

Safer Baby Collaborative | project charter

WHAT WILL THE SAFER BABY COLLABORATIVE ACCOMPLISH?

By July 2020 we intend to reduce the rate of avoidable stillbirths in the third trimester* by 30 per cent.

We will share knowledge with women, so they can better understand and manage risk factors, for example reduced baby movements, smoking and maternal sleep position. We will enable clinicians to better detect and manage fetal growth restriction and we will improve shared decision making about timing of birth with women who have risk factors.

**This initiative is targeting stillbirth at 28 weeks or more, a period of gestation in which more cases are considered to be avoidable and excludes terminations and babies with lethal congenital or chromosomal abnormalities.*

BACKGROUND INFORMATION

Reducing the rate of stillbirth is an Australian Government priority. The recently tabled Report of the Select Senate Committee Inquiry into Stillbirth Research and Education recommended that the Australian Government lead a process to reduce the rate of stillbirth by 20% over the next three years^[1].

Victoria's current stillbirth rate is 6.2 per 1000 births after 20 weeks, and 2.2 per 1000 births at 28 weeks or more^[2]. In 2016, approximately 188 stillbirths after 28 weeks were not associated with termination of pregnancy for genetic or psychosocial concerns. Awareness of risk factors for stillbirth remains low and research suggests many stillbirths are preventable.

Safer Care Victoria (SCV) is utilising its partnership with the Institute for Healthcare Improvement (IHI) to design and implement a results-oriented initiative to reduce Victoria's stillbirth rate. SCV and the IHI will deliver a Breakthrough Series Collaborative, the Safer Baby Collaborative (SBC), with work focussing on five key aspects of care:

- increasing public awareness of the importance of fetal movements
- diagnosis and management of fetal growth restriction
- improving rates of smoking cessation in pregnancy
- raising awareness of safe maternal sleep positions
- promoting appropriate timing of birth and mitigating unintended consequences/harm.

These aspects of care align with work undertaken in the United Kingdom as part of the Saving Babies Lives Care Bundle and with the Safe Baby Bundle, a piece of work being undertaken by the Stillbirth Centre of Research Excellence.

[1] Senate Inquiry

https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Stillbirth_Research_and_Education/Stillbirth/Report

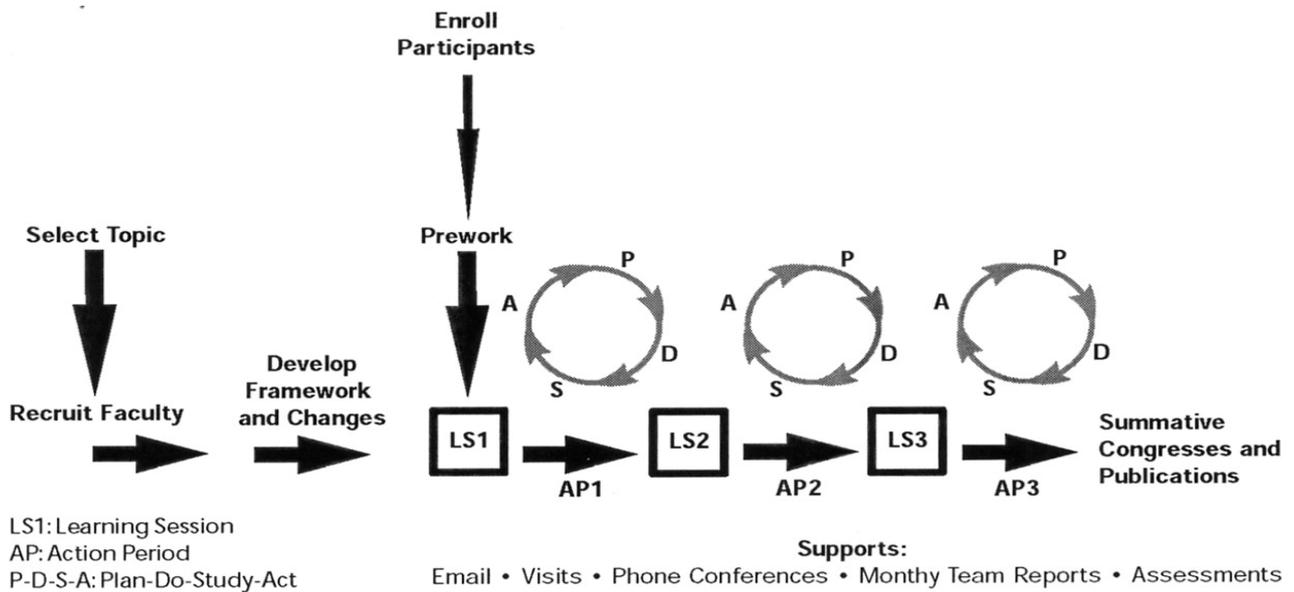
[2] Victoria's Mothers, Babies and Children 2016 <https://bettersafercare.vic.gov.au/sites/default/files/2018-03/mothers-babies-children-2016.pdf>

