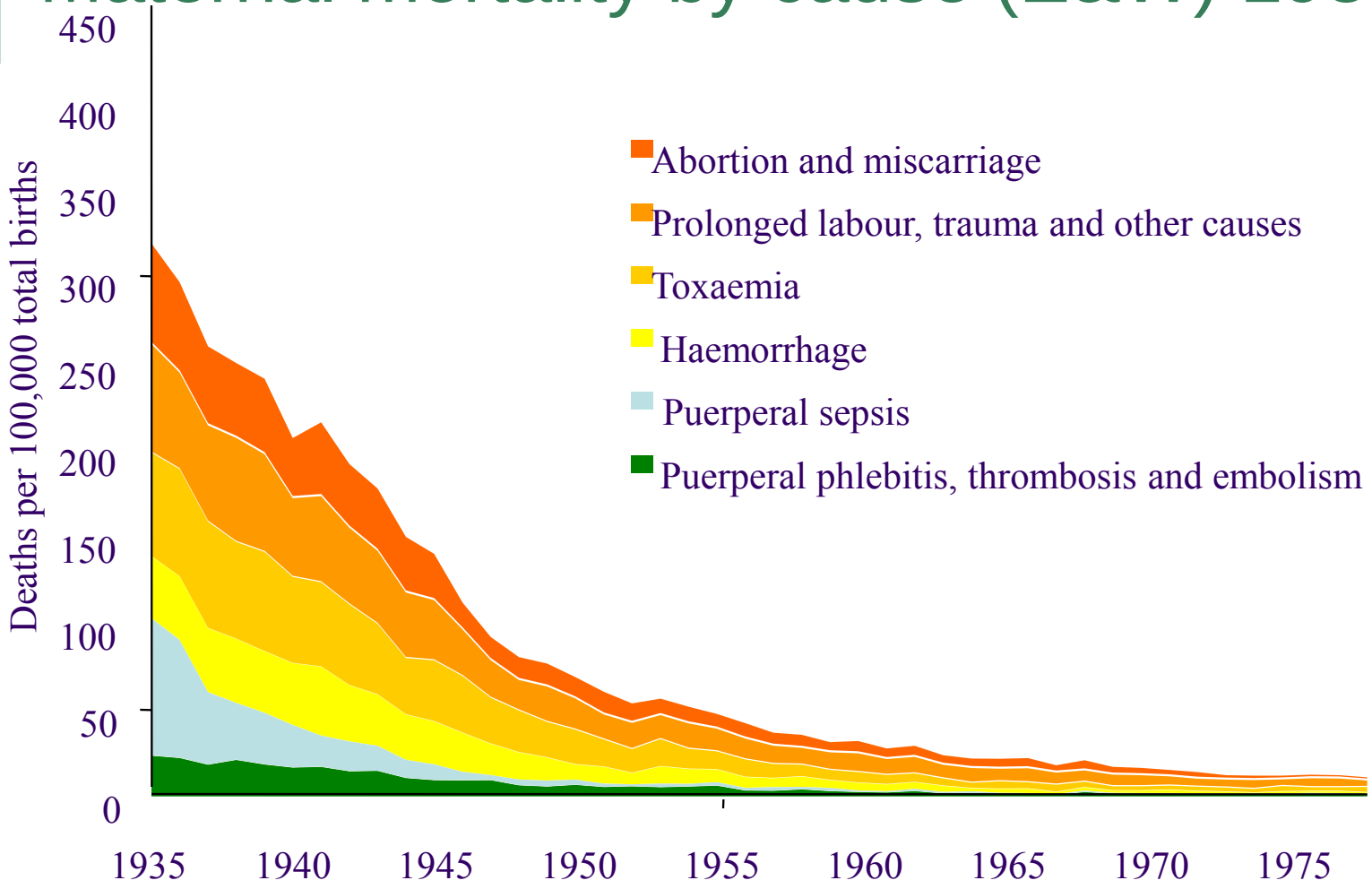
Providing optimal care: enabling safety, quality and choice

- Professor James Walker
  - Consultant Obstetrician, Leeds
  - Senior Vice-President of RCOG
  - Chairman of CMACE
  - Obstetric Advisor to NPSA

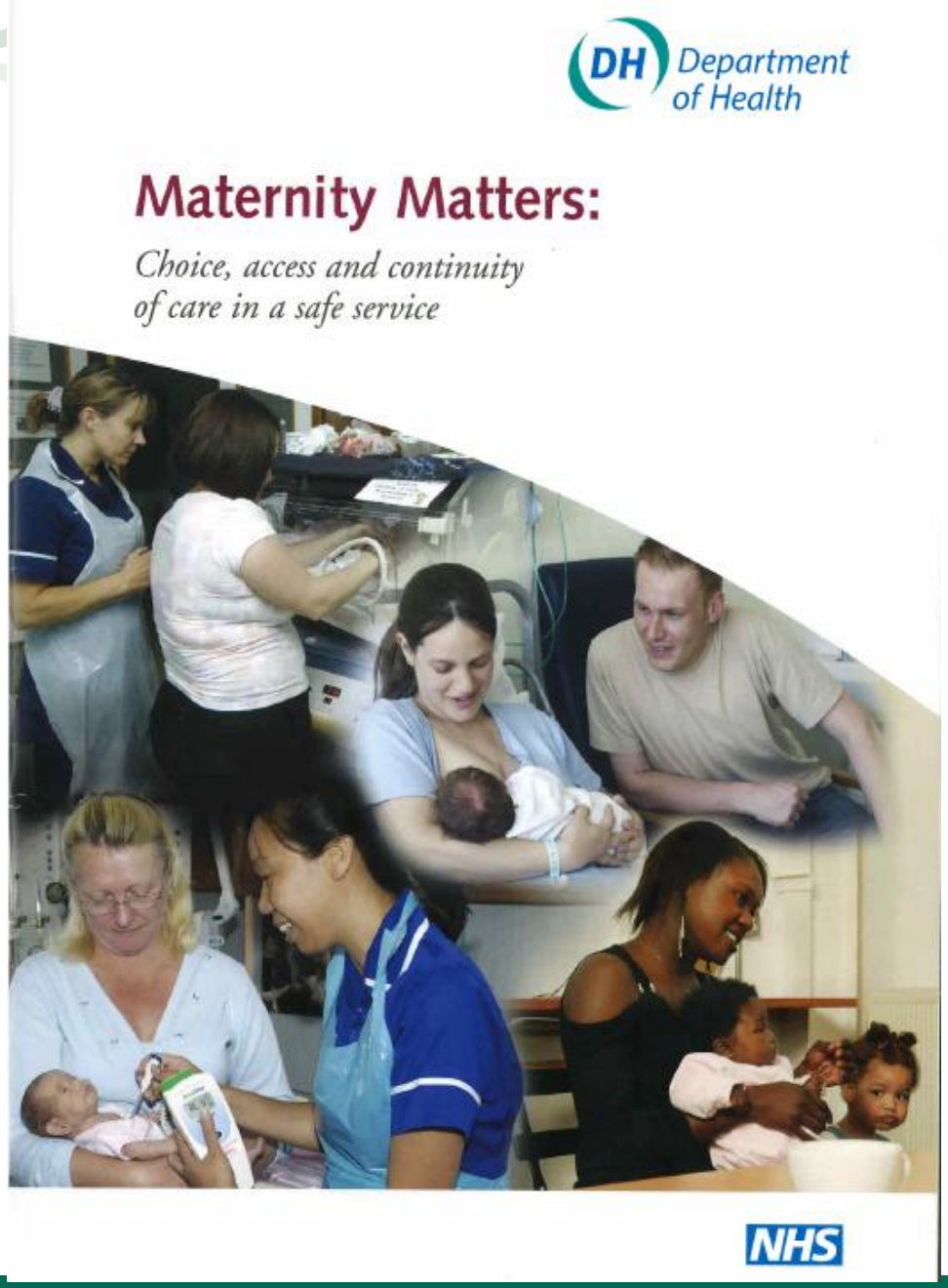
Maternal mortality by cause (E&W) 1935-78



