IMPROVING SAFETY IN MATERNITY SERVICES

A toolkit for teams

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Anna Dixon

The King's Fund
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## Abbreviations

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<tr>
<td>CMACE</td>
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<td>CNST</td>
<td>Clinical Negligence Scheme for Trusts</td>
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<td>NHSLA</td>
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<td>NPSA</td>
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<td>PROMPT</td>
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We would like to thank the following people who supported and participated in the project:

- the participating trusts for supporting their staff
- the team members from participating trusts who dedicated so much energy and commitment to their local projects
- members of the partner organisations who gave generously of their time and expertise
- the mentor sites who were willing to share their knowledge, expertise and experience of improving safety in maternity services
- leadership staff at The King’s Fund who facilitated the action learning sets and the consultancy days
- Richard Giordano and Helen McGee for research support and analysis
- OKB Ltd for providing online cardiotocography training and support for the maternity sites
- all those who reviewed and commented on earlier drafts of these materials.
When The King’s Fund launched its independent inquiry into the safety of maternity services in 2006, there was growing public concern following a number of high-profile failures in maternity care. The inquiry panel of experts from outside maternity services brought a fresh perspective to the issue with expertise in ethics, regulation, and patient safety. Their report, Safe Births: Everybody’s business (The King’s Fund 2008), made a series of recommendations about how the safety of maternity care could be improved. It drew heavily on ideas from previous work on patient safety which, although widely accepted in other clinical areas, was less familiar to those working in maternity services. Despite a focus on safety within maternity care, the approach tended to be retrospective – investigating and learning from incidents – rather than a proactive approach to assuring safety by putting in place reliable systems of care.

The King’s Fund report was one of many reports that have highlighted some of the reasons for failings in care. The Confidential Enquiries into maternal deaths in the United Kingdom have investigated all maternal deaths for many years and, through their case reviews, have highlighted some of the critical underlying causes (CMACE 2011). The Healthcare Commission published a review of maternity services in 2008 (Healthcare Commission 2008). Through its casework the National Health Service Litigation Authority (NHSLA) identifies factors which reduce the likelihood of adverse events and these are reflected in the Clinical Negligence Scheme for Trusts (CNST) standards (NHS Litigation Authority 2011). Both the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives promote standards and produce guidelines to promote high-quality care for women.

The King’s Fund was committed to seeing through the recommendations of its inquiry. With our partners (the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Healthcare Commission, the NHS Litigation Authority, the Centre for Maternal and Child Enquiries (CMACE) and the National Patient Safety Agency), we took the recommendations on the road and tested them out at meetings of multidisciplinary professionals working in maternity services.

We heard the frustrations of staff who were working on their own initiatives to translate guidelines into practical tools, who didn’t have enough time to train or develop, who felt the lack of adequate staff was sometimes unsafe, who felt overburdened by inspections and regulations and who produced action plans for every national report but never had the chance to implement them. It was clear that teams needed support to make these changes happen. As a result we launched the Safer Births programme, combining the expertise of The King’s Fund with that of our partners. We selected 12 trusts to join the programme, and this toolkit shares the experiences and lessons from those organisations.

I am proud of the achievements of the teams that took part. While the impact of the changes they have made are not easily quantified or measured in terms of outcomes of care, they have put in place many of the measures that the original
inquiry recommended as essential for safer care. Most are clear about their shared objectives (safer care for women and babies) and their roles within the wider team. They communicate effectively, they train together where they work, including in the community, they ensure staff with the right level of experience are available to meet demands, they record information clearly and use protocols to ensure guidelines are followed, they collect and review information on their performance and they feel heard and supported by their board.

Not all teams have achieved all of this and they acknowledge that they have further to go to embed and sustain the changes they have made. Many maternity services continue to face challenges and this will only increase with the financial pressures on the NHS. However, many of the changes described here do not need additional funding. They need time and commitment, leadership and a bit of know-how. I hope that the tips and tools in this resource will help you implement changes that will deliver benefits to women and families in your care.

Anna Dixon
Director of Policy, The King’s Fund
What’s in this toolkit

This toolkit contains a range of tools, templates and ‘hints and tips’ to help maternity teams improve the safety of care, and an accompanying DVD. The toolkit draws on the experiences of 12 trusts across England that took part in the Safer Births programme between October 2009 and March 2011.

Throughout the toolkit there are examples of documents and materials that have been used or developed by participating maternity teams. While not necessarily endorsed by The King’s Fund or its partners, they provide a useful starting point for teams with a desire to improve the safety of maternity care – particularly care for women in labour.

The toolkit is organised around five key areas for improvement on which the teams focused:

- teamworking
- communication
- training
- information and guidance
- staffing and leadership.

Each section begins with a brief explanation on how focusing on improvements in each area can contribute to improved safety. It then highlights some of the experiences of the maternity teams who focused on this issue and their key learning points.

There are also short summaries of tools that can be used to improve safety. These provide a brief guide to how to use the tool and signpost further resources. Where available we have included examples or templates that can be used or adapted for local use.

Finally, we provide more information about service improvement and the tools and techniques that can be used.

Throughout this toolkit the maternity teams who took part in the Safer Births programme are referred to as ‘participating sites’ or ‘Safer Births maternity teams’.
How to use the toolkit

In order to get started, we suggest you do some or all of the following:

- watch the DVD as part of a multidisciplinary meeting, discuss what safety issues your service faces and try to identify areas you might focus on for improvement
- organise an awayday, workshop or survey as suggested in the toolkit in order to understand in more detail how effectively you work as a team, what safety issues need tackling, and to develop a focus for your improvement project
- read the case studies, identify which site you might have most in common with and find out more about what they did
- use the resources to identify tools you could use in your service to help address safety issues you have identified and set about implementing them
- identify who will lead your improvement work on safety so they can use the toolkit to draw up an action plan.

Background

The Safer Births programme was developed by The King’s Fund and delivered in partnership with:

- the Royal College of Obstetricians and Gynaecologists
- the Royal College of Midwives
- the National Patient Safety Agency
- the National Health Service Litigation Authority
- the Centre for Maternal and Child Enquiries.

The programme was set up to support the implementation of the recommendations of The King’s Fund Inquiry into the Safety of Maternity Services in England published in Safe Births: Everybody’s business (The King’s Fund 2008). This identified a number of issues that support safe care including the following.

- Effective teamwork can increase patient safety; poor teamwork can jeopardise safety.
- Safe maternity teams need adequate numbers of staff with the right skills. This requires effective deployment of staff as well as employment of enough skilled staff.
- Teams can provide safe services only if their individual members have the right skills and training, as well as the appropriate resources, and if they practise relevant skills together as a team.
- Safe practice must be based on evidence about interventions that work, as set out in guidelines, protocols and other forms of guidance.
- Information about clinical outcomes can be used for summative, retrospective purposes, such as reporting on standards; but it is more crucially used for formative purposes, to help maternity teams assess and improve their own work.
- Trust boards have a fundamental duty to safeguard patients. They should demand rigorous routine information on safety from maternity units and support the collection of this information.

A summary of the recommendations is available at: www.kingsfund.org.uk/publications/safe_births.html
The role of the trust board

The inquiry heard that maternity services were often a low priority for boards and that many board members did not understand the particular safety issues facing maternity services.

Each participating site in Safer Births had a board sponsor who was able to champion the project at board level. Teams were encouraged to report to their board sponsors regularly.

National structures for safety

The inquiry heard that there was poor co-ordination between the national bodies with a role or interest in safety in maternity services and recommended that they work together to ensure a more consistent and co-ordinated approach to safety.

The Safer Births programme was therefore established as a partnership between the national bodies. All their expertise and the guidelines, tools and materials they produce were all drawn upon to support the teams to improve safety in a co-ordinated way.

Teamworking and communication

The inquiry emphasised the importance of effective teamworking and communication in the delivery of safe care. At the inquiry and during the roadshow events maternity staff reported difficulties in working relationships within the team, between different professionals, and between hospital and community-based teams. They also reported a lack of clarity about roles such as the labour ward co-ordinator and maternity support workers, and leadership was either lacking or unclear.

As part of the programme, sites were encouraged to assess the safety culture of their team using the Manchester Patient Safety Framework (MaPSaF) tool or to measure their interprofessional interactions using the University of the West of England (UWE) interprofessional questionnaire.

Some teams organised awaydays for groups of staff and many instituted more regular multidisciplinary forums where professionals could discuss common issues/cases.

The majority of the teams were encouraged to implement a structured communication tool such as Situation, Background, Assessment, Recommendation (SBAR) for one-to-one communication particularly at transfer/referral. Many teams went further than this and reorganised their handovers to make them multidisciplinary and more structured in the way information about the women in their care was communicated.

Training

The inquiry stressed that staff that work together need to train together. Maternity staff often reported they found it difficult to get time off for training, and there was evidence that there was an insufficient focus on safety awareness and skills in training programmes.

Sites were encouraged to implement skills and drills training in the workplace to develop clinical skills, particularly in emergency situations, but also to build communication and teamworking. A number of teams used PRactical Obstetrics Multi-Professional Training (PROMPT) as a training package.
Information and guidance

Maternity staff expressed frustration at multiple systems of data collection and spending a lot of time inputting data, which took them away from giving direct patient care. Despite this they reported that they had little information that was useful. The inquiry recommended that teams identified a small set of reliable information measures critical to safety.

A number of sites introduced the Maternity Dashboard as a means of monitoring performance and identifying and responding to concerns. Measuring improvement was challenging for a number of trusts given that increases in the number of reported incidents can reflect an improved culture of open reporting rather than deterioration in the actual safety of the care.

The inquiry learned that in some units recommended guidelines were either not available, or not used or followed. Furthermore, staff felt overwhelmed by the volume of guidelines and information issued nationally. The inquiry recommended a more streamlined approach and use of shorter protocols.

Sites piloted the postpartum haemorrhage bundle developed by the National Patient Safety Agency (NPSA), and a number of sites introduced the Intrapartum Care Scorecard. Some sites implemented the Modified Early Obstetric Warning Score (MEOWS) in order to ensure that the deteriorating condition of women was picked up and escalated promptly.

Staffing and leadership

There has been a lot of discussion and debate about the need for adequate numbers of staff. Maternity staff expressed concerns that the lack of available staff with the right skills and experience was a threat to safety.

Some sites focused on improving the availability of consultant cover; others used the Birthrate Intrapartum Acuity® System (BRIPAS) to establish more accurately the staffing requirements on the labour ward. Other teams were clear that they needed to improve their recruitment processes to ensure staff with the right attitudes and skills were brought into the team.

Participating sites

Twelve trusts across England took part in the Safer Births programme between October 2009 and March 2011. Table 1, opposite, provides a summary of the participating sites and their projects.
### Table 1  Safer Births programme projects

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<td>■ Reviewing and developing existing handovers</td>
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<td>■ Introducing a new all-day multidisciplinary cardiotocography (CTG) training package</td>
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<td>Improving teamworking and multidisciplinary team ownership of change in practice to improve care to</td>
<td>■ Improving organisation culture</td>
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<td>Trust</td>
<td>mothers and babies</td>
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<td>North Middlesex University Hospital NHS</td>
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<td>Trust</td>
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<td>■ Evaluating the use of Clinical picture, History, Assessment, Plan (CHAPS) tool</td>
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<td>■ Introducing the National Patient Safety Agency (NPSA) intrapartum scorecard</td>
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Unit profile

The Ipswich Hospital NHS Trust in the east of England serves a large geographical area. A significant proportion of women who use the maternity services live in rural areas. The home birth rate has been higher than the national average for some years.

Context

- Ipswich had always prided itself on supporting women who choose to deliver at home or in a midwife-led care unit. Before a clinical incident in 2007, the home birth rate was 7 per cent. In 2009/10 the home birth rate had fallen to 4.5 per cent.

- Following discussions with community midwives, it became apparent that their confidence in offering women choice of place of birth was diminishing. They felt the obstetric emergency training on offer did not address the issues they faced in clinical practice. They identified that they needed training specific to working in the community rather than the 'skills and drills' approach, which was more relevant to the hospital setting.

Project

The overall objective for the project was to establish an obstetric emergency training programme that provided community midwives with the necessary skills to deal with an obstetric emergency in the community and the subsequent transfer of the mother and her baby into the hospital maternity unit.

The expectation was that by supporting the midwives to acquire the clinical skills they had identified as necessary, they would feel more confident to offer women choice when discussing place of birth. In addition, teamworking between the community, hospital and the ambulance trust would also benefit from a more confident and skilled workforce.

Project objectives were to:

- improve teamworking
- implement training for safety
- provide guidance on safe practice
- review and standardise equipment carried by community midwives.
Process of change

Improving teamworking

Senior midwives working in either the community or the hospital setting attended an awayday. This encouraged greater understanding of each other’s roles to improve teamworking. The participants planned to spend time working alongside each other to enhance understanding and cohesive teamworking. Further awaydays have been scheduled at regular intervals.

Staff who took part in both the awayday and the Safer Births programme have reported these have been key in making them feel more valued members of the wider team.

The time devoted both to developing the leadership skills of the senior midwives and the awayday highlighted the positive impact of this investment in clinical service leaders.

Implementing training for safety

A community training programme has been delivered within a community setting since February 2011. This training covers emergency scenarios; communication using Situation, Background, Assessment, Recommendation (SBAR); the use of appropriate equipment; and record-keeping. A large proportion of the community midwives have completed this training and will attend yearly, in addition to other mandatory training.

It is hoped that the hospital labour ward co-ordinators and possibly paramedics will take part in the future.

