The ‘So What’ of Maternity Data

Exploring usage of national data at trust level

August 2022

About HQIP

The Healthcare Quality Improvement Partnership (HQIP) is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies. www.hqip.org.uk/national-programmes

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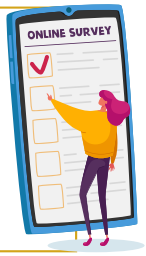
EXECUTIVE SUMMARY

WHY

This project set out to explore the 'So What', meaning how the multiple national data sets and national audits, which are relevant to maternity services, are used at the front line. Maternity is a busy space for national reports and data, and the scope of this project extended beyond the National Clinical Audit and Patient Outcome Programme (NCAPOP) reports and data, also including the National Maternity Dashboard, the Perinatal Mortality Review Tool, Getting It Right First Time and Healthcare Safety Investigation Branch reports and data.

HOW



An online survey was completed by over 100 people working in a wide variety of roles across maternity services. This explored what data was being reviewed and how it might influence quality improvement, as well as the burden of data. Free text answers contained valuable suggestions for improvement. Following the survey, a series of in depth interviews were conducted with a diverse group of clinicians and methodologists working in this area.

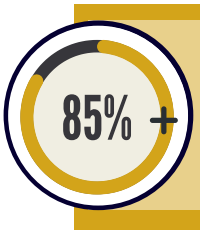
WHAT WE FOUND

The datasets that were most likely to be identified as influencing change are those which review maternal and neonatal mortality, namely those produced by MBRRACE-UK and HSIB reports.

Recommendations were commonly identified as the most useful thing within reports, particularly by clinical staff.

Resource and time constraints for quality improvement were commonly cited as barriers.

BUT



Of respondents felt that at least one national dataset was influencing quality improvement. This is encouraging.

Question responses and free text answers frequently reflected that people are feeling overwhelmed with data and reports.

Interviews had a greater focus on the data, with insight into differing approaches to local dashboards and interpretation of data.

Making Data Count training was raised several times as a great resource from NHS Improvement.

There is a strong understanding of the power of data, but staff are struggling with a lack of time and resource.

Overall staff want reduced duplication of effort and a single source for accessing both data requirements and national results and recommendations.

Useful change ideas came from both the survey and the interviews, many of which are incorporated into the recommendations, which aim to make utilisation of data and reports more accessible, ultimately leading to improvements in patient care.

RECOMMENDATIONS

1. ACROSS THE VARIOUS DATASETS:

1.1. Align metrics with NICE and other evidence-based standards
1.2. Publish a list of standardised metrics, with definitions, so that data is comparable
1.3. Do not duplicate collection of the same metric and
1.4. There must not be very similar metrics being collected.

2. NHS ENGLAND, WORKING WITH RELEVANT ROYAL COLLEGES, TO DEVELOP A SINGLE WEBSITE THAT:

2.1. Signposts to all national maternity reports and datasets (for example NCAPOP reports National Maternity Dashboard, HSIB, GIRFT, Ockenden etc.), and
2.2. Contains up-to-date guidance on all mandatory reporting requirements (for example includes NCAPOP, MIS, CQC etc.).

3. TO IMPROVE BENCHMARKING PRACTICES ACROSS MATERNITY SERVICES:

3.1. NHS England to maximise the uptake of Making Data Counts training
3.2. Align the National Maternity Dashboard to produce SPC charts as per Making Data Counts methodology, and
3.3. Audit providers to consider ways to raise the profile of benchmarked data. For example the creation of unit posters with benchmarked outcomes. It would be beneficial for NNAP to create perinatal specific unit posters aimed at staff to raise profile amongst obstetric and midwifery communities.

4. RECOMMENDATIONS FROM REPORTS:

4.1. NHS England to centrally co-ordinate recommendations
4.2 Reports to utilise the NHSE CREATED SMART framework when writing recommendations, and
4.3. HQIP and audit providers to ensure that there is clear messaging to trusts regarding evolution of NCAPOP reports to provide improvement resource rather than local recommendations.

5. LOCAL DATA SUPPORT:

5.1. National development of a suite of common audits that can be carried out in individual units, promoting a consistent standard with meaningful measures that can address national audit recommendations
5.2. NHS England to support local units in curating their data with suggestions and templates for the development of unit dashboards based on local data, and
5.3. NHS England to facilitate the development of professional networks, to enable sharing of learning and resources, reducing duplication of effort across trusts.

2. Introduction

This project has been led by the National Medical Director's Clinical Fellow at HQIP. HQIP commission the National Clinical Audit and Patient Outcomes Programme (NCAPOP) on behalf of NHS England (NHS E) and the Welsh Government. As part of the clinical fellows' role, they review all the reports and work with the NHS E Executive Quality Group Clinical Audit Sub-committee to ensure that national facing recommendations are being acted upon. The 2021-22 clinical fellow proposed this project to explore in more detail what is happening at a local level in maternity services, with outputs from the NCAPOP.

The clinical focus for this work has been in maternity for two reasons. The first is that the fellow's clinical background is in obstetrics and gynaecology, giving her a deeper understanding of the day to day challenges and applications. Second is that this is a busy space when it comes to national reports and data, both from NCAPOP and other central bodies, giving more opportunities for learning. As stakeholder engagement occurred it became clear that there was benefit in extending the reach of this project beyond only the NCAPOP. Other sources of data were therefore included, such as the National Maternity Dashboard, the Perinatal Mortality Review Tool (PMRT), Getting It Right First Time (GIRFT), Healthcare Safety Investigation Branch (HSIB) and other things as they arose in survey and interview responses.

Data is a phenomenal tool that we have at our disposal, and we are currently just seeing the tip of the iceberg of its potential to influence positive change and innovation. The recently published Goldacre Review, commissioned by the Secretary of State for Health and Social Care, explores how the NHS can deliver better, broader, safer use of NHS data for analysis and research, to drive innovation and save lives.

The NHS is currently undergoing a digital revolution and this report explores some of the challenges that maternity services are facing on the ground right now in relation to national reports, and local and centrally available data. Some of the messages are unique to maternity services, but many will be applicable across the NHS.

This report is not yet another report facing out to trusts and people doing the work 'on the ground'. We hope instead that it has managed to capture the voices of these people, and present this report to those at central bodies, such as NHS England, HQIP, audit and other report providers. The message received was that we have a passionate workforce full of ideas of how to improve things. Lots of great work is happening already, but hopefully this report and the recommendations within it can make life just a little bit easier to enact positive change on the front line. A lot of the conversations regarding potential changes have echoed work that is already underway, but perhaps hasn't yet been seen at local level, demonstrating that in many ways central bodies do have their fingers on the pulse, but there are also some other ideas here too, that you can read and digest, and will hopefully will lead to other changes that will make the lives of maternity departments a little simpler in enacting positive change.

3. Methodology

In order to reach a large number of people working at trust level an online survey was performed. Various stakeholders, including NCAPOP providers, members of the maternity team at NHS England, the CQC, and colleagues at HQIP, were consulted and a long list of potential questions was produced. This list of potential questions was then shared with these stakeholders, and their feedback used to compile the final list of questions detailed in Appendix 1. The final survey was created electronically, and user testing showed that completion should take no longer than 10 minutes. The survey was shared via Twitter, the British Intrapartum Care Society mailing list, the workstream leads of the Maternal & Neonatal Safety Improvement Programme (MatNeoSIP), a HQIP maternity themed newsletter, the National Quality Improvement (including Clinical Audit) Network (N-QI-CAN) Networking and Sharing Forum, and personal connections. The survey collected primarily quantitative data, which is shared in section 4 and Appendix 2.

Following the survey, semi-structured interviews were undertaken with those willing to share qualitative data. These participants were mainly identified through the survey, with one further approaching the project lead after the survey had closed. Interviews were conducted on Microsoft teams and were recorded and transcribed so that themes and quotes could be identified during the analysis stage of the project. Recordings have since been destroyed and transcriptions anonymised. Interview analysis is shared in section 5.

Primary analysis was completed by the project lead, with an elective medical student also watching three interviews to identify themes. Throughout the project, input was gained from both HQIP colleagues and a member of the NHS England MatNeoSIP team.

4. Survey results

The survey received 120 responses from a breadth of maternity staff located across the country. Sixteen responses were removed from the analysis as the respondents had not answered beyond question 3 (demographic questions). Seventy-four of the remaining 104 respondents completed all questions, and 30 respondents completed at last half of the survey and their responses are included in this analysis. This section of the report summarises survey results, with more quantitative data on responses available in Appendix 2.

Demographics

The largest clinical group to respond was midwives, with 42 respondents self identifying in this group, closely followed by 37 doctors.

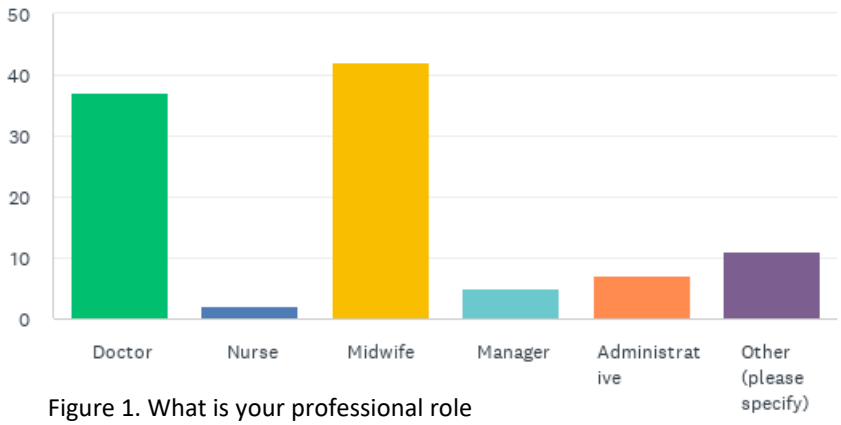


Figure 1. What is your professional role

Eleven people used the response of Other, with this including governance and audit staff, data analysts, a project manager, a diversity champion, and specific midwifery roles such as digital midwife, senior research midwife and a Director of Midwifery. Note that in analysis by role these three respondents have been included in the midwife group.

Ninety seven respondents shared where they worked, with representation from 59 different trusts and organisations.

Respondents were asked about what activities were included within their professional role, with responses including delivering maternity clinical care, and about co-ordination, leading and involvement with local audit and quality improvement, as well as involvement with national clinical audit. Just three respondents detailed that they weren't involved in any of these activities, representing two midwives and a diversity champion, and they were aware of uses of national data.

