HILL DICKINSON

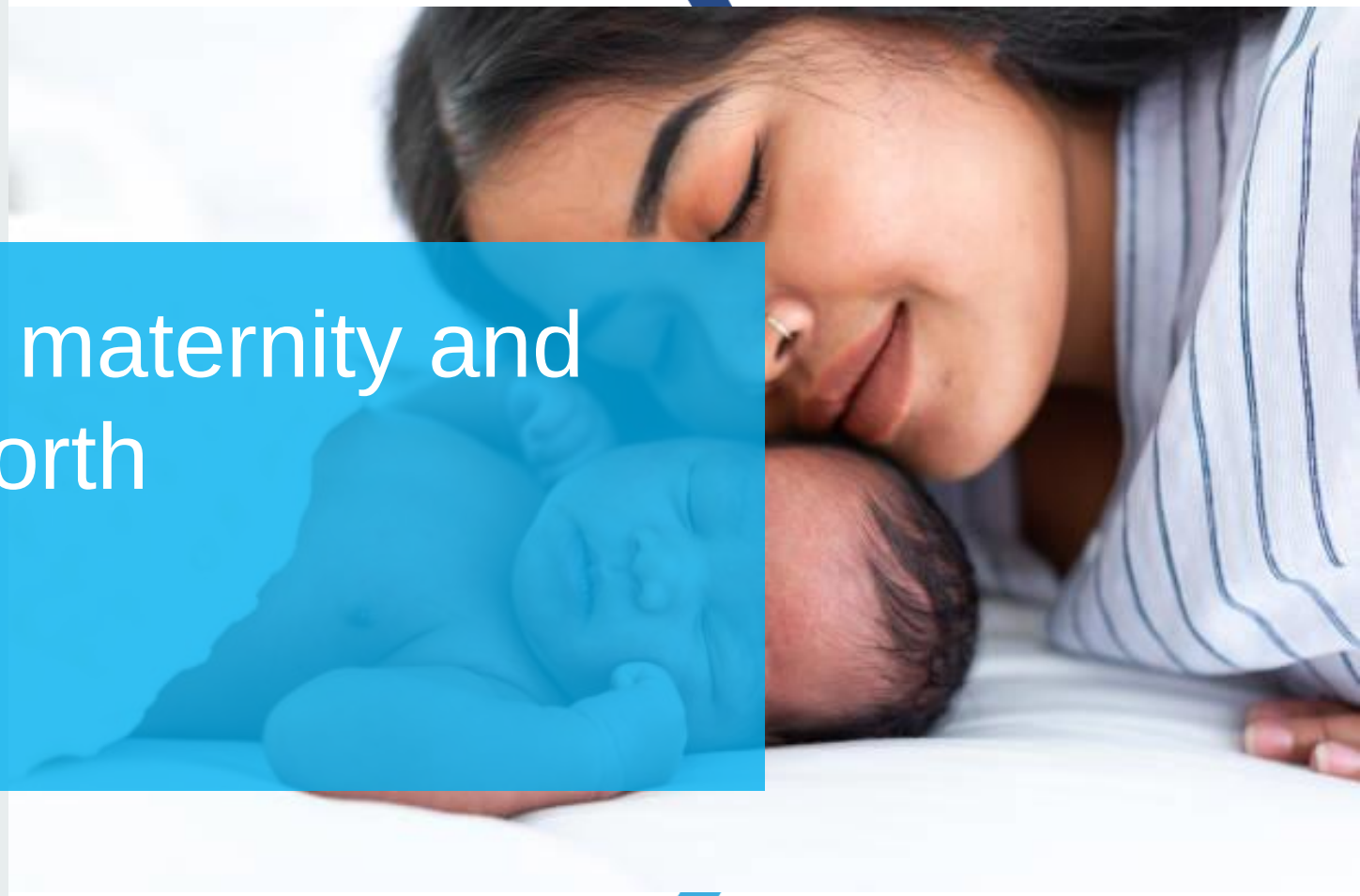
DAC BEACHCROFT

Weightmans

HEMPSONS

dwf

NHS Resolution



Collaborating for safer maternity and neonatal care in the North

6th February 2025

@NHSResolution

Advise / Resolve / Learn

Agenda -NW

12:00	Registration, Lunch & Networking	
Time	**Item**	**Lead**
12:45	Welcome & House Keeping	Caroline Latham-Parker – NHS Resolution
12:55	National & Regional Maternity Claims data	Victoria Wilkins – NHS Resolution
13:15	Consent Update	Stephen Maratos – Hempsons and Andrew Leslie - Hill Dickinson
13:45	Patient Voice	Kelly Harvey – North West Neonatal Operational Delivery Network Kirsten Mitchell - Spoons Natalie Qureshi – Voices for Choices
14:15	Scenario based panel discussion	Sarah Howard (Clinical), Alison Brennan (Legal) and Joy Foster-Christie (Patient)
15:00	Refreshment interval	
15:10	Workshop	Interactive session
16:00	Insights	Paul Greenwood - AQUA
16:20	Closing Speech	Andrew Leslie – Hill Dickinson
16:28	Close	Victoria Wilkins – NHS Resolution

Housekeeping

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

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

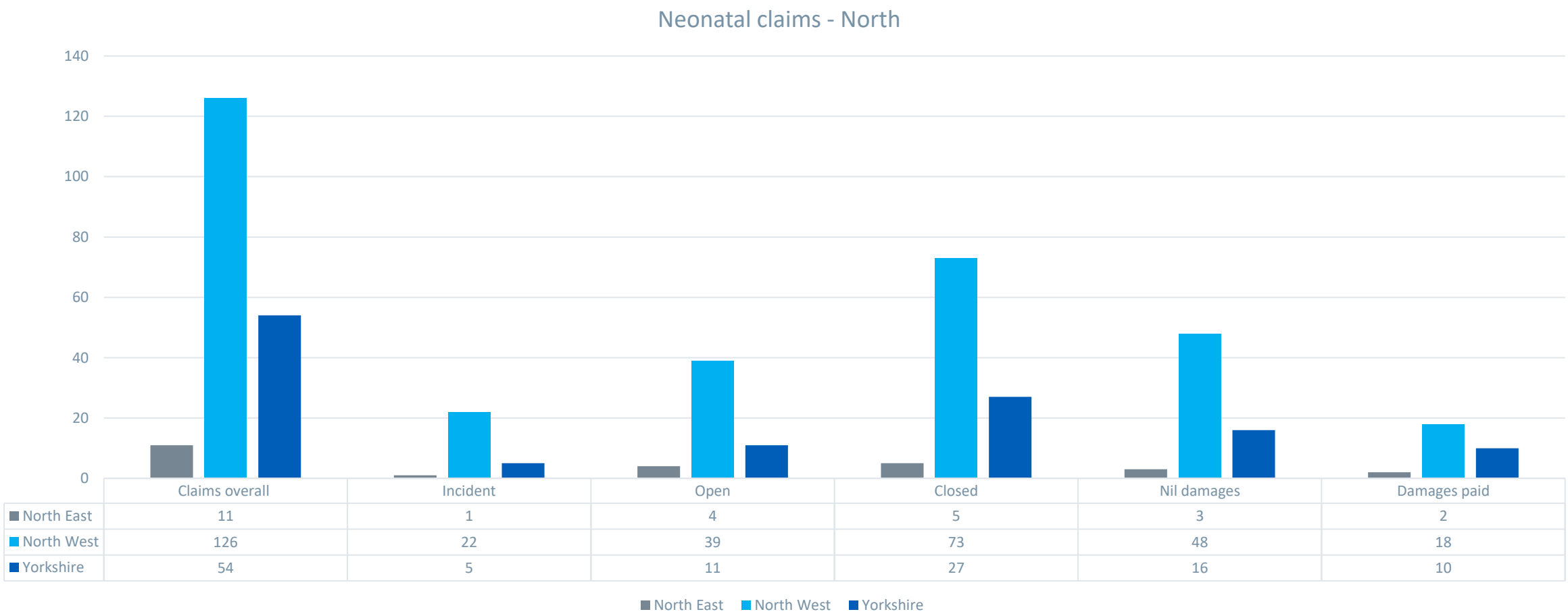
Maternity Schemes Evaluations

National and Regional Data for Maternity and Neonatal Claims

Victoria Wilkins
Associate Safety and Learning Lead (North)

February 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

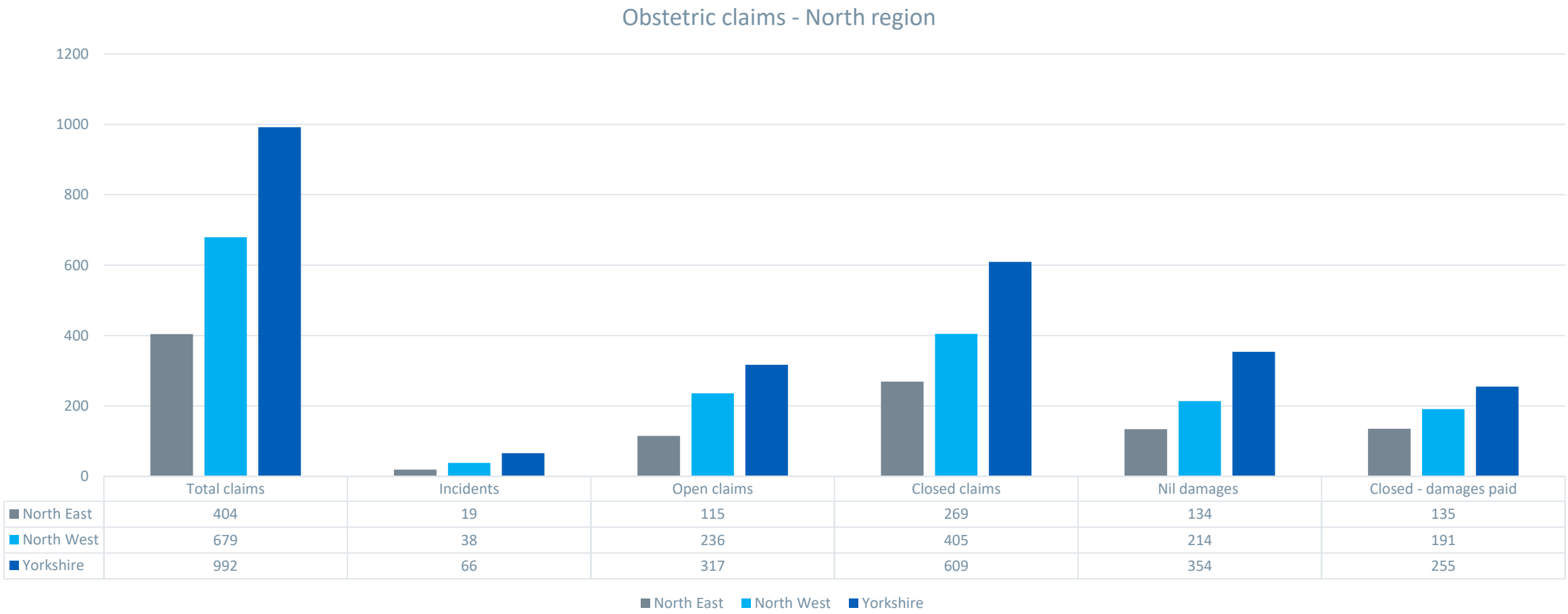
Themes:

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

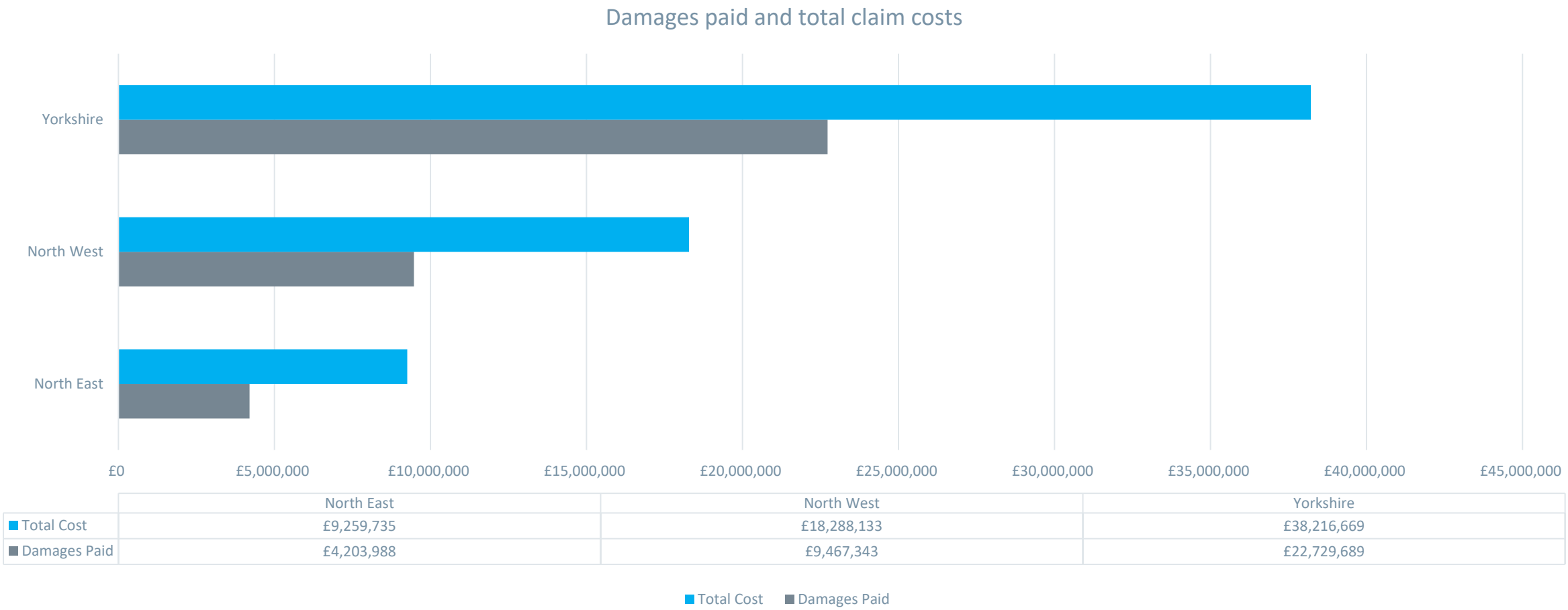
Yorkshire
- Congenital abnormality identified at birth – ano-rectal/imperforate anus
- Cannulas – extravasation/infection, cannula dressings/identification bracelets too tight

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 West

NHS Resolution

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 West - Top 5 Causes by VOLUME		Volume	Value
1	Fail/Delay Treatment	38	£1,505,030
2	Fail to Recog. Complications of	19	£1,440,115
3	Fail to Monitor 2nd Stage Labour	18	£703,439
4	Inappropriate Treatment	15	£481,849
5	Fail/Delay Diagnosis	12	£614,829

North West - Top 5 Injuries by VOLUME		Volume	Value
1	Unnecessary Pain	42	£950,616
2	Stillbirth	38	£1,578,937
3	Fatality	31	£2,386,631
4	Additional/Unnecessary Operations	21	£840,000
5	Psychiatric/Psychological Damage	16	£327,839

- *Add text to compare national and Trust*

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.
- Avoidable if intervention had occurred at the time of confirmation of reduced growth.

