The inquiry

At the end of 2006, the King’s Fund set up a small panel to inquire into the safety of maternity services in England. This inquiry was intended to be independent of the institutions and professions that are directly responsible for maternity services, and to make practical recommendations.

The panel members, although independent of maternity services, were appointed for the knowledge they brought to the subject from other areas, including patient safety in particular and health service improvement and regulation in general. This choice of members provides a different perspective from that of other projects in this area, which have been conducted by people more closely connected to maternity services and the NHS. These projects are listed in Appendix 1.

This recent increased interest and investment in safety in maternity services is very welcome and suggests there is significant national momentum to drive forward improvements. Rather than duplicating or overlapping with existing work, we have aimed to use our more distanced perspective to add value in a different dimension. So instead of conducting original research, we have considered the informed views of those who responded to our calls for evidence, as well as some of the wider literature relevant to safety in maternity services. We have tried to place their submissions in the wider context of safety and policy in general and to use it as a basis for making practical recommendations for change.

We framed our call for evidence in broad terms, and the responses we received covered a correspondingly broad range of issues, linked to safety in various ways. We have not been able to consider every issue raised in detail, nor to provide definitive answers to all the questions posed. Instead, we have adopted a more streamlined approach, focusing our report and recommendations on seven key areas that appear most crucial to improving patient safety in maternity services at this time. However, we hope that the rich variety of the responses we received, which are published alongside this report, will prove a useful resource for others with an interest in this area.

We are enormously grateful to everyone who took the time and trouble to respond to our questions, discuss their work, tell us about steps they had taken to improve safety and help us form a view on some difficult issues. Our discussions over the past year have been lengthy and involved, and we are grateful to our advisers for their constant availability for ‘reality checks’ and also to our expert peer reviewers. Full details of how the inquiry was organised and the responses on which this report is based are included in Appendix 2.
A positive approach to safety

This report is focused specifically on the safety of maternity services rather than their quality or efficiency, although both may be closely linked to safety. We have concentrated primarily on the safety of mothers and their babies during the intrapartum (delivery) period; we have restricted our remit to NHS maternity services; we have also been limited by the charitable remit of the King’s Fund to maternity services in England rather than in the United Kingdom as a whole.

In many ways maternity services are similar to other areas of health care and, indeed, to other enterprises unconnected with health. However, as newcomers to this specific area, we were struck by certain issues that are unique to maternity services and that add to the challenge of delivering these services safely. Maternity care can range from looking after women going through a natural process with little medical intervention, through to ‘high-tech’ emergency care more akin to the services provided by an accident and emergency department or intensive care unit, when complications arise. This and other issues are described more fully in the next chapter, which sets maternity services within a broad context of patient safety in general.

Nowhere have the negative aspects of patient safety been emphasised more than in the maternity services, which have been subjected to numerous reviews in recent years. The problems highlighted by these reviews have led to a great deal of discussion by the media, not all of it well informed.

Safety however, has another face, which is best described as an aspiration. To review the safety of maternity services as we came to understand is less a matter of dwelling on (recording, investigating, analysing) failure that has occurred and more a matter of striving to create and maintain a system that is geared to success. Safety is as much a matter of understanding how success is achieved as of understanding why failure happened.

Safer care, according to Michael West, is most likely to flourish in

... a climate that encourages co-operation, innovation and excellence. In particular, this is a climate characterised by optimism, confidence and celebration of success. Too many NHS environments are characterised by pessimism, cynicism, anxiety and fear of failure.

(Written evidence, unpublished)

This view was endorsed by many of the maternity professionals contributing to this inquiry, who pointed out that successes were never investigated or celebrated. In fact, by comparison with many activities, childbirth is low risk and the overwhelming majority of births in England in 2008 will be safe ones. The fact that maternal and perinatal death rates remain low should also be celebrated, as this has been achieved in the face of a number of important demographic and clinical pressures.

However, there is no room for complacency because care can always be safer, and continuing safety requires constant work; it is only achieved by reflection, adaptation to change and ceaseless vigilance. Past achievements never guarantee future safety, particularly in the face of new challenges and demands. Safety must therefore always be under review: indeed this is one of the markers of a safe system.
Our central conclusion, expressed in the title of this report, is that safety is everybody’s business. It is the responsibility of each and every member of the maternity team – not just of midwives, doctors and maternity support workers but also of housekeepers, security staff, porters and ward clerks. It is also the responsibility of wider management teams, trust boards and a range of NHS bodies and policy-makers.

We have tried to make our recommendations as practical as possible, with suggestions for new tools to support safety, ideas for sharing best practice and an overview of some of the components needed to build and support safe maternity teams.

If this report is to be effective, action is needed to take these recommendations forward. We are delighted that the King’s Fund is committed to supporting initial action to aid implementation. We recognise that where safety is concerned there are no quick fixes, and our seven main recommendations call for quite complex changes in team working. But there are immediate steps that can be taken – safety is everybody’s business now!

Onora O’Neill
Chair
Maternity Services Inquiry

BUILDING AND SUPPORTING A SAFE MATERNITY TEAM: A SUMMARY BASED ON THE RECOMMENDATIONS OF THIS REPORT

Safe maternity care calls for teamwork, and teamwork means working effectively with your colleagues in any situation, whether you know them personally or not.

- Safe teams need shared objectives: what is your team trying to achieve?
- Safe teams need good communication: how well does your team communicate?
- Safe teams need effective leadership: are your leaders focused on safety?
- Safe teams need to be adequately staffed to allow for one-to-one care in labour: do the teams at your trust achieve this?
- Safe teams need regular team training to support safer services: does your team train together?
- Safe teams need the right guidelines: do your guidelines support safety?
- Safe teams need information: does your team receive information you can use to make deliveries safer?
- Safe teams need trust boards that prioritise safety: does yours?
Recommendations to Support Teams in Delivering Safe Care

- Training for safety: Simulation-based training to enable teams to practise working together in an emergency.
- Guidance for safety: Co-ordinated guidelines supported by short usable protocols and implementation tools.
- Information for safety: Usable safety information for teams to enable them to reflect upon and improve their practice.
- Board level priority for safety: Through effective deployment of staff.
- Staffing levels to support safety: Clear objectives and roles, good communication, effective leadership.
- National policy: Clearer co-ordination to reduce the burden on teams.

Safer maternity services for mothers and babies.

TO DELIVER

SAFE TEAMS NEED

- Clearer co-ordination to reduce the burden on teams.
- Safer maternity services for mothers and babies.
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