## Completion Guidance:

1.Overview tab – please complete in full
2.Ockenden return tab – this mirrors earlier returns and requires updating on progress to 31/12/2021
3.Kirkup return tab – please note some recommendations have been greyed out – these do not require completion as they are superseded by information in the Ockenden recommendations.
(There is a 4th tab which details the Kirkup recommendations as a helpful reminder – this doesn't require any completion)

## Internal trust governance

| | Confirmation of / or planned Public Trust Board update on progress against the Ockenden action plan | Date of Public Board update | Executive sign off of this return | | |
|---|---|---|---|---|---|
| | Yes/No | please insert date | **Date** | **Name** | **Role** |
| Dudley Group of Hospitals NHS Trust | | | | | |
| Sandwell and West Birmingham Hospitals NHS Trust | | | | | |
| The Royal Wolverhampton NHS Trust | | | | | |
| Walsall Healthcare Trust | | | | | |

## LMNS sign off of the combined trust returns

| LMNS Name | Executive sign off | | |
|---|---|---|---|
| | **Date** | **Name** | **Role** |
| Name of LMNS | | | |

**Ockenden Inital report reccomendations**
**Results of Regional Update January 22**

| | | | | Updated 19/3/22 | |
|---|---|---|---|---|---|
| **IEA** | **Question** | **Action** | **Evidence Required** | **SANDWELL AND WEST BIRMINGHAM HOSPITALS** | |
| **IEA1** | Q1 | Maternity Dashboard to LMS every 3 months | Dashboard to be shared as evidence. | 100% | |
| | | | Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken. | 100% | |
| | | | SOP required which demonstrates how the trust reports this both internally and externally through the LMS. | 100% | |
| | | | Submission of minutes and organogram, that shows how this takes place. | 100% | |
| | | **Maternity Dashboard to LMS every 3 months Total** | | **100%** | |
| | Q2 | External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death | Audit to demonstrate this takes place. | 100% | |
| | | | Policy or SOP which is in place for involving external clinical specialists in reviews. | 100% | |
| | | **External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total** | | **100%** | |
| | Q3 | Maternity SI's to Trust Board & LMS every 3 months | Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion | 100% | |
| | | | Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed | 100% | |
| | | | Submit SOP | 100% | |
| | | **Maternity SI's to Trust Board & LMS every 3 months Total** | | **100%** | |
| | Q4 | Using the National Perinatal Mortality Review Tool to review perinatal deaths | Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review. | 100% | |
| | | | Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. | 100% | |
| | | **Using the National Perinatal Mortality Review Tool to review perinatal deaths Total** | | **100%** | |
| | Q5 | Submitting data to the Maternity Services Dataset to the required standard | Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS. | 100% | |
| | | **Submitting data to the Maternity Services Dataset to the required standard Total** | | **100%** | |
| | Q6 | Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme | Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme. | 100% | |
| | | **Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total** | | **100%** | |
| | Q7 | Plan to implement the Perinatal Clinical Quality Surveillance Model | Full evidence of full implementation of the perinatal surveillance framework by June 2021. | 100% | |
| | | | LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS. | 100% | |
| | | | Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure. | 100% | |
| | | **Plan to implement the Perinatal Clinical Quality Surveillance Model Total** | | **100%** | |
| **IEA1 Total** | | | | **100%** | |
| **IEA2** | Q11 | Non-executive director who has oversight of maternity services | Evidence of how all voices are represented: | 100% | |
| | | | Evidence of link in to MVP; any other mechanisms | 100% | Was 0% have enclosed evidence to show NED evidence |
| | | | Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed | 100% | |
| | | | Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions | 100% | |
| | | | Name of NED and date of appointment | 100% | |
| | | | NED JD | 100% | |
| | | **Non-executive director who has oversight of maternity services Total** | | **100%** | |
| | Q13 | Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services | Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021. | 100% | |
| | | | Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 1S Steps) | 100% | |
| | | | Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. | 100% | |
| | | **Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total** | | **100%** | |
| | Q14 | Trust safety champions meeting bimonthly with Board level champions | Action log and actions taken. | 100% | |
| | | | Log of attendees and core membership. | 100% | |
| | | | Minutes of the meeting and minutes of the LMS meeting where this is discussed. | 100% | |
| | | | SOP that includes role descriptors for all key members who attend by-monthly safety meetings. | 100% | |
| | | **Trust safety champions meeting bimonthly with Board level champions Total** | | **100%** | |
| | Q15 | Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. | Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021. | 100% | |
| | | **Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Total** | | **100%** | |
| | Q16 | Non-executive director support the Board maternity safety champion | Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken | 100% | |
| | | | Name of ED and date of appointment | 100% | |
| | | | Role descriptors | 100% | |
| | | **Non-executive director support the Board maternity safety champion Total** | | **100%** | |
| **IEA2 Total** | | | | **100%** | |
| | | Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS. 3 times a | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% | |