Cause – examples:

Failure to recognise complications of

- Patient had SVD at 38+6 weeks gestation, placenta and membranes recorded as complete.
- Patient had brisk pv bleeding 2hrs postnatal in bath. Further pv loss and abdominal pain reported overnight to midwives. Uterus documented as well contracted.
- Patient rang call bell at 09:45am and was found to have approx. 1litre blood loss, clammy skin and severe abdominal pain.
- Patient taken to theatre – 5cm x 4cm placental lobe and membranes removed.

Cause - examples:

Fail to monitor 2nd stage labour

- CTG categorised as abnormal with decelerations in first stage of labour. Patient 9cm when decision made for category 1 caesarean section.
- Caesarean section delayed for 48mins as another patient already in theatre and 2nd theatre needed.
- No monitoring of patient or FH whilst setting up of 2nd theatre, patient in anaesthetic room waiting, labour continued.
- Patient reported urges to push while spinal sited.
- Vaginal examination prior to caesarean section beginning showed full dilatation. Baby delivered, via kiwi ventouse, and required extensive resuscitation.
- Unexpected to be born in such poor condition, no monitoring of 2nd stage undertaken.

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:

Fail/Delay diagnosis

- Patient contacted triage at 40+2 weeks gestation to report SROM.
- Patient also had period type pain and irregular tightenings.
- Patient not invited into unit for SROM confirmation.
- Patient rang again 15hrs later, reporting contractions 1:5, now painful, requiring pain relief and reported reducing FM throughout the day.
- Patient attended, cord felt in front of the presenting part and sadly no FH detected.

Support considerations:

External:

- Safety and Learning – Louisa and Victoria
- Early notification team – Claire
- Maternity Incentive Scheme – Bridget and Selina
- System - internal and external - LMNS and NHS England support

Questions?

Thank you for listening

Safety and Learning team
nhsr.safety@nhs.net
020 7811 2700

@NHSResolution

Victoria Wilkins
Associate Safety and Learning Lead (North)

Victoria.Wilkins3@nhs.net

Advise / Resolve / Learn

Consent – principles & how to do it

6 February 2025

North West Maternity and Neonatal Seminar

Andrew Leslie
Partner (EN & Maternity Safety Lead)
andrew.leslie@hilldickinson.com

HEMPSONS

Consent – principles & how to do it

Stephen Maratos, partner
Hempsons LLP

There is real expertise at Hempsons at every level, from newly qualified to senior partners.

Chambers and Partners 2023

For more information visit us at www.hempsons.co.uk

GMC Professional Standards (not just a legal issue)

Decision Making and Consent (2020)

Consent is a fundamental legal and ethical principle. All patients have the right to be involved in decisions about their treatment and care and to make informed decisions if they can. The exchange of information between doctor and patient is essential to good decision making. Serious harm can result if patients are not listened to, or if they are not given the information they need - and time and support to understand it - so they can make informed decisions about their care.

Doctors must be satisfied that they have a patient's consent or other valid authority before providing treatment or care. The purpose of this guidance is to help doctors to meet this standard. It reflects the ethical principles that underpin good practice.

Regulatory and Medical Associations (lots of guidance)

RCN: Gaining consent – It's a yes or no situation. Think again! | Royal College of Nursing

GMC: Decision making and consent - professional standards – GMC

NMC: The Code

HCPC: Standards of conduct, performance and ethics |

BMA: Guidance for doctors on patient consent

RCS: 3.5.1 Consent — Royal College of Surgeons

MPS: Consent - An essential guide to consent in medical practice

MDU: Montgomery and informed consent - The MDU

NHS: Consent to treatment - NHS

GMC Decision Making and Consent

‘Seven Principles’ *<u>including</u>*

- Patients have the right to be involved in and to be supported to make informed decisions about care and treatment.
- Decision making is an ongoing process involving the exchange of relevant information specific to the individual patient.
- All patients have the right to be listened to, to be given the information they need to make a decision, and the time and support they need to understand it.
- Doctors must try to find out what matters to patients, to share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action.
- Doctors must start from the presumption that all adult patients have capacity to make decisions about their treatment and care.

Capacity – understand your patient (and do they understand you?)

‘Decision Making and Consent’ Principles 5, 6, and 7 relate to capacity.

Mental Capacity Act 2005

- Does the individual have impairment / disturbance of mind or brain (permanent or temporary)?

- If so, does it mean the person is unable to make the decision in question at the time it needs to be made? They must be able to:
    - Understand and information provided
    - Use the information to make a decision
    - Communicate their decision

- Capacity is time and decision specific.

Landmark decision: Montgomery v Lanarkshire Health Board (2015) – details for the interested

- 34yo ♀, Type I diabetic, petite build
- Consultant-led antenatal care including fortnightly USS to assess foetal size / growth (large for gestational age)
- USS 36+0 estimated delivery weight 3.9kg (if at 38+0)
- Consultant documented M *"worried about size of baby"* and accepted M expressed concern about vaginal delivery at this & previous appointments
- Consultant did not discuss risk of shoulder dystocia; advised M would be able to deliver vaginally with c-section if difficulties encountered
- Consultant's practice not to offer c-section unless estimated birth weight >4.0kg

Landmark decision: Montgomery v Lanarkshire Health Board (2015)

- IOL at 38+5
- Labour was slow and failed to progress over several hours
- Failure of head to descend naturally required intervention with forceps in theatre
- At 17:45 the head was part delivered and a shoulder became impacted; GA administered
- Various manoeuvres attempted unsuccessfully including partial symphysiotomy
- Delivery achieved at 17:57 via *“significant traction”*
- M’s son has 4 limb dyskinetic cerebral palsy due to hypoxic brain injury and Erb’s palsy

Landmark decision: Montgomery v Lanarkshire Health Board (2015) – what was the argument?

Consultant's view:	Risk of serious injury was *"very slight"* • Court accepted risk of shoulder dystocia in diabetic mothers is 9-10% with 0.2% risk of brachial plexus injury and <0.1% risk of prolonged hypoxia	Believed if mentioned, *"most women"* would ask for c-section but that *"it's not in the maternal interests for women to have c-sections"*
Ms Montgomery's view:	Was not given the option / risks not discussed, but if had been told of risk of shoulder dystocia would have asked for a c-section	**How did that go?**

What to take from Montgomery

*“The doctor is…under a duty to take reasonable care to ensure that the patient is aware of **any material risks** involved in any recommended treatment, and of **any reasonable alternative** or variant treatments.*

*The test of materiality is whether, in the circumstances of the particular case, **a reasonable person in the patient's position would be likely to attach significance to the risk**, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.”*

What is a material risk?

In ***Montgomery*** the Judge said that materiality of a risk cannot be reduced to percentages. The significance of a risk reflects factors besides its magnitude e.g.:

- Nature of the risk
- The effect its occurrence would have on the life of the patient
- The importance to the patient of the benefits sought to be achieved by the treatment
- The alternatives available and the risks involved in those.

A v East Kent Hospitals University NHS FT **(2015) -** the risk was a theoretical, negligible or background risk of the order of 1:1000 so not 'material'.

In ***Spencer v Hillingdon Hospital NHS Trust*** **(2015) -** *"would the ordinary sensible patient be justifiably aggrieved not to have been given the information at the heart of this case when fully appraised of the significance of it?"*

Not a test of hindsight (but keep up to date)

Duce v Worcestershire Acute Hospitals NHS Trust (2018)

- Elective TAH and BSO in 2008 for heavy, painful periods. Post-operatively developed chronic neuropathic pain and alleged negligent for not warning of a risk of chronic post-surgical pain.
- **Claim dismissed:**
  - In 2008, the understanding among gynaecologists of the existence of a risk of "chronic pain, or of neuropathic pain" was insufficient to justify a duty to warn of such a risk.
  - **Not required to warn of a risk of which they are not reasonably aware**.
  - Urged by multiple doctors to pursue less invasive options but patient was set on surgery.
  - Had been warned of and consented to other risks of greater magnitude / likelihood than chronic post-surgical pain.
  - Found – patient would have gone ahead with surgery when she did even if warned about chronic post-surgical pain.

What information was (or ought to have been) given at the time, and what the patient would have done with the knowledge of the risk(s) - not the consequences they are now living with.

A “reasonable alternative” (not any alternative that exists)

Bayley v George Eliot Hospital NHS Trust (2017)

- Was ilio-femoral venous stenting for chronic post-DVT symptoms a reasonable alternative or variant treatment in 2008?
- Defendant’s evidence that in 2008, **a reasonably competent vascular surgeon would not have been aware** of ilio-femoral venous stenting as an alternative.
- There were few published papers in the UK, and limited evidence of it being performed by anyone in the UK at the time.

A “reasonable alternative” (judging reasonable)

McCulloch v Forth Valley Health Board (2023)

- Cardiac case – whether should have given NSAIDS when no pain at assessment.
- What options need to be given to a patient?
- ***“Once it has been decided what are the reasonable alternative treatments, by applying the professional practice test, the doctor is then under a duty of care to inform the patient of those reasonable alternative treatments and of the material risks of such alternative treatments.”***

A “reasonable alternative”

The ‘reasonable alternative’ is a decision for the doctor applying clinical and professional judgment.

The standard is the ‘professional practice test’ and expects the doctor to decide on the ‘menu’ of alternative options, and to provide their patient with them all including explaining the comparative risks and benefits of each, so the patient can make an informed decision.

hilldickinson.com

Consent – steps to consider

Give your patient the information they need to make an informed decision:

- Objective and subjective parts to consent
- It matters what significance that particular patient and ‘the reasonable patient’ would attach to the risk.
- All discussions around consent need to be carefully documented.

A 1:1000 risk of permanent sight loss from cataract surgery: how would the focus you put on that differ between your ‘average’ patient, and a patient with only one eye?

“Good” documentation: Consent

Instead of…	*Consider…*
We discussed the options.	We discussed the options: do nothing, procedure A, and procedure B.
We discussed the risks.	We discussed the risks of each option. Patient aware if we do nothing then XYZ, but there is risk of ABC with procedure A and DEF with B.
Patient given leaflet.	Patient given leaflet X version 1 and we discussed risks & complications listed p2. Patient had no questions.

Being Practical – some common questions (and answers)

Can it be delegated?

It can **but** they must be competent in the procedure(s) being discussed, so they can provide the patient with the appropriate information on alternatives, risks and benefits.

Can I ask a junior to document the discussion and/or complete a consent form?

You can **but** check what is documented is a full and accurate reflection of the consent process. *"I said it but my Reg didn't write it down"* is not an attractive basis to defend a case.

Does it have to be face to face, or can I give / send leaflets for the patient to read?

Leaflets can be helpful **but** should only form part of a discussion. Beware of assumptions: e.g. language or format issues / ability to read and understand.

Being Practical – some common questions (and answers)

Can we use pre-printed consent forms?

Yes **but** not in place of a discussion and ensure that any additional patient-specific factors or risks are documented on as well.

Our form has a ‘tick box’ to confirm consent. Do I still need a separate note?

Will depend on the proposed treatment. More likely to be considered reasonable for a simple test than for surgery.

