Care during labour and birth – extended examples of quality improvements implemented in trusts and health boards following PMRT review ordered by type clinical improvement area

The issue with care identified	Service improvement(s) implemented
Risk of preterm labour Woman who had a previous caesarean section at full dilatation was not referred to the Preterm Clinic (had no additional surveillance, cervical length measurements or preventive management)	At booking - for all multiparous women who had a previous caesarean section there is a distinct new question that was added to the EPR as a prompt to remind the midwives to ask if the caesarean section was done at full dilatation and a reminder to refer the woman to the Preterm Clinic.
Triage services The mother had preterm labour or had preterm pre labour rupture of membranes during her pregnancy and there was a delay in the diagnosis	Triage and BSOTS* guidance was reviewed and disseminated to all staff. Transformation of triage process took place. Triage was re-located from Delivery Suite to outpatient area with dedicated telephone line and staff.
Triage services Capacity in triage and appropriate assessment of patient	An assessment couch has been introduced (in addition to the triage beds) so that all women can have a set of maternal observations and FH auscultated upon arrival. If there are concerns about either then she can be prioritised accordingly. If no problems identified then the patient can be reassured and await a full review.
Triage services CO monitoring compliance very low following return to pre-COVID guidance.	In addition to new equipment in antenatal clinic and for community midwives, equipment has also been introduced in triage and the day assessment unit (DAU) areas, to ensure any missed CO levels can be added.
Triage services A mother presented in early labour, she was not triaged immediately and when she was seen there was no fetal heart.	Review of triage system to support timely initial assessment and the introduction of a RAG rating to inform the ongoing care pathway. Triage stickers are being revised to support these changes. Maternity Assessment Unit (MAU) has been separated into a Rapid Assessment Unit and a day assessment unit.
Triage management of unbooked mothers Mother's arriving to Maternity Triage unbooked were not being booked in a timely manner and therefore not having an ultrasound scan within an appropriate timeframe.	A partial booking process was created to ensure mothers arriving to Maternity Triage unbooked are booked and receive an ultrasound scan within 72 hours.

Managing the development of intrapartum risk factors for home births Development of meconium during labour which was not escalated	A new system was introduced: Community Midwife attending homebirth should phone in and update the Sister in Charge of Labour ward every 2 hours when new intrapartum risk factors are identified.
High risk birth against guidance at home Term intrapartum stillbirth to a high risk mother following birth at home against guidance; following the initial plan the risk factors deteriorated but the plan was not reviewed and additional risks were not discussed with the women.	'High Risk Birth Against Guidance at Home' reviewed and the following changes were made: (1) Introduced a new High Risk Homebirth Pro forma, which has space for the signature and date of the Woman and the Homebirth Midwifery Lead/Consultant Midwife. (2) Women who have an initial High Risk Home Birth Against Guidance plan must have the plan reviewed at 36-38 weeks gestation. (3) For women booked for Low Risk Midwifery Led care who developed high risk features during the pregnancy, and the woman requests a High Risk Homebirth Against Guidance: these birth plans need to have an MDT Review before final signed off by the Woman and the Homebirth Midwifery Lead and Consultant Midwife. (4) High Risk at booking (Consultant Lead Care) for women booked for High Risk Consultant Lead who request a High Risk Homebirth Against Guidance: these birth plans have an MDT review by the woman's Consultant, PMRT Consultant Lead, Homebirth Midwifery Lead and the Consultant Midwife.
Information about induction of labour Lack of consistent information available for women regarding Induction of Labour	Induction of labour (IOL) Lead midwife appointed
Post-dates induction of labour No discussion of rationale/benefits for post-dates induction of labour and the risks if declined/postponed	The trust is currently in the process of reviewing the induction of labour pathway to align with NICE guidance for the recommended timing of postdates induction of labour. A postdates induction of labour decision aid patient leaflet was developed and implemented.

Caesarean section and induction of labour Service user feedback - no written information available for women requesting a LSCS on diagnosis of a stillbirth or failed induction of labour following diagnosis of a stillbirth.	A leaflet has been produced and is now in use.
Information about induction of labour Lack of consistent information available for women regarding Induction of Labour	Induction of labour (IOL) Lead midwife appointed now who has developed an infographic for IOL, available in many different languages and including an information video, which supports consistent counselling and information provided for post-dates IOL.
Partogram use in labour Partogram missed being plotted during labour for some of the mothers who had an antenatal stillbirth	Education of the midwives and staff. Posters reminding the staff about using the partogram regardless of the fetal status Regular audits by Bereavement team to check these are being followed.
Care for lethal congenital anomalies Mothers with babies with known lethal congenital anomalies who declined TOP were not invited to complete a birth plan early in pregnancy.	Birth plans modified to include antenatal, intrapartum and postnatal planning for mothers of babies with a known fetal anomaly
Managing maternal deterioration Lack of SBAR** tool and associated SOP for transfer of care following identification of maternal deterioration	SBAR SOP developed and staff training initiated
Differences in clinical opinion Challenges were faced during a mother's admission to hospital to manage the differences in clinical opinion, the ongoing plan of care, including timing of birth.	Development of a conflict of clinical opinion policy to support maternity staff.
Access to emergency care Issues around the information given to some mothers of the BAME group. Most women did not understand how to access emergency services urgently.	It is a work in progress at present moment mainly in the maternity services to assist this particular group of women to have sufficient information and to also get the right care.

*BSOTS Birmingham Symptom-specific Obstetric Triage System; **SBAR tool to aid clinical communication: situation, background, assessment and recommendation