NHS Resolution

Maternity Conference
#SaferBirthsNHS22

Best practice response and working with families

Dr Angela Kerrigan

Consultant Midwife

Wirral University Teaching Hospital NHS Foundation Trust

Mrs Catherine Cumberlidge

Quality & Safety Lead

Wirral University Teaching Hospital NHS Foundation Trust

@NHSResolution

Advise / Resolve / Learn

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Working with families at WUTH

Catherine Cumberlidge – Divisional Quality & Safety Lead

Dr Angela Kerrigan- Consultant Midwife

together we will

Support for families following incidents

- Provision of maternity care, and related activities, is inherently ‘risky’. High area for litigation.
- Services measures to ensure safety of patients, babies, staff and public through the provision of high-quality care, to an agreed minimum standard, by competent, well-trained staff within suitable, well-maintained environments.
- When incidents happen, they can occur through human error, systems failures and other factors may contribute.
- Very important to notify the patient or family as soon as possible following the incident occurs and that they have access to ongoing support.

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Duty of Candour

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Important to promote a culture that encourages candour, openness and honesty at all levels. This is an integral part of the safety culture.

Apology, saying sorry – Regulation 20 from the Health and Social Care Act 2008 (Regulated Activities) defines an apology as an expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter. An apology does not constitute an expression or implied admission of fault or liability and is not admissible in any civil proceedings as evidence of fault or liability.

Incidents which are confirmed with a severity of moderate or above meet the criteria for Duty of Candour

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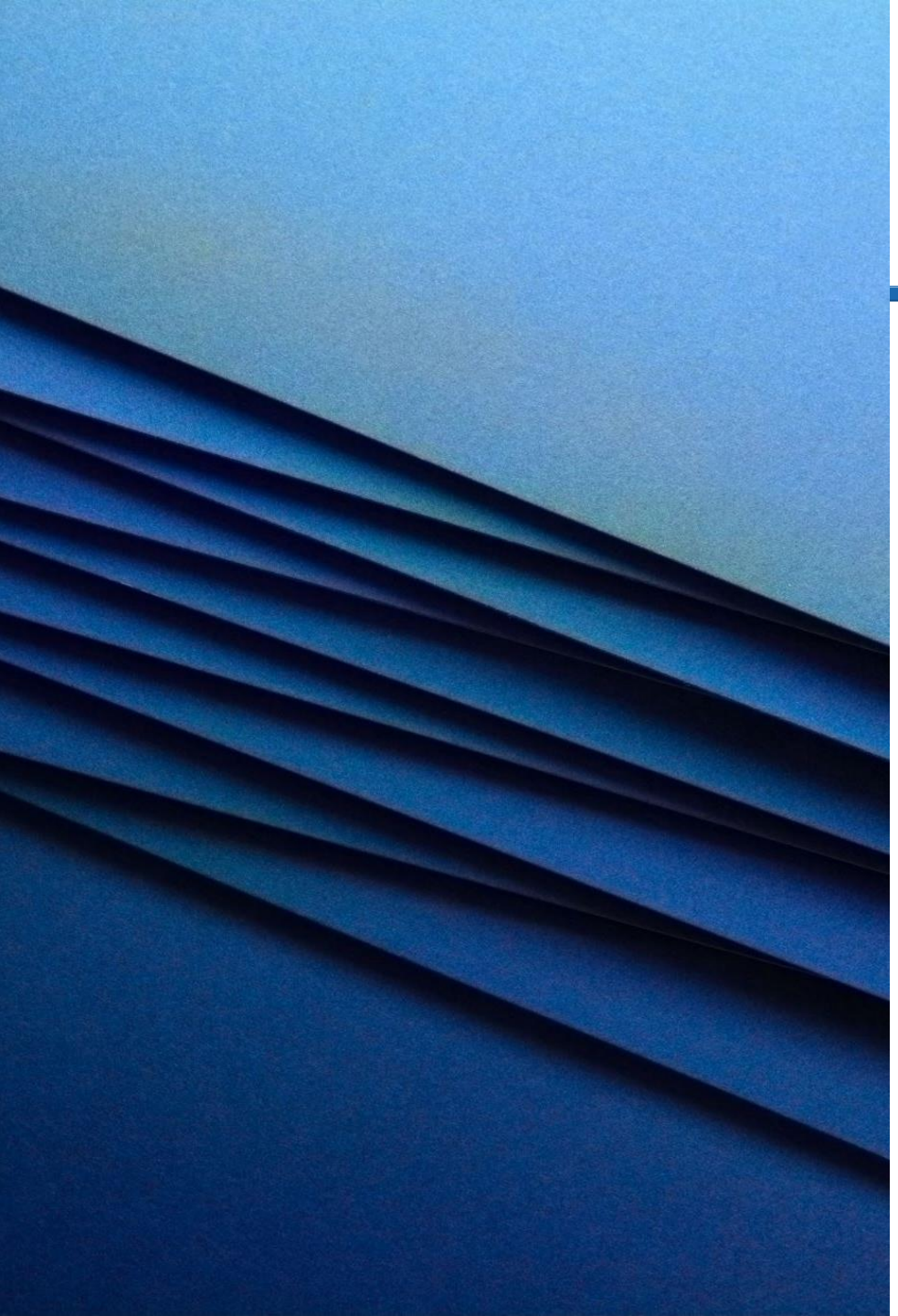

