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What makes a top hospital?

MATERNITY CARE

MAY 2014



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Part of the CHKS Thought Leadership Programme



CHKS

Insight for better healthcare



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About CHKS

CHKS has worked with healthcare organisations across the UK to inform and support improvement for 25 years. This report highlights examples of best practice in maternity care, which we aim to share throughout the NHS.

Introduction

Trust and confidence are two of the most important words women will use about their midwives and the maternity teams who care for them. They, quite rightly, expect compassionate care and high standards of clinical expertise. These are the foundations on which the relationship between women and midwives are built, and which generate the trust and confidence needed along the whole maternity pathway of care.

Midwives are the lead professionals for all healthy women with straightforward pregnancies; for those with more complex pregnancies and circumstances, both medical and social, midwives will be the key co-ordinators of care within a wider multidisciplinary team. The partnership between a midwife and woman is special and can be complicated – the woman will want to make choices and the midwife will listen, advise and navigate.

An environment in which women feel safe is the cornerstone of the open and honest dialogue required for midwives to understand the individual circumstances of each woman and her family. Much of this dialogue can be challenging for both parties when it comes to discussing the how to achieve a healthy pregnancy, a positive birth experience and a successful start to parenting.

The undeniable intimacy of this one-to-one relationship is crucial to building a woman's trust and confidence, but this trust also needs to play out across the whole maternity team and the whole care pathway. As a consequence there is a natural and important leadership role to be played by midwives in any part of the system. This is not about hierarchy or positional power, but about professional autonomy and advocacy for women, their babies and families. As such, it is a role of great importance to society. The influence of midwives reaches far beyond a one-to-one relationship; that closeness between midwives and women heralds the start of improving public health in families, communities and populations.

As midwives we recognise the challenges of our profession are legion, but we are passionate about the standard and experience of care women and their babies receive, and are pleased to see the CHKS awards celebrating exemplary midwifery and maternity care.



Birte Harlev Lam
Head of Maternity and Children's Services,
Nursing Directorate, NHS England



David Foster
Deputy Director, Nursing and Midwifery Professional
Advisory Board, Department of Health (England)

Foreword

CHKS celebrates and shares success across the health service with its annual Top Hospitals awards programme. As a result we have come across many examples of excellence in the delivery of healthcare within acute sector organisations. The idea behind this series of reports is simply to share these examples of success in the hope that other organisations can take something from each of them.

In 2014 CHKS added a new category to the awards programme, for excellence in maternity care. This award identifies outstanding maternity care and is based on an evaluation of a range of key clinical and Care Quality Commission (CQC) indicators. After analysis of these indicators, 15 trusts representing the top 10 per cent of the 148 NHS maternity providers in England, Wales and Northern Ireland were invited to submit further evidence about their maternity services.

A shortlist of four trusts was then drawn up and then presented to a panel of experts (including Judy Ledger, CEO and founder of Baby Lifeline and Jeanne Lythgoe from the directorate of midwifery, counselling and psychotherapy at the University of Salford).

This report, like others in the series, attempts to share learning from these top hospitals and establish common themes that any acute sector organisation hoping to improve its maternity care services should take into consideration.

WHAT MAKES A TOP HOSPITAL: THE OBSERVED THEMES

Quality and change

- Cost reduction through quality improvement
- Disciplined execution of change at scale
- Using data for improvement, not judgement

Safety

- “Getting to zero” – zero tolerance of harm
- Deliberate focus on reducing mortality and on other safety measures

Leadership

- Strong, stable leadership with continuity of chief executive
- Distributed leadership model that empowers clinical leaders and shifts power to patients and their families
- Investment in development
- The totality of the approach

Organisational culture

- Profound sense of mission and direction
- A mobilised workforce with a

passion to get things right for patients

- Defining and promoting values and living them every day

External influence

- Seeing the hospital as part of the wider community
- Corporate and social responsibility
- Risk sharing with commissioners
- Learning from other healthcare providers and other industry sectors

- Comparison not just with peers but worldwide

Patient experience

- What good feedback looks like
- Why staff experience is as important
- Measuring the experience of patients and staff
- How successful organisations use feedback
- Triangulating feedback with other data

Executive summary

Maternity Services are used by more than 700,000 women a year in England and the birth rate continues to rise by around 2 per cent a year¹. Maternity care costs the NHS on average £2,800 per woman for antenatal, intrapartum and postnatal care, with complex births becoming more common. Among the factors responsible are the increase in pregnancies in women over the age of 40 and growing rates of obesity, which raise the risk of gestational diabetes. These contribute to women having a greater chance of miscarriage, experiencing a more complicated labour or needing medical intervention. Further, the rate of caesarean section (c-section) in England has almost doubled since 1990. These elements all have financial implications as a result of greater intervention and longer postnatal stays in hospital.

