



Safer Births

Supporting maternity services to improve safety

Report of three regional events held in York, London and Wigan, 2009

THE KING'S FUND INFORMATION CENTRE

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Introduction

While the overwhelming majority of births in England are safe, the lack of a systematic approach to safety across maternity services is creating unnecessary risks. In 2008 the report of an independent inquiry commissioned by The King's Fund, *Safe Births: Everybody's business*, and the Healthcare Commission's review of maternity services, *Towards Better Births*, identified similar areas in need of improvement, including staffing and training, leadership, teamworking, and communication. Together with a number of other reports, guidance documents and reviews, they identified the challenges for maternity services and set out recommendations.

To enable frontline professionals working in maternity units to improve the safety of the services that they deliver to women and their babies, The King's Fund set up the Safer Births initiative, a service improvement programme, with national and local partners. The partners in the first phase of the initiative were The King's Fund, the National Patient Safety Agency, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Confidential Enquiry into Maternal and Child Health (now the Centre for Maternal and Child Enquiries), the NHS Litigation Authority and the Healthcare Commission (now the Care Quality Commission).

During the first phase of the Safer Births initiative, in early 2009, three regional interactive events were organised for an invited audience of heads of midwifery, lead obstetricians and risk managers. The events were designed to help maternity units to reflect on their current practice, the challenges to improving safety and their local priorities. They gave professionals the chance to develop local solutions as a team, share experiences and good practice and learn about a range of methods used in improvement work and patient safety. Across the three events, held in York, London and Wigan, 71 trusts were involved out of a total of 73 in the Yorkshire and the Humber, North East, London, and North West strategic health authority regions. About 40 per cent of participants were midwives; 20 per cent were obstetricians; and 20 per cent were managers or risk managers. Most teams came from consultant-led units.

During these events, which combined discussions, workshops, interactive voting and a question time session, there were first-hand accounts of what these teams thought were the major challenges to the safety of women and babies in their units, as well as the solutions they were already developing. Teams were asked to identify and discuss the main challenge to the safety of mothers and babies in their unit, put forward any specific objectives or ambitions that they had developed to improve safety and then, during workshops and discussions, focus on tools, methods and best practice examples that they could use to address that challenge.



The Royal College of
Midwives



Royal College of
Obstetricians and
Gynaecologists
Setting standards to improve women's health



NHS
National Patient Safety Agency

Summary of findings

Participants said that safety is a high priority for staff in maternity units and that improving the safety of maternity services is a goal they are actively addressing. The most commonly

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cited areas for improvement were staff shortages and poor communication between staff. Other areas were teamworking, leadership and reducing the burden of regulation. Only one or two teams said they had not discussed safety as a team prior to the event.

The teams not only proved willing to share their own solutions but also showed that they were open to ideas and willing to try new solutions. They agreed, broadly, on the need for good teamworking supported by joint multidisciplinary training, and the need to support clinical staff to put guidelines into practice. They discussed new ways of deploying staff including new support roles and changes to rotas for better teamwork and greater efficiency.

They also shared their safety challenges. Almost universally, staffing was a concern for maternity units, and in particular developing the next generation of midwifery leaders. Participants also discussed the challenge of the rising birth rate and the growing complexity of their workload, with increasing numbers of women with complex medical conditions now giving birth. Some challenges were specific to particular localities. In Yorkshire and the Humber and the North East, this included the geographical isolation of some units and led on to discussion about the optimum size for a consultant-led unit. In London it was the rising birth rate and staff shortages while in the North West there was considerable concern about the impact on safety of service reconfiguration.

Staffing and training

Staffing was the biggest concern of participants. All regions reported staff shortages. Some units had budgetary problems, leading to a freeze on recruitment. Some had difficulty recruiting staff, particularly recruiting and retaining midwives with more than one or two years' experience. Several units said that even the full complement was not adequate to meet rising demand. Birthrate Plus, the midwifery workforce planning tool, was regarded by many units as useful, although some units reported difficulties in getting trust boards to discuss their results.

