Paper 9

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.

Action Plan

Following the board meeting a detailed action plan has been formulated by Maternity Services with support and input from Corporate Nursing. The plan has been revised a number of times through regular review meetings which will continue for the next year to track progress.

Kate's parents have kindly reviewed the action plan which was shared with them towards the end of July and their views have been incorporated.

The Head of Midwifery will further review and format the action plan to allow evidence to be embedded and share with the Quality & Safety Committee for scrutiny.

Leadership of the Maternity Service

Since the previous board meeting the new Care Group Director and Head of Midwifery have commenced in their respective posts which has resulted in an improvement to pace and improvement delivery of the actions.

An independent expert midwife is also currently providing support to the service and Head of Midwifery for one day per week which is planned to continue until the end of October 2016 and will then be reviewed and extended if required. One of the roles of this individual is to provide objective oversight to Serious Incidents, including identification and the investigation process.

The Head of Midwifery attended the Quality & Safety Committee in September and provided an update on her findings to date regarding her first 21 days in post and shared her current thoughts on priorities for the coming months. A significant proportion of her time has been spent visiting and working alongside staff in clinical areas and she has found that frontline teams are keen to be heard and involved in service development and above all ready for change. Her initial focus will be on reviewing all governance processes in detail, an external staffing review and reviews of the Model of Care provided and the National Maternity Review.

The Quality & Safety Committee will meet the Head of Midwifery monthly at its regular meetings to scrutinise progress against the action plan and consider evidence provided for assurance.

Culture of the Service

The Trust plans to complete a full cultural assessment which will commence with the maternity service and include all staff. In addition to this a series of staff focus groups are planned over the next 3 months led by senior leaders and workforce team partners. The purpose of these is to understand how staff from all areas feel about the service they provide, how it is structured, and how it is run.

Conclusion

Good progress has been made against the action plan and there is a plan to explore and understand culture, which is timely now that new leadership is in place for the service.

A number of other improvement actions unrelated to this case are also underway within the service and the leadership team will track all actions in a combined way to ensure progress is effective and at acceptable pace. This improvement work will never cease as it is part of the continuous journey of the organisation, however although significant improvements have been delivered it must be accepted that there remains considerable further work to do and the journey is far from complete. Process changes and system improvements can often be straightforward to implement, however creating a culture of kindness and safety through learning is a much longer but very positive journey and we are confident of success through relentless exploration, transparency and commitment.

The Board is asked to;

- **Approve the action plan**
- **Delegate authority to the Quality & Safety Committee to provide on-going monitoring, scrutiny and challenge to its delivery.**
- **Receive an overview of progress, improvement and any concerns at each board meeting.**

Amalgamated Action Plan from all reports relating to the death of Kate Stanton Davies

	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
1	**Management review** Midwife 1 & 2's conduct should be reviewed in line with the Trust performance improvement policy	*Independent Review (November 2015)*		Management review in progress line with Trust HR policy "Performance & Development Employee Performance Management W10	31st October 2016	Sarah Bloomfield, Director of Nursing & Quality
2	**Guidelines** The Trust should seek assurance that all maternity guidelines and policies are formatted and ratified in line with Trust clinical governance processes	*Independent Review (November 2015)*	MLU Operational Policies Ludlow MLU Bridgnorth MLU Oswestry MLU Shrewsbury MLU Wrekin MLU Policies signed off at Policy Approval Group 29.03.16 (formatted and ratified in line with Trust governance processes) All future Policies will go through this process		Complete	Wendy Cutchie Lead Midwife for community services and MLUs
			Consultant Unit Operational Policy Antenatal Ward & Triage Area Policy signed off at Policy Approval Group 11.04.16 (formatted and ratified in line with Trust governance processes)	Consultant Unit Operational Policies Acute Maternity Services Postnatal Ward Delivery Suite written and in action and awaiting updating and referral to PAG	Complete	Annette Barton Lead midwife for Acute Unit and Paula Pryce Guidelines Midwife

