Promoting normal birth

Introduction

The aim: to increase the normal birth rate and eliminate unnecessary caesarean sections through midwives taking the lead role in the care of normal pregnancy and labour, focusing on informing, educating and providing skilled support to first-time mothers and women who have had one previous caesarean section.

A practical summary

Maternity services in England offer care for mothers and babies that is the envy of many other countries. However, there are concerns that intervention rates are rising. The proportion of births by Caesarean section (c-section) has steadily increased in England over the past twenty years.

Clinicians currently working in services with low c-section rates believe that maternity units applying best practice to the management of pregnancy, labour and delivery can achieve consistent rates below 20% (NHS Institute 2006, Focus On: Caesarean Section).

A focus on normalising birth results in better quality, safer care for mothers and their babies with an improved experience. Increasing normal births and reducing c-section deliveries is associated with shorter (or no) hospital stays, fewer adverse incidents and admissions to neonatal units and better health outcomes for mothers. It is also associated with higher rates of successful breastfeeding and a more positive birth experience.

These changes benefit not only women and their families but also maternity staff. Midwives are able to spend less time on non-clinical tasks and more on caring for women and their babies.

The problem

The most recent data (2008/09) reports a national c-section rate of 24.6%, a significant rise compared to 12% in 1990. There is significant variation in the c-section rate across maternity units, ranging from 12.5% to 34.6% (NHS Institute, 2007). Many units have a rate significantly higher than the World Health Organization recommended rate of 15%. Higher rates of c-section appear to be associated with older mothers and women from certain ethnic groups but even when these factors are taken into account, they do not explain the differences between trusts (Healthcare Commission, 2008). It has been suggested that this difference is influenced by cultural and organisational factors within trusts (NHS Institute, 2007).

Many women who have already had a c-section do not necessarily need to have another one for their next baby. The Royal College of Obstetricians and Gynaecologists (RCOG) suggests that around three-quarters of women should be able to have a vaginal birth after caesarean section (VBAC). However, of those trusts able to supply figures, on average only 32% of women had a vaginal birth following a previous Caesarean, with rates ranging from less than 10% to more than 60% between trusts (Healthcare Commission, 2008).

The cost

Savings can be made by increasing the number of vaginal birth and by improving the efficiency of care after Caesarean section. Depending on complications, a c-section costs between £1,370 and £1,879 (NHS Institute, 2009). The typical length of stay is three to four days. By contrast, a normal delivery will cost

between £735 and £1,097 per birth. A cost study by the NHS Institute has calculated that a potential £65.5 million could be saved by reducing the national caesarean rate by 4% and by reducing the length of stay for a c-section without complications from 4 to 2.5 days (NHS Institute, 2009). This equates to a saving of £510,000 per trust.

In 2008, the NHS Institute started a rapid improvement programme to promote normal birth and reduce c-section rates. Nineteen out of the twenty participating sites have reduced their c-section rates, with some trusts achieving reductions as high as 6% (NHS Institute, 2009).

What we can do

Focusing on VBAC can have a massive impact on c-section rates. By targeting skills and support for women following a c-section and during pregnancy, this rate can be reduced substantially – in one trust it dropped by 300%. Many women and their health professionals lack accurate information on the benefits of VBAC so that this option is not offered or supported even when it is the most appropriate choice.

If you get stuck look for help – there are people who can help whether it is from within your organisation, another organisation, your SHA region or nationally.

The recent consensus statement Making Normal Birth a Reality suggests a realistic objective of 60% as the rate of normal births, that is, births without interventions such as epidurals or episiotomies but according to the Healthcare Commission's review of maternity services, the median trust reported only 40% of births as normal and a quarter of trusts reported 32% or less (Healthcare Commission, 2008). Women with a low risk pregnancy should be able to benefit from the philosophy of normal birth and receive midwife-led care, even in an obstetric unit.

The case studies

Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust introduced massive organisational change that has had a significant impact on how maternity care is delivered.

Luton and Dunstable Hospital reduced their c-section rate from 31% to 23% in a year, through top to bottom cultural change and a commitment to normalising births.

Stockport NHS Foundation Trust focused on providing support and building the confidence of women who had previously had a c-section.

The Western Sussex Hospitals NHS Trust increased its rate of successful VBAC by more than 300% through a wide-ranging programme designed to normalise birth.

Where are the best sources of information?

NHS Institute for Innovation and Improvement (2006) Delivering Quality and Value: Focus on: High Volume Care Executive Summary
http://www.institute.nhs.uk/option,com_joomcart/Itemid,194/main_page,document_product_info/cPath,71/products_id,334.html

NHS Institute for Innovation and Improvement (2006) Delivering Quality and Value: Focus on: Caesarean section

Department of Health (2006) Hospital episode statistics 2005/2006

Healthcare Commission review of maternity services: Towards better births (2008)
www.cqc.org.uk/_db/_documents/Towards_better_births_200807221338.pdf

Department of Health, Maternity Matters: Choice, access and continuity of care in a safe service
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074199.pdf

Department of Health National Services Framework for Children, Young People and Maternity Services (2004)
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4090552.pdf

Better Birth Environment Toolkit
http://www.nct.org.uk/info-centre/getting-help/useful-links?page=3

