Royal College of Midwives

The solution series: 1

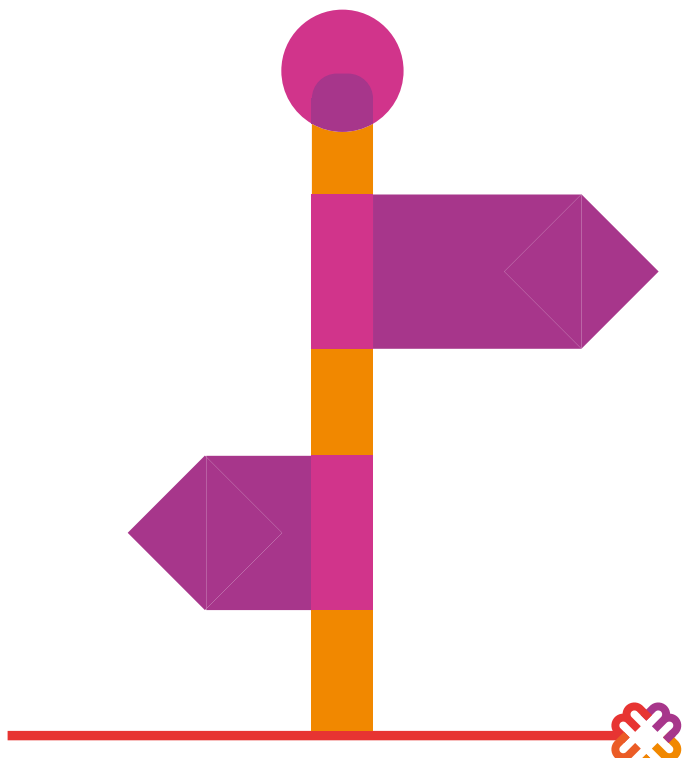
improving maternity services

learning from reviews of maternity

Learning from reviews of maternity services

The detailed reviews of maternity services across the UK which have highlighted serious failings 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 safely staffed. Each member of staff should escalate any concerns or shortfalls in staffing to managers.



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

Five key needs that were not met in the latest three key reviews

Cwm Taf Wales 2019[1,2]	Ockenden Review, The Shrewsbury and Telford Hospital NHS Trust, Final 2022[3]	Reading the signals, East Kent 2022[4]
Evidence-based guidance Easily accessible up to date evidence-based guidelines for all aspects of care.	**Escalation** Continuous risk assessments in antenatal, intrapartum and post-natal care with clear escalation processes in place.	**Escalation** Assessments carried out by the right person with clear escalation processes for all disciplines.
Positive workplace culture Supportive culture, high expectations around professional behaviour and positive staff communication with women and families	**Teamworking and workplace culture** Listening to women and families. Psychological safety assurance for staff. Facilitate multidisciplinary team (MDT) training on workplace culture and bullying. Encourage professional respect for all roles.	**Teamworking and workplace culture** Teamworking and respect across disciplines. Listening to women's concerns. MDT professionalism and delivering care with kindness and compassion.
Focus on training Enabling and monitoring of staff attendance at core training	**Focus on training** Collaborative working on audits, reviews and change management with psychological safety. Focus on civility, human factors, culture training for all, with IA and EFM training.	**Focus on training** Continuous professional development on professional behaviour, common purpose and compassionate care. Training on listening. Leadership development.

Cwn Taf Wales 2019	Ockenden Review, The Shrewsbury and Telford Hospital NHS Trust, Final 2022	Reading the signals, East Kent 2022
Visible positive leadership Visible consultant presence on labour ward and clear trigger list for calling consultants.	**Leadership** Maternity staffing and workforce planning. Support leadership development for all disciplines with succession planning. Consultant presence on labour ward.	**Leadership** Staff engagement and accountability. Provision of mentorship for midwives and support from consultants following escalation.
Learning from events Robust governance with risk management	**Learning from events** Internal oversight, governance and external accountability and learning from serious incidents.	**Learning from events** Safety incidents investigations to achieve learning from events with a no blame culture. Transparency for families with internal board level oversight. Monitoring safe performance data identifying early warning signs.

