King's Fund

maternity services inquiry

Health care professionals' views about safety in maternity services

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About the authors

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Contents

Executive summary

Objectives

This study explores health care professionals' views about safety in maternity services. It identifies aspects of care that are less safe than they should be, possible ways to improve safety and potential obstacles to achieving these improvements.

Methods

The respondents were a convenience sample (a non-probability form of sampling based on collecting data from respondents who are available or encountered) of health care professionals working in or with maternity services. They were recruited via targeted publicity aimed at professional bodies and a stand at a Royal College of Midwives (RCM) conference. Respondents were asked to self-complete a short questionnaire (with both closed and open-ended questions) on the King's Fund website or via a downloadable form. Responses were imported into QSR NVivo, and analysed using thematic content analysis.

Results

A total of 608 questionnaires were returned, 603 via the website and 5 hard copies. Seventeen responses were blank and therefore excluded from the analysis (n=591). Of all respondents, 474 (80 per cent) were midwives and 20 (3 per cent) were obstetricians. The remainder were composed of hospital doctors, neonatal nurses, paediatricians, GPs, nurses and managers. Most respondents – 409 (69 per cent) – had 11 or more years' professional experience.

The problems they identified include the following.

- **The increasing social and medical complexity of the pregnant population** More high-risk women are having babies, and maternity services are looking after women with more complex social needs. Women who book late put particular pressure on services. Vulnerable women are less likely to access services early in their pregnancies. The lack of nursing training for newer midwives can be a problem if they are looking after sicker women.
- **Low staffing levels, especially the lack of experienced midwives** This problem will worsen as the midwifery workforce ages. A lack of funded posts means that not all newly qualified midwives can find jobs. Pressure on inexperienced staff can lead some newly qualified midwives to feel unsupported, stressed and disenchanted, leading to problems with staff retention. Insufficient numbers of experienced midwives means newly qualified members of staff lack support. There is a lack of supervision for trainees and inadequate senior support. Low staffing levels in hospital can have a knock-on effect in the community as midwives are pulled in to cover the labour ward. Staff shortages mean it is more difficult for midwives to provide one-to-one care for women, which is especially important for high-risk women in labour. There is inadequate cover for sickness, maternity and annual leave. Overstressed staff are more likely to be ill.

- **Inappropriate skill-mix** There is a lack of clarity about the roles and responsibilities of maternity support workers, and a lack of clerical support for midwives. Some respondents regarded maternity support workers as unacceptable, cheap replacements for midwives. Support workers who carried out clinical tasks for which they were not trained were viewed with suspicion and thought to have an adverse impact on patient safety. Lack of clerical support meant midwives were spending more time dealing with paperwork and less time with women.
- **Low staff morale** Low morale creates a vicious cycle of increased staff sickness rates, inadequate cover, overstretched staff, less-safe care and further demoralisation. We found examples of over-tiredness, ill health and staff burnout.
- **Inadequate training and education** The shift in midwives' training from hands-on practical training to academic degrees has not necessarily improved patient safety. Lack of nursing training means newly qualified and trainee midwives are less likely to recognise sick mothers and identify abnormal situations. Midwives are expected to fund their own post-qualification training, which was felt to be unfair. Changes in medical training mean junior doctors have less experience than in the past. Within the medical profession, gynaecology is seen as a more prestigious specialty than obstetrics, which could lead to problems in the future.
- **The increasing medicalisation of birth** This can have implications for reduced normality of birth – that is, one that occurs without medical management of any kind – in low-risk mothers. It was partly thought to be a result of fewer midwives and more technology. Obstetricians did not tend to view medicalisation of birth as a problem.
- **Poor management** Respondents felt that managers lack clinical experience, are remote and too business-focused. Midwives who had been promoted into management positions lacked management skills and sometimes failed to address important staffing issues. Some heads of midwifery were poor communicators and failed to keep in touch with staff. Some managers were too concerned with finances and not enough with safety.
- **Lack of resources** There were stark messages about lack of funding for maternity services, in the context of a generally underfunded NHS. There were reports of old and broken equipment. Midwives' low rates of pay were compared unfavourably with other professions.
- **Reconfiguration** The threat of mergers was mentioned by a small number of respondents as having a detrimental effect on staff. NHS reorganisations were perceived to affect training, reduce staffing levels and negatively affect maternal safety.

Respondents identified a number of solutions, including the following.

- **More staff** More midwives would allow all women to have one-to-one care in labour. It would also reduce rates of intervention, postnatal hospital stays and release money to reinvest in services. More women would be able to deliver in birth centres or midwife-led units where intervention rates are lower. Midwives could be better deployed to improve safety. One suggestion was to employ more consultant midwives and fewer managers. More appropriately trained doctors would increase the presence of obstetric consultants on the labour ward. Midwives advocated the use of Birthrate Plus, a tool that takes case-mix (the range and types of women looked after by maternity services) into account, to calculate the required staffing levels.

- **Better teamwork and skill-mix** Mutual respect between doctors and midwives was considered crucial. Better teamwork among midwives could be facilitated by regular staff rotations. Getting the right skill-mix within teams was seen as vital to ensure safety.
- **Improved training** Introducing multidisciplinary training and in-house drill training could make maternity services safer. Respondents proposed a national standardised framework for training and a defined career pathway for support workers. There was a suggestion that a return to apprentice-style training would mean midwives were more appropriately qualified. Trusts could support midwives in their ongoing training to improve safety. Respondents noted the benefits of supervision of midwives.
- **More one-to-one care** One-to-one care in labour was very important to respondents. Midwives found it unacceptable to have to look after more than one woman in labour at a time.
- **Caseloading** Midwives who have worked with caseloads (when one midwife looks after a woman throughout her pregnancy, during labour, and postnatally) tend to favour it, as do independent midwives. If implemented widely, it would mean staff were allocated to women, not to the labour ward.
- **Better management** Managers need to understand the problems experienced by frontline staff and not become too remote. Visible support from the chief executive was considered important. Managers need to ensure good working conditions for staff. Management training for clinical staff would be beneficial. Good management leads to staff who are valued and supported and therefore work harder and are more effective and efficient. Some midwives called for less bureaucracy. It was felt that reducing the number of reconfigurations would have a positive effect on maternity services.
- **More resources** Ring-fencing the maternity budget in trusts would be a popular move. Payment by Results (PbR) does not properly reimburse for care provided by community midwives.
- **Better guidelines** The development of guidelines should involve professionals who work direct with women, and they should be evidence-based. Midwives and obstetricians should have an equal voice in the development of guidelines. They should be quickly disseminated, perhaps using a national briefing system. Local implementation of national guidelines is an effective way of working.
- **Learning from incidents** This is a key component of improving patient safety. Regular multidisciplinary meetings and a 'no blame' system of reporting and analysing incidents were regarded as vital. Some respondents were disillusioned and did not see the benefits of reporting. Others recognised that in order to build professionals' confidence in the reporting system, feedback needed to be given and they needed to see evidence that action was being taken.

Limitations of the study

The study sample was not necessarily representative of all professionals, as we targeted professional associations to recruit potential respondents. The sample favoured those familiar with the internet and who were highly motivated to answer the questions. It is possible, therefore, that negative attitudes are over-represented. We made extensive efforts to target doctors but they are under-represented in the sample. Despite these

limitations, the study provides a valuable insight into the perceptions of staff who deliver maternity services. If some of the views expressed contradict objective evidence, this suggests a need to educate and challenge professional beliefs.

Conclusions

Professionals working in maternity services identified a significant number of problems that they felt resulted in some women and their babies experiencing care that was less safe than it could be. These concerns should be acknowledged by policy-makers, professional bodies and local NHS management. Despite working in a challenging environment, professionals were able to identify a number of potential solutions that, if implemented, could secure improvements in the safety of maternity services in England. However, there are still a number of obstacles that will need to be overcome if these improvements are to be realised.

Although respondents were quick to identify problems with maternity services, they did not always make an explicit link to safety. But there is one exception: low staffing levels were felt to have a direct impact on the safety of care. They cause unsafe care by resulting in burnout and tiredness, less time for direct care and higher error rates. Low ratios of experienced staff to newly qualified staff affects the delivery of safe care. There was a clear link between low staffing levels and low morale. The timing of the call for evidence may have had an impact, as it came at the end of a financial year where the NHS was put under great pressure to reduce deficits.

Respondents expressed mixed views about maternity support workers. Some midwives felt they spent too much time on non-clinical tasks that could be carried out by clerical or support workers. This could resolve some of the apparent problems with staffing levels and improve safety of care. Maternity support workers can enhance quality of care by providing one-to-one support in labour and spending more time with vulnerable women (Sandall *et al* 2007).

Doctors and midwives expressed different views. Both groups identified lack of training as a problem for the safe delivery of maternity services. Obstetricians were concerned with the increasing medical and social complexity of the pregnant population and low morale, while midwives were worried about the increasing medicalisation of childbirth. Midwives tended to view medicalisation in normal childbirth with suspicion, while obstetricians see intervention as part of their routine practice.

Changes in the medical and social needs of pregnant women present challenges to midwives' and obstetricians' ability to deliver safe care. Pregnant women's increasingly complex needs place greater demands on maternity services. Midwives who do not have nursing training may not have the skills needed to look after medically high-risk women. Systems of identification and care pathways are needed to ensure safe care for all women, including those who are at a higher risk of an adverse outcome.

Changes in management and training are likely to have the most inter-professional support. Lack of support at board level for midwifery training and supervision was a problem, and suggestions were made about how to improve basic training for obstetricians and midwives. Midwives need sufficient clinical expertise to identify and manage complex medical cases, and obstetricians need sufficient experience of normal

labour and delivery. This could suggest the need for more shared clinical training. Clinicians who take on management roles also need better training. Generally, respondents called for better management and leadership of maternity services.

Some of the solutions suggested by respondents are dependent on more resources. But others recognise the need for change in the way care is organised – for example, providing one-to-one care in labour or improved multidisciplinary teamwork. Few solutions related directly to general methods for patient safety (for example, systematic investigation of incidents), suggesting a lack of awareness of these among maternity staff. Respondents did, however, recognise the importance of guidelines and learning from incidents. Sometimes guidelines are not well implemented, requiring administrative effort without tangible improvements in care. This suggests a lack of pre-registration and continuing professional development 'safety' training for maternity staff.

Obstacles to improving patient safety include the unwillingness of stressed staff to embrace change, lack of resources, low morale and poor relationships between staff and management. Recommendations of previous reports into maternity services have rarely been fully implemented. Managers and policy-makers need to understand the nature of these local and national obstacles if a step change in the safety of maternity care in England is to be achieved.

Introduction

The King's Fund established an independent inquiry into the safety of maternity services in England on 4 December 2006. There have been a number of recent high-profile reports on problems with both the quality and safety of maternity services. These include an investigation carried out by the Healthcare Commission into 10 maternal deaths at Northwick Park Hospital in north London (Healthcare Commission 2006).

The inquiry was tasked with summarising the available data and evidence about the safety of maternity services and some of the underlying causes of less safe care. It set out to: develop a clear analysis of the complex and interrelated factors that have a bearing on the safety of maternity services; identify the main obstacles to delivering improvements in the safety and quality of maternity care; identify robust strategies for overcoming these problems; and make recommendations about how to ensure the implementation of interventions designed to improve and evaluate outcomes for mothers, babies and families. The inquiry team was also tasked with securing support for the implementation of change among policy-makers, health service managers, practitioners and mothers.