NICE Clinical guidelines: Caesarean section
http://www.nice.org.uk/guidance/CG13

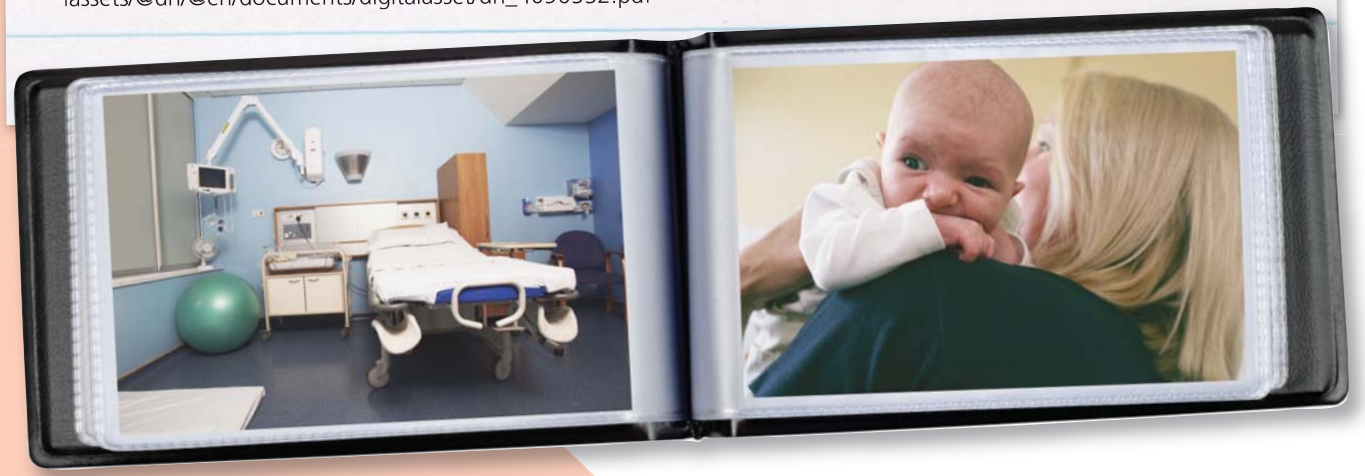
Royal College of Obstetricians and Gynaecologists – Standards for maternity care
http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRMaternityStandards2008.pdf

NHS Institute for Innovation and Improvement (2007) Delivering Quality and Value Pathways to Success: a self-improvement toolkit, Focus on normal birth and reducing Caesarean rates.

RCM campaign for normal birth.
http://www.rcmnormalbirth.org.uk/

NICE- Intrapartum guidelines: www.nice.org.uk/guidance

Other sources of information



Case study: Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust


DVD also on NHS Institute website


Printable information from the NHS Institute website

Doing it the Blackpool way

In recent years, Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust turned its fortunes around as a result of massive organisational change, which has been dubbed The Blackpool Way. No department better illustrates the impact of the Blackpool Way than maternity.

Setting the scene

The trust has approximately 2,800 births a year and had the highest c-section rate in the North West (28%).

The approach

The trust introduced a series of projects designed to improve care and support women through natural birth. These include:

- developing formalised handover
- a weekly incident review meeting
- disseminating learning throughout the hospital at all levels
- open and accessible appraisals and training for staff
- learning from other hospitals.

"We realised that the answers to our problems lay with our staff. By changing the management culture, we have released the potential of staff to make changes. The board was keen to see an improvement in c-section rates, both from a patient experience perspective and also from the perspective of quality of care and cost. We made a high level commitment to reducing c-section rates and have taken a keen interest in the work that the maternity team is doing."

Aiden Kehoe
Chief executive

How they did it

Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust had the highest c-section rates in the North West. Now, as a result of sweeping changes in the organisational culture and a focus on normalising births, it has dropped to around 22%.

The trust has introduced a wide range of measures, including weekly incident review meetings, open and accessible appraisals and training, a formalised handover using the latest improvement techniques and systems to ensure learning is disseminated throughout the hospital at all levels.

The formalised handover uses situation, background, assessment and recommendation (SBAR), a structured method for communicating critical information that requires immediate attention and action. *"We have developed an SBAR sticker which we stick into the patient's notes, and then we formally sign to say that we are handing over care from one person to another,"* says consultant midwife Nicola Parry. *"It is a way of making us stop and think about how we are communicating from one shift to the next, or from one ward to the next."*

The incident review meeting is one of the trust's key improvements. Facilitated by the clinical governance lead, this weekly meeting provides an opportunity to review any incidents. This presents a learning opportunity for the benefit of the whole team. The meetings are open to anyone who wishes to attend including consultants, midwives, healthcare assistants, paediatricians, special care nurses and colleagues from other disciplines. The atmosphere is relaxed and informal – people can come and go as they wish and anyone can contribute.

"Previously there had been a culture of mistrust," explains consultant obstetrician, June Davies. *"Incident reports were looked at in isolation by me, as the risk lead, and it took a long time for information to be fed back to the staff. Now, any incident is discussed within 24-48 hours of its occurrence and information is fed back to staff within a week. By looking at things in real-time, incidents are fresh in people's minds and we have developed a no-blame culture so that people are willing to speak out about what happened. That way we can all learn from each other."*

Each meeting begins with a discussion of further actions from the previous week. Minutes from the meeting are disseminated both horizontally to staff on the wards and vertically to the divisional board, and to governance and clinical meetings. This ensures that the learning that comes from these sessions goes right through the hospital.

A two-way appraisal system enables junior members of staff to comment on the performance of senior staff, and vice versa. It proves very beneficial in identifying improvements that individuals can make, tackling problems before they develop and improving the sense of teamwork. Training, too, is delivered in an open and accessible way. Dates are posted on notice boards and anyone linked to maternity can attend, from healthcare assistants through to paramedics. People are put into multidisciplinary teams and asked to re-enact emergencies.

"It's a good way of building teamwork and ensuring that people are speaking the same language," says practice development midwife, Moira Broadhead.

The multidisciplinary training is part of an improved package of training for midwives in Blackpool that includes normal birth study days, education about vaginal birth after Caesarean section (VBAC) and improved Cardio TocoGraph (CTG) training. The hospital has set up a weekly VBAC clinic to explain to women that a previous c-section does not preclude them from having a normal delivery next time and has also worked hard to normalise the birth environment. *"We have taken away the bed and put in birthing couches and beanbags instead,"* adds Moira. *"En-suite showers have been replaced with baths that women can use for pain relief in the early stages of labour. It is a more intensive approach and harder work for staff so we have increased staffing levels to enable us to offer more one-to-one care."*

Shift leader, Lisa Dunkley has been active in introducing aromatherapy as part of the drive to reduce pharmacological pain relief. *"There is evidence to support the positive effect of aromatherapy on women in labour,"* she explains. *"I worked in another local trust prior to this one where aromatherapy was found to have a hugely positive effect on mums and midwives. I am delivering aromatherapy training to all of the midwives. Initially it will be offered to all low risk mums, before being rolled out across all deliveries."*