The magnitude of the patient’s decision will be a factor - **An example**:

- EPR box for refusal of Down syndrome testing was ticked in midwifery records
- Midwife’s evidence was that she discussed the option and the patient declined testing
- Child was born with Down syndrome and the patient disputed that testing was offered or that she had refused
- Judge found for patient stating that the decision to refuse testing was unusual. If it had been the case, a separate record of the discussion and refusal would have been made

Remember…. You will never please everyone

Questions

HEMPSONS

Contact

Disclaimer: These slides are made available on the basis that no liability is accepted for any errors of fact or opinion they may contain. The slides and presentation should not be regarded as a comprehensive statement of the law and practice in this area. Professional advice should be obtained before applying the information to particular circumstances

Stephen Maratos

Partner

e: s.maratos@hempsons.co.uk

t: 0191 230 6045

LMNS
Greater Manchester and Eastern Cheshire
Local Maternity and Neonatal System

Voices for Choices
COMMUNITY INTEREST COMPANY

NHS
North West Neonatal
Operational Delivery Network

spoons
neonatal family support

Listening to Women and Families – Influencing Culture and Safety

The North West

Total Births 1st April 2023 to 31st March 2024:

North West: 72,088

GM: 33,174 CM: 23,935 LSC: 14,979

In Numbers

FROM 1ST APRIL 2023 TO 30TH MARCH 2024 WE HAD:

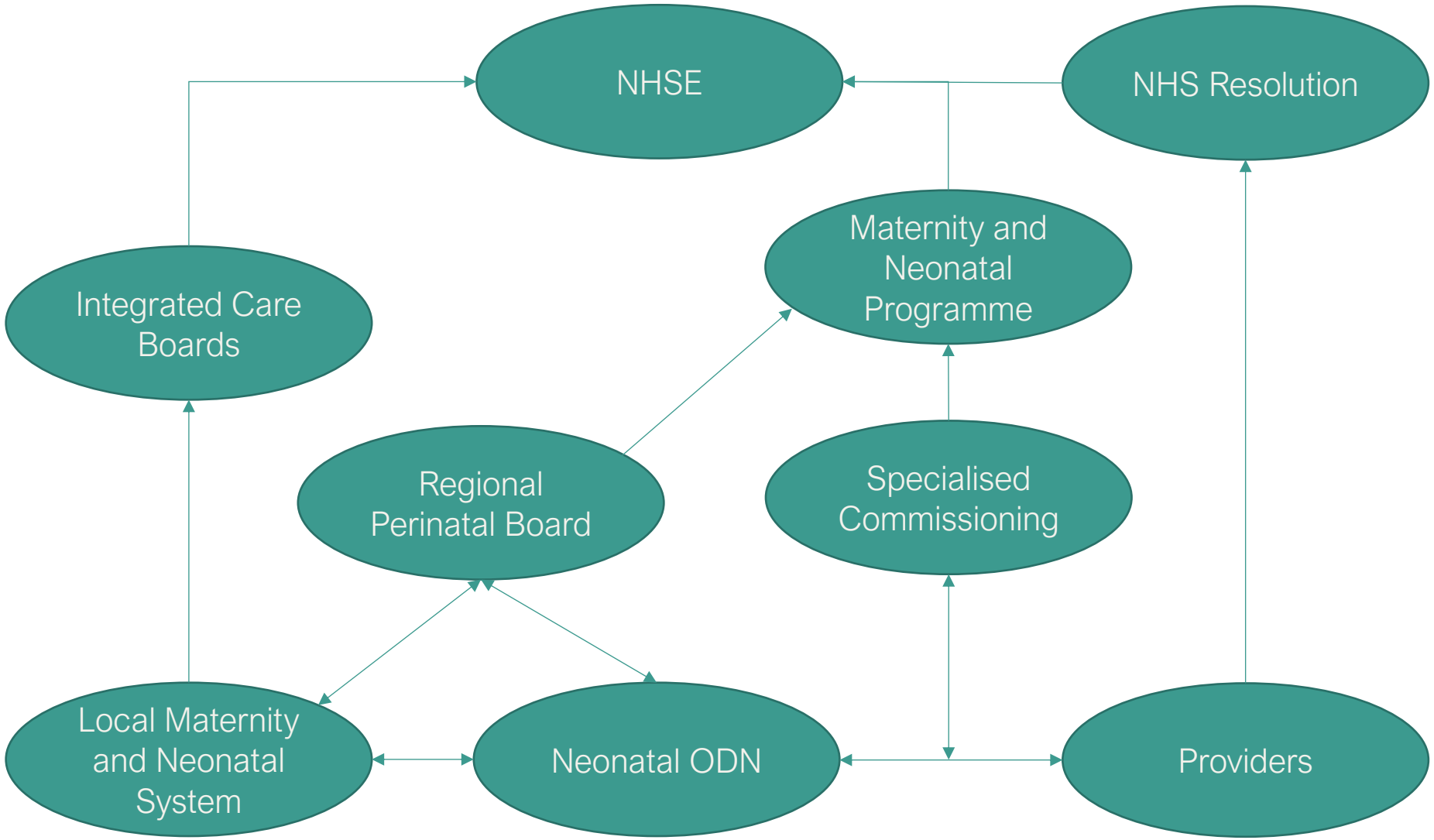
469	7,000	3,350	1,200	113,000
cots across 22 neonatal units	admissions to NNUs	premature babies admitted to NNUs	babies weighing less than1200g	neonatal unit care days

ConnectNW

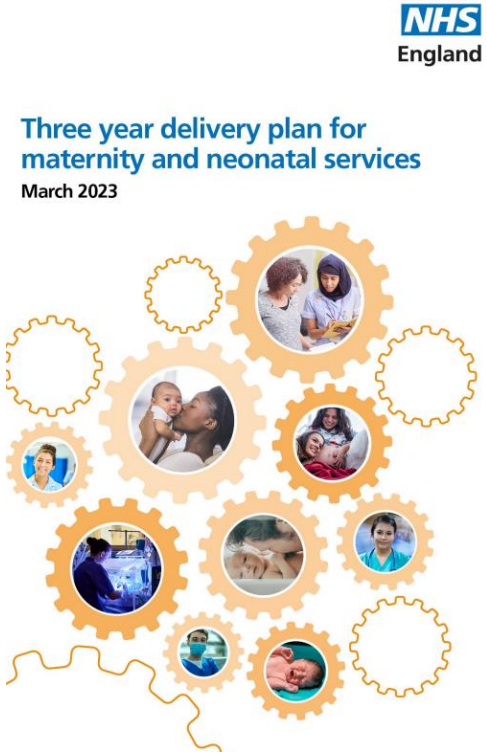
Neonatal Transport for the North West & North Wales

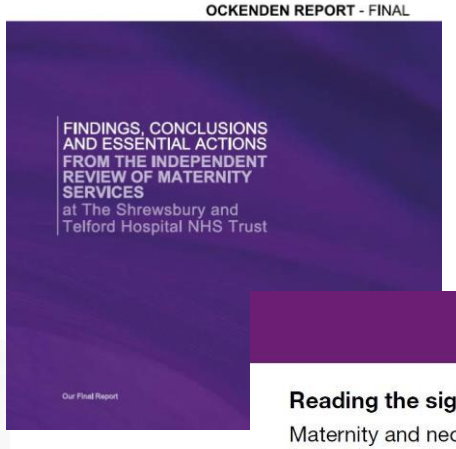
Provided by Saint Mary's Hospital

System Wide Assurance



WORKFORCE FAMILIES BABIES BIRTHING WOMEN





Drivers for Listening & Acting

"Above all, women wanted to be listened to: about what they want for themselves and their baby, and to be taken seriously when they raise concerns."

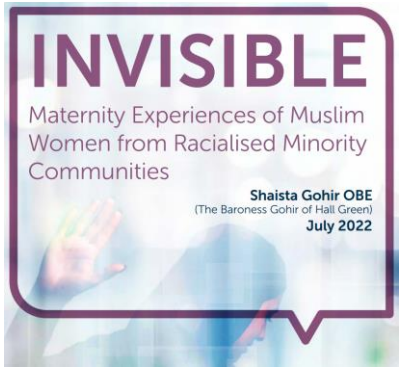
"Neonatal care is an experience I never want to go through again. Even though the unit & staff were great it was still a very lonely place. Walking in and seeing your little baby in an incubator is heart-breaking"

Drivers – Maternity

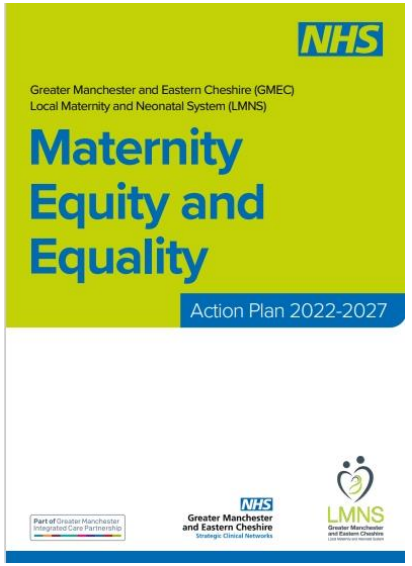
"I asked for pethidine and was told I didn't need it as I was nearly there. I then continued to labour for another 10 hours"

"I didn't want to complain whilst I was on the Post Natal ward, didn't want to be seen as the awkward black woman"

- Numerous maternity reports over the last ten years
  - common themes "not listening"
- 4-5% of women develop post-traumatic stress disorder (PTSD) after giving birth – equivalent to approximately 25,000-30,000 women every year in the UK.
- Birth Trauma affects 30,000 women across the country every year. 53% of women who experienced birth trauma are less likely to have children in the future (Birth Trauma Report)



"I was told I had a choice, but the underlying message was 'if something goes wrong on your head be it." (Induction of Labour)



Listen to Mums:

Ending the Postcode Lottery on Perinatal Care

A report by The All-Party Parliamentary Group on Birth Trauma

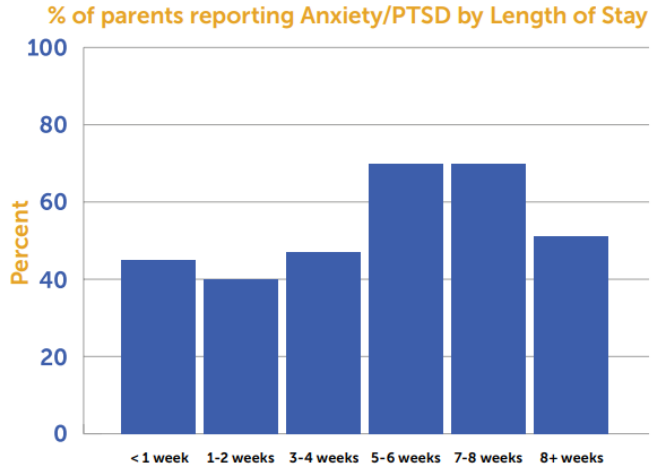
appg Birth Trauma

Drivers - Neonatal

"I developed attachment disorder with both my babies and fear being without them. It also impacted the relationship with my husband due to my anxiety and PTSD"

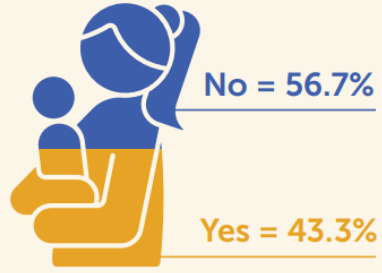
- MVP model move to M**N**VP
  - A need to acknowledge the sensitivity and uniqueness of the neonatal experience and the need for lived experience of neonatal care to reach out to this cohort of families to safely hear their experience.
  - All birthing women and their family experience maternity care but not all experience neonatal care.
- The NFaST report (2022) demonstrated how neonatal lived experience peer support was a vital part of the emotional support families need when experiencing neonatal care.
- Media attention on neonatal services through the Letby case and the Thirlwall Inquiry
  - Increase in anxiety of all families (past, current and future
  - general mistrust of the NHS
  - opportunities for families to speak up and share their views in any way they feel is safe.

"NICU is a very lonely and isolating experience that very few parents can relate to. I had extreme lows and felt very desperate at times." (Mum)

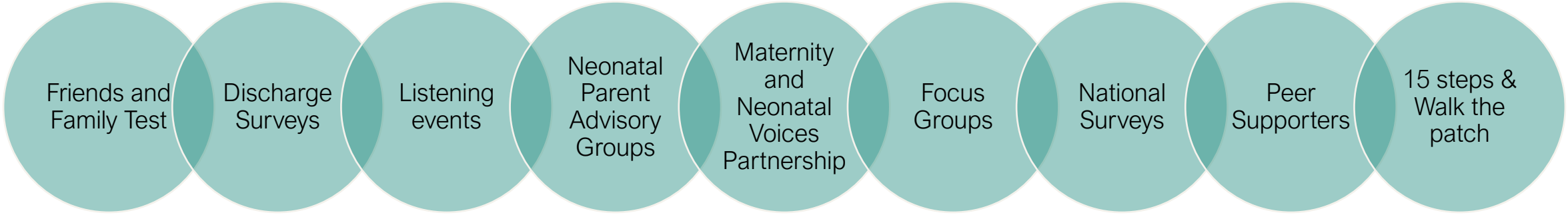


Impact on Bonding

43.3% of parents also described the experience as having had a significant impact on their relationship with their baby – either in terms of it taking longer or being harder to form a bond, or in the sense that anxiety made it difficult to parent in the way that they otherwise might.



