NHS Resolution

Safety Action B - Training

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Department of Health & Social Care

NHS England

Impacted Fetal Head At Caesarean Section

Tony Kelly, National Speciality Advisor & Perinatal Deterioration Team
NHS England

What do I want you to understand?

- What will the tool and pathway will aim to do?
- What are the principles underlying the Avoiding Brain injury in Childhood approach?
- How are we planning on implementing the approach?
- What are the challenges regarding implementation?
- What is the future thinking?

What two pathways are we discussing?

Impacted Fetal Head

Intrapartum Fetal Deterioration

Royal College of Midwives

Royal College of Obstetricians & Gynaecologists

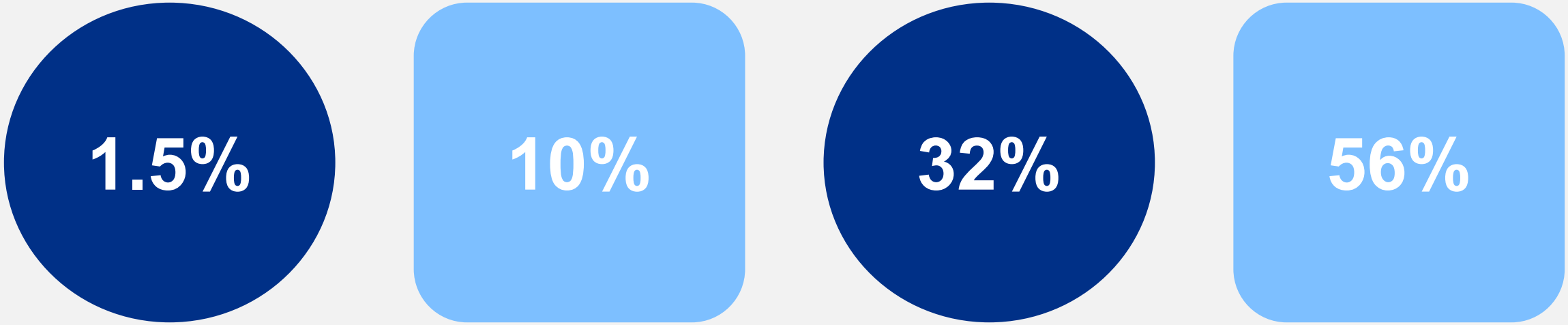
THIS.Institute The Healthcare Improvement Studies Institute

What is impacted fetal head (IFH) at caesarean section?

- Associated with caesarean birth in advanced labour
- Fetal head low and deeply engaged
- Technically difficult births
- Requires different approach from routine caesarean birth
- High risk of complications for the woman and baby

A caesarean birth where the obstetrician is unable to deliver the fetal head with their usual delivering hand, and additional manoeuvres and/or tocolysis are required to disimpact and deliver the fetal head.

How common is IFH?



of all births

of emergency caesarean sections

of caesarean sections at full dilatation

of caesarean sections **prior** to full dilatation

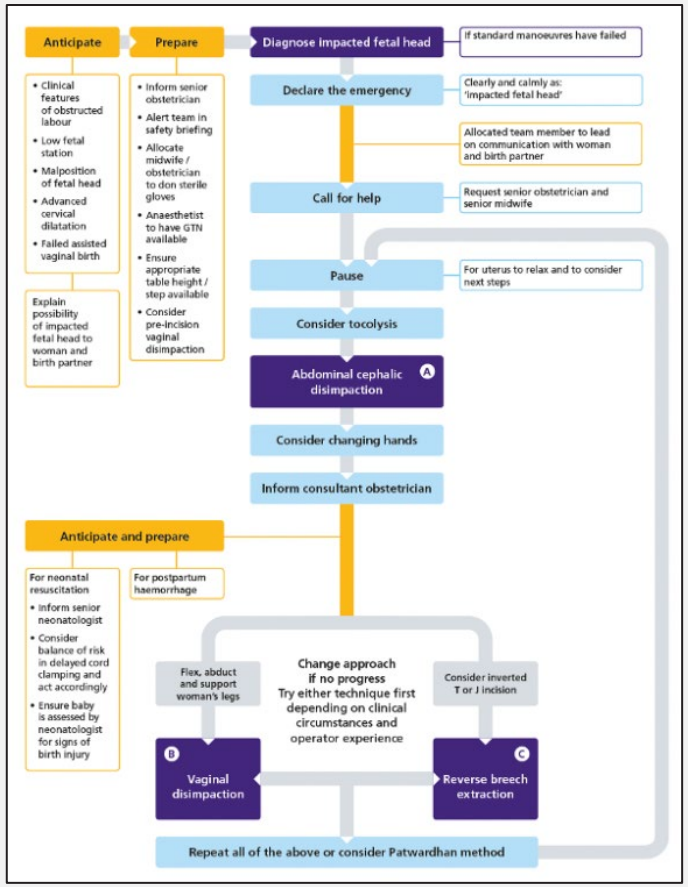
What are the complications of IFH?

