The King's Fund

Ideas that change health care

Safer Births

Supporting maternity services to improve safety

in partnership with

NHS
Litigation Authority

NHS
National Patient Safety Agency

Safer Births

› Safe Births Inquiry 2008

› Safer Births Initiative 2009

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Safe Births: Everybody's business

- Independent Inquiry into the safety of NHS maternity services in England
- The inquiry was advised by a Professor of Midwifery, an obstetrician and a statistician
- Chaired by a philosopher Onora O'Neill - other panel members: a professor of patient safety, a surgeon and the former head of CHI
- Focus on safety of mothers and babies during birth

Safe Births: Everybody's business

- Overall conclusions:
  - overwhelming majority of births in England are safe, but some births are less safe than they could or should be
  - safety is the responsibility of each and every member of all the teams working in maternity services
  - 'safe teams' are the key to improving safety

Safe Births

- The stillbirth rate of 5.4 per 1,000 births has remained virtually unchanged since 1990s
- Infant mortality rates have continued to fall from 6.1 in 1996 to 4.8 in 2006
- Maternal deaths have remained relatively stable at just over 6 per 100,000

BUT

- 62,746 maternity-related incidents were reported from June 2006 to May 2007.
- 1.5% of them caused severe harm.

The King's Fund Safe Births 2008

Maternity care in context

- Number of births has been rising since 2002
- More older mothers, with higher complication rates
- More fertility treatment = more multiple births
- More obese women, less fit for pregnancy
- More mothers who have survived serious childhood illness and need extra care
- Rising intervention rates in labour
- Increasing ethnic and social diversity, sometimes leading to communication challenges

Creating Safe Teams

Inter-professional relationships

- Doctors and midwives sometimes have differing approaches (e.g. need for intervention in labour)
- Maternity teams are not always clear about leadership and are not always well managed.
- Communication between clinicians, particularly at crunch points such as referrals between professionals, shift changes and in emergencies, is not always effective.

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Creating Safe Teams

Safe maternity teams need:

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

- Actually all teams need these characteristics

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Staffing problems

- All women should have one-to-one midwife care during labour, but often this is not available.
- Some units do not achieve the recommended level of consultant cover.
- Changes to obstetric training (EWTD) mean that specialist registrars are now likely to be less experienced
- Midwives and doctors complain that clinical time has to be spent on administrative tasks
- Midwives are sometimes diverted to tasks that could be done by others

Staffing solutions

- Safe teams need the right staff in the right place at the right time.
- Maternity units need to review demand and capacity regularly, and deploy staff effectively across peak and other times.
- National bodies should provide simple and effective tools to help managers achieve these goals in real time.

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Other proposals

- Improved guidance on safe practice including short summaries
- Better information and feedback
- Use a small set of reliable measures
- Educate board members about safety in maternity services and strengthen advocacy for maternity safety on the board
- If not for ethical or clinical reasons there is a business case!

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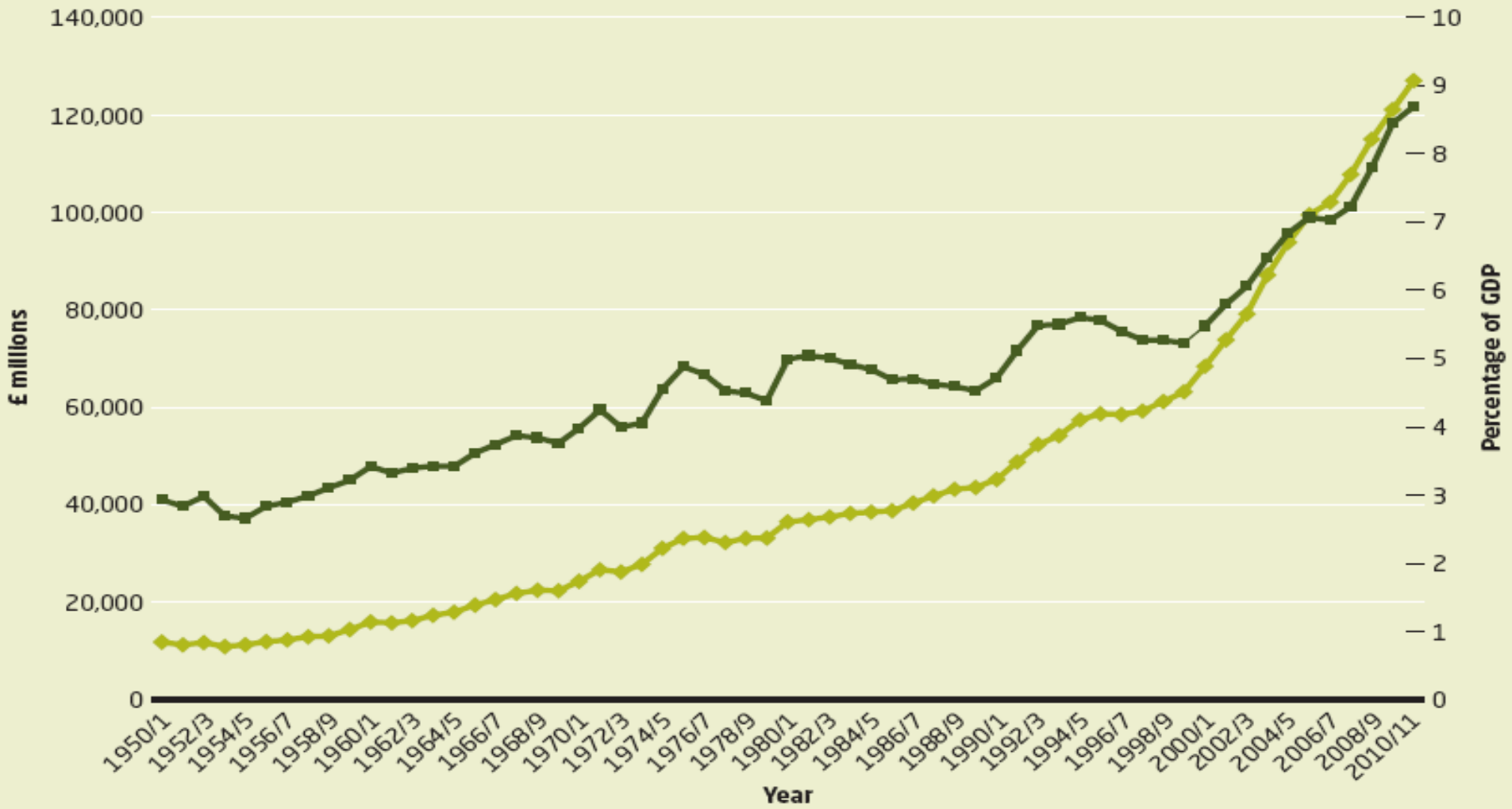
Figure 1 Real net spending on the UK NHS at 2010/11 prices and as a percentage of GDP



