The Shrewsbury and Telford Hospital NHS Trust

Recommendation ☑ **DECISION** ☑ **NOTE** (select)	The Board is asked to: • **Approve** the action plan • **Receive** an overview of progress and improvement.
Reporting to:	**Trust Board**
Date	29 June 2017
Paper Title	Improving and developing maternity services within Shrewsbury and Telford Hospital NHS Trust – Women and Children's Care Group
Brief Description	The purpose of this report is to inform and update the Board of the actions completed and ongoing in relation to improving and developing maternity services. Leadership, governance and cultural change are essential to embedding the improvements made. In addition to the details in this paper the Women's and Children's leadership team will present on key improvements. **The report includes the following in terms of improving maternity services:** An update relating to the Maternity Incident Action Plan A chronology of reviews undertaken in maternity services in recent years with outcomes Independent case review by an Independent Maternity Services Expert Advisor Response to Coroner following Regulation 28 An independent document review of the quality of investigations and implementation of their recommendations relating to a number of maternity incidents undertaken at Shrewsbury and Telford Hospitals Midwifery Led Unit service suspensions and staff relocation Information relating to the work within the care group regarding culture, behaviour and human factors Progress on the staff survey results for the Women and Children's care group. Key safety developments within maternity services The Board and Quality and Safety Committee will receive and review the improvement plans and progress within maternity services for assurance that the care of women and their babies is as safe as it can be.
Sponsoring Director	Deirdre Fowler, Director of Nursing and Quality
Author(s)	Jo Banks – Care Group Director Sarah Jamieson – Head of Midwifery
Recommended / escalated by (Tier 2 Committee)	
Previously considered by (consultation /	Private Trust Board and Quality & Safety Committee – March 2017

communication)	
Link to strategic objectives (see over)	SAFEST AND KINDEST - Develop innovative approaches which deliver the safest and highest quality care in the NHS causing zero harm
Link to Board Assurance Framework (see over)	If the maternity service does not evidence a robust approach to learning and quality improvement, there will be a lack of public confidence and reputational damage (RR 1204) If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale & patient outcomes may not improve (RR 423)

Equality Impact Assessment (select one)	● **Stage 1 only (no negative impacts identified)**
	● **Stage 2 recommended (negative impacts identified)**
	  ● negative impacts have been mitigated
	  ● negative impacts balanced against overall positive impacts

Freedom of Information Act (2000) status (select one)	● **This document is for full publication** ● **This document includes FOIA exempt information** ● **This whole document is exempt under the FOIA**

Background
Following concerns raised about maternity services and the historical pattern of perinatal mortality the Chairman of the Trust required the services to be reviewed. A number of commissioned reviews have subsequently been undertaken which culminated in the development of an action plan with 70 action points to rectify service shortcomings. The action plan has been reviewed at regular intervals; details are included in this report. Two final reviews are to commence, the first commissioned by the Secretary of State for Health to review the investigations completed on all cases of perinatal death dating back to 2000. The second will be undertaken by the Royal Colleges of Obstetrics and Gynaecology and Royal College of Midwives, to assess the service against recognised standards of expected practice. These final reviews will be reported in due course.

Introduction
This report includes a number of elements currently being undertaken within the care group and comprises of both internal and external reviews to provide reassurance that the care group is committed to providing maternity services that are safe, kind, caring, personalised and professional. The report also focuses on work undertaken within the care group to support and develop staff to deliver care which is women centred provided by high performing teams and well led in a culture that promotes innovation and continuous learning.

1. Leadership changes
Key to the work undertaken in the last year and on-going work to embed improvements are the changes made to both clinical midwifery leadership and managerial support to the care group**.** This has enabled a fresh internal view of progress and to provide leadership, focus and pace where necessary. Their energy to ensure that standards of practice and care has been welcomed, what this has done within the care group is to bring a tighter grip on governance processes, fresh insight into the safety of the service and improved team working across the midwifery services.

2. Maternity Incident Action Plan - update
The Care Group Director and Head of Midwifery have reviewed and updated the implementation of actions and their delivery. Of the original 70 actions; 3 remain in evolvement and relate to the actions in Table One below. Despite 3 actions still being in progress, the plan continues to be reviewed and monitored in the care group at its board on a monthly basis as part of the maternity services safety improvement plan and via the quality and safety committee. The care group leadership team are confident of success through persistent exploration, transparency and commitment. Collaboration with the wider Trust is vital to the delivery of all the actions described in this paper.

