Appendix B

Maternity Service User Experience of undergoing a Supervisory Investigation

Part of the:
External review of a sample of Local Supervising Authority (England) Supervisory Investigations into the standard of midwifery practice in maternity serious incidents that were conducted between 1 April 2016 and 31 December 2016

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Date 19 April 2018

Publications Gateway Reference: **08151**

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1.0 Introduction

1.1 Overview of midwifery supervision and its removal from statute

The Nursing and Midwifery Council (NMC) is the independent statutory regulator of nurses and midwives in the UK. The NMC is required by the Nursing and Midwifery Order 2001 (the Order) to establish and maintain a register of all qualified nurses and midwives eligible to practise in the UK, to set standards for their education, practice and conduct, and to take action when those standards are called into question. The Order gives the NMC powers to set rules for the regulation of the practice of midwifery (article 42).

Prior to 1st April 2017, the Order required the establishment of a Local Supervising Authority (LSA) for Midwifery in every area and required midwives in that area to give notice of their intention to practise. The NMC set LSA reporting requirements that included: Annual Reports; LSA annual audits intended to monitor standards of supervision and midwifery practice.

Local Supervising Authority

The LSAs were responsible for the statutory supervision of midwives. Statutory supervision applied to all registered midwives including those who worked outside of the NHS. The stated purpose of supervision of midwives was to protect women and babies by actively promoting a safe standard of midwifery practice. Supervision also provided a mechanism for support and guidance to every midwife practising in the UK. Each LSA appointed a practising midwife known as the Local Supervising Authority Midwifery Officer (LSAMO) who had responsibility for carrying out the statutory functions within the LSA area.

Supervisors of midwives

Each LSA appointed a number of Supervisors of Midwives (SoM) who were accountable in their role to the LSAMO. SoMs were experienced, practising midwives who had undergone education and training in the knowledge and skills needed to supervise midwives. Part of the role of a SoM was to investigate a midwife's practice following an untoward or serious incident and determine whether action was required. Recommended actions might include how the relevant midwife

might improve their practice (for example, through further training), or whether his or her fitness to practise should be called into question.

Supervisory investigations were conducted on behalf of the LSA and were independent of a

Trust's clinical governance processes. As such a provider Trust where an incident occurred was required to carry out its own investigation in compliance with the Trust's clinical governance processes. In some organisations a joint supervisory and Trust investigation was carried out. Prompted by the brave efforts of three families, who raised complaints that related to local midwifery supervision and regulation[1] (PHSO 2013) and in, as a result of investigations into incidents at Morecambe Bay NHS Foundation Trust in

2013[2], the Parliamentary Health Service Ombudsman[3] found that there was a structural flaw in the way midwifery regulation was organised, because it combined the requirements to investigate midwifery practice and to provide support for midwives. In response to these findings, the NMC commissioned The King's Fund in 2014 to undertake a review of the regulation of midwives across the United Kingdom. The King's Fund found[4] that the system of regulation of midwives was confusing for patients and the public. It also found that there was a lack of clarity for providers of maternity services about their responsibility following an incident because the provider carried out its own investigations at the same time as the LSA investigation. The King's Fund review findings recommended that midwifery supervision be removed from statute.

This recommendation was taken forward in accordance with the requirements of Section 60[5] of the Health Act 1999. With Parliamentary approval the NMC removed midwifery supervision from its regulatory legislation on 31st March 2017.

[1] Complaints raised by three families related to the failure of local midwifery supervision and regulation to identify poor midwifery practice" (The Parliamentary and Health Service Ombudsman (PHSO) 2013,),
[2] Kirkup B, The Report of the Morecambe Bay Investigation, (2015)
[3] Midwifery supervision and regulation: recommendations for change, Parliamentary and Health Service Ombudsman (2014) HC 865 London: The Stationery Office
[4] Baird B et al, Midwifery Regulation in the United Kingdom, King's Fund
[5] http://www.legislation.gov.uk/ukpga/1999/8/section/60

1.2 Background

This report was commissioned by NHS England as part of its final works in relation to statutory supervision. This review was commissioned by NHS England in response to two previous commissions both of which related to the quality of midwifery supervision. This review was commissioned by NHS England in response to two previous commissions both of which related to the quality of midwifery supervision. Although statutory supervision has been removed and replaced with a new model of supervision called A-EQUIP[6], this review still provides a valuable opportunity to highlight areas where the quality of investigations can improve the involvement of service users..

