity services across England to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred on their individual needs and circumstances. It also calls for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.

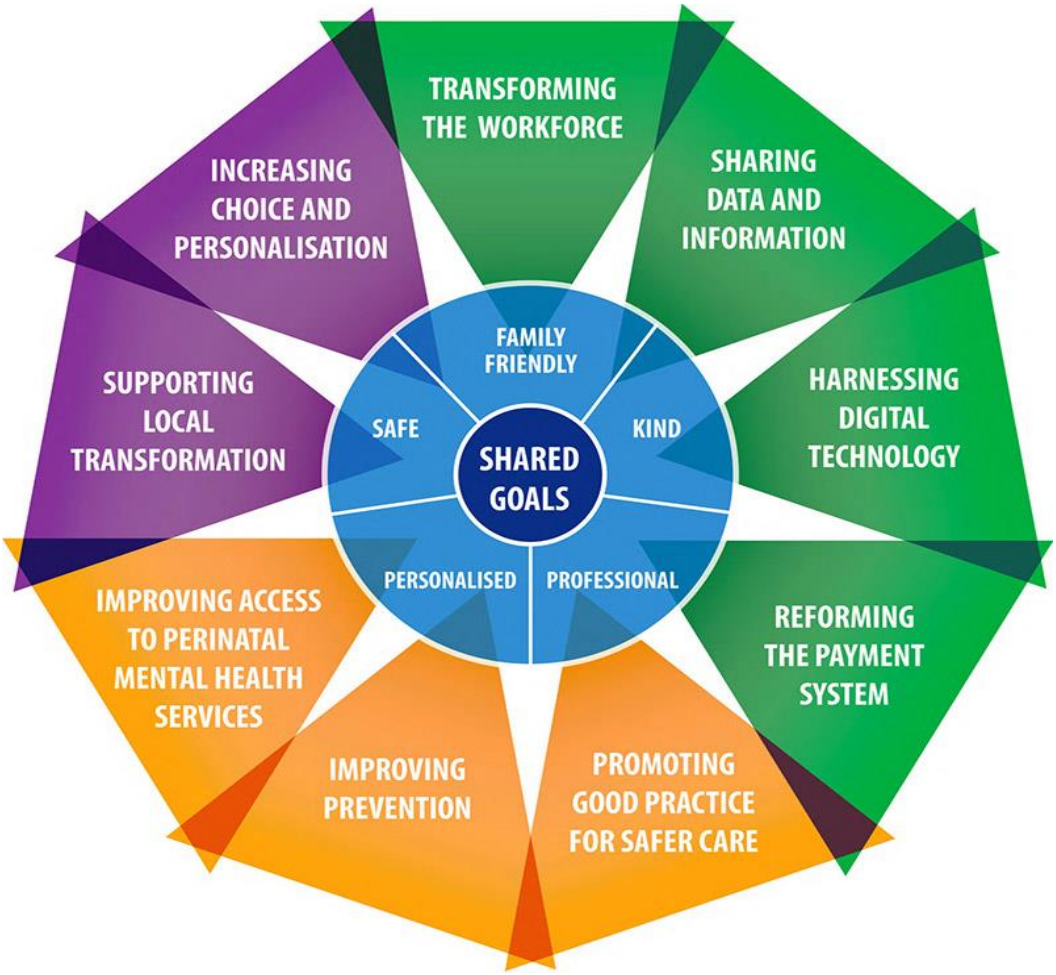
Implementing the vision set out Better Births will support the Secretary of State's ambition to halve the number of stillbirths, neonatal and maternal deaths and brain injuries by 2030.

The Maternity Transformation Programme seeks to achieve the vision set out in Better Births by bringing together a wide range of organisations to lead and deliver across 9 work streams. The programme is led by a Programme Board, supported by a representative group of stakeholders that will scrutinise and challenge decisions made by the Board.

Local transformation supported by national enabling action is key to realising the Better Births vision. Providers and commissioners of maternity services have been asked to come together to form Local Maternity Systems, which will plan the design and delivery of services of populations of 500,000 – 1,500,000 people. These Local Maternity Systems will be formed by the end March 2017 and will be

supported to put plans in place, by the end of October 2017, to deliver Better Births.

Nine national programme work streams are supporting the implementation of Better Births locally:



Elements of the Maternity Transformation Programme:

Version two of the Saving Babies' Lives Care Bundle (SBLCBv2), has been produced to build on the achievements of version one and address the issues identified in the its evaluation. This version aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice. The new fifth element is reducing pre-term birth.

This is an additional element to the care bundle developed in response to the Department of Health's 'Safer Maternity Care' report which extended the 'Maternity Safety Ambition' to include reducing preterm births from 8% to 6%. This new element focuses on three intervention areas to improve outcomes which are prediction and prevention of preterm birth and better preparation when preterm birth is unavoidable

Implications : Financial / Quality / Workforce / Policy:

Strategic /	Operational	Financial	Clinical	Legal/	Reputational	Workforce

External				Regulatory	/ Patient Experience	
√		√	√	√	√	√

RECOMMENDATION/S:

Better Births Reccommendations:

- **Personalised care,** centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.
- **Continuity of carer,** to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.
- **Safer care,** with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.
- **Better postnatal and perinatal mental health care,** to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.
- **Multi-professional working,** breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.
- **Working across boundaries** to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.
- **A payment system** that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice.