Reviewing the data

The survey aimed to explore what data people were accessing from national datasets and reports and asked two questions in order to do this. The first related to their awareness and use of various sources of national data, and the second explored the challenges in accessing local data from nationally collated datasets.

Figure 2 shows responses to 'Please indicate your awareness and use of the following sources of nationally collated data'. For each report/dataset, respondees were asked to choose from the options of:

- Not aware
- Aware, but do not use
- Aware and review overall reports
- Aware and review local data subsets
- Aware and utilise to stimulate quality improvement.

This demonstrates that the reports and datasets most commonly used to stimulate quality improvement are those from the Maternal, Newborn and Infant Outcome Review Programme (MBRRACE-UK maternal and perinatal mortality reports), the Perinatal Mortality Review Tool and HSIB reports, shown by the dark green bars on the right. The GIRFT, NPID and NNAP reports were least used by the questioned cohort. Of note the National Maternity Dashboard is most likely to be used to review local data subsets.

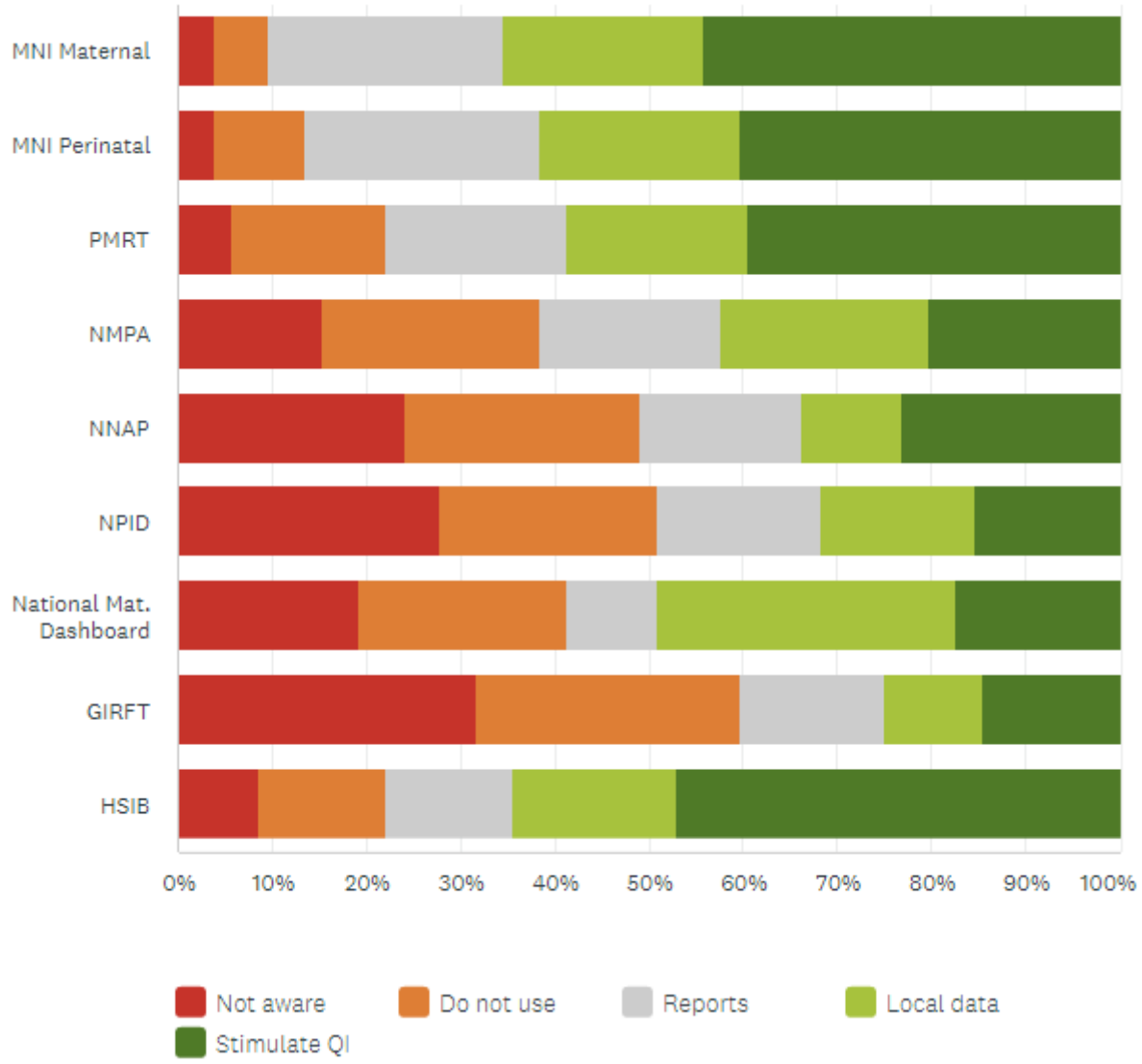


Figure 2. Please indicate your awareness and use of these sources of nationally collated data (see footnote for full report names)

MNI – Maternal, Newborn and Infant Clinical Outcome Review Programme, currently supplied by the MBRRACE-UK collaborative – separate maternal and perinatal mortality reviews
PMRT – Perinatal Mortality Review Tool
NMPA – National Maternity and Perinatal Audit
NNAP – National Neonatal Audit Programme
NPID – National Pregnancy in Diabetes Audit
National Mat. Dashboard – National Maternity Dashboard
GIRFT – Getting It Right First Time
HSIB – Healthcare Safety Investigation Branch

When results to this question were reviewed by professional group (midwives, doctors, all) similar patterns emerged. However, it became clear that midwives were most likely to respond that they were not aware of or did not use NNAP, with 26/45 (58%) self ranking this, versus 18/37 (49%) of doctors, and 51/104 (49%) overall.

The second question in this section asked, 'What challenges do you experience when accessing local data from nationally collated datasets?'. Respondents were able to select one or more options from a list. As shown in figure 3, the majority of respondents had difficulty in accessing and finding local data, with 74/104 (71%) selecting this option. When reviewed by professional group this was more problematic for midwives (78%) than doctors (62%). Almost half of all respondents also reported challenges with data quality, data completeness and data timeliness. Of note just four respondents reported that they didn't face any challenges in accessing local data and a further four advised that they don't access local data. Other examples given include the challenges of small numbers, with rounding and suppression making national datasets unusable, and the multiple sources of data, both at local level in making inputs, and at national level leading to overload.

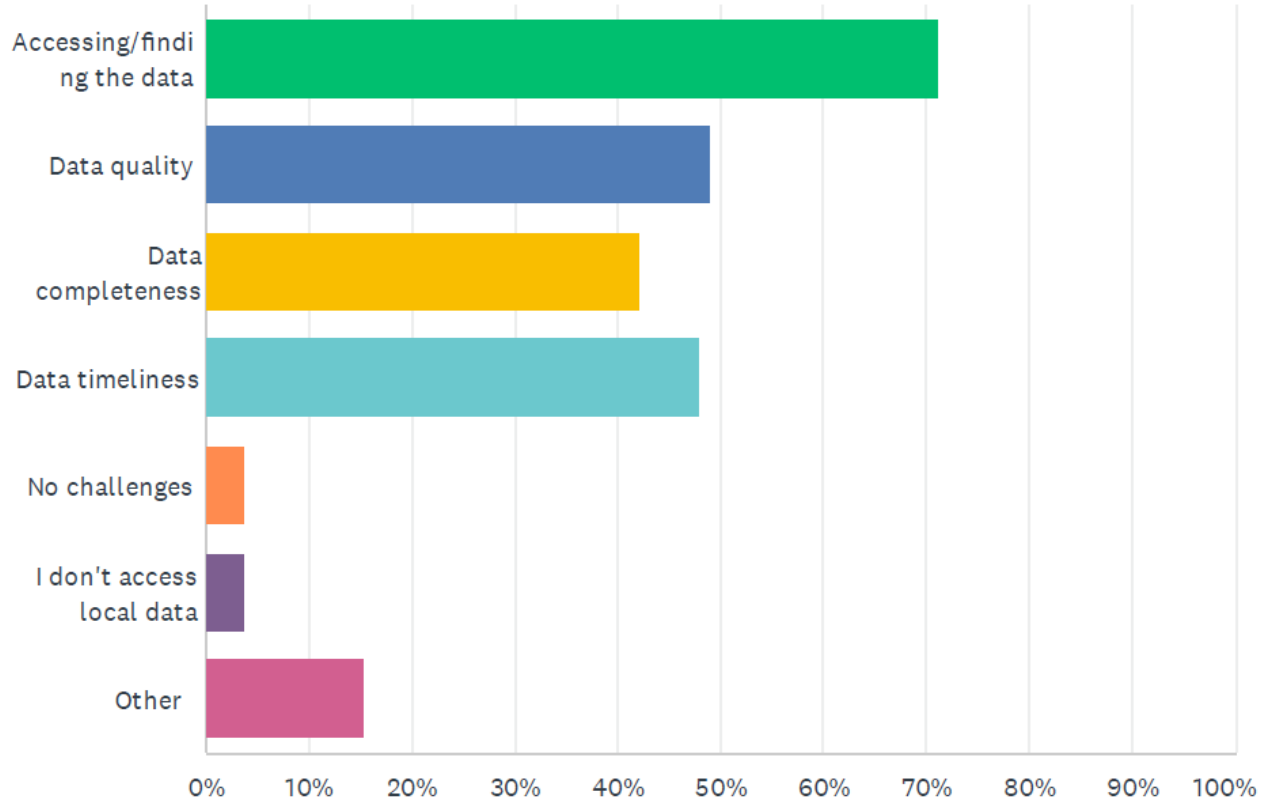


Figure 3. What challenges do you experience when accessing local data from nationally collated datasets?

Quality improvement

The survey contained three questions that aimed to explore how data can influence change within maternity units. The first exploring what is useful in reports or datasets, the second asking which reports and datasets had influenced quality improvement and the final one asking about barriers to utilising national data for quality improvement work.

Figure 4 shows weighted averages[1] (max. score 8) for all responses to the question 'What do you find useful in reports or datasets?'. Recommendations are the most popular, with 34/82 (41%) respondents ranking them as the most useful.