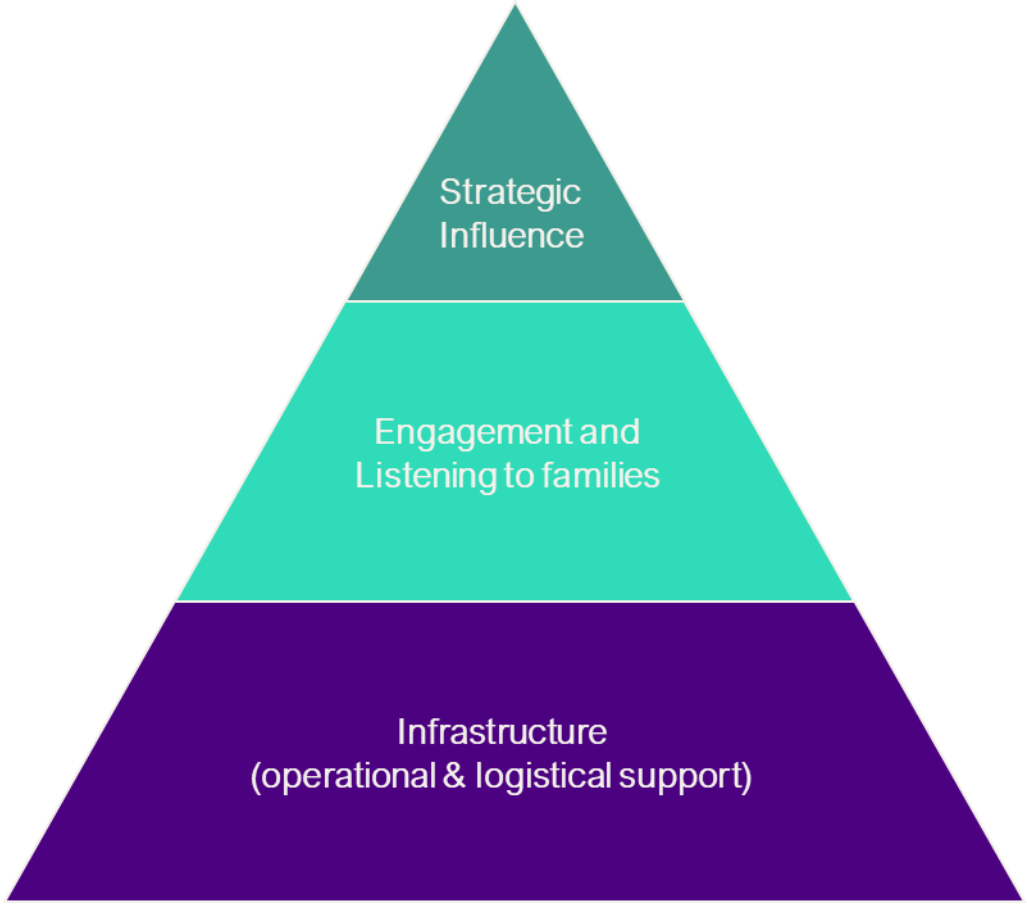
Hearing the Service User Voice



- Important to ensure service users are listened to at the time that is right for the family in a sensitive way.
  - Families need to be able to share their story in their own time and in their own way not just because someone somewhere needs a family story
- MVP transition to MNVP model
  - Historical remit to hear maternity voices
  - Recognition of the gap in identifying neonatal voice
  - New model focussing on formalisation of safely hearing the neonatal voice
- It is important we ensure the voice heard is acted upon in a timely way and makes a real difference to how we shapes services and there is a feedback loop for families to hear how their voice influenced change

What is an MNVP

Voices for Choices



MNVP Leadership provides **strategic influence** through a service user lens by participation in provider safety, quality and governance meetings

An **engagement** team use methods such as 15 Steps, surveys, community outreach, social media, VCSE partnering to gather feedback, coproduce, analyse and report

Project management, admin, accounting, IT equipment & support, wellbeing support, training (inc. safeguarding & GDPR), volunteer management

Inform

✓Monthly newsletter

✓Social Media

✓Mailing List

Co-produce

✓Project steering groups with lived experience

MNVP Service User involvement

Consult

✓Surveys

✓Digital feedback mechanisms

Co-design

✓Co-design Workshops

✓Partnership working with VCFSEs

Engage

✓15 steps

✓Walk the Patch

✓Focus groups

✓Community outreach

Project Approach

Recognise the voice heard safely through Spoons lived experience peer supporters

Build the relationship between MNVP and Spoons at unit level

Develop process for sharing feedback formally through unit managers to **ensure early response and action to feedback at unit level**

Governance behind the feedback shared by MNVP at formal trust level governance meetings

Themes collated from across GM units by Spoons to share at locality/regional level to inform strategic work

Regular reporting of peer support activity and themes to NWNODN and GMEC LMNS

End of project report summarising findings, feasibility and sustainability of the approach.

It is imperative that we hear the voice of our service users within maternity and neonatal services on a regular basis. Understanding and acting on the themes through the service user voice aims to shape and improve the quality and safety of care that women and families deserve.
(Safety Lead Midwife – GMEC LMNS)

Maternity - Service User voice

Experience of Inductions and Birth Plans

- Poor communication during induction processes, with unclear timelines and insufficient staff support.
- Limited discussion of birth preferences during antenatal care, leaving some service users feeling unsupported.
- Reports of being rushed into interventions without fully exploring alternative options.

Postnatal and Breastfeeding Support

- Limited breastfeeding support overnight and inconsistent advice on feeding options.
- Instances of service users feeling pressured to use formula instead of receiving adequate breastfeeding assistance.

Communication

- Many service users praised staff for being personable, compassionate, and explaining procedures clearly.
- Lack of consistent messaging between healthcare professionals, causing confusion, especially regarding induction plans and medical decisions.
- Limited personalisation in birth planning discussions, with a focus on practicalities rather than preferences.

Continuity and Access to Care

- Individual staff were frequently praised for personalised care, with many being named for exceptional service.
- Limited continuity of care during pregnancy, with reports of service users being unfamiliar with their named midwife.
- Issues with access to timely care, including delays in inductions due to staffing shortages and extended waits for appointments.

Neonatal Service User Voice

Lack of clarity around the process of debriefs

Lack of clarity around timely escalation of low-level complaints - Too easy to pass to PALS

Care following C-Section – Time to see baby, accessing pain relief, place on ward

Parents are often scared to complain when their baby is still on the unit

It isn't easy for parents who have experienced neonatal care to share their maternity journey as the format of MVP listening events have not been inclusive of them

Poor culture – health professionals are defensive making it hard for parents to speak up

Spoons Activity

Service summary April to December 2024

- 146 new family support referrals
- 84 home visits via Family Support Team
- 151 community sessions delivered
- 208 sessions of trauma therapy delivered
- Supporting 15 steps for maternity on the neonatal unit

Unit	Active volunteers/staff	Number of parents supported	Peer support hours provided
Bolton	3	49	123.5
North Manchester	3	72	93
Oldham	4	61	106
St Mary's	4	45	124.5
Stepping Hill	2	37	70
Tameside	1	4	6
Wigan	0	0	0
Wythenshawe	2	15	32
Total	10	283	340

"I came across Spoons on the neonatal unit when I was approached by one of their volunteers. Because I had such a mistrust of other services, I was at first dismissive of the Spoons support. How could they understand the losses I had suffered through having such early babies? But as time went on and Annabelle continued to get better, I started to open up to one of the volunteers.

One of the Spoons Family Support Coordinators visited me at home. I felt like I was doing everything wrong, so it was helpful to have someone recognise my relationship with my baby and show me that we were bonding. It really helped to build my confidence. She also put me forward for their trauma therapy service which has been so beneficial."

.(Parent supported by spoons)

"It's been great that we've been able to share our experience and opinions on research projects that Spoons have been involved in. I want our feedback to influence improvements in neonatal services, so other people have a better experience."

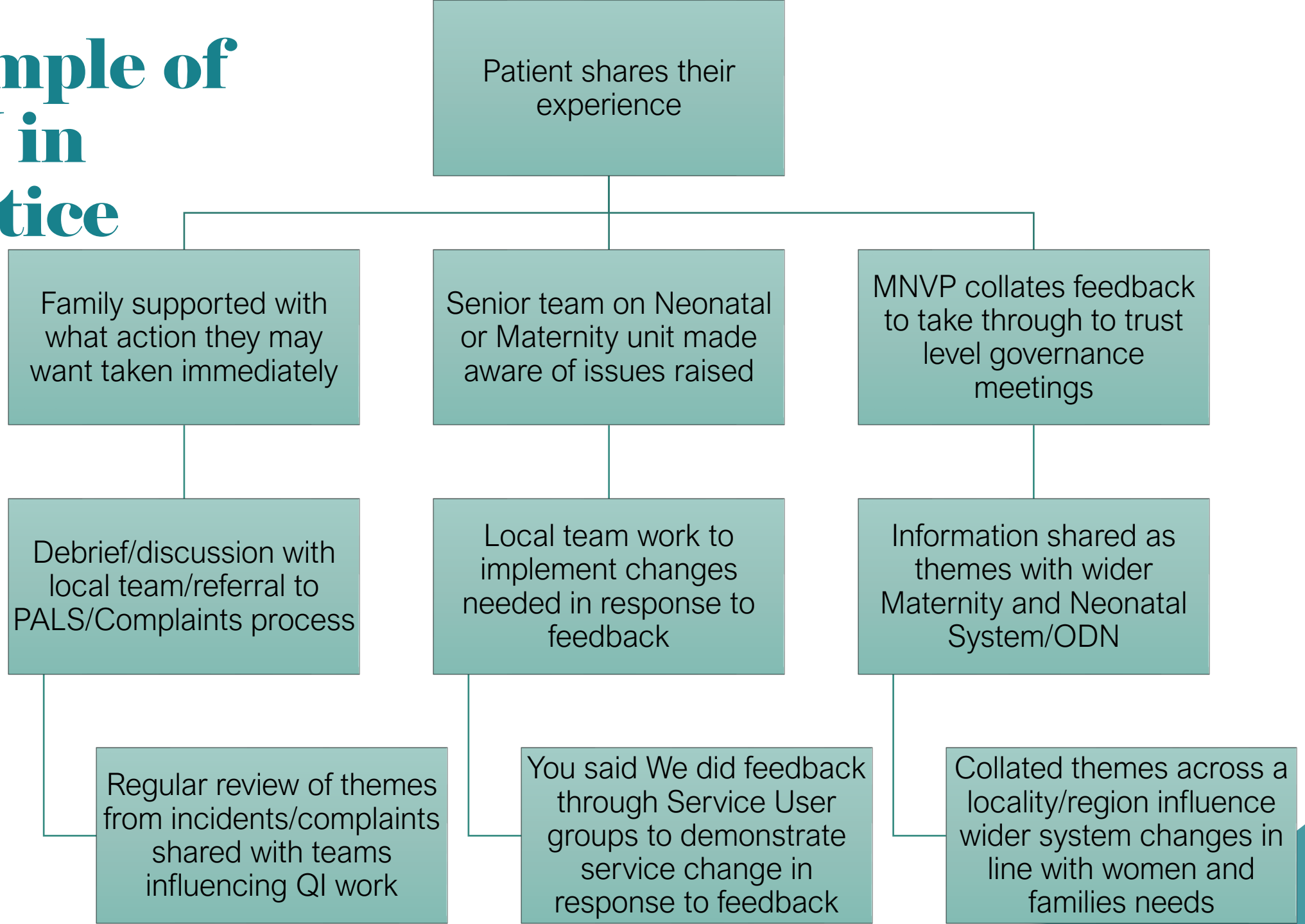
(Parent supported by spoons)

spoons
neonatal family support

15 Steps

- Observational, looking at maternity services through the lens of a service user – how does it make you feel? safe, welcoming
- Undertaken in partnership with maternity services – takes a lot of planning
- Small teams walk round hospital site & feedback positives and negatives to hospital team
- Results are written up into an action plan and taken through Trust governance processes
- Working in partnership and in a trauma informed way
- 15 Steps video
- Specific work on going nationally, regionally and locally to align maternity focused 15 steps to the specifics of a neonatal unit
    - Working collaboratively with charity partners and those with neonatal lived experience

Example of SUV in practice



Not just a tick box

Value lies in truly listening to women and families who experience our services

We CANNOT assume when we have heard a patient story at an education event/in one meeting that we have listened

Important to hear the voice of your local population on a consistent basis to truly understand how your service is being experienced

Listening and acting on what you hear in collaboration with those families and your local MNVP and Neonatal charity/peer supporters/parents WILL improve your service

When we do the possibilities of an open culture of learning and improvement can be realised

Scenario based panel discussion

Panel members (North West)

- Alison Brennan
- Sarah Howard
- Joy Foster-Christie

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 decelerations, 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 five

- 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: neonate

- 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?