| | | | | | |
|---|---|---|---|---|---|
| | | year. | LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. | 100% | |
| | | | Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. | 100% | |
| | Q17 | | Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. | 100% | |
| | | | Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. | 100% | |
| | | **Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total** | | **100%** | |
| | | Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. | Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP) | 100% | |
| | Q18 | | SOP created for consultant led ward rounds. | 100% | |
| | | **Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total** | | **100%** | |
| | | External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only | Confirmation from Directors of Finance | 100% | revisied from 0% TNA was sent with orginal submission. Have requested up to date version |
| | | | Evidence from Budget statements. | 100% | revisied from 0% TNA was sent with orginal submission. Have requested up to date version |
| | | | Evidence of funding received and spent. | 100% | |
| | Q19 | | Evidence that additional external funding has been spent on funding including staff can attend training in work time. | 100% | |
| | | | MTP spend reports to LMS | 100% | Have requested from finance |
| | | **External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only Total** | | **100%** | |
| **IEA3** | | 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% | |
| | | | Attendance records - summarised | 100% | |
| | Q21 | | LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. | 100% | |
| | | **90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total** | | **100%** | |
| | | Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. | Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP) | 100% | |
| | Q22 | **Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total** | | **100%** | |
| | | The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% | |
| | Q23 | | LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data. | 100% | |
| | | **The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place Total** | | **100%** | |
| **IEA3 Total** | | | | **100%** | |
| | | Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre | Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians | 100% | |
| | Q24 | | SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway. | 100% | |
| | | **Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total** | | **100%** | |
| | | Women with complex pregnancies must have a named consultant lead | Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead. | 100% | |
| | Q25 | | SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead. | 100% | |
| | | **Women with complex pregnancies must have a named consultant lead Total** | | **100%** | |
| | | Complex pregnancies have early specialist involvement and management plans agreed | Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman. | 100% | |
| | Q26 | | SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams. | 100% | |
| **IEA4** | | **Complex pregnancies have early specialist involvement and management plans agreed Total** | | **100%** | |
| | | Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 | Audits for each element. | 100% | |
| | Q27 | | Guidelines with evidence for each pathway | 100% | |
| | | | SOP's | 100% | |
| | | **Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total** | | **100%** | |
| | | All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. | SOP that states women with complex pregnancies must have a named consultant lead. | 100% | |
| | Q28 | | Submission of an audit plan to regularly audit compliance | 100% | |
| | | **All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total** | | **100%** | |
| | | Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres | Agreed pathways | 100% | |
| | | | Criteria for referrals to MMC | 100% | |
| | Q29 | | The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs. | 100% | Revised from 0%. maternal medicine evidence was provided in original submission and includes: Pathway, Membership & Attendance, MNMM event, W Midlands fetal medicine referral form |