Source: General Register Office and OPCS, Reproduced in Birth counts, Table A10.1.3.
Graph by Alison Macfarlane

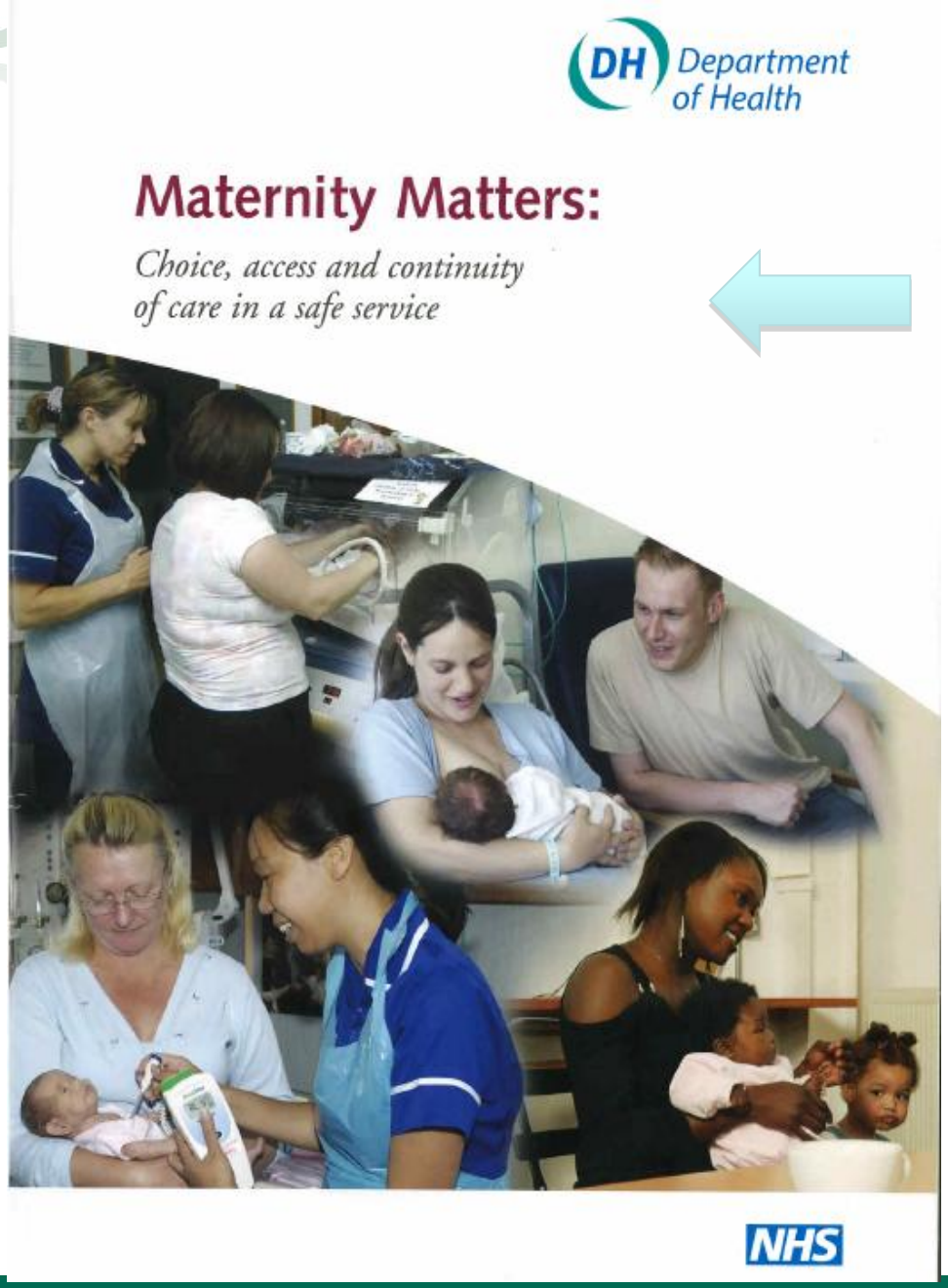
Implementing Intrapartum Safety Issues

- Redesigning services to ensure all patients are given safety, choice and quality in care
- Empowering staff to support vulnerable mothers: providing the best possible outcomes
- Providing safe care that is suitable for the needs of the particular patient
- Integrating pathways to deliver the most suitable care for mothers and babies



Maternity Matters sets the context and vision for maternity care and implementation will empower, engage and involve parents in ensuring that every child has an equal confident and healthy start to family life.