Continuity of Carer:

Cochrane review (2016)found that women who received midwife-led continuity of care were less likely to experience preterm births or lose their baby in pregnancy or in the first month following birth:

- 16 per cent less likely to lose their baby
- 19 per cent less likely to lose their baby before 24 weeks
- 24 per cent less likely to experience pre-term birth

Provide for consistency of the midwife and/or obstetrician who cares for a woman throughout the antenatal, intrapartum and postnatal periods.

Include a named midwife who takes on responsibility for co-ordinating a woman's care throughout the antenatal, intrapartum and postnatal periods.

Enable the woman to develop an ongoing relationship of trust with her midwife.
Where possible be implemented in both the hospital and community settings.

There are two main models which meet these principles which Local Maternity Systems will want to consider for implementation locally:

• Team continuity, whereby each woman has an individual midwife, who is responsible for co-ordinating her care, and who works in a team of four to eight, with members of the team acting as backup to each other. This allows for protected time, during which the other members of the team will provide unscheduled care, and the lead midwife will not be called upon. The woman gets to know all the members of the team, so at the time of the birth she has met all of its members.

• Full case loading, whereby each midwife is allocated a certain number of women (the caseload) and arranges their working life around the needs of the caseload. The backup is provided by a core midwifery team whom the woman is unlikely to have met.

To achieve continuity of carer a named midwife or buddy needs to care for women 70% of the antenatal, intrapartum and postnatal period. To achieve this, the ratio of midwife to women is 1:35.

Currently Birth rate plus criteria suggest that within community midwifery the ratio is 1:96, with the ratio on delivery suite 1:29.5. Teams will consist of 6 to 8 midwives and will be supported through the use of community hubs. National ambition was to achieve a 20% rate of women on a continuity of carer pathway by March 2019, 35% by March 2020 and 51% as the majority by 2021. The QEH and Norfolk and Waveney have declared a 0 return currently for continuity of carer due to the staffing and geographical challenges we face. Until now it has not been safe for QEH to deliver continuity of carer, however, due to an increase in recruitment we are in the position now to begin the consultation process for this new way of working. The LMS is aiming to undertake a system wide approach to continuity of carer with geographical based teams, learning lessons from early adopters. The LMS have recently appointed an 8a Better Births Midwife for each site, with 1 WTE allocated to QEH to support with the delivery of the Better Births agenda, starting in post at the end of January.

Saving Babies Lives Care Bundle Version 2

In November 2015, the Secretary of State for Health announced a national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030, with a 20% reduction by 2023. The first version of the Saving Babies' Lives Care Bundle (SBLCB) was published in March 2016 and focussed predominantly on reducing the stillbirth rate. In November 2017, the ambition was extended to include reducing the rate of preterm births from 8% to 6% and the date to achieve the ambition was brought forward to 2025. In response to the extended ambition, SBLCB version two (SBLCBv2) additionally includes the aim to reduce preterm birth and improve outcomes when preterm birth is unavoidable to further decrease perinatal mortality. This must be fully implemented by March 2020. The NHS Long Term Plan (LTP) reiterates the NHS's commitment to a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury and a reduction in preterm birth rate, from 8% to 6%, by 2025. An additional element has been included in the SBLCBv2 to address the increasing prevalence of preterm birth. This element focuses on predicting and preventing preterm birth and, when preterm birth cannot be avoided, preparing the mother and baby appropriately.

Saving Babies Lives Care Bundle version 2 comprises of 5 elements which must be met. These are made up of reducing smoking in pregnancy, Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR), Raising awareness of reduced fetal movement, Effective fetal monitoring during labour, Reducing preterm birth. Quarterly we must report our progress to NHS England and monitoring takes place within the division on a monthly basis to identify any areas where actions are required through the newly established Maternity Strategy and Safety Board.

We are currently undertaking a Gap analysis to identify any areas of concern within the Saving Babies lives care bundle version 2.

Maternity and Neonatal Safety Collaborative (MATNEO):

- Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England
- Contribute to the national ambition, set out in Better Births, of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 50%

by 2025.

The QEH were part of wave 3 and the project that has been undertaken aims to reduce, by 50%, the number of babies admitted to the neonatal intensive care unit with hypoxia by March 2020. The main areas of focus are the intrapartum risk assessment and fresh eyes review of the CTGs with work being undertaken on the culture and teamwork within the unit and learning from excellence.

The current rate of intrapartum risk assessment completion is 86% (team aim was to achieve over 30% completion by March 2020) and there have been no cases sent for cooling since March 2019 and no HIE cases since June 2019. Since the start of the MATNEO project, there has been a reduction in the number of cases of hypoxia admitted to the neonatal unit with December results hitting the target rate of 50% reduction.

The implementation of 'great catches' into the huddle aims to promote learning from excellence. There is some work to be undertaken to embed the process into every day practice and the team continues to engage the delivery suite team to do this.

A division wide vision is being developed with staff and service users to help support the culture within the division. This will be circulated more widely for comments once the first draft is complete.

The team are currently developing a poster for the March presentations with NHS Improvement and are engaged with the Local Learning System as part of the Local Maternity System to disseminate the learning and outcomes of the project.

RECOMMENDATION/S:

The Committee is asked to:

- Note the detailed contents of the paper