Initial evaluation showed that community midwives found this training beneficial and relevant, and considered it would improve their practice. Informal feedback has been very positive and the midwives feel more valued as the issues they face in the community have been recognised.

Providing guidance on safe practice

Emergency guidelines were updated to reflect the specific issues community midwives may face and record-keeping tools were adapted for community use.

Introduction of SBAR throughout the hospital and community service has ensured effective and relevant communication. A classification tool for emergency transfers has been designed and implemented to help communication for transfer.

Reviewing and standardising equipment carried by community midwives

The aim was for each community midwife to carry the same equipment and have a special box for dealing with emergencies such as postpartum haemorrhage (PPH). All community midwives now have a standardised equipment list, a list of what needs to be included in an ‘emergency box’, and how they should be laid out and organised.

Systems and processes are now in place for rolling out these changes across the community workforce. The initial apprehension felt by the community midwives has been addressed through ongoing consultation.
Project impact

The positive impact of being involved with The King’s Fund Safer Births programme was underestimated when the maternity team joined the programme. Staff have reported feeling more valued as a result of taking part in team workshops and events organised by the Safer Births programme. Local news coverage of the service has been more positive and has improved the service’s public image.

The hospital is optimistic there will be a steady and sustained increase in the number of home births.

Key lessons

Cost-effectiveness

In the current financial climate part of the reason for the success of this project was that significant financial investment was not needed, as all the resources were already accessible. The maternity team needed to invest time and reassess their goals and objectives.

Protected time

Although there was a commitment from the trust to release time for the project, in reality it was difficult to achieve this. On reflection, this may have been more achievable if the work had taken place off site to reduce interruptions and the distractions of other work pressures.

Focus

Much of the success of the project was attributable to the fact that the maternity team remained focused and had clear objectives. However, this was a significant challenge as outside parties felt that other issues could also be included in the project as it progressed. The team had to resist the ‘pulls’ in other directions that were not within the remit of their project.

Creating a vision

With any change project, the initial step is to create a ‘vision’. For the maternity team this was a fundamental element of getting staff involved in the project. Having a clear vision enabled the maternity team in the hospital to work with the community midwives to achieve the training programme they wanted and owned. The vision led to the project proposal, which was well received and helped to drive the change in training and practice forward.

Action plan

The maternity team emphasised the value of having a structured and clear plan with a realistic timeline and outcome measures from the outset, in order to achieve a vision. A detailed action plan helped to delegate tasks to the maternity team and identify people responsible for different parts of the project. Part way through the project it became apparent that they should have increased data collection at the outset, especially around morale and attitudes, in order to provide evidence of the project outcomes. Identifying and collecting measures of improvement are also important.
Unit profile

Mid Cheshire Hospitals NHS Foundation Trust manages Leighton Hospital, Crewe; the Victoria Infirmary, Northwich; and Elmhurst Intermediate Care Centre, Winsford. The Trust was established as an NHS trust in April 1991 and became a foundation trust in April 2008. It provides a comprehensive range of acute, maternity and child health services and intermediate care to a population of almost 300,000 living in Alsager, Crewe, Congleton, Knutsford, Nantwich, Northwich, Sandbach and Winsford.

Context

- The project took place against a background of organisational change that had seen four heads of the maternity department in four years. Staff turnover was low, practices institutionalised, and senior midwifery staff were disempowered. The governance structure needed major redevelopment.

- A buddy system was introduced following investigations into two major clinical incidents where poor interpretation of cardiotocographs (CTGs) was a factor. The aim was to reduce the level of variation seen when interpreting CTGs and reduce misinterpretation. Its application was inconsistent, with the first audit showing that buddying was carried out correctly only 66 per cent of the time. The maternity team aimed to review the process and identify ways to further embed this system.

Project

The original aims of the project were to decrease CTG abnormalities, decrease postpartum haemorrhage (PPH) rates, decrease rates of low cord gases and improve the use of the maternity information system.

In the early stages of the Safer Births programme, the maternity team struggled to gain ‘traction’ and enthusiasm from colleagues. They recognised that in a crisis they performed much better as a team because of a clear sense of focus, which didn’t exist on a day-to-day basis. Following the early programme meetings, they realised a key issue for any organisation was coherence both vertically and horizontally, which indicated a need for further development within the team. In addition, it was apparent that their difficulties in engaging with staff were symptomatic of dysfunctional teams rather than a lack of guidance and policies to inform practice. As a result, the maternity team revised their original objectives to include the improvement of governance arrangements.
Project objectives were to:

■ improve teamworking

■ improve communication both vertically and horizontally

■ develop more effective governance arrangements to facilitate multidisciplinary team ownership of changes in practice.

Process of change

Improving teamworking

In addressing the incidence of PPH, the maternity team found that demonstrating the scale of the problem was more effective than simply issuing new guidance and pro formas. In fact, the team was informed that staff had been unaware that two-thirds of PPHs occurred in normal deliveries without risk factors. The key issue unifying midwifery staff, health care assistants and doctors was one of early recognition and anticipation of PPH. One health care assistant suggested (and championed) a simple remedy, which involved weighing swabs at all deliveries rather than those in which PPH was suspected. This intervention started the following day.

The second intervention agreed by the team during an awayday was the completion of delivery summaries in the delivery room, at the woman’s bedside. This was felt to be necessary as having a midwife present in the room following delivery could lead to a problem being recognised earlier. However, this represented a major culture change as midwifery staff had to use the computers in the delivery suite rooms rather than in the staff office as was their usual practice. The change in practice was implemented through close negotiation and discussion with the midwives and senior management.

The trust also ran Manchester Patient Safety Framework (MaPSaF) workshops in which staff could voice their opinions and suggestions. Two key suggestions related to staffing levels and establishing a functional triage area on the labour ward were taken forward by the management team as a direct result. In addition, the workshops were considered beneficial in achieving the safety goals and the team saw an improvement in their safety culture.

The maternity team ensured a collaborative approach was taken to address issues such as reducing PPH, implementing the National Patient Safety Agency (NPSA) intrapartum scorecard and birth rate acuity tool, reviewing a buddy system for CTG interpretation and introducing the Situation, Background, Assessment, Recommendation (SBAR) tool.

Improving communication

The use of SBAR was re-launched within the period of the Safer Births programme. This involved reorganising the information recorded on the labour ward whiteboard to make handovers/rounds more efficient and effective. To support the implementation, the maternity project team developed a series of scenarios to outline how the midwifery co-ordinators could best use the system.

The SBAR initiative is now being cascaded down through the different levels of staff. The maternity team found the support and input from their colleagues from Stockport maternity unit’s Safer Births programme to be particularly instrumental in this.
In terms of staff-to-staff communication on non-patient-related issues, several alternatives were used throughout the project to ensure staff were promptly informed about changes in practice. At one MaPSaF workshop staff highlighted key obstacles to effective communication such as lack of time to read work-related emails or information about practice changes and lack of access to large volumes of guidance for new staff (all guidance is in electronic format). All of these issues have since either been resolved or are under review.

**Developing a more effective infrastructure and multidisciplinary team ownership of changes in practice**

A new governance structure was introduced and provided a framework for making decisions and effectively disseminating information.

The maternity team had introduced the Birthrate Plus tool supported by a new escalation policy. This provides dynamic objective measures of levels of staffing, risk and activity which allow early intervention on challenges to safety and quality such as acute increases in activity or unexpected decreases in staffing levels. Staffing levels had persistently been the most frequent non-clinical incident. Using the acuity tool for objective measurement of staffing levels against activity demonstrated that in most cases sufficient staff were present. It is now also used to provide the backdrop of labour ward activity as a context to major clinical incidents. It requires input every two hours and the team felt that it was a tribute to the midwives when audits demonstrated more than 95 per cent completion over three months. It is now established as routine practice.

During one of the local staff workshops organised as part of the Safer Births programme the midwifery co-ordinators for the labour ward agreed to take ownership of the buddy system for CTG interpretation. They developed a consistent approach, establishing it as part of the culture of the unit. This was a significant step considered to be key in improving the care provided.

**Project impact**

The maternity team collected the following data as part of the project evaluation. It provides a snapshot of results but is not statistically significant.

<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2010/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate incidents</td>
<td>55</td>
<td>46</td>
</tr>
<tr>
<td>Unplanned maternal admissions to ICU</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Intrapartum risk assessment completed</td>
<td>74%</td>
<td>95%</td>
</tr>
<tr>
<td>Staff recruitment – vacancies</td>
<td>22.2% (Jan 09)</td>
<td>2%</td>
</tr>
<tr>
<td>Staff retention – leavers</td>
<td>22</td>
<td>3</td>
</tr>
<tr>
<td>Sickness absence</td>
<td>4.7%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Mandatory training attendance</td>
<td>90%</td>
<td>95%</td>
</tr>
</tbody>
</table>
Key lessons

Strong leaders to champion change

Identifying strong leaders to champion change was considered paramount to the success of the improvement project. Key traits considered important in both leaders and staff involved in leading the project were:

- efficiency
- supportive manner
- ability to maintain momentum
- a fresh pair of eyes/perspective
- ability to crystallise focus
- consistency.

Networking

Networking with the other Safer Births programme maternity teams away from clinical work and away from larger groups was considered invaluable by the maternity team in focusing and progressing with their project plans. They felt it provided an opportunity to exchange and discuss ideas, issues and implementation strategies. The opportunity to have a closed discussion and gain the insight and experience of others was extremely invaluable.

Organisational culture

‘You don’t reduce caesarean section rates with policies and guidelines, you do it by changing the people’ (Professor James Walker, The King’s Fund Safer Births programme meeting, October 2009). The maternity team felt this statement resonated with their experience. They found it was important to create an environment where ideas can be advanced rather than simply pushing solutions. The coincidental appointment of a new head of midwifery and divisional general manager were pivotal in this.

Staff engagement

The MaPSaF days provided staff with a voice and the means to take changes forward, and allowed the safety culture of the unit to advance and mature. Engaging all staff at every level was very important. Feedback from staff during the project has been very positive. Staff felt that these events gave them an opportunity to voice their concerns and suggestions. The health care assistant who suggested weighing swabs from all deliveries had worked in the unit for more than 10 years. She had been invited to the PPH consultancy day led by one of the project facilitators, and became inspired to take action following this. She then led the innovation tenaciously.

Maintaining momentum is the biggest issue for success; the team felt there had been a sea change within the unit over the past year as they moved into a more consistent coherent form of governance around improving safety for mothers and babies.
North Middlesex University Hospital NHS Trust

Unit profile

The North Middlesex University Hospital NHS Trust is a diverse district hospital in Enfield, which serves the population of Haringey. Haringey is the fourth most deprived borough in London. More than 190 languages are spoken in the population, 58 per cent of whom are from minority ethnic communities.

The clinical midwifery services at the hospital are led by the head of midwifery and the clinical director. The obstetric and anaesthetic team currently provide consultant cover to the labour ward 40 hours a week. There is a maternity day unit to support antenatal care for higher risk women. Women with complications during pregnancy are seen on the labour ward. The midwifery ratio is 1:35 and midwives are visibly present in children’s centres locally. A clinical practice facilitator post was funded through NHS London in March 2009.

Risk reporting is established, the Maternity Dashboard is used and regular audits are undertaken – generally focused around Clinical Negligence Scheme for Trusts (CNST) requirements. Maternity achieved CNST level 3 in January 2008.

Context

During the project the maternity team had a number of key events and changes, some expected and others not, which influenced progress towards the final outcomes of the project. These included:

- working towards maternity CNST assessment in January 2011
- increased activity due to proposed reorganisation of maternity services
- maternity unit restructuring affecting staff morale as some band 7 and 8 registered midwives had to reapply for their jobs
- the introduction of new maternity notes
- the appointment of a new head of midwifery in 2010
- trust reorganisation leading to the creation of clinical business units
- the introduction of cost improvement projects (CIPs) impacting on the staffing establishment
- major office moves, only months before the CNST assessment, as older hospital buildings were to be demolished.
Improving safety in maternity services

Project

The overarching aim of the project was to reduce intrapartum term stillbirth and early neonatal death, through the improved recognition, appropriate referral and management of high-risk women/babies and improvement in staff communication.

Project objectives were to:

- **improve understanding of cardiotocographs (CTGs)**
- **ensure the use of syntocinon was in line with best national practice and implemented by all maternity staff**
- **increase the opportunities for multidisciplinary training and communication with particular focus on effective and prompt communication on the labour ward**
- **improve recognition and appropriate referral of high-risk women.**

Process of change

Improving understanding of CTG

The team audited the use of fetal heart rate monitoring guidelines and incorporated them into the maternity record audit tool. This enabled them to identify current practice and areas for further development and focus. In addition, they reviewed and revised the guidelines, ensuring they were based on evidence to support practice.

CTG training was introduced in all emergency skills and drills days and maternity skills workshops. The weekly update sessions continued but with renewed focus on training during labour ward rounds.

As part of the Safer Births programme, the team had free access to an online CTG package (courtesy of OKB Ltd) for a limited number of staff.

Use of syntocinon

Obstetric consultants agreed the standard regimen to be used specifically for the second stage of labour, and a copy of the syntocinon regimen was put in every delivery suite room.

The team did audits of practice, for example, compliance with guidelines for augmentation of labour and the policy for intrapartum record-keeping and general care in labour.

Multidisciplinary training

Staff increased the number of skills and drills sessions to increase opportunities for multidisciplinary training. The training included opportunities for staff to reflect on teamwork and outcomes.

