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Improving Safety in Maternity Services

Learning from Recent Independent Reviews and Implications of PSIRF

Friday 10th November 2023 **Virtual Conference**

Speakers include:

Professor Jacqueline Dunkley-Bent
Chief Midwife
International Confederation of Midwives

Professor Alex Heazell
Professor of Obstetrics
Maternal and Fetal Research Centre
University of Manchester
Clinical Director for Tommy's Stillbirth Research Centre
St Mary's Hospital, Manchester

Professor Jennifer J Kurinczuk
National Programme Lead MBRRACE
UK/PMRT Director National Perinatal Epidemiology Unit
Co-director Policy Research Unit in Maternal Health and Care
Nuffield Department of Population Health University of Oxford

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"Women should feel confident that they will receive safe, effective, compassionate maternity care that focuses on their individual needs. That is the experience of many people. But too many families still face care that puts the safety and wellbeing of women and babies at risk… Maternity services have had more policy recommendations than any other health area. But there have still been major service failures… If we do not start tackling these issues differently, there will be more tragedies."
Parliamentary Health Service Ombudsman March 2023

"The quality of maternity care is not good enough. Action to ensure all women have access to safe, effective and truly personalised maternity care has not been sufficiently prioritised to reduce risk and help prevent tragedies from occurring… our ratings as of 31 July 2022 show that the quality of maternity services is getting worse, with 6% of NHS services (9 out of 139) now rated as inadequate and 32% (45 services) rated as requires improvement. This means that the care in almost 2 out of every 5 maternity units is not good enough"
Care Quality Commission State of Care October 2022

"It's up to us as an organisation to govern ourselves when it comes to PSIRF; are we happy with the quality of the work we're producing? What are we going to do with the safety actions and areas for improvement? We are not time bound to deliver something to our commissioners by 5pm on a Friday anymore; we are bound to deliver something for our patients involved in patient safety incidents. This shift in thinking has had a huge impact on how we manage all incidents in our Trust, not just serious ones."
Lucy Winstanley, Head of Patient Safety & Quality West Suffolk NHS Foundation Trust February 2023

"The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them."
Aidan Fowler, National Director of Patient Safety, NHS England, August 2022

"Having a baby is one of the most important times for a family and when women and their babies come into contact with NHS maternity services they should receive the very best and safest care. We already know that improvements to maternity care need to be made across the country."
Donna Ockenden Chair Independent Reviews into Maternity Services at Nottingham University Hospitals NHS Trust & Shrewsbury & Telford NHS Trust 26 May 2022

"The NHS could be much better at identifying poorly performing units, at giving care with compassion and kindness, at teamworking with a common purpose, and at responding to challenge with honesty… unless these difficult vi areas are tackled, we will surely see the same failures arise somewhere else, sooner rather than later. This Report must be a catalyst for tackling these embedded, deep-rooted problems."
Dr Bill Kirkup CBE Reading the signals: maternity and neonatal services in East Kent, the report of the independent investigation October 2022

This conference emphasizes a comprehensive approach to enhance safety in maternity services. Its central objective is to learn and apply recommendations derived from recent independent reviews and implications of PSIRF, as well as experiences of implementation from an early adopters perspective. We will also be learning how maternity care is changing globally and the impact it has on safe and personal care. Another focus of this conference will be learning about the role of Maternity Voices Partnership in raising concerns over safety.

This conference will enable you to:

- Network with colleagues who are working to improve safety in maternity services
- Reflect on national developments and learning and how you can accelerate improvements in your maternity service
- Update your knowledge on the New Patient Safety Incident Response Framework and how it applies to maternity services
- Self assess your service against the Local Actions for Learning, (LAfL) and Immediate and Essential Actions from the Ockenden Report
- Develop your skills in PSIRF implementation and understand decision making in incident investigation
- Ensure assurance and accountability for implementing the recommendations and learning from Ockenden, East Kent and Nottingham
- Improving Maternity Care & Safety for Women from Black and Minority Ethnic Groups
- Understand the role and ensure effective engagements with Maternity Voice Partnerships
- Improve the way you embed the role of the MVP in services
- Reflect on training and education in maternity services and how this can be supported and improved
- Understand how you can nurture a positive culture and freedom to speak up in maternity care
- Identify key strategies for improving leadership, teamwork and culture in maternity services
- Learn from the Ockenden Report and implement recommendations regarding stillbirth
- Improve investigation and learning from adverse outcomes
- Self assess and reflect on your own practice
- Supports CPD professional development and acts as revalidation evidence. This course provides 5 Hrs training for CPD subject to peer group approval for revalidation purposes

10.00 Chair's Welcome and Introduction

Zenab Barry *Director* National Maternity Voices,
Chair of National Maternity Voices Council (to November 2022)
Co-chair Chelsea and Westminster MVP (to March 2022)