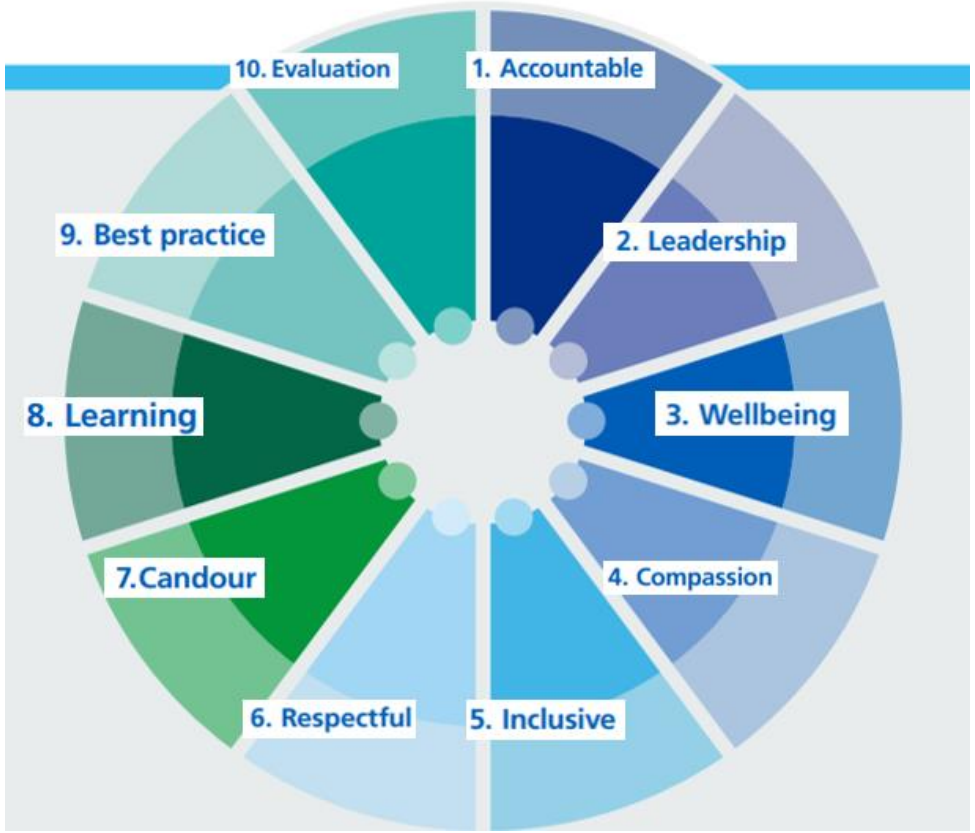
SCAN ME

Being Fair 2

NHS Resolution

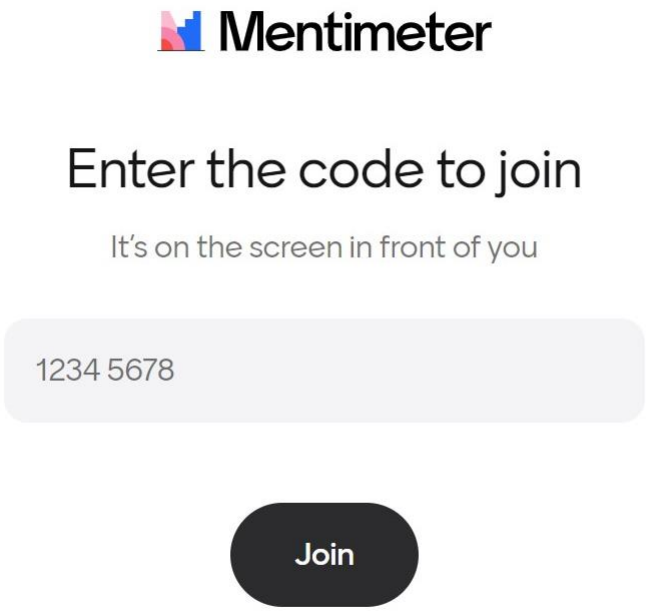
SCAN ME

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



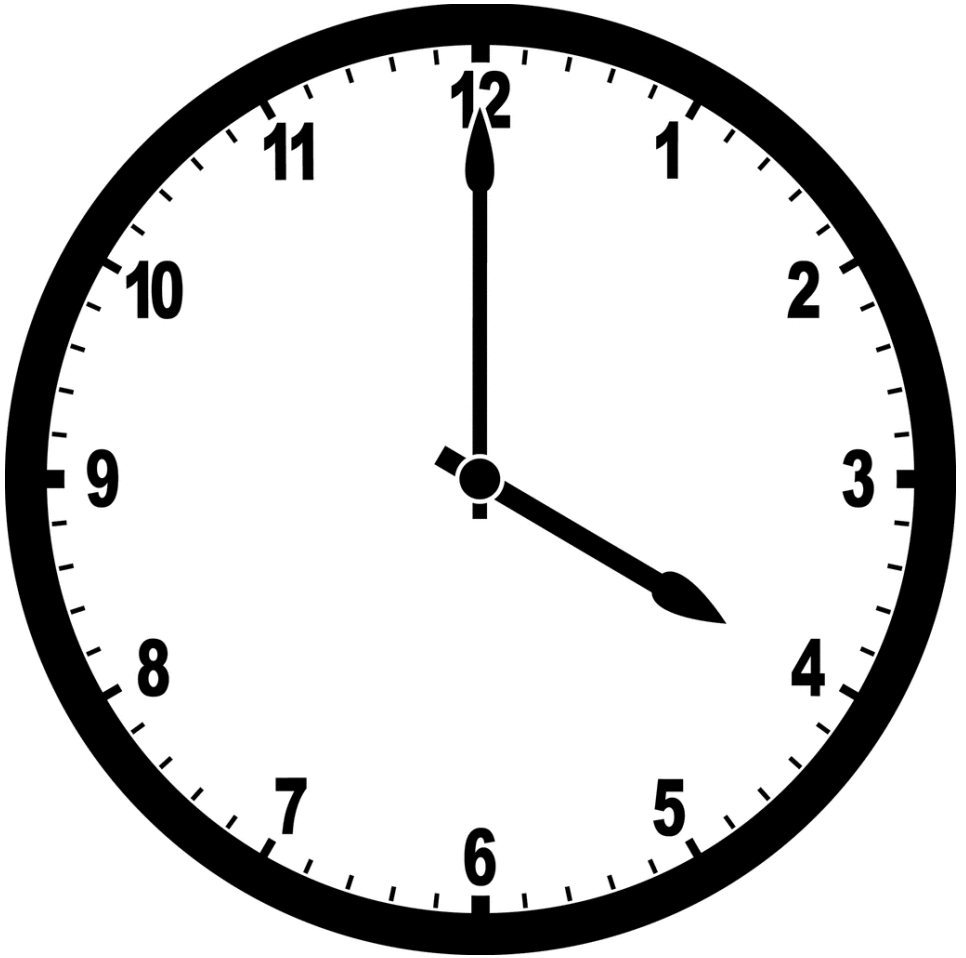
Menti

- www.menti.com
- Code: **7753 5065**



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?

aqua
Shape Change Inspire Quality Transform Care

PSIRF & culture

North West maternity & neonatal event
6th February 2025

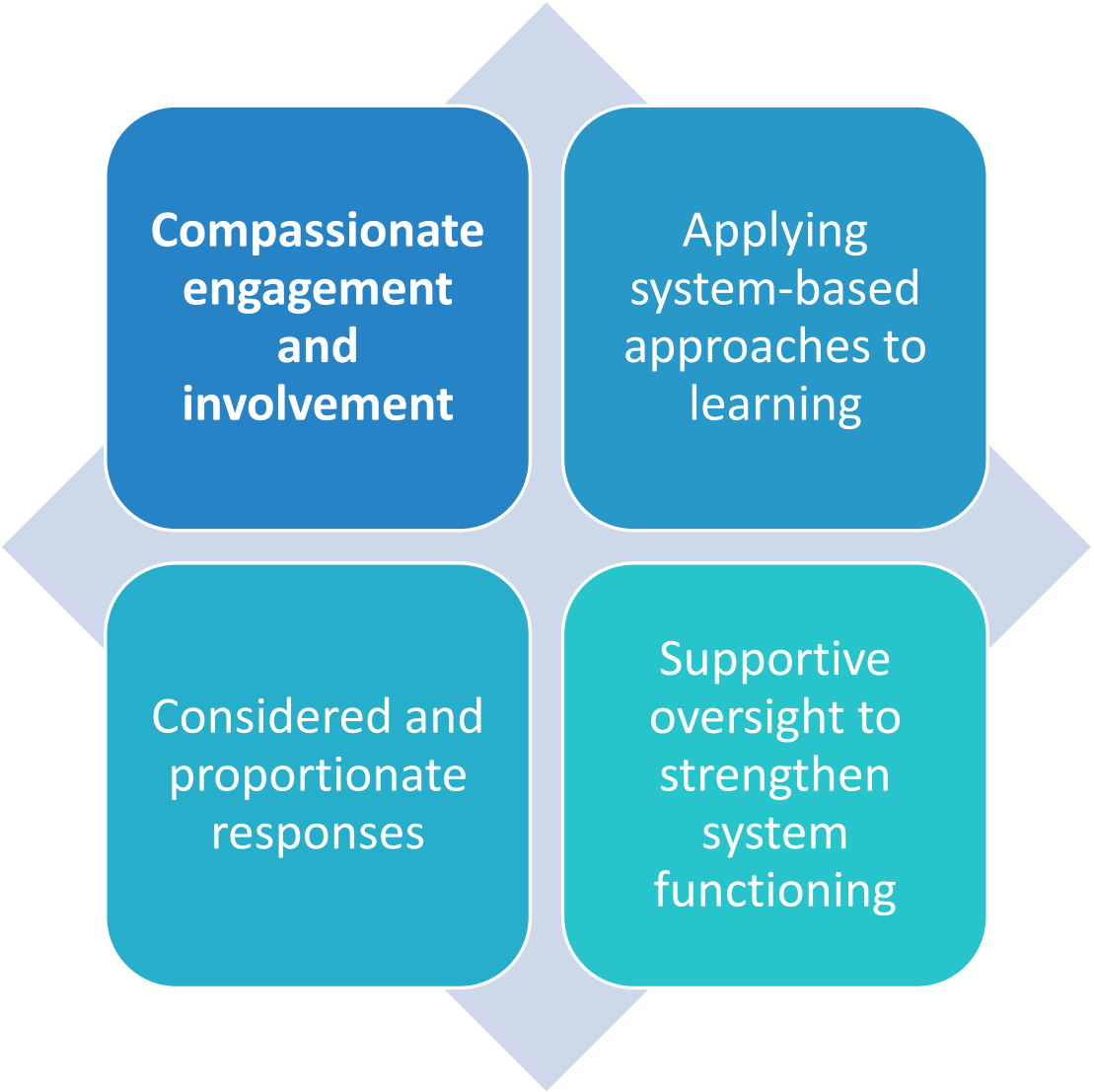
Paul Greenwood

aqua
Shape Change Inspire Quality Transform Care

Today

Overview of session:

- Background to Aqua
- Our work with safety cultures & PSIRF
- Our lessons learned



aqua
Shape Change Inspire Quality Transform Care

About Aqua

Shape change

We work with you to develop and build capability through continuous and sustainable improvement in process, strategy and culture.

Inspire quality

We identify and embed the drivers of safe, high-quality care and strive for regulatory excellence. We connect and convene to share learning, spread innovation and share best practice.

Transform care

Our solutions are informed by data, lived experience and cutting-edge innovation. We develop progressive leadership teams, design integrated models of care and accelerate system transformation.

We are an **NHS health and care quality improvement organisation** working across the NHS, care providers and local authorities to identify, refine and embed sustainable strategies for high-quality care and regulatory excellence.

Established 15 years ago, we provide **improvement expertise**, specialist **learning** and **development**, and **consultancy** services for health & care organisations through long-term **membership** and project-by-project **consultancy**.

aqua
Shape Change Inspire Quality Transform Care

Lived experience

- Aqua has 5 lived experience partners.
- They are part of the delivery team.
- They have helped co-design the training.
- It is important having that lens and the challenge it brings into the space.

SAFE CARE IMPACT 2025

aqua
Shape Change Inspire Quality Transform Care

Approved credible and quality assured PSIRF implementation programmes by NHS England and The East of England collaborative Procurement hub.

National impact working with NHS England Maternity & Neonatal safety transformation team, Patient Safety Learning, NHS resolution and well-led PSIRF interviews.