Written and oral evidence from stakeholder organisations was sought to inform the inquiry's deliberations (see the 'Inquiry into the safety of maternity services' section at: www.kingsfund.org.uk). The King's Fund also commissioned research with women who had recently given birth to explore their experience of maternity services and their views about safety (*see Women's Views about Safety in Maternity Care* at: www.kingsfund.org.uk).

Finally, the inquiry issued a call for evidence to individual professionals in order to ascertain their responses to three key questions:

- What are the main problems relating to the safety of maternity services?
- How can the safety of maternity services be improved?
- What are the barriers to achieving these improvements?

This paper analyses their responses.

There has been little qualitative research published on staff views of the safety of maternity services. Most studies focus on other aspects of maternity services such as the model of care, staff roles and staff morale. Turnbull *et al* (1995) examined changes in midwives' attitudes to their professional roles following the establishment of a midwifery development unit in a Glasgow teaching hospital. The midwives in the unit used a self-rostering system intended to improve continuity of care. While there was no significant change in the attitudes of those midwives who continued to work in a traditional way at the hospital, the attitudes of midwives working in the unit were significantly more positive. They were no more stressed than in their previous jobs. The study highlighted problems relating to liaison with colleagues. It concluded that managing change systematically and involving midwives can increase their professional satisfaction and minimise stress.

Sandall (1998) studied the relationship between midwives' work situation and likelihood of burnout. She found that midwives were more likely to experience higher levels of burnout if they had low control over decision-making and their work pattern, were working at a low grade, and for longer hours.

Lavender and Chapple (2004) conducted 15 focus groups, using an Appreciative Inquiry approach, to examine midwives' views of maternity care in England. They looked at birth setting, model of care and philosophy of care.

The main themes generated from the focus groups were cultural changes, midwifery leadership, appropriate role models, inadequate training in normality, appropriate responsibility of care divisions, choice for women, equity of care provision between high- and low-risk women and staff morale.

Lavender *et al* (2001a, 2001b, 2002a, 2002b) explored midwives' views following publication of *Making a Difference* (Department of Health 1999). This document set out the government's strategic intentions for nursing, midwifery and health visiting, and its commitment to strengthen and maximise the nursing, midwifery and health visiting contribution. Respondents generally felt positive about the prospect of their roles including greater health promotion, contributing more to public health (including targeting vulnerable groups) and increased continuity of care (for example, extending the duration of their contact with women, pre-conception input and more postnatal visiting). Some midwives felt that organisational barriers made it difficult for them to meet the needs of their local communities.

Sandall *et al* (2007) carried out a scoping study of maternity support workers in NHS trusts in England in 2006. Managers were generally positive about support workers' contributions to the overall work of maternity teams. They carried out valuable work, including supporting breastfeeding in the community, continuity of care and one-to-one support during labour, as well as caring for vulnerable women, attending home births, assisting in theatre and running antenatal and postnatal groups. There was a lot of variation between different hospitals in range of activities, training, pay and levels of competence. There were inconsistencies in governance, delegated responsibility and accountability.

Methods

We recruited an opportunistic convenience sample of health care professionals who work in maternity services. Respondents included midwives, obstetricians and gynaecologists, GPs, neonatal nurses, nurses, paediatricians and managers. They were recruited for the study via targeted publicity to professional bodies (*see* Appendix 1, page 37) and a stand at the Royal College of Midwives Annual Conference (21–23 May 2007). There was no appropriate obstetric conference at the right time. Far more midwives than obstetricians responded to the call for evidence (*see* 'Respondents' profile' section opposite), leading to potential bias in the results. Another possible source of bias is that people were more likely to respond if they had negative views. The call for evidence was live from 1 to 30 May 2007.

The questionnaire included a small number of closed, demographic questions and three open-ended questions. Respondents were asked to identify aspects of maternity care that were less safe than they should be, potential solutions to improve safety of care and any barriers to implementing these improvements. The questionnaire is reproduced in Appendix 2, page 39. Respondents could choose to answer an online questionnaire or download a form to fill in and return by post or email. The data was imported into QSR NVivo 7 and analysed by the authors using thematic content analysis.

A stratified random sample of 10 per cent of the responses was selected and read in full by the authors in order to identify themes. This initial analysis generated 39 codes. These emerging themes were reviewed and cross-checked against themes generated from the stakeholder evidence. A refined coding framework consisting of 13 codes was agreed. This was used as the basis for an analysis of the whole sample. All responses were searched electronically using keyword searches. Retrieved text was read in its context and relevant quotes were coded. The final analysis was developed and the selection of quotes reviewed by both authors. Because of the unrepresentative nature of the sample, we have not reported data in quantitative terms.

Limitations of the study

There are a number of limitations to the study that mean the results cannot be generalised nor taken to be representative of maternity staff as a whole. First, the sample were recruited via targeted information in professional journals, newsletters, email lists and conferences. Maternity staff who are not members of these professional associations were less likely to have heard about the inquiry and the call for evidence. Second, respondents had to visit the King's Fund website in order to respond to the questionnaire. It is likely therefore that respondents are over-representative of professionals with internet access and skills. Respondents are also likely to have been highly motivated to respond (given the effort required) and therefore probably had a particular interest in the issue.

While respondents recognised that care was safe for most women, the overwhelming majority of respondents thought there were problems that made care less safe than it could be. It is not possible to say whether such negative attitudes are representative or whether those with negative attitudes were more likely to respond. Third, although efforts were made to target obstetricians and doctors more generally, the response was disproportionately low compared to midwives. Thus the views of midwives are over-represented in the thematic analysis.

Respondents' profile

A total of 608 questionnaires were returned, 603 via the website and 5 hard copies. Seventeen were blank and these were excluded from the analysis (n=591). Of all respondents, 474 (80 per cent) were midwives and 20 (3 per cent) were obstetricians (see Table 1).

TABLE 1: RESPONDENTS BY PROFESSIONAL CATEGORY

Profession	Number	%
Midwife	474	80
Other	52	9
Obstetrician	20	3
GP	17	3
Manager	15	3
Nurse	8	1
Hospital doctor	3	1
Neonatal nurse	1	0
Paediatrician	1	0
Total	**591**	**100**

In the general workforce there is an approximate ratio of nine midwives to every obstetrician-gynaecologist (Smith and Dixon 2007). The ratio of midwives to obstetricians will be higher as many of the doctors who are dual-trained practise predominantly as gynaecologists. In our sample, the ratio of midwives to obstetricians is 21:1. The sample therefore significantly over-represents the views of midwives. Given the recruitment and sampling method, the responses are not necessarily representative of the views of all maternity professionals and this must be considered when interpreting the results.

Most respondents (69 per cent) had 11 or more years' professional experience. Only 5 per cent of the sample were students, and 7 per cent had been working for only between 1 and 3 years. The remaining 19 per cent of respondents had worked in maternity services for between 3 and 10 years (see Table 2).

TABLE 2: LENGTH OF SERVICE OF RESPONDENTS

Experience	Number	%
Student	30	5
1–3 years	40	7
3–10 years	112	19
11 years or more	409	69
Total	**591**	**100**

Similar themes and issues emerged in response to each of the questions. Problems and solutions were not always distinguished clearly nor indeed confined to the replies to the relevant questions. However, for the purposes of reporting the results we have organised the responses under 'problems' and 'solutions'. These themes are explored in greater detail below.

Problems

The increasing social and medical complexity of the pregnant population

Respondents identified a number of safety challenges associated with the increasing social and medical complexity of the pregnant population.

They noted that more high-risk women are having babies. Women who are older, obese or have existing medical conditions (including diabetes, HIV and hepatitis) all need more care from maternity services. Indeed, there is a significant minority of women who in the past would have died before reaching childbearing age and are now presenting to maternity services and requiring high levels of care.

Maternity services are looking after more women who have complex social needs. These include substance abuse, antenatal and postnatal mental health issues, domestic violence, asylum seekers and refugees, unbooked cases (women who do not make contact with services until very late on in pregnancy or even in labour), existing children who may be at risk, and teenage mothers. These women are especially vulnerable to poor pregnancy outcomes, and midwives do not feel sufficiently supported to provide care to them and their families. High-risk and vulnerable women have different needs at different stages of their journey through pregnancy, birth and the postnatal period.

Respondents also reported that unbooked women place particular pressures on services, especially if the woman's first language is not English.

> *Many unbooked women appear (economic migrants and asylum seekers), many of whom are unable to understand English. Interpreters are often unreliable, especially family members, which means that essential information about health, etc, may not be recorded. The women and their babies suffer as a result.*
> (Senior lecturer and midwife, more than 11 years' experience)

Respondents noted that high-risk women require more attention and time from their midwives and that this has a knock-on effect on staffing levels.

> *The increase in the complexities of the cases presented require time and meticulous planning to meet the needs of the women and their families. This leaves the midwife less time to attend to other women.*
> (Practising midwife and teacher, more than 11 years' experience)

> *The maternity activity in units serving a high-risk population require significantly different obstetric and midwifery staffing levels to those units with identical delivery numbers that serve a low-risk population.*
> (Consultant obstetrician and gynaecologist, 3–10 years' experience)

Vulnerable women may also be less likely to access services, including postnatal care, which can mean that adverse outcomes are missed.

> *There is a lot of potential for life-threatening illness to be missed postnatally, especially sepsis and thrombosis. This is a particular risk for vulnerable women who may not know how to access services.*
> (Lecturer in midwifery, more than 11 years' experience)

Respondents felt that they received insufficient training to care for high-risk or socially vulnerable women. Changes to midwifery training mean that more recently qualified midwives now have less medical knowledge.

> *Midwives without general nurse training or a period of time in acute medical settings may not be fully au fait with recognition of shock, sepsis, heart failure, etc.*
> (Head of midwifery, more than 11 years' experience)

> *Midwifery training focuses very much on normality – that is appropriate, but today we have women who are bigger, iller and who many years ago would not have survived for so long, never mind fall pregnant.*
> (Head of midwifery, more than 11 years' experience)

Obstetricians also focused on the greater medical needs of an increasingly complex pregnant population and the implications for training. They were concerned about both medical and midwifery training.

> *[The] CEMD [Confidential Enquiry into Maternal Deaths] and clinical experience suggests obstetric medicine in its broadest form (including perinatal psychiatry and drug misuse) is the area of most concern. Outside diabetes and a few dedicated other specialists scattered over the UK, [there is] little interest from medical specialties and new curriculae from the RCP [Royal College of Physicians] [are] not moving things on. The RCOG [Royal College of Obstetricians and Gynaecologists] has addressed [this] through ATSM [Advanced Training Skills Module] in maternal medicine. [There is a] need for this area to be recognised and for networks/support to be available.*
> (Consultant obstetrician, more than 11 years' experience)

The lack of nursing training for midwives was a worry. One obstetrician regretted that midwives were not trained as nurses any more, and another thought that there was:

> *… a lack of midwifery nursing training, and therefore the inability to recognise a sick mother.*
> (Consultant obstetrician, more than 11 years' experience)

Low staffing levels

Many respondents commented on problems associated with a shortage of staff, in particular the shortage of experienced midwives, a problem that will become worse as the existing workforce ages. At the same time many respondents reported that both newly qualified midwives and some experienced midwives are unable to find posts. The problem therefore appears to be a lack of funded and filled posts. According to published statistics, using a headcount measure, the number of midwives increased by 13 per cent between 1995 and 2005. But when measured as full-time equivalents, the numbers have remained almost unchanged over the past decade (Smith and Dixon 2007), despite a rising birth rate.