- Damage to uterus
- Damage to urinary tract
- Uterine bleeding
- Postpartum haemorrhage
- Hysterectomy
- Longer hospital stay

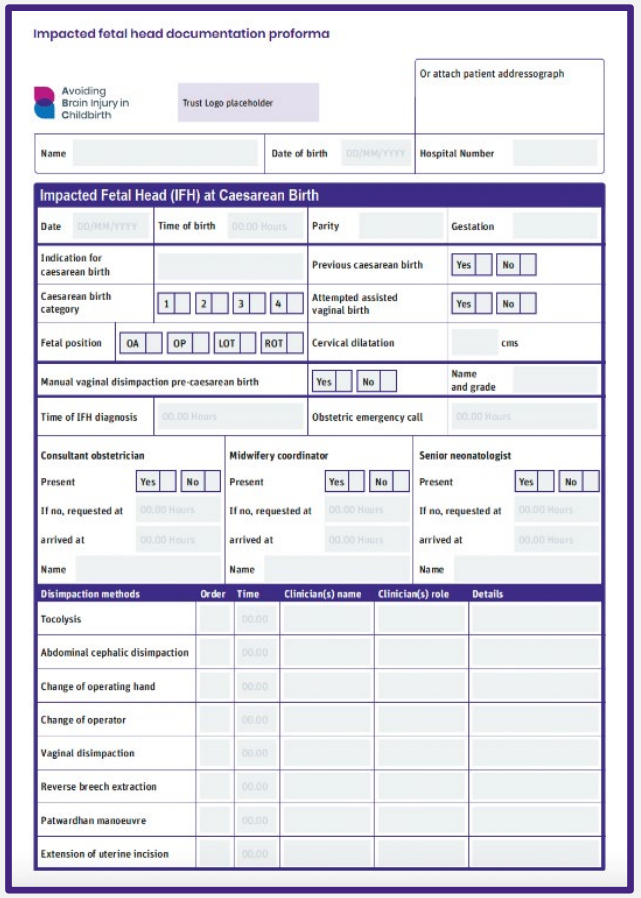
10%

- Skull fracture
- Intracranial bleed
- Nerve injury
- Hypoxic brain damage
- Neonatal death

How are we approaching improvement?



- Multi-professional training
- Standardised approach
- Specific set of manoeuvres/approaches
- Greater emphasis on communication and documentation