Patricia Hewitt
Secretary of State for Health



*Choice, access and continuity of care in a **safe service***

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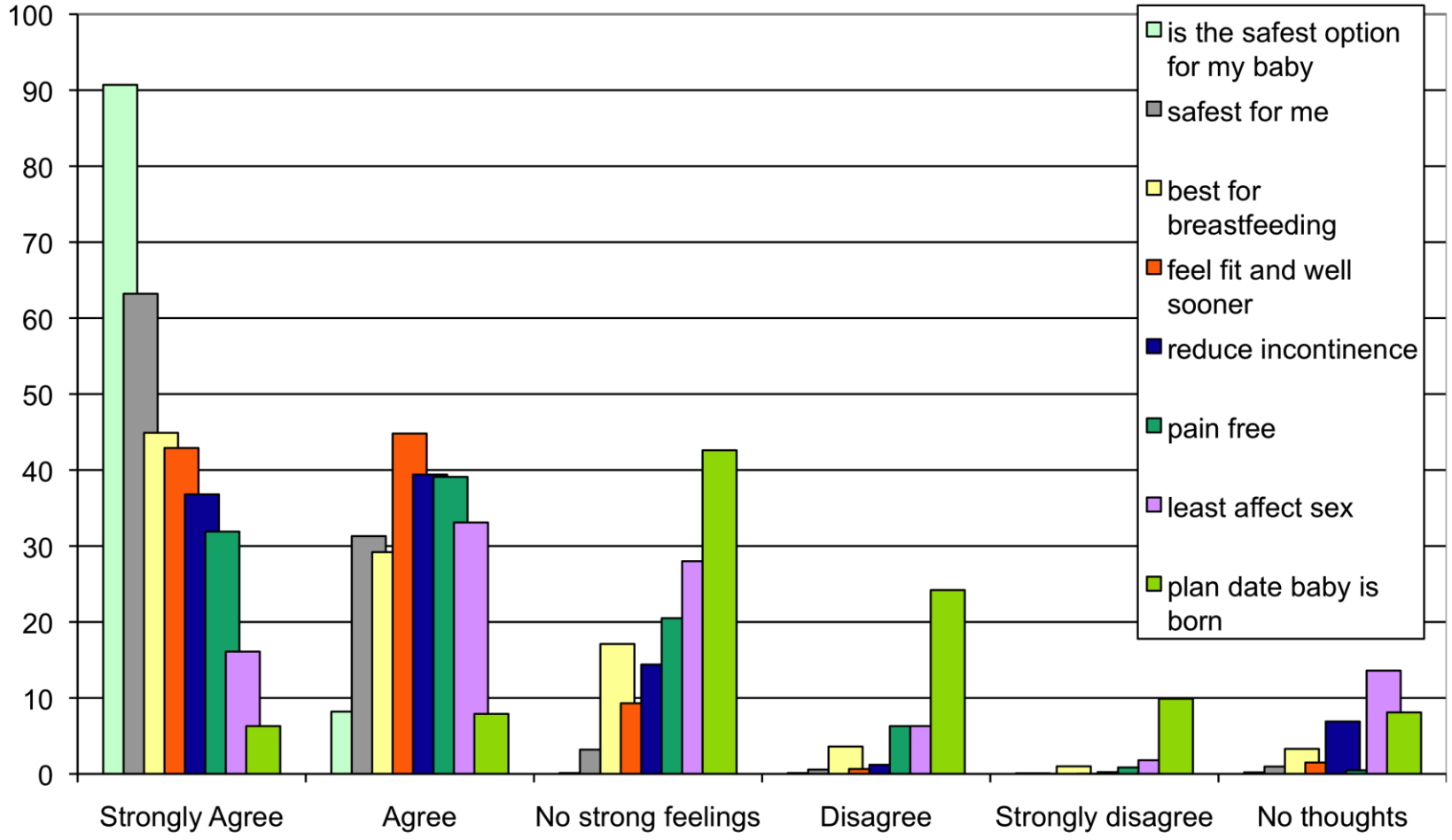
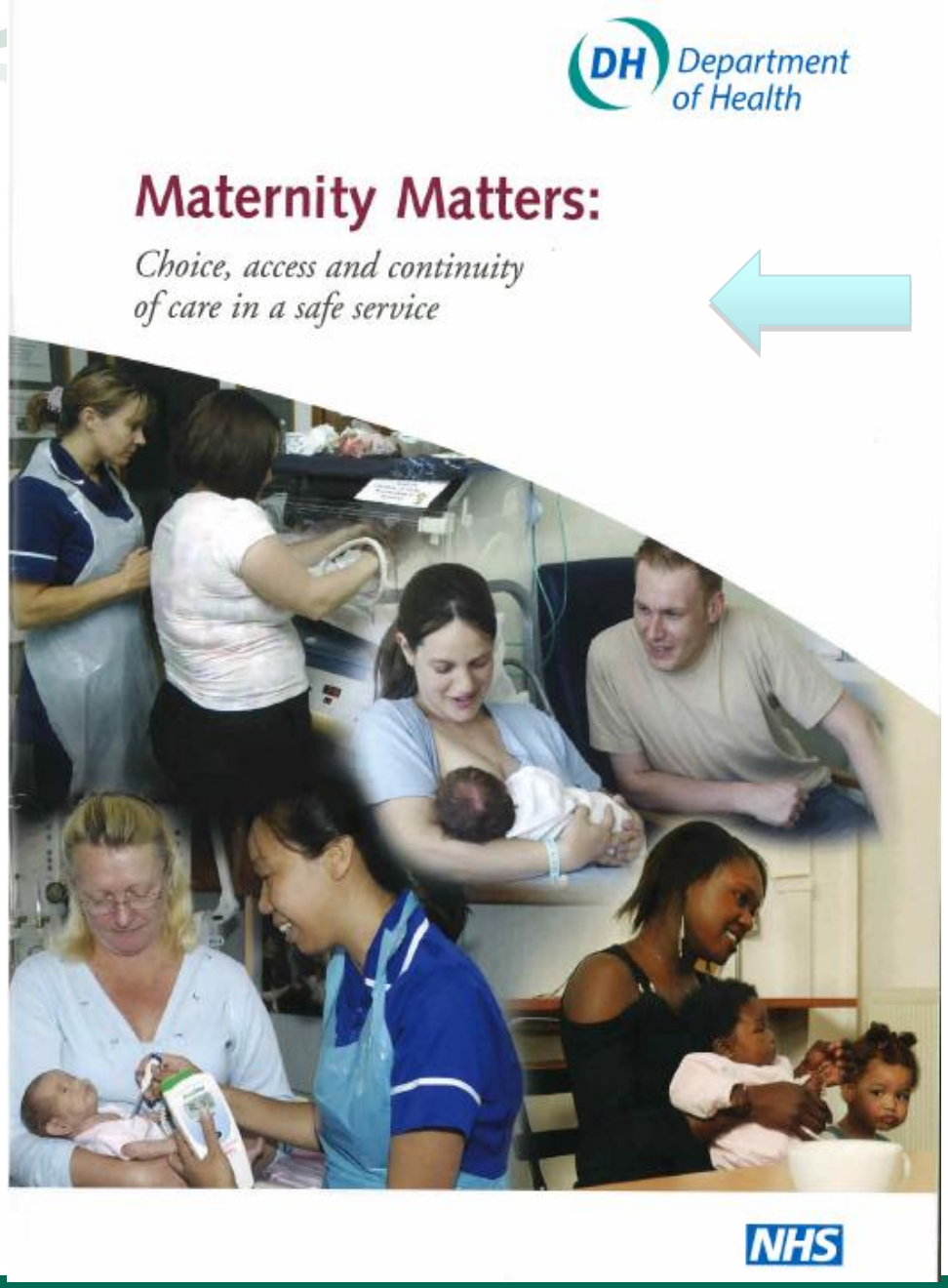
Women's views on childbirth