WHAT IS A BREAKTHROUGH SERIES COLLABORATIVE?

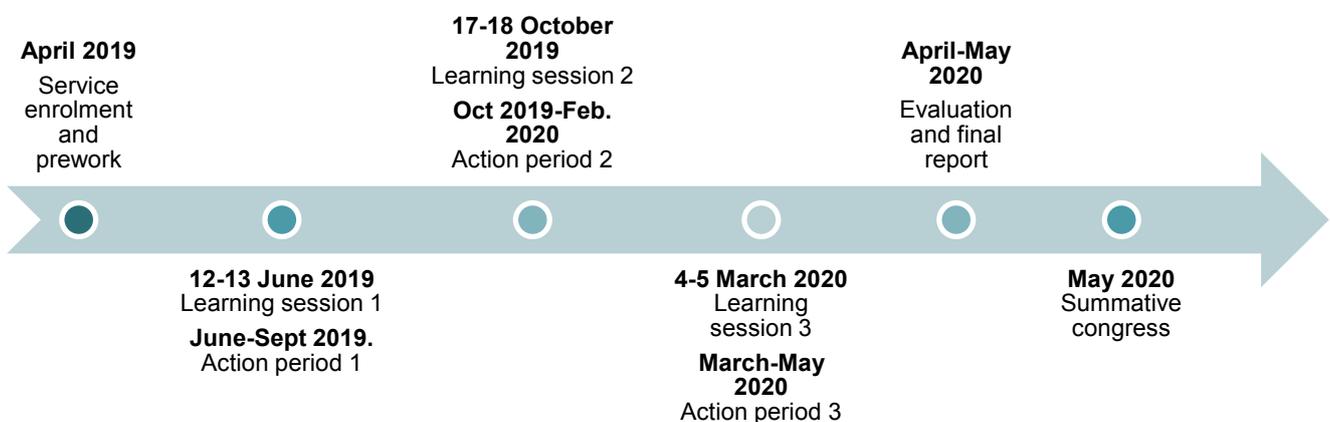
A Breakthrough Series Collaborative (BTS) involves health services working intensively together, with the support of SCV and the IHI, to achieve significant improvements. Over 12 months teams participate in three in-person learning sessions and three service-based action periods. Teams maintain continual contact with each other and the SCV and IHI team members through conference calls, online discussions, email and monthly progress reports.

During learning sessions, maternity service core teams meet to share their experiences and learn about quality improvement methodology and the proposed changes to clinical care. During action periods, service teams work together to embed and test changes using the Model for Improvement.

The IHI Breakthrough Series Collaborative



Key dates



WHAT DOES TAKING PART IN THE COLLABORATIVE MEAN FOR YOUR SERVICE?

Each participating service will need

- An executive sponsor: this person needs to engage with the work and attend day two of learning session two on 18 October
- A day-to-day team leader
- A core team (including the key contact) of an obstetrician, midwife, consumer and member with quality improvement experience, responsible for identifying champions and driving change on the clinical floor
- A wider team of 6-12 members (e.g. clinicians, managers), influencers in the organisation who can drive commitment and attention to the work and support frontline staff to test changes. This group includes a member responsible for data entry.
- Time to do the improvement work (including online meetings and site visits): in our experience, optimal results are achieved when teams can devote at least 30 hours per week to the project (shared between team members)
- Support for the core team to attend all learning sessions (3x two-day sessions)
- A commitment to implement all elements of the bundle

HOW CAN YOUR SERVICE EXECUTIVE SPONSOR SUPPORT YOU TO TAKE PART?