10.10 Case Study: PSIRF & Maternity Care

- PSIRF implementation
- monitoring adherence to the new patient safety incident response standards
- decision making around which incidents should be subject of PSIRF and After Action Reviews

10.55 The Patient Safety Incident Response Framework (PSIRF): Implementation in Maternity Care

Sue Fryer
Senior Matron. Maternity Quality Risk and Safety
Chesterfield Royal Hospital NHS Foundation Trust

- PSIRF implementation
- monitoring adherence to the new patient safety incident response standards
- what maternity incidents should be investigated under PSIRF – decision making
- advice and support to help with the transition to PSIRF

11.25 Comfort Break and Virtual Networking

11.40 EXTENDED SESSION: Implementing the learning and recommendations from the Ockenden Review, and East Kent Investigation in practice

Ingrid Henderson
Quality & Patient Safety Manager for Women's Services
University Hospitals Bristol & Weston NHS Foundation Trust

- improving care provision for mothers and babies of black and Asian populations
- understanding the root causes of higher stillbirth rates and addressing engagement and communication
- human rights in pregnancy and childbirth
- early findings from the inquiry on racial injustice in maternity care
- good practice in culturally safe, rights-respecting care

12.25 PSIRF in maternity: what do the changes mean for other processes?

Amelia Newbold
Risk Management Lead
Browne Jacobson LLP

- ensuring compliance with the duty of candour and achieving a culture of candour
- inquests and litigation:
  - record keeping, retention and disclosure obligations in the context of learning responses under PSIRF.
  - evidencing causation and/ organisational learning following a patient safety incident.
  - drafting witness statements
  - supporting staff

13.10 Lunch Break & Virtual Networking

13.40 Supporting Maternal Health Globally – Ensuring Safe and Personal Maternity Care

Professor Jacqueline Dunkley-Bent OBE
Chief Midwife
International Confederation of Midwives

- changes in maternal health globally – what we are seeing
- the ICM's contribution to safe and personal maternity care
- our experience

14.10 Supporting the Black Maternal Experience

Hilary Ibhagbemien
Programmes Manager
The Motherhood Group

- improving care provision for mothers and babies of black and Asian populations
- understanding the root causes of higher stillbirth rates and addressing engagement and communication
- human rights in pregnancy and childbirth
- early findings from the inquiry on racial injustice in maternity care
- good practice in culturally safe, rights-respecting care

14.40 EXTENDED SESSION: Improving active engagement with the local community through developing your MVP

Zenab Barry
Director National Maternity Voices
Chair of National Maternity Voices Council (to November 2022)
Co-chair Chelsea and Westminster MVP (to March 2022)

- learning from lived experience
- enabling a positive, strengths-based approach with trusting relationships and effective participation and engagement (breakout to discuss)
- the role of MVPs
- the new MVP Toolkit and developing Maternity Voices Partnerships (breakout – how might you develop your local MVP?)

15.10 Working in and embedding your Maternity Voices Partnership

Emma Taylor
Chair of Royal Berkshire Maternity Voices,
South East NHS Region Service User Voice and MVP Network Lead

- what is a Maternity Voices Partnership?
- the role of MVPs including in raising concerns over safety
- embedding the MVP into trust and service activities
- nurturing a positive culture and freedom to speak up in maternity care

15.45 Comfort Break and Virtual Networking

16.00 Reviewing and learning from adverse outcomes – MBRRACE-UK findings

Professor Jennifer J Kurinczuk
National Programme Lead
Maternal and Fetal Research Centre, University of Manchester
Clinical Director
Tommy's Stillbirth Research Centre St Mary's Hospital, Manchester

- Saving Babies Lives: national update
- learning from the Ockenden Report and implementing recommendations regarding stillbirth
- develop a strategy to achieve 50% reductions in stillbirth by 2025
- reducing stillbirth what works?

16.30 Reducing stillbirth

Professor Alex Heazell
Professor of Obstetrics
Maternal and Fetal Research Centre
University of Manchester
Clinical Director for Tommy's Stillbirth Research Centre
St Mary's Hospital, Manchester

- Saving Babies Lives: national update
- learning from the Ockenden Report and implementing recommendations regarding stillbirth
- develop a strategy to achieve 50% reductions in stillbirth by 2025
- reducing stillbirth what works?

17.00 Chair's Closing Remarks

There will be time for Question & Answers after each session

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Venue
This virtual conference will include a live stream on Zoom, interactive breakout sessions and resources available on a secure landing stage for three months after the event date.

Date
Friday 10th November 2023

Conference Fee

- ☐ £295 + VAT (£354.00) for NHS, Social care, private healthcare organisations and universities.
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