This report is an Appendix to the report *External review of a sample of Local Supervising Authority (England) Supervisory Investigations into the standard of midwifery practice in Maternity Serious Incidents that were conducted between 1st April 2016 and 31st December 2016*, also commissioned as part of this works. The review sample is comprised of NHS maternity cases in England which resulted in poor maternal and/or fetal/neonatal outcome and was subject to a supervisory investigation between the months of April through to December 2016 inclusive. These works were conducted by Debbie Graham, Independent Consultant Midwife, henceforth referred to as the reviewer

The purpose of these works was to establish whether each case included in this review, has had a robust and objective Local Supervising Authority (LSA) Supervisory Investigation into the standard of midwifery practice undertaken. Included in the review Terms of Reference is the requirement to:

> *Seek the consent of, and interview families identified on a case by case basis to understand their experience of the LSA supervisory investigation.*

Discussing safety incidents promptly, fully and compassionately can help service users cope better with the after-effects[7]. Following a clinical incident the affected family wish to know: what happened, why it happened and, if mistakes were made, that they have been identified and lessons learned to help prevent the same mistakes recurring. Good practice guidance on engaging with service users

[6] A-EQUIP is an acronym for advocating and educating for quality improvement and does not involve the investigation of incidents or any regulatory activity/function

[7] Crane M. What to say if you made a mistake. *Med Econ*. 2001; 78: 26–8, 33–6

following a clinical incident is available for healthcare organisations, including the '*Being Open*'[8]framework (2009) and the statutory duty of candour[9], which was introduced into healthcare in England in November 2014 and requires healthcare organisations to be open and honest with service users'/families following a clinical incident.

Both the duty of candour and the *Being Open* framework stipulate that following a clinical incident, a healthcare organisation should acknowledge, apologise and explain what went wrong. The *Being Open* framework states: (*I)t is important to remember that saying sorry is not an admission of liability and is the right thing to do.*[10]

The LSA document relevant to this review was *LSA Review and Processes, Version 2,* dated 20th November 2013[11] (the policy).

This review has two important limitations:

1. The reviewer noted during each of the interviews, a lack of clarity as to whether recalled events related to a supervisory or trust investigation. All findings should therefore be interpreted as relating to the service users experience of *an* investigation rather than pertaining to a supervisory investigation alone.

2. An unintentional bias may have been built into the methodology (set out below) in that service users who had issues with the investigation into their case which remained outstanding may have been more likely to agree to be interviewed.

The remainder of this report describes the consultation process and provides an analysis of the responses with recommendations.

[8] Saying sorry when things go wrong, Being Open, Communicating patient safety incidents with patients, their families and carers, National Patient Safety Agency (2009) Gateway reference 13015
[9] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20
[10] Ibid (n6)
[11] Local Supervising Authority Review and Investigation Processes, LSAMO Forum UK, Policies for the statutory supervision of midwives, Version: 2 (2016)

2.0 Method

This was an 'opt-in' review and therefore required the signed consent of each woman included in the cohort. A standard letter was sent either by NHS England or directly by the provider Trust (as preferred by some Trusts), to each of the cohort women informing them of the review, its aims and requesting their consent for their case to be included in the review. A consent form was enclosed with the letter which women were asked to sign and return within four weeks of receipt after which their case would be withdrawn from the review. The consent form included a tick-box option for women and their families to indicate if they wished to discuss their experience of undergoing a supervisory investigation with the reviewer. Women who ticked this box were first contacted by the reviewer by telephone and a face to face or telephone interview arranged. Letters to service users were sent out from July to November 2017 inclusive.

