WM QRS West Midlands Quality Review Service

NHS

Formative Review of Dudley Maternity Services

The Dudley Group NHS Foundation Trust

Visit Date: 13th February 2014 Report Date: April 2014

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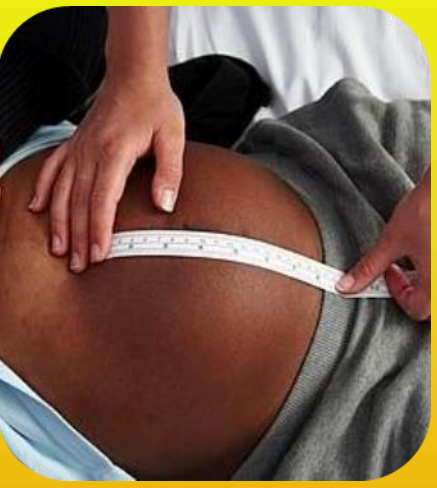



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INTRODUCTION

This report presents the findings of the formative review of maternity services at The Dudley Group NHS Foundation Trust which took place on 13th February 2014. The purpose of the visit was to help the Dudley Group NHS Foundation Trust and NHS Dudley Clinical Commissioning Group to improve clinical outcomes and service users' and carers' experiences by looking at the following areas:

1 Identify whether the proportion of midwife-led births could be increased and if so, how this could be achieved. This work should consider all stages of the pathway from booking through to delivery. This should include consideration of the potential for reducing the rate of induction of labour.

2 Explore the potential for, and potential benefits of, greater integration between community midwives and the midwife-led birthing unit.

3 Explore the potential for developing a service/approach for assessment of labour at home.

4 Explore the potential for introducing complementary therapies.

The report reflects the situation at the time of the visit. Appendix 1 lists the visiting team which reviewed the services at The Dudley Group NHS Foundation Trust.

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches although some will require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of The Dudley Group NHS Foundation Trust for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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MATERNITY SERVICES

At the time of the review, maternity care for approximately 4,900 women per year was provided by The Dudley Group NHS Foundation Trust. The combined hospital and community service was staffed by 180 midwives, 40 support workers, eight consultants and many other support staff. The Maternity Unit at Russells Hall Hospital comprised 46 in-patient beds, a delivery suite, a co-located midwife-led unit including a pool room, a triage area, a maternity ward for antenatal and postnatal women, a maternity theatre with anaesthetic and recovery rooms, and a transitional care area. A maternity outpatient unit including antenatal clinic space and a pregnancy day assessment unit. Home births, cared for by community midwives, accounted for approximately one per cent of Dudley births.

General Comments and Achievements

Reviewers were impressed by the enthusiasm and motivation to improve shown by all the staff they met. Staff were open and willing to share ideas with reviewers. They had good ideas about the future of the service and were prepared to change and implement improvements.

The service had achieved 'Baby Friendly' accreditation and had won a national award for 'Evidence into Practice' and the Trust 'Committed to Excellence Award'. Surveys of users of the service showed consistently good feedback.

The facilities at Russells Hall Hospital were light, airy, well-organised and provided an excellent environment for the provision of maternity care.

COMMON THEMES

These issues affected all of the areas which reviewers were asked to consider and, to avoid repetition, are drawn together as common themes:

Concerns

1 **Consultant Obstetrician Staffing Levels and Medical Leadership for Obstetrics**

Reviewers considered that eight consultants was a very low number for the number of births and size of the obstetrics and gynaecology service. The consultant on duty for the Labour Ward was responsible for the delivery suite, emergency and elective Caesarean sections, triage, the ante-natal ward and emergency gynaecology. The service therefore did not achieve the expected minimum standard of 66 hours per week of consultant Labour Ward presence without other responsibilities and was very far from the desirable standard for a unit of this size of 24/7 consultant presence on the Labour Ward without responsibilities elsewhere.