RAG Key:
Red: Not commenced.
Amber: In progress.
Green: Complete

Table One

Action	Progress/target completion	Rating for completion within timescale
Management review in line with Trust HR policy.	There is one case remaining to be concluded, the trust received the final report about this case in time, however in finalising other cases it raised additional questions that need to be answered from this one remaining member of staff. Capsticks have been commissioned to undertake this The NMC have been kept updated about these cases, to enable their processes to be progressed.	Amber
A complete revision and implementation of SI/ RCA training.	The provision of training in completion of RCA and investigation of serious incidents is in progress and on-going. To date five doctors and twenty-one midwives have	Green

	been through the training programme.	
A review of the Women & Children's Risk Management Strategy.	The Trust Risk Management Strategy now includes maternity, aligning all systems and processes commonly across the organisation. The Risk management strategy is currently out to consultation and is due to be signed off at the June 2017 Board Meeting.	Green

3. A chronology of reviews undertaken in maternity services in recent years with outcomes

The Shrewsbury and Telford Hospital NHS Trust Maternity Services Reviews Chronology and includes information and outcomes of independent non - Trust led processes or involvement. The chronology lists the many external reviews and oversight that maternity services have been exposed to in recent years. There have been a total of 17 related reviews and actions undertaken that provides evidence of on-going improvement within maternity services.

4. Independent review of the death of a baby by an Independent Maternity Services Expert Advisor

The advisor found that the Trust failed to fulfil its responsibility to establish the facts of this case and failed to establish accountability. It was found that the Trust abdicated its responsibility to the LSA, an organisation with no accountability to the Trust. The advisor also found that although clinical governance processes were in place c2009 there was a disconnection between policy and the systemic mechanisms in place which prevented effective clinical governance activity from being embedded into the culture of the organisation. The outcome and recommended actions following this independent review formed the Maternity Incident Action Plan and its progress defined in **item 1** of this report.

5. Response to the coroner following Regulation 28

The Trust provided assurances regarding a Regulation 28 issued by the coroner in November 2016 relating to the death of Ivy Rebecca Morris. The request issued, cited that the Trust should take action to prevent future deaths relating to 3 matters that gave the coroner concerns:

- Foetal heart monitoring
- Failure to follow midwifery guidelines
- Episiotomy

All actions have been implemented in reply to the request by the coroner and positive activities undertaken to prevent future deaths. The actions were detailed in a letter provided by the CEO to the coroner dated 13th December 2016.

6. An independent document review of the quality of investigations and implementation of their recommendations relating to a number of maternity incidents undertaken at Shrewsbury and Telford Hospitals

The Women and Children's care group are currently collating documentation and evidence to support an independent document review of the quality of investigations and implementation of recommendations relating to a number of maternity incidents within the Trust. The review is being led by NHS Improvement and will cover incidents raised to the Secretary of State in a letter of 6 December 2016; requesting an independent inquiry to alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new-born harm.

The scope and purpose of the appraisal will involve a multidisciplinary team who will review the quality of the investigations into the identified cohort (21) of incidents since 2000. The review will also identify that the investigations addressed the relevant concerns and issues, recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan.

The review process will comprise:

- A review of the investigations in the cohort including RCAs, preliminary fact finding reviews and associated action plans from each incident investigation. All will be reviewed in relation to the contemporary Trust policy and National Guidance.
- Review the relevant/associated improvement plan and pace of improvement against the timelines identified

The review panel will provide a report and recommendations of any actions required to Dr Kathy McLean, Executive Medical Director, NHS Improvement. This review has commenced with the lead reviewer assessing external documents, she intends to be in the trust to scope the substantial part of the review at the start of May; once this has been done we will know how long the panel will require to undertake the whole process. When this is known the board will be informed of timescales.

7. Maintaining Safe Midwifery Staffing

Since September 2016, there have been a number of inpatient service suspensions at the Midwifery Led Units across the County. These have been necessary to ensure the safety of women, newborns and staff during times of either building maintenance, unexpected short-term staffing absence or unprecedented demand in the high risk, high acuity consultant unit; making it necessary to invoke the Trust maternity escalation policy and procedure. During these temporary suspensions the care group makes all efforts to implement measures where possible to maintain a safe maternity service for women across the County and Mid-Wales and inform those mothers affected. However, it is of note that midwives remain available on call for home births in the local area and are available to support concerns from women requiring overnight access to a Midwife.

