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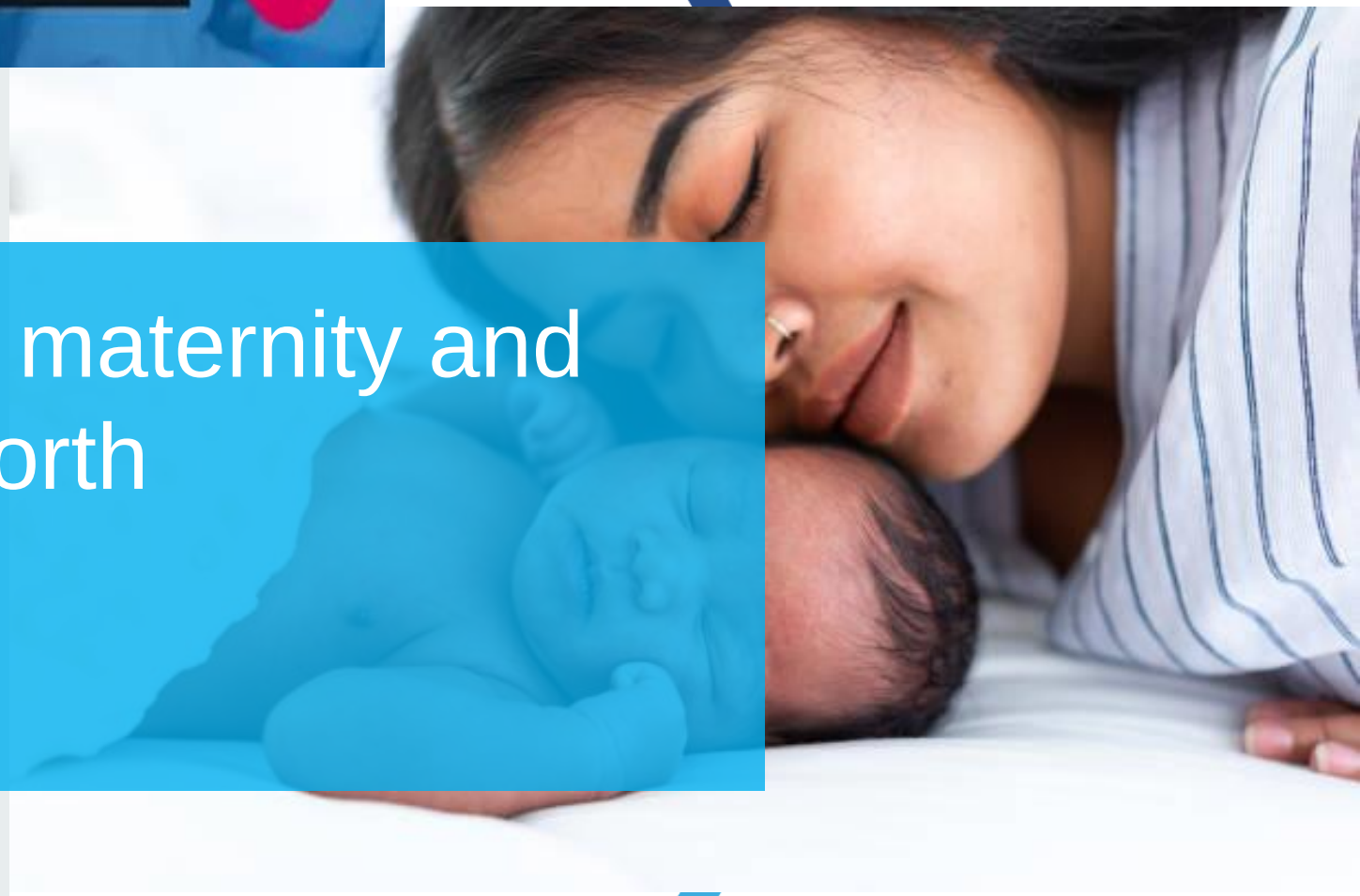
NHS Resolution



Collaborating for safer maternity and neonatal care in the North

29th January 2025

@NHSResolution

Advise / Resolve / Learn

Agenda - Y

NHS Resolution

12:00	Registration, Lunch & Networking	
Time	**Item**	**Lead**
12:45	Welcome & House Keeping	Chair
12:50	National & Regional Maternity Claims data	Victoria Wilkins – NHS Resolution
13:15	Consent Update	Emily Senior – DAC Beachcroft
13:45	Patient Voice	Nasrin Ali – MNVP lead/Service user representative
14:15	Complex Care Group	Nicola Cawley, Laura Hughes, Beth Lewis – Bradford Teaching Hospital
14:45	Scenario based panel discussion	Nicola Cawley (Clinical), Sean Doherty (Legal) and Nasrin Ali (Patient)
15:15	Refreshment interval	
15:20	Workshop	Interactive session
16:00	Insights	Lizzie Sweeting – Yorkshire and Humber Improvement Academy
16:20	Closing Speech	Sean Doherty – DAC Beachcroft
16:27	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

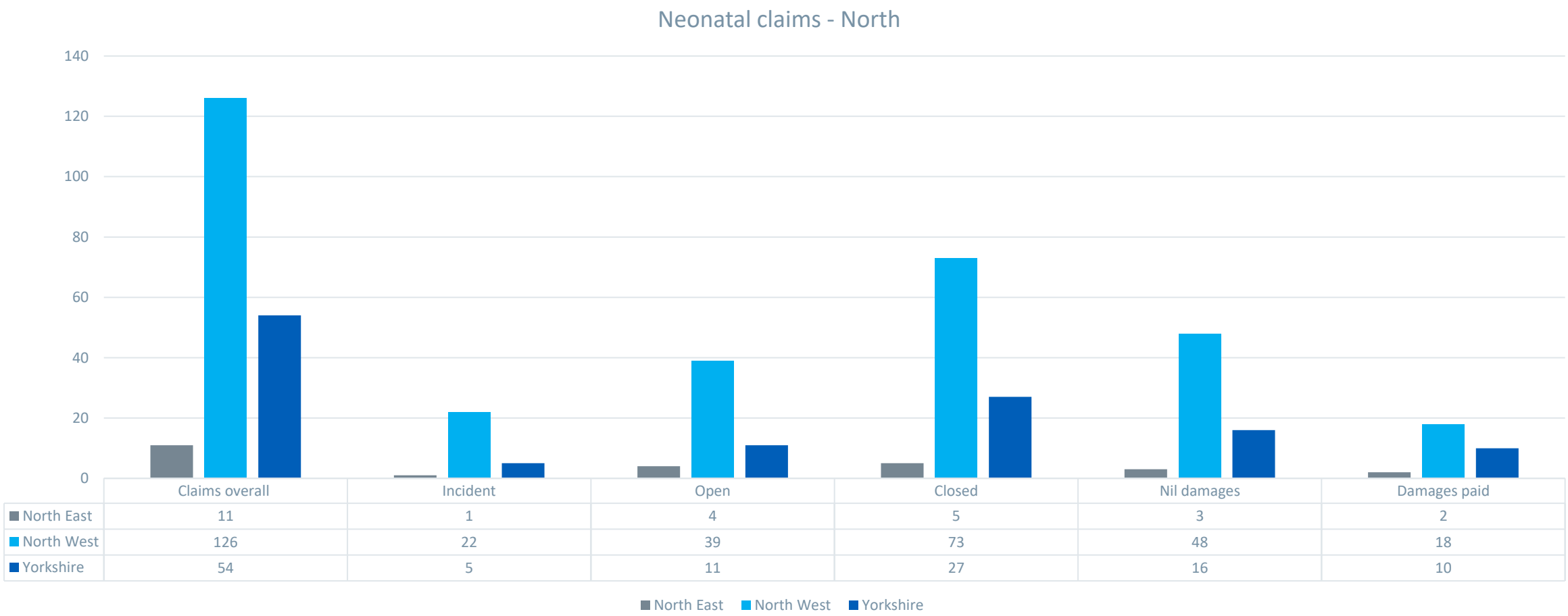
Maternity Schemes Evaluations

National and Regional Data for Maternity and Neonatal Claims

Victoria Wilkins
Associate Safety and Learning Lead (North)