A consultant obstetrician, consultant anaesthetist and two midwives attended PRactical Obstetrics Multi-Professional Training (PROMPT) training to facilitate live drills.
Communication on the labour ward

A questionnaire on labour ward communication identified areas that staff felt it was important to improve. The team also audited handover information, including the attendance of different staff groups.

A bespoke multidisciplinary session on process mapping around labour ward rounds was provided by The King’s Fund. The maternity team identified a need to review communication on the labour ward, in particular around shift change, ward rounds and relating to risk.

The team introduced Situation, Background, Assessment, Recommendation (SBAR) underpinned by training, and modified communication guidelines. These looked specifically at the use of SBAR during handover of care. Both the tool and guidelines were available on the hospital intranet. The department’s operational guidelines were revised and ratified to reflect new structures within maternity and the new communication process. A bleepholder management role was introduced in 2011 to further improve effective communication.

Record-keeping

To improve record-keeping, the project team introduced the use of, and training on, the Perinatal Institute notes for both doctors and midwives. The team also introduced Modified Early Obstetric Warning Score (MEOWS) charts and guidelines to support their use. Information on this was available on the intranet and in the library. Staff were also reminded at ward rounds about the use of the documents.

The team audited compliance with the record-keeping guidelines and introduced a system of telling staff in writing about their good or poor record-keeping practices. Copies of the letters are sent to the manager and midwife supervisor who meet with staff with poor record-keeping. The head of midwifery is kept informed in all cases.

Improving recognition and appropriate referral of high-risk women

The team focused on staff skills and staffing levels. Mandatory maternity skills workshops (twice a year) to focus on intrapartum care and communication were developed over the course of the project. This included early recognition of seriously ill pregnant women as part of mandatory resuscitation training and on maternity skills workshops.

Project impact

The maternity team collected the following data as part of the project evaluation. The data provides a snapshot of results but is not statistically significant.

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious untoward incidents associated with CTG tracing</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Term stillbirths</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Term early neonatal deaths</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Babies with a cord pH at birth of less than 7.2</td>
<td>3%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Term admissions to neonatal unit (NNU) direct from labour ward (retrospectively using NHS London SUI criteria/new NHS London classification – unexpected term admission &gt;24 hours)</td>
<td>33</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>3 ICU admissions and 4 HDU</td>
<td>4 SUI</td>
</tr>
<tr>
<td>Live births</td>
<td>3,477</td>
<td>3,578</td>
</tr>
</tbody>
</table>
Other impacts include:

- 99 per cent of midwives and obstetricians attended mandatory CTG training by the end of 2010, and 96 per cent of staff attended skills and drills training
- Discussion/training on CTG is now part of the ward round and attendance is documented
- Local guidelines were updated in Feb 2010 and compliance audited. Of the notes audited, 22 of 30 had suspicious or pathological traces and action was taken in 100 per cent of these in line with the local guidelines
- The observation of care as part of the labour audit demonstrated appropriate admission observations in 86 per cent of cases, with 88 per cent having appropriate observations documented throughout the first stage of labour including hourly monitoring of maternal pulse during auscultation of the fetal heart. Seventy-seven per cent of women had a partogram completed. All these results were an improvement on the previous audit results
- The consultant cover on the labour ward increased to 60 hours a week from October 2010, and the audit of the one-to-one care in labour during 2010 showed an improvement with an average of 89 per cent over the year
- The audit of the use of SBAR in 2010 showed more than 77 per cent compliance with onsite handover, and more than 75 per cent compliance with intrapartum/in utero transfer.

Key lessons

Breadth of project

Ensure the remit of your project is not too broad; one particular area of focus is better.

Internal project support/team

The maternity project team should commit themselves to regular planned meetings and have protected time for this.

The core team should not be too large and each individual needs to have a clear role/focus. Staff outside the core team can be used as link staff.

It is useful to have a member of the team who is also a budget holder if possible.

The benefits of working within a small core project team cannot be underestimated. Project teams report a greater bonding/teamworking within the unit to achieve a common goal and improved self-awareness as a unit – particularly when using tools such as the Manchester Patient Safety Framework (MaPSaF), and the University of the West of England interprofessional questionnaire.

Prioritising

Consider applying to be part of a national project/programme after an external review, such as the CNST assessment, so that you can use the feedback from the assessment to inform and link in with the project. Joining while in the process of preparing for the CNST assessment or a similar external review can present a number of challenges around workload management and staff availability. It was difficult to get commitment from group representatives as a result of time constraints and due to members leaving.
Measuring improvement

Though the numbers used to show improvement/impact were small, the team felt this data provided motivation and encouragement. They recognised that without the data, they would not have seen how the changes were moving them in the right direction.

Networking opportunities

The team felt that being part of the Safer Births programme enabled them to make changes faster than would otherwise have happened. Support from the process mapping and the national study days were cited as particularly useful. Both provided an opportunity for the maternity team to focus on common solutions/ideas articulated by The King’s Fund staff and other maternity teams taking part in the programme. This emphasised the importance of ongoing networking among local maternity teams and building on current relationships.

Sustainability

Ongoing training to embed the new approaches developed during the project could be hampered as a result of cost improvement programmes; motivation was considered to be a key factor in ensuring sustainability and the team felt this could be achieved by incorporating the project outputs into staff/developmental appraisals or business plans.
Introduction

The Safe Births inquiry concluded that the overwhelming majority of births in England are safe (The King’s Fund 2008); however, where some births are less safe, safe teams are the key to improving the outcome for mother and baby. It highlighted the link between poor teamwork and risk to women. It also noted the difficulties staff said they had encountered in working relationships. The inquiry stressed the need for staff to work more closely together and appreciate each other’s roles.

The organisational culture within which staff operate can also affect teamwork; it can either enable or hinder learning, innovation and change and, ultimately, safety.

Safer Births projects to improve teamwork

The maternity team at Derby Hospitals NHS Foundation Trust developed their open labour ward forum, providing an opportunity for all members of the labour ward team to share ideas and opinions. The forum also created a safe environment for medical staff, midwives, health care assistants (HCAs) and receptionists to share their experiences. Staff reported feeling valued by this opportunity. Of equal importance was the opportunity to improve interactions with other staff and to challenge interprofessional and departmental barriers.

*The project gave us the opportunity to spend time with each other and look at different aspects through different viewpoints. So we had a multidisciplinary team where different viewpoints and aspects were aired and discussed. This helped to build a cohesive and productive team...*  
Consultant obstetrician

Northampton General Hospital’s project included improving multidisciplinary teamworking. Following a Manchester Patient Safety Framework (MaPSaF) workshop to assess the department’s safety culture, the staff identified the need to clarify the roles of other team members. As a result they listed all staff and their roles and responsibilities in a document available on the labour ward which is also given to all new staff. Building on this the maternity team then worked to formalise medical labour handovers and multidisciplinary ward rounds so that staff not only know their roles and responsibilities but also the care/tasks required for mothers.

Among the interventions adopted by the maternity team at Medway NHS Foundation Trust (MFT) was strengthening the labour ward team by developing and delivering a team awayday with the support of external facilitators. These facilitators provided a fresh perspective to how the team interacted. In addition, the involvement of staff known to be influential as ‘champions’ was vital to the change process at MFT.
The maternity team at Mid Cheshire Hospitals NHS Foundation Trust focused on strengthening teamworking:

We agreed that in a crisis we performed much better as a team because of a clear sense of focus; this didn’t exist on a day-to-day basis. Our new goals were therefore better teamworking, better communication, better infrastructure and multidisciplinary team ownership of changes in practice. We wanted to define teams by common objectives, replacing our pseudo teams defined by geography...

Consultant obstetrician

In addressing the incidents of postpartum haemorrhage (PPH), the maternity team found the key issue for midwifery staff, HCAs and doctors was early recognition and anticipation of PPH. A simple remedy was suggested and championed by one of their HCAs, involving the weighing of swabs at all deliveries (rather than those where PPH was suspected). This intervention started the following day, and demonstrated good teamwork and ownership from all members of the team.

One achievement of great significance was the safety culture of the unit, which was considered by the maternity team to have advanced and matured over the programme period. This was seen in the improved MaPSaF assessment.

South Warwickshire NHS Foundation Trust also found MaPSaF workshops beneficial in improving the safety culture and teamworking. Workshops were held at the start and end of the programme. By the end the perception of staff regarding the safety culture of the organisation had moved from it being mainly a reactive/bureaucratic organisation to one which was mainly proactive.

It is more around organisational culture and teamwork... you can teach all the policies and procedures, but if you do not get the culture and the attitude right, you will get nowhere...

CEO

When looking to improve teamworking within a department, it is vital to identify the key stakeholders and their level of influence and engagement. The maternity team at South Warwickshire NHS Foundation Trust considered the labour ward co-ordinators to be in a pivotal position to improve communication with all staff groups. A team awayday run specifically for the band 7 labour ward co-ordinators provided opportunities for labour ward co-ordinators to reflect and discuss communication challenges and develop a plan of action outlining the steps necessary to address blockages to effective communication, particularly around learning from clinical incidents.

The maternity team at Northern Devon Healthcare NHS Trust also aimed to improve teamworking and focused on the working relationship between the associate specialist obstetricians and the labour ward co-ordinators. Their project included a leadership awayday. This provided the opportunity for the team to complete the Myers-Briggs Type Indicator assessment, and to discuss how their differences affected working relationships and how this could be improved. The team have increased the formal ward rounds from three to four and now have meetings to review the women’s care and discuss learning. There is a more open and honest discussion regarding clinical care issues.
This section provides a brief overview of some of the tools used by the Safer Births maternity teams to help improve teamwork, through analysing attitudes, individual styles and the organisational culture. The tools considered are:

- University of the West of England interprofessional questionnaire
- Belbin’s team roles
- Myers-Briggs Type Indicator
- Manchester Patient Safety Framework
- midwifery team awayday.

Key points for improving teamworking

- Consider creative ways to increase staff interaction and team-building, eg, forums, awaydays.
- Use recognised tools to identify the preferences, strengths, weaknesses, traits within the team, eg, Myers-Briggs Type Indicator, Belbin.
- Consider the organisational culture within your maternity unit; is it open to change, innovative, or are there pockets of resistance to change?
- Work with staff to address some of the organisational culture issues that can hamper success.
- Consider applying an organisational or safety culture analysis tool to help determine areas for further development such as MaPSaF.
## The University of the West of England Interprofessional Questionnaire

**Description**
The UWE questionnaire was developed for use as part of an evaluation of a main curriculum at the University of the West of England, focusing specifically on interprofessional interaction. One of the key purposes is to identify staff views on different aspects of interprofessional interaction and learning.

**Benefits**
- Helps to identify strengths and weaknesses as perceived by staff.
- Can be used to identify areas for further development.

**How is it used?**
- Staff complete the questionnaire of approximately 35 questions on the following categories:
  - communication and teamwork
  - interprofessional learning
  - interprofessional interaction
  - interprofessional relationships.
- Aim for all staff to complete it but if this is not possible, consider a sample of staff which best represents all grades and professional groups.
- Give staff a deadline for completion.
- Analyse the data and present it in graphs/charts.
- Feed back the findings to staff and the implications outlined.
- Where possible the data should be collected over a specific time period, eg, as a baseline at the start of a change process and after the change process.

**Tips for use**
- Where possible use the same staff for both the start and end questionnaires in order to be able to make a better comparison of results.
- A sample size greater than 30 will give more data and thus a fuller picture.
- Ensure staff receive prompt feedback to increase staff confidence in the process and likelihood of future engagement.

**Where to find this tool**


*With thanks to The University of the West of England*
The UWE Interprofessional Questionnaire

Communication and Teamwork Scale:
1. *I feel comfortable justifying recommendations/advice face to face with more senior people.
2. *I feel comfortable explaining an issue to people who are unfamiliar with the topic.
3. *I have difficulty in adapting my communication style (oral and written) to particular situations and audiences. (R)
4. I prefer to stay quiet when other people in a group express opinions that I don’t agree with. (R)
5. *I feel comfortable working in a group.
6. I feel uncomfortable putting forward my personal opinions in a group. (R)
7. I feel uncomfortable taking the lead in a group. (R)
8. *I am able to become quickly involved in new teams and groups.
9. I am comfortable expressing my own opinions in a group, even when I know that other people don’t agree with them.

Interprofessional Learning Scale:
10. My skills in communicating with patients/clients would be improved through learning with students from other health and social care professions.
11. My skills in communicating with other health and social care professionals would be improved through learning with students from other health and social care professions.
12. I would prefer to learn only with peers from my own profession. (R)
13. Learning with students from other health and social care professions is likely to facilitate subsequent working professional relationships.
14. Learning with students from other health and social care professions would be more beneficial to improving my teamwork skills than learning only with my peers.
15. Collaborative learning would be a positive learning experience for all health and social care students.
16. Learning with students from other health and social care professions is likely to help to overcome stereotypes that are held about the different professions.
17. I would enjoy the opportunity to learn with students from other health and social care professions.
18. Learning with students from other health and social care professions is likely to improve the service for patient/client.

