



briefing

May 2010

FTN Benchmarking

Driving performance improvement in **maternity services**

Key points

- 13 trusts took part in FTN's second maternity benchmarking project between September and December 2008.
- Across all healthcare resource group (HRG) codes studied, the average pay cost of medical and midwife staff corresponded to 57 per cent of direct costs (excluding overheads), and Clinical Negligence Scheme for Trusts (CNST) payments accounted for 25 per cent of direct costs on average.
- Community midwife activity is a good target for productivity improvements as 40 per cent of working time was spent on administrative tasks and travel.
- Caesarean section rates for participant trusts were on average higher than the 23 per cent national median.

A group of 13 Foundation Trust Network (FTN) member trusts took part in a benchmarking project, delivered with support from McKinsey & Company, to identify improvement opportunities in their maternity services by analysing costs and comparing performance across a number of measures.

Background

FTN Benchmarking brings together clinicians, services managers and data leads to define and agree a template of metrics that can be collected consistently across trusts to compare performance.

Projects compare cost and productivity, set against quality measures, to help participants identify the underlying reasons for performance differences and the improvement opportunities for each trust.

The benchmarking process

Each participant trust established a project team with a clinical, data and service manager lead, and a board-level sponsor to oversee the project.

Following an initial scoping phase, trusts attended a workshop where the template for collecting data was discussed in detail. During the data collection period and subsequent data validation stage support was provided by the FTN Benchmarking team, with regular contact to ensure trusts were collecting comparable data.

Participants collected activity, costs, staffing and quality metrics from 1 April 2007 to 31 March 2008. Data was collected at departmental and healthcare resource group (HRG) level. Detailed data was collected for Normal delivery without complications (N07), Assisted delivery without complications (N09) and Caesarean section without complications (N11) HRG codes. Additionally, activity diaries

for community midwives were collected for a period of two weeks.

A findings workshop provided an opportunity to discuss data findings as a group, share learning resulting from different practices and identify improvement opportunities. Trusts presented on aspects of their services that the benchmarking study identified as high performing. Individual trusts developed their own six-month action plans as a delegate group to drive improvements internally.

The final analyses of the benchmarking data focused on quality, staffing and productivity and cost drivers, as detailed below.

Benchmarking results: quality

Trusts reporting the highest labour ward bed turnover (which ranged between 0.45 and 1.17 births per labour ward bed per day) also reported the lowest satisfaction rankings of the trusts

in the benchmarking group from mothers in the Healthcare Commission Maternity Review 2007. Trusts reporting high epidural rates reported the highest satisfaction rates in the group. Participating trusts reported to the Healthcare Commission that at least 83 per cent of mothers were satisfied with their care during labour.

The average number of antenatal appointments per mother varied from 6.6 to 12.7. Most trusts provided more appointments than the NICE recommendation, which states that new mothers should attend a minimum of ten appointments and mothers with a previous birth should attend a minimum of seven appointments. Attendance at antenatal appointments was lowest amongst ethnic minority groups (see Figure 1).

On average, home births accounted for 5.9 per cent of the total normal deliveries. However,

there was great variation between trusts, the proportion ranging from 2 per cent to 11 per cent.

Most participating trusts had higher than the national median rate for caesarean sections of 23 per cent as reported in the Healthcare Commission Maternity Review 2007.

The average rate (28 per cent) of vaginal births after caesarean (VBAC) for participants was lower than the national average of 32 per cent published in the Healthcare Commission Maternity Review 2007. However, both levels of VBAC are far lower than the 75 per cent target recommended by the Royal College of Obstetricians and Gynaecologists (RCOG).

Most trusts were providing the same amount of obstetric consultant presence, irrespective of the number of deliveries. This is not in line with standards in the Safer Childbirth Report, which state that units with more than 4,000 births a year should have 60 hours of consultant presence by the end of 2008. However, trusts made it clear that they are working towards meeting the presence requirements.

Benchmarking results: staffing and productivity

Administrative tasks and travel account for 40 per cent of community midwives' working time on average.