> *There has been a… reduction in the number of staff working full-time. We might have more numbers but we do not have more midwifery hours available to staff the service. Over half the workforce is due to retire in the next 15 years with no prospects of replacing them, as the strategic health authority has cut the number of student places being commissioned – ostensibly because there are no jobs, but this is ridiculous as there is certainly work out there for them to do.*
> (Midwife, more than 11 years' experience)

There is currently a glut of student midwives with no job due to NHS cutbacks so midwives could easily be employed.
(Student midwife)

The number of midwives will fall further as many are nearing retirement age. In 2004/5, almost one-third of midwives registered to practise were aged 50 or over and just 8 per cent were under 30 (Nursing & Midwifery Council 2005). This loss of experienced midwives will have a greater impact than simply a shortfall in staffing levels and will result in a skills deficit.

Not enough is being done to address the skills shortage when the anticipated exodus occurs.
(Midwife, more than 11 years' experience)

Filling vacancies with newly qualified staff will not necessarily solve the problem, and may result in more problems. Inexperienced staff may be more likely to make mistakes as the more complex work is shifted on to fewer experienced midwives.

Shortage of midwives and increasingly the loss of experienced midwives. Our unit recently upped the number of midwives – very welcome. However, the majority are newly qualified, direct entry. This has led to an increased number of 'near misses', particularly on delivery suite.
(Midwife, more than 11 years' experience)

Low staffing levels make retention of staff more difficult. The general view was that student midwives are badly paid and there are high attrition rates from degree courses. In addition, there are few incentives for midwives to enter the profession post-registration. More than one respondent suggested the government should stop training midwives who had no prospect of employment at the end of their training.

Why would someone start a course where at the beginning of this training you are told there will be no job for you and no chance of education and career development after you finish? Why bother?
(Midwife, more than 11 years' experience)

Newly qualified midwives often feel unsupported, find the job stressful, and quickly become disenchanted.

The main problem seems to be retention. Newly qualified midwives come out into a system that is struggling to keep up with the births and is highly pressurised. Some choose to leave rather than work under that pressure or some choose to go part-time. Midwives may also leave due to a disappointment with the reality of the job under present circumstances, for example, not being able to give holistic care in labour when you have to look after two or three labouring women at once.
(Midwife, more than 11 years' experience)

I ended up going back to nursing because I felt the shortage of midwives was dangerous and I did not want to be part of an inadequate service… I was so shocked by the midwifery staffing levels compared to nursing staffing levels that I felt very vulnerable.
(Midwife, 1–3 years' experience)

The problem of retention is not confined to those working in the NHS. Among independent midwives, the inability to obtain affordable indemnity or liability insurance was also cited as a reason for leaving the profession.

> *Midwives [are] leaving the profession because of fear, stress and frustration with the system not allowing them to offer good midwifery practice.*
> (Independent midwife, more than 11 years' experience)

> *Independent midwives are being threatened because they cannot get insurance, which puts both women and midwives at further risk.*
> (Midwife, more than 11 years' experience)

Respondents noted that low staffing levels on the ward have knock-on effects on staffing levels in the community. It appears common practice for hospitals to pull in midwives from the community to cover staff shortages on the labour ward, meaning many women receive little or no postnatal and antenatal care. Staffing shortages can also result in midwives working extra shifts.

> *If hospital units are understaffed, they pull in community midwives to cover the shortfall, but these midwives may have already worked during the day before being called into units when they are on-call overnight to cover the shortages. Tiredness is a safety factor too.*
> (Midwife, more than 11 years' experience)

Respondents felt there were two main safety consequences of staff shortages: the lack of time to provide women with adequate care and higher numbers of women in their care than most midwives felt was safe. This can lead to high-risk women not receiving the care they need.

> *There is no doubt that shortage of staff in clinics, delivery suites and on the community prevents midwives from devoting enough time to the disadvantaged in the community... Routine work is often rushed because of time constraints, things get missed, signs not explored. Women see the pressure midwives are under and don't feel they can say what's on their minds.*
> (Midwife, more than 11 years' experience)

> *A lack of staff puts midwives under increased pressure and leads to a lack of satisfaction/inability to give the care we want to, leading to quitting the profession! It's catch 22.*
> (Midwife, 1–3 years' experience)

Many respondents noted that low staffing levels were further exacerbated by sickness, maternity leave and holiday cover. This creates a vicious cycle, with overstretched staff feeling stressed and therefore being off sick more frequently.

> *Lack of staff, existing staff are expected to cover shifts with a dangerous, reduced level of staff, so creating a higher sickness level because staff are overworked due to stress levels being too high.*
> (Midwifery student/maternity care assistant, 3–10 years' experience)

As a consequence of being constantly overstretched at work with no time for breaks, many midwives admitted to being tired and burnt out and therefore more likely to make errors.

Things are missed because of having to rush and cram too many consultations or too much care into one's working day. Lack of food and dehydration due to lack of breaks exacerbates this by making one function less efficiently as hunger and thirst increase.
(Midwife, more than 11 years' experience)

This account from a unit co-ordinator reflects the challenging conditions under which midwives are working.

A shortage of staff makes it unsafe for women... On planned section days there are usually three cases. There may be three people who have got epidurals in situ also. All of these women need one-to-one care, but they are usually being looked after by midwives who are also looking after someone else in labour... As the shift and unit co-ordinator I should ideally not have a case. Having two or three clients is not unusual.
(Midwife, more than 11 years' experience)

Some respondents felt that the situation faced by staff was not recognised by management.

The main problem is shortage of staff and the lack of managers (both maternity and trust) to truly recognise this. As long as we struggle through a shift, then that is ok.
(Midwife, more than 11 years' experience)

Low staffing levels can result in women being left unattended, which is frightening for both the women and their partners and can also have a negative effect on labour, according to some respondents.

Many midwives felt that they were not able to care for women's other, non-physical needs such as psychological and emotional needs.

Recognising that safety is not just physical safety – it is psychological safety, which is what is suffering with the shortage of qualified midwives.
(Midwife, more than 11 years' experience)

The shortage of other staff, such as clerical staff, also reduces the time midwives can spend providing direct care to women and their families.

Inappropriate skill-mix

Respondents' concerns about the skill-mix fell into three categories. First, they were concerned about the number of experienced midwives present; second, the role and responsibilities of maternity support workers; and third, the lack of clerical support for midwives and maternity staff.

In order to ensure safe care for women and their babies there needs to be a sufficient level of experienced midwives present at all times to support newly qualified midwives. In practice, the numbers of experienced midwives are in decline.

The skill-mix is becoming more dilute, as the ageing workforce retires and the more experienced midwives experience burnout and leave for more family-friendly and less stressful occupations, leaving the more junior staff ... to increase in numbers.
(Senior lecturer in midwifery, more than 11 years' experience)

The experienced staff leave because they're fed up working in unsafe environments… This means the only staff prepared to work in these units are newly qualified staff who don't know any better. The turnover is fast. The ward is then run on the bare minimum and the skill-mix is non-existent.
(Midwife, 3–10 years' experience)

Poor skill-mix can adversely affect patient safety. Junior staff are left unsupervised and without adequate support from more senior colleagues. The shortage of experienced midwives means that there is a lack of supervision for trainees.

Poor skill-mix on the labour ward, leaving experienced co-ordinators trying to ensure safe care given by midwives who are newly qualified and lacking experience.
(Midwife, 3–10 years' experience)

There is a marked shortage of midwives, and this is impacting on students' training. When midwives are busy the students lose out in terms of not getting adequate mentoring and support.
(Student midwife)

A number of respondents commented on the increasing use of maternity support workers or maternity care assistants. They had both positive and negative views on support workers.

Obstetricians were keen to encourage appropriate use of other staff in order to reduce some of the pressure on midwives but felt that this might be resisted.

Community obstetric assistants could do some of the postnatal visits and report back if problems required more expert input.
(Consultant obstetrician, more than 11 years' experience)

… but reluctance of midwifery professionals to devolve quasi-midwifery elements of their practice is a barrier that may have to be debated.
(Consultant obstetrician, more than 11 years' experience)

Some respondents saw maternity support workers as cheap replacements for midwives, and thought this was unacceptable. Many felt that a lack of money to employ midwives should not result in the use of maternity support workers instead.

We've spent 105 years educating midwives and eradicating lay practice. Now we're letting them in through the back door and call them maternity support workers – I'm not in favour of that!
(Independent midwife, more than 11 years' experience)

The lack of funding for midwifery care seems to be leading to the increased use of maternity care assistants to provide postnatal support in particular, which may in fact lead to a less-safe service if appropriate training is not in place. Midwives will continue to be responsible for the actions/decisions of assistants working by proxy, and I am reminded of the saying, 'Stress is responsibility without authority'.
(Midwife, 3–10 years' experience)

In some situations, support workers were carrying out midwives' duties. This was viewed with suspicion and was believed to have implications for safety, particularly where it was felt that maternity support workers were practising beyond their training or competence.

Please note that employing more maternity support workers without employing more midwives will not *alleviate the problem. This will only result in maternity support workers carrying out midwifery tasks, which the DoH [Department of Health] have already acknowledged as a problem.*
(Senior lecturer in midwifery, more than 11 years' experience)

Midwives also bemoaned a lack of clerical support. Respondents provided long lists of tasks they had to carry out that could easily be done by clerical staff, leaving midwives with more time to care for mothers. These tasks included paperwork, ordering and re-stocking equipment, data inputting, filing and writing letters and reports. This was true of community midwives as well as hospital-based midwives. Midwives generally thought they should not be cleaning, making beds, answering doors and phones, dealing with relatives or making cups of tea!

Midwives are also expected to do all the relevant paperwork to get the women discharged from the delivery suite. Why? I accept that we must write up our notes, but once this is done why could a clerical member of staff not do the rest of the paperwork? We are often working without the support of clerical staff. Until these areas are addressed, very little will change within the unit I work in.
(Midwife, more than 11 years' experience)

The introduction of computer systems into maternity wards has, in some cases, increased the workload rather than made things easier.

You spend more time completing notes and paperwork than caring for women. Take, for example, one unit I have worked in. We had simple records and one computer system to complete delivery records. Since then, three further computer programmes have been introduced. Instead of losing the previous ones we now have all of them to do. Much of the information is repeated. The original plan was to link them all together so that the information would default across to each programme but the money ran out so this never happened.
(Midwifery lecturer practitioner, more than 11 years' experience)

Junior staff felt that senior staff in particular were wasting time on administrative tasks rather than caring for women.

The senior staff are too wrapped up in red tape and bureaucracy. Their admin tasks are horrendous, but they are senior midwives as a result of the experience they have, not as a result of their admin skills! These skills are wasted, and it is such a waste of money, employing senior, experienced midwives as office clerks!
(Student midwife)

Low staff morale

Many respondents had low morale or were concerned about their colleagues' low morale.

