Maternity Newsletter
Introduction

HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

Introduction

HSIB is pleased to present the first quarterly newsletter sharing learning from trusts across the whole of England. The purpose of this newsletter is to allow clinical teams and trusts to share the changes that have been made as a result of the findings and recommendations from maternity investigations undertaken by the Healthcare Safety Investigation Branch (HSIB). These initiatives were developed by the trusts and their maternity teams, we would like to thank them for sharing their work with others.

This approach to collaborative learning supports trusts to share resources and improvement ideas that relate to similar concerns each trust experiences, as they strive to continually improve the care and safety of mothers and their babies. These examples of learning reflect what is being implemented in trusts with varying requirements to support their maternity services. This allows what is learnt in Newcastle to be known about in Penzance.

We look forward to receiving further areas of learning for our future newsletters and receiving feedback on how the content of the newsletter and the sharing of information can be improved and be informative to you in the future. With so many possible examples provided we are considering themed newsletters. All examples will be placed on our website in due course.

Sandy Lewis, Associate Director of Maternity programme and Professor James Walker, Clinical Director Maternity programme

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Regular dynamic risk assessment

We heard from HSIB ... the evidence

There were concerns regarding the recognition of the potential changing clinical condition of the mother over time, and the suitability of her remaining on the birth centre following a change in condition.

Example of HSIB safety recommendation from a report:

'The Trust support staff to ensure that mothers receive individualised care that incorporates regular comprehensive reviews and dynamic risk assessment throughout their admission.'
'The Trust to ensure staff are supported to carry out regular reviews in line with national guidance and ensure this includes a regular dynamic risk assessment of the mother's level of care.'

We did this, and it worked for us ... the change

The trust developed a clinical review proforma to be used two hourly, for each mother on the birth centre, designed to support individual clinical decision making. This is similar to a detailed documented 'fresh eyes.' In addition to supporting individual clinical decisions, it facilitates increased oversight of the acuity of the unit.

Barking, Havering and Redbridge University Hospitals NHS Trust

Risk assessments and care plans for babies at risk of hypoglycaemia

We heard from HSIB … the evidence

HSIB investigations found there was differing information relating to identification and prevention of hypoglycaemia in the newborn depending on which policy was followed. One policy referred to birth weight, one policy referred to birth centile.

Example of HSIB safety recommendation from a report

'The Trust to ensure the risk factors for hypoglycaemia in the newborn are embedded in practice and that the guidance on prevention of hypoglycaemia in the newborn is applied to all babies with risk factors'.

We did this, and it worked for us … the change

There is now a newly implemented policy for babies who are born below the 10th centile. Prior to this we did not have a clear criterion for which babies should have blood sugar monitoring as it was based on weight alone (less than 2,500g despite the centile).

The policy now clarifies and ensures that babies born whose weight is on the 2nd centile or less will require two pre feed blood sugars monitoring of more than 2.5mmol/L, have a paediatric review at birth, a feeding chart and will remain as an inpatient until day three of age when the baby will be re-weighed.

For babies between the 2nd and 10th centile they require one pre feed blood sugar monitoring of more than 2.5mmol/L and a feeding chart commenced.

All babies at risk of hypoglycaemia are reviewed on the daily ward round, where feeding and blood sugar monitoring are discussed.

Newham University Hospital (Barts Healthcare Trust)

Education to support consistency in practice

We heard from HSIB … the evidence

HSIB investigations found there was inconsistency in recording and monitoring of symphysis fundal height (SFH) measurements, and this had resulted in opportunities to detect potential small for gestational age (SGA) babies being missed.

Example of HSIB safety recommendation from a report

'The Trust to review the current process for recording and monitoring symphysis-fundal height (SFH) to ensure compliance with national recommendations for the detection of small for gestational age (SGA) babies.'

We did this, and it worked for us … the change

There has been a targeted focus on antenatal detection of small for gestational age babies. An awareness was rolled out for clinical staff, in both the hospital and in community settings. The aim was to raise awareness of the importance of SFH measurements and appropriate escalation during the antenatal period. This also involved developing practical skills of the midwife such as taking accurate non-bias measurements of the abdomen. Learning emails were sent and posters were displayed for staff awareness.

Newham University Hospital (Barts Healthcare Trust)

Tool to support documentation with neonatal emergency

We heard from HSIB … the evidence

The HSIB investigations noted inconsistency regarding the detailed documentation of the neonatal resuscitation. This was a finding and not on the contributary pathway so did not generate a safety recommendation. The Trust acted upon the learning from the finding.

We did this, and it worked for us … the change

The neonatal resuscitation guidance has been updated and commenced. A new addition to this guidance is a proforma to be used in 'real time' at neonatal resuscitations to provide more accurate documentation of the resuscitation. This has been disseminated to staff, rolled out into the clinical areas and staff have been advised to start using these for any future resuscitation.

Newham University Hospital (Barts Healthcare Trust)

Care bundle called ‘keeping mothers and babies together’

We heard from HSIB … the evidence

An observation chart for first skin to skin contact following a recent National Learning Report; Neonatal collapse alongside skin to skin contact independent report Healthcare Safety Investigation Branch (2020).