The staffing challenge took on different dimensions in different locations. Participants from London, for example, pointed out that 25 per cent of the UK's births take place within the M25 and numbers are rising. Staff are overworked and capacity is stretched to the limit, they said. The shorter distances between units in the capital compared to some rural locations meant it was possible for midwives with a full-time job at one trust to do bank work at a second, leading to concerns that many staff are exhausted. One participant said: 'We are stretched every day. There is a relentless need for beds day and night.' Another added: 'We have a workforce who do an awful lot of overtime and it is uncontrolled. They are tired.'

In York, teams from Yorkshire and the Humber and the North East argued that safety was compromised by insufficient numbers of midwives and obstetricians, exacerbated by external factors such as the implementation of the European Working Time Directive, which has had a negative impact on the level of experience of junior doctors and therefore on midwives. One risk manager said: 'The junior doctors have gone from being inexperienced to being very inexperienced.'

In Wigan, units were worried about how to maintain safe staffing levels. In one unit, 17 out of 112 midwives had simultaneously gone on maternity leave. This sudden shortfall had resulted in the local supervising authority being called in, forcing the trust board to recognise the problem. They noted: 'Supervision has for us been a bonus.'

Some teams felt powerless in the face of staff shortages but others demonstrated how they had changed the way they deployed and trained staff to deal with it. For example, some units had developed the maternity assistant role to take over clerical work, routine

blood tests, breast-feeding support or smoking cessation programmes. Other units had developed specialist roles to address women's complex needs, for example, outreach midwives for vulnerable women. At least one unit was reviewing the consultant job plan to increase their presence on the labour ward.

One trust shared how it had cut midwifery vacancy rates from 24 per cent to 3 per cent and had been able to demonstrate a reduction in serious untoward incidents associated with the use of temporary staffing. A culture of valuing every professional group as 'equal but different' also contributed to a safer service and led to reduced risk associated with communication problems. Other innovations included community midwives managing their own caseload. This increased job satisfaction and continuity of care, helping the labour ward at busy times because midwives came into hospital with 'their' women, adding to the staffing complement. Another trust had introduced flexible hours that allowed managers to call in staff at peak times without having to resort to bank staff.

There was evidence too of innovation in training as a means of improving safety. Joint training of midwives and obstetricians was seen as crucial, and a number of trusts had revamped their skills and drills training to make sure everyone knew what to do in an emergency. Anecdotally, one trust attributed low rates of perinatal injury to joint training. Another had developed a three-day joint training course that had delivered benefits for teamworking and clinical outcomes.

One team presented how it had used increased consultant cover on the labour ward not as a means to increase the number of pairs of hands available but to develop an education resource, with consultants running multidisciplinary teaching sessions on the delivery suite using cases from the past 24 hours. Midwives at another trust had developed a 'snapshot education' initiative in which senior staff discussed cases at handover.

Another team described how it was working on competencies, including going back to basics on competencies such as drug administration. Others were looking at the serious untoward incidents in a more systematic way, identifying those that could provide useful learning opportunities.

Leadership

Discussion around leadership identified two areas of concern: leadership at board level and leadership at unit level. The consequence of a lack of leadership at either or both levels and difficulties in getting the board to engage with maternity services contributed to feelings of disenfranchisement and disaffection among staff. One midwife said: 'Poor practice becomes the norm because there is inertia in addressing it.'

Some teams felt that boards were not aware of the safety agenda in maternity services. Units that had completed the workforce planning tool Birthrate Plus had not always been able to present their results to boards, meaning that progress stalled. Participants discussing this issue characterised maternity services as a 'Cinderella service', starved of resources and attention. They hoped that the renewed focus on safety brought about by national reports and additional funds allocated to PCTs to commission new services would translate into a sharper focus at board level. This will require leaders in maternity services to develop and present a strong evidence-based case for service improvements, backed up with relevant data. Some units may need to develop new skills to do this.

Participants felt that there was a need for strong leaders at unit level to tackle specific issues, such as resolving conflict. Among participants, however, many of whom were leaders within their units, there was a sense that they were struggling. One talked about middle managers lacking confidence, which led to inappropriate escalation. She said: 'As senior midwives we are constantly firefighting and spend most of our time unblocking

beds.' In some places there was a lack of senior people in leadership posts. One midwifery manager said: 'It's all very well developing leaders but you have to have people in the posts to be developed.'

