Clinical Senate Forum
21st April 2016

“Better births – improving outcomes for maternity services”
Welcome and introductions

Dr Andy Mitchell, Clinical Senate Forum Co-Chair
Medical Director, NHS England (London Region)

Jane Clegg, Clinical Senate Forum Co-Chair
Interim Chief Nurse, NHS England (London Region)
Better Births – improving outcomes for maternity services in England

Baroness Julia Cumberlege
Independent Chair, National Maternity Review
National Maternity Review

Overview
BETTER BIRTHS
Improving outcomes for maternity services in England
The Five Year Forward View for maternity care
664,543
number of births in England in 2014

FEWER THAN 1 IN A 1000 BIRTHS
Resulted in safety incident being reported that led to severe harm or the death of the baby or their mother

£560m
Annual cost of compensating families for negligence during Maternity care

£4.7 billion
Total estimated annual NHS spend in Maternity services

NATIONAL MATERNITY REVIEW
Figure 1. Shared goals and workstreams
What happened
PERSONALISED CARE
10% of women surveyed by NFWI would prefer a home birth.

6% of women surveyed by NFWI preferred to give birth in an FMU.

49% of women surveyed by NFWI would prefer to give birth in an AMU.

Only 25% of women would choose to give birth in an OU.
Maternity clinical network

Organising specialist services | Sharing best practice and benchmarking network
Services could include:

- Obstetric unit
- Obstetric services in the community
- Diagnostics
- Home birth team
- Community midwives
- Social services
- Health visitors
- GP support
- Midwifery practices

Hospital

Community Hub

Located in e.g. children’s centre, GP practice, midwife-led unit
LOCAL MATERNITY SYSTEM

Community hub
CHILDREN'S CENTRE

Community hub
GP PRACTICE

Community hub
COMMUNITY CENTRE

Community hub
MIDWIFERY CENTRE

OBSTETRIC UNIT

SHARED CLINICAL GOVERNANCE AND INFORMATION SHARING

NATIONAL MATERNITY REVIEW
London’s maternity services: new opportunities and drivers for change

Professor Donald Peebles
Co-Clinical Director and Obstetric Lead London Maternity Strategic Clinical Network

Professor Jane Sandall
Professor of Social Science and Women's Health King’s College London

Jessica Read
Local Supervising Authority Midwifery Officer for London
PRIORITIES

Priority work areas for London

• Improvement in women’s and families experience of care
• Reduction in stillbirth rates
• Reduction in maternal morbidity and mortality
CORE SCN TEAM

Co-Clinical Directors - Donald Peebles
                      Donna Ockenden

SCN Assoc Director – Lucy Grothier

Senior Project Manager – Caroline Moren

Project Manager – Michaela Adeniji
PAN-LONDON WORKING

Pan-London groups hosted:

- Strategic Clinical Leadership Group (SCLG)
- Commissioning Advisory Group (CAG)
- Maternity Outcomes Group
- London Heads of Midwifery group (HOMS)
KEY LINK GROUPS

- PnMH Networks
- Maternity Networks
- Neonatal networks
- CCGs/Collaboratives
- Public health and screening groups
- Royal Colleges
Current and planned work areas (working groups and work streams)

- **Stillbirth working group** – fetal monitoring toolkit; improved detection of fetal growth restriction
- **Maternal morbidity and mortality** – outputs expert panel members; collaborative process for review of maternal deaths
- **User experience working group** – “Whose shoes” pilots, pan-London rollout; user experience guidance document; case studies booklet
- **Core dashboard/dataset** – development of standardised core dashboard to collate data to support identified outcomes
- **Perinatal mental health** – collaborative working within mental health and maternity SCNs
Work streams (outputs)

**Toolkits** – midwifery-led care; fetal fibronectin, postpartum haemorrhage; continuity of care; outpatient induction of labour; reducing stillbirth through improved detection of fetal growth restriction; PPI case studies; user experience; FGR toolkit

**Guidance** – early access to maternity service and standardised proforma development

**Maternity service specification** - template developed with maternity commissioners and used for local commissioning intentions
Better Care – Better Outcomes!

