Parents may feel unable to approach nurses and doctors because they are busy responding to critically ill patients. Some hospitals have family support staff, but in the current climate there are pressures on funding for these posts.

A challenge for staff is knowing how much information parents want. Some will want to know much more than others. Some units have developed folders for parents explaining the care and equipment in use.

What we really need is to make sure parents feel able to approach staff when they want to ask questions and ensure there is staff time to do so.’ On this issue, there were encouraging signs for nurses in particular. They were judged to be sensitive to feelings and emotions (scoring 85 out of 100), while the question about being able to talk to staff generally scored 88.

Northampton General Hospital neonatal practice development nurse Valerie McGurk says it can be ‘really tricky’ to get this right. ‘For some, no amount of communication will ever be enough, but others are less keen to know everything.’ She added that staff need to remember how difficult it is for parents. ‘Many will not have known they were going to end up with a baby in neonatal care. It is an alien environment, which can obviously be distressing.

‘You will often find that, as the parents get to know staff, communication improves. The important thing - and most hospitals do this - is to make sure parents are there for the daily reviews. Then they can ask the questions they want answers to.’ She highlighted another issue: being given conflicting information, which scored 67.

But some of the problems will be difficult to resolve. She says: ‘Where possible, we will try to place mothers with a baby in neonatal care in a separate room, but even then they will still be on a ward with babies. That is unavoidable, I am afraid.’

Bliss chief executive Caroline Davey says the results present a ‘valuable opportunity’ for hospitals and her own organisation to work together ‘to ensure that all babies born too soon, too small or too sick have the best possible chance of survival’.

The Neonatal Survey 2014 is available at tinyurl.com/olwgz5q

Nick Triggle is a freelance writer

**MPs urge new government to set up watchdog to monitor patient safety**

Select committee says it is time to establish facts and evidence early and involve parents fully in investigations, writes Nick Triggle

The NEW government needs to act quickly to create a national body to investigate patient safety incidents in England, according to a committee of MPs, who heard about the experiences of bereaved parents.

A report by the House of Commons public administration select committee before the general election campaign got under way says this is needed because the current system is ‘too complicated’, takes ‘too long’ and ‘lacks’ a systematic approach. The cross-party group took evidence from a variety of organisations, including the stillbirth and neonatal death charity Sands, which had gathered information from parents who had lost babies.

The committee points to evidence that parents reported a ‘tendency for staff to patronise and discount their legitimate concerns as ‘just grief speaking’. This is despite unexpected stillbirths and neonatal deaths being classed as serious untoward incidents that should be followed by an investigation.

The MPs’ report also highlights the feeling among many parents that they are ‘excluded from the investigative process’. In total, it says that there are 12,000 avoidable deaths and more than 10,000 serious incidents every year.

The MPs’ report came after the Morecambe Bay hospital inquiry into baby deaths, which revealed that 11 babies and one mother had died unnecessarily at Cumbria’s Furness General Hospital over a decade because deaths and safety incidents were not acted on properly. After that ministers conceded a national investigations body may be needed.

Committee chair Bernard Jenkin says the time has come for action. ‘There needs to be investigative capacity, so the facts and evidence can be established early, without the need to find blame and regardless of whether a complaint has been raised. Our proposals will help transform the safety culture of the NHS.’

**Consistency**

Responsibility for investigating patient safety is shared by the Care Quality Commission and Parliamentary and Health Service Ombudsman nationally, and NHS trusts locally.

The committee says that a national body would bring consistency and would need to be staffed by ‘professionally qualified investigative staff’ able to support and oversee local investigations with clear criteria on when the national body should take the lead. The body would also be responsible for disseminating any lessons learned.

Meanwhile, each clinical commissioning group should appoint independent medical examiners to look at hospital deaths and keep families informed. In time they will be able to refer cases to the national body. The committee also recommends the addition of human factors and incident analysis modules to staff training.

A Sands spokesperson says that the recommendations should be prioritised by incoming ministers. ‘We think that raising the standard of investigation when a baby dies and ensuring that services have the mechanisms to learn and improve will save lives.’

RCN professional lead for children and young people’s nursing Fiona Smith added: ‘When things go wrong, it is important that there is transparency and honesty and a proper and consistent way of investigating issues.’

Read the report at tinyurl.com/n995pd2

Nick Triggle is a freelance writer