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Women’s safety alerts in maternity care: is speaking up enough?

Susanna Rance,1 Christine McCourt,2 Juliet Rayment,2 Nicola Mackintosh,1 Wendy Carter,3 Kylie Watson,4 Jane Sandall1

ABSTRACT

Patients’ contributions to safety include speaking up about their perceptions of being at risk. Previous studies have found that dismissive responses from staff discouraged patients from speaking up. A Care Quality Commission investigation of a maternity service where serious incidents occurred found evidence that women had routinely been ignored and left alone in labour. Women using antenatal services hesitated to raise concerns that they felt staff might consider irrelevant.

The Birthplace in England programme, which investigated the quality and safety of different places of birth for ‘low-risk’ women, included a qualitative organisational case study in four NHS Trusts. The authors collected documentary, observational and interview data from March to December 2010 including interviews with 58 postnatal women. A framework approach was combined with inductive analysis using NVivo8 software.

Speaking up, defined as insistent and vehement communication when faced with failure by staff to listen and respond, was an unexpected finding mentioned in half the women’s interviews. Fourteen women reported raising alerts about safety issues they felt to be urgent. The presence of a partner or relative was a facilitating factor for speaking up. Several women described distress and harm that ensued from staff failing to listen.

Women are speaking up, but this is not enough: organisation-focused efforts are required to improve staff response. Further research is needed in maternity services and in acute and general healthcare on the effectiveness of safety-promoting interventions, including real-time patient feedback, patient toolkits and patient-activated rapid response calls.

INTRODUCTION

There has been increasing interest internationally in the ability of patients and their families to contribute to their own safety.1–3 There is some evidence that patients can detect suspected adverse events earlier than professionals.4 However, most interventions have focused on educating patients and encouraging them to question staff on pre-established issues such as hand washing and medication.5 Patients’ readiness to speak up was substantially affected by the quality of their relationships with staff.6 Many were reluctant to challenge professionals because of previous experiences of not being heard or having their input belittled, or fear of victimisation.7–11

Less is known about the role of women speaking up in maternity services. A study of interaction in antenatal clinics found that women used indirect ways to broach issues that worried them, feeling that they might not be considered valid by staff.12 Women’s narratives about birth trauma referred to professionals’ neglect of communication and their own feelings of powerlessness.13 In an investigation of a maternity service where serious incidents had occurred, the Care Quality Commission documented cases of women ‘routinely being ignored and their description of their labour being dismissed by staff; being left alone for long periods of time while in labour; being spoken to rudely by staff; and not receiving adequate pain relief’.14 UK media have reported on incidents when staff failed to attend to labouring women’s safety alerts.15–18

A report on stillbirths and neonatal deaths found that many bereaved parents had suspected something was wrong and had raised alerts which staff did not consider to be valid.19

The Birthplace in England research programme was designed to provide a solid evidence base regarding the quality and safety of different places of birth for ‘low-risk’ women. Its component studies aimed to map the configuration of maternity services; compare perinatal and...
maternal outcomes by planned place of birth at the start of care in labour; compare cost effectiveness of birth settings; and investigate factors related to service organisation and staffing which are associated with the quality and safety of maternity services, especially during transfer and escalation of care.

The qualitative organisational case studies provided insights into staff and user experiences. One unexpected finding was the frequency of women’s accounts about speaking up to staff during antenatal, intrapartum or postnatal care. This paper focuses on situations in which women felt the need to speak up, and on the distress and harm that ensued when staff failed to respond in a timely way.

METHODS
Study aim and design
Birthplace case studies were carried out in four NHS Trusts across England to explore the policies and practices through which high-performing organisations aim to improve safety and quality of care. Sites were selected among the Trusts that were most highly ranked in Healthcare Commission assessments of maternity services. Further selection criteria were variation in geographical location, Index of Multiple Deprivation, and service configuration covering combinations of obstetric units, alongside midwifery units and/or freestanding midwifery units. Site characteristics are shown in online supplementary appendix 1.