Continuity of Care

Professor Jane Sandall, Division of Women’s Health and Centre for Implementation Science, King’s College, London
Safe and high quality care

- Safety increased by understanding and reinforcing the ability to bridge gaps and discontinuities in care, reducing variations in outcomes
- Requires models that meet each woman and baby’s health, personal and social needs and preferences
- To date little sustainable development of relational continuity models of care in the NHS
- Evidence now too strong to ignore (Cochrane review, Kirkup, MBRACE, Birthrights, FYF National Maternity Review)
- Opportunities to improve outcomes for those groups who are at higher risk of maternal and infant death and morbidity as a result of pregnancy and birth, and who more often experience failures in care
- Efforts need now to focus on implementation and scale-up (RCM Better Birth Campaign, Green Templeton Report)
Evidence: improving outcomes and Women’s experience

Women who received models of midwife-led continuity of care

- 7x more likely to be attended at birth by a known midwife
- 16% less likely to lose their baby
- 19% less likely to lose their baby before 24 weeks
- 15% less likely to have regional analgesia
- 24% less likely to experience pre-term birth
- 16% less likely to have an episiotomy

Women's Experience

- Women attended at birth by a known midwife reported higher ratings of maternal satisfaction with...
- Information
- Advice & Explanation
- Place of Birth
- Preparation for Labour and Birth
- Choice for Pain Relief
- Feeling in Control

Implementation

**Aim:** To increase the number of women accessing continuity of midwife care in London.

Midwifery continuity of carer (MCoC) models are where midwifery care is provided by the same midwife or by a small group of midwives for a woman. The woman is able to get to know this midwife/ small group of midwives throughout an entire pregnancy. This care begins in early pregnancy, continues through pregnancy, labour and birth, to the end of the postnatal period.
Point of Care Audit 22 trusts (929 women)

- Data collected by the Trust on a six monthly basis.
- Data collection takes place on a day in the first week of February and August 2016, and Trusts select most convenient day of this week for collecting the data.
- Data is collected by conversation with the woman / partner.
- Data is collected at the point of care by maternity staff as part of their daily routine on the postnatal ward, home visit or community postnatal clinic. This may be over the phone if appropriate.
- The sample size is 100% of postnatal women and babies seen on the day of survey in hospital and community settings.
## Continuity SCN

<table>
<thead>
<tr>
<th>Continuity</th>
<th>Yes/always CQC</th>
<th>Yes/always SCN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If you saw a midwife for your antenatal check-ups, did you see the same one every time?</td>
<td>36% CQC 2015</td>
<td>24% (9-73%)</td>
</tr>
<tr>
<td>2. Had you met any of the midwives (staff) who cared for you during your labour and birth before you went into labour?</td>
<td>25% CQC 2010</td>
<td>9% (3-32%)</td>
</tr>
<tr>
<td>3. Did any of the midwives who you saw in the postpartum period care for you during your pregnancy and labour and birth?</td>
<td>12% (0-36%)</td>
<td></td>
</tr>
<tr>
<td>4. When you were at home after you had your baby. Did you see the same midwife every time?</td>
<td>28% CQC 2015</td>
<td>12% (0-35%)</td>
</tr>
</tbody>
</table>
## Quality

