Safer baby collaborative – Phase 2 Charter

## What will the Safer Baby Collaborative accomplish?

### By June 2021 we intend to reduce the rate of stillbirths in the third trimester\* by 30 per cent

This will be accomplished by focusing on:

* Consistent, reliable use of the bundle of clinical care:
  + improving rates of smoking cessation in pregnancy
  + screening and diagnosis of fetal growth restriction
  + increasing awareness of the importance of fetal movements
  + raising awareness of safe maternal sleep positions
  + promoting shared decision-making around timing of birth.
* Partnering with women during pregnancy, to support identification of risk factors and shared decision making.

\**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, with work currently being undertaken across Victoria, New South Wales, Queensland, Western Australia and the Australian Capital Territory. Prior to Phase 1 of the Safer baby collaborative, 2017 Victorian data demonstrated a stillbirth rate of 6.3 per 1000 births after 20 weeks, with 159 stillbirths after 28 weeks[[1]](#footnote-1). More recently released data from 2018 demonstrated some improvement, with a total stillbirth rate of 6.0 per 100 births after 20 weeks and the number of stillbirths after 28 weeks decreasing to 1161. However, awareness of risk factors for stillbirth is perceived to be low and research suggests many stillbirths are avoidable.

Utilising our partnership with the Institute for Healthcare Improvement (IHI), we commenced the Safer baby breakthrough series collaborative in June 2019, with the aim of reducing the rate of stillbirth in participating services through introduction of an evidence-based bundle of care. This bundle of care aligns with work undertaken in the United Kingdom as part of the Saving Babies Lives Care Bundle and with the Safer Baby Bundle work being undertaken by the Stillbirth Centre of Research Excellence. Phase 1 was ended in April 2020, due to the coronavirus (COVID-19) pandemic, and Phase 2 is commencing in November 2020.

### Phase 1 – what progress did we make?

#### Progress towards our aim

* The rate of stillbirth across participating services decreased by 27 per cent.

#### Improvements in process measures

* Smoking cessation during pregnancy increased from 11 per cent to 28 per cent.
* Use of the ‘Ask Advise Help’ brief advice intervention increased from 15 per cent to 38 per cent.
* Use of carbon monoxide analysis increased from 18 per cent to 41 per cent.
* Screening for fetal growth restriction increased from 3 per cent to 32 per cent.
* Measurement and plotting of symphyseal fundal height (SFH) increased from 63 per cent to 88 per cent.
* Provision of information on decreased fetal movements increased from 23 per cent to 54 per cent.
* Provision of information on maternal sleep position increased from 9 per cent to 44 per cent.
* Percentage of women who reported being involved as much as they wanted in decision making about the timing of their baby’s birth increased from 18 per cent to 25 per cent.

## What does taking part in phase 2 of the collaborative mean?

### Phase 2 – Key dates for our six-month program

* 24 November 2020 – Kick off session
* 16 December 2020 – Virtual office (optional attendance for support and Q&A)
* 20 January 2021 – 1st virtual forum
* 10 February 2021 - Virtual office (optional attendance for support and Q&A)
* 24 March 2021 – 2nd virtual forum
* 26 May 2021 – Wrap up

Coaching calls with Improvement Advisors in training to be arranged.

#### Each participating service needs

* An executive sponsor who is supporting the work and ideally able to attend virtual forums with their team. We know from Phase 1 that active partnership between service leadership and the collaborative team is essential to achieve results. Teams succeed when a senior leader sponsors their work. The executive sponsor is responsible and accountable to the service for performance and results of improvement work. They may not be an active member of the collaborative team but support the team to achieve their aim by connecting with them regularly, removing barriers to their progress and championing their work to others in the service.
* A day-to-day team leader.
* A core team: This team may be comprised of an obstetrician, midwife, consumer and member with quality improvement experience. The team is responsible for identifying champions and driving change on the clinical floor.
* A wider team of six to 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 dedicated to do the 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 virtual forums.
* A commitment to implement all elements of the bundle.