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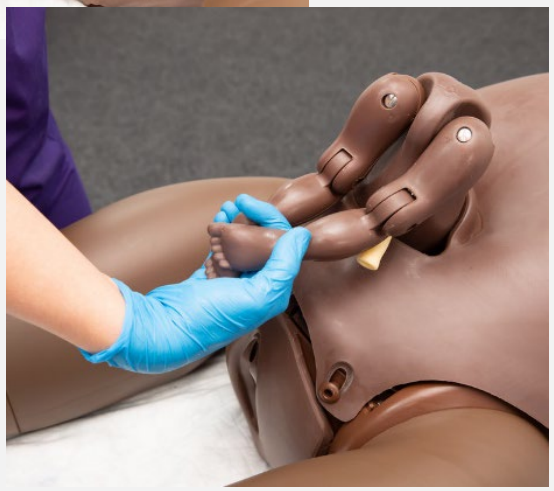
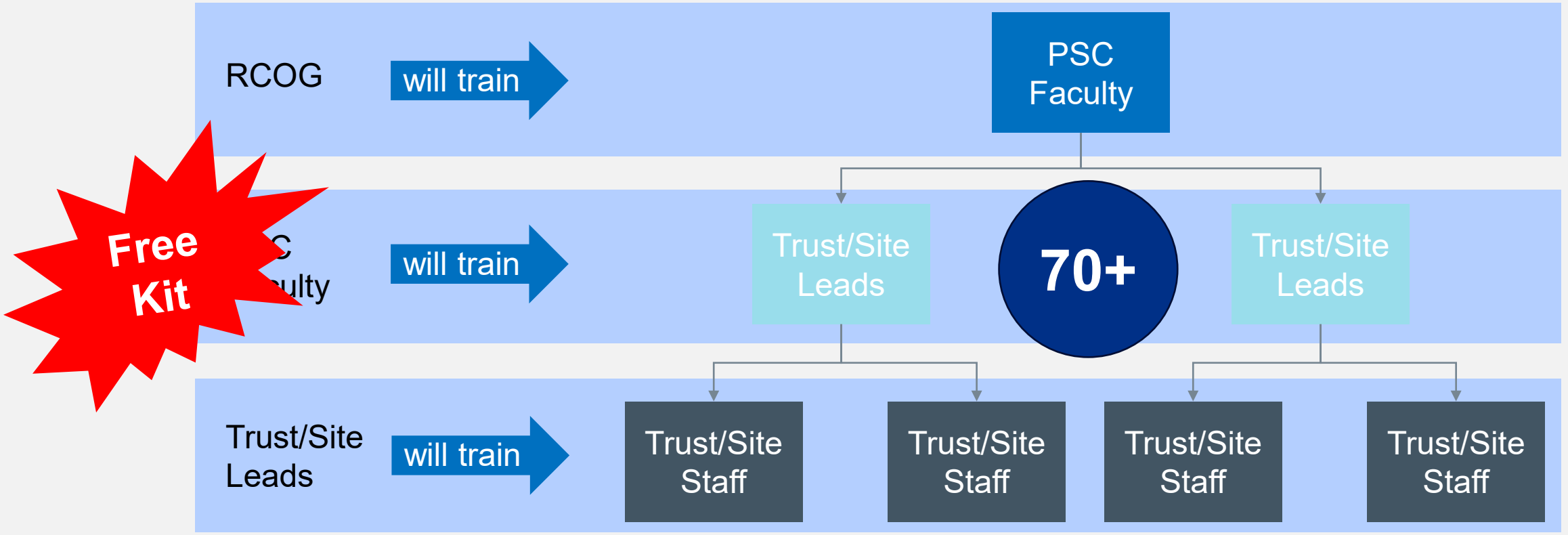
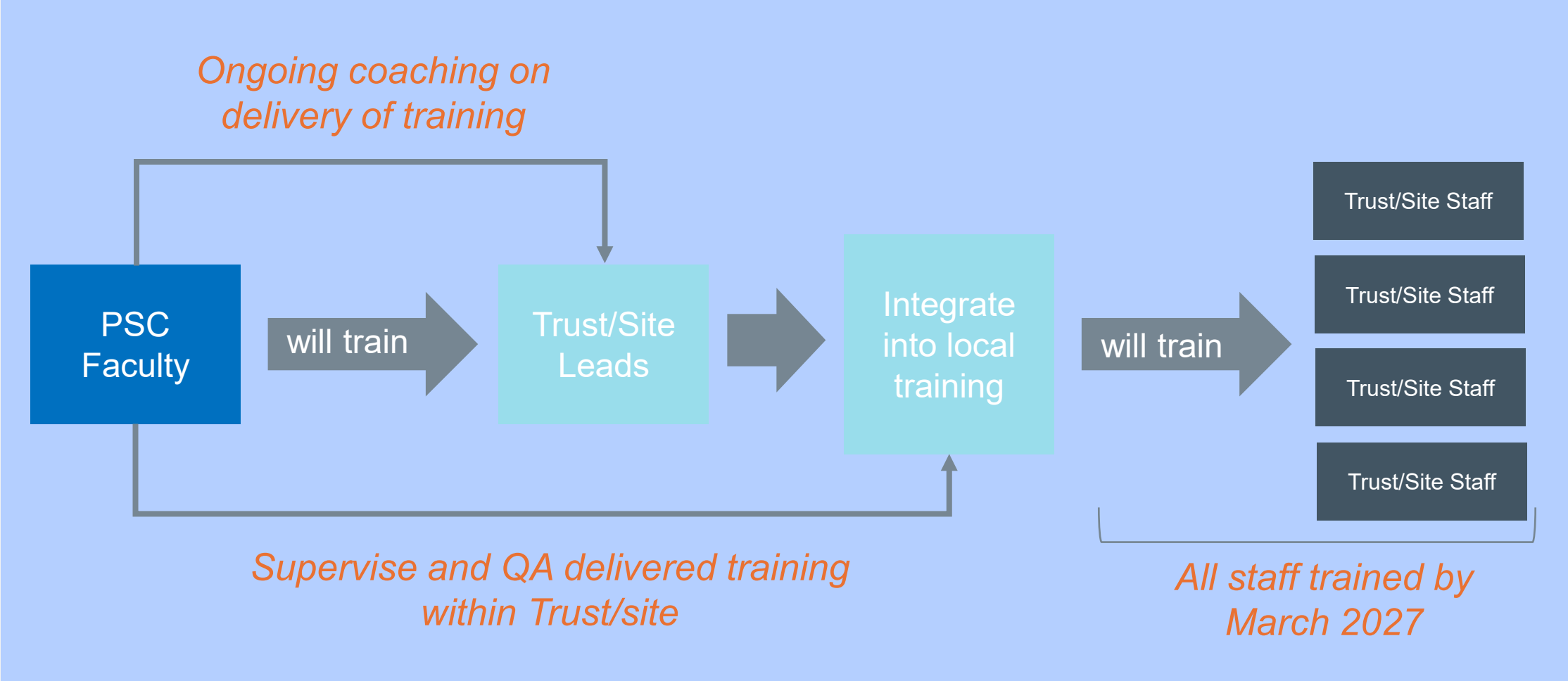