There was a wide variation between trusts in the number of annual deliveries per consultant WTE, ranging from 1,636 to 534. This productivity measure shows less

Figure 1. Average number of antenatal appointments compared to NICE guidance

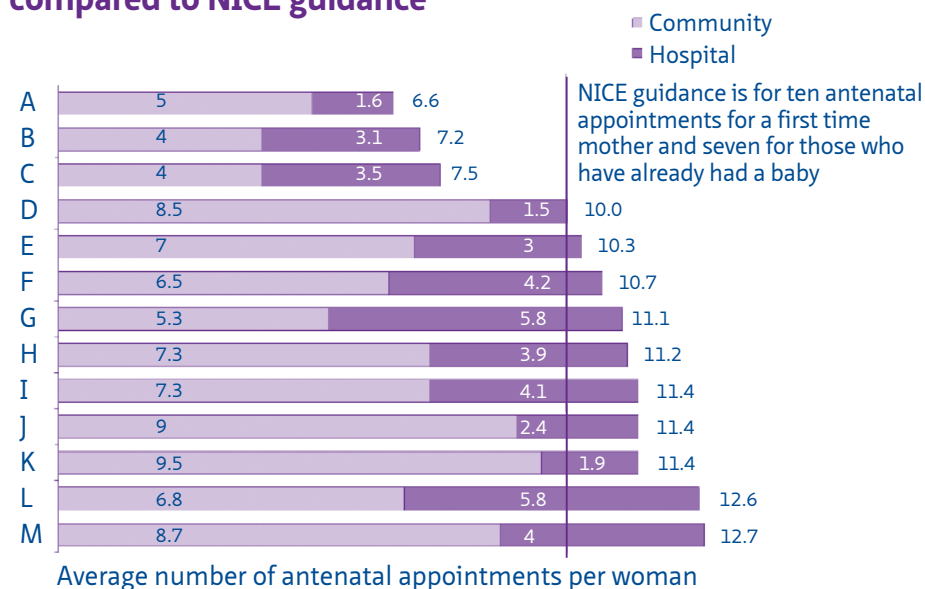
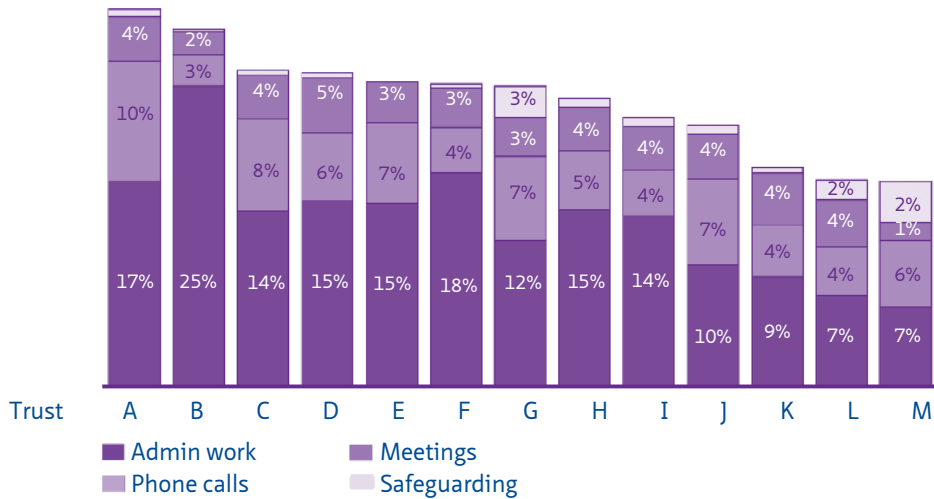


Figure 2. Community midwife diaries – breakdown of time outside of direct patient care (excluding travel time)



variation between trusts if junior obstetrician WTEs are added to consultant WTEs, to take them into account in the calculation (range 337 to 137 deliveries per obstetrician).

Most trusts' average number of annual deliveries per midwife (ranging from 28 to 36) is above the 28 deliveries per midwife level recommended by the Safer Childbirth Report to ensure consistent one-to-one care. This productivity measure was calculated by dividing all delivery HRG spells plus home births by midwife WTEs (including both hospital and community midwives). However, the higher number of deliveries per midwife did not correlate with reduced quality outcomes for mothers (measured as 3rd/4th degree tears and emergency readmissions) and babies (measured as Apgar scores at 5min and stillbirths) being reported by trusts.

Benchmarking results: costs

Cost build-up analysis for each HRG code studied (N07, N09 and

N11) showed that all participating trusts have total costs that are above the tariff income. Trusts generally can cover their direct costs but cannot fully cover their CNST and overhead costs from tariff income.

