Paper 6

| | |
|---|---|
| **Reporting to:** | **Trust Board, 30 June 2016** |
| **Title** | Trust Board Update – Progress report on learning and actions following the death of Kate Stanton-Davies |
| **Sponsoring Director** | Sarah Bloomfield, Director of Nursing and Quality |
| **Author(s)** | Sarah Bloomfield, Director of Nursing and Quality |
| **Previously considered by** | N/A |
| **Executive Summary** | Following the extraordinary Trust Board Meeting on 4th April, the board agreed that the case of the death of Kate Stanton-Davies would be a standing agenda item on the public session of each board meeting. This paper presents a progress report against the recommendations of the independent review considered at that meeting and gives an outline of the proposed legacy outcomes from this case. |
| **Strategic Priorities**<br>1. Quality and Safety<br><br><br><br><br><br><br>2. People | ☒ Reduce harm, deliver best clinical outcomes and improve patient experience.<br>☐ Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards<br>☐ Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme<br>☐ To undertake a review of all current services at specialty level to inform future service and business decisions<br>☐ Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme<br>☒ Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work |
| 3. Innovation<br><br>4 Community and Partnership<br><br><br>5 Financial Strength: Sustainable Future | ☐ Support service transformation and increased productivity through technology and continuous improvement strategies<br>☐ Develop the principle of 'agency' in our community to support a prevention agenda and improve the health and well-being of the population<br>☐ Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies<br>☐ Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme |
| **Board Assurance Framework (BAF) Risks** | ☒ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience<br>☐ If we do not work with our partners to reduce the number of patients on the **Delayed Transfer of Care** (DTOC) lists, and streamline our internal processes we will not improve our 'simple' discharges.<br>☐ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff<br>☐ If we do not achieve safe and efficient **patient flow** and improve our processes and capacity and demand planning then we will fail the national quality and performance standards<br>☒ If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve<br>☐ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients<br>☐ If we are unable to resolve our (historic) shortfall in **liquidity** and the structural imbalance in the Trust's **Income & Expenditure** position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment |

| | |
|---|---|
| **Care Quality Commission (CQC) Domains** | ☒ Safe<br>☐ Effective<br>☒ Caring<br>☐ Responsive<br>☒ Well led |
| ☒ **Receive** ☐ **Review**<br>☐ **Note** ☐ **Approve** | **Recommendation**<br>To RECEIVE the progress report against the recommendations of the independent review |

# Trust Board Update – Progress report on learning and actions following the death of Kate Stanton-Davies

**Introduction and Content**

Kate Stanton-Davies died approximately 6 hours after being born at the Midwifery Led Unit in Ludlow on 1st March 2009. Kate's death was avoidable, and the Trust Board met on 4th April 2016 for an Extraordinary Board Meeting held in public, to discuss the independent review authored by Debbie Graham which was commissioned by the Trust. The case, its management, and actions required were discussed to ensure that all learning from this milestone case is captured and delivered in order to ensure that the service for women and their babies is the safest and kindest it can be.

**The report made 9 recommendations to the trust;**

1) Midwife 2's conduct should be reviewed in line with the Trust's Performance Policy.
2) The Trust should seek assurance that all maternity guidelines and policies are formatted and ratified in line with Trust clinical governance processes.
3) To better understand whether women birthing in a stand-alone MLU had fully understood their birth choice, an audit of women who have required intrapartum transfer into PRH from an MLU should be undertaken.
4) To ensure that good practice models are utilised, a review of the current system for the provision of antenatal care should be conducted with the aim of identifying which groups of women would most benefit from receiving continuity of care.
5) Review of the evidence base for midwives to 'double glove' when providing intrapartum care.
6) The Trust should seek assurance that all maternity incidents are subjected to an internal investigation in line with trust policy.
7) SaTH should formally inform Ms Davies and Mr Stanton of the lessons learnt by the trust from Kate's death, including action plans developed to address identified issues.
8) The Trust should publically acknowledge the failings identified in this review and the harm they have caused Ms Davies and Mr Stanton.
9) The Trust should work with Ms Davies and Mr Stanton to establish a fitting memory to their daughter Kate.

