NHS Improvement

Patient Safety Alert

Resources to support safer care for full-term babies

23 February 2017

Alert reference number: NHS/PSA/RE/2017/001

Resource Alert

It is a priority for the NHS to reduce avoidable harm that can lead to full-term babies (babies born after 37 weeks of pregnancy) being admitted to neonatal units.[1] The number of unexpected admissions to neonatal units is seen as a proxy indicator that preventable harm may have been caused at some point along the maternity or neonatal pathway.

NHS Improvement has been working with parents, front line clinicians, data analysts and subject specialist experts to understand factors contributing to admission of full-term babies. After a thorough review of patient safety reports, neonatal hospital admission data and litigation claims data this work has focused on four key areas:

- hypoglycaemia
- jaundice
- respiratory symptoms
- asphyxia (brain injury due to lack of oxygen during or soon after birth).

While some term baby admissions are entirely appropriate (for example babies born with a congenital abnormality), up to 30% of neonatal unit admissions between 2011 and 2013 were considered avoidable. We found that the need for improved identification of babies at risk of deterioration was a common theme. Although we focused on avoiding harm requiring admission, we also identified learning in relation to babies whose care could have been managed in a setting that kept mother and baby together in hospital or in the community.

Admission to a neonatal unit can lead to unnecessary separation of mother and baby. There is overwhelming evidence that separating mother and baby at or soon after birth can adversely affect the mother-child attachment process,[2] maternal perinatal mental health, and neonatal physical wellbeing and neurodevelopment. Preventing separation, except for compelling medical indications, is essential in providing safe maternity services.

To support staff in preventing avoidable admissions of full-term babies NHS Improvement has produced a resource (https://improvement.nhs.uk/resources/preventing-avoidable-admissions-full-term-babies) that:

- explains our findings, and how they can be used to identify local improvement priorities
- provides suggestions for local case review after unplanned admissions of full-term babies
- signposts a range of resources, academic journal publications, guidelines and e-learning from organisations including the British Association of Perinatal Medicine, the National Institute of Health and Care Excellence, Health Education England, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists and the Care Quality Commission
- provides links to open access journal articles.

We will continue to build on and update the resources on our website.

Actions

Who: All providers of NHS-funded maternal and neonatal care

When: To begin as soon as possible and be completed by 23 August 2017

1. Review the resource signposted in this alert and identify how your maternity and neonatal teams can use it to improve the safety of care and keep mothers and babies together whenever it is safe to do so.
2. Develop an action plan to ensure any relevant resources are introduced into clinical practice.
3. By circulating this alert or through local alternatives (such as newsletters or local awareness campaigns) ensure that staff are aware of factors contributing to admission of full-term babies and the availability of this resource (or local equivalents)

Sharing resources and examples of work

If there are any resources or examples of work developed in relation to this alert you think would be useful to others, please share them with us by emailing patientsafety.enquiries@nhs.net

See page two for references, stakeholder engagement and advice on who this alert should be directed to.

NHS Improvement (February 2017) Contact us: patientsafety.enquiries@nhs.net Publication code: IT 01/17

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Alert stage:	Two - Resources

References

1. Department of Health. NHS Outcomes Framework www.gov.uk/government/uploads/system/uploads/attachment_data/file/513157/NHSOF_at_a_glance.pdf
2. Jeannette T. Crenshaw (2014) Healthy Birth Practice #6: Keep Mother and Baby Together— It's Best for Mother, Baby, and Breastfeeding. Journal of Perinatal Education. Fall 23(4): 211–217

Stakeholder engagement

- Atain working groups
- Department of Health
- NHS England
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- NHS Litigation Authority
- Bliss
- Neonatal Data Analysis Unit
- UNICEF-BFI
- National Patient Safety Response Advisory Panel (for a list of members and organisations represented on the panel, see improvement.nhs.uk/resources/patient-safety-alerts/)

Advice for Central Alerting System officers and risk managers

This alert asks maternity and neonatal teams to co-ordinate implementation. We recommend getting advice from your head of midwifery or the clinical director for maternity services, and the lead consultant of your neonatal unit, who will be able to identify who to direct this alert to.