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			Maternity and Obstetric Clinical Guidelines and SOP's are already formatted and ratified in line with the Trust clinical Governance process		Complete	Annette Barton Lead midwife for Acute Unit and Jacqui Bolton & Paula Pryce, Guideline Midwives
			Guidelines monitored monthly by Guideline Group (147 guidelines) Current progress 15.07.16 92% within 3 months of date	As of 31st August 2016 there are 9/147 guidelines that require updating.	30th November 2016	Jacqui Bolton Paula Pryce Guideline Midwives
3	**Audits** An audit of women who have required intrapartum transfer to PRH from a stand-alone MLU should be undertaken to ascertain whether they had fully understood their	*Independent Review (November 2015)*	**BIRTH CHOICE AUDIT** Local Patient Survey of women conducted January - March 2016 which covered Risk assessment, care in labour and Antenatal Care Just under half of the women surveyed were not	Action Plan to address survey design and feedback from women to be progressed and completed Action plan to be presented at the Patient Information Experience Panel meeting on 6th July 2016 for scrutiny and challenge.	31st October 2016	Sally Allen Audit Lead Joy Oxenham Patient Experience Lead

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	birth choice		given a choice of location for antenatal check-ups. However, 96.5% of those surveyed were satisfied with the location of their antenatal check-ups **Internal Risk assessment audit May – July 2015.** This audit was undertaken as part of a follow up action following on from the NHSLA Level 3 assessment in (Standard 4 Criterion 3), March 2013. This was one of 2 standards in 50 that the Care Group failed to achieve in achieving CNST level 3.		Completed	Wendy Cutchie Lead Midwife MLU and Community Services Sally Allen – Audit Lead

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			External Risk Assessment audit – (Aug – Dec 2015) External risk assessment audit was undertaken to ensure that every woman has a flexible plan of care adapted to her own particular requirements for antenatal care (CEMACH 2011, Maternity Matters 2007, NSF 2004, NICE 2007 & 2008, RCOG 2007, RCOG 2008).		Complete	Jo Banks Associate Director of Patient Safety
			External table top review Transfers from MLU to the Consultant Unit in March 2016. Meeting held 7th March 2016		Complete	Helen Jenkinson Deputy Director of Nursing and Quality

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
4	**Women who require more care** A review of the current system for the provision of antenatal care should be conducted to ensure that good practice models are incorporated and to identify which groups of women would most benefit from receiving continuity of care	*Independent Review (November 2015)*	The current operational systems that are in place are as follows: The process of identification of those groups of women who would most benefit from receiving continuity of care commences with confirmation of pregnancy referral and the booking system supported by Medway. Additional support has been supplied by the appointment of a Specialist Midwife for supporting women with additional needs (October 2015), in particular mental health and substance and alcohol misuse. Continuity of care is supplied through the professional groups working within the following clinics and within the community: TIMS Mental health needs Safeguarding Substance and alcohol	A review of the current systems of provision of care is being undertaken by the HOM. To include: 1. Benchmark of National Maternity Services (2016) 2. Review of Information given to women on birth choice. 3 Review of Booking for Maternity Care (Including referral for care) Guideline Clinical practice is supported by guidance, the most recent guidance development is Supporting Women with Additional Needs Full review 25th April 2016 additional update 16th June 2016.	 Completed Due end of September 2016 Due end of November 2016 Completed	Anthea Gregory Page, Deputy Head of Midwifery 1. Maternity Management team 2. Judith Ockenden, Patient Information Lead 3. Jacqui Bolton, Guideline Midwife Jacqui Bolton Guideline Midwife Melanie Stubbs Medway Lead Karen Butterill, Specialist Midwife for Improving Women's Health