Having achieved a reduction in c-section rates and an increase in successful VBAC – up from 50% to 65% – there is a palpable sense of pride in their achievements among the staff. *"Over the last few years, the maternity department has made huge leaps forward,"* says chief executive, Aiden Kehoe. *"We appreciate that this has taken a massive effort from everyone but the results are worth it. Feedback from patients is more positive, we have a better approach to risk management and the patient experience is far better than it was a few years ago."*

"Confidence has increased amongst the staff, particularly more junior staff. We all use the same approach and there is a clear understanding between us about the history, expectations and plan of care for each woman. The way we promote normal birth is not regimented but we make clearly-documented decisions. The midwives are buzzing from the changes and there has been a huge rise in job satisfaction. We have moved from a culture of anxiety to one which is proactive in encouraging VBAC but that also accepts that intervention is necessary in some instances."

Lisa Dunkley
Shift leader

Local results

The trust saw its c-section rate drop from 28% to 22% and increased successful VBAC from 50% to 65%. The trust developed a process to ensure a faster response to incidents involving whole multidisciplinary teams.

Impact on quality of care

The overall aim of the work is to provide the support and information mothers need in order to make an informed choice about the place and method of birth.

Impact on patient experience

A normal birth means mother and baby go home sooner after birth. Improvements in care include offering aromatherapy to all low risk mums, with plans to roll out the service to all women.

Impact on staff experience

Multidisciplinary training includes normal birth study days, where staff are put into multi-professional teams and asked to re-enact emergencies. A two-way appraisal system enables junior members of staff to comment on the performance of senior staff, and vice versa. The work has increased team working and removed the culture of mistrust.

Impact on cost reduction

The trust has reduced its rate of c-sections by one-fifth. A 5.4% reduction equates to 162 c-sections fewer than in the previous year. Taking the c-section without complication cost of £2,198 this generates a cost reduction of £356,076 but must be balanced with the costs of an alternative method of delivery, which, if we assume is normal birth without complications at a cost of £996, would cost £161,352 for the 162 births.

So actual cost saving is £356,000 minus £161,000 = £194,724

Key themes and methodology

Using SBAR to improve communication

A key change in Blackpool has been the introduction of the patient safety tool: Situation, Background, Assessment and Recommendation (SBAR). Derived from the aviation industry, SBAR is a structured method for communicating critical information that requires immediate attention and action.

The trust has developed an SBAR board on which midwives and obstetricians write information relevant to each woman in the delivery suite. It provides a structured system for communicating, particularly amongst multidisciplinary teams and it gives more junior staff a vehicle for making themselves heard in a way that everyone will listen to. The system was adopted over the August bank holiday in 2009. Initially, it was greeted with some shock and scepticism. Within 12 hours everyone was on board and no-one wanted to go back to the previous system.

Find out more at:
www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/sbar_-_situation_-_background_-_assessment_-_recommendation.html

The NHS Institute Safer Care webpage (www.institute.nhs.uk/safer_care/safer_care/sbar_resources.html) features resources on SBAR including SBAR presentations, prompt cards, posters and an e-learning module.

Improvement tip

SBAR: Situation, Background, Assessment, Recommendation

SBAR is an easy to remember method that you can use to frame conversations, especially critical ones, requiring a clinician's immediate attention and action. It enables you to clarify what information should be communicated between members of the team, and how. It can also help you to develop teamwork and foster a culture of patient safety. The tool consists of standardised prompt questions within four sections, to ensure that staff are sharing concise and focused information. It allows staff to communicate assertively and effectively, reducing the need for repetition. The tool helps staff anticipate the information needed by colleagues and encourages assessment skills. Using SBAR prompts staff to formulate information with the right level of detail.

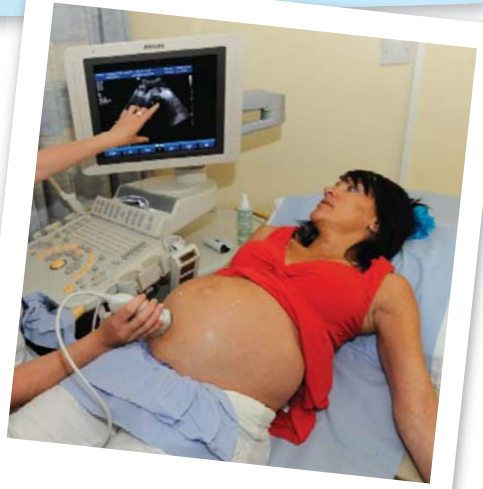
Further information available from the NHS Institute website

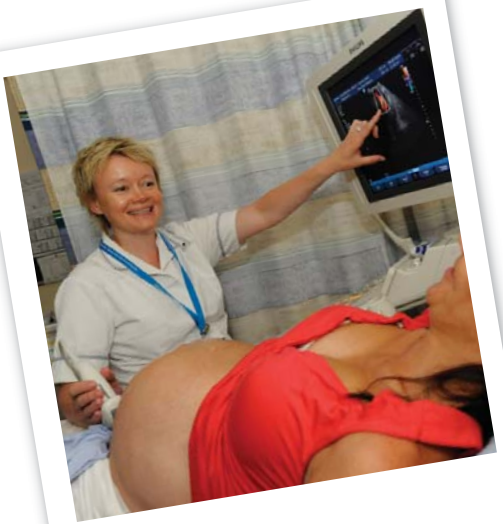
"The SBAR board gives us an easy way of identifying which women are likely to require intervention or review and who is high and low risk. The scheme has now been extended to handover between shifts and between wards as it provides a consistent way of communicating which everyone understands. Other parts of the hospital are following maternity's lead and adopting SBAR as a communication tool."

Dr June Davies
Consultant obstetrician

"This has only become possible as a result of cultural change. No one department can change the culture of an organisation; it must be led from the top."

