Royal College of Midwives

The solution series: 1

Improving maternity: learning from reviews of maternity services

Learning from reviews of maternity services

The detailed reviews of maternity services across the UK over the last six years have highlighted serious failings and are a vital place for us all to start, as organisations, leaders and individual practitioners when we are seeking to improve the quality of the care we provide.

Underpinning the ability of any maternity service to provide consistently safe, high quality maternity care is safe staffing. All maternity services must have robust approaches to ensuring that their midwifery and obstetric staffing levels are safe and meet national standards. Each maternity service leader and manager has a responsibility to monitor staffing, trigger escalation pathways and ensure the unit is staffed safely. Each member of staff should escalate any concerns or shortfalls in staffing to managers.

In addition to safe staffing, here we highlight key needs that were **not met** in the three key reviews:

Kirkup Report, Morecambe Bay, 2015	Cwm Taf, Wales, 2019	Ockenden interim report, Shrewsbury and Telford, 2020
Assessment and escalation Appropriate identification of risk and deterioration, with prompt escalation and treatment as required.	**Evidence based guidance** Easily accessible, updated evidence based guidelines for all staff for all aspects of care.	**Continuous risk assessment and escalation pathway** Ongoing risk assessment throughout pregnancy – particularly around place of birth and care of women with complex needs. Enabling staff to escalate concerns and have concerns responded to and appropriate intervention instigated.
Multi-disciplinary teamwork Positive cooperation and working relationships between midwives, obstetricians and neonatologists, with mutual respect for expertise.	**Positive workplace culture** Supportive culture, high expectations around professional behaviour and positive staff communication and communication with women and families.	**Kindness and compassion** Listening to women and families, treatment of all with kindness and compassion; provision of appropriate bereavement care and support.
Focus on CPD Robust approaches to monitor attendance at mandatory training and enable maintenance of skills through shadowing in other units and services.	**Focus on CPD** Enabling and monitoring of attendance of staff at core training.	**Focus on CPD** Development of multi-disciplinary training to underpin multi-disciplinary working. Consistent training and updating on electronic fetal monitoring.

Kirkup Report, Morecambe Bay, 2015	Cwm Taf, Wales, 2019	Ockenden interim report, Shrewsbury and Telford, 2020
Visible, positive leadership High quality leadership, management and monitoring.	**Visible, positive leadership** Consultant obstetrician presence on labour ward and clear trigger list for calling consultant.	**Visible, positive leadership** Visible strong leadership and senior support – to include consultant obstetrician presence on labour ward and regular ward rounds.
Investigation Timely and appropriate response to complaints and adverse events, with detailed investigation and engagement with families.	**Learning from events** Robust governance with risk management meetings and learning for all staff after adverse events.	**Strong governance and organisational memory** Clear strong processes to ensure learning from serious adverse events and to engage with families.

Learning from success

While it is vital that there is learning from failure, it is also imperative that we focus on what can be learned from success. The Healthcare Improvement Studies Institute (THIS Institute) has published a helpful 'For Us' Framework, based on an extensive ethnographic study, which sets out the seven key features of a safe maternity unit.

Two maternity services in England – Queen Charlotte's and Chelsea and East Surrey Hospital – are currently rated as 'outstanding' by the Care Quality Commission (CQC).

Seven key features of these units from the CQC inspection report are highlighted below:

THIS Institute Seven features of safe maternity services	Queen Charlotte's and Chelsea CQC report, 2019	East Surrey Hospital CQC report, 2019
1. Commitment to safety and improvement at all levels, with everyone involved	The service **managed patient safety incidents** well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and appropriate support.	The service provided **mandatory training** in key skills to all staff and made sure everyone completed it. Staff spoken to had a clear understanding of key midwifery skills and were regularly provided with training updates.
2. Technical competence, supported by formal training and informal learning	Staff treated and cared for women with **compassion, patience, dignity and respect**. Feedback from people who used the service and their relatives was continually positive about the care they received and the way staff treated them.	There was a strong, visible **person-centred culture**. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. The women and partners spoken to during the inspection were very complimentary about the care and attention they had received. For example, women and partners described their care as 'outstanding'. Other comments included 'staff were amazing', 'my midwife listened and was supportive' and 'staff were caring and listened'.

THIS Institute Seven features of safe maternity services	Queen Charlotte's and Chelsea CQC report, 2019	East Surrey Hospital CQC report, 2019
3. Teamwork, cooperation, and positive working relationships	The service was responsive to parents who had suffered a loss, such as miscarriage, stillbirth or neonatal death. The services provided **extensive support and resources to bereaved women** and were committed to continually improving the care and services they provided for bereaved parents.	The bereavement midwife worked closely with the gynaecology team to ensure women received **sensitive care following a pregnancy loss** at any gestation. Pathways of care had been designed to support women and partners with contact and support was offered up to two years following the birth of their baby. We observed examples where parents were supported to take their baby home for a few hours, for a walk outside or given the time to hold, bathe and dress their baby.
4. Constant reinforcing of safe, ethical, and respectful behaviours	There was a **high level of staff satisfaction** across all disciplines and equality groups. Staff were proud of working in the service, spoke highly of the culture and the improvcement they had made to the service since the last inspection.	There was a **24-hour multidisciplinary review of specific high-risk cases as well as twice daily safety huddles**. Safety huddles were short multidisciplinary briefings designed to give clinical and non-clinical staff opportunities to escalate and discuss any operational concerns. Staff felt these briefings were beneficial and inclusive to all staff.

