British Association of Perinatal Medicine

National Patient Safety Improvement Programmes

Maternity and Neonatal

In collaboration with the Maternity and Neonatal Safety Improvement Programme and developed by a Multiprofessional BAPM working group.

Building Successful Perinatal Optimisation Teams

A Toolkit to support delivery of the Perinatal Optimisation Pathway

February 2023

Contents

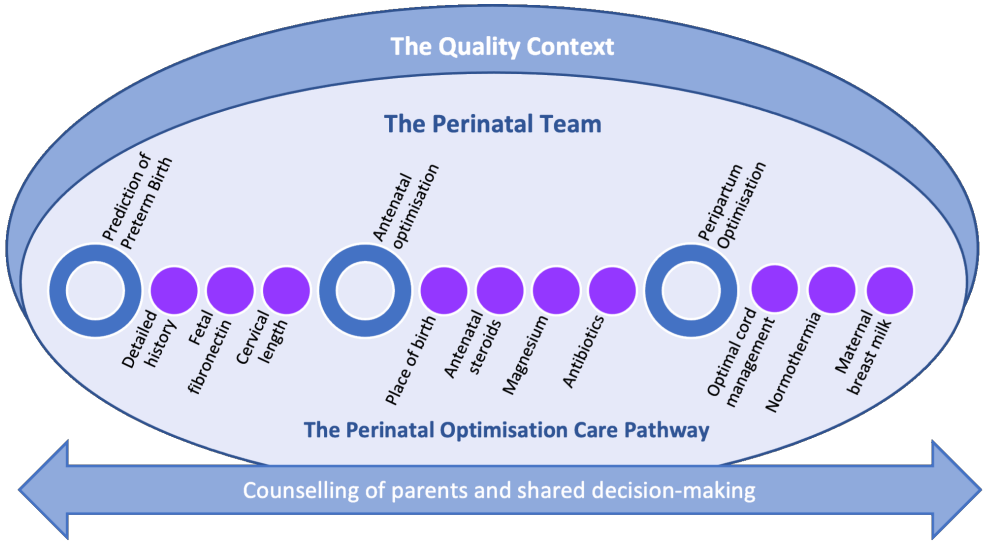
Statement on Inclusive Language and Practice

BAPM is aware that the use of gendered language such as mother and maternal, as well as breast and breastmilk feeding, can make some families feel excluded. When we use these words in this document we are referring to all birthing people and people, regardless of their gender identity. When supporting individual families, professionals should ensure that they use the terms that the family identifies with, as well as their desired pronouns. Professionals should be aware of the range of nuances around birth and lactation in the LGBTQ community. Readers should look elsewhere for specialised information in these contexts. A general overview can be found here: www.hifn.org/sex-gender-orientation.

Building Successful Perinatal Teams
The Perinatal Optimisation Care Pathway

The Perinatal Optimisation Care Pathway

Perinatal optimisation refers to The BAPM 'Perinatal Optimisation Care Pathway' and is the process of reliably delivering evidence-based interventions in the antenatal, intrapartum and neonatal period to improve preterm outcomes. The pathway is supported by four BAPM toolkits (Antenatal Optimisation, Optimal Cord Management, Normothermia and Maternal Breast Milk) which are a focus of the implementation programme led by Maternity and Neonatal Safety Improvement Programme, NHS England and NHS Improvement (MatNeoSIP) and it supports key recommendations from the Neonatal Critical Care Transformation Review and the Saving Babies Lives Care Bundle v2.



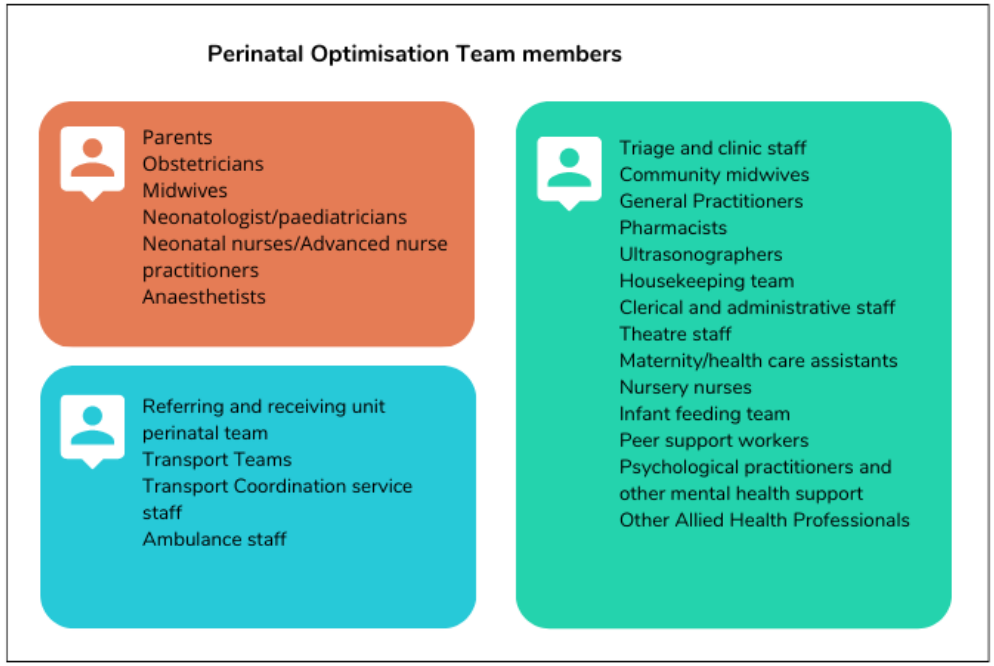
Reliable delivery of the this Pathway depends on a strong teamworking culture, high quality communication habits and pursuit of common goals within perinatal teams, undertaken within a favourable quality context where the structure and processes support an optimal environment for delivering quality improvement (read more here).

What is culture and why is optimal perinatal culture important?

Culture refers to the various components of institutional life which are shared across a workplace or organisation. These include the beliefs, attitudes and assumptions of members and their activities, such as their behaviours, practices and interactions. These normalised and shared ways of thinking, practising and behaving are what comes to be seen as appropriate and acceptable. The expressions of this culture are the social and cognitive 'glue' which binds members together, becoming both 'the way *people think* around here' and 'the way *things are done* around here'. Culture thus has a continuous and permeating impact on both individual and team functioning. Hence, fostering a positive culture is of fundamental importance to safeguard safe practice and to deliver consistent high quality care.