The study’s approach was guided by the Institute of Medicine’s definition of quality as comprising six dimensions: safety (‘avoiding injuries to patients from the care that is intended to help them’), effectiveness, timeliness, efficiency, equity and patient centredness. To enrich this framework we explored local meanings of quality and safety in the accounts of users and providers.

The semi-structured interview schedule (see online supplementary appendix 2) was phrased in broad terms to explore respondents’ experiences without introducing notions they might feel drawn to repeat. Women could frame their narratives differently in response to questions such as: ‘How was the birth experience for you?’ and ‘Is there anything you wish had been different about the care you received?’ At an early stage of fieldwork we noted spontaneous references to speaking up in several interviews. As with other emerging topics, interviewers prompted women to recall details and draw conclusions by asking: ‘Can you tell me more about that?’ and ‘What do you think about that now?’.

Data collection
The study team was composed of four health services researchers: principal investigators JS and CM and researchers SR and JR. From March to December 2010 the team collected field data and gathered policy and site documents (>200). SR and JR carried out participant observation with contributions from NM and KC on one site (n=50 transcripts). SR and JR carried out 86 semi-structured, face-to-face, audio-taped interviews with staff, managers and stakeholders. Interviews with postnatal women (n=58) and partners (n=6) were carried out by SR and JR with contributions from CM and WC. Interviews and field notes were transcribed in full.

In this paper only findings from interviews with postnatal women and partners are reported. The sample was guided by maximum variation sampling to include women with a range of socio-demographic characteristics and experiences, such as complications and transfer, and data saturation when interviews were sufficient to respond to research questions.

Online supplementary appendix 2 presents details of the recruitment and interview processes.

Data analysis
A framework approach was used that combined deductive and inductive analysis, commencing with definitions of quality and safety and amending the framework as new themes emerged from the data. Analysis was further guided by discussions with the study’s co-investigators and advisory groups.

SR and JR coded all interview and field note transcripts independently using NVivo8 software. In team meetings, differences of interpretation were discussed and a consensually agreed set of analytic categories was developed. The resulting thematic tree included the NVivo nodes ‘Users speaking up/not speaking up’ and ‘Staff response’. The former node, containing 175 references from 57 sources, was one of the most frequently referenced categories in the study. This led to speaking up being identified as a key theme, among other dimensions of safety and quality of care, for women’s experiences in different places of birth.

Given its importance, a secondary phase of manual coding of all user interview data was carried out to further develop the subthemes presented in this paper: women who did and did not speak up, concerns and safety alerts, partners’ and relatives’ supportive roles, and staff failure to listen and respond.

FINDINGS
The first result of the analysis was a redefinition of speaking up in the context of maternity services. Studies in other areas of healthcare have alluded to roles taken on by patients such as reporting, informing and vigilance; asking factual questions about their treatment; challenging professionals about safety concerns; giving practice improvement feedback, questioning and advising practitioners, confronting staff, and attempting to change care practices.

The most relevant definition for this analysis was that of Lyndon et al who referred to clinicians speaking up about safety concerns in labour and delivery in terms of assertive communication and
‘stating concerns with persistence until there is a clear resolution’. Speaking up was defined as *insistent and vehement communication when faced with failure by staff to listen or respond on at least one occasion*. Insistence was the main feature that differentiated speaking up from ‘just speaking’ and being heard. Levels of vehemence varied depending on the urgency of the situation as perceived by the woman.

**Women who spoke up**

Of the 58 women interviewed, 30 reported speaking up in the course of their latest pregnancy or birth. The similarity in numbers of women who spoke up and those who did not was also reflected across socio-demographic groups (table 1).

**Women who did not speak up**

Women who did not speak up could also have experienced problems in their maternity care, but for different reasons they did not insist or communicate vehemently with staff. Of 28 women who did not speak up, 15 considered that professionals had greater knowledge, or opted for a strategy of compliance with clinical authority when complications arose. On the basis of their own or others’ past experiences, some women feared that they could be labelled over reason they did not insist or communicate. Four women said they had thought of speaking up but lacked certain resources: time or an opportunity to intervene; clarity of mind when struggling with pain, the effects of anaesthesia or feeling unwell; information about their condition or treatment; and/or confidence in their own knowledge. Some expressed regret or self-blame for not having been more assertive, as in the case of this woman who had
did not need to do so because they had dialogic communication with staff who listened and responded promptly. Some women commented that the quality and continuity of their care had been exceptional given the constraints on NHS staff time. They gave credit to professionals who made them feel at ease and did not trivialise their concerns: “... you felt like you could come out with the stupid questions, you know, and you wouldn’t feel silly” (postnatal woman 23, site 3).

