The Shrewsbury and Telford Hospital NHS
NHS Trust

Enclosure 2

Reporting to:	**Trust Board, 4 April 2016**
Title	Learning and Actions Resulting from the Case of Kate Stanton Davies
Sponsoring Director	Sarah Bloomfield - Director of Nursing & Quality
Author(s)	Sarah Bloomfield - Director of Nursing & Quality
Previously considered by	N/A
Executive Summary	This paper outlines the learning and actions that have taken place either wholly or partly because of the avoidable death of Kate Stanton Davies. It also identifies learning still in progress and yet to be completed, which will be overseen by the Quality & Safety Committee who will provide assurance to the board on the robustness, completion and effectiveness of the actions described, and overall on the quality and safety of the maternity service.
Strategic Priorities ☒ Quality and Safety ☐ Healthcare Standards ☐ People and Innovation ☐ Community and Partnership ☐ Financial Strength	**Operational Objectives** Deliver all key performance targets.
Board Assurance Framework (BAF) Risks	☒ Deliver Safe Care or patients may suffer avoidable harm and poor clinical outcomes and experience ☐ Achieve safe and efficient Patient Flow or we will fail the national quality and performance standards ☐ Clear Clinical Service Vision or we may not deliver the best services to patients ☐ Good levels of Staff Engagement to get a culture of continuous improvement or staff morale and patient outcomes may not improve ☐ Appoint Board members in a timely way or may impact on the governance of the Trust ☐ Achieve a Financial Risk Rating of 3 to be authorised as an FT
Care Quality Commission (CQC) Domains ☒ Safe ☐ Effective ☒ Caring ☒ Responsive ☒ Well led	**Outcomes** Standard 17
Recommendation	The Board is asked to: ☒ **Receive** ☐ **Note** ☒ **Review** ☒ **Approve**

Paper 2

Actions and Learning following the death of Kate Stanton Davies

Learning and Actions identified prior to the independent review

The following table covers actions and improvements that have been undertaken either wholly or partly as a result of Kate Stanton Davies death in the period 2009 – 2015.

Theme	Action	Status
Policies and guidelines	Standard Operating Policies implemented for Midwifery Led Units which have subsequently been reviewed and ratified by the trust Policy Approval Group	Complete 2015
Policies and guidelines	Intrapartum care of Women on a Midwifery Led Unit or Home Birth guideline reviewed regularly	Complete (reviewed 2012, 2015, 2016)
Policies and Guidelines	Risk Assessment of Place of Delivery Guidelines regularly updated	Reviewed 8 times between 2010 and 2015.
Policies and guidelines	Transfer guidelines updated. Recently reviewed again and approved through the trust Policy Approval Group	Complete 2016
Training	Joint training on Neonatal Stabilisation with midwifery staff and ambulance service staff	Implemented 2013 and continues
Training	Neonatal Life Support. Every midwife is required to do this every 4 years and attend an annual refresher. MLUs and Community staff prioritised.	Implemented 2011 and continues

Training	Midwives rotation through low and high risk areas formalised.	Revised in 2013 and continues
Transfer	Transfer PODS purchased	Complete 2009
Transfer	Audit of all transfers from MLUs to Consultant Led Unit of women in labour.	Implemented 2010, however revised 2015 to include focus on clinical outcomes.
Vulnerable women	Appointment of Specialist Midwife to support vulnerable women	Complete 2015
Training	Skills Drills extended to MLUs and cover related issues such as neonatal deterioration and stabilisation.	Implemented in 2011 and continues with further training equipment purchased in 2016
Risk Assessment	Audit of risk assessments of place of birth completed regularly	Implemented 2012 and continues
Risk Assessment	Revised antenatal records to give clarity on antenatal risk assessment	Implemented 2010
Risk Assessment	Revised information available to women on place of birth both in written leaflet form and on trust website.	Last updated 2014
Record keeping	Regular audits of standards of record keeping	Implemented 2010

Learning and Actions in response to Independent Review Report recommendations

Recommendation	Action	Status
Midwives 1 & 2 conduct should be reviewed in line with Trust's performance policy	Appropriate action is being taken.	In progress
The Trust should seek assurance that all maternity guidelines and policies are formatted	Clear guidance given on process to be followed and current policies reviewed by Trust	Complete

and ratified in line with Trust clinical governance processes	Governance Team	
	MLU Operational Policies and Escalation Policy have now been formatted, and ratified by Trust Policy Approval Group (PAG)	Complete
	Consultant led unit policy to be reviewed by PAG at next meeting	Due for completion May 2016
To better understand whether women birthing in a standalone MLU had fully understood their birth choice, an audit of women who have required intrapartum transfer into PRH from MLU should be undertaken.	Risk Assessments of Place of Birth audited, reaudit completed with external oversight.	Completed March 2016, report to Quality and Safety Committee April 2016
	Post natal survey of women on informed decision making in choice of birth location	Commencing April 2016
	Audit of intrapartum transfers from MLU to Consultant Led Unit	Revised audit commenced, quarterly reports will go to Quality & Safety Committee from May 2016
	Weekly notification of MLU to Consultant Led Unit transfers to Director of Nursing	Complete and continues
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.	Antenatal care continuity reviewed against NICE guidelines and reported on monthly maternity dashboard.	Complete and continues
	Current model under further review to ensure highest risk groups of women are identified and prioritised. This will be further strengthened by the specialist midwifery teams.	Some at risk groups already identified and supported by specialist midwives. Will be fully complete May 2016
Review the evidence base for midwives to 'double glove' when providing intrapartum care.	This practice is not endorsed by the Trust. Correct practice being reinforced across service and spot checked.	Complete and continues