Each time a suspension of inpatient services at an MLU is considered; this is communicated and discussed with the Head of Midwifery, Care Group Director, Clinical Director and Director of Nursing and Quality. A risk assessment is undertaken as per escalation procedure and plan in place to support the MLUs and Consultant Unit. Where possible, services are maintained however the recently appointed Care Group Director and Head of Midwifery are clear, in that patient safety is paramount. At each suspension the communication team are involved to support communication with local media and service users.

8. Culture Development Plan

The quality of care provided can be predicted by engagement of healthcare workers which is in turn influenced by their experience as an employee. Research within the NHS setting has demonstrated this link through the work of West et al (2002, 2006 and 2011) who have found established links between good Human resources management (HRM) practices, attitudes and behaviours of staff and patient outcomes.

The care group have started the development of a cultural assessment process and tool which will commence with the inclusion of all staff during April 2017. The work focuses on organisational support to understand and develop staff values, attitudes and behaviours. It has been developed to support the Women and Children's Care Group to embed Values-Based leadership and further develop the culture of continuous learning that exists. A combination of quantitative and qualitative information has been used to support the development of a plan with key members of the Senior Management team leading facilitated feedback and listening events with staff.

It is recognised that this work is embryonic and as more information is gathered through the PDSA cycle, additional interventions will be identified that further support learning and development within the Leadership team and across the Care Group. This work has been delayed due to the "training pause" implemented within the Trust as part of a solution to ensure safe staffing in quarter 4 of the financial year. The cultural assessment will be used to identify and celebrate the key behaviours necessary to maintain safe and kind care. An initial session was held during December 2016 that involved all staff within the care group. The aim is for staff to understand how staff from all areas view the service they provide, how it is structured, how it is run and the importance of behaviour in developing an open and safe culture.

9. Staff survey results for Women and Children's

The care group are eagerly awaiting the individual staff survey results for Women and Children's, following the recent organisational Trust wide results. The Care Group will be accountable for the delivery of actions resulting from the survey and will be supported by the care group HR Business Partners. For consistency and in accordance with the response plan presented at the workforce committee in February with the strategic leadership of the staff survey response plan led by the Workforce Directorate. The key areas that the care group will focus on are:

- The care group will manage the feedback from staff as part of staff conversations work to sense check our staff employment experience
- Survey results will be shared with managers to progress through team meetings and the governance meeting framework.
- A care group wide communication will be shared via managers to reach all staff areas.
- Any actions we have identified through staff feedback will be linked to the care group priorities and challenges. Following an initial engagement session with staff during December 2016; the views of staff have already indicated that they are aligned to the overall direction and vision of the care group.

Likewise, the care group have fully embraced the "Values in Practice" awards, with regular nominations being submitted, judged and presented by the senior management team on a weekly basis.

10. Key safety developments within maternity services

Over the past eight years maternity services within the Trust has undertaken a number of safety improvement developments to support the delivery of the safest care possible to women and their families within Shropshire. These are:

- Following the publication of the Saving Babies Lives report of 2009 maternity services looked at how to improve perinatal mortality rates. An enhanced programme for the detection of growth restriction based on the GROW programme was introduced and the Saving Babies Lives care bundle embedded into the maternity safety strategy.

- Between 2009 - 2015 there has been a fall in the UK perinatal mortality rate and following analysis of data; within the Trust in 2009 the rate was above the UK average. By 2012 this had fallen to 7.15 per 1000 births against the national average of 7. In 2014 we had 5.8 per 1000 births against the national average of 6.6, however in 2015 our rate did increase again to 7.40 against 6.5 in 2015; currently our rate is at 6.05 we are expecting the national rate to be published in May. Since 2016, in line with recent CQC recommendations; maternity services analyses all perinatal deaths using a standardised tool to assess any developing trends. Following the announcement that MBBRACE are to develop a standardised national tool the maternity leads approached the organisation offering help to support the development of the tool and be a test site. Likewise, within the local network we have helped to develop links with other units by developing a system for external scrutiny of perinatal cases where the cause of death is unclear or there is variation in opinion within the service.

