

Maternity and Gynaecology

GIRFT Programme National Specialty Report

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GIRFT Joint Clinical Leads for Maternity and Gynaecology

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(Addendum added November 2024)



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Foreword from Professor Tim Briggs

I am delighted to recommend this Getting It Right First Time review of maternity and gynaecology, led by David Richmond and Rob Sherwin.

This report comes at a time when the NHS has undergone profound changes in response to the COVID-19 pandemic. The unprecedented events of 2020/21 – and the extraordinary response from everyone working in the NHS – add greater significance to GIRFT's recommendations, giving many of them a new sense of urgency.

Unlike many other medical interventions, a pregnancy cannot be deferred. While maternity services have continued during the pandemic, precautions such as limiting visitors and face-to-face contact have changed the experience of birthing and postnatal care. Unlike births, many gynaecological surgeries and appointments were cancelled or delayed as a result of COVID-19.

Maternity care has been the focus of several major investigations and inquiries, with enormous amounts of work already under way to address the issues raised. There are significant challenges in gynaecology too, where waiting lists have grown to levels not seen for a decade.

In recent years, several landmark reports and investigations have been published on maternity services. This GIRFT report is aligned with these reports and builds on them, highlighting the significant progress made to date and supporting the delivery of existing recommendations.

The recommendations set out in this report are based on deep-dive visits to trusts, alongside data and audits. Implementing the recommendations in this report will help to protect women's safety, increase patient choice and improve patient experience. The recommendations will also tackle unwarranted variation, while reducing reliance on hospitals.

David and Rob found many examples of excellence from the trusts visited as part of their review, a few of which are shared in this report as case studies. Like other GIRFT clinical leads, they have been impressed by the dedication of all who work in maternity and gynaecology and encouraged by their engagement with the GIRFT programme and their commitment to improving the care they provide.

This support is vital to the GIRFT programme, which can only succeed with the backing of clinicians, managers and everyone involved in delivering care.

My greatest hope is that this report will provide further impetus, encouragement and support to all those working in maternity and gynaecology to work shoulder to shoulder to improve women's choices, experiences and outcomes.



Professor Tim Briggs CBE

GIRFT programme Chair and National Director of Clinical Improvement for the NHS

Professor Tim Briggs is Consultant Orthopaedic Surgeon at the Royal National Orthopaedic Hospital NHS Trust, where he is also Director of Strategy and External Affairs. He led the first review of orthopaedic surgery that became the pilot for the GIRFT programme, which he now chairs. Professor Briggs is also National Director of Clinical Improvement for the NHS.

Introduction from David Richmond and Rob Sherwin

Maternity and gynaecology and their association at times may seem strange and yet in reality they cover the entire life course of a woman from cradle to grave. Any impact at the start of life can have such enormous ramifications in later epochs. Maternity care has repeatedly been in the media spotlight recently, sadly often for the wrong reasons. There is an enormous amount of work going on to address the issues raised, much of it behind the scenes at NHS England and NHS Improvement, the royal colleges, the Healthcare Safety Investigation Branch and MBRRACE, to name but a few.

Maternity is truly a 24/7 specialty with many births occurring unpredictably out of 'normal hours'. In England, there are around 600,000 births every year; most are delivered safely and the mother and baby have an excellent outcome. Tragically, not all do, and there is a concerted effort by all to improve outcomes further for both the baby and the mother. The ambitions to reduce stillbirth, neonatal death and maternal mortality by 2025 are to be welcomed. There has been substantial progress in all these areas over recent decades; a simple demonstration of this is that maternal death rates are now expressed in terms of the number per 100,000. However, to underline how far we still have to go, perinatal mortality rates are still measured per 1,000.

Gynaecology remains one of the busiest acute specialties in terms of outpatient visits and surgical procedures. The COVID-19 pandemic has changed the doctor-patient interaction dramatically, and we believe for the better. The pandemic has forced the specialty, like others, to look at the primary medical interface more closely and increase use of remote advice and guidance, telephone consultation and triage, preoperative consultation and patient initiated follow-up, as examples. As waiting lists have grown to levels not seen for a decade, alternative surgical options are being developed and the need for traditional inpatient stay analysed. Patients themselves are increasingly questioning the need for intervention and balancing the outcome/risk equation more closely.

This report shines a light on current practice, and supports recommendations already published in the many other recent reports that have examined both gynaecology and maternity. It notes where these recommendations have not yet been fully actioned or delivered. In addition, the report includes new recommendations with a timescale for delivery.

Sharing details of variation in outcomes and practice is just as evident in this report as with other GIRFT topics. For us, this is an opportunity to reflect on practice and continue to learn – in its simplest terms, is the patient getting the best option and could I do it differently? Auditing outcomes of the intervention and the patient experience and then benchmarking locally, nationally and even internationally must be the template for us all.

This report has taken much longer than anticipated, partly because of the need to dovetail with other important maternity reports such as that from the royal colleges in the shape of the NMPA report, which straddled the time period of the GIRFT visits. That in turn necessitated a review of the GIRFT data used for this report. In some respects, we think both are complementary, emphasising many of the recommendations and providing more up to date analysis of the current metrics.



David Richmond

GIRFT Joint Clinical Lead for Maternity and Gynaecology

David is currently a non-executive director at Birmingham Women and Children's NHS Foundation Trust and a Clinical Ambassador for GIRFT in the south west region. He retired from clinical practice after demitting office as President of the Royal College of Obstetricians and Gynaecologists 2016 after 40 years in clinical practice.



Rob Sherwin

GIRFT Joint Clinical Lead for Maternity and Gynaecology

Rob is currently the Director of Women's Health Service at Auckland District Health Board, New Zealand, where he works clinically as a Urogynaecologist and is accountable for the clinical, safety, human resources and financial outcomes of the service. He previously worked as a Consultant and Associate Medical Director at the Whittington Hospital, London.

Statement of support

The Royal College of Obstetricians and Gynaecologists (RCOG)

This national report from GIRFT into maternity and gynaecology care adds to our knowledge and understanding of current practice, outcomes and experiences of care in obstetrics and gynaecological services across England. Analysis and reporting of data play a vital role in supporting trusts to understand their own performance and benchmark against others, both locally and nationally, to drive continuous improvement and learn from best practice elsewhere.

As the report notes, maternity care continues to be under intense political and media scrutiny, as part of a shared national ambition to ensure the safest possible care for all women giving birth in this country and for their babies. The recommendations within the GIRFT report will chime with all those working across the system to improve care and add weight to initiatives and workstreams already under way.

The equal focus within this report on gynaecology as well as maternity care is to be welcomed, recognising that women engage with these services throughout their life course and that much of the workforce works across both areas of the specialty. While maternity services have continued to provide care throughout the pandemic, albeit in changed circumstances, in common with other specialties much of the gynaecological care which is normally offered has been paused or greatly reduced. The insights from the GIRFT report into both maternity and gynaecology care will add to the resources available to trusts as they begin to focus on the restoration of services following the second peak of the pandemic.



Mr Edward Morris

President

Royal College of Obstetricians and Gynaecologists



Royal College of
Obstetricians &
Gynaecologists

Executive summary

This Getting It Right First Time report into maternity and gynaecology has been a long time in development. The deep-dive visits to trusts began in 2017; however, before the report could be completed, the clinical lead Rob Sherwin took up a post in Auckland, New Zealand. His successor, David Richmond, was appointed in 2019, but progress was then halted by the COVID-19 pandemic.

During the period of developing the report, NHS provision of both maternity and gynaecology services has been under considerable scrutiny and subject to a number of changes – including, of course, the impact of COVID-19.

Maternity

In maternity, there has been a series of initiatives – summarised in the report – with a major emphasis on the safety of the mother and of the newborn child. These are clearly incredibly important programmes, particularly in the way they seek to respond to inequalities in birth outcomes between different ethnicities and socio-demographic groups. However, because the overwhelming majority of births in England are safe, the issues being addressed – stillbirth, traumatic injury and maternal death – typically only affect a small proportion of births a year. They are therefore not well suited to examination via the GIRFT methodology, which seeks to identify and learn from variation in the care provided and its outcomes.

Focus on the patient experience and patient choice

Instead, the team has sought to focus on other issues around maternity care which affect all births: these are mainly issues related to the patient experience and patient choice. Much of the data we used was drawn from the National Maternity and Perinatal Audit (NMPA), the most robust and comprehensive data available on maternity. We strongly support the recommendations made in the NMPA's 2019 clinical and organisational reports and have sought to build on those that are relevant.

Variation in adherence to best practice

We have looked at the provision of antenatal care, including the number of appointments mothers have with maternity professionals, the continuity of care and access to additional relevant support. Within each of these topics, we found greater variation than would have been expected; our recommendations restate the importance of providers adhering to existing best practice in these areas. It is also clear that to enable providers to meet key goals, particularly around continuity of care, there needs to be further investment in the midwifery workforce.

We examined the birth itself, looking at variation between trusts in the rates of instrumental delivery, induction and caesarean section.

Clearly, the use of any of these methods must be on a case-by-case basis, reflecting the mother's choice and a number of clinical factors. Some variation in rates is therefore to be expected, and indeed rates in any one trust would be expected to change from one year to the next, reflecting their caseload. However, again the variation between providers was more pronounced than we expected. The extent of this variation indicates that trusts have markedly different approaches to the use of these different methods of assisted birth, which do not necessarily reflect current best practice or maternal choice. A useful area for future study would be to examine the impact of these different approaches on outcomes. In the interim, we would hope to see a reduction in the scale of variation.

Examining change over time

One advantage of the long development period of the report was that it allowed us in some instances to compare data over a few years. In the case of induction, we were able to look at comparable data for induction rates in 2016/17 and again in 2019-20; while the analytics methodologies were not wholly the same, the data showed a marked rise in the national average induction rate in just three years, from 27.9% to 39%. One possible explanation for this is the publication in 2019 of version two of the Saving Babies' Lives care bundle, which strongly reinforced the need for timely induction.

Protecting women from harm

While this appeared to be a positive trend, another comparison over time highlighted a lack of progress. This was around the rate of obstetric anal sphincter injuries (OASI). NMPA data for 2016/17 found that the national average OASI rate was 3.4%. When we examined data for 2019/20, the average had barely changed. This was disappointing because there has been a major initiative to encourage the adoption of care bundles to reduce OASI rates. These bundles have been proven to have a positive impact on the risk of mothers suffering these painful and debilitating injuries; there needs to be a renewed emphasis on introducing bundles, backed by training for the whole team in how to avoid OASI.

Protecting women from harm was also a key focus of two other high-profile reports published in 2020 that have a clear link to this GIRFT report.

In December 2020, the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust led by Donna Ockenden published its emerging findings and recommendations. Among those findings, it noted that '*There was clear evidence that the operating obstetricians were not following established local or national guidelines for safe operative delivery.*' At the heart of our maternity recommendations is a similar principle; that trusts should seek to adhere to the wealth of best practice guidance that exists around maternity care.

In July 2020, The Independent Medicines and Medical Devices Safety Review (IMMDS) chaired by Baroness Julia Cumberlege published its report. One of the catalysts for the review was a growing volume of evidence that a specific gynaecological procedure – the insertion of vaginal mesh to address stress urinary incontinence and pelvic organ prolapse – was causing severe and chronic pain among some of those treated. The IMMDS Review made several recommendations around the future safety evaluation of medical devices; at the heart of these was that 'a central patient-identifiable database should be created by collecting key details of the implantation of all devices at the time of the operation.'

This strong recommendation superseded our own provisional one and is being taken forward with the creation of a national Medical Devices Information System.

Gynaecology

As our data shows, even before the publication of the IMMDS Review, there was evidence of a change in practice, with mesh procedure levels reducing before a national moratorium on them was imposed. This demonstrates the importance of tracking patient outcomes to help improve care and provision; we recommend the adoption of similar registries for recording data about other gynaecological procedures and increasing the visibility and consistent use of patient-reported outcome measures across the country.

Reducing reliance on hospitals, improving the patient experience

This will be particularly important as we seek to encourage more day surgery in gynaecology – the evidence to date is that it is as safe and reliable for many procedures, including hysterectomy – and more patients to self-manage their conditions, with the support of primary care and physiotherapy.

Such approaches not only reduce pressure on hospitals but, more importantly, offer a better patient experience in many cases. We found a number of highly successful examples of these approaches in action. The impact of COVID-19 will have certainly resulted in many more. It has served to accelerate the shift towards fewer face-to-face appointments and hospital admissions, making greater use of advice and guidance, as an interim step between the GP and the hospital, and increasing reliance on and trust in digital care.

Evaluating digital and virtual care

We strongly believe that the use of digital and virtual health will continue even after the worst phases of the pandemic pass. However, it is important that there is some evaluation of what has worked well – and less well – so that digital models of care can be optimised and pathways developed that use digital and virtual channels in the best way alongside face-to-face care. It is also crucial that digital care is built into job plans and training.

Addressing barriers

In the interim, we identified some areas where there are unnecessary barriers to providing gynaecology services in primary or intermediary care. The most obvious of these is around the use of Contraceptive and Sexual Health (CASH) services, which are typically funded by local authorities. CASH nurses regularly insert hormone-releasing intrauterine devices (coils) for contraceptive purposes but under current commissioning arrangements are not permitted to conduct exactly the same procedure to help regulate heavy menstrual bleeding. The use of intrauterine devices is NICE's primary recommendation for the treatment of heavy menstrual bleeding, where there are no other identified pathology or specific concerns – but the devices can only be inserted for this purpose in hospital. We believe this restriction should be lifted.

Cost savings through procurement

Like other GIRFT reports, we have also looked at ways to improve clinical standards and procurement. The NHS Spend Comparison Service identified opportunities to save £700k a year on the nationwide procurement of just two items regularly used in gynaecology procedures.

Litigation

Also like other workstreams, we have looked at the issue of litigation. Gynaecology accounts for 7% of all medical negligence claims received by NHS Resolution, putting it in the top five specialties for number of claims. While the average cost of these claims is comparatively low, there is clearly an opportunity for improvement.

Maternity, meanwhile, accounts for 9% of the number of new clinical claims received by NHS Resolution annually – but the cost of these is immense. It accounts for half of the value of all claims received, dwarfing all other specialties. In recognition of this, there are numerous initiatives under way to:

- understand the causes of claims, and make improvements to practice as a result;
- accelerate the reporting of incidents, to enable support to be provided to families sooner; and
- increase the safety of maternity care, based on what is learned from claims.

There is some evidence to suggest that these targeted initiatives are making progress: the number of new claims notified to NHS Resolution against maternity in 2019/20 was 911, compared to 1172 in 2013/14. However, this figure is still too high and the costs of claims keep rising. By reducing the number of claims further – essentially, by reducing the number of babies receiving traumatic injuries, such as brain injuries, at birth – the cost savings would be immense, not only in relation to litigation fees and settlements but the lifetime costs of providing NHS care for these children. More importantly, reducing these errors would also have a massive impact on individual lives.

Next steps

Our recommendations for maternity care add to a large volume of existing recommendations for the specialty. We are acutely aware that trusts are still implementing many of these changes, or even working out how to. We have therefore sought to minimise the additional burden on trusts, and instead focus on reinforcing existing best practice – using GIRFT as a lever for improvement.

In gynaecology, our recommendations are designed to support and accelerate the ongoing shift towards making more effective use of primary and intermediary care, reducing the burden on hospitals and providing more choice to women.

We recognise that the impact of COVID-19 will continue to affect providers' ability to make the changes we propose, but we believe that many of the changes to practice introduced in response to the pandemic actually support our recommendations – which are listed in full on page 11.

About the analysis

The GIRFT programme is based on a combination of data analysis, to identify variation in aspects of NHS practice and outcomes, and deep-dive visits to trusts, that explore the reasons behind that variation. Those visits are overseen by our clinical leads: practitioners in their field, with a wealth of relevant experience. They lead to a national report, like this, with practical, evidence-based recommendations for change. In this workstream, while the data in some cases refers to the whole of the UK, the recommendations apply specifically to the NHS in England.

For this workstream, the majority of deep-dive visits took place in 2016, before our then clinical lead Rob Sherwin took up a post in Auckland, New Zealand. As this report shows, this was a time of considerable change in NHS maternity provision, with a host of new initiatives introduced in response to the recommendations of major reports such as the National Maternity Review's *Better Births*,¹ the Royal College of Obstetricians and Gynaecologists' (RCOG's) *Each Baby Counts*² and the Saving Babies' Lives Care Bundle.³

Given these changes in provision, and the change of clinical lead, we sought to refresh data in some areas, to provide a more relevant picture of the state of maternity care. This was then delayed by the COVID-19 pandemic. As a result, the report uses a mix of data, some from core NHS sources and some from other national reports. While it looks at many aspects of maternity provision, it does not address in depth some of the more recent initiatives, such as greater focus on maternal mental health, the success of Maternity Voices Partnerships (MVPs) in driving local change, or the impact of other changes made following the publication of the NHS Long Term Plan. We are also aware that more up-to-date information is available in some areas.

NHS gynaecology provision has seen fewer changes over the same time span. However, it has of course been affected by COVID-19. The report acknowledges some of the changes in practice that have been introduced to help provide safe care to patients during the initial wave of the pandemic – many of which will of course remain in place at least in the short term as the NHS seeks to prepare for any future increases in transmission.

These changes have not yet been fully evaluated and any reported outcomes in this report are based on first person experiences rather than quantitative data.

Maternity

We have used the GIRFT methodology – of identifying and examining unwarranted variation – to pinpoint potential barriers to the implementation of the existing body of recommendations, and to highlight areas where further investigation may be of value.

In examining maternity care, we have looked at data relating to four key areas:

- care and support before, during and after birth;
- the birth;
- the mother; and
- the baby.

We have sought to identify areas of unwarranted variation in the care pathways, the choices offered and birth outcomes.

In some areas, we have analysed data sourced from Hospital Episode Statistics (HES). In other areas, we have chosen to rely on the National Maternity and Perinatal Audit (NMPA). Its most recent reports are the 2019 clinical report and 2019 organisational report. With data on at least 97% of the 728,620 births in NHS maternity services in England, Scotland and Wales between 1 April 2016 and 31 March 2017, the NMPA offers the most robust and comprehensive data available on maternity and – through its links with the National Neonatal Research Database – on neonatal care.

Using NMPA data provides a fuller picture of the state of maternity care than we would otherwise have been able to show; the NMPA is casemix adjusted, and uses data from the national Maternity Services Data Set (MSDS)⁴ which GIRFT was not able to do at the start of our review (in the future, the GIRFT team will be able to use the MSDS).

We strongly endorse the recommendations in the NMPA's 2019 clinical and organisational reports. Future GIRFT work in relation to maternity will be closely aligned with the NMPA.

¹ NHS National Maternity Review (2016) *Better Births* <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

² See <https://www.rcog.org.uk/eachbabycounts>

³ NHS England (2019) *Saving Babies' Lives Version Two* <https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf>

⁴ See <https://www.digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set>

Gynaecology

Gynaecology is one of the busiest specialties in the NHS, accounting for almost 4% of all outpatient attendances.⁵ It also has one of the highest numbers of planned/elective admissions. While referral to treatment (RTT) statistics indicate that waiting times in gynaecology are better than some specialties – and indeed that performance in gynaecology is better than the NHS average – in 2019-20, around one in five patients did not complete their intended treatment pathway within 18 weeks.⁶ However, at the time of writing (as with many other acute specialties), the impact of COVID-19 has extended waiting times and there are nearly 12,000 gynaecology patients waiting 52 weeks or more for care.

With such high numbers, it is important to optimise the delivery of care by streamlining pathways and increasing non-consultant led care – for example, by increasing access to gynaecology services in primary and intermediate care (including independent sector providers contracted to the NHS).

Our analysis has therefore focused on data that gives an insight into access to services – whether community/outpatient services, or following admission – and waiting times. We have used HES data around gynaecology appointments and surgery, looking at methods and readmission rates. In addition to the data originally produced for this report, from 2017-18, we have refreshed the data to look at comparative figures from 2019-20. Where the trends were the same, we have included only the more recent charts; where there was a significant difference, we have included data from both analyses.

Our intention was to examine data about the different approaches to managing cancer between trusts, the rates of surgery and key outcomes such as readmissions, complications, length of stay and mortality. In future, GIRFT hopes to access data from the National Cancer Registration and Analysis Service (NCRAS) to compare to surgical data available in HES.

⁵ See Elective Care Transformation Programme (2019) *Transforming elective care services: Gynaecology*
<https://www.england.nhs.uk/wp-content/uploads/2019/06/gynaecology-elective-care-handbook.pdf>

⁶ See NHS England (2020) *Referral to treatment (RTT) waiting times statistics for consultant-led elective care 2019/20 Annual Report*
<https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/11/RTT-Annual-Report-2019-20-2.pdf>

Recommendations

Maternity

Recommendation	Actions	Owners	Timescale
1. Review antenatal care ensuring schedules as outlined in NICE guidance are followed. Follow the Saving Babies' Lives Care Bundle 2 as outlined in the NHS Long Term Plan.	<p>a For uncomplicated pregnancies, trusts to follow NICE guidance CG62 Antenatal care for uncomplicated pregnancies, as a minimum.</p> <p>b Trusts to follow NICE guidance NG121, Intrapartum care for women with existing medical conditions or obstetric complications and their babies, as applicable.</p> <p>c Trusts, CCGs and NHS England and NHS Improvement to work with royal colleges and professional bodies to address care inequalities, such as racial and geographical inequalities, and complex social factors,⁷ and develop strategies to engage the at-risk groups identified in their region.</p>	Trusts, CCGs, ICSs	For immediate action
2. Review and act upon comprehensive maternity patient experience data.	<p>a All CCGs to have a Maternity Voices Partnership (MVP) and to actively seek to capture patient views from the whole of the local population, exploring relevant methods to expand participation in patient surveys and increase response rates from under-represented groups.</p> <p>b Trusts to promote greater use of the Friends and Family Test.</p> <p>c Trusts to meet national mean (2019/20) of patient experience response rate, then pursue top decile of performance.</p> <p>d Trusts and CCGs to monitor national patient experience data through NPEU⁸ and CQC reporting and act upon published findings.⁹</p>	CCGs, MVPs	For substantial progress within 12 months of publication
3. Strive towards healthy BMI rates and smoking rates in line with top decile of performance.	<p>a Integrated care systems (ICS) or other local partners to review uptake of smoking cessation programmes and identify barriers to participation and action accordingly.</p> <p>b Integrated care systems (ICS) or other local partners to encourage use of obesity services for women of childbearing age.¹⁰</p>	ICSs, local partners	For substantial progress within 12 months of publication

⁷ Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (NICE) <https://www.nice.org.uk/guidance/cg110>

⁸ You and Your Baby Survey 2018 (NPEU) 2019. <https://www.npeu.ox.ac.uk/maternity-surveys>

⁹ CQC, 2020. Maternity services survey 2019. <https://www.cqc.org.uk/publications/surveys/maternity-services-survey-2019>

¹⁰ Care of women with obesity in pregnancy RCOG 72 (2018) <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg72/>

Maternity (continued)

Recommendation	Actions	Owners	Timescale
4. Improve recording of data about key aspects of maternity care, including outcome data for mothers and babies. For example, spontaneous birth, caesarean section, assisted birth.	a Trusts to improve data capture, such as local audit, that can then be used to inform and optimise: <ul style="list-style-type: none"> i. Rates of caesarean section and maximise use of Robson classification. ii. Mode of birth in line with evidence-based best practice. iii. Rates of babies born at term who are small for gestational age, as defined in Saving Babies Lives Care Bundle volume 2. iv. Rate of induction, including clinical reasoning. b Local Maternity Systems (LMS) to actively monitor 12 month rolling average rate of serious incidents and referrals to HSIB in each hospital.	Trusts	For substantial progress within two years of publication
		LMS	For substantial progress within 12 months of publication
5. Increase focus on reducing the rate of obstetric anal sphincter injury (OASI) so that all trusts achieve OASI levels similar to those at the top decile of trusts.	a All trusts to implement an OASI care bundle and improve the safety of episiotomy when indicated.	Trusts	For immediate action
	b All trusts to audit the effectiveness of the implemented/established OASI care bundle.	Trusts	Ongoing

Gynaecology

Recommendation	Actions	Owners	Timescale
6. Treat gynaecology patients in the most appropriate setting for their condition.	a Trusts to re-examine outpatient pathways with a view to maximising use of Advice and Guidance and virtual clinics, cutting unnecessary appointments and introducing patient-initiated follow-up.	Trusts	12 months
	b RCOG to provide advice, based on NICE guidance, of which diagnostics are appropriate to be carried out or commissioned by GPs prior to referral to secondary or specialist care, to increase opportunities to discharge at first appointment.	RCOG, GIRFT	12 months
	c Trusts to work with local partners to identify where patient-initiated follow-up would be feasible and put in place necessary structures to move to a patient-initiated follow-up model.	ICSs, Trusts	12 months
	d CCGs to increase availability and use of intermediate care settings for conservative treatment (particularly physiotherapy) to allow hospital gynaecology departments to focus more on surgery.	CCGs	12 to 18 months
	e CCGs to commission CASH services to conduct intrauterine device insertion for heavy menstrual bleeding in relevant cases.	CCGs	12 months
	f Trusts to examine opportunities for digitally-enabled care, particularly for conservative treatment and to support self-management.	Trusts	For substantial progress within 12 months of publication

Gynaecology (continued)

Recommendation	Actions	Owners	Timescale
7. Expand role of nurses and other members of the wider gynaecology team to enable them to work at the top of their licence.	a Trusts to train and support nurses, physiotherapists, sonographers and other members of the team to conduct diagnostic and therapeutic gynaecological procedures (and in particular, endoscopy) to increase provider capacity.	Trusts	2 years
8. Ensure that benign hysterectomy procedures are only offered when clinically indicated, as per NICE guidelines and Evidence-Based Interventions (EBI) programme statutory guidance.	a Providers and commissioners to review local practice and criteria for offering benign hysterectomy against NG88 <i>Heavy menstrual bleeding: assessment and management</i> and EBI statutory guidance. b Providers to adopt a local review process to audit all benign hysterectomies.	CCGs, Trusts	6 months 12 months
9. Increase use of appropriate setting for surgery, with a shift to day case and/or outpatient procedures for endometrial ablation, hysteroscopy, treatment of Bartholin's abscess, vaginal prolapse repairs and cystoscopy, to the rates recommended by the British Association of Day Surgery (BADS). See addendum on p113 for updated recommendation and additional action (Nov 2024)	a Trusts to review processes against BADS recommended best practice for day surgery, ¹¹ then review performance via Model Hospital. b Trusts to ensure sufficient multidisciplinary training is provided to all staff involved in the delivery of day surgery and/or outpatient procedures. c GIRFT to discuss with NHS England and NHS Improvement the feasibility of using alternative ways to continue to incentivise change through methods of payment once block contracts are reviewed. d CCGs / Trusts to review availability of appropriate recovery and analgesia facilities to increase rates of outpatient and day case surgery.	Trusts Trusts GIRFT, NHS England and NHS Improvement pricing team CCGs, Trusts	6 to 12 months 12 to 18 months 12 months 6 to 12 months
10. Ensure that there is adequate expertise and availability for day case hysterectomies when clinically indicated.	a Training providers and royal colleges to include identifying suitable candidates for day case hysterectomy, and procedures for day surgery, as part of their curricula. b GIRFT to work with trusts to enable and facilitate the delivery of day case hysterectomy where appropriate, identifying and addressing any barriers.	RCOG, HEE, statutory education bodies GIRFT, Trusts	12 months 12 months
11. Following the introduction of the Medical Devices Information System, consider introducing national registries with mandatory reporting for other gynaecological procedures.	a Existing registry owners to work together, supported by GIRFT, to agree a joined-up approach to the recording of relevant data.	GIRFT, NHSX, NHS Digital, HQIP, RCOG and other professional bodies	For immediate action
12. Consider including PROMs for gynaecology surgery in the national PROMS programme or other established national audit.	a Review existing PROMs to identify those that could be included in the national PROMS programme or other established audit. Identify any gaps and establish follow-up outcome measures at 12 months initially and then to develop further. b Consider including PROMs identified as a result of action 12A above in the national PROMS programme or other established national audit.	GIRFT, RCOG and other professional bodies NHS England and NHS Improvement	12 months 18 months

Gynaecology (continued)

Recommendation	Actions	Owners	Timescale
12. Consider including PROMs for gynaecology surgery in the national PROMS programme or other established national audit.	<p>c Collaborate with the wider multi-disciplinary team to develop new PROMs where gaps were identified as a result of action 12A.</p> <p>d Establish and implement Patient Reported Experience Measures (PREMs) for feedback, initially at 12 months and then to develop further.</p>	NHS England and NHS Improvement, GIRFT, RCOG and other professional bodies Trusts, RCOG and other professional bodies	18 months 18 months
13. Include surgeon-specific data reported under the National Consultant Information Programme (NCIP) as part of every surgeon's appraisal.	<p>a Individual clinicians to reflect on surgical data, including outcomes, as part of their annual appraisal.</p> <p>b Department heads and clinical directors to monitor procedure-level data reported under NCIP to help identify departmental development and procurement needs, inform recruitment strategies and address local anomalies.</p> <p>c Clinical directors and individual surgeons to work together to identify where individuals have insufficient recent experience, as defined by relevant professional bodies, to perform specific procedures.</p>	Clinicians, Clinician managers and Trusts Trusts Clinicians, Trusts, RCOG and other professional bodies	12 months 12 months 12 months
14. Continue to support the development of surgical outcome metrics.	<p>a Continue to develop metrics for use by surgeons and departments as part of the National Consultant Information Programme (NCIP). Use data that is routinely collected.</p> <p>b Identify any further metrics needed that are not covered by existing audits. Consider developing such metrics.</p>	NCIP, RCOG GIRFT, RCOG and other professional bodies	12 months 12 months

Procurement

Recommendation	Actions	Owners	Timescale
15. Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and by sharing best practice.	<p>a GIRFT to use sources of procurement data, such as the NHS Spend Comparison Service and relevant clinical data, to identify optimum value for money procurement choices, considering both outcomes and cost/price.</p> <p>b GIRFT to identify opportunities for improved value for money, including the development of benchmarks and specifications. Identify best practice and procurement excellence, that lead to the most favourable procurement outcomes.</p> <p>c Trusts, ICSs and GIRFT to use the new Category Towers to benchmark and evaluate products and seek to rationalise and aggregate demand with other trusts to secure lower prices and supply chain costs.</p>	GIRFT GIRFT ICSs, Trusts, GIRFT	12 months 18 months 18 months

Litigation

Recommendation	Actions	Owners	Timescale
<p>16. Continue to support trusts in achieving the Maternity Incentive Scheme's (MIS) safety actions.</p>	<p>a All trusts to familiarise themselves with the new MIS conditions and location of supporting materials e.g. MIS webinars available on NHS Resolution's website.</p> <p>b Trusts to reinforce duty of candour and provide support for staff and families during and post investigation of incidents.</p>	Trusts	For immediate action
<p>17. Reduce litigation costs by application of the GIRFT Programme's five-point plan.</p>	<p>a Clinicians and trust management to assess their benchmarked position compared to the national average when reviewing the estimated litigation cost per activity. Trusts will have received an updated version of this for obstetrics and gynaecology in the GIRFT and NHS Resolution 'Litigation Data Pack'.</p> <p>b Clinicians and trust management to discuss with the legal department or claims handler the claims submitted to NHS Resolution included in the data set to confirm correct coding to that department. Inform NHS Resolution of any claims which are not coded correctly to the appropriate specialty via CNST.Helpline@resolution.nhs.uk</p> <p>c Once claims have been verified, clinicians and trust management to further review claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. If the legal department or claims handler needs additional assistance with this, each trust's NHS Resolution panel firm should be able to provide support.</p> <p>d Claims should be triangulated with learning themes from complaints, inquests and serious incidents (SI) and where a claim has not already been reviewed as an SI we would recommend that this is carried out to ensure no opportunity for learning is missed. The findings from this learning should be shared at morbidity and mortality meetings or other departmental/directorate meetings for all frontline clinical staff in a structured format.</p> <p>e Where trusts are outside the top quartile of trusts for litigation costs per activity GIRFT will be asking national clinical leads and regional team directors to follow up and support trusts in the steps taken to learn from claims. They will also be able to share with trusts examples of good practice where it would be of benefit.</p>	Trusts	<p>For immediate action</p> <p>Upon completion of 17a</p> <p>Upon completion of 17b</p> <p>Upon completion of 17c</p> <p>For continual action throughout GIRFT programme</p>

About maternity and gynaecology

Maternity and gynaecology are separate medical disciplines often, but not always, provided by a single department in a hospital.

Maternity covers the care of mothers and their babies, before and during pregnancy and in the first few weeks after birth. Gynaecology is concerned with the health of women and in particular the female reproductive organs.

Maternity

In 2019-20, there were just under 600,000 live births in England – the lowest figure in over a decade.¹² Just under half of births (49.4%) are managed solely by midwives. The remainder are managed by a combination of doctors and midwives. This represents a change in practice over recent decades: in 1989-90, 75% of births were managed solely by midwives.¹³ Around 1 in 50 births takes place at home, supported by midwives.¹⁴ In 2019, there were 13,407 home births in England and Wales.¹⁵

In addition to the live births, maternity and gynaecology teams also support women who have early pregnancy complications such as miscarriage and ectopic pregnancy or whose pregnancy results in stillbirth. In 2019, the stillbirth rate was the lowest ever in England¹⁶ at 3.8 per 1,000 births, down from 5.1 per 1,000 births in 2010. The government's aim is to reduce the rate of stillbirths by half in England by 2025 compared with 2010.

While there remain concerns that many stillbirths and neonatal deaths could be avoided,¹⁷ and that stillbirth rates are substantially higher in the most deprived communities than in the least deprived, this indicates a positive underlying trend. It is supported by improvement initiatives such as the Saving Babies Lives Care Bundle (SBLCB)¹⁸ and greater Continuity of Care for mothers, as recommended in Better Births.¹⁹

Gynaecology

The majority of hospitals that have a maternity unit also have a gynaecology department. In 2018/19, NHS hospitals in England provided 3,680,000 gynaecology outpatient appointments – only three specialties provided more²⁰ – plus 767,000 inpatient admissions (only six specialties admitted more).²¹ Most of these patients have been referred from primary care, including GPs, community-based women's health clinics or contraception and sexual health (CASH) clinics.

Gynaecologists care for women with a range of chronic conditions such as heavy or irregular menstrual bleeding, vaginal prolapse, endometriosis, urinary and faecal incontinence and infertility, all of which can seriously affect a woman's quality of life – as can menopause, another key area of gynaecology care and support. Much of the work around assisted conception therapies are in the private sector. In addition, the specialty deals with acute conditions that can present a risk to a woman's life, such as ectopic pregnancy and other early pregnancy complications, ovarian cyst complications and gynaecological cancers, most commonly ovarian, cervical and uterine. Gynaecology departments also oversee termination of pregnancy, of which there were just over 207,000 in 2019.²² Termination rates have increased over the last three years.

Other gynaecological emergencies include pelvic infection, ovarian cyst accidents, genital tract bleeding and pelvic abscess formation. Treatment for acute conditions can involve surgery and the specialty carries out a wide range of procedures including vaginal, open, laparoscopic and – now – robotic surgery. However, the majority of day-to-day care in the specialty is non-surgical.

¹² See <https://www.digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2019-20>

¹³ See <https://files.digital.nhs.uk/99/EEAA99/hosp-epis-stat-hesnational-2019-20.xlsx>

¹⁴ See <https://www.nhs.uk/conditions/pregnancy-and-baby/where-can-i-give-birth/>

¹⁵ See <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthcharacteristicsinenglandandwales/2019>

¹⁶ See <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsummarytablesenglandandwales/2019>

¹⁷ See <https://www.rcog.org.uk/globalassets/documents/guidelines/research-audit/each-baby-counts/each-baby-counts-report-2018-11-12.pdf>

¹⁸ See <https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/>

¹⁹ See <https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/>

²⁰ See <https://files.digital.nhs.uk/B3/523049/hosp-epis-stat-outp-main-spec-2018-19-tab.xlsx>

²¹ See <https://files.digital.nhs.uk/46/78F330/hosp-epis-stat-admi-main-spec-2018-19-tab.xlsx>

²² See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf

Patient demographics

Gynaecology departments see and treat women across the entire age spectrum, from young girls with paediatric or adolescent conditions through to later years. In maternity, the age range is narrower, with the overwhelming majority of mothers aged between 20 and 40 and the average age for a mother now 30.7 years.²³ The fertility rate for women over 40 is gradually increasing and is now higher than for those under 20.

One factor in this changing pattern is fertility treatment (reproductive medicine), which now forms a significant share of the specialty's overall workload and results in approximately 3% of all babies born in the UK.²⁴

Many pregnant women are generally in good health, although the 2019 National Maternity and Perinatal Audit (NMPA) clinical report highlighted that more than half of pregnant women (50.4%) whose body mass index (BMI) was recorded at booking were either overweight or obese.²⁵

A range of data shows that maternity outcomes for Black and minority ethnic (BAME) groups are worse than for the population as a whole. These include higher risk of stillbirth and neonatal death and higher risk of maternal mortality. This report has focused on variation between trusts and their provision rather than variation in outcomes between socio-demographic and ethnic groups; however, this is clearly a critical issue for ongoing analysis and studies such as the MBRRACE-UK programme²⁶ examine these differences in more depth.

Maternity and gynaecology provision today

There are gynaecology and maternity departments in every hospital trust in England. Many have more than one unit. For example, there are in total 218 maternity units,²⁷ divided into:

- 45 obstetric units where midwives and obstetricians care for women in labour;
- 112 units where there is an obstetric unit (OU) and a co-located alongside midwifery unit (AMU); and
- 61 free-standing midwifery units (FMUs), where midwives care for labouring women and are able to consult with and transfer women to obstetric units when necessary.

Just under three quarters of births²⁸ took place in sites where there is both an obstetric unit and an AMU. According to the 2019 NMPA clinical report, '*the proportion of women recorded as giving birth in an alongside midwifery unit in England rose substantially between the 2015/16 and 2016/17 reporting years from 9% to 17%*'.

Units vary considerably in their maternity workload, from approximately 400 births a year (1-2 per day) to more than 8,500 (20+ per day). Maternity units also have to provide some oversight of the 13,000 home births a year; again, this workload varies.

In general, trusts with the busiest maternity units also have the largest gynaecology departments. Gynaecology workload varies between areas: in six CCGs, there were more than 20,000 new gynaecology outpatients a year (equivalent to approximately 400 new patients a week). However, in 13 CCGs, there were fewer than 3,000 new outpatients a year (57 a week). This is in part related to the size of the population served.

²³ See <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsummarytablesenglandandwales/2019>

²⁴ Based on data in Human Fertilisation and Embryology Authority (2020) Fertility treatment 2018 Trends and figures <https://www.hfea.gov.uk/about-us/publications/research-and-data/fertility-treatment-2018-trends-and-figures/>

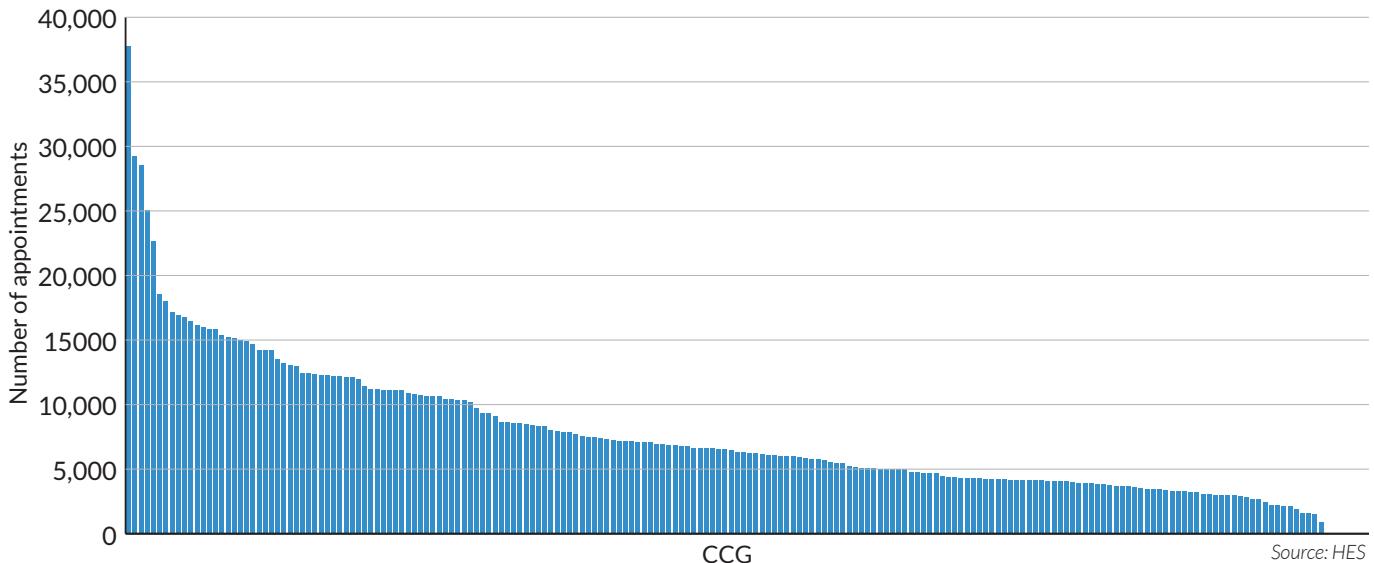
²⁵ See National Maternity and Perinatal Audit (NMPA) clinical report 2019 <https://www.maternityaudit.org.uk/pages/reports>

²⁶ MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK <https://www.npeu.ox.ac.uk/mbrrace-uk>

²⁷ See National Maternity and Perinatal Audit (NMPA) organisational report 2019 <https://www.maternityaudit.org.uk/pages/reports>

²⁸ See National Maternity and Perinatal Audit (NMPA) clinical report 2019 <https://www.maternityaudit.org.uk/pages/reports>

Figure 1: First outpatient appointments in gynaecology by CCG, 1 April 2019 to 31 March 2020



The maternity and gynaecology workforce

According to the 2018 Royal College of Obstetricians and Gynaecologists (RCOG) Workforce Report,²⁹ there were over 2,600 consultants in obstetrics and gynaecology in the UK, plus 1,000 specialty doctors and 1,800 trainees. NHS workforce data from April 2020 shows that there are over 22,000 midwives.

There are recognised shortages in the maternity and gynaecology workforce. Trainee numbers are also decreasing. In 2018, the GMC identified a 6.8% decline in the number of obstetrics and gynaecology trainees compared to 2012. According to the NMPA, 87% of obstetric units reported a gap in their middle-grade rota, with 83% saying they had used locums to cover middle-grade rotas in the previous three months. The RCOG Workforce Report also highlighted the fact that almost a third of those who start the obstetrics and gynaecology training programme do not finish – one of the highest attrition rates of all specialties. In addition, around 12% of specialty and associate specialist (SAS) doctors and trust doctors are leaving the NHS each year.³⁰

Further, the RCOG has highlighted that 30% of consultants are approaching retirement in the next five years. It seems probable that the COVID-19 pandemic will have an influence on the future shape of the maternity and gynaecology workforce, as it will for all specialties: accelerating some retirements and delaying others.

Concerns also exist around midwife numbers, where for some years the Royal College of Midwives (RCM) has identified a shortfall of around 3,500 midwives, based on current birth rates and the goal to provide women in labour with one-to-one midwifery care. While at 85% of sites, an estimated 95% of women do receive one-to-one care, only 51% of sites confirmed that this was available for all women.

In March 2018, the NHS announced plans to create 3,000 new training places for midwives and in March 2020, the Nursing & Midwifery Council (NMC) reported an increase of over 1,000 midwives compared to the previous year.³¹ However, as the RCM has highlighted, one in three midwives is now over 50 – leading to concerns about workforce sustainability.³²

The NHS Interim People Plan – published in June 2019, following the publication of the NHS Long Term Plan – included actions to promote the profession to young people and increase recruitment into midwifery, and to increase the overall number of nursing training places (which include midwifery).³³ We also note and welcome NHS England and NHS Improvement's announcement in March 2021 of new funding of more than £95m annually to help boost midwife and obstetrician numbers and training, following the recommendations in the Ockenden report.

²⁹ RCOG (2018) *Workforce Report* <https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/rcog-og-workforce-report-2018.pdf>

³⁰ *ibid.*

³¹ NMC Register data (2020) <https://www.nmc.org.uk/about-us/reports-and-accounts/registration-statistics/>

³² RCM (2017) *The gathering storm: England's midwifery workforce challenges* <https://www.rcm.org.uk/media/2374/the-gathering-storm-englands-midwifery-workforce-challenges.pdf> and RCM (2018) *State of Maternity Services Report* <https://www.rcm.org.uk/media/2373/state-of-maternity-services-report-2018-england.pdf>

³³ See https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

There are also well-documented issues around the training and numbers of other healthcare professionals that support maternity and gynaecology. For example, both disciplines make extensive use of radiology services, from maternal ultrasound and neonatal imaging to specialist gynaecological examinations and interventional radiology procedures. However, as the GIRFT national report for radiology has highlighted, demand for radiology services is growing far faster than capacity.³⁴ If unaddressed, shortages in the sonographer and radiographer workforce may affect trusts' ability to deliver some of the recommendations in this report, but also other key initiatives, such as the comprehensive and more frequent ultrasound examinations recommended in the Saving Babies' Lives Care Bundle version two.³⁵ The report of the Independent Review of Diagnostic Services, led by Professor Sir Mike Richards, has recommended that the NHS recruits an additional 2,000 radiologists and 4,000 radiographers to address current and projected imaging needs.³⁶

Major studies and initiatives

While the last few decades have seen substantial improvements in maternity and gynaecology outcomes and provision, it is recognised that there are ongoing issues about the quality and continuity of services. These have led to a series of initiatives to improve care.

- In 2015, the RCOG launched *Each Baby Counts* – a quality improvement programme designed to reduce stillbirths and the number of children who are left severely disabled as a result of incidents occurring during term labour.³⁷
- In 2016, the National Maternity Review – commissioned as part of the NHS Five Year Forward View – published its report *Better Births*.³⁸ This set out recommendations for improvements to the overall maternity experience and care, and to address differences across the country.
- In 2016, NHS England introduced the Saving Babies' Lives Care Bundle, aiming to reduce perinatal mortality. An updated version was published in 2019.³⁹
- Also in 2016, the Department of Health published *Safer Maternity Care: Next steps towards the national maternity ambition*,⁴⁰ an action plan setting out its vision for making NHS maternity services some of the safest in the world. A progress report and next steps were published in 2017.⁴¹

NHS England and NHS Improvement have committed to halving the rate of stillbirths, neonatal deaths, maternal deaths and intrapartum brain injuries, as well as cutting the rate of preterm births. A number of programmes now exist to help achieve these goals.

Alongside these, there have been a series of further initiatives, such as The Maternity and Neonatal Safety Improvement Programme,⁴² updates to NICE guidance and a host of additional audits and studies including the NMPA and the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) programmes.⁴³ Issues related to maternity and gynaecology are also covered in the 100-Day Challenge and Model Hospital.

Many of the recommendations of these initiatives are still being implemented, and while the short-term impact appears positive, it is hoped that the long-term change will deliver even better outcomes.