A total of 15 women consented for their case to be included in the case notes review of the supervisory investigation into their case. Of these women 9 consented to be interviewed (60%) regarding their experience of being subject to a supervisory investigation. At 4 of the interviews (44%) the woman's partner was also present. The reviewer captured the couple's experiences at each of these interviews. The couple's responses to each statement were then amalgamated by the reviewer and are presented below as the experiences of one participant. Interviews were held either by telephone (n4) or in the participant's home or other convenient location (n5)

Table 1 shows the cohort sample by the outcome for each woman who participated in this consultation (n9)

Table 1: cohort sample by outcome

Poor outcome	**No of cases**
Neonatal/fetal	7
Maternal/neonatal/fetal	2
Total	**9**

The interview statements were developed by the reviewer and are based on good practice standards in compliance with the statutory duty of candour. Each interview was conducted by the reviewer using the prompt statements as set out in proforma 2 available at appendix 1. The participant's responses were either noted down or tape recorded with the participant's permission. Participants were advised that their responses would be treated as confidential in that no response would be attributable to any person. The reviewer advised that no individual issues, complaints or concerns could be dealt with in the interview setting but that if the session raised any concerns or anxieties for them these should be addressed by the provider Trust. The contact details of the relevant Trust Patient Advice and Liaison Service (PALs) or nominated contact person was made available to participants by the reviewer. In addition, in the event that the reviewer formed the opinion that a given woman may contact a Trust, the reviewer sent an email to the Head of Midwifery advising them as such, thereby enabling preparation for the contact.

In analysing the service user consultation findings the written notes and recordings from each session were analysed and themes identified before being themed together. This method uses elements of grounded theory research and involves reading and re-reading responses, looking for similarities and differences[12]. Themes emerge from word repetitions, key words and comparing and contrasting statements with each other taking care to accurately reflect what each participant was saying.

The next section of this report presents a table of the findings from this consultation. The subsequent sections present the findings from each statement, set out in the same order as the consultation proforma. Recommendations are presented in the final section of this report.

[12] Hitchcock, G. and Hughes, D. 1995 Research and the Teacher 2nd ed. London Routledge

3.0 Findings

The desired level of active participation in an investigation differed between service users. Some participants reported that they had been informed of an investigation too late (or indeed not at all) whilst other participants reported that they had been informed at too early a stage when they were feeling confused.These findings are now described in detail.

Table 2 shows a summary of the consultation findings for each of the cases in the review cohort (n9) as assessed against the 22 review criterion in proforma 2

Table 2: summary of service user experience consultation findings

	Interview statement	**Agree**	**Undecided**	**Disagree**
1	I was informed both verbally and in writing that a supervisory investigation was being undertaken into my case	**4**	**1**	**4**
2	I understood that a supervisor of midwives would review the standard of midwifery practice in my case and was aware of what a supervisory investigation could and could not do	**1**	**1**	**7**
3	The supervisory investigation process was described to me and a likely timescale given both verbally and in writing	**3**	**1**	**5**
4	I was given the name and contact details of the SoM carrying out the investigation	**4**		**5**
5	I had a face to face meeting with the SoM carrying out the investigation into my case	**2**	**2**	**5**
6	I was advised both verbally and in writing on how I could contribute to the investigation process			**9**
7	My views were sought on how I wished to be involved with the investigation		**1**	**8**
8	I received both written and verbal updates on the progress of the investigation at regular intervals			**9**
9	I felt able to raise any concerns I had with the investigating SoM	**2**		**7**
10	My voice was heard	**2**		**7**
11	I felt an equal partner in the investigatory process			**9**
12	I had confidence in the supervisory investigation process to resolve any concerns I may have had		**2**	**7**
13	The investigation findings were explained to me both verbally and in writing		**1**	**8**
14	All of my questions were answered	**4**		**5**
15	I am confident that all of the facts relating to midwifery practice in my case have been established, and any lessons to be learnt identified and acted upon	**1**	**2**	**6**
16	I am happy with the time it took to complete the investigation	**2**	**3**	**4**
17	The outcome decision recommendations were explained to me both verbally and in writing	**2**		**7**
18	I was treated with courtesy, sensitivity and respect at all times	**2**	**3**	**4**
19	My privacy and confidentiality was protected at all times	**3**	**4**	**2**