All eight consultants covered obstetrics and gynaecology and, although a lead consultant for maternity services was identified, the reviewers were advised that none of the consultant job plans reflected a particular interest in obstetrics. Women generally stayed with the consultant under whose care they were booked with little or no transfer of care to consultants with a particular interest or expertise in different aspects of obstetric care. Specific clinics were run for pregnant women with diabetes and for those with haematological disorders but women with other medical conditions were pooled and seen by all consultants. Reviewers suggested that the appointment of one or more consultants with an Advanced Training Skills Module in advanced antenatal care or maternal medicine would provide more specialist expertise and promote consistency of care.

Reviewers met only two of the eight consultants and no junior medical staff. The high workload for only eight consultants may explain why more medical staff were not available on the day of the review but may be symptomatic of a relative lack of medical involvement in driving improvements in maternity services. Partnership working between medical and midwifery staff was evident but, given their high workload,

consultants will have little time for service review and development. Many of the recent improvements in the service appeared to have been midwife-led and leadership of service improvement by medical staff was not evident. Because of the pressures on medical staff, reviewers encouraged midwives to continue to expand their roles and drive service improvements. Appointment of more consultants with a particular interest in obstetrics would improve joint working, leadership and service development.

2 **Maternity Information System**

The service did not have an effective maternity information system. As a result, considerable time and effort was spent on gathering and analysing data and appropriate audit data were not easily available. This issue may also be affecting the service's ability appropriately to count its activity resulting in a shortfall of income. The long-term benefits of gathering robust data are likely to outweigh the initial costs of implementation of a Maternity Information System.

3 **Competence and Confidence of Community Midwives for Intra-partum Care**

Community midwives were averaging only one home birth per year. Although told that community midwives considered they had appropriate competences, reviewers were not sure how competence and confidence could be maintained with this low level of activity. Reviewers suggested that appropriate competence assessment of intra-partum care by community midwives should be undertaken. This issue could also be addressed by rotation of community midwives to the midwife-led unit – so long as they were taking full responsibility for intra-partum care while on the unit.

Further Consideration

1 At the time of the review there were no support workers on the midwife-led unit. Reviewers suggested that, with appropriate training, support workers could act as the second person present at births on the midwife-led unit. In due course, support workers may also provide support at home births.

2 Reviewers were told that some community midwives had worked with the same general practices for many years. While recognising the importance of continuity of relationships with general practitioners and their patients, there is also the potential for clinical isolation. Participation in appropriate audits as well as rotation through the midwife-led unit may help to address this.

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Increasing the Proportion of Midwife-led Births

Reviewers considered that the proportion of midwife-led births for the size of unit was good. A lot of work had already been done to increase the proportion of midwife-led births and staff who met reviewers were committed to further improvements. The excellent environment on the unit helped this work. Reviewers made the following suggestions for further increasing the proportion of midwife-led births:

1 Consider changing the admission criteria for the midwife-led unit to include induction of low risk women and allow these women to stay on the midwife-led unit unless they need oxytocin.

2 Provide another pool or pools: All rooms were big enough for a 'pool in a box' which may also be less heavy.

3 Review the messages being given to women about midwife-led care, including in 'Your Maternity Guide' and verbally by midwives. A more positive message about the unit, including the benefits of co-location, may be helpful.

4 Parent-craft classes on 'active birth' were offered to women booked for the midwife-led unit. It may be helpful to offer similar classes to high risk women.

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Reducing the Rate of Induction of Labour

Audit data suggested that most of the inductions were appropriate, although these data were approximately three years old. All staff who met reviewers were committed to reducing the rate of induction of labour, although reviewers met only two consultants and no other medical staff were available for discussions on the day of the visit. Reviewers made the following suggestions for reducing the rate of induction of labour:

1 NICE guidance on membrane sweeps prior to formal induction did not appear to be being consistently applied. Reviewers were told that membrane sweeps were not routinely offered at less than 40 weeks gestation. For example, women with diabetes and others booked for induction at less than 40 weeks should be offered a membrane sweep from 37 weeks. It may be helpful to audit the extent to which this guidance is implemented. The information leaflet on membrane sweeps could be issued for all women at 36 weeks gestation.