While the many existing reports and initiatives underline that the overwhelming majority of births in England are safe, errors within maternity and gynaecology care do occur and as a result, the level of litigation relating to childbirth in particular remains consistently high. In 2017, NHS Resolution introduced an Early Notification scheme,⁴⁴ based on criteria set out in *Each Baby Counts*, to help address potential claims and more importantly improve understanding of the incidents that led to them and how they could be avoided. This scheme is discussed in more detail as part of the litigation section of this report. NHS Resolution's Maternity Incentive Scheme, which seeks to embed best practice, and the Healthcare Safety Investigation Branch's Maternity Investigation Programme, which identifies wider learning opportunities from individual investigations, are also examined in the litigation section.

³⁴ For a summary of the workforce issues, see the GIRFT Radiology report <https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2020/11/GIRFT-radiology-report.pdf>

³⁵ NHS England (2019) Saving Babies' Lives Version Two <https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf>

³⁶ Report of the Independent Review of Diagnostic Services for NHS England (2020) *Diagnostics: Recovery and Renewal* <https://www.england.nhs.uk/wp-content/uploads/2020/11/diagnostics-recovery-and-renewal-independent-review-of-diagnostic-services-for-nhs-england-2.pdf>

³⁷ See <https://www.rcog.org.uk/eachbabycounts>

³⁸ NHS National Maternity Review (2016) *Better Births* <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

³⁹ NHS England (2019) Saving Babies' Lives Version Two <https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf>

⁴⁰ Department of Health (2016) *Safer Maternity Care: Next steps towards the national maternity ambition* <https://www.gov.uk/government/publications/safer-maternity-care>

⁴¹ Department of Health (2017) *Safer Maternity Care The National Maternity Safety Strategy - Progress and Next Steps* <https://www.gov.uk/government/publications/safer-maternity-care-progress-and-next-steps>

⁴² See <https://www.improvement.nhs.uk/resources/maternal-and-neonatal-safety-collaborative/>

⁴³ See <https://www.npeu.ox.ac.uk/mbrrace-uk>

⁴⁴ See <https://www.resolution.nhs.uk/services/claims-management/clinical-claims/clinical-negligence-scheme-for-trusts/early-notification/>

The NHS Long Term Plan

Many of these initiatives were highlighted in the NHS Long Term Plan, published in January 2019, which made improvements to maternity care and outcomes a clear priority.⁴⁵ It set the target of halving maternity-related deaths by 2025, and stated that the NHS will:

- roll out the Saving Babies' Lives Care Bundle across every maternity unit in England in 2019;
- ensure that every trust in England with a maternity and neonatal service is part of the Maternity and Neonatal Safety Improvement Programme, via the patient safety networks;
- encourage all maternity services to introduce an accredited, evidence-based infant feeding programme, such as the UNICEF Baby Friendly Initiative;
- support the establishment of Maternal Medicine Networks, which will further ensure women with acute and chronic medical problems have timely access to specialist advice and care at all stages of pregnancy;
- continue to support the Maternity Incentive Scheme which rewards the delivery of ten key maternity safety actions through a Clinical Negligence Scheme for Trusts (CNST) rebate;
- implement an enhanced and targeted continuity of carer model, so that by March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally. There will be a particular focus on improving outcomes for the most vulnerable mothers and babies. By 2024, 75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period;
- improve access to and the quality of perinatal mental health care for mothers, their partners and children;
- improve access to postnatal physiotherapy to support women who need it to recover from birth;
- offer all women who smoke during their pregnancy specialist smoking cessation support to help them quit, and extend the programme to the partners of expectant mothers who smoke;
- redesign and expand neonatal critical care services to improve the safety and effectiveness of services and experience of families, with actions to:
 - increase the number of Neonatal Intensive Care cots;
 - improve triage within expert maternity and neonatal centres so that the right level of care is available to babies as close to the family home as possible;
 - enhance the experience of families during the worrying period of neonatal critical care, including by appointing care co-ordinators to work with families within each of the clinical neonatal networks across England; and
 - increase the number of neonatal nurses and expand the roles of some allied health professionals.

In addition, the NHS Long Term Plan seeks to make more maternity information available to mothers using digital channels. By 2023/24, all women will be able to access their maternity notes and information through their smart phones or other devices.

Further initiatives and reports

Since the publication of the NHS Long Term Plan, there have been several further initiatives shaping maternity and gynaecology care – some as a direct result of the NHS Long Term Plan and others in response to other factors. The following all relate in some way to unwarranted variation and themes covered in this GIRFT report:

- In July 2019, following the launch of the NHS Patient Safety Strategy, the Maternal and Neonatal Health Safety Collaborative was renamed as the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP).⁴⁶ Led by the National Patient Safety team and covering all maternity and neonatal services across England, it aims to improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and providing a high-quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England. This will support the ambition to reduce the national rate of preterm births from 8% to 6% and reduce the rate of stillbirths, maternal deaths, neonatal death and brain injuries occurring during or soon after birth by 50% by 2025 – a national target set out in Better Births.

⁴⁵ See NHS (2019) *Long Term Plan* paragraphs 3.8-3.21
<https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/maternity-and-neonatal-services/>

⁴⁶ See <https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative/>

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- In January 2020, the Care Quality Commission published its annual survey on the state of maternity services.⁴⁷ Though this found that the majority of women had a positive experience of maternity care, there were some areas where care fell short. A subsequent themed report, *Getting safer faster: key areas for improvement in maternity services*,⁴⁸ noted that 'Maternity services stand out as one of the core services we inspect that is not making improvements in safety fast enough.' The key areas identified by the CQC for improvement were:
 - governance, leadership and risk management;
 - individual staff competencies, teamworking and multi-professional training; and
 - active engagement with women using maternity services.
 - In July 2020, The Independent Medicines and Medical Devices Safety Review led by Baroness Cumberlege published its report. Several of the topics under review related to maternity and gynaecology, including the use of mesh for urinary incontinence and the use of sodium valproate in pregnancy. It recommended substantial change to the safety evaluation of medical devices and the creation of a central patient-identifiable database in relation to the use of devices. It also recommended supporting and recompensing those who have suffered ill-effects from a mesh implant (as well as those who suffered from other devices).⁴⁹
 - In December 2020, the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust published its emerging findings and recommendations based on the first 250 cases.⁵⁰ While its findings focused on this particular trust, the review, led by Donna Ockenden, identified seven immediate and essential actions to improve care and safety in all maternity services. These ranged from safety actions throughout pregnancy, such as enhanced fetal monitoring, to ensuring women's voices are listened to and changing the way training is delivered for the whole team. We strongly support all of these recommendations; they are not repeated here purely because trusts should already be taking them forward.
 - In December 2020, the MBRRACE study published its latest analysis of perinatal mortality, using data from 2018. This showed that the risk of stillbirth or neonatal death was considerably higher for babies of Black and Asian ethnicities compared with babies of white ethnicity.⁵¹ Its January 2021 report into maternal deaths found that mothers from Black backgrounds were four times more likely to die in childbirth than mothers from white backgrounds, while mothers from Asian backgrounds were twice as likely to die in childbirth compared to mothers from white backgrounds.⁵²

Responding to the COVID-19 pandemic

After the deep-dive visits for this report had been completed, the COVID-19 pandemic hit, heralding the biggest health response worldwide in living memory. Like all areas of NHS provision, maternity and gynaecology were affected.

At phenomenal speed, trusts, departments and staff completely overhauled their ways of working to adapt to this novel threat. We have seen many services cancel in-person clinics and instead conduct outpatient appointments virtually; postpone elective surgery and delay cancer treatments.

While many treatments and investigations can be delayed to a later date, a pregnancy cannot be deferred. Maternity appointments, normally a time for both the woman and family, pivoted to only allowing the woman to attend. Additional precautions were introduced around the birthing process, such as limiting the number of visitors or encouraging mothers to return home from hospital earlier. Postnatal care too involved less face-to-face contact.

⁴⁷ See <https://www.cqc.org.uk/publications/surveys/maternity-services-survey-2019>

⁴⁸ See <https://www.cqc.org.uk/publications/themed-work/getting-safer-faster-key-areas-improvement-maternity-services>

⁴⁹ The Independent Medicines and Medical Devices Safety Review (2020) First Do No Harm <https://www.gov.uk/government/publications/independent-medicines-and-medical-devices-safety-review-report>

⁵⁰ See HM Government (2020) - Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust (Ockenden Report) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

⁵¹ MBRRACE-UK (2020) Perinatal Mortality Surveillance report for births in 2018 <https://www.npeu.ox.ac.uk/mbrrace-uk/reports>

⁵² MBRRACE UK (2021) Saving Lives, Improving Mothers' Care <https://www.npeu.ox.ac.uk/mbrrace-uk/reports>

This without doubt changed the experience for women and their families. Joint guidance from the NHS, the RCOG, the RCM and Maternity Voices Partnerships⁵³ emphasised that mothers should still have choice around the birth; however, it also acknowledged that temporary changes to maternity services may be necessary. The RCOG also released a suite of guidance⁵⁴ to educate and support healthcare professionals, patients and the general public while several other specialist societies developed protocols around the use of virtual care and providing COVID-safe treatment, including surgery. These protocols were invaluable in keeping the system open, as far as was possible; they have not yet been fully evaluated, but it seems likely that some of the changes to practice introduced in response to the pandemic may become part of ongoing care.

We have not examined data about birth choices or experiences during the pandemic, nor have we looked at data around access to gynaecology over the same period. This will undoubtedly be important information for the future, as will a range of outcome data, to understand whether any aspects of care or groups of patients were negatively affected.

However, our understanding from colleagues working in frontline provision is that many of the service changes introduced at speed have proved successful. Patients, mothers and families have accepted the need for change and adapted readily. Trust IT systems proved more robust than was often expected. It therefore seems highly likely that some of the changes we included in our recommendations – particularly around making greater use of virtual care, minimising unnecessary admissions and reducing length of stay – are likely to accelerate.

Having a clinic virtually provides a range of benefits. By not attending a hospital for their appointment patients and mothers decrease their risk of exposure at the appointment, but also in their journey to the appointment, often by public transport. This means fewer people using public transport, reducing contamination and risk of community transmission, while allowing those who must travel to do so with greater safety. For the trusts themselves, virtual clinics can be held from a single office, utilised by the clinician. The room will not require stringent cleaning between every appointment, thus maximising the number of appointments that can be provided. For clinicians themselves, it also reduces the risk of contracting COVID-19.

While the benefits appear high, there are some concerns. Clinicians report difficulties contacting some patients and suggest that many virtual consultations take longer than those in person. There are also concerns that patient privacy may be compromised depending on living and working arrangements; that vulnerable women may be missing out on care; and that it can be difficult to visually assess the condition of a patient over video links. This is a particular issue for newborn babies, leading to the Royal College of Paediatrics and Child Health emphasising, in its COVID-19 guidance for neonatal settings:

“... where possible, investigations and tests should be performed before discharge from the maternity or neonatal unit. Maternity units should aim to maintain sufficient staffing in order to perform the necessary screening before discharge.”⁵⁵

As cases and transmission rates decreased during summer 2020, the health service set a course to reset and restore services to address a mounting backlog of patients. However, such efforts needed to be balanced against the risks of further ‘waves’ of COVID-19 and spikes in transmission. It is clear that the coming months will see ongoing pressures on frontline provision and resources. Priorities may well change and decisions have to be made at a local, regional and national level about the future shape of all areas of NHS provision.

While there is scope for some elective surgery to be delayed, it is clearly not possible for maternity care to be postponed. We note that RCOG and the RCM have both made clear their views that staff should not be redeployed away from frontline maternity care – a view we fundamentally support.

In this context, it is clearly possible that the delivery of some of our recommendations may be delayed; for now, however, we have included them all as the logical outcome of our work in this specialty and because many of the recommendations we make will support effective and accessible care, both during outbreaks and on the journey to restore services.

⁵³ See <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/05/C0441-maternity-leaflets-cv19-planning-your-birth.pdf>

⁵⁴ See <https://www.rcog.org.uk/en/guidelines-research-services/coronavirus-covid-19-pregnancy-and-womens-health/>

⁵⁵ RCPCH (2020) COVID-19 - guidance for neonatal settings
<https://www.rcpch.ac.uk/sites/default/files/generated-pdf/document/COVID-19--guidance-for-neonatal-settings.pdf>

Maternity – findings and recommendations

Care and support before, during and after birth

As there are similar objectives across all pregnancies, it would be expected that there is a substantial degree of consistency in the care offered – particularly antenatally (before birth) for uncomplicated pregnancies. We examined data around antenatal appointments and continuity of care to see how consistent care is between trusts.

Frequency of antenatal appointments for uncomplicated pregnancies

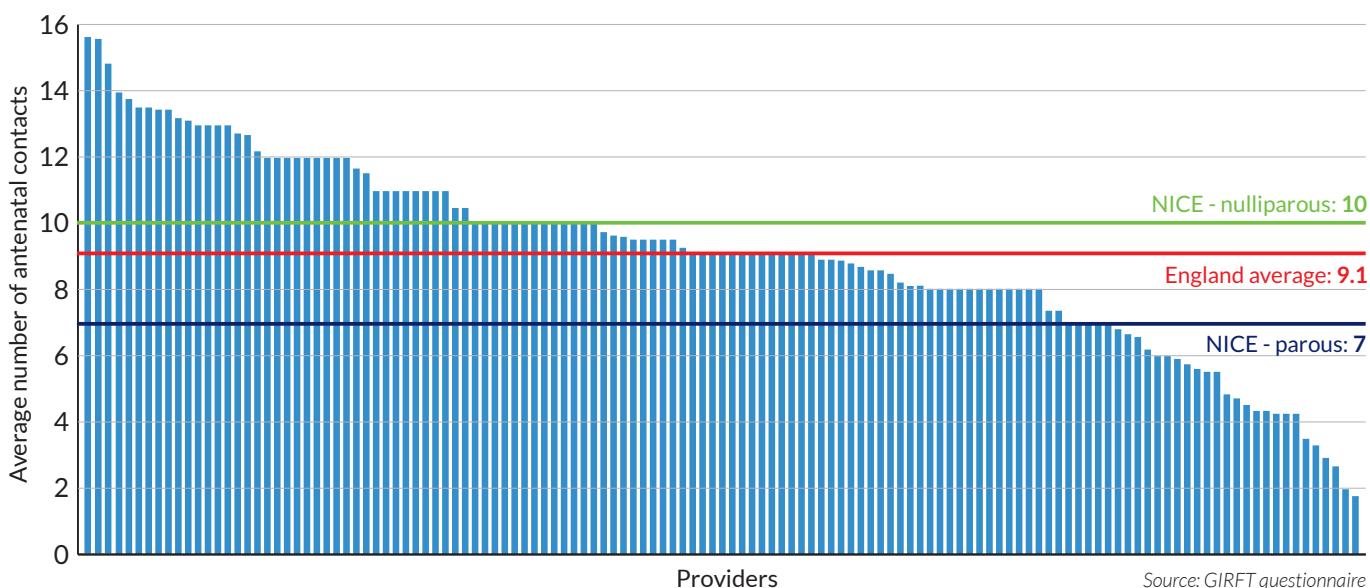
In its guideline *Antenatal care for uncomplicated pregnancies*,⁵⁶ NICE made the following recommendation on the frequency of antenatal appointments:

"For a woman who is nulliparous [i.e. a first-time mother] with an uncomplicated pregnancy, a schedule of 10 appointments should be adequate. For a woman who is parous with an uncomplicated pregnancy, a schedule of 7 appointments should be adequate."

This includes consultant and midwife appointments for the ongoing monitoring of maternal and fetal health and to support birth planning.

We asked each provider what their average number of antenatal contacts per birth is. As **Figure 2** shows, the variation was substantial, with 15 providers offering on average fewer than five appointments and 28 providers offering more than 12.

Figure 2: Average number of antenatal contacts per birth, by provider



Source: GIRFT questionnaire

As these were the average figures, this would suggest some women received rather more than 12 and others fewer than five – a substantial difference from the NICE guidance.

Importantly, we did not ask providers to differentiate between parous (those who have given birth before) and nulliparous (those who have not given birth before) women, nor between whether contact was with a doctor or a midwife. Further, we did not ask them to separate data about women with complicated pregnancies, who had more appointments – which is also in line with relevant NICE guidance, such as the guidelines on:

- Diabetes in pregnancy (NG3)⁵⁷
- Hypertension in pregnancy (NG133)⁵⁸
- Pregnancy and complex social factors (CG110).⁵⁹

⁵⁶ NICE (2017) CG62 Antenatal care for uncomplicated pregnancies <https://www.nice.org.uk/guidance/cg62/chapter/1-Guidance>

⁵⁷ NICE (2015) NG3 Diabetes in pregnancy: management from preconception to the postnatal period <https://www.nice.org.uk/guidance/ng3>

⁵⁸ NICE (2019) NG133 Hypertension in pregnancy: diagnosis and management <https://www.nice.org.uk/guidance/ng133>

⁵⁹ NICE (2010) CG110 Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors <https://www.nice.org.uk/guidance/cg110>

Our own analysis has not yet explored whether there is any correlation between the average number of appointments offered and the socio-economic status of the trust and the area it serves; this may provide a valuable insight.

Even allowing for these potential differences, the responses indicate that many providers are not adhering to NICE guidance, with many providing more contacts than are recommended and some providing fewer. While the NICE guidance should – rightly – be seen as a minimum, the data indicates considerable variation between trusts that we suspect may be unwarranted.

One factor that can influence the number of antenatal contacts provided is where appointments are missed or not arranged. In general, the onus is on a pregnant woman (or her family) to make appointments with a midwife at an appropriate stage; where they do not do so, it appears that this is not always recognised by providers in a timely fashion, meaning the woman misses out on some of the appointments she should have.

The National Reporting and Learning System (NRLS) has identified a number of incidents where women have missed one or more of the contacts they should have had during pregnancy and the trust has either not recognised this or not followed up with the woman – resulting in a subsequent potential safety issue. There is some evidence to indicate that during the COVID-19 pandemic those most likely to miss appointments – often due to fear of being exposed to the virus – were from the most disadvantaged groups.

This is not something we looked at during our deep-dive visits or initial analysis, and it only affects a small minority of pregnancies. However, it is clearly important that the system as a whole has a means of identifying, at an appropriate time, where a woman has missed antenatal appointments, so that action can be taken promptly, for the wellbeing of the mother and the baby. We therefore welcome the work currently underway by the Early Warning Safety Surveillance and Response group and the Maternity Transformation Programme to address this.

Continuity of care

In addition to examining the overall number of appointments, we also sought to investigate continuity of care during pregnancy.

Continuity of care offers other major advantages in terms of outcomes; a 2016 study by Cochrane⁶⁰ found that women who received midwife-led continuity of care were:

- 16% less likely to lose their baby;
- 19% less likely to lose their baby before 24 weeks; and
- 24% less likely to experience pre-term birth.

The NHS Long Term Plan has committed to enhancing the availability of continuity of care, with the aim that ‘by March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally’.⁶¹

This is a challenging ambition, which requires investment in the workforce – in terms of skills but also numbers of midwives; put simply, many trusts have not been able to fund or recruit trained midwives fast enough to provide the continuity of care they would like to offer.

The initial target was that 50% of women should be booked onto a continuity of carer pathway by March 2020. However, because of a recognised shortage in midwife numbers, this was then changed in the NHS Standard Contract 2019/20, which stipulated that 35% of women should be booked onto a continuity of carer pathway by March 2021. The current aim is for 35% by July 2021 and at the time of writing it is not clear that this will be reached.

We wholly support the aim but would reiterate the need for realistic targets in this area. As a priority, continuity of care should be focused on the mothers and babies most at risk.

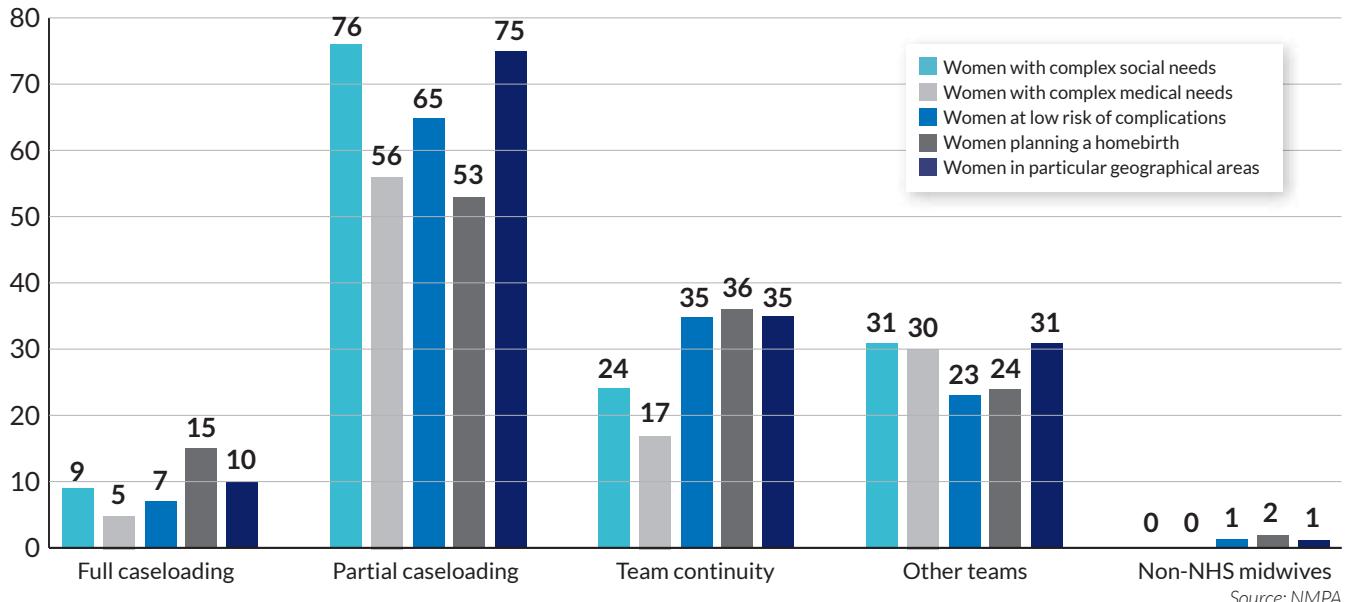
The NMPA organisational report found that, as of January 2019, while ‘85% of services are in the process of implementing continuity of carer models’, ‘nearly all currently serve only particular, sometimes small, groups of women with these models’.⁶² It added: ‘Only five trusts and boards used full caselowering or team continuity for all women, with the others currently using such models for specific groups.’

⁶⁰ Sandall, J., Soltani, H., Gates, S., et al. (2016) *Midwife-led continuity models of care compared with other models of care for women during pregnancy, birth and early parenting* https://www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early-parenting

⁶¹ NHS Long Term Plan paragraph 3.13

⁶² NMPA organisational report, executive summary, page X

Figure 3: Number of trusts and boards using a care model for a particular group of women in January 2019



Source: NMPA

We understand there has been progress since then. While full data is not yet available, we know that more trusts have introduced continuity of care models, while others have expanded existing ones. The Nursing and Midwifery Council (NMC) has made ‘promoting and providing continuity of care’ one of the domains of its professional standards⁶³ and the Maternity Transformation Programme has prioritised the issue, under the Supporting Local Transformation workstream.

One important aspect of continuity of care is the use of phone or digital contact between mothers and midwives. This can be a more flexible option, particularly for minor queries and support. This has been further proven during the COVID-19 pandemic, where face-to-face access has been limited but mothers understandably want information about what they might expect around the birth or to allay concerns. Video calls and instant messaging are both easy and reliable ways to do this; it seems likely that there will be greater appetite for using both as a standard part of antenatal care in the future.

Continuity of care: prioritising deprived areas and BAME mothers

In the NHS Long Term Plan implementation framework, a commitment was made to provide targeted funding to local maternity services in 2021/22 to 2023/24 to support the most deprived areas, to address health inequalities.⁶⁴ This reflects the recognition that babies born to mothers in the most deprived quintile have a 30% increased risk of neonatal mortality.

Data also shows that Black/Black British babies have a 121% increased risk for stillbirth and 50% increased risk for neonatal death compared to white babies, while Asian/Asian British babies have a 55% higher risk of stillbirth and 66% increased risk of neonatal mortality, again compared to white babies. These gaps are widening, rather than shrinking.⁶⁵

As a result, trusts are rightly prioritising the introduction of continuity of care models for BAME mothers and those living in the most deprived areas.

We understand that the next NMPA ‘sprint audit’ will be examining inequalities and their impact on maternity care. We welcome this and look forward to its findings.

Maternal experience: the Friends and Family Test

While it does not directly assess outcomes, one way of examining the impact of more (or less) frequent contact on the patient experience would be to compare Friends and Family Test scores for antenatal care with the frequency of contact/continuity of care to see if more frequent contact or continuity of care improves the patient experience.

⁶³ NMC (2019) Standards of Proficiency for Midwives <https://www.nmc.org.uk/globalassets/sitedocuments/standards/standards-of-proficiency-for-midwives.pdf>

⁶⁴ See <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/06/long-term-plan-implementation-framework-v1.pdf>

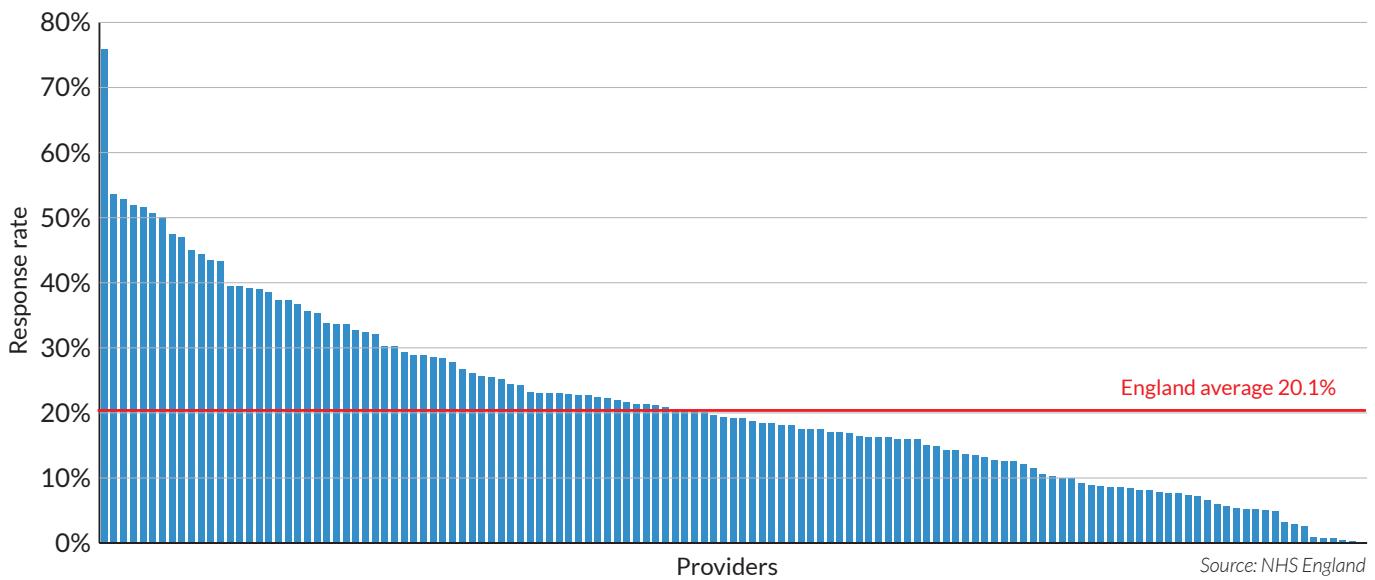
⁶⁵ See <https://www.england.nhs.uk/ltpmidmenu/maternity/targeted-and-enhanced-midwifery-led-continuity-of-carer/>

Currently, the Friends and Family (F&F) Test is used at four time points during a woman's maternity care where experience is assessed:

1. antenatal care;
2. the birth itself;
3. in-patient postnatal experience; and
4. postnatal community services.

However, the test is not used consistently across providers – and even within providers. Women are not obliged to respond and nationally, only 20.1% of births are covered.⁶⁶ Only seven providers had a response rate of over 50%.

Figure 4: Responses to the F&F Test as a percentage of births, by provider, 1 April 2019-29 February 2020⁶⁷



Average scores for each time point are high:

Table 1: Average Friends and Family Test scores for maternity, by time point, 1 April 2019-29 February 2020⁶⁷

Friends and Family Response Summaries	Average England Score
Percentage who would recommend the service (antenatal)	95.0%
Percentage who would recommend the service (birth)	96.2%
Percentage who would recommend the service (postnatal - community)	95.9%
Percentage who would recommend the service (postnatal - ward)	94.3%

Source: NHS England

⁶⁶ See <https://www.england.nhs.uk/wp-content/uploads/2018/09/fft-mat-jul-18-v2.xlsx>

⁶⁷ Friends and Family test data was not reported in March 2020 so Figure 4 and Table 1 above show data for the cumulative 11-month period for financial year 2019/20.

However, given the low response rates, particularly for postnatal community care, these scores are not very revealing. We are aware that in April 2020, a new question was introduced to the Friends and Family Test, with a view to inviting feedback on the overall experience of using the service.⁶⁸ This may be more relevant for maternity services. It may also be beneficial to reduce the number of time points at which mothers are asked for feedback, while focusing on increasing overall response rates, particularly from demographic groups that are currently under-represented in terms of the response to the Friends and Family Test. We came across trusts using a range of techniques to increase response rates: the case study below is one such example.

Further, to gain a richer insight into the mother's experience of care, trusts should also look to make more extensive use of other surveys and studies, such as those led by the National Perinatal Epidemiology Unit (NPEU) and conducted by the Care Quality Commission (CQC). These indicate that there is a much broader variation in the patient experience than the Friends and Family Test captures; as more detailed assessments, they also provide greater insight.

At a local level, Maternity Voices Partnerships (MVPs) are beginning to provide value.⁶⁹ At the time of our deep-dive visits, these were relatively new; they are now more established and having a significant, positive impact on aspects of local maternity provision. Importantly, MVPs go beyond just gathering information about patient experience to focus on learning from mothers' and families' feedback to make targeted local improvements to maternity care. They can also focus on specific issues or demographic groups.

We would encourage CCGs to support their local MVP and ensure that feedback from the MVP is considered appropriately within decision-making at CCG and trust level. However, in the absence of alternative quantitative measures, we feel that work should continue to increase responses to the Friends and Family Test; while it is by no means a comprehensive measure, it is widely used and understood.

Finally, the NHS Long Term Plan also underlined that the goal of providing personalised maternity care and introducing Personalised Care and Support Plans (PCSPs) for pregnant women. This should increase safety but also improve women's experience of maternity care. By the end of August 2019, at least 26 trusts were offering PCSPs for maternity and more than 14,000 women were benefiting from them. It will be important to evaluate the impact of this move towards more personalised care.

CASE STUDY

Improving response rates for the Friends and Family Test

University Hospitals of Leicester NHS Trust

During our deep-dive visits, we met a number of trusts taking innovative approaches to increasing response rates – and, more broadly, gathering richer feedback about their maternity services.

At University Hospitals of Leicester NHS Trust, a care assistant or other member of the team asks mothers to provide feedback on the day of discharge. Feedback is collected on an iPad, with the care assistant typically collecting it 10-15 minutes later. This has resulted in high, and improving, response rates: in 2015/16, its response rate was 53.26% and this rose to 56.16% in 2017/18.

BMI

According to the 2019 NMPA clinical report, 2016-17 was the first time that more than half of women whose body mass index (BMI) was recorded at booking were overweight or obese.

While 46.7% of women whose BMI was recorded were in the healthy weight bracket – BMI of between 18.5 and 24.9 – the increase in the number who were overweight is a concern. Being overweight increases the risks to the mother and baby, including higher risk of miscarriage and stillbirth, and of complications during birth. In particular, overweight women are more likely than those of a healthy weight to have an instrumental birth and more likely to have a postpartum haemorrhage.

⁶⁸ See <http://www.england.nhs.uk/fft/>

⁶⁹ See <http://www.nationalmaternityvoices.org.uk/>

Because of the association between obesity and these heightened risks, weight management appears an important issue in achieving the NHS Long Term Plan's target of halving stillbirth, maternal mortality, neonatal mortality and serious brain injury rates by 2025.

However, this is an area that is outside of the control of maternity services – not least because by the time a woman is in contact with them (i.e. she is pregnant) the opportunity for safe weight loss may have passed. Instead, weight reduction would ideally occur before a woman seeks to become pregnant, through public health and primary care services. GPs and other local partners may be well placed to signpost weight management programmes, particularly where they are aware that a woman wishes to become pregnant.

Once a woman is pregnant, there is still opportunity for weight management and advice on healthy eating, as set out in the NICE guideline *Weight management before, during and after pregnancy*.⁷⁰ However, this also may be best delivered by a wider range of services working together. In this context, we fully support the NMPA clinical report recommendation that:

“Maternity services, primary care and public health services should work together, with the involvement of local service users, to have appropriate provision to support weight management prior to, during and after pregnancy.”

However, we also noted that the NMPA organisational report found that only 45% of trusts had weight management support – largely unchanged from the previous year.

The NHS Long Term Plan committed to action on obesity⁷¹ and increased access to weight management services in primary care. In relation to maternity, the most appropriate focus here may be on postnatal and interpregnancy weight management. We envisage primary care providers working closely with these services, to encourage attendance. Weight management could also be part of a personalised care and support plan (PCSP).

In July 2020, the government published a policy paper outlining a strategy for tackling obesity, which – in addition to previously known risks – has also been identified as increasing the risk of becoming seriously ill with, or dying from, COVID-19. The high-level strategy did not mention maternity specifically, but it did reaffirm the commitment to expand weight management services available through the NHS, among other actions.⁷²

This is an area that will be examined further in the next NMPA sprint audit and we look forward to its findings.

Smoking cessation

Smoking has long been associated with poor fetal growth, a substantially increased chance of preterm birth, miscarriage and stillbirth and respiratory problems for the baby after birth. This has been part of public health campaigns for some time and the NHS Long Term Plan specifically highlighted smoking cessation in antenatal care as an area for improvement.

The NMPA clinical report found that 58,301 mothers in England were smokers at the time they gave birth – equivalent to 10.9%. A further 11,786 had been smokers at booking (i.e. the point at which their pregnancy is formally recorded by the maternity unit) but had stopped smoking by the time they gave birth.

NHS Digital data from Q2 2020-2021 recorded that 9.9% of mothers were smokers at the time of giving birth, a slight increase from 9.8% in Q1 2020-2021, the lowest quarterly value since data collection began.⁷³ The end of year data for 2019-20 showed that 10.4% of mothers were smokers at the time of giving birth, indicating a marginal improvement from the NMPA data – equivalent to around 5,000 fewer mothers who were smokers.⁷⁴ However, this is still some way short of the national ambition that 6% or less of mothers should be smokers at the time of delivery.

As **Figure 5** shows, there is considerable variation in this. In Q2 2020-21, just 21 out of 135 CCGs met the national ambition level; 15 of these were in London.

⁷⁰ NICE (2010) PH27 *Weight management before, during and after pregnancy* <https://www.nice.org.uk/guidance/ph27>

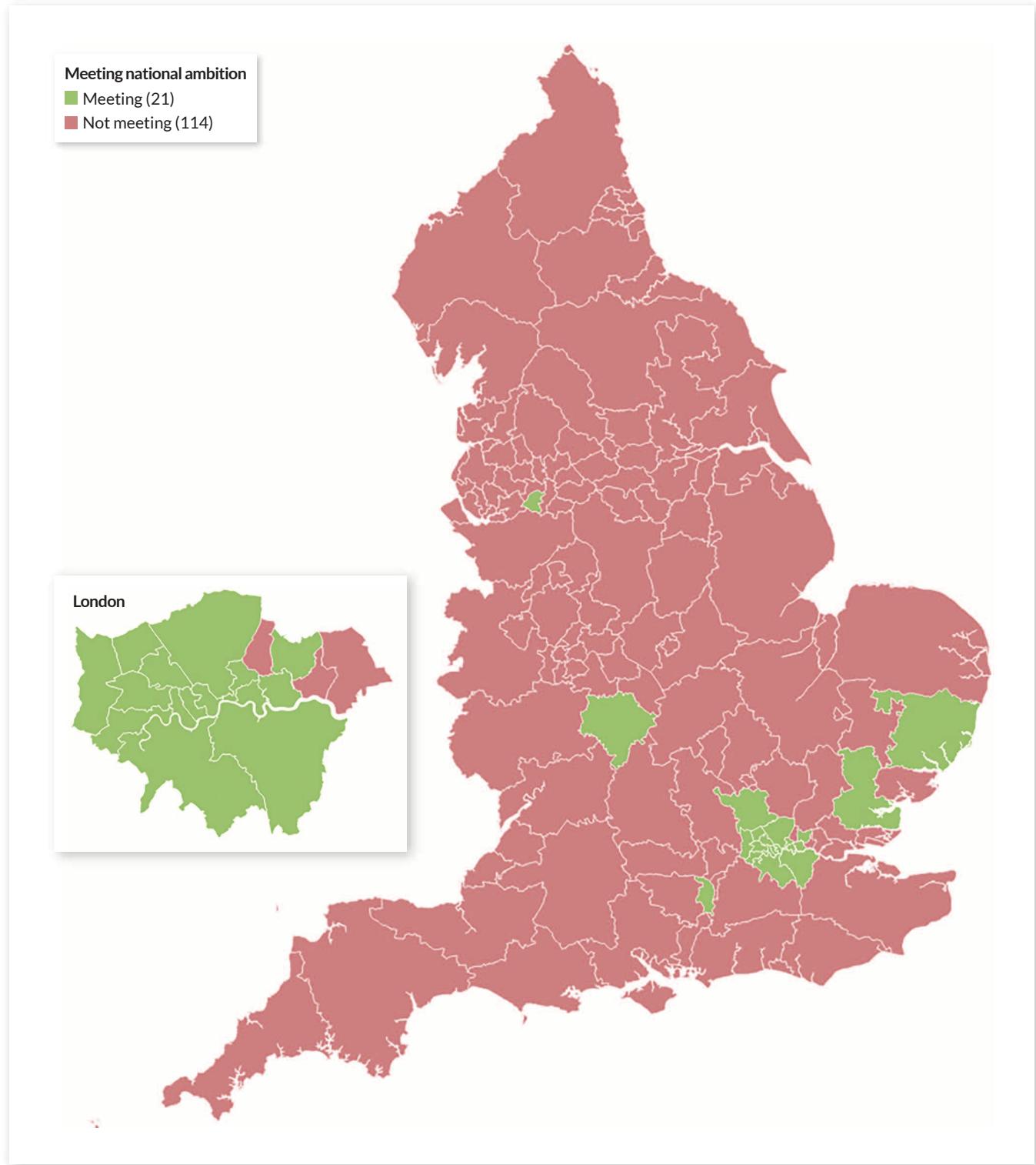
⁷¹ See <https://www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/obesity/>

⁷² See <https://www.gov.uk/government/publications/tackling-obesity-government-strategy/tackling-obesity-empowering-adults-and-children-to-live-healthier-lives#covid-19-and-obesity>

⁷³ See <https://www.digital.nhs.uk/data-and-information/publications/statistical/statistics-on-women-s-smoking-status-at-time-of-delivery-england/statistics-on-womens-smoking-status-at-time-of-delivery-england---quarter-1-2020-21/part-2>

⁷⁴ See <https://www.digital.nhs.uk/data-and-information/publications/statistical/statistics-on-women-s-smoking-status-at-time-of-delivery-england/statistics-on-womens-smoking-status-at-time-of-delivery-england-quarter-4-2019-20>

Figure 5: Meeting the national ambition for reducing maternal smoking at the time of delivery, by CCG, July - September 2020

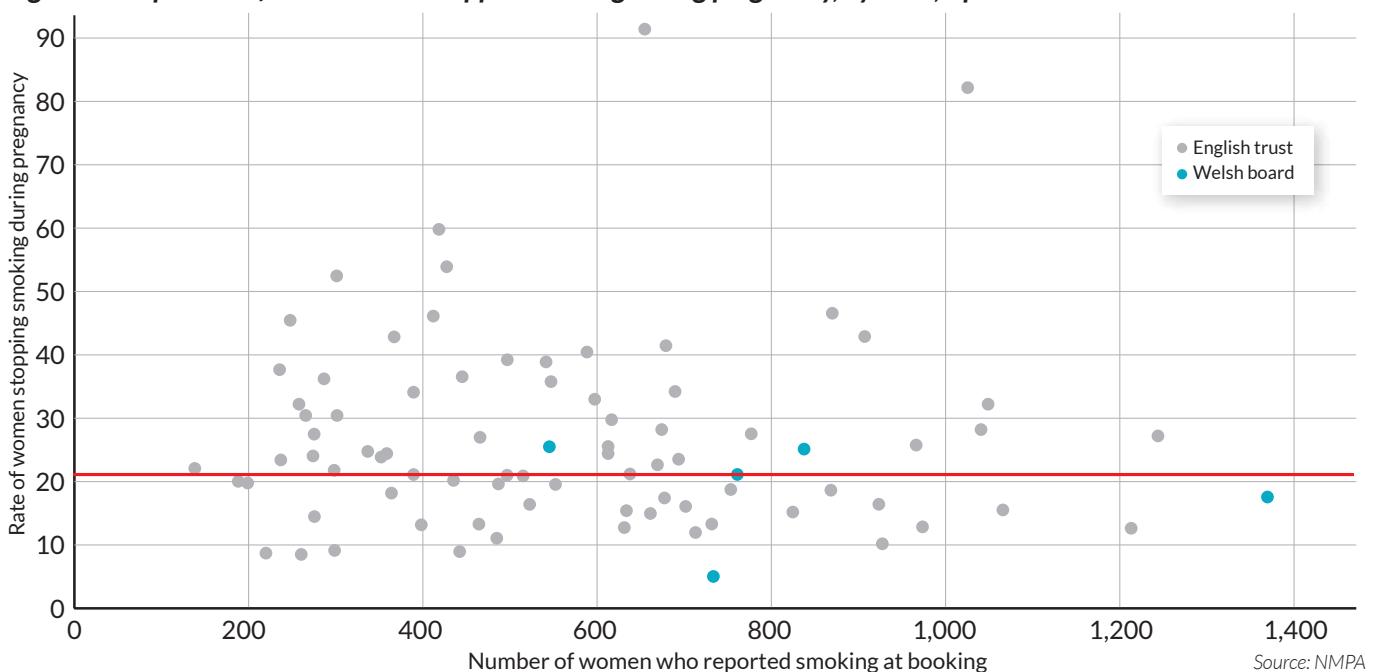


Source: NHS Digital

The NMPA organisational report found that smoking cessation services were only available at 72% of trusts (a similar figure to the previous report). The NHS Long Term Plan has committed to making a smoke-free pregnancy pathway available to all pregnant women by 2023/24 – so this should change over the next five years. A key part of this will be the initiatives set out in version two of the Saving Babies’ Lives care bundle to test carbon monoxide exposure in all pregnant women at the antenatal booking appointment, with appropriate referral to a smoking cessation programme or support from a trained stop-smoking advisor. Smoking cessation could also be included as part of a Personalised Care and Support Plan (PCSP).

Access to a programme, of course, is only the first step; the key question is whether that programme helps women stop smoking. NMPA data from across England shows extreme variation between trusts in the proportion of smokers who stopped smoking during pregnancy. It is not clear how these success (or failure) rates relate to the availability or quality of trusts’ smoking cessation programmes.

Figure 6: Proportion of smokers who stopped smoking during pregnancy, by trust, April 2016–March 2017



The evaluation of the Saving Babies’ Live Care Bundle version one found similar variation between trusts observing that ‘smoking cessation rates varied considerably by trust with some achieving a 40% rate cessation rate whilst others only 10%’.⁷⁵

As well as focusing on smoking cessation during pregnancy, NICE’s guideline covering this topic⁷⁶ also looks at ongoing support in the first year after childbirth to discourage mothers from restarting. This is an important point to emphasise, for the child’s development.

Maternity units should support and actively promote smoking cessation programmes, but we would also encourage further research into what makes some programmes much more successful than others.

The evaluation of the Saving Babies’ Live Care Bundle version one reported ‘a large proportion of women referred for smoking cessation report not attending their referral appointment.’ It also noted that ‘in many areas smoking cessation services are not provided within maternity services and require referral to another location or care provider’. This is an issue that NHS RightCare is examining as part of its maternity focus packs; there may be an opportunity for GIRFT to work with NHS RightCare and other relevant public health partners here. Similarly, Public Health England is focusing on reducing maternal smoking as part of the ‘improving prevention’ workstream of the Maternity Transformation Programme.

We are also aware that, in line with the commitment in the NHS Long Term Plan, a new NHS smoking prevention programme is being developed. We will explore whether our work can be of use to this programme.

⁷⁵ See Widdows, K., Roberts, S.A., Camacho, E.M., Heazell, A.E.P. (2018) Evaluation of the implementation of the Saving Babies’ Lives Care Bundle in early adopter NHS Trusts in England. Maternal and Fetal Health Research Centre, University of Manchester <https://www.e-lfh.org.uk/wp-content/uploads/2020/02/SPIRE-evaluation.pdf>

⁷⁶ NICE (2010) PH26 Smoking: stopping in pregnancy and after childbirth <https://www.nice.org.uk/guidance/ph26>

Smoking cessation for women's partners

The NHS Long Term Plan also underlined the risks of secondary smoke inhalation on unborn children. As well as providing all expectant mothers with access to a new smoke-free pregnancy pathway, including focused sessions and treatments, it emphasised that this programme will also be available to the partners of pregnant women.