Midwives want to give good care. They recognise that this is not always possible within the constraints of the system and lack of staff. They are lacking in morale and not motivated at present as they see more idealistic blue-sky vision and are tired of trying to make things happen on fresh air.
(Midwife, more than 11 years' experience)

Respondents identified several factors as contributing to low morale, including low pay and lack of resources, as well as lack of support from peers and senior managers.

The disparity between obstetricians' and midwives' pay was also commented on.

> *One consultant salary would fund three midwives and as they are the ones who actually look after the women in labour it would make more sense to have more of them.*
> (Midwife, more than 11 years' experience)

Lack of support for maternity services at trust board level has been demoralising for some.

> *Trusts not giving high enough priority to maternity services, cutbacks affecting departments even when they have shown to be efficient in allocating their funding, demoralises staff.*
> (Midwife, more than 11 years' experience)

Lack of peer support from colleagues has also led to problems.

> *The whole service is so exhausted that we have little energy for supporting our colleagues. This leads to burnout and midwives leaving, hence worse staffing levels.*
> (Midwife, more than 11 years' experience)

Low morale creates a vicious cycle in maternity services – it increases staff sickness rates, and inadequate cover means other staff are overstretched and so their morale deteriorates. As a consequence care becomes less safe, the staff working in unsafe environments feel more demoralised, and so the cycle goes on.

> *There is a high level of staff sickness, which creates a cycle of overstretched staff/stress/sickness.*
> (Consultant obstetrician, more than 11 years' experience)

> *One main issue is the lack of cover provided for maternity leave and long-term sickness. Midwives left working are expected to pick up the workload of colleagues who are absent from work due to these reasons. This then invariably leads to more stress and sickness!*
> (Midwife, more than 11 years' experience)

> *Midwives are so cheap for the service and skill they provide, but studies confirm the corrosive effect of working in unsafe environments due to lack of support, primarily lack of staff but also equipment.*
> (Midwife, 3–10 years' experience)

Respondents reported examples of over-tiredness, ill health and staff burnout. Some who had a record of long service in the NHS reported high levels of dissatisfaction.

> *I have been a midwife for 11 years and… am actively seeking employment to leave the NHS for good. I… have recently had six weeks off with depression and am also taking anti-depressants… As a very experienced midwife, never in my life have I suffered with stress or depression before due to work issues.*
> (Midwife, more than 11 years' experience)

Some felt that low morale had a direct impact on the safety of care for women and their babies.

> *[there is]… low morale among midwives… underpaid, so stretched and stressed that accidents are inevitable.*
> (Independent midwife, more than 11 years' experience)

> *Stressed and overstretched care providers cannot provide safe care.*
> (Independent midwife, 3–10 years' experience)

Inadequate training and education

Many respondents regarded training as an important issue that affects safety. They highlighted inappropriate and inadequate training (for both midwives and doctors) as well as a lack of continuing professional development (CPD). There was thought to be insufficient training for new managers.

A large number of respondents felt that midwife training was inadequate and inappropriate. Some felt that the shift to academic degrees from 'on-the-job' training had not necessarily improved patient safety. The lack of hands-on experience for newly qualified midwives meant that many were unable to empathise with labouring mothers.

> *This job is a practical one, a vocational one. It requires aptitude to this kind of work and commitment to women… I am seeing very few future HoMs [heads of midwifery]… Once qualified, the new midwives soon stop referring to evidence, so what is the point? I feel very strongly that we should go back to an apprenticeship model… training does not prepare them for the realities of the job, ie, 24-hour, 365 days a year.*
> (Midwife, more than 11 years' experience)

> *More practical 'hands-on' philosophy is needed in training – do you really need to be degree level? If so, maybe I should leave now. But unfortunately there is a 'new' way of midwives – where they do not spend as much time with the women, talking and building relationships, they tend to leave them labouring alone and go back only as needed.*
> (Midwife, more than 11 years' experience)

The lack of medical experience and nursing skill in newly qualified midwives can be a problem, as they may be less likely to recognise sick mothers. This can leave midwives struggling to distinguish between normal and abnormal situations.

> *Midwives [are] routinely unable to recognise the difference between normal and abnormal scenarios, resulting in inappropriate intervention for low-risk women and late/lack of referral in higher-risk situations, resulting in poor outcomes. [This is] related to education and training.*
> (Midwife, 3–10 years' experience)

Respondents were also concerned about changes in medical training.

Reduced funding has directly affected staff training and insecurities about training have made it difficult to recruit more doctors, despite the fact that there are many unemployed consultants.

Due to changes in junior doctors' training (partly because of the European Working Time Directive (EWTD)), younger doctors are not gaining as much experience as they did in the past.

> *The new training means the registrars, who still do most of LW [labour ward] work (even with 40 hours' consultant cover, 40 hours are less than 25 per cent of weekly hours), things are missed that in the old days would not have been missed. Also, the registrars have much less surgical experience than in the past.*
> (Consultant obstetrician and gynaecologist, more than 11 years' experience)

> *Changes in junior doctors' training and hours have resulted in doctors gaining less experience than in the past. Even recently appointed consultant obstetricians are less experienced than those of 10 years ago. This results in increased intervention in birth (as a result of decreased confidence in the birth process) together with increased fear over litigation and the rise of risk management (which is often perceived in a negative way), also resulting in an increase in arguably unnecessary intervention (especially increasing caesarean section rates), which reduce safety and expose mothers to increased risk of complications and possible problems in future pregnancies.*
> (Consultant midwife, more than 11 years' experience)

> *[There is a] lack of 'on-the-job' training and supervision for registrars by the consultants, who only attend labour ward in an emergency. One consultant remarked to me that he couldn't remember the last time he did an instrumental delivery or a vaginal breech and would not therefore be happy coming in to teach the registrars. On another occasion a registrar who had never repaired a third-degree tear was told over the phone to just 'get on with it' when she asked the consultant to attend the labour ward and help her.*
> (Midwife, more than 11 years' experience)

> *… care being delegated to less experienced staff with less available senior supervision. A similar problem affects junior medical staff who, with new working hours and preparations for the EWTD, are really not getting the adequate hands-on practical experience they need to feel confident and capable in the role of consultant.*
> (Consultant obstetrician, more than 11 years' experience)

Within the medical profession, gynaecology is regarded as a more attractive and prestigious career option than obstetrics. There is a growing problem with lack of sub-specialisation and erosion of experience and leadership as more experienced consultants move to specialise in gynaecology only. Conversely, problems can also arise if trainee doctors choose to specialise only in obstetrics rather than in a joint specialty and have insufficient surgical training.

> *The RCOG is suggesting that new consultants in O&G might be trained for obstetrics and depend on their gynaecologically trained colleagues to bale them out of surgical difficulties. This is plainly dangerous, with up to 25 per cent of deliveries by caesarean section and the more difficult type of repeat procedure becoming more and more common in the working lives of the next generation of consultants.*
> (Consultant obstetrician, more than 11 years' experience)

It is important that midwives keep their knowledge up to date so they can maintain good standards of care. One particularly important issue is that midwives are expected to attend

training in their own time and are not paid for it. Unsurprisingly, this is unpopular. There was a general feeling that there are insufficient funds for CPD.

[The] CPD [budget] is raided to cover financial deficits.
(Student midwife)

Midwives should have paid time away from their work environment to reflect on practice and learn from difficult situations. They should not be expected to study in their annual leave and to pay for this study time.
(Midwife/independent midwife, 3–10 years' experience)

Some respondents thought that doctors lacked training in normality and this increased levels of intervention. Doctors were thought more likely to intervene while midwives were more likely to take a 'wait and see' approach.

Junior doctors are taught by senior obstetricians who have never delivered a breech birth or let alone a normal birth without medicalising the process. Skilled midwives require the time to teach their junior colleagues when to intervene with medical assistance and when to give more confidence and skill to empower women to birth naturally.
(Infant feeding specialist, ex-community midwife, more than 11 years' experience)

There were different views about current midwifery training. Some respondents thought that normality was not promoted sufficiently. Others were concerned that midwifery training focused too much on normality.

Also the difficulties in supporting students in normal care. So many students have not had much experience with low-risk normal care they see epidural, syntocinon and active pushing as normal and a spontaneously labouring woman as out of control.
(Midwife, 3–10 years' experience)

The current training programme for student midwives concentrates too much on normality. Newly qualified midwives are ill-equipped to deal with the rising number of high-risk women that are becoming pregnant.
(Clinical governance midwife, more than 11 years' experience)

Medicalisation of birth

Some respondents were worried about the increasing medicalisation of childbirth and the effect on maternal safety of reduced normality for low-risk mothers. Increased medicalisation was thought to be due to fewer midwives and more technology.

The move to a greater focus on normality cannot be over-emphasised as the way forward for women to be less exposed to interventions that potentially lead to 'higher-risk' situations.
(Head midwife, more than 11 years' experience)

The introduction of technology has medicalised the childbearing process, taking it from a normal physiological life event to, in some instances, a process to be feared, increasing anxiety for women and their partners.
(Midwife, more than 11 years' experience)

Greater use of epidurals and continuous fetal monitoring leads to increased interventions, which in turn increase the likelihood of iatrogenic maternal morbidity and mortality (those caused by professionals' actions).

> *Continuous monitoring is used instead of midwifery care – this has been shown to increase caesarean section rate, which in turn increases maternal morbidity and mortality.*
> (Independent midwife, 3–10 years' experience)

> *High caesarean section rates produces iatrogenesis, therefore more sick pregnant women for the future, therefore in turn the big divide between staffing levels and workload becomes bigger and unsafe!!*
> (Maternity risk manager, more than 11 years' experience)

The place where a woman chooses to give birth was also seen to impact on the normality of the birth. Some respondents believed a low-risk woman who chooses to give birth in a high-risk consultant-led unit stands a greater chance of a medicalised, interventionist labour and delivery.

> *[Insisting women deliver in large units with 6,000+ annual deliveries] is against public demand and will result in less one-to-one care, increased medicalisation, increased instrumental and operative deliveries and more maternal morbidity and mortality.*
> (Midwife, 1–3 years' experience)

> *Women who are low-risk are still afraid that they will have a problem giving birth, and choose to deliver at high-risk units, which are already overstretched, due to many units joining forces to centralise resources. The high-risk units are medicalised, so intervention is much higher due to the number of clients there, and women labour much slower as they share a midwife with two or three other women.*
> (Midwife, more than 11 years' experience)

Another reason suggested for increased medicalisation was poor birth preparation for women and their partners. Women often feel scared when they go into labour, which raises their levels of stress hormones and the likelihood of intervention.

Obstetricians and midwives held different views as to whether intervention is itself a cause of safety problems. Obstetricians who responded to the call for evidence generally did not raise the medicalisation of birth as a problem. There was, however, some agreement for the view that normality should be encouraged. One doctor thought that hospitals should try to:

> *Give MWs [midwives] back their professional identity and let them work to help women through a normal pregnancy, delivery and puerperium* [the period from the third stage of labour to the uterus's recovery after childbirth, approximately six weeks] *without fear of not meeting a target, or being criticised for using common sense. Give them their confidence back so they can recognise and manage normality and detect and refer abnormality.*
> (Obstetrician, more than 11 years' experience)

Poor management

Respondents identified poor management as a cause of safety problems. Managers were seen to lack clinical experience, to be remote and to approach the service purely from a business perspective.