The trust should seek assurance that all maternity incidents are subjected to an internal investigation in line with Trust policy.	All incidents reviewed against national Serious Incident criteria by the Patient Safety Team which sits outside the Maternity Service.	Complete and continues
	All Serious Incidents now formally reviewed for need for management investigations.	Complete and continues
	Non maternity service representatives invited to SI/RCA meetings to ensure objectivity and challenge.	Complete and continues
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.	The Trust will write to Ms Davies and Mr Stanton following the board meeting of 4th April 2016, explicitly supporting the approved independent review report and enclosing action plans.	To be completed April 2016
	The Trust will write to or meet Ms Davies and Mr Stanton at their preference at least every 3 months to update them on progress against the learning needs identified and provide evidence to support this.	To be agreed with Ms Davies and Mr Stanton during April 2016
The Trust should publically acknowledge the failings identified in this review and the harm they have caused Ms Davies and Mr Stanton.	To be acknowledged at the board meeting held in public on 4th April 2016.	For completion 4th April 2016
The Trust should work with Ms Davies and Mr Stanton to establish a fitting memory to their daughter, Kate.	Kate's story, the impact on her family and the importance of being honest, transparent and open when things go wrong will, with her parents' permission, be used in training for staff;	To be agreed with Ms Davies and Mr Stanton

	Staff working in the Women and Children's Care Group will receive this training and it will be included in the induction training of all staff new to this service. Kate's story will also be used as a case study in training for all staff on reporting, managing, learning from incidents and the critical importance of the duty of candour and its impact on patients and families.	To be agreed with Ms Davies and Mr Stanton

Further learning to supplement the independent review recommendations identified by Ms Davies and Mr Stanton at the request of the Trust

Theme	Action	Status
Safety	Review staffing model for MLUs	In progress, due for completion April 2016
Safety	Work with Dr Alison Bedford-Russell to ensure that risk assessment practice meets best practice guidelines and reflects regional work on antenatal risk assessment	In progress, due for completion April 2016
Safety	Review all information given to women on risk assessment for place of birth supported by the Maternity Engagement Group.	Will be reviewed by MEG at May 2016 meeting
Training	Review the training provided to staff in appropriate risk assessment of place of birth, including ensuring informed decision making is supported.	Training will be updated following completion of revised patient information and commenced in June 2016

Training	Review skills drills, neonatal stabilisation training and scenario training to ensure that is delivered in context of a service in a rural setting	In progress, due for completion April 2016

Learning in relation to the Local Supervising Authority

In February 2014, the Stanton Davies family wrote to NHS England setting out their concerns about the quality of the midwifery Local Supervising Authority (LSA) Investigation which was undertaken following the death of their daughter Kate. In response to the concerns raised, NHS England commissioned an independent review of this LSA investigation and the final report was received in August 2015.

The independent review report concluded that the original LSA investigation was not fit for purpose and made a number of recommendations to NHS England that have been fully accepted. An action plan in response to these recommendations was developed and implemented by NHS England (Midlands and East).

The actions taken by NHS England (Midlands and East) in response to the independent review included:

- The completion of a new LSA investigation led by an LSA Midwifery Officer external to the Midlands and East Region
- The development and implementation of a peer review audit process to seek assurance that the issues identified for this investigation were not apparent in other LSA investigations
- A review of all supervisory investigations undertaken at the Trust on behalf of the West LSA since 2009.

The new LSA investigation was completed in December 2015 and was shared with the family in January 2016.

The peer review audit identified opportunities to strengthen the LSA investigation process and as a direct result, changes have been made to the investigation procedures and template within the Midlands and East Region. The outcome of the peer review audit will be shared with the NHS England Maternity Programme Board to enable any wider learning to be considered. The review of all LSA investigations undertaken at the Trust since 2009 is expected to complete by end April 2016 and NHS England (Midlands and East) will share the findings with the Trust to enable any additional learning that may emerge from the review to be incorporated into the Trust's action plans.

Conclusion

All learning will be monitored through the Quality and Safety Committee in the form of formal action plans, which will provide assurance to the board on a quarterly basis. The committee will continue to receive assurance of the quality and safety of the service through regular metrics such as the maternity and neonatal dashboards. The committee will be receiving the following reports for scrutiny and challenge in the coming months;

- MMBRACE – Report already received, the committee will scrutinise a review of all neonatal deaths and still births that occurred in 2013
- SI table top review and Multidisciplinary review of neonatal/maternal deaths and SIs from 2009 onwards
- Postnatal survey results
- Morecambe bay action plan review
- RCOG report of obstetric indicators
- Monthly feedback from interim Consultant Midwife and subsequently newly appointed Head of Midwifery

The avoidable death of Kate Stanton Davies and subsequent inadequate investigation and responsiveness of the Trust has caused irreparable damage to her parents Ms Rhiannon Davies and Mr Richard Stanton. This lifelong impact must never be forgotten by the organisation and we will continue to learn from this case both within the Women and Children's care group and across the whole organisation for many years to come. To implement improvements and continuously test them and our service against the standard of "what would have been the best care for Kate?" is the only acceptable outcome of this review.