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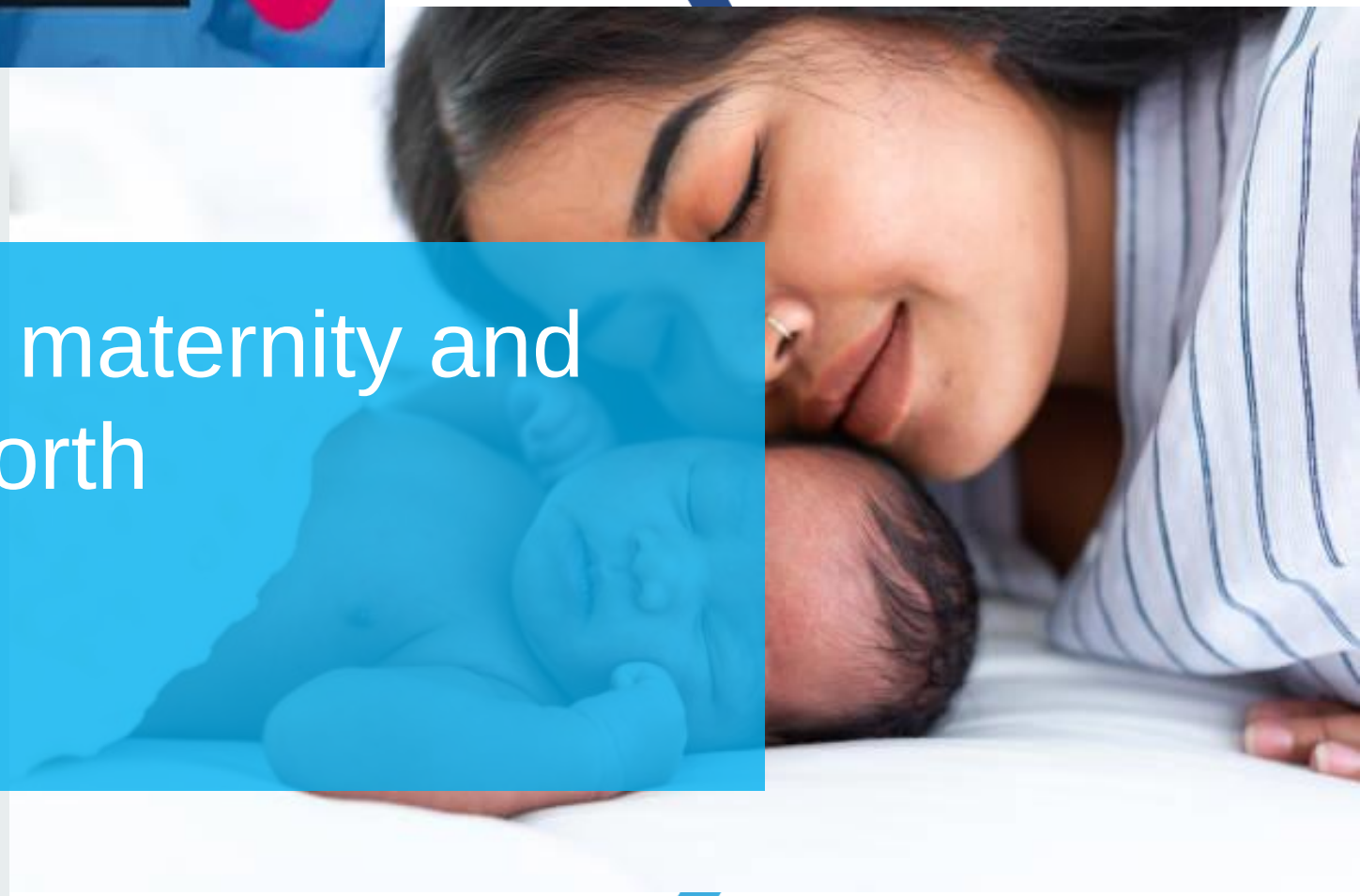
NHS Resolution



Collaborating for safer maternity and neonatal care in the North

17th January 2025

@NHSResolution

Advise / Resolve / Learn

Agenda -NE

NHS Resolution

12:00	Registration, Lunch & Networking	
Time	Item	Lead
13:00	Welcome & House Keeping	Caroline Latham-Parker – NHS Resolution
13:05	National & Regional Maternity Claims data	Victoria Wilkins – NHS Resolution
13:30	Consent Update	Suzanne Landels - DWF
14:00	Patient Voice	Roz Vinton – Service User Representative
14:30	Scenario based panel discussion	Lisa McQueen (Clinical), Stephen Maratos (Legal) and Roz Vinton (Patient)
15:00	Refreshment interval	
15:10	Workshop	Interactive session
16:00	PSIRF	Paula Elliot – Health Innovation
16:20	Closing Speech	Stephen Maratos - Hempsons
16:30	Close	Victoria Wilkins – NHS Resolution

Housekeeping

- Facilities
- Breaks
- Health & Safety
- Mobile phones
- Social media

About NHS Resolution

Our purpose is to provide expertise to the NHS to resolve concerns fairly, share learning for improvement and preserve resources for patient care.

Strategic aims

Resolution
Resolve concerns and disputes fairly.

Intelligence
Provide analysis and expert knowledge to drive improvement.

Intervention
Deliver interventions that improve safety and save money.

Fit-for-purpose
Develop people, relationships and infrastructure.

Safety and Learning Team Structure

Safety and Learning

Focus
- All Specialties

Aim
- To support members and beneficiaries of NHS Resolution schemes to understand their own claims risk profiles to target safety activity and share learning for improvement across the health service nationwide.

Contact:
nhsr.safetyandlearningenquiries@nhs.net

Maternity Programmes

Early Notification (EN)

Focus
- Maternity & Neonatal Services

Aim
- To support proactive investigation and early resolution of birth injury cases, reduce litigation and legal costs, disseminate learning across trusts to improve maternity care, and create a more transparent process with greater support for families and staff involved.

Contact:
nhsr.enteam@nhs.net

Maternity Incentive Scheme (MIS)

Focus
- Maternity & Neonatal Services

Aim
- To support the Department of Health and Social Care's National Maternity Safety Ambition by financially incentivising Trusts to take action to improve maternity safety.

