Humber and North Yorkshire Health and Care Partnership

Local Maternity and Neonatal System

ROLES AND RESPONSIBILITIES OF THE PRETERM BIRTH LEAD TEAM

Guidance for implementation

Introduction

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Preterm birth (PTB), defined as birth at less than 37+0 week's gestation, is a common complication of pregnancy, comprising around 8% of births in England and Wales. Prematurity is the most significant cause of mortality in children under five and is associated with significant morbidity in surviving infants. PTB is estimated to cost health services in England and Wales £3.4bn per year.

The NHS Long Term Plan has an ambitious goal to reduce stillbirth, neonatal mortality and serious brain injury by 25% by 2020, and 50% by 2025[1]. This has been further developed recognising that the national ambition won't be achieved unless the rate of preterm births is reduced and the Government set an additional goal to reduce the national rate of preterm births from 8% to 6%[2]

Element 5 of the Saving Babies Lives Care Bundle Version 3[3] focuses on reducing spontaneous preterm birth via prediction, prevention, and preparation. There are evidence-based perinatal interventions to reduce the risk of preterm mortality or serious brain injury. Perinatal optimisation refers to the process of reliably delivering these evidence-based interventions in the antenatal, intrapartum and neonatal period to improve preterm outcomes. A large proportion of Element 5 includes the delivery of perinatal optimisation to eligible preterm babies.

The establishment of a PTB lead team in Trusts is essential for compliance with Element 5 of the SBLCBv3. The team will provide leadership and oversight of the implementation of Element 5 of SBLCBv3 and is a key function to successfully meet the national ambition to reduce the rate of preterm births and reduce stillbirth, neonatal mortality and serious brain injury. The PTB lead team will contribute to developing and sustaining a culture of safety, learning and support in line with the 3-year delivery plan for maternity and neonatal services[4].

The purpose of this document is to support Trusts to implement an effective PTB lead team. It will provide guidance on the responsibilities of the PTB leads to ensure standardisation of the roles in line with national recommendations and ensure teams have the capacity to effectively fulfil their function.

Preterm Birth Lead team staffing resource.

SBLCBv3 Intervention 5.1 mandates that each provider Trust should have:

- An obstetric consultant lead for preterm birth, delivering care through a specific preterm birth clinic, or within an existing fetal medicine service
- An identified local preterm birth /perinatal optimisation midwife lead
- A neonatal Consultant lead for preterm perinatal optimisation
- An identified neonatal nursing lead for preterm perinatal optimisation

[1] NHS Long Term Plan v1.2 August 2019
[2] DH Title (publishing.service.gov.uk)
[3] NHS England » Saving babies' lives: version 3
[4] 6.1-three-year-delivery-plan-for-maternity-and-neonatal-services.pdf (maternityresourcehub.com)

These positions require formalised and adequate time resource appropriate to the size of the maternity and neonatal service. The British Association of Perinatal Medicine (BAPM) has produced a toolkit for 'Building Successful Perinatal Optimisation Teams.[5] The toolkit provides recommendations on staffing resource and job plans for the preterm birth lead team:

- 1PA (4hrs a week) each for Obstetric and Neonatal leads in a large maternity/NICU unit
- 0.5WTE (2.5 days a week) each for midwife/neonatal in a large maternity/NICU unit.

The term "large" is not defined within the toolkit but Trusts should consider staffing resources based on number of sites, the number of referrals into their preterm birth prevention clinic and neonatal unit classification/expected patient activity levels. Definition of NICU unit status is determined by the number of days of intensive care delivered; More than 2,500 intensive care days per annum is considered a large unit.[6] [7].

Review of SBLCBv3 Element 5 audit outcomes can provide Trusts with information on current performance around preterm birth rates, off pathway births and perinatal optimisation, mortality and morbidity. Performance data, process and outcome indicators can function as a lever for allocating resources to the preterm birth lead team.

Trusts may wish to consider pre-existing roles that already encompass preterm birth prevention/perinatal optimisation or patient safety and/or quality improvement and revise the role's portfolio to include the functions of the preterm birth lead team ensuring adequate time is given that reflects the workload. Integration into the wider maternity team should be considered, particularly for the Midwife and Nursing lead roles. For example, the Midwife lead may be based within the Pregnancy Assessment Centre, antenatal ward or Clinical Governance. The preterm birth leads will need to have flexibility to work across all areas of the maternity and neonatal service and develop close links with fetal medicine clinics, NICU teams, NICU outreach team, Perinatal Mental Health Teams, Tobacco Dependency Treatment Services and service user groups particularly their local Maternity and Neonatal Voices Partnership (MNVP).

Training and Development

The BAPM toolkit recommends training in leadership, communication and quality improvement to fulfil the remit of the role successfully. Trusts should consider upskilling of the PTB lead team to include:

QSIR (Quality Service Improvement and Redesign)

[5] Building Successful Perinatal Optimisation Teams | British Association of Perinatal Medicine (bapm.org)
[6] Microsoft Word - Optimal size of NICUs final June 2014 (amazonaws.com)
[7] LNU_doc_Nov_2018.pdf (amazonaws.com)

Leadership programmes: RCM. RCN. Perinatal Culture and Leadership programme

Enhanced Clinical skills such as TV scanning.