Many more were worried about the future and an emerging experience gap in the midwifery profession. They reported a workforce that consisted of a handful of very experienced staff at senior level, a reasonable supply of new entrants but very few in between because mid-career midwives had either gone into the community or left the profession. This was echoed across all regions. One said: 'In five years' time all the senior midwives on my unit will retire.' In Wigan, one team reported that more than half of their midwives were due to retire in the next five to seven years. The unit in which 17 midwives had gone on maternity leave simultaneously had received 40 applications for the posts, but none of the applicants had been qualified for more than two years.

There was a range of initiatives designed to nurture leadership at all levels. Several units had implemented preceptorships for newly qualified staff, giving more experienced staff the opportunity to provide them with support and, by supervising their practice, develop their own leadership and management skills. One trust had introduced succession planning to develop the more experienced members of the team into future leaders.

Teamworking and communication

Teamwork was an issue that teams felt they could address by using strategies such as joint handovers, mandatory joint training, shared guidelines and spending social time together. Many teams, however, felt that teamwork in their unit was poor or even non-existent. Participants talked about bullying and racism, poor relationships between senior midwives and senior registrars, and ineffective communication.

There were many initiatives under way to improve both teamworking and communication. Many of the teamworking solutions tried by units were based in training initiatives. For example, some units had found that improving their skills and drills exercises had improved not just skills but also teamwork. Another trust was keen to set up an awayday for consultants and midwives to help understand each other's role. Others had developed or improved induction programmes for new staff.

Solutions to improve communication issues, meanwhile, tended to be policy-based. One unit had tackled racism and bullying within the team by introducing a zero tolerance policy with agreed communication criteria, including a rule that only English is spoken between team members.

Several units said that communication during transfer from midwifery-led to consultant-led care was a crucial safety issue. One trust discussed a service change in 2007 in which a consultant-led unit became midwifery-led, with the consequence that intrapartum transfers were then made to a consultant-led unit at a second trust nearby. The two units developed joint guidelines and two-way communication, resulting in excellent relationships between staff at the two trusts. A review of transfers has found them to be timely and appropriate, and mutual respect for each other's professional practice and role had developed.

In other places, improved teamwork and communication was a by-product of initiatives designed to address other issues. For example, one trust had looked at shift patterns, introducing 12-hour shifts in which obstetricians' and midwives' handovers take place at the same time. This was in part a response to the need to increase consultant cover in obstetrics, but had knock-on benefits such as reducing communication problems and shortening the quiet period between handovers when staff on a shift that is about to end are reluctant to initiate interventions.

Use of information and guidance

Maternity units, in common with the rest of the NHS, have to provide information for managers, the trust board and regulators. And as in the rest of the NHS, there is a tension between seeing this as a means of supporting safe, high-quality practice and viewing it as an unnecessary burden.

The Clinical Negligence Scheme for Trusts (CNST), which is managed by the NHS Litigation Authority, is a good example of this. The risk management programme that forms part of CNST is run to increase safety; trusts that achieve high marks in their assessment, which usually takes place every two or three years, benefit from a discount on their contributions to the shared risk scheme. Some teams discussed how they struggled with the CNST inspection, with small units in particular feeling overburdened. One said: 'When CNST comes up we are all working seven days a week and taking work home. Women get no infant feeding advice for ages because the midwife who does this is our computer whizz and she is off doing CNST. We cannot sustain it.' However, others had tried to turn preparation for a CNST assessment into a process, arguing that the inspection team should be able to visit on any day and find the same standards in place. They had employed strategies such as allocating different areas of work to different staff members. This shared the workload and gave ownership. Another had changed guidelines on the labour ward as a result of its work towards Level 3 CNST, improving safety and providing a tangible financial benefit for the trust.

Some teams talked about old IT systems, or even a complete lack of IT, that left senior midwives spending hours gathering and compiling data for trust returns and inspections. Two-thirds of the teams attending the events said their trust had adopted a 'clinical dashboard', a computerised tool that gives continuous, near-real-time feedback on key performance indicators. Green lights indicate that all is well, but a red light should trigger a rapid response. One trust that had been placed on special measures by the Healthcare Commission had developed and implemented a maternity dashboard that has subsequently been implemented in other maternity units throughout the country. It was reported to have had real benefits for highlighting potential risk.