	Interview statement	Agree	Undecided	Disagree
20	I was given both verbal and written information regarding where I could get support e.g. counselling/independent advice	**1**		**8**
21	I could access translator services if I needed them	**n/a**		
22	I received both a verbal and written apology from the Trust			**9**

Statement 1

I was informed both verbally and in writing that a supervisory investigation was being undertaken into my case

Of the total (15), 9 participants consented to be interviewed

- 4 (44%) agreed with this statement
- 5 (56%) disagreed with this statement. All 5 (100%) participants recalled being informed either verbally or in writing that a Trust investigation would take place. Of these participants (n5) the reviewer found written documentation in the LSA records of 2 (40%) participants that a letter informing them of the intended supervisory investigation had been sent to them. Documentation also recorded that the LSA had not received a response to their letter from these participants.

The findings from the responses to this statement indicate a lack of clarity between investigations undertaken by a SoM on behalf of the LSA and that undertaken by the provider Trust under their Clinical Governance processes. During interviews the reviewer observed that participants were often unclear as to whether a particular aspect of their experience they were recalling related to a supervisory or Trust investigation. An example being, one participant who was recalling her experience of, what she believed to be, a meeting with a SoM to the reviewer recalled the presence of a consultant obstetrician at the meeting. Although it is possible that a joint supervisory and Trust meeting was held, it is also possible that the participants was recalling a meeting that related to a provider Trust investigation only. This confusion is reflected in the responses received to all of the statements in this review.

Statement 2

I understood that a supervisor of midwives would review the standard of midwifery practice in my case and was aware of what a supervisory investigation could and could not do

Of the 4 participants who reported that they had been aware that a supervisory investigation would take place

- 1 (25%) agreed with this statement
- 1 (25%) was undecided
- 2 (50%) disagreed with this statement.

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place

- 5 (100%) disagreed with this statement

Samples of direct quotes from participants to this statement are:

> *"I wasn't exactly sure how this would work and I was not aware of the extent "(*of the investigation)
>
> *"I thought everyone would be looked at"*

These findings suggest that the scope of a supervisory investigation was poorly understood within the sample group. This finding is applicable to both the supervisory and Trust investigations.

Statement 3

The supervisory investigation process was described to me and a likely timescale given both verbally and in writing

Of the 4 participants who reported that they had been aware that a supervisory investigation would take place

- 3 (60%) agreed with this statement
- 1 (20%) was undecided

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place

- 5 (100%) disagreed with this statement

The findings to the responses to this statement relates to both supervisory and provider Trust investigations.

Statement 4

I was given the name and contact details of the SoM carrying out the investigation

Of the 4 participants who reported that they had been aware that a supervisory investigation would take place

- 3 (75%) agreed with this statement
- 1 (25%) disagreed with this statement

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place

- 5 (100%) disagreed with this statement.

Of the 5 participants who were aware of a provider Trust investigation only, 1 (20%) recalled being given the name and contact details of the person undertaking the Trust investigation.

Statement 5

I had a face to face meeting with the SoM carrying out the investigation into my case

Of the 4 participants who reported that they had been aware that a supervisory investigation would take place

- 2 (50%) agreed with this statement. One reported that she had an initial meeting with a SoM followed by a second meeting on completion of the investigation. One respondent informed the reviewer that she had only been invited to meet with the investigating SoM after the investigation had been completed rather than at the start of the investigation as she would have wished.
- 2 (50%) disagreed with this statement.