- Maternal mortality is both rare and extremely distressing. Over the past few years the department has worked hard on managing maternal sepsis as the leading direct cause of maternal death. All staff has received specific training in the recognition and treatment of sepsis alongside the use of a trigger symbol to denote the commencement of the golden hour for treatment.

- Maternity services successfully bid for and joined wave 2 of the National Maternal & Neonatal Health Safety Collaborative. This looks to be a comprehensive initiative that will allow maternity services to work in partnership through 2017 with other similar Trusts in order to improve patient safety and learn together.

- In 2015/6, maternity services ran a series of workshops, in conjunction with BPP University, for all levels of staff within the unit. The workshops aimed to improve collective leadership across the department with the introduction of a 'safety pause' in which members of the team were asked to speak out if they had concerns regarding safety. The staff members were also given instruction on enhanced communication and human factors and how they can impact upon safety. Since the workshops we have worked with BPP to evaluate the impact by analysing our complaints. We found that the number of instances where communication was cited as an issue has reduced from 57 in 2013/14 to 27 in 2015/16 – a reduction of 53%. A significant reduction was also noted in the level of complaints regarding the attitude of staff – a reduction of 50% compared to 2013/14. As a result of this improvement we are planning to extend the training using part of the recent award we have received from Health Education England as part of the NHS Improvement Collaborative.

- Across the whole of the country one of the largest areas of error within obstetrics is the misinterpretation of cardiotocographs (CTGs), as shown by the NHSLA. Two years ago, the service successfully bid for and secured funding from the Sign up to Safety initiative. The funding allocation improved training using an electronic training package. Similarly, the delivery suite coordinators have undertaken a two day CTG master class. The funds have also been used to purchase CTG telemetry and archiving software and hardware which will allow for review of CTG traces remotely whist a woman is in labour. This regular 'fresh eyes' approach has been shown to reduce the chance of the tracing being misread by using additional reviewers without disturbing the woman in labour. In addition, staff have been trained in the use of Dawes-Redman antenatal CTG analysis and in the process of buying additional machines to support this.

- We have surveyed our midwifery staff on Delivery suite regarding awareness of the process for confirming the fetal and maternal heart beat and correct identification and differentiation of the two. The results demonstrate that all midwifery staff completing the survey (100%) were aware of the steps required to ensure the identification and correct monitoring of the fetal heart and maternal heart rates. All staff completing the survey (100%) felt that they had received adequate training in how to ensure the identification and correct monitoring of the fetal heart and maternal heart rates and felt confident in their ability to do so. None of the staff completing the survey felt that they wanted further training on this element of monitoring of the fetal heart and maternal heart rates. The next steps will be to roll out this survey to all midwifery and medical staff responsible for conducting CTG monitoring in the antenatal and community settings.

- Since moving to PRH, the maternity department has developed a new maternity triage system. The unit was one of 3 units in the West Midlands to trial the newly developed Birmingham Symptom Specific Obstetric Triage system (BSOTS). The trial was conducted within NIHR and results are to be published in the near future. The department was able to successfully replicate the system and the team was highly commended by the trial team from Birmingham.

- The Maternity Unit always works very closely with the neonatal department, particularly around patient safety. After the death of a baby the Midwife Led Unit (MLU) stabilisation course was developed (MIST course). This course, based upon a similar course in Scotland is the first in England. The whole day course is run in conjunction with West Midlands Ambulance Service (WMAS) and West Midlands Neonatal Transport Service (WMNTS) and is structured as a life support course with a mixture of lectures, skills stations and scenarios. All community midwives attend every 4 years in addition to the UK NLS Resuscitation Course. Each course also has four paramedics in attendance, mostly from WMAS but now also from Powys along with midwives from Powys. The neonatal department has been among the first in the West Midlands to commence neonatal simulation training using electronic manikins in a purpose built simulation room, purchased from charitable donations. The feedback from the course has been excellent and the course has been presented at the British Association of Perinatal Medicine.

- Along with developments in neonatal training there has been a significant investment in equipment in order to ensure that each MLU across the county has the same equipment as each other and the Consultant Unit, such as resuscitaires, transfer pods, resuscitation kits, stabilisation kits, and transfer kits. Charitable bids in 2016 enabled the purchase of portable saturation devices specifically for neonatal use to be available for transportation; which are unavailable for many similar units across the country.

- As part of the Trust Friends and Family test, maternity services continues to record a high level of service user respondents (February 2017 - 98.8%) that state that they are likely or extremely likely to recommend the service/care they received.