Similarly, the national audit office reported that £482 million was paid out in 2012-2013 for maternity clinical negligence claims – a third of the total NHS clinical negligence bill and a fifth of the total maternity budget. Maternity claims have risen by 80 per cent in the past five years.

Despite all this, NHS hospital trusts must still address the growing challenge of providing high-quality maternity services within tight budgetary constraints.

We know that good maternity provision is flexible, appropriate and accessible to all women. It emphasises pregnancy and birth as essentially a normal physical and psycho/social life events and provides seamless care for women who may need additional medical support.

However, we have not seen an improvement in maternity outcomes across all hospital trusts. Although the CQC's survey of maternity units in 2013 did find improvements in some aspects of maternity services, there were concerns around inconsistent levels of information and support. In some cases, for example, basic details such as medical history were not known.

So what are the best hospitals trusts doing to improve maternity care? The starting point for many is the culture of the organisation. Evidence has shown² that smaller, midwife-led units have better outcomes and some trusts have found that adopting the culture and flat hierarchical structure found in these units is beneficial. At the same time, trust leaders have to be supportive of this approach and accept a distributed leadership model. This gives midwives the autonomy to make decisions and try out new initiatives; some of the best initiatives come from the nurses and midwives on the wards.

Leading maternity units also understand the importance of the user experience and of involving mothers and their families. They are using tools such as the Friends and Family Test and many others to monitor the service they provide on an ongoing basis.

Using information to analyse and understand variance with peer providers, national requirements or guidelines is also a feature of the top maternity units. They understand that not only do they need to use their bespoke dashboards and other tools to monitor performance and quality, the information needs to be made available to commissioners, patients and the public.

Finally, providing evidence to the board that requirements and guidelines are being met comes as second nature to these trusts. This commitment to openness and transparency is an important step on the improvement journey and one that all these leading trusts have taken.

Strong leadership and a supportive culture



Leaders and managers need to create supportive, caring cultures, within teams, within organisations and in the system as a whole, in the way that organisations relate to each other. Leaders at every level have a responsibility to shape and lead a caring culture.

Compassion in practice. Nursing, Midwifery and Care Staff: Our Vision and Strategy.
Department of Health 2012

This series of reports has shown that strong leadership is vital to effecting lasting organisational change. We have seen how important it is to have senior leaders who show their commitment and are able to communicate a vision. Helen Bevan, chief of service transformation at NHS Improving Quality, says: "Success comes when leaders have been able to frame what the organisation has set out to achieve in a language that everyone can connect with." One of the best ways to define this purpose is through a narrative. She points to evidence showing that organisational change is more successful where leaders have encapsulated their goals using such a narrative.

This view is echoed in *Compassion in Practice*³, which says there is a correlation between strong leadership, a caring and compassionate culture and high-quality care. The document says leaders at every level have a responsibility to shape and lead a caring culture. However, we have also seen how a distributed leadership model has been beneficial at top-performing hospitals. These benefits occur when senior leaders ensure that members of staff are given responsibility, autonomy and support.

There is evidence for the link between this distributed leadership model and improved performance. The report of the King's Fund Commission on Leadership and Management in the NHS, *The future of leadership and management in the NHS: No more heroes*⁴, states that high performance requires distributed leadership, including clinical champions. "Effective leadership for improvement requires engaging doctors to participate in redesign efforts and to build support for these activities among their colleagues," the report says. King's Fund chief executive Professor Chris Ham points out that top-performing organisations often demonstrate collective leadership, rather than heroic leadership. "A good leader is someone who engages from the board to the ward. They will have good clinical leaders and great managerial support behind them," he says.

Compassion in Practice recommends action in two areas for creating strong leadership and a supportive culture. It calls for a national leadership development programme that will underpin the vision for nursing, midwifery and care staff. This would include change management skills, building coalitions of support, and communication and engagement with staff, patients, service users, carers and other stakeholders.

As for creating a supportive environment, the document says staff providing care should be nurtured and supported to be positive about their role. This means enabling involvement in decision making; promoting healthy and safe work environments; creating worthwhile and rewarding jobs in which every role counts; supporting each other; being accountable and being prepared to embrace innovative working and new technology.