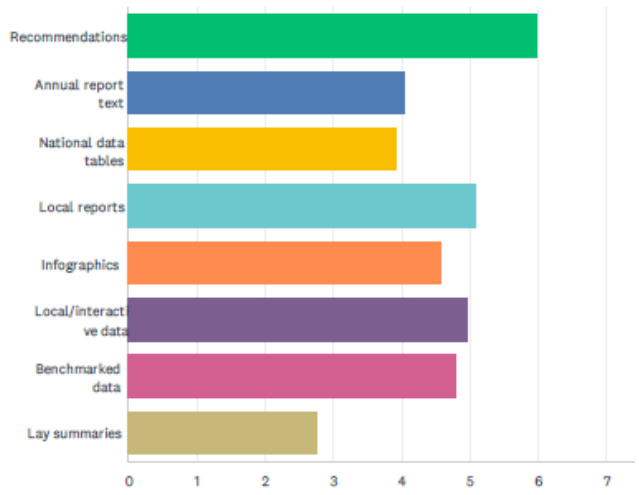


Figure 4. What do you find useful in reports or datasets? (weighted averages[1] for all responses)

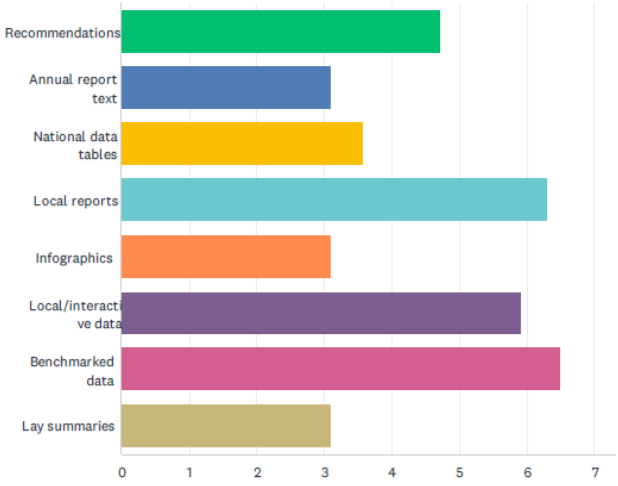


Figure 5. What do you find useful in reports or datasets? (weighted averages[1] for managers and administrative)

When this question was reviewed by professional group, recommendations remained the most popular response for both midwives and doctors, with half of midwives ranking them first and 47% of doctors. Overall there weren't significant differences between these two professional groups, other than a slightly greater preference for local reports in the midwifery group compared to doctors. When viewing the responses of those that identified as either manager or administrative there was a far greater focus on data, with benchmarked data, local/interactive data and local reports scoring highest on weighted averages (Figure 5).

The second question asked which national reports and datasets had influenced quality improvement projects that the respondent was aware of in their unit (figure 6). It is very encouraging that over 85% of respondents felt that at least one national dataset was influencing quality improvement. Respondees were also able to provide examples here, which included both improvement projects as a result of outlier status (for example for post-partum haemorrhage), and improvements as a result of recommendations.

[1] Weighted averages are calculated by using multipliers to reflect the ranking of responses when calculating the average score.

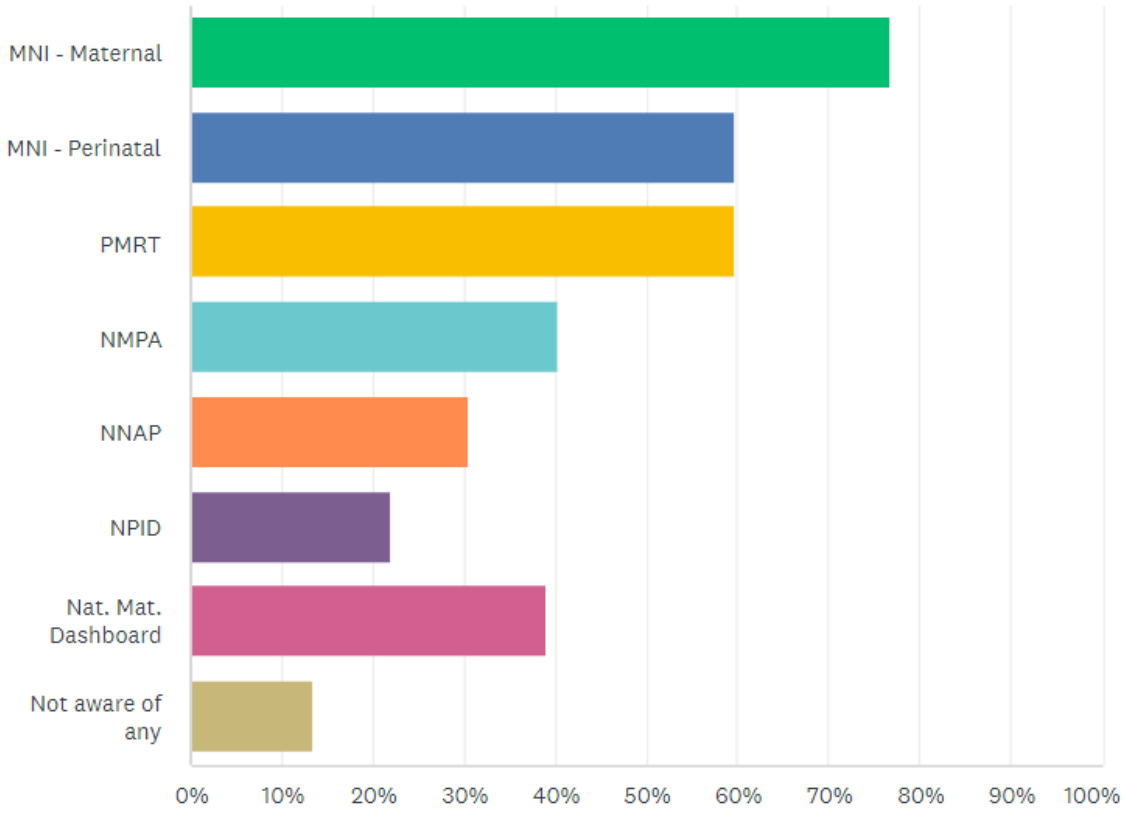


Figure 6. Which datasets have influenced QI projects within your unit

The final question in this section explored the barriers to using national data for quality improvement (QI) work, giving seven options to rank from never problematic through to always problematic. This clearly demonstrated that the biggest barriers were felt to be resource constraints for QI and time constraints for analysis, with 53/78 (68%) and 52/79 (66%) respectively rating these as often or always problematic, followed closely by data timeliness, with 38/76 (50%) rating this as often or always problematic. Understanding of data presented and QI methodology knowledge were far less of a problem, with just 13/76 (17%) and 16/77 (21%) respectively rating these as often or always problematic. Data quality and metrics available were between these two groups, most often being ranked as sometimes problematic. As with other questions more detail is available on the responses in Appendix 2.

There was also the option to add a freetext answer to this question, and 14 respondents added further comments. These included the challenges of multiple competing priorities, both at Board, CQC and CNST level, as well as the sheer volume and frequency of data in the face of workforce challenges.

'The system is completely overloaded and everyone is drowning'

Data burden

Figure 7 shows the responses of all participants to the question 'Do you have difficulties prioritising and acting upon all national datasets/reports?'. 43/75 (57%) of respondents often or always have difficulties in prioritising and acting upon all national datasets/reports.

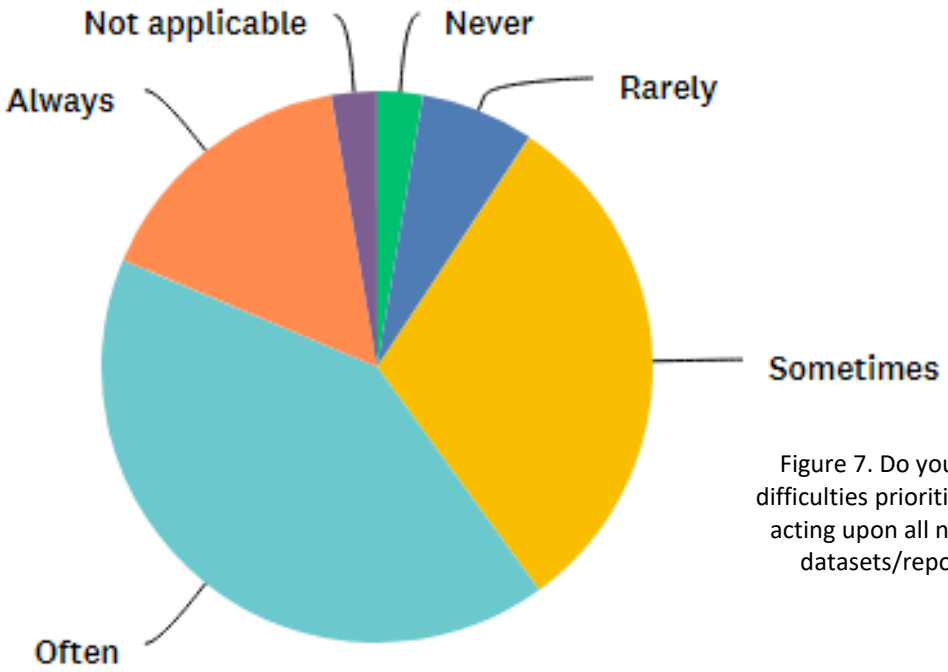


Figure 7. Do you have difficulties prioritising and acting upon all national datasets/reports?

For the final quantitative question respondents were asked to give an overall ranking of the programmes from the most to the least useful. Figure 8 shows the responses to this question as weighted averages[1]

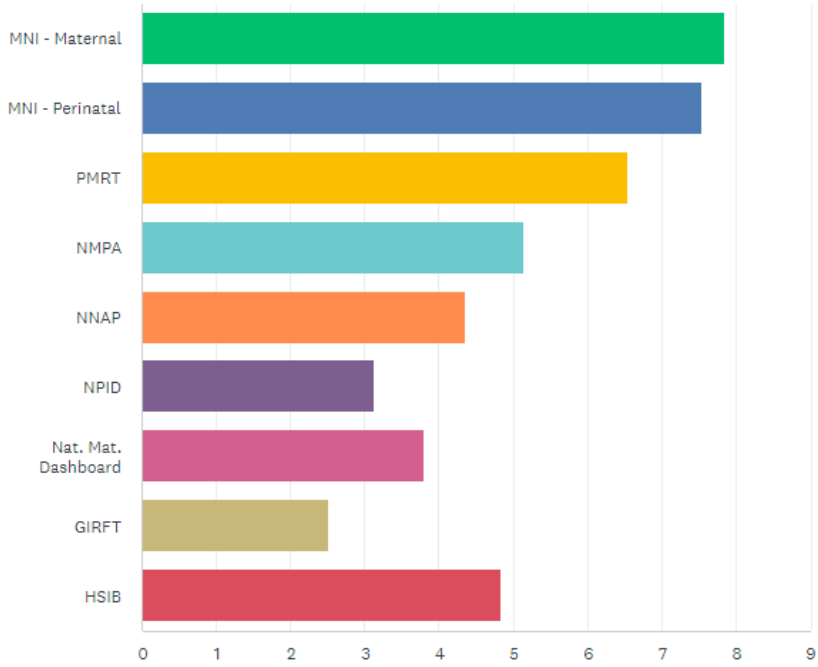


Figure 8. Please order these programmes from the most to the least useful in your experience?