We did this, and it worked for us … the change

The purpose of the bundle aims at promoting good initial care, particularly in the first hours of life post-delivery and to identify ‘at risk babies’ and reduce separation of mothers and babies. The care bundle includes:

- Initial assessment of babies with respiratory distress after birth.
- First hour care pathway (skin to skin, feed within the first hour, temperature monitoring and risk assessment).
- A modified Newborn Early Warning Trigger and Track (NEWTT) observations chart.
- Feeding chart for parents.
- A QR code that links to a parent information leaflet.
- An observation chart for first skin to skin contact.

London North West University Healthcare NHS Trust

System change for placental histology

We heard from HSIB ... the evidence

The importance of placentas being sent for histology which came out as an issue in four HSIB reports clearly identifying that the Trust did not always adhere to sending placentas for babies that meet the criteria for placental histological examination.

The HSIB safety recommendations, highlighted that the Trust must ensure the placentas are sent for pathological examination including histology as the results often provides useful information, which potentially could provide an explanation for what happened and to help with the planning of future pregnancies.

We did this, and it worked for us ... the change

- Tightened awareness and training for staff in relation to the importance of sending placentas.
- Developed the guideline 'Placental Histology Examination' to provide evidence based guidance for clinical staff involved in requesting and sending of placentas to histopathology.
- All placentas are now labelled and kept for 24 hours before they are disposed. Laminated posters are now in the clinical areas where placentas are checked as a reminder to staff.
- Highlighted at the safety huddles on labour ward , 'Maternity Risky Business' newsletter, 'Message of the week', 'Hot topics' circulated electronically. The information has also been displayed in the clinical areas risk notice boards, maternity risk road shows and mobile clinical governance learning boards.

North Middlesex University Hospital NHS Trust

Neonatal Early warning score tool

We heard from HSIB ... the evidence

A term baby receiving care in the low dependency area of our Neonatal Unit unexpectedly deteriorated and was subsequently diagnosed with necrotising enterocolitis. The BAPM NEWTT chart is widely used on postnatal wards, but its use on neonatal units is less common.

There had been some signs including temperature instability earlier in the day and it was unclear whether this had been escalated to the senior clinical team. There was no early warning score tool used, which may have assisted staff in recognising the deteriorating clinical picture. HSIB recommended we consider implementing the NEWTT chart for every baby regardless of clinical location.

We did this, and it worked for us ... the change

Following the HSIB report we successfully implemented the use of early warning score charts for all babies receiving special care on our Neonatal Unit. The charts are based on BAPM NEWTT criteria, but adapted for corrected gestational age. Since then there has been positive feedback from staff regarding the early warning score charts and no adverse incidents associated with their use have been reported.

The Hillingdon Hospitals NHS Foundation Trust

Antenatal Fetal Monitoring guidance

We heard from HSIB ... the evidence

A HSIB investigation highlighted that there were four different Trust guidelines which made reference to the use, interpretation or management of antenatal CTG's. We were made aware that some staff reported applying intrapartum guidance to antenatal situations. There appeared to be a lack of consistent approach.

We did this, and it worked for us ... the change

We were already aware of a gap in clinical guidance for the interpretation of antenatal CTGs' and were collaborating with neighbouring Trusts to develop agreed protocols regarding antenatal fetal monitoring when an incident occurred which HSIB investigated. This highlighted the importance of embedding this guidance promptly. The antenatal fetal monitoring guideline was ratified in February 2020. In particular we invested in computerised cardiotocography (cCTG) to supply a superior visual interpretation in non labour situations. Newly appointed CTG Champion Midwives support the staff with training and everyday interpretation.

Royal Free London NHS Foundation Trust

Birth Choices guideline (women wishing to consider a place of birth outside of guidance, or a caesarean birth without medical indications)

We heard from HSIB ... the evidence

HSIB found that antenatal counselling with a Mother who was choosing to have a caesarean section was not in line with Montgomery (2015) standards. This Mother was not referred to the birth choices clinic hence did not have a robust plan identifying her preference should she go into labour prior to her scheduled caesarean section date. The plan for a scheduled caesarean section was not followed when the Mother presented in labour. It was identified that that there was a need for consistent and holistic counselling for all mothers at an appropriate time in the pregnancy, with an emphasis on counselling to Montgomery standards.

We did this, and it worked for us ... the change

The HSIB recommendations highlighted the need for a clear pathway for midwives to ensure that all women considering a caesarean section were referred to the birth choices clinic. The incorporation of a flowchart for staff to use to assist in appropriate referral to the birth options service was developed. Antenatal counselling now has an emphasis on 'what matters to you?' to assist clinical staff in supporting a mother's decisions. This has led to a structured and supportive approach for counselling mothers who wish to have a birth outside of local guidance or a caesarean section that is not medically indicated. The flowchart to assist in appropriate referral was included in the birth choices guideline.

Imperial College Healthcare NHS Trust

Recording of the fetal heart rate in second stage in a graph form

We heard from HSIB … the evidence

The fetal heart rate in second stage was written in free text in the mother's notes. The change in the baby's heart rate over time was not identified as there was no pictorial view.