Recommendations

Recommendation	Actions	Owners	Timescale
1. Review antenatal care ensuring schedules as outlined in NICE guidance are followed. Follow the Saving Babies' Lives Care Bundle 2 as outlined in the NHS Long Term Plan.	<ul style="list-style-type: none"> a For uncomplicated pregnancies, trusts to follow NICE guidance CG62 Antenatal care for uncomplicated pregnancies, as a minimum. b Trusts to follow NICE guidance NG121, Intrapartum care for women with existing medical conditions or obstetric complications and their babies, as applicable. c Trusts, CCGs and NHS England and NHS Improvement to work with royal colleges and professional bodies to address care inequalities, such as racial and geographical inequalities, and complex social factors,⁷⁷ and develop strategies to engage the at-risk groups identified in their region. 	Trusts, CCGs, ICSs	For immediate action
2. Review and act upon comprehensive maternity patient experience data.	<ul style="list-style-type: none"> a All CCGs to have a Maternity Voices Partnership (MVP) and to actively seek to capture patient views from the whole of the local population, exploring relevant methods to expand participation in patient surveys and increase response rates from under-represented groups. b Trusts to promote greater use of the Friends and Family Test. c Trusts to meet national mean (2019/20) of patient experience response rate, then pursue top decile of performance. d Trusts and CCGs to monitor national patient experience data through NPEU⁷⁸ and CQC reporting and act upon published findings.⁷⁹ 	<ul style="list-style-type: none"> CCGs, MVPs Trusts Trusts Trusts, CCGs 	<ul style="list-style-type: none"> For substantial progress within 12 months of publication For immediate action For substantial progress within two years of publication For substantial progress within 12 months of publication
3. Strive towards healthy BMI rates and smoking rates in line with top decile of performance.	<ul style="list-style-type: none"> a Integrated care systems (ICS) or other local partners to review uptake of smoking cessation programmes and identify barriers to participation and action accordingly. b Integrated care systems (ICS) or other local partners to encourage use of obesity services for women of childbearing age.⁸⁰ 	<ul style="list-style-type: none"> ICSs, local partners ICSs, local partners 	<ul style="list-style-type: none"> For substantial progress within 12 months of publication For substantial progress within two years of publication

⁷⁷ Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (NICE) <https://www.nice.org.uk/guidance/cg110>

⁷⁸ You and Your Baby Survey 2018 (NPEU) 2019. <https://www.npeu.ox.ac.uk/maternity-surveys>

⁷⁹ CQC, 2020. Maternity services survey 2019. <https://www.cqc.org.uk/publications/surveys/maternity-services-survey-2019>

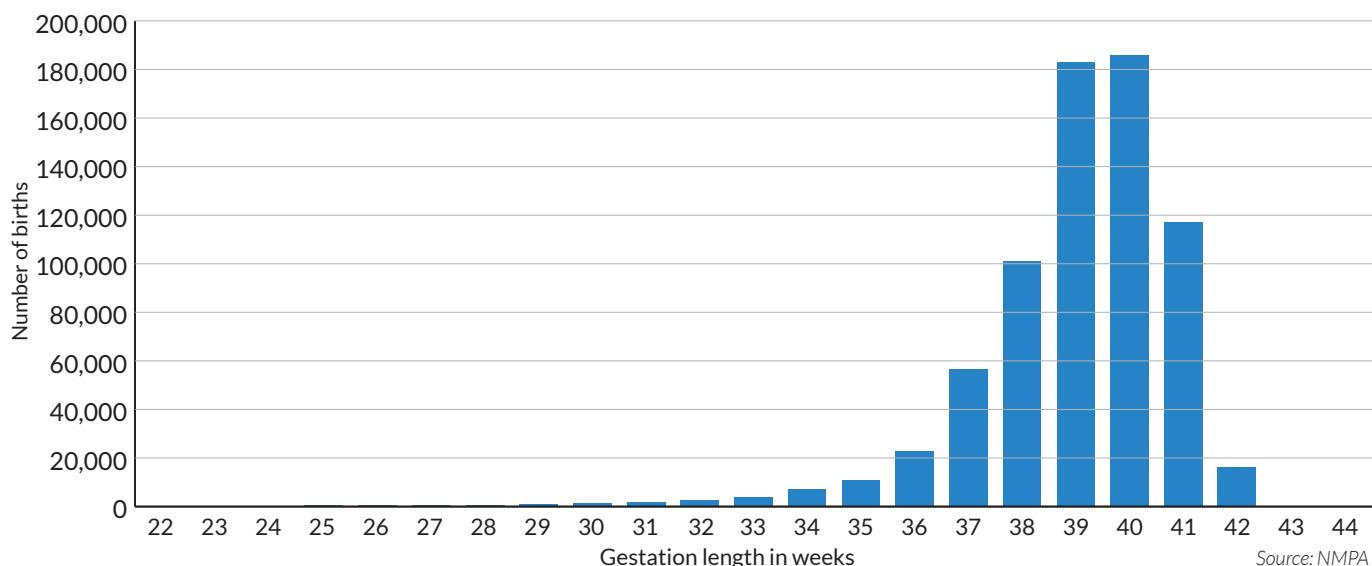
⁸⁰ Care of women with obesity in pregnancy RCOG 72 (2018) <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg72/>

The birth

As set out in the NMPA clinical report, the majority of women go into labour spontaneously between 37 and 42 weeks of pregnancy; this is known as term.

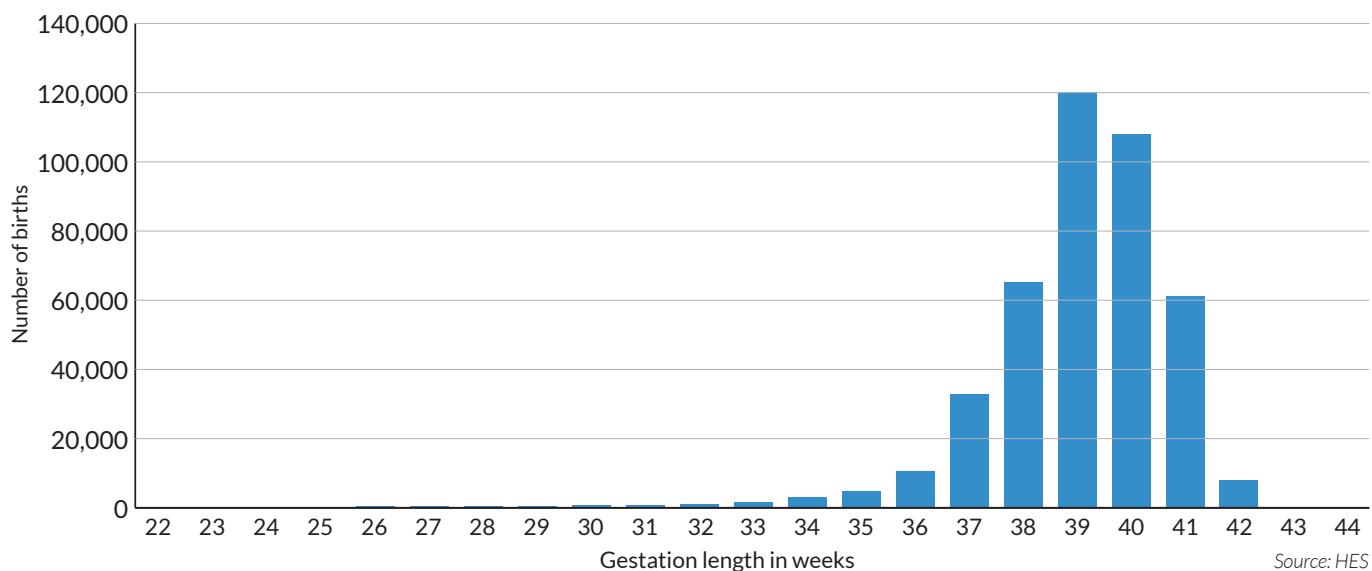
NMPA data covering 2016-17 recorded that 93.8% of singleton babies were born at term; for twins, the proportion was lower.

Figure 7a: Gestational age at birth in completed weeks in England, Scotland and Wales in 2016/17



Analysis conducted by GIRFT for 2019-20, covering births in England only, found a similar picture.

Figure 7b: Gestational age at birth in completed weeks in England, 1 April 2019 to 31 March 2020



It is generally accepted that term birth offers the best outcomes for the baby and the mother. However, this is not always the case; there are some pregnancies where the risk of stillbirth increases at term. A key aspect of the Saving Babies' Lives care bundle is to improve the way trusts identify babies at risk of this, so that they can be delivered pre-term then receive additional care, such as in a neonatal intensive care unit.

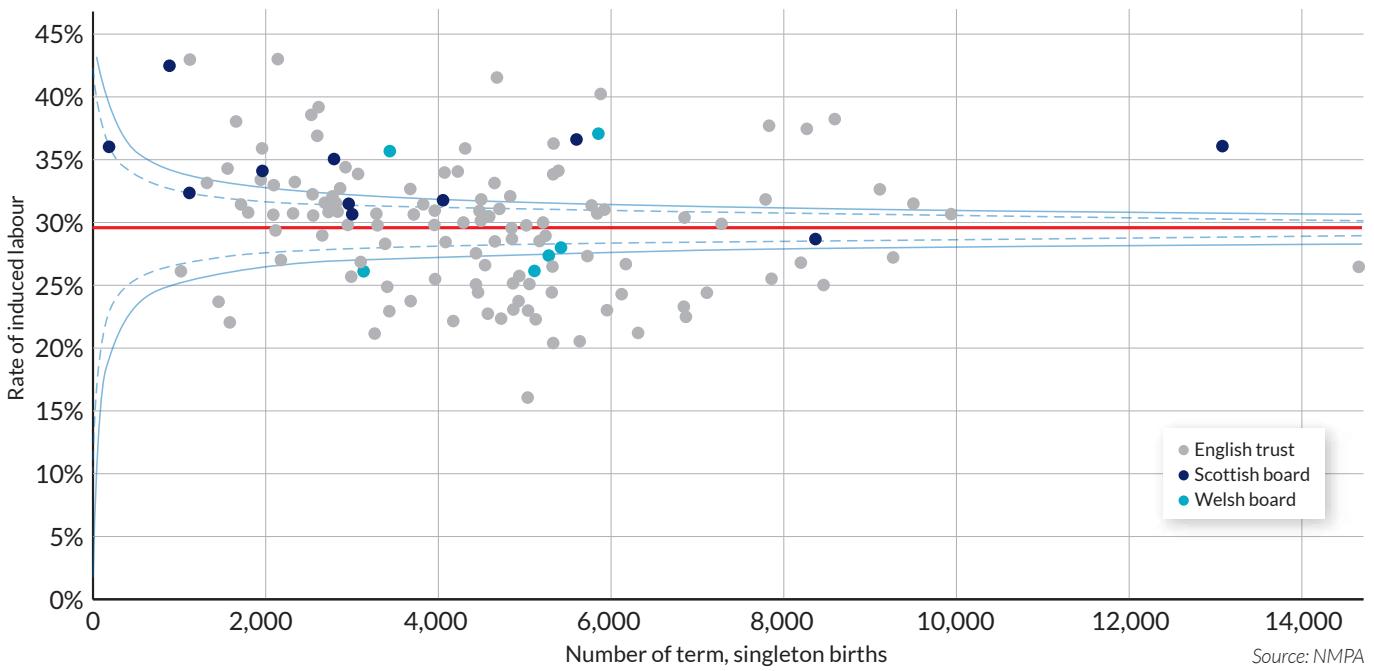
Induction

Where women reach term without spontaneously going into labour, they are typically offered induction of labour at >41 weeks.

According to the 2019 NMPA clinical report, 29.2% of women who gave birth at (or after) term to a single baby during the reporting year were induced; this amounted to 162,000 births. The proportion increased compared to the 2017 NMPA clinical report, which found that 27.9% of women were induced. The 2019 NMPA clinical report notes that this increase coincided with the introduction of the Saving Babies' Lives care bundle, which led to changes in the approach to fetal monitoring; where this monitoring identified that the baby was not growing sufficiently or that its movement had reduced, action – such as induction – could be taken. As a further demonstration of the impact of this improved monitoring, over the same period, there has also been a small decrease in the proportion of small-for-gestational-age babies born after 40 weeks (55.3% to 52.3%).

However, the NMPA clinical report also commented: 'There remains substantial variation, beyond that which would be expected due to chance, in the rates of key measures of maternity care such as induction of labour.' This variation is shown in **Figure 8a**.

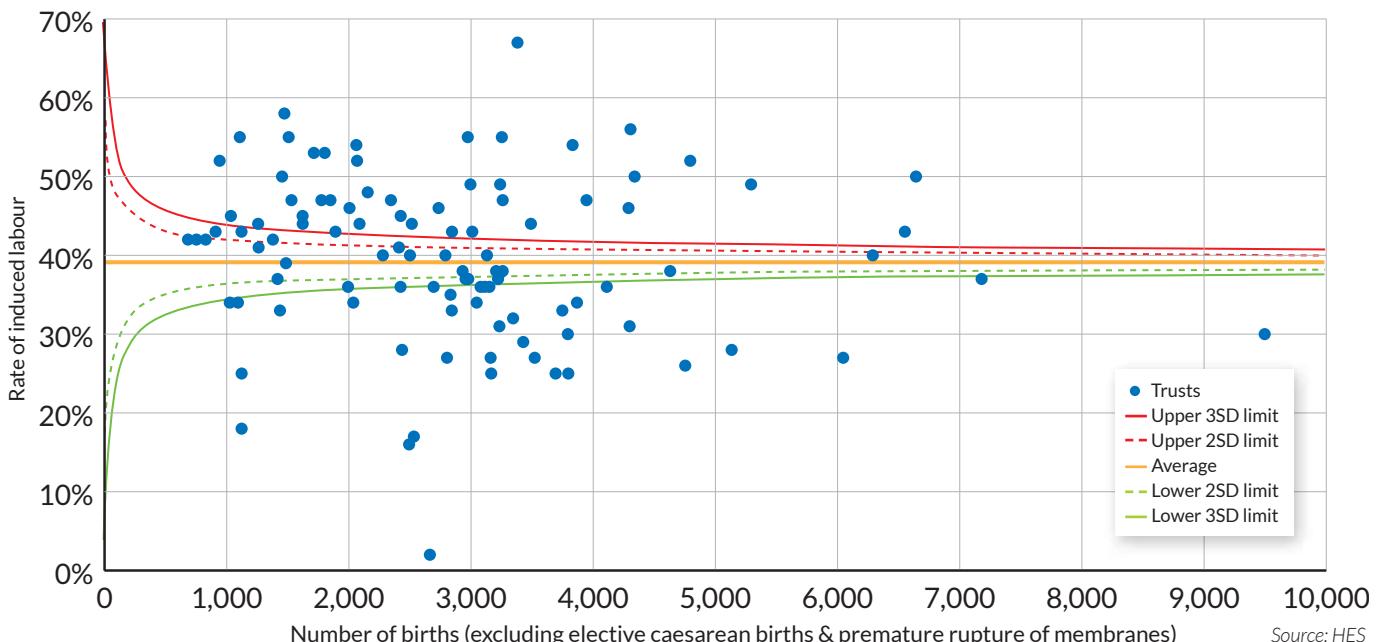
Figure 8a: Proportion of women with a singleton pregnancy at term who have an induction of labour, by trust, April 2016–March 2017



This variation is sufficiently broad to suggest that, despite the Saving Babies' Lives care bundle, there remain differences in practices between providers around induction (i.e. it is not simply a result of casemix).

The importance of timely induction was reinforced in version two of the Saving Babies' Lives care bundle, published in 2019. It was therefore interesting to note that in 2019–20, the mean rate of induced labour rose to 39%, as shown in **Figure 8b** (this covered English trusts only). The variation in rates appears broader, with 17 trusts having an induction rate of 50% or above.

Figure 8b: Rate of induced labour, by trust, 1 April 2019 to 31 March 2020⁸¹



Note: Trusts that have coded more than 20% of the DELONSET field as 9 (Not Known) have been removed

Source: HES

Version two of the Saving Babies' Lives Care Bundle also noted that: 'The NICE guidance and data from the ARRIVE study provide contradictory evidence as to whether induced labours are associated with a longer hospital stay or more painful labours. Induction of labour may also increase the workload of the maternity service which has the potential to impact the care of other women.'⁸²

During our first deep-dive visits, we explored the approach taken to managing induced labour at different trusts. It is clear that providers have adopted different policies around issues such as:

- the number of weeks at which the provider offers to induce labour, with some offering induction at 41-42 weeks of pregnancy and others offering induction at 39 weeks;
- whether induction is initiated through outpatients (e.g. through the insertion of a pessary or use of prostin tablets or gel) rather than admitting the mother;
- the use of mechanical interventions, including catheters, to dilate the cervix; and/or
- the use of artificial rupture of the membrane (ARM) – with some providers having dedicated induction bays, or even wards, staffed by midwives trained to carry out the procedure.

A useful direction for future work would be to examine the impact of these different approaches on outcomes. For example, we would like to be able to understand whether different policies affect length of stay after birth, rate of admission to neonatal intensive care, maternal injury or haemorrhage and the proportion of babies born small for gestational age.

This kind of analysis would be firmly in line with the following NMPA clinical report recommendations:

8. The NMPA, together with MBRRACE-UK and national organisations responsible for collating and managing maternity datasets, should continue to monitor for evidence of improvements in the rate of detection of small-for-gestational-age babies and of stillbirth. They should evaluate this alongside the impact on women, their babies and service providers from possible increased induction rates, following the implementation of national initiatives such as the Saving Babies' Lives care bundle.
9. National bodies should work with clinicians, women and their families to identify areas where guidance and standardisation could be improved to reduce variation in clinical practice around key aspects of maternity care.

⁸¹ Number of births excludes elective caesarean deliveries & premature rupture of membranes.

⁸² NHS England (2019) Saving Babies' Lives Version Two pg 20
<https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf>

The first step towards this greater understanding needs to be taken at a local level with individual trusts auditing their use of induction (including by different methods) and the outcomes for the mother and baby.

CASE STUDY

Co-ordinating induction of labour

Manchester University NHS Foundation Trust

A dedicated elective induction of labour team at Manchester University NHS Foundation Trust co-ordinates between eight and 11 induction appointments a day. The team is led by a Band 7 co-ordinator, supported by five midwives, to enable effective management of the elective pathway alongside the emergency work.

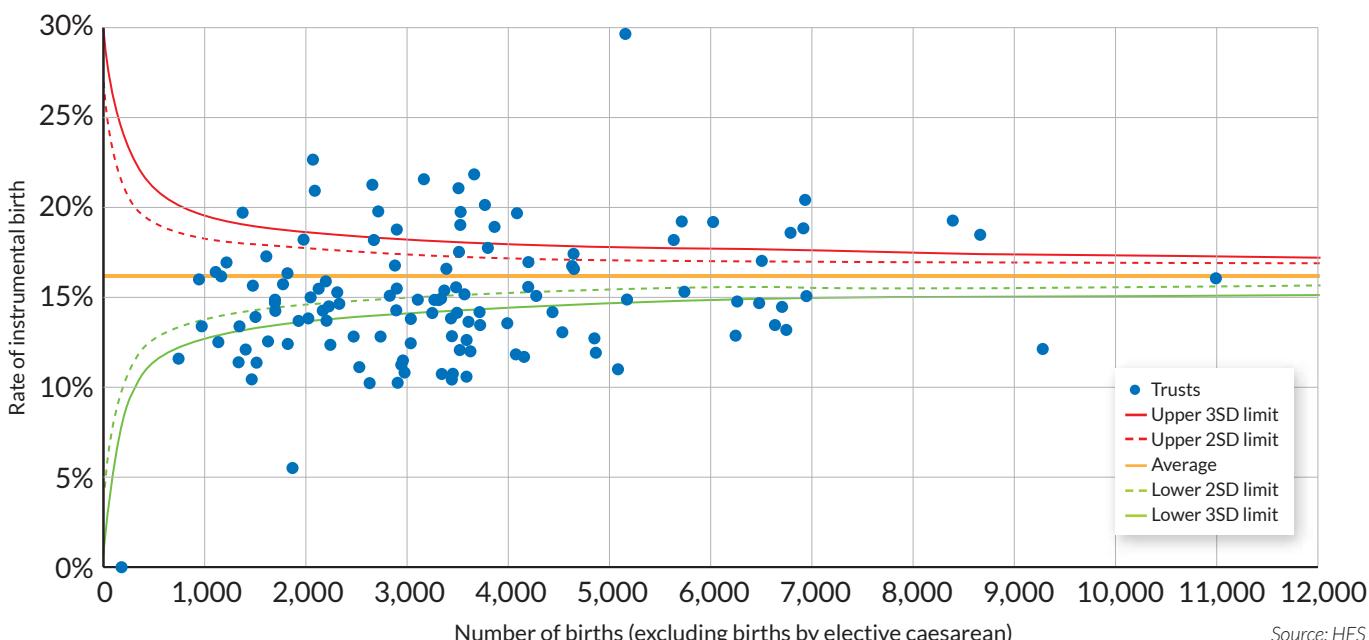
Either an administrative assistant or midwife telephones the mother when a bed in the antenatal ward is available. The induction process is commenced on an antenatal ward and mothers are then transferred to the delivery unit for ARM/syntocinon. Each mother is allocated a midwife who will provide care during the process and ensure timely assessment and review, and consultants are involved in planning and oversight, particularly where there is an increase in activity in the delivery unit.

Assisted birth/instrumental delivery

Assisted birth refers to any birth when babies are delivered vaginally but using either a vacuum cup or forceps. The NMPA found that 12.6% (approximately 60,000) of all births in England during the reporting year involved the use of instruments. This was the same percentage as in the previous NMPA clinical report. NHS maternity statistics for 2018-19 reported that 13% of births involved the use of instruments.⁸³ This indicates a degree of consistency in the assisted birth rate over the past five years.

We analysed data for assisted birth in England in 2019-20. The mean rate across trusts was 16.1% - so slightly higher than the rates recorded by the NMPA. Barring a couple of outliers, the overwhelming majority of trusts were within 7% of the mean.

Figure 9: Rate of instrumental birth, by trust, 1 April 2019-31 March 2020



⁸³ See <https://www.digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2018-19-Summary-Table-5>.

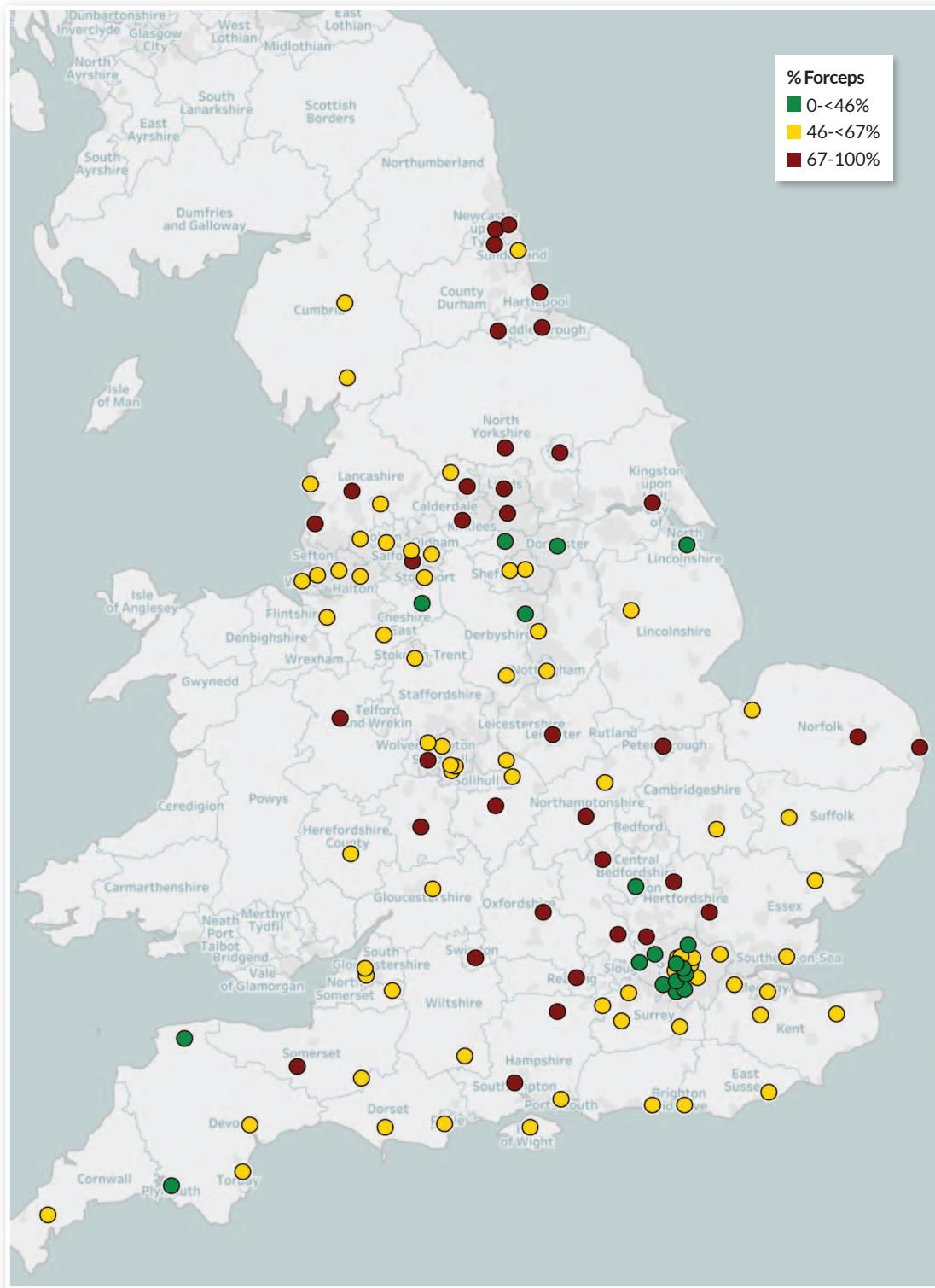
At present, we do not really know much about the impact of this variation. As with other areas of maternity care, there is limited data on the outcomes for mother and baby from assisted birth as a whole, or from the different methods of instrumental delivery.

In line with the NMPA recommendation 9 cited above, it seems likely that guidance and standardisation could be improved, to reduce variation in the use of assisted birth; however, the first step must be to understand the variation and the outcomes. As with induction, this can start by trusts auditing their own use of assisted birth.

GIRFT analysis established that, between 1 April 2019 and 31 March 2020, 56% of assisted births in England were conducted using forceps. Given that RCOG guidance states that surgeons should 'choose the instrument most appropriate to the clinical circumstances and their level of skill', we expected that usage of the two methods would not vary significantly between providers. However, the data we examined suggested otherwise. In a number of areas, there appeared to be a strong preference for one option rather than the other.

Figure 10 below shows the rate of forceps usage in each area. Providers who used forceps in 46-66% of assisted births (national average 56% +/-10%) are shown in yellow. Those who used a higher percentage of forceps are marked in red and those with a lower percentage of forceps are shown in green.

Figure 10: Proportion of assisted births using forceps, by trust, 1 April 2019-31 March 2020



Source: HES

It seems unlikely that this variation is simply a reflection of casemix. For example, in the majority of London trusts, forceps use was below the national average, while a large number of home counties trusts had above average forceps use. While we could speculate on reasons, the key point is that the variation is greater than we would expect. By examining outcomes from assisted birth, it may be possible to clarify best practice in different circumstances and reduce the variation.

One of the trusts where forceps use was significantly above average was the Shrewsbury and Telford Hospital NHS Trust. In its emerging findings, the Ockenden Report examining maternity care at this trust noted that there was 'evidence in a number of cases of repeated attempts at vaginal delivery with forceps, sometimes using excessive force; all with traumatic consequences.' The report commented that: 'There was clear evidence that the operating obstetricians were not following established local or national guidelines for safe operative delivery.' This should not be taken to suggest that above average forceps use is unsafe, but rather to emphasise the need to reflect on variation from common practice.

Supporting maternal choice around birth

Patient choice is integral to NHS care and the NHS Choice Framework sets out a series of choices relating to maternity services.⁸⁴ These include the choice of where a mother wishes to give birth: at home, in a midwife-led facility or in hospital. Logically, it might be expected that such choices should extend to the actual method of birth, but as has been pointed out in some media channels, many pregnant women feel they have not been allowed to make a choice in relation to this. In particular, it has been claimed that 'pregnant women asking for caesarean sections face repeated obstacles from most NHS trusts and are sometimes refused outright'.⁸⁵

The underlying reason for conducting a caesarean section is to protect the health and wellbeing of the baby and/or mother. However, as a major surgical procedure, caesarean section typically results in longer stays in hospital and there are marginally higher risks to the mother. Further, once a woman has had a caesarean section, the risks of uterine rupture during future spontaneous birth are higher – although this is still comparatively rare.

For these reasons, it is generally desirable to avoid caesarean section where there is a safer alternative. It should however be recognised that there are some advantages for mothers from caesarean section: perineal tears and sphincter damage are prevented and pelvic floor trauma consequences (such as incontinence and prolapse) reduced. The timing of an elective caesarean section can also be planned.

In its 2019 clinical report, the NMPA stated that between 1 April 2016 and 31 March 2017, 25.5% of women who gave birth at term in England – just over 145,000 – had a caesarean section. NHS maternity statistics for 2018-19 showed that 29% of deliveries were via caesarean section.⁸⁶

Of those covered by the NMPA, around 64,000 were elective procedures; equivalent to 11.1% of all births in 2016-17. Among primiparous women (first-time mothers), 21.2% had an emergency caesarean section compared to 9.5% of multiparous women (those who have given birth before).

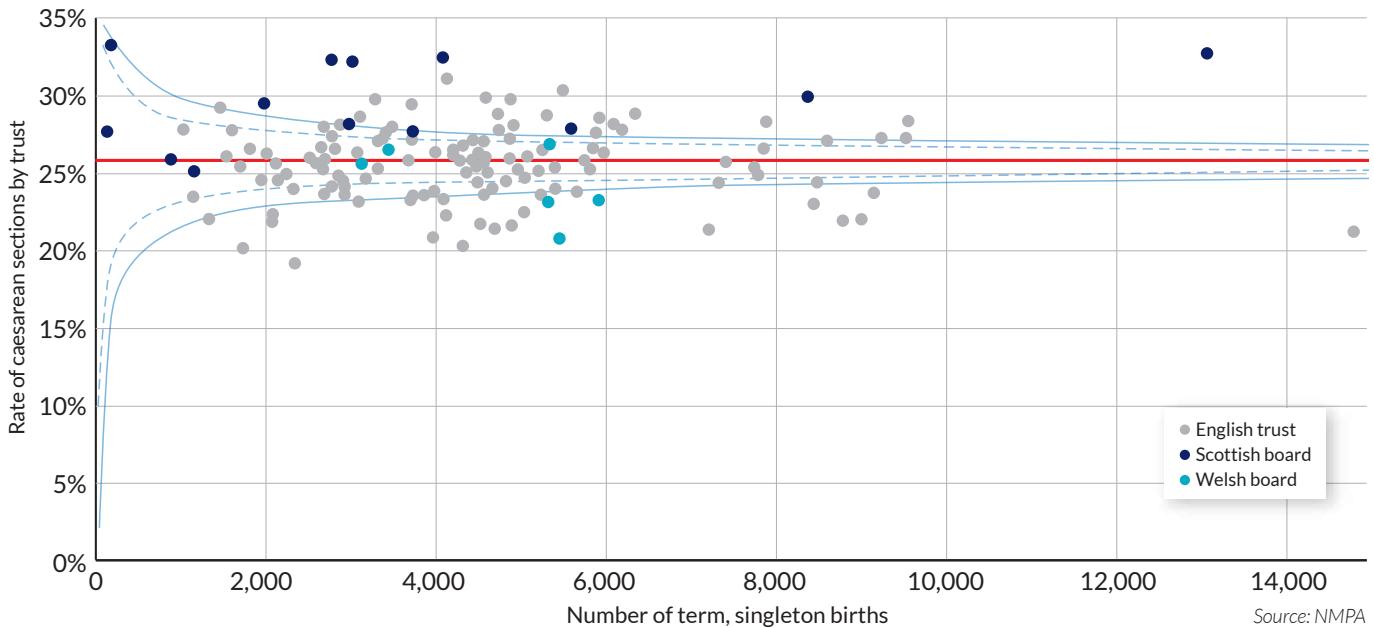
We wanted to understand how the caesarean rates at individual providers compared to the national picture. The 2019 NMPA clinical report provided a casemix adjusted analysis of caesarean section rate by trust.

⁸⁴ See <https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs#section-2-maternity>

⁸⁵ See Daily Express, 22 August 2018, 'NHS 'routinely refuses' to let mums have C-sections'
<https://www.express.co.uk/news/uk/1006651/pregnancy-nhs-refuses-elective-c-sections-caesarean-pregnancy-birth>

⁸⁶ See <https://www.digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2018-19-Summary-Table-5>.

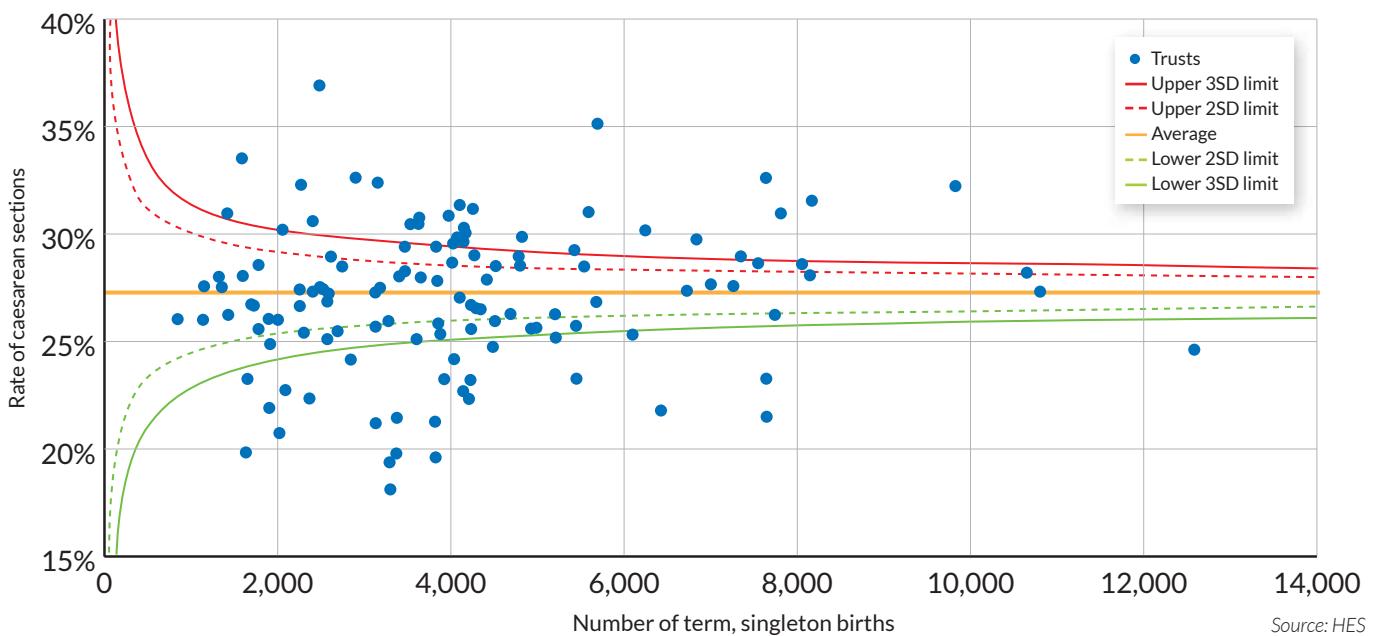
Figure 11a: Casemix adjusted trust- and board-level proportions of women giving birth to a singleton baby at term who have a caesarean section birth, April 2016-March 2017



As **Figure 11a** above shows, in 2016-17 the overwhelming majority of providers were within 5% of the national average for the overall caesarean rate.

When we looked at the data for 2019-20 (for England only, not casemix adjusted), the mean rate had risen slightly, to 27%, but the variation widened. Though these figures are not directly comparable, the increase in variation is nonetheless striking.

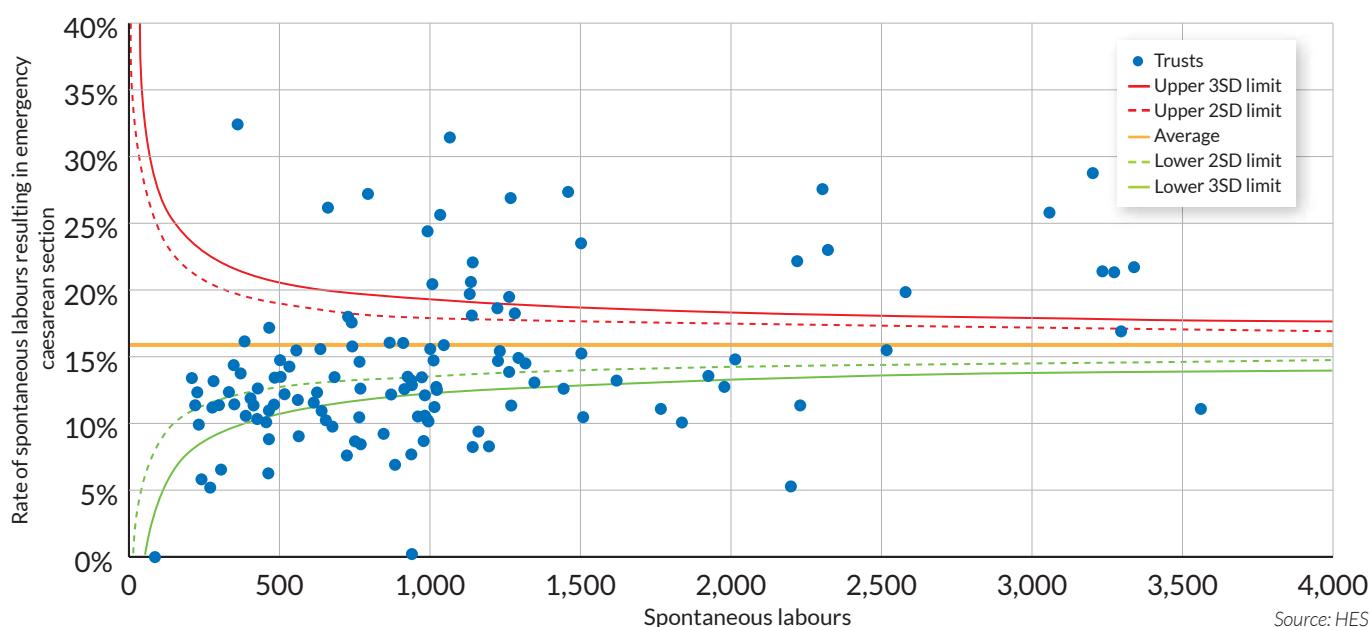
Figure 11b: Rate of caesarean sections, by trust, 1 April 2019 to 31 March 2020



We then looked at HES data for emergency caesareans and elective procedures. Again, this was from 2019/20, three years later than the data examined in the NMPA's 2019 clinical report (which looked at 2016/17). It was not casemix adjusted.

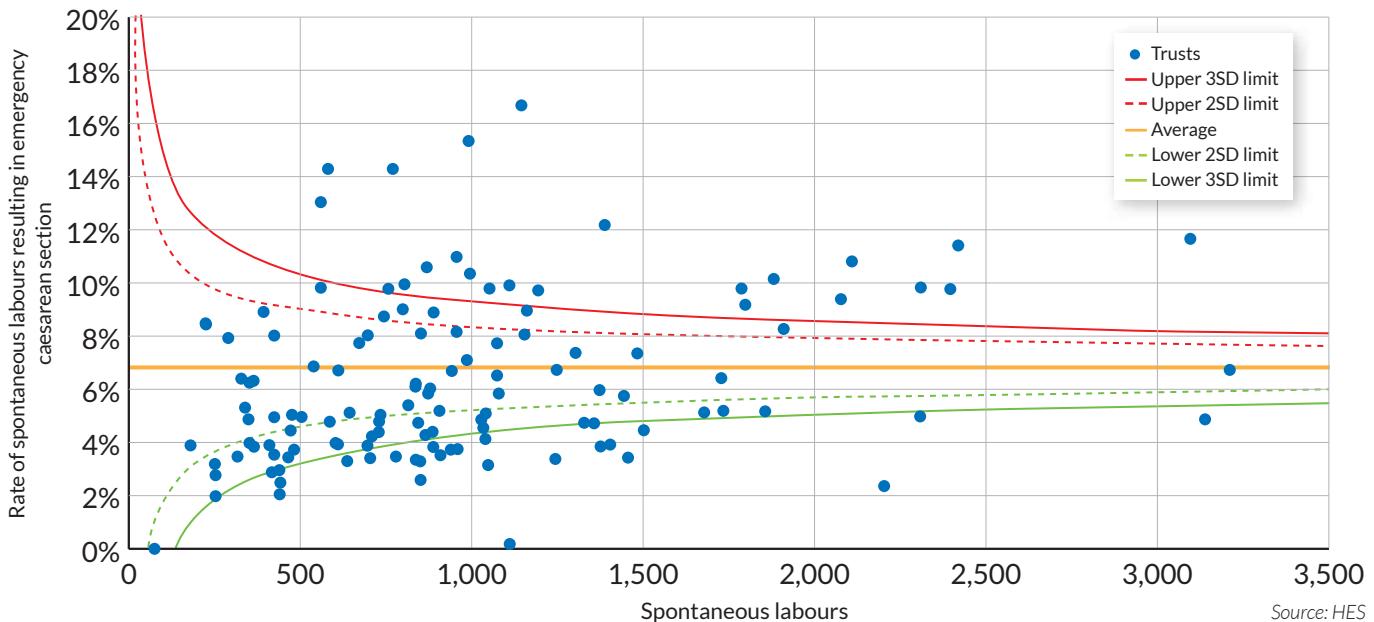
Figure 12 shows that for primiparous mothers, the emergency caesarean rate varied from 5% to over 30% - a six-fold variation. This variation does not appear to be related to the total number of spontaneous labours at a trust: 5% rates can be seen at providers who managed fewer than 500 spontaneous labours and one that oversaw 2,000. Similarly, there are trusts with a rate of 25% who managed more than 3,000 spontaneous labours and who managed fewer than 1,000. The average rate was 15.8%.

Figure 12: Rate of spontaneous labours resulting in emergency caesarean section, primiparous women, by trust, 1 April 2019 to 31 March 2020



The rate of emergency caesarean sections among multiparous women was significantly lower over the same period. However, the variation was at least as broad, with 22 providers conducting emergency caesarean sections in 10% of spontaneous labours involving multiparous women and 41 trusts conducting emergency caesarean sections in under 4% of such labours.

Figure 13: Rate of spontaneous labours resulting in emergency caesarean section, multiparous, 1 April 2019 to 31 March 2020⁸⁷



Source: HES

The broad variation shown in emergency caesarean rates, even among providers with similar numbers of spontaneous labours, suggests that different providers have different policies and definitions of what constitutes an emergency.

There is a lack of available data that shows the outcomes of emergency caesarean. To help identify best practice trusts should be encouraged to record more data about their decision-making and the outcomes. Relevant information could include whether full dilatation was reached before a decision was made to conduct an emergency caesarean: such procedures are associated with a higher risk of fetal trauma (particularly where they are conducted because the fetal head is impacted deep in the pelvis). Recording data about dilatation may be relevant to future evaluation and to potential litigation.

There are internationally recognised models for determining whether an emergency caesarean is required: the Robson classification is recommended by the World Health Organisation and offers a consistent model for decision-making.⁸⁸

We recommend the adoption of the Robson classification across all trusts. Because this will provide a more consistent approach across all trusts, it should help reduce the variation in emergency caesarean rates – though not necessarily reduce the rates of emergency caesarean themselves.

Elective caesarean section

NICE guidelines recommend that providers should offer a planned, or elective, caesarean section 'if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option'.⁸⁹ The guidelines also state that if a particular obstetrician is unwilling to provide a planned caesarean section, they should refer the mother to an obstetrician who is willing to do it.

Given this nationwide guidance, it might be expected that over the total number of births in a year there would be broadly similar rates of elective caesarean sections across providers, and that the majority of providers would be clustered closely around the national average. However, as **Figures 14(a & b)** and **15** show, this is not the case.

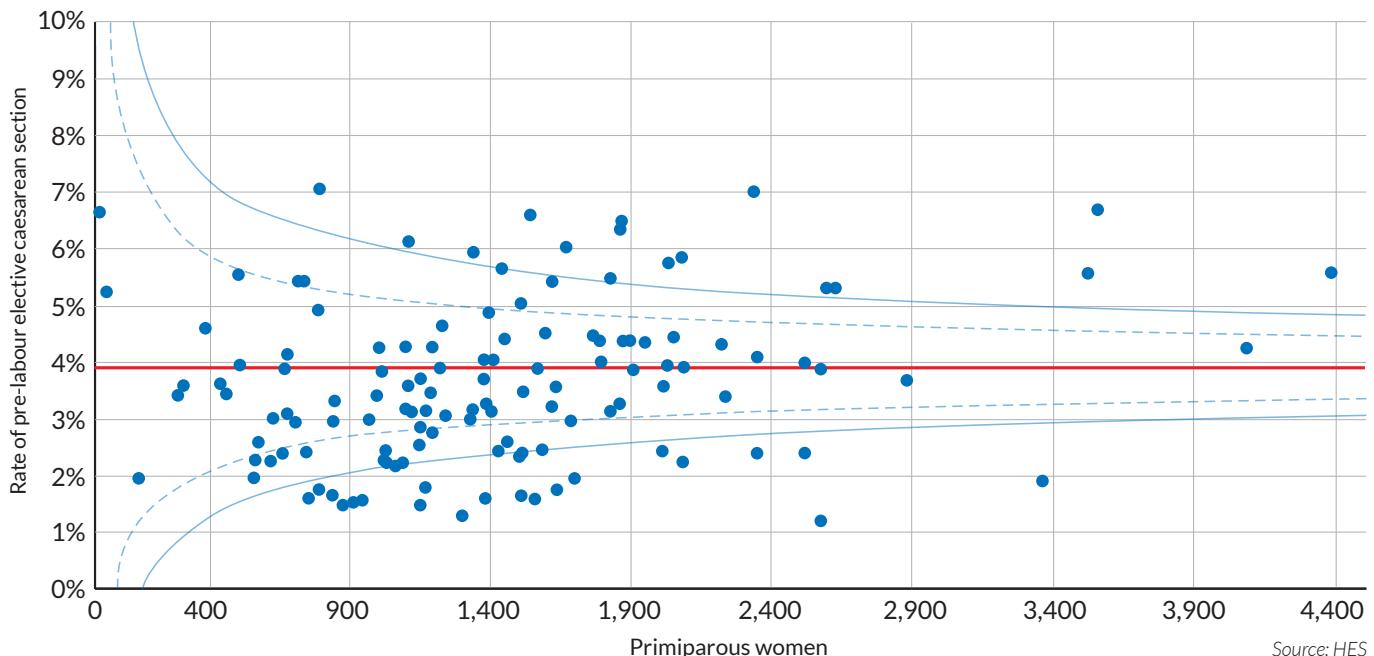
Figure 14a shows that in 2017-18, among primiparous women, the rates for elective caesarean section ranged from just above 1% to 7%, with a mean rate of 4%.