- Abdominal disimpaction
- Vaginal disimpaction
- Reverse breech extraction
- Patwardhan method
- Incision extension (inverted T or J)
- Tocolytics
- (Fetal pillow)

How are we planning on implementing the approaches?



How are we planning on implementing the approach?



What are your requirments as an organisation?

- To integrate IFH training into your skills drills training for this year
- Engage with your local PSC clinical faculty to secure the training for your local Trust leads
- Aim to have trained all staff by end of March 2027

Neonatal Resuscitation Training Requirements

Elizabeth Pilling
Consultant Neonatologist
Neonatal CRG

Minimum Training Requirements

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- Trusts must ensure that all staff who may act as an unsupervised first attender or primary resuscitator at any birth (including all midwives)
  - complete annual neonatal resuscitation training
  - assessed as meeting at least basic capability, as defined in the BAPM Neonatal Airway Safety Standard
  - Where further enhanced training is in place for additional staff groups, this should continue (e.g. NLS or equivalent).

Why?

- NHS resolutions EN scheme 2nd report- 32% of cases identified issues with neonatal resuscitation
- 11% of MNSI investigations identified difficulties with airway management

Resuscitation Council UK certified courses

- NLS
  - “standard” course
  - 1 day course
  - Covers all “basic” requirements
  - Includes assessment
- OH-NLS *new*
  - Out of hospital neonatal resuscitation course
  - 1 day course, focused on neonatal resus out of hospital
  - Covers BAPM “basic” requirements
  - Includes assessment
- ARNI
  - Advanced resuscitation of the Newborn Infant
  - 2-day course
  - Covers more advanced neonatal resuscitation- for “2nd responder”

BAPM Airway standards-Basic

- Can provide effective airway support and ventilation via facemask or laryngeal mask (LM) for babies ≥ 34 weeks with normal anatomy.
  - Familiar with equipment needed for airway management in babies ≥ 34 weeks.
  - Can demonstrate how to correctly size and apply facemask.
  - Can provide effective mask ventilation (including jaw thrust and 2-person technique).
  - Can determine LM size required, insert LM, & provide effective ventilation via LM.
  - Can assess facemask/LM ventilation using colorimetric CO2 detector and clinical assessment.
  - Familiar with local escalation plan for a baby requiring skills beyond Basic capability.
- ~~Annual assessment to demonstrate all required BAPM Basic airway skills in a~~ simulated or appropriate clinical setting or a combination of both.

