1 April 2016

The Shrewsbury and Telford Hospital NHS Trust

Putting Patients First

Focusing on clinical quality and improvement in The Shrewsbury and Telford Hospital NHS Trust

Learning and improving when things go wrong

Taking lessons from the findings of the independent Maternity Review

An independent Maternity Review was published on 1 April 2016. It looks at the tragic death of Kate Stanton-Davies in 2009, hours after being born at Ludlow Midwife-Led Unit. The report looks at both the care and treatment provided to Kate and her mother and the Trust's subsequent handling of Kate's parents' concerns and the governance around the management of the incident itself. This newsletter reflects on the case and the findings of the independent review. The full report can be found at www.sath.nhs.uk/independentreview and will be discussed at a special meeting of the Trust's Board at the Shropshire Conference Centre at the Royal Shrewsbury Hospital at 3pm on Monday 4 April 2016:

I would like to apologise unreservedly for the shortcomings in care provided by The Shrewsbury and Telford Hospital NHS Trust (SATH) that contributed to the death of Kate Stanton-Davies in 2009.

I would also like to apologise that the way this Trust handled the complaints raised by Kate's parents, Rhiannon Davies and Richard Stanton, fell far short of the standards we all have a right to expect, and that this added significantly to the pain and distress they had already experienced.

Today's report makes difficult reading – even more so because it has only come about because of the determination of Richard and Rhiannon to bring to light the failures of the original investigation, the quality of care we should have afforded them and our failings in protecting Kate when she was at her most vulnerable.

It is important that this independently commissioned report was carried out by somebody the family had confidence in. We believe that what we have been presented with is a fair and balanced report. The nature of the report's contents requires us, and other organisations, to ensure we are listening to families without them having to go to such lengths in order for their voices to be heard.

Simon Wright

Chief Executive

We fully acknowledge the failings identified in this report and the harm they have caused to Richard and Rhiannon.

The report describes how this Trust failed to fulfil its responsibility to establish the facts of the case and to establish accountability. Rather, it abdicated that responsibility to the Local Supervisory Authority (LSA), which is independent of the Trust. In 2017, the rules around LSAs undertaking such investigations will change. This Trust also did not put Kate's parents at the heart of the way it responded to their complaint, it did not address the issues they raised and its responses contained factual inaccuracies.

This inadequate response placed an even greater burden on Rhiannon and Richard, who ensured that external reviews took place to tackle the deficiencies of our own investigations. The Trust will be using this report to see if it raises any questions about the responsibilities of any individuals involved.

We fully accept the recommendations in the report. We will hold a transparent process to ensure that they are seen through to their full conclusion, and updates on our progress will be reported to our Trust Board meetings, which are held in public.

We have already taken significant steps including:

- Substantial training for our midwifery staff, including initial orientation combined with subsequent rotation to ensure comprehensive knowledge
- Additional education with four-yearly national neonatal resuscitation training and annual statutory updates to enable them to react appropriately if a baby suddenly deteriorates
- Offering more opportunities for early intervention and ensuring more open discussion with patients or their families about how they want their concerns to be addressed
- Recognising that our previous approach when responding to complaints was too defensive and ensuring that our letters and other feedback are focused more on learning and improvement
- Strengthening our complaints team, including an experienced new Head of Complaints
- Making sure that the Trust Board has regular discussions on the complaints we receive and how they are being handled

"I would like to apologise unreservedly for the shortcomings in care."

At our Midwife-Led Units, our Midwives undergo training in various scenarios which may occur during childbirth to ensure their skills and techniques are up-to-date. We also hold "skills drills" at our Consultant-Led Unit. These ensure that our Midwives are able to manage any emergency situation, however rare.

A Focus group has taken place involving staff from our Midwife-Led Units and the Consultant-Led Unit, which focused on ensuring they were aligned and compliant with policy. Focus groups also looked at workforce development, staff rotation and safety as well as highlighting what we offer to attract new staff and keep existing staff. These led to some positive developments. We have carried out a review of 10 cases about transferring patients from MLUs and found that in all 10 cases, staff had followed policy and had safe transfers.