Learning from success

While it is vital that there is learning from failure, it is also vital to focus on what can be learnt from success. The THIS Institute has published a helpful 'For Us' Framework,[5] based on an extensive ethnographic study, which sets out the seven key features of a safe maternity unit; few maternity services in England are rated as 'outstanding' by the Care Quality Commission (CQC).[6] Seven key features of these units from the CQC inspection report are highlighted below:

Key features from the CQC inspection report

THIS Institute Seven features of safe maternity services	CQC report 2023, London region: Outstanding	CQC report 2023, south of England: Outstanding
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 suitable support.	The service **provided mandatory** training in key skills to all staff and made sure everyone completed it. Staff we spoke to had clear understanding of key midwifery skills and were regularly provided with training updates.

THIS Institute Seven features of safe maternity services	London Region Trust CQC report 2023 'Outstanding'	South Of England Trust CQC report 'Outstanding'
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 we spoke with 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'.
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.

THIS Institute Seven features of safe maternity services	London Region Trust CQC report 2023 'Outstanding'	South Of England Trust CQC report 'Outstanding'
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 improvement 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.
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.

THIS Institute Seven features of safe maternity services	London Region Trust CQC report 2023 'Outstanding'	South Of England Trust CQC report 'Outstanding'
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.
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. We found the head of midwifery to be highly respected by all staff we spoke with. Staff felt valued and listened to and told us 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?

Do we have any of the five issues noted in the three reviews?	There are some issues here - what next steps are we taking?	We are confident that we don't have any of these problems
Risk assessment and escalation		
Evidence-based guidance readily available		
Multidisciplinary team working and positive workplace culture		

Do we have any of the five issues noted in the three reviews?	There are some issues here - what next steps are we taking?	We are confident that we don't have any of these problems
Kindness and compassion		
Focus on CPD		
Visible positive leadership		
Learning from adverse events		

Do we have the seven elements of safe maternity service listed from the THIS institute 'For Us' framework?	There are some issues in our service/team with the implementation of this element of safe maternity service	We are confident that we have implemented this element of safe maternity service
1. Commitment to safety and improvement at all levels, with everyone involved	Yes ☐ No ☐	Yes ☐ No ☐
2. Technical competence, supported by formal training and informal learning	Yes ☐ No ☐	Yes ☐ No ☐
3. Teamwork, cooperation, and positive working relationships	Yes ☐ No ☐	Yes ☐ No ☐
4. Constant reinforcing of safe, ethical, and respectful behaviours	Yes ☐ No ☐	Yes ☐ No ☐
5. Multiple problem-sensing systems, used as basis of action	Yes ☐ No ☐	Yes ☐ No ☐
6. Systems and processes designed for safety, and regularly reviewed and optimised	Yes ☐ No ☐	Yes ☐ No ☐
7. Effective coordination and ability to mobilise quickly	Yes ☐ No ☐	Yes ☐ No ☐

	What action can we take today?	What action can we take over the next 6 months?
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?		

References

1. Independent Maternity Services Oversight Panel. Clinical review programme. *Cwm Taf Morgannwg University Health Board. Thematic maternal category report. Executive summary*. 2021. independent-maternity-services--oversight-panel-executive-summary-thematic-maternal-category-report.pdf (gov.wales) [Accessed 11 March 2024].
2. Royal College of Midwives (RCM), Royal College of Obstetricians and Gynaecologists (RCOG). *Review of maternity services at Cwm Taf Health Board on 15-17 January 2019*. REPORT OF RCOG REVIEW (gov.wales) [Accessed 11 March 2024].
3. Independent Maternity Review. *Ockenden report – Final. Findings, conclusions, and essential actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust*. HC 1219. 2022. OCKENDEN REPORT - FINAL (ockendenmaternityreview.org.uk) [Accessed 11 March 2024].
4. Kirkup B. Reading the signals. *Maternity and neonatal services in East Kent - the Report of the Independent Investigation*. HC681. London: House of Commons, 2022. assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1111992/reading-the-signals-maternity-and-neonatal-services-in-east-kent_the-report-of-the-independent-investigation_print-ready.pdf [Accessed 11 March 2024].
5. THIS. Institute. *7 features of safety in maternity units. For Us framework*. https://for-us-framework.carrd.co/ [Accessed 11 March 2024].
6. Care Quality Commission (CQC). *Safety, equity and engagement in maternity services*. 2022. https://www.cqc.org.uk/publications/themes-care/safety-equity-engagement-maternity-services [Accessed 11 March 2024].

Additional resources

Royal College of Midwives (RCM). *Safety and improvement projects and initiatives.* [no date].
www.rcm.org.uk

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