## How will we know that change is an improvement?

### Data collection

During quality improvement activities, teams collect and use data over time in order to assess change, adjust their hypotheses along the way and understand the impact of changes tested in a wide range of conditions. Data is used to understand if changes are leading to improvement and to determine teams’ next steps.

The following measures will be collected by the teams throughout Phase 2 of the collaborative.

#### Outcome measures

* Number and rate of stillbirths at 28 or more weeks gestation
* Percentage of women who cease smoking between conception and birth

#### Process measures

* Percentage of women who receive ‘Ask, Advise, Help’ at each antenatal visit
* Time between women reporting decreased fetal movements (DFM) and commencement of a cardiotocograph (CTG)
* Percentage of women who are screened for FGR risk factors at each antenatal visit
* Percentage of women who have their SFH measured and plotted on a growth chart
* Percentage of women provided with DFM information and education
* Percentage of women provided with maternal sleep position (MSP) information and education
* 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 give birth by induction of labour or caesarean section prior to 39 weeks
* Percentage of babies admitted to special care nursery after 37 weeks

## What changes can we make that will lead to improvement?

Phase 2 Driver diagram

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| **AIM** |  | **PRIMARY DRIVERS** |  | **SECONDARY DRIVERS** |  | **CHANGE IDEAS** |
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| By June 2021 we intend to reduce the stillbirth\* rate by 30% in participating health services.   *\*Stillbirth is defined as birth without signs of life at 28 weeks or more, excluding terminations and lethal congenital or chromosomal abnormalities.* |  | Partnering with women |  | At booking |  | * Discuss expected length of pregnancy with all women * Include the consumer-designed poster and sticker, outlining 5 bundle elements, in all booking packs * Include information about stillbirth risk factors (smoking, FGR, DFM, maternal sleep position) |
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|  |  | At pregnancy care appointments |  | * Discuss stillbirth risk factors (smoking, FGR, DFM, maternal sleep position) at every visit * Share links to the Stillbirth CRE Safer Baby Bundle consumer site   ***Bundle element 3: Management of decreased fetal movements***   * Share the ‘Movements matter’ resources with every woman   ***Bundle element 4: Promoting optimal maternal sleep position***   * Share the ‘Sleep on side’ video and resources with every woman * Ask every woman about sleep position, during pregnancy care appointments in the third trimester |
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|  |  | When planning for timing of birth |  | ***Bundle element 5: Shared decision-making around timing of birth***   * Use shared decision-making tools to guide and document discussions * Share the ‘Every week counts’ resource with all women * Screen for stillbirth risk at term |
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|  | Application of evidence-based clinical care |  | Routine professional development |  | * Incorporate education and simulation training on the five clinical interventions * Create training videos for the five clinical interventions * Introduce daily SBC huddles in antenatal clinic, to gather feedback and share information * Incorporate teach-back skills * Identify opportunities for in-the-moment teaching, reflection and clinical reasoning development |
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|  |  | Every episode of care |  | ***Bundle element 1: Promoting smoking cessation***   * Screen for smoking behaviours using the Ask, Advise, Help brief advice intervention * Refer to Quit services * Include partners and other family members in screening and referral * Share information with GPs |
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|  |  |  | ***Bundle element 2: Detection and management of fetal growth restriction (FGR)***   * Screen all women for their risk of FGR * Use a consistent technique for measuring symphyseal fundal height (SFH) * Plot symphyseal fundal height (SFH) and estimated fetal weight (EFW) on growth charts |
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|  |  | When reported |  | ***Bundle element 3: Management of decreased fetal movements***   * Assess all women who report DFM as soon as possible * Ask every woman how long has passed since she first perceived DFM |
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1. Victoria’s Mothers, Babies and Children 2018: <https://www.bettersafercare.vic.gov.au/sites/default/files/2019-12/CCOPMM%20REPORT%20-%20FINAL_181219.pdf> [↑](#footnote-ref-1)