The aim of focus groups is to find ways we could improve the service through education and service improvements. We've also looked at other ways we can improve. Overall the work showed that we have a safe service, but need to ensure that we are constantly looking at ways to improve and ensuring we are in line with national guidance.

When serious incidents do occur, we adhere to expectations under the Duty of Candour Regulations, to ensure we are open and transparent with patients and their families about how we will put things right where safety has been compromised.

Having recently joined the Trust, I am reassured that the report finds that learning from these tragic events has led to considerable improvements in Maternity Service Clinical Governance and the Trust's complaints processes.

This Trust offers a safe service for mothers, babies and families but there is clearly more that we must do to ensure that the learning from Kate's care is put into practice. It is important for all mothers and their families who are placing their trust in us to know their child will be safe in our care. We want to provide every level of assurance we can to any mothers coming to us.

Nothing can make up for the loss of Kate but I sincerely hope that the improvements we have made and continue to make and the lessons we have learned and continue to learn will ensure that these tragic events are not repeated, but instead go to inform and shape our maternity care both now and in the future.

Continuing to learn how we can make improvements to Maternity Services

The publication of the independent Maternity Review highlights a number of areas where we need to make improvements and I'd like to take this opportunity to thank Richard Stanton and Rhiannon Davies for their determination in ensuring their voices have been heard and that lessons are learnt.

The care provided for Rhiannon and her daughter Kate Stanton-Davies in 2009 failed to meet the high standards we set for every one of our patients and I'd again like to apologise to Rhiannon and Richard for this.

We fully accept the recommendations of this report and are committed to taking the action required because we can clearly see how this will improve patient care.

We have learnt a lot from this tragic incident. We have already made a number of improvements since 2009 but recognise we have more work to do on our journey.

The Trust has made significant improvements, both to the standards and safety of maternity care, and to the way we handle complaints, concerns and incidents.

I'm confident that today we have a good Maternity Service that provides a quality service

Sarah Bloomfield

Director of Nursing and Quality

to women and their families in Shropshire, Telford & Wrekin and mid Wales.

This has been supported by the Care Quality Commission (CQC) which last year rated our Maternity Services as "Good" and the Friends and Family Test. In January 99.6% of respondents said they would recommend the service to friends and family if they needed similar care or treatment.

The findings of the CQC's 2015 Maternity Survey also showed the Trust performing about the same or better than other Trusts in most areas.

However we recognise there is more we can do to improve and, in addition to completing the recommendations in the Maternity Review, I want us to continue to work to understand directly from women and other service users about how we can make the necessary improvements.

We want people who use our services to let us know what we can do to give everyone the best experience possible.

I'd like to thank our staff for their hard work and dedication to making the service the best it can be and this was supported in the CQC inspection where women and relatives told inspectors they received a good standard of care from all members of staff within Maternity Services.

"We fully accept the recommendations of this report and are committed to taking the action required."

I'd again like to thank Richard and Rhiannon for ensuring that learning happens as a result of Kate's death.

We are committed to taking the actions required from the recommendations and to continue to learn from the terrible experience of Kate's parents.

Ensuring our staff always have quality and safety at the forefront of their minds

Nurses, Midwives, Therapists and Doctors train to come in to healthcare because they want to help people in their time of need and because they recognise that by working together we can help most patients to get better and have a better quality of life.

Because of these honourable aims it is particularly challenging when mistakes occur or patients suffer an adverse outcome. It feels like what should have happened didn't and there must be a fault or someone must have done something wrong.

That is why, at SATH and in the NHS as a whole, we focus so much on learning when adverse outcomes have occurred. If we learn the real lessons we can prevent other incidents from happening. If we learn the real lessons we can show that we have taken seriously what has happened. Also, if we learn the real lessons we can help colleagues, many of whom also will be hurting as a result of a tragic outcome.

This is why it is so important that we do encourage people to report incidents, even small ones, so that we can learn from

Dr Edwin Borman

Medical Director

them. It's why it's so important that we take seriously the opportunity to learn when we have managed to avert a more serious outcome.

"The Trust has worked so hard to learn lessons from this case."

Cases such as the one of Kate Stanton-Davies are tragic for the family and very painful for the clinicians involved to recognise why they could or should have done better.

When serious incidents happen we must review our practice and find ways of making it better.