HSIB recommended that the Trust implement a second stage of labour partogram for clinicians to plot fetal heart rates for mothers having intermittent auscultation.

We did this, and it worked for us … the change

We developed a second stage partogram which allows for the fetal heart and other observations to be clearly plotted, and trends to be identified early.

Guys and St Thomas' NHS Foundation Trust

Escalation tools to support safety

We heard from HSIB … the evidence

We had several investigations that identified opportunities for learning regarding the management of mothers awaiting admission after triage and our escalation pathways, including the need to ensure that activity and staffing within the maternity unit was recorded accurately, and that the escalation policy was robust.

We did this, and it worked for us … the change

To help with patient flow we have introduced BSOTS (The Birmingham Symptom-specific Obstetric Triage System) to support timely assessment and triage of women who present to our Maternal Fetal Assessment Unit. We have also enhanced our escalation pathways to include increased contact between the site manager and senior midwifery manager on-call, twice daily sit-rep meetings which include reviewing staffing levels, expected clinical activity, available beds and high risk cases, and we also hold a weekend staffing review meeting prior to the weekend.

University College London Hospitals NHS Foundation Trust

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Consistency of advice to mothers reporting reduced fetal movements

We heard from HSIB … the evidence

One of our investigation reports highlighted learning in relation to the advice we had given to a mother about reduced fetal movements. This meant that we recognised we needed to ensure mothers are provided with consistent written and verbal information about 1) when to report reduced fetal movements 2) what action to take.

We did this, and it worked for us … the change

We have shaped a new build within the electronic records system which prompts staff to consider this risk factor and to support staff to give the same advice each time.

To progress this work further we have planned a focus group with our Maternity and Neonatal Voice Partnership to understand where woman get their advice and why women may not access services.

Cambridge University Hospitals NHS Trust

Standardisation of contact numbers for mothers contacting maternity services with concerns

We heard from HSIB … the evidence

One of the findings in an investigation report highlighted a need to ensure clear communication in how to access maternity services to make sure mothers have and are able to use the appropriate contact number when needing advice.

We did this, and it worked for us … the change

We redesigned and reworded the mothers' handheld maternity notes to detail more specific instruction as to the appropriateness of where to call and when, with concerns/general queries.

This revised contact advice is now also echoed in the message mothers hear when they reach their community/continuity midwives' voicemail. All community and continuity midwives' voicemail messages are consistent and follow a script to minimise the risk of misinterpretation of concerns that require prompt reporting.

James Paget University Hospitals NHS Trust

Handover systems - increasing the reliability of handover information

We heard from HSIB ... the evidence

Investigations highlighted the need to ensure that our system for handover of care included all vital information when mothers are transferred between clinical areas, including referral in from the community team to the hospital.

We did this, and it worked for us ... the change

Using a Quality Improvement process, we developed bespoke SBAR stickers for each clinical aspect of care – community transfer in/antenatal inpatient/intrapartum and postnatal care. Following introduction of this system, we undertook a review of five sets of notes per week for six weeks to identify if all vital information was provided in each clinical area attended by the woman at handover. We were able to identify 95% compliance within this time frame.

The stickers set out the information required to be handed over in each scenario. The format for the stickers continues to evolve to ensure staff engagement and ease of use, which is informed by weekly review of records.

East and North Hertfordshire NHS Trust

Increasing capacity for placental histology to ensure compliance with Royal College of Pathologists guidance

We heard from HSIB … the evidence

That, in line with national guidance, live birth placentas that meet the criteria must be sent for pathological examinations, including histology.

We did this, and it worked for us … the change

We worked with our pathology department to source a private company who had the capacity to process our live birth placentas meeting the criteria specified. A service level agreement is now in place and our local guidance has been amended to reflect these changes. This has also been shared within our Local Maternity and Neonatal System and other trusts within the West Midlands who are also affected by the regional and national shortage of perinatal pathologists.

University Hospitals Coventry and Warwickshire NHS Trust

Aide Memoire for neonatal resuscitation

We heard from HSIB … the evidence

HSIB told us that the contemporaneous documentation of our neonatal resuscitation was limited. It was suggested that the development of a resuscitation proforma may be helpful in acting as a prompt for clinical management as well as aiding accurate documentation.

We did this, and it worked for us … the change

We generated and rolled out a standardised 'aide memoir' neonatal resuscitation checklist to support contemporaneous documentation and avoid conflict of observer's and practitioner's documentation.

The proforma was reviewed at the neonatal governance and delivery suite forum. It was finalised and we have started to use it.

University Hospitals Leicester NHS Trust

Sharing of guidelines changes

We heard from HSIB ... the evidence

The Trust to implement a robust pathway to ensure any guidance changes are embedded in clinical practice in a timely and effective process.

We did this, and it worked for us ... the change

To help improve the communication with staff of any changes in local guidelines a Google Drive has been set up which helps communicate direct changes/ updates to staff via email. Once staff have opened the link and reviewed the changes the compliance is updated via the Google drive system. This can then be monitored through the governance team. It has simplified the process making it more user friendly for all staff.