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

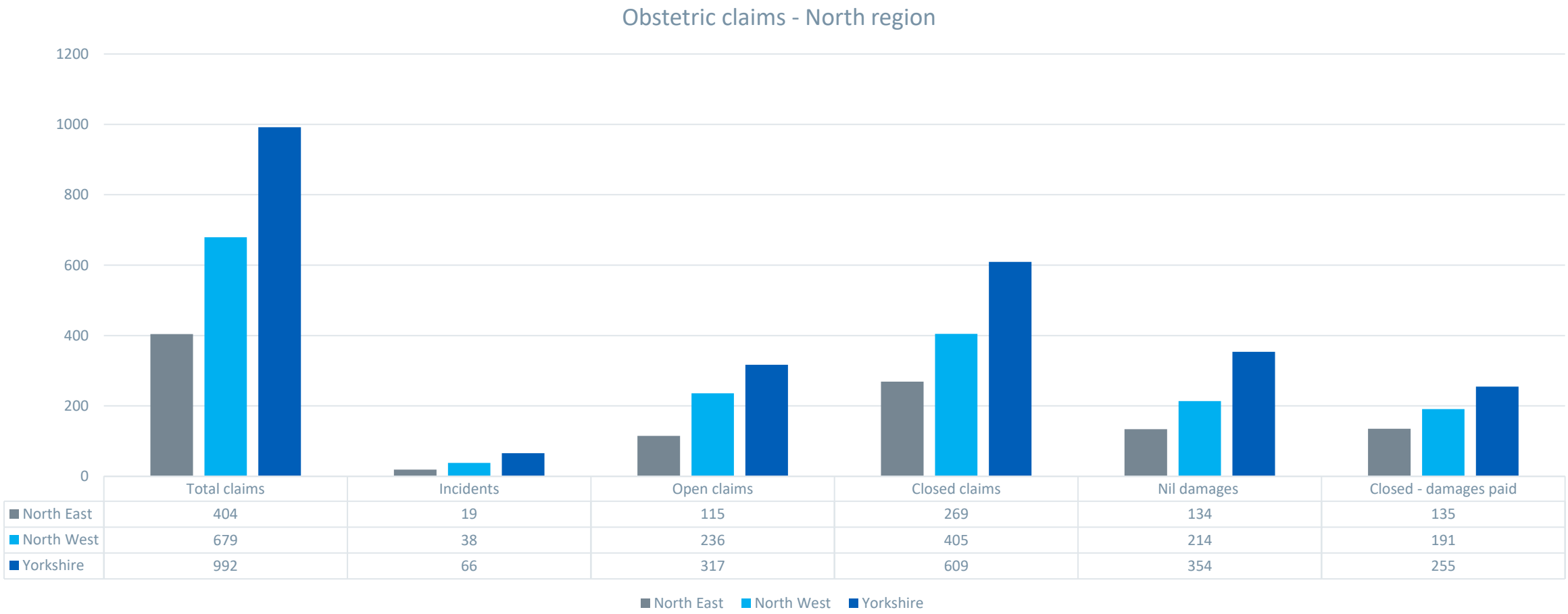
North West
- Infection – not recognised soon enough
- Wrong patient, wrong or no test carried out or wrong report read or misinterpreted
- Wrongly sited TPN/UVC lines

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

Neonatal considerations:

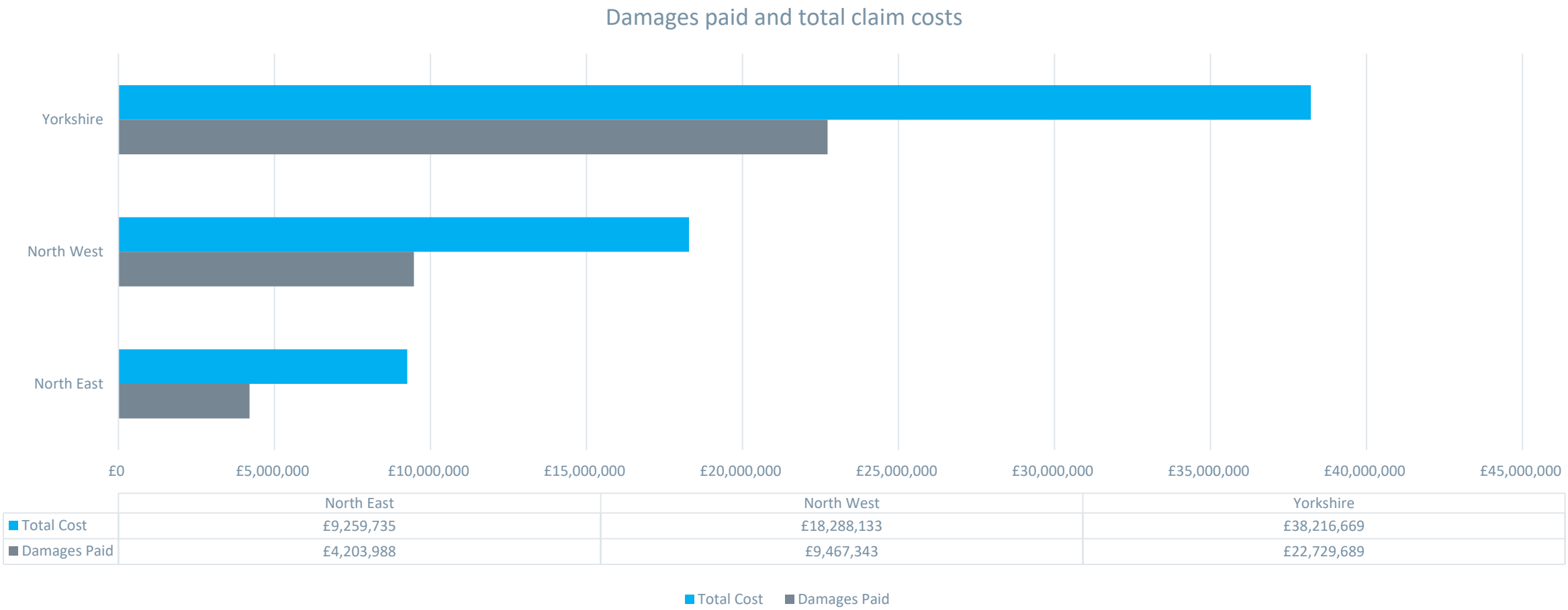
- First checks – supervision, competence, escalation
- NIPE – competence, skill, escalation
- Identification of patient – when testing, double checking of verbal and written reporting information, double checking identity for procedures
- Where are the gaps? What are the mitigations?
- Identification bands/security tags/cannulas – daily checks? Who is responsible for checking?

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 – Yorkshire

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

Yorkshire - Top 5 Causes by VOLUME		Volume	Value
1	Fail/Delay Treatment	63	£7,740,108
2	Fail/Delay Diagnosis	37	£1,534,443
3	Fail to Recog. Complication of	26	£1,491,116
4	Inadequate Nursing Care	24	£354,058
5	Fail to Monitor 2nd Stage Labour	20	£1,032,547

Yorkshire - Top 5 Injuries by VOLUME		Volume	Value
1	Stillbirth	65	£2,915,253
2	Unnecessary Pain	47	£852,241
3	Additional/Unnecessary operation	41	£1,966,904
4	Fatality	34	£3,482,698
5	Pressure Sores	23	£262,000

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:

Fail/Delay diagnosis

- Patient contacted triage at 40+2 weeks gestation to report SROM.
- Patient also had period type pain and irregular tightening's.
- 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.

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 on the bed, clammy skin and severe abdominal pain.
- Patient taken to theatre – 5cm x 4cm placental lobe and membranes removed.

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 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:

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.
- 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.

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

DAC BEACHCROFT

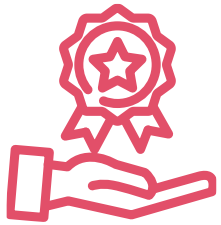
CONSENT UPDATE

Maternity and Neonatal Collaborative

29 January 2025

Emily Senior
Partner
Clinical Risk

Support for Clinical Teams



Act on claims for alleged clinical negligence against NHS Trusts, private practitioners (including GPs and dentists)

HCPL team advise on regulatory issues and Inquests

The Basics

- Right of all patients to be involved and supported.
- Give the patient the information they need to decide what treatment or procedure they want, if any
- Individualistic approach
- All reasonable treatment options to be included
- Material risks to be discussed
- A two-way conversation
- Presumption of capacity
- Written and recorded

Legal Background

- A move away from medical paternalism
- *Montgomery v. Lanarkshire Health Board* [2015] – Supreme Court
- Question: Was a doctor negligent in not informing a pregnant diabetic woman that there was a 9-10% risk of shoulder dystocia during vaginal delivery?
- Answer: YES
- *"The doctor is therefore 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.***"
- 'Materiality':

  "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."

Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 11

- The *Montgomery* test:
  - Did the doctor explain the risks that:
    a) An objective reasonable person would attach significance to (objective limb); *and*
    b) The particular patient would attach significance to (subjective limb)?
- *Both* limbs must be satisfied to discharge your duty.
- *Bolam* no longer has a role to play when considering what risks should have been discussed with a particular patient.

Reasonable treatment options

Reasonable alternative treatments

- *McCulloch v. Forth Valley Health Board* [2023] – Supreme Court
- Question: Was a doctor negligent in not discussing NSAIDS for a history of chest pains on the basis that they didn't judge it appropriate to do so as the patient was not in pain?
- Answer: NO

Reasonable treatment options

- The *Bolam* test still applies to the question of reasonable alternatives:

- *"[A medical professional] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art…Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view."*

- When a doctor decides that only some of the possible treatment options are reasonable and that view is supported by a reasonable body of medical opinion, the doctor is not negligent

- You are *not* necessarily required to disclose each and every possible treatment option if not reasonable

Montgomery clarification

Informed consent in the real world – a selection of post-*Montgomery* cases

- *Duce v. Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307
  - A clinician is not required to warn of a risk of which s/he cannot reasonably be taken to be aware.
- *Tamsin v. Barts* [2015] EWHC 3135 (QB)
  - No obligation to advise of the risks of fetal blood sampling because they were negligible
- *A v. East Kent Hospitals University NHS Foundation Trust* [2015] Med LR 262
  - No obligation to warn patients about risks that are theoretical and not material
- *Webster v. Burton Hospitals NHS Foundation Trust* [2017] EWCA Civ 62
  - Even if there was evidence of the benefits to not intervening, mother's clear factual evidence was that she would have wanted delivery. Maternal choice.
- *Bayley v. George Eliot Hospital NHS Trust [2017] EWHC 3398 (QB)*
  - Ilio-femoral venous stenting not a 'reasonable alternative' at the time

Does more precise language assist?

- *Thefaut v. Johnston* [2017] EWHC 497
- What degree of information needs to be given about the risks *and benefits*?
- *"…there should be at least a 90% chance of ridding you of your leg pain…I think that there is every chance that your back pain will settle as well."*
- Experts agreed that the chances of improving leg pain were c. 85% and chances of improving back pain were no higher than 65%.
- Conclusion : resist percentages!
- Suggestion that a reduced consent process was necessary because the Claimant was a midwife was rejected

Claims Data – Informed Consent

What themes do we see?

- Induction of labour using oxytocin (VBAC/uterine rupture)
- Progression to emergency caesarean with associated injuries
- Forceps injuries to baby
- (Neonatal feeding support)

Examples of consent issues

- **Records**
  - Is there a documented process?
  - Is a signed consent form enough?
  - Is verbal consent enough?

- **Timing**
  - Has patient had an opportunity to digest the information given?

- **Information given**
  - Is there a leaflet?

- **Options**
  - Has the patient been fully informed?

Challenges with consent

- Subjectivity – do you know your patient?
- Emergency scenario
- Language
- Cultural sensitivity e.g. feeding support
- Level of understanding

Where does AI fit in?

AI being used in the care pathway

AI being used to improve documentation
e.g. GOSH Tortous Assistant to transcribe appointments

How to reduce the risk of a claim for failure to obtain informed consent

- Be familiar with the legal framework and up to date law
- Consent is often a process- start early
- Avoid assumptions about previous care
- Is it recorded?
- Has all the information been given?
- Is the patient aware of the options?
- Do you know your patient?

Further Information

GMC Guidance on consent

- https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent

NHS Resolution

- https://resolution.nhs.uk/resources/the-benefits-of-supported-decision-making-consent/
- https://resolution.nhs.uk/resources/nadines-story-consent/
- https://resolution.nhs.uk/resources/an-introduction-to-nadines-story/

DAC Beachcroft LLP: Collections page

- https://www.dacbeachcroft.com/en/gb/collections/clinical-negligence/

Contact Details

Emily Senior

Partner – Clinical Risk

T: +44 (0) 113 251 4860
M: +44 (0) 7805 763 968
esenior@dacbeachcroft.com

dacbeachcroft.com

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NHS Resolution

Patient Voice

Nasrin Ali

Maternity Complex Care Panel

Bradford Teaching Hospitals
NHS Foundation Trust

What is the ‘complex care panel’?

Multi-disciplinary care planning for women and birthing people with complex social needs.

This includes:

- Safeguarding concerns
- Substance abuse
- Mental health
- Homelessness/housing issues
- Learning disability, difficulties and neurodiversity
- Physical disability

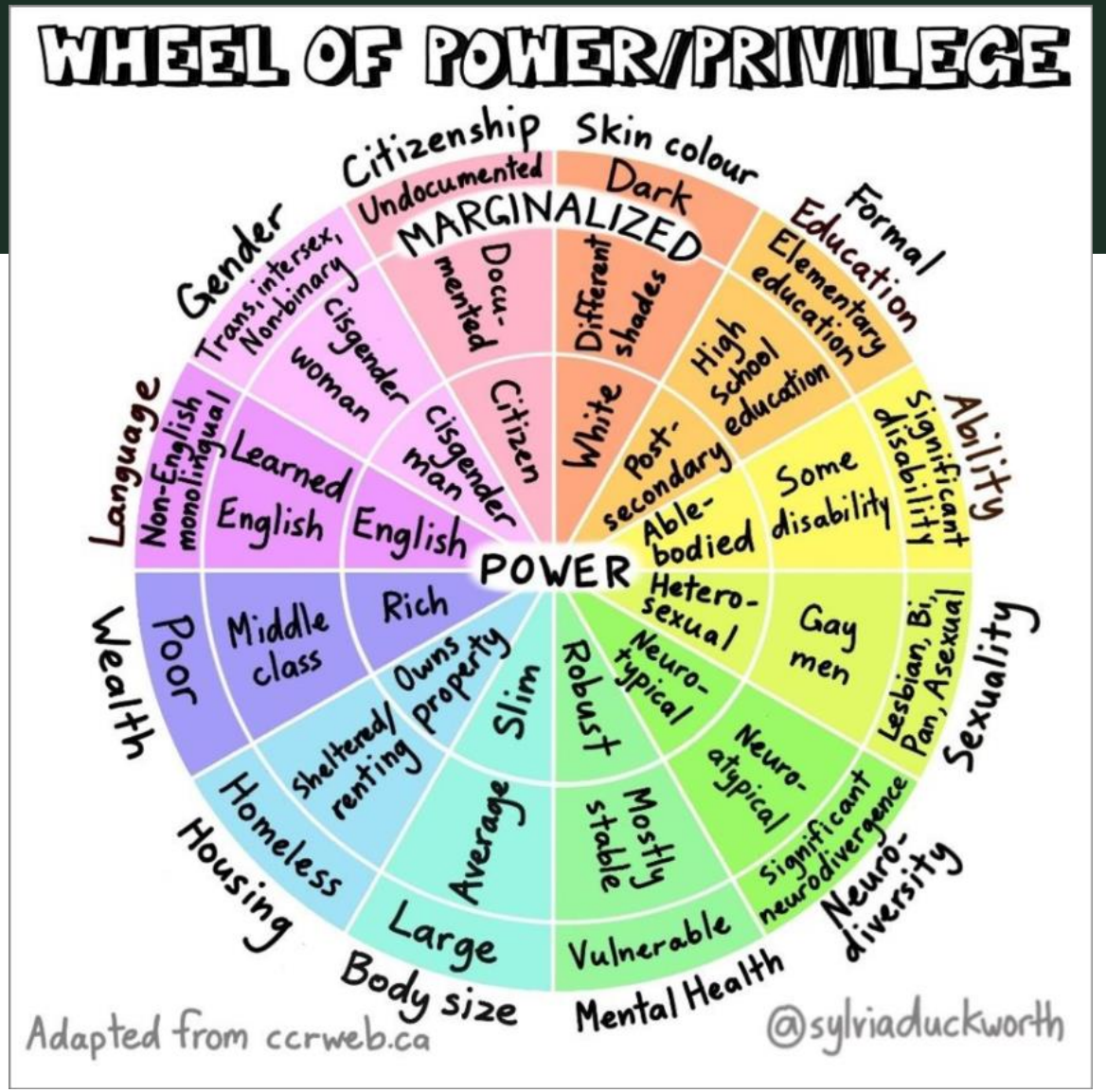
Aims

- Recognition of the increasing complex needs of women accessing maternity services by taking an MDT approach to planning care
- Support community midwives and offer a space for supervision/awareness in risk assessing and planning complex care
- Directing the most appropriate women to Acorn, Birch, 1:1 Parent Education in line with their capacity
- Making best use of local support services for the family's needs
- Meet national and local agendas for safeguarding and complex care