Recommendation -
The Board is asked to:
Receive an overview of progress and improvement within maternity services.

Management Review						
Recommendation/Action	**Source**	**Actions completed**	**In Progress**	**Due by**	**Person Responsible**	**Evidence**
Midwife 1 & 2's conduct should be reviewed in line with the Trust performance improvement policy	*Independent Review (November 2015)*		The trust now has all four management reports which have been reviewed and individual cases have diary dates for final accountability hearings. The NMC have been kept updated about these cases, to enable their processes to be progressed. There is one final case which additional questions need to be addressed prior to decision making, Capsticks have been commissioned to underytake this work.	31st March 2017 REVISED DEADLINE 31st May 2017	Director of Nursing & Quality	Completion of HR process. This action has commenced and is in progress. The action is delayed and expected to be completed by the end of May 2017.

Guidelines						
Recommendation/Action	**Source**	**Actions completed**	**In Progress**	**Due by**	**Person Responsible**	**Evidence**
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		Completed	Lead Midwife for community services and MLUs	See actions completed. Policies available and uploaded onto Trust intranet.
		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) Acute maternity Services postnatal ward and deliverySuite subsequently copmpleted		Completed	Lead Midwife for Acute unit and Guidelines Midwife	See actions completed. Policies available and uploaded onto Trust intranet.
		Maternity and Obstetric Clinical Guidelines and SOP's are arealdy formatted and Ratified in line with the Trust clinical Governance process		Completed	Lead Midwife for Acute unit and Guidelines Midwife	See actions completed. Guidelines and SOPs avalable and uploaded onto Trust intranet.
		Guidelines monitored monthly by Guideline Group (147 guidelines) Current progress 15.07.16 92% within 3 months of date		Completed		See actions completed. Guidelines and SOPs avalable and uploaded onto Trust intranet.
		The guidelines are in a constant state of review whether this is in relation to the routine time review process or due to response to SI/HRCR etc. The current state of the guidelines list is generated for the Quality and Safety report (monthly) and in addition the number of guidelines can vary as we amalgamate/revise into a SOP or no longer required, therefore, the number will continue to fluctuate over time. However, those guidelines relating to the independent review are all completed.		Completed	Guidelines Midwives	See actions completed. Guidelines and SOPs avalable and uploaded onto Trust intranet.

Audits						
Recommendation/Action	**Source**	**Actions Complete**	**In Progress**	**Due by**	**Person Responsible**	**Evidence**
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 birth choice	*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 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		Completed	Head of Midwifery	See Action completed. Audits are on-going and reveiwed at Maternity Governance. Audit cycle and plan available from Women and Children's audit team.
		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	Lead Midwife MLU and Community Services Audit Lead	See Action completed. Audits are on-going and reveiwed at Maternity Governance. Audit cycle and plan available from Women and Children's audit team.
		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).		Completed	Associate Director of Patient Safety	See Action completed. Audits are on-going and reveiwed at Maternity Governance. Audit cycle and plan available from Women and Children's audit team.
		External table top review Transfers from MLU to the Consultant Unit in March 2016. Meeting held 7th March 2016		Completed	Deputy Director of Nursing and Quality	See action completed. Table top review paper available.
		Action Plan to address survey design and feedback from women to be progressed and completed		Completed	Audit Lead Patient Experience	See Action completed. Audits are on-going and reveiwed at Maternity Governance. Audit cycle and plan available from Women and Children's audit team.
		Action plan to be presented at the Patient Information Experience Panel meeting on 6th July 2016 for scrutiny and challenge.		Completed	Audit Lead Patient Experience	See Action completed. Audits are on-going and reveiwed at Maternity Governance. Audit cycle and plan available from Women and Children's audit team.