Contact:
nhsr.mis@nhs.net

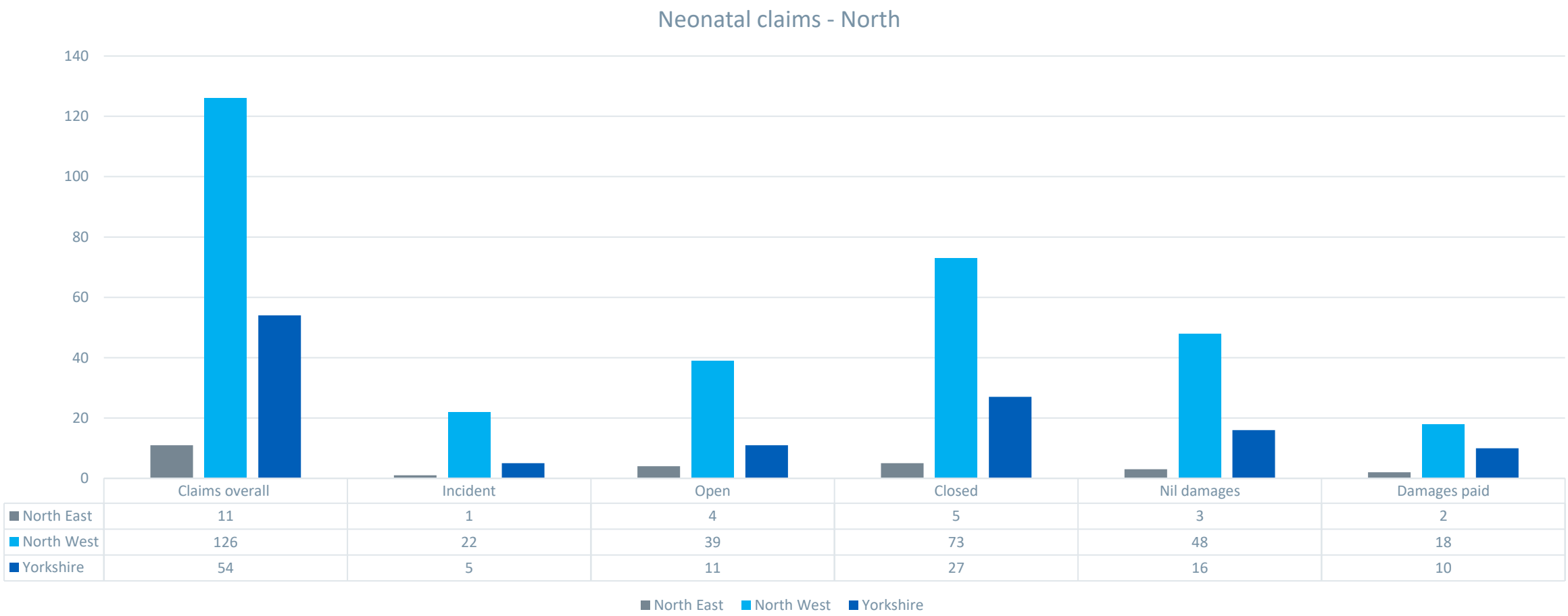
Maternity Schemes Evaluations

National and Regional Data for Maternity and Neonatal Claims

Victoria Wilkins
Associate Safety and Learning Lead (North)

January 2025

Neonatal Claims 2014-2024 – North



	Claims overall	Incident	Open	Closed	Nil damages	Damages paid
North East	11	1	4	5	3	2
North West	126	22	39	73	48	18
Yorkshire	54	5	11	27	16	10

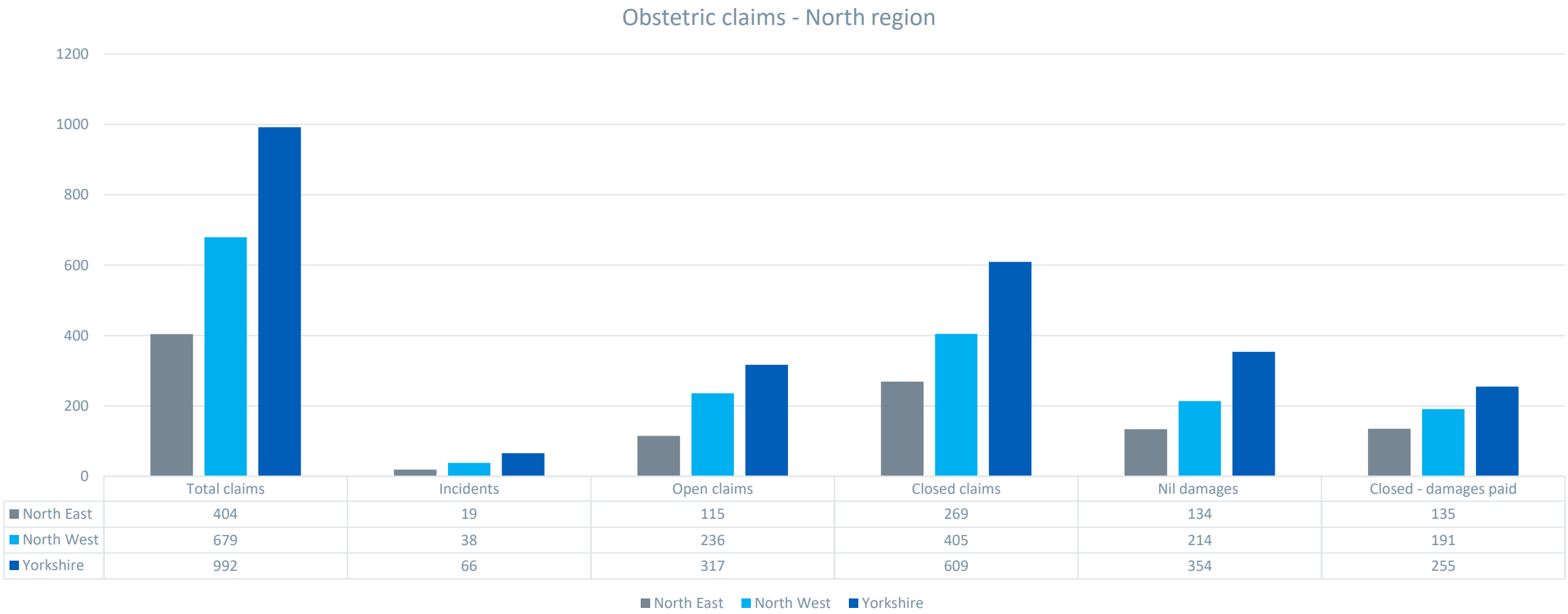
Themes:

North East
- Congenital abnormality not identified at birth – ano-rectal/imperforate anus
- GBS infection – not recognised soon enough

North West
- Infection – not recognised soon enough
- Wrong patient, wrong or no test carried out or wrong report read or misinterpreted
- Wrongly sited TPN/UVC lines

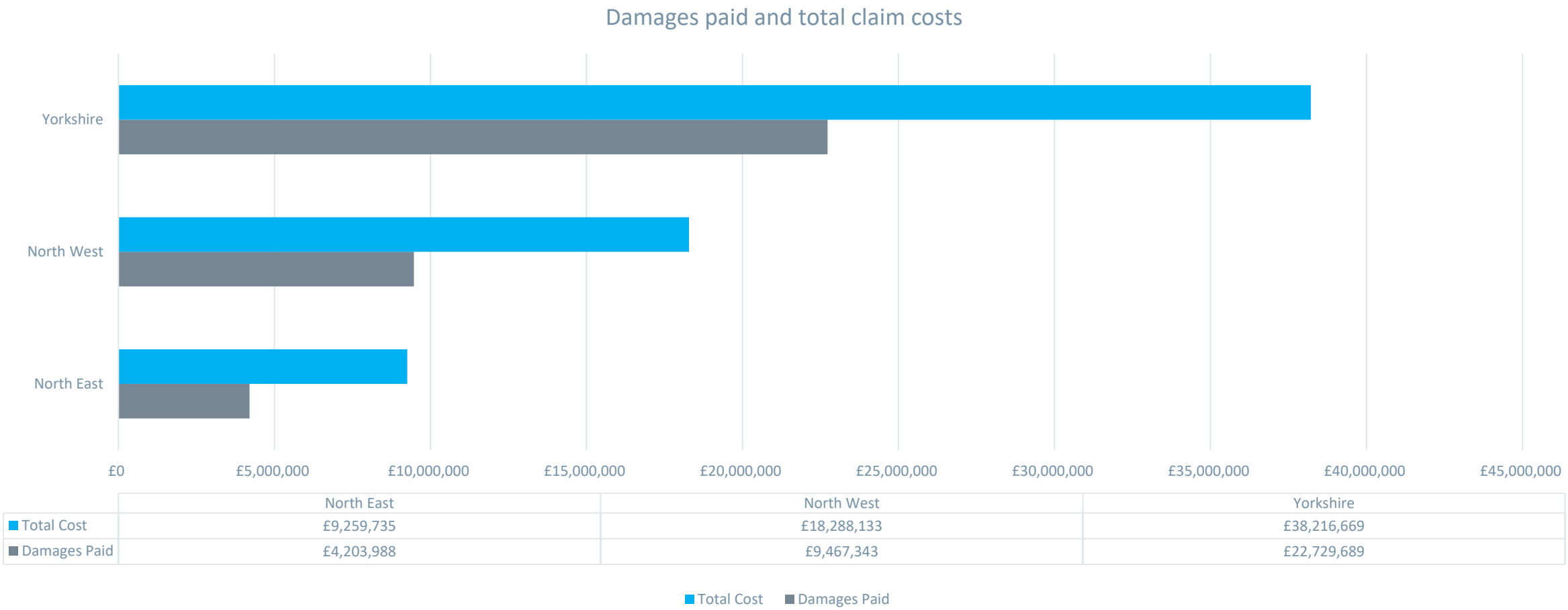
Yorkshire
- Congenital abnormality identified at birth – ano-rectal/imperforate anus
- Cannula's – extravasation/infection, Cannula dressings/identification bracelets too tight

Obstetric claims 2014-2024 – North



	Total claims	Incidents	Open claims	Closed claims	Nil damages	Closed - damages paid
North East	404	19	115	269	134	135
North West	679	38	236	405	214	191
Yorkshire	992	66	317	609	354	255

Obstetric claims – the cost



	North East	North West	Yorkshire
Total Cost	£9,259,735	£18,288,133	£38,216,669
Damages Paid	£4,203,988	£9,467,343	£22,729,689

Obstetrics - Top Cause & Injury Codes 2014 to 2024 – North East

NATIONAL Top 5 Causes by VOLUME		Volume	Value
1	Fail / Delay Treatment	1944	£3,239,915,068
2	Failure/Delay Diagnosis	773	£857,688,973
3	Fail To Recog. Complication Of	527	£672,864,417
4	Fail To Make Resp To Abnrm FHR	422	£2,243,196,884
5	Fail To Monitor 2nd Stg Labour	422	£1,537,563,073

NATIONAL Top 5 Injuries by VOLUME		Volume	Value
1	Stillborn	1052	£102,560,722
2	Unnecessary Pain	986	£175,545,703
3	Fatality	749	£155,204,780
4	Adtnl/unnecessary Operation(s)	736	£48,307,925
5	Psychiatric/Psychological Dmge	711	£278,671,220

North East - Top 5 Causes by VOLUME 2014-2024		Volume	Value
1	Fail/Delay Treatment	24	£555,493
2	Inappropriate Treatment	12	£209,187
3	Operator Error	7	£124,236
4	Inadequate Nursing Care	7	£80,451
5	Foreign Body Left in Situ	7	£60,373

North EAST - Top 5 Injuries by VOLUME		Volume	Value
1	Stillbirth	18	£691,640
2	Additional/Unnecessary Operations	18	£212,066
3	Unnecessary Pain	17	£216,581
4	Psychiatric/Psychological Damage	15	£291,678
5	Fatality	14	£1,099,281

Data correct as of 30.06.24

Cause - examples:

Fail/delay treatment

- Reduced growth recognised; USS confirms but no timely escalation for obstetric review is made.
- Intervention is not timely enough and patient suffers an IUD.
- Deemed avoidable if intervention had occurred at the time of confirmation of reduced growth.