A guideline for non-compliance of individuals updating themselves has also been developed.

Sandwell and West Birmingham NHS Trust

Equipment to support safety

We heard from HSIB … the evidence

The Trust to ensure that oxygen saturation monitors are readily available and accessible for use across the labour ward.

We did this, and it worked for us … the change

We ordered and fitted a locked cupboard in each delivery room which contains an oxygen saturation monitor, sonicaid and thermometer. These are accessed by the individual midwife's key.

Kettering General Hospital NHS Trust

Safe care tool

We heard from HSIB … the evidence

One of our recommendations was 'The Trust to ensure that a member of the intrapartum team maintains a helicopter view to maintain situational awareness to ensure the safe management of complex clinical situations.'

We did this, and it worked for us … the change

The Trust has developed a 'Safe Care' Tool for both low risk and high risk women. This tool gives the oversight of all aspects of intrapartum care to another person to help identify evolving clinical risk factors. An initial overview of all aspects of care is undertaken including analgesia options, fetal monitoring, maternal observations, liquor colour etc. This assessment is then re-examined every two hours for low risk and hourly for high risk women with another clinician. Any changes in circumstances are then identified, for example, has the woman now fulfilled the prolonged rupture of membranes criteria. The results of these reviews are used by the labour ward co-ordinator to help them to maintain a helicopter view.

North West Anglia Trust

Risk assessment and the midwifery led unit (MLU)

We heard from HSIB … the evidence

The Trust to ensure their guidance on admission and transfer criteria in the midwifery led unit is followed and embedded in practice.

We did this, and it worked for us … the change

The ward managers reviewed the processes around the admission and transfer criteria, introducing a Red Amber Green (RAG) rating system for the woman's admission in labour, that aligned with the identified MLU Inclusion and Exclusion Criteria Guideline based on NICE Guidance. The aim of this quality improvement (QI) was to evidence the mother's suitability for MLU against the Trust guidance. The updated process was subject to an initial weekly review of records for six weeks to demonstrate compliance. The aim was to reach 95% compliance for evidencing risk assessments on presentation in labour.

East and North Hertfordshire NHS Trust

Competency assessment for intermittent auscultation (IA)

We heard from HSIB … the evidence

The Trust to ensure that staff are supported to complete IA in line with national guidance.

We did this, and it worked for us … the change

QI methodology was used to ensure compliance with IA standards. This was achieved by undertaking a survey of 10 sets of notes to review the use of IA, the compliance with local guidance and an improvement plan was developed as a result of the findings. IA competency assessments were also held on a 1:1 basis to evidence understanding via real time surveys. The MLU yearly workshop was updated to include teaching on IA local learning. The workshops and surveys of learning outcomes initially ran for six weeks to identify knowledge and learning needs, and these informed the fetal monitoring training package for all staff.

East and North Hertfordshire NHS Trust

Supporting staff in systematic approach to CTG interpretation

We heard from HSIB … the evidence

The Trust to ensure that staff are supported to use a consistent categorisation tool and a systematic approach to CTG interpretation which aids clear communication and escalation of concerns.

We did this, and it worked for us … the change

We reviewed and redrafted current guidance that relates to fetal heart rate monitoring to ensure consistent and clear guidance is available to all users.

New 3-part guidance has now gone live and been rolled out.

1 Antenatal CTG
2 Intrapartum intermittent auscultation (IIA)
3 Intrapartum electronic fetal monitoring

We have provided regular multi-disciplinary team CTG meetings via MS Teams with good MDT attendance. We have also regularly audited compliance with documentary requirements for CTG classification and plans of care.

"The fetal monitoring guidance has been a triumph, with the new guidance so much better and fit for purpose. The Fetal Monitoring Midwife has been influential in re-establishing twice weekly CTG meetings that are well attended as well as initiating IIA assessments as part of mandatory training.

She has also been influential, along with the education team at UHL, in the development of a month of shared learning across the network throughout May 2021 (Monitoring May)."

University Hospitals Leicester NHS Trust

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Intermittent auscultation risk assessment

We heard from HSIB ... the evidence

Recommendations from the Trust's HSIB reports included areas for improvements surrounding suitability for continuation of intermittent monitoring and frequency of recording the fetal heart rate.

Although local guidelines are in line with NICE guidance and set out indications for transferring to continuous monitoring, regular formal risk assessment was not an embedded practice. In line with Saving Babies' Lives version 2, 'fresh ears' should occur every hour and staff should undertake an annual competency assessment for intermittent auscultation.

We did this, and it worked for us ... the change

Based on the SBAR communication tool, we devised a local risk assessment tool which encourages staff to undertake a holistic review of the clinical situation including progress, evolving risk factors and a partogram review. This is undertaken hourly with a second midwife.

For homebirths, if a second midwife is not present this takes place via the telephone. This valuable tool has enabled staff to formally record and consider any new risks which may impact on the wellbeing of the baby. We supported staff through the implementation via the fetal monitoring midwife and Midwife Led Unit manager. Following the roll out of continuity teams, we've put processes in place to ensure that all staff undertaking intermittent auscultation are confident in undertaking it and have been assessed as competent to do so.