Other initiatives to improve information-gathering included a trust that had employed a part-time midwife to support staff to get clinical coding right. This had not only ensured that the unit received the correct income for the work it had undertaken but had also enabled analyses of client case-mix and improved the quality of information provided to the board. Another trust had appointed a dedicated team of two to manage risk and governance within its maternity services.

Some units highlighted the gap between what the guidance says should be in place and the reality on the ground, for example, 40 hours of consultant obstetric cover per week is now recommended for labour wards. Some teams reported that although this was officially in place, they still struggled to find support when needed. Others said that this could be achieved only if consultants took on a role that was largely training.

Elsewhere, staff in maternity units were using cost-effective initiatives to improve adherence to guidelines and evidence-based practice. For example, one trust had started summarising guidelines, producing more effective and user-friendly documents for staff. Another had developed pocket guides to hot topics.

Other concerns

Some of the participants worried that the choice agenda could jeopardise safety. Popular or new units had experienced queues outside labour wards while other units that had been on special measures imposed by the regulators were demoralised. One midwife said:

'The reputation of the hospital has been damaged. Women are saying they do not want to come and deliver with us, which is disappointing.'

Several teams cited the complexity of the caseload as another challenge, including a rising number of obese women. Across all three events midwives talked about experienced staff being pulled away from the labour ward to develop targeted services for vulnerable women such as drug and alcohol users or teenage mothers, although in some cases this was seen as an opportunity to innovate. The rising birth rate coupled with rising levels of complexity posed a double challenge, with units caring not only for higher numbers of mothers and babies but also for more sick babies and mothers with more complex needs than a decade ago. This was perhaps most acutely felt in London. The capital's population is not only diverse – requiring staff to use interpreters and understand different cultural norms – but also highly mobile, posing a challenge to providing continuity of care.

Teams in rural units were worried about ease of access, particularly with longer distances between units, and how reconfiguration of services would impact on safety. They felt that there was insufficient planning and communication around major service changes with both staff and mothers.

The issue of how to provide one-to-one support for women in labour came up repeatedly, with several trusts using innovative ways to make sure women are admitted to the labour ward only once they are in established labour. Two methods were mentioned: triage (using experienced midwives to assess women) and assessment units that are open 24 hours a day.

Conclusion

The events gave maternity professionals the chance to discuss in some detail with their team members, and with other units, their main patient safety challenge, as well as the opportunity to share experiences and good practice. Through the table talk discussions and workshops, all of which were facilitated, it was possible to tease out potential solutions and examples of local activity to improve the safety of services.

Although there are significant challenges facing maternity services, and the lack of staff and poor communication were of great concern to the majority of units, teams were able to see that many solutions did not depend on having greater resources or more staff, but on better deployment of limited resources, stronger leadership within units and across professional disciplines, and more effective teamworking.

Some of the local examples of best practice were innovative, such as joint training of teams from two different trusts between which transfers are made, while others were simple changes such as more thorough and effective induction programmes that took little resource but could really make a difference.

There was an enthusiasm for networks to share learning and to help trusts continue to learn from each other. It was notable that many of the teams had not met before and were interested, and in some instances surprised, to learn of improvement work being undertaken within the same region. The vast majority of teams wanted to improve the safety of their services and there was a real will to drive this forward. Many of them felt that they wanted practical advice on how to do this, tailored to their particular local circumstances, not simply guidance.

Next steps

To help meet the need for practical advice and support, and to enable frontline maternity professionals to improve the safety of services, the Safer Births initiative has launched an improvement network. This will work intensively with up to 12 multidisciplinary maternity teams over a period of 18 months from September 2009. The main focus will be in the areas of:

- staffing
- training
- leadership
- teamworking
- communication
- the use of guidance and information.

Participating units will be encouraged to identify a focus for their improvement activity, pilot safety tools and approaches, evaluate their impact, and share learning with others.

Regional events over the period of the improvement network will bring together participating trusts with other trusts in the same SHA region, to help share learning and best practice. Learning, tools and reports produced by the network and the Safer Births partners will be shared with all interested trusts through regular updates and online at www.kingsfund.org.uk/saferbirths.

The partners in the second phase of the Safer Births initiative are The King's Fund, the National Patient Safety Agency, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Centre for Maternal and Child Enquiries, and the NHS Litigation Authority.

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