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			misuse Diabetes Neurological disease Endocrine disease Haematological disease Previous traumatic delivery Renal disease Monitoring of continuity of care of all women in the community reported on: The Maternity Clinical Dashboard. Monitoring of 1 to 1 in labour reported on the Maternity Clinical Dashboard.	<u>National Maternity Review 2016 (Cumberlege Report):</u> Currently there is a high attainment of the requirement of small groups of midwives (4-6) looking after individual women in the community during the antenatal and postnatal period. A review of systems to support the intrapartum requirements is being undertaken. <u>MODELS OF CARE</u> A review of the models of care that supports continuity of care in the MLUs and the consultant Led Unit is underway. • Models of Care Workshop held April 12 2016 • Weekly meetings in progress • Finance and Marketing exercise undertaken • CCG input	Benchmarking undertaken 05 July 2016 Review of complete by end of October 2016 Briefing Paper to Care Group Board October 2016 To be presented formally to CCG's at Clinical Advisory Panel following consideration by Trust Board – December 2016	Anthea Gregory Page, Deputy Head of Midwifery Wendy Cutchie Lead Midwife MLU and Community Services supported by Care Group Management team Anthea Gregory-Page Deputy Head of Midwifery

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
5	**Governance processes** The Trust should seek assurance that all incidents are subject to an internal investigation in line with Trust policy	*Independent Review (November 2015)*	The revised Incident /near-miss reporting and investigation policy (including Serious Incidents and Never Events) policy was presented to and ratified at PAG June 2016 RCA Training Day run in Trust from 2011 **External Audit** External scrutiny of Obstetric Serious Incident proformas from 2009 – 2015 has been completed.	RCA Proforma to be reviewed and updated to ensure critical information is gathered and tabular timeline included In Kate's memory and legacy, a complete revision of SI/ RCA training to provide a suite of training to include technical skills of investigation/ RCA but also Kate's Story and impact on her family, staff and Trust. Human factors, developing a safety culture and Duty of Candour Process for triangulation to be included in the Women's & Children's Risk Management Strategy – following completion of Trust wide review of triangulation September 2016	Complete 30th November 2016 31st October 2016	Samantha Carling Patient Safety Team Manager Jo Banks Associate Director of Patient Safety Sam Carling Patient Safety Team Manager Samantha Carling Patient Safety Team Manager/ Joy Oxenham Patient Experience Lead/ Sarah Bloomfield Director of Nursing & Quality/ John Jones Deputy Medical Director

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			Women & Children's Services comply with the above Trust Policy The relevant CCG is invited to all Serious incident investigation meetings to provide the external scrutiny of commissioners All staff identified in a Serious Incident investigation are now referred to a preliminary Supervisory and Management investigation and a decision tool is used to determine whether a full investigation is required. A full Supervisory investigation is supported by an external Supervisor of Midwives.	External Midwife overview of identified SI's commenced in July 2016	30th October 2016	Sarah Bloomfield Director of Nursing & Quality/
6	**Acknowledgement of failings and the harm caused** The Trust should acknowledge the failings in both care and complaint handling that occurred and the	*Ombudsman Report 2014* *Independent*	**TRUST ACTIONS: Response to Ombudsman:** An unreserved apology was sent to Mr Stanton and Ms Davies from the Trust for the failure to investigate the treatment and standard of care		Complete	LSAMO Peter Herring Chief Executive

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
	injustice Ms Davies and Mr Stanton suffered as a consequence and apologise for them The Trust should publically acknowledge the failings identified in this review and the harm that they have caused Ms Davies and Mr Stanton	*Review (November 2015)*	received by Ms Davies and Kate. Date:16.01.2015 The Trust apologised for the failings in the Trust's complaint handling process. Date: 16.01.2015 **Response to Independent Review**: The Trust has publically accepted the findings of the Independent Review and has publically apologised to Ms Davies and Mr Stanton (Public Board Meeting 4 April 2016). **Actions taken by Trust Officers:** CEO has written to Richard Stanton and Rhiannon Davies, 14th April 2016 Chairman and Director of Nursing have met with Richard Stanton and	Communication with the Director of Nursing for quarterly updates	1st Update shared in July 2016 Complete Complete	Peter Latchford Chairman Simon Wright Chief Executive Sarah Bloomfield Director of Nursing & Quality Sarah Bloomfield Director of Nursing & Quality Simon Wright Chief Executive Peter Latchford