⁸⁷ It is important to note that the Y-axis on Figure 13 goes up to 20%; in Figure 12, it goes up to 40%

⁸⁸ See https://www.who.int/reproductivehealth/topics/maternal_perinatal/robson-classification-implementation/en/

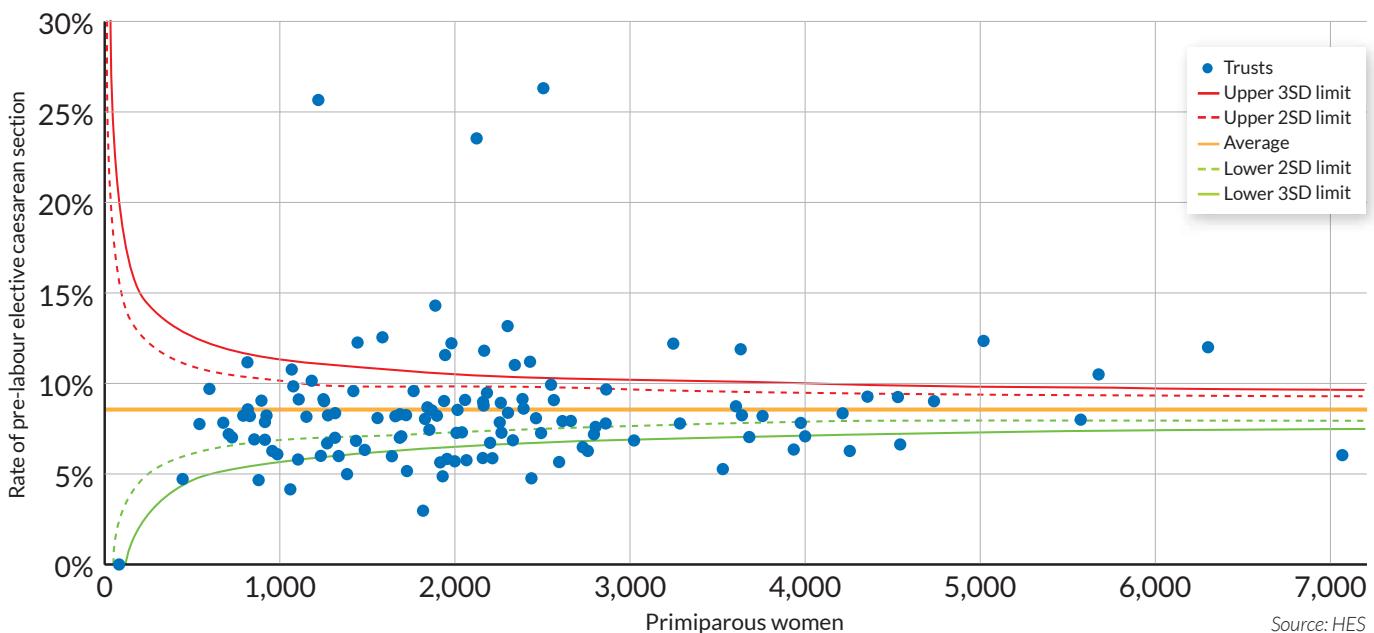
⁸⁹ NICE (2012) CG132 Caesarean section <https://www.nice.org.uk/guidance/cg132>

Figure 14a: Rate of pre-labour elective caesarean section, primiparous⁹⁰ women, by trust, 1 April 2017 to 31 March 2018



This was already greater variation than might be expected. However, just two years later, the range was from 3% to 26%, with the mean rate rising to 8.6% – as **Figure 14b** shows.

Figure 14b: Rate of pre-labour elective caesarean section, primiparous women, by trust, 1 April 2019 to 31 March 2020



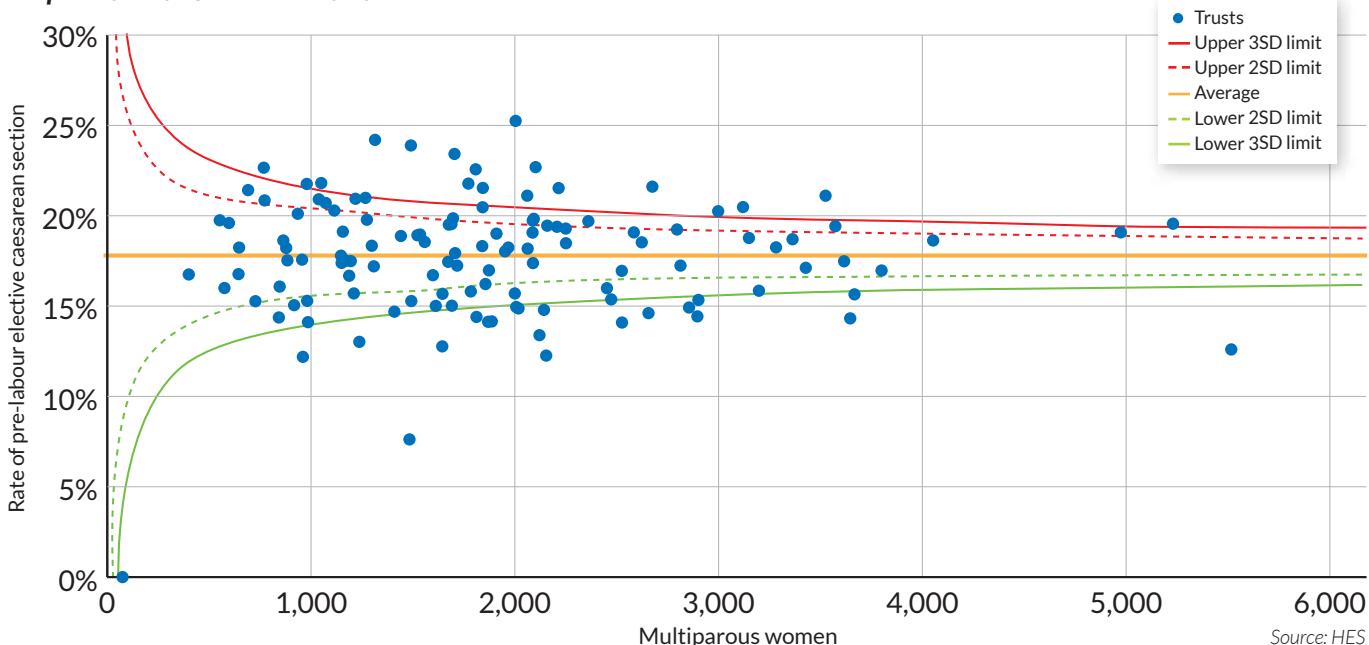
⁹⁰ This includes all primiparous patients age 15-45, giving birth to a single baby, at term, when the baby is in the cephalic position.

It seems highly unlikely that, at any trust, a quarter of all primiparous women will have an elective caesarean section; it is possible that this may be a coding issue. Clearly, the three outliers at around 25% will also affect the mean. However, even if these were discounted, the available data indicates a marked increase in the rate of elective caesarean section between 2017-18 and 2019-20. The data does not however explain why; this is something that we believe merits further investigation.

There has also been an increase over the last two years in the number of multiparous women having an elective caesarean section. However, this was not as marked. In 2017-18, the range for elective caesarean rates for multiparous women was from just above 7% to 22%, with a mean rate of 14%. (The elective caesarean rate for multiparous women is inevitably higher than primiparous, as RCOG guidelines⁹¹ recommend that a woman who has had a caesarean section should be offered a choice between a planned repeat elective caesarean section and a planned vaginal birth, unless there is a strong clinical indication for a caesarean section.)

As **Figure 15** shows, in 2019-20, there was only one provider with a rate below 10% and several with a rate over 20%, leading the mean to rise to 17.8%.

Figure 15: Rate of pre-labour elective caesarean section, multiparous women,⁹² by trust, 1 April 2019 to 31 March 2020



Aside from the apparent trend of increasing elective caesarean section rates overall, the impression the data gives is of a substantial variation between trusts. This variation is sufficiently broad that, rather than just reflecting maternal choice, it also reflects different 'custom and practice'. This was confirmed during GIRFT deep-dive visits when providers described their approaches to offering pre-labour elective caesarean.

For example, the policy at one provider was not to offer mother-requested caesarean section at all. This provider is therefore not working in line with NICE guidance. Other providers also reported that they work to a high threshold for supporting caesarean section based purely on maternal choice. Some described pathways where any woman who requests a caesarean section must see a second obstetrician or consultant midwife before the request is accepted.

Such approaches are likely to have a direct impact on neighbouring providers, who may also be approached by women who request a caesarean section but could not have one at their 'home' provider. There is also some indication that this affects satisfaction with maternity care – with some women frustrated at having to travel further from home to exercise their permitted choice.

⁹¹ See RCOG (2015) Green-top Guideline No 45: Birth after Previous Caesarean Birth <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg45>

⁹² This includes all multiparous patients age 15-45, giving birth to a single baby, at term, when the baby is in the cephalic position.

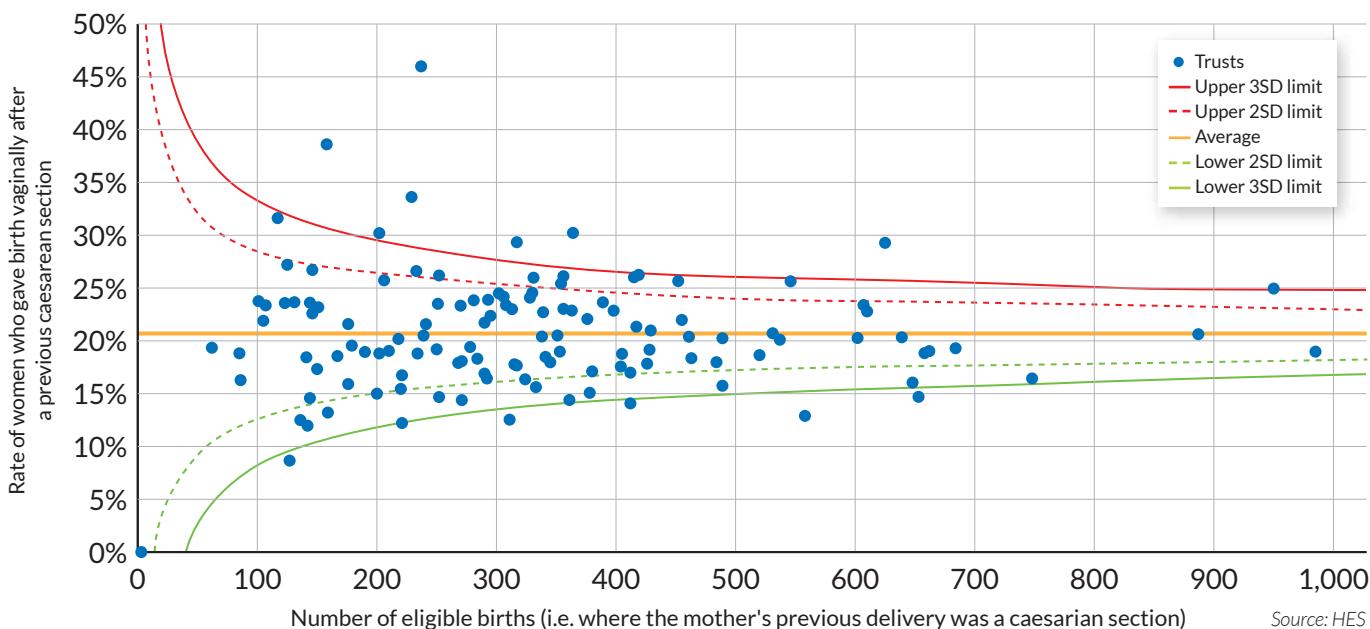
Because it is driven by casemix and patient choice, it is neither possible nor appropriate to set a ‘target’ or optimum rate for elective caesarean section. However, the GIRFT approach allows us to identify variation, then work with outliers to examine the reasons behind their different rates and where necessary support changes in practice that align them fully with NICE guidance. This in turn should lead to a decrease in variation over time.

Supporting choice for future deliveries

As noted above, once a woman has had a caesarean section, this can affect future deliveries. The NMPA sought to examine whether such choice appears to be routinely offered, by gathering data about vaginal births after a previous caesarean. Overall, it found that, in 2016-17 in England, just under 25% of women giving birth to a second child, following a caesarean section for the first birth, did so vaginally. There was considerable variation behind the national average.

The data for 2019-20 showed a similar pattern. While the national ‘rate’ for vaginal birth after caesarean had dropped to 20.7%, there was still considerable variation, from 9% to 46%. As **Figure 16** shows, 15 trusts had a rate of 15% or under and six had a rate of over 30%.

Figure 16: Proportion of women who have a vaginal birth after caesarean, by trust, 1 April 2019-31 March 2020



While choice is likely to be a factor in the variation visible, the breadth of this variation suggests that other factors may also be of significance, such as local guidance and thresholds for caesarean and the use of other methods of induction. Put another way, there may be different choices available in different locations.

We asked units to describe the processes that were in place to support women who have delivered by caesarean section to help them make a decision about future births. There were three main approaches described.

1. Some units have dedicated consultant programmed activity time for postnatal ward rounds. Where a woman has delivered by caesarean section, the consultant will discuss the potential impact of this on future deliveries. Feedback on this ‘hot debrief’ approach is that it is sometimes too hot; mothers need time to reflect on their birth and many could not recall what had been said during the debrief.
2. Birth afterthoughts clinics, led by senior midwives, offer mothers the opportunity to discuss future birth plans. Taking place a few weeks after giving birth, these offer a range of advantages beyond being able to advise women on future deliveries; they are also a means of gathering feedback and checking on mother and baby. Some units offered this as an ‘opt-in’ service available to all mothers, while others signposted specific mothers. Those with an opt-in model noted that the women who chose to attend were not necessarily those identified by midwifery and obstetric staff as potential beneficiaries of the service.

3. The third approach waits until women who have previously had a caesarean section are pregnant again. They are then invited to a 'birth choices' clinic led by senior midwives, where they are offered information about their birth choices; the aim is not to reduce maternal request caesarean section rates but to enable informed decisions.

Improving data to inform practice

Overall, the data available around caesarean section indicates greater variation than would have been expected in relation to whether mothers receive an emergency – or in particular, an elective – caesarean section. However, the data at present is insufficient to draw detailed inferences from; in particular, we would welcome being able to examine not only the basic rate of caesarean section (elective/emergency) but also the indications for it and other options considered. Crucially too, we would like to consider the outcomes of the decisions.

Similar issues occur in relation to other methods of birth, such as induction and instrumental delivery. This additional layer of data would be invaluable to help reach an evidence-based consensus on best practice.

We have therefore focused our recommendation on improving the depth and quality of data gathered around these key aspects of maternity care. The first step would be at trust level, enabling audit at local maternity system (LMS) level, and then at regional level.

We are aware that RCOG is exploring how different data sets around maternity care and safety can be combined and we look forward to the outcomes of this work.

Recommendation

Recommendation	Actions	Owners	Timescale
4. Improve recording of data about key aspects of maternity care, including outcome data for mothers and babies. For example, spontaneous birth, caesarean section, assisted birth.	<p>a Trusts to improve data capture, such as local audit, that can then be used to inform and optimise:</p> <ul style="list-style-type: none"> i. Rates of caesarean section and maximise use of Robson classification. ii. Mode of birth in line with evidence-based best practice. iii. Rates of babies born at term who are small for gestational age, as defined in Saving Babies Lives Care Bundle volume 2.⁹³ iv. Rate of induction, including clinical reasoning. <p>b Local Maternity Systems (LMS) to actively monitor 12 month rolling average rate of serious incidents and referrals to HSIB in each hospital.</p>	Trusts LMS	For substantial progress within two years of publication For substantial progress within 12 months of publication

⁹³ This reflects the fact that there are different definitions of small for gestational age, including a subtle difference between the definition used by the NMPA and that used in the Saving Babies Lives Care Bundle version two. The NMPA used the definition of SGA set out in the RCOG Green-top Guideline on SGA fetuses, which is 'an infant born with a birth weight less than the 10th centile.' See RCOG (2013) Green-top Guideline 31 on The Investigation and Management of the Small-for-Gestational-Age Fetus https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf. A different definition of SGA was used in the Saving Babies Lives' Care Bundle version two, which refers to SGA as being babies with an estimated fetal weight (EFW) less than or equal to the 10th centile at 40 weeks. The focus of the care bundle is increasingly on those babies identified as having fetal growth restriction (FGR); broadly babies with EFW or abdominal circumference (AC) less than the 3rd centile. For a full definition, see Saving Babies Lives' Care Bundle version two Appendix D <https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf>

The mother

Under this broad heading, we focused on maternal safety and the prevention of avoidable harms during pregnancy and birth. We did not look at maternal death; this is covered in exemplary detail by the MBRRACE-UK study and we fully support its work and findings.

Improving the safety of episiotomy

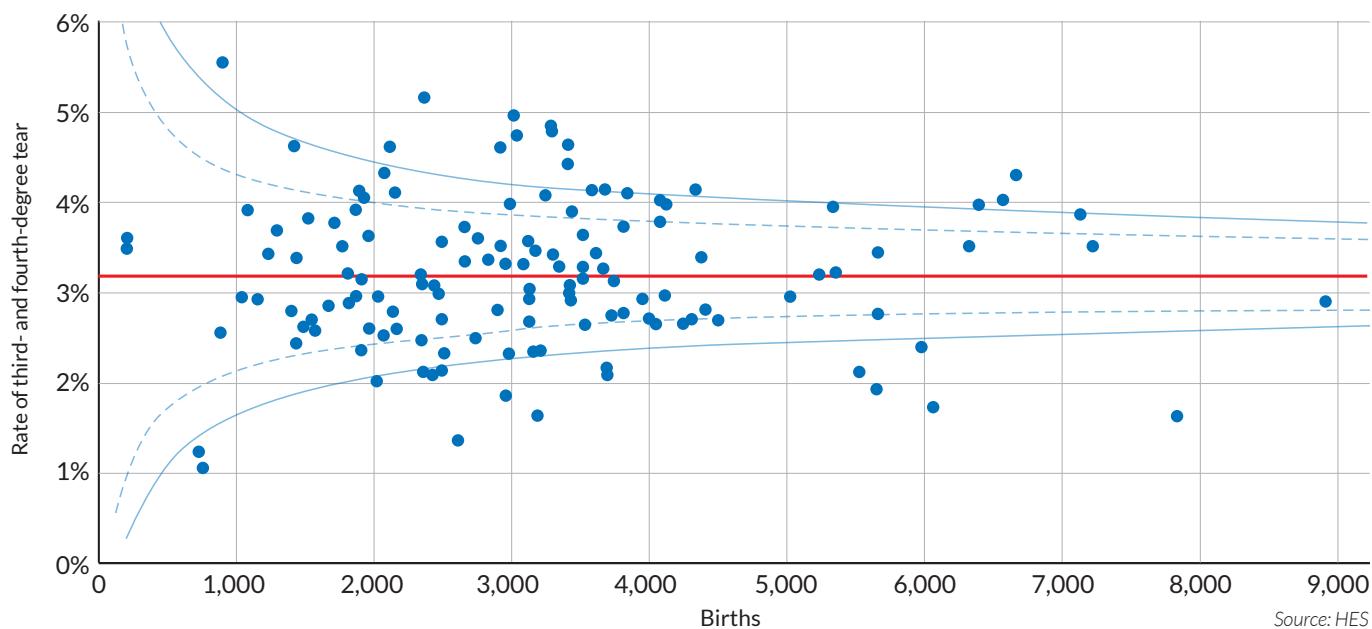
The NMPA clinical report highlighted that over 21% of all singleton, cephalic, vaginal births in England involve an episiotomy – a surgical incision between the vagina and perineum to enlarge the opening for the baby to pass through. Where assisted birth is required, the episiotomy rate rises to over 86%. Episiotomy training for all relevant staff is essential, not only to ensure it is offered at the right time but more importantly to focus on ensuring the incision is performed correctly.⁹⁴

Reducing perineal injury during birth

The risk of perineal injury during birth is relatively common. Apart from adding to the pain and discomfort associated with giving birth, third- or fourth-degree perineal tears of the anal sphincter and rectal mucosa respectively – also known as OASI – can result in mothers needing additional surgery meaning longer stays in hospital. In the longer term, they can also cause continence issues.

The 2019 NMPA found that third- or fourth-degree tears occurred in 3.4% of all vaginal births in England during 2016/17 (14,744 women out of 426,534).⁹⁵ However, the rates of OASI vary considerably between providers, from over 5%, meaning more than 1 in 20 women suffer an OASI to under 2%, so fewer than 1 in 50 women. This was apparent when we first examined HES data around OASI for 2017/18.

Figure 17a: Third- and fourth-degree perineal tear rates by trust, 1 April 2017 to 31 March 2018

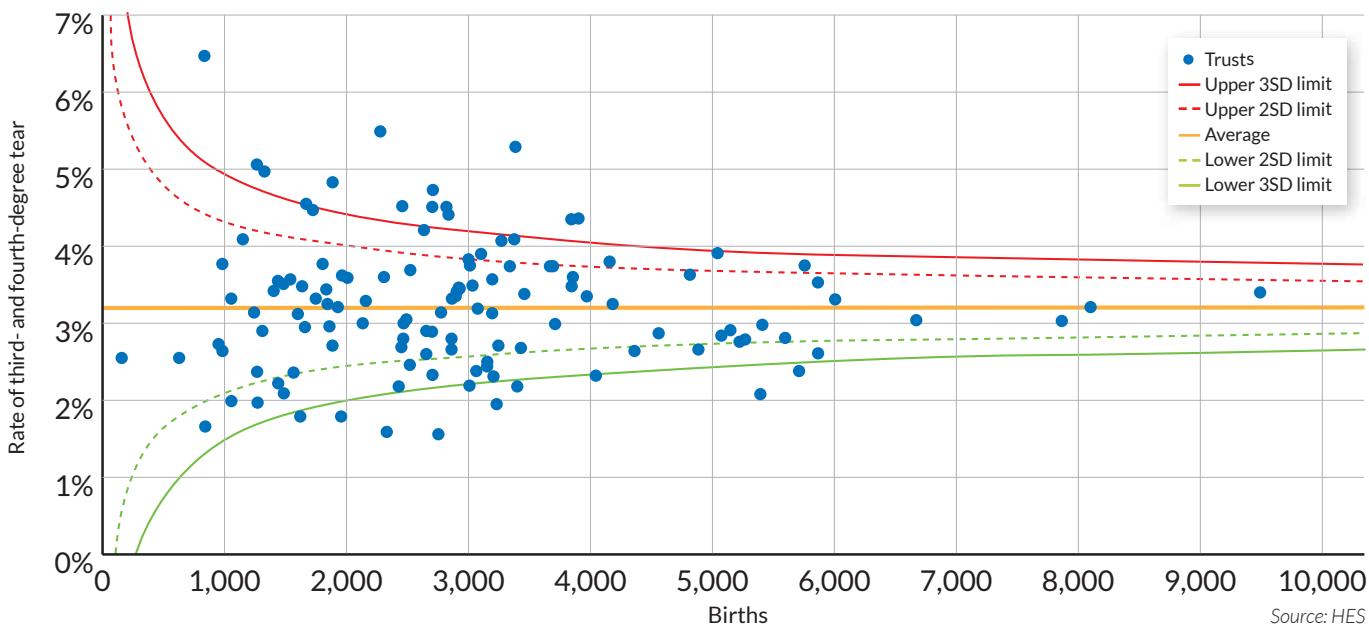


⁹⁴ See <https://www.nice.org.uk/guidance/mtg47>

⁹⁵ See NMPA clinical report 2019 pg 53 <https://www.maternityaudit.org.uk/pages/reports>

Disappointingly, when we looked at the data for 2019/20, the picture was very similar – or even arguably slightly worse. As **Figure 17b** shows, there remains extensive variation between trusts and the mean rate is still just over 3%.

Figure 17b: Third- and fourth-degree perineal tear rates by trust, 1 April 2019 to 31 March 2020



The reason this lack of improvement is of concern is that it has now been well-established that there are several factors that can help reduce OASI rates. These include more effective use of episiotomy – particularly during assisted birth – and the use of dedicated OASI or perineal care ‘bundles’. These are multidisciplinary approaches that help build awareness among all staff of the risk factors for OASI and provide best practice guidance on taking appropriate measures during the birth to avoid third- and fourth-degree tears.

A number of care bundles have been developed and implemented, including:

- the OASI Care Bundle jointly developed by Croydon Health Services NHS Trust, the RCOG, the RCM and the London School of Hygiene and Tropical Medicine;⁹⁶
- the PEACHES programme, originally developed at Guy's and St Thomas' NHS Foundation Trust in London;⁹⁷ and
- STOMP, developed at Medway NHS Foundation Trust.⁹⁸

The OASI Care Bundle was piloted at Croydon Health Services NHS Trust and in the first year of using it, the OASI rate was reduced from 4.5% to 2.5%. The pilot was extended to more sites and similar results were seen. As a result, this was recommended for wider roll-out, with trusts invited to participate and receive initial training from the RCOG and the RCM.

The available evidence – which covers a period before additional restrictions on maternity care came into force as a result of COVID-19 – suggests that not enough trusts have adopted care bundles or taken sufficient steps to reduce OASI. We therefore want to reinforce the recommendation, setting the provisional goal for all trusts to achieve the OASI rates of the current top 10%. This would bring the mean rate down to around 2% and result in around 4,500 fewer women a year suffering an OASI during birth.

It is important that maternity teams are aware of the risks of OASI and that there is sufficient communication to them about the risks and how to mitigate them. The care bundles have such information; it is up to individual providers to ensure it is distributed. In addition, it is also crucial that pregnant women are informed of the risks of OASI as part of the information given to them at the start of their maternity journey, so they can consider this as part of their birth plan and make fully informed choices. This includes, where appropriate, informing women who may be at higher risk for physiological reasons, and noting where particular birth options could also increase the risk.

⁹⁶ See <https://www.rcog.org.uk/OASICareBundle>

⁹⁷ See <https://www.guysandstthomas.nhs.uk/news-and-events/2015-news/december/20151203-midwives-win-chairmans-choice-award.aspx>

⁹⁸ See <https://www.ncbi.nlm.nih.gov/pubmed/27164486>

We are aware that RCOG is currently beginning an OASI2 programme, seeking to evaluate and compare different approaches to the implementation of the OASI Care Bundle to support wider adoption and sustainability. Given the slow progress to date, we welcome this programme, along with the related intent from the RCOG to update its guidance on management of third- and fourth-degree perineal tears.

Access to postnatal physiotherapy

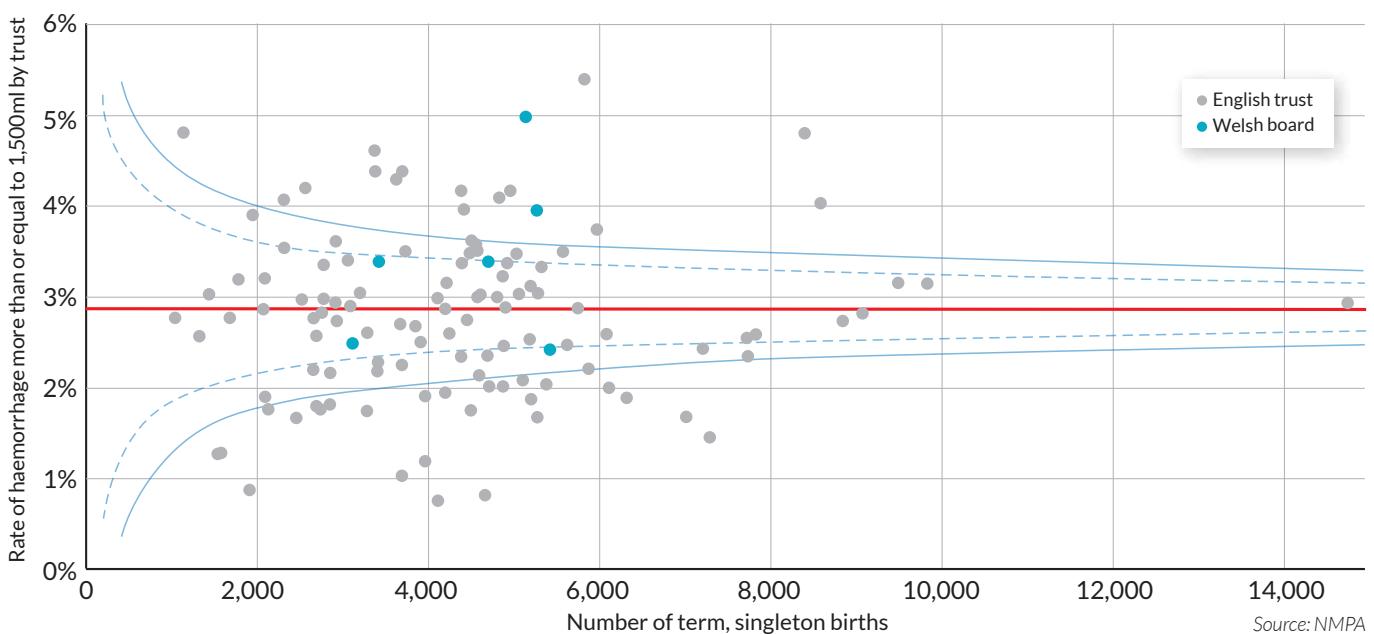
The NHS Long Term Plan has also committed to improving access to postnatal physiotherapy to address incontinence and pelvic organ prolapse. It stated: ‘We will ensure that women have access to multidisciplinary pelvic health clinics and pathways across England via referral. Clinics can also provide training and support for local clinicians working with women, such as GPs and midwives.’ We strongly support all aspects of this statement and in particular would emphasise that physiotherapy can be delivered effectively through primary and intermediary care rather than requiring women to return to hospitals. One limiting factor is a shortage of specialist physiotherapists.

Postpartum haemorrhage

Postpartum haemorrhage refers to heavy bleeding from the vagina after the baby's birth. It is one of the most common causes of maternal mortality. Severity is measured in terms of the amount of blood lost, with haemorrhage of over 1,500ml deemed ‘massive’.

The NMPA found that in England, 2.8% of women had a haemorrhage of 1,500ml or more in the reporting year. However, there was considerable variation in haemorrhage rates between trusts, as **Figure 18** shows.

Figure 18: Casemix adjusted proportion of women who had a singleton baby at term, who had a postpartum haemorrhage of 1,500ml or more, by trust, April 2016–March 2017



As can be seen, there is variation here from under 1% of births – so less than 1 in 100 women having a massive postpartum haemorrhage – to over 5% (1 in 20).

However, this may be – at least in part – a reflection of an unreliable approach to measuring postpartum haemorrhage. For some providers, measurement is by a form of educated guess, based on a staff member’s assessment of how much blood the mother lost. Other providers increase the accuracy of blood loss assessment by weighing swabs and pads.

Given the potentially severe consequences of massive postpartum haemorrhage, it would be of real value to identify where rates are higher than expected. At present, we cannot really do this. One alternative approach would be to examine the number of mothers who receive a blood transfusion; this would arguably be a better indicator of severe blood loss than the current visual estimates. However there is also variation in transfusion practice between trusts and between clinicians.

As noted above, the NMPA has recommended that 'All maternity services should review their clinical practices to ensure an accurate diagnosis and effective prevention and management of postpartum haemorrhage.' Our proposed approach would align with this recommendation.

Recommendation

Recommendation	Actions	Owners	Timescale
5. Increase focus on reducing the rate of obstetric anal sphincter injury (OASI) so that all trusts achieve OASI levels similar to those at the top decile of trusts.	a All trusts to implement an OASI care bundle and improve the safety of episiotomy when indicated. b All trusts to audit the effectiveness of the implemented/established OASI care bundle.	Trusts	For immediate action Ongoing

The baby

In the UK today, a greater proportion of babies are being born safely than ever before. Stillbirth (defined as when a baby is born without signs of life after 24 completed weeks of pregnancy) rates are the lowest the UK has ever recorded. The NHS Long Term Plan reiterates the NHS's commitment to a 50% reduction in stillbirth in England, noting that 'since 2010, despite increases in some risk factors such as age and comorbidities of mothers, there has been an 18.8% reduction in stillbirths [and] a 5.8% reduction in neonatal mortality'.⁹⁹ This indicates substantial progress over the last decade; before that, the stillbirth rate had barely changed for the preceding 20 years.

In 2019, the stillbirth rate was the lowest ever in the England and Wales¹⁰⁰ at 3.9 per 1,000 births (in England only 3.8 per 1,000 births). However, this still means that approximately 1 in every 250 births in England and Wales was a stillbirth – equivalent to just over 2,500 a year or almost seven a day. While significant progress continues to be made to reduce this rate, more than 20 high-income countries have a lower stillbirth rate than the UK.¹⁰¹

The neonatal mortality rate in England and Wales in 2018 was 2.8 per 1,000 live births (approximately 1 in every 350).¹⁰² This rate was unchanged from 2017.

Variation in stillbirth and perinatal mortality rates

As the NHS Long Term Plan highlighted, infant mortality and stillbirth are far more likely in the most deprived communities in England. It cited data from 2014-16, but the latest available data from the Office for National Statistics (ONS) shows the same picture.

Table 2: Stillbirth and infant death rate by Index of Multiple Deprivation, England, decile 2018

	IMD decile	Live births	Stillbirth rate	Infant death rate
Most deprived	1	84,863	5.7	5.3
	2	76,846	4.7	4.5
	3	73,467	4.1	4.0
	4	66,949	3.9	4.1
	5	61,609	4.2	3.3
	6	59,891	3.7	3.4
	7	55,029	3.3	3.3
	8	52,310	3.2	2.7
	9	50,033	3.1	3.3
	10	44,654	2.7	2.7
Least deprived				

Source: ONS¹⁰³

The NHS Long Term Plan therefore announced specific measures to care for women with heightened risk of pre-term birth, including younger mothers and those from deprived backgrounds.

The latest data indicates that in the most recent years there has been a slight narrowing in the infant mortality rate between the most and least deprived areas. However, the gap remains substantial.

⁹⁹ NHS Long Term Plan para 3.8

<https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/maternity-and-neonatal-services/>

¹⁰⁰ See <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsummarytablesenglandandwales/2019>

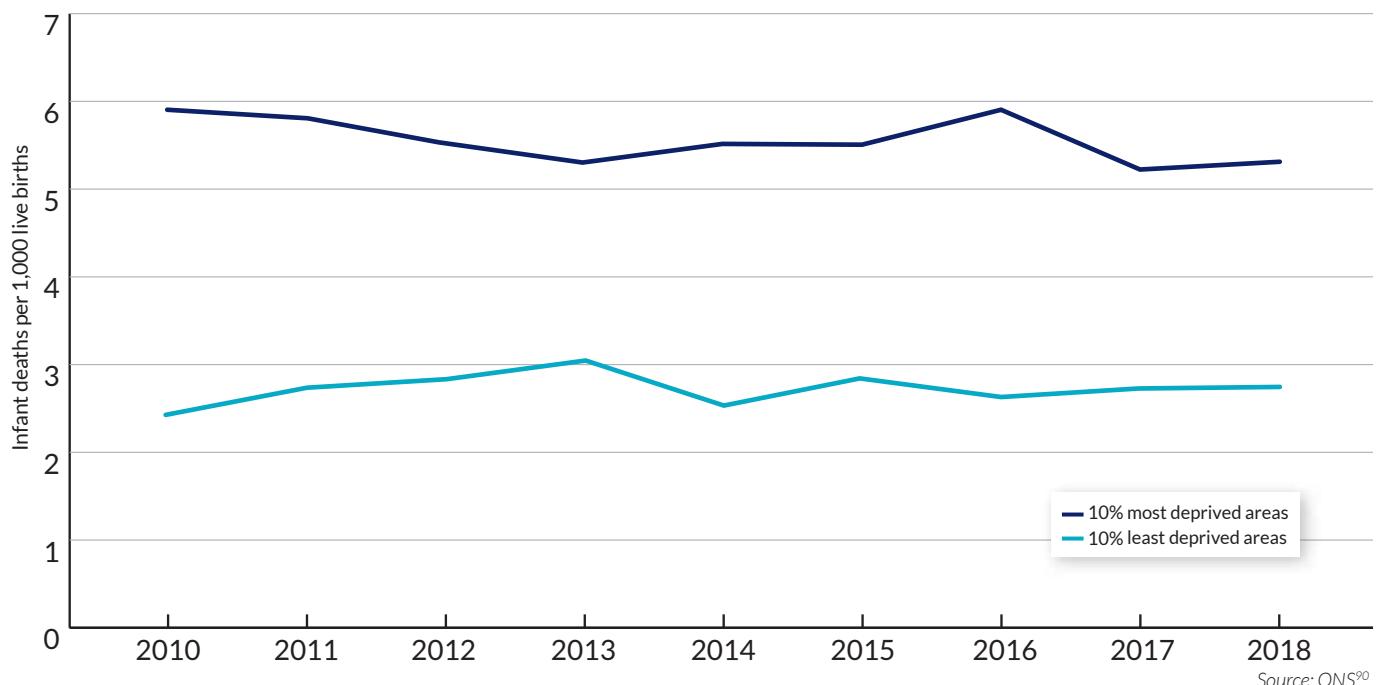
¹⁰¹ See [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)01020-X/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)01020-X/fulltext)

¹⁰² See ONS data on Child and infant mortality in England and Wales: 2018

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018>

¹⁰³ See <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018>

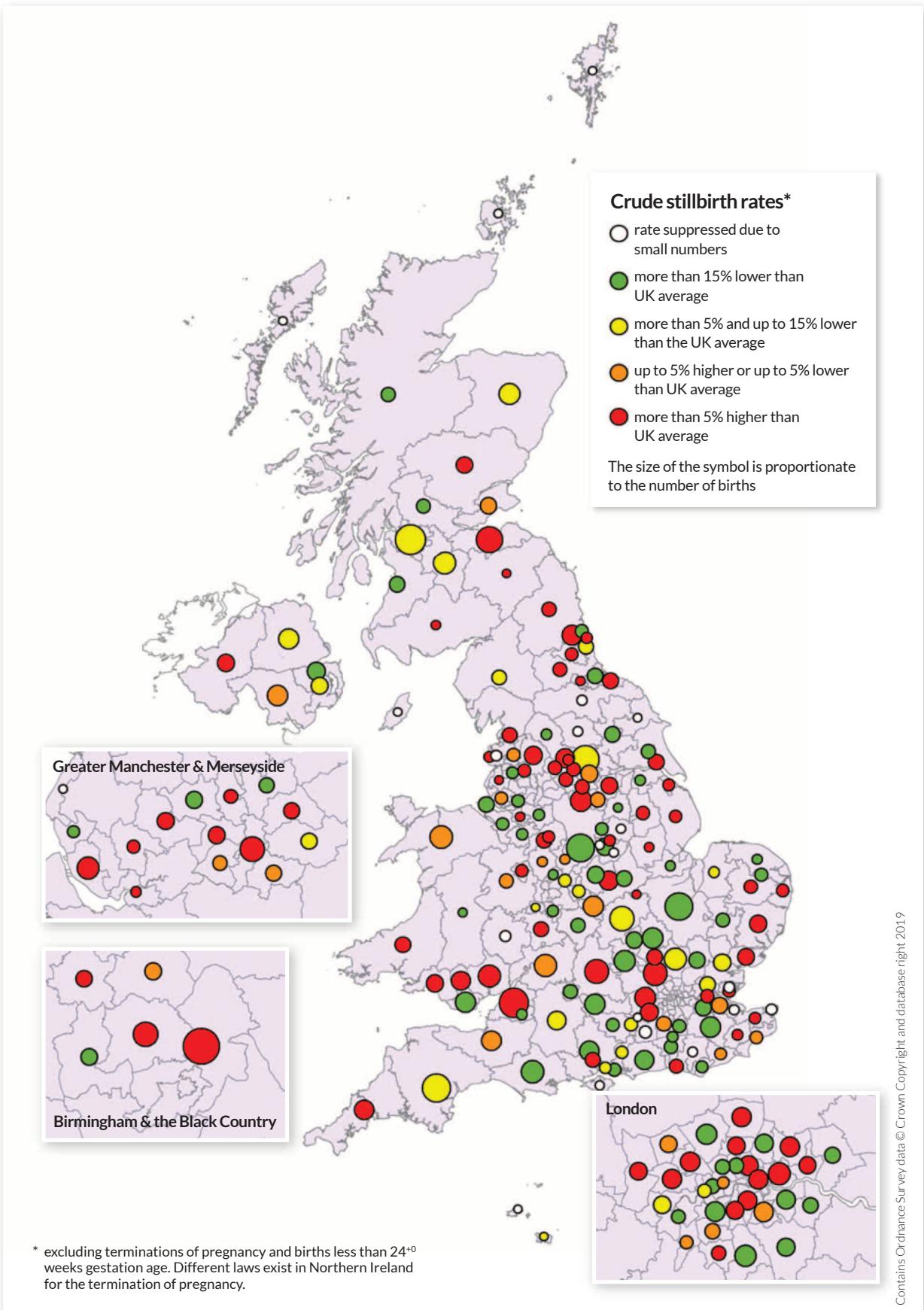
Figure 19: Differences in infant mortality rate between the most and least deprived areas of England, 2010 to 2018



There is also considerable regional variation in stillbirth and perinatal mortality rates, as has been demonstrated by the MBRRACE-UK study.¹⁰⁴

¹⁰⁴ Draper ES, Gallimore ID, Smith LK, Fenton AC, Kurinczuk JJ, Smith PW, Boby T, Manktelow BN, on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2018. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester. 2020.

Figure 20: Crude stillbirth rates by Clinical Commissioning Group (England), Health Board (Scotland and Wales), Local Commissioning Group (Northern Ireland), and Crown Dependency based on postcode of mother's residence at time of delivery: United Kingdom and Crown Dependencies, for births in 2018



Some of this variation reflects levels of deprivation, but this is not always the case.

The Office of National Statistics (ONS) publishes time series data on neonatal mortality and stillbirth rates in England and Wales. As cited above, in 2019, the stillbirth rate in England and Wales fell to 3.9 stillbirths per 1,000 total births, reaching an all-time low since records began in 1927 for the third year running. In England, the stillbirth rate has seen a 21% decrease between 2010 and 2018.

While this is a positive finding, there has been over the same period a small increase in neonatal deaths; this may be as a result of interventions, without which would previously have resulted in stillbirth.

We know that there are a range of factors that increase the likelihood of stillbirth – including maternal smoking and obesity. As noted in previous sections of this report, the NHS Long Term Plan has set out commitments to increase the reach of smoking cessation programmes and maternal weight management.

A number of initiatives aiming to reduce stillbirths in England are being implemented as part of the Maternity Transformation Programme. Activity has been staggered over the last three years, with some initiatives undergoing a phased implementation e.g. continuity of carer and the Saving Babies' Lives Care Bundle. Others, anticipated to have a positive impact on stillbirth reduction are still to be implemented (for example, Networked Maternal Medicine). A series of assumptions which account for time lags to realise the impact of interventions have been made. These assume 1.5 years to implement each initiative; one year to embed the intervention and two years across which the impact would be seen. While these are crudely-based assumptions, it is anticipated that further progress is likely to be seen in the next two to three years as interventions continue to embed. Importantly, mortality data is published with a 1-2 year lag after the data period. Hence, the latest published rates do not reflect efforts in the months/years since that period.

The Saving Babies' Lives Care Bundle was introduced in 2016 – and updated in 2019 – to address other identified risks, including through increased monitoring and risk assessment throughout pregnancy. It also supports prevention through the provision of 'Safe and Healthy Pregnancy Information' to help women reduce the risks to their baby; preterm birth prevention through implementation of specialist clinics; and, where preterm birth is inevitable, the clinically appropriate use of magnesium sulphate, which is estimated to help reduce the number of pre-term babies born with cerebral palsy by up to 700 per year. While we naturally support this, we would highlight that there remain risks associated with the incorrect use of intravenous magnesium sulphate. These are arguably exacerbated by the fact that many of the currently available licensed products require staff to undertake complex calculations and dilution before administering the medication; we believe there would be value in simplifying this, by providing products that require less 'intervention' before they are administered by staff, who are often working under pressure.

At the heart of the Better Births vision to provide care which is safe and personalised and which puts the needs of the woman, her baby and family at the centre, is the idea that continuity of care throughout the maternity journey (before, during and after birth) improves safety and outcomes. Women who receive continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience preterm birth. This model of care is currently being targeted towards women from BAME groups and those living in deprived areas, for whom midwifery-led continuity of carer is linked to significant improvements in clinical outcomes.

Maternity and neonatal safety champions are charged with working across regional, organisational and service boundaries to develop strong partnerships, promoting the professional cultures needed to deliver better care. They play a pivotal role in ensuring that mothers and babies continue to receive the safest care possible by adopting and sharing best practice. Central to this is the need for safety champions to work with clinical directors, heads of midwifery and neonatal service leads, to draw on a range of data sources to monitor progress and implement safety initiatives, aimed at achieving the national ambition by 2025.

Detection of fetal growth restriction in term babies

One of the most important advances in antenatal care has been the ability to monitor the fetus more closely in the womb. Where the fetus appears to be growing slowly, birth can be expedited e.g. induction of labour and further care provided on a neonatal unit. This is a key strand of the Saving Babies' Lives Care Bundle.

The NMPA examined how effective providers appear to be at identifying fetuses that are small for gestational age (SGA),¹⁰⁵ who may be experiencing fetal growth restriction. It found that, despite the additional guidance in Saving Babies' Lives, the majority of babies whose weight is below the 10th centile are not born before 40 weeks.

¹⁰⁵ As detailed in footnote 93, the NMPA used the definition of SGA set out in the RCOG Green-top Guideline on SGA fetuses, which is 'an infant born with a birth weight less than the 10th centile.' The Saving Babies Lives' Care Bundle version 2 defined SGA as being babies with an estimated fetal weight (EFW) less than or equal to the 10th centile at 40 weeks.

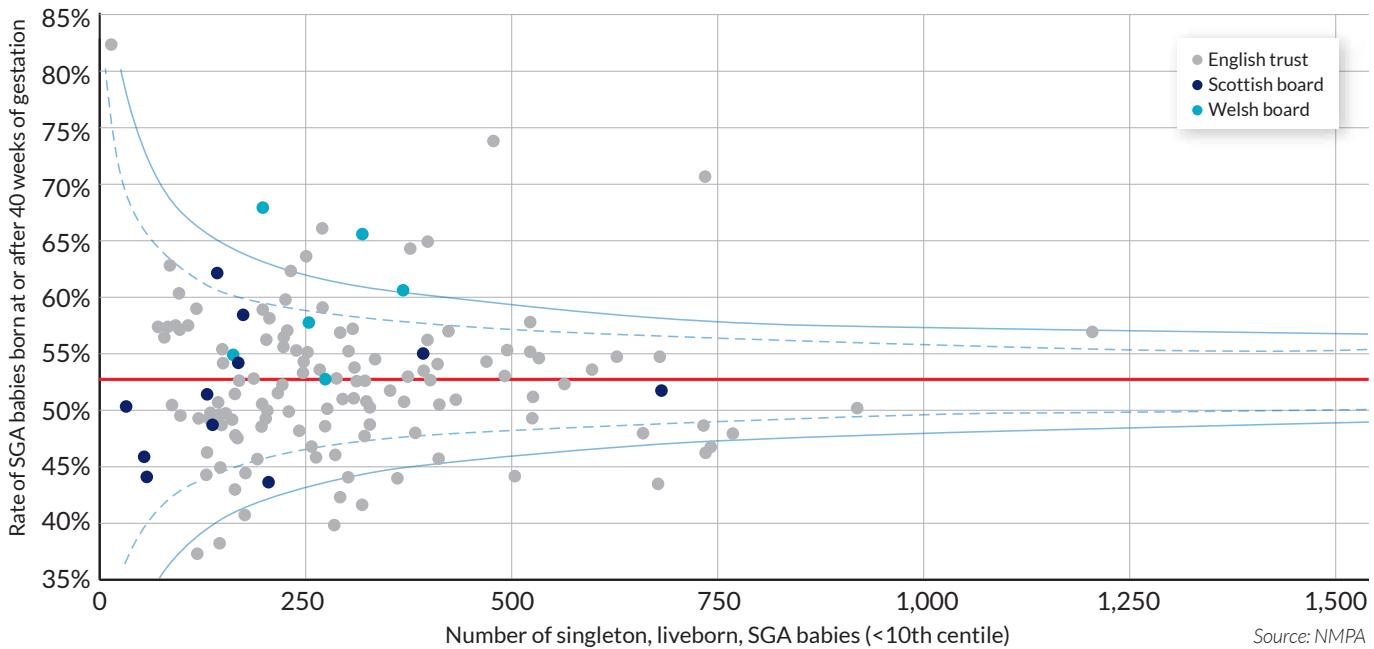
Table 3: Proportion of term babies born small for gestational age at or after 40⁺⁰ weeks

England	
Number of trusts/boards included in analysis	124
Number of babies included in analysis	38,913
Number of all babies at term with birthweight <10 th centile, who are born at or after 40 ⁺⁰ weeks	20,357
Proportion of term babies who are born with weight <10 th centile	7.2%
Proportion of term babies born with weight <2 nd centile	1.0%
Proportion of all babies at term who are <10 th centile, who are born at or after 40 ⁺⁰ weeks (adjusted)	52.3%

Source: NMPA

The NMPA report examined the rate of SGA babies born at term by trust and found that, while the majority were close to the mean, there were a few outliers with markedly higher rates of SGA babies being born at term.