> *The employment of managers who have not the first idea how midwifery works but because they have an MBA [Master of Business Administration] it is presumed they know what they are doing.*
> (Midwife, more than 11 years' experience)

> *Too many highly paid administrators… haven't the faintest idea of what it's like to care for sick vulnerable people, often from areas of high social deprivation, and the challenges of working in an inner city area.*
> (Midwife, infant feeding co-ordinator, more than 11 years' experience)

> *[The] head of midwifery [is] not always in touch with staff issues and this leads to poor communication and low staff morale.*
> (Midwife, more than 11 years' experience)

On the other hand, midwives who were promoted into management positions often lacked managerial skills and were blamed for failing to address important staffing issues. Some heads of midwifery were reportedly poor communicators and failed to keep in touch with staff issues.

> *Attention needs to be given to the quality of management of midwives by midwife managers. I have experienced very poor management at times through my career. I have also had a short period when I was a poor manager myself. I quickly realised that it was not going to be my forte and returned to full-time practice as a midwife. Effects of the poor management have been inequalities of service in the catchment areas, poor sickness and absence monitoring and failure to deal with bullying. All these things again affect retention and staffing numbers.*
> (Midwife, more than 11 years' experience)

One respondent thought that managers were too concerned with financial issues and that this had safety implications.

> *Some of our managers are only concerned with balancing books, not the safety of women and children. For example, when we are stretched to absolute capacity on a busy delivery suite we have been told we are not allowed to tell women we are busy! What the hell is that all about? Midwives need to be heard (the ones on the front line) before a mother dies!*
> (Midwife, 3–10 years' experience)

Lack of resources

Respondents had stark views about lack of funding for maternity services. The lack of funding underpinning the National Service Framework was also perceived to be a problem.

> *Without appropriate funding for maternity services I predict a rise in the number of direct maternal deaths and fetal/neonatal death, which could be preventable.*
> (Community midwife manager, more than 11 years' experience)

Some respondents reported that they were having to work with outdated or broken equipment.

> *The replacement of equipment has been allowed to slide over the years, with a reactive approach to replacing when extinct. With the recent financial problems, the problem is exacerbated. We are now reaping the folly of not having a programme for renewal. There are sometimes funds earmarked for capital monies, but no provision for smaller items. This is unfair. So ICUs [intensive care units] will get a very expensive piece of kit that might be used four times a year, but the wards are without basic equipment such as blood pressure monitors. Lives are put at risk because they cannot be monitored properly. Staff are running up and down wasting precious time looking for basic stuff.*
> (Midwife, more than 11 years' experience)

Others felt their work was not sufficiently rewarded. Midwives' low rates of pay were compared unfavourably with other professions.

> *Tube train drivers earn more than the average midwife.*
> (Community midwife, 3–10 years' experience)

Reconfiguration

Although not mentioned by a large number of respondents, the threat of reconfigurations and mergers in maternity services was reported to have a detrimental effect on staff.

> *Stop the reconfiguration of maternity services causing the closure of medium-sized maternity units in district general hospitals.*
> (Midwife, more than 11 years' experience)

Reorganisations in the NHS are perceived to affect training, reduce staffing levels and negatively affect maternal safety.

> *Maternity services have been organised to help the training needs of medical staff in this country. Vast impersonal baby factories are contributing to the near misses.*
> (Midwife, more than 11 years' experience)

> *My colleagues and I are fed up with things constantly changing, which is so costly as along with a new idea comes a new set of paperwork, and study sessions which are mandatory, and deplete the numbers of staff on the front line.*
> (Midwife, more than 11 years' experience)

Solutions

More staff

Most respondents thought that employing more staff would make maternity services safer. More midwives was the most common request, including consultant midwives. Some respondents also felt that having more doctors would improve safety.

A number of respondents thought the simplest solution was for trusts to employ more midwives. There were many useful explanations about how this should be done and how it would improve safety. The general argument was that more midwives would mean better care for all women, high-risk or not, wherever they chose to birth their babies. More midwives would mean more women having normal births, which would reduce the caesarean section rate, the length of postnatal hospital stay, and therefore release money to provide better services. Finally, more low-risk women would be able to give birth in birth centres or midwife-led units where intervention rates are lower.

It was felt that increasing staffing levels would have a positive knock-on effect in terms of improved working conditions and safer care.

> *More employees would mean adequate rest breaks (some shifts have none), time for mutual support and reflection where poor outcomes occur and thus safer births for women as learning and development are fostered.*
> (Midwife, 3–10 years' experience)

For others, the solution was not simply having more midwives but changing their way of working and level of seniority. One felt that midwives needed to be better deployed to make a difference to the safety of care.

> *Not just more midwives, but better-trained, more autonomous midwives, committed to provide one-to-one care. It means letting go of the shift system and hierarchical managerial structure that we inherited from the nursing era and having midwives work when they're needed, where they're needed for the women that need them.*
> (Independent midwife, more than 11 years' experience)

Some respondents thought there were too many managers at the cost of too few midwives. One respondent thought there was a need for:

> *… more staff at the caring end of midwifery… [There are] too many senior staff having meetings about improving care but not doing any. They should all do one shift a week on the ward.*
> (Midwife, more than 11 years' experience)

An increase in the number of consultant midwives would have a positive effect on safety, according to one respondent.

> *Consultant midwives in every trust to develop the quality of midwife-led care, not just 'manage' it.*
> (Consultant midwife, more than 11 years' experience)

Respondents also called for many more appropriately trained doctors to ensure that there would be increased presence of consultant obstetricians on the labour wards in future. One respondent felt strongly that:

> *[Consultants'] job plans should insist on labour ward presence, not sitting in offices waiting to be called! You would not go in a plane without a qualified pilot.*
> (Midwife, more than 11 years' experience)

Better teamwork and skill-mix

Lack of teamwork and poor communication are major contributory factors to poor patient safety (Leonard *et al* 2004). Therefore it is not surprising that respondents suggested better teamwork and an appropriate skill-mix as solutions to safety problems.

Mutual respect between midwives and obstetricians was thought to be crucial. Respectful colleagues are more likely to work together as a team towards the goal of patient safety.

> *Strong leadership and the ability to provide care as a team is really important; midwives respecting their obstetric colleagues and vice versa – they are two professions and this must be recognised.*
> (Midwife, more than 11 years' experience)

Even among midwives, respondents felt that teamwork could be improved by regular rotation of staff.

> *All senior midwives should regularly rotate to other wards so they don't become staid. It ensures that everybody works together as a team because they can all remember the stresses the others are under rather than each ward continually working against and bitching about each other!*
> (Midwife, 1–3 years' experience)

Obstetricians also thought teamwork was important. One respondent explained that:

> *We need to ensure colleagues have respect for each other and can help one another, working as a team for the common goal of patient safety and satisfaction.*
> (Obstetrician, more than 11 years' experience)

Getting the right skill-mix within teams was also seen to be vital to ensure safety. One respondent thought that if the skill-mix was right, many other aspects of care would fall into place.

> *[The ideal is] adequate staffing levels with a skill-mix that encourages professional development and supports less-experienced staff to become competent and confident in their practice and women's ability to give birth.*
> (Midwifery lecturer, more than 11 years' experience)

Improved training

Many respondents suggested that maternity services could be made safer by introducing multidisciplinary training. It has the potential to improve perinatal outcomes for rare emergencies (for example, shoulder dystocia and hypoxic-ischaemic encephalopathy). One midwife described the benefits.

> *I think that there should be a stronger focus on midwives and doctors training together for some aspects of professional development, for example, managing normal births (doctors could have work experience at stand-alone birth units; midwives could improve their understanding of the use of forceps/ventouses so that they know when it is being applied and used appropriately).*
> (Midwife, more than 11 years' experience)

One respondent thought that multidisciplinary training would generate greater respect among colleagues.

> *We are not always good team players and would benefit from more collaborative working sometimes. Plenty of mutual respect can be achieved by multidisciplinary training and staffing levels that give us time to get to know each other more.*
> (Midwife, more than 11 years' experience)

Changing the relationship between doctors and midwives could be one way to increase normality. An independent midwife thought that:

> *Obstetricians would do well to serve some of their training being mentored by senior midwives so they gain a better understanding of normality in childbirth. They can then understand better when not to interfere with the process and when action is necessary. Society as a whole now views birth as a dangerous emergency. Many of us no longer believe in women's innate ability to give birth and treat pregnant and labouring women like disasters waiting to happen.*
> (Independent midwife, 3–10 years' experience)

One independent midwife had some positive ideas for obstetricians:

> *… and some education for doctors, keen to go into obstetrics, that we, as midwives, love them! We love them to be there, sometimes just to be there, not interfering, not seeing a normal (but longer) birth as a problem, but being there when women really do need help – which happens – to give the right intervention, at the right time, in partnership with women, their partners and their midwives, in an honest, not coercive way. Yes, I'm looking for utopia!*
> (Independent midwife, more than 11 years' experience)

More in-house drill training can improve the safety of mothers and babies. Training sessions need to be run on a regular basis, and staff need to be given time to attend these sessions.

> *Safety improved by… providing quality… training on skills and drills and major obstetric emergencies on a monthly refresher basis.*
> (Specialist midwife sonographer, 3–10 years' experience)

Respondents felt there should be a national standardised framework for training support workers and a defined career pathway. A senior lecturer in midwifery suggested that:

> *The role of the maternity care assistant requires national guidance, providing direction as to the safety of tasks they are required to do, the level of training, where that training is delivered (it is generally delivered locally within the trusts), with a nationally recognisable qualification with accountability to a professional body.*
> (Senior lecturer in midwifery, more than 11 years' experience)

Some respondents suggested that a return to apprentice-style training would mean midwives were more appropriately qualified.

> *I think a return to basic midwifery training in units would be a definite improvement. I would suggest that a basic nursing certificate is essential prior to taking up midwifery.*
> (Retired midwife, more than 11 years' experience)

Supporting midwives in their ongoing training would make maternity services safer. Trusts should support midwives in lifelong learning and not expect them to pay for their own courses or attend in their own time. One respondent explained the explicit impact on safety.

> *Existing training and risk management operations should continue. Midwives should have paid time away from their work environment to reflect on practice and learn from difficult situations.*
> (Midwife, 3–10 years' experience)

Supervision of midwives is a statutory requirement and is intended to protect the public. It provides mentorship and support for midwives separate from NHS management structures as well as having a role in standard setting, evaluation of practice and professional development (Nursing & Midwifery Council 2007). Respondents generally noted the benefits of the supervision system, though they felt it could be better supported by trusts. Proper supervision requires protected time and this is not always made available.

> *Supervision of midwives, for example, is not understood and so undervalued, leaving the supervisors feeling undervalued and often abused as they prop up a failing system, often doing unrecognised on-calls despite working their full hours. There is no funding but there is an expectation that this will happen.*
> (Midwife, more than 11 years' experience)

> *Ensure midwifery supervision is adequate and effective by ensuring supervisors of midwives have sufficient time to carry out supervisory duties effectively and are adequately remunerated for same.*
> (Community midwife and supervisor of midwives, more than 11 years' experience)

More one-to-one care

Respondents used the term 'one-to-one care' with two meanings. The first meaning was one-to-one care during active labour. The second meaning referred to caseloading, when one midwife looks after a woman throughout her pregnancy, during labour and postnatally.