Women who require more care						
Recommendation/Action	**Source**	**Actions Complete**	**In Progress**	**Due by**	**Person Responsible**	**Evidence**
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		Completed	Associate Director of patient safety	See Actions completed. Report available following scrutiny of incidents.
		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.		Completed	Head of Midwifery	See Actions completed. Report available following supervisory investigations.
		RCA Proforma to be reviewed and updated to ensure critical information is gathered and tabular timeline included		Completed	Patient Safety Team Manager	See actions complete. Reveised RCA proforma available on Trust intranet.
		The provision of training in completion of RCA and investigation of serious incidents is in progress and on-going. To date five doctors and twenty-one midwives have been through the training programme.		01.04.2017	Associate Director of Patient Safety Patient Safety Team Manager & Communications lead.	training record of staff trained
			The Trust Risk Management Strategy now includes maternity, aligning all systems and processes commonly across the organisation. The Risk management strategy is currently out to consultation and is due to be signed off at the June 2017 Board Meeting.	1st April 2017	Associate Director of Patient Safety Patient Safety Team Manager & Head of Assurance.	
		External Midwife overview of identified SI's commenced in July 2016		Completed	Director of Nursing	See Action completed. Report available.

Women who require more care						
Recommendation/Action	**Source**	**Actions Complete**	**In Progress**	**Due by**	**Person Responsible**	**Evidence**
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 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.		Completed	Head of Midwifery	See action completed. Specialist midwife appointed.
		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 misuse Diabetes Neurological disease Endocrine disease Haematological disease Previous traumatic delivery Renal disease		Completed	Head of Midwifery	See action completed. Clinics delivered.
		Monitoring of continuity of care of all women in the community reported on: The Maternity Clinical Dashboard.		Completed	Head of Midwifery	See action completed. Maternity dashboard availbale on intranet.
		Monitoring of 1 to 1 in labour reported on the Maternity Clinical Dashboard.		Completed	Head of Midwifery	See action completed. Maternity dashboard availbale on intranet.
		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)		Completed		
		2. Review of Information given to women on birth choice.		Completed	Patient Information Lead	See action complete. Information leaflet available.
		3. A total of 9 reviews have been carried out on the booking guidelines since 2010. Most recently there has been a full review carried out in February 2015 and February 2016. The process for booking and referral for care is clearly defined within the existing guideline.		Completed	Guideline Midwife	See action completed. Guidelines available.
		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	Medway Lead Specialist Midwife for Improving Women's Health	
		National Maternity Review 2016 (Cumberlege Report): 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.		Benchmarking undertaken 05 July 2016 Completed	Deputy Head of Midwifery Lead Midwife MLU and Community Services supported by Care Group Management team	This benchmarking and review is complete. The Trust meets the requirements of the continuity of carer for Antenatal and Postnatal Care, however the Trust have not met the requirements for Intrapartum Care. Continuity of Care is provided on a one to one basis during labour
		Models of Care: 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		Complete	Care Group Director/Head of Midwifery/DON&Q	A National Maternity Transformation Programme Board has been established alongside a Maternity Transformation Council to support and challenge the design and delivery of the the National Maternity Review (Better Births); published in February 2016. The national review set out a clear vision for maternity services across England to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred on their individual needs and circumstances. The Maternity Transformation Programme will drive forward the implementation of the review, including work to reduce the rate of stillbirths, neonatal and maternal deaths in England as set out by the Secretary of State for Health. In response to the national programme, a Shropshire and Telford & Wrekin Local Maternity System (LMS) has been established. The Shropshire and Telford & Wrekin LMS brings together providers, commissioners and service users across the Shropshire and Telford & Wrekin STP footprint. The Shropshire and Telford & Wrekin LMS Programme Board will lead this work, through representatives from partner organisations who are empowered to discuss, agree and implement the transformation required across maternity services.

Acknowledge of failings and the harm caused.