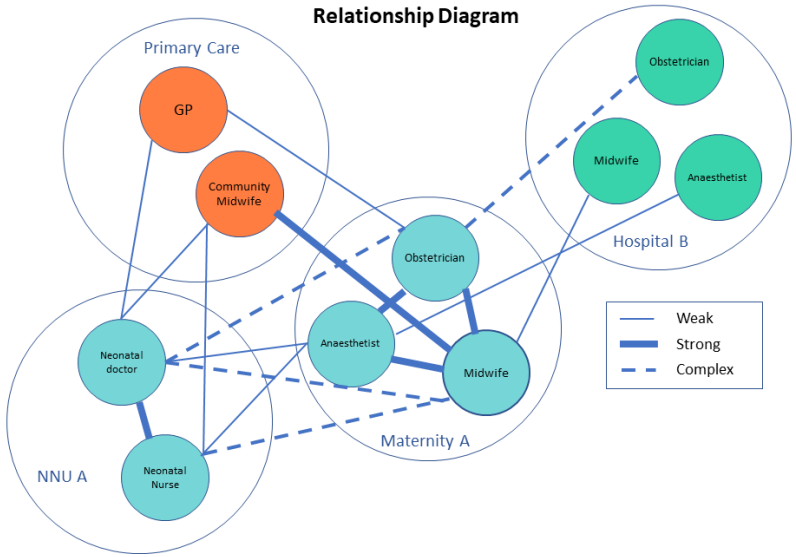
This resource will enable Perinatal Optimisation Teams to assess their quality context, team interactions, functioning and ways of working and to use this assessment to provide intelligence about culture and readiness for change. It then becomes possible to plan improvements in team relationships and infrastructure towards the shared goal of improving preterm outcomes (read more here).

The Perinatal Optimisation Team



The Perinatal Optimisation Team includes all those who input into the care of pregnant women and their babies, to ensure best outcomes. It is not simply a group of service Obstetricians, Midwives and Neonatologists/Paediatricians, but instead has parents and babies at the heart, and extends widely to include many other professionals across primary and secondary care (read more here).

All members require recognition of their value, inclusion in the shared work, and encouragement to help shape the service as *one single* perinatal optimisation team with a single shared vision.



Team Activity:

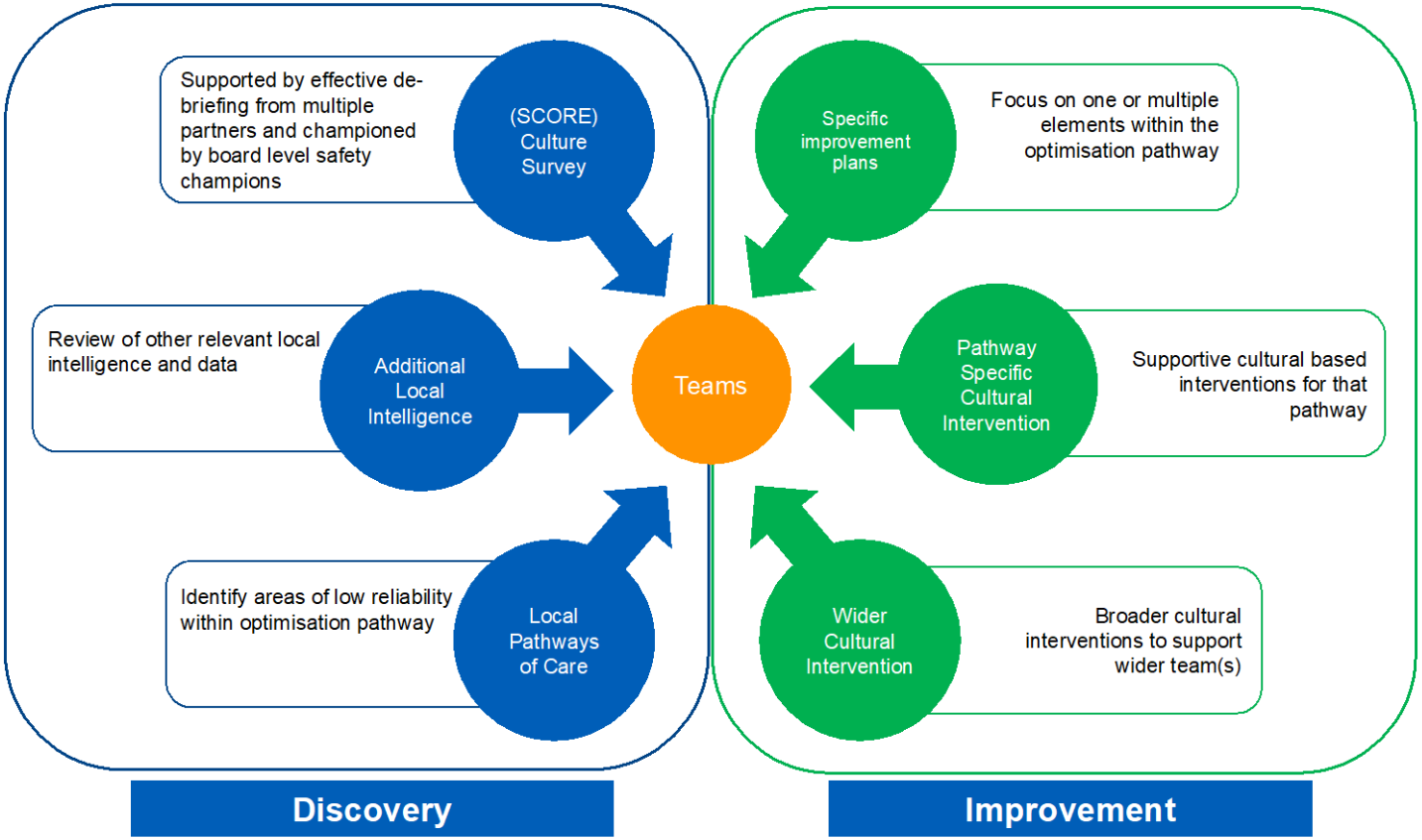
1. As a multidisciplinary perinatal group, take some time to think about your core optimisation team and the relationships with the various other individuals and groups with whom you work.
    a. Together describe this as a diagram, using the size and type of connectors to reflect the perceived strength of relationships between teams (see example)
    b. Ask questions to understand why some relationships are strong and effective
    c. Ask what can be done to mirror that relationship between other staff groups
    d. Ask what relationships are a priority for development and why
2. Use the tools described in the next section as a starting point to define the strengths and limitations of your current relationships.