Interprofessional Interaction Scale:
19. Different health and social care professionals have stereotyped views of each other. (R)
20. The line of communication between all members of the health and social care professions is open.
21. There is a status hierarchy in health and social care that affects relationships between professionals. (R)
22. Different health and social care professionals are biased in their views of each other. (R)
23. All members of health and social care professions have equal respect for each discipline.
24. It is easy to communicate openly with people from other health and social care disciplines.
25. Not all relationships between health and social care professionals are equal. (R)
26. Health and social care professionals do not always communicate openly with one another. (R)
27. Different health and social care professionals are not always cooperative with one another. (R)
Interprofessional Relationships Scale:

28. I have an equal relationship with peers from my own professional discipline.
29. I am confident in my relationships with my peers from my own professional discipline.
30. I have a good understanding of the roles of different health and social care professionals.
31. I am confident in my relationships with people from other health and social care disciplines.
32. I am comfortable working with people from other health and social care disciplines.
33. I feel that I am respected by people from other health and social care disciplines.
34. I lack confidence when I work with people from other health and social care disciplines. (R)
35. I am comfortable working with people from my own professional discipline.

Scoring

In the Communication and Teamwork Scale, statements are scored from 1 (strongly agree) to 4 (strongly disagree). (R = item score is reversed). Since it is assumed that all respondents will have experience of communication and group work at an informal level, the neutral point is omitted for this scale. The maximum score for this scale is 36, while the minimum is 9. Scores from 9–20, 21–25, and 26–36 are considered to indicate respectively positive, neutral and negative self-assessment of communication and teamwork skills.

In the other three scales, statements are scored from 1 (strongly agree) to 5 (strongly disagree), the neutral point being included. For the Interprofessional Learning and Interprofessional Interaction Scales, scores from 9–22, 23–31, and 32–45 indicate respectively positive, neutral and negative attitudes towards interprofessional learning and perceptions of interprofessional interaction (both these scales have a maximum score of 45 and a minimum of 9).

The Interprofessional Relationships Scale has a maximum score of 40 and a minimum of 8. Scores from 8–20, 21–27, and 28–40 indicate respectively positive, neutral and negative attitudes towards the respondent’s own interprofessional relationships.

*The statements marked * were taken from an existing scale used for self-assessment of communication skills by candidates applying for fast-stream entry to the Civil Service (Crown Copyright 2001), and are reproduced with the permission of the Controller of HMSO and the Queen’s Printer for Scotland.
Belbin’s team roles assessment is a questionnaire used to help identify people’s behavioural strengths and weaknesses in the workplace.

**Benefits**
- The tool is accepted and used widely within and outside health care.
- It can be used to identify the development needs of the team and the strengths and weaknesses of a team. For example, imbalances such as too many ‘shapers’ in the team resulting in a lack of clear direction and completion due to a lack of co-ordinators and ‘completer finishers’.

**How is it used?**
- A copy of the Belbin self-perception inventory questionnaire is sent to all participating staff either as a hard copy or an online link.
- If online, it is important staff have adequate access and support to access computers, etc.
- The questionnaire takes approximately 20 minutes to complete.
- Once completed, the information is submitted as advised as part of the package and a report will be generated.
- Every member of staff is given their own report and interpretation which outlines their preferred role within a team.

**Tips for use**
- Incorporate the use of the tool as part of staff training programme or workshop.
- Involve a Belbin specialist to provide expert advice and interpretation of results.
- Provide support for staff who may not agree with their identified team role profile.
- Reinforce the worth of all team members and roles so staff are reassured that their team role is as important as others.
- Consider the benefits of an organisation-wide investment in the tool for a more cost-efficient package.

**Where to find this tool**
www.belbin.com/rte.asp?id=1
### Myers-Briggs Type Indicator (MBTI)

<table>
<thead>
<tr>
<th><strong>Tool</strong></th>
<th><strong>Myers-Briggs Type Indicator (MBTI)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>The Myers-Briggs Type Indicator (MBTI) assessment is a psychometric questionnaire. It is a widely used questionnaire which measures psychological preferences. It gives indicators of staff perception of their external environment and decision-making tendencies.</td>
</tr>
</tbody>
</table>
| **Benefits** | - The tool is known to be valid and reliable.  
- The underpinning theory of the psychological type was introduced by Carl G Jung in the 1920s. |
| **How is it used?** | - Send a copy of the MBTI questionnaire to all participating staff either as a hard copy or an online link.  
- If online, it is important staff have adequate access and support to access computers, etc.  
- Once completed the information is submitted as advised as part of the package and a report will be generated.  
- Issue every member of staff with their own report and interpretation. |
| **Tips for use** | - Incorporate the tool as part of the staff training programme or workshops.  
- Involve an MBTI specialist to provide expert advice and interpretation of results.  
- Provide support for staff who may not agree with their identified MBTI profile.  
- Reinforce the benefits and worth of all team members so staff are reassured that their profile is as important as others’. |
<p>| <strong>Where to find this tool</strong> | <a href="http://www.myersbriggs.org/my-mbti-personality-type/mbti-basics">www.myersbriggs.org/my-mbti-personality-type/mbti-basics</a> |</p>
<table>
<thead>
<tr>
<th><strong>Tool</strong></th>
<th>Manchester Patient Safety Framework (MaPSaF)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Used to help identify the safety culture within a team, department or organisation using a structured framework, and developing a plan of action to improve the current culture.</td>
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</table>
| **Benefits** | - Brings staff together to review the safety culture.  
- Provides opportunity to identify the strengths and weaknesses of a team/organisation.  
- Improves communication between staff.  
- Can help meet the requirements of external bodies/national standards. |
| **How is it used?** | - It is usual practice to have a planning/design team of, for example, senior midwives, a representative from learning and development, a professional educator and a risk manager.  
- The team agrees the desired intention/objectives/goals and organises the workshop.  
- Once the programme is agreed, arrange a facilitator and a suitable venue, and provide sufficient notice for staff to attend. A lead time of around 6–8 weeks may be needed.  
- Give a brief presentation of MaPSaF at the workshop, to set the context of the workshop.  
- Invite staff to assess their team/department and then the wider organisation according to a set of safety criteria/standards to identify the current position.  
- Give staff the opportunity to discuss their assessments with the wider group in order to gain a consensus on the safety culture of the organisation.  
- Once consensus is reached, conduct a gap analysis of the current state and the desired safety culture state.  
- A SMART (specific, measurable, achievable, relevant, timed) action plan is developed from the gap analysis.  
- The action plan is managed and incorporated into a governance and safety plan.  
- Provide staff with an opportunity to evaluate the workshop/day in order to help shape future events.  
- It is important that any outputs from the day, such as action plans, concerns raised, etc, are followed through and the outcomes communicated to staff. This will increase staff confidence and the credibility of future events.  
- After approx 6–12 months run another MaPSaF workshop to determine the extent to which the team/organisation/department has progressed. |
| **Tips for use** | - Consider the group size for the workshops: too large will be difficult to facilitate, too small may not provide the breadth/scope of opinion needed.  
- Consider the preparation of the facilitator, eg, if delivering the workshop to a number of groups within the organisation ensure a consistent approach is taken.  
- Consider the skill-mix of the workshop group, eg, whether it would be beneficial to have a group of midwives, or a mixed group of midwives and obstetrician plus administrators. Consider the pros and cons of this for your organisation. |
| **Where to find this tool** | www.nrls.npsa.nhs.uk/resources/?EntryId45=59796 |

With thanks to the NPSA
# Midwifery team awayday

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description</th>
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</table>
| **Description** | The team awayday is bespoke to the specific development needs of your team of midwives. The key aim is to provide an opportunity for staff to reflect as a team on their:  
  - management/leadership styles  
  - communication skills  
  - interpersonal skills  
  - areas for further personal or department improvement.  
  The awayday should provide an opportunity for the team to take time out of their day-to-day running of the department, and reflect on their performance, leadership style and skills and agree on actions for further development. |

| What are the benefits? |  
  - Contributes to strengthening the team.  
  - Increases the confidence of team members.  
  - Enhances managerial and leadership skills.  
  - Can be used for all grades of staff. |

| How is it used? | General recommendations include:  
  - Set up a planning/design team, for example, including senior midwives, a senior manager, a representative from learning and development and where possible a representative from all staff grades.  
  - Agree the desired intention/objectives/goals and need for an awayday.  
  - Canvass the opinion and input from staff in order to help shape the programme according to their identified needs.  
  - Once the programme is agreed, arrange the speakers/presenters and a suitable venue, and provide sufficient notice for staff to attend. A lead time of around 6–8 weeks may be needed.  
  - Ensure there is opportunity for staff to evaluate the day to help shape future events.  
  - It is important that any outputs from the day, such as action plans, concerns raised, etc, are followed through and the outcomes communicated to staff. This will increase staff confidence and the credibility for future events. |

| Tips for use |  
  - Consult widely with staff to gain ideas/insight for staff development.  
  - Consider the use of external facilitators.  
  - Consider structuring the day around the ‘hot topic’ or ‘hot issues’ of the day.  
  - Ensure a varied and interactive programme to maintain interest and momentum.  
  - Include various activities and consider time out for staff to reflect or deal with urgent calls if absolutely necessary.  
  - Early planning is essential to ensure the clinical area is adequately staffed.  
  - Consider support for staff following the sessions. For example, how will you support staff who become aware of a weak area and a need for development? What kind of support mechanism is available within the clinical setting to address this?  
  - Consider how the outputs from the day will be translated to the core business of the department. For example, how will any action plan that has been agreed be put into practice and followed through in the clinical setting? It could be achieved through incorporating this into governance actions plans, for example. |

| Where to find further information | www.institute.nhs.uk/building_capability/general/leadership_home.html |
Sample awayday information

Labour ward team awayday
Leading change in practice
(Date, Venue)
09.45 – 16.00

Purpose of the day
As labour ward team members you play a key role in leading and embedding safety improvement changes in practice.

This is a day to give you some time and space to think about leadership and change. We hope that the day will give you time away from the clinical area to think with your colleagues about your role within the team. Specifically we want to focus on aspects of your role and how you work as part of the team to take on changes that contribute to improving safe practice.

Throughout the day we will be inviting you to take part in a number of different activities, exercises and discussions to give you the chance to think about, discuss and try out new approaches in relation to:

- the leadership aspects of your role
- your preferred approach to working and communicating with others
- your impact on others and how to increase your ability to influence effectively
- the opportunities and barriers you see to implementing and embedding change in practice.

We hope you will find the day interesting and stimulating. We are sure that the ideas and thinking you generate throughout the day will be invaluable for taking the safety improvement work forward in your unit.

Programme for the day
9.45 Refreshments
10.00 Welcome and introduction
10.15 Agreeing purpose and expectations
10.30 A day in the life of a labour ward co-ordinator
   Triumphs and tribulations
11.30 Break
11.50 What’s my communication style?
   How do I like to do things?
   How do I work with others?
13.00 Lunch
14.00 Introducing change and making it stick
   Working with real issues identifying:
   - opportunities and barriers for change
   - strategies to increase influencing capacity
15.40 What next?
16.00 Review and end
Sample template for the evaluation of awaydays

Maternity team awayday
Evaluation

THANK YOU for attending our awayday. We are keen to hear your comments and will use them to help us to plan future awaydays. Please complete this evaluation and leave it with one of the facilitators. Thank you again.

Overall

How would you rate the awayday overall? (Please circle the relevant number)

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Please give your reasons below for the scores:
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What did you enjoy about the day?
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What did you want more of?
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What did you want less of?
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What would you like to see featured in future awaydays?
___________________________________________________________________________________________
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### Awayday sessions

How would you rate the relevance of the following sessions? (Please circle the relevant number)

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Please give your reasons below for the scores:

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Do you have any comments on the venue, refreshments, or organisation of the event?

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**Thank you for completing this form. Your feedback is important in helping us to plan future team awaydays.**
Communication

Introduction

Effective communication is key to all clinical care, particularly in the maternity services, where there may be multiple handovers of care. Communication is effective only if the relevant information is actually made available to, and understood by, those who need to act on it.

The King’s Fund (2008)

Safer Births highlighted the importance of effective communication in the safe delivery of care. Communication issues are particularly important in maternity services where there may be multiple handovers depending on the duration of labour; transfers between home settings and hospital, often in an emergency; and referrals between midwives and obstetricians. Failure to communicate information clearly and to ensure that it has been received and understood has been highlighted as a cause of unsafe care. Improving communication was one of the key things that the maternity teams focused on in their improvement projects. Teams were encouraged to use a structured communication tool such as Situation, Background, Assessment, Recommendation (SBAR) for communication between team members. Teams also modified SBAR to improve communication at handovers.

Safer Births team projects

The maternity team at Derby Hospitals NHS Foundation Trust revived the departmental newsletter to share best practice and innovation from elsewhere in the department.

The maternity team at Mid Essex Hospital Services NHS Trust found that strengthening the communication channels and processes between the midwives and obstetricians had positive effects on their teamwork. Following discussions and consulting with staff, three structured ward rounds were introduced on the labour ward, with each participant required to contribute to the care planning. Records were kept of the discussion, plan of care and attendees. The introduction of a more dedicated handover period, both during the formal ward rounds and the bedside handovers, was considered to be a key outcome of the project.

The importance is putting the women and babies at the focus of your care, and communication affects that. You can have the best of everything in place, the best people, the best equipment, but if your communication is not right, it will affect everything...

Senior midwife

The team at Kingston Hospital introduced SBAR. They held a launch event using workshops and poster displays to communicate to a wider audience the changes around the use of SBAR and structured handovers. The team ran an awareness-raising campaign to embed the use of the tool. This involved discussions at relevant team
meetings, such as operational service meetings, multidisciplinary team meetings, and audit meetings, as well as information circulated by email.

They took a number of practical steps to improve communication at handover including minimising distractions and interruptions by diverting all phones to a central phone staffed by the midwifery unit leader during the handover, and ensuring the drug keys were given to the senior midwife who was not involved in the handover. They also relocated the whiteboard to a less busy area.