<table>
<thead>
<tr>
<th></th>
<th>Quality processes</th>
<th>Yes/always CQC</th>
<th>Yes/always SCN</th>
<th>No CQC</th>
<th>No SCN</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Thinking about your antenatal care, were you involved enough in decisions about your care?</td>
<td>77% CQC 2013</td>
<td>70% (55-94%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Were you (and/or your partner or a companion) left alone during labour and birth by midwives or doctors at a time when it worried you?</td>
<td></td>
<td></td>
<td>75% CQC 2015</td>
<td>78% (49-100%)</td>
</tr>
<tr>
<td>7</td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td></td>
<td></td>
<td>18% CQC 2015</td>
<td>9% (0-23%)</td>
</tr>
<tr>
<td>8</td>
<td>If you were transferred during labour (such as from home to hospital or from a midwife led centre to the labour ward) were the reasons for this, including what to expect and the time needed for transfer explained to you?</td>
<td></td>
<td></td>
<td>25% (90-55%)</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Were you told who you could contact if you needed advice about any emotional changes you might experience after the birth?</td>
<td>75% CQC 2015</td>
<td>54% (14-80%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Were you given enough information about your own physical recovery after the birth?</td>
<td>57% CQC 2015</td>
<td>64% (42-77%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Discussion

• Low levels of continuity on average but wide variation
• Not always able to compare with CQC
• Relationship between continuity and quality?
• Learning from high performers?
INCREASE IN MIDWIFERY LED CARE

JESS READ
Increasing the number of births at home and in midwifery led units: *A best practice toolkit*
Background

<table>
<thead>
<tr>
<th>Year</th>
<th>Total births in London</th>
<th>% home births and MU births</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-14</td>
<td>131,531</td>
<td>15% (Homebirth rate 1.3%)</td>
</tr>
<tr>
<td>2014-15</td>
<td>130,820</td>
<td>16% (Homebirth rate 1.7%)</td>
</tr>
<tr>
<td>2015-16</td>
<td>Currently being collated</td>
<td></td>
</tr>
</tbody>
</table>

- Of the 27 Trust sites providing maternity services in London only 1 does not have an alongside midwifery unit (AMU)
- There are 3 freestanding midwifery units in London (FMU)
- **June 2015** best practice toolkit launched by the London Maternity SCN to increase the number of births at home and in midwifery led units
Reality of the situation

- Approximately 45% of women at the end of pregnancy are eligible to access midwifery led settings (Sandall J et al 2014)

- Less than half of women in London using maternity services felt that they were offered a choice of birth in an AMU or an FMU (Rogers 2014)

- A quarter of women in London using maternity services felt that they were offered a home birth (Rogers C 2014)

- Women from lower socio-economic groups report a poorer experience of care (Lindquist A et al 2014)
The ambition

- To see year on year increase in the number of women accessing AMU / FMU and home birth and their chosen place of birth.
- Recommendations include:
  - Attendance to the choice agenda
  - Facilities commensurate with promotion of normal birth
  - Dedicated staffing consideration
  - Evidence based guidelines
  - Localised referral pathways
  - Auditable standards
London work streams and the national maternity review

• Personalised maternity care budget – 3 regions in London submitted bids to become pioneer sites (SW London, NC London and NE London)

• Development of maternity hubs community model

• Postnatal and perinatal mental health work streams in progress

• Safer care – new maternal death SI review panel process for London to promote safer practices and share learning; pan-London dashboard development; early access guidance to improve referral into maternity services;

• Multiprofessional working – 5 local maternity networks with robust collaborative working both internally and externally facing; encourage further multiprofessional training

• Working across boundaries – robust maternity pathway development and agreed guidelines within local maternity networks, maternity service specification development for commissioners agreed pan-London,
Improving perinatal mental health

Dr Liz McDonald
Perinatal Mental Health Faculty, Royal College of Psychiatry and Chair of the London Perinatal Mental Health Clinical Network
PERINATAL MENTAL HEALTH

Dr Liz McDonald

(See separate presentation at www.londonsenate.nhs.uk/2016/04/18/clinical-senate-forum-21-april-2016-better-births-improving-outcomes-for-maternity-services/)
Quality standards for maternity care

Professor Donald Peebles
Co-Clinical Director and Obstetric Lead London Maternity Strategic Clinical Network

Dr David Richmond
President, Royal College of Obstetricians and Gynaecologists

Cathy Warwick CBE
Chief Executive, Royal College of Midwives
LONDON QUALITY STANDARDS

• 27 standards developed in February 2013 for maternity
• Covers intrapartum part of maternity pathway only and include standards on key services, training and women’s experience

Standard 1 – Obstetric units to be staffed to provide 168 hours a week (24/7) of obstetric consultant presence on the labour ward

London definition includes: The consultant is physically present on the labour ward and has no other clinical commitments. Planned caesarean section lists are covered by a separate consultant.
Consultant presence on labour ward – London Maternity SCN definition

The number of hours per week that a consultant obstetrician is present in the obstetric-led labour ward.