Building Successful Perinatal Optimisation Teams
Discovery: The starting point

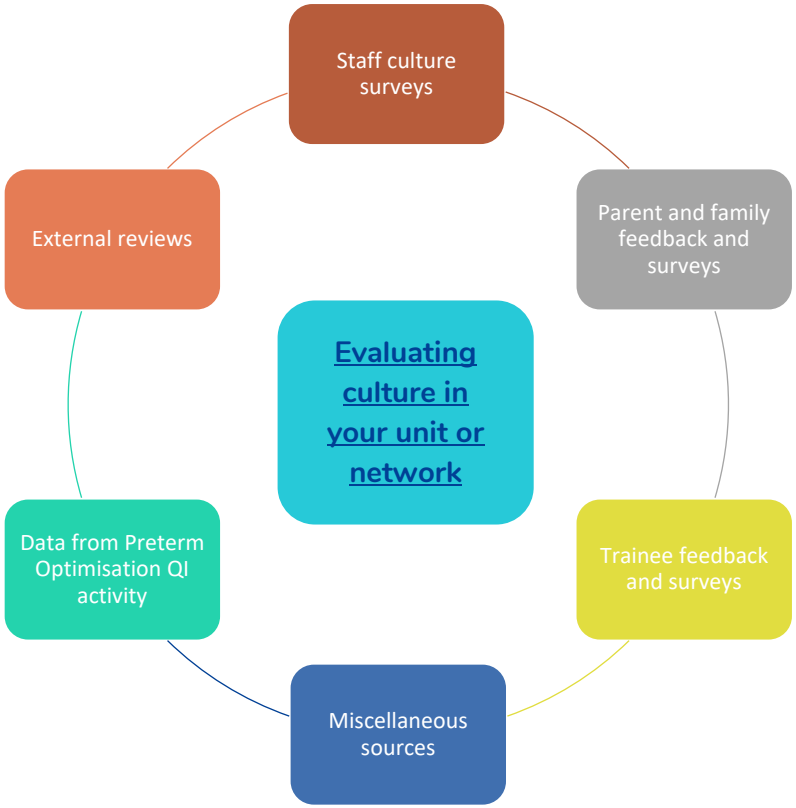
Using intelligence to begin to improve culture

Approaching an ambition to improve culture can be daunting and may feel overwhelming for any team or organisation. Understanding how to undertake the work, ensuring that the aim is clear to all involved and building confidence are all key steps. Aims may vary according to particular areas of current strength/need for improvement within teams. Ultimately all teams must aim to:

1. self-assess in an honest, accountable and comprehensive fashion ('Discovery'), and
2. enhance their team culture and context for the good of parent and infant outcomes, and staff working ('Improvement')



Discovery: The measurement of culture



Measurement is the first step towards improving the culture and context within your unit. In gaining an understanding of the culture in your service, and the climate experienced by staff, women, parents and families, valuable data and insight can be drawn and used as intelligence in identifying areas for improvement and change. Evaluating the baseline culture in your service or network can include a range of tools which will provide you with both quantitative data and a qualitative narrative.

It is recommended that services do not rely only on one source of data but to cast the net wide so as best to capture the experience of all in the team. We suggest gathering intelligence from at least one item under each of the following tools or data sources provided below. As steering the culture of a team is by nature slow, teams are encouraged not only to undertake a re-evaluation of culture once every two to four years, but to be both responsive to interim intelligence and proactive in seeking feedback to the changes that have been undertaken.

Click on each box in the diagram for examples of data that can be collected.

During the early 'discovery' phase, it is essential to ensure that the views of all groups are represented including Allied Health Professionals. The view of the culture of any service is very dependent on where you sit within that service. Broadly speaking, senior leaders/managers will often view culture more positively than more junior and/or frontline staff. Understanding these different views of culture is key to planning and unlocking momentum for change.

Having undertaken analysis and assessment of culture and your context for change, you will have identified themes for improvement. The next section suggests activities for teams to undertake to better understand the nature of the problem they wish to address, and provides a range of solutions which may be implemented according to the needs and capabilities of the service. These solutions are not prescriptive and will not be suitable in all settings. Many are based on professional recommendations and opportunities, and others supported by evidence of effectiveness either in the published literature or through experiential use.

Building Successful Perinatal Optimisation Teams Improvement: Enhancing perinatal optimisation team culture and context

1. Improving effective leadership in Perinatal Optimisation

Successful implementation of perinatal optimisation is highly dependent on strong coherent leadership at both local and network level. It is recommended that all specialties have nominated Perinatal Optimisation leads. These positions require formalised and adequate time resource appropriate to the size of the service, and training in leadership, communication and quality improvement to fulfil the remit of the role successfully. Leadership is required to be visible throughout all elements of the perinatal optimisation pathway, dynamic in response to service needs and proficiency measures, as well as self-reflective on effectiveness, style, and reach.

Activities

Multidisciplinary group/service management group including Perinatal Optimisation Leads

- Identify who are the leaders for preterm birth and preterm outcomes in your service/network, if any?
  - What is the current remit for these individuals and is this adequately resourced? Are they able to take on leadership in Perinatal Optimisation?
  - If there are no current Perinatal Optimisation leads, who has the skills and style required for your service?
- Who are your Maternity and Neonatal Safety champions and Trust Board Safety champions?
  - What is the relationship between these individuals and how can it be optimised?
  - What would be the remit if you as a group could write the job description?
  - What is needed to start developing these roles so that perinatal optimisation can be achieved for every woman and her baby?
  - Are additional skills and training necessary?