Cause - examples:

Inappropriate treatment:

- Patient presented with raised blood pressure and vomiting at 26 weeks gestation.
- Not recognised as pre-eclampsia, given fluids to rehydrate, fluid balance not managed or recorded.
- Patient developed pulmonary oedema and fluid overload leading to cardiac arrest.
- Patient survived but baby did not.

Cause - examples:

Operator error

- Patient had a category one caesarean section.
- Post operatively catheter removed and patient unable to void. No record of amount of urine in catheter at time of removal or in postoperative period.
- Patient complained of increasing abdominal pain.
- Bladder USS and USS 12hrs post caesarean section showed an empty bladder and fluid filled abdomen.
- Returned to theatre – bladder injury repaired.

Cause - examples:

Inadequate nursing care

- Patient had twin pregnancy and pregnancy induced hypertension. IOL at 35 weeks gestation - prostaglandins, ARM and oxytocin infusion required.
- Patient had epidural. Twin 1 – vaginal delivery, Twin 2 – breech delivery in theatre – 1hr 20mins after Twin 1 delivered.
- Patient developed pressure ulcers on buttocks. Not noted until day 4 postnatal when patient mentioned soreness to community midwife and area examined.
- Patient reports had complained to midwives, doctors and anaesthetist on the ward her buttocks were not feeling as normal – reporting soreness, bruised feeling and numbness. No assessments made.

Cause – examples:

Foreign body in situ

- Patient had forceps delivery in the room.
- Patient sustained a 4th degree tear and moved to theatre for suturing.
- Patient suffered a 1.5l PPH in theatre.
- Day 9 postnatal patient complained of very sore vagina, offensive discharge and abdominal pain.
- Community midwife examined perineum and found retained swab in vagina.

The developments in Consent: Montgomery (2015) to McCulloch (2023)

The Law – applicable tests on Consent

- *Montgomery v Lanarkshire Health Board [2015]: A duty to take reasonable care to ensure that the patient is aware of any material risk involved in any recommended treatment and of any reasonable alternative or variant treatments*

- *McCulloch & others v Forth Valley Health Board 2023:* Recommended treatments that are appropriate and "reasonable" in the clinical judgment of treating doctor.

Montgomery v Lanarkshire Health Board 2015

- **Facts:**
- Mrs Nadine Montgomery, who had diabetes, gave birth by vaginal delivery to a baby while under the care of an obstetrician, Dr M. Sadly, her baby suffered severe birth trauma as a result of shoulder dystocia.
- Dr M had, however, not warned Mrs Montgomery of this risk nor, offered her the option of an elective caesarean section. Mrs Montgomery consequently sought damages in negligence. Two lower courts found against her, citing the *Bolam* principle. The Supreme Court reversed this decision in their judgment delivered in March 2015.
- **Court judgement:**
- The “Montgomery model "of consent – **move from medical paternalism, to patient autonomy**
- Disclosure of *material risks* – pertinent to patient and not the clinician: would a patient “attach significance to it”
- Disclosure of *benefits* as well as risks- i.e. what is intended outcome of treatment
- Disclosure of risks and benefits - not just for the intervention being considered, but for any reasonable *alternatives* that may be available, this can include **no** treatment.
- Disclosure by way specifically of *dialogue* between the clinician and patient – “patient understands her condition such she can make an informed decision”

Montgomery v Lanarkshire Health Board 2015 – Consent now defined by lawyers?

- The model of consent is not a **legal invention.** The *Montgomery* judges based it on submissions by the GMC. They cite, in particular, GMC guidance on shared decision-making as the basis of consent (General Medical Council):

- "*The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. […] The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one.*"

- **Case established it is a shared decision.**

McCulloch v Forth Valley Health Board (Supreme Court) July 2023

- **Facts:**

- Mr McCulloch attended hospital with chest pain. Tests results were compatible with pericarditis. He was treated and discharged a week later.

- 2 days after discharge he was readmitted with pleuritic chest pain. Cardiologist Dr L was asked to review the echocardiogram. She determined this did not give cause for concern and after seeing Mr McCulloch on the ward, now feeling much better with no chest pain, no medical treatment was given. In particular, the risks and benefits of NSAID's were not discussed with him.

- 3 days later, Mr McCulloch was discharged home. The following day he suffered a cardiac arrest, taken to hospital but died in the ED.

McCulloch v Forth Valley Health Board (Supreme Court) July 2023

- **Allegations & Defence:**

- It was alleged that Dr L should have offered NSAID's and that had she done so, Mr. McCulloch would have taken them and on the balance of probabilities, his life would have been saved.

- Dr L said she did not prescribe NSAIDs because in her **professional judgment** it was not a reasonable option. He had not been in pain and there was no clear diagnosis of pericarditis. He had a history of gastric upset and other gastro-intestinal symptoms which were contra-indications for such treatment. However, had the patient been in pain Dr L conceded she would probably have prescribed NSAIDs.

McCulloch v Forth Valley Health Board (Supreme Court) July 2023

- **Court case & Judgment:**

- At the first instance trial, the judge concluded that the views of both experts were ***logical and reasonable*** and on the basis of Bolitho, there was no claim.
- The Judges concluded that the correct test to apply, to what constitutes a **reasonable alternative** treatment is the ***professional practice test*** – i.e. the **Bolam test**. In other words, the reasonable alternatives is a matter falling within medical expertise and professional judgment.
- It was accordingly ruled that Dr L applied her professional judgment to the situation and that NSAID's did not have to be discussed.
- Claim failed.

McCulloch v Forth Valley Health Board (Supreme Court) July 2023 – so where are we now?