Active partnership between service leadership and the collaborative team is essential to achieve results.

Teams succeed when a senior leader sponsors the work. The executive sponsor is responsible and accountable to the service for performance and results of improvement work. They are not an active member of the collaborative team but support the team to achieve their aim.

Executive sponsors:

- Encourage the improvement team to set appropriate goals and agree on the team charter
- Provide the team with resources, including staff time and operating funds - our experience is that the total resources required to do this work will be at least one full-time equivalent (FTE)
- Ensure that improvement capability and other technical resources are available to the team
- Regularly review the work of the team
- Communicate to internal and external audience the importance of the project and its emerging results
- Develop a plan to spread the successful changes from the improvement team to the rest of the organisation

WHAT ARE WE TRYING TO ACCOMPLISH?

A reduction in avoidable stillbirths at 28 or more weeks gestation

- 30%, or more, reduction in the number of stillbirths based on a 2017-2019 baseline
- 95%, or higher, compliance with the clinical bundle of care components
- 95%, or more, women are screened for stillbirth risk using the agreed checklist

- 95%, or more, of women identified at risk from screening will receive intervention as per agreed clinical guidance
- 95%, or more, of the time teach back is used when sharing information with women during pregnancy.

HOW WILL WE KNOW THAT CHANGE IS AN IMPROVEMENT?

Family of measures *(Please note these are drafts to be refined with participating health services)*

Outcome measures

- Number and rate of stillbirths at 28 or more weeks gestation.
- Percentage of women who cease smoking* between booking and birth
- Percentage of compliance with all elements of clinical bundle of care

Process measures

- Percentage of women who have reported decreased fetal movement (DFM), from 28 weeks gestation whose care was appropriately escalated (as per bundle)
- Percentage of women provided with decreased fetal movement information (at booking and 28 weeks)
- Percentage of women who undertake carbon monoxide (CO) breath analysis at booking and 28 weeks
- Percentage of women, identified as smoking, with documented referral to smoking cessation service
- Percentage of women with documented risk assessment for FGR at every antenatal episode of care from 24 weeks gestation.
- Percentage of women whose fetal growth was measured as per the agreed clinical guideline, from 24 weeks
- Percentage of women, identified as at risk of FGR, from 24 weeks gestation who were referred as per the agreed clinical guideline
- Percentage of women with symphyseal fundal height (SFH) measurement taken and plotted on growth chart from 24 weeks gestation
- Percentage of women who report being involved as much as they wanted to be with decision-making around timing of birth

Balance measures

- Percentage of women who have labour induced before 39 weeks gestation, where FGR has not been confirmed and uteroplacental Dopplers and amniotic fluid levels are normal.
- Percentage of babies admitted to special care nursery after 37 weeks
- Rate of caesarean sections

**Operational definition to be confirmed at first learning session*

WHAT CHANGES ARE PROPOSED?

Clinical bundle of care

Overarching clinical care

- Use of standardised screening tool for stillbirth risk
- Embedding consistent use of agreed clinical guidelines
- Using teach back to educate women about stillbirth risk factors

Smoking cessation

- Carbon monoxide analysis at booking and 28 week's gestation, as part of screening for smoking
- Referral to smoking cessation for women identified as smoking
- Online training and resources for maternity clinicians
- Resources for women and families

Maternal sleep position (MSP)

- Education for women about safe sleeping in the third trimester

Fetal growth restriction (FGR)

- Consistent screening for FGR risk
- Online learning package for clinicians
- FGR clinician workshop

Decreased fetal movements (DFM)

- Online learning package for clinicians on responding to DFM

Timing of birth

- Optimising informed consent before undertaking induction of labour.

Awareness raising

- Promoting the #movementsmatter campaign
- Promoting safe maternal sleep position