The nine remaining women who did not speak up had not needed to do so because they had dialogic communication with staff who listened and responded promptly. Some women commented that the quality and continuity of their care had been exceptional given the constraints on NHS staff time. They gave credit to professionals who made them feel at ease and did not trivialise their concerns: “... you felt like you could come out with the stupid questions, you know, and you wouldn’t feel silly” (postnatal woman 23, site 3). Even during critical experiences, ‘just speaking’ in a positive care relationship was sufficient to get heard. One teenage mother had a complicated birth with an epidural and ventouse delivery. Although she suffered bruising and severe pain she described her overall experience as good and she also felt she was given special support because she was young:

**Table 1** Postnatal women (n=58) who spoke up and did not speak up in latest pregnancy or birth by age, ethnicity and parity

<table>
<thead>
<tr>
<th>Age group</th>
<th>Women in sample (n=58)</th>
<th>Women who spoke up (n=30)</th>
<th>Women who did not speak up (n=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20</td>
<td>9</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20–29</td>
<td>16</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>30–39</td>
<td>31</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>≥40</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ethnicity</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>50</td>
<td>26</td>
<td>24</td>
</tr>
<tr>
<td>Black minority ethnic</td>
<td>8</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Parity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primiparous</td>
<td>41</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Multiparous</td>
<td>17</td>
<td>10</td>
<td>7</td>
</tr>
</tbody>
</table>

I have been thinking quite a lot about, I was almost like, should I have been more vocal about that, should I have made them get [named midwife] in, should I have ... because I’m pretty sure they wouldn’t have cut, like [named midwife] would have ... But obviously in the height of it all you don’t ... you don’t ... you can’t really think it through ... But it all happened so quickly in the end that I lost that window of opportunity ... I think it’s probably more me and my husband, we should have been more ... if I felt that strongly about things I should have waved my birth plan from the moment I got in there. [Postnatal woman 23, site 1]

The nine remaining women who did not speak up had not needed to do so because they had dialogic communication with staff who listened and responded promptly. Some women commented that the quality and continuity of their care had been exceptional given the constraints on NHS staff time. They gave credit to professionals who made them feel at ease and did not trivialise their concerns: “... you felt like you could come out with the stupid questions, you know, and you wouldn’t feel silly” (postnatal woman 23, site 3). Even during critical experiences, ‘just speaking’ in a positive care relationship was sufficient to get heard. One teenage mother had a complicated birth with an epidural and ventouse delivery. Although she suffered bruising and severe pain she described her overall experience as good and she also felt she was given special support because she was young:

Interviewer: Can you tell me how the birth experience went for you?

Woman: Um ... well, well ... my birth was ... um ... complicated but it was, it was good ... it helped how the midwives were with me. They made sure I knew what was going on, they made sure I was comfortable and they listened to me as well and that was important ...

Interviewer: Did you think as a young parent you were treated differently from other mothers?

Woman: I think if anything I got more support because I was young mum than other mothers would have. I think at [hospital] they do understand that when you are younger that sometimes things can hit you a little harder because like you are still growing emotionally. So, yeah, but, I had the same midwife all the way through my pregnancy. I had like constant support and help. [Postnatal woman 28, site 2]

**Concerns and safety alerts**

Previous studies have referred to ‘safety concerns’ as the topic of speaking up, but we noted a qualitative difference between expressions of concern and safety alerts. Women tended to raise concerns...
hesitantly, especially if they were first-time mothers, feeling that staff might put their worries down to anxiety or inexperience. Nevertheless, some learned in practice how to press for a response:

... you had to be quite insistent, you had to be confident enough to say, well I do need something and I will press that buzzer, and ... not be put off if they are ... sort of impatient, or short with me. Just stand your ground and say ... um ... “I need to ... I was meant to have the result of this test and I haven’t heard anything, and what's happening?” Or, “When is my catheter going to be taken out?” Or, you know, that kind of thing. “What’s going on?” [Postnatal woman 17, site 2]

Safety alerts were characterised by increasing levels of vehemence when women felt the need for an immediate response, as in this case:

I panicked like mad, and um, they [midwives] were still insistent that they weren’t going to get any more [Entonox], so I turned round and I said, “Right, I want you to call the ambulance then, because I’m not staying here. I’m not going to go through this” ... I was really mad. I remember being exceptionally mad ... I just felt like I was being ignored ... I felt like I was screaming and no one was listening. I felt like my wishes were being completely disregarded, at that point. [Postnatal woman 32, site 3]

Expressions of concern and safety alerts sounded different, but they could be conceptualised as poles on a continuum. If a woman’s concern remained unheard, her condition or that of her baby might deteriorate leading to a situation she felt to be urgent. If response was further delayed, the woman could abandon scruples about challenging staff and make vehement calls for help. In the case just cited, the woman passed from repeated requests for pain relief at home to an angry demand for transfer because she felt profoundly unsafe. Even when speaking up proved effective and physiological harm did not ensue, the emotional pressure women endured could negatively mark their overall experience of care.

**Topics of women's safety alerts**

A total of 14 of the 58 women reported speaking up in situations they felt to be urgent. They came from all sites and had varied socio-demographic characteristics. Box 1 provides examples of safety alerts about requests for attendance in labour, signs of risk in labour and neonatal pathologies.

**Partners’ and relatives’ supportive roles**

Women who spoke up were socio-demographically diverse, but there was some commonality in the factors they mentioned as enabling them to call for staff’s attention. One already mentioned was the vehemence that came from the sheer urgency of their feelings of being at risk. Another was the confidence some women acquired from information found in online searches: “Really, all in internet, I sit, I read all night, all day ...” [postnatal woman 19, site 2]. A facilitating factor mentioned by 13 of the 14 women who spoke up with urgent safety alerts was the presence of a partner or relative. The roles of these supporters included the following:

- encouraging the woman, backing up her requests;
- speaking up on her behalf, for example if she had little English;
- becoming the main speaker if the woman was focused on labour, in pain, weakened or unwell;
- Taking on critical caring responsibilities, including delivery of a baby when staff failed to attend in time.

The examples in box 2 show the importance women gave to this support, but they also convey the augmented tensions in labour and birth when those involved felt unsafe, fearful or angry.

When women were unaccompanied they seemed to have less success in standing their ground. One woman spoke up successfully with her partner’s support about meconium-stained waters (see box 1), but when he was not with her postnatally she felt unable to communicate with staff about difficulties...
with breastfeeding: “Is a lot doctor, a lot midwife, but I feel like I’m alone, in one island, and nobody … can help me … but after when coming, er … X [partner], X helped me” [postnatal woman 19, site 2].

One of the women who reported speaking up about a safety issue she considered urgent did not have a partner or relative present. Despite her insistence, she was unable to obtain the presence of a midwife to attend her planned home birth. She had to transfer in, her cervix was found to be 7 cm dilated and her waters were broken. The baby was born suddenly and she could not get off the bed quickly enough for the delivery:

I had a second degree tear because it was so quick … I lost a lot of blood, I nearly had to stay in. I nearly had to go to surgery for stitches … They [staff] said, “We had midwives to come out.” They weren’t convinced that I was that far gone. They listen—even when you talk to them on the phone—to how you’re breathing and talking. I’m one of those people who don’t show it. [Postnatal woman 5, site 1]

This woman was 34, she had given birth before and she was an active NCT member: all characteristics denoting experience, knowledge and agency that could have favoured her negotiation with staff. Her suggested recommendation to the service was ‘Listen to the second time mums more’. However, our findings suggest that whatever women’s characteristics, they were more likely to be heard if they had a partner or relative present to reinforce their request. This potential was illustrated by one woman whose partner managed to obtain the presence of a midwife to attend their planned home birth, although the service was refused to others that night on the grounds of staff shortages (a situation corroborated in other interviews). She attributed their success to stubborn personalities and also to the influence of her father’s legal background: “… my dad’s brought us up that, you know … these are your rights, you know your rights, and that’s that” (postnatal woman 13, site 1).