Solutions to consider

Nominated local Obstetric, Neonatal and Midwifery Leads for Perinatal Optimisation both at network and unit level. This role will involve:

- **Job plan resource** for QI for each Lead appropriate to size of unit (e.g. 1 PA each for Obstetric and Neonatal, and 0.5WTE for nursing/midwifery in a large maternity and NICU unit)

- **Role and remit:**
- To foster shared goals around Preterm Birth (PTB) and PT outcomes
- To embed Perinatal Optimisation interventions across the perinatal team using QI methodologies so that they are delivered with high reliability
- To review performance of Perinatal Optimisation interventions together and share learning across the perinatal team
- To assess and develop elements of perinatal team culture to reliably deliver interventions eg maternity unit culture in relation to optimising capacity
- To work to secure Trust engagement in perinatal optimisation

- **Training:**
  To include training in QI, in leadership including in clinical skills, and in advanced communication.

Humility. Kindness. Curiosity. Bravery.

Read Improvement stories on Clinical Leadership and on Trust Board Level Engagement

Enhancing Trust board level support of clinical leaders in Perinatal Optimisation

The success of a perinatal optimisation team lies not only with clinical engagement but also with engagement at the managerial level. This has been exemplified by the Triumvirate leadership model used in adult disciplines to allow managers to work in close liaison with clinical leaders (physicians and nurses) to better understand challenges and constraints, and to develop shared goals. Involvement of HR and finance is also important in regular meetings to plan and execute workforce models and make business plans. Effective Trust engagement and support has shown to provide confidence and stability to frontline clinical teams to drive forward changes.

A model to enhance Trust engagement:

Local Maternity and Neonatal Systems (LMNS)

- Both Maternity and Neonatal systems established in every board (NHS England)

Trust Safety Champions

- To meet regularly with clinical teams to understand Perinatal Optimisation priorities
- To meet regularly with Trust board to escalate locally identified issues (NHS England)

Trust Perinatal Quality Surveillance Model

- Ensure the PQSM includes Perinatal Optimisation outcomes (NHS England)
- Raise awareness to the Trust board of the importance of high quality perinatal services in relation to long term outcomes

Board reviews

- Ensure Perinatal Optimisation is on the agenda at the monthly board review of perinatal safety and quality and the LMNS surveillance group (NHS England)

Raise awareness

- Highlight national programmes, toolkits, guidance to Trust boards
  - Encourage Trust board representation at SPSP-MCQIC learning events (NHS Scotland)
  - Engage managers in understanding what is needed to secure financial incentives where Perinatal Optimisation compliance is achieved ie MIS 6-10 (CNST, NHS England)

2. Safe and person-centred pathways of care

Person-centred maternity and neonatal care is identified as a clear priority for safety and improvement in recent national safety strategies and QI programmes. The key features are respectful and safe communication; in which women and families are actively heard and are given understandable evidence-based information, to enable informed and supported decisions about their care and that of their baby. This requires compassionate collaboration and knowledge sharing between healthcare professionals, women and families in a supportive environment that recognises their individual circumstances and preferences. In order to deliver such care, staff need to operate in psychologically safe and compassionate environments, facilitated by compassionate staff at all levels.

Development of bespoke tools such as the iDecide consent tool and Tommy's app in maternity, facilitates women and families to make informed choices and provides standardised and comprehensive information with explanation of risks, benefits, and alternatives for specified clinical situations and interventions. A key element in improving parents' experiences must be to understand what they currently feel about the service provided. Listening to women and families is at the root of effective and compassionate adverse event investigation while co-production of services ensures women and their families are central to strategic decision-making, planning and implementation. However, perinatal services should recognise the value of paying service users for their contribution in this way.

Activities

Multidisciplinary group setting

- Review the guidelines relevant to perinatal optimisation and PTB. Has there been involvement of all relevant groups in their creation? What perspective or knowledge can your professional group offer? Has the woman, her family and baby been adequately considered?
- 15 Steps for Maternity/Neonatal
  Use this toolkit to understand what parents of a PT baby experience as they access maternity care in your unit. You may want to focus on seldom heard groups such as single parents, parents on low incomes or parents who have previously experienced pregnancy loss
- Consider different scenarios from the teams' experience (see example below) and discuss elements of person-centred care.

Read Improvement story here

Solutions to consider

- Have shared Perinatal Optimisation guidelines across the network that are:
  - co-developed across the perinatal team from all unit levels, and with ambulance services to ensure women are transferred in a timely way to the right hospital
  - consistent across network except where adaptation is needed to reflect local service
  - easy to access, easy to follow, and that standardise practice ensuring high reliability
  - accompanied by co-designed, comprehensive, easy to follow information for families.
- Develop network wide pathways for optimal location of care that are supported by at least daily MDT assessment of capacity and supported by a central network referral process and centralisation of perinatal retrieval.
- Consider using established triage systems to expedite assessment of women in PTL.
- Care pathways through pregnancy and preterm birth should be centred around the woman and her family, incorporating her situation, concerns and preferences and:
  - optimise continuity of care between teams
  - identify risks for PTB with escalation to appropriate care pathway
  - be in line with the UK Government promise of moving healthcare closer to home
  - be informed by integrated IT systems so risks can be identified early
  - be reviewed regularly so anticipated risks allow teams to respond more effectively
  - be consistent with the BAPM Enhancing Shared Decision-Making principles
  - include the views of service users who are renumerated for their time and contribution.
- Establish a parent advisory group at network level to seek user experience and to ensure co-design of care pathways for women at risk of PTB and their babies.
- Consider the incorporation of a cultural competency framework in staff training.