The team at Northern Devon Healthcare NHS Trust introduced the SBAR tool in both verbal and written communication at the daily ward rounds. They also designed a sticker for the women’s medical notes to be used when a request was made for a review by an obstetrician of a woman under the care of a midwife, and for those considered to be high risk where a woman was receiving shared care.

The maternity team at Barts and The London NHS Trust introduced SBAR into their labour ward, promoting its use through visual aids and stickers on all telephones. In order to embed the use of SBAR further members of the Safer Births team received training as SBAR trainers and then incorporated SBAR into training programmes.

In addition to the SBAR aspect of the project, the maternity team also reviewed the multidisciplinary labour ward handover. The team developed standards which outlined who should attend the meeting, its format – ie, the type of topics/areas to be discussed – and advice around preparing for the meeting. Once the multidisciplinary handover of care guidelines were agreed, they were embedded into staff’s roles and responsibilities.

South Warwickshire NHS Foundation Trust maternity team sought to improve communication within its maternity unit by introducing weekly emails to staff with information on the maternity wards, community and any Clinical Negligence Scheme for Trusts (CNST) issues. Important information relevant to all staff was posted throughout the staff areas including the staff toilets.

Many of the maternity teams found it difficult to quantify and qualify the extent of improvements in communication: it is important to clearly define the features of effective communication against which to benchmark current practice. What does good handover and one-to-one communication look like, whether over the phone or face-to-face? For example, how long does the interaction take, what information is exchanged, how accurate is the information and was the appropriate action recommended and taken? Effective communication is also one area of effective teamworking that can be measured using the University of the West of England (UWE) interprofessional questionnaire. Staff opinions on the effectiveness of communication and the number of clinical incidents/complaints associated with poor communication can also be used to measure improvements.

*The programme has definitely improved safety. We have seen much better communication between the two teams (midwives and obstetricians), and co-ordination during handover...We are much quicker to identify a woman or a baby at risk. We get people talking to each other that much more quickly and much more accurately, and it results in getting to the baby that much quicker...*

Consultant obstetrician
This section provides a brief overview of some of the tools used by the Safer Births maternity teams to help improve communication. The tools considered are:

- maternity newsletter
- Situation, Background, Assessment, Recommendation (SBAR) including samples of ward handovers, audits and stickers.
<table>
<thead>
<tr>
<th><strong>Tool</strong></th>
<th><strong>Maternity newsletter</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>An electronic or paper document to communicate news items or key information to a specific audience.</td>
</tr>
</tbody>
</table>
| **Benefits** | - Disseminates information effectively.  
- Can increase team interaction.  
- Useful tool to keep all staff informed of changes within the organisation.  
- Useful tool for promoting the trust. |
| **How is it used?** | - Consider the purpose, aims and objectives of the newsletter, and your target audience.  
- Ensure a good skill and professional mix of staff is invited to be part of the team responsible for developing and designing the content. The team can communicate electronically if face-to-face meetings are difficult.  
- Agree a list of contributors and a programme of topics over the course of, eg, a year so you can begin to plan and delegate tasks.  
- Agree how the newsletter will be distributed to staff.  
- It is vital you consider how to build a rapport with the readers, for example, through a question and answer section or allowing the staff to contribute their views and comments.  
- The use of pictures, etc, can be helpful to add variety to the content and text.  
- Including anonymised real-life case studies or good news stories can also add interest. |
| **Tips for use** | - Identify the most suitable key member of staff or team to take responsibility for the newsletter.  
- Agree the style and content/format.  
- Compare your plan with other well-respected newsletters.  
- Pilot a version and canvass feedback and ideas.  
- Promote the use of the newsletter to staff through committees, etc.  
- Evaluate the effectiveness of the newsletter through feedback.  
- Consider incorporating quizzes or some activity to encourage interaction with the reader.  
- Agree the most appropriate location to file/archive copies. |
<p>| <strong>Where to find this tool</strong> | For examples of newsletter templates see <a href="http://www.womenshealthcare.co.uk/safermaternitycare1.pdf">www.womenshealthcare.co.uk/safermaternitycare1.pdf</a> |</p>
<table>
<thead>
<tr>
<th>Tool</th>
<th><strong>Situation, Background, Assessment, Recommendation (SBAR)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>SBAR provides a structured method for communicating critical information about patients.</td>
</tr>
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</table>
| **Benefits** | - Contributes to effective escalation of intervention in patient care.  
- Increases patient safety.  
- Enhances handovers.  
- Can be used for urgent and non-urgent communication. |
| **How is it used?** | SBAR is used to clarify information that needs to be communicated between health care professionals by using an easy-to-remember mechanism that is used to frame the conversation.  
The health care professionals structure their conversation around:  
S – the **situation** of concern/discussion  
B – the **background** of the client/patient under review  
A – an **assessment** of the client's/patient's condition  
R – the **recommendations** for immediate and future care. |
| **Tips for use** | - Consult widely with staff to gain co-operation to use the tool.  
- Use SBAR stickers to act as prompts.  
- Structure the ward documentation around the SBAR model.  
- Structure the handovers around the SBAR model.  
- Ensure SBAR is incorporated in teaching sessions and educational programmes/training.  
- Ensure SBAR is incorporated into the communication/operations policy/strategy. |
| **Where to find this tool** | Information on SBAR can be found in a number of places including:  
www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/sbar__situation__background__assessment__recommendation.html |
**Sample: SBAR tool for ward handovers**

*(Can be adapted for use on the ward whiteboards)*

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<tr>
<th>Name</th>
<th>Situation</th>
<th>Background</th>
<th>Assessment</th>
<th>Recommendation/Plan</th>
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</thead>
<tbody>
<tr>
<td>Location</td>
<td>Gravida</td>
<td>Obstetric history</td>
<td>MEOWS/MEWS</td>
<td>Tests</td>
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<td>Parity</td>
<td>Medical history (include allergies)</td>
<td>CTG</td>
<td>Treatment (timeframe)</td>
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<td>Reason for admission</td>
<td>Social (eg, child protection)</td>
<td>Blood/urine results</td>
<td>Discharge planning</td>
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<td>Type of delivery and why</td>
<td>Fluid balance</td>
<td>Information leaflets</td>
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<td>Mental/medical/obstetric health concerns</td>
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<td>Prompt: 1</td>
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</tbody>
</table>
### Sample: SBAR handover audit tool

<table>
<thead>
<tr>
<th>Key questions</th>
<th>Recording</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of handover?</td>
<td>Ward office</td>
</tr>
<tr>
<td></td>
<td>Manager’s office</td>
</tr>
<tr>
<td></td>
<td>At bedside</td>
</tr>
<tr>
<td></td>
<td>Other location</td>
</tr>
<tr>
<td>Did the location facilitate handover?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Method of handover</td>
<td>SBAR approach clearly identified and used.</td>
</tr>
<tr>
<td></td>
<td>Structured approach without using SBAR.</td>
</tr>
<tr>
<td></td>
<td>Unstructured approach with irrelevant information or missed information.</td>
</tr>
<tr>
<td>Was handover time interrupted?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Under the circumstances was the interruption appropriate?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Comment</td>
<td></td>
</tr>
</tbody>
</table>

With thanks to Northern Devon Healthcare NHS Trust 2011
### Sample: SBAR sticker template

**SBAR - Situation, Background, Assessment, Recommendation**

**escalation proforma**

Please use this proforma to structure your handover & place in notes

<table>
<thead>
<tr>
<th><strong>Dr’s name:</strong></th>
<th><strong>Designation:</strong></th>
<th><strong>Date:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MW name:</strong></td>
<td><strong>Ward:</strong></td>
<td><strong>Time:</strong></td>
</tr>
<tr>
<td><strong>Patient’s name:</strong></td>
<td><strong>ME(O)WS:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Reason for call &amp; concern:</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Admission date & time:**

<table>
<thead>
<tr>
<th><strong>With:</strong></th>
<th><strong>G P</strong></th>
<th><strong>Gestation:</strong></th>
<th><strong>Type delivery:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FHR/CTG:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Their condition has changed since:</strong></td>
<td>(hrs)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Last obs were**

<table>
<thead>
<tr>
<th><strong>RR</strong></th>
<th><strong>HR</strong></th>
<th><strong>BP</strong></th>
<th><strong>Temp</strong></th>
<th><strong>SaO2</strong></th>
<th><strong>AVPU</strong></th>
<th><strong>Pain score</strong></th>
<th><strong>Urine output</strong></th>
<th><strong>mls/hr</strong></th>
</tr>
</thead>
</table>

I need you to  by when:

What would you like done in the meantime?

Ask receiver to repeat key information back to you to ensure understanding

---

With thanks to Northern Devon Healthcare NHS Trust 2011
Introduction

The Safe Births report stated ‘Staff that work together must train together’. This approach not only helps staff to recognise their unique but complementing roles but also helps to remove barriers to effective communication and teamwork. The Safe Births report recommended the use of simulation-based training, which assesses clinical skills as well as communication and teamworking. Skills and drills training within the staff’s own unit would be most beneficial.

At the core of a safe team is a well-trained and skilled workforce. This could not be more essential in identifying and responding to emergency situations within maternity. Both midwives and junior doctors can often feel ill-equipped or lacking in confidence when presented with an emergency situation in the hospital or the community. Indeed, with childbirth taking place at home, in midwifery-led units, or out of hours, staff need to be effectively prepared for any eventuality.

Safer Births projects to improve staff training

The Safer Births maternity team at Ipswich Hospital NHS Trust (IHT) was committed to supporting community midwives in home deliveries through a series of training programmes and initiatives. Home birth deliveries are often in high demand. However, it requires the skills and confidence of community midwives to not only deliver babies unaided in such a setting, but to recognise early on if the labour requires medical attendance or intervention. While a large number of home births are without complications, and are safe, a clinical incident in the home can have dire consequences for mother and baby.

The aim of the Safer Births project delivered by the team at IHT was to strengthen the confidence and skill of the workforce around home births. Improving teamworking, in particular communication, between the hospital and community teams, was identified as a key issue at an awayday for senior midwives from both teams. This had a positive outcome, helping to clarify roles and providing networking opportunities. More importantly, it created a sense of teamwork instead of a ‘them and us’ culture. A similar team approach was also used to update the emergency guidelines. The obstetric emergency training programme was revised and developed further to include the use of Situation, Background, Assessment, Recommendation (SBAR), and emergency scenarios delivered within the community setting were acted out in training. The improvement in training has led to increased confidence among community midwives and improved teamworking.

The maternity team at South Warwickshire NHS Foundation Trust developed training for labour ward co-ordinators and reviewed and developed the monthly multidisciplinary clinical incidents meeting. Although lessons learned from these meetings were published in their bimonthly newsletter, similar clinical incidents continued to occur. Following consultation with staff, they changed the format of the
meetings to include more interaction through the use of structured questions, as well as clearly defined learning outcomes. In addition, junior staff were specifically targeted to attend and take part.

Other maternity teams within the Safer Births programme implemented different initiatives to improve the skills of staff within labour wards, for example, cardiotocography (CTG) training programmes. Northampton General Hospital NHS Trust reviewed staff training around CTG interpretation. This included the redesign of prompting stickers to help interpret CTGs. The maternity team at Medway NHS Foundation Trust introduced a new multidisciplinary CTG training day which included a pre-course training manual and an assessment test at the end. North Middlesex University Hospital included CTG training on all emergency skills and drills days. Mid Cheshire Hospitals NHS Foundation Trust reviewed and developed its existing buddy system so more experienced midwives work with junior midwives to review CTG recordings and the resulting course of action. This helped reduce CTG misinterpretation.

Medway NHS Foundation Trust introduced a new multidisciplinary training package called Practical Obstetrics Multi-Professional Training (PROMPT), in conjunction with other tools such as SBAR and Modified Early Obstetric Warning Score (MEOWS) to create a more realistic representation of an emergency. Such joint training programmes can help to break down barriers between professional groups and departments, and provided a greater insight into professional cultures and pressures, in a non-threatening environment.

### Key points for improving training

- Undertake a training needs analysis for all key staff groups.
- Review current training including schedules and content to make the most of opportunities for joint training.
- Adopt a multidisciplinary approach to reviewing, developing and delivering training programmes.
- Use lessons gained from clinical incidents to aid and inform training sessions.
- Embed tools used in practice such as SBAR and MEOWS into training sessions.
- Develop a framework around training to support staff and address poor performance or poor attendance.