Mid Cheshire Hospitals NHS Foundation Trust

Neonatal emergency call

We heard from HSIB … the evidence

A baby was found collapsed on the postnatal ward and several phone calls were made to contact the neonatal team members. The Trust should ensure that staff are aware to use the 2222 emergency number for any neonatal collapse on the postnatal ward.

We did this, and it worked for us … the change

We placed a laminated sign onto the resuscitaire reminding staff to ring 2222 if a baby had collapsed. We've done skills drills scenarios based on this case. We reminded all staff and ward clerks to ring 2222 and ask for the neonatal team. We've placed an emergency buzzer next to the resuscitaire which alerts staff on the ward. A similar incident occurred recently and the midwife instigated a 2222 call promptly.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

System to identify number of episodes of reduced fetal movements

We heard from HSIB … the evidence

To develop and implement a robust system for ensuring the number of episodes of reduced fetal movements is clearly documented for all clinicians' attention.

We did this, and it worked for us … the change

We introduced a visual aid within the mothers' handheld notes, which identifies when a mother has had an episode of reduced fetal movements. This prompts the clinicians across the maternity service to complete the RCOG assessment pro-forma for reduced fetal movements.

We've introduced an electronic record on our maternity system when a mother presents with reduced fetal movements, which prompts care pathways and in turn provides a failsafe.

Hull University Teaching Hospitals NHS Trust

Intrapartum monitoring

We heard from HSIB … the evidence

Several HSIB investigations highlighted learning related to fetal monitoring during intrapartum care. This included categorisation of CTGs, lack of a 'fresh eyes' approach and escalation.

We did this, and it worked for us … the change

Following these incidents, we have appointed a clinical safety lead who has developed and introduced a 'fresh eyes' sticker and hourly reviews. This has enabled staff to correctly interpret and categorise a CTG and escalate as needed.

As a Trust we also wanted to identify if there were any cultural issues which may be acting as a barrier to staff escalating concerns. In collaboration with a human factors expert, we will shortly be holding a series of multi-disciplinary staff engagement workshops to explore issues with escalation from the ground up and discuss workable solutions.

Sheffield Teaching Hospitals NHS Foundation Trust

An organisation with a memory

We heard from HSIB … the evidence

A number of HSIB reports cited a loss of situational awareness as a contributing factor to incidents and recommended that staff should be made aware of the possibility of this.

We did this, and it worked for us … the change

Regular multidisciplinary team human factors training is now available and is stored electronically to improve access for staff. This builds on clinical themes from investigations and common influencing factors such as situational awareness, task fixation, and effective escalation within the team.

Anecdotally, staff are now being seen to discuss the influencing factors within cases they are involved in and to identify how to overcome these in future.

The Leeds Teaching Hospital NHS Trust

Theatre - a high risk environment in more ways than one

We heard from HSIB ... the evidence

It was identified in cases where trial of forceps was required in theatre, there was a loss of situational awareness specifically relating to oversight of a deteriorating CTG, and thus delivery was not appropriately expedited.

We did this, and it worked for us ... the change

We identified that due to the highly complex nature of the operating theatre environment, it was very difficult for the team to maintain an oversight of the CTG as there were many other tasks requiring simultaneous attention.

A second midwife now attends the operating theatre. Their role is exclusively around maintaining adequate fetal monitoring and escalating concerns to the team.

The Leeds Teaching Hospital NHS Trust

Sepsis or pyrexia in labour?

We heard from HSIB … the evidence

An HSIB investigation found that staff had been falsely reassured by the effects of paracetamol on maternal temperature and so sepsis was not seriously considered until later in care.

We did this, and it worked for us … the change

We circulated 'Learning bursts' which have been viewed by all staff, focussing on management of maternal sepsis, and the impact of sepsis on intrapartum care.

Alongside other interventions, including case discussions where sepsis was missed, sepsis is now more in the forefront of the minds of the clinical teams.

The Leeds Teaching Hospital NHS Trust

Model change to support safety

We heard from HSIB … the evidence

The need to ensure all mothers reporting a possible antepartum haemorrhage are seen for an obstetric assessment.

We did this, and it worked for us … the change

We set up an early warning score traffic light system in our maternity triage department. This directs that all mothers presenting with an antepartum haemorrhage are seen urgently and receive a doctor review and examination.

Stockport NHS Foundation Trust

Evaluation of effectiveness of resuscitation

We heard from HSIB … the evidence

That during neonatal resuscitation, staff should evaluate the effectiveness of the resuscitation being undertaken in line with new-born life support algorithms, with the clear identification of a leader during emergency situations.

We did this, and it worked for us … the change

We instigated a programme of multi-disciplinary simulation training to discuss human factors and leadership in emergency situations. We used the 'just culture guide' to help staff requiring additional support. We undertook a review of our emergency trolleys to ensure that equipment was located in the most appropriate drawer and followed this up with 'scenario' training.