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No obstetricians

Obstetrician/Midwife Interface

Its all about mother and baby

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Mortality / 10,000 births

Faith assembly	480	87.2
Others	180	0.9

(Kaunitz et al, Am J Ob Gyn;150: 826)

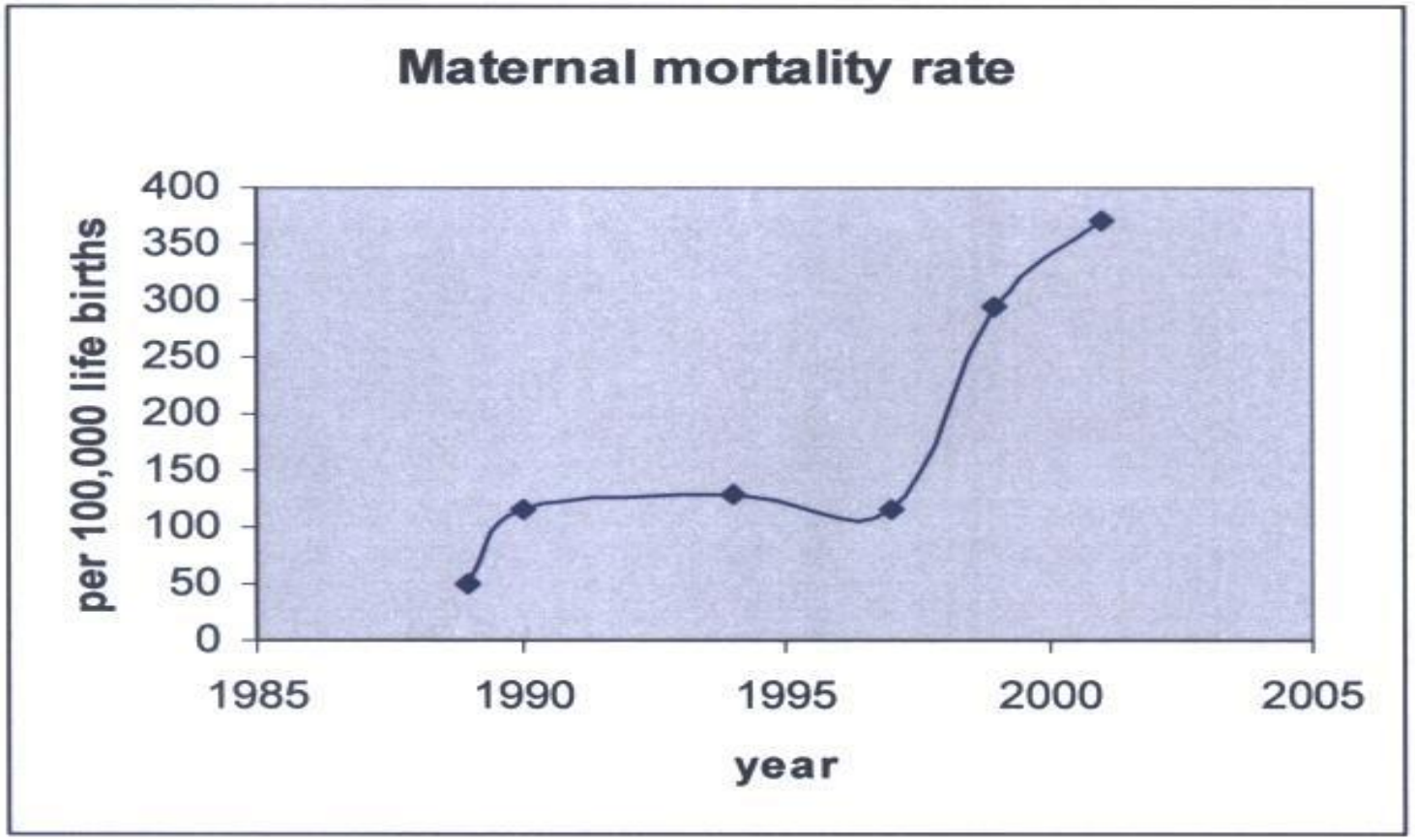
Saving Mothers Lives

	Maternal Mortality/100,000 births
Faith Assembly	872
UK 2002-2005	14
Difference	**858**

6000 mother's lives saved per year in the UK
25 per hospital per year

Maternal Mortality in Iraq

Figure 2: Maternal mortality rate.



NHS
National Patient Safety Agency
National Reporting and Learning Service

Northwick Park

Investigation

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

August 2006

Healthcare Commission

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Working in Partnership

- Instilling Trust
- Embedding a safety culture
- Learning and developing safer practices
- Risk assess
- Designing care pathways and escalation
- Demonstrating Improvements

Kings Fund - Safe Births

- Although a midwife's primary task is the management and promotion of normal pregnancy and childbirth
- midwives must also be skilled risk-managers, monitoring pregnant and labouring women for any deviations from the norm
- making crucial decisions about referral to obstetricians where necessary.