- McCulloch has in effect “reigned in” how wide Montgomery appeared to be, in clarifying what the court meant in their 2015 ruling by “reasonable alternative or variant treatment”

- Example:
- Patient presents with an illness. There are ten possible treatment options available to the Clinician, supported by a responsible body of medical opinion, but the Clinician exercising clinical judgment, and likewise supported by a responsible body of medical opinion, decides that only four of them are reasonable, **the clinician is not negligent for failing to tell the patient about the other six, even though they are possible alternatives.**

- **Note!**
- **Montgomery still applies (risks, benefits – the advisory role) but ONLY when the Clinician has used their clinical judgement as to what treatments are reasonable in the case before them.**

Case example 1

- **Facts:**
- C has a hip replacement (MoM) in 2006. He had been advised to have one 4 years earlier due to significant pain, but C would not take the time off work as he was a very busy professional.
- Due to concerns regarding MoM hips in 2012, annual follow up commenced. At each attendance, blood levels were in acceptable range and hip on imaging was stable. Conservative management continued each year.
- In summer 2020, hip clicking was noted, but hip was still stable. 6 months later C presented with an acute and sudden stem failure, due to fracture of the neck of the stem.
- Complex revision required.
- **Allegations:**
- C alleged in light of knowledge of issues with MoM hips he should have been offered a hip replacement earlier and would have avoided more complex revision and foot drop.
- **Clinician view:**
- Revision not medically indicated at any stage.
- Would not have offered revision early as an option, based on C having previously been reluctant to take time off work and other than advising of clicking for one week at the summer 2020 appointment, he had no problems.

- Defence?
-

Case example 1 cont'd….

- Montgomery – Claimant lawyers would have said **NO**. Clinician should have discussed/offered revision earlier.
- McCulloch – **Yes.** Clinician used his **"professional judgement".** There was only a need to discuss other

Case example 2

- **Facts:**
- C had congenital heart problems and underwent a “redo” sternotomy procedure.
- During entry to the chest, there was an injury to the aorta, which caused a massive haemorrhage.
- C sustained a brain injury due to a prolonged period of hypoxia.
- **Allegations:**
- Failed to offer other surgical options including entry via the groin. Had this been offered and undertaken, the injury to the aorta would have been avoided.
- **Clinician view:**
- It was not reasonable to offer surgery via entry in the groin, due to C's future treatment requirements. The valve being replaced had only lasted around 6 years (an unexpectedly short period) and if C required another replacement before another major procedure planned for when C turned 30, there would be the option of it being performed percutaneously, if the groin wasn’t unnecessarily opened at that time.

- **Defence?**

Case example 2 cont'd…..

- Montgomery – Claimant will say **NO**. Clinician should have discussed surgery via entry in the groin.
- McCulloch – **Yes.** Clinician used his **"professional judgement"** There was only a need to discuss other treatment options in light of patient requirements and as C required extensive surgery later, which could be hindered by entering via the groin now, it was not necessary to discuss surgical entry via the groin.

Common Obstetric scenarios and consent risks..

- Reasonable treatment option:
- Oxytocin administration – Warn of uterine rupture and or emergency C section?.
- Forceps use – Can cause injuries to baby?

- Language barrier – Mother's whose first language is not English, may struggle with understanding procedures, such as repeated internal examinations, instrumental deliveries and C sections.

- Advising of reasonable (in your professional opinion) treatment options, material risks of those options and noting in records lowers risk of claims.

- Any further questions?

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Roz Vinton

Service User Voice Rep
North East and Yorkshire Regional Maternity Team

Local MNVP Lead

NHS England North East and Yorkshire

Patient voice

How the patient voice can impact and influence culture around patient care.

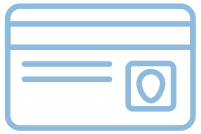
NHS England North East and Yorkshire

Can including the patient voice improve patient care?

How do we include the patient voice?

What can we do about the themes?

What are the themes from service users?



How can we look after ourselves?

NHS England North East and Yorkshire

How do we include the patient voice?
A look at Maternity and Neonatal Voices Partnerships

Gathers insights from:

- Community services
- Volunteers
- Neonatal Parent Advisory Group
- CQC survey
- Trust patient experience
- Birth Reflections
- Social media
- Surveys
- Research
- Other

Shares insights and coproduces improvements with:

- Local Trust maternity and neonatal services
- LMNS
- NHS Regional Teams

Provides strategic oversight:

- Quality and Safety teams
- Safety Champions
- Governance

NHS England North East and Yorkshire

Themes from Service Users

- Choice of place of birth
- Language and accessibility
- Inductions
- Communication

NHS England North East and Yorkshire

What makes a good birth?

NHS England North East and Yorkshire

‘Having a safe delivery and healthy baby’

I felt so supported and cared for. They knew I wanted to do skin to skin after the birth so they helped me to do it even while I was still in surgery.

The care we have received once again was everything above exceptional! This time around was very quick, less painful and a great experience. We were treated with respect and high levels of care and that’s all we could ask for.

What makes a traumatic birth?

NHS England North East and Yorkshire

What can we do?

NHS England North East and Yorkshire

Name
Explain
Listen

NHS England
North East and Yorkshire

Say your name

The consultant walked in, cut me open, pulled out my baby and left the junior to close me up. She never looked at me or spoke to me. I felt like a piece of meat.

After my first traumatic birth I asked in my next birth plan that every single member of staff who came into the room introduced themselves. It was amazing how much difference it made.

Explain

They took my baby straight to NICU, no one told me what was happening. I thought she had died. It was 4 hours before they told me she was alive.

I could tell it was getting tense, they couldn’t get my blood pressure down. The consultant came in and crouched down to speak to me. He waitied for a contraction to pass and then explained the next steps. I still remember his name, he calmed the whole room down.

Listen

My midwife was so kind and patient. She calmed me down and just listened to me when I was worried.

I told them I was in pain but they said birth is painful. This is my fourth baby! I know it is painful, but something was wrong. When they finally got a consultant because I kicked up such a fuss they realised my uterus had ruptured.

Your everyday is their once in a lifetime.

NHS England North East and Yorkshire

Thank you

NHS England North East and Yorkshire

Scenario based panel discussion

Panel members (North East)

- Lisa McQueen
- Stephen Maratos
- Roz Vinton

NHS Resolution

Scenario – Part one

- Gravida 1, Para 0
- BMI 27, non-smoker
- IOL for post maturity at 41+0 weeks gestation
- Has had 3rd prostaglandin and midwife has begun the 3hr post prostaglandin CTG monitoring

Scenario – Part two

- 10mins into the CTG monitoring 2 decelerations are recorded
- The midwife is not present in the room as she is caring for another patient
- The patient presses the call bell as she hears the heartbeat reducing and is worried something is wrong

Questions:

- Has any harm occurred? Legal and clinical perspective
- How does this feel? Patient perspective

Scenario – Part three

- The CTG was initially monitored for a further 15mins with the midwife present in the room.
- Following further deceleration's, the midwife escalates to the coordinator and to the registrar on call.
- An ARM is performed with clear liquor, patient is 2cm dilated.
- Over the next hour contractions become 1:3 and increase in strength. The CTG has a lot of loss of contact as the woman is moving around the bed and frequently changing positioning.