The consultant is physically present on labour ward and has no other clinical commitments. Planned caesarean section lists are covered by a separate consultant.
### London Quality standards – self-assessment 2014

#### Consultant presence on labour ward

<table>
<thead>
<tr>
<th>Maternity Services</th>
<th>North Central</th>
<th>Middlesex, Essex, Hertfordshire and the City (ME2L)</th>
<th>North West</th>
<th>South East</th>
<th>South West</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard 1:</strong> Obstetric units to be staffed to provide 168 hours a week consultant on labour ward.</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td><strong>Standard 2:</strong> Midwifery staffing ratios to achieve a minimum of 1:4 midwife to confirmed established labour from a midwife, across all birth settings.</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td><strong>Standard 3:</strong> Midwifery staffing levels should ensure that there is one consultant midwife for every 900 expected normal births.</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td><strong>Standard 4:</strong> All women are to be provided with 1:1 care during established labour from a midwife, across all birth settings.</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

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**Consultant presence on labour ward**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Weekday</th>
<th>Weekend</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Central</td>
<td></td>
<td></td>
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<td>Middlesex, Essex, Hertfordshire and the City (ME2L)</td>
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<tr>
<td>South West</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Maternity Network A – 4 Trusts – network dashboard data
Consultant cover on labour ward

<table>
<thead>
<tr>
<th>Trust</th>
<th>2013-14</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>98 hours</td>
<td>98 hours</td>
</tr>
<tr>
<td>B</td>
<td>40 → 60 hours</td>
<td>60 → 98 hours</td>
</tr>
<tr>
<td>C</td>
<td>98 hours</td>
<td>98 hours</td>
</tr>
<tr>
<td>D</td>
<td>102 → 137 hours</td>
<td>132 → 158 hours</td>
</tr>
</tbody>
</table>
RCOG RESPONSE TO LONDON QUALITY STANDARDS

DAVID RICHMOND
RCM RESPONSE TO LONDON
QUALITY STANDARDS

CATHY WARWICK
Discussion
Chair: Donna Ockenden
Moving forward

Donna Ockenden
Co-Clinical Director and Midwifery Lead for the London Maternity Strategic Clinical Network

Professor Debra Bick
Professor of Evidence Based Midwifery Practice, Division of Women’s Health, King’s College London

Miss Florence Wilcock
Chair, User Experience Working Group, Maternity SCN and Consultant Obstetrician, Kingston Hospital NHS Foundation Trust
REDUCTION IN MATERNAL MORBIDITY AND MORTALITY

DONNA OCKENDEN

Aims of work stream are:

• To streamline and integrate the maternal death SI process across London to encourage learning from shared experiences and interrogation of themes that may emerge
• To centralise the requests for external panel members and share learning across London
• To encourage and improve communication flows between provider units, CCGs, coroner’s office and pathology services to encourage more timely reporting and conclusion of any inquests deemed necessary
• To provide a pool of clinical experts in relevant clinical specialties and review process experts to assist provider units with undertaking maternal deaths panel reviews within the identified timescale of 60 working days
POSTNATAL CARE

DEBRA BICK
Improving postnatal care in London

- Relatively neglected area of the maternity pathway
- Current models of care ‘not fit for purpose’. Missed opportunity
- Health profile of women who become pregnant has changed
- 90% of maternal deaths occur post delivery
- High rates of physical and psychological morbidity
- Low rates of exclusive breastfeeding to 6 months