Figure 21: Casemix adjusted trust/board level proportions of babies born at term (at or after 40⁺⁰ weeks) with weight below the 10th centile, by trust, April 2016-March 2017



While there appears to have been some improvement in the detection rate of the SGA fetus over recent years, the variation shown above seems unwarranted. Version two of the Saving Babies' Lives Care Bundle restated the importance of risk assessment and management of babies at risk of fetal growth restriction,¹⁰⁶ but we understand that this is currently the least widely implemented element of the programme.

¹⁰⁶ See <https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf>

Where serial ultrasound is used among women identified as at higher risk of having an SGA baby, it appears to aid detection of SGA fetuses.¹⁰⁷ However, we are aware that there are distinct pressures on the sonography workforce and at present in many areas demand exceeds capacity. This is not simply about the absolute numbers of sonographers available, but also in ensuring they have the skills required to conduct the kind of examination recommended in version two of the Saving Babies' Lives Care Bundle. Perhaps in part as a result of these capacity constraints, where are also differences in provider policies about when ultrasound should be used.

We are aware that a range of research is underway to determine the most appropriate points at which to conduct ultrasound.

Version two of the Saving Babies' Lives Care Bundle also emphasised the importance of differentiating between a fetus that is SGA and those who may have fetal growth restriction – which has a far greater risk of stillbirth. Interventions should naturally be targeted at the latter group, some of whom will be detected through the additional scanning. Personalised Care and Support Plans (PCSPs) can then usefully identify the interventions and support that are most appropriate for each woman.

We support the actions identified in the Care Bundle – which we summarise as risk assessments of all pregnant women, improved multidisciplinary training around SGA screening (how to conduct it and how to interpret or review it) and more consistent use of growth charts – and also strongly advocate the greater use of RCOG's Green-top Guideline on the investigation and management of the SGA fetus which provides valuable insight to support risk stratification.¹⁰⁸ We recognise that there needs to be an investment in sonography capacity to enable this.

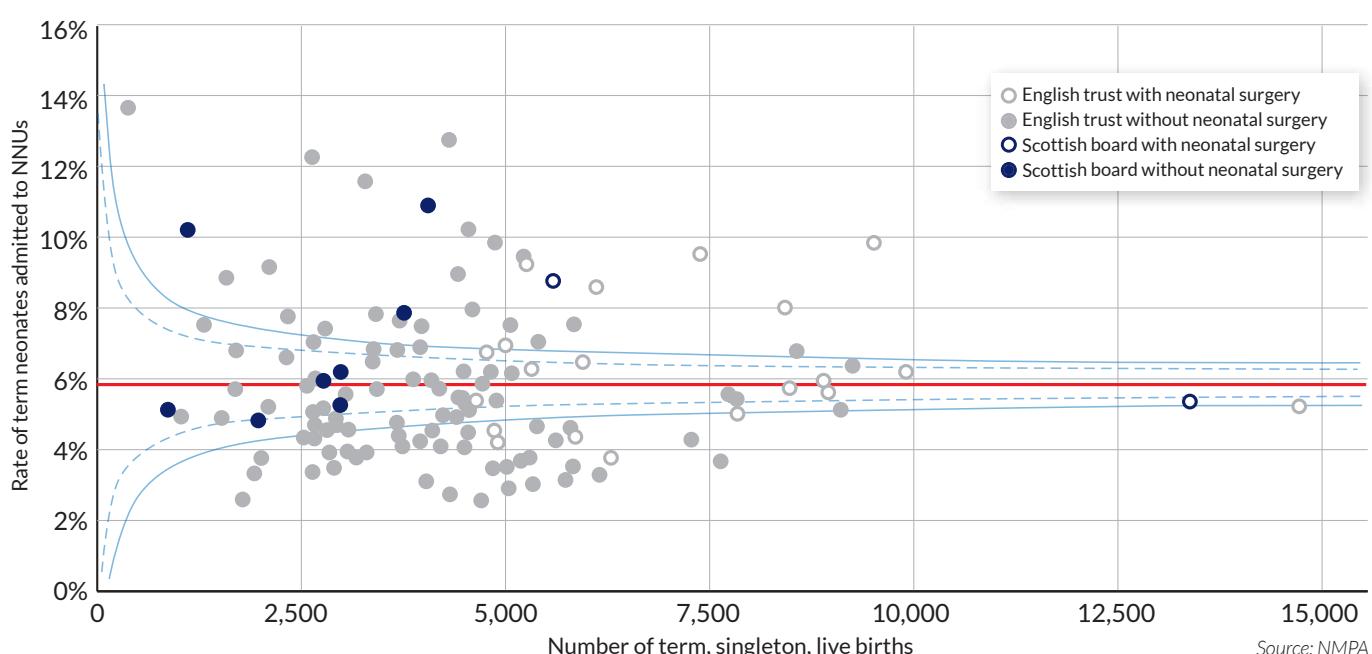
Admission to neonatal units

The NMPA found that 41.7% of babies born in England between 34⁺⁰ and 36⁺⁶ weeks (late preterm) were admitted to a neonatal unit – compared to 5.7% of babies born between 37⁺⁰ and 42⁺⁶ weeks.¹⁰⁹

The time frame for this measure is limited to the first 72 hours of life in order to reflect morbidity that is more likely to be attributed to events around the time of birth.

However, it also found substantial variation between trusts in admission rates for both term and preterm babies. As can be seen in **Figure 22** below, among trusts with approximately 5,000 term singleton live births, the variation in neonatal admission is from over 12% (approximately 600 babies) to under 3% (approximately 150 babies).

Figure 22: Casemix adjusted proportion of singleton babies born at term who are admitted to a neonatal unit, by trust, April 2016-March 2017



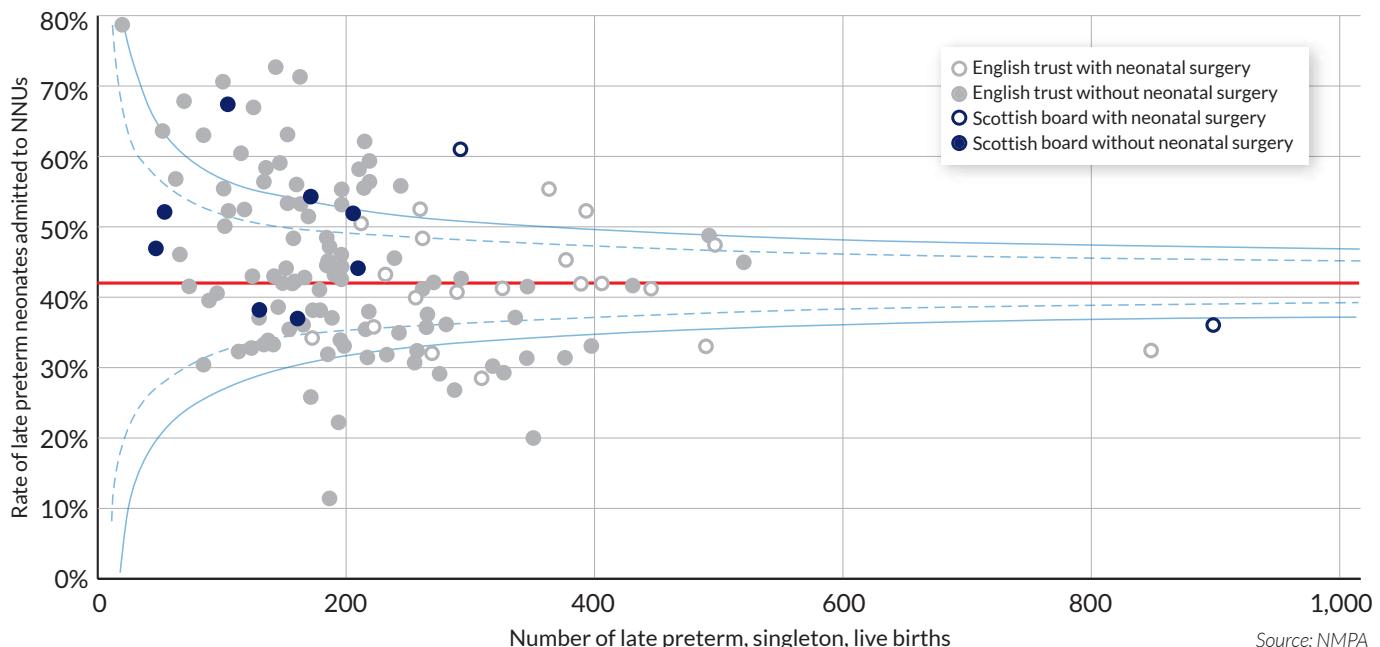
¹⁰⁷ See Widdows, K., Roberts, S.A., Camacho, E.M., Heazell, A.E.P. (2018) Evaluation of the implementation of the Saving Babies' Lives Care Bundle in early adopter NHS Trusts in England. Maternal and Fetal Health Research Centre, University of Manchester <https://www.e-lfh.org.uk/wp-content/uploads/2020/02/SPIRE-evaluation.pdf>

¹⁰⁸ RCOG - Small-for-Gestational-Age Fetus, Investigation and Management (Green-top Guideline No. 31) <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg31/second-edition-2013;third-edition-currently-in-development>

¹⁰⁹ In examining neonatal admissions, the NMPA excluded babies admitted to neonatal transitional care and babies requiring non-invasive ventilatory support such as CPAP (continuous positive airway pressure). For full details of the analysis, see pages 41-43 of the NMPA clinical report.

Figure 23 demonstrates even broader variation. If we look purely at trusts with around 200 late preterm singleton births, it can be seen that there are several trusts where over 60% of these babies (approximately 120) are admitted to neonatal care; there are then a few where the admission rate is around 20% and one at just over 10%.¹¹⁰

Figure 23: Casemix adjusted proportion of singleton babies born late preterm who are admitted to a neonatal unit, by trust April 2016-March 2017



Source: NMPA

The NMPA notes that such variation perhaps reflects 'different organisational provision for babies requiring additional care after birth'. In particular, we would expect the data to be affected by the availability of transitional care.

Under transitional care models, where babies need additional support (but not intensive care), this can be provided with the mother remaining with the baby and being the main care giver. For many mothers and babies, this is a better option than the baby being admitted immediately to a neonatal unit, with several recent studies highlighting the benefits in terms of mother-child bonding and outcomes for the baby.¹¹¹

The NMPA data does not show which of the trusts also offered transitional care, but we understand that many trusts currently have limited space and provision. Where transitional care is not available, this leads to greater pressure on neonatal units and in particular on neonatal intensive care cots. The NHS Long Term Plan has made a specific commitment to address shortages of these. While this is naturally welcome, we feel that by investing in more transitional care provision, trusts may be able to reduce their demand for neonatal intensive care and the use of neonatal units.

Encephalopathy rates

Hypoxic-ischaemic encephalopathy can occur if the supply of blood or oxygen to the fetal brain is reduced below critical levels. This can occur both before and during labour. Where this is dealt with quickly – typically via therapeutic cooling, supported if necessary by mechanical ventilation for life support – the baby can develop normally; however, in cases of more severe encephalopathy, there are risks of cerebral palsy, epilepsy and cognitive development issues. It can result in the baby dying.

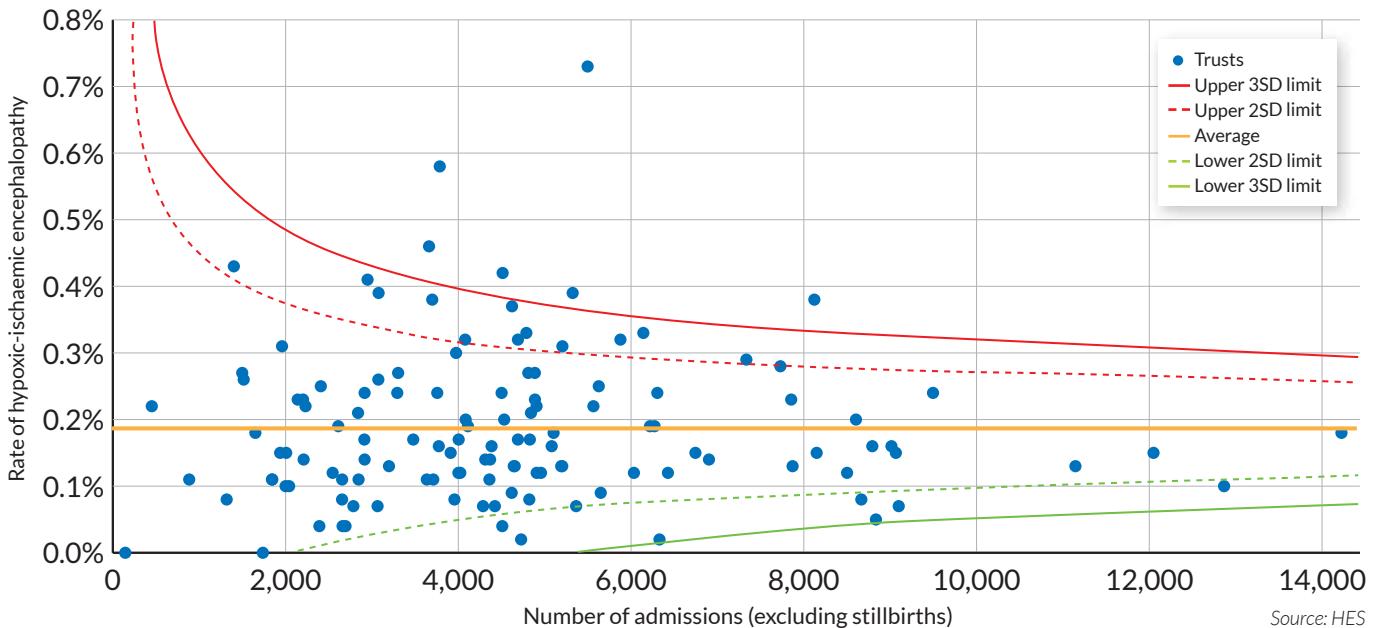
HES data for 2019-20 shows considerable variation in the rate of encephalopathy between trusts with similar numbers of admissions. At least some incidences of encephalopathy are potentially avoidable, whether through identifying higher risk pregnancies or through rigorous monitoring and recognition of abnormal fetal heart rate traces during the birth. We therefore

¹¹⁰ It should be noted that the Y-axis on Figure 23 runs from 0-80%; in Figure 22, it was 0-16%; these are therefore not directly comparable.

¹¹¹ See Battersby, K., Michaelides, S., Upton, M. and Rennie, J. (2017) Term admissions to neonatal units in England: a role for transitional care? A retrospective cohort study <https://bmjopen.bmjjournals.org/content/7/5/e016050> and NHS Improvement (2017) Reducing harm leading to avoidable admission of full-term babies into neonatal units https://www.improvement.nhs.uk/documents/764/Reducing_term_admissions_final.pdf

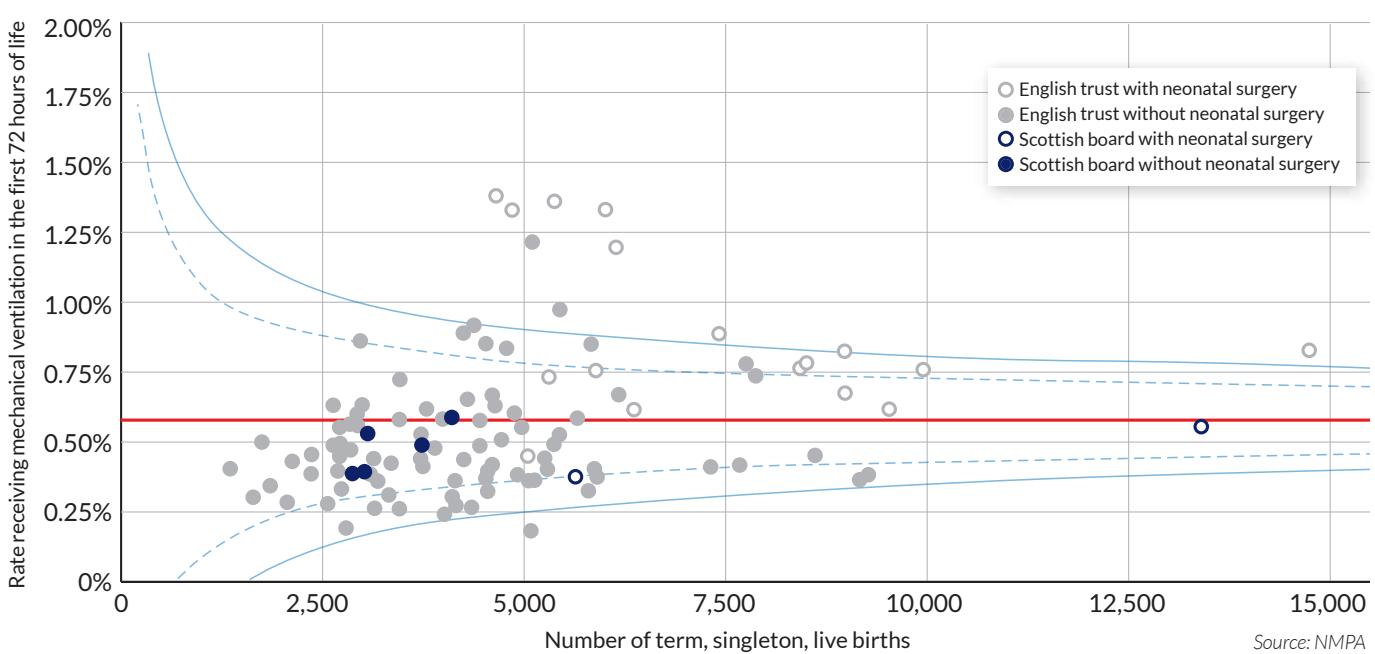
encourage all trusts to provide suitable training to the whole multidisciplinary team involved in managing births, around the use of fetal heart rate monitoring and in particular in relation to identifying risks and abnormalities, and responding to them appropriately. We further urge those trusts with higher rates (at least two standard deviations above the mean) to review all their cases of encephalopathy to identify whether there are opportunities to improve practice and reduce risk.

Figure 24: Rate of hypoxic-ischaemic encephalopathy, by trust, 1 April 2019 to 31 March 2020



The NMPA also looked at mechanical ventilation rates and found that 5.8 in 1,000 babies born between 37^{+0} and 42^{+6} weeks of gestation received mechanical ventilation in the first three days of life. Again, it found a number of trusts and boards where the use of ventilation was higher than expected, even after adjustment for maternal casemix factors.

Figure 25: Casemix adjusted trust/board level proportions of singleton babies born at term who receive mechanical ventilation in the first 72 hours of life, by trust, April 2016–March 2017



The NMPA clinical report made the following recommendations in relation to this area:

11. Maternity and neonatal service providers with higher than expected levels of mechanical ventilation between 37^{+0} and 42^{+6} weeks should work together to explore reasons behind the variation and implement any changes to clinical practice identified.
- 12a. Maternity and neonatal service providers with higher than expected rates of encephalopathy between 35^{+0} and 42^{+6} weeks should work together to explore reasons behind the variation and implement any identified actions and changes to clinical practice.
- 12b. National projects working in the area of neonatal brain injury (NNAP, NMPA, Each Baby Counts) should work together to develop an agreed, jointly used, measurable definition for neonatal encephalopathy as a component of neonatal brain injury to ensure consistent measurement.

We fully support these recommendations.

It may also be instructive to explore the link between trust encephalopathy rates and their litigation costs; one of the key reasons for litigation in maternity is preventable brain injury.

The use of cooling has grown rapidly in recent years. We are aware that different trusts have different thresholds for when cooling should be used. Research that looks at the outcomes for the baby, following the use of cooling under different circumstances, could be of value in understanding what might represent best practice around this potentially crucial intervention.

The Healthcare Safety Investigation Board investigate incidents that meet the Each Baby Counts criteria, which include the use of cooling. Its most recent national learning report¹¹² did not mention cooling but future reports may do so.

Care for the newborn baby

Repeated studies have found that there are a range of health benefits associated for both mothers and babies with breastfeeding and early skin-to-skin contact. Further, early skin-to-skin contact is shown to improve breastfeeding initiation and to support the development of a close and loving relationship between mother and baby, with a wealth of physical and emotional benefits for both. UNICEF-UK's Baby Friendly Initiative cites similar benefits.¹¹³

Based on this, the RCM has stated its view that exclusive breastfeeding for the first six months of a baby's life is the most appropriate method of infant feeding – a position supported by RCOG. However, both bodies recognise that if, after being given appropriate information, advice and support on breastfeeding, a woman chooses not to do so, or to give formula as well as breastfeeding, her choice must be respected.

Despite this strong support for breastfeeding, Public Health England statistics show that fewer than half of mothers in England are breastfeeding at 6–8 weeks.¹¹⁴ This measure captures the proportion of babies given any breast milk, regardless of route and of additional formula feeding also given. While the latest figures show a marginal increase on previous years, this is still lower than many other European countries – a point noted in the NHS Long Term Plan.

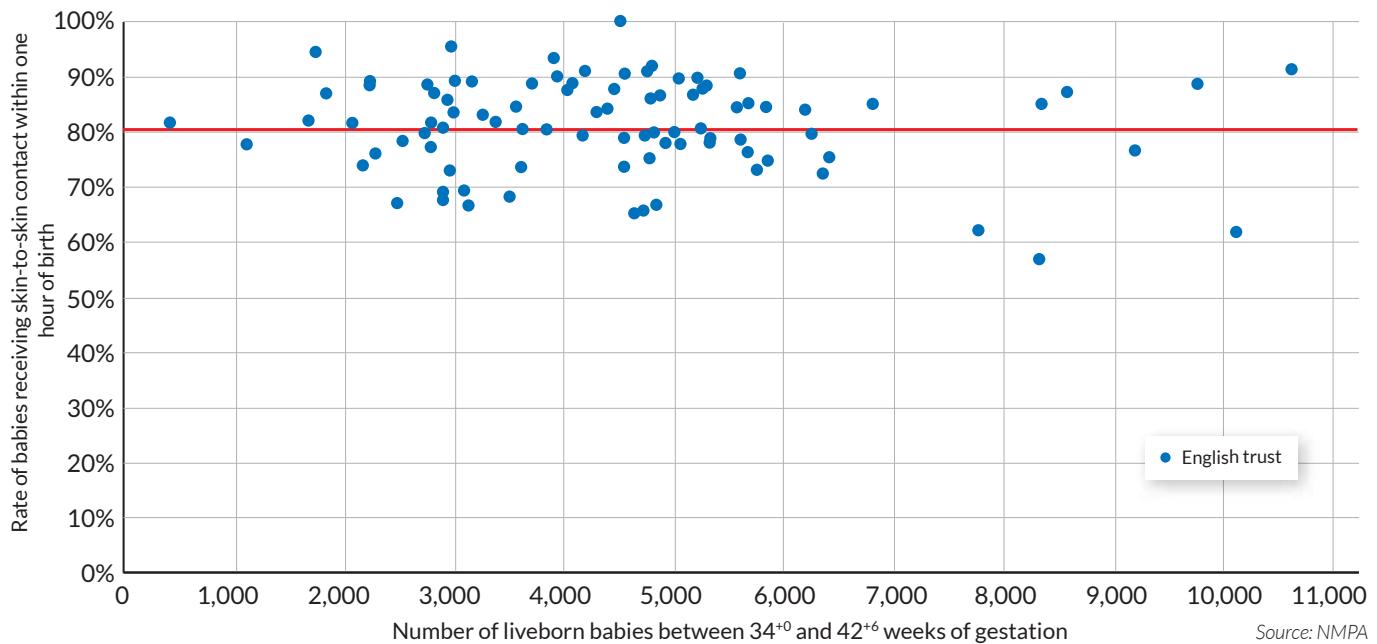
NMPA data showed that 82.2% of babies born between 37 and 42 weeks of gestation receive skin-to-skin contact within an hour of birth. For babies born between 34 and 36 weeks, the figure drops to 56%. But behind the national figures, the NMPA found considerable variation between providers as **Figure 26** shows.

¹¹² HSIB (2020) National learning report: summary of themes arising from the HSIB maternity programme
<https://www.hsib.org.uk/documents/224/hsib-national-learning-report-summary-themes-maternity-programme.pdf>

¹¹³ See <https://www.unicef.org/babyfriendly/wp-content/uploads/sites/2/2019/04/Baby-Friendly-Initiative-Theory-of-Change.pdf>

¹¹⁴ <https://www.gov.uk/government/statistics/breastfeeding-at-6-to-8-weeks-after-birth-2018-to-2019-quarterly-data>

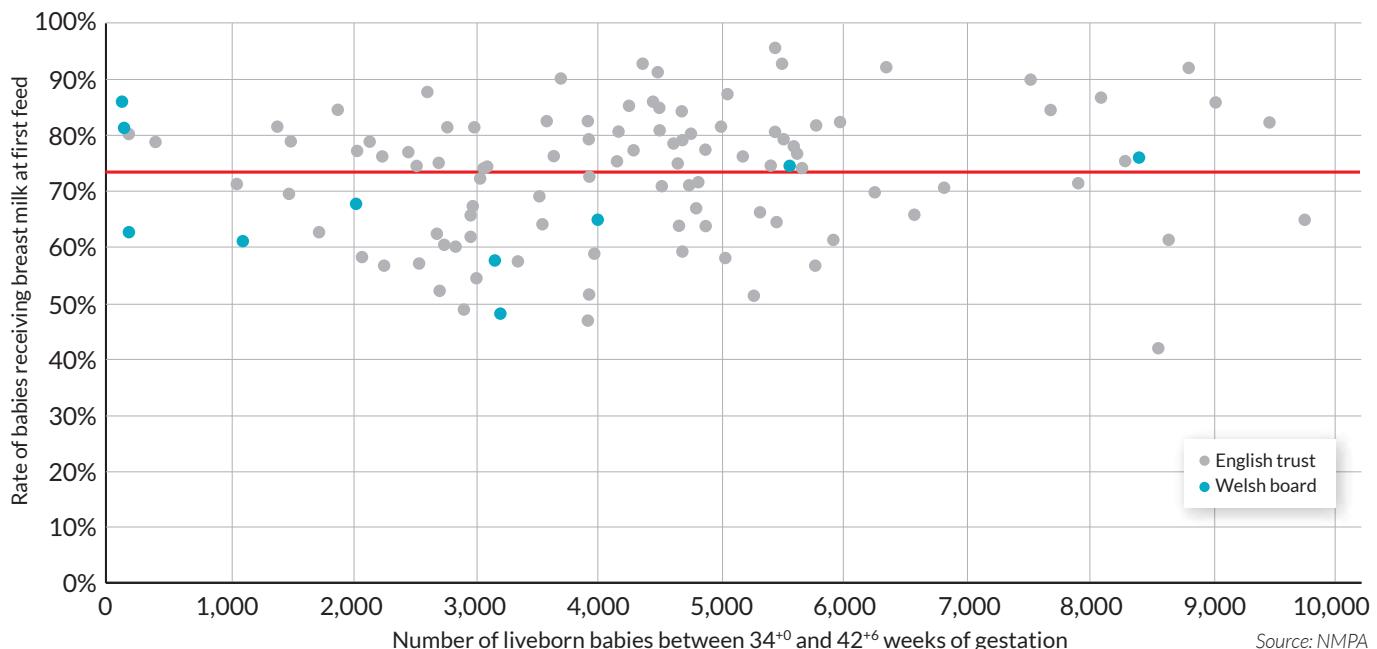
Figure 26: Proportion of babies born between 34 and 42 weeks who receive skin-to-skin contact within one hour of birth, by trust, April 2016–March 2017



While there are a number of providers where over 85% of babies receive skin-to-skin contact within an hour of birth, there are also some – including some of the largest providers in terms of number of babies born – where fewer than two-thirds are recorded as doing so.

There is also considerable variation in the proportion of babies who receive breast milk at their first feed and at discharge. Nationally 73.8% of babies born between 34 and 42 weeks received breast milk as their first feed and 72% at discharge. But at provider level, the proportions range from over 90% to under 50%.

Figure 27: Proportion of babies born between 34 and 42 weeks who receive breast milk at first feed, by trust, April 2016–March 2017



The NHS Long Term Plan also noted that there appears to be substantial regional variation in care for newborn babies: it highlighted that 80% of babies are breastfed at 6-8 weeks in London compared to 32% in the North East. While demographic factors and maternal choice clearly have a role to play, and as the NMPA report notes, there may be recording differences, the variation is widespread.

The UNICEF-UK Baby Friendly Initiative champions a range of interventions to support breastfeeding. This includes supporting early skin-to-skin contact. 61% of maternity services are fully accredited, with a further 30% already working towards accreditation. The NHS Long Term Plan has set a requirement that all maternity services should achieve accreditation under an evidence-based infant feeding programme, such as the UNICEF Baby Friendly Initiative. We recognise that accreditation can be a costly exercise and that there may also be other, local barriers to achieving accreditation; during future work, we will seek to understand and address any such barriers.

We also understand that research is planned to develop a framework for evaluating the impact of attaining UNICEF Baby Friendly Initiative accreditation on care and outcomes. We welcome this; the aim of any such accreditation is to improve care.

As a result, it would be expected that there should be a change in the rates of breastfeeding over the next few years; this will be an important area to monitor. In future deep dives, we would be interested in examining the impact of achieving accreditation on care for the newborn baby, and to learn more about barriers to change, so that they can be addressed.

Gynaecology – findings and recommendations

Optimising outpatient pathways

Outpatient pathways account for the majority of the gynaecological workload – so offer the greatest opportunity to identify, and reduce, unwarranted variation as well as to improve the patient experience. Such opportunities must be considered together with the delivery of gynaecology within primary care, which drives referrals to hospital services and plays a pivotal role in ongoing management of patients once they are discharged.

The GIRFT process – both the provider questionnaire and the deep-dive visits – has helped paint a detailed picture of the extensive variation in the delivery of gynaecology services across the NHS. It should be underlined that the core analysis was undertaken before the COVID-19 pandemic began. In response to the pandemic, there have been considerable changes to the way outpatient services and primary care are delivered across all specialties. Many of these changes, introduced out of necessity, are likely to play an important role in the future shape of service delivery.

For example, the widespread adoption of advice and guidance services, consultations delivered virtually or via phone as an interim step between seeing a GP and referral to hospital, has proved successful.

The NHS Advice and Guidance (A&G) service allows GPs to request diagnosis and management advice from a specialist team before or instead of referring women to hospital. GPs can attach additional information to the A&G request.

A&G is the most widely used platform and operates on the standard NHS e-Referral System (e-RS). A national e-RS A&G Toolkit is available to guide commissioners, clinicians and managers. Other commercial A&G platforms can be used instead of e-RS or to supplement e-RS A&G.¹¹⁵

Some clinicians told us they consider that the e-RS A&G system offers the following key benefits:

- full integration with the standard e-Referral System means minimal duplication of work for GPs;
- provides a way to keep records for future audit; and
- no added up-front costs for the health system (in contrast to independently developed systems that may have one-off, maintenance or per-patient costs).

Core principles

As in all specialties, the focus of transforming gynaecology outpatient pathways must be to ensure that the right patients are seen in the right setting by the right clinician. This not only underpins a better patient experience but also typically improves patient outcomes while reducing unnecessary demand on hospital services and specialist care, meaning that those who do need the specialist resource may be seen sooner.

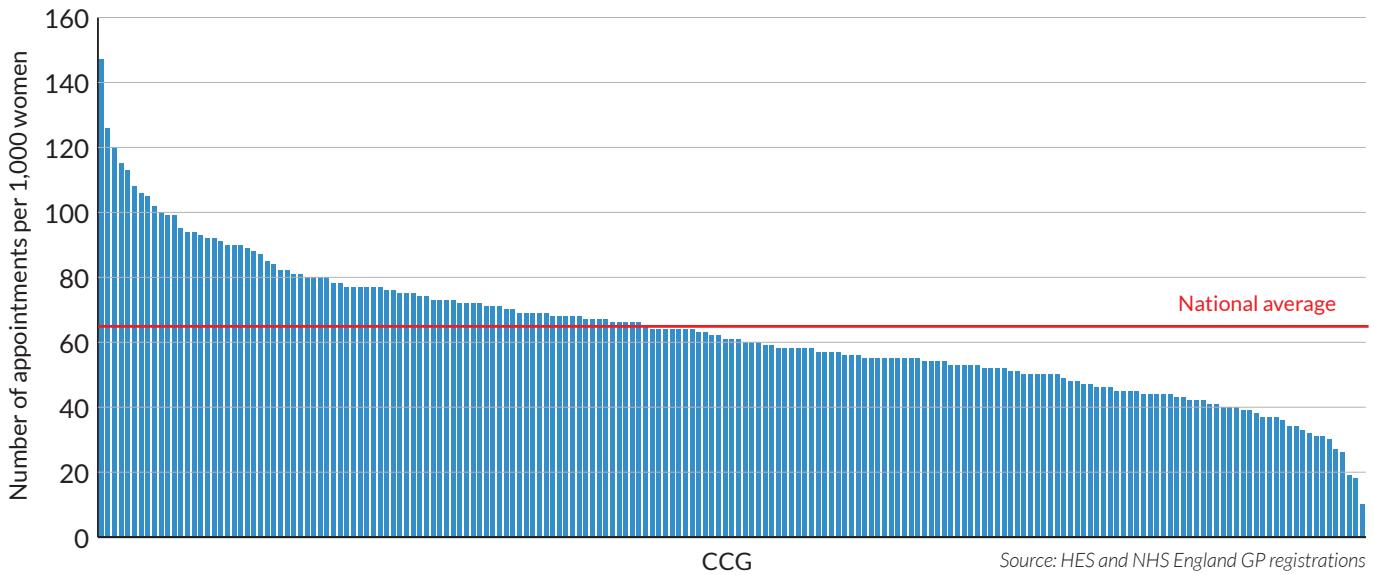
In general, the consequence of reducing variation should be that a greater number of women are treated in primary care, rather than as outpatients. However, this is predicated on primary care having a sufficiently skilled workforce, access to diagnostic imaging where required and the availability of conservative treatment modalities such as physiotherapy. Among those referred, the goal would be to reduce reliance on inpatient services, with more women treated as day cases or as outpatients.

Variation in referral rates from primary care

To help build a picture of the scale of variation in outpatient pathways, we examined the referral rates per population from each CCG in England.

¹¹⁵ See <https://www.digital.nhs.uk/services/e-referral-service/document-library/advice-and-guidance-toolkit>

Figure 28: Number of first gynaecology outpatient appointments per 1,000 women, by CCG, 1 April 2019-31 March 2020



Source: HES and NHS England GP registrations

Some variation would be wholly expected here, but the variation is pronounced. There are ten CCGs which provided over 100 first appointments per 1,000 women and five which provided fewer than 30. This indicates that there is a substantial difference in the approaches taken to referrals, which in turn suggests there is a substantial difference in the range of gynaecology services offered in primary care.

Variation in follow-up care

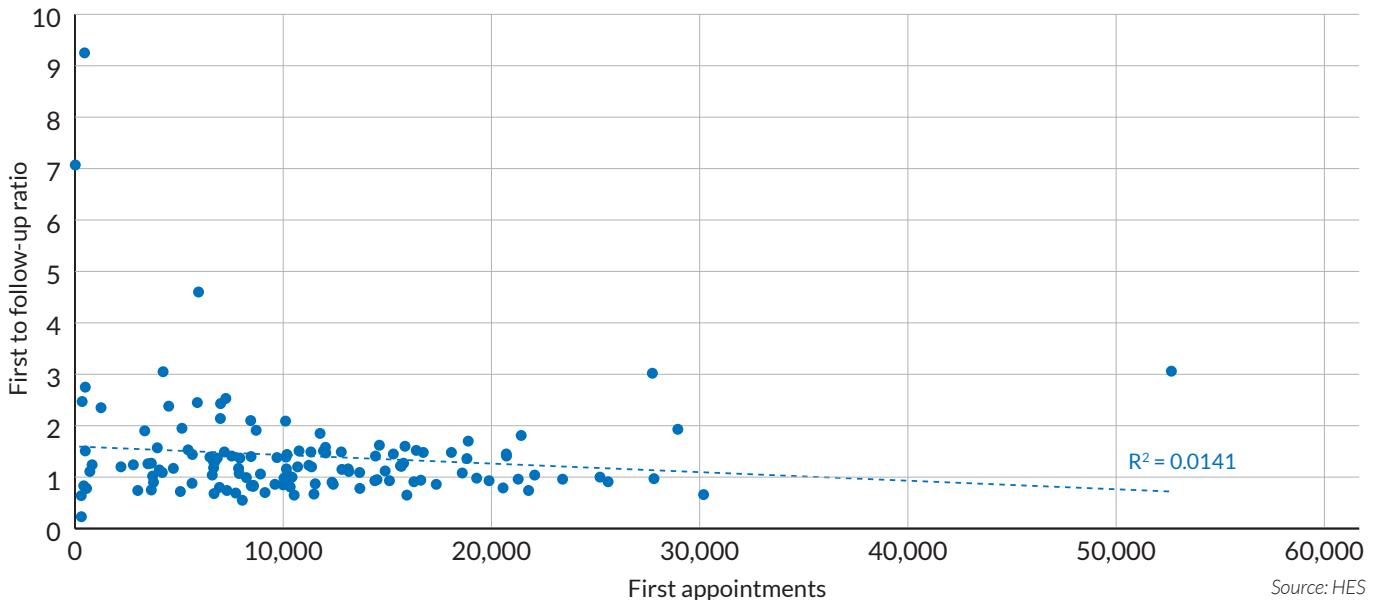
The GIRFT team also compared the outpatient 'first to follow-up ratio' for gynaecology providers. This figure looks at the total number of follow-up appointments across all women seen by a provider, compared to the total number of first appointments offered.

Clearly, some conditions require multiple follow-up appointments – such as fertility treatment, or for any kind of cancer. However, it may be assumed that these higher numbers of follow-ups would be balanced out by those who can be treated and discharged from hospital care at the first appointment, and then supported in primary care if required. Therefore, it would be expected that the overall ratio would be close to 1:1 at most providers.

As **Figure 29** shows, the majority of gynaecology units had a first to follow-up ratio close to 1:1, regardless of the number of appointments. However, there were a number of providers with a first to follow-up ratio greater than 1:2, meaning for every new patient on average two follow-up appointments were given.

There were also some providers with a first to follow-up ratio of 1:0.5 or less – which suggested that the majority of new attendances did not result in any follow-up appointments.

Figure 29: Number of outpatient first appointments and first to follow-up ratio, by trust, 1 April 2019 – 31 March 2020



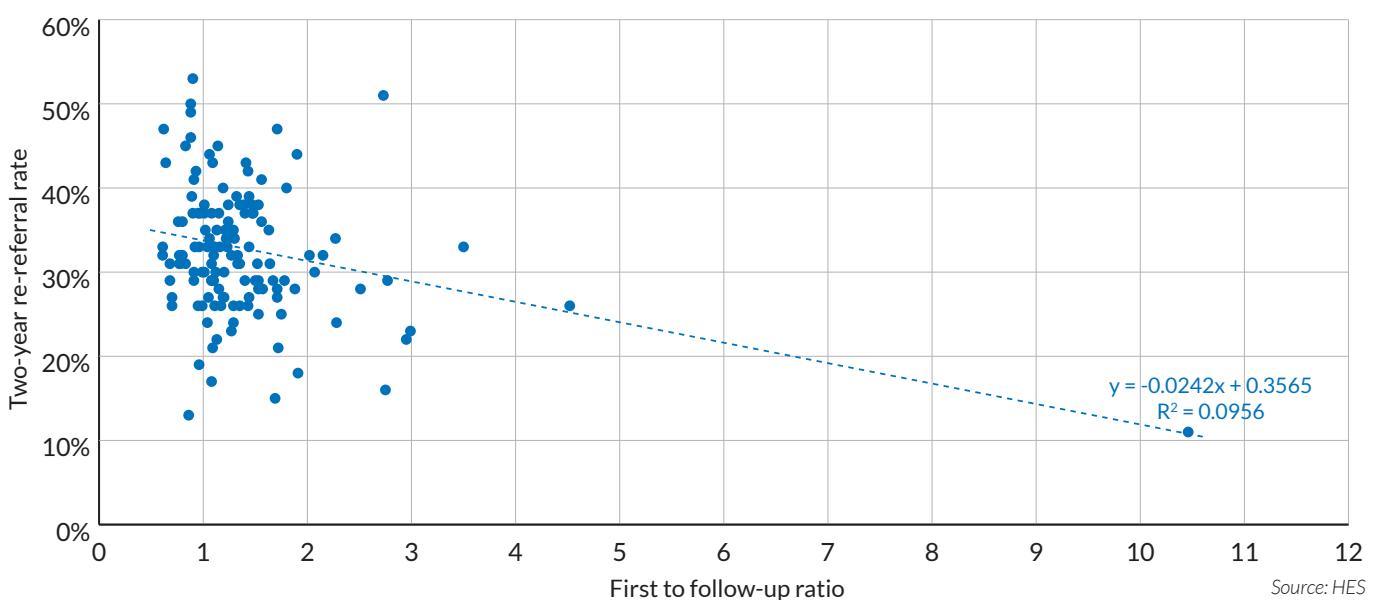
Given this extensive variation across a large sample of providers, it seems reasonable to suggest that the ratios reflect custom and practice within providers, rather than being clinically driven.

Impact of fewer follow-up appointments

Clearly the goal must be quality of care, rather than quantity. We have not been able to correlate first to follow-up ratios with patient experience – as there are few consistent measures of that – or outcomes, due to a lack of outcome data overall.

However, data is available around re-referral rates. If providers, who had a lower first to follow-up ratio, then had to deal with a higher proportion of re-referrals, this could indicate that their approach to follow-up was insufficient. The chart below uses the first to follow-up ratio from 2017-18 as the basis; this allows us to look at re-referrals within two years (i.e. up to 2019-20).

Figure 30: Outpatient first to follow-up ratio compared to outpatient re-referral rate by trust, 1 April 2017 to 31 Mar 2018



Overall, the evidence does not suggest that having a lower first to follow-up ratio results in a markedly higher rate of re-referrals. Based on this metric it therefore appears that units with higher first to follow-up ratios can and should consider taking steps to reduce their follow-up ratio. This could free up capacity to see more new referrals sooner and mean women have to attend fewer hospital appointments.

Strategies to reduce follow-up appointments

During deep-dive visits, we asked providers with lower first to follow-up ratios to explain their approach. Some of the strategies adopted include:

- focusing on the relationship with primary care, introducing shared care agreements for certain conditions and improving the advice and guidance given to GPs about when to refer and appropriate conservative management;
- adopting a policy of patient-initiated follow-up for specific conditions (see below);
- discharging patients directly from theatre after certain routine surgery, then sending results in writing or using telephone follow-up rather than requiring a separate discharge appointment;
- offering 'one stop' clinics for some common conditions, such as intrauterine system fitting – which include consultation, ultrasound scan and possibly hysteroscopy all in the same session (see addendum, p113). Where an intrauterine system is recommended, this can then be fitted on the day;
- adopting an outpatient clinic template that intentionally includes more new appointments than follow-ups (e.g. booking seven new appointments and five follow-ups as the standard for a four-hour consultant-led clinic);
- actively reviewing patient management plans made by junior doctors to confirm the need for follow-up; and
- reviewing the first to follow-up ratios for specific gynaecology clinics – and potentially by clinician – to identify unwarranted variation.

CASE STUDY

Integrated approach to reducing first to follow-up ratio

Oxford University Hospitals NHS Foundation Trust

Oxford University Hospitals NHS Foundation Trust has taken a range of steps to reduce the first to follow-up ratio for gynaecology. With the team committed to reducing the average number of follow-up appointments, it reviewed its clinical pathways so that wherever possible women received relevant investigations and conservative treatment before the initial consultation. It then put in place a requirement that only consultants could schedule post-operative face-to-face follow-ups, and instead introduced nurse-led telephone clinics for the majority of follow-up activity.

These practical approaches came from providers around the time of our deep-dive visits and remain valuable. Of course, COVID-19 has changed the landscape and meant that in many cases first appointments have been virtual, with women then being offered a face-to-face appointment for further investigations as necessary.

A growing share of follow-up care has also been virtual, and this seems likely to continue. For example, most women should not be required to attend hospital for results, except for cancer diagnosis, which can easily be provided by phone during a virtual clinic.

These shifts in practice may necessitate a rethinking of the relevance of the first to follow-up ratio – as well as revising job plans to take account of the time spent on virtual appointments. Consideration must also be given to issues such as staff training and team working and interaction; few medical professionals, accustomed to dealing with patients in person and motivated by that face-to-face interaction, would welcome a purely virtual care model.

At present we do not have sufficient data about how the delivery of care has changed in response to COVID-19, nor more importantly an understanding of how this translates into long-term change.

In general, we anticipate that we will see increased use of virtual care to complement face-to-face care. The guiding principle in any such change should always be how technology can be used to enhance care, not simply to replace contact.

Access to imaging

Since the deep-dive visits took place, Professor Sir Mike Richards was commissioned by NHS chief executive Sir Simon Stevens to review diagnostic services as part of the NHS Long Term Plan. Professor Richards' report was published in October 2020 and recommended the creation of community diagnostic hubs.¹¹⁶ These would potentially support the aim of reducing the number of hospital appointments, as diagnostic imaging could be undertaken at the hubs, whether before a consultant's appointment or as a result of one.

We believe that it is crucial that, as well as making imaging available in new ways, providers also review their pathways to ensure that imaging is offered at the most relevant point in the pathway to minimise duplication of effort and unnecessary appointments. For instance, if a consultant will need imaging to confirm a GP's referral, then the imaging may be best arranged before the consultant appointment. If there is a range of potential conditions, it may be more appropriate for the consultant appointment to take place first, so that the most relevant imaging modalities can be selected.

Focusing on primary and intermediate care, and independent sector provision

One of the underlying reasons for variation in outpatient services is the variation in provision in primary care, with some areas having extensive gynaecology services and support and others dealing with large numbers of referrals where the woman has received very little first-line care.

It might therefore be assumed that extending primary care services, and making provision more uniform, would help reduce reliance on secondary care and provide a more convenient service to women. However, many GP practices are already overstretched and GPs themselves may not have the capacity to offer more gynaecology care.

In some areas, CCGs use independent sector providers to help increase the availability of gynaecology services. While there are some highly successful examples, we are also aware of feedback from hospital gynaecology departments that the independent sector typically focuses on a limited range of conditions, which are often more straightforward to handle. Some of the gynaecology departments we visited then indicated that this affected their casemix, as they have a greater proportion of more complex cases.