Scenario – Part four

- The midwife continues to care for other patients so is in and out of the room.
- 1hr after the ARM, the midwife requests a fresh eyes check on the CTG. The coordinator attends to do this but complains she is busy and briefly checks the CTG and leaves without documenting the fresh eye check electronically or discussing verbally with the midwife.
- The midwife documents the CTG review as baseline 135, cont 1:4, and no further decelerations. In reality, the baseline has risen since the CTG commenced, the patient is contracting 1:3, not 1:4 and shallow decelerations are present.

Question:

- Has any harm occurred? Legal and clinical perspective
- How does this feel? Patient perspective

Scenario – Part 5

- 1hr 45 after the initial CTG trace began
- Patient is grunting and writhing on bed, cont 1:2 strongly
- Midwife returns to room and CTG shows various decelerations and a current 4 minute long bradycardia with no signs of recovery
- Midwife pulls emergency buzzer
- Category 1 caesarean section carried out under GA at 7cm dilated

Clinical outcome: baby

- Poor respiratory effort at birth, low apgar’s, required resuscitation, sent for cooling at 6hrs of age
- MRI day 7 showed mild to moderate HIE

Question:

- Potential breaches of duty and causation - neonate. Legal perspective
- How does this feel? Clinical and patient perspective

Discussion:

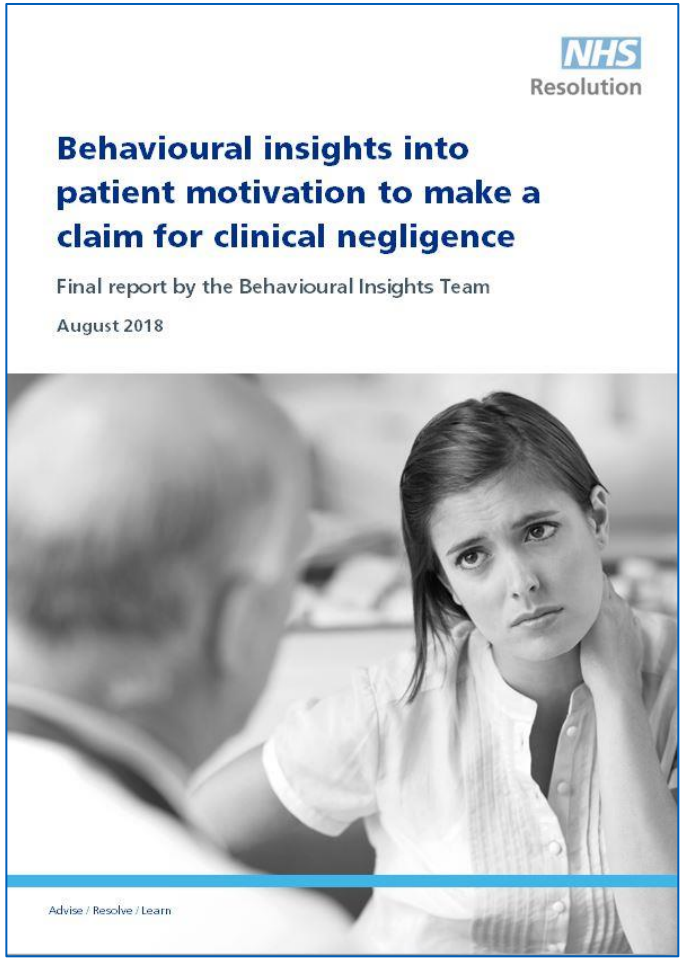
- Clinical – impact of caring for more than one patient at a time, human factors and situational awareness
- Clinical - quality of fresh eyes, electronic records
- Legal – breach of duty – non recognition of labour, incorrect categorisation of CTG, electronic records
- Legal – Causation - timing of delivery
- Patient voice – no 1:1 care in labour, category 1 caesarean section, separation from baby during cooling, subsequent impact of injury on mother, baby and family

Refreshment break – 10mins

Workshop

Culture

- Saying sorry is always the right thing to do
- Q – Does the culture of your unit and/or team encourage saying sorry? (Professional duty of candour)
- Q – How does the culture of your unit/team support you to say sorry?