One-to-one care during labour was very important to respondents. Midwives found it unacceptable to have to look after more than one labouring woman at a time. Birthrate Plus, a tool for calculating staffing levels that takes case-mix into account, was mentioned by many as the standard that should be aimed for. Yet respondents noted that many hospitals did not employ the number of midwives recommended by Birthrate Plus. One respondent felt the impact on safety could not be overstated.

> *The inability of trusts to embrace the idea of one-to-one care in labour has got to be the single most important factor in safety.*
> (Midwife, more than 11 years' experience)

Another respondent described how one-to-one care can avoid interventions and therefore, by implication, morbidity and mortality.

> *One-to-one care in labour reduces the numbers of women opting for epidurals and opiates in labour and thus avoids the cascade of interventions.*
> (Midwife, 3–10 years' experience)

Although one-to-one care may be the gold standard for women in labour, in the event of understaffing it can have knock-on effects on other parts of the service, as one obstetrician explained:

> *The ethos of allowing patient choice means that low-risk women often get excellent one-to-one care through midwifery-led units – almost like private care at the expense of those in need of high-risk obstetric care. Providing one-to-one care in labour (which I am in agreement with) with current staffing levels means that often PN [postnatal] care is neglected.*

Caseloading

There have been successful pilots of caseload midwives throughout the world. A recent study of caseloading in south London showed successful outcomes (Berry 2005). There is some evidence to suggest that caseloading can potentially improve quality and safety because it improves access for socially and medically complex women. They are then less likely to become 'lost' in the system, there is greater continuity of care, the health professional has clear responsibility for care, and professionals and students learn swiftly as women act on their advice.

Caseload midwifery tends to be popular with both midwives and the women they care for and leads to better outcomes, as one respondent explained.

> *I worked as a midwife in a Sure Start co-funded one-to-one caseloading team. It was great, the women loved it, we had excellent soft outcomes (satisfaction, DNA [did not attend] rates, uptake of services) and hard outcomes were as expected, because we*

worked within the hospital's obstetric-led protocols. The midwives loved working in this way and had great job satisfaction. The obstetricians loved our way of working, because we as midwives knew detailed information about 'our' clients and problems could be solved more efficiently.
(Independent midwife, more than 11 years' experience)

Another respondent suggested that this model of care not only produces good outcomes for mothers and babies but also enhances the safety of services and results in improvements in public health. The Albany Midwifery Practice (www.albanymidwives.org.uk) in south London was praised as:

… an example of how a social model of caseloading midwifery can achieve astounding outcomes for women across the risk spectrum.
(Consultant midwife, more than 11 years' experience)

Independent midwives work with their own caseloads and were keen to explain the benefits.

I now work as an independent midwife, offering the gold standard of maternity care that I always wanted to offer under the NHS – one-to-one care – and I have time to make sure that my practice is up to date and evidence-based.
(Independent midwife, 3–10 years' experience)

The introduction of caseload midwifery would mean allocating staff to individual women, not to the labour ward. This would entail a major shift in the approach to maternity care and would bring the UK in line with the system that operates in New Zealand – a positive example mentioned by a number of respondents.

I believe that a New Zealand-type model of maternity care could transform the maternity services in this country. Women should have the choice to have an independent midwife and birth at home or a birthing centre if they wish. I believe that the initial higher costs would be more than compensated for by the improvement in outcomes, and hospital facilities could be reduced, thus in the long term saving huge amounts of money.
(Independent midwife, 3–10 years' experience)

The 'one mother, one midwife' campaign (www.onemotheronemidwife.org.uk) was mentioned by a number of respondents. It advocates for women to be able to choose their midwife at the start of pregnancy and be looked after individually. One respondent thought that:

It would require imaginative management and a reorganisation of resources to provide this style of care, but will save money in terms of more normal births and less damaged mothers and babies.
(Midwife, 3–10 years' experience)

Better management

Respondents thought that better management could improve patient safety. They felt that managers needed more training and that in general the burden of administration needed to be reduced.

Some respondents felt that in order to improve safety, managers needed to understand the issues faced by staff on the front line and not become too remote. For example, midwifery managers should remain close to midwives on the wards.

> *Managers need to remain part of the midwifery workforce and not evolve into trust nodding donkeys!*
> (Midwife, more than 11 years' experience)

An obstetrician suggested a potential solution to this.

> *Managers need to listen to staff working on the 'shop floor'. Senior staff need to support juniors, not destructively criticise. Staff need seniors they can feel confident to approach if they feel lacking in experience. This needs a culture change and the seniors need to be selected not on whether they have several pieces of paper, but whether they have the man-management skills to run a safe ship. People are the way forward for safety, not targets.*
> (Consultant obstetrician, more than 11 years' experience)

Visible support from the chief executive was also identified as having a positive impact on safety.

> *We have never seen our chief executive in the maternity unit. A high-profile visit would improve morale and help us to take forward initiatives we have developed.*
> (Midwife, more than 11 years' experience)

Respondents also felt that management needed to ensure that staff were not working long hours and that working conditions supported the delivery of safe care. If midwives and doctors work for too long without a break they become tired and hungry and more prone to making errors.

> *For managers and supervisors to respect that when a midwife is tired and says that she feels she cannot think straight any more, let alone drive a car to do a home/hospital assessment in the middle of the night, that her self-awareness and professional boundaries are respected and not railroaded.*
> (Midwife, more than 11 years' experience)

> *Provide staff with rest rooms and treat their break times as protected time. Respect them as adults and professionals who are free to go for a walk, close their eyes, put their feet up and recover if they are expected to work 12-hour shifts.*
> (Midwife, more than 11 years' experience)

The transition between caring for women and becoming a manager is not always a smooth one. A number of respondents raised the issue of management training for both doctors and midwives. It was felt that it would be beneficial for staff to have specific training before taking up management posts. One community midwife thought that:

> *[We need to] ensure managers have an understanding of their staff's role on their unit, and provide better training for them.*
> (Community midwife, more than 11 years' experience)

Respondents were able to identify the benefits of good management. In organisations and teams where staff feel valued and supported, they generally work a lot harder and are more effective and efficient.

> *At the end of the day if staff feel they are valued, the majority of them will give 110 per cent even if it means going over hours, no breaks and always having to search for equipment.*
> (Midwife, more than 11 years' experience)

> *Improve morale of staff by making them feel valued, rewarding good work, and supporting them.*
> (Consultant obstetrician, more than 11 years' experience)

Some midwives felt they were spending too much time filling in forms. They suggested that by cutting down on bureaucracy it would allow them to spend more time with women, thereby improving safety. As one midwife commented ruefully:

> *Cut the paperwork, some of which takes longer than delivering a baby!*
> (Midwife, 3–10 years' experience)

Others felt that reconfiguration and reorganisations took up too much of managers' time and attention and this had a detrimental effect on care. Reducing the number of reconfigurations in the NHS would therefore have a positive effect on maternity services.

> *Not to keep reconfiguring the NHS! Please leave our very experienced senior midwife managers to do their job. Modern matrons are not part of the midwife model. Do not ask our midwives to do their rota, they have a difficult enough job managing/supervising midwives.*
> (Midwife, more than 11 years' experience)

> *Decrease the amount spent on constant pointless change strategies, designed to make managers appear to be proactive when we all know these changes only act as a smokescreen to cover up the fact we are hideously understaffed.*
> (Midwife, more than 11 years' experience)

More resources

Many respondents thought that more resources would solve some of the safety problems in maternity services.

Some suggested that ring-fencing funding for maternity services would make a difference, citing other departments overspending to the detriment of maternity services. They also

called for greater recognition of the needs of maternity services and to be given higher priority when resource allocation decisions were taken within trusts.

> *The funding allocated to maternity services should be ring-fenced. Currently maternity services are not prioritised and money is diverted to other services.*
> (Professor of midwifery, more than 11 years' experience)

> *A commitment to funding and recognising that although a lot of maternity care is uncomplicated, when it is complicated and if it goes wrong it can be catastrophic. It is a complex service, which needs to be recognised.*
> (Midwife, more than 11 years' experience)

A number of respondents mentioned the need to reform Payment by Results (PbR), which does not currently offer sufficient reimbursement for the care provided by midwives in the community.

> *PbR also needs to include midwifery activity whereas currently community care is provided on block contract. This does not reflect or cover the cost of the vast amount of work that midwives provide. It is imperative that commissioning includes correct tariffs for midwifery activity.*
> (Consultant midwife, more than 11 years' experience)

Respondents felt that appropriate levels and methods of funding could potentially ensure that more midwives were available for one-to-one care, which would improve safety.

Better guidelines

A number of respondents welcomed the use of guidelines and described a variety of ways they could be used to address patient safety issues. However, they felt that the development of guidelines should involve professionals who actually work with women. Midwives and obstetricians should have an equal voice in the development of professional guidelines, and these should be evidence-based. One midwife was disappointed that:

> *Midwives [are] not involved in development of the guidelines and protocols that they are supposed to use.*
> (Midwife, 3–10 years' experience)

A long-qualified midwife thought it was important to keep in mind who the guidelines were designed to help.

> *[We should be] putting the mother and baby at the heart of all protocols and procedures.*
> (Midwife, more than 11 years' experience)

One respondent thought that national guidelines should be clearly and quickly disseminated.

> *… so that each hospital does not have to reinvent the wheel.*
> (Midwife, more than 11 years' experience)

Another suggested establishing a national briefing system to:

> *… automatically inform maternity units of best practice or changes in national guidelines.*
> (Bereavement midwife, 3–10 years' experience)

There was a suggestion that the local implementation of national guidelines is the most effective way of working and that better integration between units following national guidelines would facilitate clinical excellence.

One obstetrician warned that guidelines should not undermine clinicians' confidence to make professional judgements in specific circumstances.

> *I see an improvement with a drive to more guideline-driven working, which can counterbalance lack of experience; but this can also be dangerous as sometimes guidelines have to be ignored, and with less experience staff feel less able/empowered to do so. Also, the recognition of when to leave a guideline path may be lacking.*
> (Obstetrician, more than 11 years' experience)

Learning from incidents

Learning from adverse incidents is one of the key components of patient safety. There are numerous initiatives that seek to reduce incidents that impact on patient safety and ensure that lessons are learned from them. These include the Clinical Negligence Scheme for Trusts (CNST), the National Patient Safety Agency's (NPSA) National Reporting and Learning System (NRLS), and Healthcare Commission investigations. A number of respondents emphasised the importance of learning from incidents as a key way of improving safety. Some had suggestions as to how such learning can most effectively be implemented. One respondent thought it critical that:

> *[We] ensure we all learn from any adverse event or near miss in a constructive and non-judgemental way.*
> (Consultant obstetrician, more than 11 years' experience)

Others felt that regular multidisciplinary meetings and a 'no blame' system of reporting and analysing incidents were vital.

Some respondents were disillusioned and did not see the benefits of reporting incidents. They felt that unless a serious incident occurred, safety issues were not addressed.