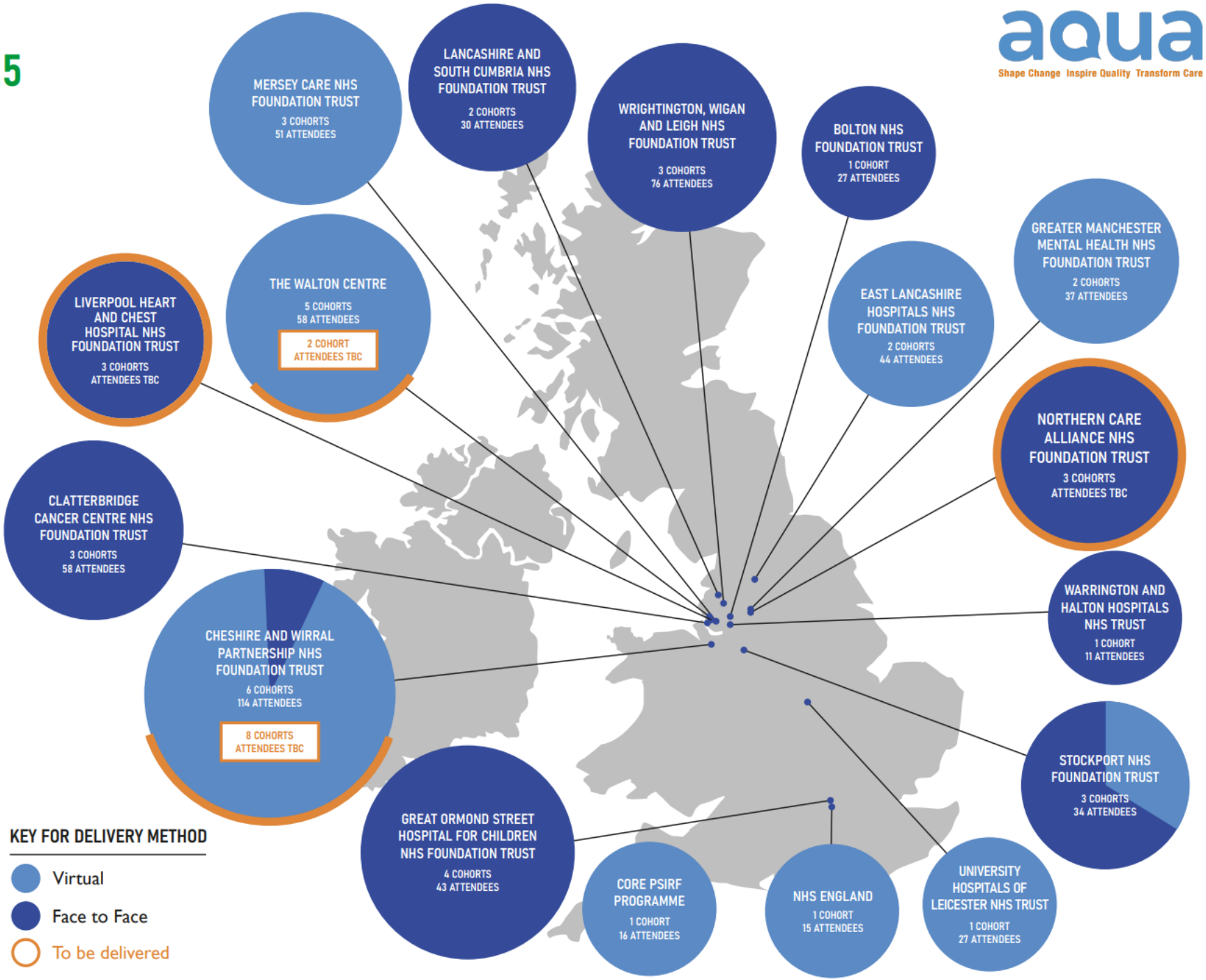
Lived experience partners at the heart of the compassionate engagement programme.

Delivered / planned delivery of PSIRF programmes to 17 organisations from across England involving 54 cohorts.

Delivered to 651 attendees across 4 programme offerings.

Flexible approach meeting the organisation's needs: 25 face to face & 29 virtual cohorts, 13 bespoke and 5 consultancy programmes with organisations.

480 attendee places on planned programmes but yet to be delivered.



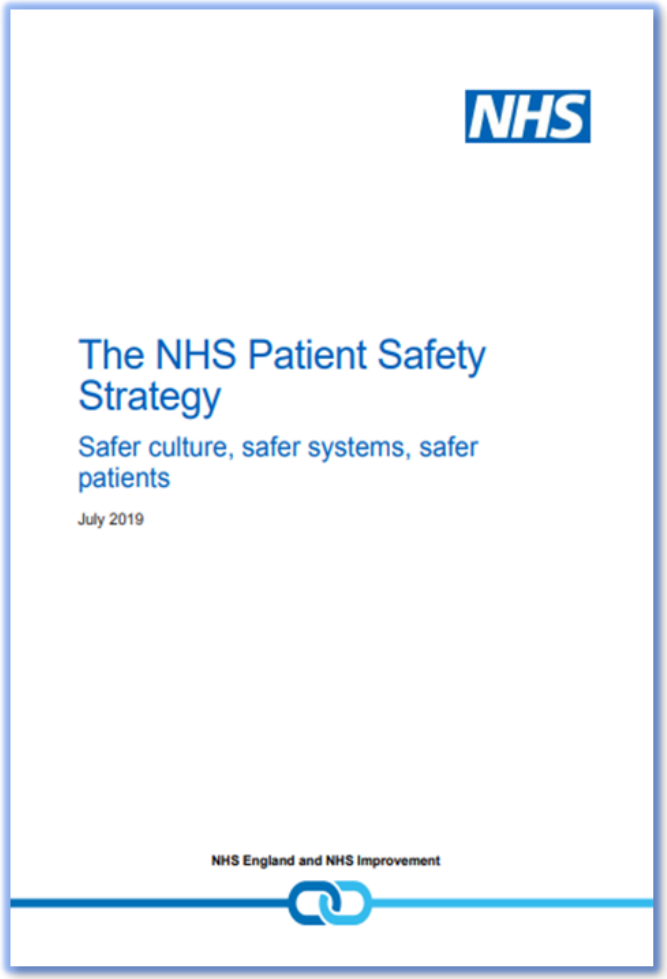
@Aqua_NHS
Advancing Quality Alliance
enquiries@aqua.nhs.uk
www.aqua.nhs.uk

aqua
Shape Change Inspire Quality Transform Care

Safety culture

aqua
Shape Change Inspire Quality Transform Care

Safer culture

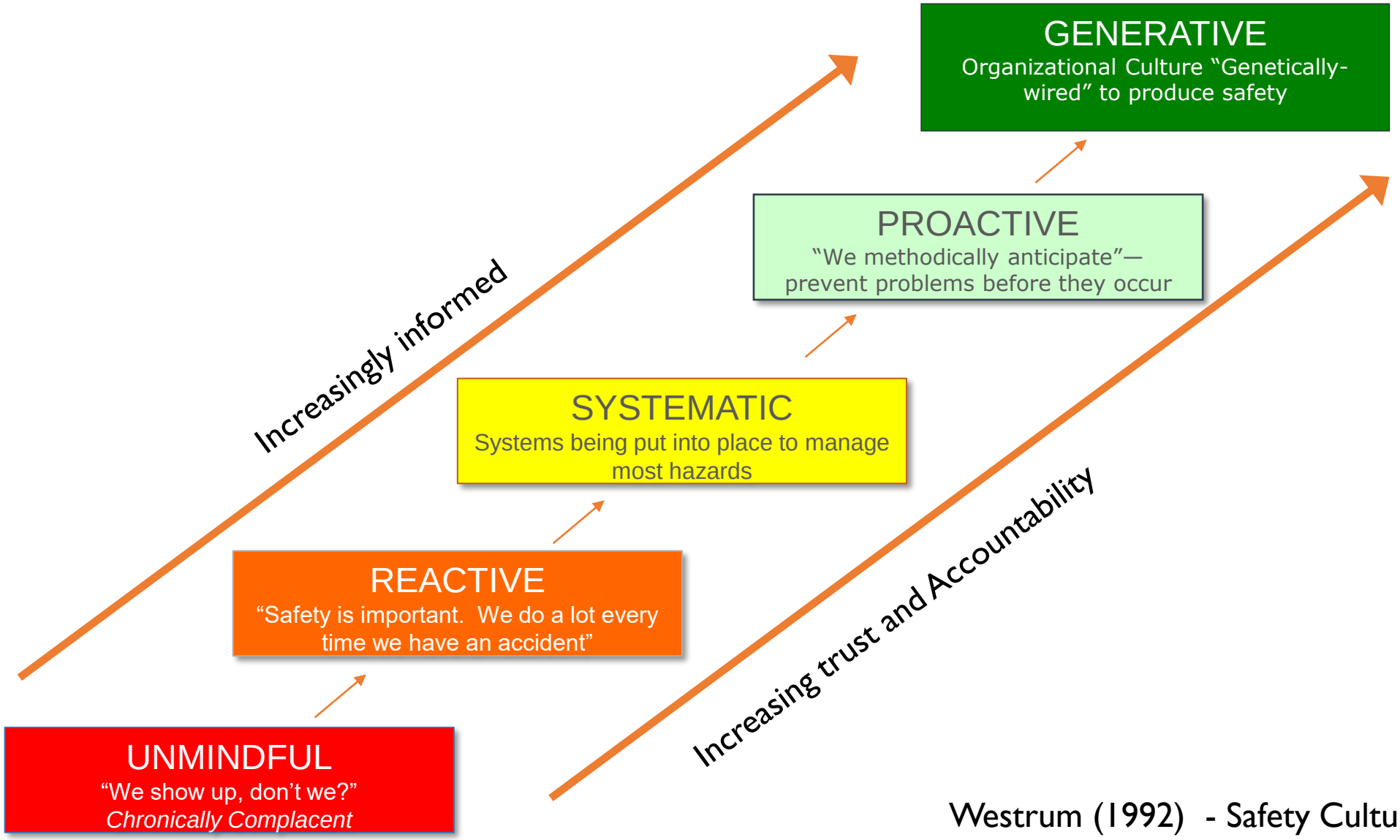


Report template - NHSI website (england.nhs.uk)

- **Psychological safety for staff:** Psychological safety operates at the level of the group not the individual, with everyone knowing they will be treated fairly and compassionately by the group if things go wrong, or they speak up to stop problems occurring.
- **Diversity:** Team psychological safety is characterized by a climate of inclusivity, trust and respect, where people feel able to thrive as themselves.
- **Compelling Vision:** Before leadership can be practiced well, there needs to be a vision of what we want to achieve. .. the vision needs to be explicit, not reliant on assumption.
- **Leadership & Teamwork:** Compassionate leadership creates psychological safety and encourages team members to pay attention to each other; to develop mutual understanding; to empathise and support each other.
- **Open to Learning:** To develop a culture of learning, the system must focus on what needs to change rather than punitive actions.

aqua
Shape Change Inspire Quality Transform Care

Safety culture



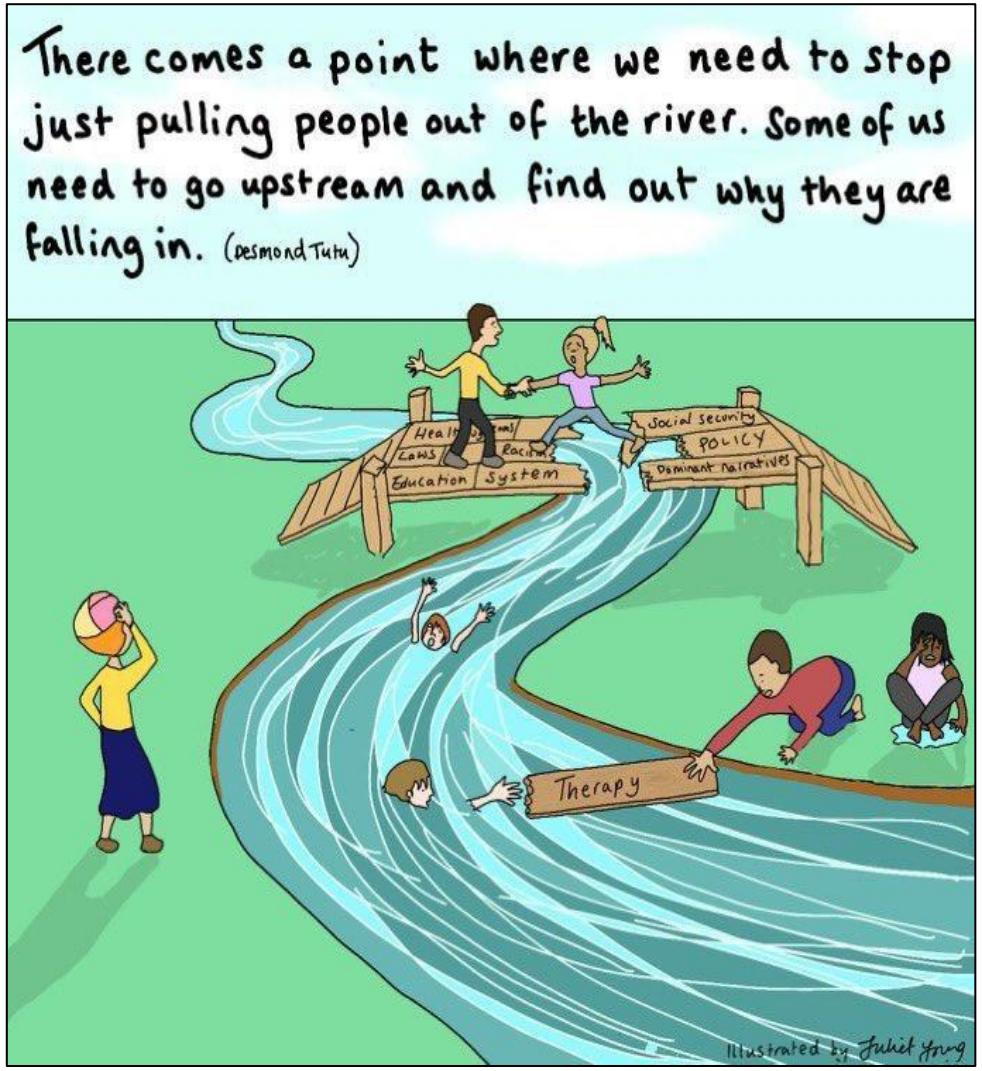
Westrum (1992) - Safety Culture maturity

aqua
Shape Change Inspire Quality Transform Care

Safety I vs safety 2

aqua
Shape Change Inspire Quality Transform Care

A systems approach



- Humans are fallible, mistakes are inevitable
- The best of people can make the worst of mistakes
- Errors are often shaped and provoked by upstream (system) factors
- Recognise patterns in errors and failures
- Learn from errors and prevent future errors
- Change working conditions and system to prevent / reduce error
- Build a safety culture