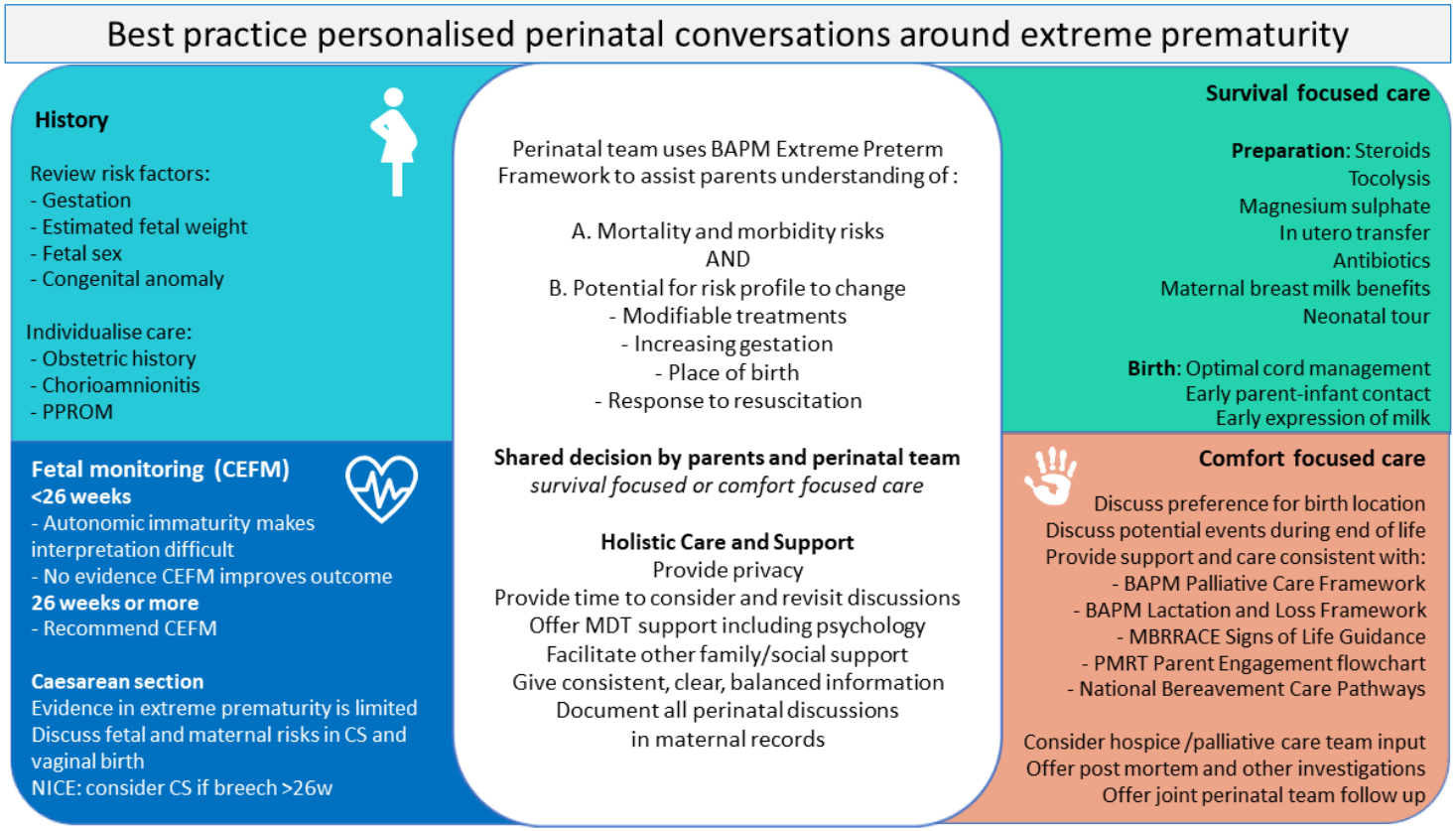
Reliable. Consistent. Standardised. Person-centred. Compassionate.

Understanding Person-Centred Care

Consider the following clinical situation and the role of the individual members of the perinatal team in her care:

Ruth is 43 years of age, in her third pregnancy and presents to maternity triage at 23+2 weeks gestation with preterm ruptured membranes. This is an IVF pregnancy and Ruth has experienced two miscarriages previously. The baby is breech presentation on ultrasound.

a. What should the individual members of the perinatal team communicate to Ruth about perinatal outcomes, optimisation, and planning for birth?
b. How might Ruth's individual circumstances influence her priorities and the interventions considered?
c. How can person-centred care be facilitated in this case, and across the perinatal pathway?



Best practice in providing/g person-centred care in Perinatal Optimisation

Parent preparation for preterm birth (PTB) and involvement in baby's care	Addressing parent needs and concerns	Listening to parents to improve experience
Use personalised Maternity Care plans in anticipation of preterm birth. Implement targeted and enhanced midwifery-led Continuity of Carer. Information for families at risk of, or who have had a PT baby: antenatal conversations about benefits of perinatal optimisation and breastmilk, stabilisation of their baby and the neonatal journey including potential transfer for different levels of care and potential changes in plan due to changing clinical situations. Information in a format appropriate to language and communication needs. Joint discussions are informed by the BAPM framework. Handheld passports delineating benefits and receipt of interventions which accompany mother and baby through any interhospital transfers (BAPM passport). Offer parents a Neonatal Unit tour prior to birth. Units should consider facilitating a virtual tour for parents who cannot visit. Embed a family integrated care approach in the Neonatal Unit which addresses specific needs of PT babies and their families, including active encouragement to participate in ward rounds. Seek accreditation/audit compliance against the Bliss Baby Charter and Baby Friendly Initiative standards. Consider using the National Perinatal Advance Care Plan where comfort focused care is planned.	Provide psychological support for parents in PT clinic, during neonatal stay and in the first year after discharge/death (e.g. Maternal Mental Health Services, Specialist Neonatal Psychologist). Ensure the mother is actively involved in any care decisions relating to future pregnancies and that these are clearly documented in the maternal notes. Parental communication about their baby's progress by senior neonatal staff as soon as possible after birth, even if on a different site and at key times of illness/transition. Parents are encouraged to touch and hold their baby as soon as is clinically safe after birth. Parents are actively involved in shared decision-making about their baby's care. Use vCreate/virtual ward rounds/BadgerNet Diary to provide parents with updates on their baby's progress and involve them in shared decision-making when they cannot be present. Ensure parent facilities are fit for purpose, that food is provided and that reduced mobility, post-operative care, analgesia and accessibility requirements for women are considered. Ensure views/questions about the mother's care and their baby's care are actively sought from families during stay and at opportunities of joint debrief with the obstetrician and neonatologist before discharge. Parents are provided with support after discharge and information about follow up programmes. Consider the valuable role of AHPs in relationship building with parents.	Seek views of the parent experience throughout their stay and after discharge, including that of the baby in childhood, through a range of mechanisms. Develop a rapid process to address feedback from parents, including that relating to complaints using an action plan which can be later audited. Parental representation in service development and QI is essential. Parental involvement should be reviewed regularly by the perinatal quality team to ensure there are views represented from all users, including fathers and minority groups and specifically those who have delivered preterm. Perinatal services should recognise the value of paying service users for their contribution in this way.