| | | | | | |
|---|---|---|---|---|---|
| | | **Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total** | | **100%** | |
| **IEA4 Total** | | | | **100%** | |
| **IEA5** | Q30 | All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional | How this is achieved within the organisation. | 100% | |
| | | | Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. | 100% | |
| | | | Review and discussed and documented intended place of birth at every visit. | 100% | |
| | | | SOP that includes definition of antenatal risk assessment as per NICE guidance. | 100% | |
| | | | What is being risk assessed. | 100% | |
| | | **All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total** | | **100%** | |
| | Q31 | Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. | Evidence of referral to birth options clinics | 100% | |
| | | | Out with guidance pathway. | 100% | |
| | | | Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. | 100% | |
| | | | SOP that includes review of intended place of birth. | 100% | |
| | | **Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total** | | **100%** | |
| | Q33 | A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. | Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust) | 100% | |
| | | | How this is achieved in the organisation | 100% | |
| | | | Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above. | 100% | |
| | | | Review and discussed and documented intended place of birth at every visit. | 100% | |
| | | | SOP to describe risk assessment being undertaken at every contact. | 100% | |
| | | | What is being risk assessed. | 100% | |
| | | **A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total** | | **100%** | |
| **IEA5 Total** | | | | **100%** | |
| **IEA6** | Q34 | Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring | Copies of rotas / off duties to demonstrate they are given dedicated time. | 100% | Have changed from 0% as now have rotas |
| | | | Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. | 100% | |
| | | | Incident investigations and reviews | 100% | |
| | | | Name of dedicated Lead Midwife and Lead Obstetrician | 100% | |
| | | **Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total** | | **100%** | |
| | Q35 | The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health | Consolidating existing knowledge of monitoring fetal wellbeing | 100% | |
| | | | Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision | 100% | revised from 0% - course attendance. JDs attached in original submission |
| | | | Improving the practice & raising the profile of fetal wellbeing monitoring | 100% | |
| | | | Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. | 100% | |
| | | | Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post | 100% | |
| | | | Keeping abreast of developments in the field | 100% | |
| | | | Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. | 100% | |
| | | | Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training. | 100% | |
| | | **The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total** | | **100%** | |
| | Q36 | Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? | Audits for each element | 100% | |
| | | | Guidelines with evidence for each pathway | 100% | |
| | | | SOP's | 100% | |
| | | **Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total** | | **100%** | |
| | Q37 | Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% | |
| | | | Attendance records - summarised | 100% | |
| | | | Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. | 100% | |
| | | **Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total** | | **100%** | |
| **IEA6 Total** | | | | **100%** | |
| | Q39 | Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery | Information on maternal choice including choice for caesarean delivery. | 100% | |
| | | | Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites. | 100% | MVP is currently reviewing evidence |

| | | | | | |
|---|---|---|---|---|---|
| IEA7 | | **Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total** | | **100%** | |
| | Q41 | Women must be enabled to participate equally in all decision-making processes | An audit of 1% of notes demonstrating compliance. | 100% | |
| | | | CQC survey and associated action plans | 100% | |
| | | | SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded. | 100% | |
| | | **Women must be enabled to participate equally in all decision-making processes Total** | | **100%** | |
| | Q42 | Women's choices following a shared and informed decision-making process must be respected | An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction. | 100% | |
| | | | SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded. | 100% | |
| | | **Women's choices following a shared and informed decision-making process must be respected Total** | | **100%** | |
| | Q43 | Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? | Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021. | 100% | |
| | | | Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) | 100% | |
| | | | Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. | 100% | |
| | | **Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total** | | **100%** | |
| | Q44 | Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. | Co-produced action plan to address gaps identified | 100% | |
| | | | Gap analysis of website against Chelsea & Westminster conducted by the MVP | 100% | |
| | | | Information on maternal choice including choice for caesarean delivery. | 100% | |
| | | | Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites. | 100% | Revised from 0% - See above for MVP |
| | | **Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total** | | **100%** | |
| **IEA7 Total** | | | | **100%** | |
| WF | Q45 | Demonstrate an effective system of clinical workforce planning to the required standard | Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan | 100% | LMNS minutes now included. BR+ report included in original submision |
| | | | Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. | 100% | |
| | | | Most recent BR+ report and board minutes agreeing to fund. | 100% | |
| | | **Demonstrate an effective system of clinical workforce planning to the required standard Total** | | **100%** | |
| | Q46 | Demonstrate an effective system of midwifery workforce planning to the required standard? | Most recent BR+ report and board minutes agreeing to fund. | 100% | |
| | | **Demonstrate an effective system of midwifery workforce planning to the required standard? Total** | | **100%** | |
| | Q47 | Director/Head of Midwifery is responsible and accountable to an executive director | HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director | 100% | |
| | | **Director/Head of Midwifery is responsible and accountable to an executive director Total** | | **100%** | |
| | Q48 | Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: | Action plan where manifesto is not met | 100% | |
| | | | Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care | 100% | |
| | | **Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: Total** | | **100%** | |
| | Q49 | Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. | Audit to demonstrate all guidelines are in date. | 100% | |
| | | | Evidence of risk assessment where guidance is not implemented. | 100% | |
| | | | SOP in place for all guidelines with a demonstrable process for ongoing review. | 100% | |
| | | **Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total** | | **100%** | |
| **WF Total** | | | | **100%** | |