We are aware that similar views were expressed by hospital departments to GIRFT teams in other workstreams that make extensive use of independent sector provision. In response, in the ophthalmology national report, GIRFT has committed to conducting deep-dive visits with independent sector providers, and to commissioning analysis to understand how far current national tariff prices are sensitive to case and activity mix.¹¹⁷

Specialist gynaecology clinics as part of an integrated care system

An alternative approach to extending primary care, or increasing use of independent sector provision, focuses on the commissioning of intermediate or community-based gynaecology services at dedicated clinics with specialist staff, perhaps as part of an integrated care system (ICS) model.

Clinic staff could include specialist physiotherapists for continence issues and specialist nurses who are trained in some common procedures such as fitting and changing of pessaries and intrauterine devices, some uses of ultrasound and hysteroscopy, cystoscopy, endoscopy and colposcopy. There are approved training programmes for nurses in these areas.

Such services not only reduce pressure on hospitals, but also on GPs – many of whom will deal with only small numbers of gynaecology cases. Where this occurs, it may be better for the woman to be referred to a dedicated clinic or a practice where there is a GP with an extended role (GPwER) or a practice nurse, who has a significant women's health workload.

Addressing a commissioning disconnect: the relationship with CASH services

Aside from community gynaecology, many providers referred during deep dives to the Contraceptive and Sexual Health (CASH) services in their area. Such services should benefit patients and providers; disappointingly, however, we found no good examples of CASH services working effectively with acute providers, or community providers, to deliver benign gynaecology care.

¹¹⁶ Report of the Independent Review of Diagnostic Services for NHS England (2020) Diagnostics: Recovery and Renewal <https://www.england.nhs.uk/wp-content/uploads/2020/11/diagnostics-recovery-and-renewal-independent-review-of-diagnostic-services-for-nhs-england-2.pdf>

¹¹⁷ See <https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2019/12/OphthalmologyReportGIRFT19P-FINAL.pdf> page 61-62

One factor is that CASH services are commissioned via local authorities, so separate from CCGs. Although this should not be insurmountable, in practice it has a direct impact on care.

To illustrate the issue, at CASH services, nurses regularly insert hormone-releasing intrauterine devices (coils)¹¹⁸ for contraceptive purposes. The same intrauterine devices are also used by gynaecology providers to help regulate heavy menstrual bleeding.

This is a common condition and a common procedure. According to NICE, 'About 1 in 20 women aged between 30 and 49 years consult their GP each year because of heavy periods or menstrual problems, and menstrual disorders comprise 12% of all referrals to gynaecology services.'¹¹⁹ NICE recommends considering intrauterine devices as the primary treatment to offer women with heavy menstrual bleeding but no other identified pathology or specific concerns.¹²⁰

Yet under current commissioning arrangements, CASH services are not permitted to insert intrauterine devices to regulate menstrual bleeding – even where they have the diagnostic facilities and appropriately trained clinicians.

Given that these same staff carry out the same procedure on a regular basis for contraceptive purposes, this appears a counter-productive restriction. Lifting it, through some form of joint commissioning agreement, would potentially benefit women and providers. It would also support the overall direction of the NHS Long Term Plan. NICE guidance clearly sets out recommendations on the physical examination and laboratory tests needed to diagnose the condition and identify whether the woman is suitable for treatment with an intrauterine device.

We have therefore included an action under recommendation 6 that CCGs should commission CASH services to conduct intrauterine device insertion for heavy menstrual bleeding in relevant cases.

Non-surgical treatment for urinary incontinence and pelvic organ prolapse

Similar opportunities to share the workload between primary and secondary care and reduce unnecessary referrals to the hospital can be found in non-surgical treatment for urinary incontinence and pelvic organ prolapse.

For both conditions, the initial diagnosis and treatment can take place in primary or intermediate care; this can include the use of physiotherapy and/or first-line medications for incontinence, as recommended by NICE¹²¹ and also the fitting of vaginal pessaries for prolapse. In many areas, clinical services have been arranged so that GPs can access women's health physiotherapy, to help women strengthen their pelvic floor, without referral into secondary care.

Yet for both conditions, we continue to see large numbers of referrals to hospital services, even for first-line treatment.

One way to measure progress towards treating a greater proportion of women in primary or intermediate care (where appropriate) would be for providers to monitor how many of those referred to hospitals receive surgery. This is known as the surgical conversion rate. In a surgical specialty such as gynaecology, where the referral process is working well to make best use of hospital care, there should be a high conversion rate, with the majority of women referred receiving surgery.

Making more effective use of the gynaecology team

Once women are referred to a hospital, there is often no need for their care to be provided by a consultant. Many providers are already using the skills of other members of the gynaecology team to conduct diagnostic and therapeutic procedures, support women and provide advice on managing ongoing conditions.

- As noted above, nurses are increasingly responsible for fitting and changing intrauterine devices and pessaries; some also conduct hysteroscopies, cystoscopies and colposcopies, use ultrasound for certain purposes and provide botox injections in the bladder for urge incontinence. At some providers, they conduct urodynamic studies and change suprapubic catheters. Most nurse-led procedures can take place in an outpatient setting.
- Pharmacists assist in the delivery of a range of non-surgical treatments, for conditions such as heavy menstrual bleeding and endometriosis.
- Pelvic, obstetric and gynaecological physiotherapists play a critical role in the delivery of conservative treatment for incontinence – with recent guidance recommending they could also be trained to fit pessaries, so providing a single point of contact for the treatment. They also support post-surgical recovery.

¹¹⁸ These are often known as Mirena coils, based on the name of the manufacturer most commonly used.

¹¹⁹ See NICE (2018) NG88 Heavy menstrual bleeding: assessment and management <https://www.nice.org.uk/guidance/ng88/chapter/Context>

¹²⁰ See NICE (2018) NG88 Heavy menstrual bleeding: assessment and management <https://www.nice.org.uk/guidance/ng88/chapter/Recommendations>

¹²¹ See NICE (2019) NG123 Urinary incontinence and pelvic organ prolapse in women: management <https://www.nice.org.uk/guidance/ng123/>

There are also a range of opportunities for the wider team to assist in pre-operative preparation and post-operative follow-up, with some providers opting to introduce nurse-led discharge for relevant conditions.

Using the whole team more effectively can often mean women receive diagnosis or treatment sooner, and access treatment at a more convenient time or location for them. Women may also benefit from receiving the treatment from a team member with whom they have already built some rapport.

We believe that all providers should be considering how they can make greater use of the wider team to increase flexibility and capacity in gynaecology services. Training and supporting all members of the team to work at the top of their licence, and to perform such procedures, benefits women and providers alike.

There are now established courses to train nurses and other members of the gynaecology team in relevant skills. For example, for hysteroscopy, the British Society for Gynaecological Endoscopy (BSGE) offers approved training.¹²² Similar approved courses exist for colposcopy and other procedures. Providers need to ensure that team members not only receive funding for such training, but also that job planning incorporates time for learning and development.

Supporting self-management

There are a number of clinical conditions within gynaecology that lend themselves to self-management, such as urinary incontinence and pelvic organ prolapse. The aim here is to give women tools and information so that they understand their symptoms and can monitor the effectiveness of the treatment.

Where it is introduced effectively, self-management reinforces conservative management strategies, reduces the need for women to attend hospital for routine check-ups and means they may need to have fewer internal examinations.

Self-management of vaginal pessaries has been introduced by a number of providers, giving women with pelvic organ prolapse guidance on how to check the pessary is in the correct position, and on cleaning and replacing it themselves, rather than needing to attend hospital. The choice remains with the woman, but for many this is a preferred option, particularly for those who may require a pessary for the long term.

Women who opt for self-management must also be supported – whether by a hospital gynaecology service or by specialist intermediate care, such as advice and guidance services.

Self-management can also be supported in other ways, for example by sending email or SMS alerts to women when the pessary is due for replacement. This is an issue that has been a greater concern during the COVID-19 pandemic, where women with no other health concerns have understandably not wanted to attend a clinic – so may have used the same pessary for a long period.

To underpin this, providers need to ensure that they record the type of pessaries being used by their patients, including if a woman chooses to change the type of pessary she is using.

Indications from providers that offer self-management are that it typically leads to improvement of symptoms and also reduces referrals to primary and secondary care. Many women are keen to take a more active role and welcome having a personalised care and support plan (PCSP) that includes some element of self-management. However, because the approach relies on patients taking a degree of responsibility for their own care, it may not be appropriate for all women.

¹²² See <https://www.bsge.org.uk/hysteroscopy/>

CASE STUDY

Patient-initiated follow-up and self-management

Northumbria Healthcare NHS Foundation Trust

Northumbria Healthcare NHS Foundation Trust has introduced a process of patient-initiated follow-up for a range of conditions. The process was first introduced for gynaecology cancer. On discharge, women are given a list of symptoms which would merit a review. If they have a problem, they can contact nurse specialists by telephone; where appropriate, a follow-up appointment is then arranged within a few days rather than waiting for routine review.

With the process proving beneficial, it has now been extended into other areas of gynaecology. Women are typically given a list of potential alternative treatments at the first visit, which they can work through with their GP. If they still have issues, then they are able to contact the department for review. The approach is recognised as being more responsive to the woman's needs. It also reduces unnecessary reviews, which are often felt to be unsatisfactory and a poor use of time by both patient and clinician.

Making virtual care the norm: some practical considerations

The COVID-19 pandemic has meant a huge proportion of outpatient clinics moved to video or telephone. This has been hugely positive – giving patients greater flexibility in terms of their appointments and helping build acceptance of digitally-enabled care. It seems likely that this will lead to far greater reliance on and trust in virtual care, from both patients and professionals.

As we move forward, it is important that there is some evaluation of digital channels, to help identify what has worked well and where services need to improve. This may also inform future decisions about the best balance of services, identifying the clinical conditions or points along the patient journey where face-to-face care is most necessary.

Virtual clinics must not become just an additional part of the consultant workload. Instead, they should be considered as part of rethinking the care offer, using different members of the gynaecology team to provide a service to women that genuinely complements in-person services. Time needs to be allocated within job plans to virtual care. This kind of thinking therefore should inform decisions about what services are offered virtually and to which groups of patients.

Virtual clinics then become part of an overall shift in the way gynaecology services are offered and delivered – one that also incorporates improved access to self-management strategies, better gynaecology provision within primary and intermediate care services, including CASH services, and more effective use of the wider team. The aim of this shift is to improve the patient experience and increase choice, by making care more accessible outside the hospital and traditional consultant-led models.

Recommendations

Recommendation	Actions	Owners	Timescale
<p>6. Treat gynaecology patients in the most appropriate setting for their condition.</p>	<ul style="list-style-type: none"> a Trusts to re-examine outpatient pathways with a view to maximising use of Advice and Guidance and virtual clinics, cutting unnecessary appointments and introducing patient-initiated follow-up. b RCOG to provide advice, based on NICE guidance, of which diagnostics are appropriate to be carried out or commissioned by GPs prior to referral to secondary or specialist care, to increase opportunities to discharge at first appointment. c Trusts to work with local partners to identify where patient-initiated follow-up would be feasible and put in place necessary structures to move to a patient-initiated follow-up model. d CCGs to increase availability and use of intermediate care settings for conservative treatment (particularly physiotherapy) to allow hospital gynaecology departments to focus more on surgery. e CCGs to commission CASH services to conduct intrauterine device insertion for heavy menstrual bleeding in relevant cases. f Trusts to examine opportunities for digitally-enabled care, particularly for conservative treatment and to support self-management. 	Trusts RCOG, GIRFT ICSs, Trusts CCGs CCGs Trusts	12 months 12 months 12 months 12 to 18 months 12 months For substantial progress within 12 months of publication
<p>7. Expand role of nurses and other members of the wider gynaecology team to enable them to work at the top of their licence.</p>	<ul style="list-style-type: none"> a Trusts to train and support nurses, physiotherapists, sonographers and other members of the team to conduct diagnostic and therapeutic gynaecological procedures (and in particular, endoscopy) to increase provider capacity. 	Trusts	2 years

Reducing the length of stay

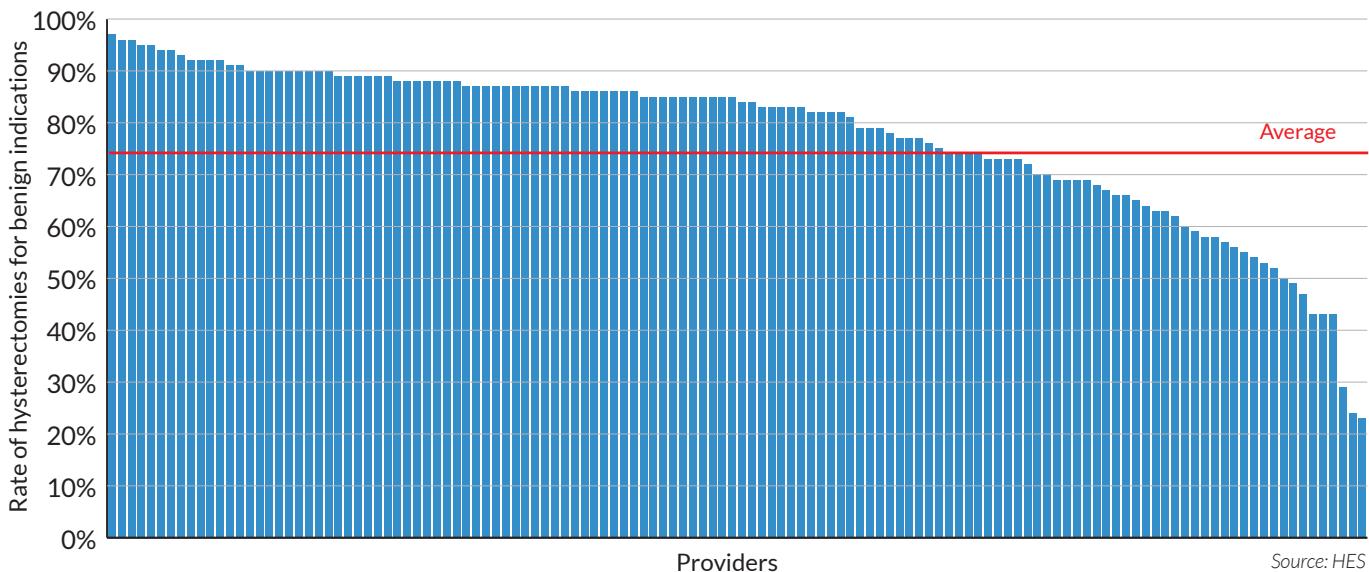
As well as seeking to avoid unnecessary appointments and referrals, the GIRFT process has also identified opportunities to reduce the length of stay for women who have been admitted to gynaecology departments. While this affects a smaller number of women overall, the benefits in terms of freeing up capacity within departments may be even greater.

Avoiding unnecessary procedures

The shortest stays of all are achieved by not undertaking unnecessary procedures. While clearly few providers would assume they conduct any procedures unnecessarily, previous studies – notably the NHS Improvement Atlas of variation in health and care¹²³ – have shown there is considerable variation across the country in the number of women who undergo a hysterectomy.

A key factor in this variation is the use of hysterectomy for benign indications, such as heavy menstrual bleeding. As **Figure 31** shows, while nationally around three-quarters of hysterectomies are for benign indications, there are 23 providers where at least 90% are for these reasons – while at eight providers, fewer than half are. Clearly, at specialist cancer trusts, the proportion of hysterectomies for benign indications will be lower.

Figure 31: Proportion of hysterectomies for benign indications, by trust, 1 April 2019-31 March 2020



Historically, one of the most common reasons for hysterectomy was heavy menstrual bleeding.

The NHS Evidence-Based Interventions Programme highlighted that infection is common following hysterectomy and also identified other rare, but serious, potential complications.¹²⁴ Building on the 2018 NICE guideline on heavy menstrual bleeding,¹²⁵ the NHS EBI set out in its statutory guidance that 'hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding' and that it should be considered only in specific circumstances.¹²⁶ It then included a range of alternative treatment options.

We are aware that some providers are still in the process of adapting practice to reflect the EBI statutory guidance. This needs to accelerate.

¹²³ <https://www.improvement.nhs.uk/resources/atlas-variation-health-and-care/>

¹²⁴ See NHS England (2018) Evidence-Based Interventions: Guidance for CCGs <https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf> page 32

¹²⁵ See NICE (2018) NG88 Heavy menstrual bleeding: assessment and management 1.3.3. <https://www.nice.org.uk/guidance/ng88/chapter/Recommendations>

¹²⁶ NHS England (2018) Evidence-Based Interventions: Guidance for CCGs <https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf> page 30

The use of hysteroscopy is also believed to vary considerably. This led to NICE specifically addressing the use of hysteroscopy in its 2018 guideline on heavy menstrual bleeding, and recommending that providers ‘take into account the woman’s history and examination when deciding whether to offer hysteroscopy or ultrasound as the first-line investigation’.

It is also clearly crucial that patient choice is actively considered here and personalised care and support plans (PCSPs) developed, with patients. As part of this, women must have access to relevant information about different treatment options, so that they can then give truly informed consent to the chosen treatment pathway or procedure.

Increasing the use of day surgery

At a number of providers, an increasing proportion of diagnostic and therapeutic procedures like hysteroscopy, endometrial polypectomy,¹²⁷ endometrial ablation (discussed further below) and balloon catheter insertion for the treatment of Bartholin’s abscess are being conducted via outpatient services. Vaginal repairs and some hysterectomies are undertaken as day cases.

The fact that such a wide variety of surgery can now be undertaken as day cases reflects advances in a range of areas, from pre-operative preparation of patients, particularly setting expectations when counselling for the procedure, to enhanced recovery, pre-emptive analgesia, anaesthesia and in particular laparoscopic surgery.

As well as reducing the need for inpatient stays, this approach offers patient experience benefits: time under anaesthetic is typically shorter and overall recovery typically faster, as the procedures selected for day surgery are typically minimally invasive.

The British Association of Day Surgery (BADS) has identified a range of common gynaecology procedures which could be conducted either in a procedure room (i.e. a suitably clean area outside an operating theatre) or as day surgery (zero-night stay).¹²⁸ In the latest edition of its directory, BADS suggested that many biopsies could be conducted in a procedure room and 95% of female incontinence procedures could be conducted as day surgery (based on the practice of tape insertion) – as could a substantial proportion of hysterectomies and procedures to address endometriosis. The table below, reproduced with BADS’ permission, summarises its recommendations for day surgery in gynaecology.

¹²⁷ A procedure to remove polyps in the lining of the uterus.

¹²⁸ BADS defines day surgery as a procedure that is planned as a day case, with the patient admitted, operated on and discharged on the same calendar day. Historically, best practice tariffs related to day surgery have used the same definition.

Table 4: BADS recommendations for percentage of common gynaecology procedures that could be conducted in the procedure room or as zero-night stay (please see report addendum on p113)

Description	% that could be conducted in procedure room	% that could be conducted as zero-night stay
Vaginal hysterectomy (including laparoscopically assisted)		60
Laparoscopic total/subtotal abdominal hysterectomy		50
Myomectomy (including laparoscopically)		50
Therapeutic endoscopic operations on uterus (including endometrial ablation)	50	45
Endometrial biopsy/aspiration + hysteroscopy	90	9
Laparoscopic oophorectomy and salpingectomy (including bilateral)		80
Therapeutic laparoscopic procedures including laser, diathermy and destruction e.g. endometriosis, adhesiolysis, tubal		85
Operations to manage female incontinence		95
Colposcopy (+/- biopsy)	95	5
Destruction of lesion of cervix uteri (including loop diathermy and laser)	90	10
Cone biopsy of cervix uteri (including laser)	50	50
Posterior colporrhaphy		70
Anterior colporrhaphy		80
Anterior and posterior colporrhaphy		60
Marsupialisation of Bartholin cyst	25	75
Termination of pregnancy		99
Female sterilisation	20	80
Evacuation of retain products of conception		95
Removal of products of conception from fallopian tube (ectopic pregnancy) including laparoscopically		55

Source: BADS Directory of Procedures 6th Edition. Reproduced with the permission of the British Association of Day Surgery (BADS) <https://www.bads.co.uk>

However, despite this clear professional view that these procedures can and should be routinely offered as day surgery, our analysis found that there is still considerable variation in provider practice. The sections below examine trends for certain procedures.

Common feedback from providers with low levels of day surgery

During the GIRFT deep-dive visits, a common thread emerged among providers with lower levels of day surgery overall: that because they are keen to retain dedicated gynaecology wards or maintain their inpatient bed base, this provided a disincentive to move activity to day case or outpatients. By contrast, at providers who had moved to caring for gynaecology patients on female inpatient wards, day surgery rates were generally higher.

Another recurring barrier to conducting procedures in an outpatient or day surgery setting is a lack of adequate analgesia and recovery facilities – whether in the department or in the hospital as a whole. This can restrict the number of procedures

considered and the types; anything that requires longer recovery may not be deemed feasible. For some providers, the best solution would be a dedicated recovery room or suite within the gynaecology department; however, at others, it may prove more cost-effective to have access for one or two days a week to a shared day surgery unit, where women can be admitted and prepared for surgery, undergo the procedure and then recover all in the same place.

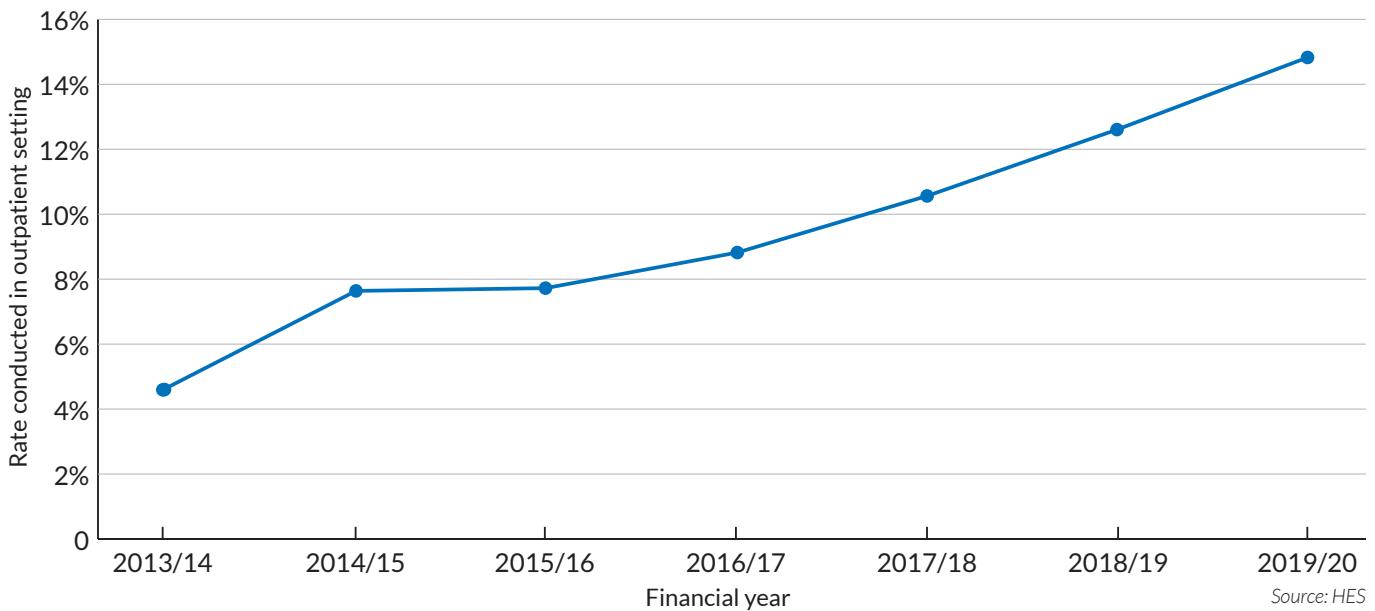
While there were different views expressed about specific practical barriers to increasing the use of day surgery, our overall impression is that the underlying solution to many of these practical issues is a cultural shift. The barriers identified are typically resolvable if there is a broader commitment across the whole CCG or ICS to day surgery; that way, expectations can be managed across the entire patient journey, care pathways redesigned to facilitate day surgery and teams trained to work in that way.

Endometrial ablation procedures via outpatients

Endometrial ablation is a surgical procedure to help reduce heavy menstrual bleeding. It is typically offered if women have not responded to an intrauterine device, or do not wish to have one inserted. Endometrial ablation can be performed using a number of different devices and the procedure typically lasts under ten minutes.

Over 60% of trusts now offer it as an outpatient procedure (under local anaesthetic) in at least some cases. However, there are some providers where it is only available under general anaesthetic, often with overnight admission. In recent years, there has been an increase in the overall percentage of endometrial ablation procedures conducted via outpatients, which is now just over 14% (see **Figure 32**). However, at some providers the proportion is far higher, at over 80%.

Figure 32: Percentage of endometrial ablation procedures conducted in outpatient settings, 1 April 2013 to 31 March 2020



BADS suggests that 95% of such procedures could be conducted in a day surgery setting – many in procedure rooms. There is an opportunity to increase substantially the proportion of endometrial ablation procedures conducted in an outpatient setting – reducing the length of stay, the number of admissions and the pressure on gynaecology wards while improving patient experience.

CASE STUDIES

Conducting endometrial ablation as day surgery or as an outpatient procedure

Walsall Healthcare NHS Trust

At Walsall Healthcare NHS Trust, a decision was made to conduct endometrial ablation as day surgery or as an outpatient procedure whenever clinically appropriate. Under the direction of one of the department's consultants, a business case was made to adapt job plans, allocate suitable space and secure additional funding for cameras and scopes. The multidisciplinary programme has helped reduce the demands on the main surgical theatres, cut the need for (and costs associated with) admissions, make more effective use of all team members and above all, improve the patient experience.

Wrightington Wigan and Leigh Teaching Hospitals NHS Foundation Trust

At Wrightington Wigan and Leigh Teaching Hospitals NHS Foundation Trust, it has been the default approach to offer endometrial ablation as an outpatient procedure for over 15 years. The trust has developed robust processes and ensured that patients have full information on the approach from the outset. The gynaecology unit has its own treatment rooms where the procedure is conducted, meaning women attend a familiar setting (and are treated by familiar staff). However, there is a separate waiting area and recovery facilities available where needed. The trust has found that by making this an outpatient procedure, it has been able to reduce waiting times to under four weeks on average – compared to an estimated eight weeks for a day case admission. The main barrier the trust faced was related to tariffs and the fact that the CCG initially proposed that only the outpatient follow-up appointment tariff was applicable. This has now changed and a higher tariff has been agreed.

The trust also offers a one-stop outpatient hysteroscopy service – which has been in place since 2001. Women who fit the criteria for two-week rule are referred by GPs through Choose & Book and seen promptly in the one stop setting, where a transvaginal scan is readily available along with a diagnostic hysteroscopy as appropriate. This facilitates an earlier diagnosis and reassurance thus improving efficiency and patient satisfaction.

Another factor that some providers indicated affects their readiness to conduct endometrial ablation as an outpatient procedure is the fact that there is no suitable outpatient tariff.

A best practice tariff was introduced to encourage more providers to conduct hysteroscopy in outpatient settings; this led to a significant change in practice. For 2019/20, best practice tariffs were introduced for conducting laparoscopic total/subtotal abdominal hysterectomy and vaginal hysterectomy as day cases, as well as for day case laparoscopic oophorectomy and salpingectomy. The impact of COVID-19 led to the introduction of block contracts in 2020/21; however, we believe there is a clear opportunity to review this approach and explore ways to incentivise, through tariff, a shift to conducting more gynaecological procedures, as day cases, or better still in outpatient settings with no admission required.

Adopting day surgery for hysterectomies

Even before the introduction of the best practice tariff referred to above, a growing number of providers were routinely conducting hysterectomies as day surgery, either performed laparoscopically or vaginally. These providers include:

- Torbay and South Devon NHS Foundation Trust;
- Northumbria Healthcare NHS Foundation Trust;
- Portsmouth Hospitals NHS Trust; and
- Ashford and St Peter's Hospitals NHS Foundation Trust.

The primary advantage of this approach is that it allows women to recover from the surgery in the comfort of their own home. It has therefore proved popular with women.

CASE STUDIES

Day case hysterectomies

Torbay and South Devon NHS Foundation Trust

Since 2014, Torbay and South Devon NHS Foundation Trust has offered hysterectomies as day surgery. It has developed a robust standard operating procedure, beginning with patient selection and extending through post-operative care. The option is discussed from an early stage, so women are fully aware of the intent and what the procedure will entail. Women are admitted on the day, surgery is conducted laparoscopically or vaginally according to surgical indication and there are clear instructions on discharge. The day after surgery, nurses call each patient to check on their wellbeing. The hospital has also introduced a network of approved volunteers to provide overnight care for any woman who lives alone, hence enabling them to benefit from the day case pathway.

Feedback from the approach is excellent, with 100% of women who have had day surgery reporting being satisfied with the service. There have been very low rates of post-operative pain or nausea and vomiting the day after surgery and unplanned admission rates of 7%. Now, around 85% of the trust's hysterectomies are conducted as day cases.

Northumbria Healthcare NHS Foundation Trust

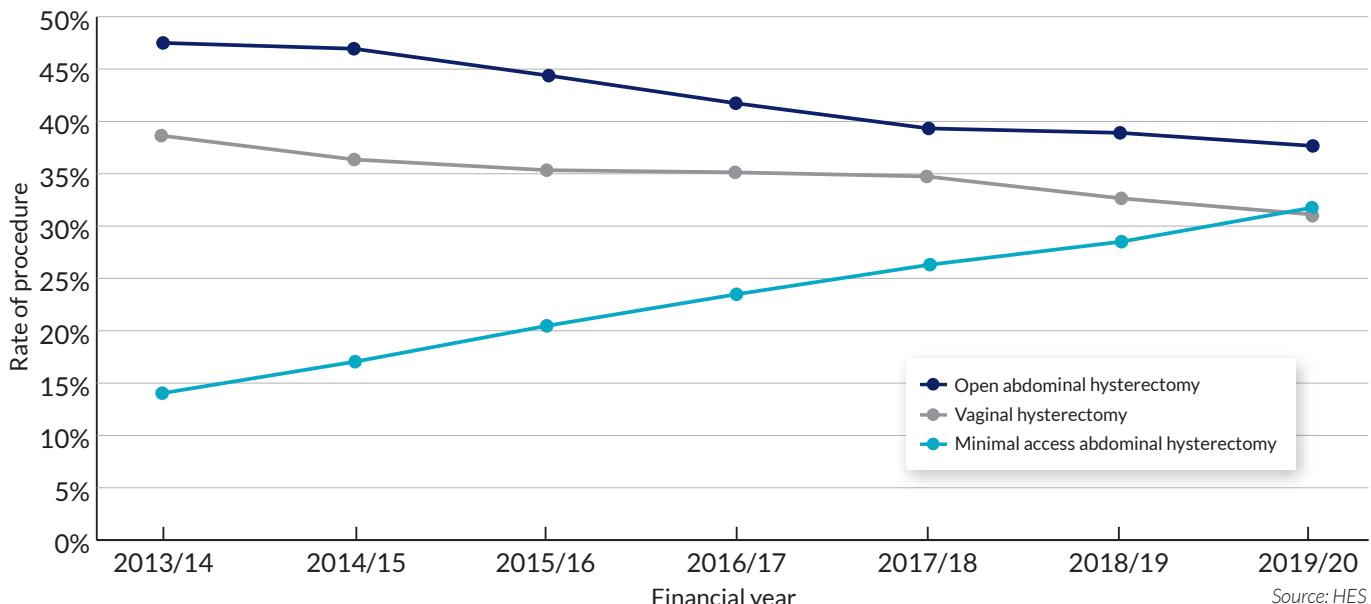
Northumbria Healthcare NHS Foundation Trust conducts around 70% of benign hysterectomies as day cases. It introduced the approach around five years ago and now has an established process, starting with advising women from the moment they are listed for surgery that the intention is to conduct the procedure as a day case. Procedures are then scheduled for a morning list and there is a standardised approach to anaesthesia. Once back on the ward, women are reviewed by the surgeon and then in most cases seen again before discharge. If a woman experiences bladder dysfunction (approx. 7% of cases), she may be catheterised and discharged, to return within a couple of days. The whole team is now accustomed to the approach and it is seen as hugely positive by patients. The trust also believes it has helped keep waiting times down.

There are three broad surgical methods of hysterectomy, divided by the route of access:

- open abdominal;
- vaginal; and
- minimal access abdominal (laparoscopic).

As **Figure 33** below shows, over recent years there has been a consistent increase in the proportion of benign hysterectomies conducted laparoscopically and a fall in the use of open abdominal surgery.

Figure 33: Surgical method for benign hysterectomies, 1 April 2013 to 31 March 2020



Source: HES

The underlying data (**Table 5**) also shows that the overall number of benign hysterectomies has fallen over the same period by around 25% – probably reflecting the increased use of conservative treatments and endometrial ablations.

Table 5: Procedural trends in benign hysterectomy across NHS trusts in England 2013-2020

Year	Total	Open Abdominal		Vaginal		Minimal Access Abdominal	
		Number	%	Number	%	Number	%
2013/14	34,351	16,309	47%	13,245	39%	4,797	14%
2014/15	32,860	15,391	47%	11,911	36%	5,558	17%
2015/16	31,291	13,880	44%	11,035	35%	6,376	20%
2016/17	30,417	12,625	42%	10,665	35%	7,127	23%
2017/18	28,305	11,110	39%	9,768	35%	7,427	26%
2018/19	28,580	11,131	39%	9,314	33%	8,135	28%
2019/20	26,403	9,885	37%	8,202	31%	8,316	31%

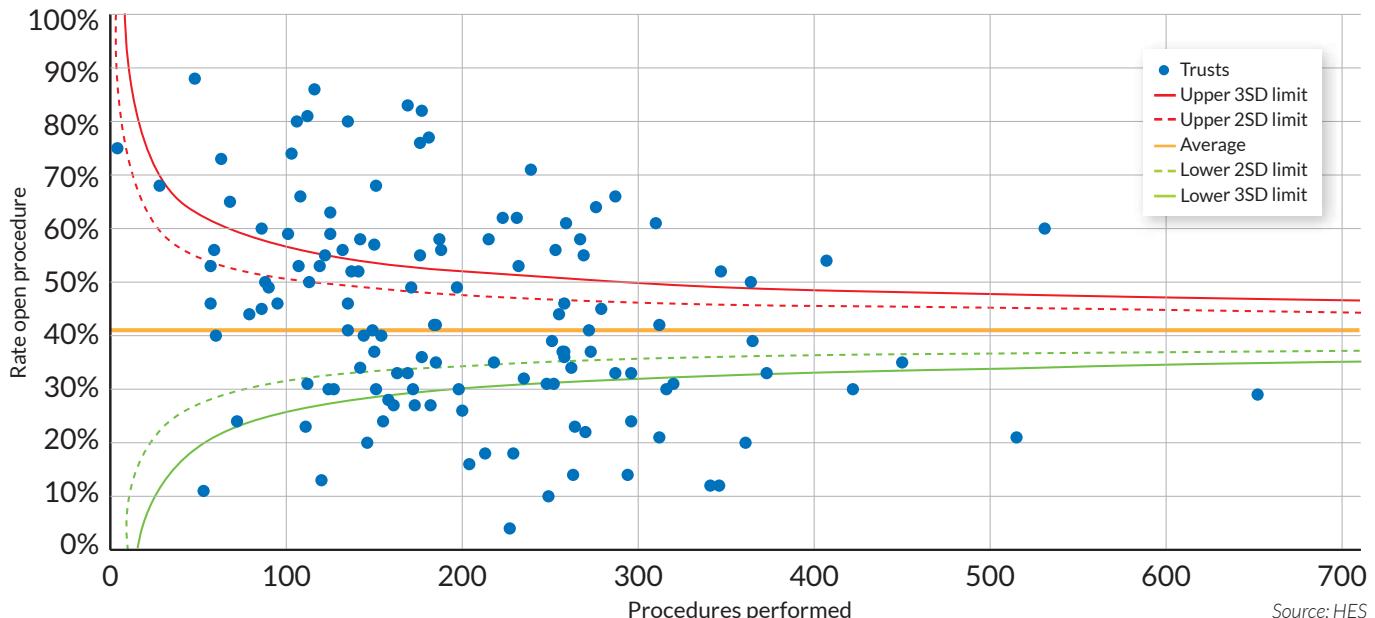
Source: HES

However, while the overall trends appeared clear, there was considerable variation in procedural choice between providers.

As a broad generalisation, benign hysterectomies in women under 50 years old are performed because of menstrual irregularities, fibroids or endometriosis.

The degree of variation in the percentage of open operations, regardless of procedure volumes performed, appears extreme. At seven providers more than 80% of benign hysterectomies among women under 50 were conducted as open surgery; at 13 providers, fewer than 20% were. Nationally, the average is just over 40%.

Figure 34: Percentage of benign hysterectomies performed as open procedures for women under 50 years, 1 Apr 2018 to 31 Mar 2020



Source: HES

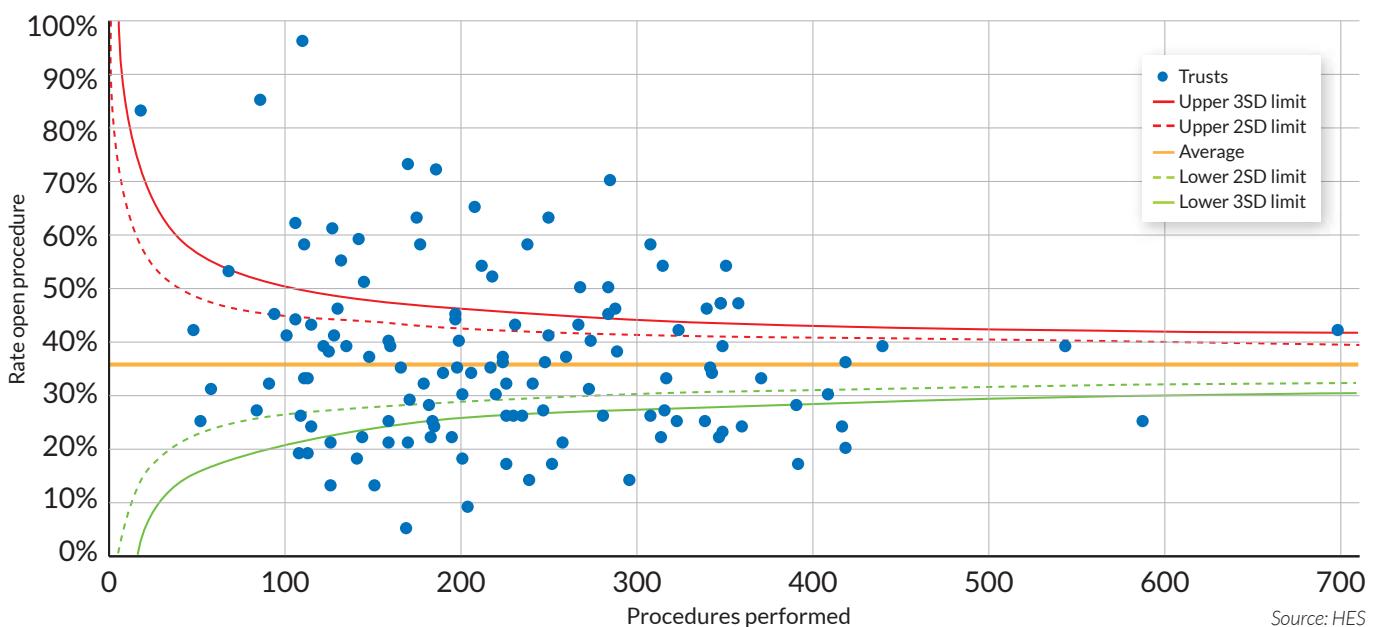
Looking purely at providers conducting around 150 benign hysterectomies on women under 50 years of age during the same two-year period, there is a four-fold variation in the use of open surgery.

It seems unlikely that the casemix and clinical indications are so different as to justify the extreme variation; instead, the data suggests that at some providers there is an excessive reliance on open surgery when other, less invasive methods may be clinically viable.

For women over 50 years of age the predominant indication for hysterectomy is utero-vaginal prolapse, requiring vaginal surgery. The proportions of open procedures are therefore generally lower, as **Figure 35** shows.

Nonetheless, given this predominant indication, it is surprising that 25 providers conducted over 50% of benign hysterectomies on this age group via open surgery.

**Figure 35: Percentage of benign hysterectomies performed as open procedures for women 50 years and over,
1 Apr 2018 to 31 Mar 2020**



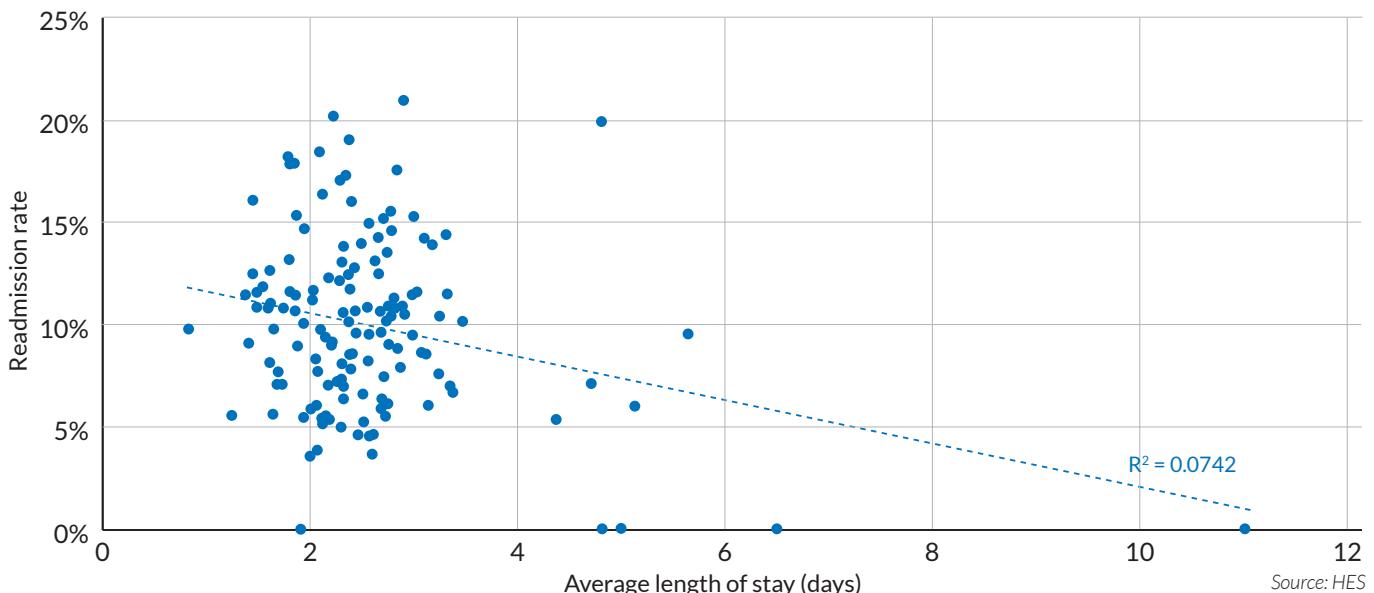
In the deep-dive visits, we asked providers: 'Do you offer all surgical routes of access for hysterectomy and are there mechanisms to allow women who are suitable and opt for minimally invasive surgery to be cross referred, if the surgeon that they are seeing does not offer minimally invasive approaches?'

Some units acknowledged that they lacked provision for laparoscopic surgery. Others stated they have capacity and referral mechanisms to ensure that, where appropriate, women are able to choose the surgical route of access.

Readmission rates for shorter stays

Another possible explanation for preferring the more traditional open surgery could be that it might reduce risk of complications or readmissions. We looked at readmission rates within 30 days to see if these were higher following shorter lengths of stay (including day cases). As **Figures 36a** and **36b** below show, there was no strong correlation between providers with shorter average length of stays following hysterectomy – associated with laparoscopic or day surgery – and rates of readmissions.

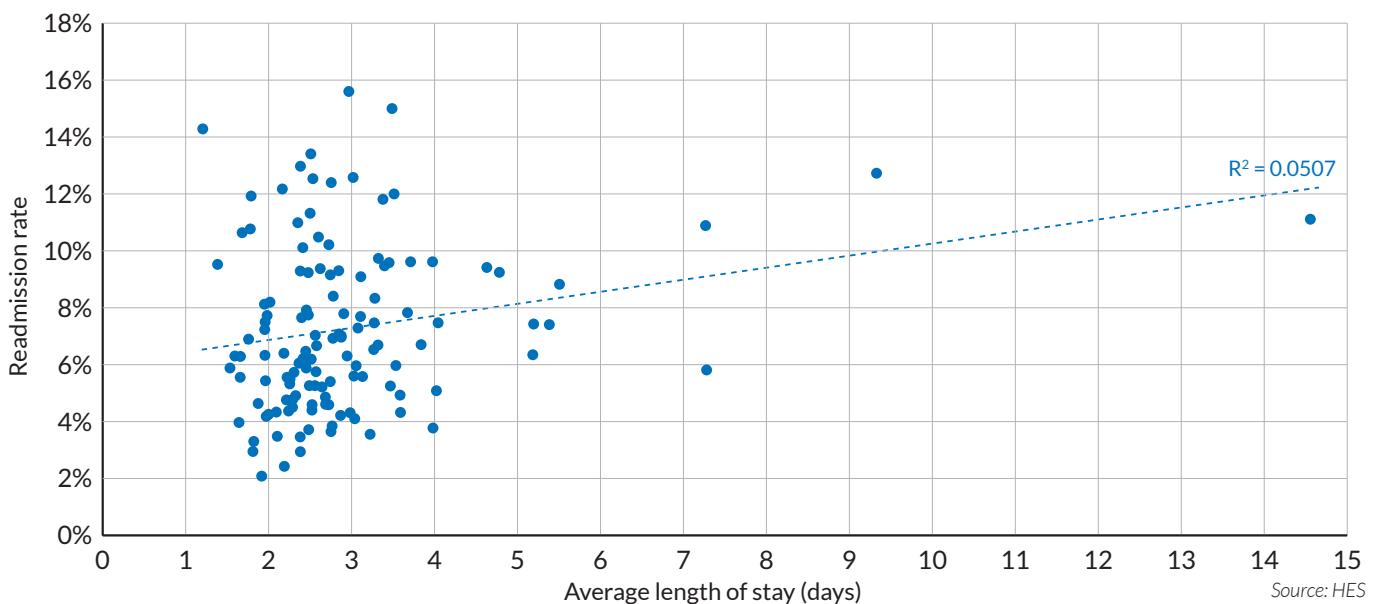
Figure 36a: Readmission rate vs. length of stay for benign hysterectomies (patients <50 years) by provider, 1 April 2016 to 31 March 2018



GIRFT re-examined the same data for the period April 2018 to March 2020. This again showed no strong correlation between shorter lengths of stay and higher readmission rates. However, there was a positive change: readmission rates overall appear to have dropped. In the period shown in figure 36a above, at least half of providers had a readmission rate of over 10% and several had rates of more than 15%.

In **Figure 36b** below, only two providers had rates over 15% and the densest concentration was between 4% and 8%.

Figure 36b: Readmission rate vs. length of stay for benign hysterectomies (patients <50 years) by provider, 1 April 2018 to 31 March 2020



This may be explained in part by changes in coding practice. For example, a common follow-up for women with urinary retention after vaginal hysterectomy and prolapse repair is ‘trial without catheter (TWOC)’. During deep-dive visits, some units confirmed that they code women attending for TWOC as day attendances, while others code this as a readmission.

