

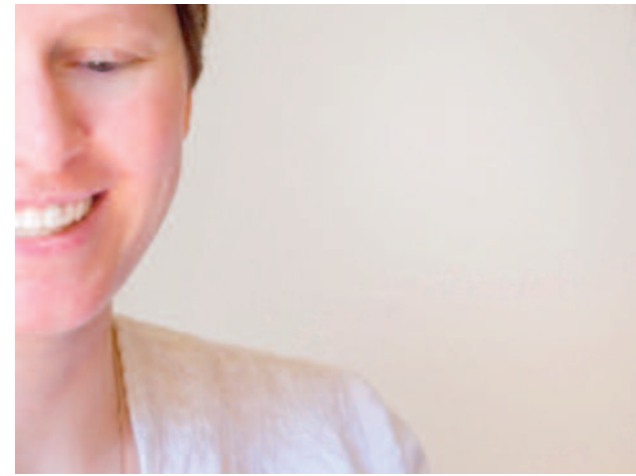
Safe Births

Everybody's business

An independent inquiry into the safety of maternity services in England

Conclusions and recommendations

King's Fund



This summary presents the conclusions and recommendations of a small independent panel set up by the King's Fund in 2007 to inquire into the safety of NHS maternity services in England.

The panel members, selected for their expertise in areas related to health and patient safety, concentrated primarily on the safety of mothers and babies during birth.

They based their findings on oral and written submissions from a broad range of relevant organisations and individuals and on visits to selected maternity units in England, as well as on the published data on safety in general and on safety in maternity services in particular.

Their overall conclusions are as follows:

- the overwhelming majority of births in England are safe; however, some births are less safe than they could and should be
- safety is the responsibility of each and every member of all the teams working in and supporting maternity services – not only of midwives and obstetricians, but also of anaesthetists, support staff, managers and trust boards
- 'safe teams' are the key to improving the safety of maternity services.

1 How safe are maternity services?

Discussion of safety issues tends to focus on risk and harm and the ways in which things go wrong. However, it is important to think about the causes of success as well as about those of failure.

Discussion should also focus on the positive actions that create and maintain a system that achieves maximum reliability and resilience.

There is much on which to build. The maternity services have a strong tradition of championing safety, of pioneering quality initiatives (such as the drives for woman- or family-centred and evidence-based care) and of using women's views to inform service planning.

Conclusions

- Giving birth in England in 2008 is likely to be safe for the overwhelming majority of women and babies.
 - The stillbirth rate of 5.4 per 1,000 total births has remained virtually unchanged since the mid-1990s, despite a reduction in the threshold for registering stillbirths from 28 to 24 weeks' gestation in 1992.
 - Rates of infant mortality have continued to fall over the same period, from 6.1 per 1,000 live births in 1996 to 4.8 per 1,000 in 2006.
 - Maternal deaths directly attributable to problems in pregnancy or at birth have remained relatively stable at just over 6 per 100,000 maternities since the mid-1980s.
 - Nevertheless, safety 'incidents' in maternity are regularly reported. Some 62,746 maternity-related incidents were reported from 1 June 2006 to 31 May 2007. Sixty-six per cent of these caused no harm to mothers or babies; 21 per cent caused 'low harm' and 1.5 per cent caused severe harm.
- In spite of the data that is available it is not possible to say how safe it is to give birth in England, or to compare this with the safety of maternity services elsewhere. This is partly because the outcome measures used are only broad indicators of safety, partly because the data collected in different jurisdictions are not comparable, and partly because information systems do not collect enough information about adverse outcomes other than deaths.

2 Maternity services in context

There is a useful amount of evidence about the features of maternity care most relevant to safety and about ways in which these have changed in recent years.

- **Sudden transitions:** Although pregnancy and birth are normal physiological processes, unexpected emergencies can develop rapidly.
- **Two lives:** The fact that maternity services have to care for two or more lives (mother and baby or babies) simultaneously raises the stakes and sometimes – as with caesarean sections – may involve a conflict of interest between mother and child.
- **Duration of care:** Maternity care is delivered over a long period, often in different settings and involving many professionals, ranging from midwives and obstetricians to social workers.
- **Women's experiences:** The quality of the birth experience can have lasting effects on mothers, babies and families.
- **Changing demands:** Some recent changes in the pregnant population have important implications for safety in maternity services. Changes in recent years include:
 - numbers of births have risen since 2002 and are projected to increase
 - there are more older mothers, with higher rates of complication
 - there is more fertility treatment, leading to a higher rate of multiple births
 - there are more obese women, who are less fit for pregnancy
 - there are more women who survive serious childhood illness and go on to have children, and who need extra care in pregnancy and childbirth
 - there are rising rates of intervention in labour, in particular in rates of caesarean section
 - there is increasing social and ethnic diversity, sometimes leading to communication difficulties and other social and clinical challenges in maternity care.