Nicola Parry
Consultant midwife





Case study: Luton and Dunstable Hospital


DVD also on NHS Institute website


Printable information from the NHS Institute website

Top to bottom culture change delivers outstanding results

When c-section rates peaked at 31% in April 2009, it was a wake-up call for Luton and Dunstable Hospital's maternity department. A year later, rates are averaging around 22% – well below the national average. The hospital has achieved this through top to bottom cultural change and a commitment to normalising births.

Setting the scene

The trust has approximately 5,500 babies born each year and had a c-section rate of 31% in April 2009.

The approach

The trust introduced a midwife lead for normality, to champion normal birth with staff and pregnant women and developed a birth option clinic for women who had previously had a c-section.

Normality study days were designed for community staff and 'skills books' created for maternity care assistants which detailed training and competencies for each individual.

"Luton is a deprived area and we had lost our focus on normal birth due to the large numbers of high risk women coming onto the unit. Since 2009, we have succeeded in turning that around with a change in culture towards making birth a normal experience. Women now remain under the care of a midwife throughout their pregnancy unless there is a good reason to do otherwise."

Katie Chilton
Delivery suite matron

How they did it

"Like all hospitals, we were concerned by the rising c-section rate," says head of midwifery, Helen Lucas. *"We are a level three neonatal unit and there was generally a perception among staff that this made us a 'high risk' unit. In 2008, we started using the maternity dashboard to give us a month-by-month picture of the number of c-sections taking place. The following year, we employed a midwife to lead on the normalising agenda. Since that time, there has been a drive to change attitudes and behaviours. We are now seeing c-section rates coming down and normal deliveries, particularly VBAC (vaginal birth after Caesarean) rising significantly.*

"We have introduced a daily multidisciplinary review meeting to look at all of the deliveries over the preceding 24 hours and staff at every level are encouraged and empowered to speak out and give their opinion – even challenge senior staff," she continues.

Consultant and lead obstetrician, Bright Gympoh, has acted as a champion for the normalising births agenda. He believes this is the key to achieving organisational change. Bright comes from Ghana, where Caesarean sections are rare and he was disturbed by the rising rate of c-sections when he joined the hospital 12 months ago. *"My advice to anyone embarking on this type of work is to get a midwife who is keen on normal births together with an equally keen consultant and leave them to drive any changes,"* he says.

Midwife Heidi Beddall trained within a low risk unit and joined Luton and Dunstable to gain experience of working in a high-risk environment. When the post of midwife lead for normality came up, she was keen to go back to her roots and pursue her passion for normal birth. She has been instrumental in introducing a range of training and support initiatives, including a birth options clinic for women who are requesting a c-section after a previous section or a traumatic birth experience. *"Women come along to the clinic after they have seen the consultant if they are requesting a c-section,"* says Heidi. *"We discuss all of the issues and talk about the physical, social and emotional impact of different birth choices. Even if women don't ultimately choose a VBAC, I want them to feel fully debriefed and counselled before they make their birth plan."*

While it is impossible to measure the impact of this work on every woman's experience, feedback has been extremely positive. In a recent audit, 80% of women who had spoken to Heidi or Bright about their birth choices went on to attempt a VBAC and around half were successful.

"I can pick up the phone to Heidi at any time if I have a question and I know I can refer any woman to her for support in normal birth."

Marianne Musemeci
Midwife

Luton and Dunstable has been careful to ensure that its philosophy on normalising birth extends to every staff level. Training is provided for maternity care assistants, coordinated by senior midwife, Karen Billington. *"We want maternity care assistants (MCAs) to feel part of the team and to be involved in discussions about normalising birth,"* she says. *"MCAs are the first point of contact for women coming onto the unit and they set up the rooms for birth, so it is important that they understand the impact of the birth environment on outcomes and are fully on board with the idea of normalising birth. As well as training MCAs on how they can help women to have a normal birth, we make sure they understand the nature of emergencies so they can respond appropriately when a situation is urgent. Now, when we receive thank you cards they often mention the MCA by name and thank her for the care she gave."*

All maternity care assistants are given information cards when they join the hospital explaining terminology and providing a list of key contacts and telephone numbers. Karen introduced the concept of skills books for maternity care assistants from elsewhere in the hospital. The books provide detail on training and competencies for each individual.

Community midwives are also regarded as crucial to promoting normal births and can now attend normality study days, held on Saturdays. *"Normality starts in the community,"* says Helen. *"It's important that community midwives feel supported."*

New mum Charlotte Barnett recently had a successful VBAC, thanks to the support she received from Heidi and her team. *"My first baby was 9lb 11oz and was delivered by emergency Caesarean,"* she says. *"I assumed my next baby would be big and I didn't think I could have a natural birth. Heidi said she could coach me and I kept in contact with her throughout my pregnancy. She even came with me to see the consultant. She showed me how to get the baby into the right position, how to cope with the contractions and what positions would help me to have a normal delivery. Robert came within 50 minutes. It was a good experience. I wanted to have a natural birth for the health of the baby and I was home the same afternoon. The baby was relaxed because I was relaxed."*

More improvements are planned, including a pre-birth clinic, which will advise women on the process of early labour and provide information on self-care. In May 2010, a new midwifery-led birthing unit will open, providing four ensuite rooms and a birth environment geared towards normalising birth.

"This is what midwifery is all about," says Helen. *"Giving birth is natural."*

"I am proud of the fact that we have built a fantastic team and everyone is working together much better than they did a year ago. We have successfully implemented and maintained the daily review meeting and we now run a regular birth options clinic, which will soon be expanded to cover pre-natal care. It has been absolutely fantastic – this is a great place to work."

Bright Gympoh
Consultant and lead obstetrician

Local results

Impact on quality of care

80% of the women who attend the birth options clinic to discuss their birth choices went on to attempt a VBAC and around half were successful.

The unit plans now to open a pre-birth clinic, designed to advise women on the process of early labour and encourage self-care.

Impact on patient experience

Women now have a wider range of options and more information to make a choice that is right for them.

They also have greater opportunity to discuss their concerns with staff.

Impact on staff experience

The trust focused on improving staff skills through targeted training programmes, including normality study days for community midwives, which are held on Saturdays to improve access.

In addition, all maternity care assistants are given information cards explaining terminology and providing a list of key contacts and telephone numbers. Skills books provide details on training and competencies for each individual.

