Consultation response

The King's Fund response to the NHS Litigation Authority's consultation on pilot maternity clinical risk management standards

7 October 2008

This paper is a response by The King's Fund to the NHS Litigation Authority's Pilot Clinical Negligence Scheme for Trusts Maternity Clinical Risk Management Standards (hereafter known as the Standards). The King's Fund seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, developing leaders and improving services. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas. In 2008 The King's Fund published a report of a year-long inquiry into the safety of maternity services in England, *Safe Births: Everybody's Business* (O'Neill 2008). Our response reflects the focus of that Inquiry, namely the safety of intrapartum care, and draws on the findings of the Inquiry to make some recommendations.

We welcome the new principles on which the assessment standards are based. These rightly ensure that maternity services will no longer be reassessed on lower levels as they progress through the standards. We hope that this will reduce the administrative burden on trusts undergoing assessment that was problematic for a number of individuals and stakeholder organisations who submitted evidence to our Inquiry (Smith and Dixon 2008). We welcome the intention of the Standards to support maternity services in taking a proactive approach to improvement, to empower maternity services to determine how to manage their own risks and to contribute to embedding risk management into the maternity service's culture. *Safe Births: Everybody's Business* emphasised that patient safety should be a key focus for trust boards (O'Neill 2008).

We broadly agree with the choice and organisation of the standards and the criteria they contain. The idea that Level 1 deals with establishing effective risk management systems, Level 2 with the implementation and sometimes monitoring of these systems and Level 3 with monitoring compliance with systems and addressing deficiencies is clear and logical and applied throughout the Standards.

Safe Births: Everybody's Business reported staffing problems including issues with shared leadership, with the division of roles and with communication between midwives and obstetricians. In standard 1 criterion 2 (leadership), we suggest the mandatory presence of a supervisor of midwives for each shift on the labour ward, as well as an experienced midwife co-ordinator. The rationale for this is the statutory system for supervision of midwives, which has an important role to play in providing leadership focused on safety. Supervision is provided by experienced midwives, who undertake further specific training; all midwives, whether they are practising in hospital or in the community or are self employed, are required to accept this supervision. Supervisors provide support, advice and guidance on practice issues and encourage further development of skills and knowledge (O'Neill 2008).

Standard 1, criterion 6 is concerned with policy on guideline development and management. *Safe Births: Everybody's Business* highlighted the need for short actionable protocols. We

hope that trusts are supported to achieve this standard by appropriate national guideline development from the Royal College of Obstetricians and Gynaecologists and the National Institute for Health and Clinical Excellence.

We welcome the consideration of the deployment of midwives in standard 1, criterion 3. *Safe Births* concluded that although increasing staffing to appropriate employment levels was important, that alone would not improve safety unless staff were deployed effectively. In standard 1 criterion 4 (organisation of staffing levels (obstetricians)), we are pleased to see that the recommendations of *Safer Childbirth* (RCOG *et al* 2007) are being used. *Safe Births: Everybody's Business* recommended the use of evidence-based guidelines backed by professional organisations (O'Neill 2008).

In standard 1 criterion 8 (incidents, complaints and claims) no mention is made of reporting incidents to the National Patient Safety Agency (NPSA) through the National Reporting and Learning System (NRLS). The role of strategic health authorities in the reporting of serious untoward incidents is also not considered. We propose that these are explicitly included in the Standards.

Safe Births: Everybody's Business clearly stated the importance of consistently following agreed national guidelines. This applies to a number of clinical criteria in the standards. In standard 3 criterion 7 (pre-existing diabetes), level 1 point (d) should be re-written, as *all* women treated with insulin during pregnancy - that is the vast majority, whether type 1 or type 2 - need to be aware of the risks of hypoglycaemia and hypoglycaemia unawareness, not just those with type 1 diabetes (CEMACH 2007). The terminology used in the NICE guideline for diabetes in pregnancy also refers to 'women with insulin-treated diabetes' (NICE 2008).

Standard 4 criterion 3 (patient information and discussion) should include information about infant feeding. The Department of Health website states: The Government is fully committed to the promotion of breastfeeding, which is accepted as the best form of nutrition for infants to ensure a good start in life. Breast milk provides all the nutrients a baby needs. Exclusive breastfeeding is recommended for the first six months of an infant's life.' (Department of Health 2008). In 2005 (the most recent data available), 78 per cent of mothers in England initially breastfed their babies; 48 per cent of all mothers in the UK were still breastfeeding their babies at 6 weeks, and this figure dropped to 25 per cent at 6 months. Three-quarters of all mothers had given their baby milk other than breast milk by the age of 6 weeks (The Information Centre 2007). Women need to be given information during pregnancy about the benefits of breastfeeding. This rationale is also relevant to standard 5, criterion 5 (newborn feeding), in which we feel that breastfeeding is insufficiently promoted or supported.

We welcome standard 4 criterion 5 about the handover of care. *Safe Births: Everybody's Business* backed the use of formal communication protocols such as SBAR (situation-background-assessment-recommendation) for improving communication at patient handover. In the same vein, standard 4 criteria 7 and 8, which refer to a systemic approach to training and skills drills are to be welcomed. *Safe Births* recommended courses such as MOSES (Multidisciplinary Obstetric Simulated Emergency Scenarios), which trains teams in real-time scenarios, using real vital signs monitors, clinician actors, and mannequins controlled by clinical observers, who assess the process through a one-way mirror.

In conclusion, we support the overall aims of the NHS Litigation Authority's Pilot Clinical Negligence Scheme for Trusts Maternity Clinical Risk Management Standards and hope that their successful implementation will be part of the continuing drive to further embed a safety culture in the maternity services in England.

References

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