[1] Weighted averages are calculated by using multipliers to reflect the ranking of responses when calculating the average score.

Suggestions for improvement

Question 11 in the survey was an optional question asking participants whether they had any suggestions for improvement. Twenty six individuals responded here, and responses are included in full in Appendix 3 for completeness.

Multiple respondents expressed frustration at the timeliness of reports, for example '*often QI projects are done before release of publication so learning needed no longer relevant*'.

Another emerging theme related to having a single location to source information, detailing audits that are national requirements, as well as linking to data and reports. A suggestion was that this could be hosted on a Royal College site.

There is frustration that there are not standardised outcome measures, with some reports using different definitions for the same outcomes.

More than one person commented on the need for easier access to benchmarking tools.

There were multiple comments relating to recommendations, including *'should all be pulled together into one set of recommendations'*, *'less ambiguity in some of the national recommendations in terms of implementation',* and *'organisations coming together to produce datasets and recommendations'*. There was also expressed frustration at the volume of reports and recommendations, with requests for reducing duplication and streamlining the system.

It will be valuable for audit providers to review Appendix 3 in full as they may find useful suggestions for improvement.

5. Interviews

Ten interviews were conducted with a variety of both clinical and corporate professionals working within maternity services and/or with maternity data across England. This included three consultant obstetricians, with the relevant roles of labour ward lead, risk lead and clinical effectiveness lead. It also included four midwives, which included a governance lead, PMRT midwife, digital midwife, and a consultant midwife. Finally, there was a clinical audit facilitator who worked at whole trust level and had a non-maternity clinical background, a service delivery programme lead working on the maternity improvement plan at trust level with a corporate background, and a data analyst working on insights in maternity care at a trust level.

Interviewees were asked to describe their professional roles, and then further questions to explore, for example, what data they were using, challenges they faced, their confidence in using and interpreting data, preferences for timely or assured data and how they have used national data in quality improvement. Questions varied depending on both their role and the responses received. All interviewees were asked what could be done centrally to help them. The aim was for interviews to be conducted in 30 minutes, though several lasted longer. Themes were drawn from interview transcripts and are described below.

Data being used to assess local performance

Most interviewees working within maternity services were aware of local dashboards and would use these to review how they were performing, often benchmarking against trusts within their Local Maternity and Neonatal System (LMNS). One person advised that they would also look at local data from National Audits, and if they were identified as an outlier this would focus them to perform local audit, whereas they would see it as fine if they were within the normal gradient. The clinical audit facilitator utilised NCAPOP reports and the local data within them to feed into the trust clinical effectiveness report.

Whilst some trusts are still using 'RAG' (red, amber, green) ratings on their dashboards, several interviewees explained that they were moving away from this and developing their data to use Statistical Process Control (SPC) and run charts.

Even within locally produced data reports there remains concerns regarding data quality

'I also think there's a massive problem in our trust with accuracy of data… …there's been some real concerns about where that information comes from and how accurate it is, so there's a bit of distrust amongst quite a lot of the midwives that what they see happening clinically day to day isn't always what seems to be pulled out by the BIU onto the dashboard.'

National Maternity Dashboard

Not all interviewees working in maternity services were aware of the national maternity dashboard.

'honestly I don't know how to find the national dashboard. It's just not something that I… I'm sure I could if I tried, if I looked hard enough and I know the right people to ask.'

'And the fact that I get people asking me about regional data all the time, and so clearly nobody in the region is aware of this national dashboard, which is a worry. So the information must have gone somewhere to advertise it, I'm just not sure where.'

Others were aware of it, but not necessarily using it. One interviewee did explain about concerns regarding data quality with their business intelligence unit (BIU) submitting Maternity Services Data Set (MSDS) data obtained from a less reliable dataset than was being used for their internal dashboard, but also explained that this was improving. A similar comment was made by another interviewee, who felt that MSDS submission being part of the Maternity Incentive Scheme (MIS) was helping to drive improvements in data quality. A further two interviewees spoke with me about utilising SPC with the national data, and the data analyst has actually built software that will convert the MSDS into SPC charts to improve data interpretation and benchmarking ability, though they did explain that the data should be made more useable. The following comment was made by one of the midwife interviewees:

'I would quite like to see some kind of standardised approach so that it automatically generates an SPC chart from the data rather than us having to calculate it and kind of map it out. I think that would be a great tool to have.'

Interpreting the data

All interviewees were asked if they were confident in interpreting the data that they look at. Most advised that they were confident, though two admitted that they sometimes struggled. One of these found that the varying ways in which data may be presented when looking at different reports could lead to confusion, and another answered '*Yes and No*'. They explained that it was often possible to *'just make the data fit to what you want'*.

Interviewees were not prompted further on this question, but two clarified that they would consider the clinical context of the data, often working in a team. Five interviewees did talk about SPC and run charts, with two naming 'Making Data Counts' training, and a further person describing it. All three were very enthusiastic about this training, with two being directed to it by their trusts, and the third finding it via social media.

'So, our integrated performance report at board level now follows the Making Data Count recommendations and I could see the potential for having a common visual language, right the way down from board level, all the way through the process.'

'the Making Data Count training should just be absolutely everywhere and mandatory'

Timely vs Assured data

When considering the availability of data there is often a tradeoff that needs to occur. Assuring data takes time, and so when data is available within a shorter timescale it is more prone to have errors. Interviewees were asked about their preference between fast data, that's maybe not as 'clean', or data that comes slower, but that they can be more confident in?

This question had varied responses, with two interviewees expressing a preference for timely data

'if you do a yearly audit on something, it's too late. It might be assured data and it might be validated and everything, but that was over a year ago and things are changing so quickly and influencing factors and variables are changing all the time. So I'd much rather have that quick data to be able to react to and make health care current, then I would data that's taken ages to publish.'

Three interviewees expressed a preference for assured data, though this included caveats such as ideally within a year

'Depends what I want it for, but ultimately it will be assured data. That's the gold standard.'

Four interviewees saw the value of both and did not commit either way

'It would almost be both, because you need the immediate data, so having awareness of what's potentially going on, but subject to some data validation.'

'I don't know, I'm on the fence.'

'I think there's a place for both, but I think being able to update is key'.

Quality Improvement

I explored how national data and reports might be influencing quality improvement at trust level, as well as discussing what quality improvement support was available locally.

No interviewees provided specific examples of QI that had occurred as a result of national datasets, though one did respond that the national dataset often drives what local audit occurs. One interviewee advised that their QI often happens in response to national drivers, and another advised that the evidence behind a lot of their improvement work is supported by national drivers. Two interviewees advised that QI would more likely occur because of specific actions given to the trust, for example by the CQC or HSIB.

Many of the interviewees were working at trusts with maternity departments that had been identified as being in difficulty, and several mentioned that QI work had greatly improved with the addition of specific funding and resource for this.

One person was working in a pilot site for the new Patient Safety and Incident Response Framework (PSIRF) and she described to me how this was working in practice, with a refocus on improvement on the back of incidents. They look for where local concerns are mirrored in the national data, using the findings to help drive improvements.

'the evidence behind a lot of the improvement work is supported by national drivers'

Data collection

Issues raised around data collection mainly related to data quality, both in the challenge of making people realise the importance of data entry at the point of care, and in the process of extraction of data by Business Intelligence Units (BIUs). One interviewee explained the culture at her trust that contributes to poor data entry:

'It's within a document and just gets missed because people aren't used to it being picked up, so they just don't fill it out, and I think part of that just links to just human nature, you'll only ever fill out the basics of what you need to do sometimes to get through something a bit quicker.'

Another talked about how the challenges of extracting data and their thoughts on the variation of resource across the country:

'some trusts I think will be on to this and some trust will be way behind and it will be a spectrum so that you know and it won't be the Obs & Gynae departments, it will be whatever they call the data people, the people who do the data mining and supply. Have they got a data warehouse, how many people are staffing it? You know, even a recommendation of actually you need a dedicated person for just maternity.'

Several interviewees discussed the huge efforts undertaken at trust level to 'clean' data up when inconsistencies were found. Some also highlighted that a lot of the data collection for audits/PMRT et cetera that is currently done by people with clinical backgrounds but could be done by appropriately skilled people in administrative roles and that clarity of what roles are needed set out for each piece of work would be useful. This comment highlights how guidance about what is needed to support these functions would be helpful:

'a national thing saying every hospital of this many deliveries should have this amount of audit midwives, this amount of admin support, this…, then maybe that would be clearer.'

Further suggestions for improvement

Interviewees were asked about whether they had any suggestions for improvement, and this section gives detail on those that aren't covered in the sections above.

Many interviewees felt that it would help to have more central co-ordination, both in the outputs from reports and the inputs required from trusts. Suggestions included all reports (for example NCAPOP, HSIB, NICE, PMRT etc.) being assimilated by one body, either with a standardised process for recommendations which would reduce the variation in interpretation, or even just a monthly publication that had all new things in one place, ensuring that recommendations don't contradict each other and are ideally based on data and evidence. The importance of clear recommendations in leading to action was recognised.

'So if it came out as clear guidance like Ockenden's done - Trusts must do this and this then it kind of becomes a must do, rather than a that's interesting let's ignore it.'

Further to this, for data outputs, it was suggested that being able to download all available data in one place would be very helpful.

For inputs there were both suggestions regarding the required mandatory reporting being via a single portal, and also requests for clearer guidance for mandatory audits, with all requirements listed in one place. This includes both data reporting requirements for things such as MSDS and NCAPOP data, and those local audits that should be done, for example as part of the Maternity Incentive Scheme (MIS).

'These are the audits you need to do', and also for these audits they've ***'predefined the outcome for you and the tool and the data you need to pick out rather than you being a little bit arbitrary and choosing what you want to get the data that they need'.***

In addition to this there were suggestions that having a list of standardised metrics produced centrally would be useful:

'a starter list of 'here's as a minimum what you ought to be thinking about doing' or even more than that here is 'Everything' that is valid to measure.' … 'So, it would be nice if there was essentially an available metrics list or even more broadly than that, some sort of best practice around operational view plus measurement for improvement.'

'Centrally approved and mandated set of data and the definition of what that data is.'