This section provides a brief overview of some of the tools used by the Safer Births maternity teams to help improve training. The tools considered are:

- PRactical Obstetrics Multi-Professional Training (PROMPT)
- cardiotocography (CTG) online training programme
- see also 'Midwifery team awayday' on page 28 as this tool can be used for both teamworking and training.
<table>
<thead>
<tr>
<th>Tool</th>
<th>PRactical Obstetrics Multi-Professional Training (PROMPT)</th>
</tr>
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<tbody>
<tr>
<td><strong>Description</strong></td>
<td>The PROMPT course is a multi-professional training package that enables midwives, obstetricians and anaesthetists to implement a fully evaluated obstetric emergencies course within their own maternity units.</td>
</tr>
</tbody>
</table>
| **Benefits** | - Provides a framework for multi-professional training programmes.  
- Can be used for developing teamwork.  
- Endorsed by professional bodies such as the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists.  
- Its use is in line with national recommendations from bodies such as the National Health Service Litigation Authority (NHSLA), The King’s Fund and CMACE.  
- It is used worldwide, eg, in the United Kingdom, the United States, Italy, Australia, New Zealand, Hong Kong, Singapore, Fiji. |
| **How is it used?** | - It includes fully evaluated obstetric emergencies in the format of interactive drills and workshops for use in maternity units as part of a training programme.  
- The package includes manuals, a 'train the trainer' course, and CD of lectures/interactive lectures.  
- A follow-up support package is available and includes email support and 12 months’ telephone support.  
- The package is delivered as part of the ongoing training programme for staff.  
- The structure of the day can be formatted around the PROMPT material.  
- Staff must be given the opportunity to evaluate workshop effectiveness.  
- Areas identified for further improvement can be included in future workshops. |
| **Tips for use** | - Consult widely with staff to get co-operation to attend and use materials.  
- Ensure PROMPT is incorporated in teaching sessions and educational programmes/training. |
<p>| <strong>Where to find this tool</strong> | <a href="http://www.prompt-course.org">www.prompt-course.org</a> |</p>
<table>
<thead>
<tr>
<th>Tool</th>
<th>Cardiotocography (CTG) online training programme</th>
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<tr>
<td><strong>Description</strong></td>
<td>Continuous cardiotocography (CTG) is a form of electronic fetal monitoring for assessment during labour. A growing number of organisations are developing training tools to equip staff to interpret the CTG traces. These training tools are being made available online. The website package provides a structured and flexible method for training staff in monitoring and interpreting CTG recordings.</td>
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</table>
| **Benefits** | - Enhances CTG interpretation and improves staff performance and practice.  
- Real-life cases are often used.  
- Staff receive feedback on their actions.  
- Administrators can set assessments with pass marks. |
| **How is it used?** | - The designated administrator is issued with a clear start-up guide specific to the type of package used.  
- The administrator includes the trainees/users into an account by adding their names and email addresses and activates their accounts.  
- Users are sent their login details.  
- The administrator assigns the trainees into groups based on either their skillsets or their roles, eg, all midwives, junior doctors. This is useful for assigning CTG tests or practice cases.  
- The administrator monitors the uptake of the programme and the progress of staff, identifying any areas for further training for individual staff or groups of staff. |
| **Tips for use** | - Give staff briefing sessions before online training to allay anxieties and provide an opportunity to ask questions.  
- Develop a performance framework around its use, eg, pass marks, and actions to be taken if staff perform below the pass mark, eg, further tutoring, coaching or supervision.  
- Consider a team approach to the programme – in practice it is the norm for CTG interpretation to take place as part of a team intervention.  
- Incorporate CTG online training into the training schedule.  
- Appoint a designated administrator who has the authority and respect of staff – they will have access to staff results, etc.  
- Consider appointing support staff to help with monitoring uptake, and sending reminders, etc, to the staff.  
- Ensure there is IT support to address any online/technical difficulties staff may have. |
| **Where to find this tool** | Information on CTG training is available from a number of places including:  
www.rcog.org.uk/stratog/elfh-resources  
www.e-lfh.org.uk/projects/efm/index.html |
Introduction

The Safe Births inquiry learned that in some units recommended guidelines were not available, used or followed. Furthermore, staff felt overwhelmed by the volume of guidelines and information issued nationally some of which were not considered useful. In addition, staff were frustrated at multiple data collecting systems, which were time consuming and took them away from giving direct patient care. The inquiry recommended a more streamlined approach to information and guidelines, with short summaries of key recommendations, and a small set of reliable information measures critical to safety. Information and guidance provided to staff should facilitate a structured and systematic approach to care to help reduce variations in practice and standards. Ultimately this is likely to have a positive impact on quality of care provided to mothers and babies.

Safer Births projects to improve information and guidance

The maternity team at Derby Hospitals NHS Foundation Trust reviewed and amended key documents in order to promptly record accurate information on the mothers’ care and conditions. The unit introduced a new high-dependency unit (HDU) chart designed for discharge information, and antenatal information was included in the neonatal records and plans to ensure seamless care of the neonates.

_The importance of sharing manageable amounts of information with staff cannot be overemphasised in order to improve local performance._

Senior midwife

The North Middlesex University Hospital also introduced guidelines and tools including the Modified Early Obstetric Warning Score (MEOWS) chart. In addition, the team developed robust patient records to improve record-keeping. The process was strengthened by practice audits to determine compliance with the documentation. Poor practice, as well as good, was recognised and communicated to staff and their respective supervisors of midwives.

Mid Cheshire Hospitals NHS Foundation Trust implemented the intrapartum scorecard and the birthrate acuity tool and found these provided an objective measurement of workload, staffing, complexity of cases and risk; the team were able to base their new escalation policy on information from these tools. In the event of a major clinical incident it provided an accurate analysis of concurrent levels of staffing, activity and risk. A similar system has now been employed within the paediatric unit. In addition, they found that a robust governance structure, which ensured effective dissemination of information and guidance, was important.

Other maternity teams, for example, Northampton General Hospital, implemented MEOWS, and found this effective in managing and monitoring the condition of mothers. The team also implemented the Maternity Dashboard and found it beneficial to monitoring improvement in care delivery.
Ipswich Hospital NHS Trust reviewed and standardised the equipment carried by community midwives to improve the mothers’ pathway between the community and hospital. By eliminating superfluous and unnecessary items, variation in practice was reduced and ultimately the likelihood of delayed response in the event of an emergency.

One concern raised by a number of the maternity teams was the danger of ‘re-inventing the wheel’, hence the opportunity to network with other units was invaluable as it allowed the sharing of tools and documentation and prevented staff from having to start from scratch.

*Networking was the greatest thing to get new ideas and incorporate that into our guidelines...*  
— Midwife

---

### Key points for improving information and guidance

- Undertake a review of current information and guidance and determine whether they are fit for purpose.
- Prioritise the information and guidance to be reviewed/updated according to government/regulators’ demands, recommendations from national bodies, and feedback from staff.
- Approach other maternity units/organisations to share and learn from their experience and guidance.
- Review training to ensure it includes changes in documentation/information.
- Adopt a multidisciplinary approach to reviewing documents.
- Regularly audit staff compliance to new guidance/information and share best practice/address poor performance.

---

This section provides a brief overview of some of the tools used by the Safer Births maternity teams to help improve information and guidance. The tools considered are:

- equipment checklist for community midwives
- MEOWS
- Maternity Dashboard
- intrapartum toolkit
- management of postpartum haemorrhage guidelines.
### Equipment checklist for community midwives

#### Delivery bag equipment
- Delivery pack
- Delivery instrument pack
- Suture pack
- Separate stitch holder
- Sterile and non-sterile gloves
- Green plastic aprons x 2
- Lubricating jelly sachets/tube
- Torch
- Amnihook x 2
- In/out catheter x 2
- Vicryl rapide x 3
- Incontinence pads x 12
- Large yellow clinical waste bags x 2
- Small clinical waste (placenta) bags x 2
- Pack of 5 swabs (x-ray detectable) x 4
- Entonox mouth pieces x 2
- Spare cord clamps
- Mucous extractor
- Ambubag (single use)
- #01 and #02 face masks
- 00 & 01 guedel airways
- 500mls normal saline
- Blood bottles – blue, small red, green, brown x 2 each
- Needles for venepuncture

#### Emergency box
- Chloraprep one-step
- Indwelling catheter and bag
- Tourniquet x 2
- IV cannulae 16g x 2
- 5ml saline flush
- Syringes 5ml x 1 (for flush)
- Syringes 2ml and green needles x 4
- 3 way connector (Protect A-set)
- IV giving set x 2
- IV line labels x 2 (white)
- Drug additive labels x 2
- Tegaderm dressing x 2
- Transpore tape
- Syntocinon 10iu x 4 amps
- 1 x 500ml 0.9% sodium chloride
- Small gauze pack
- Plastic bag
- Incontinence pad
- Blood bottles – blue, small red, green, brown x 1 each
- Gloves
- Misoprostol 200mcgs x 5 tablets

Note: Syntocinon must be replaced according to hospital policy.

Also need crib sheets and paperwork pack.

---

**Drug box**
- Syntometrine 1ml x 2 amps
- Syntocinon 5iu x 2 amps
- Lignocaine 1% x 10mls x 2
- Vitamin K 0.2% x 2 amps and syringes
- 1, 2, 5 & 10ml syringes x 2 of each
- Green and orange needles x 4 of each
- Sterets
- Drawing-up needles
- Entonox cylinder x 2 (in cases)
- Oxygen cylinder x 1 (in case)
- Meter head + spare rubber washer

Note: Syntocinon and syntometrine must be replaced according to hospital policy.
### Equipment checklist for community midwives

**Bag contents**

**Equipment**
- Sphygmomanometer
- Stethoscope
- Sonicaid and gel
- Baby weighing scales (between 2)
- Measuring mat
- Tape measure
- Scissors
- Digital thermometer and sheaths
- Aprons
- Multistix
- Syringes, needles, sterets, plasters
- Blood bottles
- MSU bottles
- Swabs and appropriate medium
- Sharps container
- Lancets

**Documentation**
- Antenatal notes
- Referral forms
- Leaflets
- Conversion charts
- Path forms/TST forms
- Neonatal screening forms
- Telephone list

**Documents**

**Home birth pack**
- Blue labour notes (MRO 996)
- Post-natal booklet (MRO 1772)
- Birth notification (DMI 04445-10) plus envelope
- Baby record sheet (MRO 1760)
- Midwifery report sheet (MRO 093)
  - Yellow – Community office [name of ward]
  - Blue – Health visitor (on discharge)
  - White – GP (after delivery)
- Post-delivery thromboprophylaxis form (MRO 1652)
- Newborn blood spot card and plaster (NHS)
- ‘How to contact a midwife’ (DMI 6427-09)
- Information for women – cot death, register a birth/ post-natal exercises breastfeeding support

**Additional documents**
- Parent-held child record (red book)
- New baby guide
- Meconium leaflet

*Check presence and expiry dates of all equipment regularly and after each use.*

*Record on monthly returns form and return to team leader/ manager each month.*
<table>
<thead>
<tr>
<th>Tool</th>
<th><strong>Modified Early Obstetric Warning Score (MEOWS)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>MEOWS provides a structured method for monitoring the women's condition and identifying deterioration.</td>
</tr>
</tbody>
</table>
| **Benefits** | Recommended by NICE CG50.  
A simple scoring system which can be calculated using parameters measured for all acute patients. |
| **How is it used?** | Observations are taken and recorded on the maternity chart, for example, respiratory rates, oxygen saturation, heart rate, temperature, blood pressure, neurological status, AVPU (alert, voice, pain, unresponsive), urine output, pain scores.  
The scores are totalled and the doctor told if the pre-determined trigger scores are reached. |
| **Tips for use** | Consult widely with staff to gain co-operation.  
Consider the guidelines on when to use and when not to use the tool.  
Incorporate it as part of a maternal observation chart for specific women.  
Consider developing its use alongside an escalation policy.  
Incorporate it into teaching sessions and educational programmes/training. |
| **Where to find this tool** | Information on MEOWS is available in a number of places including:  
www.oaa-anaes.ac.uk/content.asp?ContentID=356  
www.evidence.nhs.uk/search?q=Early%20Warning%20Scores%20for%20Maternity  
<table>
<thead>
<tr>
<th><strong>Tool</strong></th>
<th><strong>Maternity Dashboard</strong></th>
</tr>
</thead>
</table>
| **Description** | The Maternity Dashboard is a clinical performance and governance scorecard. Broadly four categories are suggested:  
- clinical activity  
- workforce  
- clinical outcomes  
- risk incidents/complaints or patient satisfaction surveys.  
The primary objective of using a Maternity Dashboard is to monitor various aspects of clinical governance at the same time, so corrective action can be taken when there is deviation from expected performance. |
| **Benefits** |  
- Shown to be beneficial in monitoring performance and governance.  
- Helps to identify patient safety issues in advance so prompt and appropriate action can be taken to ensure woman-centred high quality, safe maternity care.  
- Can be used to assure the board of the quality and safety of maternity units.  
- Has been recommended by the Chief Medical Officer. |
| **How is it used?** | Maternity units set local goals for each of the parameters to be monitored, as well as upper and lower thresholds.  
A suggested approach is to use the traffic light system.  
**Green:** when the goals are met (that is, within the lower threshold).  
**Amber:** when the goals are not met (that is, above the lower threshold but still within the upper threshold). If a parameter is in amber, it indicates that action is needed to avoid entering the red zone. When a parameter falls into the ‘amber’ zone, action should be taken to restore it with minimal resources.  
**Red:** when the upper threshold is breached. If a parameter enters the red zone then immediate action is needed from the highest level to maintain safety and to restore quality. Red in any of the parameters requires very close scrutiny and often an immediate action or intervention; for example, a red in ‘Erb’s palsy secondary to shoulder dystocia’ may require a review of the cases to identify any training needs. |
| **Tips for use** | Consult widely with staff to gain co-operation and ‘buy in’.  
Consider the guidelines on when to use and when not to use the tool.  
Incorporate it as part of the department’s governance/quality meetings.  
Develop its use alongside an escalation policy.  
Consult with senior managers/board members to ensure it meets the needs of the board.  
Enlist the support of the IT department to provide expert input into its development.  
Consider involving individuals who can co-ordinate collection of monthly data.  
It is important to crosscheck the data to ensure accuracy; for example, the operation book in the operating theatre could be checked to verify the number of caesarean sections for the month.  
The Maternity Dashboard should be continuously updated and data compared on a month-to-month basis. |
With thanks to the Royal College of Obstetricians and Gynaecologists |
### Intrapartum toolkit

**Description**
The tool has been developed by the National Patient Safety Agency to improve safety within maternity by providing guidance and resources to support improvement in monitoring and investigating incidents.