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			Rhiannon Davies and offered an unreserved apology 28.04.15			Chairman Sarah Bloomfield Director of Nursing & Quality
7	The Trust should work with Ms Davies and Mr Stanton to establish a fitting memory to their daughter Kate	*Independent Review (November 2015)*		Suggestions: 1. Care Group staff Induction for all staff: Kate's Story to be added to induction pack	31st October 2016	Anthea Gregory-Page Deputy Head of Midwifery
8	**Review of on call arrangements** Expectation of on-call Midwives to live close enough to be able to respond	*Extraordinary Trust Board Meeting (April 2016)*	In 2016 there was a review of the expectations of the on call midwife with an expectation of a travel time to attendance of 30 minutes. April 2016 SOP cascaded as per the guideline process as described above April 7th 2016		Complete	Wendy Cutchie Lead Midwife MLU and Community Services Jacqui Bolton Guideline Midwife
9	**Lack of contemporaneous midwifery notes** Limited information	*LSA Supervisory 2009*	**Information to support other health care professionals** Comprehensive multi-	Maternity Information System roll out of antenatal record proposed and due	31st March 2017	Medway team

	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
	available for other health professionals and unable to establish the time of collapse	*Rule 43 Report HM Coroner 2013* *Independent Review (November 2015)*	disciplinary hand held records including comprehensive contemporaneous care notes and summary information sheets from Maternity Information System held by patients. This enables contemporaneous records to be available to professionals in all health care settings (GP surgery; MLU; CU; other Trusts) Maternity Information System (electronic patient record) with record of Booking information; risk assessment ; intrapartum care and post natal care available in all SATH sites delivering maternity care. Available for printing to support transfer of care. **Actions taken because of professional failure at the time of collapse:-** ▪ Midwife Supervisory review of practice 2009 with recommendations (acknowledge that this was later found not fit for purpose)	quarter 4 2016/17 It is custom and practice to photocopy additional MIS record not present in the hand held record and intrapartum care documentation when transferring out of county. The transfer guideline is to be updated to make this explicit.	31st October 2016	Jacqui Bolton Guideline Midwife

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			▪ Further midwife supervisory review 2015 with recommendations Record keeping was addressed individually via the NMC Supervision of Midwives framework and the recommendations have been completed by the two midwives concerned 2009 Further actions progressed from 2015 review **System developments: Handover of Care (onsite) guideline 2010 - SBAR transfer form developed**. The SBAR handover of care on transfer from a ward to ward, or unit to unit was developed in line with national recommendation. This is now part of the transfer of care guideline for both mother and baby. The maternal and neonatal transfer guidelines have been developed and updated as follows. • Transfer (by Ambulance) of a	An audit for transfers of mother or baby from an MLU to consultant unit has been undertaken and the report is complete. This is now to become a continuous audit The audit report is to be completed and signed off at Maternity Governance meeting It will then be discussed at the Quality & Safety	Complete 30th September 2016 October 2016	Sue Brown, Wendy Tyler, Wendy Cutchie Rachel Lloyd Audit – Women's & Children Centre Wendy Cutchie Lead Midwife Community services Sue Brown Specialist Midwife Sarah Bloomfield Director of Nursing & Quality

	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			Woman in the Antenatal, Intrapartum and Postnatal Period v5.5 (171) Developed updated with SBAR tool 4th April 2016 • Handover of Care (onsite) v5.2 (064) • Maternal and Neonatal Transfers from Wrekin MLU to Women's and Children Centre SOP v1.2 (019) • Transport Arrangements for the Movement of a Sick Newborn into Hospital from Home or a Midwife-Led Unit v4.2 (169) with SBAR April 2016 (this will be developed further below) • Recognising and Stabilising the sick newborn in midwifery led units & attended home births V1 – September 2016 **Recognition of the sick neonate and management** **1.** Yearly mandatory training includes	Committee Meeting		Alison Moore Consultant neonatologist (development) now replaced by Wendy Tyler – Consultant Neonatologist

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			▪ Newborn Life Support (Statutory Safety Update) annual - A local but mandatory midwifery update including newborn life support scenarios (multi professional) The training facilitators' handbook was developed by the Consultant Neonatologist and Lead Midwife for Education. This included the theory, practical neonatal resuscitation scenarios specific to midwife led units, in addition to the Neonatal Life Support requirements for updating and training . ▪ NLS –National Newborn Life Support course (accredited by the	Audit of MLU records of care in labour May 2016 will be discussed at Quality & Safety Committee	19th October 2016 Complete	Wendy Cutchie Lead Midwife MLU and Community Services Sarah Jamieson Head of Midwifery Sue Brown Specialist Midwife