Several interviewees identified a need for improved education regarding quality improvement. It was felt that making the differences between QI and audit clearer, with greater links between the two would be beneficial. Certainly, from the interviews it was clear that there was often a large disconnect between audit and QI. One interviewee identified how the obstetrics and gynaecology training curriculum has changed to

have a big push for research, for example with Good Clinical Practice (GCP) certification and an Advanced Professional Module in Clinical Research, and that perhaps the same needs to occur for audit and QI to make data more effective:

I'm not sure they really understand where data comes from, how it's collected, how it can be used or not useful, and I must think that if they know, they may be more able to challenge…maybe be the next generation that will actually say we don't need to keep doing all these audits or these are the ones that we really should be doing and pave the way.'

Professional networks and the value of these was a theme that emerged from several interviews. Sharing of learning and resources can both improve practice and provide professional support. This was raised both in the form of having networks of professionals performing the same role (for example maternity audit leads, analysts) across trusts to be able to cross reference practice, and in the form of forums in order to discuss programmes of work and share learning. The interviewed analyst was keen for there to be more sharing across trusts, using open source software, and explained about the NHS-R community, which aims to support the learning, applications and exploitation of R (a free software environment for statistical computing and graphics) in the NHS.

Speaking to the obstetrician who was a clinical effectiveness lead they explained the lack of any formal induction into the role and felt that the same was probably true for midwives in similar roles. They felt that guidance on what induction or training should be undertaken for these roles would be very welcome – for example, a recommendation to undertake Making Data Counts training.

The PMRT midwife advised that it would be helpful to have central guidance on actions to undertake for cases where the overall grading has identified issues that may or would have affected outcome:

'Should you look at this through the SI process? or is using a PMRT process with a good action plan enough? Where is duty of candour sitting with all of that when we are saying that our care was suboptimal?'

Another interviewee advised they felt it would be helpful to pull out more detail in their local dashboard regarding preventable vs non preventable outcomes and gave the example of using PMRT C/D gradings rather than all cases put together.

One interviewee made suggestions regarding how NCAPOP report content could be clearer from their front pages. This related to how reports are dated, with both the date of publication on the report, and a more consistent approach between providers in whether the report year in the report name related to either the reporting year or the publication year. They also advised that MBRRACE reports can be hard to distinguish between maternal and perinatal:

'It would be great if they all sat in their different sections. And then there was a little bit of information at the top just to say that this is what they are.'

Another interviewee advised that IT support in the form of central recommendations on what IT systems are best to use for a particular purpose would be useful.

6. Commentary

The aim of this project was to evaluate the 'So What', learning what is actually happening on the ground with the data and reports that are shared with trusts. It can't be ignored that maternity services are currently under more pressure than ever before, with maternity care concerns once again in the spotlight with the Ockenden report, alongside a severe staffing crisis across the country.

As an obstetrics and gynaecology trainee I have to acknowledge the risk of confirmation bias with this analysis. To minimise this all interviews were fully transcribed prior to analysis and 30% were also watched by Allan Cameron, a medical student on elective at HQIP, to also draw out themes. Having a clinical obstetric background was a valuable asset when conducting interviews, both in building rapport and in my understanding of the issues discussed.

A strength of this project is the wide variety of professionals that engaged in both the survey and the interviews, which enabled a broad perspective of experiences to be explored. A limitation is that as most interviewees were from different trusts it was impossible to get the entire picture of the situation at any one trust. I note that there were two interviewees from one trust, but they were working in quite separate areas and did not refer to each other's work at all.

MBRRACE-UK are the collaboration for the Maternal, Newborn and Infant Core Outcome Review Programme, producing both maternal and perinatal mortality reports. The same collaboration are also responsible for the Perinatal Mortality Review Tool (PMRT) programme. In the survey responses, these work programmes, along with HSIB, are the most likely to influence quality improvement work at trust level.

The survey found that GIRFT, NPID and NNAP were less utilised by the respondents. Getting It Right First Time (GIRFT) reports were previously not easy to access, requiring a log in to the NHS futures platform. Whilst this is available to anyone with an NHS.net email address, this initial barrier may deter busy healthcare professionals. Of note, the GIRFT report mainly uses NCAPOP data for evaluating maternity care. It is not surprising that the National Pregnancy in Diabetes (NPID) audit was less utilised as this is a specialised area of maternity care, with most hospitals likely to have allocated individuals providing care for pregnant women with diabetes. The National Neonatal Audit Programme (NNAP) assesses the care of babies admitted to neonatal units. It was included in this project as several of their measures relate to obstetric intrapartum care rather than direct neonatal care. It is concerning that around a quarter of survey respondents were not aware of NNAP and another quarter do not use it at all. My concern is that this may reflect an expectation that measures are all related to direct neonatal care.

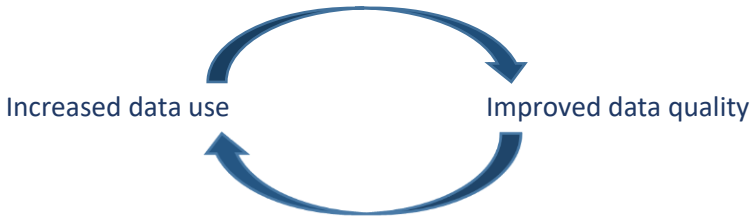
The survey found that clinicians found recommendations to be the most useful aspect of reports. When discussing this in the interviews it was clear that recommendations are more likely to lead to specific action as they are harder to ignore. However, we must also recognize that the system is overwhelmed and so more recommendations is not always the answer. The NCAPOP is currently evolving, with a move for recommendations to be national facing when possible, with improvement resources signposted for trusts instead. As this occurs it is important that those at trust level understand the change so that important improvement drivers aren't lost.

It was interesting that non-clinicians were more interested in data and benchmarking from reports and datasets. Performance benchmarking is established in driving quality improvement, and an area in which networks can work well to establish best practice.

The biggest challenge people faced when accessing local data from national datasets was accessing or finding the data. This echoes other frustrations expressed, with there being no single source of information for reports, data or requirements. Maternity departments are inundated with both requests for data and actions/recommendations, with seemingly no central co-ordination of these. Several people made suggestions of change relating to this.

Data timeliness was also identified as a challenge by almost half of survey respondents. During the interviews, when exploring whether people have a preference for timely data or assured data I expected that most people would opt for timely data, however I found that there is a strong understanding for the need for assurance.

My expectation prior to the interviews was that we would mostly discuss the National Clinical Audit and Patient Outcomes Programme and how this relates to Quality Improvement. But the direction of most interviews moved to details about the data – how data was being curated locally and the challenges of national data. We need to get the data right in order for the QI to follow, but using the data (for QI) raises its profile and stimulates improved data quality, and so we need to work on both simultaneously.



It is no surprise that amongst the biggest limitations on using the data are time and resource. From the interviews it was clear that the workforce is keen to make improvements, but in order for us to do this we need to be able to work smarter.

'I think it is time. I think the willingness is there, the interest is there, it's just the resources that are needed.'

The amount of duplication of effort happening up and down the country was a stark finding from the interviews, with the majority utilising locally curated data 'dashboards' rather than national resources. This project finds examples of many of the data problems identified by the Goldacre review. The Goldacre Review shines a light on data potential and includes recommendations to improve analytic collaborative working. Speaking with an analyst was hugely insightful and I feel strongly that we need to enact these recommendations, building networks of maternity analysts to improve collaborative working and code sharing.

No two maternity departments will be the same and each will face unique challenges, but central guidance about standardised metrics and how to report data would be very welcomed. Making Data Count training is an existing NHS E resource, and its benefits were mentioned several times. The Making Data Count team support the most challenged trusts and also provide regular online webinars that are freely available to NHS staff, with recordings available on the NHS Futures platform. I propose that we embrace this training as a specialty, enabling a common language across all maternity services for assurance and improvement work. As the national maternity dashboard matures it would be hugely beneficial for it to have SPC run charts in Making Data Counts format.

'anywhere you can have either a central or a system wide solution is really good'

We have huge opportunities in our new data driven world. The more we use the data, the better is gets and the more powerful it becomes. I believe that with improved co-ordination we can accelerate this journey, maximising the outputs of finite resources. The suggestions for change from this project are curated into five recommendations that aim to make life a little easier for those working ‘on the ground’.

7. Recommendations

1. Across the various data sets:
   1.1. Align metrics with NICE and other evidence-based standards
   1.2. Publish a list of standardised metrics, with definitions, so that data is comparable
   1.3. Do not duplicate collection of the same metric and
   1.4. There must not be very similar metrics being collected.

2. NHS England, working with relevant Royal Colleges, to develop a single website that:
   2.1. Signposts to all national maternity reports and datasets (for example NCAPOP reports, National Maternity Dashboard, HSIB, GIRFT, Ockenden etc.) and
   2.2. Contains up to date guidance on all mandatory reporting requirements (for example includes NCAPOP, MIS, CQC etc.).

3. To improve benchmarking practices across maternity services:
   3.1. NHS England to maximise the uptake of Making Data Counts training
   3.2. Align the National Maternity Dashboard to produce SPC charts as per Making Data Counts methodology.
   3.3. Audit providers to consider ways to raise the profile of benchmarked data. For example, the creation of unit posters with benchmarked outcomes. It would be beneficial for NNAP to create perinatal specific unit posters aimed at staff to raise profile amongst obstetric and midwifery communities.

4. Recommendations from reports:
   4.1. NHS England to centrally co-ordinate recommendations
   4.2. Reports to utilise the NHS E CREATED SMART framework when writing recommendations and
   4.3. HQIP and audit providers to ensure that there is clear messaging to trusts regarding evolution of NCAPOP reports to provide improvement resource rather than local recommendations.

5. Local Data support:
   5.1. National development of a suite of common audits that can be carried out in individual units, promoting a consistent standard with meaningful measures that can address national audit recommendations
   5.2. NHS England to support local units in curating their data with suggestions and templates for the development of unit dashboards based on local data
   5.3. NHS England to facilitate the development of professional networks, to enable sharing of learning and resources, reducing duplication of effort across trusts.

8. Appendix 1. Survey Questions

The 'So What' of Maternity Data

The 'So What' of Maternity Data is a project being led by Josie O'Heney, an obstetrics and gynaecology trainee who is currently on secondment as the National Medical Director's clinical fellow at HQIP. This survey explores how maternity data is being utilised at trust level. We would like to develop a better understanding regarding what data is helpful and current barriers to using data, with a particular focus on quality improvement. At the end of the survey there is an opportunity to share your name and email address if you would be willing discuss in more detail the challenges that maternity units are facing. The survey should take less than 10 minutes to complete.