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place

- 5 (100%) disagreed with this statement

Of the 5 participants who were aware of a provider Trust investigation only:

- 4 reported meeting with a representative undertaking the Trust investigation.
- 1 reported that she had not had an opportunity to discuss her case with any healthcare professional. She informed the reviewer that she remained very upset by her experience and would like to have spoken to someone. The reviewer advised this participant to contact her provider Trust to address any outstanding issues. A contact details for the relevant Trust were provided by the reviewer.

Statement 6

I was advised both verbally and in writing on how I could contribute to the investigation process

Of the total number of participants interviewed all (n9) disagreed with this statement whether it applied to a supervisory or Trust investigation

Samples of direct quotes from participants to this statement are:

> *"I would have liked to have been involved from the beginning as what is written in my notes and what actually happened is different"*
>
> *"I was very tired when I was first contacted and on reflexion I had more questions"*

Of the total respondents to this statement (n9) 8 (89%) expressed a wish to be involved in the investigatory process. Of these respondents, 3 raised concerns that the investigation into their case was based solely on midwifery documentation and their version of events, which differed from that documented in their clinical notes, had not been taken into account. The reviewer advised each of these participants to contact the relevant provider Trust to address any outstanding issues. Contact numbers for the relevant Trust PALs or equivalent service were also given to the participants by the reviewer.

Statement 7

My views were sought on how I wished to be involved with the investigation

Of the total 4 participants who reported that they had been aware that a supervisory investigation would take place

- 1 (25%) was undecided. This participant reported that she and her partner had been consulted on whether they wished to be involved but not how. However she reported that she was satisfied by the way the investigation was conducted
- 3 (75%) disagreed with this statement

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place

- 5 (100%) disagreed with this statement

There was varying opinion amongst the respondents as to the best timing and way to involve service users in an investigation. 3 participants recounted being approached whilst still in-patients by a member of the maternity staff (it was not clear in each case whether this was a SoM or Trust investigator) to inform them that an investigation would be carried out. All 3 respondents expressed an opinion that this was inappropriate as they were unable to concentrate at this time and therefore fully appreciate what was being said to them.

Statement 8

I received both written and verbal updates on the progress of the investigation at regular intervals

Of the total number of participants interviewed all (n9) disagreed with this statement whether applied to a supervisory or Trust investigation

Statement 9

I felt able to raise any concerns I had with the investigating SoM

Of the 4 participants who reported that they had been aware that a supervisory investigation would take place

- 2 (50%) agreed with this statement
- 2 (50%) disagreed with this statement

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place

- 5 (100%) disagreed with this statement – this response applied to the Trust investigation

Samples of direct quotes from participants to this statement are:

> *"I did raise my concerns but I only had the opportunity after I received the report"*
>
> *"We raised our concerns but felt we weren't listened to"*

Statement 10

My voice was heard

Of the 4 participants who reported that they had been aware that a supervisory investigation would take place

- 2 (50%) agreed with this statement – 1 of these respondent's reported that she felt both she and her husband were listened to.
- 2 (50%) disagreed with this statement

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place

- 5 (100%) disagreed with this statement

Statement 11

I felt an equal partner in the investigatory process

Of the 4 participants who reported that they had been aware that a supervisory investigation would take place

- 1 (20%) agreed with this statement
- 3 (80%) disagreed with this statement

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place

- 5 (100%) disagreed with this statement

Samples of direct quotes from participants to this statement are:

> *"We had a personal view and this was difference from the midwives professional stance. It would have been helpful if we had an advocate who was there for us"*
>
> *"We had the initial engagement and then the report came. We were not actively encouraged to participate."*
>
> *"We would have taken up the opportunity to be more involved"*

It is unclear whether these findings relate to supervisory and/or Trust investigations.