**Benefits**
The intrapartum toolkit gives access to online resources which can support maternity units/team to:
- undertake robust investigation using root cause analysis into patient safety incidents
- improve monitoring of patients’ conditions
- improve safety in clinical practice
- describe staffing activity levels
- feed information gathered on labour ward activity and staffing into the Royal College of Obstetricians and Gynaecologists (RCOG) dashboard.

**How is it used?**
- The toolkit can be downloaded from www.nrls.npsa.nhs.uk/resources/collections/intrapartum-toolkit/?entryid45=66358. It includes resources on:
  - the intrapartum scorecard and data collection tool
  - placenta praevia after caesarean section care bundle
  - intrapartum-related perinatal deaths review pro forma
  - root cause analysis course.
- Staff may need training and support to access and implement elements of the toolkit if they are unfamiliar with online tools and computers.

**Tips for use**
- Consider including the toolkit as part of a wider maternity governance framework.
- Ensure staff are trained on how to access the online material.
- Liaise with the IT department for support around use of the tools online.
- Consider a multidisciplinary approach to the implementation of the care bundles to ensure ‘buy in’ from all key staff.
- Consider the involvement of data analysts to help support with the use of ‘data’ run charts, etc, where these may be new to staff.

**Where to find this tool**
www.nrls.npsa.nhs.uk/resources/collections/intrapartum-toolkit/?entryid45=66358
www.nrls.npsa.nhs.uk/resources/collections/intrapartum-toolkit/
### Tool: Prevention and management of postpartum haemorrhage – RCOG guidelines

**Description**

The Royal College of Obstetricians and Gynaecologists' (RCOG) guidelines on the prevention and management of postpartum haemorrhage (PPH) are part of its green-top guidelines series. They were first developed in May 2009 and have since been revised twice, most recently in April 2011.

The primary objective of these guidelines is to support staff to provide care that is evidence-based.

They cover:
- the definition of PPH
- keys to the prevention of PPH
- an overview of risk factors for PPH
- management issues such as fluid replacement, communication, resuscitation, the decision for hysterectomy, etc.

**Benefits**

- Equip staff to recognise PPH, and take actions for its prevention and management.
- Increases the confidence and knowledge of all members of the maternity team.
- Is underpinned by an in-depth literature review.
- Updated regularly.
- Can meet the requirements of external bodies/national standards.

**How are they used?**

- The guidelines are available from the RCOG’s website.
- They stress the importance of applying clinical judgement on each situation.
- They include a pro forma for a PPH chart and a flowchart which summarises the key steps for managing a major PPH.

**Tips for use**

- Ensure the guidelines are accessible to staff.
- Print copies for staff that can’t access the online version.
- Consult widely with staff to get co-operation for the use of the guidelines.
- Consider a multidisciplinary approach to the implementation of the guidelines to ensure ‘buy in’ from all key staff.
- Monitor for updates.
- Consider presenting/displaying the flowchart in clinical areas.
- Incorporate it into teaching sessions and educational programmes/training.

**Where to find this tool**


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Introduction

The Safe Births inquiry highlighted that while staffing levels are important, how staff are deployed is crucial to ensuring a safe service. Maternity staff expressed concerns that the lack of available staff with the right skills and experience was a threat to safety.

The King’s Fund study on staffing in maternity units (Sandall et al 2011), which looked at the available evidence on skill-mix, found that the evidence linking outcomes with absolute staffing levels in maternity is mixed; the skill-mix of available staff and the way they are deployed was more important than absolute numbers. It made a number of recommendations including:

- midwife-led models of care should be deployed across the service for low- and medium-risk women, with a view to providing a more cost-effective service that releases obstetricians to focus on women with more complex needs
- nurses could be used more widely to free up the time of midwives and doctors
- further guidance is needed to establish appropriate levels of training and supervision of maternity support workers
- the deployment of both midwives and doctors in out-of-hours services should be reviewed to ensure sufficient experienced and senior staff
- continuity of care should be encouraged. The use of continuous lay support during labour, in addition to clinical care, could improve women’s experiences and should be further explored. Some evidence suggests that continuity of midwife support delivered via a caseload model of care can have better outcomes
- there should be greater use of non-clinical staff to do administrative or clerical work, freeing up clinical staff to focus on patient care.

Discussions during the inquiry identified two areas of concern: leadership at board level and leadership at unit level. The consequence of a lack of leadership at either or both levels, and difficulties getting the board to engage with maternity services, contributed to feelings of disenfranchisement and disaffection among staff.

The lack of experienced midwives who could take on management positions and leadership roles was a particular concern, with many senior midwives reaching retirement age.
Safer Births projects to improve staffing and leadership

The maternity team from Northampton General Hospital NHS Trust identified the need to strengthen their midwife recruitment process to combat low staffing levels and a lack of the appropriate skill-mix. They drew up a new recruitment process with robust shortlisting criteria and assessment. The interview questions were modified to include clinical scenarios and cardiotocography (CTG) interpretation. The process was streamlined by restricting the staff involved to help reduce variation. The team created a practice development team to provide the additional training and support for new staff members.

The aim of Stockport NHS Foundation Trust’s Safer Births project was to improve safety and outcome for mothers and babies out of hours. Before joining the programme the maternity department had introduced a resident consultant to provide an out-of-hours onsite consultant presence within the labour ward. The Safer Births programme gave them the opportunity to formally evaluate this initiative, its impact on safety and quality indicators. This also involved reviewing and re-evaluating the roles of other key professionals to ensure improved joint working. A key benefit from the project was senior clinical leadership providing training opportunities for junior medical staff.

Some sites implemented tools to help determine staffing levels needed in relation to clinical activity.

The maternity team at Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) introduced the Birthrate Intrapartum Acuity® System (BRIPAS) into their clinical area, and used the data and findings to develop their escalation policy. In addition, BRIPAS provided objective data to assess the level of staffing, activity and risk to women, and determine whether additional staff were needed.

> The acuity tool had a great impact because everyone likes numbers because they are objective. Staff liked it because it gave them a voice – they could demonstrate why it was busy and how busy it was. Management was impressed because it provided objective data...

Senior manager

The maternity team at Stockport NHS Foundation Trust trialled the intrapartum scorecard. The tool enabled the team to record intrapartum activity and the number of midwives available for intrapartum care. In addition to the correct number of staff to meet the activity of the clinical area, the organisational culture is also key for a safe environment and care.

Early on in the Safer Births project, the maternity department at MCHFT identified the need to develop the infrastructure and culture of the unit as paramount to the success of any project. The development of a culture conducive to change and innovation, and a governance framework to support it, was the focus of their project. They ensured a collaborative approach to address issues such as reducing postpartum haemorrhage, implementing the National Patient Safety Agency (NPSA) intrapartum scorecard and Birthrate Intrapartum Acuity® System.

The in-depth consultation with staff, cascading of information to all levels of staff, as well as the use of the governance framework to help the decision-making process, have been instrumental to the team’s progress.

At times the team found that major ‘culture change’ issues could potentially result in major resistance from pockets of staff. However, with strong working relationships and support of line management, these challenges were overcome.
Finally, leadership is vital to drive forward improvement and sustain changes. One area of focus was the development of the labour ward co-ordinators through a series of bespoke midwifery development workshops/awaydays. A number of the sites provided a range of these workshops with the support of the Safer Births programme, and reported an improvement in staff confidence and team working.

Leadership was evident at all levels of the organisation. The inquiry had heard that maternity services were often a low priority for boards and that many board members did not understand the particular safety issues facing maternity services. Sites participating in the Safer Births programme engaged with their board-level sponsors and reported to them regularly. For example, the chief executives at South Warwickshire NHS Foundation Trust and MCHFT had high profiles within the Safer Births project, supporting staff and midwife awaydays.

This [attendance by the chief executive at the midwives awayday], made staff feel valued and emphasised the importance given to the day...

Midwife

This section provides a brief overview of some of the tools used by the Safer Births maternity teams to help improve staffing and leadership. The tools included are:

- Birthrate Intrapartum Acuity® System (BRIPAS)
- midwifery leadership development workshop.
<table>
<thead>
<tr>
<th><strong>Tool</strong></th>
<th><strong>Birthrate Intrapartum Acuity® System (BRIPAS)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>BRIPAS is a ‘predictive/prospective’ tool which enables assessment of real time workforce planning within the delivery suite using clinical indicators. Acuity is a measure of the intensity of need arising from the number and clinical status of women and the infants during labour and delivery.</td>
</tr>
<tr>
<td><strong>What is its purpose?</strong></td>
<td>BRIPAS enables health care workers to classify women admitted to the delivery suite in order to identify the acuity or demand and allocate the appropriate ratio of midwife time to meet staffing standards.</td>
</tr>
</tbody>
</table>
| **Benefits** | ■ It is informed by clinical indicators and enables a more proactive and prospective approach to management of risk factors and better use of staffing within the delivery suite, as well as informing workforce planning within the wider midwifery service.  
■ BRIPAS is based on the Birthrate Plus® tool which has been cited by national bodies such as the Royal College of Obstetricians and Gynaecologists, and the Royal College of Midwives. |
| **How is it used?** | ■ Regular clinical assessments take place, eg, every two or four hours.  
■ Staff make clinical, resource management and workforce decisions based on these hour-by-hour assessments.  
■ Classification in the higher need categories is an indicator for an increased ratio of midwife to women. |
| **Tips for use** | ■ Consult widely with staff to gain co-operation and ‘buy in’ as some staff may consider the data collection labour intensive.  
■ Consider incorporating this into the policies and guidelines within the department, with particular reference to the escalation policy.  
■ Consider the impact this may have on wider workforce issues and consider involving business/human resources managers in the review of the findings.  
■ Ensure BRIPAS is incorporated in teaching sessions/induction days and educational programmes/training. |
| **Where to find this tool** | The Acuity System is only available from Birthrate Plus® www.birthrateplus.co.uk  
For further information on the use, score system, etc, contact Marie Washbrook: mariewashb@aol.com |

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### Midwifery leadership development workshop

#### Description
The key aim is to provide an opportunity for the staff to develop new or existing clinical or non-clinical skills such as managerial leadership. The workshop will be tailored to the specific development needs of the midwifery team. The workshop should provide an opportunity for the clinical leaders to take time out of their day-to-day running of the department, and focus on their personal and professional leadership development.

#### Benefits
- Contributes to strengthening the leadership team.
- Increases the confidence of team leaders.
- Enhances managerial and leadership skills.
- Can be used for all grades of clinical leaders.
- Useful for retaining staff.
- Can help to inform staff personal development plans.

#### How is it used?
General recommendations include:
- develop a planning/design team, eg, senior midwives, a representative from learning and development and a professional educator
- agree the intention/objectives/goals and need for the workshop
- if possible canvass the opinion and input from staff to help shape the programme according to identified needs
- organise the speakers/presenters, suitable venue, and provide sufficient notice for staff to attend. A lead time of around 6–8 weeks may be needed
- ensure there is opportunity for staff to evaluate the workshop to help shape future events.
- It is important that any outputs from the day, such as action plans, concerns raised, etc, are followed through and communicated to staff. This will increase staff confidence and the credibility for future events.

#### Tips for use
- Consult widely with staff to gain ideas/insight for staff development.
- Consider using external facilitators.
- Consider structuring the day around current hot issues.
- Ensure a varied and interactive programme to maintain interest and momentum.
- Include various activities and consider time out for staff to reflect or deal with urgent calls if absolutely necessary.
- Consider ongoing support for staff, eg, how will you support staff who are made aware of their weakness and need for development? What kind of support mechanism is available within the clinical setting?
- Consider whether the workshop will be accredited or become part of personal development plans.
- Consider how the outputs from the day will be translated to the core business of the department. For example, where an action plan has been agreed by the staff as part of the workshop, how will that be put into practice and followed through in the clinical setting? This can be achieved through incorporating it into governance actions plans, for example.

#### Where to find this tool
[www.institute.nhs.uk/building_capability/general/leadership_home.html](http://www.institute.nhs.uk/building_capability/general/leadership_home.html)
General service improvement tools

Introduction
The aim of the Safer Births improvement programme was to support maternity teams to improve the safety of care provided to mother and babies during labour.

The programme allowed the maternity teams to develop their projects according to local needs and challenges. It built on their existing safety initiatives, such as those arising from regulatory requirements and national standards as outlined by the Care Quality Commission, NHS Litigation Authority and Royal Colleges.

Most clinical teams and frontline staff grapple with the challenges of improving services while ensuring service and care delivery are uninterrupted. Often it falls to clinical staff to balance improvement work and their ongoing clinical commitments. The need to provide tested and tried solutions, which can be applied in a rapid and cost-effective way, is vital to improving the quality and safety of care. A range of general service improvement tools can be used to support the implementation of many local improvement projects, whatever their aim. This section includes some of the tools used within the Safer Births improvement programme and others which are recommended.

Safer Birth projects’ use of service improvement tools

In order to review the mother’s journey through the triage unit, the maternity team at Northampton General Hospital NHS Trust did a process-mapping exercise to identify areas for improvement. The outcome has been key to informing the business case for further redevelopment funding.

Most of the Safer Births maternity team leads felt confident in articulating the goals and objectives for the projects. However, a common finding was the goals were often too broad, vague, immeasurable or unachievable for the timescale and resources allocated, for example a goal to ‘reduce the number of stillbirths’, or to ‘reduce the maternal deaths’. Most of the trusts revised their project goals. The development of robust action plans, with clear measures of success, signposting, timelines, and owners for actions are essential. This enables a focused approach and a well-defined remit.

