Local maternity transformation plans and improving safety – a crib sheet for Local Maternity Systems

Across England, Local Maternity Systems have been embedding initiatives to improve safety within local maternity transformation plans, and continue to develop plans in this area. A review of local transformation plans shows that all have strengths, but not always in the same areas. Feedback from Local Maternity Systems is that they would find it helpful to identify some of the best practice to help them further develop their own plans. At the same time, there is a number of safety-related initiatives being promoted nationally and Local Maternity Systems have asked for more advice on where the Local Maternity System can add value. This "crib sheet" responds to these requests.

Key components of good practice in building safety into local transformation plans

1. Strong clinical leadership

The best plans contain evidence of strong clinical leadership across the range of healthcare professionals involved in caring for women and their babies, and across organisational boundaries. There are clearly identified leaders responsible for developing and implementing safety initiatives, and they have engaged widely with the clinicians they lead. In doing this, they make use of the safety champions in local NHS Trusts.

2. Analysis of data and information

The best plans use quantitative and qualitative data to identify priorities for the Local Maternity System. They consider:

- Public health outcomes: the characteristics of the local population, the prevalence of risk factors, such as smoking, and the potential impact on pregnancy outcomes. Public Health England have produced data packs for Local Maternity Systems and "Fingertips" profiles.
- Clinical outcomes: between their own Local Maternity System and others, and between individual services within their own Local Maternity System, as reported through the Maternity Services Dataset (MSDS), MMBRACE-UK, Each Baby Counts, the National Maternity and Perinatal Audit, the Neonatal Critical Care Review etc. To support this, NHS England is making a basket of National Maternity Indicators and Clinical Quality Improvement Metrics available through a user configurable data viewer shortly.
- How well providers meet relevant recommendations from reports such as Five years of Cerebral Palsy Claims, MBRRACE-UK and Each Baby Counts, as well as CQC reports.
- Health inequalities: by breaking down clinical and public health outcomes by population groups to understand which groups of women are being well served, and which less so.
- Family experience: what local women say about the safety of their maternity services and how they want them to change. The best Local Maternity Systems go beyond the CQC maternity survey and the Friends and Family Test, and undertake their own engagement with families, working with their local Maternity Voices Partnership.

- Staff experience, in particular what they say about safety, and staff satisfaction: as with family experience, the best Local Maternity Systems go beyond the NHS Staff Survey and undertake local engagement to understand the detail.
- Information from incident reporting: incident reports can reveal themes and trends and the most commonly reported incidents and the descriptions of these incidents can be used to inform where safety improvement work should be focused.
- Cultural factors: the best Local Maternity Systems consider whether their services have the right culture, including whether they put women at the centre of care, work mutli-professionally, and make learning and improving services an integral part of their day to day activities.

3. Changes proposed follow on from the analysis

The best local transformation plans identify specific actions which directly address the issues identified through the analysis of data. These include changes to:

- Clinical pathways, such as changes to the gestational diabetes pathway, or a review of how pathways work for a particular population group.
- Systems and processes, such as a review of how handovers take place.
- Training, such as a multi-disciplinary team safety training package to address team working issues.
- Staffing and skill mix, such as meeting an identified need by investing in staff with specific mental health skills.
- Public health interventions, such as routine CO screening of pregnant women is and effective pathways into specialist smoking support. Some plans consider population level activities, such as to reduce smoking within the local community.

4. Alignment across the Local Maternity System

Whilst the best plans recognise that different providers face different challenges and have their own safety improvement plans, they also draw activity into a coherent set of actions which aim to ensure a consistent set of high quality pathways of care across the Local Maternity System.

5. Levels of ambition and trajectories

Finally, the best plans identify level of impact the proposed changes may have on reducing rates of stillbirth, neonatal death and brain injuries.[1] Useful resources to support measurement for improvement are available through NHS Improvement. Setting an informed level of ambition and trajectory will help the Local Maternity System focus on delivery. Commissioning for improvement by including it in provider contracts and reviewing it as part of contract monitoring will help to maintain a focus on delivering it.

National initiatives which can add value to local transformation plans

There are a number of initiatives which have been promoted by the NHS and the Department of Health nationally, and analysis of your data sources will provide evidence for including these within your plan.

[1] Rates of maternal death may be too low to set a level of ambition at Local Maternity System level.