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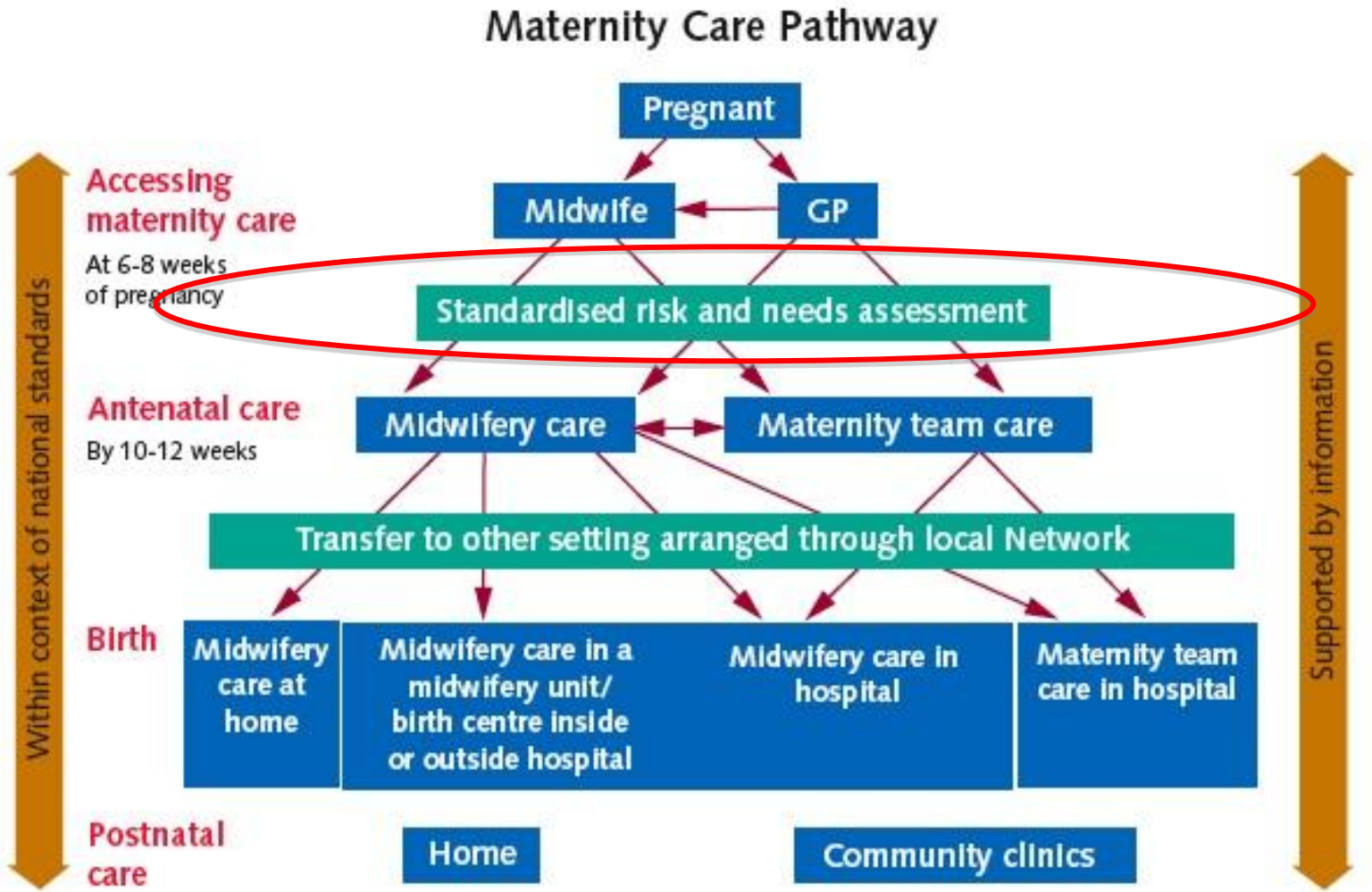

Figure 1: Choice commitments along the maternity pathway

Things look straight-forward

But sometimes they’re not!

Direct and indirect deaths by maternal age: UK 1985-2002

	Number	Rate/100,000
<20	89	8.6
20-24	219	7.3
25-29	415	8.6
30-34	393	11.7
35-39	251	19.6
40+	81	35.5

Effect of Obesity

Table V Cesarean delivery rate among nulliparous patients

	Cesarean delivery	OR (95% CI)	*P*-value
Overall	22.7%	—	—
Control	20.7%	—	—
Obese	33.8%	1.7 (1.4-2.2)	<.01
Morbidly obese	47.4%	3.0 (2.2-4.0)	<.01

Characteristics	No. of patients	No. of failed VBAC	% Of failed VBAC	OR (95% CI)	*P* value
BMI					
<25	277	39	14.1	1.00 (ref.)	< .001
25-29.9	191	39	20.4	1.57 (0.96-2.55)	
30-39.9	191	53	27.7	2.34 (1.47-3.73)	
>40	66	20	30.3	2.65 (1.42-4.96)	

Socio-Economic Classification UK 2000-2002

Husband's/partner's occupation	MMR (95% CI)
Prof / Managerial	4.1 (2.7- 5.9)
Intermediate	8.3 (5.5-11.8)
Routine / manual	7.0 (5.2- 9.2)
Not classified	76.7 (59.2 - 97.7)
Total	9.3 (7.9-10.7)
Single mothers	27.9 (21.5 - 40.0)