Return on investment calculation

Costs of the following inputs were calculated for the project: staffing for the birth options clinic; daily case note review sessions; and normality study days. Impact costs were calculated in terms of money saved as a result of more babies being delivered by normal birth rather than by Caesarean section. For every £1 spent Luton and Dunstable generated £1.11 of benefits over a year. This calculation does not take into account the additional quality benefits that have not been monetised including mothers' increased satisfaction with care nor any additional costs incurred in community midwifery.

Further information available from the NHS Institute website

Key themes and methodology

Learning from human factors

Luton and Dunstable hospital has introduced learning from human factors as part of the drive towards safer birthing and promoting normality. This approach recognises that the majority of substandard care can be attributed to human factors. The trust uses a range of communication tools, particularly SBAR (situation-background-assessment-recommendation), to ensure that everyone on the team feels able to speak out in the interests of patient safety. Work at the trust focusing on human factors is in its infancy but is already contributing towards a change in culture.

Human factors encompass all those factors that can influence people and their behaviour. In a work context they are the factors relating to the work environment, the job itself and the organisation and the individual characteristics which influence people's behaviour at work.

Healthcare professionals are human beings and, like all human beings, are fallible. In our personal and working lives we all make mistakes in the things we do, or forget to do, but the impact of these is often non-existent, minor or merely creates inconvenience. However, in healthcare there is always the possibility that the consequences could be catastrophic. It is this awareness that often prevents incidents as we purposefully heighten our attention and vigilance when we encounter situations or tasks we perceive to be risky.

Some of the common human factors that can increase risk include:

- mental workload
- distractions
- the physical environment
- physical demands
- device/product design
- teamwork
- process design.

Find out more from the NHS Institute's Safer Care web pages: http://www.institute.nhs.uk/safer_care/general/human_factors.html or the Patient Safety First website: http://www.patientsafetyfirst.nhs.uk/Content.aspx?path=/interventions/additionalguidence/humanfactors/

Download the 'How to' Guide for Implementing Human Factors in Healthcare: http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/Human%20Factors%20How-to%20Guide%20v1.2.pdf

Visit the NHS Institute or Patient Safety First websites for a video of a story which illustrates human factors issues. In 'Just a Routine Operation', Martin Bromiley, an airline pilot, discusses his personal experience of healthcare.

Further information available from the NHS Institute website

Other sources of information

"Human factors are all the things that make us different from logical, completely predictable machines. How we think and relate to other people, equipment and our environment. It is about how we perform in our roles and how we can optimise that performance to improve safety and efficiency. In simple terms it's the things that affect our personal performance."

Clinical Human Factors Group (CHFG)
http://www.chfg.org

"We have introduced a daily multidisciplinary review meeting to look at all of the deliveries over the preceding 24 hours. Initially, the idea was greeted with some scepticism as people expected it to be all about blame, but we use a human factors approach to say 'what did we do well?', 'what could we have done better?' and 'if we encounter this situation again, what would we do differently?' Staff feel empowered and happy to come to the meetings. The hierarchy has diminished and junior staff are happy to liaise with senior colleagues. I was delighted when a junior colleague spoke out and corrected me recently. We are also using human factors to interpret CTGs in a more uniform way."

Bright Gympoh
Consultant and lead obstetrician

Case study: Stockport NHS Foundation Trust


DVD also on NHS Institute website


Printable information from the NHS Institute website

Empowering clinicians to optimise opportunities

Stockport NHS Foundation Trust has a strong tradition of working to promote normality in childbirth. In 2008, the trust began focusing on reducing the rate of Caesarean sections focusing on building confidence and support in women who had previously had a c-section.

Setting the scene

The trust had 4,000 births a year, with a c-section rate of 24%. The trust was chosen as a pilot site for the NHS Institute's Focus on Normal Birth and Reducing Caesarean Section Rates toolkit.

The approach

Stockport established its first service users' forum to involve parents in developing services. These developments include:

- a weekly VBAC clinic after women's 20 week scan
- VBAC workshops where women talk about their experience and answer questions
- a post-natal debrief in response to feedback
- a 'Choices' DVD, outlining delivery options for women, now available on the trust's website
- facilitated 'time-out' sessions for delivery suite coordinators.

In addition, the trust hold a weekly audit of c-sections and a daily review of emergency c-sections to monitor what is happening in real-time. The trust set a target for 20% of births to take place outside the delivery suite by March 2010.

"Like everywhere, our c-section rate was rising and in 2007 we decided this was a good time to go back to basics and look at how we were supporting women in achieving a normal birth. We introduced a Normal Birth campaign looking at parent education. The programme was changed to include an active birth workshop for all parents and we established a triage system to encourage women to stay at home in early labour. When the NHS Institute for Innovation and Improvement introduced its Focus on Normal Birth and Reducing Caesarean Section Rates toolkit, we were delighted to be chosen as a pilot site. We chose to focus on VBAC as we have always been keen to avoid unnecessary interventions and to allow women to give birth as they are designed to."

Julie Estcourt
Head of midwifery

How they did it

Women who have undergone a c-section are less likely to give birth naturally in future pregnancies, even when the pregnancy is normal. Maternity staff at Stockport recognises these women often simply need support and information to have a natural birth.

One of the trust's first actions was to establish a weekly vaginal birth after Caesarean (VBAC) clinic, giving women the opportunity to talk face-to-face with either a consultant midwife or obstetrician. *"Women who have had a previous Caesarean have a lot of unanswered questions and, often, a high level of anxiety,"* says consultant midwife, Debbie Garrod. *"We were keen to introduce a service that would allow them to talk about what had happened and to make a plan for their next delivery. We offer parents the opportunity to come to a VBAC workshop, which focuses on practical preparation for birth, but we find that many women, and often their partners, need the opportunity to sit with someone face-to-face and tell their story. We make sure that the woman either talks to a supervisor of midwives or consultant so that we can support her if she requests care outside normal guidelines.*

"This is a very powerful process and the women often say they feel better just to be able to talk about what happened to them in their last pregnancy," adds Debbie.