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			Resuscitation Council UK) 4 yearly - Midwives that are working in a midwife led unit on community undertake this course every four years - 92% of midwives in the community and MLU settings have been trained in NLS as of August 2016 ▪ Neonatal Stabilisation course 4 yearly (Multidisciplinary training with ambulance services) ▪ NIPE (Newborn Infant Physical Examination) In addition the MLUs undertake the following training: - All MLUs undertake **"Live skills drills"** in their local area 2011 - Manikins for simulation live skills drills for all MLUs were purchased 2016 NEWS (Neonatal Newborn Early Warning Score) was			

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			developed in 2013 – enhanced observations for at risk babies were introduced **Standards of Care and Information recording:** 2006 -2015 (November): Intrapartum care of a woman on a midwife led unit or home birth guideline developed. This guideline is updated triennially or sooner if local needs or national guidance recommend and has been updated a total of eighteen times since its first publication in 2006 in line with national recommendations and local learning. **Guideline** Maternity Records v3 (136) updated Nov 2015 **The Maternity Early Warning Score (MEWS)** was fully revised in 2014 following recommendations from CNST level 3.		Complete Complete Complete	Jacqui Bolton Guideline Midwife Anthea Gregory Page Deputy Head of Midwifery

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			Staff guidance with regards record keeping: 1. Maternity Records v3 (136) 2015, guidance regarding the importance of record keeping. This guideline is updated triennially or sooner if local needs or national guidance recommend. It was first introduced in June 2010 and has since had 7 further updates and is available to all Midwives.		Complete	

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
10	**a. Transfer arrangements** Review transfer guideline of a sick newborn to a neonatal unit Review transfer guideline to include prompt communication with NNU and details required for emergency transfer	*SaTH Mortality (Death) Review 2009* *Rule 43 Report HM Coroner 2013*	**Guideline** System developments Handover of Care (onsite) guideline 2010 -SBAR transfer form developed. The SBAR handover of care on transfer from a ward to ward, or unit to unit was developed in line with national recommendation. This is part of our transfer of care guideline for both mother and baby. The maternal and neonatal transfer guidelines have been developed and updated as follows: Transfer (by Ambulance) of a Woman in the Antenatal, Intrapartum and Postnatal Period v5.5 (171) updated with SBAR tool 4th April 2016 Handover of Care (onsite) v5.2 (064) Maternal and Neonatal Transfers from Wrekin MLU to Women's and Children Centre SOP v1.2 (019)	Development of Community/MLU dashboards to include Transfer audit information Process to ensure all areas are notified if the helipad is closed.	30th September 2016 Completed August 2016	Wendy Cutchie Lead Midwife MLU and Community Services Anthea Gregory-Page Deputy Head of Midwifery

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
	b. Transfer and stabilisation training		Transport Arrangements for the Movement of a Sick Newborn into Hospital from Home or a Midwife-Led Unit v4.2 (169) with SBAR April 2016 (this matter will be developed further below) Transport pod was purchased for use in an ambulance Ludlow 19.04 10 Other PODS for all MLUs between April - November 2010 **Multi agency Meetings (Ambulance services);** Continued work with the Ambulance Service Immediate response: Meetings held: 23.07.2009 Multiagency meetings for Reconfiguration: Working Group 1: 14.12.12 Working Group 2: 05.12.12 & 23.01.13 Working Group 3: 14.12.12 & 22.01.13			

	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			Working Groups 1, 2 & 3: 27.02.13 **2013 (December): Neonatal Stabilisation Training.** This is an additional training package to the accredited Newborn Life Support certificate. The collaborative training package was developed to educate and support midwives and ambulance personal that were required to stabilise and support the neonate prior to transferring to the nearest neonatal unit. The training was modelled on a successful package that had first been developed and implemented in Scotland. These courses are held 1-2 times per year. **Guidelines to support practice:** 1. The Resuscitation of the Neonate on a MLU/Home Guideline– had a full review in 2015. 2. Transport			Wendy Tyler Consultant Neonatologist