Staff failure to listen and respond

Speaking up gave no guarantee of being heard or responded to. Women described the following types of staff behaviour that made speaking up both difficult and necessary:

- ignoring requests or dismissing safety alerts;
- delaying or withholding information, care or support;
- disbelieving the woman’s account of stage in labour or symptoms in self or baby;
- responding brusquely or rudely to requests for help;
- refusing labouring women admission or sending them home feeling unsafe;
- refusing presence of midwife to attend a planned home birth.

Box 3 illustrates women’s accounts of deterioration in their condition or harm that ensued in labour or postnatally after their safety alerts went unheard.

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**Box 2 Examples of partners’ and relatives’ support**

**Becoming the main speaker: ‘we are entitled to a home birth’**

… they said, “Oh, there’s no midwife, you’re going to have to come in.” And [husband] said, “No, [X]’s said she’s having a home birth, we’ve been told by our midwife we are entitled to a home birth, you need to send somebody out.” Um … and er … she [hospital operator] said, “Oh well, call us back in half an hour, or ….” you know, […] But I know when [husband] then phoned again, they said, “We haven’t got anybody.” He’s like, “No, You’re sending somebody out.” [Postnatal woman 13, site 1]

**Backing up the woman’s demand for explanation: ‘My sister had to tell them …’**

… after um they gave me the epidural and they pressed the crash button … so many people were sticking needles inside of me and I was really scared and no one could explain to me what was going on. My sister had to tell them all to stop that, let them basically explain to me cause I didn’t know what was going on, because I was really scared and I was like what is going on with the baby and what is going on with me cause by that time I was so numb from basically from my neck all the way down and I didn’t know what was going on. [Postnatal woman 27, site 2]

**Taking on critical caring responsibilities: ‘we just delivered a baby’**

So [partner] called the, I think the, yeah, called the hospital as well, and er … and he said, “Yeah, we just delivered a baby.” And um … and they were like, “Yeah, what’s the due date?” He’s like, “Look, due date? The baby’s here, we just delivered it” … and then they told him to, yeah, just gave him a little bit instructions and told him to call the ambulance as well. So he was on the phone like one with the ambulance and one with the midwife. And they told him, yeah, he should, we should wrap him in a towel and put it on my chest. But I wasn’t really happy, he looked at me like, “You have to put him on your chest,” and I was like, “No.” He was like, “[X], I’m not joking!” And I was like, “No, just don’t really …” And he’s like, “[X], we put him on your chest now.” [Postnatal woman 20, site 2]
When staff did take the time to listen and explain, even after a traumatic event, there was the potential for women to have more positive feelings about their overall experience. One woman had an infection and fever during labour and an emergency caesarean when the fetal heart rate dropped. She was upset at not seeing her baby at birth because he was rushed to intensive care. The next day she spoke to a midwife who gave her an explanation, and the woman ended her interview by expressing some satisfaction with the care she received:

... we [woman and midwife] spoke about it the next day because he was still in special care, and I was kind of like upset that the whole thing had gone that way ... my midwife at the time, she said, ... “when they cut you, um, the baby’s head wasn’t really down in your pelvis”, so you know, I could have gone the full ten centimetres dilation and had to have an emergency Caesarean anyway. And the cord was all round his neck and ... there was multiple things that, you know. So ... I’ve kind of got over it ... you know, it’s fine and he’s here and ... I was quite happy with the care that I had. [Postnatal woman 25, site 3]

DISCUSSION

Many ‘patient involvement in patient safety’ initiatives have been based on a deficit model which supposes that patients need to be given specific facts and stimuli to engage in safety-promoting behaviours. In recent years it has been argued that patients in acute and general healthcare settings have the potential to act as safety buffers by voicing concerns and pre-empting failures in care. Our analysis shows that women using maternity services also demonstrate this ability. Guided by experiential and embodied knowledge and online information which is being increasingly consulted, they can raise alerts about safety issues before professionals are aware there is a problem. The frequency in our data of accounts of women speaking up suggests that this practice may be common, potentially effective and worth supporting.