Blackpool Teaching Hospitals NHS Foundation Trust

Neonatal resuscitation response

We heard from HSIB … the evidence

It was identified that the neonatal staff required additional assistance with resuscitation in theatre. The initial call for the neonatal team was put out and all were in attendance. Additional support was required but the bleep holders were already present and the only other option to alert additional staff was to call the busy unit. Our neonatal unit and maternity theatre are not co-located.

We did this, and it worked for us … the change

We introduced an additional neonatal bleep holder to respond to complex emergencies.

Bolton NHS Foundation Trust

Training to support safety

We heard from HSIB … the evidence

The need to ensure that multidisciplinary training is provided for in the management of an impacted fetal head at caesarean section and that all obstetric staff are aware of the value of early use of tocolysis in the management of a difficult caesarean section birth.

We did this, and it worked for us … the change

We've ensured that training covering the management of an impacted fetal head at caesarean section and the value of early use of tocolysis is now included as part of the multidisciplinary training provided on the Trust's Practical Obstetric Multi-Professional Training (PROMPT) day.

Lancashire Teaching Hospitals NHS Foundation Trust

Improved pool birth information

We heard from HSIB … the evidence

The Trust to ensure that staff clearly explain and document the risks and benefits of using a birthing pool to mothers and their families prior to the use of a birthing pool. This should include an explanation of when exiting the pool might be urgent.

We did this, and it worked for us … the change

We added a section about water birth into our 36-week birth preferences talk with all mothers covering risks and benefits and this is documented within the mother's electronic patient record. We displayed a poster in all birth rooms which contains risks and benefits but also explains reasons why a mother may be asked to leave a pool.

We also created a risk assessment sticker to be completed by staff with a mother before entering the pool. This is then attached to her notes to ensure risk, benefits and reasons for exiting the pool and emergency situations are discussed and documented in a standardised format.

University Hospitals of Morecambe Bay NHS Foundation Trust

Learning from fetal monitoring

We heard from HSIB ... the evidence

Some investigations highlighted improvements were needed in documenting the classification of a CTG in line with NICE and adherence to hourly fresh eyes as per 'Saving Babies' Lives version 2'.

We did this, and it worked for us ... the change

We appointed a fetal monitoring lead who has taken many approaches as a result of the feedback from HSIB.

Firstly, we updated the trust guidelines, created new 'fresh eyes' stickers and created new training packages.

Recently we launched new fetal monitoring meetings and 'learning from case studies' for all staff to participate in.

All these actions combined have resulted in an improvement in the classification, escalation and management of CTGs, 'fresh eyes' compliance and staff awareness of incidents.

Barnsley Hospital NHS Foundation Trust

Learning from a case of delay to expedite birth

We heard from HSIB ... the evidence

This case was in relation to a delay in episiotomy due to missing equipment.

HSIB advised that the Trust to ensure systems are in place to ensure essential equipment that may be required during a birth is available in the labour rooms.

We did this, and it worked for us ... the change

We created episiotomy grab boxes for each birthing room which contain all the necessary equipment. These are located on the trolley in each room and restocked after use.

Barnsley Hospital NHS Foundation Trust

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Outpatient induction of labour

We heard from HSIB ... the evidence

The Trust induction of labour guideline should be revised to support all clinical staff in the removal of prostaglandin vaginal pessaries in accordance with the manufacturer's instructions.

The Trust to review local guidance to ensure that mothers undergoing outpatient induction of labour are encouraged to attend the maternity unit when experiencing uterine contractions to facilitate monitoring of fetal wellbeing in line with national guidance.

We did this, and it worked for us ... the change

We updated our induction of labour policy and introduced a new risk assessment for the use of prostaglandin vaginal pessaries, particularly in the outpatient setting. This is in line with the manufacturer guidance. The main changes were:

- Ensuring mothers understood the risks of going home
- Ensuring they lived within a safe distance to enable quick return to hospital
- Advise the mothers to remove the pessary when experiencing regular contractions.

University Hospitals Sussex NHS Foundation Trust

Vaginal birth after caesarean pathway (VBAC)

We heard from HSIB … the evidence

Following two cases of ruptured uterus in mothers wishing to have a VBAC, who were undergoing induction of labour, there was a need ensure that mothers who are planning a VBAC have information based on national guidance during pregnancy and labour. The discussion should be revisited at appropriate intervals, with explicit confirmation of the mother's choice for birth in late pregnancy with the obstetrician. Mothers who are having an induction of labour following a previous caesarean section are to be reviewed by an obstetrician on admission, have a full risk assessment regarding the method for commencing induction of labour documented following the discussion and agreement by the mother.

We did this, and it worked for us … the change

VBAC guideline was changed along with information for mothers who have had a previous caesarean section. If a mother decides for a VBAC and needs to have an induction of labour, the decision is made with the obstetric consultant along with a plan of care. Mothers are informed that they can opt out at any time of the induction of labour process if safe to do so.

Dartford and Gravesham NHS Trust

Management of the latent phase of labour

We heard from HSIB … the evidence

There is no national guidance for the management of mothers who are inpatients in the latent phase of labour. This leads to different management for these mothers. There was a need to develop a guideline providing clear guidance for staff relating to the care and observation of mothers and babies in the latent phase of labour.