	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			Arrangements for the Movement of a Sick Newborn into Hospital from Home or a Midwife-Led Unit v4.2 (169) for the ambulance service for transporting pre-term babies/ neonates from home in Shropshire. 3. Emergency Department Admissions v6 (087) Sept 2014 guideline for accepting and resuscitating neonates **Pathway** 1. Clinical Pathways devised and displayed on SaTH intranet September 2014 **Equipment:** 1. Laryngeal Mask Airway masks were purchased for the units for paramedic use 2. PANDA resuscitaires are standardised in all areas and available in all MLUs at RSH/PRH. All training uses these resuscitaires. Daily			

	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			checking procedure in place in all areas which have a PANDA resuscitaire			
13	**Identification of the abnormal** Training for midwives to identify and act on the abnormal including the possible significance of a large placenta	*Rule 43 Report HM Coroner 2013* *Ombudsman Report 2014*	**To be read in conjunction with Sections 9 and 10** **Guideline:** Intrapartum Care on a Midwife led unit or homebirth **Reason;** Continued capture of inquiry of the significance of an enlarged placenta **Date :** Vs 6.6 Jan 2013 **Newborn Early warning assessment tool (NEWS) Implemented:** to enable earlier identification of the sick new born. **Date:** 27.09.13 **Intrapartum Care on a**	The care group is also currently reviewing the New Born Early Warning Track and Trigger assessment tool.	30th November 2016 Complete	Paula Pryce Guideline Midwife Wendy Tyler Consultant Neonatologist Paula Pryce

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			Midwife led Unit or home birth **Date:** Jan 2013 further update 17.06.16 **Reason:** To ensure appropriate use of a stethoscope to determine the baby's heart rate following birth.			Guideline Midwife
14	**Lack of family liaison** There was a failure of the part of the Trust to properly explain what happened and to keep Kate's parents informed. Early and clear lines of transparent communication will help to identify and address any concerns	*Rule 43 Report HM Coroner 2013*	**Care Group Action:** Bereavement Midwife appointed in January 2011 Patient Experience Midwife appointed in June 2011 Both the Bereavement Midwife and Patient Experience Midwife attend case reviews to help ensure questions and queries are raised on behalf of parents and to act as advocates. Additional support has been supplied by the appointment of a Specialist Midwife for supporting women with additional needs (October 2015), in particular mental health and substance and alcohol			Jan Latham Bereavement Midwife Joy Oxenham Patient Experience, Women's & Children Centre

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	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			misuse. **Trust Action:** The Trust has also completely revised the Complaints process to improve thoroughness, openness and empathy of responses and timelines of responses.		Complete	Head of PALS & Complaints
15	**Risk assessment form** Following assessment by the NHSLA, the Trust made the recommended changes to the risk assessment form. The Ombudsman requested further reassurance on compliance.	*Ombudsman Report 2014*	A risk assessment audit was undertaken as part of a follow up action following on from the NHSLA Level 3 assessment in (Standard 4 Criterion 3), March 2013. This was one of 2 standards of 50 that the Care Group failed to achieve. **Internal Risk assessment** Audit May – July 2015 **External Risk ASSESSMENT SITE OF DELIVERY AUDIT :** (Aug – Dec 2015) **Reason:** To ensure that every woman has a flexible plan of care adapted to her own particular requirements for antenatal care (CEMACH 2011, Maternity Matters		Complete Complete	Associate Director of Patient Safety

