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HEALTHCARE SAFETY
INVESTIGATION BRANCH

International Maternity Expo

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Background

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- In November 2017, the Secretary of State for Health announced a new maternity safety strategy – and directed HSIB to conduct **1000** independent safety investigations
- The investigation element is part of an national strategy to improve maternity safety
- A maternity implementation team was established to develop the approach, the methodology, and recruit investigation teams
- The programme started in **April 2018**, with full national coverage expected by **April 2019**

Maternity Programme Roll Out

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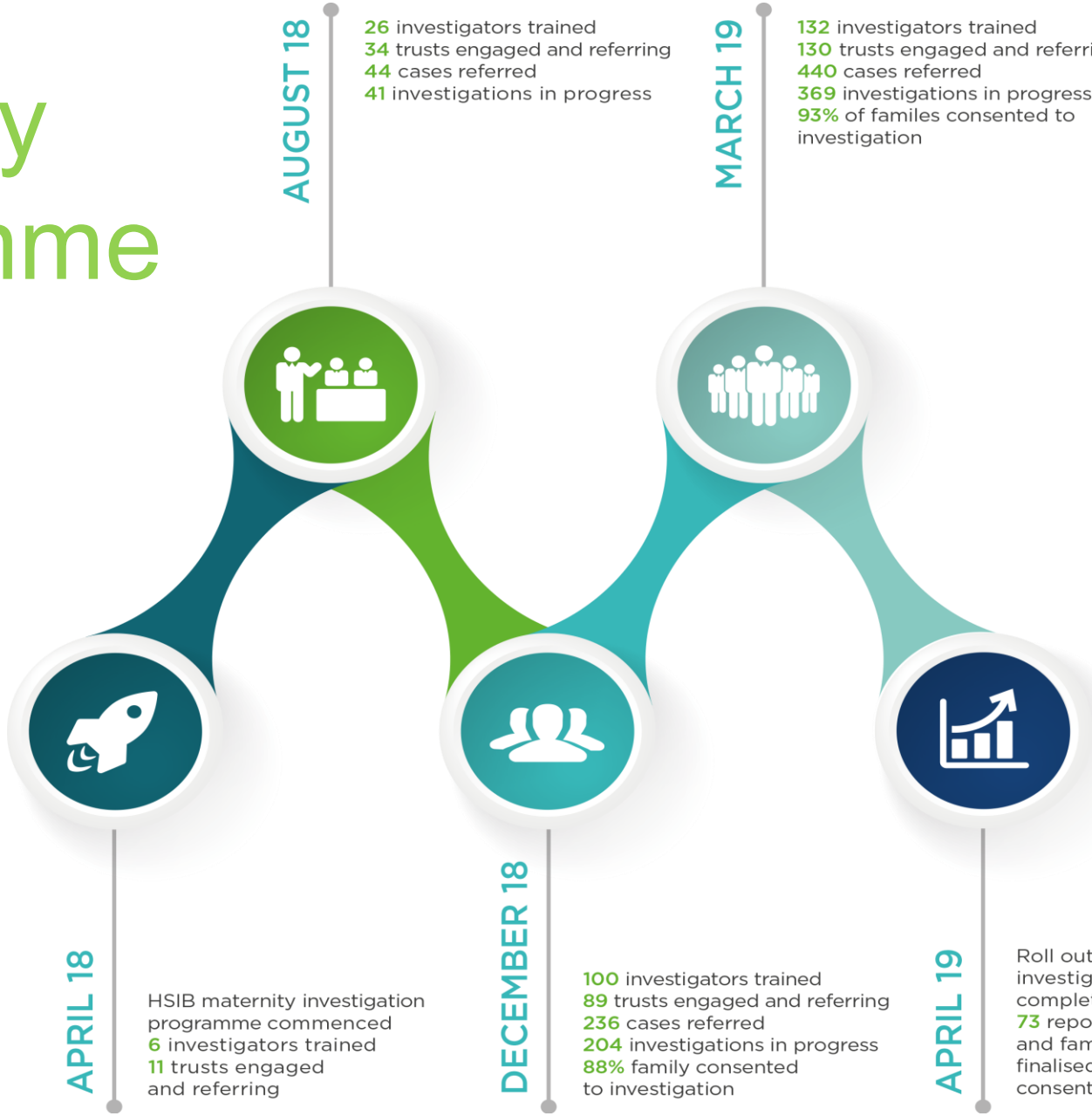
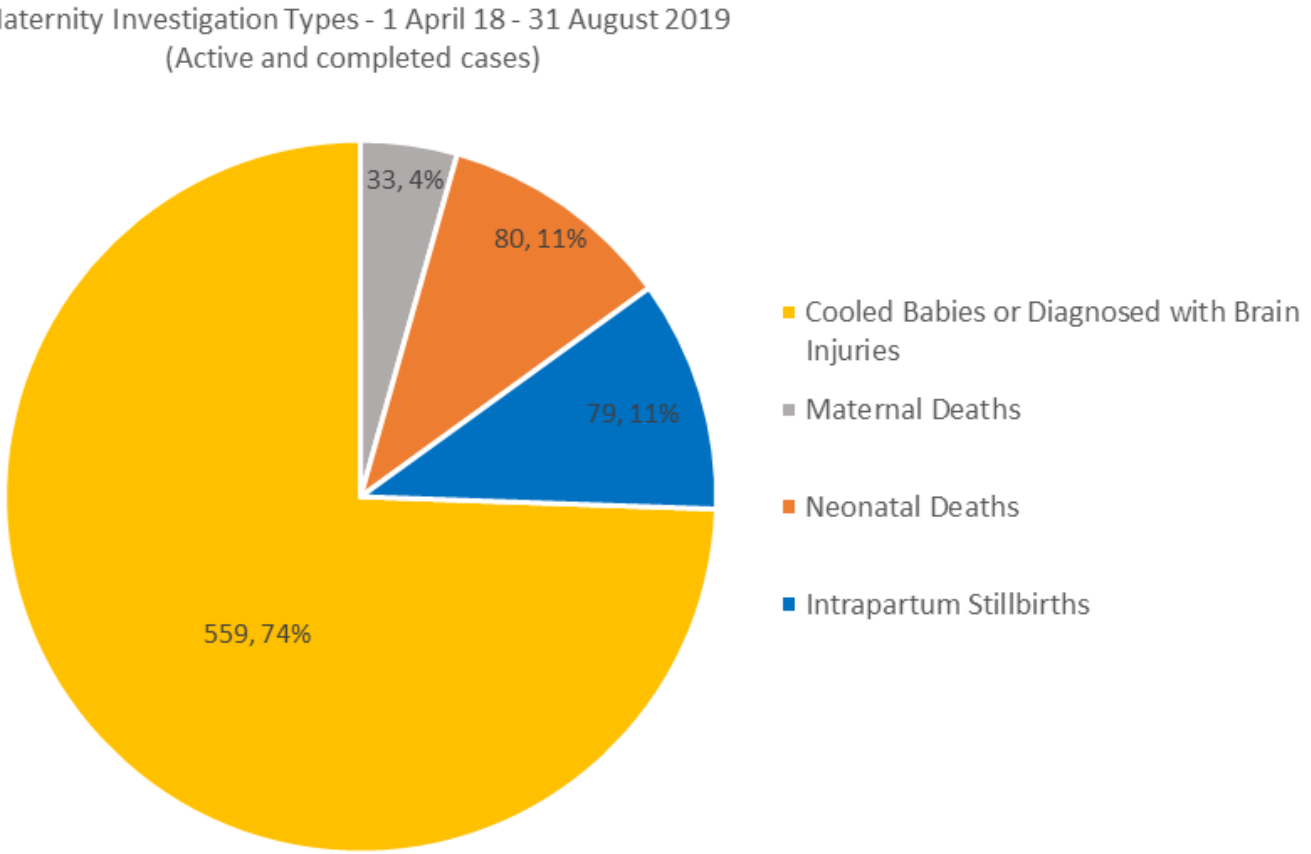