We did this, and it worked for us … the change

We developed our own guideline, which ensures that there is forward planning to monitor progress into established labour, taking risk factors and mothers individual wishes into account.

Dartford & Gravesham NHS Trust

Dedicated support for COVID-19 related concerns

We heard from HSIB … the evidence

It was recognised that mothers may not be getting the necessary care and support they need and with the additional pressure put on primary care, it was often problematic for them to access advice and guidance.

We did this, and it worked for us … the change

Medway Foundation Trust are very proud to be one of the first maternity units in Kent, Surrey and Sussex to run a service for mothers during the difficult and challenging times of COVID-19. We offer a service for mothers to call a dedicated telephone line, which is covered by senior midwives, who ask the relevant and pertinent questions in line with NHS England and Public Health guidance on signs and symptoms of COVID-19.

If COVID-19 is suspected a pulse oximeter is provided to them at home with guidance on how to use pulse oximeter, a logbook and information, on keeping and staying safe and who to call and what to do if any signs of deterioration.

Low molecular weight heparin is organised and arranged to collect and for the mothers to administer at home. Mothers are reassured with receiving daily telephone calls to go through symptoms and prompt early escalation if any deterioration is recognised.

Medway NHS Foundation Trust

Prevention of postnatal collapse of babies

We heard from HSIB ... the evidence

HSIB provided us with evidence to support the optimal positioning of babies during skin to skin to reduce the risk of sudden unexpected postnatal collapse and how important it is to ensure that staff are able to observe babies during this period.

We did this, and it worked for us ... the change

The biggest affected change is around positioning of babies to prevent suffocation. This has led to display of posters in all rooms visible to mothers, and in the antenatal clinic areas to ensure mothers can see and read these during pregnancy. It also had a direct effect (combined with the introduction of measured blood volume in the unit) of ensuring there is a second person in the room until suturing is completed, and part of the role of this second person is to observe and support mother and baby's positioning.

We have increased the number of computers on wheels available to reduce the need for midwives to leave the room post-birth to complete paperwork. We now have a stay in the room policy, which enables greater vigilance during the immediate post delivery period. This also means that the mothers are not left alone immediately following birth, they feel more supported, and this improves their overall birth experience.

Buckinghamshire Healthcare NHS Trust

Placental histology

We heard from HSIB … the evidence

An HSIB report recommended that placentas were sent for pathological examination including histology in line with national guidance (Royal College of Pathologists, 2019), and that a robust process was adopted to ensure labelling of a placenta at the bedside in line with national guidance.

We did this, and it worked for us … the change

We introduced a system where all placentas were labelled with the mother's demographic details and when the placenta could be disposed of (24 hours later). Our 'Third stage of labour' guidelines were updated to reflect this change, and a communication launch ensued. An initial audit to test the effectiveness of the change showed 100% compliance in stand-alone birth units, and 84% elsewhere. To address the shortfalls, awareness was raised by relaunching posters and adding in a narrative regarding the process and this was shared in ward-based communication in each birth area. A re-audit demonstrated 100% compliance in all areas.

Gloucestershire Hospitals NHS Foundation Trust

Safe positioning of babies during skin to skin contact

We heard from HSIB … the evidence

To ensure 'vigilant observation of the mother and baby should continue, with prompt removal of the baby if health of either gives concern'. This was also an extract contained within a national report on this same theme.

We did this, and it worked for us … the change

- Our emergency team now has an allocated member responsible for babies and partners during all emergencies for that shift.
- We created posters to raise awareness of safe positioning for skin to skin.
- We are developing videos in collaboration with the neonatal unit to support APGAR assessment in practice including assessment of babies with darker skin tones.
- We have incorporated a skin to skin update as part of our infant feeding topic on our mandatory training.

University Hospital Southampton NHS Foundation Trust

Caring for mothers with complex mental health

We heard from HSIB … the evidence

To consider face to face multidisciplinary care planning involving mothers for pregnancy, labour, birth and the postnatal period and to review our perinatal mental health provision in particular for emergency psychiatric support.

We did this, and it worked for us … the change

- Involving and supporting mothers in all multi-professional care planning meetings during pregnancy.
- Psychiatric liaison services involved throughout care planning and clear pathways of communication established for all admissions- this has since been included in our perinatal mental health guidance.
- Mothers allocated a midwife as a support only during labour and birth– to be a midwife from their caseloading team.
- We have compiled a list of professionals with additional training in skills such as motivational interviewing to support in complex cases where there are barriers to communication.

University Hospital Southampton NHS Foundation Trust

Facilitating choice of place of birth conversations

We heard from HSIB … the evidence

In response to local HSIB investigations, the Montgomery ruling (2015) and recommendations from the Ockenden report (2020).

- The Trust develop a guideline and staff training to ensure that conversations around choice of place of birth were based on objective evidence-based information out lining all potential risks to mother and baby.
- Shared decision-making conversations are facilitated in a way that enables mothers to make informed choices about place of birth.
- There is a clear process for how and when the conversations take place and how they are evidenced through standardised documentation in the mother's personal care record.

We did this, and it worked for us … the change

- New Guideline written and shared.
- Audit midwife provides quarterly data for community midwives to openly share with mothers and families.