Recommendation/Action	Source	Actions Complete	In Progress	Due by	Person Responsible	Evidence
Acknowledgement of failings and the harm caused The Trust should acknowledge the failings in both care and complaint handling that occurred and the injustice the parents 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 the parents	*Ombudsman Report 2014*	TRUST ACTIONS: Response to Ombudsman: An unreserved apology was sent to the parents from the Trust for the failure to investigate the treatment and standard of care received by mother and baby. Date:16.01.2015		Completed	Chief Executive	See Action complete. Trust CEO wrote to family and an apology publicly provided at Trust Board.
		The Trust apologised for the failings in the Trust's complaint handling process. Date: 16.01.2015		Completed	Chief Executive	See Action complete. Trust CEO wrote to family and an apology publicly provided at Trust Board.
	Independent Review (November 2015)	Response to Independent Review: The Trust has publically accepted the findings of the Independent Review and has publically apologised to the parents (Public Board Meeting 4 April 2016).		Completed	Chairman Chief Executive Director of Nursing & Quality	See Action complete. Trust Board minutes available.
		Actions taken by Trust Officers: CEO has written to the parents, 14th April 2016 Chairman and Director of Nursing have met with the parents and offered an unreserved apology 28.04.15		Completed	Chairman Chief Executive Director of Nursing & Quality	See Action complete. Trust Board minutes available.
		Communication with the Director of Nursing for quarterly updates - update 21.12.16 - on-going action. Update 13.01.17 - on-going communication in place via DON&Q.		1st Update shared in July 2016	Director of Nursing & Quality	Action complete and on-going.
The Trust should work with the family to establish a fitting memory to their daughter			Contact has been made with the new born and maternity network who have access to a company of actors used for advanced communication. It is hoped that the creation of a video about such cases as experienced by the family, will very firmly put in place good learning material for health professionals, and equally represent a mark of respect for the memory of their daughter. We still need to seek the family consent to this piece of work, if we get their agreement we aim to have the video ready for September 2017. Updated - 15.06.2017 - Following feedback from the family. This option is not supported and thereofore the action no longer required.	31st March 2017	Care Group Director/HOM/Comms team	

Review of on-call arrangements						
Recommendation/Action	**Source**	**Actions Complete**	**In Progress**	**Due by**	**Person Responsible**	**Evidence**
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		Completed	Lead Midwife MLU and Community Services Guideline Midwife	See action complete. SOP available on Trust intranet.

Lack of contemporaneous midwifery notes						
Recommendation/Action	**Source**	**Actions Complete**	**In Progress**	**Due by**	**Person Responsible**	**Evidence**
Limited information available for other health professionals and unable to establish the time of collapse	LSA Supervisory 2009 Rule 43 Report HM Coroner 2013 Independent Review (November 2015)	Information to support other health care professionals Comprehensive multi-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 Trust		Completed	Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team.
		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		Completed	Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team.
		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) ☐ 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		Completed	Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team.
		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 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 New-born 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 new-born in midwifery led units & attended home births V1 – September 2016		Completed	Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team.
		1. Yearly mandatory training includes ☐ New-born Life Support (Statutory Safety Update) annual - A local but mandatory midwifery update including new-born 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 New-born Life Support course (accredited by the 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 (New-born 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		Completed	Head of Midwifery	See action complete. Completion of training audited and reported at care group board.
		NEWS (Neonatal New-born Early Warning Score) was developed in 2013 – enhanced observations for at risk babies were introduced		Completed	Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team.
		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		Completed	Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team. Guideline available on Trust intranet.
		The Maternity Early Warning Score (MEWS) was fully revised in 2014 following recommendations from CNST level 3.		Completed	Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team. Guideline available on Trust intranet.
		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.		Completed	Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team. Guideline available on Trust intranet.
		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.		Completed	Guideline Midwife	See action completed. Audit plan and cycle available form W&C audit team. Guideline available on Trust intranet.
		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		Completed	Audit – Women's & Children Centre	See action completed. Audit plan and cycle available form W&C audit team. Guideline available on Trust intranet.
		The audit report is to be completed and signed off at Maternity Governance meeting. The audit is being completed every month but will be reported quarterly, the first report was presented to the Maternity Governance Meeting on the 21.12.15 and will be presented to the Quality & Safety Committee Meeting on 22nd December 2016.		Completed	Lead Midwife Community services	See action completed. Audit plan and cycle available form W&C audit team. Guideline available on Trust intranet.
		It will then be discussed at the Quality & Safety Committee Meeting on the 22.12.16. JB to present to Q&S on the 22.12.16.		Completed	Director of Nursing & Quality	See action completed. Audit plan and cycle available form W&C audit team. Guideline available on Trust intranet.
		Audit of MLU records of care in labour May 2016 will be discussed at Quality & Safety Committee. This will go to the next Quality & Safety Committee - Update 13.01.17 - Audit completed. Pending Q&S Committee.		Completed	Lead Midwife MLU and Community Services Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team. Guideline available on Trust intranet.

