NHS Resolution

Case story

Language and digital barriers to accessing maternity care and advice

Part of NHS Resolution's maternity campaign 2022/25
#ImprovingMaternityOutcomes

Advise / Resolve / Learn

Early Notification
Case story guidance

Background

In Advise, resolve and learn Our strategy to 2025, our second strategic priority is to share data and insights as a catalyst for improvement and our third is to collaborate to improve maternity outcomes. Aligned with these aims we have gathered together learning from our Early Notification Scheme and produced a number of case stories to help support learning from harm identified through claims.

These resources

Our case stories are illustrative and based on recurring themes from real life events. These experiences have been highlighted and shared with you, to help identify potential risks in your clinical area, promote learning and prevent fewer incidents like these occurring in the future.

How to use the case stories

There are various ways you may use the case stories, from individual self-directed learning to support continuous professional development to using them in a team environment. The idea is that by learning from the experience of others, maternity unit staff will be able to change their approach to care.

As you read or discuss the examples of incidents that we are sharing we ask you to consider the following:

- Could this happen in my organisation?
- What changes within my organisation or team might I consider after reading the material, including individual practice?
- What information should I share with the team?
- How can I share the learning from this case story?
- Who else needs to know?

Practical applications

1. Consider the key elements of the case story and through reflection apply the learning to influence your practice in the future.
2. Use this case study as a point of discussion at appropriate multi-disciplinary team meetings, safety huddles, and/or human factor's training.
3. Use this case study to create a multi-disciplinary simulation in the clinical area or on mandatory training.
4. Review your claims scorecard to identify whether there are any themes which relate to this case story and identify where improvements could be made.

Case Story

This case story is illustrative based on a range of examples of real events. NHS Resolution is sharing the experience of those involved to help prevent a similar occurrence happening to patients, families and staff. As you read about this incident, please ask yourself:

- Could this happen in my organisation?
- Who could I share this with?
- What can we learn from this?

Topic: Language and digital barriers to accessing maternity care and advice.

Key points:

- Language barriers are associated with a disproportionate risk of poor birth outcomes, with women and people who give birth struggling to access, engage with maternity services and communicate concerns to healthcare professionals.
- All healthcare professionals have a responsibility to ensure that they personalise care by identifying what needs an individual may have and making sure their planned care reflects this. For women and people who give birth whose first language is not English this may mean using a face-to-face or telephone interpreter and providing information in a translated format so that understanding, consent, and shared decision making are not compromised.
- While a shift to have all maternity notes in digital format aims to improve access to information, staff must ensure women and people who give birth are aware of how to navigate the application and access relevant information in a language they understand.
- Staff must ensure that women and people who give birth have access to a device that enables them to access their maternity notes. There must be processes in place to provide handheld paper notes in situations where women and people who give birth are unable or choose not to access their notes and information in digital format to ensure they are not disadvantaged.
- When individual staff phone numbers are provided as a point of contact, women and people who give birth must be made aware of alternative numbers to access clinical advice twenty-four hours a day, seven days a week. This information should also be available within the maternity notes provided and discussed at the booking and subsequent appointments.

Maternity Story

Ms A booked in her first ongoing pregnancy at nine weeks gestation. The booking

appointment took place with a community midwife at a local GP surgery. Prior to the booking appointment, the midwife was not aware that English was not Ms A's first language. An interpreter had not been arranged and a telephone interpreter service was not used or offered as Ms A appeared to understand what was being said to her. During the booking appointment the midwife ensured Ms A had downloaded the digital notes application to her smart phone and informed her of the information available for her to access, including her pregnancy record, advice relating to pregnancy and contact numbers to discuss or report any concerns. Ms A was provided with the midwife's work mobile phone number and was informed it was for non-emergency queries such as rescheduling an appointment.

The antenatal period was uneventful, and Ms A attended all of her scheduled appointments and ultrasound scans. Ms A was informed that it was important to monitor her baby's movements during pregnancy and was asked if these were normal at each appointment. On a review at a later date, it was discovered that Ms A did not access the information leaflets available on the digital application including the leaflet relating to fetal movements in pregnancy and where to access advice if a change in movements occurs.

At 37+5 weeks gestation Ms A was worried that her baby was not moving as much as usual, and she sent a text message to her community midwife on the mobile telephone number that had been given at her booking appointment. As it was the weekend, and the community midwife was not on call she did not access her work mobile. Ms A remained worried the following day and when she didn't receive a reply to a second text message, she telephoned the mobile phone number and left a voice message reporting reduced movements over the last two days. On returning to work on the Monday the midwife read the text messages and listened to the voicemail and called Ms A who said she was still worried that her baby was not moving and that she had started to experience some irregular uterine contractions. Ms A confirmed that she had not reported a change in the baby's movements via any other means or attended the hospital for assessment over the weekend. The midwife told Ms A to attend the maternity triage straight away for a fetal wellbeing assessment and called to inform staff that the Ms A would be arriving.