MATERNITY INVESTIGATIONS SUMMARY

Total Investigations (1 April 2018 - 30 September 2019)

*134 = 39 did not meet HSIB criteria, 87 duplicated, 6 congenital abnormalities, 2 Sudden Infant Death

MATERNITY INVESTIGATIONS CATEGORIES



Further information on cooled babies investigation type is currently being collected

Maternity Family Engagement

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Family Feedback Quotes

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I couldnt have asked for a better service. They were brilliant and so supportive especially after such a traumatic birth. I cant fault them. they have also followed up with any queeries we had with the birth process. They have been fantastic.

We are very grateful to the hsib for all there hardwork in finding out the truth.

Our investigator was kind, sympathetic, professional and thorough and made sure we knew she was available for us at anytime we had any questions.

Our investigator was brilliant and I would like to thank the team for being so thorough and understanding.

We feel they were very thorough and considered everything we asked

Overall I think we have learnt a lot together. I thank you from the bottom of my heart. Our case will, in the next 12 months make history and you played a huge part in in, thank you, thank you!!

Only my gratitude to how [redacted] has handled the investigation from start to finish

We all had a chance to be involved as much or as little as we wanted. I hope that my input will assist you in knowing that grand parents have a great deal to offer and are hugely affected by baby loss.

The chance to tell our story in detail and feel listened to. Being able to contact our investigator whenever we needed to. Knowing how thorough the process was.

The depth of the investigation was very good - things came up that I had not thought of myself. Also the report was frank and did not 'sugar coat' recommendations. I can see it is independent

Our lead investigator kept in regular contact to update us and handled the initial contact and meeting sensitively

[redacted] and the team were so helpful with everything. They kept us updated throughout the whole process and answered every question we had and were massively supportive.

The entire process was dealt with in a professional, sympathetic and discreet manner. Many thanks to [redacted] and [redacted] for their kindness.

The report was extremely detailed and thorough. We are very happy with the work carried out by all involved throughout this investigation.

My story was heard and taken seriously

What have we learnt so far ?

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- Assessment of mothers and Babies
  - Risk assessment on initial booking for maternity care
  - Identification of Small Gestational Age (SGA) , Large Gestational Age (LGA)
  - Confirmation of Labour –
    - ‘ The magic 4 cm’
    - Administration of opioids – discharging mothers home
  - Apgar scores – how they are carried out
- Number of attendances prior to admission
  - Accumulation of risk – Reduced fetal movements/ Vaginal bleeding/ Anxiety
- Location of assessment
  - Presentation of mother in established labour to areas identified for assessment/transitional care
  - Capacity in Delivery units
- Transfers
  - Monitoring of mothers and baby during transfer between clinical areas

Communication

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- Communication to Mothers and Fathers
  - Triage – What service and structure is in place
    - Who is the advice/guidance given by
    - What information is given
    - How it is recorded
    - How it is shared between clinical areas
  - Pre-labour rupture of membranes – when to attend /what to do/ information given
  - Post-natal care – Transfer of baby's to neonatal units
- Handover
  - Communication of care, when transferring mothers from one area to another
  - Communication between staff at change of shifts – Why was the IOL started ?
- Fresh Eyes
  - How is it applied in practice ?

Intrapartum findings

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- Group B strep
  - Screening – When should it be done / Why was it done
  - Swabs taken and not reviewed – no red flags - no action
  - Information given to mothers in relation to Group B strep
    - What should they say when informing maternity unit that they think they are in labour
    - What advice should they expect to be given –**told to stay home until labour "established"**
  - Awareness on admission if identified as positive and increased risk
  - Timely administration of IVAB
- Shoulder dystocia
  - Anticipating
  - Managing
  - Time delay between delivery of head and body
  - Neonatal presence

CTG monitoring

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- CTG machines – different machines in unit/different paper – scales
- Disconnection to go to the toilet /availability of telemetry
- Recording of maternal heart rate
- Categorisation –
  - Use of different tools or combination of tools
  - Medical staff not using tools
- Escalation of concerns
  - False reassurance – confirmation bias
- Response when conservative measures are not successful

Neonatal Resuscitation/Collapse

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- Anticipation of baby requiring resuscitation at delivery
  - What level of support will be required due to condition of baby during labour
  - Skill mix /training of staff doing resuscitation
  - Allocation of scribe to obtain contemporaneous notes
- Location of Resuscitaires
  - baby's taken away from parents /transferred outside of room or down a corridor
  - Checking of resuscitation equipment
- Senior oversight/escalation
- Baby delivered in retrievable condition and resuscitation is prolonged
- Placement and positioning of baby post birth – Skin to Skin
  - Observation of baby – Apgar score
  - Staff supporting mother and baby
  - Response to mothers/fathers concerns
  - Transfer responsibility of baby to mother who may not be physically able to see/reposition baby

Organisational issues

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- ‘Helicopter’ view of care
  - Who co-ordinates care when multiple specialities are involved
  - Mothers admitted outside of maternity services
  - Mothers admitted to maternity services needing other speciality involvement
- Hierarchy/Culture
  - Challenging poor behaviour
  - Apportioning blame
  - Supporting staff ‘Second victim’
- ‘Work as imagined’ versus ‘Work as done’
  - Policies/guidelines
  - Targets that influence decisions /care

Next steps – Sharing learning

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- HSIB Early Learning Report – end of 2019
- Collaboration:
  - LMS/LLS – share learning
  - Clinical Networks
  - EBC/MBRRACE/NHSR
  - Skin to Skin – UNICEF Baby Friendly Initiative
  - CTG Monitoring – RCOG
  - Strep B – Nottingham University Clinical trial
  - EBC Learn & Support – Escalation
  - Providing information to support -Addressing inequalities in perinatal and maternal mortality work with NHS-E
  - WS2

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Questions ?