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National report highlights impact and suggests improvements to reduce the risk of delays to critical interventions during birth

Identifying improvements in maternity care to help reduce the risk of delays in crucial interventions during labour when a baby is suspected to be unwell is the focus of HSIB's latest national investigation report.

The report was compiled after a review of 289 of their maternity investigations into intrapartum stillbirths, neonatal deaths and potential severe brain injuries. In 14.9% of the cases the delay was a contributory factor.

Several key national reports on maternity safety were reviewed as part of the investigation as delays to intrapartum intervention is a well-known risk. Findings from both national reports such as those published by the Each Baby Counts Programme and HSIB's maternity investigations suggest that there are recurring themes that underpin these delays.

As well as the 289 maternity investigations and in-depth reviews of national reports, HSIB's findings were informed by observations at two NHS trusts, interviews with NHS staff, subject matter advisors and those working at a national level in maternity safety. Rather than examine further examples of when things had gone wrong, the investigation looked at what enables things to go right and so help foster improvement. The investigation placed emphasis on organisational resilience rather than a reliance on individuals. For example, loss of 'situation awareness' has been identified as a common theme in national reports with the focus often placed on the individual staff member and training recommended. HSIB's report states that this should 'more appropriately be seen as the outcome of interactions between staff and all other elements that make up a work system and hence is an organisational issue.'

As a result of the investigation, one recommendation has been made to the CQC on assessing factors such teamwork and psychological safety in its regulation of maternity units. Based on the evidence gathered, the report also sets out a series of questions to consider in order to help staff identify strengths and opportunities for improvement within their own maternity unit.

Dr Louise Page, Maternity Clinical Advisor at HSIB said: "*It is important for us to examine any themes that emerge across our maternity investigations and this report draws together the key reports and initiatives and the common focus areas of attention.*

"Our approach with this investigation was to understand what can help things work well and examine factors within a maternity unit that can promote consistent safe performance despite the fluctuating

demands of circumstances. The investigation also identified that there may be opportunities to share learning from Trusts that had made changes that had appeared to have a positive impact on managing the risk of delays. Our report reiterates the importance of teamwork and psychological safety in providing effective care, reflected in the safety recommendation we have made to the CQC.

"We recognise that work to mitigate these delays is a key focus nationally and feel that this report adds a valuable perspective on organisational resilience. At a time when there is unprecedented pressure on maternity services across the NHS, we hope this report will aid Trusts and contribute to the shared goal of improving safety for mothers and babies across the country."

- ENDS

Media contacts

Please contact Carey or Karl for further details and interview requests:

Carey Taylor, HSIB Communications and Engagement manager Carey.Taylor@hsib.org.uk 07710 114 191

Karl Heidel, HSIB Associate Director of Communications and Engagement Karl.Heidel@hsib.org.uk 07596 334 927

Generic email: media@hsib.org.uk

Notes to editors

Report attached in email from media@hsib.org.uk

Recommendations

It is recommended that the Care Quality Commission, in collaboration with relevant stakeholders, includes assessment of relational aspects such as multidisciplinary teamwork and psychological safety in its regulation of maternity units.

About HSIB

The formation of HSIB is a world-first and represents a landmark moment for the NHS in England. HSIB's purpose is to help improve safety in the healthcare system by developing recommendations and sharing lessons from investigations. HSIB will improve patient safety through effective and independent investigations that do not apportion blame or liability. More details can be found at www.hsib.org.uk