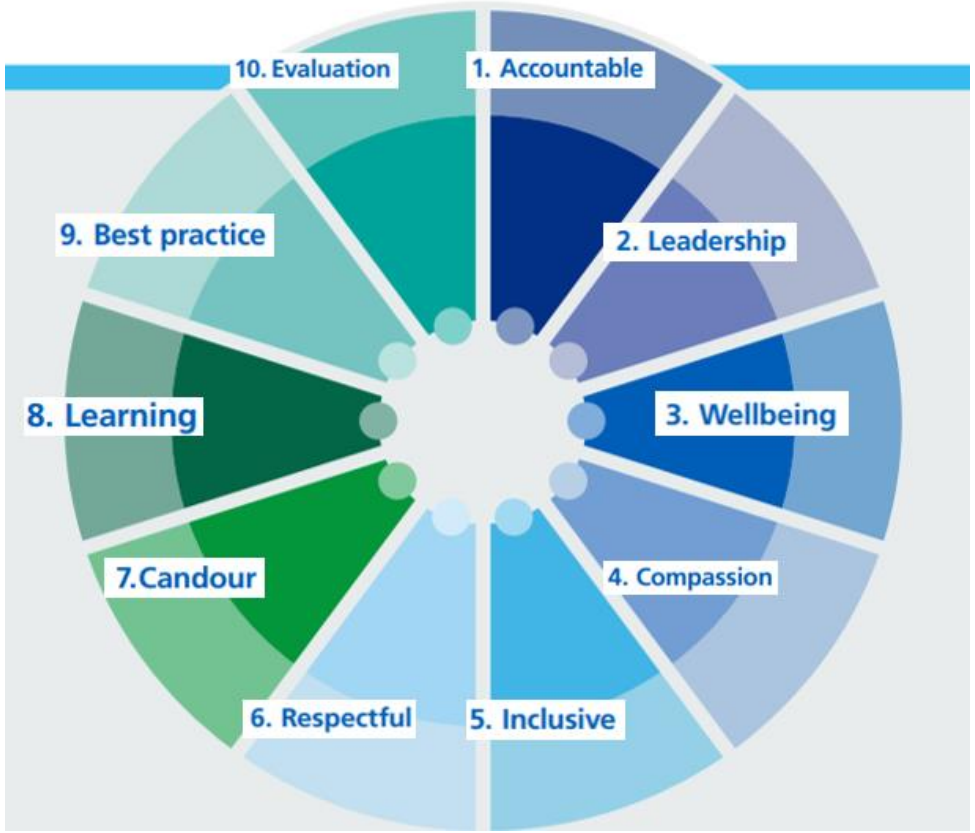


Being Fair 2

NHS Resolution

SCAN ME

The just and learning culture charter outlines the key features of a safe and fair workplace.
This includes:



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- www.menti.com
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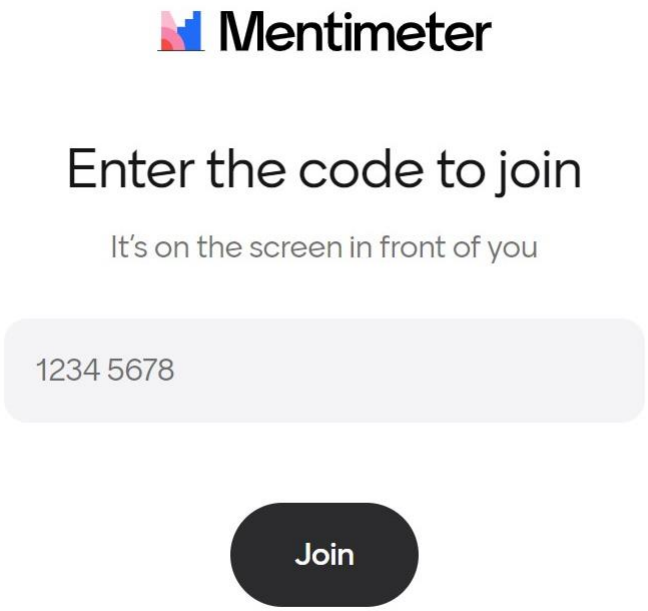
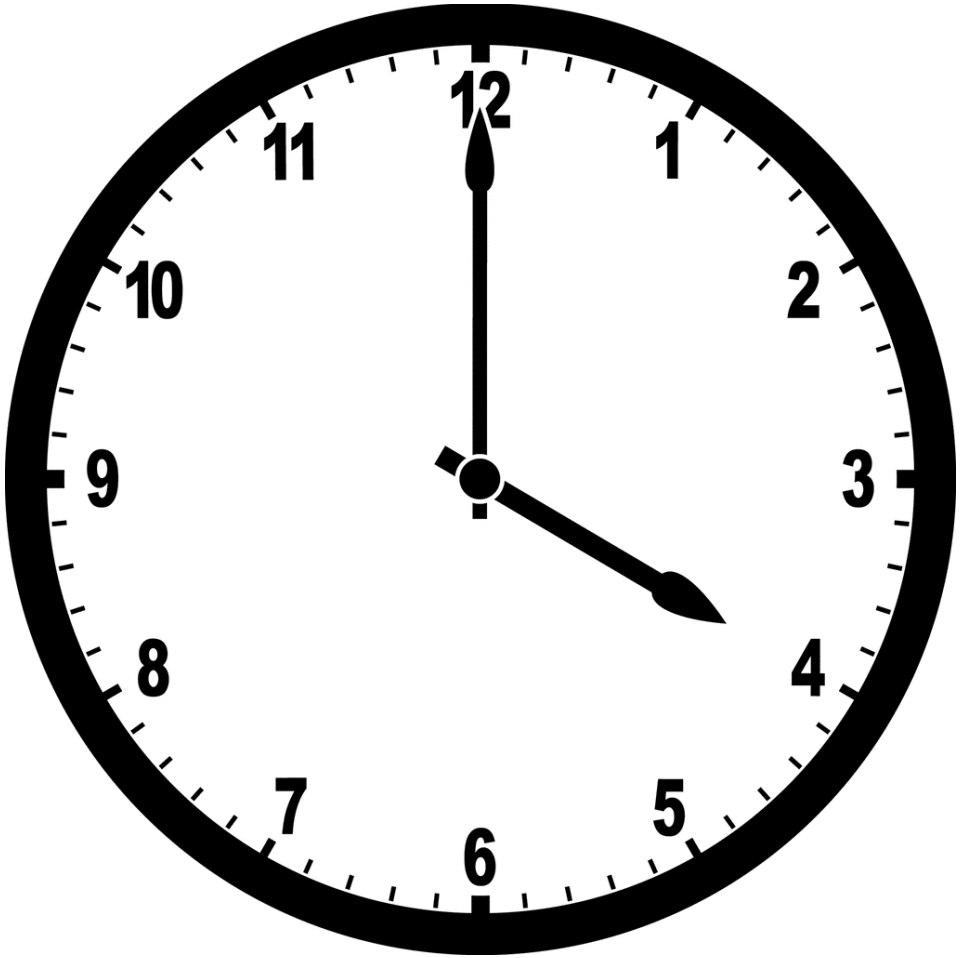


Breakout groups

- 4 areas – go to number given when registered for your first area – 1 – 4
- Move on from each area when indicated, in a clockwise direction
- Return to seats by 15:55, ready to start next session at 16:00



Questions:

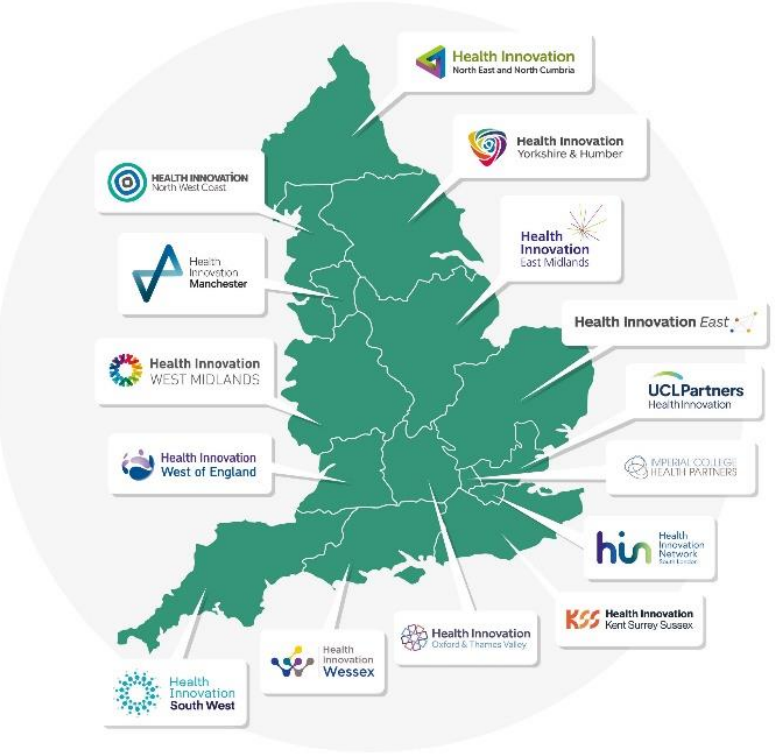
1) How do you think students would describe your culture?
2) What qualities are needed in leaders to be able to lead well? Do your leaders have these qualities? If not, why not?
3) What are the elements required at your unit/team to create a just and learning culture? Does this include data insights?
4) Do you feel able to speak up? Do others feel able to speak up? If not, why not?

Health Innovation
North East and North Cumbria

North East North Cumbria Health Innovation Network and Patient Safety Collaborative

Perinatal Culture and Leadership Programme
Patient Safety Incident Response Framework

Health Innovation Networks and Patient Safety Collaboratives



The Health Innovation Network (formerly known as AHSN Network) is the innovation arm of the NHS and the collective voice of the 15 health innovation networks across England. They were established by NHS England in 2013 to help adoption and spread of innovation at pace and scale to improve health outcomes and generate economic growth.

NHSE National Patient Safety Improvement Programmes fund 15 regionally based Patient Safety Collaboratives (PSCs) , hosted by the Health Innovation Network, which bring together the NHS, industry, academic, third sector and local organisations to foster innovation and improve health.

NHS England (NHSE) National Patient Safety Improvement Programmes (SIP)

- The programmes are a key part of the NHS Patient Safety Strategy, launched in July 2019 and updated in February 2021, to deliver safety and quality improvements across the NHS in England. They are managed and led by NHSE National Patient Safety Team.
- They aim to support and encourage a culture of safety, continuous learning and improvement across the health and care system, helping to reduce the risk of harm and make care safer for all
- The programmes are delivered by NHSE National Patient Safety Improvement Programmes Team working with PSC's who support integrated care systems and local health providers, to bring about practical improvements to patient safety.

SIP Programmes

- **Maternity and Neonatal SIP** (Preterm Birth & Deterioration in women and babies)
- **Perinatal Culture and Leadership Programme** (PCLP) for maternity services
- **Deteriorating Patient** (Reducing deterioration using PIER in systems and implementation of Martha's Rule)
- **Medicines Safety** (reducing the use of high-dose opioids in non-cancer pain and two areas of medicine pipeline exploration work in support of potential future medicine safety programmes)
- **System Safety** (embedding of the Patient Safety Incident Response Framework (PSIRF) in hospitals and the implementation of PSIRF in primary care)

Perinatal Culture and Leadership Programme (PCLP)

Phase	Rationale
1. Quad leadership development	Perinatal services to connect as a team and provide the head space needed to problem solve and plan for the future
2. Culture survey	An opportunity for Trusts to gain insight into each team's safety culture, to help them identify strengths and to understand the role that relationships have in supporting improvement
3. Cultural conversations	Leaders will be supported by an independent culture coach to have conversations about the SCORE survey findings. They will then be supported to co-develop an improvement plan based around identified key themes

Systems Safety programme

- Main focus currently is the Patient Safety Incident Response Framework (PSIRF).
- The PSIRF replaces Serious Incident Framework (2015).
- The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy.
- The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

Compassionate engagement and involvement of those affected by patient safety incidents

Application of a range of system-based approached to learning from patient safety incidents

Considered and proportionate responses to patient safety incidents

Supportive oversight focused on strengthening response system functioning and improvement

PSIRF and Maternity services

- PSIRF applies to all NHS organisations and all services within the organisation, including Maternity. There is no separate guidance.
- Each Trust has developed a PSIRP and would have included consideration of maternity related issues as part of their data analysis/development of their safety profile and local priorities. They may have a maternity specific section in the plan.
- There are some incidents which will continue to be national priorities and investigated the same way as before – such as those meeting Health Services Safety Investigation Branch (HSSIB) criteria and Child Deaths.

PSIRF in the NENC

Organisations at different stages – some still at early stages of implementation.
Most have a published Patient Safety Incident Response Plan (PSIRP) and many are now reviewing them one year on.
All organisations agree with the principles and are working towards a culture change.
There are challenges in procuring and delivering training in PSIRF and learning responses.
There is opportunity for closer links with Quality Improvement and Education teams in trusts.
Further work is required around how we implement learning and improvement from patient safety incidents – both in individual trusts and as an ICS.
PSIRF impact is not yet being measured.

PSC Plans

Working with ICB and LMNS

- Collaboration across the NENC
- Support embedding and sustainability
- Events and training
- Agree and collect metrics

Patient Safety Improvement Network

PSIRF community of practice

Family Liaison Officer/Engagement Lead community of practice

Patient Safety Celebration and learning event in March 2025

NENC collaboration around patient safety themes

Piloting PSIRF in primary care

Get in touch, we can support with:

Implementation of PSIRF and PCLP	Connecting with others	Developing case studies	Promoting examples of excellence	Coaching
Quality Improvement	Sustainability planning	Critical friend	Planning	Collaboration

Visit our website: Health Innovation North East and North Cumbria

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Closing Speech

Feedback

- We really hope you have found today's event informative and helpful.
- Please help us to continue to deliver meaningful events by completing our evaluation form using the paper form or the QR code.
- https://www.smartsurvey.co.uk/s/7T3PIK/

Thank you!