The Health Foundation
Inspiring Improvement

Snapshot

Safer maternity services

Experiences and learning from our 'improving the safety of maternity services' programme

Identify Innovate Demonstrate Encourage

What are we doing?

Evidence and practice have shown that harm in maternity services is often related to poor communication. This can be due to problems such as a lack of planning, poor team dynamics, and a lack of standard responses to clinical situations.

The Health Foundation is supporting a programme of work to improve the safety of maternity services. Pascal Metrics have been commissioned to engage and support the maternity units of four NHS organisations in a range of improvement activities.

ABOUT THE PROGRAMME

The two-year programme began in June 2009 with four participating sites:

- **Calderdale and Huddersfield NHS Trust**
- **Luton and Dunstable NHS Foundation Trust**
- **NHS Tayside**
- **North Bristol NHS Trust.**

These sites are engaged in a combination of training, ongoing measurement and peer support activities all aimed at improving the safety culture.

In particular:

- improving leadership engagement at both senior and clinical level
- developing teams to improve teamwork and communication
- introducing walk-rounds to build a systematic and cyclic flow of information between senior leaders and clinical providers to improve care and reduce clinical risk
- introducing and testing reliable processes of care and standard responses to certain situations
- helping teams build skills in practical improvement methodology to support ongoing positive change and learning.

Pascal Metrics is delivering a programme of support on behalf of the Health Foundation.

This began with a cultural survey and focused interviews with staff to investigate the cultural and clinical strengths and weaknesses in each site. They then introduced a tailored leadership, team training and improvement programme for each organisation.

During the two year programme, five collaborative meetings will be held with safety champions from the four hospitals to further facilitate shared learning. Pascal Metrics will also continue to provide ongoing expert support, delivered through a mix of onsite meetings, remote support and online sessions.

The Health Foundation also provided direct funding to each participating organisation. This contributed towards programme staff time for dedicated activities, and short term start-up for new permanent posts or activities linked to education and development.

For more information about Pascal Metrics visit www.pascalmetrics.com

Our learning so far?

CALDERDALE AND HUDDERSFIELD NHS TRUST

Calderdale and Huddersfield NHS Trust wanted to improve safety in their maternity services by testing out changes in four main areas: clinical care, communication, leadership and education. They set clear targets to reduce avoidable harm to mothers and babies. They also wanted to see a marked improvement in communications, through the widespread use of the SBAR tool (a model for situational briefing reminding people to provide information about the situation, background, assessment and recommendation).

Changes introduced

Clinical care: the team have focused on improving the antenatal care pathway. In particular they want to improve the identification and management of both obese women's maternal health and small for gestational age babies. They have adapted the hand held patient record to improve efficacy, and introduced customised growth charts for all women. They are also in the process of introducing third trimester ultrasound scans for all women with a BMI of over 35.

Communication: the SBAR communication method has been introduced to streamline and standardise handovers in the Trust's two birth centres. This is now being spread throughout the unit and will be used for all transfers of care. Pre-operative safety briefings have also been introduced in theatre and plans are in place to make multi-professional safety briefings and debriefing sessions part of everyday practice in all in-patient areas.

Leadership: the unit has introduced leadership walk-rounds, which are already helping to acknowledge the issues raised by clinical staff and implement action plans as a result of what has been learned. These are also building better communication between management and front line staff.

Education: Improvement awareness sessions have been introduced for clinical staff plus a range of open invitation sessions. The format for multi-disciplinary training days on obstetric emergencies has also been adapted incorporating several different safety topics.

Challenges and learning so far

- Baseline data proved quite difficult to obtain, making it hard to measure improvement accurately.
- It became clear that links with quality assurance work were essential to complement existing projects and avoid duplication of time and effort.
- The Trust has recently restructured resulting in a merger of maternity services. This caused some discomfort and disruption and has inevitably impacted on the project.
- Appointing a midwife with dedicated time to drive and coordinate the project proved to be a very valuable investment.

Dr Harriet Nicholls, Consultant Anaesthetist and project lead for the 'Improving the safety of maternity services' programme

'Working with the Health Foundation and Pascal Metrics has enabled us to achieve far more than we could have alone. By bringing four sites together we could learn from each other and having access to a body of experts has helped sustain my own energy in leading a change programme.'

LUTON AND DUNSTABLE NHS FOUNDATION TRUST

Luton and Dunstable NHS Foundation Trust wanted to improve safety in their maternity unit by focusing on cultural change. They identified key teamworking behaviours they wanted to introduce or improve across all clinical areas. These included briefing, debriefing, and structured communications, using tools such as SBAR and Closing the Loop.

Changes introduced

They began by testing out one area of teamwork behaviour in each clinical area, partly to 'prove the concept' but also to try and develop 'experts in the field'. So far the following changes have been introduced:

- debriefing after all elective caesarean section and day emergency lists
- briefings held prior to a majority of caesarean section list (including emergency cases)
- briefings every morning prior to antenatal clinics
- the structure of the ward handover has been changed to incorporate the SBAR tool. This together with other changes means the handover takes less time and staff find it clearer to identify outstanding tasks
- neonatal ICU ward rounds now close the loop after each patient's review
- SBAR is used when calling colleagues to theatre or to the delivery suite
- a new briefing structure was developed for use in the delivery suite for multi-disciplinary team handover, which was designed to flatten the hierarchy of the team.