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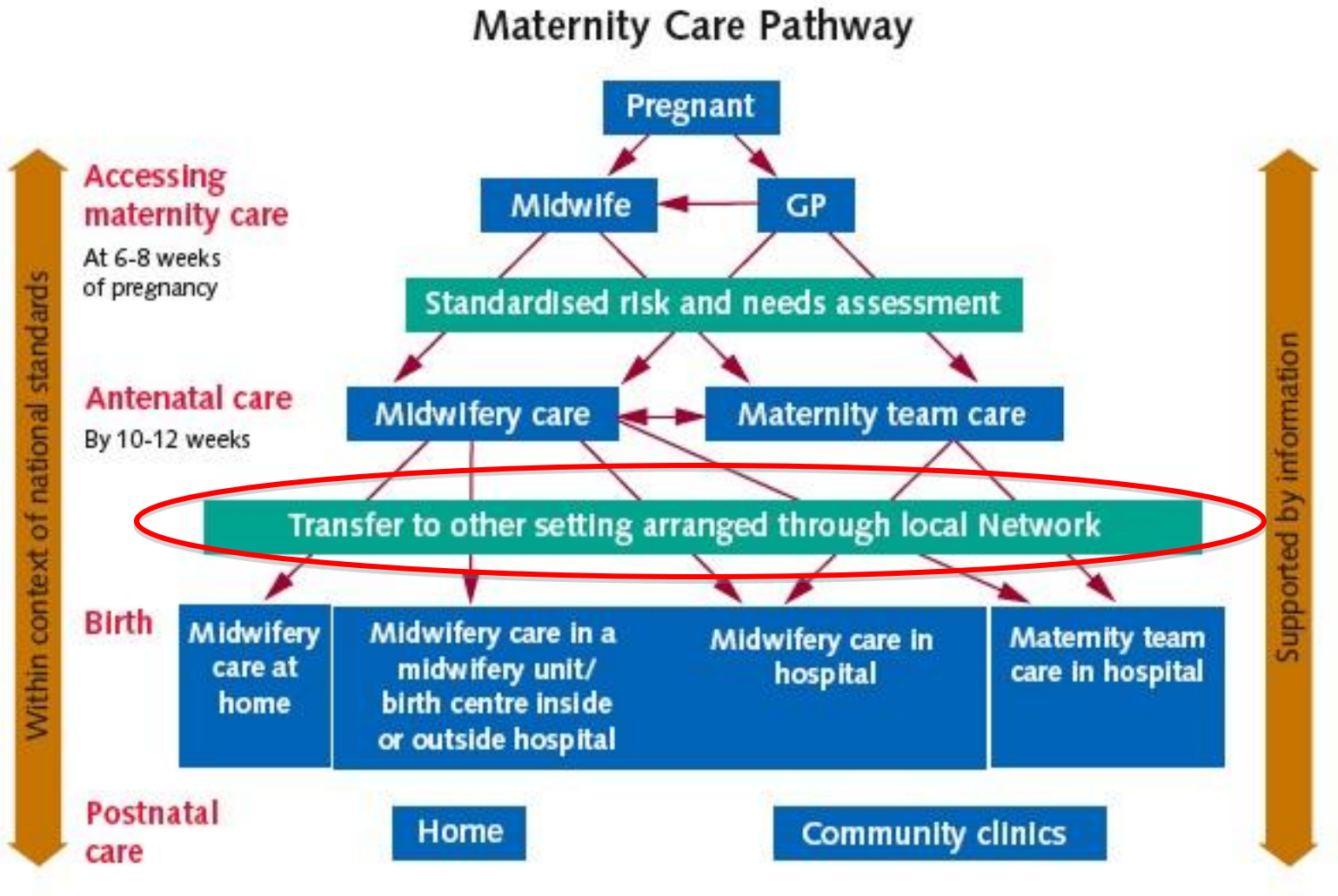
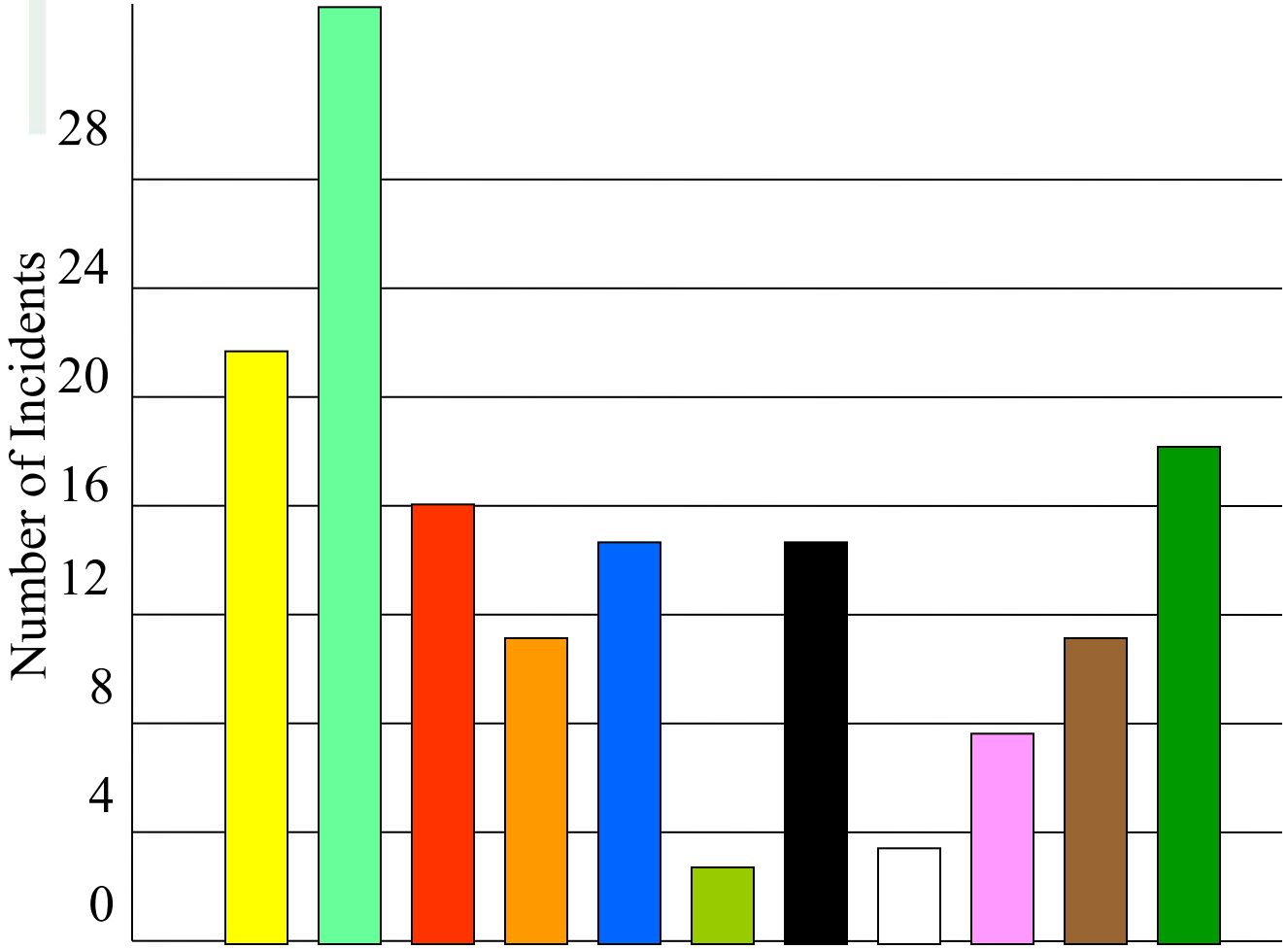