The largest categories of cost across all types of deliveries are medical and midwife staff costs and CNST payments. On average,

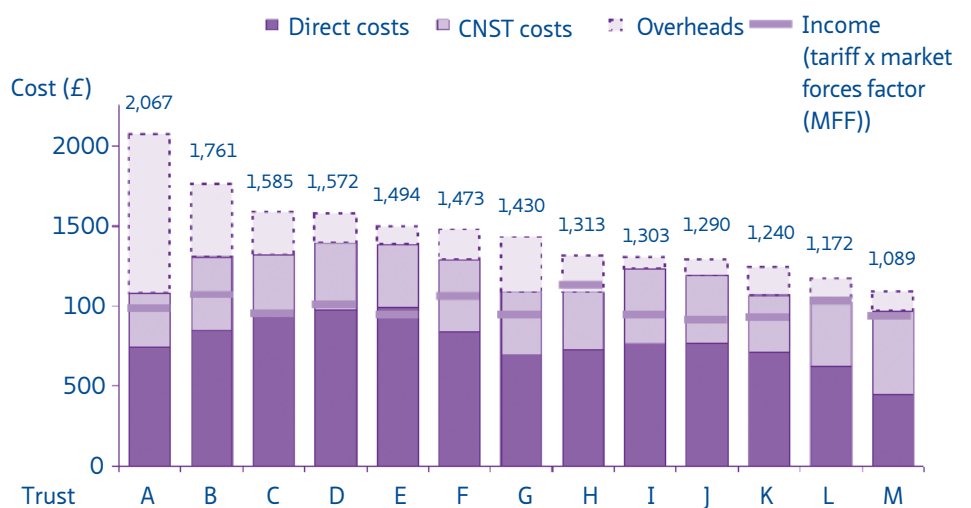
this corresponds to 57 per cent and 25 per cent respectively of reported direct cost excluding overheads for all HRG costs. For HRG codes representing assisted deliveries and caesarean section, medical pay costs rise to 30 per cent (from 24 per cent associated with normal deliveries), and the costs of theatres make up 7 per cent and 13 per cent respectively.

There was a large variation in the income from block contracts for community midwife activity (weighted by time, for example antenatal clinic appointments, 1; home birth, 20), even accounting for differences in services covered. The estimated income per community midwife activity varies from £7 to £29 depending on the block contract negotiated by the trust with their primary care trust (PCT).

Actions

The trusts involved in the project used the findings for this project and the shared learning at the

Figure 3. Normal delivery without complications (N07) cost build-up



workshop to develop action plans to drive improvement initiatives. A number of actions were regarded by participants as key to future development:

- Most participants highlighted a reduction in the caesarean section rate and increase in VBACs as a target for improvement in the quality of their service.
- Trusts identified the streamlining of community midwife activity as essential to drive improvements. It was suggested that new IT

systems could positively impact on time spent on administration tasks. Route planning was also suggested to drive productivity; however, this could impact on mothers' satisfaction with the service.

- Further negotiation with PCTs could be conducted to ensure that community midwife activity is fully reimbursed to cover costs and to drive better coordination of care.
- A review of staffing (including the level of medical cover) and

assessment of recruitment needs could ensure that trusts comply with regulations, to sustain safety and patient satisfaction.

- A thorough review of the coding practices was included in their six-month action plan by most trusts to ensure that income into the unit accurately reflected activity.

Participating trusts found that taking part in this benchmarking study provided strong ideas to improve performance.

Get involved

FTN Benchmarking uses detailed cost and quality data, sourced from trusts, to compare performance and productivity at the right level for action. Projects are designed to bring clinicians and managers together and to facilitate networking and learning in an open, supportive and confidential environment.

Projects are open to all FTN members (both authorised and aspirant trusts). For further information, visit www.nhsconfed.org/FTNBenchmarking or contact Liz Smith, Benchmarking Manager, at liz.smith@nhsconfed.org

The Foundation Trust Network

The Foundation Trust Network (FTN) was established as part of the NHS Confederation to provide a distinct voice for NHS foundation trusts. We aim to improve the system for the public, patients and staff by raising the profile of the issues facing existing and aspirant foundation trusts and strengthening the influence of FTN members.

For more information, contact ftn@nhsconfed.org or visit www.nhsconfed.org/ftn

NHS CONFEDERATION



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