* 1. What is your professional role?

- [ ] Doctor
- [ ] Nurse
- [ ] Midwife
- [ ] Allied Health Professional
- [ ] Manager
- [ ] Administrative
- [ ] Other (please specify)

* 2. Within your professional role(s) which of the following do you do? (select all that apply)

- [ ] Deliver maternity clinical care
- [ ] Co-ordination of audit work
- [ ] Co-ordination of quality improvement work
- [ ] Involvement in National Clinical Audit
- [ ] Lead on local clinical audit projects
- [ ] Involvement in local clinical audit projects
- [ ] Leading on quality improvement projects
- [ ] Involvement in quality improvement projects
- [ ] None of the above

3. Which trust do you work within?

The 'So What' of Maternity Data

We would like to understand what data is being reviewed from national datasets and reports.

* 4. Please indicate your awareness and use of the following sources of nationally collated data

	Not aware	Aware, but do not use	Aware and review overall reports	Aware and review local data subsets	Aware and utilise to stimulate quality improvement
Maternal, Newborn and Infant Outcome Review Programme - Saving Lives, Improving Mothers' Care (MBRRACE-UK)	◯	◯	◯	◯	◯
Maternal, Newborn and Infant Outcome Review Programme - Perinatal Mortality Surveillance (MBRRACE-UK)	◯	◯	◯	◯	◯
Perinatal Mortality Review Tool Programme (PMRT)	◯	◯	◯	◯	◯
National Maternity and Perinatal Audit (NMPA)	◯	◯	◯	◯	◯
National Neonatal Audit Programme (NNAP)	◯	◯	◯	◯	◯
National Pregnancy in Diabetes Audit (NPID)	◯	◯	◯	◯	◯
National Maternity Dashboard	◯	◯	◯	◯	◯
Getting It Right First Time (GIRFT)	◯	◯	◯	◯	◯
Healthcare Safety Investigation Branch (HSIB)	◯	◯	◯	◯	◯

* 5. What challenges do you experience when accessing local data from nationally collated datasets? (select all that apply)

- ☐ Accessing/finding the data
- ☐ Data quality
- ☐ Data completeness
- ☐ Data timeliness
- ☐ I don't experience any challenges
- ☐ I don't access local data
- ☐ Other (please specify)

The 'So What' of Maternity Data

We would like to understand how data can influence change within maternity units.

* 6. What do you find useful in reports or datasets? (drag to order from 1 - most useful to 8 - least useful)

Recommendations		N/A
Annual reports with descriptive text		N/A
Tables of national data within annual reports		N/A
Local reports		N/A
Infographics		N/A
Data tables with site/trust level results / Interactive data		N/A
Benchmarked data		N/A
Lay summaries		N/A

* 7. Which nationally collated datasets have influenced quality improvement project(s) that you are aware of within your unit (for example as variation identified or from report recommendations)? (select all that apply)

- [ ] Maternal, Newborn and Infant Outcome Review Programme – Saving Lives, Improving Mothers' Care
- [ ] Maternal, Newborn and Infant Outcome Review Programme – Perinatal Mortality Surveillance
- [ ] Perinatal Mortality Review Tool programme
- [ ] National Maternity and Perinatal Audit
- [ ] National Neonatal Audit Programme
- [ ] National Pregnancy in Diabetes Audit
- [ ] National Maternity Dashboard
- [ ] I am not aware of any QI influenced by nationally collated datasets in my unit

Please can you provide an example (optional)

* 8. What are the current barriers to using national data for quality improvement work?

	Never problematic	Rarely problematic	Sometimes problematic	Often problematic	Always problematic	N/A
Data quality	◯	◯	◯	◯	◯	◯
Metrics available	◯	◯	◯	◯	◯	◯
Data timeliness	◯	◯	◯	◯	◯	◯
Understanding of data presented	◯	◯	◯	◯	◯	◯
Time constraints (for analysis)	◯	◯	◯	◯	◯	◯
Resource constraints (for QI)	◯	◯	◯	◯	◯	◯
Quality improvement methodology knowledge	◯	◯	◯	◯	◯	◯

Other barriers (please specify)

The 'So What' of Maternity Data

There are many sources of data and recommendations aimed at maternity departments and we would like to understand if you struggle with the burden of data received.

* 9. Do you have difficulties prioritising and acting upon all national datasets/reports?

Never	Rarely	Sometimes	Often	Always	N/A
◯	◯	◯	◯	◯	◯

* 10. Please order these programmes from the most (1) to the least (9) useful in your experience? (drag to order)

≡	Maternal, Newborn and Infant Outcome Review Programme – Saving Lives, Improving Mothers' Care (MBRRACE-UK)	☐ N/A
≡	Maternal, Newborn and Infant Outcome Review Programme – Perinatal Mortality Surveillance (MBRRACE-UK)	☐ N/A
≡	Perinatal Mortality Review Tool programme (PMRT)	☐ N/A
≡	National Maternity and Perinatal Audit (NMPA)	☐ N/A
≡	National Neonatal Audit Programme (NNAP)	☐ N/A
≡	National Pregnancy in Diabetes Audit (NPID)	☐ N/A
≡	National Maternity Dashboard	☐ N/A
≡	Getting It Right First Time (GIRFT)	☐ N/A
≡	Healthcare Safety Investigation Branch (HSIB)	☐ N/A

11. Do you have any suggestions for improvements in relation to national data? (optional)

The 'So What' of Maternity Data

12. Would you be willing to undertake a short interview to discuss the themes of this report further?

- ◯ Yes
- ◯ No

If yes, please provide your name and email address

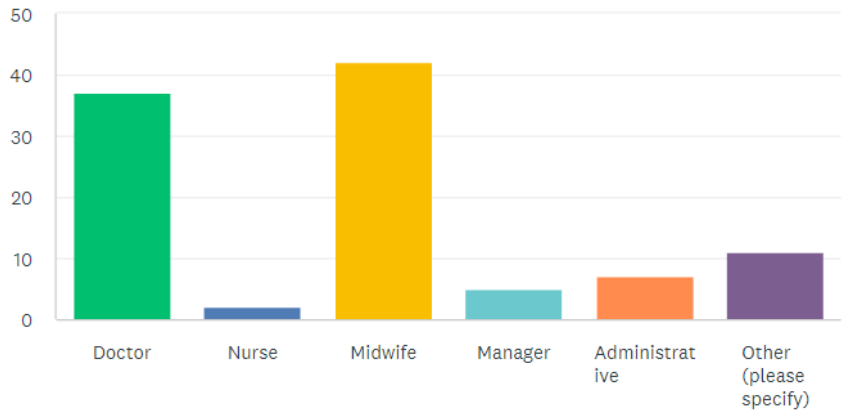
13. Would you be willing to submit a short case study to be considered for publication on the HQIP website regarding quality improvement work?

- ◯ Yes
- ◯ No

If yes, please provide your name and email address

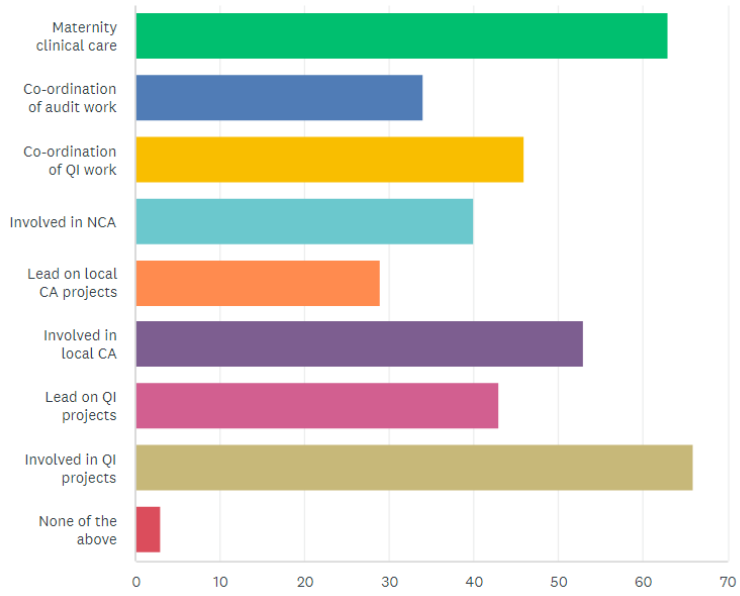
9. Appendix 2. Survey results (quantitative)

Q1. What is your professional role?



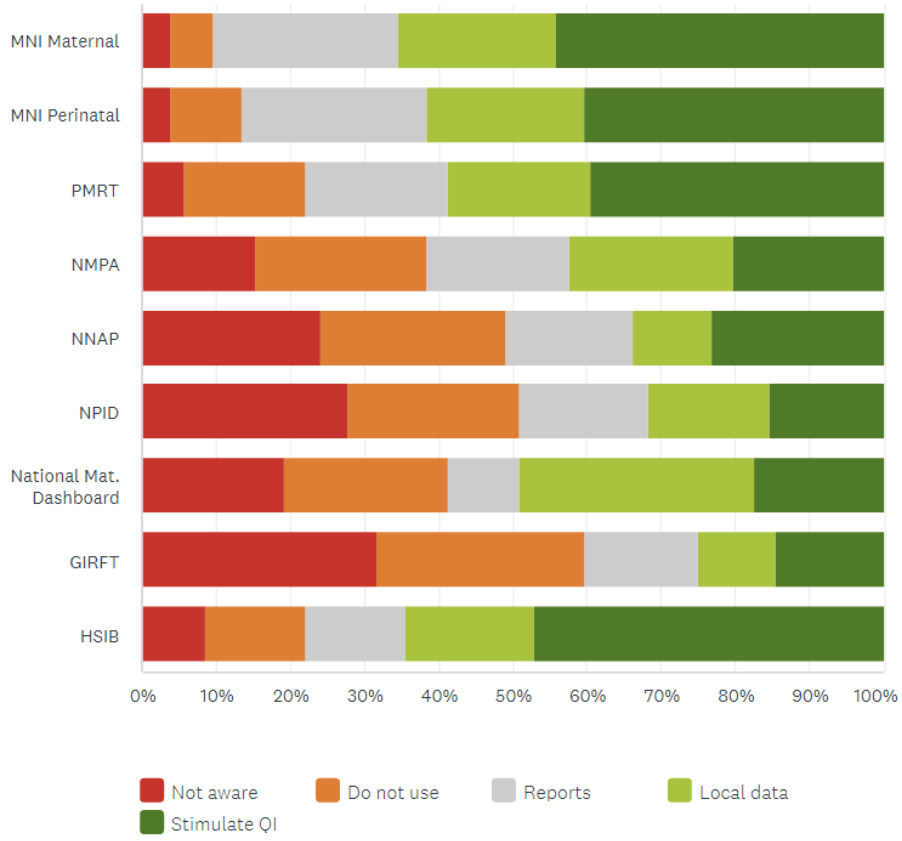
Doctor	37
Nurse	2
Midwife	42
Manager	5
Administrative	7
Other (please specify)	11
Total Respondents	**104**