Statement 12

I had confidence in the supervisory investigation process to resolve any concerns I may have had

Of the 4 participants who reported that they had been aware that a supervisory investigation would take place

- 2 (50%) were undecided on this statement
- 2 (50%) disagreed with this statement

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place

- 4 (100%) disagreed with this statement

Samples of direct quotes from participants to this statement are:

"I half did and I half didn't. For example the SoM mentioned that the midwives were really upset which wasn't helpful"

"I didn't really know what to expect"

Statement 13

The investigation findings were explained to me both verbally and in writing

Of the 4 participants who reported that they had been aware that a supervisory investigation would take place

- 1 (25%) agreed with this statement
- 1 (25%) was undecided. This respondent's version of the events under investigation differed from that documented in her clinical notes by the attending midwife. The investigating SoM offered to meet with the participant to discuss the findings of the investigation. However the couple did not wish to meet with the SoM whilst issues remained outstanding.
- 2 (50%) disagreed with this statement. One of these responder's informed the reviewer that she had received a copy of the Trust investigation report

Of the 5 participants' who reported being either undecided or unaware that a supervisory investigation would take place

- 5 (100%) disagreed with this statement – these responses related to the Trust investigation

Of the total number of participants interviewed who reported being subject to a Trust investigation only (n5):

- 2 received a copy of the Trust final report. Neither of these participants received a verbal explanation of the investigation findings.
- 1 received a document which she described as a 'risk assessment' that did not contain an explanatory narrative
- 2 had not received a copy of their Trust investigation report or received a verbal explanation of the investigation findings.

Statement 14

All of my questions were answered

Of the 4 participants who reported that they had been aware that a supervisory investigation would take place

- 3 (75%) agreed with this statement. 1 of these respondent's indicated that she was *"not happy with a couple of the answers but it* (the SoM investigation report) *was detailed"*
- 1 (25%) participant disagreed with this statement. This related to the differing versions of events as described above.

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place:

- 1 agreed with this statement in relation to the Trust investigation. However, this respondent commented that she remained '*uneasy'* regarding the incident events.
- 4 (100%) disagreed with this statement – these responses related to Trust investigations

Statement 15

I am confident that all of the facts relating to midwifery practice in my case have been established, and any lessons to be learnt identified and acted upon

Of the 4 participants who reported that they had been aware that a supervisory investigation would take place:

- 1 (25%) agreed with this statement
- 2 (50%) were undecided. Both of these respondents expressed uncertainty whether the recommendations from their cases had been acted upon.
- 1 (25%) disagreed with this statement

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place:

- 1 (25%) was undecided – this related to the Trust investigation. This respondent expressed uncertainty that all of the *'background'* events that may have contributed to her incident and not just the midwife's practice had been investigated.

- 4 (75%) disagreed with this statement

Samples of direct quotes from participants to this statement are:

> *"We would have like it but we didn't receive feedback"*
>
> *"The Head of Midwifery visited us* (at home) *but gave the impression that she didn't want to get involved"*

Statement 16

I am happy with the time it took to complete the investigation (the LSA standard for completion of investigation is 60 working days)[13]

Of the 4 participants who reported that they had been aware that a supervisory investigation would take place

- 2 (50%) agreed with this statement. Of these respondent, 1 investigation was completed in 60 working days and 1 was completed in 75 working days

- 1 (25%) was undecided. This respondent's investigation was completed in 55 working days

- 1 (20%) disagreed with this statement. This respondent's investigation was completed in 60 working days.

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place

- 5 (100%) disagreed with this statement. All 5 participants stated that they were unaware of when the supervisory investigation was commenced and completed. 3 of these respondents reported that they had received a final investigation report from their provider Trust. The reviewer was informed that, one was completed in 6 months, one had taken 10 months and one had taken

[13] Ibid (n7) Table 1, Step 2

1 year to complete. It was not within the remit of this consultation to verify these reported findings.