What makes an incident moderate or severe harm?

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Moderate harm – Harm that requires a moderate increase in treatment, and significant, but not permanent, harm, for example a 'moderate increase in treatment' means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another area (such as intensive care).

Severe harm – Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

Duty of Candour Process

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- The most senior health professional or nominated clinical lead for the patient is the Duty of Candour Lead. The patient or their family/carer are verbally informed (face to face and as soon as practically possible) that a suspected patient safety incident has occurred and this is followed up with a Duty of Candour letter within 10 working days of the incident being confirmed as moderate harm or above.
- The content of the Duty of Candour discussion will cover the following points:
  - An expression of genuine sympathy, regret and a meaningful apology for the harm that has occurred.
  - Current known facts about the incident (from the 72 hour review or incident form)
  - Explain that additional information may come to light as the investigation proceeds and that substantiated developments can be communicated
  - Agree how the patient and/or family/carer would like to be kept informed (a meeting may be requested)
  - Patients must be reassured that access to treatment and the continuity of their care will continue according to their clinical needs
  - They should be informed that they have the right to continue their treatment elsewhere if they prefer.

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Serious incident investigation process

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- Report incident with 5 days (1 day for serious incidents).
- CIF (clinical incident form)
- Rapid Review (presented at SI panel)
  - Within 72 hours (3 working days)
  - Multi-disciplinary panel not involved in the incident
  - Review timeline and documentation
  - Identification of any care delivery problems or omissions
  - Any immediate actions to ensure safety of patients, staff and the general public
  - Immediately learning and actions

If further investigation required:

- Hot Debrief
- Table Top
- Local Review
- Root Cause Analysis/Serious Incident investigation
- Report to StEIS within 48 hours
- Just Culture Guidance
- Nationally moving towards PSIRF in the next 12 months. National defined timescales for SI reporting are 48 hours from identification on to StEIS, rapid review within 72 hours and 60 day full investigation the other timescales are internal. These will all be revised with the trust PSIRF plans.

Engagement with families who raise concerns

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- Robust complaints process in place
- Timely response to families – staff demonstrate a caring approach that a family is waiting for a complaint response
- No complaints responses breaching the time frame
- Actions plans from complaints feed into wider Trust work – Patient Experience Strategy

Patient Experience Vision

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We care, we listen and we act

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Patient experience strategy

- Promise groups in progress – All groups multi-disciplinary.
- Task and Finish groups in progress for work to contribute to strategy.
- Meeting organised with Regional Community Engagement Lead for a project to support families that have gone through gynaecology and breast health and/or maternity services who identify as a LGBTQIA+ People / Families.

Communication with families through the maternity journey

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WIRRAL Maternity Voices

Working in partnership to improve maternity services

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Maternity and Wirral MVP

Close relationship with maternity team and MVP Chair

Live service user update and Q&A on social media

Direct communication pathway with senior midwifery team

Maternity and Wirral MVP

Quarterly listening events across Wirral

Walk and talk events

Key to success

- Close collaboration
- Funding for MVP
- Facilitating MVP Chair direct access to senior midwifery team
- Pre-empting Independent Senior Advocate role

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