Figure 1: Choice commitments along the maternity pathway

Obstetric Incidents – Contributing Organisational Factors

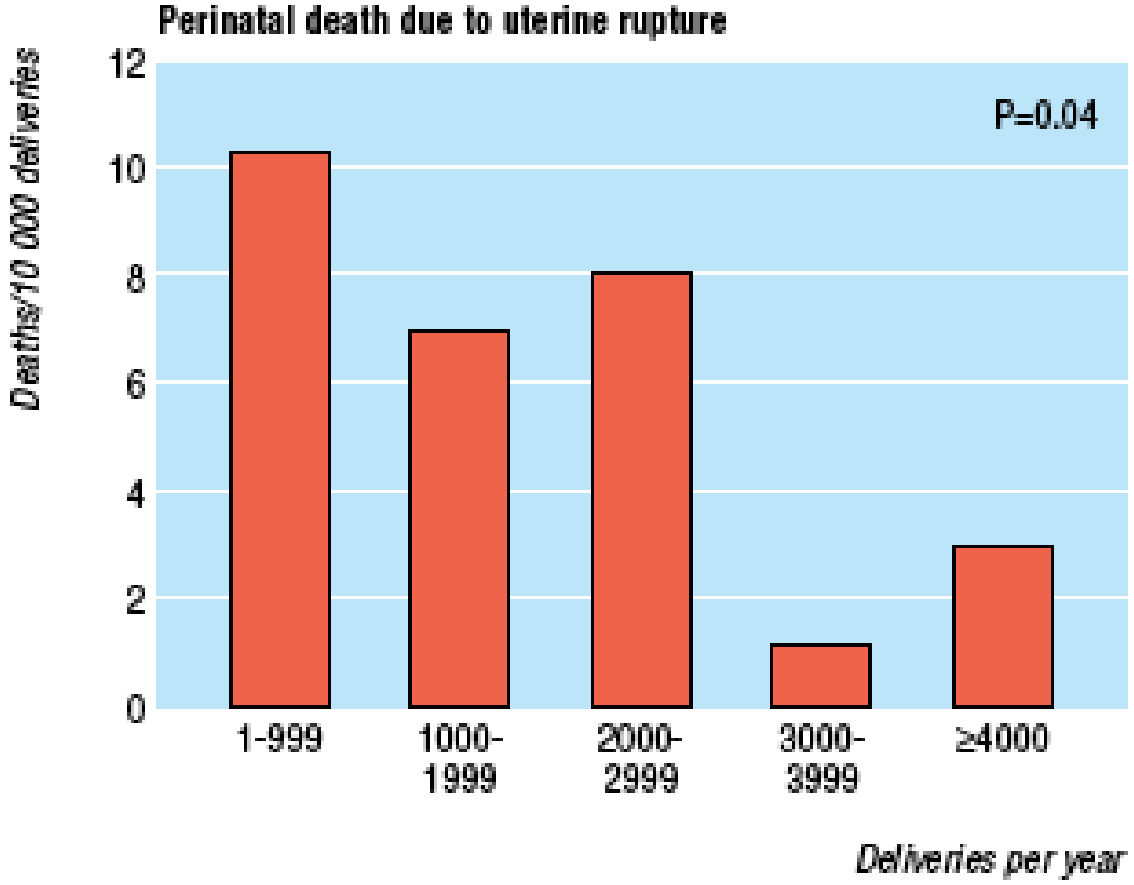


- Busy or heavy workload
- Delay following call for assistance
- Delay of over 30 mins for emergency Caesarean
- Inadequate staff or education or training
- Insufficient or inadequate staff
- Lack of assistance for staff
- Lack of staff
- Lack of supervision for staff
- No clinical guideline available
- Results not available
- Senior staff not available

Table 3.7 What was the problem? (756 notable factors graded 2 or 3)

What was the problem?	Grade 2 or 3 Noteable factors	(%)
Failure to act appropriately	377	(50%)
Failure to recognise problem	226	(30%)
Communication failure	116	(15%)
Failure to supervise	15	(2%)
Lack of human resource	7	(1%)
Factor not stated	15	(2%)
Totals	**756**	

VBAC Perinatal Deaths/10000



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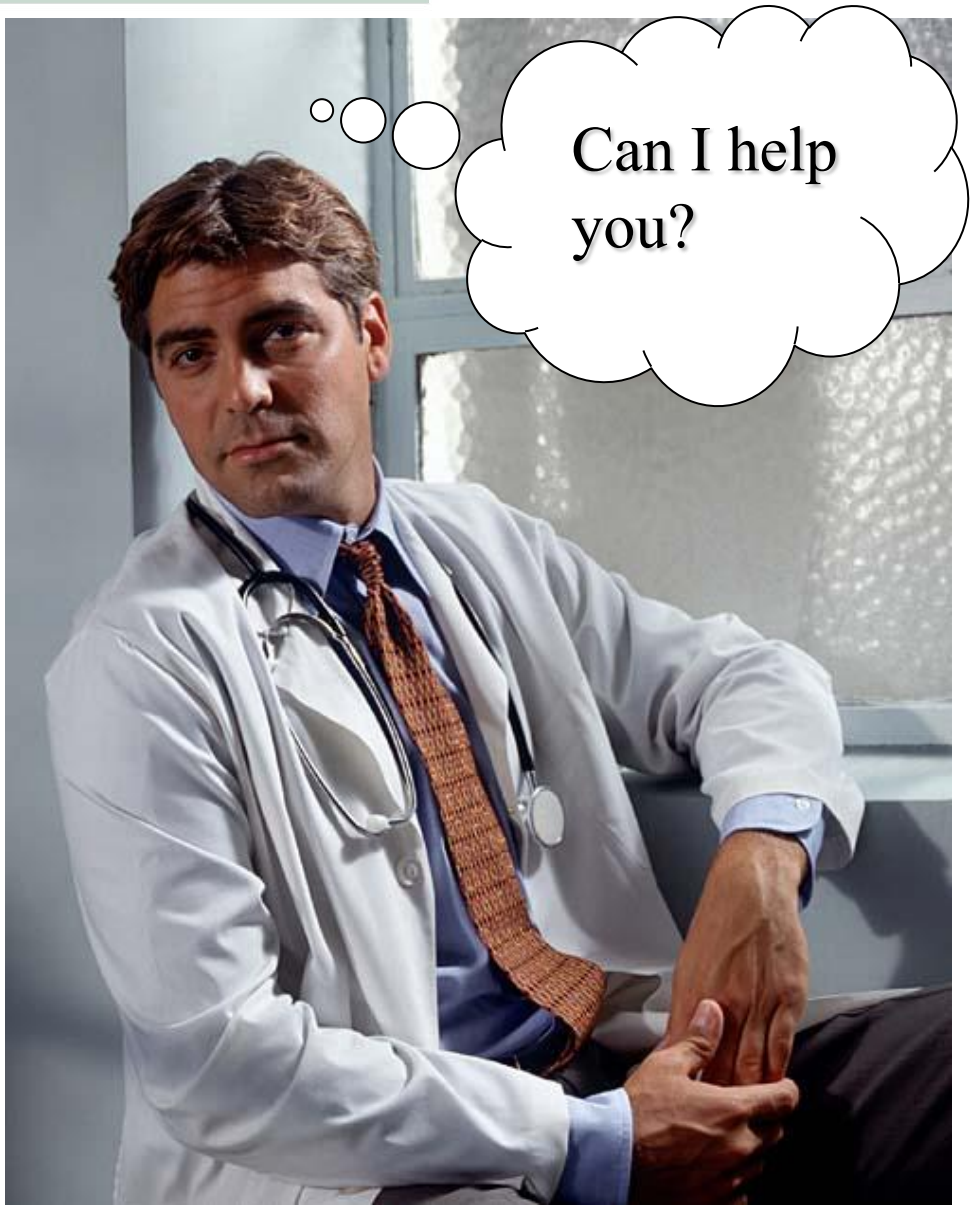
Midwife managed delivery unit: a randomised controlled comparison with consultant led care