Women attend the clinic at between 20 and 24 weeks of pregnancy and the discussion is documented in the medical notes using a pro forma. Consultant obstetrician, Claire Candelier says: *"It is useful for women who may be worrying about their birth options to be able to come to the clinic some time after their 20 week scan. Previously, discussions didn't take place until around 36 weeks which was too late. Depending on the complexity of their previous c-section, either Debbie or I spend half an hour with each woman, asking her to identify her issues. Our role is to give her the right information and to offer reassurance. We send a letter to the woman's GP summarising our discussion."*

After being seen in the VBAC clinic, women and their partners are invited to attend an evening VBAC workshop where they can hear women talk about their own experience and answer questions. *"When I had my second pregnancy, I wanted to deliver normally,"* says Claire Blankley, who leads the workshop. *"I was given the opportunity to talk to midwives and clinical staff but what I really would have liked was to talk to someone who'd been through that experience. It's great to feel that I am helping, and this section of the evening is generally evaluated highly by the women who come along."*

The trust is now developing a post-natal debriefing in response to feedback from the VBAC work. Staff have collaborated with service users to design a letter that will go out to women who have had a c-section, with a copy sent to the GP explaining the reasons for the intervention. It has been important to get the language right, replacing medical terms with user-friendly language, translating terms like 'failure to progress' into 'slow progress in labour'.

The team is analysing the number of inductions of labour in relation to the number of c-sections and, from this, agreeing to review and update the guidelines on induction. A new service users' forum held a series of five 'talkback' events, including events for fathers, teenagers and members of the Muslim community. Among the suggestions from the events were that all women should be given the contact details of their own midwife to overcome occasional problems in getting through to the triage department, and that information should be made available online for women to download when they want it.

Stockport maternity service places a high priority on promoting choice regarding the place of birth, including home and birth centres for 'low risk' women. There are two birth centres and a delivery suite for higher risk deliveries. VBACs take place in the delivery suite and some women are making informed choices to use the pool for labour and birth following a previous c-section. The team set a target for 20% of births to take place outside the delivery suite (i.e. in the birth centre or at home) by the end of March 2010 and is close to achieving this.

Since choosing to focus on the VBAC pathway, the work being done in Stockport to normalise births has broadened out to encompass all aspects of the maternity service. In fact, planning for VBAC now starts with the letter that will go out to women immediately after a c-section. Debbie comments: *"Using women's stories to go back and explore what you are doing is far more powerful than any audit. It makes you wake up. The working relationship between midwives and obstetricians is key. You need the right interventions at the right time. As we take this work forward, working in partnership will be the most important contributor to our ongoing success."*

"In normalising births, it is important to start at the very beginning as we have done and to look at the core basics," adds Julie. *"Fundamentally, that's what is at the heart of good midwifery."*

"We recognise that this needs to be a multidisciplinary approach, involving everyone who has contact with pregnant women. A chance comment can make all the difference to a woman's confidence in her ability to deliver normally, so we all need to do whatever we can to build the parents' confidence."

Debbie Garrod
Consultant midwife

Local results

Impact on quality of care

Women are more prepared for their birth experience.

The VBAC service is being evaluated and audited, from local data resource Euroking, along with feedback from parents.

There is an increased opportunity for homebirth.

Impact on patient experience

Women are invited to attend a weekly VBAC clinic following their 20-week scan to help reduce any anxiety.

The trust set up a service user's forum to feed back and learn from women's experiences.

Using more simple language enables women and their families to understand complex information.

Impact on staff experience

Staff morale has improved as they become confident that they are providing a high quality service.

Impact on cost reduction

The trust continues to monitor the c-section rates and although it has not yet recorded a drop in the rate it is confidence that the improvement is continuing to have an impact on patient experience and on the quality of care they provide.

Key themes and methodology

The power of women's stories

Stockport maternity service promotes choice regarding the place that women would like to give birth, including home and birth centres for 'low risk' women. Key to their improvement work has been listening to women talk about their experiences, which provides insights into how things can work better. Staff recognised that often women and their partners simply needed to sit face-to-face with someone and talk about their previous experiences and their concerns for future birth.

In designing the new birth centre, the team spoke to women to get their views on the physical design and the pathway through the unit.

It goes without saying that childbirth should be viewed as a positive experience, with no unnecessary interventions, where the women and family feel empowered in making decisions with support from staff.

One of the ways that can help to achieve the above is using the actual experiences of women and their families to design services and care environments.

Stockport used the Better Birth Environment Toolkit when improving their birth environment for women and families. The toolkit enables staff to research women's perspectives on their local birth environments and to benchmark feedback against a UK wide survey on what women said was important to them.
http://www.nct.org.uk/info-centre/getting-help/useful-links?page=3

Other sources of information

The NHS Institute's ebd approach (experience based design) provides a method for working with patients and staff to capture and improve their experiences. For more information, see:

http://www.institute.nhs.uk/quality_and_value/experienced_based_design/the_ebd_approach_(experience_based_design).html

Further information available from the NHS Institute website

Healthcare organisations have demonstrated that they have significant skills in improving the performance and reliably of services but they have not always placed equal focus on the aesthetics of experience – how it feels to use or be part of the service. The ebd approach provides the opportunity to build on previous successes by focusing more attention on this third component – the experience of care.

"This is the first time we have systematically involved service users and we are very pleased with the results. As well as suggesting minor improvements they have played a key role in redesigning the birth centre using the National Childbirth Trust's 'Better Birth Environments' toolkit. It is a really homely environment with subdued lighting, birthing balls and beanbags. Women are encouraged to mobilise and the bed is no longer the primary focus of the room. We have three birthing pools, as well as one on the delivery suite."

Mandy Green
Delivery suite coordinator

Case study: Western Sussex Hospitals NHS Trust


DVD also on NHS Institute website


Printable information from the NHS Institute website

Reclaiming birth for women and midwives

The Western Sussex Hospitals NHS Trust has increased its rate of successful vaginal births after Caesarean section (VBAC) by more than 300% and continues to reduce its overall Caesarean section rate through a wide-ranging programme designed to normalise birth.