3. Effective teamworking, shared goals and positive communication

The perinatal team is a stable, bounded group of individuals, interdependent in their teamworking to achieve a shared goal of perinatal optimisation. Independent of this, "teaming" is where individuals come together quickly to solve new, urgent or unusual problems with shared goals. This might include an urgent referral of a woman at 22 weeks to a tertiary centre; resolving a sudden crisis in network capacity; or the rapid achievement of all optimisation measures in a woman who presents at 28 weeks in labour. Both effective teamworking and teaming are crucial to the achievement of perinatal optimisation for all preterm babies, and require investment in relationship building, leadership, agreement on shared goals, high quality structured communication, human factors and situational awareness. These processes need to in the context of a culture of a psychologically safe and compassionately led environment.

Activities

Multidisciplinary setting

- In this activity each consider how much you know about your colleagues' roles, daily work, and challenges? Take a few hours to 'walk in their shoes'? @WhoseShoes
- What do your colleagues not understand about your job? Share what would be helpful for them to know/ understand.
- Together watch talk A and talk B about psychological safety and discuss its relevance in your unit
- What do women and families say about how your teams work together? Review recent feedback or complaints.
- Discuss together what good teamworking looks like and how can you work together to overcome identified challenges.
- Identify and review recent episodes of teaming. What went well and what could be better? Was communication optimal? Was situational awareness lacking? What knowledge or skills are needed to team better next time?
- Use the Safety Culture Cards, NHS Education Scotland to stimulate discussion about teamworking culture.
- Does your team have a shared mental model to achieve optimal perinatal care for a preterm infant? Ask staff (maternity, neonatal and others) what they aim to achieve when women present in preterm labour? Does this differ, why? E.g. competing care priorities after birth may prevent support for early expression within 1 hour.
- Explore the resources from Civility Saves Lives.

Respect. Communication. One vision. Psychological safety. `

Solutions to consider

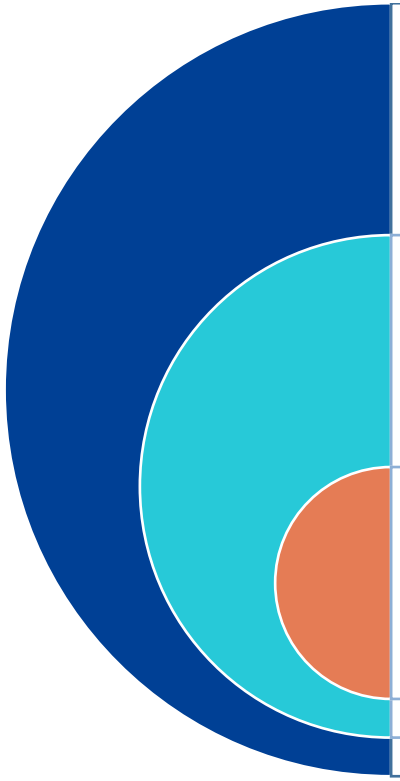
- Foster non-hierarchical relationships and psychological safety within and between perinatal teams throughout the network to allow round the clock access to specialist advice about women and babies, shared review of PTB cases, shared PTB guidelines and care pathways. See guidance about perinatal MDT meetings.
- Agree shared team goals of reducing mortality, IVH, BPD and NEC through implementation of the Perinatal Optimisation Pathway. Including Perinatal Optimisation goals in all staff inductions. View PERIPrem resource.
- Grow awareness of team roles by involvement of the neonatal team in PTB and fetal medicine clinics, inviting maternity teams to follow up clinics, skills drills and simulation on perinatal optimisation; and joint ward rounds and teaching
- Establish daily safety huddles to discuss women at risk of PTB. Have a shared approach to maternity and neonatal capacity and flow huddles to ensure right baby, right place, right time
- Employ structured handovers such as SBAR for communicating clinical concerns especially at critical information-sharing timepoints
- Encourage training of all staff to a high level of situational awareness in relation to PTB from diagnosis through birth and into the first hours of life
- Conduct routine pre-briefs and hot and cold debriefs for PTBs with availability of 1:1 support where required (see below)
- Find ways of celebrating success together in Perinatal Optimisation

Read Improvement stories: Shared Goals, Everyone's Business, Improving team culture for Junior Trainees, MDT Simulation, Shared Perinatal Teaching, Cross-disciplinary Shadowing

Respect. Communication. One vision. Psychological safety.`

Fostering shared goals during a preterm birth

The following approach may help to develop a shared mental model across the team, before, during and after a preterm birth.



Preparation

- Capacity discussion to involve maternity and neonatal teams
- Structured handover between teams
- Joint perinatal conversations with families with MDT input using BAPM framework
- Obstetric, neonatal and midwfery discussion with parents about breastmilk benefits
- Team agreement on appropriateness of transfer, steroids, magnesium and antibiotics

At birth

- As one perinatal team, use checklists to verbalise potential concerns, management plans and collective goals
- Stabilisation pre-brief
  - role allocation including normothermia role
  - confirm plans for optimal cord management (ideally as routine during WHO checklist)
  - provide neonatal support for maternity staff during optimal cord management

After birth

- Carers of mother and baby to collaborate in providing milk expression support
- Agree team roles in maintaining normothermia and achieving Golden Hour priorities
- Hot debrief for staff support and identification of immediate safety issues
- Cold debrief/case review for gap analysis and identification of improvement goals
- Joint perinatal debrief with parents before discharge

Communication culture in perinatal optimisation:

Culture that stifles change and action	Culture that promotes change and action
"sorry we're closed to all admissions as soon as we are over our numbers- try again tomorrow"	"let's talk about how we can find the space for this high risk mother as it is so important for her baby to be in the right place if she gives birth"
"triage is so busy, there's no way we can prioritise women who may or may not be in preterm labour"	"how can we re-structure triage pathways to ensure the right women have rapid access to the right care?"
"helping this mum to express is not our job; that's the role of labour ward"	"if we give this mum information about the benefits of breastmilk for her baby, can you show her how to express within an hour of birth?"
"we can't manage deferred cord clamping- it feels too risky and babies get cold, it's easier for us to give the baby straight to the neonatal team"	"let us, the neonatal team, support you while we wait at least 60 seconds, as this could be so important in improving this baby's survival"
"this mother is young and on her own so there's no point in asking her to express"	"we believe all mothers deserve information about the benefits of breastmilk for their preterm baby, so they can make an informed choice"
"we don't have the time to spend teaching the parents how to give their baby colostrum and it's not safe"	"if we teach parents how to tube feed their baby safely, it gives us more time and empowers parents to be partners in care"
"parents can't visit as the ward round is going on"	"parents are part of the team, never visitors, and their input to the ward round is invaluable"

Consider episodes of communication you have experienced that have impressed, disheartened or even upset you, or other people? What factors may have led to this style of communication? What impact might re-phrasing the conversation have had? How might this person be trying their best at this time? What have you learned?
Consider bringing staff groups together to develop communication guidelines for the overall team – this can give ownership and helps to develop a sense of 'how we like to do things here'.