Jeanne Lythgoe, from the directorate of midwifery, counselling and psychotherapy at the University of Salford, believes a positive culture as one where there is supportive challenge. "This is about having minimal hierarchy and promoting autonomy amongst midwives, so they feel able to contribute."

A supportive environment that encourages midwives to innovate is closely linked to a culture

of care and compassion. This can be achieved by enabling involvement in decision-making and creating worthwhile, rewarding jobs in which every role counts. Evidence shows² that midwife-led continuity of care is associated with key benefits for mothers and babies, and has no identified adverse effects compared with models of medical-led care and shared care. As well as a normal and rewarding experience for the mother, other benefits include a reduction in the use of epidurals, and fewer episiotomies and instrumental deliveries. Women themselves are more satisfied with the level of continuity offered by this model of care.

“I feel there may be something about using a sickness model to care for essentially well women in the main, yet expecting them to feel cared for and relaxed in this medically driven environment. It is a culture that impacts on the staff who adapt to this model, probably for their own survival, making it difficult for women to get the care and support they need and driving more mechanisation in line with the general critical care approach,” says Lythgoe.

The challenge facing many maternity departments is that maternity staffing models are often based on the traditional models used elsewhere in the organisation. These hierarchical models inhibit midwives’ ability to be autonomous.

One way in which this is being addressed is by reviewing organisational culture. For instance,

THE CULTURAL BAROMETER

In 2008, research carried out by a project team (involving the NHS, trades unions, the Healthcare Commission and the Academy of Medical Royal Colleges) with staff from 50 NHS Trusts and a range of GP practices found that staff commitment, engagement and productivity was strongly linked to four elements. These were the resources to deliver quality care, the support needed to do a good job, a worthwhile job that offers the chance to develop and the opportunity to improve teamworking.

These elements were used to design a barometer that can be used to test the culture of care on a regular basis. The barometer was designed to complement existing regulation and inspection frameworks so that it could be used by staff as a reflective developmental tool, while also providing an organisational mechanism for benchmarking departments.

The barometer presents a series of statements that individuals are encouraged to read to help them characterise the nature of the culture in their organisation. A simple assessment rating system has been applied to each statement, which helps identify if action is needed. Key features of the barometer are that it:

- is a mechanism for ward to board communication
- acts as an early warning system to identify care culture ‘red flag’ areas in an organisation
- is short and quick to complete
- complements not duplicates other measures, quality programmes and regulation
- enables reflection and identification of actions required

the development of a cultural barometer (see box) can be used to help managers, leaders and staff at the frontline to reflect on the culture of their organisation. The barometer has been tested in the acute setting at three hospital sites with 2,000 nursing staff in total to determine what it takes to ensure that culture is measured in a way that is meaningful and effective, and also develop a toolkit and infrastructure that allows the barometer to be used effectively.

CASE STUDY 1

BRINGING A SMALL ORGANISATION CULTURE TO ONE OF ENGLAND'S LARGEST NHS TRUSTS

East Kent Hospitals University NHS Foundation Trust provides maternity and neonatal care across the whole of east Kent. The trust provides maternity and neonatal services at two hospitals as well as multiple community sites, such as GP surgeries and children's centres, and sees 7,500 births each year.

Jane Ely is divisional director at the trust and acknowledges there are unique challenges faced by acute sector organisations covering such large geographical areas. "Three trusts were brought together to make one. We used to have a number of smaller stand-alone birthing centres yet we now aim to support women to give birth at home, or in midwifery-led, low-risk units co-located with our labour wards and neonatal units, she says."

"Large doesn't have to make anything more complex yet if there are clinical complications, we can provide full support from our obstetric and neonatal teams."

Midwife-led units are integral to the service. Staff work in teams and the emphasis is on close working, with community midwives rotating into the units so it is possible for a community midwife to see a birth all the way through. As well as encouraging close working, the trust hopes to support a culture of openness. "We have combined meetings with maternity and neonates and we use all means of communication including newsletters, video links to meetings and team brief," says Jane.

She also emphasises the importance of ensuring every woman is involved in her own care and able to make informed decisions. The trust has an antenatal video looking at the pregnancy journey,

which can be downloaded from its website. "Our approach is to risk-assess throughout the pathway and ensure each woman is involved. We want to give her confidence in the healthcare professionals around her and the environment. There is a great deal we have to do in terms of the statutory requirements, but the administration should all be going on 'behind the scenes', which means each woman can bond with her baby and be confident when she goes home without any concerns."