Setting the scene

In 2007, the trust had a c-section rate of 27% and a rate of vaginal births after Caesarean section (VBAC) of 26%.

The approach

A new birth centre for low risk births opened in 2009 at St Richards Hospital in Chichester.

The trust was an early adopter site for the NHS Institute's Focus on Normal Birth and Reducing Caesarean Section Rates toolkit, identifying VBAC as their priority pathway. This led to the introduction of the VBAC lead and midwife counsellor role.

Every woman who leaves hospital following a c-section is given a letter explaining the reasons for the intervention and outlining her choices for next time. The birth afterthought service provides women with a telephone number for support from the midwife counsellor.

Other improvements in care include a new weight management in pregnancy clinic for women with a raised BMI, and an initiative inviting service users to ward rounds so staff can hear, firsthand, what women are saying about their experience. COOS Cards: The trust added a section for comments on its service cards and this information is fed back to staff.

A band five midwives' 'club' provides staff development through protected time for study days and a more robust preceptorship programme.

> "I am delighted that normalising birth is one of the High Impact Actions. It puts the focus back onto making services safe and pulls back the over-medicalisation of birth. It has put maternity onto the agenda at last and reclaimed birth for women and midwives."
>
> Carole Garrick
> Head of midwifery

How they did it

When the newly merged Western Sussex Hospitals NHS Trust opened a new birth centre for low risk births in 2009, it was the ideal opportunity to focus on normalising births. The trust introduced a wide range of improvement measures focusing on the experience of women using the service.

The trust has increased its rate of successful vaginal births after Caesarean section (VBAC) from 26% in 2006 to 84% in 2009. Overall, c-section rates have come down from a peak of 27% in 2007 to 25% in 2009, and the numbers are continuing to fall.

The new birth centre at St Richards Hospital in Chichester was developed in consultation with service users, and has two birthing pools and an environment to encourage normal birth, including Bradford birthing couches and mood lighting. Community midwives work alongside hospital midwives, enabling them to bring their experience of home birthing onto the unit, and staff wear everyday clothes rather than uniforms. Alongside the birth centre sits a consultant-led unit, which also has its own birthing pool. The hospital recently reported its first successful VBAC in the pool for a woman who had previously had twins by c-section.

"Two or three years ago, this unit was threatened with closure," says consultant obstetrician and gynaecologist, Matthew Jolly. *"However, following the appointment of a new head of midwifery and the refurbishment of the labour ward, we were given the opportunity to redesign the service for women. We have recruited more consultants with a profound interest in obstetrics but who are also competent gynaecologists. We have introduced a day assessment unit where we can see women with antenatal problems. And we have developed an open culture, with shared ownership of problems and challenges. There is still more to do but we have made a positive start. The key is to take a holistic approach, looking at both the culture and the organisation of the service."*

"Now, every woman who leaves hospital following a Caesarean is given a letter explaining the reasons for it and outlining her choices for next time," says Annie Hamilton, the VBAC lead and midwife counsellor. *"This begins the normalisation process even before her next pregnancy. In addition, we have introduced the birth afterthought service. Women are given my telephone number as part of their post-natal information and they, or their partners, can ring me at any time to discuss the birth experience. I am a trained counsellor and, alongside their GP and health visitor, I can support women who may be suffering from post-partum post traumatic stress and discuss their future birth options."*

Healthy women who would like a VBAC are not required to attend a hospital clinic unless they reach 41 weeks of pregnancy without going into labour. A daily handover meeting now takes place on the labour ward, providing an opportunity for the team to review all of the c-sections from the preceding 24 hours. Midwife Anita Clarke says: *"The meetings are an opportunity to make sure we are evaluating our practice and that everyone is following the guidelines correctly. We all have a voice: the consultants and registrars are happy for the midwives to have an input; there is a lot of respect on both sides. It is a better place to work and I feel as though my opinion is valued."*

The trust has also changed the competency pathway to improve skills training for newly qualified midwives. *"We have revised our competency document so the focus is on normalising birth,"* explains clinical skills facilitator Jill Hutchings. *"In addition to medical skills, such as cannulation and suturing, we want our midwives to develop competencies in water birthing and normalising birth as part of a more holistic approach to childbirth. Initially, some midwives were in awe of the process of normal birth, while others thought they didn't need any of this information. Now, they are elated by the process. It is all about enabling midwives and banging the drum for normal birth long and loud enough so that people will listen."*

Practice development midwife Sarah Bolger invited normal birth champion, Dennis Walsh, to speak at a recent two-day training workshop attended by 40 midwives, doctors, paramedics and neonatal staff. *"The challenge in this type of training, which is not mandatory, is in motivating people to attend,"* she says. *"Everyone wants to give the best care they can and by showing them how much better their working environment would be if we could facilitate normal birth, we demonstrate that it is in the best interests of both staff and service users to promote normality."*

Obesity is one of the biggest risk factors linked to maternal morbidity and poor outcomes. Community midwife, Lisa Cosgrove helped to establish a weight management in pregnancy clinic for women with a raised BMI. *"Initially, it was quite a negative experience for women coming for their 15-week appointment to be told they have a raised BMI,"* says Lisa. *"Now, we are doing something more positive. Women are invited to come along and receive advice on diet and exercise, as well as being given guidelines on what is a safe level of weight gain during pregnancy. Women with a BMI over 30 have an increased risk of diabetes and women with a BMI over 35 are more likely to have a c-section, so this is contributing to the normalisation agenda at the same time as making women healthier and improving their birth outcomes."*

"We are committed to normalising all births, even those that are considered high risk. Ours was one of the first high risk labour wards to install a birthing pool and we are all delighted by the recent successful VBAC using it. The consultant-led delivery suite offers the same type of care as is available in the birth centre, but with additional back-up, if required."

Kelly Pierce
Senior midwifery manager

"The involvement of service users is crucial. Often, women will get involved in the maternity services liaison committee when they have experienced a problem themselves. We want them to performance manage us and let us know how we're doing."

Carole Garrick
Head of midwifery and associate director

Local results

Impact on quality of care

The trust increased its rate of successful VBAC from 26% in 2006 to 84% in 2009. Water births now account for 5% of all births and c-sections reduced by 2% and are continuing to fall.