Transfer Arrangements/Transfer Stabilisation Training						
Recommendation/Action	**Source**	**Actions Complete**	**In Progress**	**Due by**	**Person Responsible**	**Evidence**
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*	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) 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		Completed	Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team. Guideline available on Trust intranet.
		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 Working Groups 1, 2 & 3: 27.02.13		Completed	Head of Midwifery	See action completed.
		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.		Completed	Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team. Guideline available on Trust intranet.
		Guidelines to support practice: 1. The Resuscitation of the Neonate on a MLU/Home Guideline– had a full review in 2015. 2. Transport 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		Completed	Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team. Guideline available on Trust intranet.
		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 checking procedure in place in all areas which have a PANDA resuscitaire		Completed	Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team.
		Development of Community/MLU dashboards to include Transfer audit information		Completed	Lead Midwife MLU and Community Services	See action completed. Audit plan and cycle available form W&C audit team.
		Process to ensure all areas are notified if the helipad is closed.		Completed	Deputy Head of Midwifery	See action completed. Guideline available on Trust intranet.

Identification of the abnormal						
Recommendation/Action	**Source**	**Actions Complete**	**In Progress**	**Due by**	**Person Responsible**	**Evidence**
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		Completed	Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team. Guideline available on Trust intranet.
		New-born Early warning assessment tool (NEWS) Implemented: to enable earlier identification of the sick new born. Date: 27.09.13		Completed	Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team. Guideline available on Trust intranet.
		Intrapartum Care on a 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.		Completed	Head of Midwifery	See action completed. Audit plan and cycle available form W&C audit team. Guideline available on Trust intranet.
		The care group has reviewed the New Born Early Warning Track and Trigger assessment tool. Update 13.01.17 - NEWTT has been reviewed by the care group. Implementation will impact on clinical capacity. Implementation will therefore be aligned with maternity Safety Improvement Plan.		Completed	Consultant Neonatologist	See action completed. Audit plan and cycle available form W&C audit team. Guideline available on Trust intranet.

Lack of family liaison						
Recommendation/Action	**Source**	**Actions Complete**	**In Progress**	**Due by**	**Person Responsible**	**Evidence**
There was a failure of the part of the Trust to properly explain what happened and to keep the 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 misuse.		Completed	Head of Midwifery	See Actions Completed. All RCAs now have Duty of Candour included and evidenced. Audit and review of implementation of DoC is undertaken via Patient Safety Team
		Trust Action: The Trust has also completely revised the Complaints process to improve thoroughness, openness and empathy of responses and timelines of responses.		Completed	Head of Midwifery	See Actions Completed. Complaints report submitted quarterly to CQC and Q&S Committee.

Risk assessment form						
Recommendation/Action	**Source**	**Actions Complete**	**In Progress**	**Due by**	**Person Responsible**	**Evidence**
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 2007, NSF 2004, NICE 2007 & 2008, RCOG 2007, RCOG 2008). An antenatal clinical risk assessment audit Completed May 2016		Completed	Head of Midwifery	See action completed. Audit cycle and plan availble form W&C audit team.

Ensure women receive adequate information to make an informed choice as to place of birth						
Recommendation/Action	**Source**	**Actions Complete**	**In Progress**	**Due by**	**Person Responsible**	**Evidence**
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		Completed	Head of Midwifery	See action completed. Patient information booklet available and supplied from LG Davies.
		Information relating to place of birth was made available on the Trust website November 2012		Completed	Head of Midwifery	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.		Completed	Head of Midwifery	Survey results.
		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 is now audited continuously by Medway system and has sown to be 100% compliant		Completed	Joy Oxenham Patient Experience, Women's & Children Centre	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 is now audited continuously by Medway system and has sown to be 100% compliant
		The methodology of this survey was reviewed and has now been updated in line with expectations and is completed monthly.		Completed	Graeme Mitchell Associate Director of Patient Experience	The methodology of this survey was reviewed and has now been updated in line with expectations and is completed monthly.

Recommendation/Action	Source	Actions Complete	In Progress	Due by	Person Responsible	Evidence
A new Supervisory Investigation should be undertaken by external supervisors to the region	*External Review of Midwifery Supervisory Investigation August 2015*				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		Regional LSAMO – Joy Kirby	
To seek assurance that the weaknesses in the LSA investigatory process c2009 identified in this review are no longer inherent in the current process	*External Review of Midwifery Supervisory Investigation August 2015*	Actions to be undertaken by regional LSAMOs			Regional LSAMO – Joy Kirby	
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 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			Joy Oxenham Patient Experience	

APPENDIX 1

Neonatal Issues Identified for Neonatal Clinical Governance from Independent Review

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) Lead for newborn resuscitation (1 & 2)	1. July 2016 2. May 2016-Apr 2017
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 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
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)
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