3 Safe maternity teams

Most maternity care is delivered by teams rather than individuals. Effective teamwork can increase patient safety; poor teamwork can jeopardise safety. The inquiry found a number of recurrent difficulties in teamwork.

PROBLEMS

✘ **Interprofessional relationships**

Doctors and midwives sometimes have differing approaches to care, and in particular to the need for intervention in labour.

✘ **Difficulties with leadership and management**

Maternity teams are not always clear about leadership and are not always well managed.

✘ **Difficulties with communication**

Communication between clinicians, particularly at crunch points such as referrals between health professionals, shift changes and in emergencies, is not always effective.

SOLUTIONS

✓ Safe maternity teams need:

- clarity about team objectives and roles
- effective leadership
- clear and agreed procedures for communication.

4 Staffing for safety

PROBLEMS

- ✘ **Shortage of midwives** It is widely accepted that all women should have one-to-one midwife care during labour, but often this is not available.
- ✘ **Inadequate consultant cover** Some maternity units do not achieve the recommended level of consultant cover.
- ✘ **Inexperience** Safety may be compromised if staff have insufficient experience. Changes to obstetric training as a result of the European Working Time Directive mean that specialist registrars are likely to be less experienced on completion of training than in the past.
- ✘ **Administrative overload** Midwives and doctors complain that clinical time has to be spent on administrative tasks that could be done by clerical staff.
- ✘ **Inappropriate deployment of clinical skills** Midwives are sometimes diverted to tasks that could more appropriately be done by maternity support workers, theatre support staff, nurses or cleaners.

Safe maternity teams need adequate numbers of staff with the right skills. This requires effective deployment of staff as well as employment of enough skilled staff.

SOLUTIONS

- ✓ Safe teams need the right staff in the right place at the right time. Without systems to ensure effective deployment of maternity teams and their members, employing more staff may not improve safety.
- ✓ Maternity units need to review demand and capacity regularly, ensure that they employ enough staff with the right mix of skills, and deploy them effectively across peak and other times.
- ✓ National bodies, including the Department of Health, should provide simple and effective tools to help managers achieve these goals in real time.

5 Training for safety

Teams can provide safe services only if their individual members have the right skills and training, as well as the appropriate resources, and if they practise relevant skills together as a team.

PROBLEMS

- ✘ **Poor uptake of training** Training requirements are not always met, sometimes because of difficulties in securing time off for training and in funding cover for those who would be absent.
- ✘ **Lack of specific safety training** Clinicians do not receive enough education in general safety awareness and skills.

SOLUTIONS

- ✓ Teams that work together should also train together, with regular training taking place on the labour ward rather than on 'away days' and being seen as a core activity rather than an optional extra.
- ✓ Simulation-based training, which assesses clinical, communication and team skills within a single exercise, should be offered to all maternity staff, ideally within their own units.
- ✓ Safety awareness training should be introduced into mainstream professional education.

6 Guidance on safe practice

Safe practice must be based on evidence about interventions that work, as set out in guidelines, protocols and other forms of guidance.

PROBLEMS

- ✘ **Guidelines not available** Some units do not have the recommended guidelines in place. Even where guidelines are available, they are not always used or followed.
- ✘ **Guidelines not useful** Government, professional bodies and other organisations issue too many guidelines for maternity staff. Many are repetitive and lengthy, and some are inconsistent with others.

SOLUTIONS

- ✓ A single set of evidence-based guidelines that are backed by all relevant organisations, including the National Institute for Health and Clinical Excellence (NICE), should be produced.
- ✓ Short summaries and one-page protocols should be prepared to make the guidelines usable.
- ✓ All staff should be trained to use these protocols, and their implementation should be regularly audited.

7 Information for safety

Information about clinical outcomes can be used for summative, retrospective purposes, such as reporting on standards; but it is more crucially used for formative purposes, to help maternity teams assess and improve their own work.

PROBLEMS

- ✘ **Information not useful** Information relevant to safety is regularly collected from maternity services through many different systems, but teams do not receive enough feedback to learn lessons that would help them improve their performance.
- ✘ **Time-wasting systems** Clinicians complain of multiple data-collection systems that take up large amounts of time at the expense of time for patient care. The new IT systems being implemented and planned in many trusts do not permit integrated data collection and handling.

SOLUTIONS

- ✓ Maternity teams need manageable amounts of information about their own performance, combined with information about national performance that they can use for benchmarking purposes.
- ✓ Trust boards should ensure that maternity teams collect, use and reflect on a small set of reliable information measures that are critical to safety.
- ✓ Pending an effective national information system, simple systems for capturing information on safety should be designed, implemented and maintained locally.