Q2. Within your professional role(s) which of the following do you do? (select all that apply)



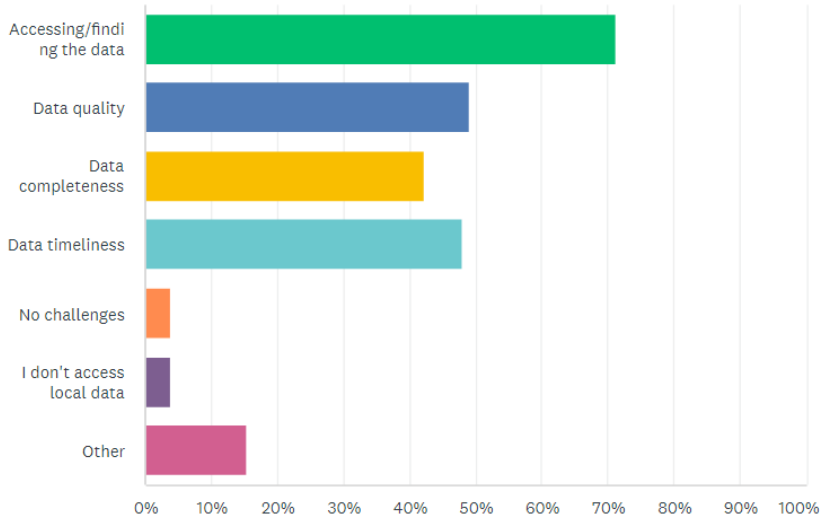
Deliver maternity clinical care	63
Co-ordination of audit work	34
Co-ordination of quality improvement work	46
Involvement in National Clinical Audit	40
Lead on local clinical audit projects	29
Involvement in local clinical audit projects	53
Leading on quality improvement projects	43
Involvement in quality improvement projects	66
None of the above	3
Total Respondents	**104**

Q4. Please indicate your awareness and use of the following sources of nationally collated data



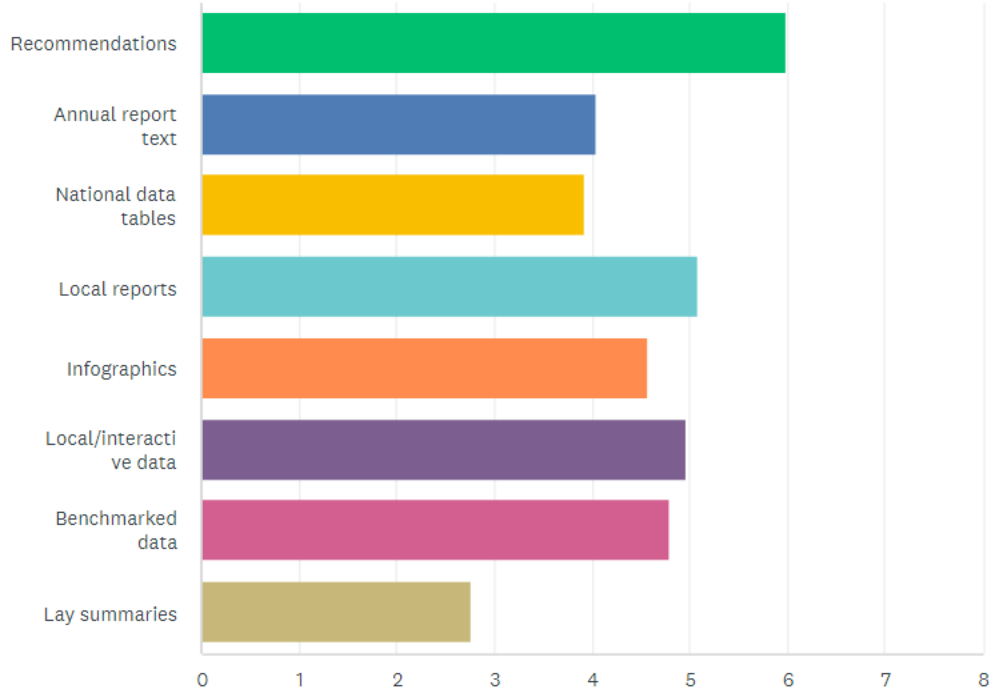
	Not aware	Aware, but do not use	Aware and review overall reports	Aware and review local data subsets	Aware and utilise to stimulate QI	**Total**	**Weighted Average**
Maternal, Newborn and Infant Outcome Review Programme - Saving Lives, Improving Mothers' Care (MBRRACE-UK)	4	6	26	22	46	**104**	**3.96**
Maternal, Newborn and Infant Outcome Review Programme - Perinatal Mortality Surveillance (MBRRACE-UK)	4	10	26	22	42	**104**	**3.85**
Perinatal Mortality Review Tool Programme (PMRT)	6	17	20	20	41	**104**	**3.70**
National Maternity and Perinatal Audit (NMPA)	16	24	20	23	21	**104**	**3.09**
National Neonatal Audit Programme (NNAP)	25	26	18	11	24	**104**	**2.84**
National Pregnancy in Diabetes Audit (NPID)	29	24	18	17	16	**104**	**2.68**
National Maternity Dashboard	20	23	10	33	18	**104**	**3.06**
Getting It Right First Time (GIRFT)	33	29	16	11	15	**104**	**2.48**
Healthcare Safety Investigation Branch (HSIB)	9	14	14	18	49	**104**	**3.81**

Q5. What challenges do you experience when accessing local data from nationally collated datasets? (select all that apply)



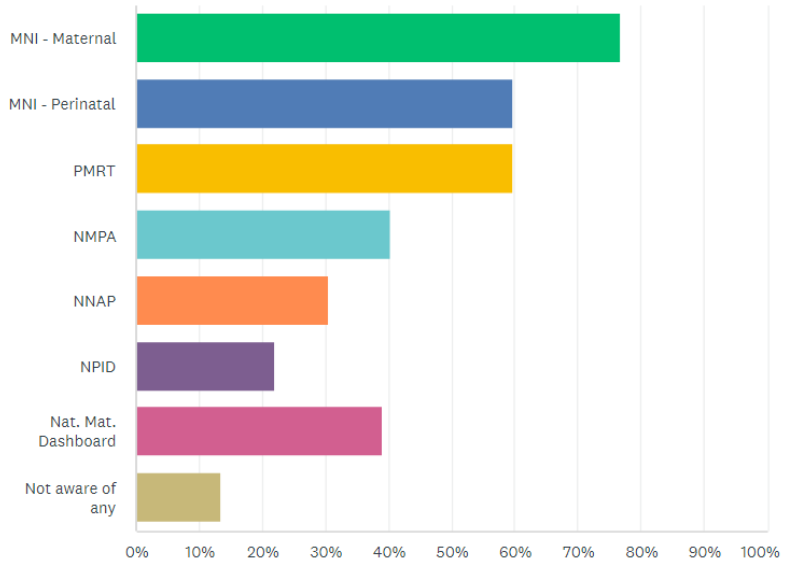
Accessing/finding the data Other (please specify)	74
Data quality	51
Data completeness	44
Data timeliness	50
I don't experience any challenges	4
I don't access local data	4
Total Respondents	**104**

Q6. What do you find useful in reports or datasets? (from 1 – most useful to 8 – least useful)



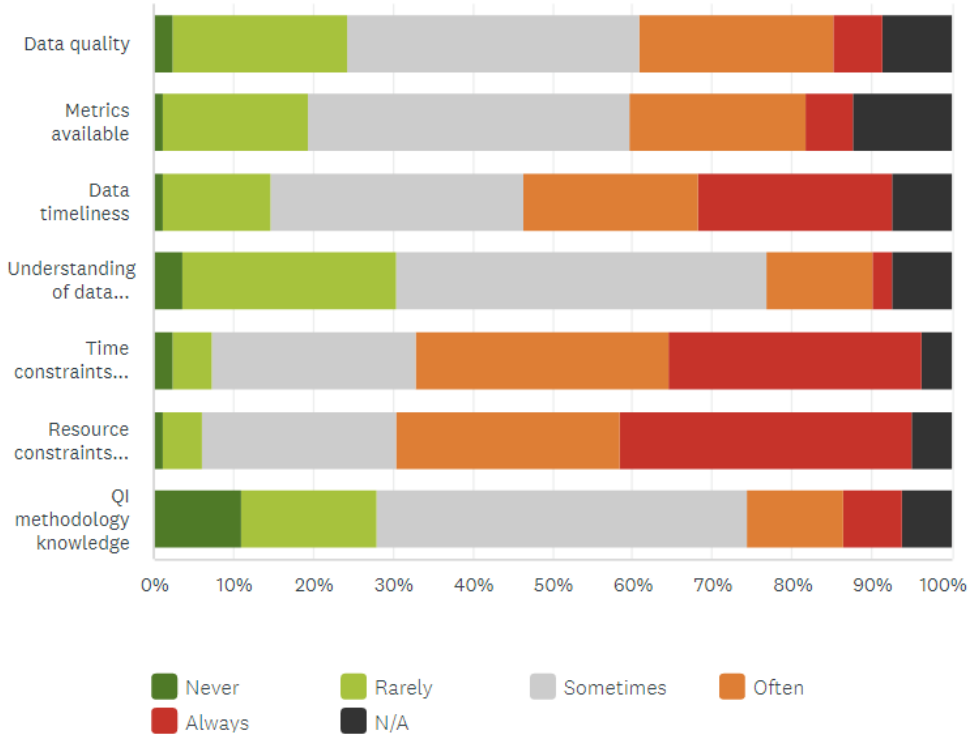
	1	2	3	4	5	6	7	8	N/A	Total	Weighted Average
Recommendations	34	11	7	4	10	9	5	2	0	**82**	**5.98**
Annual reports with descriptive text	5	7	10	15	10	8	16	11	0	**82**	**4.04**
Tables of national data within annual reports	3	6	7	12	20	10	17	6	1	**82**	**3.93**
Local reports	8	13	17	11	16	10	4	3	0	**82**	**5.09**
Infographics	5	19	7	10	9	15	12	5	0	**82**	**4.57**
Data tables with site/trust level results / Interactive data	10	13	17	9	9	9	7	7	1	**82**	**4.96**
Benchmarked data	12	11	11	14	3	12	14	4	1	**82**	**4.80**
Lay summaries	5	2	6	7	5	8	6	41	2	**82**	**2.77**