Impact on patient experience

There is much greater emphasis on normal birth, particularly following a Caesarean section and women have a greater range of birth environments to choose from. Women can attend ward rounds so they can hear, firsthand, from other women about their experience. They also have access to a midwife counsellor who can provide debriefing and support following a traumatic birth experience.

Impact on staff experience

Staff can gain additional feedback from women through a new comments section on comments on our services (COOS) cards and have access to a range of training and development opportunities focused on normalising birth.

Impact on cost reduction

A 2% reduction in c-section rates equates to savings of £96,285.80 per annum. These savings are set against the high capital costs (new birth centre and labour ward refurbishment) in year one, which together with staff costs are greater than the 2% saving in c-section rates. However, these capital costs will not recur in year two and assuming equivalent staff costs and c-section reductions for the second year these High Impact Actions move toward a positive return on investments. There are also benefits that it has not been possible to monetise within the model such as increased home births and VBAC, plus earlier discharges for those who have hospital births.

Further information available from the NHS Institute website

Key themes and methodology

Focusing on both the culture and the organisation of the service

Focusing on the overall goal of reducing c-section rates was the key to success for the team. Using normalising birth as the driver, the team worked on changing the culture and on how they organised services.

By priortising the VBAC pathway the trust was able to discuss the principles of care in the management of their patients. One of these new processes was a discussion and a post-discharge letter given to women following a Caesarean, which explained the reasons for the c-section and outlined her choices for her next birth. This was seen as an important step to ensure women had the right and accurate information about the event of their labour and birth and how these may affect their future births including the possibility of a VBAC. This might be seen as a fairly minor change – but it gave the clinicians the opportunity to use their skills and experience to support women and, hopefully, increase the likelihood of a vaginal birth in the future.

Looking at both the culture and organisation of services is not easy, but the NHS Institute's self improvement toolkit has practical advice on using self-assessment workshops that will help maternity services to explore their current practices relating to c-section and help the team work through what are the cultures, behaviours and processes and to stimulate ideas and aspirations for your future services.

Improvement tip

In common with many of the case studies featured in this chapter, Western Sussex Hospitals NHS Trust used the NHS Institute's Delivering Quality and Value Pathway to Success a self-improvement toolkit: Focus on normal birth and reducing Caesarean section rates. In the toolkit there are 3 clinical pathways:

- keeping first pregnancy and labour normal
- vaginal birth after Caesarean (VBAC)
- elective Caesarean section.

Each pathway lists the principles of care underlying each stage of a women's progress through it and illustrates the behaviors and practices that trust's believe have contributed to their success.

The tool also outlines a pathway of organisational characteristics where changes in culture and practice might have the greatest benefit in reducing c-section rates.

http://www.institute.nhs.uk/quality_and_value/high_volume_care/focus_on:_caesarean_section.html

Further information available from the NHS Institute website

"Women now feel that they can exert more choice and tell us what they would find helpful. The dialogue between us has improved. It is all part of a wider approach to monitoring the effectiveness of care, which includes talking about performance, involving doctors and midwives in audits and analysing and acting on statistics."

Carole Garrick
Head of midwifery
and associate director

How to measure…Promoting normal birth

The national picture

National statistics concerning the method of delivery are published yearly by the Information Centre using Hospital Episode Statistics (HES) however HES data can be unreliable for mode of birth because it misses out births in the catchment of a maternity service that occur outside hospital. Maternity services usually keep detailed statistics from an information system or manual recording based on birth registers. Comparator information can be obtained from the annual returns to the Royal College of Obstetricians and Gynaecologists and from the LSA annual reports published for each SHA. The Care Quality Commission is currently monitoring maternity data quality.

Hospital episode statistics Link:
http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1024

Please note that Operating Procedure Codes (OPCs) and Healthcare Resource Groups (HRGs) two coding system used in hospitals are differently defined and are not interchangeable.

How is normal birth defined?

The Information Centre (IC) defines a normal birth as: "A normal delivery is one without induction, without the use of instruments, not by Caesarean section and without general, spinal or epidural anaesthetic before or during delivery. Procedures related to assisted deliveries are excluded, except repair of laceration."

Although the above defines a normal birth if a Caesarean section is replaced by an assisted birth or by a spontaneous vaginal birth even if any of the exclusions above are not met, it is seen as a success, even if not the gold standard.

What is an "unnecessary" Caesarean section?

A c-section is 'unnecessary' if it is unlikely to provide any benefit to mother and/or baby. At the point of deciding on an emergency c-section, very few operations are 'unnecessary'. However, there are ways in which we can avoid reaching that decision point.

- Selective use of admission Ctg (% low risk women who have admission Ctg)
- Skills in assisted birth (% assisted births)
- External cephalic version services (% singleton breech where ECV was attempted)
- Timely use of oxytocic drugs (women with 'delay in labour' that was diagnosed and treated according to NICE guidelines).

Elective c-sections may be considered 'unnecessary when they are performed in the absence of a medical indication or for reasons outside the parameters of best clinical practice .

How might normal births be recorded and measured locally?

Normal birth registers in birth units collect normal birth Information via local information systems however you may also want to measure some process measures as well:

- % of women who contribute to their birth plan
- % of clinical staff who are aware of monthly c-section rates and trends

Measures you might consider for VBAC.

- % women giving birth vaginally who have had (one) previous c-section

Interim measures for VBAC

- % of women who have had (one) c-section choosing VBAC at time of booking
- % of women who have had (one) c-section choosing VBAC at 37 weeks' pregnancy
- % of women who receive a verbal debriefing within 48 hours of c-section
- % of women who receive written information within 48 hours of c-section.

Measure when making improvements

If you are starting to work on increasing normal births and reducing c-sections you should begin by looking at what you are already measuring, and also what other teams in your department or organisation may be collecting, so that you save time and use existing systems if they are appropriate. Use the **seven steps to measurement** framework outlined in the measurement section (page 21) to link together what you are already collecting around pressure ulcers and to understand gaps where you might need to collect extra information.