8 The role of trust boards

Trust boards have a fundamental duty to safeguard the patients for whom their staff provide care. They should demand rigorous routine information on safety from maternity units and support the collection of this information. Safety information should form part of the ‘balanced scorecard’ of key performance indicators that should be the first agenda item at every board meeting.

PROBLEMS

- ✘ **Low priority for maternity** Many contributors claimed that maternity services were of low priority for trust boards. Some claimed that this was due to the absence of centrally imposed targets, which are set for other areas of health care and command board attention.
- ✘ **Poor focus on safety** Although health care is the core business of the NHS, trust boards pay relatively little attention to clinical matters, including patient safety. We note that this may be due partly to the fact that clinical members are in a minority on boards, and partly to the intense pressure on chairs and chief executives to focus on financial health and national targets.

SOLUTIONS

Boards should take the following steps to improve safety.

- ✓ Prioritise safety, communicate that priority to staff and patients and make data on safety publicly available.
- ✓ Educate board members about safety issues in maternity services and strengthen advocacy for maternity safety on the board.
- ✓ Have governance structures in place to assure safety, including strengthening safety committees and systems for collecting and reporting safety information.
- ✓ Improve understanding of local safety issues through regular executive ‘walk-rounds’ of units, including maternity units, analysis of safety indicators and detailed review of safety incidents.
- ✓ If boards are not persuaded by the ethical and clinical case for engaging in safety they should at least regard it as a business imperative. In an era of patient choice, boards need to understand the damage that safety lapses can cost them in what will be an increasingly competitive market.

9 National structures for safety

A number of national bodies are concerned with patient safety, and some with maternity safety in particular. These include the Healthcare Commission, the Confidential Enquiry into Maternal and Child Health (CEMACH), the NHS Litigation Authority (NHS LA) and the National Patient Safety Agency (NPSA).

PROBLEMS

- ✗ **Administrative overload** The large number of different national organisations with a stake in maternity safety places considerable administrative burdens on staff, without delivering commensurate safety improvements ‘on the ground’.
- ✗ **Poor co-ordination** The links between these bodies are not always well understood, even by those working in them.
- ✗ **Low priority for maternity safety** Although policy attention to maternity services has increased, the focus on safety has not. The only government target for maternity is linked to choice rather than safety. Although the Healthcare Commission monitors standards on safety, none of these is specific to maternity.
- ✗ **Clinical Negligence Scheme for Trusts (CNST) standards** These standards, set and monitored by the NHS LA, have not provided trusts with sufficient incentives to improve maternity safety.
- ✗ **Poor impact of recent NHS reforms** The Payment by Results (PbR) financial reform seems unlikely to act as a lever for improving maternity safety, although patient choice and commissioning have some potential to do so.
- ✗ **Poor regional planning and support** There is a need for stronger regional leadership, particularly for contingency planning when units have to close for safety reasons, and for ensuring adequate support during reconfiguration, when units may be particularly vulnerable to safety problems.

SOLUTIONS

- ✓ Standards for the safety of maternity services should be set and monitored by just one body – the Healthcare Commission (in future the Care Quality Commission) on the advice of other relevant bodies.
- ✓ Existing standards should be distilled into a smaller number that are critical to safety.
- ✓ Strategic health authorities and others providing regional leadership for maternity services should offer special support to trusts undergoing reconfiguration.
- ✓ The Department of Health should ensure that financial incentives are aligned to promote the safest care, and develop commissioning and patient choice as drivers for improvement.

Resources

The King's Fund is committed to following up work on the inquiry. We will work in partnership with other organisations to take the findings and recommendations of the inquiry forward. We want to explore and test out the ideas set out in the report with maternity units interested in driving up safety standards. You can get involved in a number of ways.

FIND OUT MORE AND FEED BACK

For further information about the inquiry, to download or order a copy of the full report and to feed in your views on the recommendations, please visit www.kingsfund.org.uk/maternity

KEEP UP TO DATE

If you would like to receive email updates including information on how we plan to follow up the work of the inquiry, please sign up at www.kingsfund.org.uk/updates. Make sure you select 'maternity' under areas of interest. Alternatively fill out the form below, photocopy and fax it back to 0207 307 2809.

ATTEND A SEMINAR

Maternity safety in practice seminar series:

Seminar 1: Measuring for improvement – moving beyond learning from incidents – **April 2008**

Seminar 2: Creating an effective team to provide one-to-one care – **Summer 2008**

Seminar 3: Working in high-risk situations – **Autumn 2008**

For more information visit www.kingsfund.org.uk/maternityevents

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