> *We fill in loads of incident forms but never see any actions from them.*
> (Midwife, more than 11 years' experience)

> *A general opinion from midwives is: 'It'll take a critical incident before any changes take place.' Why wait until then? Why subject a family and the staff involved to tragedy, when it could be prevented sooner?*
> (Midwife, 1–3 years' experience)

> *Safety depends on awareness of risk. Despite all the agencies available to reduce risk, ie, CNST, Patient Safety Agency, nothing happens till we have another Northwick Park incident [where 10 maternal deaths occurred in one unit in three years].*
> (Consultant obstetrician and gynaecologist, more than 11 years' experience)

Other respondents recognised that in order to build professionals' confidence in the reporting system, feedback needed to be given and they needed to see evidence that action was being taken.

> *By ensuring that safe codes/incident forms reporting are actioned and regularly fed back to units so that a belief in reporting unsafe situations that will result in solid action and change for the better is instilled and becomes something that midwives can have confidence in.*
> (Midwife, 1–3 years' experience)

> *I think that the process of audit has to be more than a paper exercise and that the findings should be regularly incorporated to perinatal mortality/morbidity meetings, which includes the things we do well as well as those things we need to improve upon.*
> (Midwife, more than 11 years' experience)

> *'Safer' can (quite wrongly) mean, to some, substituting bureaucracy and triple checking, rather than having inherently safe systems.*
> (Obstetrician, more than 11 years' experience)

Barriers to improving safety

Generally, the barriers to improving safety were similar to the problems that respondents identified. But one important point they made was that staff who are stressed are often resistant to change. This makes it difficult for changes to be implemented even if there is good evidence in the form of guidelines or recommendations that such changes will improve safety and outcomes.

> *Generally, morale is low, with staff unable to work any harder. When staff feel overworked and undervalued they are resistant to change.*
> (Midwife, 3–10 years' experience)

> *I consider that midwives themselves could be a barrier to the introduction of changes in maternity services. They are often exhausted, working long, unsocial hours, poorly paid considering they are autonomous practitioners, conceivably viewing changes as adding more pressure and stress on them, further reducing their work/life balance.*
> (Midwife, 1–3 years' experience)

Inadequate management and poor staff–management relationships were also identified as barriers to the implementation of change.

> *Management's handling of staff morale, motivations, implementation of changes that are poorly structured to a workforce that has had enough.*
> (Midwife, 3–10 years' experience)

A number of respondents also identified lack of money and current financial constraints as a barrier to improving safety.

> *Given the current climate in the NHS of trying to claw back overspend and keep this year's spending within budget, every aspect of care is being examined to reduce cost... Staff are a hugely expensive commodity and so job-vacancy freezing is a particular problem. Also, as cost is seen as the all-important goal, then it becomes a matter of how can we give an 'adequate' service rather than how can we offer the 'best' service.*
> (Midwife, 3–10 years' experience)

Conclusions

This research has highlighted a number of safety concerns identified by midwives, obstetricians and other health professionals who work in maternity services, as well as a number of solutions for improving safety.

These professionals identified a significant number of problems that they felt resulted in some women and their babies experiencing care that was less safe than it could be. These concerns should be acknowledged by policy-makers, professional bodies and local NHS management. Despite working in a challenging environment, professionals were able to identify a number of potential solutions that, if implemented, could secure improvements in the safety of maternity services in England. However, there remain a number of barriers that will need to be overcome if improvements are to be realised.

Despite the limitations of the study (*see* Introduction, page 3), it provides a valuable insight into the perceptions of staff working in maternity services. While objective evidence may not always support the findings presented here, it is nonetheless important for anyone seeking to improve the safety of maternity services to acknowledge the perceptions of the health care professionals who provide the service. When staff perceptions about the causes of unsafe care are contradicted by evidence, it suggests a need to educate and challenge professional beliefs. But changing clinical practice will be difficult if professionals do not believe that such changes are legitimate or will address the root problem.

While many respondents were readily able to identify problems, not all made the link to safety explicit. However, they stated that problems such as staffing shortages, inappropriate skill-mix, low staff morale, inadequate training and education, poor management and lack of resources had important consequences for their ability to deliver safe maternity services.

Staffing levels were a major concern for respondents and were felt to have a direct impact on the safety of care. Staffing shortages cause unsafe care because they result in staff burnout and tiredness, a lack of time for direct care, and higher error rates. There also appears to be a lack of senior and experienced medical staff in maternity units to deliver safe care; in particular, the ratio of experienced to junior staff and trainees was thought to be dangerously low. Low staffing levels were blamed on a shortage of training posts, funded positions in the NHS, poor retention of staff, costs of insurance, lack of recognition by management and the ageing workforce. There was a clear link between low staffing levels and low morale. The level of despondency among staff working in maternity services was readily evident from the responses. Low morale was characterised by examples of ill health, exhaustion and burnout.

The overwhelming concern about lack of staff and financial resources may partly reflect the timing of the call for evidence, which coincided with the end of the financial year, when the NHS was under enormous pressure to reduce deficits. In some trusts this resulted in compulsory or voluntary redundancies and cuts to vacant posts (Thorlby and Maybin 2007). There was also considerable media coverage following calls by the Royal

College of Midwives for an extra 3,000 midwives (*see* 'News' section at: www.rcm.org.uk) in order to implement the recommendations of *Maternity Matters* in April (Department of Health 2007), and a Panorama programme highlighting safety concerns in maternity services in May (*see* 'Panorama' section at: www.bbc.co.uk/news).

Respondents had mixed views about the introduction of maternity support workers. Midwives reported that too much time was taken up with non-clinical tasks that could be carried out by either clerical staff or support workers. If they were able to spend this time undertaking their primary midwifery tasks, it might resolve some of the problems and improve safety. A study of trusts in England found that maternity support workers enhanced the care provided by the maternity team, including one-to-one care in labour, and provided more time for vulnerable women (Sandall *et al* 2007). It could also be cost effective, making more productive use of expensive inputs. Respondents' main concerns focused on support workers undertaking tasks that require a higher level of clinical skill than they are trained for. Sandall *et al* (2007) also identified a lack of standards for training, supervision and pay and variable arrangements in place for ensuring appropriate delegation of responsibilities.

Although far fewer doctors responded to our survey than midwives, there were some differences in the responses given by different groups of professionals. Both obstetricians and midwives were most likely to see lack of training as a problem for maternal safety. Among obstetricians, the problems most commonly mentioned (after lack of training) were the increasing social and medical complexity of the pregnant population and low morale, whereas among midwives the most common concern (after lack of training) was the increasing medicalisation of childbirth.

The more experienced midwives and obstetricians, who had been working for more than 11 years, thought lack of training, low staff morale and lack of adequate skill-mix were the biggest problems. They were most likely to suggest more staff as a solution.

There appears to be a difference between midwives' and obstetricians' views of appropriate levels of intervention. Many midwives view the increasing medicalisation of childbirth with suspicion, while obstetricians (whose role is primarily to look after those mothers and their babies who have problems) see intervention as part of their routine practice. This sometimes unacknowledged clash between the professions is an important cause of miscommunication and suspicion.

This suggests that there remains a lack of consensus about the appropriate and safe level of intervention. Simplifying the divide somewhat, obstetricians see intervention as an appropriate response to the complex needs of pregnant women, while midwives are trained to respect and support normal childbirth and see medical intervention as introducing greater potential for harm. Evidence indicates that once obstetric intervention in labour begins, further intervention is likely. For example, women whose labours are induced need more pain relief, and those who have epidurals are more likely to have an instrumental delivery and sustain damage to their perineums. Long-term morbidity post-childbirth (including painful intercourse and incontinence) is most likely to be related to instrumental and caesarean deliveries (Johanson and Newburn 2001). Furthermore, women who have caesarean sections can carry risks into their subsequent pregnancies; there is an increased risk of the potentially life-threatening complications of placenta

praevia, placenta accreta and abruption (Shorten 2007). Failed inductions can lead to distressed babies and emergency caesarean sections.

It is, however, undoubtedly true that in many cases timely interventions (for example, assisted deliveries, emergency caesarean sections) have saved mothers' and babies' lives and it is important to take a measured view. The National Institute for Health and Clinical Excellence (NICE) guidance on caesarean section summarises the likely risks and benefits compared to a vaginal birth (National Collaborating Centre for Women's and Children's Health 2004). Building a professional consensus about what constitutes safe care, and what interventions are appropriate under which circumstances, is necessary in order to promote safer care. Unless consensus is reached, it will not be possible to ensure consistent decision-making, clarify pathways of care for different levels of risk and implement protocols for use when foreseeable complications develop. There is a need to build mutual understanding of the respective roles and competencies of those working in midwifery and obstetrics. As Page (2007) noted, while all women need midwives, some also need obstetricians; a balance between the two professions is vital.

Both midwives and obstetricians viewed the changes in the needs of pregnant women in their care as a challenge to their ability to deliver safe care. Increasingly complex medical needs (for example, prevalence of diabetes and mental health problems) and social needs (for example, more pregnant women presenting who are recent migrants, non-English speakers or substance abusers) were identified. This in itself is not directly a cause of sub-standard or unsafe care. But the increasing complexity of the medical and social needs of pregnant and labouring women places greater demands on maternity services, influencing both the type of care provided and the skills required of staff. In particular, midwives who have not undergone nursing training may not have the skills required to look after high-risk women with medical needs. In order to ensure high safety standards for all women, systems of identification and agreed care pathways are needed so that women who are at higher risk of an adverse outcome for themselves or their babies are cared for appropriately.

Despite professional differences in their approach to childbirth, both obstetricians and midwives frequently mentioned a number of problem areas, including management and training. Generally, respondents commented on the inadequacy of management and felt the need for better leadership of maternity services. Changes in these areas are likely to have the most interprofessional support. There was also concern at the lack of support at trust level for midwifery training and supervision.

Respondents also made suggestions about how to improve basic professional training for obstetricians and midwives. Training should ensure that midwives have sufficient clinical expertise to identify and manage more complex medical cases, and that obstetricians have sufficient experience of normal deliveries to ensure they are confident to allow women to progress without intervention where appropriate. This might suggest the need for more shared clinical training. For those clinicians who took on management roles, respondents felt that better training was needed.

Respondents suggested a number of solutions to the problems identified, which they believed could improve the safety of maternity services. Some of these suggestions are directed outside the profession – for example, demands for increased resources for

maternity services. But others recognise that change is needed in the way care is organised (for example, providing one-to-one care for women in labour) or the way professionals practise (for example, improving multidisciplinary teamwork and making better use of other skills within the team).

Few solutions related directly to safety approaches adopted in other clinical areas, suggesting a lack of awareness of general methods for ensuring safe patient care among maternity staff. However, some respondents recognised the importance of clinical guidelines and of learning from incidents. Some expressed concern at the way guidelines and learning from incidents are implemented, often requiring administrative effort without tangible benefits in terms of improvements in care. This suggests a lack of 'safety' training as a component of both pre-registration training and continuing professional development of maternity staff. Efforts such as those announced by the National Patient Safety Agency to proactively promote a safety culture within maternity services are therefore to be welcomed.

Respondents also identified barriers to the implementation of measures to improve patient safety. These include the unwillingness of stressed staff to embrace change, lack of money, low morale and poor relationships between staff and management. The recommendations of previous reports into maternity services have rarely been fully implemented. Managers and policy-makers need to understand the local and national barriers to implementing change if a step change in the safety of care for mothers and their babies in England is to be achieved.