Core responsibilities of the preterm birth lead team

The preterm birth lead team are responsible for the implementation and oversight of Element 5 of SBLCBv3. They will lead initiatives on the prediction and prevention of preterm birth and perinatal optimisation of babies born early. Focus on preterm birth prediction and prevention will sit with the obstetric and midwifery lead whilst focus on perinatal optimisation will sit with the neonatal and midwifery leads. However, the team will work cohesively recognising their value and inclusion in their shared work to help shape the service as one team with a single shared version.

In order to fulfil the functions of the PTB lead team and successfully effect change and improvements in outcomes, the following lists the key responsibilities of the members of the team in line with the SBLCBv3 and BAPM guidance for successful perinatal optimisation teams:

- Develop and review Trust guidelines around preterm birth and perinatal optimisation
- Embed perinatal optimisation interventions using QI methodologies
- Multidisciplinary review performance of perinatal optimisation interventions
- Multidisciplinary review of off pathway births using the regional review tool
- Participation in PMRT reviews where cases involve preterm babies
- Engage in audit and action planning using NNAP and Neonatal ODN data
- Engagement with MNVP to co-produce services and survey patient experience
- Share learning and examples of excellence across the perinatal team and with partner Trusts
- Staff education
- Attendance at LMNS perinatal forum
- Engagement with Y&H CN Preterm Birth Group and Neonatal ODN.
- Support research and involvement in clinical trials

Reducing Inequality

Smoking in pregnancy is a major health inequality and prevalence is higher in women who experience high levels of deprivation. Smoking is a predisposing risk factor for preterm birth and is the single biggest modifiable risk factor for poor birth outcomes. PTB lead teams should develop links with their local tobacco dependency treatment services and support interventions within Element 1 of the SBLCBv3.

Pre-term birth is a major health inequality, with mothers in the most deprived 10% income group twice as likely to have preterm births compared to those from the least deprived decile. The proportion of preterm births also varies by ethnicity, with infants of Black Caribbean parents more likely to experience preterm birth.

Improving equity of services and clinical care requires a focus on ensuring that services and resources are accessible and understandable for disadvantaged women. The PTB lead team will champion improving equity with a mission to reduce the health inequalities gap.

Exemplar: Additional Duties for the preterm birth midwife lead

Based on best available evidence midwifery continuity of carer delivers safer and more personalised care and can help prevent preterm birth. Women receiving Continuity of Carer are 24% less likely to experience preterm birth[8] [9]. National guidance recommends that services should consider ensuring relational continuity within more medicalised pathways[10].

Whilst it may not be possible to deliver continuity of carer across the whole maternity journey, the positive impact of relationship-based care on preterm birth outcomes occurs during the antenatal period. Leeds Teaching Hospitals NHS Trust are an exemplar for the Preterm Birth specialist midwife role[11] and how this can provide continuity of carer for women at high risk of preterm birth.

Where possible, Trusts should consider enhancing the preterm birth lead midwife role to include clinical duties such as:

- Participation in preterm birth prevention clinics
- Caseload women at high risk of preterm birth – hospital based antenatal care for those women who have a cervical suture or are commenced on progesterone following an enhance antenatal pathway.
- Maternity ward visits for women who have had a positive fetal Fibronectin result to co-ordinate counselling of women, discussion with the neonatal team and commencement of the peri-prem passport
- Provide standardised postnatal care for women who have preterm babies admitted to NICU.

Where smaller units have lower numbers of women at risk of preterm birth or experiencing preterm birth, the WTE for the role could be adjusted to ensure the workload meets capacity. Alternatively, to avoid creating a specialist midwife role, provision could be achieved by considering allocating the lead role to an existing member of the workforce within pregnancy assessment centres or antenatal clinic areas.

Where it is deemed not possible to carry out clinical functions, identifying an existing role whose portfolio can be expanded to included preterm birth and who can allocated protected time to contribute to the functions of the preterm birth lead team will still ensure the requirements of SBLCBv3 are met by the midwifery team.

[8] Interventions during pregnancy to prevent preterm birth: an overview of Cochrane systematic reviews - Medley, N - 2018 | Cochrane Library
[9] Antenatal interventions for preventing stillbirth, fetal loss and perinatal death: an overview of Cochrane systematic reviews - Ota, E - 2020 | Cochrane Library
[10] B0961_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf (england.nhs.uk)
[11] The Introduction of a Specialist Preterm Birth Midwifery team at Leeds Teaching Hospital (youtube.com)

- **Further guidance**
  - BAPM and NNAP toolkits
  - Maternity and Neonatal Safety Improvement Programme
  - SPSP Maternity and Children Quality Improvement Collaborative (MCQIC) – Neonatal Care
  - https://www.weahsn.net/our-work/transforming-services-and-systems/periprem/
  - https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019.
  - NICE Guideline NG25 'Preterm labour and birth'
  - NICE Diagnostics Guidance DG33 'Biomarker tests to help diagnose preterm labour in women with intact membranes'
  - Ockenden Report (2022) Element 9
  - UK Preterm Clinical Network 'Reducing Preterm Birth: Guidelines for Commissioners and Providers'