Support for families and carers is equally important and Jane points to the expansion of the midwife-led units at each site (12 rooms in total). There are ensuite rooms that allow partners (and other family members) to stay, providing support, companionship and reassurance. The trust has also developed a policy for partners, which sets out a stated aim to support mothers who want their partner or significant other to be able to stay with them and their newborn baby throughout their inpatient stay.

As for meeting requirements and guidance, the trust has developed an automated maternity/neonatal dashboard that enables it to monitor quantitative and quality standards (workforce, birth statistics, performance against CQUIN targets). It shares this with commissioners and users. The dashboard monitors indicators such as mortality. "At one point, the dashboard alerted us to our mortality ratio and after further analysis it became clear this was linked to how we were recording our transitional care babies (as well babies). With the improved recording we are now confident the ratio is accurate," says Jane.

User involvement and experience

The quality of care that a woman receives in the maternity department is just as important as the way she is treated by a nurse, midwife or member of care staff. Being treated kindly with respect and dignity and being listened to are themes that are often talked about in nursing.

Maternity units face a common challenge in this respect as they strive to meet safety requirements and at the same time as ensure that mothers and their families are listened to and have a good experience.

One way to involve maternity service users is through Maternity Services Liaison Committees (MSLCs) – locally based groups of all those involved in maternity care. They usually include care providers as well as people who have had experience of maternity services. In England, MSLCs report to the local commissioners of maternity services and also have strong links with other bodies, including care networks, labour ward forums and the local authority.

However, there are places where MSLCs do not exist or do not work well; in such areas ways to include a user perspective need to be sought. There is a strong history of user involvement in maternity services, from the National Childbirth Trust to specialist self-help groups such as the Stillbirth and Neonatal Death Society as well as national charities such as Best Beginnings and local children's centres and family support groups.

The Friends and Families (FFT) test is helping many units gather timely feedback on the services they provide. The first FFT results for NHS-funded maternity services were published in January 2014, with data was compiled from feedback from pregnant women and mothers of newborn babies who expressed their views on the quality of services.

The test asks women up to four questions at three stages during their pregnancy, seeking feedback about antenatal services, the labour ward/ birthing unit or home birth services, the postnatal ward and postnatal community services. The results provide an opportunity for maternity units to improve patient experience and work with public forums and patient groups to promote continuous improvement.

The trusts shortlisted for the CHKS excellence in maternity care award all put effort into ensuring mothers are involved in their care, with an emphasis on the user experience. Burton Hospitals NHS Foundation Trust takes a proactive stance on communicating with service users and involving relatives. Its website includes virtual tours of both Queen's Hospital and Samuel Johnson Community Hospital maternity unit, while personal tours of the unit can be arranged for women and their partners where need is identified – for example, where there is a fear of hospital environments or if parents are new to the area. Maternity services lay representatives are encouraged to join boards and committees in order to provide a patient perspective and inform service development.

On special care baby units, trusts encourage parents to phone when they are not on the unit, while relatives and carers can contact families on the unit when they are there. Parents are encouraged to keep diaries and photographs of the baby are given to parents on admission.

One aspect of maternity care that Jeanne Lythgoe believes is of particular concern to

mothers is being sure they will have continuity of care from midwives. Although the NHS has a stated ambition for continuity through the maternity pathway, this does not always happen in practice. Lythgoe points to the dramatic growth in the number of women paying for private midwifery services because they know they will get continuity. “We are even seeing the development of alternative models of care from private midwife groups working externally to the NHS. These organisations are setting up contracts with CCGs based on payment for care they deliver in partnership with particular trusts,” she says.

CASE STUDY 2

IMPROVING CARE FOR WOMEN WITH PREGNANCY-INDUCED HYPERTENSION

City Hospitals Sunderland NHS Foundation Trust provides a wide range of hospital services including accident and emergency, surgical and medical specialties, therapy services, maternity and paediatric care. The maternity service operates a hybrid integrated team model with five teams of midwives working across the city of Sunderland and surrounding areas, together with acute hospital-based services.

The trust was involved in an innovative digital technology project using telehealth to monitor women at risk of developing mild pregnancy-induced hypertension (PIH) and gestational diabetes. PIH affects one in every 14 women and although it more commonly occurs during a first pregnancy, it can also occur in subsequent pregnancies. Gestational diabetes affects 5 per cent of pregnant women booking at City Hospitals – above the national prevalence rate of 3.5 per cent. The aim was to ensure a continued safe pathway of care for women with PIH and gestational diabetes and explore the potential reduction in hospital and community activity through home monitoring.