Appendix 1: Targeted publicity to professional bodies

REACHING TARGET AUDIENCES

Target audience	Channel of communication	Action/outcome
Midwives	RCM members	Call for evidence was sent out by email to all RCM members in England (approx. 30,000) who have email.
	RCM annual conference	Exhibition stand – attended by 500 midwives. Leaflet outlining the call for evidence in 500 delegate packs.
	Independent Midwives Association's email bulletin	Actively engaged with inquiry – have asked all of their 150 members to respond individually via email bulletin sent w/b 7 May 2007.
	The Midwives Information and Resource Service (MIDIRS). This is the biggest website used by midwives	This is the main online training and information resource for midwives outside of RCM, with 3,000 unique hits per month. It has a link on its news page and will continue to update it. www.midirs.org/midirs/midweb1.nsf/Z45/47996C797599A0B1802572CD00532128.
	Journal of Family Health Care (for health care professionals working with babies, infants and children)	Will offer coverage later.
	Baby Lifeline charity	Have emailed information to midwives on their list.
	Midwifery journals	*The Practising Midwife*. Deadline too early for call for evidence, but will cover outcomes.
Obstetricians and gynaecologists	RCOG email update	Call for evidence emailed to RCOG members w/b 7 May 2007.
	doctors.net	An email bulletin was sent to 2,300 obs and gynaes in the UK on 21 May 2007. This was also hosted on the doctors.net website, which a further 3,000 obs and gynaes have access to.
Nurses	RCN website + email update/ newsletter	Email bulletin sent to members w/b 14 May 2007.
	Nursing Standard magazine	Coverage
	Nursing Times	Coverage achieved in 15 May and 22 May 2007 issues.

continued overleaf

REACHING TARGET AUDIENCES *continued*

Target audience	Channel of communication	Action/outcome
Paediatricians	British Association of Paediatric Medicine	Email bulletin sent to members.
	Royal College of Paediatrics & Child Health	Considering posting link on website – confirm.
Health visitors	Community Practitioners' and Health Visitors Association	Information and link posted on website on 1 May 2007.
	Community Practitioner magazine	Deadline too early for call for evidence.
GPs	Royal College of GPs email bulletin (weekly)	Email bulletin sent to all members w/b 7 May 2007.
	doctors.net	An email bulletin was sent to 16,000 GPs in the UK on 21 May 2007. This was also hosted on the doctors.net website, which a further 26,000 GPs have access to.
	Magazines	*GP* magazine had news item on 25 May 2007.
Health profs – general	*Health Service Journal*	News article in issue of 3 May 2007 (p 5) + issue of 24 May 2007 + email alert sent to *HSJ* subscribers on 1 May 2007.
	Maternity Matters conference	Baroness O'Neill spoke at the London regional launch of this Department of Health conference on 21 May 2007 – over 100 profs were there.
	King's Fund bi-monthly newsletter (13,000 people)	Details of the call for evidence sent on 10 May 2007.
	Royal Society of Medicine	Sent information to Council, which then takes it to Maternity & Newborn Forum meetings.
	London Health Observatory + Association of Health Observatories	Call for evidence placed on both websites.
	Antenatal teachers	National Childbirth Trust sent an email with details to their forum of 400 antenatal teachers w/b 14 May 2007.
Admin/ managers	NHS Confederation	

Appendix 2: Questionnaire

1. Your evidence

Please complete the following questions if you are a professional working in or with maternity services in the United Kingdom and would like to submit evidence to the King's Fund's inquiry into the safety of maternity services in England. More information on the call for evidence can be found at www.kingsfund.org.uk/callforevidence.

The questions are deliberately broad and open ended as we are still at an exploratory stage of the inquiry. However, feel free to include specific examples.

Please note that you can give your evidence anonymously if you wish.

The closing date for submitting your evidence is 30 May 2007.

1. Do you think there are aspects of maternity services that are less safe for women and their babies than they should be? If so, what are the main problems?

2. How do you think the safety of maternity services can be improved?

3. Can you identify any factors or issues that make it hard to introduce changes to improve the safety of maternity services?

4. Do you have any further comments?

2. About you

We would like to ask you to give some details about your role and experience. This is because we will analyse responses to identify if there are any differences in perspectives by role and experience.

5. What is your profession?

6. How many years of experience do you have?

3. Next steps

We will analyse your response, and the key themes that emerge from all the evidence we receive from professionals will inform the next stage of our inquiry, during which we will take oral evidence from selected individuals. Our findings will be published in a final report next year.

7. Would you would be happy for us to quote from your response in our final report?

☐ I am happy for you to quote from my response and give my name
☐ I am happy for you to quote from my response if this is done anonymously
☐ Please do not quote from my response

8. Would you be willing, if invited, to provide more detailed evidence to this inquiry?
☐ Yes
☐ No

9. Would you like us to contact you to let you know the outcome of the inquiry?
☐ Yes
☐ No

10. First name

11. Surname

12. Email address

13. Organisation

14. Postal address

Thank you for taking the time to submit your evidence. Please email your completed form to maternity@kingsfund.org.uk.

Bibliography

Berry H (2005). *Briefing Paper: The one-to-one caseload midwifery project.* London: King's College. Available at: http://www.kcl.ac.uk/projects/1to1caseload (accessed on 29 January 2008).

Department of Health (2007). *Maternity Matters: Choice, access and continuity of care in a safe service*. London: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073312 (accessed on 19 November 2007).

Department of Health (1999). *Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare*. London: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007977 (accessed on 16 January 2008).

Healthcare Commission (2006). *Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between April 2002 and April 2005*. London: Healthcare Commission. Available at: www.healthcarecommission.org.uk/_db/_documents/Northwick_tagged.pdf (accessed on 19 November 2007).

Johanson R, Newburn M (2001). 'Promoting normality in childbirth'. *British Medical Journal*, vol 323, pp 1142–3.

Lavender T, Chapple J (2004). 'An exploration of midwives' views of the current system of maternity care in England'. *Midwifery*, vol 20, iss 4, pp 324–34.

Lavender T, Bennett N, Blundell J, Malpass L (2002a) 'Midwives' views on redefining midwifery 3: continuity of care'. *British Journal of Midwifery*, vol 10, iss 1, pp 18–22.

Lavender T, Bennett N, Blundell J, Malpass L (2002b) 'Midwives' views on redefining midwifery 4: general views'. *British Journal of Midwifery*, vol 10, iss 2, pp 72–7.

Lavender T, Bennett N, Blundell J, Malpass L (2001a). 'Midwives' views on redefining midwifery 1: health promotion'. *British Journal of Midwifery*, vol 9, iss 11, pp 666–70.

Lavender T, Bennett N, Blundell J, Malpass L (2001b). 'Midwives' views on redefining midwifery 2: public health'. *British Journal of Midwifery*, vol 9, iss 12, pp 743–6.

Leonard M, Graham S, Bonacum D (2004). 'The human factor: the critical importance of effective teamwork and communication in providing safe care'. *Quality & Safety in Health Care*, vol 13 (suppl. 1.), pp i85–i90.

National Collaborating Centre for Women's and Children's Health (2004). *Caesarean Section Clinical Guideline*. London: RCOG Press. Available at: www.nice.org.uk/guidance/CG13/guidance/pdf/English (accessed on 3 April 2007).

Nursing & Midwifery Council (2007). *Supervision of Midwives*. Available at: www.nmc-uk.org/aArticle.aspx?ArticleID=2098 (accessed on 29 January 2008).

Nursing & Midwifery Council (2005). *Statistical Analysis of the Register 1 April 2004 to 31 March 2005*. London: Nursing & Midwifery Council. Available at: www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=856 (accessed on 16 March 2007).

Page L (2007). 'Is there enough evidence to judge midwife led units safe? Yes'. *British Medical Journal*, vol 335, p 642.

Sandall J (1998). 'Occupational burnout in midwives: new ways of working and the relationship between organisational factors and psychological health and well-being'. *Risk, Decision and Policy*, vol 3, no 3, pp 213–32.

Sandall J, Manthorpe J, Mansfield A, Spencer L (2007). *Support Workers in Maternity Services: A national scoping study of NHS trusts providing maternity care in England 2006*. London: King's College. Available at: www.kcl.ac.uk/content/1/c6/02/16/41/SupportWorkersinMaternityServicesREVISED.pdf (accessed on 20 November 2007).

Shorten A (2007). 'Maternal and neonatal effects of caesarean section'. *British Medical Journal*, vol 335, pp 1003–4.

Smith A, Dixon A (2007). *The Safety of Maternity Services in England*. London: King's Fund. Available at: www.kingsfund.org.uk/current_projects/maternity_services_inquiry/index.html (accessed on 20 November 2007).

Thorlby R, Maybin J (2007). *NHS Finances 2006/7: From deficit to a sustainable surplus?* London: King's Fund. Available at: www.kingsfund.org.uk/publications/briefings/nhs_finances.html (accessed on 5 October 2007).

Turnbull D, Reid M, McGinley M, Shields N (1995). 'Changes in midwives' attitudes to their professional role following the implementation of the midwifery development unit'. *Midwifery*, vol 11, pp 110–19.

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Improving. Maternity Services in Australia. The Report of the Maternity Services Review. Report of the Maternity Services Review February 2009.Â In maternity services, where most pregnancies follow a normal pattern, we must ensure, first, that practice is based on evidence and, second, that we are not allowing our safety and quality concerns to prevent us acting on evidence that supports changes to practice. Risk must always be a carefully monitored balance of safety and informed choice.Â As with many aspects of health care in Australia, maternity care is characterised by a mix of Commonwealth, state and private funding and service delivery. States and territories play a major role through public hospitals in particular. Maternity care is an integral component of primary health care and a free health service for pregnant women. Within South Africa, the Maternal and Child Health programme is located in general development policies, which are focused on meeting the basic needs of rural and urban communities, maximising human resources potential, enlarging the economy and spreading its benefits to all South Africans. To comply with these principles, the then Minister of Health announced free health care services for pregnant women and children under the age of 6 years in July 1994. MATERNAL MORTALITY. Maternal mo... The National Health Service Litigation Authority (NHSLA) has developed a separate assessment scheme for maternity units, encompassing a wide range of standards.7 The equivalent schemes in Wales and Scotland are the Welsh Risk Pool8 and the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS),9 respectively. While maternity care is widely recognised as a high-risk specialty, risk management is also pertinent to gynaecological practice. 2. Patient safety, risk management and quality of care.Â Safety is one dimension of the quality of care but initiatives to enhance patient safety usually drive other dimensions as well. Objective: to explore health-care professionals' views about safety in maternity services. This paper identifies aspects of care that are less safe than they should be, possible ways to improve safety, and potential obstacles to achieving these improvements. This study was part of the King's Fund inquiry into the safety of maternity services in England. Design: qualitative study with a sample of health-care professionals who work in maternity services and who responded to the call for evidence. Data were collected by questionnaire and analysed using thematic content analysis. Setting: maternity professionals throughout England were invited to take part. According to the participating health professionals, the structural conditions were frequently not suitable for providing targeted group-oriented care services. Additionally, a shortage of time and staff resources also limited the necessary flexibility of treatment measures in the care of mothers with physical disabilities. The importance of interprofessional teamwork for providing adequate care was highlighted. The health professionals regarded interprofessionalism as an instrument of quality assurance and team meetings as an elementary component of high-quality care. On the other hand, the interviewees perceived a lack of action competence that was attributed to a low number of cases and a corresponding lack of experience and routine.