Sources: HM Treasury (2009); OHE (2009).

Real spending (left axis)

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Institute for Fiscal Studies

How cold will it be?

Institute for Fiscal Studies

2011 - 2017

- ‘tepid’ - real increases of 2 per cent 2011-13
  3 per cent 2013-17
- ‘cold’ - zero real change 2011- 2017
- ‘arctic’ - real reductions of 2 per cent 2011-14
  1 per cent 2014-17

- Rises of c2 per cent for the NHS could mean 4.5 per cent cuts in other departments

IFS / The King’s Fund 2009

Safer Births Initiative

- Launched Sept 2008
- National partners: RCM, RCOG, NPSA, CEMACH (CMACE), NHSLA
- Regional and local partners
- Phase I: regional events (Jan-Apr 2009)
- Phase 2: service improvement network

  From Sept 2009
- Phase 3: Further research

  March 2010

Phase 1: Regional events

- To support implementation of Safe Births: Everybody's *business*
- Yorkshire & Humber and North East, London, North West
- Objectives:
  - Reflect on safety challenges
  - Exchange ideas
  - Learn about approaches and tools to improving safety in maternity services
- Each unit brought Head of Midwifery, Lead Obstetrician, Clinical Governance Manager /Supervisor of Midwives or similar

Phase 1: Regional events

Issue	Y&H and NE	London	NW
Safety	88%	86%	87%
Increasing staffing levels	44%	44%	41%
Choice	23%	24%	30%
Addressing inequalities in access	19%	23%	19%
Reducing obesity	13%	10%	11%
Smoking cessation	4%	5%	6%
Reducing healthcare-associated infections	4%	4%	6%

Phase 1: Regional events

Issue	Y&H and NE	London	NW
Lack of staff	68%	56%	92%
Lack of communication between staff	54%	52%	100%
Burden of regulation and data collection	21%	5%	49%
Poor team working	17%	29%	35%
Lack of information or data about your team's performance	17%	13%	35%
Lack of effective leadership	7%	15%	31%
Poor deployment of staff	5%	10%	27%
Too many guidelines and standards to follow	10%	7%	17%

Phase 2: Service Improvement Network

- Launched Sept 2009
- To enable frontline professionals to improve the safety of their services
- Focuses on intra-partum care
- More than a 50 applications
- 12 multidisciplinary maternity teams; 18 months from Sept 2009
- Staffing, training, leadership, team working, communication, use of guidance and information
- Pilot safety tools and approaches, evaluate impact, share learning

Participating maternity units

- Northern Devon Healthcare Trust
- The Ipswich Hospital NHS Trust
- Barts and The London NHS Trust
- South Warwickshire General Hospitals NHS Trust
- Kingston Hospital NHS Trust
- Medway NHS Foundation Trust
- Derby Hospitals NHS Foundation Trust
- Northampton General Hospital NHS Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- Mid Essex Hospital Services NHS Trust
- North Middlesex University Hospital NHS Trust
- Stockport NHS Foundation Trust

Approach

- Consultancy support and access to others in the network; face-to-face networking and learning opportunities; a secure online facility for exchanging information and learning
- 'Knitting together' key national organisations concerned with patient safety in maternity services
- Further regional events bring network members and other teams together to help share learning
- Resources, reports and tools available to all maternity health care professionals through regular programme updates

Phase 3: Further work

- Project commissioned by The King's Fund led by Patient Safety and Service Quality Research Centre, King's College, London
- Synthesise evidence on workforce deployment and skill mix in maternity services with a focus on the impact on safety
- Is it possible to deliver a 'safe' maternity service by using staff more effectively?
- Expected to report March 2009

More information

- Sign up for Safer Births updates:
  - Postcards, CMACE stand no.59
  - www.kingsfund.org.uk/saferbirths
- Contact:
  - Rhiannon Handslip, Network Co-ordinator Safer Births

    r.handslip@kingsfund.org.uk
  - Susanne Cox, Service Improvement Lead Safer Births

    s.cox@kingsfund.org.uk

Thank you

www.kingsfund.org.uk