We knew what we wanted; we worked through the process… we knew our aim. The action plan was useful because we could work through it methodically.

Consultant

A number of the maternity teams were experiencing simultaneous multiple changes across their organisation, resulting in staff feeling overwhelmed and disengaged. In order to make change seem more achievable, some found it helpful to use an improvement methodology such as PDSA cycles (plan, do, study, act). This allows teams to ‘road test’ ideas on a small scale before widespread implementation.
On reflection we found that smaller changes were far easier to make and embed in clinical practice, eg, the CTG [cardiotocography] stickers were a great success. In contrast, changes like the redevelopment of the triage/assessment area we found to be an onerous task and it met with staff resistance.

Senior midwife

Never underestimate the impact even the smallest change can have.

Senior midwife

Sustainability of an improvement project can be a challenge if it has not been planned at the start of the project. Teams might find the sustainability tool useful to identify the areas where further work is needed to ensure the change process is implemented and becomes embedded in the organisation. Every organisation needs to be aware of ‘hotspots’ of resistance to change and proactively engage with such staff groups or clinical areas.

The maternity teams tended to base their judgement regarding the effectiveness/outcome of their improvement on anecdotal evidence and staff perceptions. Only a small number of teams were able to track specific indicators such as reduction in staff sickness levels, caesareans sections, and clinical incidents as signs of improvements. All the teams recognised the importance of having clear improvement measurements to help quantify any improvements made but many found this difficult to achieve in practice.

The data [collected as part of the improvement measurements] provided motivation and we could see that the changes implemented were moving us in the right direction.

Senior midwife

Measuring improvement is essential to determine whether change has had the desired impact or affect. Where possible, the measures of improvement need to be linked with the projects’ objectives. There are two main type of measurement of improvement that can be particularly useful for maternity teams:

- outcome measures – the end result of an improvement work such as a reduction in emergency caesarean sections or maternal deaths

- process measures – the process and structures/systems in place to support the delivery of the desired outcome, for example, percentage compliance with the use of the Situation, Background, Assessment, Recommendation (SBAR) tools or percentage attendance at a Practical Obstetrics Multi-Professional Training (PROMPT) training session.
The following section provides a brief overview of some of the tools used across the board by the Safer Births maternity teams. Tools included are:

- plan, do, study, act (PDSA) cycle
- action planning
- process mapping
- sustainability model.

### Key points for service improvement

- Consider the appointment of service improvement experts for specialist/independent advice.
- Prioritise areas to be improved/developed according to stipulation from government/regulators, recommendations from national bodies, and clinical incidents.
- Approach other maternity units/organisations to share and learn from their experience and guidance.
- Develop a project team and champion to help shape the improvement initiative and agree the desired outcomes.
- Consider a multidisciplinary approach if possible.
- Consider a board sponsor champion if possible.
- Undertake a sustainability assessment before starting the improvement.
- Use PDSA cycles as part of the project.
- When selecting measures of improvement, avoid overcomplicating and don’t re-invent the wheel.
- Look first at the measurements that are already in use on a day-to-day basis and consider incorporating them into your project.
- Consider the expert advice from a data analyst and the IT department which will help to simplify the process.
### Plan, do, study, act (PDSA) cycle

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description</th>
<th>Benefits</th>
<th>How is it used?</th>
<th>Tips for use</th>
<th>Where to find this tool</th>
</tr>
</thead>
</table>
| **Description** | PDSA cycles provide a framework for developing, testing and implementing changes for improvement. The PDSA cycle is used to test an idea by trialling and assessing a change before full implementation. | - Needs less time and money therefore involves less risk.  
- Offers invaluable lessons on what works and what does not work.  
- Staff and patients find the process less disruptive as it's on a smaller scale.  
- Increased likelihood of staff engagement and ownership in the wider change if they have been involved in the earlier PDSA cycle. | The four stages of the PDSA cycle are:  
1. Plan – the change to be tested or implemented.  
2. Do – carry out the test or change.  
3. Study – collect and study the data before and after the change and reflect on what was learned.  
4. Act – plan the next change cycle or full implementation based on the findings from stage 3. | - Consult widely with staff to gain co-operation and 'buy in' to the PDSA process.  
- Consider ways to disseminate the learning. | www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html |

With thanks to the NHS Institute of Innovation and Improvement
### Tool: Action planning

**Description**

An action plan is a series of steps needed to achieve a goal, aim or objective. It breaks a larger objective into smaller achievable steps.

The key purpose is to keep the project on track, on time, and in focus. It also ensures all the necessary activities are included.

**Benefits**

- Provides clear direction.
- Ensures objectives are ‘do-able’.
- Highlights the resources needed.
- Provides a clear timeline with deadlines.

**How is it used?**

- Identify the objective/goal.
- Determine the current situation.
- Determine the desired situation/the ‘hope for’ the future: what does it look like/how will you know when you have arrived there? How will you measure that this has been achieved? Record this.
- Identify the gaps between the current situation and the desired situation/outcome.
- Record the steps required/activities needed to close the gaps.
- Identify the key staff and resources required to support the steps/activities.
- Identify the deadline.
- Consider the risks to the organisation if the objective is not met.
- Record the above into an action plan or template (sample overleaf).
- Build in time to review the actions and escalate to senior management if actions cannot be achieved.
- Identify the evidence that will confirm that the necessary steps have been completed.
- Identify the evidence that will confirm that the desired outcome has been achieved.
- Record this in the action plan.

**Tips for use**

- Consult widely with staff to gain co-operation and ownership of the action plan.
- Consider dissemination of the plan to staff to raise awareness.
- Consider a governing committee to hold staff to account for the delivery of the action plan.
- Consider identifying a board sponsor or senior manager who will be a champion, promote the work and provide expertise and advice on resources.

**Where to find this tool**

There is a lot of information on action planning. For example:

www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/action_planning.html

With thanks to the NHS Institute of Innovation and Improvement
### Sample action plan

<table>
<thead>
<tr>
<th>Objective</th>
<th>Current state</th>
<th>Future state</th>
<th>Actions planned</th>
<th>Review date</th>
<th>Deadline</th>
<th>Measures of success</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure all multidisciplinary handovers are structured around the SBAR model</td>
<td>There is a variation in the format and standard of multidisciplinary handovers</td>
<td>SBAR is embedded within all handovers carried out within maternity services</td>
<td>Implement ‘hot topics’ as part of multidisciplinary team handover&lt;br&gt;SBAR communication audit for one week&lt;br&gt;Identify SBAR champions</td>
<td>Jan 2011</td>
<td>March 2010&lt;br&gt;End May 2010&lt;br&gt;June 2010</td>
<td>Guidelines for multidisciplinary handovers are in place and used by all staff within maternity services (100%)</td>
<td>Random audit of multidisciplinary handovers&lt;br&gt;Relevant guidelines&lt;br&gt;Minutes of relevant meetings</td>
</tr>
<tr>
<td>To ensure MEOWS is implemented within maternity services</td>
<td>MEOWS is not widely used across the department</td>
<td>MEOWS documentation is embedded within the service</td>
<td>MEOWS charts in place&lt;br&gt;Staff training – incorporate into PROMPT training&lt;br&gt;Develop audit tool&lt;br&gt;Audit presentation – agree recommendations</td>
<td>Jan 2011</td>
<td>April 2010&lt;br&gt;August 2010&lt;br&gt;August 2010&lt;br&gt;Jan 2011</td>
<td>Staff have undertaken training on MEOWS and it is implemented in to their practice</td>
<td>A random review of documentation within maternity services&lt;br&gt;Staff training records</td>
</tr>
<tr>
<td>Objective</td>
<td>Current state</td>
<td>Future state</td>
<td>Actions planned</td>
<td>Review date</td>
<td>Deadline</td>
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<td>Evidence</td>
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<tr>
<td>Measures of success</td>
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# General service improvement tools

## Process mapping

<table>
<thead>
<tr>
<th>Tool</th>
<th><strong>Process mapping</strong></th>
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</table>
| **Description** | Process mapping involves mapping the patient’s journey as it is and not as it is intended to be. The process results in a visual diagram and flow of the specific routes and stages involved in each step. This may be a journey through a department or procedure.  
Process mapping can be used to highlight the strengths and weaknesses along a patient's/client's pathway. It can highlight problems such as duplication in the process and bottlenecks and begin to identify areas for improvement and solution. |
| **Benefits** | - Can improve team-building as all key staff are involved, and can see the broader picture and their unique contribution.  
- Helps to clarify roles and responsibilities.  
- Helps to identify waste and facilitate a ‘lean’ approach to maternity services.  
- Is an inexpensive process and can also lead to savings. |
| **How is it used?** | - Set up a planning/design team consisting of, eg, senior midwives, clinicians, a service improvement lead/educator, and senior staff from other disciplines.  
- Agree the desired intention/objectives/goals and need for the process mapping.  
- Once the programme is agreed, arrange the facilitator, and a suitable venue, and provide sufficient notice for staff to attend. A lead time of around 6–8 weeks may be needed.  
- Invite all key staff to map out the clients' journey through their departments. Key symbols which depict the duplication, bottlenecks, etc, can be included in the process (ample supplies of flipcharts, sticky notes, pens, etc, will be needed!).  
- If possible involve the end user – they can provide a more detailed account of their journey through the department.  
- Ensure a SMART (specific, measurable, achievable, relevant, timed) action plan comes out of the process.  
- The action plan must be managed and incorporated into a governance and/or service improvement plan.  
- It is important that the results of the day – the action plan, concerns raised, etc, are followed through and communicated to staff. This will increase staff confidence and the credibility for future events. |
| **Tips for use** | - There are different methods for doing process mapping so it is important to identify the most suitable for the scale of the project or activity to be reviewed.  
- Consider the use of external facilitators who will be objective and act as a ‘critical friend’.  
- Consider allocating up to a day for this process as it can be lengthy. |
| **Where to find this tool** | [www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/process_mapping_-_an_overview.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/process_mapping_-_an_overview.html) |

With thanks to the NHS Institute of Innovation and Improvement
<table>
<thead>
<tr>
<th>Tool</th>
<th>Sustainability model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>The sustainability model is a diagnostic tool used for planned projects developed by the NHS Institute for Innovation and Improvement. It is a diagnostic tool that identifies strengths and weaknesses in a project’s implementation plan and predicts the likelihood of sustainability.</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
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<tr>
<td></td>
<td>Embeds new practice.</td>
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<td></td>
<td>Identifies the barriers to change.</td>
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<td></td>
<td>Increases the quality of care to the patient.</td>
</tr>
<tr>
<td></td>
<td>The project is more likely to be cost-efficient.</td>
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<tr>
<td></td>
<td>Likely to increase staff morale.</td>
</tr>
<tr>
<td></td>
<td>Will help to identify projects with longevity.</td>
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<tr>
<td></td>
<td>The tool has been developed working closely with frontline health care staff.</td>
</tr>
<tr>
<td><strong>How is it used?</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The sustainability tool focuses on three categories:</td>
</tr>
<tr>
<td></td>
<td>– process</td>
</tr>
<tr>
<td></td>
<td>– staff</td>
</tr>
<tr>
<td></td>
<td>– organisational issues.</td>
</tr>
<tr>
<td></td>
<td>The project lead/team read through each of the categories and their related factor descriptions/factor levels and selects the factor level which best fits the description of their project or situation.</td>
</tr>
<tr>
<td></td>
<td>All the scores are entered into a master score system (MSS) (available in the sustainability guide).</td>
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<tr>
<td></td>
<td>The MSS gives guidance on how to score each factor to create the sustainability score.</td>
</tr>
<tr>
<td></td>
<td>Once you have the project’s overall sustainability score you display it in graph or chart format for easier interpretation.</td>
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<tr>
<td></td>
<td>The NHS Institute for Innovation and Improvement advises that scores below 55 will need to lead to the development of a plan of action to increase the likelihood of success.</td>
</tr>
<tr>
<td><strong>Tips for use</strong></td>
<td></td>
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<td></td>
<td>The NHS Institute for Innovation and Improvement recommends applying the sustainability tool at the planning stage of the project, during the testing period and once it has been implemented.</td>
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<td></td>
<td>Where factors have been identified for improvement, the project team should identify one or two of the key factors as a priority and possibly consider ‘quick win’ areas.</td>
</tr>
<tr>
<td></td>
<td>A group from the project team and/or department should complete the sustainability diagnostic model for a full and ‘richer’ sample.</td>
</tr>
<tr>
<td><strong>Where to find this tool</strong></td>
<td><a href="http://www.institute.nhs.uk/sustainability_model/general/welcome_to_sustainability.html">www.institute.nhs.uk/sustainability_model/general/welcome_to_sustainability.html</a></td>
</tr>
</tbody>
</table>

With thanks to the NHS Institute of Innovation and Improvement
And finally...

Key enablers to improving safety

- dedicated time to focus, learn, listen, plan
- support from the board
- engaged and supportive frontline leaders
- a positive organisational culture
- other patient safety initiatives
- access to national programmes and professional bodies
- access to external critical friend approach/mentoring
- networking opportunities.

Key challenges to be overcome when seeking to improve safety

- historical conflicts between professional groups, departments and other hospitals
- conflicting priorities between cost improvement, need for development and staffing
- the need for inspirational and effective leaders
- workforce issues, eg, lack of staff, poor skill-mix
- low staff morale
- lack of staff engagement
- financial constraints
- low staffing levels
- challenges on how to measure improvement and demonstrate return on investment
- achieving sustainability and spread of improvement.
References