Nevertheless, according to our definition, the need to speak up is associated with at least one precedent of being unheard or ignored. Several interviewees rationalised staff failure to listen in terms of overload in NHS services. The sites studied, despite being located in Trusts assessed as high achieving, may sometimes have functioned in the ‘unsafe zone’ where ‘staff may not have adequate resources to prevent errors and mitigate safety threats’. The failure to listen so frequently reported in our study may be associated with institutional cultures that normalise reduced attention to women’s calls for help.

Former studies have found that more educated/better-off/white women may be more able to stand up for themselves in maternity services than women from disadvantaged social groups. However, they also noted the compensatory effects of programmes supporting women in situations of vulnerability.

In our study, women with varied socio-demographic characteristics were able to speak up. The potential social disadvantage of some teenage mothers was apparently mitigated by the care they received from case-loading midwives providing continuity of care.

Women who spoke up with urgent safety alerts had a contextual factor in common that they mentioned as positively influencing their ability to obtain a response: the supportive presence of a partner or relative. There is ambivalence in this finding because the empowering effect of an ally’s presence had its counterpart in the relative insufficiency of a woman’s lone voice to get heard, however well informed or experienced she was. This begs the questions: should maternity service users have to depend to this degree on the presence of a companion to negotiate safe care? Are unaccompanied women more exposed to risk?

CONCLUSIONS AND FUTURE DIRECTIONS

It can be concluded that many women are speaking up but this is not enough: staff need to listen and respond. Staff awareness needs to be raised about the value of women’s concerns regarding situations they feel to be unsafe and the need for case-by-case assessment of all safety alerts. Efforts should be made to improve communication and staff response, with special attention to women in situations that make speaking up difficult.

These transformations are notoriously difficult to achieve and they often require changes in institutional culture and practice. UK examples of such interventions include the Real Time Patient Feedback initiative in the Royal Devon and Exeter NHS Foundation Trust and the Patient Toolkit and patient incident reporting strategies currently being developed by the Yorkshire Quality and Safety Research Group. US examples include The Joint Commission’s ‘Speak Up’ campaign, and the ‘Condition H’ help line for patient-activated rapid response calls at the University of Pittsburgh Medical Center. Examples from Australia include the Clinical Excellence Commission’s ‘Partnering with Patients’ programme and the REACH Toolkit, which incorporates an evidence-based literature synthesis on patient and family-activated rapid response. Research is needed in maternity services, and in acute and general healthcare, on the effectiveness of organisation-focused interventions that aim to create enabling conditions for users’ contributions to their own safety.

LIMITATIONS AND STRENGTHS

The strengths of the study include the use of qualitative methods which allowed in-depth investigation of women’s narratives about their experiences of maternity care, and the large number of participants with a range of socio-demographic characteristics from differently configured sites in four geographical areas, thus increasing potential relevance of the findings for maternity services across England.
Since the study purposively sampled some women on each site who had experienced complications and transfer, the resulting sample cannot be taken to represent, or indicate prevalence in, the wider population of maternity service users. This paper reports only on findings from the women’s interviews subgroup; perspectives from providers, researcher observations and other data sources are not shown here. A methodological limitation of our investigation of speaking up is that it is based on a secondary phase of analysis of data from a study that had broader aims and research questions. Specific questions on speaking up were not included in the interview schedule and the topic arose spontaneously. Thus, depth and breadth of data on the topic were not systematically achieved across all interviews. Study sites were selected among Trusts that were most highly ranked in Healthcare Commission assessments, and this limits generalisability of our findings across maternity services.

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Contributors JS and CM were the principal investigators for the study and contributed to data collection and analysis of the case studies which were led by SR and JR as researchers. SR was the main author of the paper. NM, KW and WC contributed to data collection. All authors contributed to drafting the paper.

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