The partnership team included NHS England, Sunderland City Council, Gateshead Foundation Trust, Gateshead Council, South Tyneside Foundation Trust and South Tyneside Council. The team used the NHS Telehealth Florence system – a secure, web-based patient home monitoring service, which interacts with patients via

text messaging, to monitor blood glucose, weight, blood pressure and proteinuria levels, depending on the protocol required.

Women with PIH measure blood pressure and test for proteinuria at home, texting results back to the hospital obstetric department via the Florence system. Specific alerts direct patients to continue home monitoring or to refer themselves to hospital for further assessment. The system stores minimal patient identifiers with clinical readings received and compares these to pre-programmed parameters set in the system by clinicians. Women with gestational diabetes monitor their pre- and post-meal blood glucose levels and their weight, texting back results via Florence, which the diabetes team monitors, advising or altering treatment accordingly.

The system is used to interpret incoming patient data and act on it in compliance with the clinical pathway. For alerts or critical breaches, the system passes patient alerts directly to the hospital paging system.

The use of the Florence system means community midwifery visits, consultant clinic attendance and repeated day assessments in hospital are reduced. Evaluation of home monitoring of mild PIH is ongoing but early results suggest that considerable cost savings can be achieved with increased patient satisfaction and a reduction in intensive health service interactions.

Intelligent use of data



Choosing appropriate measures and gathering accurate data can provide powerful evidence for the impact of your changes. Measurement for improvement is not about making judgements. It uses data intelligently to inform progress against aspirational aims. It differs from measurement for performance which is about standards and targets.

Making improvements in maternity services, NHS Improving Quality⁵

The best maternity units already provide clear, comparative information about the quality of their services for CCGs, Health and Wellbeing Boards, local authorities and patients and the public. This is because they have the commitment and courage to publish data so that commissioners, staff, patients and the public are able to see what is being measured and what is being done to improve care.

At City Hospitals Sunderland NHS Foundation Trust, dashboards are produced in order to manage and monitor performance against national and local targets, internal targets and directorate-specific targets. These dashboards provide information to the board so it can monitor and manage the overall performance of the trust.

The maternity service and the neonatal unit (where applicable) are monitored against various performance targets. These include: access to maternity services within 13 weeks; breastfeeding and smoking cessation rates; depression in pregnancy; VTE assessments; healthcare-associated infections; real-time feedback surveys; Friends and Family Test results; NHS Safety Thermometer; incident reporting; complaints; and contracting activity.

At Burton Hospitals NHS Foundation Trust, the maternity dashboard is accompanied by a narrative report, which is submitted and presented each month by the head of midwifery. This report relates to obstetric activity and intervention rates, data from key performance indicators and staffing. Complaints and any clinical incident concerns or reported serious incidents are also brought to the attention of the board.

A clinical performance and governance scorecard is used by East Kent Hospitals University NHS Foundation Trust to monitor the implementation of the principles of clinical governance on the ground. This helps to identify patient safety issues in advance so that timely and appropriate action can be taken to ensure woman-centred, high-quality, safe maternity care. The dashboard is presented at the divisional board and within divisional performance reviews with the trust's executive team.

In addition, East Kent produces a tabular dataset showing performance against a number of key maternity outcomes split by site. The statistics are presented to non-executive directors and local commissioning bodies. The trust says this dataset has been hugely important in identifying and tackling inequalities between sites and units.

The table (above, right) gives an example of the information that could be collected and presented to local commissioners, patients and the public.

BALANCED SCORECARD

This measures and benchmarks maternity against a series of metrics determined by the National Operating Framework across the following domains: patient safety; effectiveness; patient experience; valuing people; innovation; access and productivity; finance; and data quality.

MATERNITY STATISTICS

This is a dataset showing performance against a number of key maternity outcomes. Key statistics include: volume of deliveries by birth method, c-sections rates; still births; postpartum haemorrhage and first- to fourth-degree tears.

MATERNITY TRACKER REPORT

This is a report that combines activity and demand against planned levels, coupled with live forecasting. The report covers all aspects of obstetrics and maternity, from booking to postnatal discharge.

NEONATAL DASHBOARD

This dashboard looks at key metrics including total parenteral nutrition, bloodstream infection rates and retinopathy screening.

MIDWIFE:BIRTH RATIO

Data on the indicative midwife:birth ratio.

KEY PERFORMANCE INDICATORS

KPIs relating to aspects of service delivery such as: environmental cleanliness; hand hygiene; care bundles for electronic fetal monitoring; surgical site infections; and aseptic non-touch technique.