- Results
  - 34% were transferred antepartum
  - 16% were transferred intrapartum
  - 46% were delivered in the midwives unit
  - Primigravid women (43%) were significantly more likely to be transferred intrapartum than multigravid women (8%).


Can I help you?

Working in Partnership?

- Team working
- Guidelines to inform
  - Routine
- Checklists to focus
  - Prompts
  - Memory aids
  - Care Bundles
- Drills for skills
  - Regular
  - For all
- Audit trail
  - Prove what you do

The labour ward team

Where are the different skills?

The A Team

Does the Team Fit Together?

Is everyone happy?

We need to work together and share the learning from our mistakes to try and stop them happening again …..

Daily Case Note Review

Working in Partnership?

- Team working
- Guidelines to inform
  - Routine
- Checklists to focus
  - Prompts
  - Memory aids
  - Care Bundles
- Drills for skills
  - Regular
  - For all
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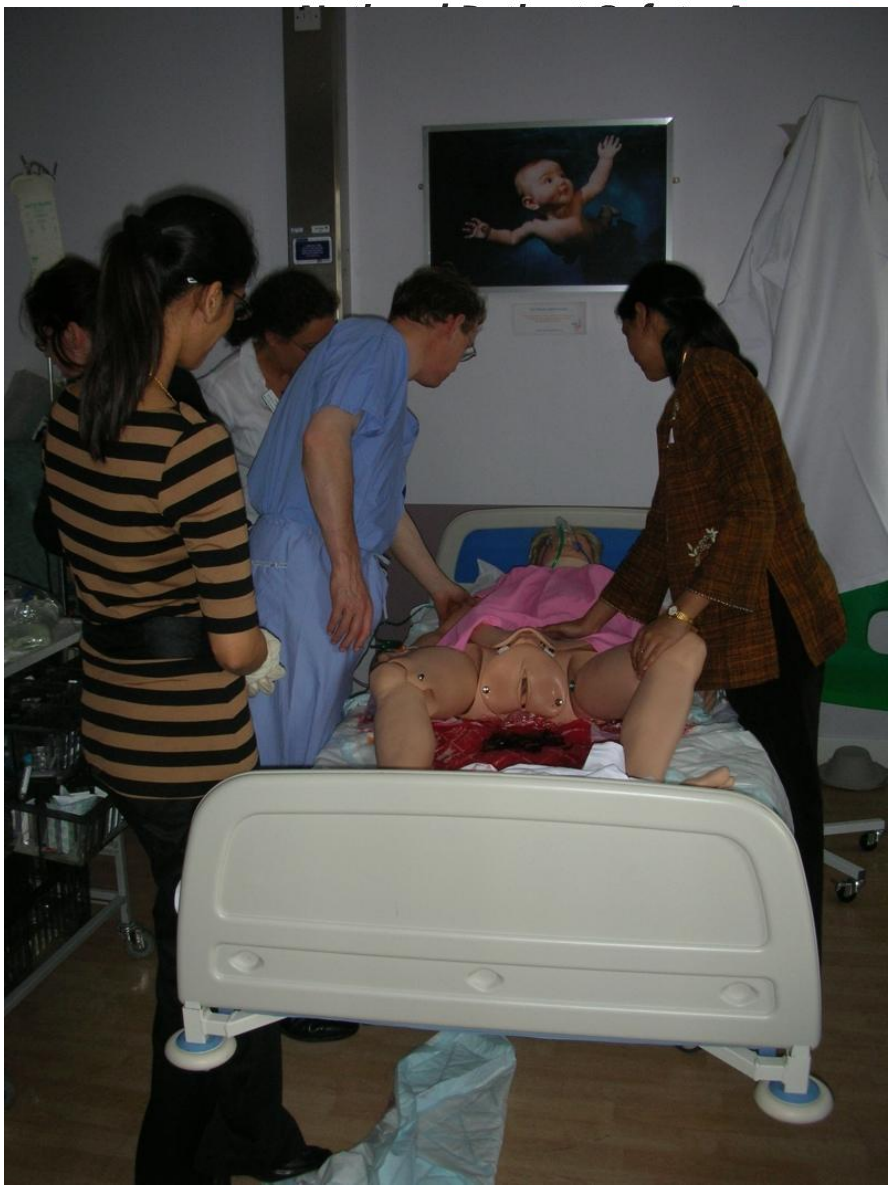
YMET -Drills

- PPH
  - Train as a team
- Think of everything
  - How to set up
  - Who to involve
  - Follow a checklist
  - Have a note taker



Consultant presence in SJUH (2004)

Year	**2003**	**2009**
Total Births	- 3840	- 4671
CS rate	**- 26.1%**	**- 19.13%**
◦ Emergency	-10.79%	- 11.95%
◦ Elective	-15.30%	- 7.19%
Instrumental Birth	**- 10.33%**	**- 10.39%**
◦ Forceps	- 5.09%	- 8.29%
◦ Ventouse	- 5.24%	- 2.10%
Breech Birth	- 0.36%	- 0.75%
Midwife Birth	**- 63.12%**	**- 69.73%**
◦ Midwife led	- 28%	- 31%
◦ Home Birth	- 0.5%	- 0.7%

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Keeping the mother and baby safe