Royal United Hospitals Bath NHS Foundation Trust

Escalation pathway

We heard from HSIB ... the evidence

The Trust should review the escalation pathway for mothers who present to antenatal day assessment unit with significant antepartum events to ensure safe care is delivered in a timely way in the optimum environment.

We did this, and it worked for us ... the change

The BSOTs triage system (Birmingham Symptom-specific Obstetric Triage System) has recently been initiated at the maternity unit to ensure mothers receive the level and quality of care appropriate to their clinical need. A standard clinical triage assessment is completed by a midwife within 15 minutes of the mother's attendance which should take around 5 minutes. Standardised symptom-specific algorithms are then used to allocate clinical priority, immediate care and further investigations of the 8 most common reasons for attendance.

Treatment is guided according to clinical need and allows staff to maximise effective use of available resources and manage the mother's expectations on waiting times. It has the added benefit of decreasing staff stress levels.

BSOTS has been found to improve the safety of mothers and babies attending triage as a proven, reliable way of assessing clinical priority. Additionally, it is user friendly regardless of level of experience and standardises care among clinicians. Although this system is in its infancy, locally, we have already found that outcomes for mothers, communication and the management of the department, as a whole, has been improved.

University Hospitals Dorset NHS Foundation Trust – Poole Maternity Unit

Handover and obstetric review

We heard from HSIB ... the evidence

The Trust needs to implement a robust system for obstetric handovers, which communicates the level of risk for the mother and baby, and which enables identification of urgent action required.

We did this, and it worked for us ... the change

In line with Ockenden and HSIB recommendations, we have introduced twice daily consultant led face-to-face ward rounds, 7 days a week.

The Birmingham Symptom-specific Obstetric Triage System (BSOTs) has also been introduced, this has led to a more standardised approach to providing assessment and care, as well facilitating clearer and more concise handovers.

Continuation and promotion of the use o use of a formalised SBAR sticker at handover.

Salisbury NHS Foundation Trust

Fetal monitoring

We heard from HSIB … the evidence

The Trust needs to implement cardiotocograph (CTG) assessment tools to reflect the risk of mother and baby, which includes, and is not exclusive to the assessment of the CTG.

The Trust should ensure that staff are reminded of the importance of recognition of a deteriorating CTG.

We did this, and it worked for us … the change

'Fresh eyes' hourly reviews continue.

- A CTG sticker for antenatal CTGs had been developed and is now in use.
- A fetal surveillance midwife has now been appointed.
- A mandatory fetal monitoring half day study with assessment has been introduced, as well as continuation of mandatory annual completion of the K2 learning programme.
- Weekly CTG case review meetings continue with multidisciplinary team involvement is now being run on Microsoft Teams which has enabled higher attendance rates.

Salisbury NHS Foundation Trust

Implementation of a process for Mothers who decide to birth outside of guidance

We heard from HSIB ... the evidence

The Trust to ensure a robust system is implemented for when mothers choose to birth outside of guidance, which includes an individualised care plan agreed by the mother and father and the senior clinical multi-disciplinary team.

We did this, and it worked for us ... the change

Tripartite meetings have been introduced which take place at around 32 weeks and include the mother/partner, the homebirth midwife and the named consultant. This meeting ensures that risks are discussed and understood, supporting the mother/partner to make truly informed decisions and also supports individualised care planning. A complex care plan is developed at the meeting which is signed by all parties.

Yeovil District Hospital NHS Foundation Trust

Clinical escalation in emergency situations, training and review

We heard from HSIB … the evidence

Ensure that emergency communication and escalation procedures/ processes are understood and used by all staff. This includes recognising what and when to communicate and how to escalate.

We did this, and it worked for us … the change

Funding was agreed for bespoke human factors training for three, one hour interactive training sessions to include communication, cognitive bias and escalation tools.

We are launching a year long Quality Improvement project working on clinical escalation, with a number of focus groups for each ward and community area. This will be supported by the Trust's Quality Improvement and Patient Safety Teams and will inform us of themes to focus on. Examples of things that will be discussed are:

- What is clinical escalation?
- What does good clinical escalation look like?
- What makes a response to clinical escalation positive, even if the person cannot attend right away?
- What makes you decide who to escalate to?
- What stops you escalating to someone?
- How easy do you find it to challenge de-escalation?

Once the themes have been identified this will inform our improvement work. We will work in collaboration with service users to provide insight into how we make meaningful and purposeful changes in order to provide high quality maternity services at the Trust.

North Bristol Trust

Sharing learning from HSIB investigations

We heard from HSIB … the evidence

The importance of sharing learning from HSIB investigations with the perinatal team.

We did this, and it worked for us … the change

We incorporate learning from HSIB investigations into our welcome newsletters for midwives on rotation. This ensures that midwives are made aware of all learning and developments and are updated. We now have a small team of practice education facilitators, who have joined our practice development midwife and fetal monitoring lead. They are proving very popular, especially with supporting the continuity of care midwives now rotating into central delivery suite with mothers.

University Hospitals Bristol and Weston NHS Foundation Trust

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