What Good Might Look Like-1

A local training register showing annual neonatal resuscitation training and capability sign-off for all relevant staff, supported by completed assessment records.

- Target 100% of “first attenders”
- NB Basic standards are the bare minimum- tier 2 and 3 neonatal staff should have higher level (at least)

Assessments clearly mapped to the BAPM standard, demonstrating that staff meet basic capability before undertaking unsupervised primary resuscitator roles.

- Can be achieved locally or via Resuscitation Council courses (NLS, OH-NLS, ARNI)
- Tools/scenarios available on BAPM website
- Ensure staff assessed for all rotations (e.g. foundation doctors)

What Good Might Look Like-2

Scenario-based training plans reflecting local environments and escalation pathways, with updates informed by recent incidents or debriefs and service user feedback about communication during neonatal emergencies. Scenarios include community births.

- Learning from local incidents

A training needs analysis used to shape the annual programme and identifying any areas requiring additional support.

- Additional needs will vary on local organisation and clinical need

Evidence of neonatal resuscitation compliance and capability included in routine maternity/neonatal training reports to the Board, ensuring ongoing oversight of any gaps or risks

- Aiming for 100% all year around

Flash teams and their significance

- These professional groups rarely interact outside of clinically complex encounters and therefore have a limited understanding of the other's priorities and scope of practice (skills, drugs, equipment)

- Ambulance Clinicians have a lack of exposure and training.
- Limited diagnostic equipment
- Limited or no access to patient information
- When we do interact its often time critical
- Conflict occurs.....

Challenges

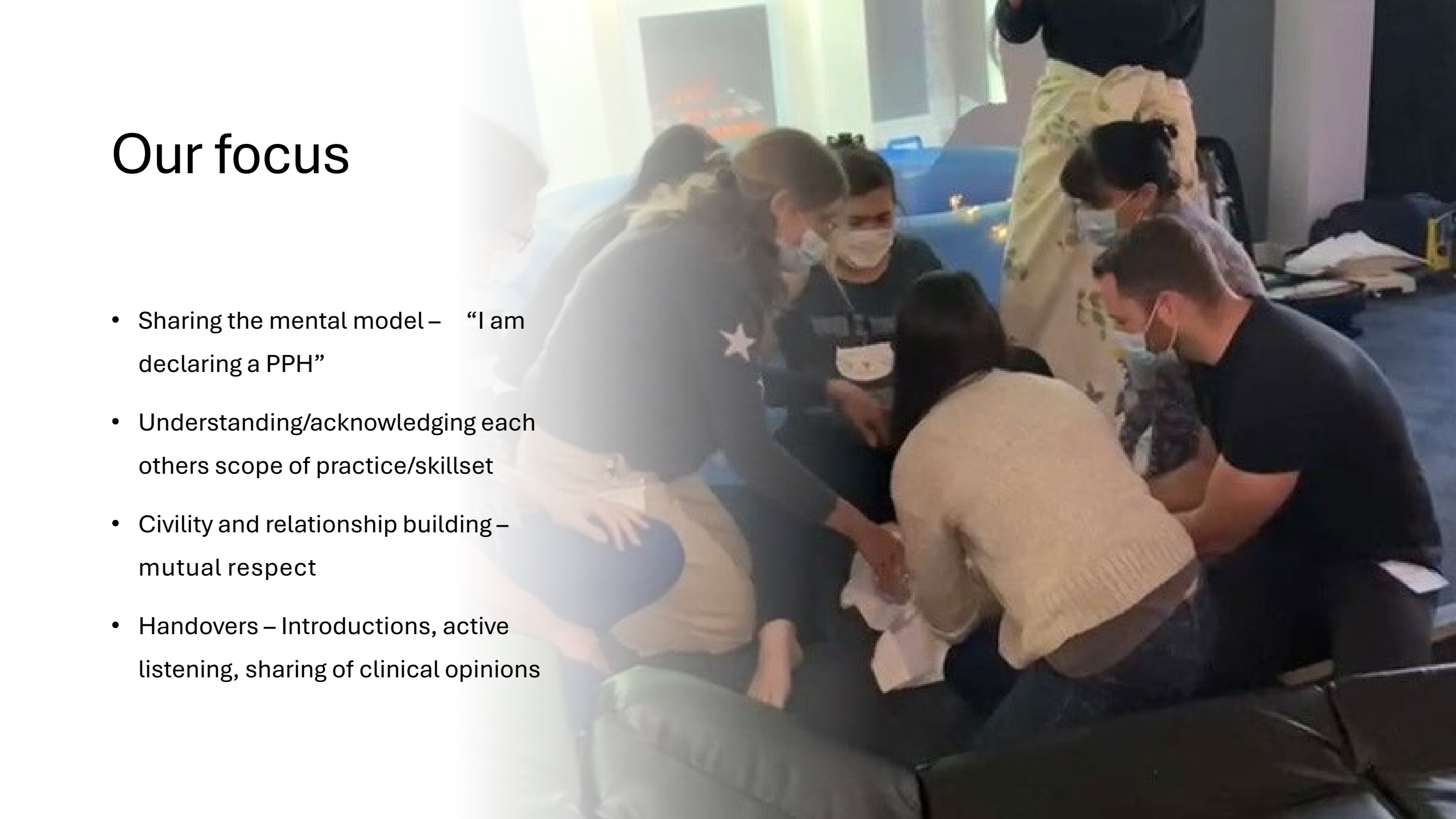
- Releasing staff across organisations
- Ambulance engagement & time
- Competing system pressures
- Different teams, equipment & guidelines
- Homebirth team logistics