	Recommendation/ Action	Source	Actions completed	In Progress	Due by	Person Responsible
			2007, NSF 2004, NICE 2007 & 2008, RCOG 2007, RCOG 2008). **An antenatal clinical risk assessment audit** Completed May 2016			
	Ensure women receive adequate information to make an informed choice as to place of birth	*Ombudsman Report 2014*	The patient information booklet was updated to include risks and benefits of Midwife Led Unit births 2012 Information relating to place of birth was made available on the Trust website November 2012 **Survey:** A local Maternity survey was conducted and women who gave birth during January, February and March 2016 at all SaTH maternity units were invited to participate. Areas covered included information given to enable birth choice.	The patient electronic record now has the facility to record that the patient information booklet has been given to the patient and compliance audited. This audit has not been undertaken yet, The methodology of this survey is under review as the context of the question includes women where the option of delivery other than the CU would be against professional advice and therefore choice of place of birth may be limited as described by NICE compliant risk assessment. This will therefore be changed for the next survey in October 2016 onwards	31st October 2016 December 2016	Joy Oxenham Patient Experience, Women's & Children Centre Graeme Mitchell Associate Director of Patient Experience

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	A new Supervisory Investigation should be undertaken by external supervisors to the region	*External Review of Midwifery Supervisory Investigation August 2015*	Completed			LSA NHS England
	The Midwife's capability to carry out the function of a SoM should be assessed, in compliance with LSA policy and NMC standards. The assessor should be determined by Midlands and East NHS England Regional Director of Nursing Quality as line manager.	*External Review of Midwifery Supervisory Investigation August 2015*	Completed			LSAMO Joy Kirby
	To seek assurance that the weaknesses in the LSA investigatory process c2009 identified in	*External Review of Midwifery Supervisory Investigation August 2015*	Actions to be undertaken by regional LSAMOs.			Regional LSAMO – Joy Kirby

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	this review are no longer inherent in the current process Being open when things go wrong		Patient safety incident reporting requires Duty of Candour discussion to be undertaken as part of notification Care Group: Patient safety incidence with harm: 1. **SI:** Following completion of SI investigation the family are offered an appointment with the Care Group Director/Medical Director and Head of Midwifery. At this meeting the minutes; tabular time line and SI proforma are shared with the family and copies are offered to the family 2. **High Risk Case Review** following a HRCR the family are offered a meeting with	To be included in the Care Group Risk Management Strategy – September 2016		Joy Oxenham Patient Experience

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			the CD in maternity/neonatology and the deputy HOM/ lead nurse. At this meeting the minutes; tabular time line and SI proforma are shared with the family and copies are offered to the family			

APPENDIX 1

Neonatal Issues Identified for Neonatal Clinical Governance from Independent Review of Kate

Issue Identified	Current status	Further action required	Responsible staff member (s)	Implementation Date
Apgar score - midwives are not taught to listen to heart rate with a stethoscope	Mandatory newborn life support training at SaTH teaches that the heart rate is listened to (not felt) in line with Resuscitation Council UK guidance	1. Reinforce this message through all available training for midwives 2016/17 year— annual newborn resuscitation updates, MLU stabilisation training 2. Alert to all midwifery staff using Medway alert system 3. Included in maternity newborn resuscitation guidelines	Midwife education lead (1 & 2) Lead for newborn resuscitation (1 & 3) Maternity Guidelines Midwives (3) Medway team (2)	1. Commence May 2016 - completion expected by April 2017 2. July 2016 3. July 2016
If Apgar score unsatisfactory @ 1 & 5 min for a 3rd score to be calculated @ 10 min		1. Incorporation into midwifery guidelines for newborn resuscitation 2. Reinforced at training above	Maternity guidelines midwives (1) Midwife education lead 2)	1. July 2016 2. May 2016-Apr 2017

			Lead for newborn resuscitation (1 & 2)	
If poor tone at birth does not improve to call neonatal team for advice & transfer baby to consultant unit	MLU stabilisation guideline written & accepted at governance March 2016 Within training on MLU stabilisation training course	1. Check within maternity newborn resuscitation guidance 2. Check MLU stabilisation guidance on intranet 3. Check within transfer of a sick baby guidance	Maternity guidelines midwives & newborn resuscitation lead (1, 2 & 3)	1. July 2016 2. July 2016 3. July 2016
Baby temperature target is now (2016) 36.5-37.5 & interventions to warm cool babies should be prompt & documented	MLU stabilisation guidance & course	1. Check within maternity newborn resuscitation guidance 2. Check clear in MLU stabilisation guidance 3. Check guidance for hypothermia management for maternity	Maternity guidelines midwives (1, 2 & 3) & newborn resuscitation lead (1 & 2)	1. July 2016 2. July 2016 3. July 2016