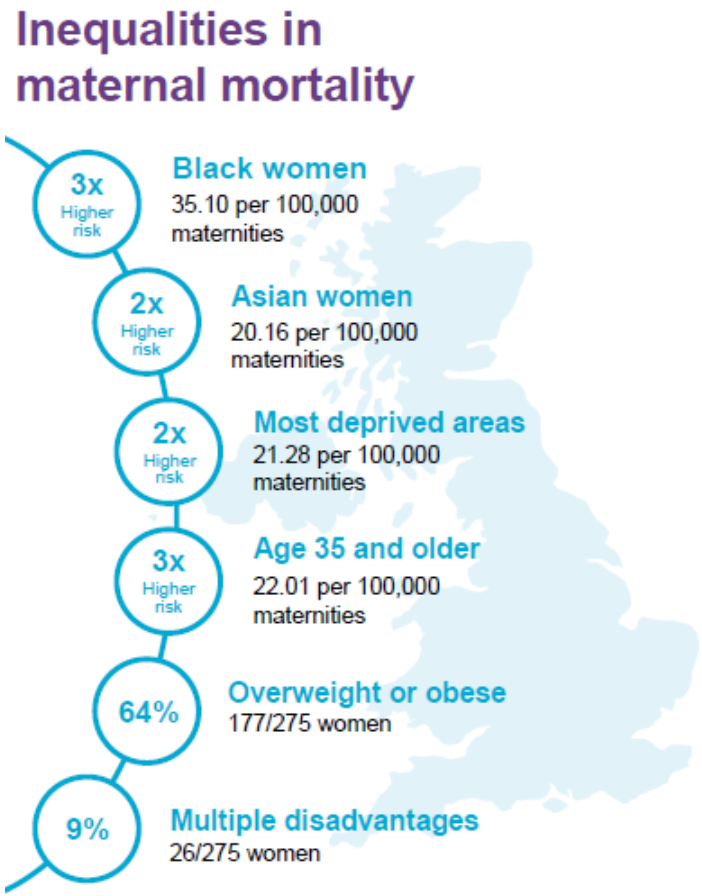
Disparities in healthcare

One study found 38% of people with a learning disability died from an avoidable cause, compared to 9% without a learning disability

Average life expectancy for people experiencing homelessness is 45 for men and 43 for women. (UK average is 79.4 for men and 83.1 for women)



Impacts on maternity outcomes

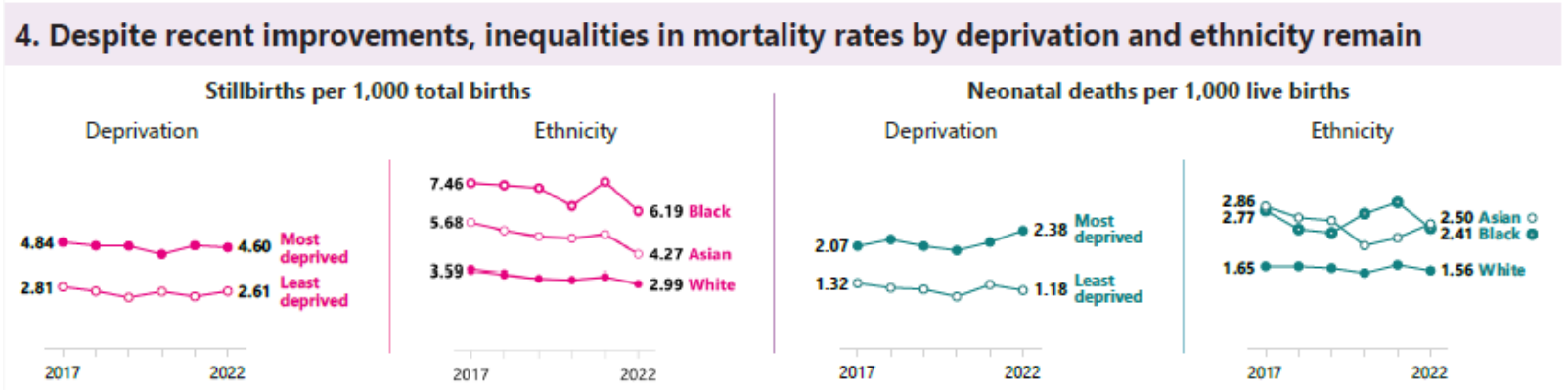


(Felker et al on behalf of MBRRACE- UK, 2024)

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

***Multiple disadvantages include:**

Substance abuse
Mental health diagnosis
Domestic abuse
Childhood abuse
Asylum seeker or refugee
Learning difficulties



(Gallimore et al on behalf of MBRRACE- UK, 2024)

Position Statements

RCM Position Statement – "**A growing body of evidence suggests that women who experience severe and multiple disadvantage during pregnancy are more likely to experience poor maternity outcomes and more likely to report poorer experience of maternity care**"

RCOG Position Statement – "**Understanding and responding to how the wider contexts of women's lives shape their health is crucial to sustainably addressing health inequalities across the life course and supporting reproductive opportunity, choice and outcomes.**"

Birch Clinic and Acorn Team

Antenatal clinic for perinatal mental health

Joint obstetric and midwife care planning

Close liaison with BDCT mental health services including Specialist Mother and Baby Service

Birch Criteria

Previous or current psychiatric disorder requiring input from community mental health team or psychiatry

A history of inpatient mental health care

Current/previous history of psychotic illness, schizophrenia, bipolar

Current severe depression, anxiety or trauma (review GAD/PHQ score)

Recent suicide attempt/self-harm (within the past 2 years)

First degree relative with bipolar disorder or postpartum psychosis in absence of personal illness

Acorn Criteria

Substance / Alcohol Misuse
Any misuse of drugs / alcohol / legal highs / prescription drugs in addition to:
Chaotic lifestyle
Previous children removed
Crime to fund habit
Partner who also misuses substances / alcohol
Exclude if: in receipt of a regular prescription eg. Methadone and coping well; no other issues; children reside with parents; settled lifestyle & good support network.

Complex Mental Ill Health
Current inpatient

Asylum Seekers / Homeless
Living on the streets
Residing in a hostel / squat / crash-pad
In supported accommodation (due to MH, LD)

Learning Disability or Physical Disability (PD)
Diagnosed with LD and:
Known to Waddiloves
LD or PD affecting ability to parent / self-care
Partner also diagnosed with LD or other complex needs

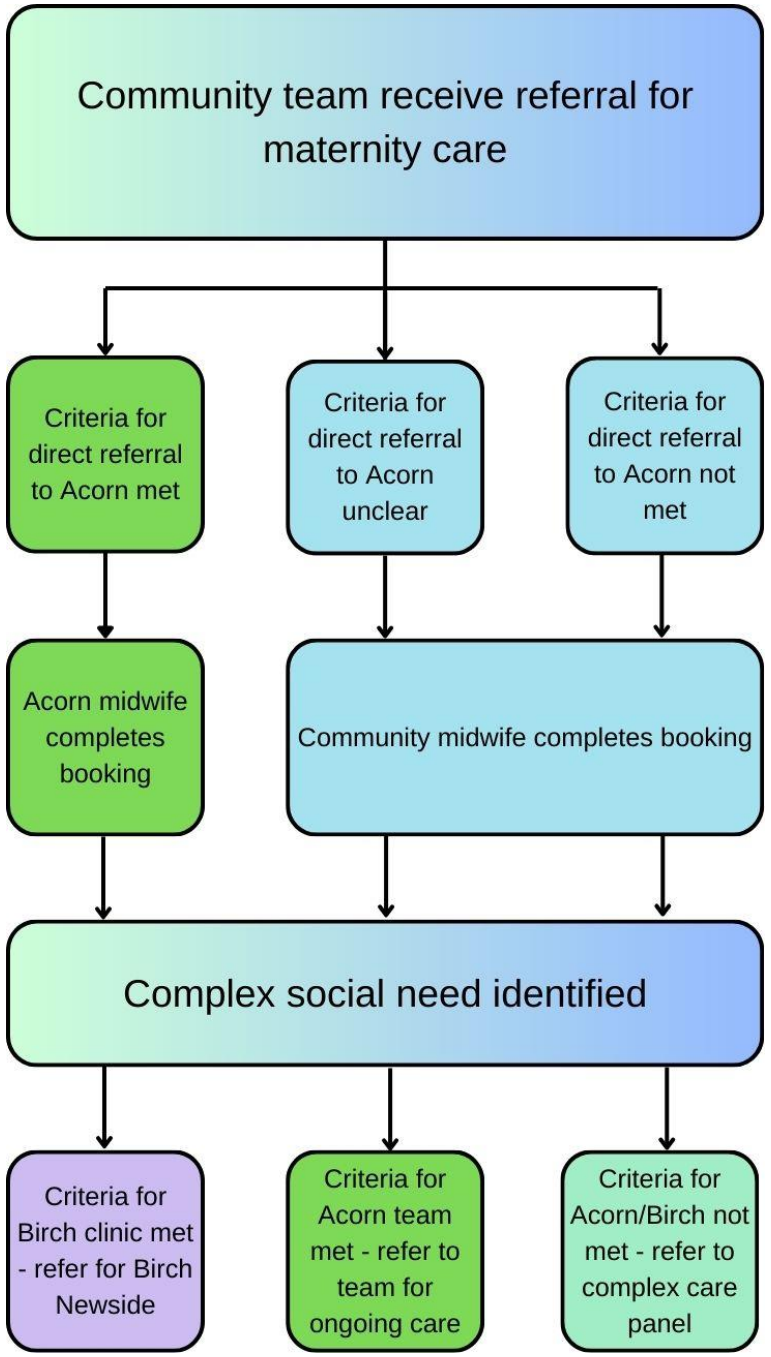
Complex Safeguarding
Victim of sexual exploitation, for example:
CSE / sex worker / rape or sexual abuse victim with on-going psychological damage
Victim of trafficking / modern slavery