INFECTION CONTROL

Data on community acquired *C. difficile* and MRSA rates

CASE STUDY 3**IMPROVING RECOVERY FOR MOTHERS AFTER C-SECTION**

Burton Hospitals NHS Foundation Trust provides a wide range of services to a population of around 360,000 people across South Staffordshire, South Derbyshire and North-West Leicestershire. There are approximately 3,300 deliveries per year at the maternity unit at Queen's Hospital and the stand-alone, midwife-led unit at Samuel Johnson Community Hospital in Lichfield combined.

One of the strengths of the unit is the close working relationship between the obstetric, midwifery, anaesthetic and paediatric hospital-based staff and as well as the staff in the community. An example of this is the way the improved care pathway for women having an elective caesarean section was designed and introduced.

Katharina Anwar, clinical director, division of women and children, says the idea for the pathway arose when it was noticed that some women – for example, those with babies on the neonatal unit – mobilised more quickly than others, possibly because mothers are highly motivated to be reunited with their babies at the earliest opportunity. She says “We realised that an early return to normality, including rejoining the family unit at home as soon as possible, would be desirable for most women and so decided to improve this pathway to enable this and reduce the variation in the patients’ experience.”

The enhanced recovery principle was applied to the care pathway, including management of patient and staff expectations particularly around mobilisation, early removal of the urinary catheter, minimising side-effects from analgesia, and ensuring

that there were no avoidable delays in the discharge process by introducing midwife-led discharge, community-based baby checks and earlier post-discharge support from the community midwives.

This was further promoted by putting women who had had a caesarean section in a six-bed bay rather than in side rooms, as this encouraged more interaction with other patients and the midwives, bringing about a more supportive environment and a reinforcement of the mother's expectations.

The whole team was involved in coming up with and developing the ideas and all the changes were implemented within six weeks thanks to close working relationships and continuous team support and dialogue.

The aim of this was to improve the patient experience but it also had the added benefit of reducing lengths of stay without compromising patient safety; in December 2012, 80 per cent of women went home the day after an elective caesarean, compared with 10 per cent in May 2012. There has been no increase in maternal or neonatal readmission rates and a telephone questionnaire confirmed women were not having problems with either pain or breastfeeding following discharge.

Katharina believes that a great deal of change is top-down because trusts are told to save money or meet a national imperative. By contrast, the part of the improved care pathway initiative at Burton was developed and owned by the whole team to improve care locally, which she believes was key to its success.

Assurance standards in maternity care

Leading maternity units take practical steps to identify risks, develop improvement programmes and ultimately demonstrate they have systems in place to provide the best possible care to mothers, babies and their families.

These units regularly report key performance data on activity and outcomes to commissioners. Although there is a specified minimum dataset, they use more detailed reporting, assuring commissioners that these are reported regularly to the board.

Some trusts use guideline monitoring to keep local guidelines in line with NICE, Royal College of Obstetricians and Gynaecologists and Nursing and Midwifery Council recommendations. They use email, personal contact and meetings to ensure all clinical members of the unit have the opportunity to participate in guideline development. This means all documents produced are multidisciplinary and locally relevant, while maintaining a patient-centred focus.

City Hospitals Sunderland NHS Foundation Trust convenes a weekly monitoring group at which priorities for clinical audit are identified. Audit topics are allocated to volunteering leads, then the group supports audit tool formation, data collection, analysis and presentation. Feedback from audit work is entered into a monitoring report, which is submitted to the board.

As a leading provider of healthcare intelligence and improvement services, CHKS has developed an assurance programme for maternity units. This combines data analysis with a programme of evidence based, best practice standards. Using an independent onsite review against this framework, and expert consultancy support, this creates a powerful and unique

CASE STUDY 4

RISK MANAGEMENT

The *Pseudomonas* outbreak in Northern Ireland in December 2011 led to the death of four babies and was a testing time for maternity and neonatal units. The Western Health and Social Care Trust says lessons have been learned from the outbreak and points to significant environmental and systems changes that have improved practice in relation to infection prevention and control.

The trust is committed to high-quality, safe and accessible patient-focused health and social care services. It puts great emphasis on a culture of openness and accountability and on effective communication within the Trust and with the community.

The trust recognises that the identification and effective management of risks provides a valuable opportunity to improve patient care and says it is vital to develop and maintain systems and procedures that minimise risks to patients, clients, visitors, and staff.

To manage and report risk and incidents, each maternity department has developed a trigger list, based on Royal College of Obstetricians and Gynaecologists guidelines, to accompany its

clinical incident reporting system. The trust's risk management midwives investigate and report on all incidents, identify trends and develop action plans with the multiprofessional team. These midwives work closely with the risk management department and contribute to staff newsletters with feedback from incidents in 'lessons of the week'.