1. Good data is a prerequisite

As set out above, Local Maternity Systems need reliable, standardised sources of data to help you understand what care, outcomes and quality look like in your area and where improvements can be made. Not all maternity providers are currently routinely and electronically collecting data and submitting it to the MSDS. If this applies to any of the service providers in your Local Maternity System, you will want to make resolving this issue a key deliverable of your plan.

2. Investigations

Responsibility for carrying out an investigation where a serious incident has occurred lies with the provider and commissioner of the service, and/or the Healthcare Safety Investigation Branch when a case is subject to Each Baby Counts reporting and for maternal deaths. The Local Maternity System has two specific roles to play which it will want to reflect in its plan:

- Ensuring that the approach to investigations is consistent and in line with national guidance across the Local Maternity System. This is to make it easier to undertake the investigation across boundaries and to share the learning. A standardised Perinatal Mortality Review Tool, which will be made available shortly, will help with this.
- Sharing and embedding the learning from serious incident investigations, near misses and other causes of harm within the Local Maternity System. This is likely to require more than just circulating information, so as to ensure that the information is reviewed and acted on, and changes evaluated.

3. Shared clinical governance

Better Births recommended that Local Maternity Systems should develop shared clinical governance, including standards and protocols to ensure that women and babies get the care they need, when they need it. Implementing Better Births: a resource pack for Local Maternity Systems (section 2.3.4) provides some advice on how to go about this.

4. Saving Babies' Lives care bundle

Saving Babies' Lives is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice:

- Reducing smoking in pregnancy
- Risk assessment and surveillance for fetal growth restriction
- Raising awareness of reduced fetal movement
- Effective fetal monitoring during labour

These elements were identified by experts through a process of engagement and consensus building over a 12 month period since 2014. As such, implementing them will be amongst the first things that Local Maternity Systems should consider as deliverables in their plans.

5. Reducing admission of full term babies to neonatal units (Atain)

NHS Improvement has identified through the Atain project that over 20% of admissions of full term babies to neonatal units could be avoided. By providing services and staffing models that keep mother and baby together we can reduce the harm caused by separation. There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding,

long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reasons, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

6. Maternity and neonatal services working together

Neonatal care is organised across Operational Delivery Networks (ODNs), which may cover more than one Local Maternity System, and delivered alongside local and specialist maternity care. Local Maternity Systems need to ensure that providers, ODNs and commissioners (of both neonatal and maternity services) are working together in a single system approach, to ensure integration across the whole maternity and neonatal pathway. Guidance, supported by bespoke data packs, has been provided to each Local Maternity System. In particular, Local Maternity Systems will want to ensure that, where possible, all women at less than 27 weeks' gestation are able to give birth in hospitals with a neonatal intensive care unit, and that there are clear guidelines for antenatal transfer in the event of impending birth at less than 27 weeks.

7. Maternity and Neonatal Health Safety Collaborative

The collaborative is a three-year programme run by NHS Improvement to support improvement in the quality and safety of maternity and neonatal units across England. The support offer is split into three waves with 44 trusts taking part in wave 1 in 2017/18 and the others following in 2018/19 or 2019/20. Nominated improvement leads will build their knowledge of improvement theory by attending nine days of learning sessions during each wave, and each trust will receive a visit to build local capability in quality improvement and provide structured support to local teams to assess their service and develop innovative plans that lead to measurable improvements. NHS Improvement will also support all 134 NHS trusts to focus on system-level improvement through communities of practice to support Local Maternity Systems. The community of practice is an 'improvement forum' where individuals, across different professions, and from different organisations, come together to share and learn about improvement approaches and outcomes. Local Maternity Systems will want to take any activities which emerge from the collaborative and integrate them into the local transformation plan.

8. Continuity of carer

Evidence shows that continuity models improve safety and outcomes. In particular, it shows that women who had midwife-led continuity models of care were:

- Seven times more likely to be attended at birth by a known midwife
- 16% less likely to lose their baby and 19% less likely to lose their baby before 24 weeks
- 24% less likely to experience pre-term birth
- 15% less likely to have regional analgesia
- 16% less likely to have an episiotomy.

Implementing continuity of carer will therefore be a key element of Local Maternity System plans for improving safety. Guidance on how to go about it was published in December 2017.