2 A proforma-based approach to the induction pathway may be helpful. This may act as both a prompt for decision-making and a useful audit tool. This could also be used to drive consistent senior input to decision-making about induction. Reviewers were told that junior medical staff would usually make this decision, even when the criterion category was 'other'. Senior involvement in all women in the 'other' category would be appropriate.

3 Further audit work on the induction rate may be helpful, looking particularly at whether the unit's rate of induction of labour is appropriate for the population of women who use the service. It may also be helpful to review the threshold on the maternity dashboard. This was set at 18% which reviewers considered was too low and so would always show up as red.

4 The maternity dashboard flashed red when the instrumental birth rate was under 9%. Reviewers queried whether this parameter had been set incorrectly and whether this should be **over** 9%. The rationale for all parameters on the dashboard may benefit from review as the lead consultant was not aware of why they had been chosen.

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Integration Between Community Midwives and the Midwife-led Birthing Unit

Progress was being made on increasing integration between community midwives and the midwife-led unit (MLU). Community midwives were doing one supernumerary shift per month on the MLU. The community midwives who met reviewers were keen to integrate with MLU staff and to improve the service offered. Reviewers made the following suggestions for improving integration between community midwives and the MLU:

1 Strengthening rotation of community midwives: A variety of models for achieving this are available. Some require additional staffing but others could be achieved within existing staffing. Reviewers also recommended that community midwives take full responsibility while on the MLU rather than observing or being supernumerary.

2 The introduction of assessment of labour at home may help to improve communication between community and hospital-based midwives as well as promoting normality and reducing the number of women going through triage. However it is recognised that this will impact upon available resources and is likely to require a fully informed and costed analysis prior to implementation

3 Flexibility of staffing between community and the MLU may be helpful, particularly in response to fluctuations in workload.

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POTENTIAL FOR DEVELOPING A SERVICE OR APPROACH FOR ASSESSMENT OF LABOUR AT HOME

Reviewers considered that community-based assessment of labour at home could be introduced and would have several benefits (see above). This could be achieved in a variety of ways, including a hybrid model where clinic-based assessment close to the women's home is offered during normal working hours and home assessment is covered, whenever possible, by the on call team at other times. Introduction of this service may require 'start up' funding but could then become self-financing, especially if the 'cap' on the number of births in the Dudley service was lifted. It may also be helpful to undertake an anonymous survey of community midwives' attitudes to home birth with the aim of understanding any anxieties that may be communicated to mothers, consciously or unconsciously.

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POTENTIAL FOR INTRODUCING COMPLEMENTARY THERAPIES

A good leaflet on complementary therapies had been developed and several staff were keen to make these therapies more widely available. The potential to improve women's experience of delivery through this approach had been clearly identified and articulated. Reviewers made the following suggestions about introducing complementary therapies:

1 Staff will need to be appropriately trained in the provision of complementary therapies. It is unlikely that the Trust would fund this training as these therapies are not included in the maternity tariff and do not have a quantitative evidence base. Given the enthusiasm of staff there may be other ways of ensuring that appropriately trained staff are available for this service.

2 Reviewers suggested that, so long as appropriately trained staff were available, the service could be introduced for a trial period and evaluated. As well as improving the birth experience, introducing complementary therapies may reduce the number of epidurals and /or reduce the length of stay. A small reduction in either of these would pay for the complementary therapy service.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Dr Adam Gornall	Consultant in Feto-maternal Medicine and Gynaecology	The Shrewsbury & Telford Hospital NHS Trust
Dr Tracey Johnston	Consultant in Feto-maternal Medicine	Birmingham Women's NHS Foundation Trust
Julie Baker	Senior Midwife	Burton Hospitals NHS Foundation Trust
Elaine Newell	Director of Midwifery/ Clinical Director for Maternity & Perinatal Medicine	Sandwell & West Birmingham Hospitals NHS Trust
Tolulope Majebi	User Representative	

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