aqua
Shape Change Inspire Quality Transform Care

PSIRF

Involvement and engagement

Learning and improving future safety

Helping us to understand work as done

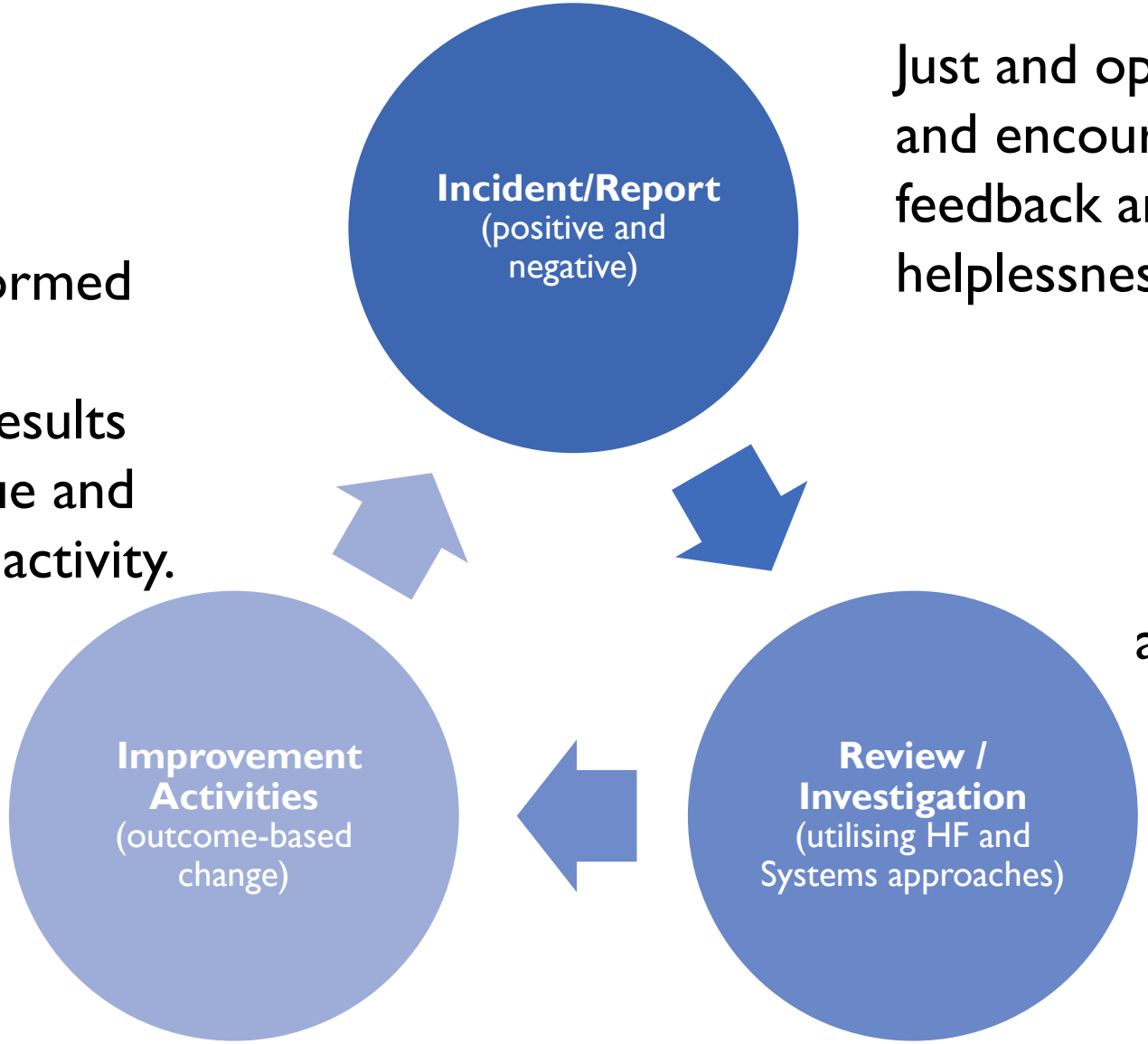
Proactively working to maintain safety

aqua
Shape Change Inspire Quality Transform Care

Safety & improvement culture

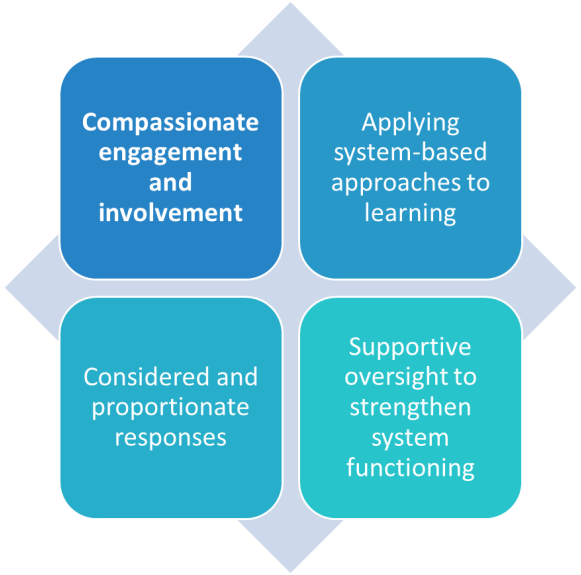
Just and open culture that supports and encourages reporting, provides feedback and reduces learnt helplessness.

QI work that is informed by the review and produces tangible results that represents value and supports reporting activity.



Appropriate to incident using system based approaches to understand the contributing factors for both success and failure.

aqua
Shape Change Inspire Quality Transform Care

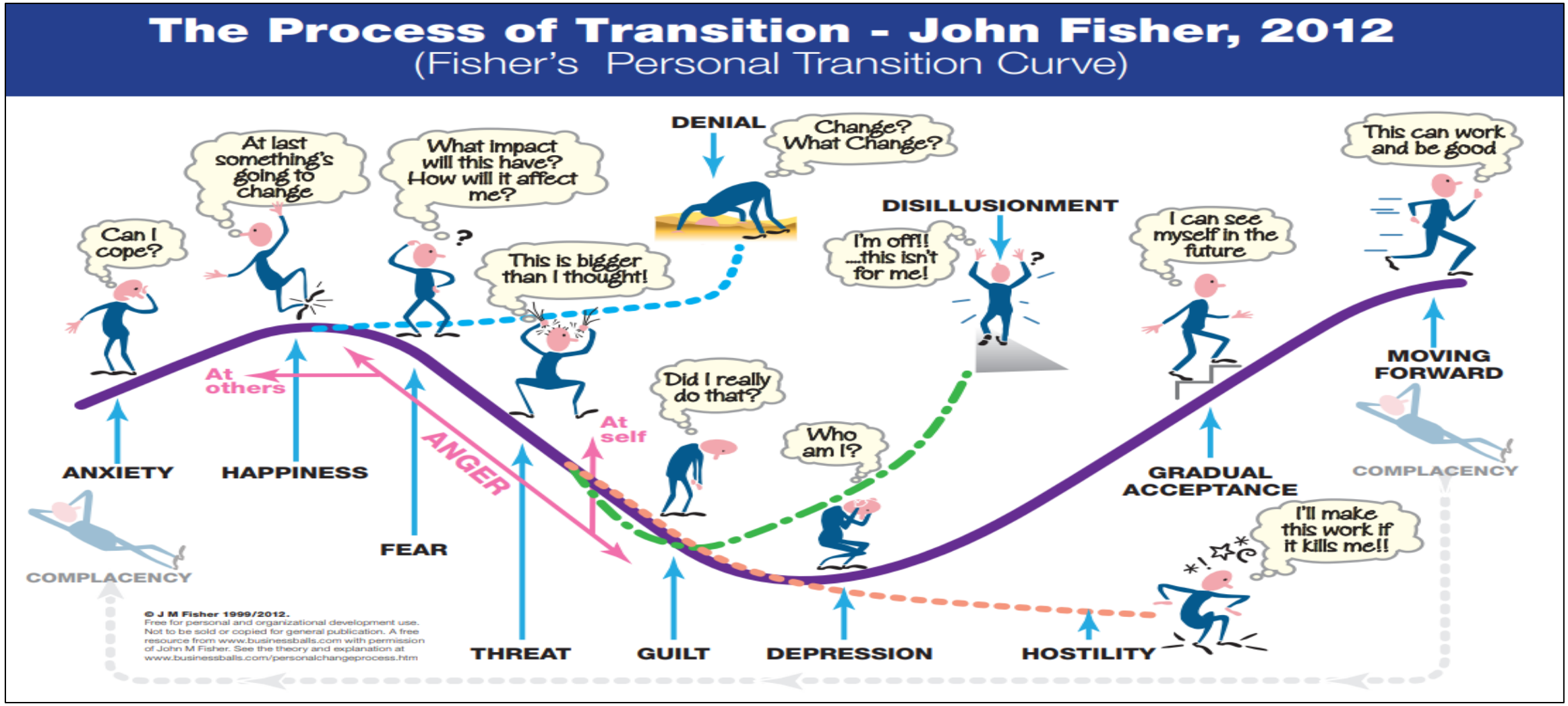


Compassionate engagement

Involvement of all

aqua
Shape Change Inspire Quality Transform Care

Understanding human responses



https://www.businessballs.com/change-management/personal-change-stages-john-fisher/

aqua
Shape Change Inspire Quality Transform Care

Trauma informed

Definition

'Individual trauma results from an **event***, series of events, or set of circumstances that is* **experienced** *by an individual as physically or emotionally harmful or life threatening and that has lasting adverse* **effects** *on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.'*

SAMSHA (2014)

Principles of Trauma informed care

1. Safety
2. Trustworthiness
3. Peer support
4. Collaboration
5. Voice and choice
6. Cultural, historical and gender issues

Remember the 4 R's

- **Realise**
- **Recognise**
- **Respond**
- **Resist re-traumatising (compounded harm)**

Trauma Informed Care and staff experience?

Vicarious traumatisation refers to “the cumulative transformative effect on the helper working with the survivors of traumatic life events”

The impact of vicarious trauma occurs on a continuum and is influenced by a number of factors such as role and how much traumatic information a practitioner is exposed to, the degree of support in the workplace, personal life support, and personal experiences of trauma

The influence of vicarious trauma can be seen and felt on both personal and professional levels, and in some instances, the community level

(Trauma Informed Practice Guide)

General wellness: Encouraging and incentivising activities like yoga, meditation, and exercise. Wellbeing action plans

Organisational: Fostering a culture that allows clinicians to seek support; keeping caseloads manageable; and providing sufficient mental health benefits

Education: Providing targeted training that create awareness of chronic emotional stress and the importance of self-care; and

Supervision: Facilitating staff wellness through management strategies such as reflective supervision.

Menschner (2016)

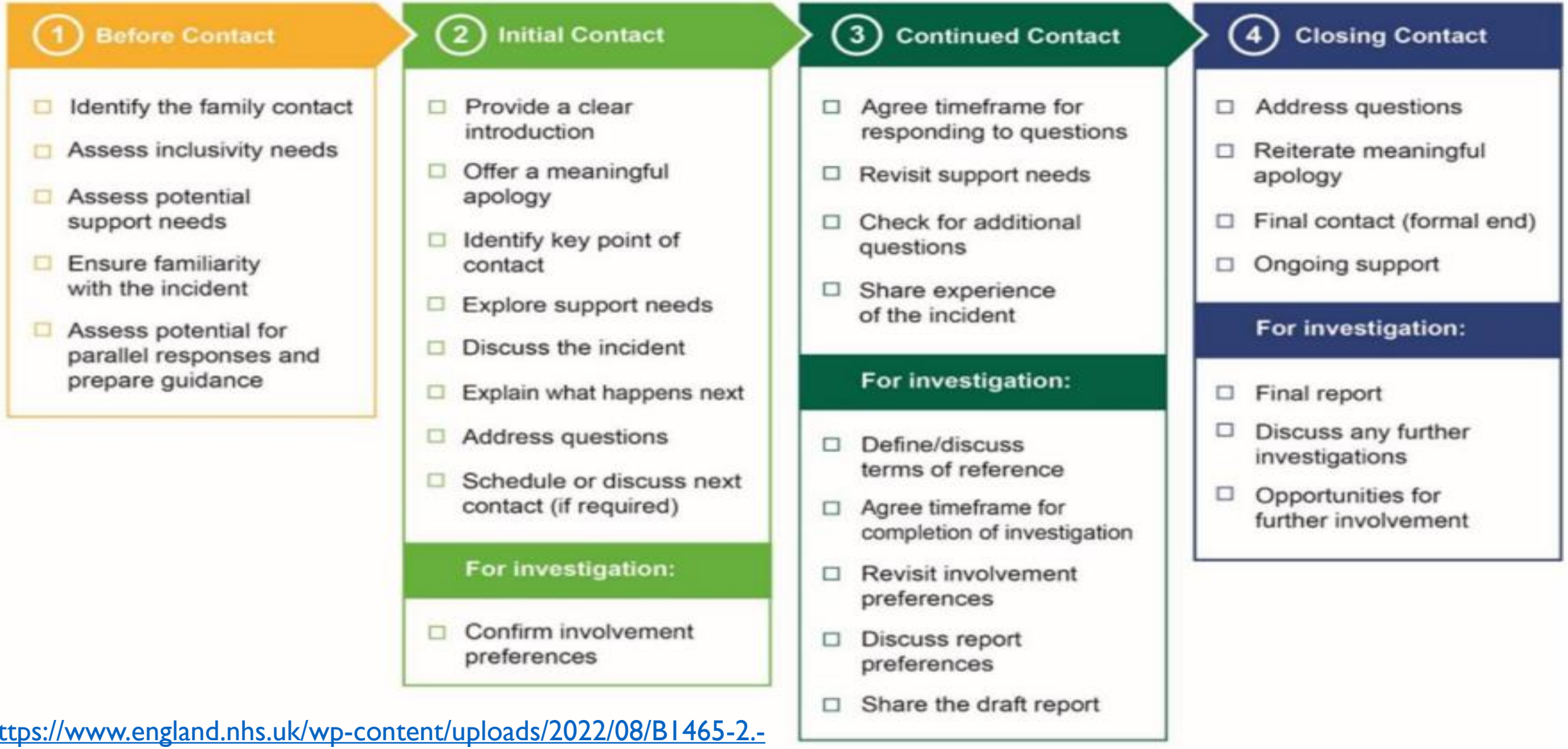
aqua
Shape Change Inspire Quality Transform Care