Continuity of midwifery care team

Caring for women and families with a range of vulnerabilities

Small caseload, flexible appointment locations and named midwife

Referral Pathway



Panel Meeting

- Fortnightly meetings
- Aim for representation from maternity colleagues in mental health, safeguarding, parent education, obstetrics, Acorn team and community managers
- Review history and referral
- Recommendations made to community midwife for implementation by 16 weeks (or next antenatal appointment if late referral)

Case Study 1 – Acorn

G2P0 (1x miscarriage) - 22 years old

Born in Slovakia, Roma ethnicity – spoke and understood one specific Slovakian dialect

Social complexities - hearing loss, learning disability, extensive safeguarding concerns with both her and partner's family

Maternity input – Acorn team midwife, obstetrician, parent education midwives, specialist midwife, Learning Disability Nurse

External services – Children's social care, adult social care, Waddilove's LD service

Development

- Women choosing homebirth outside of guideline or against medical advice were added to the complex care panel in August 2024
- Provides supervision for community midwives managing care that would normally be outside their scope of practice
- Obstetric or neonatal oversight of the potential risks where direct conversations have been declined by the birthing person
- Holistic consideration of the woman's needs with involvement of specialist midwives

Case Study 2

G13 P7-. 40 y/o essential hypertensive 35/40. Declining obstetric input and planning homebirth against medical advice. Considering freebirth/no midwifery care until birth imminent. Declines all routine labour care. Supported by a doula.

History: NVD, CS then 5x VBAC. SGA <10th, preterm 35/40, LGA >98th, shoulder dystocia, GDM, laparotomy - ovarian torsion, sepsis and ICU long stay.

Case discussed at panel.

Audit

70 referrals/cases discussed between April 2024 and January 2024

Referral by category	**Count**	**%**
Mental Health	44	63%
Safeguarding (including domestic abuse)	35	50%
Homebirth against medical advice	7	10%
Physical Disability	7	10%
Substance Abuse	7	10%
Learning Disability	6	9%
Housing/Homeless	5	7%
Recent Migrant	1	1%
Referrals with more than 1 complexity	24	34%
Total referrals	**70**	

Gestation at referral	**Count**	**%**
0-12	31	49%
13-28	21	33%
28-40	10	16%
Postnatal	1	2%
Total (excluding homebirths)	**63**	

Transferred to community team	**Count**	**%**
Yes	30	43%
No	30	43%
Already under continuity team	10	14%

Future Plans

- Continued promotion to increase referrals
- Roll out attendance for community midwives on a rotational basis as part of their safeguarding training/supervision
- Embed the referral pathway into the booking form
- Service evaluation

Any Questions?

Thank you for listening

Scenario based panel discussion

Panel members (Yorkshire)

- Nicola Cawley
- Sean Doherty
- Nasrin Ali

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.

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 variable 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.
- Patient perspective – waking from a GA and baby is not with you

Discussion:

- Clinical – as a consultant you are unaware until the situation is escalated to you. Concerns: non recognition of labour, incorrect categorisation of CTG, quality of fresh eyes
- Legal – Causation - timing of delivery – can it make a difference?
- 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 – 5 mins

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?

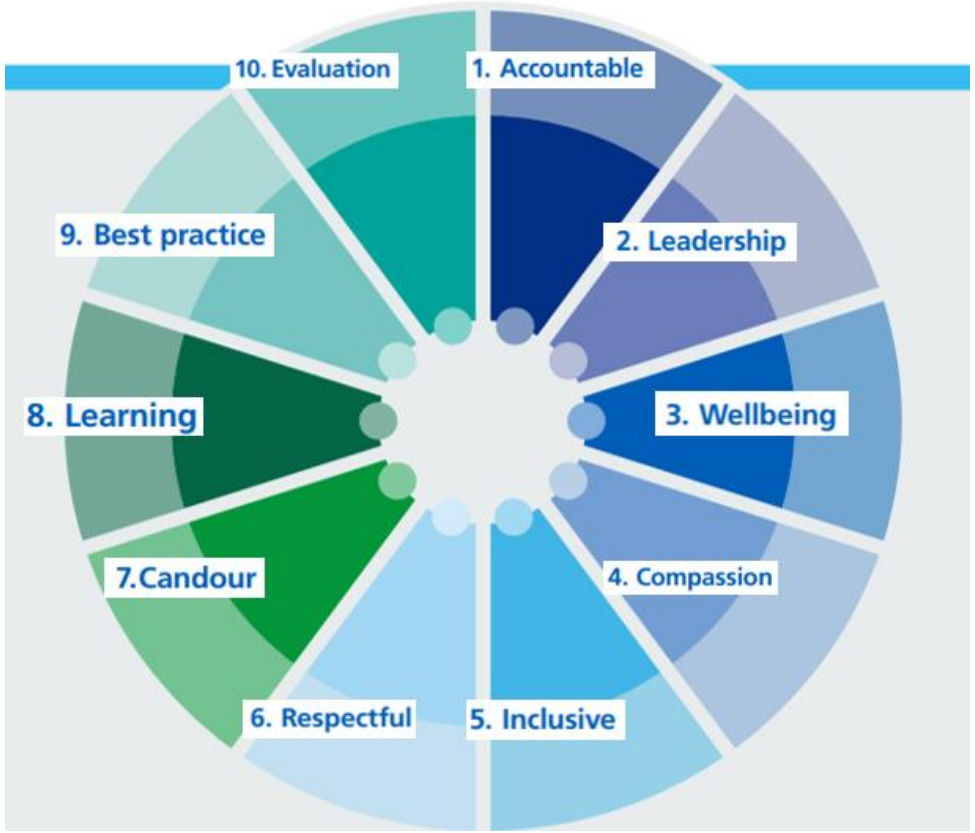
SCAN ME

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:



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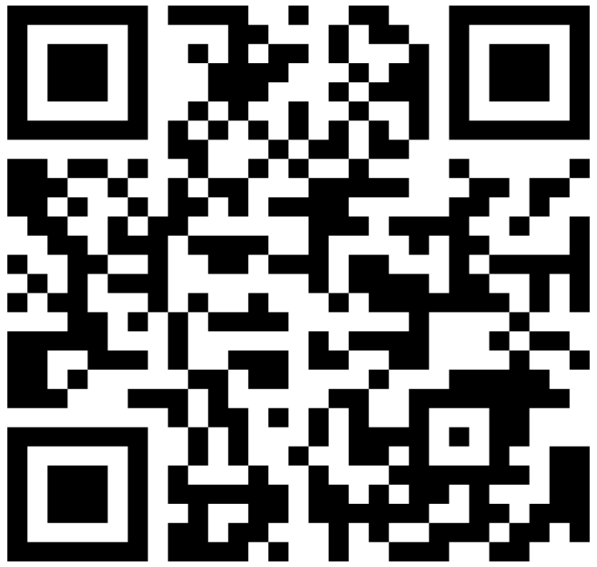
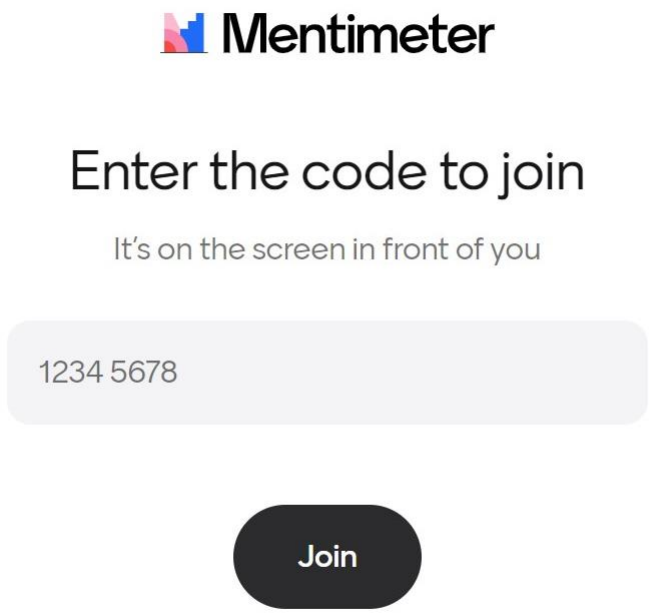
- www.menti.com
- Code: **3837 2811**





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?

PSIRF + Just Culture

Dr Lizzie Sweeting
Improvement Academy

Improvement Academy

Second Victim Support

YQSR
Yorkshire Quality and Safety Research Group

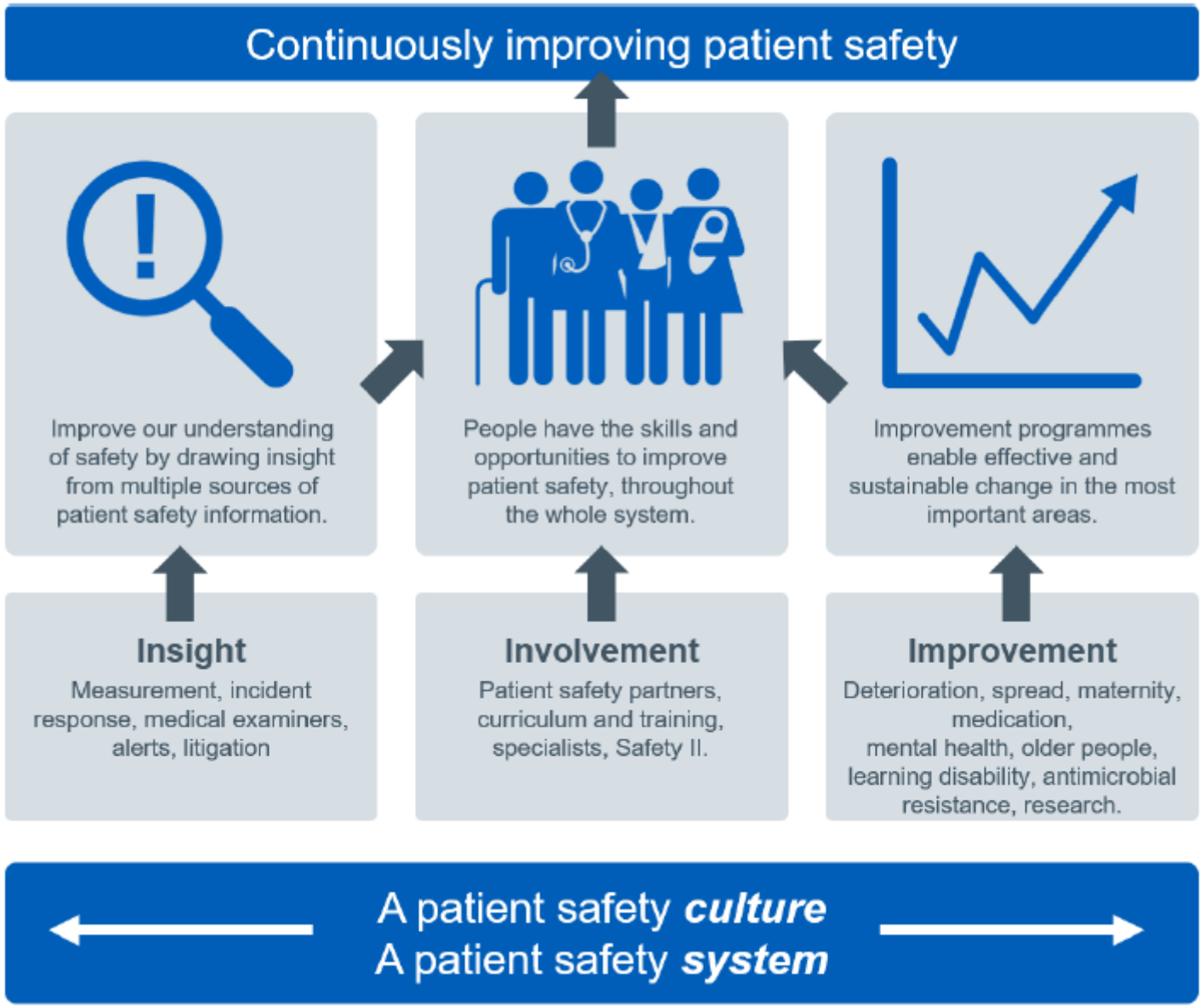
Learn Together
Supporting involvement after safety events in healthcare

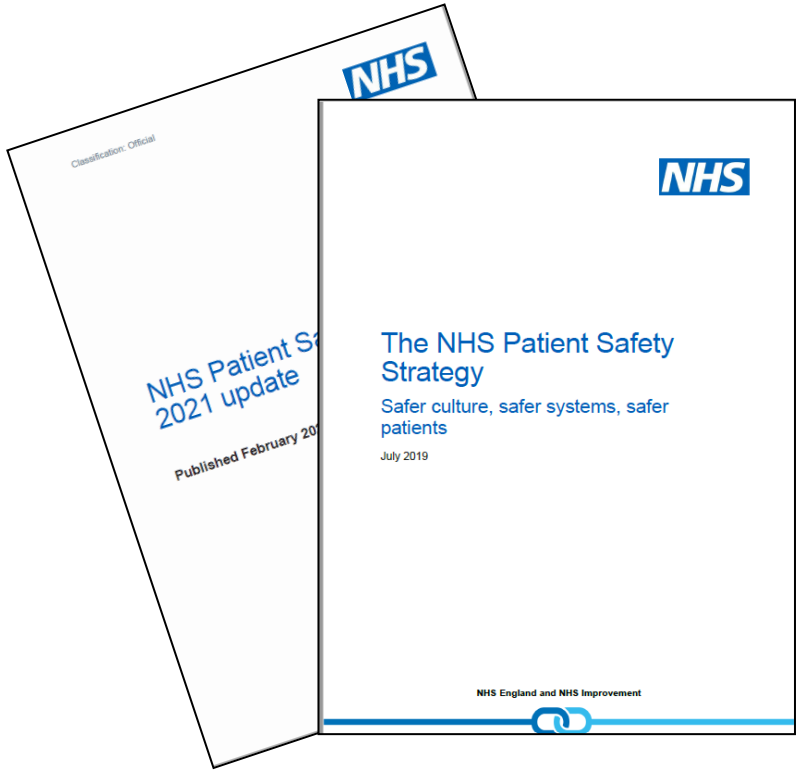
Aims and objectives

- To improve understanding of PSIRF and why we have changed our approach to investigations

- To consider what is needed to support just and learning culture

National Patient Safety Strategy





"from talking about harm to talking about safer systems that provide the right care, as intended, every time and learning from what works, not just what does not."
Aiden Fowler

Person vs System View of Incident Causation

Old View (Person Focus)	New View (System Focus)
Sees ‘human error’ as the cause of trouble	Sees ‘human error’ as a symptom of deeper trouble
‘Human error’ is an acceptable conclusion of an investigation	‘Human error’ is only the starting point for further investigation
Says what people failed to do	Tries to understand why people did what they did (without hindsight bias)
Says what people should have done to prevent the outcome	Asks why it made sense for people to do what they did (local rationality principle)

Dekker, S. (2014). “The field guide to understanding human error” 3rd edition, extended, re-organized, simplified. Boca Raton, FL London New York: CRC Press