Given the accepted benefits to the patient of less traumatic surgery, and the fact that there appears to be no negative association with shorter days, it seems logical to adopt laparoscopic methods where possible – based on both clinical need and patient choice. This then opens the possibility of following the examples of some providers and offering hysterectomy as day surgery.

Increasing the use of day surgery

With day surgery offering a positive benefit in terms of patient experience, we asked providers that conduct a significant share of their gynaecology procedures as day cases what steps they had taken.

All emphasised that for day surgery to be successful, providers need to consider the whole patient pathway and take practical steps to address potential barriers. While the exact approaches vary, some of the common themes are listed below.

- Not all patients and clinical indications are suitable for day surgery. Units that predominantly perform hysterectomies for patients with large, multi-fibroid uterus, extensive endometriosis, or other pathologies may not have patients suitable for this approach.
- Trusts need to train the whole surgical and support team – not just the surgeons – to support day surgery.
- Appropriate protocols may be needed for admission, anaesthesia, analgesia and discharge. Nurse-led discharge, in line with BADS guidance, is often crucial to ensure that patients do go home on the day of surgery.
- Patient education is essential. Patients must be made aware of the intended day case approach early in their decision-making, so they can prepare themselves accordingly. Consistency of message is required, with patients receiving detailed information about what they can expect before, during and after the operation (e.g. in terms of pain, bleeding, sutures) and about what may be abnormal. When they are discharged, patients must be given contact details of the surgical team in the event of any concerns.
- Providers should follow best practice guidance for enhanced recovery,¹²⁹ from choice of anaesthetic and regional blocks to providing a protein or energy drink shortly before surgery.
- Providers need to plan their surgical lists carefully and schedule any day surgery procedures earlier in the day, to allow maximum time to recover on the day.
- The discharge process needs to be well-managed. Paperwork must be complete and staff available to conduct all necessary checks on the patient at the right time.
- It is important that consideration is given to the post-operative support available to patients. In particular, providers have emphasised the need to ensure the patient has company on the night after their operation in case of any complications. Some units in the first 24 hours after surgery offered telephone contact in case of concerns. One unit goes as far as offering appropriately screened volunteers who can stay for the first night in the woman’s home, for those who live alone or with no next of kin. A different trust explicitly identifies procedures, such as hysteroscopy, where there is no need for most patients to have company at home overnight post-procedure – thus again making a greater proportion of patients eligible for day surgery.

As it is expected that one consequence of the COVID-19 pandemic will be an ongoing drive to reduce the number of inpatient admissions where there is a viable alternative, these recommended practices should be of use to many trusts. However, it must be recognised that even if following these recommended practices, there are some units where patient demographics and geography may make it harder to achieve high numbers of day cases.

¹²⁹ See e.g. Trowbridge, E., Dreisbach, C., Sarosiek, B., et al. (2018) Review of enhanced recovery programs in benign gynecologic surgery (*International Journal of Urogynecology*) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6030000/> and more general guidance at <https://www.evidence.nhs.uk/search?q=enhanced+recovery>

Recommendations

Recommendation	Actions	Owners	Timescale
<p>8. Ensure that benign hysterectomy procedures are only offered when clinically indicated, as per NICE guidelines and Evidence-Based Interventions (EBI) programme statutory guidance.</p>	<p>a Providers and commissioners to review local practice and criteria for offering benign hysterectomy against NG88 <i>Heavy menstrual bleeding: assessment and management</i> and EBI statutory guidance.</p> <p>b Providers to adopt a local review process to audit all benign hysterectomies.</p>	CCGs, Trusts	6 months
<p>9. Increase use of appropriate setting for surgery, with a shift to day case and/or outpatient procedures for endometrial ablation, hysteroscopy, treatment of Bartholin's abscess, vaginal prolapse repairs and cystoscopy, to the rates recommended by the British Association of Day Surgery (BADS).</p> <p>See addendum on p113 for updated recommendation and additional action (Nov 2024)</p>	<p>a Trusts to review processes against BADS recommended best practice for day surgery,¹³⁰ then review performance via Model Hospital.</p> <p>b Trusts to ensure sufficient multidisciplinary training is provided to all staff involved in the delivery of day surgery and/or outpatient procedures.</p> <p>c GIRFT to discuss with NHS England and NHS Improvement the feasibility of using alternative ways to continue to incentivise change through methods of payment once block contracts are reviewed.</p> <p>d Trusts / CCGs to review availability of appropriate recovery and analgesia facilities to increase rates of outpatient and day case surgery.</p>	Trusts	6 to 12 months
<p>10. Ensure that there is adequate expertise and availability for day case hysterectomies when clinically indicated.</p>	<p>a Training providers and Royal Colleges to include identifying suitable candidates for day case hysterectomy, and procedures for day surgery, as part of their curricula.</p> <p>b GIRFT to work with trusts to enable and facilitate the delivery of day case hysterectomy where appropriate, identifying and addressing any barriers.</p>	RCOG, HEE, statutory education bodies	12 months

¹³⁰ BADS Directory of Procedures, Sixth Edition

Examining pathways for treating urinary incontinence

Urinary incontinence is one of the most common reasons for referral to a gynaecology department. The NICE clinical guideline on the management of urinary incontinence in women¹³¹ recommends starting with conservative treatments such as pelvic floor muscle training for stress incontinence and bladder re-training for overactive bladder. Such treatments can typically be initiated in primary or intermediate care and delivered by women's health physiotherapists, potentially without needing a referral to a consultant. (It is clearly important that payments to trusts support this approach of emphasising conservative treatments first).

Where these treatments do not have the desired results, for overactive bladder the next stage may be to prescribe medication, and for stress incontinence, the most common next step after conservative treatment may be surgery. As this can be a sensitive issue, care decisions should always be made in consultation with the women and all options explained, before a PCSP is developed.

Procedure trends for stress incontinence

Where conservative treatment for stress urinary incontinence has not been effective, some women may be offered and accept surgical treatments. While there are a range of surgical treatments available, for many years the most common were procedures using trans vaginal sub-urethral synthetic mesh tapes, such as tension-free vaginal tape (TVT) or trans obturator tape (TOT).

With a growing body of evidence building that vaginal or pelvic mesh was causing severe and chronic pain among some of those treated, and in some cases leading to other symptoms, in February 2018 Baroness Julia Cumberlege was appointed to chair a review of how the healthcare system in England responds to reports about harmful side effects from medicines and medical devices. The medical device under review was pelvic mesh implants.

In July 2018, the NHS imposed a high vigilance restriction period on the use of any vaginal mesh.

Where mesh procedures were deemed the only viable treatment option – such as when no suitable alternative existed, and/or where delay would risk harm to the woman – mesh was only to be used under strict adherence to NICE Interventional Procedure Guidance¹³² and with the woman's full consent.¹³³

The RCOG amended its training curriculum and recommended that surgeons reskill in the performance of other procedures for stress incontinence such as colposuspension, para-urethral injections and fascial slings.

In February 2020, NHS Specialised Commissioning published service specifications for complex surgery for urinary incontinence and vaginal and uterine prolapse¹³⁴ and for the management of women with complications of mesh inserted for urinary incontinence and vaginal prolapse (including, where necessary, surgery to remove the mesh).¹³⁵ These mean that procedures under these categories can only be conducted by approved specialist providers that have demonstrated their ability to adhere to best practice pathways.

The Independent Medicines and Medical Devices Safety Review (IMMDS), chaired by Baroness Julia Cumberlege, published its report on 8 July 2020, having heard from a large number of women about the considerable harm that pelvic mesh had had, and was continuing to have, on their physical and mental wellbeing. The IMMDS Review made several recommendations around future safety evaluation of medical devices and around supporting and recompensing those who have suffered ill-effects from a mesh implant (as well as those who suffered from other devices).¹³⁶ It also recommended that 'a central patient-identifiable database should be created by collecting key details of the implantation of all devices at the time of the operation.'¹³⁷ This strong recommendation superseded our own and is being taken forward with the creation of the Medical Devices Information System, as directed by the Secretary of State for Health and Social Care. The Information System will include a pelvic floor registry which will support the collection of a clinically agreed set of data items relating to pelvic floor surgery for an individual patient. We welcome this and would further encourage a similar approach in all areas of major gynaecological surgery.

¹³¹ NICE (2013) NG171 Urinary incontinence in women: management <https://www.nice.org.uk/guidance/cg171>

¹³² There are in fact nine NICE interventional procedure guidelines relating to urinary incontinence, covering different procedures.

¹³³ See <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/mesh-safety-alert/>

¹³⁴ See <https://www.england.nhs.uk/wp-content/uploads/2020/02/1649-urinary-incontinence-vaginal-uterine-prolapse-service-specification-pdf.pdf>

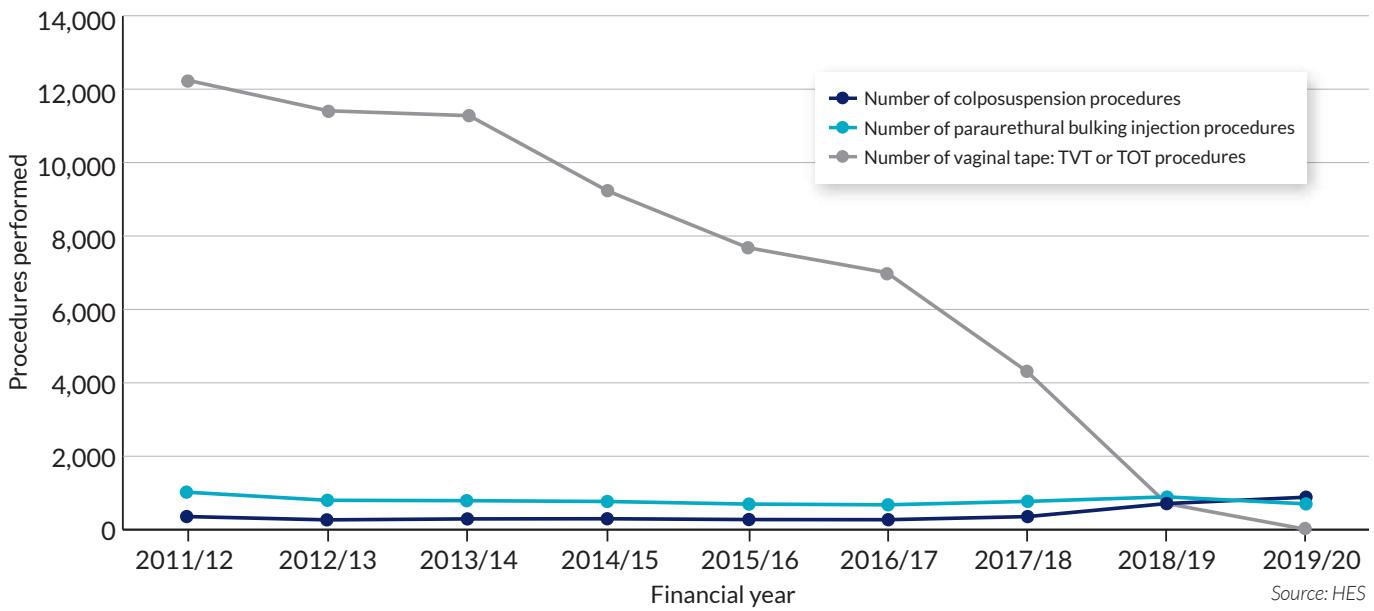
¹³⁵ See https://www.engage.england.nhs.uk/consultation/gynaecology-surgery-and-complex-urogynecology/user_uploads/complications-of-vaginal-mesh-draft-service-specification.pdf

¹³⁶ The Independent Medicines and Medical Devices Safety Review (2020) First Do No Harm <https://www.gov.uk/government/publications/independent-medicines-and-medical-devices-safety-review-report>

¹³⁷ This is recommendation 7 of the IMMDS Review.

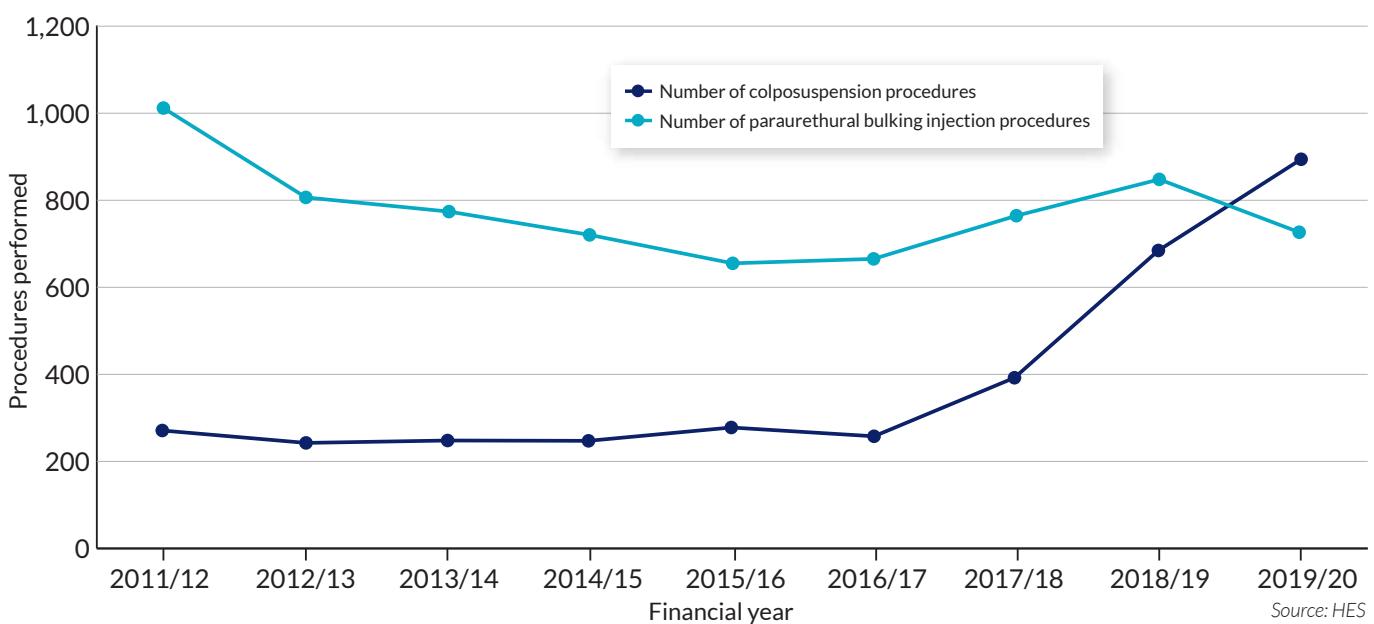
The IMMDS Review noted that mesh procedures for urinary incontinence ‘rapidly declined from July 2018.’ However, as **Figure 37** shows, the number of vaginal tape procedures (including trans obturator tape or TOT) had already been dropping for some years – from over 12,000 a year in 2011/12 to just over 4,000 a year in 2017/18.

Figure 37: Procedural volumes for urinary incontinence 1 April 2011 to 31 March 2020



Looked at more closely, there has also been a steady rise in the last four years in the number of paraurethral injections and particularly colposuspension procedures performed – albeit the overall numbers are still relatively low. This is in line with the changes to the training curriculum recommended by RCOG.

Figure 38: Procedural volumes for paraurethral injections and colposuspension procedures, 1 April 2011 to 31 March 2020



More broadly, the total number of continence procedures performed per annum has reduced to extremely low levels. This probably reflects changes in referral patterns to secondary care and an increase in perseverance with conservative treatments for women concerned about mesh procedures.

The IMMDS Review recommended – at the time of the pause in mesh procedures – that further research, including audit, be undertaken to understand the nature and extent of mesh-associated complications. We support that, but also note that given the increase in paraurethral injections, it is now of prime importance to assess the efficacy of this alternative, including looking at costs and the number of injections that need to be conducted per patient. A 2012 study, following up women over two years after their initial injection, indicated that the approach was largely safe;¹³⁸ however, ongoing vigilance is also important to ensure that there are no complications as a result of surgical learning curves or the large-scale adoption of this approach. There are also questions about how long the effects of an injection last, and how soon a repeat injection may be required.

Botox injections for urge incontinence

A common treatment for urge incontinence after failed medical treatment is the injection of botox into the bladder muscle wall via a cystoscope. The injections appear to be effective for several months and can then be repeated – though obviously with recurring costs and additional appointments.¹³⁹

Like paraurethral injections, they can also be conducted as outpatient procedures and some providers are offering this. We heard of a number of examples of outpatient clinics where women underwent cystoscopy and received botox as outpatients, being able to walk in and out of the clinic room and return to their daily activities.

However, many units are not currently offering or not recording cystoscopy and botox injections as an outpatient procedure – even though there has been a best practice tariff for outpatient cystoscopy.

We also found there was great variation in which surgical teams performed these procedures: urology, gynaecology or a mixture of both teams. In some providers, this led to the absurd situation of two departments in the same trust providing the same procedure in completely different ways. For example, women seen by urology might receive a botox injection using a flexible cystoscope in an outpatient clinic, while women seen in gynaecology would have the procedure in theatre, under sedation, using a rigid cystoscope. In terms of patient experience, this difference is hard to justify.

Gynaecological cancer

Gynaecology departments deal with four common forms of cancer:

- uterine cancer;
- cervical cancer;
- ovarian cancer; and
- vulval cancer.

Our intention was to examine data about the different approaches to managing cancer between trusts, the rates of surgery and key outcomes such as readmissions, complications, length of stay and mortality after years. However, the available data was limited. In future, GIRFT hopes to access data from the National Cancer Registration and Analysis Service (NCRAS) to compare to surgical data available in HES.

¹³⁸ See Tooze-Hobson, P., Al-Singary, W., Fynes, M., et al. (2012) Two-year follow-up of an open-label multicentre study of polyacrylamide hydrogel (Bulkamid®) for female stress and stress-predominant mixed incontinence <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3448051/>

¹³⁹ Data around the use of botox for this purpose is limited. It is possible to determine total botox purchases by department, but this procurement information is not then attributed to a specific procedure.

Driving continual improvement

Throughout this report, a series of issues have been highlighted around the availability and quality of data related to maternity and gynaecology. While – as in other workstreams – there are concerns about the quality and depth of coding, the biggest issue for gynaecology in particular is a lack of information about patient reported outcomes.

Most established measures of patient outcomes relate to surgical procedures. These include well-known measures such as length of stay, readmission and reoperation rates. However as only around 1 in 10 gynaecology patients undergo surgery, these measures do not account for the majority of the care provided.

The need for more PROMs in gynaecology

In some clinical areas, such as urinary incontinence, pelvic organ prolapse, endometriosis and gynaecological cancer, there are disease-specific Patient Reported Outcome Measures (PROMs) which can be used to assess the woman's predominant symptom and assess the change in their condition following surgery. These don't just allow evaluation of care quality; they can also directly inform care. For example, women may be asked to provide feedback on urinary function and sexual function post-surgery, as part of assessing the need for further treatment.

PROMs are not available for all gynaecological conditions (surgical and non-surgical) and there is no specific requirement to use them. However, they are extremely valuable, particularly for high-volume surgical interventions. Further, as well as the short-term responses, gathered a few weeks after surgery or even a year after, there would be enormous value in understanding longer-term outcomes of a procedure – after five years or even ten. This would provide insights into whether different approaches are more likely to result in longer-term complications or, where devices of any sort are involved, whether some devices are more likely to need replacement. Such insights could help improve the information given to women to help them choose and provide informed consent for a procedure; it can also inform analysis of the long-term cost-effectiveness of ostensibly similar surgical options.

We recognise that there are cost implications to developing and implementing PROMs, and these must be considered along with the potential additional burden on trusts. It may be beneficial to take a sample approach rather than collecting data from every procedure. Digital collection of PROMs would support this aim, increasing timeliness of the data and giving women greater access to their own PROMs data, as well as being more cost-effective.

With more data gathered, there will be an opportunity to incorporate PROMs into assessments, such as those conducted by the CQC or HQIP, and to use PROM data within the development of NICE indicators. There may also be an opportunity for a formal research programme to allow for the development of more meaningful, pragmatic PROMs.

Whatever decisions are made, there needs to be a degree of consistency and specialty-wide agreement. While numerous professional bodies and societies already collect some PROMs data in gynaecology, this is not done systematically or consistently. Many surgeons do not contribute to this data collection.

We are aware that there has been ongoing discussion about how PROMs could be included in for the pelvic floor registry, as part of the Medical Devices Information System. Because this will be mandatory for providers, it will ensure there is a more comprehensive dataset about pelvic floor surgery than previous optional data collections. The British Society of Urogynaecology (BSUG) and others involved have sought to ensure there is scope for PROMs to be included in the data set, which would be of clear benefit to our understanding of the short and long-term outcomes of different procedures. However, any patient reporting will clearly be voluntary; BSUG has proposed that patients should be able to report directly to the registry, independent of clinicians.

We fundamentally support the creation of the pelvic floor registry and the intent to include PROMs within it. However, we believe that this same principle should be extended more widely to all urogynaecology procedures. A logical place to start would be to examine the possibilities to expand and integrate the existing registries related to urogynaecology, managed by BSUG, the British Association of Urological Surgeons (BAUS) and The Pelvic Floor Society (TPFS). The aim would be to agree a single set of relevant data to collect about every procedure. Clearly, this would require organisational cooperation, plus funding: however, we believe it would be of significant benefit to past and future patients alike.

CASE STUDY

Improving coding and data collection

Sandwell and West Birmingham Hospitals NHS Trust

Sandwell and West Birmingham Hospitals NHS Trust has taken practical steps to improve the quality and depth of its coding and data collection.

All outpatient activity, including details of procedures, is undertaken by dedicated gynaecology outpatient teams at the point of departing the patient from the clinic. Inpatient activity is recorded by a central team, collecting information about documented diagnosis, comorbidities and procedures from the patient notes.

The outcome is a far more consistent and comprehensive record, which not only helps fulfil national requirements but also enables the trust to use the data locally to examine its own performance.

Surgeon performance and the role of the National Consultant Information Programme (NCIP)

Data from PROMs can also be valuable in allowing surgeons to appraise and improve their performance. This data can and should be linked to data covering surgical volumes and complications.

At present, it is difficult using HES data to attribute cases to specific surgeons; access to surgical data directly from theatre operating systems will enable high-quality surgeon specific data to be analysed and benchmarked. This is an issue that is already been examined by the National Consultant Information Programme (NCIP),¹⁴⁰ which has consulted with gynaecologists and representative bodies to determine what data and outcome metrics should be collected at surgeon level about gynaecology procedures.

NCIP aims to support clinicians with learning and continuous self-development, as well as improving the quality of data recorded about common procedures and their outcomes. For each of 13 common gynaecology procedures, data is already gathered for the Commissioning Data Set (CDS) that feeds into Hospital Episode Statistics (HES) about length of stay, complication rates and readmissions – all attributed to the consultant responsible for the initial surgery.

The crucial aspect of NCIP is presenting that data back to clinicians so they can benchmark their patient outcomes against comparable national and unit level data. This will allow them to identify potential improvements to their clinical practice. Individual consultant-level data will not be available for external publication. The procedures and metrics for each specialty have been developed with relevant professional associations and royal colleges and the NCIP portal has been made available to a number of ‘early adopter’ trusts ahead of a wider rollout to trusts during 2021/22.

We believe this is a change that will benefit providers, patients and individual clinicians. While it is currently focused on work undertaken within the NHS, there would be clear benefits from extending it to all gynaecology practice, including work undertaken in the independent sector.

We would also underline that clinical outcome data should wherever possible be considered in context. That might include examining outcomes in relation to patient data – for instance, to consider complication rates in the context of comorbidities, where that information is available. The other crucial factor is surgical volumes: where a clinician has conducted 100 procedures, with 5% resulting in complications and readmissions, that might be more relevant than a 100% success rate after five procedures. This kind of detail can then potentially inform discussions around whether surgeons should have a minimum level of recent experience to conduct certain procedures. We would look to professional bodies and specialist societies to examine this issue in more detail and, if appropriate, to make recommendations about the required level of recent experience.

¹⁴⁰ See <https://www.gettingitrightfirsttime.co.uk/associated-projects/ncip/>

Recommendations

Recommendation	Actions	Owners	Timescale
11. Following the introduction of the Medical Devices Information System, consider introducing national registries with mandatory reporting for other gynaecological procedures.	<p>a Existing registry owners to work together, supported by GIRFT, to agree a joined-up approach to the recording of relevant data.</p>	GIRFT, NHSX, NHS Digital, HQIP, RCOG and other professional bodies	For immediate action
12. Consider including PROMs for gynaecology surgery in the national PROMS programme or other established national audit.	<p>a Review existing PROMs to identify those that could be included in the national PROMS programme or other established audit. Identify any gaps and establish follow-up outcome measures at 12 months initially and then to develop further.</p> <p>b Consider including PROMs identified as a result of action 12A above in the national PROMS programme or other established national audit.</p> <p>c Collaborate with the wider multi-disciplinary team to develop new PROMs where gaps were identified as a result of action 12A.</p> <p>d Establish and implement Patient Reported Experience Measures (PREMs) for feedback, initially at 12 months and then to develop further.</p>	GIRFT, RCOG and other professional bodies NHS England and NHS Improvement NHS England and NHS Improvement, GIRFT, RCOG and other professional bodies	12 months 18 months 18 months
13. Include surgeon-specific data reported under the National Consultant Information Programme (NCIP) as part of every surgeon's appraisal.	<p>a Individual clinicians to reflect on surgical data, including outcomes, as part of their annual appraisal.</p> <p>b Department heads and clinical directors to monitor procedure-level data reported under NCIP to help identify departmental development and procurement needs, inform recruitment strategies and address local anomalies.</p> <p>c Clinical directors and individual surgeons to work together to identify where individuals have insufficient recent experience, as defined by relevant professional bodies, to perform specific procedures.</p>	Clinicians, Clinician managers and Trusts Trusts Clinicians, Trusts, RCOG and other professional bodies	12 months 12 months 12 months
14. Continue to support the development of surgical outcome metrics.	<p>a Continue to develop metrics for use by surgeons and departments as part of the National Consultant Information Programme (NCIP). Use data that is routinely collected.</p> <p>b Identify any further metrics needed that are not covered by existing audits. Consider developing such metrics.</p>	NCIP, RCOG GIRFT, RCOG and other professional bodies	12 months 12 months

Procurement

In 2016, NHS Improvement mandated all trusts to submit their monthly purchase order data to a central database – the Purchase Price Index & Benchmarking data tool (PPIB). This was the first time a single national dataset of procurement information had been established for the NHS. The GIRFT programme has been analysing this data to better understand the variation in products and brands used and prices paid across NHS trusts. This analysis has been a feature of previous GIRFT reports, with examples of extreme variation in the number of brands used by clinicians.

What has become clear is that this variation is often down to clinical choice, and there has been a growing list of examples where the evidence-base to support these decisions has been weak: in some cases, patient safety has been compromised. Unsurprisingly, this has received media attention and there have been debates in Parliament about what could be done to improve the situation.

The extreme variation not only compromises patient safety, but it also adds significant costs to the NHS Supply Chain, as every brand used requires inventories and NHS purchasing leverage is compromised. Addressing variation therefore not only improves safety and efficacy but provides the opportunity to secure better deals and improved value for money for trusts.

To help, GIRFT has established a programme to root out unwarranted variation, improve the evidence-base to enable better decision-making, accelerate adoption of new proven technologies, and improve overall value for money by reducing supply chain costs. The GIRFT Clinical Technology Optimisation programme has been working with GIRFT clinical leads to examine the data and evidence that support products. In some workstreams, national Clinical Technology Advisory Panels (CTAPs) have been established with leading clinicians from the specialty to address safety, efficacy, innovation and value – with the objective of providing better information to clinicians and procurement professionals across the NHS.

In addition to this, in 2019 NHS Improvement launched a new NHS Spend Comparison Service to replace the PPIB dataset.¹⁴¹ The new service allows trusts to compare the products they use and prices they pay with other trusts across the NHS. The service is primarily targeted to NHS procurement staff, but GIRFT is working to tailor the data for medical directors and NHS clinicians, and place it alongside clinical outcome and HES data, so they can better understand the consequences of the decisions they make.

GIRFT has also been working with the new NHS operating model for procurement, including the new Category Towers, to develop plans for helping trusts and clinicians to address variation and improve value for money.

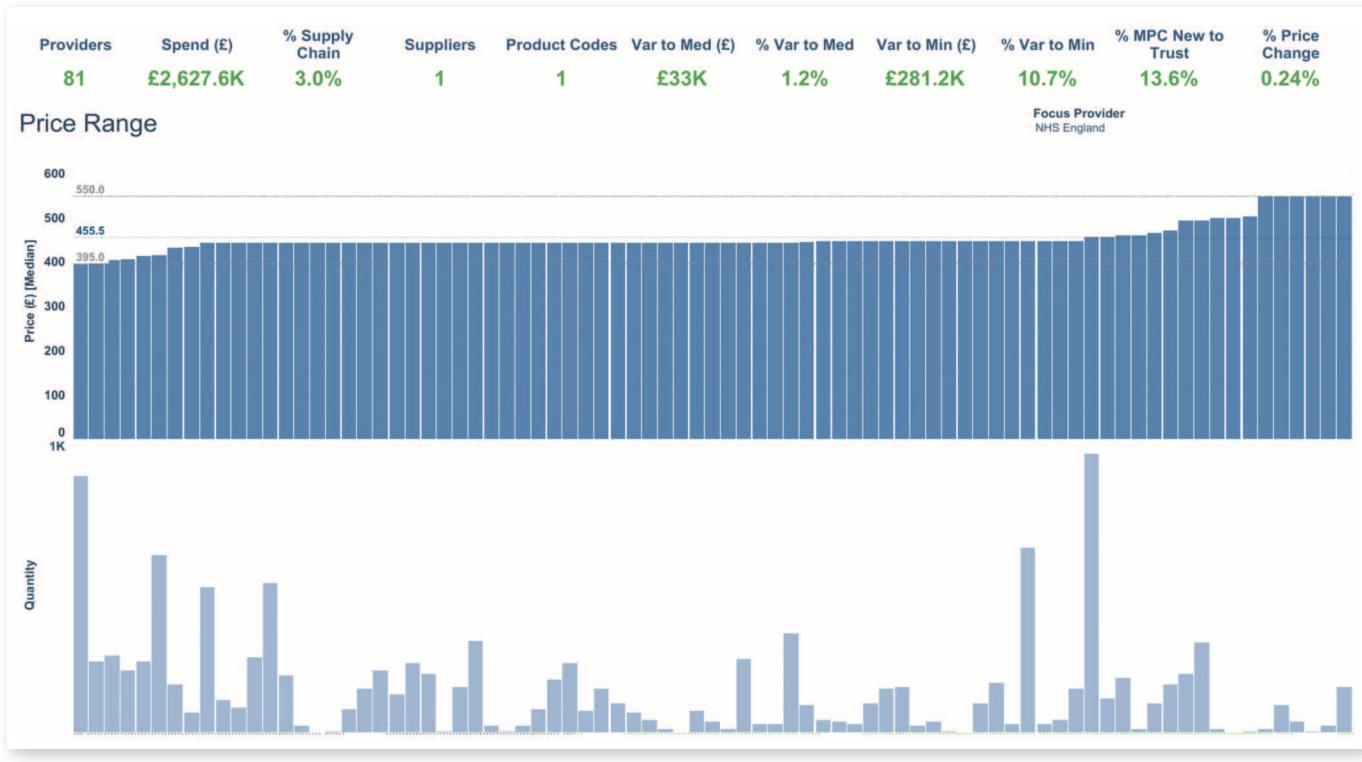
Unwarranted variation

Analysis of the NHS Spend Comparison Service data reveals significant variation in brands consumed and prices paid for products used in maternity and gynaecology services. For example, between October 2018 and October 2019, NHS trusts spent in total over £2.6m buying a specific device for hysteroscopic tissue removal; however, the prices paid per item ranged from £395 to £550, with no apparent correlation between prices paid and volumes bought. This is demonstrated in **Figure 39** below.

If every trust bought this item at the lowest price, it could save the NHS £280k a year, on this item alone.

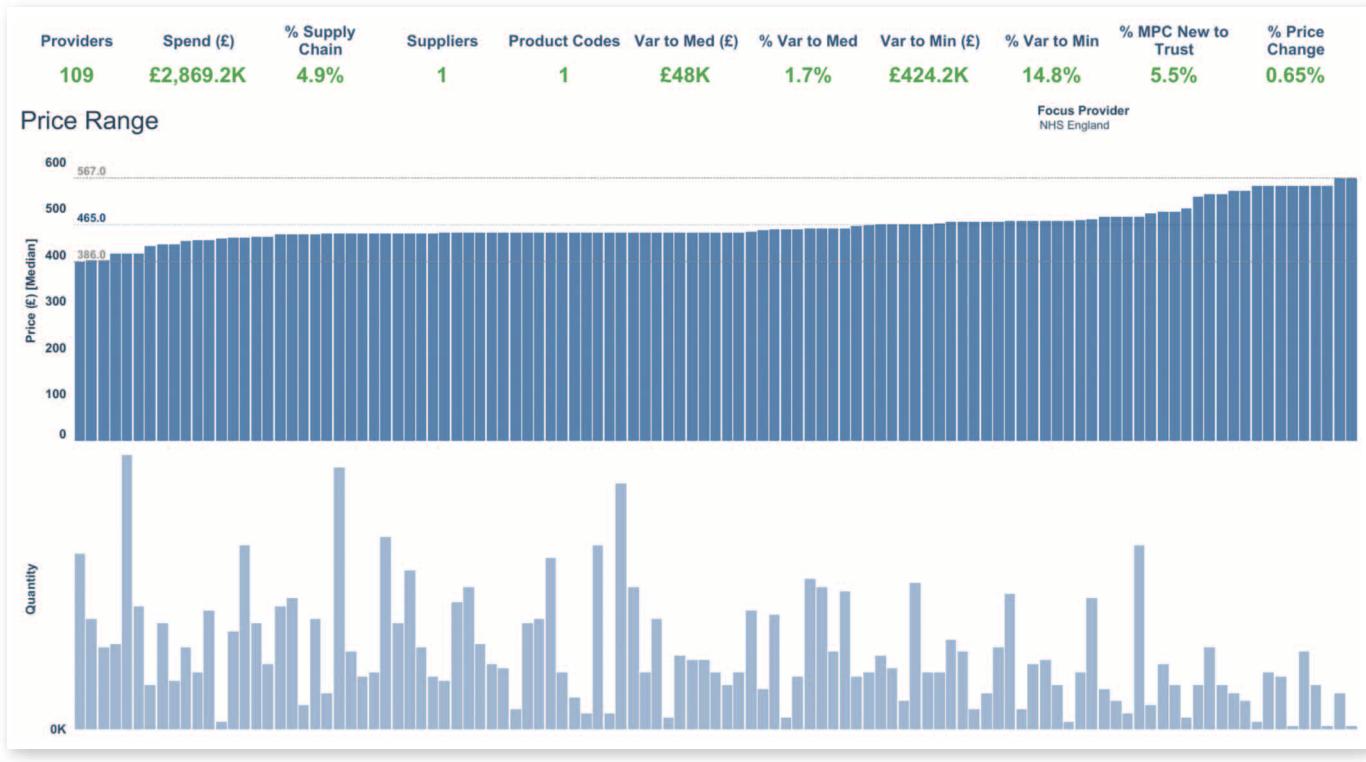
¹⁴¹ <https://www.digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/spend-comparison-service>

Figure 39: Prices paid and volumes bought of a specific single-use item used in hysteroscopy, by trust, October 2018–October 2019



A similar story applies to the most commonly purchased device for endometrial ablation, where there was variation between £386 per item and £567, as shown in **Figure 40** below. Over the same period, NHS trusts spent over £2.8m on this device; if all trusts achieved the lowest price paid, the NHS could save £424k.

Figure 40: Prices paid and volumes bought of a specific single-use item used in endometrial ablation, by trust, October 2018–October 2019



Although not solely used in maternity and gynaecology, another item where there was huge variation in prices was a specific brand of harmonic scalpel. During the year, NHS trusts spent over £12m on this product alone and again there was significant variation in prices paid. The highest price paid was £482 whilst the lowest was £352, and again there is no correlation between volumes purchased and prices paid. If all trusts achieved the lowest price paid then the NHS could save as much as £2.2m a year.

There were areas where the variation in prices paid was smaller. For example, the majority of trusts paid £9.02 per item for a commonly used intra-uterine device (IUD), but two trusts paid £9.45 per item for the same device. For a different IUD from the same manufacturer, most trusts paid £9.11 per item, but five trusts paid more – with two paying £10 per item.

Reducing unwarranted variation and improving value for money

Over the coming months, and using the new Spend Comparison Service data, the GIRFT procurement team will be working with GIRFT clinical leads and trusts to understand more about the variation in procurement costs across all clinical specialties. The GIRFT programme recognises that there are often sound clinical reasons behind the device and treatment method choice, and that patient quality outcomes, product evidence and product innovation are key considerations alongside supply chain efficiency and best value. As part of this review, the GIRFT team will provide trusts with curated data and will be asking medical and procurement teams to validate and provide evidence for choices made.

The goal is not absolute cost savings, but better value for money: gaining consensus about which products should be available and the appropriate price envelope; selecting products that minimise the need for replacement, alteration or further surgery.

The Department of Health and Social Care is expecting the new procurement category towers to help trusts reduce the level of variation in procurement by flexing the buying power of the NHS. Trusts are encouraged to work with the new category towers to support the rationalisation and standardisation of procurement.

Recommendation

Recommendation	Actions	Owners	Timescale
15. Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and by sharing best practice.	a GIRFT to use sources of procurement data, such as the NHS Spend Comparison Service and relevant clinical data, to identify optimum value for money procurement choices, considering both outcomes and cost/price.	GIRFT	12 months
	b GIRFT to identify opportunities for improved value for money, including the development of benchmarks and specifications. Identify best practice and procurement excellence, that lead to the most favourable procurement outcomes.	GIRFT	18 months
	c Trusts, ICSs and GIRFT to use the new Category Towers to benchmark and evaluate products and seek to rationalise and aggregate demand with other trusts to secure lower prices and supply chain costs.	ICSs, Trusts, GIRFT	18 months

Reducing litigation in maternity

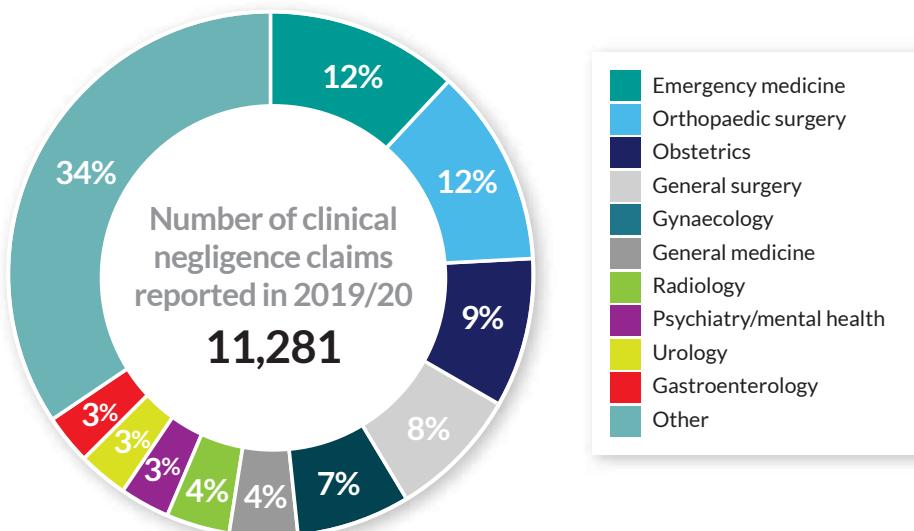
Maternity incidents can have devastating consequences for affected children and their families, and can be traumatic for the NHS staff involved. They also have significant financial consequences for the NHS in terms of the cost of compensation.

This section provides an overview of the volume and value of maternity claims made against the NHS in England, together with conclusions which have been drawn from the analysis of maternity claims data at national level and recommendations for how this can be used to make services safer for mothers and babies.

National picture: maternity claims in England

Claims for compensation made against NHS bodies in England are handled by NHS Resolution which is an arm's-length body of the Department of Health and Social Care, tasked with managing indemnity schemes and resolving compensation claims on behalf of the Secretary of State for Health and Social Care. NHS Resolution's main indemnity scheme is the Clinical Negligence Scheme for Trusts (CNST), which covers all maternity units in England.¹⁴² Overwhelmingly, the total cost of clinical negligence across the NHS is driven by maternity claims (shown as 'obstetrics' in **Figures 41, 42 and 43**). These represent 9% of the number of new clinical claims received by NHS Resolution annually, but half of the value of claims received and 72% of the £82.8 billion provision reported for secondary care as at 31 March 2020.

Figure 41: The number of clinical negligence claims reported in 2019/20 by specialty from a total of 11,281¹⁴³

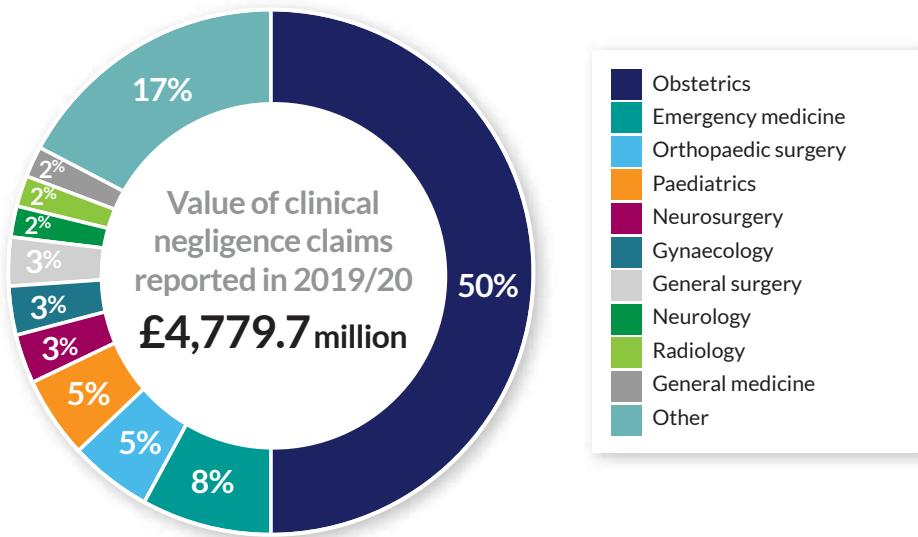


Source: NHS Resolution Annual Report & Accounts 2019/20

¹⁴² See <https://www.resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/>

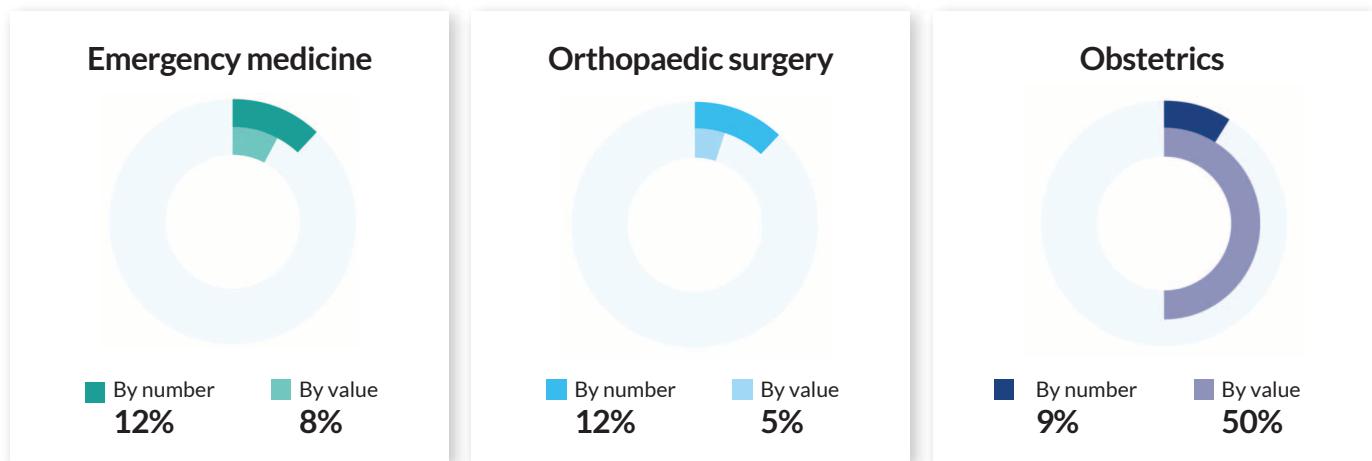
¹⁴³ This excludes 401 claims and incidents related to NHS Resolution's Clinical Negligence Scheme for General Practice.

Figure 42: Value¹⁴⁴ of clinical negligence claims reported in 2019/20 by specialty across all clinical negligence schemes from a total of £4,779.7 million¹⁴⁵



Source: NHS Resolution Annual Report & Accounts 2019/20

Figure 43: The top three specialties for clinical claims received by volume and value, 2019/20



Source: NHS Resolution Annual Report & Accounts 2019/20

The highest value claims arise from brain injury at birth, often as a result of a delay in responding to fetal distress and/or performing a caesarean section. The injured child can have significant care needs for life as a result, meaning that compensation is required for a complex care regime, equipment and accommodation for decades ahead. While frequently these settlements are paid by way of periodical payments (i.e. a lump sum up front and an annual income stream for life), the value of an individual settlement can reach a total of £20-30 million. As a result, on average every baby born in England now carries an indemnity cost of £1,100.

The number of new claims notified to NHS Resolution against maternity between 2013/14 to 2019/20 has declined from 1172 to 911 claims. During this period, however, the number of new claims for brain injury at birth has remained relatively steady and the value of such claims has risen significantly, reaching £1.8 billion in the 2019/20 financial year. **Figure 44** is derived from NHS Resolution's Annual Report and Accounts for 2019/20.

¹⁴⁴ This is the total value of the claim including damages, claimant and NHS legal costs and includes both paid and outstanding costs. Valuations are liable to change for any individual claim before settlement.

¹⁴⁵ This excludes 401 claims and incidents related to NHS Resolution's Clinical Negligence Scheme for General Practice.

Figure 44: A comparison of the number and total value¹⁴⁶ of claims for NHS maternity cerebral palsy/brain damage claims over time across all clinical negligence schemes



Source: Derived from NHS Resolution Annual Report & Accounts 2019/20

NHS Resolution's CNST is funded by contributions from its members (NHS trusts and independent sector providers of NHS care). The scheme is funded on a pay as you go basis, which means that NHS Resolution only collects what it expects to pay out in compensation and associated costs (such as legal fees) in any one given year. Given that costs are deferred into the future through periodical payments and that there is a time lag between when an incident occurs and the claim is paid, the cost collected annually from members does not fully reflect the true cost of harm incurred within that year. For example, in 2019/20 CNST collected £2.4 billion from the NHS to fund the cost of claims (for all specialties); however, the cost of harm incurred in that year was estimated at £8.3 billion.