Midwifery and medical representatives from the trust also attend the regional maternity quality improvement group and have developed regional tools and protocols (such as antenatal and intrapartum cardiotocography stickers, vaginal examination stickers and in-utero transfer forms) to improve care and communication between staff.

In addition, the trust says within women and children's care, the ambitions arising from the 2013 Keogh Mortality Review have been incorporated into the Trust Quality 2020 quarterly reports. Regular simulated multidisciplinary 'skills and drills' take place on management of obstetric emergencies and a report on each drill is produced and lessons identified and fed back to all involved.

performance measurement and improvement programme. It benchmarks the organisation using the data and the standards and, through the gap analysis, advises on improvements. It highlights good practice, while setting an agenda for service and team development, making sure all staff are questioning what is done, how it's done and how they can make it better.

NATIONAL STANDARDS, GUIDANCE AND PROFESSIONAL RECOMMENDATIONS

NATIONAL STANDARDS AND REQUIREMENTS	NATIONAL GUIDANCE	PROFESSIONAL RECOMMENDATIONS
<p>CNST The Clinical Negligence Scheme for trusts (CNST) is a pay-as-you-go, non-profit, pooled fund to cover negligence claims. Organisations receive a discount on the maternity element of their CNST contributions where they can demonstrate compliance with the CNST maternity clinical risk management standards.</p>	<p>NICE NICE has nine guidelines relating to birth and 29 relating to pregnancy, including those for caesarean section, antenatal care, perinatal mental health, diet, smoking and exercise.</p>	<p>RCOG STANDARDS OF MATERNITY CARE In 2008, the joint Royal Colleges published national standards for maternity care. Their purpose is to provide guidance for the development of equitable, high-quality services across the UK. They provide a valuable tool and resource for commissioners and providers to plan and quality-assure maternity services.</p>
<p>NATIONAL SCREENING COMMITTEE The UK National Screening Committee of the NHS deals with all aspects of screening and supports implementation of screening programmes. The six NHS antenatal and newborn screening programmes all contain a series of mandatory quality standards and KPIs.</p>	<p>CONFIDENTIAL ENQUIRIES From the 1950s to 2011, three-yearly reviews of all maternal and infant deaths were undertaken. In 2012, the Healthcare Quality Improvement Partnership established the Maternal, Newborn and Infant Clinical Outcome Review Programme.</p>	<p>RCOG: HIGH-QUALITY WOMEN'S HEALTHCARE This report looks at how women's health services in the NHS could be configured to provide high-quality, safe and timely care.</p>
<p>TOOLKIT FOR NEONATAL SERVICES In 2009, the Department of Health published guidance to improve the care provided for premature and sick babies and their families. It includes a set of eight principles for high-quality neonatal services and a framework to assist commissioners.</p>	<p>INSTITUTE FOR INNOVATION AND IMPROVEMENT: FOCUS ON NORMAL BIRTH AND REDUCING CAESAREAN SECTION RATES Aims to help local health communities and organisations improve the quality and value of care for promoting normal outcomes.</p>	
<p>PREPARATION FOR BIRTH AND BEYOND This is a practical tool that aims to improve outcomes for babies and parents through a refreshed approach to antenatal education that moves beyond traditional models. It covers the physiological aspects of pregnancy and birth, but also addresses the emotional transition to parenthood in greater depth and recognises the need to include fathers and other partners in groups and activities.</p>	<p>PROMOTING AND SUPPORTING BREASTFEEDING The Baby Friendly Initiative is a World Health Organization and UNICEF programme.</p>	

Conclusion



Women have identified that they value clear, consistent information and the opportunity to be listened to and included as active partners in decision-making. They have highlighted the positive impact of care given by teams that work together, communicating effectively under clear clinical leadership.

Making Improvements in Maternity Services,
NHS Improving Quality

Having a baby is 'the single largest reason for admission to hospital'⁶ and the experience mothers and babies have inevitably has an impact on their long-term health.

Acute sector organisations are facing many challenges, but at first glance one of the most difficult would seem to be that of providing high-quality, safe maternity services within constrained resources and in the face of an increase in the number of complex births and other factors with financial implications.

However, some trusts have found that by addressing the culture within their maternity units the foundations for improvement can be laid. This is because a flatter hierarchy and a small-unit mentality encourages midwives to contribute, which in turn means that initiatives are driven from the ward up and are more likely to have staff buy-in.