**Kirkup report recommendations**
**Regional Update 31st December 2021**

**Those that are greyed out are superseded by Ockenden and do not need completing on this tab.**

| | | | | | Black County and West Birmingham | | | |
|---|---|---|---|---|---|---|---|---|
| **Kirkup Action no.** | **Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information)** | **Action** | **Suggested documents that may support Trust assurance.** | **Documents submitting** | **THE DUDLEY GROUP** | **SANDWELL AND WEST BIRMINGHAM HOSPITALS** | **THE ROYAL WOLVERHAMPTON** | **WALSALL** |
| **1** | **R1, R13, R24** | Ensure that an open and honest approach is taken to any incident | Critical friend is allocated for every level 4/ 5 incident (SI's) | | | | | |
| | | | Women and their families are kept informed of the progress of | | | | | |
| | | | Women and their families are invited to contribute to the | | | | | |
| | | | Offering an apology | | | | | |
| | | | Ensure that all nurses and midwives are aware of their | | | | | |
| **2** | **R1, R13** | Review the current processes for obtaining feedback from the public to increase the information received | Offering women and their families the opportunity to make | | | | | |
| | | | Ensuring that national/ local awareness opportunities are | | | | | |
| | | | Continue to support the LSA in the feedback mechanism to staff | | | | | |
| | | | Share patient stories | | | | | |
| **3** | **R2** | Review the current skills and drills programme across the directorate to ensure that a wide range of scenarios are included across all clinical settings, including bespoke skills drills for different clinical areas | Ensure a high quality training scheme is delivered | | | | | |
| **4** | | Foster a culture of shared learning between clinical departments that supports effective communication and practice development | Minutes of meetings showing MDT working | | | | | |
| **5** | **R2** | Review the current preceptorship programme | Midwives/ Nurses are allocated a buddy in each clinical area and that this is supported by the clinical team. | Preceptorship pathway booklet | | Green | | |
| | | | The buddy midwife is allocated time to support the preceptee | Preceptorship booklet | | Green | | |
| | | | Midwives are supported throughout the programme, progress is monitored and there is a clear plan developed for any midwife | Preceptorship booklet | | Green | | |
| | | | Midwives are confident and competent to go through the gateway within the agreed timeframe | Preceptorship booklet | | Green | | |
| **6** | **R2** | Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme | Utilise PMA feedback | PMA information booklet, newsletter and feedback from PMA lead | | Green | | |
| **7** | **R2, R3** | Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce | Develop a robust support package for new band 6 midwives | SWBH welcome pack, B6 portolio | | Green | | |
| | | | Completion of the Mentoring module | SSSA (Standards for student supervision and assessment) covered on Mandatory | | Green | | |
| | | | Suturing competency | B6 portfolio | | Green | | |
| | | | IV therapy competency | Iv fluid and medicine administration | | Green | | |
| | | | Care of women choosing epidural anaesthesia. | Obstetric anaesthetic booklet | | Green | | |
| **8** | | Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care | Practice educator reports and feedback | SWBH welcome pack, B6 portolio | | Green | | |
| **9** | **R2** | Review the current induction programme for locum doctors | Locum policies | MS / EM documentatio - to attach | | Green | | |
| **10** | | Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group. | | MS / EM documentatio - to attach | | Green | | |
| **11** | **R2** | Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session. | Practice educator meeting notes, discussion with DoMS/HoMs | No maternal AIMS course is run at the Trust, however, we have an enhanced module at Level 7 with internal and external candidates - booklet attached | | Green | | |
| **12** | **R2** | Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford | Practice educator reports and feedback | Neonatal module handbook, foundation course email | | Green | | |
| **13** | **R2** | Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition | Incident review and feedback, related lessons learnt, training opportunities | Deteriorating woman case is presented on MMD - presentation and case provided | | Green | | |
| **14** | **R2** | Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, core huddles, NICU news | | Lessons Learned Event - Learning from Maternity incidents an annual review. Trolley dashes (IV fluids, scribing). 1-2-1 Template for reflection, ToR for weekly incident meeting | | Green | | |