Statement 17

The outcome decision recommendations were explained to me both verbally and in writing

Of the 4 participants who reported that they had been aware that a supervisory investigation would take place

- 2 (50%) agreed with this statement.
- 2 (50%) disagreed with this statement. 1 respondent had declined to meet with the investigating SoM as differing accounts of the incident remained outstanding.

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place

- 5 (100%) disagreed with this statement – these responses related to Trust investigations

Statement 18

I was treated with courtesy, sensitivity and respect at all times

Of the 4 participants' who reported that they had been aware that a supervisory investigation would take place

- 2 (50%) agreed with this statement
- 1 (25%) was undecided
- 1 (25%) disagreed with this statement

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place

- 4 (100%) disagreed with this statement

Samples of direct quotes from participants to this statement are:

"We thought we would be invited to be on the panel. We phoned the secretary twice for dates but we were never called back. Then we were told that the investigation was completed"

The Trust are *"Trying to avoid me because they made a mistake"*

"Not answering our questions and the letter we received lacked sympathy they did not offer condolences"

Statement 19

My privacy and confidentiality was protected at all times

Of the 4 participants who reported that they had been aware that a supervisory investigation would take place

- 2 (50%) agreed with this statement
- 1 (25%) was undecided
- 1 (25%) disagreed with this statement

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place

- 2 (20%) agreed with this statement – this related to Trust investigations
- 2 (50%) were undecided
- 1 (20%) disagreed with this statement

Samples of direct quotes from participants to this statement are:

"We had no contact so we don't know who was spoken to"

"The meetings were held in a room off the maternity corridor and we bumped into people we knew who were going home with their new baby and they wondered what we were doing there. This really affected the way I felt in the meeting"

Statement 20

I was given both verbal and written information regarding where I could get support e.g. counselling/independent advice

Of the 4 participants who reported that they had been aware that a supervisory investigation would take place

- 1 (25%) agreed with this statement
- 3 (75%) disagreed with this statement

Of the 5 participants who reported being either undecided or unaware that a supervisory investigation would take place

- 5 (100%) disagreed with this statement

Statement 21

I could access translator services if I needed them

This statement did not apply to all (n9) of the participants

Statement 22

I received both a verbal and written apology from the Trust

Of the total number of participants (n9), all (100%) disagreed with this statement. 2 respondents (22%) reported receiving a verbal apology. However both of these respondents commented that they did not think that the apology they received was meaningful.

Samples of direct quotes from participants to this statement are:

> *"We were seen by the Head of Midwifery immediately after* (the incident) *and she said that under duty of candour she had to give us an apology. It would have been better if she hadn't said anything"*
>
> *"We were given an apology at the meeting but it wasn't from the heart, it was just formal"*

Statement 23

Any other comments

Samples of direct quotes from participants are:

> *"I was given papers for the community midwife when I was discharged from hospital but they never came and I haven't had contact with the hospital so I still have them"*
>
> *"The doctor said after surgery 'we are surprised you are alive'. I was too upset to ask for an investigation and I didn't know one had happened. We would like another baby but I am too scared after last time"*
>
> *"There should be more support for families following an incident – we really feel let-down"*

These responses illustrate the impact not experiencing a meaningful, supportive and inclusive investigatory process may have on service users.

4.0 Conclusion

It was not always possible for the reviewer to distinguish whether a participant's recollection of events related to a supervisory or trust investigation. All findings should therefore be interpreted as relating to the service users experience of *an* investigation rather than pertaining to a supervisory investigation alone.

The reviewer found the majority of service users who participated in this consultation reported a poor experience of undergoing an investigation. This finding is consistent with the national picture for the standard of service user engagement in investigations across the NHS. In their 2016 report the Care Quality Commission (CQC) noted: (*T)hroughout our review, families and carers have told us that they often have a poor experience of investigations…. The extent to which families and carers are involved in reviews and investigations of their relatives varies considerably.* [14]

It is recognised that following a clinical incident the engagement of the affected family is essential. Knowledge of how they will be able to contribute to the process of investigation, for example by giving evidence helps to provide affected families with confidence that the findings of an investigation will be robust, meaningful and

[14] Learning, candour and accountability, A review of the way NHS trusts review and investigate the deaths of patients in England, CQC (2016)

that lessons will be learned from to prevent the likelihood of similar incidents happening again.