Social Capital

Social capital can be defined as the networks of relationships among people who work in a particular team, enabling that team to function effectively. What motivates people is the bonds, loyalty and trust that they develop from working together.

Social capital within teams has been severely depleted during the Pandemic. Normal human interaction has been restricted and the ability to connect with each other impaired by the use of masks and distancing measures.

Re-build your team's social capital by:

- providing shared social areas for the perinatal team
- organising joint perinatal team social events
- organising team fundraising events
- having a shared social media space where ideas can be exchanged and successes celebrated
- spotlighting each month a 'day in the life' of different members of the perinatal team
- holding 'walk in their shoes' sessions
- celebrating individual successes, birthdays, weddings and births

4. Effective and continuous learning from episodes of error, excellence and near miss

A visible and transparent learning system embedded within the maternity and neonatal service allows concerns to be captured and acted upon and a cycle of learning and improvement introduced. The pursuit of quality through continuous learning, should enable a safety culture while discouraging a blame culture. A good learning system involves the development of a shared purpose; identification and review of harm in a systematic way, capturing concerns and acting on these through cycles of improvement; ensuring reliability of clinical systems that are in line with evidence; a gathering of intelligence and insight through a curiosity about how care is being delivered and the experiences of women and families; anticipation of risk and recognition of success; and a clear process to share and elicit learning from how things go right as well as wrong.

Activities

Multidisciplinary setting

- Use the 'Just Culture, Learning and Reporting' and 'Risk Awareness and Management' Prompts from the Safety Culture Cards, NHS Education Scotland

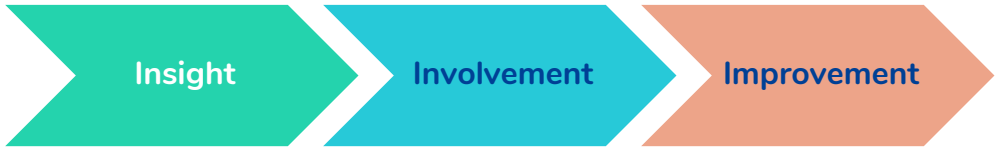
- Discuss:
  - How learning from PTB is shared throughout the team. Ask a range of staff if they can access this learning and if not, why not?
  - Do neonatology and maternity teams share governance meetings and have opportunities to discuss PTB cases together?
  - How is learning from PTB with successful outcomes shared?
  - Are the data about perinatal optimisation easily accessible to all within the team to enable positive discussions?
  - Are neonatal data shared on maternity dashboards and vice versa?

Solutions to consider

Networks

- Oversight of all perinatal optimisation measures and compliance
- Oversight of in utero and ex utero transfer services, and maternity bed and neonatal cot location services
- Mechanism for review of PTB deaths and births of <27w outside of a NICU setting
- Encourage unit engagement with national or shared learning platforms e.g. the Maternity Safety Support Programme (MSSP) and the FutureNHS Platform

See next page for local solutions:



Transparency. Accountability. Learning. Improvement.

Read Improvement story about Shared Network Learning here

Insight

- Have a list of clear adverse event reporting triggers that includes those relevant to PTB including ex utero transfer of a baby <27w
- Use monthly reports to detail rates of perinatal optimisation compliance using BadgerNet and maternity data systems- shared with both neonatal and maternity patient safety teams.
- Have mechanisms for units to learn why compliance with perinatal optimisation has not been achieved (exception reporting, deep dives)
- Undertake MDT mortality review using the Perinatal Mortality Review Tool and according to national standards and including all units who cared for baby, transport teams, ambulance teams, with active seeking of parental concerns
- Undertake MDT reviews following serious preterm morbidities such as severe intraventricular haemorrhage and surgical necrotising enterocolitis

Involvement

- Hold shared multi-professional perinatal mortality/morbidity meetings where perinatal optimisation compliance is examined for each PTB
- Ensure families have the opportunity to input their questions to any mortality or morbidity review process
- Involve the Maternity Voices Partnership
- Hold regular perinatal optimisation workshops open to all staff to present results and explore barriers using actual clinical cases as vignettes
- Engage with national or organisational shared learning platforms for example the Maternity Safety Support Programme (MSSP)

Improvement

- Develop action plans from shared analysis and from collation of perinatal optimisation themes derived from mortality reviews, adverse event or incident reviews, complaints or process mapping.
- Use HSIB style Maternity newsletter, BAPM QI Storyboard and MCQIC learning events to promote learning about PTB between Trusts
- Develop a platform to learn from excellence in perinatal optimisation (eg Learning from Excellence/Greatix) as well as from error/near miss
- Share learning using a multimodal strategy
  - safety huddles and safety briefings
  - safety alerts and newsletters
  - safety learning boards
  - through all training scenarios (eg. simulation training, human factor workshops)
  - social media platforms or local/regional website

5. Engagement in audit, benchmarking and research

Adopting a commitment to the improvement in the quality of perinatal care, of which audit and benchmarking play significant roles, builds a strong foundation in safety culture. Audit and benchmarking are crucial in understanding the optimal delivery of standardised, evidence-based care and in doing so perinatal teams can compare their practice against evidence-based national guidance, analyse shortfalls in care, and provide solutions.

Perinatal optimisation, human factors and healthcare culture are all current areas of active research and learning. High functioning units will have a culture which supports timely critical review of new findings and active adoption of truly evidence-based medicine, will seek participation in perinatal research where possible, and will involve parents in both evidence-based change as well as any active research on the unit.