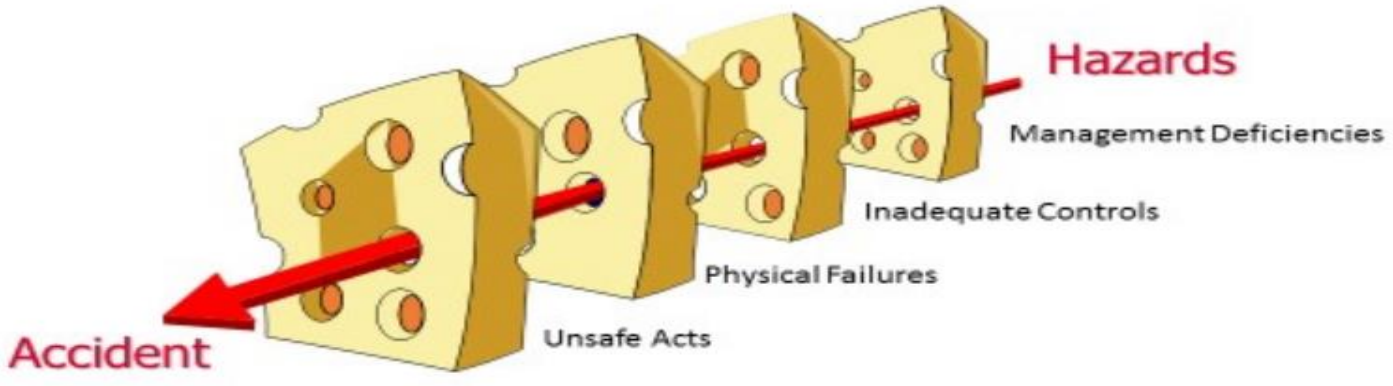
Why is a Systems Approach Better?

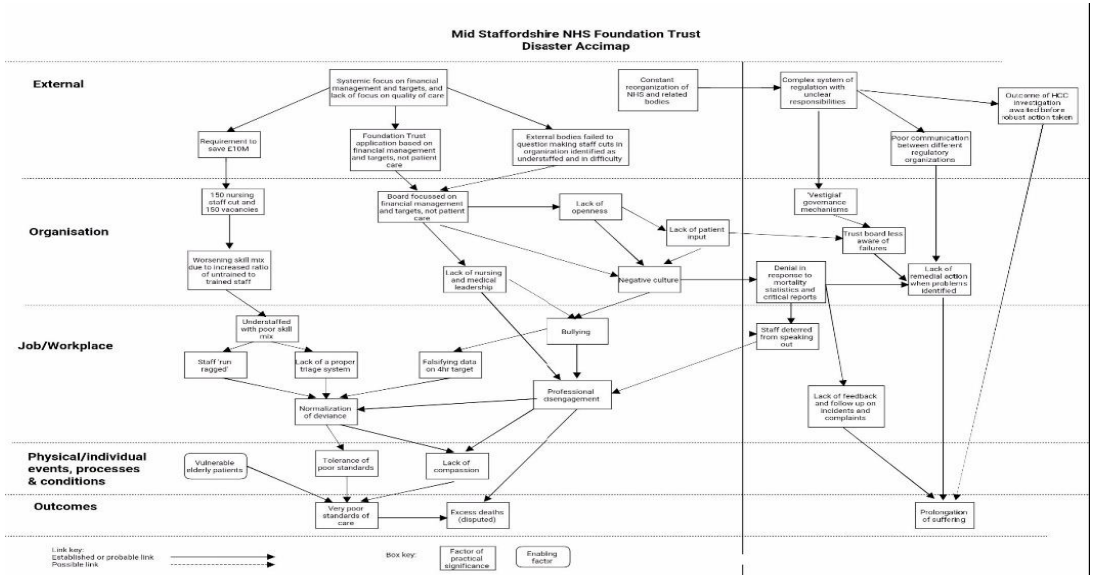
- A person-based approach does not give a comprehensive understanding of the incident
- Help us understand complexity
- Action plans that focus on individuals tend to have limited reach, limited longevity, and limited effectiveness
- Action plans that focus on the system are much more likely to be effective
- Just culture – we should not blame people for being unfortunate enough to work in a poorly designed and/or overloaded system

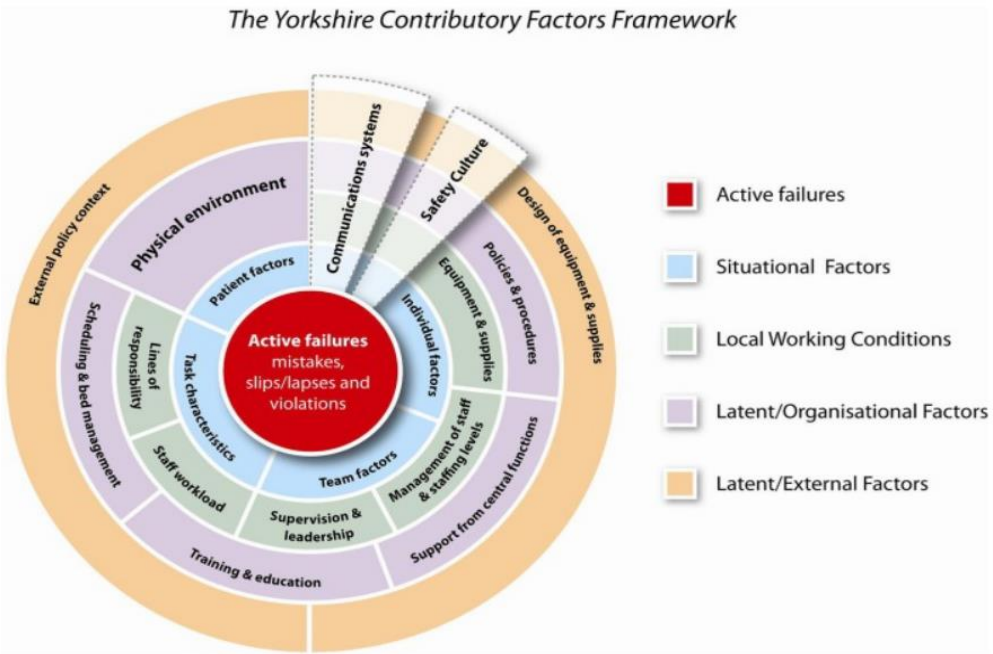
Mind Your Language

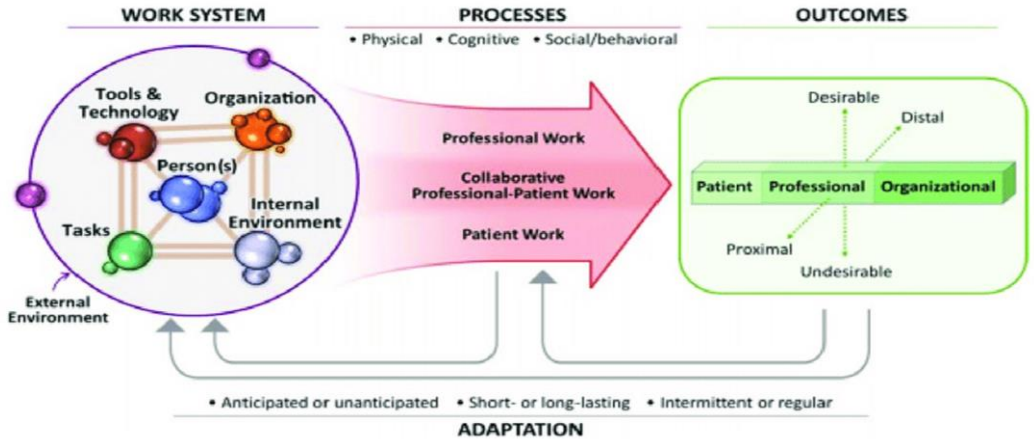
- In a systems approach, use neutral non-judgemental language
  - E.g. “procedure X did not…” as opposed to “person y failed to…”
- Avoid/caution use of the word ‘cause’, refer to contributory factors and findings instead
- Avoid ranking contributory factors
- Avoid counterfactual reasoning* – this ignores the complexity of the situation at the time

Systems Models of Incident Causation









Based Upon:

Just Culture:

- *“A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system **to learn** without fear of retribution”* N. Williams

Involvement:

- Aims to ensure that patients, staff, and our partners have the skills and opportunities to improve patient safety

Why is This Needed?