Changes have been communicated to staff via memos and posters. These have helped to reinforce and share the benefits of better team communication.

Challenges and learning so far

- **Start small:** even if it's with one patient and one midwife. If a change works it will grow very quickly.
- **Keep communicating:** build the will, be positive, and sell the benefits. Share outcomes wherever possible. Case studies can help as they provoke recognition and inspire other areas to try the same. It's also important to measure and display compliance.
- **Time and resources:** in clinical areas that are frequently busy and struggle with staffing, it can be difficult to find 'space' to test out changes.
- **Interpretation:** there have been some differences in interpretation regarding when, where, and how SBAR in particular should be used. This remains an area for discussion.
- **Create energy:** over 50 per cent of staff attended a four hour session on teamwork behaviours. While difficult to achieve in terms of staff planning, the energy and enthusiasm generated by having such a large and diverse group learning together was well worth the effort.

NHS TAYSIDE

NHS Tayside also chose to introduce new communication tools and behaviours in order to improve the culture and safety within their maternity services. They have focused on developing the structure of briefings and debriefings. They hope these changes will help bring about a 20 per cent reduction in both postnatal readmissions, and in ante natal waiting times for the labour suite. They also want to be able to chart an improvement in staff perception of the safety culture.

Changes introduced

The main change was to introduce SBAR as a tool to improve staff communication at transition points.

SBAR has been introduced within the Dundee Community Midwifery Unit. The team are using it when patients are transferred from the unit to the main labour ward, to improve communication and therefore safety levels. The SBAR format is also being implemented and tested by other community midwifery units within Tayside to improve and standardise the handover process between teams.

The teams have also introduced briefing and debriefing for elective caesareans, which they have been testing since November 2009. This has enabled a critical analysis of performance and procedures, meaning issues get addressed and problems solved on a daily basis.

Challenges and learning so far

- Communication: it's been vital to ensure all are aware of the aims of the maternity collaborative and of the individual pieces of work taking place. However, shift patterns and the fact that many staff work part time made communication more difficult.
- As always, limited staffing levels and financial resources impact on efforts to improve patient safety and implement positive change. It takes strength of purpose and resolve to overcome these challenges.
- A maternity newsletter is being published monthly to maintain awareness of the project and improvements taking place. This has been a good opportunity to highlight and commend good practice and work done both by individuals and specific areas.
- The learning sessions proved vital for sharing good practice and understanding what worked. The networking element has made it more likely that staff will continue to share good practice once the initial input ceases.

Key learning points

Pascal Metrics have also outlined some key learning points that have emerged from across the four participating sites.

BUILDING BRIDGES BETWEEN TWO PHILOSOPHIES

Midwifery and obstetrics are based on very different approaches and yet the two teams must work together closely in order to provide the best care. The four maternity units in this collaborative have built impressive bridges between these two philosophies. However, the interface and transition points must be constantly monitored, and continual effort made to ensure communication and transparency.

OBTAINING LEADERSHIP COMMITMENT IS VITAL

In general there seems to be poor perception of hospital management by front line staff. This highlights the need for effective communication between senior leadership and frontline providers.

EFFECTIVE, MOTIVATED LEADERSHIP IN CLINICAL AREAS IS ESSENTIAL TO PROGRESS AND SUCCESS

Projects have been much more successful where they have been supported locally by clinicians.

RESOURCES TO DRIVE IMPROVEMENT IN MATERNITY ARE SCARCE

The volume of work in the maternity centres is impressive relative to the staffing, and the ratio appears to have worsened in the past few years in three of the sites working in this collaborative. However the reasons in the various sites differ. In two sites, patient volume has increased. In a third site, while patient volume has increased slightly, the bigger problem is finding staff for open positions.

YOU NEED STAFF WITH THE RIGHT SKILLS

Knowledge of fundamental improvement skills is increasing in the maternity units, but is not strong, even in organisations that have been involved in hospital-wide improvement efforts like the Safer Patients Initiative. This may speak to the relative isolation of maternity divisions within a hospital or trust compared to medicine and surgery.

Resources

There are a number of useful websites where you can find practical tools:

www.npsa.nhs.uk

www.institute.nhs.uk

www.patientsafetyfirst.nhs.uk

www.ihi.org

www.nhshealthquality.org

www.1000livesplus.wales.nhs.uk

www.hscsafetyforum.com

www.kingsfund.org.uk

How to get involved?

To make real and sustainable change to improve patient safety, we need everyone to be involved.

- *Look out for our award schemes: Closing the Gap and Shine*
- *Apply for Generation Q, our leadership programme, which includes specialist training in quality improvement*
- *In 2011 we will be recruiting for the demonstration phase of our Safer Clinical Systems programme*
- *Find out what is happening in your local area and consider how you could get involved.*

You can find out more at www.health.org.uk or email us at info@health.org.uk

The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK. We want the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable. We believe that in order to achieve this, health services need to continually improve the way they work.

We are here to inspire and create the space for people, teams, organisations and systems to make lasting improvements to health services.

Working at every level of the healthcare system, we aim to develop the technical skills, leadership, capacity, knowledge, and the will for change, that are essential for real and lasting improvement.

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