Current issues

- Challenged maternity services can displace risk into the community with implications for ambulance service
- We are the service that can't say no....
- MDT training is a common recommendation, but it remains very intrapartum/hospital focused, mw's, obstetrics, anaesthetists etc.
- Ambulance service is generally the first point of care and yet not considered in the wider maternity system

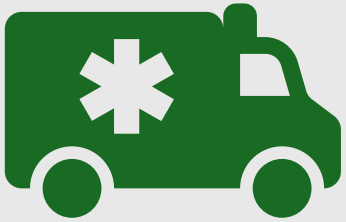
Our focus

- Sharing the mental model – “I am declaring a PPH”
- Understanding/acknowledging each others scope of practice/skillset
- Civility and relationship building – mutual respect
- Handovers – Introductions, active listening, sharing of clinical opinions



Bringing the woman or birthing person’s voice

- Real stories in training
- Voices of women & families
- Lived experience of transfer
- Keeps care person-centered



However, there is an absence of strategy acknowledging the ambulance service and their input at a national and local systems level.

It’s time to recognise the ambulance service’s role in maternity care, including them in local and national recommendations.

Department of Health & Social Care

NHS Resolution

Multi-professional Training

Kirsty Maclennan, Consultant Anaesthetist, Obstetric Anaesthetic Representative MIS

MIS safety action B and the Anaesthetist

- The who (anaesthetic)
- The what
- The opportunities and top tips

Anaesthetic workforce

- **Who**
  - Permanent
  - Rotating (LED / NTN)
- **When**
  - Annual
  - Protected training

- **What**
- ½ day maternity emergencies training
- 3 months to gain compliance
- Transferrable if within 1 year

Image from CLWRota website

Maternity emergencies training

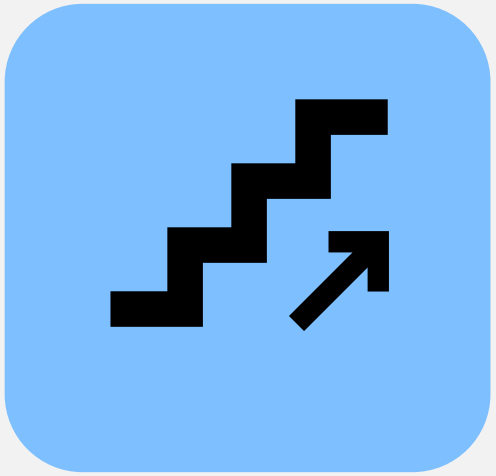
- Obstetric emergencies
  - Collapse
  - PPH
  - Uterine inversion
  - Shoulder dystocia

- Local learning
  - Governance
  - What worries you / your staff
  - Location / kit

Importance of team training

Closed loop

Info sharing



Escalation pathways

Situational awareness

Team performance

Teams that work together…..

…Should train together.

Insitu simulation

Hospital based

Community based

In summary

- Train as a team
- Your place, your people, your problems
- Think of the bigger team
- Share your learning