Grunting commencing some time after birth or not settling within 30 min of birth requires advice from & referral to the neonatal team	MLU stabilisation guidance & course covers this	1. Check clear within MLU stabilisation guidance 2. Check clear within transfer of a sick baby guidance	Maternity guidelines midwives & newborn resuscitation lead (1 & 2)	1. July 2016 2. July 2016
Reluctance to feed and/or poor sucking reflex is a cause for concern & requires advice from the neonatal team to be sought	MLU stabilisation guidance & course	1. Check clarity in MLU stabilisation guidance	Maternity guidelines midwives & newborn resuscitation lead (1)	1. July 2016
Any concerns regarding a baby's health in an MLU to call the neonatal team	MLU stabilisation guidance & course		-	-
If concerned about a baby monitor using neoNEWS & never leave the baby unattended	MLU stabilisation guidance & course	1. Check clarity in MLU stabilisation guidance	Maternity guidelines midwives & newborn resuscitation lead (1)	1. July 2016

When resuscitating a baby and there is no heart rate response chest wall movement MUST be seen before commencing chest compressions	This has been SaTH practice in line with the Resuscitation Council UK guidance	1. Reinforce this message through all available training for midwives 2016/17 year— annual newborn resuscitation updates, MLU stabilisation training 2. Alert to all midwifery staff using Medway alert system	Midwife education lead (1 & 2) Lead for newborn resuscitation (1) Medway team (2)	1. Commence May 2016 - completion expected by April 2017 2. July 2016
If a baby is not breathing effectively BREATHE for the baby always NB a baby with poor tone is highly likely to have a partially if not fully obstructed airway	This has been SaTH practice in line with the Resuscitation Council UK guidance	1. Reinforce this message through all available training for midwives 2016/17 year— annual newborn resuscitation updates, MLU stabilisation training	1. Midwife education lead & lead for newborn resuscitation	1. Commence May 2016 - Apr 2017

Amalgamated Action Plan from all reports relating to the death of Kate Stanton Davies

A response in heart rate is when the heart rate is above 100 beats per minute	This has been SaTH practice in line with the Resuscitation Council UK guidance	1. Reinforce this message through all available training for midwives 2016/17 year— annual newborn resuscitation updates, MLU stabilisation training	1. Midwife education lead & lead for newborn resuscitation	1. Commence May 2016 - Apr 2017
When a newborn in an MLU requires resuscitation & stabilisation utilise the support of additional midwifery & WSA staff	Within teaching for newborn resuscitation & MLU stabilisation	1. Reinforce this message through all available training for midwives 2016/17 year— annual newborn resuscitation updates, MLU stabilisation training 2. Local MLU skills drills to practice newborn resuscitation & stabilisation within local teams	1. Midwife education lead & lead for newborn resuscitation 2. MLU unit managers with midwife education lead (nb manikins sourced by midwife education lead; scenarios/simulations can be the same as those taught on the MLU stabilisation course)	1. Commence May 2016 - Apr 2017 2. To commence asap (August 2016 following MLU/NLS facilitators meeting in July 2016)

Amalgamated Action Plan from all reports relating to the death of Kate Stanton Davies

When transporting a baby from the MLU to the ambulance NEVER carry the newborn and ALWAYS move on a stretcher continuing resuscitation ideally with saturation monitoring	Within teaching for newborn resuscitation & MLU stabilisation Within transfer of a sick newborn guidance	1. Check clarity in transfer of a sick newborn guidance	1. Maternity guidelines midwives	1. July 2016
Annual newborn life support updates are supported by Advanced Neonatal Nurse Practitioners & NLS instructors	Since key Resuscitation Officer changed role this has not been met. Current Resuscitation Officer training to be NLS providers but Resus Council do not routinely support Resuscitation Officers to become instructors as few midwives are NLS instructors	1. Support for an increased number of NLS instructors within midwifery (will require funding for GIC course and release for 2 days per annum to teach on national NLS courses)	1. Head of Midwifery to promote within W&C centre	1. On appointment of new Head of Midwifery