**Dr Angharad Care, Dr Rachel McFarland, Gemma Morgan – Written evidence (PRT0068)**

## Background information

1. The Cheshire and Mersey preterm birth network is a network of doctors, midwives and researchers representing all maternity units in this geographic location. We work to deliver a high-quality preterm birth prevention and optimisation services across the Northwest. The points listed below were raised in a multi-disciplinary team meeting and I have permission to share these collective opinions from the network chair, Dr Rachel McFarland – Consultant Obstetrician at Liverpool Women's Hospital.
2. Due to the national aim to reduce the national preterm birth rate from 8% to 6%, saving babies lives has been the driving force behind the growing preterm birth service, changing a previously research driven model, to a hybrid clinical/research model. The teams providing care are growing and are multi professional. In June 2023 Saving babies lives published its 3rd version, and within this bundle they specified outcome indicators in which trusts should benchmark their compliance. This has been used and developed into a tool for trusts to demonstrate their compliance to LMNS's across the country. It is now the role of the LMNS to provide assurance for trust compliance.
3. We are submitting our current experience of delivering to the benchmarking standards of SBLV.3 and how these impact on current delivery of care across the North West of England, and areas where we are focussing on improvements.

## Summary of Experience

4. *Time consuming data collection, need for improvement of maternity IT systems.* The tool for preterm birth has 27 evidence points, the largest in the entire bundle, incorporating both maternity and neonatal care. Of these points, 9 of those require recurrent audits, and a further 8 require regular neonatal optimisation data. The workload is vast, and the digital systems within maternity are not conducive to this vast data collection. Due to the varying level of units within the region of Cheshire and Mersey, those responsible for providing this data vary, the majority of the responsibility and data collection is being conducted and presented by clinical staff. As an ongoing review of compliance this contributes to ongoing loss of clinical time for data collection and submission. There are audit requests that are not easy to provide, as the data is difficult to collect.  For example, collecting data on fetal fibronectin usage. As this is a bedside tool, this is not easily auditable within patient records, and requires searching individual records for evidence of use. Currently most trusts in the region are providing manual audits for this data, which is not only time consuming, but also subjective and has increased potential for errors in reporting. Trusts across the region use different maternity programmes for their electronic patient records and often use multiple programmes for prescribing, note keeping, ordering tests etc. and trying to collate data across different programmes can be challenging and time consuming for those collating data.

5. *Heterogeneity in Standardisation.* The tool was developed and rolled out nationally, however the responsibility of compliance target ranges was to be set by each individual LMNS (Local Maternity and Neonatal System). This approach highlighted that regions may have differing challenges or quality improvement targets that required differing ranges. What this does not consider is the varying levels of care need within trusts. For example, trust compliance targets are

set for their region, so a tertiary referral centre, caring for extremely high risk patients, with an onsite level 3 neonatal intensive care unit will be measured against a district general hospital with an onsite level 2 neonatal unit, this is particularly evident in the case of neonatal brain injury, as brain injury rates are higher in the extremely premature births, in which local units do not have the facilities to accommodate.

6. *The need for a maternity dashboard to aid both the trusts and the LMNS.* The neonatal ODN is known for its work and data collection, they have a well-established dashboard that is automatically populated via their EPR Badgernet, this allows for easy data collection and review of optimisation tools. Within maternity, trusts have varying EPR, therefore this type of dashboard does not exist. A maternity dashboard displaying the data requested for Saving babies lives would allow for more accuracy, ensure data is readily available for clinicians, trusts, LMNS and commissioners to help nationally benchmark and review outcomes. This is not only a trust issue, for all of the audits conducted and submitted, they require review by the LMNS which also requires additional time and resource. The creation of a specialise dashboard would reduce time away from those working within the LMNS to continue to drive workstreams and reduce time reviewing varying audits and templates. At present the LMNS is working on developing a standardised template for audits, to streamline the review process. A dashboard would allow for redirection of skills, clinical time and resources to be focussed on improving services and outcomes.

7. *Quality assurance work and agreement on definitions.* The data inputted into Badgernet does not always reflect important measurements. For example, a mother may receive antibiotics in labour but the data tools will only record the *time the last antibiotic was given*. If that was less than 4 hours ago it does not count as

"receiving antibiotics in labour" as it would be regarded as insufficient time to take effect. However, if this was the second dose and the first antibiotic was given over 12 hours ago, again, it is not recognised as it is not the time the last antibiotic was given. Therefore there is a frustrating sense that we are not recording or capturing good practice when it is happening which can be demotivating for units.

8. *Increased resource to deliver continuity of postnatal care from high risk clinics* This large draw on resource and large volume of work to deliver SBLV3 does not allow us to deliver parts of the service that we feel would be most useful for our service users. These are particularly continuity with postnatal care for women from high risk clinics – once they are discharged from the clinic (often around 28 weeks) there is no continuity in their support for breastfeeding or planning for delivery.

9. We are unable to give patients much time per appointment. Therefore, the focus of the appointments in preterm birth prevention services has become around cervical length measurement and treatment and we have no structure for professional mental health support for women who have experienced preterm birth or those who become anxious needing to be seen in a high risk clinic.

10. We also do not have the resource to help our service users with specific needs relating to the low socioeconomic population we serve with our clinic. Transport to get to clinic, assistance with childcare, housing standards, time for education around preterm birth optimisation or ongoing education for preexisting children born preterm and benefits of smoking cessation

*27 March 2024*