Corrigendum: Strengthening open disclosure in maternity services in the English NHS: the DISCERN realist evaluation study

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Disclaimer: This report contains transcripts of interviews conducted during research that contain language that some readers may find offensive and contains descriptions of events that some readers may find distressing.

Corrigendum issued December 2024
Corrigendum DOI: 10.3310/LPDG1854
DOI: 10.3310/YTDF8015

This report should be referenced as follows:

Adams M, Sanford N, Bevan C, Booker M, Hartley J, Heazell A, *et al.* Strengthening open disclosure in maternity services in the English NHS: the DISCERN realist evaluation study. *Health Soc Care Deliv Res* 2024;**12**(22). Corrigendum to *Health Soc Care Deliv Res* 2024;**12**(22):i, v, xix, 16

Corrigendum notice

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This paper[1] is corrected as follows:

Order of authors has been updated.
The abbreviation MST has been updated to MSTF for Maternity Safety Training Fund.

Reference

1. Adams M, Sanford N, Bevan C, Booker M, Hartley J, Heazell A, *et al*. Strengthening open disclosure in maternity services in the English NHS: the DISCERN realist evaluation study. *Health Soc Care Deliv Res* 2024;**12**(22). https://doi.org/10.3310/YTDF8015

List of abbreviations

CAG	Confidentiality Advisory Group
CG	clinical governance
CIG	Co-investigator Group
C–M–O	context–mechanism–outcome
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CTG	cardiotocography
DoC	Duty of Candour
DoM	Director of Midwifery
EA	Explanatory Account
EBC	Each Baby Counts
ENS	Early Notification Scheme
GP	general practitioner
HCP	healthcare provider
HoM	Head of Midwifery
HRA	Health Research Authority
HSDR	Health and Social Care Delivery Research
HSIB	Healthcare Safety Investigation Branch
ISA	Independent Senior Advocate
IT	information technology
LMNS	Local Maternity and Neonatal System
MDT	multidisciplinary team
MSTF	Maternity Safety Training Fund
MVP	Maternity Voices Partnership
NHS	National Health Service
NHSI	National Health Service Improvement
NHSR	National Health Service Resolution
NIHR	National Institute for Health and Care Research
OD	open disclosure
PAG	Project Advisory Group
PDM	Practice Development Midwife
PI	principal investigator (site-specific)
PMA	Professional Midwifery Advocate
PMRT	Perinatal Mortality Review Tool
PPI	patient and public involvement
PSIRF	Patient Safety Incident Response Framework
PSS	Patient Safety Strategy
QI	quality improvement
R&D	research and development
RCOG	Royal College of Obstetricians and Gynaecologists
REC	Research Ethics Committee
Sands	stillbirth and neonatal death charity
SI Framework	serious incident framework
SP	study phase
SSG	Study Steering Group
SU	service user
ToR	terms of reference

Note

In this report, the term *woman* is used to refer to pregnant people, as those involved in the study identified as women. However, the results of this report will be of interest to all child-bearing people.

detailed guidance on family involvement was required.[109,111] In some cases, recommendations signposted to existing outside guidance, such as that by the stillbirth and neonatal death charity (Sands).[55,111,112] Concurrently, two consultation documents were produced to inform policy development in ways that aligned the interests of families and HCPs.[57,113] These stated that both parties value the opportunity for meaningful apology,[57] increased family involvement in reviews and investigations,[57] a single point of contact[57] and continuity of carer.[113]

Enhancing communication

Despite mounting recommendations in previous years for increasing family involvement, in 2018, a progress update on the Each Baby Counts (EBC) programme revealed that only 41% of parents were invited to be involved in reviews. This was an increase from 34% in the previous EBC report, but still startlingly far from involvement ambitions.[116] The EBC recommendations that followed these statistics were mainly focused on procedural compliance, but reiterated that families should be informed of any reviews and investigations taking place and be invited to contribute according to their wishes.[116] The Maternity Safety Training Fund (MSTF), one of the other mechanisms set out for achieving the national maternity ambitions, also released an evaluation report in 2018 which listed the training opportunities provided to staff around maternity safety. Disappointingly, none of the offered trainings were related to family involvement or disclosure, other than training on the DoC.[130] The content of this training was not described, and it was not one of the 'popular' courses selected by the Trust. The course was also not featured in the MSTF catalogue, but rather was included as a course funded by the programme in the 'other' category.

Also in this year, National Health Service Improvement (NHSI) launched their scheme for 'Maternity Safety Champions' operating at the front-line, regional and national levels.[114] Maternity Safety Champions are representatives who act as ambassadors for improving safety in maternity care by learning and sharing best practice. Notably, this programme does not include a SU representative; however, the guidance recommends that champions '*work with service users to address their needs, particularly in the redesign of new services*' (p. 10). Although no advice on how to achieve this work is given, it is the first time that a co-design approach to family involvement in maternity safety/service improvement is recommended.

The year 2018 did not yield many new recommendations for SU involvement; however, NHSI produced a document on promoting effective spoken communication between clinicians and patients.[115] This highlighted factors like providing the right environment for communication, ensuring information is accurate and understood, listening, conveying an attitude of respect and aligning expectations as facilitators to effective communication.[115] Although not specifically about disclosure, these principles can be applied to the practice. However, as Iedema *et al.* pointed out the following year in their report on the findings of this initiative, translating these principles from work-as-imagined to work-as-done presents a number of challenges.[137] Namely, there are differences between factually accurate communication and cultural, emotional and situationally sensitive communication, between imagined calm contexts for communication and the reality of the hospital setting, and between structured, evidence-based communication templates and individual, flexible, situated judgement. As such, it is unsurprising that these recommendations were not carried into future policy documents.

Conceptualising families as active partners rather than passive recipients

In mid-2019, the publication of the new NHS Patient Safety Strategy (PSS) marked a significant shift in the potential for patient and family involvement.[120] Transparency, providing opportunity for families to raise concerns and the use of the Patient Safety Incident Response Framework (PSIRF) and ENS were emphasised, and family involvement was embedded in a wider national strategy. The first ENS progress report, published in 2019, highlighted that the programme would enable families to receive answers, support and compensation more quickly. The ENS report did not reflect any of the developments in family involvement recommendations since 2015, instead integrating the original DoC steps of apology, openness, candour and providing support.[121] The biggest addition to existing recommendations in