Bick et al 2015, Chapter 8, CMO Report
To consider how maternity care providers in London can identify and implement priorities for improvement

Work will reflect CQC findings & recommendations of recent policy reports and confidential enquiries (i.e. MBRRACE-UK, National Maternity Review – Better Births, NICE guidance)

Improving women’s experience of postnatal care integral
Objectives

To be finalised but could include:

• review of maternal mortality and severe morbidity in first year postnatally and implications for postnatal services in London

• review of reasons for readmission

• support to plan ‘seamless’ transfer of care from pregnancy to postnatal

• potential for ‘triage’ on transfer from hospital to promote appropriate pathways of care

• implementation of interventions to support uptake and duration of exclusive breastfeeding

• training needs of healthcare staff
Taking work forward

- Draft survey of postnatal care in London (standards, practices, etc)
- Review of postnatal service specification and contracts – could these be standardised?
- Review of postnatal discharge records/communication of information across health sectors

Need to add to group expertise: GPs, health visitors, neonatologists, commissioners, service users – please consider!
USER EXPERIENCE

FLORENCE WILCOCK
• Emphasis on importance of both service user involvement and effective multidisciplinary teams – Kirkup & Francis reports, Health & Social care act 2012.

• Recommendations from NHS Maternity Review: Personalised care, multi professional working without barriers and work across boundaries.

• Improving service user experience in maternity became a priority area for NHS England and the London Strategic Clinical Network because of the results of the 2013 CQC Maternity survey

• July 2014 bespoke maternity version of the ‘Whose Shoes’ tool designed. Women & staff were involved from the start, including real scenarios from complaints, comments on social media and debriefs.
5 Pilot Workshops Oct 14-March 15
Kingston, Lewisham & Greenwich, West Middlesex, Barking, Havering & Redbridge and Whittington

Principles

• Co – design / creativity
• Inclusivity, Equality and respect
• Think differently, Think beyond boundaries
• Local devolved leadership … and fun!
  • Pledges to take action, work closely together and share results

Further workshops since pilot Greenwich, PRUH, GSTT, Kings, Croydon, UCLH & 3 more beyond London.

Let's take a look at a workshop in action
Outcomes

- Pledges at each individual workshop
- SCN Maternity Experience toolkit
- Empathy film with training package (themes from workshops)
- SCN published Top 10 best practice case studies Patient and public involvement in quality improvement
The vision outlined in this report will only become reality if individual midwives, obstetricians and other healthcare professionals act on it. There needs to be a grass roots movement to improve maternity care. This means every individual taking personal responsibility for supporting improvement whether it be by engaging with local improvement initiatives, constructively challenging poor practice, building better relationships with members of other professions or making the most of opportunities to learn and improve skills.”

- #MatExp is a grassroots movement: organic, inclusive, and passionate.
- From the initial objective to improve maternity care across London it has become an unstoppable change platform to transform maternity experience everywhere!
March 2016 successful bid for #MatExp phase 2 ‘Nobody’s patient’ : Want to get involved?

matexp.org.uk

• The SCN user experience workshop guide, film and training pack are available on the website and at: http://www.londonscn.nhs.uk/networks/maternity-childrens/maternity/

• Information on ‘Whose Shoes®’ is available at http://nutshellcomms.co.uk/
Discussion
Chair: Jane Clegg

How could future networking models for maternity services be developed to support choice and continuity of care?

What should their key features be?
CONTACTS

• E-mail –
  england.maternityscn@nhs.net
• Website: http://www.londonscn.nhs.uk
• Work stream contacts
  • Debra Bick – postnatal care
debra.bick@kcl.ac.uk
  • Liz McDonald – perinatal mental health
  lizmcdonaldclifford@gmail.com
  • Jess Read – midwifery led care
  jessicaread@nhs.net
  • Jane Sandall – continuity of care
  jane.sandall@kcl.ac.uk
  • Florence Wilcock – user experience
  Florence.M.Wilcock@kingstonhospital.nhs.uk
Closing remarks

Andy Mitchell