That is why the Trust has worked so hard recently to learn the lessons from this case and why we continue to work so hard to learn the lessons from cases of mortality and Serious Incidents (SIs) that occur.

Part of that learning includes partnering with the Virginia Mason Institute in Seattle—recognised as one of the safest hospitals in the world—and sharing ideas with them to improve care for our patients.

Colleagues at SATH can help by:

- Challenging colleagues if they consider that they are doing something incorrectly;
- "Stopping the line" if something has happened that could harm a patient;
- Reporting incidents that will then be reviewed; and
- Learning from these incidents and changing practice to make it as safe as possible.

Colleagues can help by ensuring they are putting patients first and always making the quality and safety of care their top priority.

In this edition of Putting Patients First

Ensuring our Maternity Services improve and we continually learn when things go wrong

Mr Andrew Tapp

Medical Director for the Women and Children's Care Group

Anthea Gregory-Page

Acting Head of Midwifery for the Women and Children's Care Group

"This tragedy has informed and shaped the service developments in maternity care in many ways but particularly around the provision of care in our Midwife-Led Units."

We and the Women and Children's Care Group welcome the report by Debbie Graham and recognise that the tragic death of Kate Stanton-Davies was avoidable as concluded by H.M. Coroner in 2012 and the Parliamentary and Health Care Ombudsman in 2014. We and the Women and Children's Care Group apologise to Richard Stanton and Rhiannon Davies for the terrible loss of Kate, the inadequacy of the investigation that followed and the effect this will have had on them and their wider family.

This tragedy has informed and shaped the service developments in maternity care in many ways but particularly around the provision of care in our Midwife-Led Units.

The 2013 CCG Maternity Review concluded that the model of service provision seen in Shropshire with a Consultant-Led Unit supported by local Midwife-Led Units was "safe and robust and appropriate for a mixed rural and urban population". The issues identified through the individual reports into the death of Kate and internal critical appraisals have resulted in continuous service improvement.

Mothers in Shropshire, in keeping with national guidance, have a number of birthplace options and information to aid selection is imperative. We have introduced a patient handheld booklet and this, together with improved patient maternity information for women and their families, has been continuously developed since then based on national guidance and local information.

A mother's birthplace choice is informed by this and her own considerations, complemented by knowledge of her physical health, previous childbirth history, and social and mental health needs and any changes that may occur during a pregnancy. Confirmation that this risk and choice assessment is conducted and recorded has been correctly challenged and the reliability of this process has been supported by training, a full revision of the booklet and information and subsequent audit.

If a mother has specific medical, mental health or other requirements we have a comprehensive service of specialist antenatal clinics supported by obstetricians, nurse specialists and speciality midwives, and a new specialist midwife post for improving women's health has been funded.

When a mother chooses to have a baby in one of our Midwife-Led Units she needs to be confident that our staff are appropriately trained for the unexpected and are supported by guidelines and continuous training programmes.

Supporting areas of care

The training needs of our midwifery staff are identified to support the areas of care that they may work within and there is a process of initial orientation combined with subsequent rotation to ensure comprehensive knowledge.

There are numerous evidence-based, agreed and systematically developed guidelines for our midwifery staff and, in particular, the guideline for care in labour has been regularly updated in keeping with published National guidance.

When a baby is born, over and above the initial assessment, we have introduced an early warning assessment to assist midwives to identify if a baby becomes unwell with guidance for transfer.

If a baby suddenly becomes unwell our

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midwives in the Midwife-Led Units (and those undertaking home births) have additional education with four-yearly national neonatal resuscitation training and annual statutory updates. With the help of our hospitals' Leagues of Friends we have purchased appropriate resuscitation equipment and "PANDA" resuscitation units.

To complement resuscitation training we have introduced stabilisation training and integrated this training with Ambulance Services. The safe transfer from a Midwife-Led Unit is enhanced by the use of a mobile cot for use in ambulances, and supported by strengthened, agreed guidance with the ambulance services for the transfer of both babies and mothers.

Handover of care between different providers can be complex. We use a national process to handover care supported by electronic maternity information systems. Unfortunately not all outcomes are as we would wish.