Engagement Principles

https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf

aqua
Shape Change Inspire Quality Transform Care

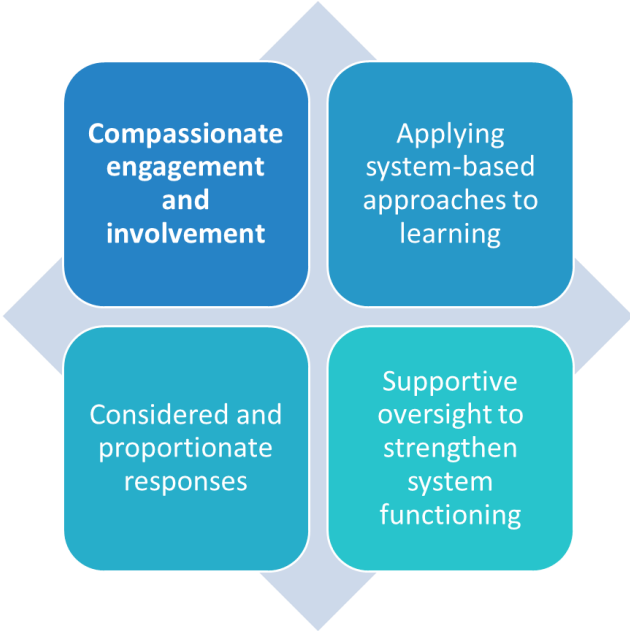
Four Steps of Engagement



https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf

aqua
Shape Change Inspire Quality Transform Care

Supportive oversight



aqua
Shape Change Inspire Quality Transform Care

Data insights

Be open to sourcing and triangulating various sources of safety information both qualitative and quantitative

- ✓ Incidents (including analysis of free text)
- ✓ Complaints
- ✓ Conversations with staff and patients
- ✓ Friends and Family test data
- ✓ Patient safety incident investigation reports (PSIIs)
- ✓ Clinical notes
- ✓ Findings of other learning response approaches – rapid learning, reviews, swarm huddles, after action reviews, structured judgement reviews, horizon scanning, MDT reviews of a case or safety theme.
- ✓ Minutes from relevant quality and safety committee/governance meetings
- ✓ Walkthroughs / Observations of patient care
- ✓ Performance data

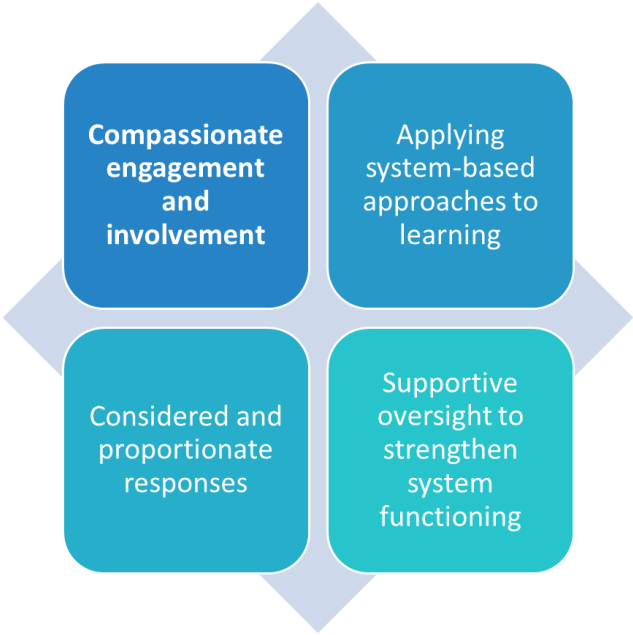
https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Top-tips-for-thematic-reviews-v1-FINAL.pdf

aqua
Shape Change Inspire Quality Transform Care

Strategies for improving insight

- ✓ Actively seeking 'work as done'
- ✓ Questioning 'work as imagined'
- ✓ Providing a safe and supportive environment for staff to identify common workarounds
- ✓ Following 'hunches' / safety risks identified by those who have the best insight (staff/ patients)
- ✓ **Be curious**

aqua
Shape Change Inspire Quality Transform Care

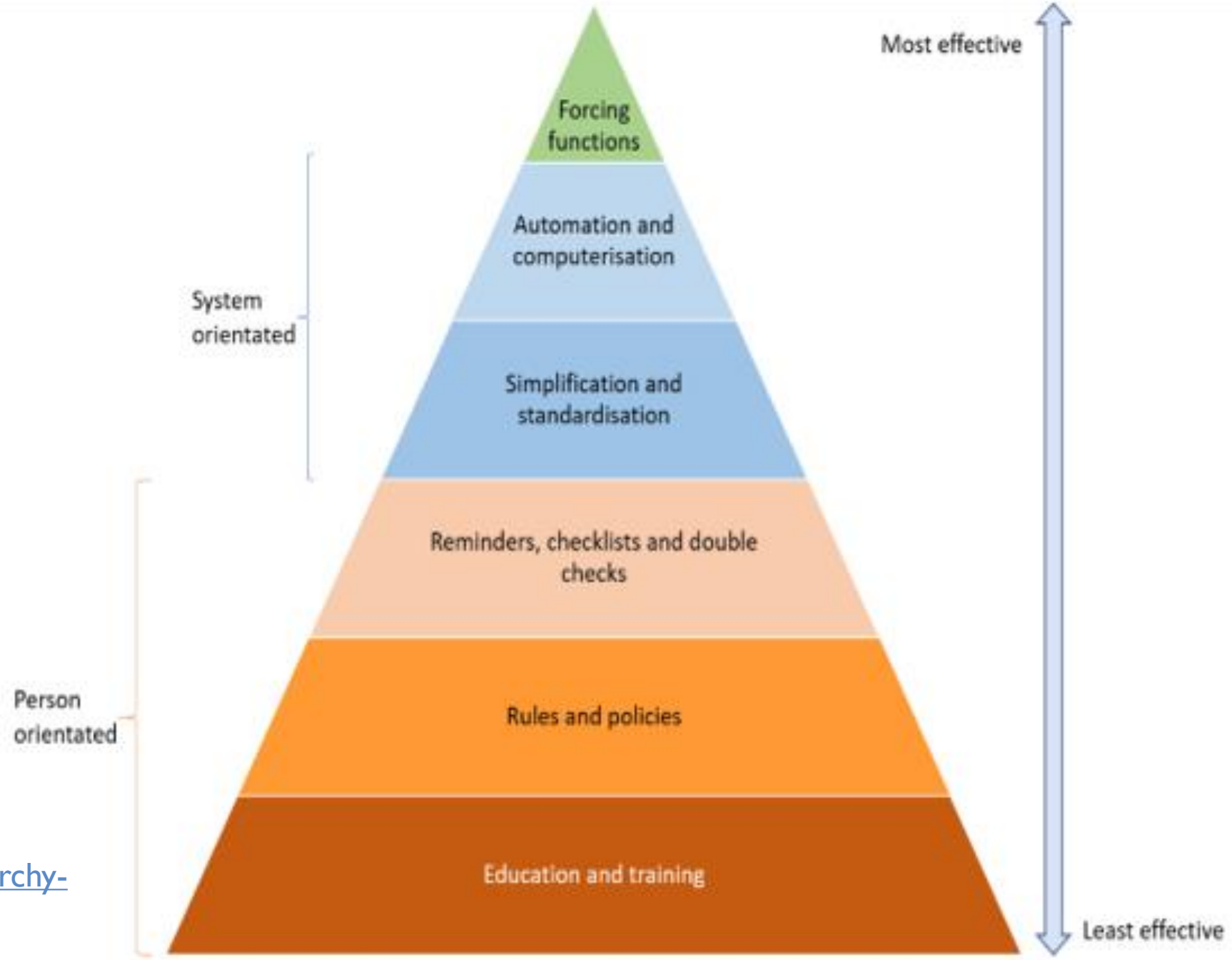


Proportionate responses

Effective action planning

aqua
Shape Change Inspire Quality Transform Care

Effective changes



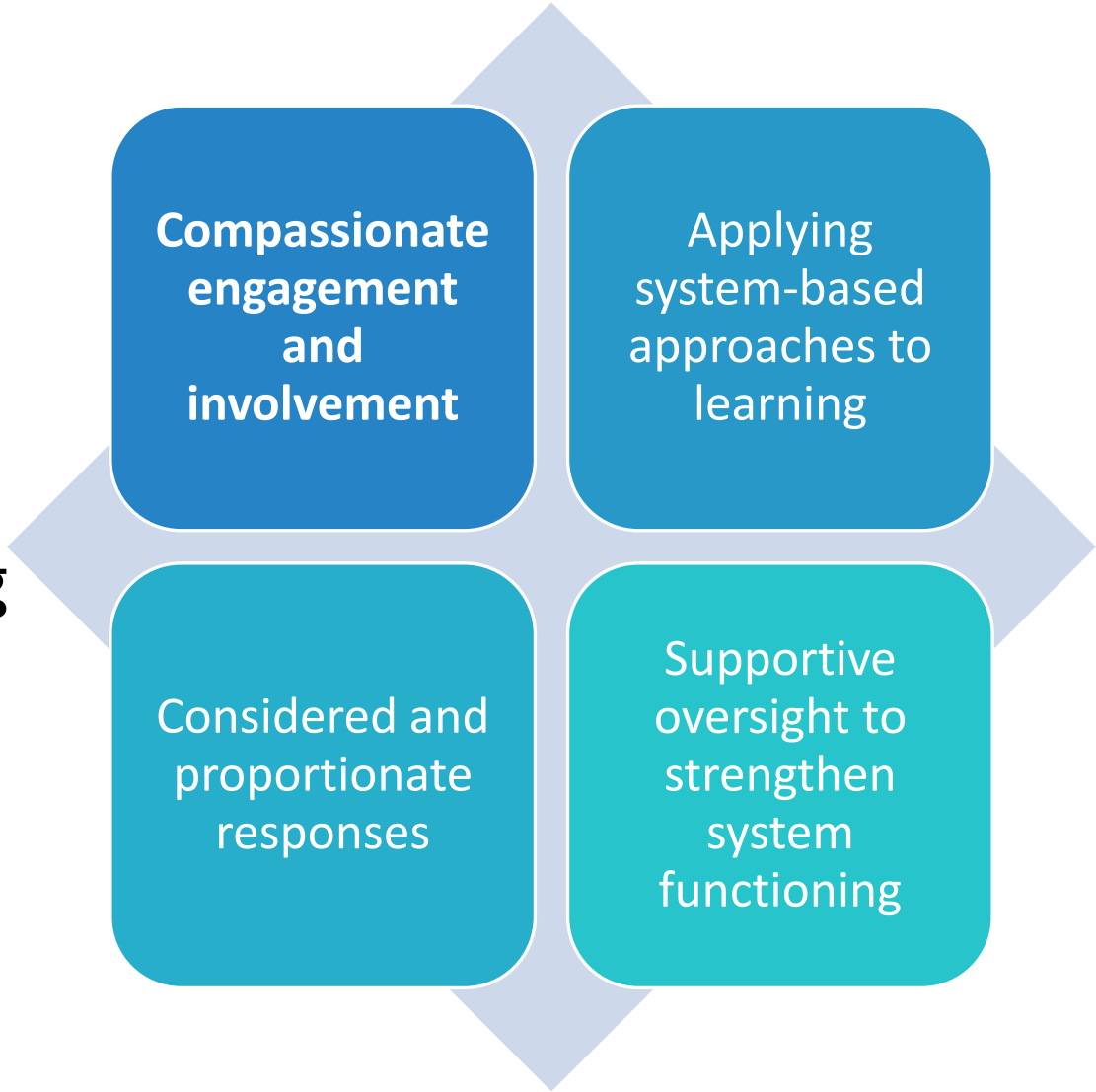
https://ismpcanada.ca/resource/hierarchy-of-effectiveness/

aqua
Shape Change Inspire Quality Transform Care

Lessons learned

Our themes emerging:

- Maturity & resourcing of investigators / teams
- Nervousness about principled vs prescriptive approach –straddling safety I and 2 (SIF vs PSIRF)
- Embracing proportionality recognising a steep learning curve
- Enthusiasm to treat people with respect & compassion
- Keen to adopt systems approach balanced with accountability



aqua
Shape Change Inspire Quality Transform Care

Paul.greenwood@aqua.nhs.uk

@Aqua_NHS Advancing Quality Alliance

3rd Floor, Crossgate House, Cross Street, Sale, M33 7FT
Call: 0161 206 8938
Email: enquiries@aqua.nhs.uk
www.aqua.nhs.uk

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…