This consultation has not identified a best practice approach to the timing of service user engagement following a clinical incident. The findings show that the desired level of active participation in an investigation differs between service users. Some participants reported that they had been informed of an investigation too late (or indeed not at all) whilst other participants reported that they had been informed at too early a stage when they were feeling confused. However, all participants stated that they wished to be involved throughout an investigation. In particular, participants stated that when undertaking an investigation, equal weight should be given to the service user's evidence as that given to the documented records. Furthermore, some participant's stated that they wished to be involved after the investigation had been concluded so that they could be assured that the recommendations from their case had been actioned.

The current NHS Serious Incident framework published in 2015 sets expectations for when and how the NHS should conduct a safety investigation. This framework is currently being revised to better support the system to respond appropriately when things go wrong. The findings of this case note review and in particular the absence of evidence that the duty of candor had been upheld for all women and the poor experience of families involved, will be shared with NHS Improvement to support the plans to improve the process for engaging with patients when things go wrong

5.0 Recommendations

This report should be shared widely, including but not limited to:

- Service users who participated in the engagement consultation
- Service users who formed part of the cohort sample who did not participate in the engagement consultation but indicated on their consent form that they would like to receive the final report
- Participating provider Trusts.
- NHS Improvement for contribution to the review of the NHS Serious Incident framework
- The Healthcare Safety Investigation Branch

Acknowledgements

This review would not have been possible without the cooperation and support of many people, to all of whom I wish to extend my thanks and gratitude. Particular thanks are extended to the service users who kindly shared their experiences with me

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Website

http://www.legislation.gov.uk/ukpga/1999/8/section/60

Appendix 1

Service User Consultation proforma

Case note review proforma 1

	Criteria
1	The SoM fully investigated the midwife's practice as documented in the clinical records
2	The incident chronology was determined
3	All issues identified by the reviewer were addressed
4	Key staff were interviewed
5	Key staff were asked to provide a written statement
6	No documentation was missing
7	The SoM documented communication with the parents/family
8	Compliance with statutory duty of candour is documented

Service users' experience review proforma 2

	Interview statements	Agree	Undecided	Disagree
1	I was informed both verbally and in writing that a supervisory investigation was being undertaken into my case			
2	I understood that a supervisor of midwives would review the standard of midwifery practice in my case and was aware of what a supervisory investigation could and could not do			
3	The supervisory investigation process was described to me and a likely timescale given both verbally and in writing			
4	I was given the name and contact details of the SoM carrying out the investigation			
5	I had a face to face meeting with the SoM carrying out the investigation into my case			
6	I was advised both verbally and in writing on how I could contribute to the investigation process			
7	My views were sought on how I wished to be involved with the investigation			
8	I received both written and verbal updates on the progress of the investigation at regular intervals			
9	I felt able to raise any concerns I had with the investigating SoM			
10	My voice was heard			
11	I felt an equal partner in the investigatory process			
12	I had confidence in the supervisory investigation process to resolve any concerns I may have had			
13	The investigation findings were explained to me both verbally and in writing			
14	All of my questions were answered			
15	I am confident that all of the facts relating to midwifery practice in my case have been established, and any lessons to be learnt identified and acted upon			
16	I am happy with the time it took to complete the investigation			
17	The outcome decision recommendations were explained to me both verbally and in writing			
18	I was treated with courtesy, sensitivity and respect at all times			
19	My privacy and confidentiality was protected at all times			
20	I was given both verbal and written information regarding where I could get support e.g. counselling/independent advice			
21	I could access advocacy/translator services if I needed them			
22	I received both a verbal and written apology from the Trust			