In such circumstances we now have much improved and robust methods for the identification, reporting and the investigation of incidents and although the Care Quality Commission (CQC) report on Women and Children's Services in 2014 was 'Good', the reporters did identify areas for further education within the Consultant-Led Unit. Following the identification of an incident the investigation should be appropriate and thorough, and Debbie Graham's report does identify weaknesses in our process in 2009.

Continuous improvements

Nationally, within the Trust and within Women and Children's Services there have been continuous improvements in the management of serious and high risk incidents with training of staff in Root Cause Analysis (RCA) methodology and documentation.

Having undertaken effective investigations of incidents we may find, in a number of cases, that medical and midwifery care may have contributed to a tragic outcome and we have a system that supports candid feedback with formal family meetings. This, in turn, is supported by the coronial process and professional support, training and investigation.

"Significant and substantive continuous improvement has been informed by this tragedy and by other local, regional and national information."

This process has been enhanced by the development of a bereavement service and the appointment of a dedicated Specialist Bereavement Midwife who provides individual care for the patient and for their family. The Bereavement Service has built links to both internal and external agencies such as the Child Death Overview Panel and the Children's Hospice.

As a service we welcome external reviews and indeed had the Clinical Commissioning Group (CCG) - which commissions the services we provide - sponsored Maternity Review in 2013 which found the service to be safe; Clinical Negligence Scheme for Trust's (CNST) Assessment with attainment of Level 3 in 2014; and the CQC visit in 2014. These reports have been supported by individual Healthwatch reports on the Midwifery Led Units. In welcoming these reports, we recognise that safety and quality of care are a continuous process and we must never rest on our laurels in these areas.

Health service provision is informed and shaped by service users as recently demonstrated during the reconfiguration programme, when women and children's inpatient services moved to Telford in September 2014.

We have strengthened user and family input with the launch of the Maternity Engagement Group following the 2013 Maternity Services Review, as well as introducing the Midwife Led Unit Forum and specific "enter and view" visits.

Information that we supply to our service users is read and edited by the Patient Information Group. Service users' views are also captured in national surveys and the Friends and Family Test.

More intimately we supply a 'Talk About' service for individual women and families to discuss their pregnancy and birth experience and patients have direct access to the Patient Advice and Liaison Service, supported by the Patient Experience Midwife and complaint services, which have been strengthened.

Women also have direct access to Supervisors of Midwives who will meet individuals who feel they need additional advice or support.

Significant and substantive continuous improvement has been informed by the tragedy Rhiannon, Richard and their wider family have suffered, as well as by other local, regional and national information and this service improvement continues.

If you have any comments or concerns about the report or anything you have read in this edition of Putting Patients First, please call our Patient Advice and Liaison Service (PALS) on 01952 282888.

Help us to provide the best care possible at SATH by sharing your experiences

Overall, the feedback we receive from patients is very positive and we welcome your compliments. However, we know there are times when we do not always get things right.

On these occasions we welcome your feedback, as this helps us to improve the care we provide.

There are a number of ways you can share your feedback—good or bad—about our Women and Children's Services:

- Speak to your named Midwife or one of our members of staff in person to raise concerns or offer praise
- Call our Patient Advice and Liaison Service (PALS) on 01743 261691 or 01952 282888
- Email our Patient Advice and Liaison Service (PALS) at pals@sath.nhs.uk
- Write to Patient Experience Lead, Haematology Corridor, Princess Royal Hospital, Telford, TF1 6TF
- Help us by joining our Maternity Engagement Group. Find out more by searching MEG at **www.sath.nhs.uk**

Independent advice and support is also available from Healthwatch Shropshire or Telford and Wrekin and Powys Community Health Council (CHC) -

- **Healthwatch Shropshire:** 01743 237884 or email the team via enquiries@healthwatchshropshire.co.uk
- **Healthwatch Telford and Wrekin:** 01952 739540 or email info@healthwatchtelfordandwrekin.co.uk
- **Powys CHC:** 01686 627632 or email enquiries.powyschc@waleschc.org.uk

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Make It Happen
We Value Respect
Together We Achieve

The Shrewsbury and Telford Hospital NHS Trust

Our Putting Patients First newsletter provides you with news and updates from The Shrewsbury and Telford Hospital NHS Trust (SATH). Thank you to those who have contributed to this edition.