Activities

Multidisciplinary setting

- Is there a lead for perinatal optimisation audit with sufficient job plan resource? Who performs audit and is there multidisciplinary collaboration? Is training needed?
- How much does missing data impact on your benchmarking data? Do staff understand the value of data in your service?
- Which units or networks perform well in areas you do not? What about their practice can be adopted locally?
- How does your unit/network share your results across different professional groups? How does your unit/network share these results with parents?
- Reflect on your research culture - focus on perinatal optimisation, evidence review, contributions to science.
- Think about parental engagement in research. Are all families given an opportunity to participate in research if eligible? What proportion are actually recruited? Does your unit help families understand ongoing research?
- Identify Trust and University R&D department leads/key contacts – how can they support research on your unit?

Solutions to consider

- Engage with benchmarking of Perinatal Optimisation interventions and outcomes both within the network and nationally through submission of data to the network dashboard, NMPA, NNAP, MBRRACE
- Use NNAP Online to compare your results with similar units
- Document evidence of an action plan to address outlier status from NNAP, NMPA, MBRRACE within 3 months of identification
- Share data openly with staff through various communication channels including poster boards, newsletters, collaborative audit afternoons
- Hold data sessions to raise awareness of key data points, the significance of missing data and the team's role in contributing to data accuracy.
- Share the changes made in response to results and projected pathway of PDSA cycles
- Neonatal units should use the customisable poster from the NNAP, 'Your Baby's Care' in which service performance is displayed publicly along with national comparison data and an action plan
- Identify high performing units for processes and outcomes that you wish to improve. Contact these units to understand their success.

Measure. Compare. Study. Explore. Learn.

Read story about Using Optimisation Data for Improvement here

Developing a positive research culture around Perinatal Optimisation

⇒ Ensure clinical supervisors and nursing managers are aware of research training opportunities for trainees and nurses:
- RCPCH Training in Research for the Benefit of Children
- RCOG Advanced Professional Module in Clinical Research
- Good Clinical Practice Training
- BAPM Research skills training days
- Local research study days

⇒ Ensure there are Neonatal and Obstetric research leads familiar with Perinatal Optimisation and that they have adequate support.

⇒ Raise staff awareness of the importance of accurate data input to improve the power of research studies underway and of ongoing perinatal optimisation research through poster boards, teaching and journal clubs.

⇒ Ensure perinatal optimisation guidelines and their implementation are robustly based on evidence.

⇒ Encourage an attitude of equipoise in clinical practice where there is little evidence in PTB, thereby creating an enthusiasm for involvement in clinical trials.

⇒ Every unit involved in preterm research studies should commit to ensuring that every eligible mother and/or baby has the opportunity to participate. Offer parent teaching and engagement sessions about ongoing research in the department.

⇒ Create a regular dedicated perinatal joint specialty journal club – promoting involvement of consultants, trainees, midwives, nursing staff, ANNPs and allied healthcare professionals, with focus on papers relevant to perinatal optimisation practice.

⇒ Incorporate learning and practising critical appraisal skills within the unit's educational program for all staff groups.

⇒ Create a unit calendar with key conference/society meeting deadlines and aim to submit abstracts relating to the unit's Perinatal Optimisation improvement activity with involvement of all staff groups; trainees, midwives, nurses and ANNPs. Encourage attendance at national and international meetings for all professional groups, signposting to funding opportunities and sources.

⇒ Identify or create a unit/trust parents and past-patients engagement group. Involve the group in research plans, patient information process and clinical guidelines development. Consider renumerating such individuals for their time and contribution.

⇒ Larger units may be able provide clinical research nurse and fellow posts, as well as supporting clinical academic rotations for trainees with focus on perinatal practices / implementation research.

6. Establishing capability and capacity for quality improvement

Quality improvement can only be successful where teams have adequate resource (including time), and are trained in improvement science methodology. These skills cover a wide remit including quality planning, defining the problem, developing a shared purpose, planning and implementing changes, test and measuring improvement, and implementing, embedding and sustaining change. These are outlined in each of the BAPM toolkits and supported in the BAPM Quality Resources. The improvement literature around Perinatal Optimisation indicates that where teams have or acquire these skills in undertaking quality improvement, there are additional benefits to the extent of the change seen.

Activities

Multidisciplinary Setting

- Use the BAPM Quality Indicators document and tool to assess compliance and undertake a gap analysis in relation to these neonatal quality indicators
- List the individuals/teams in your service undertaking quality improvement in perinatal optimisation. How many have formal training in QI? What local or network training or coaching is available for these individuals/teams? Do they have time to access national learning and engage with quality organisations? How can this be improved?
- Consider what improvement work is currently undertaken in perinatal optimisation. How can the data burden be reduced? Is there potential to secure resource for a data analyst?
- Does the service have an Improvement plan? Is Perinatal Optimisation included in this and is this item reviewed regularly to assess progress? Are parents involved in developing this plan?

Solutions to consider

Training in quality

- Engage with Quality organisations with a Perinatal Optimisation remit eg MCQIC, MatNeoSIP, GIRFT, PERIPrem, BAPM
- Share and access podcasts, webcasts, resources on BAPM quality pages
- Hold basic QI training using BAPM QI MadeEasy resources to achieve 'buy in' from the wider perinatal team

Perinatal Optimisation Improvement Plan

- Secure data analyst resource for Perinatal Optimisation activity
- Use a robust measurement strategy to reduce data burden and avoid duplication of effort using a bundled approach where possible, using the BAPM Perinatal Optimisation Passport to facilitate data collection
- Develop an Improvement Plan with Perinatal Optimisation leads which is proportionate to capacity and capability
- Use the BAPM Perinatal Optimisation toolkits to plan your Improvement
- Plan inviting all stakeholders to contribute with ideas for improvement
- Use person-centred approach to ensure what matters to patients and families e.g. length of stay, family inclusion and disability at 2 years is measured
- Access Trust QI coaching to support your improvement journey

Capacity. Training. Planning. Study. Share.

Read story about Staff Engagement in Improvement here

BAPM

Leading Excellence in Perinatal Care

This document was produced by the British Association of Perinatal Medicine (BAPM).

BAPM a membership organisation that is here to support all those involved in perinatal care to optimise their skills and knowledge, deliver and share high-quality safe and innovative practice, undertake research, and speak out for babies and their families.

We are a professional association of neonatologists, paediatricians, obstetricians, nurses, midwives, trainees, network managers and other health professionals dedicated to shaping the delivery and improving the standard of perinatal care in the UK.

Our vision is for every baby and their family to receive the highest standard of perinatal care. Join us today.

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