| **15** | **R3** | Review the current process for staff rotation to ensure that a competent workforce is maintained in all clinical areas. | | B6 rotation | | Green | | |
| **16** | **R2, R3, R4** | Review and update the Education Strategy | | | | | | |
| **17** | **R3** | Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations | | Orientation Template for community starters, Roster indicating SN period, External Bank induction to inpatient services | | Green | | |
| **18** | **R3** | Offer opportunities to other heads of service for staff from other trusts to broaden their experience by secondment or supernumerary status | | | | | | |
| **19** | **R5** | Develop a list of current MDT meetings and events and share with staff across the directorate | | | | | | |
| **20** | **R8** | Develop and implement a recruitment and retention strategy specifically for the obstetric directorate | | See documentation from EM / MS & Rota | | Green | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **21** | | Review the current midwifery staffing establishment to ensure appropriate staffing levels in all clinical areas | | | | | | |
| **22** | | Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention | | Exit Survey, Exit Interview Guidance for Managers, Holding Stay conversations, Pre-leavers process, Leavers checklist | | Green | | |
| **23** | | Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns | | DSMLU Forum minutes for Feb 21, April 21, July 21, Sept 21, Nov 21. Community Forum Agenda (last 6 months) | | Green | | |
| **24** | **to multi-site trusts.** | Improve working relationships between the different sites located geographically apart but under the same organization. | | Maternity matters meme (cross site), SOPs for: Allocation of work, Duty Midwife, On call, Digital calendars, | | Green | | |
| **25** | **R9** | Reiterate to all staff via email and team meetings the roles and responsibilities of the consultant obstetrician carrying the hot week bleep. | | | | | | |
| **26** | **R11, R12** | Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported and the rationale for learning from incidents. | | Induction presentation | | Green | | |
| **27** | **R11, R12** | Including a review of the processes for disseminating and learning from incidents | | | | | | |
| **28** | | Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively | All consultants to have completed RCA training | | | Green | | |
| | | | Identified midwives to have completed RCA training | | | Green | | |
| | | | Staff who have completed RCA training undertake an | | | Green | | |
| | | | Develop a local record of staff who have completed RCA training | | | Green | | |
| **29** | **R12** | Ensure that the details regarding staff debriefing and support are completed on the Trust incident reporting system for all level 4 and 5 incidents | | | | | | |
| **30** | **R12** | Ensure that all Serious Incidents (SI's)are fedback to the staff | | | | | | |
| **31** | **R12** | Identify ways of improving attendance of midwives at SI's feedback sessions | | | | | | |
| **32** | **R13** | Maternity Services Liaison Committee involvement in complaints | Collation of complaints reports | | | | | |
| **33** | **R14** | Review the current obstetric clinical lead structure | | | | | | |
| **34** | **R15** | Review past SI's and map common themes | Thematic reviews | | | | | |
| **35** | **R23** | Ensure that maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths are reported, reviewed and an investigation undertaken where appropriate | Maternal deaths, stillbirths and early neonatal deaths reports | | | | | |
| **36** | **R26** | Ensure that all staff are aware of how to raise concerns | Whistle blowing staff policy | AB evidence attached - to upload | | Green | | |
| **37** | **R31** | Provide evidence of how we deal with complaints | | AB evidence attached - to upload | | Green | | |
| **38** | **R31** | Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area | Identifying situations where local resolution is required | AB evidence attached - to upload | | Green | | |
| **39** | **R32** | Develop a plan to maintain a supervision system beyond the decommissioning of the LSAs once national recommendations have been agreed. | Implementation of the A-AQUIP model | | | | | |
| **40** | **R38** | Ensure that all perinatal deaths are recorded appropriately | Sending the completed form to the Deputy Director of Nursing/ Head of Midwifery and the Divisional Clinical Effectiveness | | | | | |
| **41** | **R39** | Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained | MBRRACE action plan | LK / PB to complete | | Green | | |