On arrival at triage Ms A was experiencing uterine contractions once every three to four minutes (1:3-4). A cardiotocograph (CTG) was commenced which showed a baseline rate of 150 bpm, absent variability, and no accelerations. An obstetric review was requested and the CTG was categorised as pathological, a decision was made for a category 1 caesarean section. The baby was delivered 22 minutes later.

The baby boy was delivered in poor condition. Arterial cord pH was 6.85, with a base excess of -19.2 and lactate of 10.7. Venous cord pH was 6.98, with a base excess of -16.3 and a lactate of 8.2. He required extensive resuscitation and met the criteria for 72 hours of therapeutic hypothermia (cooling). An MRI on day six showed changes associated with chronic partial hypoxia and a diagnosis of stage 3 hypoxic ischaemic encephalopathy (HIE) was made. He was discharged home receiving nasogastric feeds and on medication to control seizures, with support from the community paediatric team.

Learning points

This case highlights the importance of:

- Using professional language interpreters and translators to reduce communication barriers. Under the 2010 Equalities Act[6], people who don't speak English have the right to be provided with an interpreter when they are dealing with public sector organisations. Appropriate use of interpreter services can reduce health inequalities by improving access to care and facilitating informed decision-making[5]. It should be clear to all staff on accessing the maternity record that an interpreter is required, and additional time should be allocated for consultations[1,2].

- Providing information in a format or language that meets the needs of the individual. A person with conversational fluency in English may not be able to understand, discuss or read health related information proficiently in English. Work is progressing to enable all women and people who give birth to access their maternity records and information relating to their pregnancy in a digital format, through their smart phone or other device[5,3]. Any information or materials provided should be available in different languages or alternative formats such as printed, braille or Easy Read[1] to meet the needs of those most at risk of experiencing health inequalities[5]. Advice and information on how to access and navigate the application and report problems should always be discussed at the booking appointment, and this should be revisited at each antenatal appointment.

- If an individual on the other end of a telephone number which has been provided as a point of contact is unavailable (e.g. due to annual leave), women and people who give birth should be signposted to alternative numbers. One example could be to set up an automated response to text messages and a clear voice message for calls to inform women and people who give birth who to contact twenty-four hours a day, seven days a week to discuss any concerns.

- Checking that women or people who give birth understand who to contact at any stage of their pregnancy for advice or to discuss concerns. This should always be discussed at the booking appointment and revisited at each antenatal appointment[1]. Advice and information on how to contact the midwifery team for non-urgent advice and how to contact the maternity services about urgent concerns should be included in the discussion and supported by written information in an accessible format. Always check that women and people who give birth understand the information provided, and how it relates to them[1].

Considerations for your hospital

- Do staff have access to interpreter services at every contact and are they aware of how to arrange them?
- When an interpreter is required, are staff supported to allocate additional time that will be needed for the consultation?
- Do staff ensure that women and people who give birth have access to their digital maternity records and materials and know how to navigate them?
- Is information available in various formats or languages?
- Do women and people who give birth know who to contact to for non-urgent advice and urgent concerns?
- When individual staff phone numbers are provided, are women and people who give birth signposted to alternative numbers to access advice twenty-four hours a day, seven days a week? Is this information easily accessible? How are you currently informing women and people who give birth that an individual is on annual leave, or not available when they have been provided with their direct phone number?

What has happened as a result?

This case story is illustrative. If a similar case were to occur in real life, then it would be referred to NHS Resolution's Early Notification Scheme. NHS Resolution's in-house, specialist teams will review all available information about the care received, to decide whether there is any evidence of substandard care which could potentially result in compensation.

The expertise of NHS Resolution is used to proactively assess the legal risk and provide early support to families where liability is established.

NHS Resolution supports an open, transparent discussion between clinicians and families following adverse events[3]. The scheme is also designed to improve the experience for NHS staff by time limiting the need for protracted involvement in the legal process and rapidly share learning.

It is very important to note that no amount of money is comparable with the loss of a child or a child living with lifelong neurological injuries. Where poor outcomes occur as a result of deficiencies in care, NHS Resolution aims to resolve all such claims or cases fairly and as quickly as possible.

The current compensation cost to the NHS for a baby who has long term severe brain injury is on average £13.5 million. The human costs to the babies, families and clinical teams involved are immeasurable.

Resources:

1. Antenatal Care- National Institute for Health and Care Excellence- August 2021 Antenatal care (nice.org.uk)

2. Guidance for Commissioners: Interpreting and Translation Services in Primary Care- NHS England- 2018 NHS England » Guidance for Commissioners: Interpreting and Translation Services in Primary Care

3. NHS Resolution Saying Sorry June 2017 Saying Sorry

4. The NHS Long Term Plan- NHS- January 2019- NHS Long Term Plan v1.2 August 2019

5. Three year delivery plan for maternity and neonatal services- NHS England- March 2023 NHS England » Three year delivery plan for maternity and neonatal services

6. Equality Act- 2010- https://www.legislation.gov.uk/ukpga/2010/15/

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maternity campaign 2022/25
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