**Progress against the recommendations and other actions**

A number of processes have been commenced/completed in relation to this case, some of these prior to the April board meeting. These are detailed in the below table along with summary outcomes and indications of external stakeholder involvement along with mapping to the above recommendations.

| Action | Outcome |
|---|---|
| Multidisciplinary review of all Serious Incidents relating to still births and neonatal deaths from 2009-2015. (Recommendation 6)** | Some points of learning identified to improve RCAs and one deep dive required. |
| Detailed case review of a Maternal and Intrapartum death from 2014 by external Consultant Obstetrician and Consultant Midwife.** | Positive feedback in relation to correct learning and actions identified from case. Recommended review of Trust RCA proforma |

| | |
|---|---|
| Multiple clinical audits including; Risk Assessment of place of delivery, and Transfers from Midwifery Led Units to Consultant Led Unit. (recommendation 3)** | Audits showed high level of compliance with policies and guidelines. |
| Review by external interim Expert Midwife over 8 week period, including Standard Operating Procedures (recommendation 2), Supervision of Midwives, midwifery culture, governance processes.** | Policies revised and ratified by Policy Approval Group, support of Supervisors of Midwives team, recommendations in relation to team working, and positive feedback about MLUs and Governance processes. |
| Survey of Women's experience of the service with particular reference to informed choices of place of delivery (recommendation 3).* | Positive result with majority of women reporting a positive experience and informed choice. However, this was not universal and some women felt that they did not have all the information they needed, therefore further work to ensure all women feel supported to make informed choice is required. |
| Revision of the on call policy for Midwifery Led Unit staff. | On call response time reduced to 30 minutes. |
| Unannounced visits by patient representatives to all Midwifery Led Units to discuss care with women and midwifery teams.** | These visits have recently commenced and once complete will be reported to the Patient Experience and Engagement Panel and to the Quality & Safety Committee. |
| Detailed action plan collating all actions since 2009 and those still to be implemented (recommendations 4, 5, 6, 9) . Draft version to Quality & Safety Committee in June 2016 and final draft to be shared with Kate's parents in July 2016, (recommendation 7).* | Further actions in relation to supporting parents after bereavement, where there has been a serious incident, to be added. No actions out of deadline on plan. |
| Detailed review of maternity services quality performance data, including national and local reports, presented at the Quality and Safety Committee in June 2016.* | Presentation received by committee, monthly assurance information will be provided. Further presentation on Midwifery Led Units expected by the committee in the Autumn. |
| Healthwatch Shropshire Enter and View report about 4 of the trust's 5 Midwifery Led Units.** | Very positive feedback from women who have used MLUs with specific focus on informed choice, quality of care and transfer from MLU to consultant unit. |

**Involved SaTH staff external to the Women and Children's Care Group for scrutiny and challenge*
***Involved professionals and volunteers external to SaTH for scrutiny and challenge*

**Outstanding recommendations not met by the above actions**

- Recommendation 1 - appropriate action is being taken.
- Recommendation 8 was completed at the board meeting on 4th April. Personal and written apologies, and acknowledgments of failings, have been given to Kate's parents.
- Recommendation 9 – see below.

**A legacy for Kate – Understanding the impact when things go wrong**

One of the most significant points of learning from this case, for both the care group and the Trust, is one of openness, candour and transparency. Whilst there have been improvements in this area, there is more we can and must do in memory of Kate to make sure that other parents do not have the same experience as Ms Davies and Mr Stanton.

The trust is currently revising the Serious Incident Policy and making changes to the Root Cause Analysis template following feedback from the external case review of a maternal death case. Once this is complete, a training programme built around Kate's case will be developed and implemented for all care groups, aimed at staff who are responsible for reporting, investigating and managing incidents. This will focus on the technical aspects of ensuring a robust and rigorous process of investigation is adopted but also on the human aspect of the process.

How we communicate with patients and relatives when things go wrong is critically important, and we must work hard to make sure that we do this well every time. The support that we provide for families during such difficult times can have a significant impact on the grieving process and is often remembered for many years after the incident. We see and hear the positive impact of this when we do it well and sadly we also see through Kate, what happens when we do it badly. Supporting and coaching staff to be both skilled and motivated to have those often difficult but important conversations through this training, is one step towards creating the culture of safety and kindness that we aspire to have.

In addition to the above programme, there will be specific training for staff within the Maternity Service in relation to Kate's case and its impact on her parents, the staff and the trust as a whole. Also within the care group, a suite of safety training developed from 2012 onwards in response to Kate's death will be further developed this year and shared nationally to promote the highest standard of safety training, particularly aimed at staff working in low risk Midwifery Led Units. This training includes neonatal resuscitation, neonatal stabilisation (in partnership with the ambulance service), skills drills and recognising deviation from the norm. Compliance with this programme will be reported within the aforementioned detailed action plan reported to the Quality and Safety Committee.

**Conclusion**

Whilst good progress has been made in relation to many of the actions required, it should be acknowledged that there remains further improvement work to do. Process changes and system improvements can often be straightforward to implement, however creating a culture of kindness and safety is a much longer but very positive journey.

Thanks and recognition are due firstly to Kate's parents for working with the Trust to understand the facts and the impact of Kate's death. Secondly to the other women who have shared their experiences of care with us along with their suggestions for improvement. Lastly, thanks to the staff within the Maternity Service who have embraced the learning from this case and are seeking positive change.