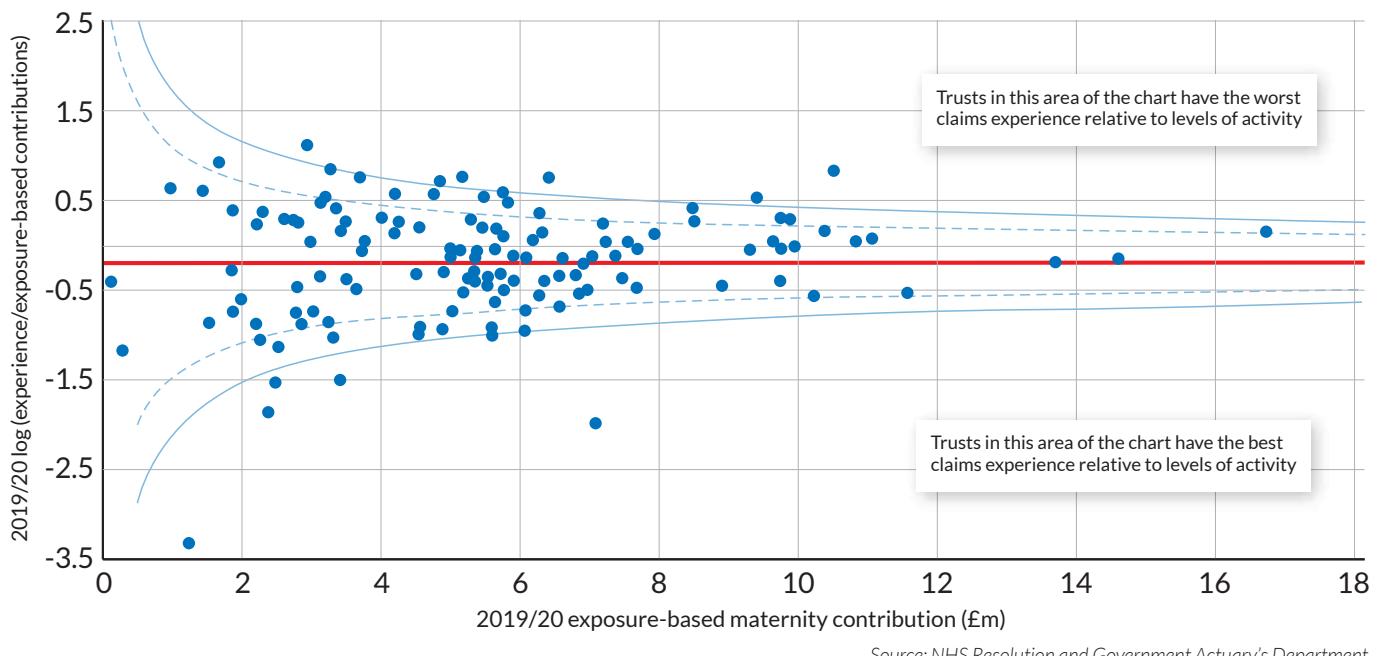
The distribution across providers

The distribution of the cost of maternity claims between providers is determined by a blend of claims experience and the activity undertaken (exposure). NHS Resolution, informed by its actuarial advisors, then applies further layers to the methodology, such as a cap on the overall level that the price can increase by, to avoid price shocks for providers. For maternity, there is also an adjustment to allow for higher staffing levels per birth reducing contributions.

The chart below (**Figure 45**) shows all the trusts that provide maternity services, mapped according to experience and exposure-based contributions for the 2019/20 financial year. The contributions are paid by trusts for the part of the indemnity scheme which covers maternity services. This has been displayed as a funnel plot to allow for the higher volatility experienced in lower volume units. There is significant variation between trusts. A vertical axis value of the experience/exposure-based contributions close to 0 indicates that the trust's claims experience is in line with expectations given the level of activity (in this case the number of births) for the trust. A positive value suggests that the trust has had a worse claims experience than expected given its level of activity, while a negative value suggests that the trust has had a better claims experience than expected given its level of activity.

¹⁴⁶ This is the total value of the claim including damages, claimant and NHS legal costs and includes both paid and outstanding costs. Value of claim is as of last year end (31/3/2020) for all claims, irrespective of the notification year.

Figure 45: Comparison of experience and exposure-based maternity contributions for CNST 2019/20¹⁴⁷



Source: NHS Resolution and Government Actuary's Department

Since the metric uses paid and outstanding claims experience, it reflects historical claims rather than claims currently being incurred. This has the advantage of using more certain data relating to actual known or settled claims, but with the disadvantage that there will be a significant time lag between an incident happening that gives rise to a claim and that claim impacting the levels of the benchmark. This may mean that the trust may have changed significantly in the time since the claims experience underlying the relativity occurred. NHS Resolution is seeking to address this through the Early Notification scheme (EN).

Current initiatives on maternity claims

NHS Resolution has taken a three-pronged approach to its work with the NHS and wider system partners, such as the royal colleges on maternity, namely:

- **research** – in-house clinical staff conducting a deep dive into the causes of maternity incidents and the adequacy of the investigations that follow;
- **early notification** – moving upstream to capture incidents, share learning in real time and to support the hospital in its response as well as undertaking an early liability investigation to address compensation needs; and
- **incentives** – using CNST pricing to reward trusts who deliver against safety actions which have cross-system support.

Research on maternity claims

A thematic analysis of five years of cerebral palsy claims¹⁴⁸ identified clinical and non-clinical themes that resulted in a claim for compensation between 2012 and 2016. Key findings published in 2017 included evidence of poor quality serious incident investigations, an over-representation of breech births, errors with fetal heart monitoring and shortcomings in the adequacy of staff training and obtaining informed consent.

¹⁴⁷ Funnel plot dashed light blue lines represent +/- 2 standard deviations from the mean. The solid lines represent +/- 3 standard deviations from the mean.

¹⁴⁸ Five years of cerebral palsy claims <https://www.resolution.nhs.uk/resources/five-years-of-cerebral-palsy-claims/>

The report identified seven recommendations for improvement to reduce the incidence of avoidable cerebral palsy, summarised below:

1. seeking insight from women and their families as part of serious incident investigations;
2. for the Healthcare Safety Investigation Branch (HSIB) to determine what ‘good looks like’ when developing investigations;
3. independent peer review for all cases of severe brain injury, intrapartum stillbirth and early neonatal death;
4. improved emotional support for staff involved in an adverse event;
5. trust boards ensuring staff undergo annual locally led multi-professional training for breech birth;
6. a focus on cardiotocograph (CTG) interpretation and training; and
7. trusts to monitor the effectiveness of training through closer scrutiny of clinical outcomes/indicators, and publish results.

Other publications providing learning from maternity claims are available on NHS Resolution’s website,¹⁴⁹ including:

- Early Notification Scheme Progress Report (2019);
- Understanding the risk of maternal and neonatal hyponatraemia;
- Fetal surveillance;
- Neonatal jaundice – Did you know? leaflet;
- Maternity pressure ulcers – Did you know? leaflet;
- Analysis of ten years of maternity claims (2012); and
- Being fair guide.¹⁵⁰

In addition, NHS Resolution runs a programme of learning events based on clinical themes arising in claims.¹⁵¹

Early notification

NHS Resolution seeks to get closer to the point of incident of the most serious maternity incidents and, with its Early Notification (EN) scheme,¹⁵² to accelerate the investigation of entitlement to compensation. Where such entitlement is established, NHS Resolution aims to reduce the burden on families by offering support, information and, if possible, financial assistance to access care, respite and, where needed, psychological support. Learning is also shared with the maternity unit reporting the matter and nationally, in relation to common themes.

Under the EN scheme, trusts are required to report incidents that meet the Each Baby Counts criteria.¹⁵³ In its first year of operation, April 2017 – March 2018, 746 qualifying cases were reported to the scheme. An analysis of a sample of 96 of these cases identified five broad clinical themes, and six supporting recommendations and actions for the wider health system (see **Table 6**).

In response to the COVID-19 pandemic, requirements for reporting cases to EN have been changed to reduce the reporting burden on trusts. Trusts are required to report all qualifying cases from April 2020 directly to HSIB.

¹⁴⁹ See https://www.resolution.nhs.uk/resources/?fwp_resources_themes=maternity

¹⁵⁰ See <https://www.resolution.nhs.uk/resources/being-fair/>

¹⁵¹ See <https://www.resolution.nhs.uk/events/>

¹⁵² Early Notification scheme: <https://www.resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/>

¹⁵³ Each Baby Counts criteria include actively cooled, Hypoxic Ischaemic Encephalopathy (Grade 3), comatose and seizures and decreased central tone.

Table 6: Summary of clinical themes and recommendations from NHS Resolution's Early Notification (EN) scheme progress report¹⁵⁴

Key findings	Recommendations
<ul style="list-style-type: none"> Key themes in investigations included limited support to staff, insufficient family involvement and confusion over duty of candour. 	<ol style="list-style-type: none"> All families whose baby meets the EN criteria and requires treatment and separation from them for a potentially severe brain injury should be offered a full and open conversation about their care. This should include an apology in accordance with the statutory duty of candour, a description of the intended investigation process and options for their involvement in investigations. An independent package of support should be offered to all NHS staff to manage the distress that can be associated with providing acute health services and in particular to those involved in incidents. Support should address mental health, wellbeing and post-incident care with access to referral for psychological assessment and intervention where required. This should be confidential and independent of appraisal or the revalidation processes.
<ul style="list-style-type: none"> Issues with fetal monitoring were a leading contributory factor in 70% of cases. In 63% of all cases investigated, at least two or more factors were identified; a delay in acting on a pathological CTG was the most common factor. 	<ol style="list-style-type: none"> There is an urgent need for an evidence-based standardised approach to fetal monitoring in England. Effective improvement strategies require an in-depth understanding of the social mechanisms underpinning the process, not just the technical issues. Research in this area should be prioritised urgently.
<ul style="list-style-type: none"> Impacted fetal head and/or difficult delivery of the head at caesarean section was a contributory factor in 9% of cases in this cohort. 	<ol style="list-style-type: none"> Increase awareness of impacted fetal head and difficult delivery of the fetal head at caesarean section, including the techniques required for care. Research to understand the prevalence, causes and management of impacted fetal head is a priority, along with effective training in the management techniques.
<ul style="list-style-type: none"> Concurrent maternal medical emergencies in labour, including significant maternal hyponatraemia, occurred in 6% of cases in this cohort. These maternal medical emergencies were common causes of neonatal seizures and encephalopathy. 	<ol style="list-style-type: none"> Work with existing national programmes to improve the detection of maternal deterioration in labour, including monitoring as well as the implementation of evidence-based guidance in all birth settings. Research to understand the prevalence and cause of significant hyponatraemia in labouring mothers in England should also be prioritised.
<ul style="list-style-type: none"> Failings in immediate neonatal care and resuscitation were an important but under-recognised factor affecting 32% of the cases in this cohort. 	<ul style="list-style-type: none"> Increase awareness of the importance of high-quality resuscitation and immediate neonatal care on outcomes for newborn babies. This requires collaboration between the whole multidisciplinary team.

¹⁵⁴ See NHS Resolution (2019) *The Early Notification scheme progress report: collaboration and improved experience for families* <https://www.resolution.nhs.uk/wp-content/uploads/2019/09/NHS-Resolution-Early-Notification-report.pdf>

Incentives

The Maternity Incentive Scheme (MIS), run by NHS Resolution, incentivises the delivery of safer maternity care through the achievement of ten safety actions agreed by the national maternity champions and a collaborative advisory group which brings together other arm's-length bodies, royal colleges and other national stakeholders.

The scheme was introduced in 2017 and uses the pricing lever of the CNST to reward trusts that deliver against the ten safety actions.¹⁵⁵

While it may be challenging to isolate the quantitative impact of the MIS from other maternity initiatives, feedback from participating trusts indicates that it has given greater prominence at board level to the actions required to increase maternity safety. Providers have highlighted the following benefits in particular:

- improvement in safety culture;
- improvement in trust board engagement in maternity issues;
- additional funding to recruit to key clinical posts in maternity services; and
- greater influence for multi-disciplinary working, e.g. across anaesthetic and neonatal services.¹⁵⁶

The incentive fund is created by collecting 10% on top of the maternity component of the CNST contribution. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the 10% element of their contribution to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Trusts that do not meet all ten safety actions will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against any actions they have not achieved

Year three of the scheme began on 20 December 2019, but the reporting requirements were paused in March 2020 due to COVID-19. Trusts were encouraged to continue to apply the principles of the ten safety actions, in order to continue work to improve quality and safety in maternity services.

The scheme was relaunched on 1 October 2020 and the MIS safety action leads have integrated learning and key messages from the response to COVID-19 into several of the safety actions. In addition, safety action 10 has been updated to introduce an action in relation to the statutory duty of candour. Trusts will be required to confirm that they have had open and honest conversations with families when incidents occur, and that they have informed them about the role of HSIB and the Early Notification scheme.

The conditions of the scheme in year three have been strengthened to ensure all elements of the actions are confirmed when the declaration is completed (see Appendix A, on page 112). Trusts are required to self-certify their performance against the maternity safety actions by getting Board sign-off. NHS Resolution publishes the Maternity Incentive Scheme verification process and continues to investigate any concerns of potential mis-certification for the Maternity Incentive Scheme.

¹⁵⁵ Maternity Incentive Scheme:
<https://www.resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/>

¹⁵⁶ Maternity Incentive scheme, an interim evaluation <https://www.resolution.nhs.uk/wp-content/uploads/2020/05/Maternity-Incentive-Scheme.pdf>

Maternity incentive scheme year three safety actions

1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
2. Are you submitting data to the Maternity Services Data Set to the required standard?
3. Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into Neonatal units Programme?
4. Can you demonstrate an effective system of clinical workforce planning to the required standard?
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?
6. Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?
7. Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
8. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?
10. Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme?

For further information see the full conditions of the maternity incentive scheme.¹⁵⁷

A focus on consent

Between 2012 and 2017, 728 claims across the NHS were under review due to the complexities around consent; 94 applied to obstetrics. In 2015, the Montgomery ruling (see below) emphasised the importance of clinicians discussing with patients the various treatment options available, including doing nothing, as part of shared decision making.¹⁵⁸ Shared decision making is critical to developing a shared understanding of issues such as risk, relative to the context of the patient and their own views and values.

Montgomery ruling

In 1999, Nadine Montgomery gave birth vaginally to Sam at Bellshill Maternity Hospital, Lanarkshire. The birth was complicated by shoulder dystocia.¹⁵⁹ Medical staff performed the appropriate manoeuvres to release Sam, but the 12-minute delay resulted in hypoxic insult with consequent cerebral palsy.

Mrs Montgomery has type 1 diabetes and is small in stature. Therefore, there was a higher risk of shoulder dystocia if she attempted vaginal birth. During pre-natal appointments, she expressed concern to her consultant about whether she would be able to give birth vaginally. Despite Mrs Montgomery raising these concerns, the doctor did not warn Mrs Montgomery of the risk of serious injury from shoulder dystocia or offer the possibility of an elective caesarean section.

Mrs Montgomery subsequently brought a claim against Lanarkshire Health Board, stating that she should have been advised of the 9-10% risk of shoulder dystocia associated with vaginal delivery, even though the risk of a grave outcome from such an incident was small. She also claimed she should have been offered the option of giving birth by caesarean section, and that this would have prevented the child's injury.

In 2015, the Supreme Court ruled in her favour¹⁶⁰ and awarded her £5.25 million compensation. The ruling also changed practice in relation to consent. Doctors must now provide patients with information about all material risks that a reasonable person in the patient's position would be likely to attach significance to. The Montgomery ruling has clarified consent law and accelerated the adoption of shared decision-making models across all specialties.

Learning materials based on this case are available on the NHS Resolution website¹⁶¹ – they include a video with Nadine Montgomery, some further explanation on the legal context and a leaflet on the benefits of supported decision making.

¹⁵⁷ See <https://resolution.nhs.uk/wp-content/uploads/2021/03/Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf>

¹⁵⁸ See <https://www.resolution.nhs.uk/wp-content/uploads/2018/09/Did-you-know-The-benefits-of-supported-decision-making-consent-WEB.pdf>

¹⁵⁹ This is when the baby's head has been born, but one of the shoulders becomes stuck behind the mother's pubic bone, delaying the birth of the baby's body. See <https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-shoulder-dystocia.pdf>

¹⁶⁰ See <https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf>

¹⁶¹ See <https://www.resolution.nhs.uk/resources/consent-legal-context/>, <https://resolution.nhs.uk/resources/nadines-story-consent/> and <https://www.resolution.nhs.uk/resources/the-benefits-of-supported-decision-making-consent/>

NHS England and NHS Improvement initiatives

Better Births

Better Births, the report by the National Maternity Review, was published in February 2016¹⁶² and set out a clear vision for maternity services across England ‘to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred on their individual needs and circumstances.’

It also called ‘for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.’

The framework identified seven key priorities:

1. personalised care;
2. continuity of carer;
3. better postnatal and perinatal mental health care;
4. a fair payment system for providers;
5. safer care;
6. multi-professional working; and
7. working across boundaries.

Maternity Transformation Programme

The Maternity Transformation Programme was established to implement the recommendations from the Better Births report by bringing together a wide range of organisations.¹⁶³ Although not directly targeted at litigation, by improving patient satisfaction and safety, this work should have a positive impact on litigation levels.

The Maternity Transformation Programme co-ordinates a range of initiatives and activities which collectively seek to achieve the vision set out in Better Births and the Secretary of State’s maternity safety strategy. The information and intelligence that comes from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK) and Each Baby Counts (EBC) are essential for ensuring that efforts are focused in the right places.

Saving Babies’ Lives Care Bundle

The Saving Babies’ Lives Care Bundle was introduced in 2016¹⁶⁴ by NHS England in response to the Secretary of State for Health announcing the government’s ambition to half the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030, with a 20% reduction by 2020. It was designed to reduce stillbirth and early neonatal death. It brings together elements of care that are recognised as evidence-based and/or best practice:

1. reducing smoking in pregnancy;
2. risk assessment and surveillance for fetal growth restriction;
3. raising awareness of reduced fetal movement;
4. effective fetal monitoring during labour; and
5. reducing preterm birth (introduced in version two, 2019)

Version two of the Saving Babies’ Lives Care Bundle was published in 2019¹⁶⁵ with an introduction of a fifth element: Reducing preterm birth. The second version of the care bundle emphasises continuous improvement with a reduced number of process and outcome measures. The implementation of each element will require a commitment to quality improvement with a focus on how processes and pathways can be developed and where improvements can be made.

Implementation of the care bundle is incentivised as part of the maternity incentive scheme safety action six.

¹⁶² <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

¹⁶³ <https://www.england.nhs.uk/mat-transformation/>

¹⁶⁴ NHS England (2016). *Saving Babies’ Lives: a care bundle for reducing stillbirth*. Available from: <https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf>

¹⁶⁵ NHS England (2019). *Saving Babies’ Lives Version Two: A care bundle for reducing perinatal mortality*. Available from: <https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/>

Maternity and Neonatal Safety Improvement Programme

The Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) was previously known as the Maternal and Neonatal Health Safety Collaborative, but was renamed following the launch of the NHS Patient Safety Strategy¹⁶⁶ in July 2019. MatNeoSIP is led by the National Patient Safety team and covers all maternity and neonatal services across England. It continues to be supported by 15 regionally-based Patient Safety Collaboratives.¹⁶⁷

The programme aims to improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and providing a high-quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England. This will support the ambition to reduce the national rate of preterm births from 8% to 6% and reduce the rate of stillbirths, maternal deaths, neonatal death and brain injuries occurring during or soon after birth by 50% by 2025 – a national target set out in Better Births. The programme focuses on three areas of improvement:

1. improving the proportion of smoking-free pregnancies;
2. optimising and stabilising preterm infants;
3. improving the early recognition and management of deterioration of mothers or babies.

Royal College of Obstetricians and Gynaecologists

Each Baby Counts

Each Baby Counts is RCOG's national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. The Each Baby Counts project brings together the results of local investigations into stillbirths, neonatal deaths and brain injuries to understand the bigger picture and share the lessons learned.

Healthcare Safety Investigation Branch

The Healthcare Safety Investigation Branch (HSIB) is a Department of Health and Social Care funded organisation, hosted by NHS England and NHS Improvement. Its aim is to improve patient safety through effective and independent investigations that don't apportion blame or liability.

Maternity investigations

The HSIB maternity investigation programme is part of a national action plan to make maternity care safer. HSIB is undertaking approximately 1,000 independent maternity safety investigations to identify common themes and influence systemic change.

As a national and independent investigative body, this programme has the following objectives:

- use a standardised approach to maternity investigations without attributing blame or liability;
- work with families to understand their perspective;
- improve maternity safety investigations by working with NHS staff and support local trust teams; and
- identify themes from the 1,000 reports and influence change across the national maternity healthcare system.

¹⁶⁶ See <https://www.improvement.nhs.uk/resources/patient-safety-strategy/>

¹⁶⁷ See <https://www.improvement.nhs.uk/resources/patient-safety-improvement-programmes/#h2-patient-safety-collaboratives>

Reducing litigation in gynaecology

Although the costs brought against gynaecology are very modest compared to maternity, gynaecology is in the top five specialties for number of claims.

Table 7: Volume and cost of medical negligence claims against gynaecology notified to NHS Resolution 2013/14 to 2017/18

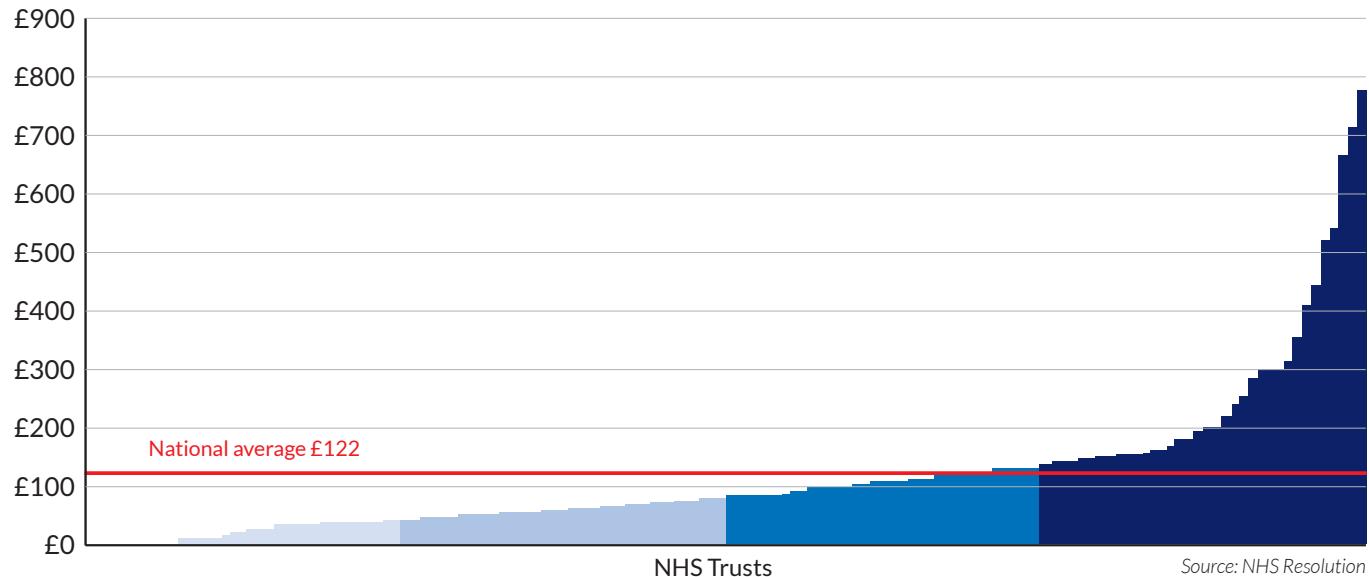
Year	No. of claims	% change in Claims No.	Total costs (£m) (including estimated and reserve values)	% change in Total costs
2013/14	705	-	66.7 million	-
2014/15	679	-4%	66.2 million	-1%
2015/16	622	-8%	77.0 million	16%
2016/17	590	-5%	77.0 million	0%
2017/18	557	-6%	88.3 million	15%
Total	3153	-	375.2 million	-

Data source: NHS Resolution 2013/14 to 2017/18

Though there has been a slight drop in volume of claims against gynaecology, the total value of these claims has increased over the five-year period.

Alongside the national picture, we have examined litigation levels at different providers. As the graph below shows, there is significant variation in the cost of claims against different trusts. For gynaecology, there were several providers with an estimated cost of £0 per gynaecology admission while the most expensive was £773 per gynaecology admission.

Figure 46: Variation in estimated litigation costs for gynaecology per admission in England between trusts, 2013-2018 (Denominator includes all gynaecology admissions)



Source: NHS Resolution

In this same period, 3153 claims were recorded for gynaecology. The most common causes for claims were:

Table 8: Claim categories for gynaecology, 2013-2018

Category of Claim	Number of Claims	% Total Claims
Judgement and/or timing	1410	45%
Unsatisfactory outcome to surgery	746	24%
Consent	415	13%
Retained foreign object post-operation	101	3%
Failed sterilisation	80	3%

Source: NHS Resolution 2013/14 to 2017/18

The most common cause for a claim relates to the judgement or timing of care decisions made. In gynaecology, lack of fully informed consent has played a role in many claims which were attributed to 'unsatisfactory outcome of surgery'. A substantial proportion of these claims may have been avoidable through a robust consenting process, in which an informed patient had been involved in shared decision-making. Many trusts are beginning to adopt standardised consent forms for common procedures to mitigate against this area of litigation.

However, it is important to note that for this standardised process to truly mitigate litigation, the provider must be able to demonstrate that the options, benefits, risks and any additional procedures noted in the standardised consent form have been explained in person to each patient, taking into account the implications of the Montgomery ruling. The use of both consent ahead of the day of surgery, to allow a cooling off period for planned procedures, and the provision of appropriate information leaflets are also important.

It is always concerning to see instances of foreign bodies and instruments having been retained following surgery. In 2012, the Never Events policy framework recognised both 'foreign body left in situ' and 'retained instrument post-operation' in one never event category called 'retained foreign object post-operation.' This redefined never event includes retention of any items that should be subject to a formal counting /checking process at the commencement of the procedure and a counting /checking process before the procedure is completed (such as swabs, needles and instruments). These events along with the other surgical never events of 'wrong site surgery' represent system failure and are patient safety issues that can be eradicated by more diligent organisation and closer adherence to tools including the WHO Surgical Safety Checklist, national safety standards for invasive procedures (NATSSIPS) and LOCSSIPS (local standards).

It was clear during GIRFT visits that few clinicians had knowledge of the claims or settlements that their unit had been involved in. Ensuring clinical staff have the opportunity to learn from claims in conjunction with learning from complaints, serious incidents and inquests will lead not only to improved patient care, but also to reduced costs both in terms of litigation itself and the management of the resulting complications of potential incidents. Learning from claims should have the same parity as education that is generated from significant events.

Recommendations

Recommendation	Actions	Owners	Timescale
<p>16. Continue to support trusts in achieving the Maternity Incentive Scheme's (MIS) safety actions.</p>	<p>a All trusts to familiarise themselves with the new MIS conditions and location of supporting materials e.g. MIS webinars available on NHS Resolution's website.</p> <p>b Trusts to reinforce duty of candour and provide support for staff and families during and post investigation of incidents.</p>	Trusts	For immediate action
<p>17. Reduce litigation costs by application of the GIRFT Programme's five-point plan.</p>	<p>a Clinicians and trust management to assess their benchmarked position compared to the national average when reviewing the estimated litigation cost per activity. Trusts will have received an updated version of this for obstetrics and gynaecology in the GIRFT and NHS Resolution 'Litigation Data Pack'.</p> <p>b Clinicians and trust management to discuss with the legal department or claims handler the claims submitted to NHS Resolution included in the data set to confirm correct coding to that department. Inform NHS Resolution of any claims which are not coded correctly to the appropriate specialty via CNST.Helpline@resolution.nhs.uk</p> <p>c Once claims have been verified, clinicians and trust management to further review claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. If the legal department or claims handler needs additional assistance with this, each trust's NHS Resolution panel firm should be able to provide support.</p> <p>d Claims should be triangulated with learning themes from complaints, inquests and serious incidents (SI) and where a claim has not already been reviewed as an SI we would recommend that this is carried out to ensure no opportunity for learning is missed. The findings from this learning should be shared at morbidity and mortality meetings or other departmental/directorate meetings for all frontline clinical staff in a structured format.</p> <p>e Where trusts are outside the top quartile of trusts for litigation costs per activity GIRFT will be asking national clinical leads and regional team directors to follow up and support trusts in the steps taken to learn from claims. They will also be able to share with trusts examples of good practice where it would be of benefit.</p>	Trusts	<p>For immediate action</p> <p>Upon completion of 17a</p> <p>Upon completion of 17b</p> <p>Upon completion of 17c</p> <p>For continual action throughout GIRFT programme</p>

Notional financial impact

The recommendations outlined in this report have identified a range of opportunities to make NHS maternity and gynaecology services more flexible and patient-focused. They seek to reduce unwarranted variation in practice and pathways, while ensuring services are easy to access, including via digital channels. They further encourage providers to opt for less invasive gynaecology surgery, with faster recovery times.

Because these recommendations also serve to reduce demands on hospital resources, they could provide a tangible financial benefit. Below, we calculate the notional financial opportunity from specific changes to practice as being between £75m and £125m a year. This opportunity is in addition to the potential cost savings in procurement.

These figures provide a financial value for a wide range of efficiency opportunities, which may not be cash-releasing.

The figures are based on a selection of metrics (shown in **Table 9**) and provide an indication of what may be possible. The metrics do not represent a comprehensive set of all opportunities discussed in the report. NB: The gross notional financial opportunities put an estimated value on the resource associated with variation based on all providers achieving at least the average or best quartile performance.

In addition to the specific areas outlined in the table, the report has identified a total spend of £375m on litigation in relation to gynaecology over a five-year period; the annual costs of maternity claims are measured in billions of pounds. Implementation of the GIRFT programme's five-point plan for litigation should help reduce these costs, and more importantly still improve safety for mothers, babies and women.

Table 9: Notional financial opportunities

Improvement	Standard			Target		
	Target	Activity opportunity*	Gross notional financial opportunity**	Target	Activity opportunity*	Gross notional financial opportunity**
Reduce the rate of OASI (obstetric anal sphincter injury) - 3rd/4th degree perineal tears <i>(Recommendation 5)</i> Opportunity: reduce OASI (tear) rate. <i>Note: opportunity does not include any potential reduction in litigation costs.</i> <i>Financial opportunity estimated based on non-elective NZ3/4 - delivery with surgery less delivery without surgery reference cost (17/18) uplifted to 20/21 prices.</i>	National average <i>Base data: HES April 19 - March 20.</i>	3.21% OASI rate	1,100 OASI procedures	£2.0m	Best quartile 2.66% OASI rate	2,400 OASI procedures £4.4m

Table 9: Notional financial opportunities

Improvement	Standard			Target		
	Target	Activity opportunity*	Gross notional financial opportunity**	Target	Activity opportunity*	Gross notional financial opportunity**
Reduce unwarranted variation in outpatient pathways - moving to a 1:1 new to follow-up outpatient ratio <i>(Recommendation 6a)</i> Opportunity: reduce outpatient follow-up attendances <i>Base data: HES April 19 - March 20</i> <i>Note: calculation excludes cancer or assisted reproduction related outpatients.</i> <i>Financial impact estimated based on gynaecology (502) follow-up outpatient reference cost (17/18) uplifted to 20/21 prices.</i>	National average 1:1.3 outpatient new to follow-up ratio	332,200 follow-up outpatient attendances	£44.2m	1:1 outpatient new to follow-up ratio	548,400 follow-up outpatient attendances	£72.9m
Reduce unwarranted variation in outpatient pathways - reduce re-referral rates <i>(Recommendation 6c, d, e)</i> Opportunity: reduce re-referred new outpatient attendances. <i>Base data: HES April 19 - March 20.</i> <i>Financial impact estimated based on gynaecology (502) new outpatient reference cost (17/18) uplifted to 20/21 prices.</i>	National average 35% re-referral rate	43,200 first outpatient attendances	£7.1m	Best quartile 28% re-referral rate	113,000 first outpatient attendances	£18.5m
Increase use of day surgery for all minor gynaecology procedures <i>(Recommendation 9)</i> Opportunity: shift from inpatient to day case setting. <i>Base data: HES April 18 - March 19.</i> <i>Financial impact estimated based on average gynaecology excess bed day reference cost (17/18) uplifted to 20/21 prices.</i>	75% shift to BADS targets 75% shift to BADS day case targets	28,400 bed days	£16.3m	100% shift to BADS targets 100% shift to BADS day case targets	37,800 bed days	£21.6m

Table 9: Notional financial opportunities

Improvement	Standard			Target		
	Target	Activity opportunity*	Gross notional financial opportunity**	Target	Activity opportunity*	Gross notional financial opportunity**
Increase proportion of endometrial ablation procedures conducted in an outpatient setting (Recommendation 9) Opportunity: reduce endometrial ablation elective admissions <i>Base data: HES April 19 - March 20.</i> <i>Note: BADS target recommends 90% endometrial ablations are carried out in an outpatient setting.</i> <i>Financial impact estimated based on HRG MA12 excess bed day reference costs (17/18) uplifted to 20/21 prices.</i>	Clinical view 50% outpatient procedures	2,900 elective admissions delivered as outpatients	£5.3m	Clinical view 75% outpatient procedures	4,900 elective admissions delivered as outpatients	£6.6m
Optimise pathways to reduce length of stay - move to laparoscopic surgery for benign hysterectomies where clinically appropriate (from open procedures) (Recommendation 10) Opportunity: increase laparoscopic hysterectomies (which have an average length of stay that is 1.92 days lower than open procedures) <i>Base data: HES Apr 18 to March 20.</i> <i>Financial impact estimated based on gynaecology excess bed day cost - reference costs (17/18) uplifted to 20/21 prices.</i>	National average Reduction to 41% open procedures	1,700 bed days	£0.5m	Best quartile Reduction to 30% open procedures	3,300 bed days	£1.0m
Total			£75.4m			£125m

Notes to table:

* The total activity opportunity is shown, generally based on one year of activity data. Unless otherwise stated, the standard calculation looks to move all providers to national average with the target moving providers to best quartile.

** Costing financial opportunity: unless otherwise stated, cost estimates are based on national average of 2018/19 reference costs, uplifted to 2020/21 pay and prices using tariff inflation. Gross savings are identified i.e. any costs required to achieve the recommendation are not.

About the GIRFT programme

Getting It Right First Time (GIRFT) is a national programme designed to improve treatment and care by reviewing health services. It undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience, without the need for radical change or additional investment. While the gains for each patient or procedure may appear marginal, they can, when multiplied across an entire trust – and even more so across the NHS as a whole – deliver substantial cumulative benefits.

The programme was first conceived and developed by Professor Tim Briggs to review elective orthopaedic surgery to address a range of observed and undesirable variations in orthopaedics. In the 12 months after the pilot programme, it delivered an estimated £30m-£50m savings in orthopaedic care – predominantly through changes that reduced average length of stay and improved procurement.

The same model has been applied in more than 40 different areas of clinical practice. It consists of four key strands:

- a broad data gathering and analysis exercise, performed by health data analysts, which generates a detailed picture of current national practice, outcomes and other related factors;
- a series of discussions between clinical specialists and individual hospital trusts, which are based on the data – providing an unprecedented opportunity to examine individual trust behaviour and performance in the relevant area of practice, in the context of the national picture. This then enables the trust to understand where it is performing well and what it could do better – drawing on the input of senior clinicians;
- a national report, that draws on both the data analysis and the discussions with the hospital trusts to identify opportunities for improvement across the relevant services;
- an implementation phase where the GIRFT team supports providers to deliver the improvements recommended.

GIRFT and other improvement initiatives

GIRFT is part of an aligned set of workstreams within NHS England and NHS Improvement. It is the delivery vehicle for one of several recommendations made by Lord Carter in his February 2016 review of operational efficiency in acute trusts across England.

The programme has the backing of the Royal Colleges and professional associations and has a significant and growing presence on the Model Hospital portal, with its data-rich approach providing the evidence for hospitals to benchmark against expected standards of service and efficiency. The programme also works with a number of wider NHS programmes and initiatives which are seeking to improve standards while delivering savings and efficiencies.

Implementation

GIRFT has developed an implementation programme designed to help trusts and their local partners to address the issues raised in trust data packs and the national specialty reports to improve quality. The GIRFT team provides support at a local level through the NHS England regional teams, advising on how to reflect the national recommendations into local practice and supporting efforts to deliver any trust specific recommendations emerging from the GIRFT visits. GIRFT also helps to disseminate best practice across the country, matching up trusts who might benefit from collaborating in selected areas of clinical practice. Through all its efforts, local or national, the GIRFT programme strives to embody the ‘shoulder to shoulder’ ethos that has become GIRFT’s hallmark, supporting clinicians nationwide to deliver continuous quality improvement for the benefit of their patients.

Glossary

Maternity & Gynaecology terms

AMU

Alongside midwifery unit – a maternity unit managed by midwives which is in the same location as an obstetrics department.

Antenatal

Before birth. Antenatal care covers all pregnancy-related care and support offered to pregnant women (and their families).

CASH

Abbreviation for contraception and sexual health – refers to CASH clinics.

Cephalic

When the fetus is positioned with its head pointing down.

Colposuspension

A surgical procedure to treat stress incontinence in women. Involves lifting the neck of the bladder and then stitching it into the lifted position.

Encephalopathy

A disease or injury that damages the brain function.

Endometrial

Of, or relating to, the womb. In this report, mostly used in the context of endometrial ablation, a surgical procedure to help reduce heavy menstrual bleeding. It is conducted via radiofrequency and the procedure typically lasts under ten minutes.

Episiotomy

A surgical incision in the perineum, made to facilitate delivery and reduce the risk of tearing.

FMU

Freestanding midwifery unit – a maternity unit managed by midwives which is in an entirely different location from the obstetrics department.

Hysterectomy

A surgical procedure to remove the womb (uterus). It can be total or partial.

Hysteroscopy

Examination of the inside of the womb, using a small camera.

Multiparous

A medical term to describe a pregnant woman who has previously given birth.

Nulliparous

A medical term to describe a woman who has never previously given birth.

OASI

Obstetric anal sphincter injury. An umbrella term for third- and fourth-degree perineal tears, where the anal sphincter is damaged during vaginal delivery.

Paraurethral

In this report, refers to the injection of urethral bulking agents to relieve stress incontinence. This procedure is also known as periurethral injection.

Parous

A medical term to describe a pregnant woman.

Pelvic organ prolapse

When one or more of the organs in the pelvis slip down from their normal position and bulge into the vagina.

Perinatal

Related to, or around the time of, giving birth.

Perineal

Related to the perineum (the area between the anus and the vulva). In this report, mostly referred to in connection with perineal tears (see OASI).

Postnatal

After the birth.

Primiparous

A medical term to describe a pregnant woman who has not previously given birth.

Stillbirth

The birth of a baby without signs of life at or after 24 weeks of gestation.

TVT

Tension-free vaginal tape. TVT procedures involve the insertion of the tape – made of a polypropylene mesh – around the urethra to prevent urinary leakage. They are currently paused on the NHS, pending the introduction of additional safety measures.

Ventouse

A method of instrumental delivery, using a suction cap attached to the baby's head.

Professional bodies and NHS initiatives

BADS

British Association of Day Surgery

Best Practice Tariff

Tariffs are structured and priced to incentivise and adequately reimburse providers for the cost of high-quality care.

BSGE

British Society for Gynaecological Endoscopy

BSUG

British Society of Urogynaecology

Maternity Incentive Scheme

A scheme to reward trusts that deliver against ten safety actions relating to maternity.

NMPA

The National Maternity and Perinatal Audit is a national audit of NHS maternity services across England, Scotland and Wales. It was commissioned in July 2016 by the Healthcare Quality Improvement Partnership (HQIP). It is led by the RCOG in partnership with the RCM, the Royal College of Paediatrics and Child Health (RCPCH) and the London School of Hygiene and Tropical Medicine (LSHTM).

RCM

The Royal College of Midwives

RCN

The Royal College of Nursing

RCOG

The Royal College of Obstetricians and Gynaecologists

Acknowledgements

This has been quite an experience, in part because it was my colleagues, Rob Sherwin and project manager Lauren van den Bergh, who initiated the project in early 2017, developed the deep-dive metrics and questionnaire and undertook the massive exercise of visiting every trust in England before I came on board. The friendly, supportive and enthusiastic reception from the clinical teams, management, coders, and commissioners was superb and often illuminating.

Rob departed for New Zealand (perhaps restorative!) and I was asked to take up the reins and complete the report. To that end, I have been indebted to Lauren for her support and enormous depth of knowledge and experience. I am also grateful to the GIRFT policy team, initially Maria Dawson and then Kathleen Reinoga, who kept us on point, with Matthew Barker and Will Pank providing encouragement and support in the background.

To the analytics team in its broadest sense, from Jamie Day to Madeleine Connolly, Paul Bell and Adam Fearing; thank you all for your understanding and more often patience with my frustration of coding rules and regulations. I have learned much, so thank you.

Finally, to Paul Roberts, who expertly crafted the detail of the text with an extraordinary level of professional understanding.

David Richmond

My abiding memory of my time carrying out this GIRFT review is feeling lucky to have met so many clinicians trying to make a positive difference to patient outcomes, and of hearing so many innovative ways of achieving that goal.

I am grateful to the maternity and gynaecology teams who welcomed us during the deep dives; for the warmth of their hospitality, despite the trepidation they were probably feeling at having 'outsiders' presenting their data in front of executive leaders. Some units were, and continue to be, under local and national scrutiny – it's worth noting that those units are staffed by good people, trying to do good work.

It is also worth noting that within the same guidelines and policies it is possible to practice with a degree of freedom. There is no 'one size fits all' approach to medicine, but a common vision of the desired outcome is essential.

I would like to thank Lauren van den Bergh, whose enthusiasm, good humour and amazing organisational skills made it possible for us to visit all of the maternity units in England and to collate the examples of 'best practice' that are included in this report. I would also like to thank the data scientists at Dr Foster and GIRFT for their amazing analytical skills and hard work in producing the data for this report and for the GIRFT deep dive visits.

The GIRFT review was uplifting and motivating to me personally. In my work in New Zealand I've tried to share many of the innovative ways of working I observed during our visits and I will be forever grateful for the insights I have gained.

Rob Sherwin

Data and copyright acknowledgements

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- NHS England and NHS Improvement;
- NHS Digital;
- NHS Resolution;
- NHS Spend Comparison Service;
- The National Maternity and Perinatal Audit (NMPA);
- MBRRACE-UK.

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Appendix A: Maternity Incentive Scheme revised conditions

- The Healthcare Safety Investigation Branch (HSIB) is now a member of the MIS collaborative group, and will be able to support with the sense check process of submissions.
- Changes have been made to the trust Board declaration form and now trusts are required to declare compliance against each safety action's sub-requirements.
- Trust chief executives will be required to sign the declaration form in three places and confirm the following:
 - compliance with the ten safety actions;
 - that a discussion with commissioners has occurred; and
 - that the trust is not aware of findings within any national reports which may contradict compliance with the MIS.
- The Care Quality Commission (CQC) will explore compliance with elements of the MIS during inspections of maternity services via its Key Lines of Enquiry. There will be ongoing discussions with the CQC regarding inspection findings, and how this relates to the MIS mis-certifications.
- Regional Chief Midwives will provide oversight and guidance for trusts regarding the MIS. This will be done via trust updates at the Local Maternity System (LMS) meetings. In addition, progress with MIS will be discussed at a regional level via the Joint Strategic Oversight Group or the Quality Surveillance Group, where maternity services and progress with the MIS will be a standing agenda item. If concerns are identified by Regional Chief Midwives, these will be escalated to NHS Resolution for further review and action as required.
- A series of recorded webinars are in development to support trusts in understanding the requirements for the MIS safety actions. Each safety action lead will present key details and requirements of their safety actions. The webinars will be available to trusts on the NHS Resolution website.
- The NHS Resolution team will continue to publish the MIS verification process and continue to investigate any concerns of potential mis-certification for the MIS.

Addendum (November 2024)

At the time of writing this report in 2020/21, the authors highlighted the British Association of Day Surgery (BADS) recommendations for the percentage of common gynaecology procedures that could be conducted in the procedure room or as zero-night stay. One of the report's key recommendations was that providers should work to increase their use of appropriate setting for surgery, to the rates recommended by the BADS, for day case and/or outpatient procedures for hysteroscopy, endometrial ablation, treatment of Bartholin's abscess, vaginal prolapse repairs and cystoscopy. For hysteroscopy, the BADS suggested rates for endometrial biopsy/aspiration and hysteroscopy are 90% in the procedure room and 9% as zero-night stay.

Since publication of this report, we have heard from patient groups that there are women who experience high levels of pain while undergoing these procedures in outpatient and day case settings. In some cases, patients do not have access to the information they need to make an informed decision about their treatment setting and pain control.

GIRFT's role is to provide guidance to NHS trusts to help improve the delivery of services and in doing so we follow the professional standards and recommendations of the professional bodies. As such, we have been working closely with the Royal College of Obstetricians and Gynaecologists (RCOG) and the British Society for Gynaecological Endoscopy (BSGE) and BADS to support hospital trusts in improving women's choice of appropriate settings for gynaecological procedures and, for women who choose this, supporting the shift to more day case and outpatient procedures.

Advances in the processes that support day case and outpatient gynaecology procedures (including pre-operative preparation of patients, enhanced recovery, pre-emptive analgesia, anaesthesia and hysteroscopic surgery) and in the available patient information mean there is scope for more women to avoid unnecessary inpatient stays or to undergo procedures with a shorter time spent under anaesthetic, supporting a faster recovery.

However, GIRFT advocates that where trusts are looking to increase day case and outpatient rates **it is imperative that all women undergoing day case and outpatient procedures are given clear and accurate information to enable them to make informed decisions about their preferred treatment setting and pain control. Ultimately, the decision on care setting for this procedure must be made with the patient, after due consideration of all relevant information.**

In line with this, Recommendation 9 in this report has been amended post-publication (November 2024)*.

We support and are guided by the RCOG Green-top Guideline on Outpatient Hysteroscopy (no 59, published September 2024), which provides clinicians with up to date, evidence-based information regarding outpatient hysteroscopy with particular reference to minimising pain and optimising the experience of the patient, and the RCOG good practice paper Pain Relief and Informed Decision Making for Outpatient Hysteroscopy (February 2023), which outlines to clinicians and systems what a good outpatient hysteroscopy service should look like in order to achieve the optimal clinical and psychological outcomes for women.

*Updated recommendation 9 for this report:

Increase use of appropriate setting for surgery, with a shift to day case and/or outpatient procedures such as hysteroscopy, endometrial ablation, treatment of Bartholin's abscess, vaginal prolapse repairs and cystoscopy.

- Trusts to review metrics against national performance for day surgery and/or outpatient procedures via Model Health System.
- (New action) Trusts to ensure that all patients undergoing day case and outpatient procedures are given clear and accurate information to enable them to make informed decisions about their preferred treatment setting and pain control.
- Trusts to ensure sufficient multidisciplinary training is provided to all staff involved in the delivery of day surgery and/or outpatient procedures.
- GIRFT to discuss with NHS England the feasibility of using alternative ways to continue to incentivise change through methods of payment once block contracts are reviewed.
- Trusts/ICBs to review availability of appropriate recovery and analgesia facilities to enable and support outpatient and day case surgery.

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