THIS Institute Seven features of safe maternity services	Queen Charlotte's and Chelsea CQC report, 2019	East Surrey Hospital CQC report, 2019
5. Multiple problem-sensing systems, used as basis of action	The service had a **vision** for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.	The leadership focused on **continuous improvement** and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. The introduction of the innovation huddle encouraged maternity teams to integrate ideas and improvement into their practice. The huddle took place on the obstetric unit and was complemented by the use of a visual management board.
6. Systems and processes designed for safety, and regularly reviewed and optimised	People could access the service when they needed it. Women were given a choice of times and dates for antenatal clinic appointments. There were **clear pathways** for all pregnant women to access the right services for their needs, with excellent access to specialist midwives.	Evidence showed the service **regularly reviewed the effectiveness of care** and treatment through local and national audits to improve outcomes. The service developed safety pin notices from areas of concern highlighted, following review of audits. The safety pins were used to share lessons and guidance with all staff to improve patient care. Safety pins were displayed in all clinical areas, discussed within safety huddles and weekly updates sent to staff.

THIS Institute Seven features of safe maternity services	Queen Charlotte's and Chelsea CQC report, 2019	East Surrey Hospital CQC report, 2019
7. Effective coordination and ability to mobilise quickly	There was an **effective system in place to assess, respond to and manage risks to patients**. Staff could recognise and respond to signs of deterioration and emergencies. Staff completed and updated risk assessments for each patient.	The midwifery senior leaders and matrons had an **inspiring shared purpose** to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture. The Head of Midwifery was found to be highly respected by all staff spoken with. Staff felt valued and listened to and advised that the Head of Midwifery was visible daily and would offer support whenever asked.

Self check-in: how well are we doing in our service/team/ward?

From the Ockendon report, which key issues have we identified that needs improvement in our maternity service?		Where issues have been identified – what next steps are we taking?	How confident are we that all areas are being met
▶ Risk assessment and escalation	☐		
▶ Evidence based guidance readily available	☐		
▶ Multi-disciplinary team working and positive workplace culture	☐		☐ very confident ☐ somewhat confident ☐ confident ☐ not confident at all
▶ Kindness and compassion	☐		
▶ Focus on CPD	☐		
▶ Visible positive leadership	☐		
▶ Learning from adverse events	☐		

Self check-in: how well are we doing in our service/team/ward?

Do we have the 7 elements of safe maternity service listed from the THIS institute 'For Us' Framework?	Where elements of safe maternity service are lacking, what issues have been identified in your service/team with the implementation? Which of the seven elements have you identified that are lacking in your service?	How confident are we that we have implemented all elements of safe maternity service
1. Commitment to safety and improvement at all levels, with everyone involved ☐		
2. Technical competence, supported by formal training and informal learning ☐		
3. Teamwork, cooperation, and positive working relationships ☐		☐ very confident
4. Constant reinforcing of safe, ethical, and respectful behaviours ☐		☐ somewhat confident
5. Multiple problem-sensing systems, used as basis of action ☐		☐ confident
6. Systems and processes designed for safety, and regularly reviewed and optimised ☐		☐ not confident at all
7. Effective coordination and ability to mobilise quickly ☐		

Self check-in: how well are we doing in our service/team/ward?

	How can we improve?	What suggestions can we make as a team or an individual to managers to address any problems?	What resources do we need?
What action can we take today?			
What action can we take over the next six months?			

Name of reviewing midwife _____ Date of review _____

Key resources to support you in improving safety and quality

RCM Safety and quality improvement
rcm.org.uk/promoting/professional-practice/safety-quality-improvement

NHSE Safety in maternity care next steps, 2017
assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

NHSE commitment to quality, 2016
www.england.nhs.uk/wp-content/uploads/2016/12/nqb-shared-commitment-frmwrk.pdf

CQC report on key areas for improvement to make maternity services safer
Getting safer faster: key areas for improvement in maternity services | Care Quality Commission (cqc.org.uk) 2020

THIS Institute 'For Us' framework on safe maternity services
thisinstitute.cam.ac.uk/research-articles/seven-features-of-safety-in-maternity-units-a-framework

for-us-framework.carrd.co

sciencedirect.com/science/article/pii/S0277953619300334?via%3Dihub

Maternity services with an outstanding rating from CQC
Imperial – Queen Charlotte's and Chelsea and St Mary's hospitals Queen Charlottes and Chelsea Hospital (cqc.org.uk)

East Surrey
East Surrey Hospital (cqc.org.uk)

Key resources to support you in improving safety and quality

Recent reviews of maternity services

Ockenden report
Maternity services at the Shrewsbury and Telford Hospital NHS Trust (donnaockenden.com)

Cwm Taf review reports
Report of RCOG review gov.wales Cwm Taf Health Board maternity services 2019 independent-maternity-services--oversight-panel-executive-summary-thematic-maternal-category-report.pdf (gov.wales)

Kirkup report into Morecambe Bay
The Report of the Morecambe Bay Investigation (publishing.service.gov.uk)

Making the case for resources locally
digital.nhs.uk/services/mobile-technology-investment-toolkit/resources/requesting-funds-for-mobile-working-in-community-services---business-case-template

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