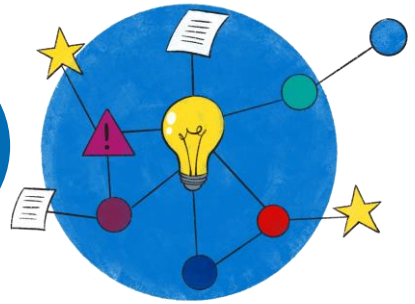
- Years spent investigating – did we really make things safer?
- Do we really learn what has gone wrong (or right)?
- Do the actions address the real problems identified?
- Do we include patients and families as well as we could?
- Do we support staff well?

- Need to free up resources to focus on making the improvements needed

Effective Learning and Improvement

Compassionate engagement and involvement of those affected by patient safety incidents

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



Considered and proportionate responses to patient safety incidents

Supportive oversight focused on strengthening response system functioning and improvement

What does PSIRF hope to achieve?

Improved use of resources:

- Moving away from ‘reactive’, hard to define or arbitrary thresholds for Serious Incidents.
- Proactive resource planning based on a thorough understanding of patient safety incident profiles and ongoing improvement activity.

Broadened approach to learning:

- Promoting a range of methods for responding to and learning from patient safety incidents.
- Timelines are more flexible and set in consultation with the patient and/or family – removal of 60-day deadline.
- Quality of response and resulting improvement work is the priority.

Improved experience for those affected:

- Expectations are clearly set for informing, involving, and supporting those affected by patient safety incidents, particularly patients, families, and staff.
- Aligned with ongoing research around improving patient and family involvement.

Strengthened governance and oversight:

- Commissioners and local system leaders assure plans and systems for generating insight from incidents and delivering improvement.
- Provider boards are accountable for individual report sign-off rather than bureaucratic submission to commissioners.

In Summary

- PSIRF is based on a just and learning culture and supportive involvement of all
- It is needed because we have spent years and lots of resource investigating but had limited success in making things safer
- It aims for considered and proportionate responses, compassionate engagement, uses systems approaches to learning and making improvement and supportive oversight
- Providers have more autonomy to decide what to investigate and how best to elicit learning from events
- Quality improvement methodology to ‘fix’ the problems identified

Some Useful Terms

Open Culture

- Staff feel comfortable discussing patient safety incidents and raising safety issues with both colleagues and senior managers

Just Culture

- Staff, patients and carers are treated fairly, with empathy and consideration when they have been involved in a patient safety incident or have raised a safety issue

Reporting Culture

- Staff have confidence in the local incident reporting system and use it to notify healthcare managers of incidents that are occurring, including near misses
- Barriers to incident reporting have been identified and removed:
  - Staff are not blamed and punished when they report incidents
  - They receive constructive feedback after submitting an incident report
  - The reporting process itself is easy

Learning Culture

- The organisation:
  - Is committed to learn safety lessons
  - Communicates them to colleagues
  - Remembers them over time

Informed Culture

- The organisation has learnt from experience and is able to identify and mitigate future incidents because it:
  - Learns from events (for example, incident reports and investigations)

Definition of Just & Learning Culture

- ***"To have confidence as a member of staff or a patient that when things go wrong, support for everyone will be the primary goal and that learning for improvement will be pursued with openness and transparency."***

  Improvement Academy and Patient Safety Translational Research Centre

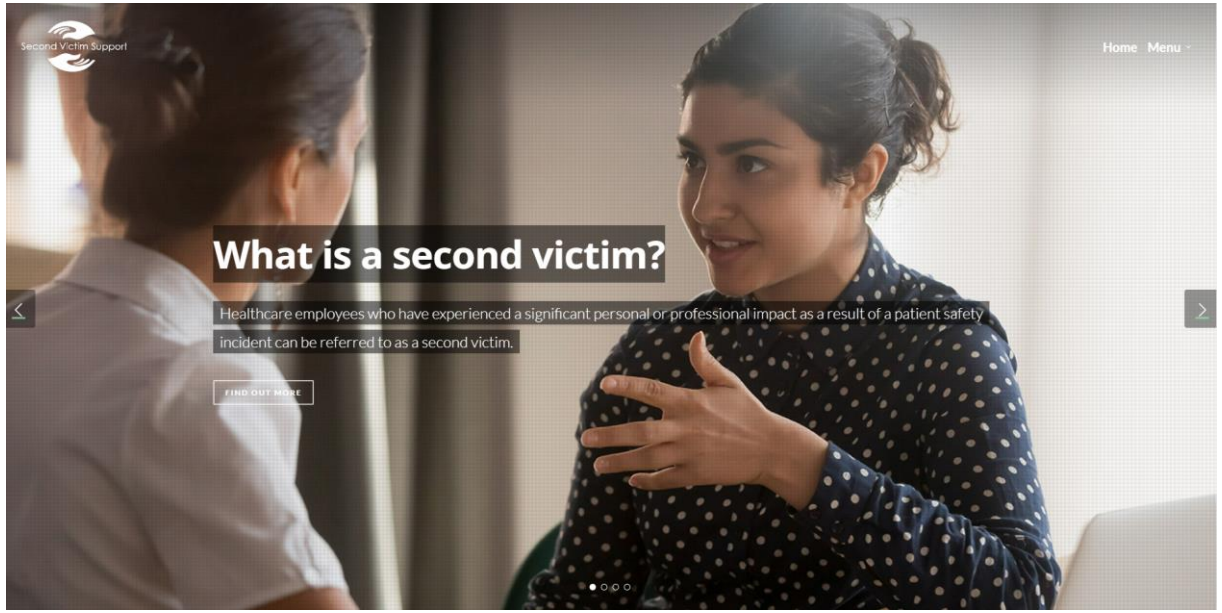
A Just & Learning Culture Approach

- Duty of Candour carried out
- Assess the needs of ALL those involved
- Ask staff members their insights into how to prevent this happening again/involve staff in QI
- Be open and honest with the patient and family during the investigation
- Work to improve the culture of the department
- Work to improve the system as a whole

What About Accountability?

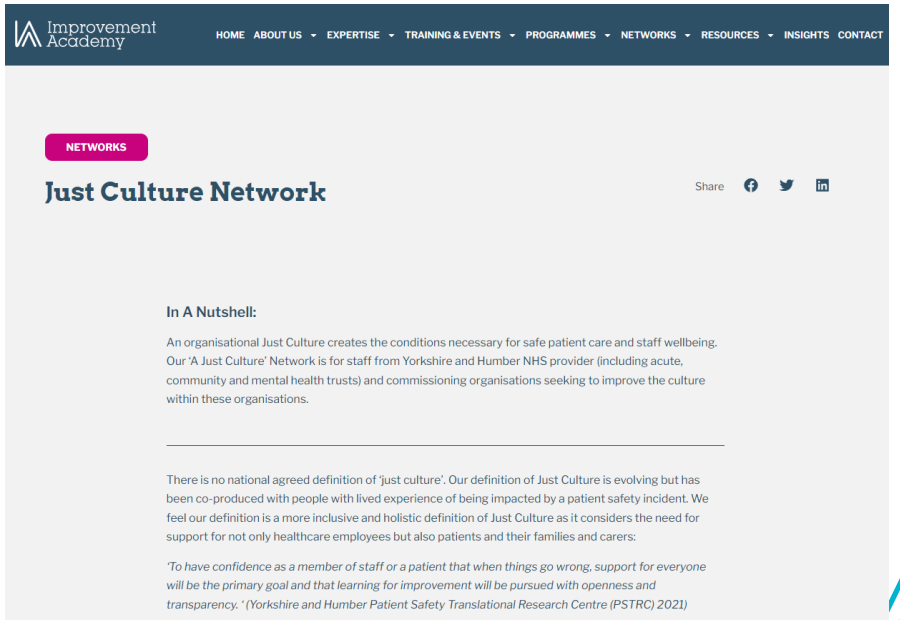
- A Just & Learning Culture does not remove accountability
- A Just & Learning Culture starts by acknowledging that fallibility and imperfection are human conditions
- An organisation with a Just & Learning Culture will establish a positive learning climate for **all staff** to benefit and learn from these mistakes

Second Victim and Just & Learning Culture



- Second Victim:
  - https://secondvictim.co.uk/

- Just Culture:
  - https://improvementacademy.org/networks/a-just-culture-network/



Upcoming training

- FREE training session
- Face-to-face

- Friday 21st February 2025
- 0900 – 1600

- If you are interested in joining, please email Academy@yhia.nhs.uk to register

Contact:

Academy@yhia.nhs.uk

@Improve_Academy

@ImprovementAcademy

Closing Speech

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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…