Trusts that are delivering excellent maternity care have a number of other things in common. Staff and user feedback is used to ensure services are meeting expectations and that concerns are being addressed. For example, the Friends and Families test is used to gather timely feedback.

Ensuring the availability of relevant information about the unit – how performance compares with peers and against national requirements – is another area that is common to these trusts. The use of maternity dashboards means they can see at a glance where there are problems and are prepared for any eventuality. Information is collected from a number of different data sources including, but not limited to, the patient administration system, clinical maternity and neonatal systems, incident reporting and benchmarking applications. This is usually part of a trustwide commitment to transparency and a desire to improve the quality of information that is made available about services.

Finally, trusts ensure they are able to identify risks, develop improvement programmes and demonstrate they have systems in place to provide the best possible care to mothers, babies and their families. This means regularly reporting key performance measures on activity and outcomes to their commissioners.

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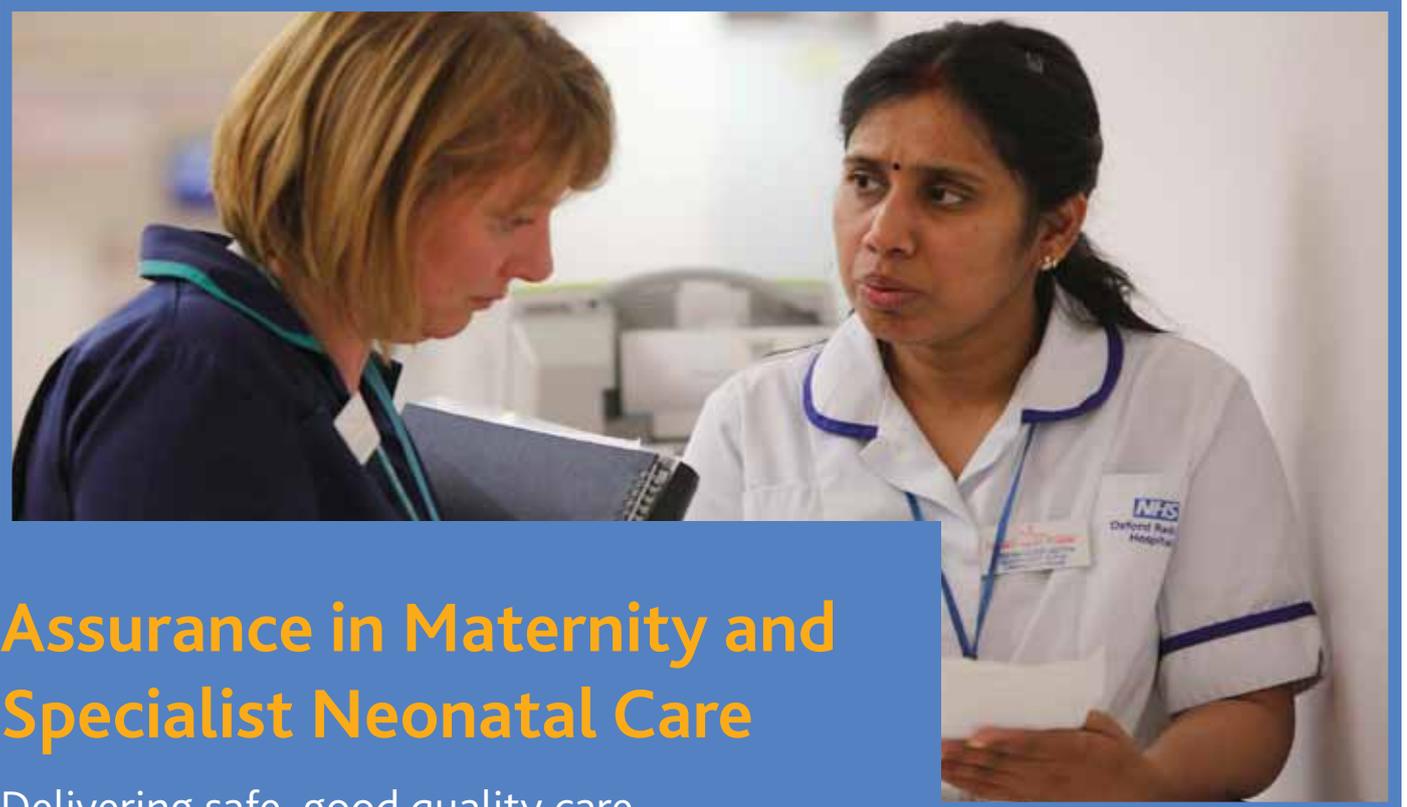
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