Q7. Which nationally collated datasets have influences quality improvement project(s) that you are aware of within your unit (for example as variation identified or from report recommendations)? (select all that apply)



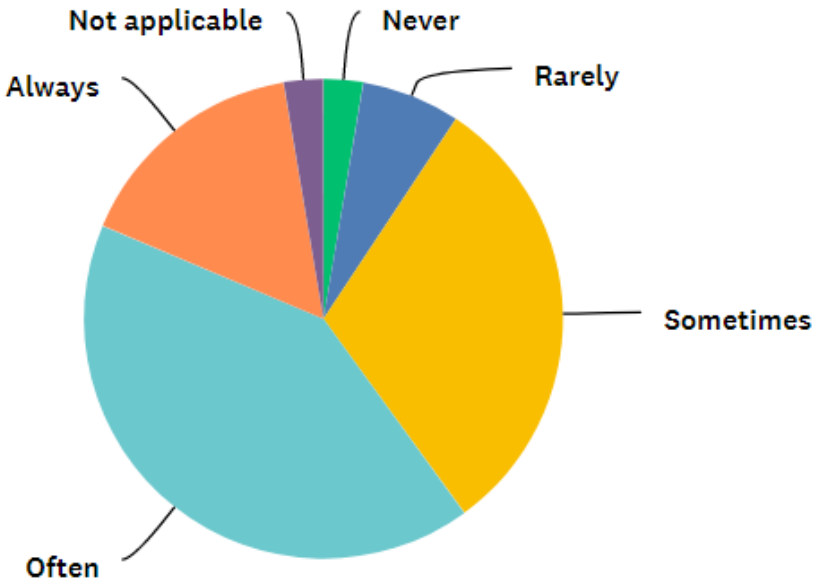
Maternal, Newborn and Infant Outcome Review Programme - Saving Lives, Improving Mothers' Care	63
Maternal, Newborn and Infant Outcome Review Programme - Perinatal Mortality Surveillance	49
Perinatal Mortality Review Tool programme	49
National Maternity and Perinatal Audit	33
National Neonatal Audit Programme	25
National Pregnancy in Diabetes Audit	18
National Maternity Dashboard	32
I am not aware of any QI influenced by nationally collated datasets in my unit	11
Total answered	**82**

Q8. What are the current barriers to using national data for quality improvement work?



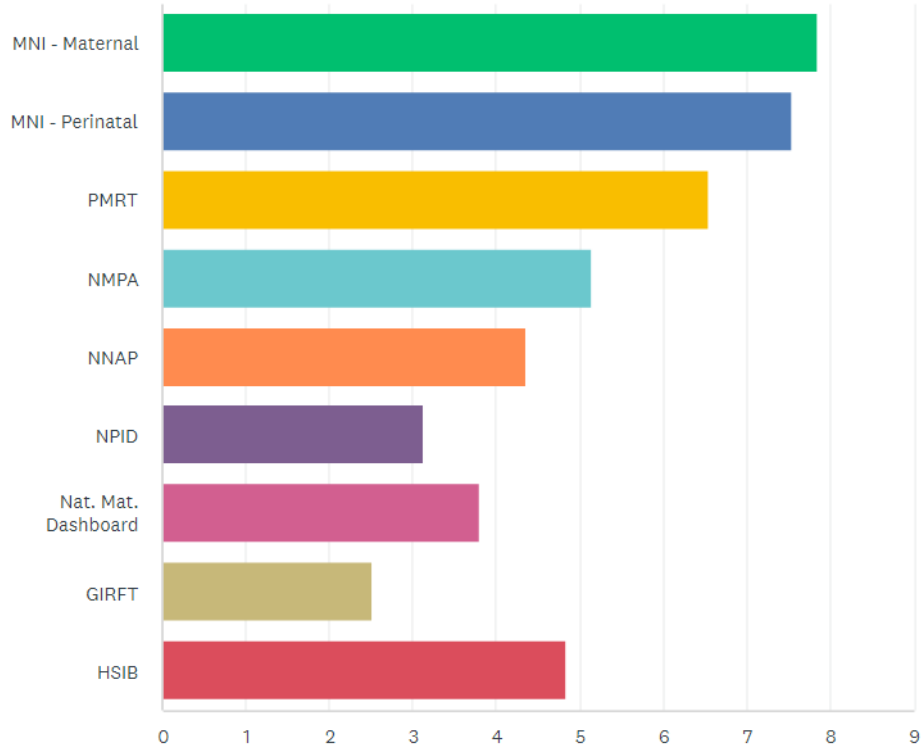
	Never problematic	Rarely problematic	Sometimes problematic	Often problematic	Always problematic	N/A	Total
Data quality	2	18	30	20	5	7	**82**
Metrics available	1	15	33	18	5	10	**82**
Data timeliness	1	11	26	18	20	6	**82**
Understanding of data presented	3	22	38	11	2	6	**82**
Time constraints (for analysis)	2	4	21	26	26	3	**82**
Resource constraints (for QI)	1	4	20	23	30	4	**82**
Quality improvement methodology knowledge	9	14	38	10	6	5	**82**

Q9. Do you have difficulties prioritising and acting upon all national datasets/reports?



Never	2
Rarely	5
Sometimes	23
Often	31
Always	12
Not applicable	2
Total Respondents	**75**

Q10. Please order these programmes from the most (1) to the least (9) useful in your experience?



	1	2	3	4	5	6	7	8	9	N/A	**Total**	**Weighted Average**
Maternal, Newborn and Infant Outcome Review Programme - Saving Lives, Improving Mothers' Care (MBRRACE-UK)	37	12	8	9	2	1	0	2	0	4	**75**	**7.85**
Maternal, Newborn and Infant Outcome Review Programme - Perinatal Mortality Surveillance (MBRRACE-UK)	9	36	17	4	3	2	0	0	0	4	**75**	**7.54**
Perinatal Mortality Review Tool Programme (PMRT)	5	9	24	21	5	3	1	0	1	6	**75**	**6.55**
National Maternity and Perinatal Audit (NMPA)	2	3	7	13	25	10	4	4	1	6	**75**	**5.14**
National Neonatal Audit Programme (NNAP)	6	2	2	4	13	18	13	6	5	6	**75**	**4.36**
National Pregnancy in Diabetes Audit (NPID)	0	1	3	1	2	17	18	15	9	9	**75**	**3.12**
National Maternity Dashboard	6	1	1	3	8	9	16	17	5	9	**75**	**3.79**
Getting It Right First Time (GIRFT)	2	1	0	2	3	6	12	13	27	9	**75**	**2.52**
Healthcare Safety Investigation Branch (HSIB)	5	7	9	14	9	2	1	7	15	6	**75**	**4.86**

10. Appendix 3. Survey results (qualitative)

Q11. Do you have any suggestions for improvements in relation to national data? (optional)

Free text answers as entered:

1. Should all be pulled together into one set of recommendations. Also need a single source of all audits that are national requirements as there's no single list of these.
2. Many of these audits provide data which are already known: locally and from other reviews (particularly GIRFT and LMNS are good at repeating, without providing new information or insight)
3. Less reports and less recommendations for the system
4. Maternal Focused-Ethnicity, haemoglobinopathies, mental, social wellbeing. Mother must be a priority and not subjugated.
5. More timely- often QI projects are done before release of publication so learning needed no longer relevant
6. There is a lot of national data out there with regards to maternity services. Now I do not use all of them, so they are not all relevant to me, however I really like the PMRT, NNAP and NPID. I find some of the MBRRACE-UK audits to be to slow and behind. They make recommendations but the data is from two years ago, can the process be sped up so the data is up to date and not behind, if it can be done for the rapid covid reports how come it cannot be done for the rest of the reports. Some of the data is extremely hard to find on the websites (MBRRACE), I feel it should be easily accessible. I also find the MBRRACE-UK website in general awful to navigate, at the very least the different groups/subjects of the reports should be in a different colour to highlight them, it is extremely difficult to find what you are looking for on the MBRRACE-UK website and is not clear to the lay person, the reports all have very similar titles but sit under different branches on MBRRACE-UK, but this is not clear or obvious. This to me reduces its value of the report, it makes me feel that if it is not easily accessible and obvious why has it been produced and who is it aimed at, even though they are available for the public, it does not feel that they have been produced with everyone in mind.
7. Site Specific Infographics
8. data needs to be meaningful and accurate i.e., outcome measures that lead to a focus on improving safety not just process measures. data needs to be collectable from existing reporting systems not reliant on poorly resourced manual inputting
9. Less ambiguity in some of the national recommendations in terms of implementation
10. Standardised datasets and measures. These audits have different definitions / measures / etc
11. Recommendations made from national reports should have a solid evidence base that has weighed up the pros and cons of different management options, rather than sweeping recommendations based on individual cases.
12. When reports are published ready made benchmarking tools should be included. A one stop website for all the data to be located on
13. "Little point in reports that reference data for 2-3 years previous, need easy access to benchmarked data that has standardised outcome measures e.g. something as simple as PPH is recorded in different ways in all trusts. Lots of national data excludes twins - means that less clinically meaningful for QI work / benchmarking as this is the very group that needs QI for work on PeriPrem"
14. Just put it in one place please :)
15. The MDDS is not accurate - errors in the way data is pulled e.g.: Robson group 1.
16. Training and support in the clinical areas to understand this
17. Organisations coming together to produce datasets and recommendations
18. Give people more time - stop duplication. There is just too much in the system
19. Often find HSIB recommendations are just a quick fix approach. Often it is a one off event with a one off problem that will probably never occur again and they become fixated on this minute detail and cause a

lot of work and reports to correct this small thing rather than thinking about the bigger picture of maternity services under resourced and understaffed.

20. Portion of RCOG website sign posting to each (and other) reports of relevance and interest.
21. Streamline and align
22. The data must be easy to download and load into a computer for analysis. Csv files, with time-series information ideally all in the same file. Monthly data released separately (e.g. MSMS/MSDS) is very difficult to use. Ideally some pre-prepared analysis would be available - why do all 150+ maternity trusts need to develop their own methods when a centrally recommend approach and toolset could be developed.
23. There is too much information and not sure which is the best one to utilise.
24. Less audits and reporting
25. Utilisation the same definitions
26. Timely production of findings.

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