**Recommendations from the published Kirkup report**

| | |
|---|---|
| **1** | The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act. This should begin immediately with the response to this Report. |
| **2** | The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review will be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere if applicable |
| **3** | The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015. |
| **4** | Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation. This should be completed by September 2015. |
| **5** | The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment. These measures should be identified by April 2015 and begun by June 2015. |
| **6** | The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment. This should be completed by June 2015. |
| **7** | The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. This should be in place by September 2015. |
| **8** | The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. Development of the strategy should be completed by January 2016. |
| **9** | The University Hospitals of Morecambe Bay NHS Foundation Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. This approach should be begun by September 2015. |
| **10** | The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as 'buddying' and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy. If a suitable partner is forthcoming, this arrangement should be begun by September 2015. |
| **11** | The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy. |
| **12** | The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016. |
| **13** | The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee. This should be completed, and the improvements demonstrated at an open Board meeting, by December 2015. |
| **14** | The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015. |
| **15** | The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services. This work is already underway with the facilitation of Monitor, and we would not seek to vary or add to it, which would serve only to detract from implementation. We do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed. |
| **16** | As part of the governance systems work, we consider that the University Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. This should be completed by December 2015. |
| **17 & 18** | The University Hospitals of Morecambe Bay NHS Foundation Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017. 18. All of the previous recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care Quality Commission and Monitor. In the particular circumstances surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups. |
| **Recommendations for the wider NHS** | |
| **19** | In light of the evidence we have heard during the Investigation, we consider that the professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation. Action: the General Medical Council, the Nursing and Midwifery Council. |
| **20** | There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them. Action: NHS England, the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the National Institute for Health and Care Excellence. |
| **21** | The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments. Action: NHS England. |
| **22** | We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. Action: Health Education England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Midwives. |

| | |
|---|---|
| **23** | Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that |
| **24** | We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. Action: the Care Quality Commission, NHS England. |
| **25** | We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts. Action: the Department of Health, the Care Quality Commission |
| **26** | We commend the introduction of a clear national policy on whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. Action: the Department of Health. |
| **27** | Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards. Action: the General Medical Council, the Nursing |
| **28** | Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts. |
| **29** | Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, all Trusts. |
| **30** | A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. Action: NHS England, the Care Quality Commission. |
| **31** | The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. Action: the Department of Health, NHS England, the Care Quality Commission, the Parliamentary and Health Service Ombudsman. |
| **32** | The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (*Midwifery regulation in the United Kingdom* ) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the system. Action: the Department of Health, NHS England, the Nursing and Midwifery Council. |
| **33** | We considered carefully the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance by Monitor, given the close inter-relationship between Trust decisions in each area. However, we were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial implications. The close links, however, require a carefully coordinated approach, and we recommend that the organisations draw up a memorandum of understanding specifying roles, relationships and communication. Action: Monitor, the Care Quality Commission, the Department of Health. |
| **34** | The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave us cause for concern, in particular the breakdown in communication between the Care Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow-up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap. Action: the Care Quality Commission, the Parliamentary and Health Service Ombudsman. |
| **35** | The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear, and we are concerned that potential ambiguity persists. We recommend that NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. Action: the Care Quality Commission, NHS England, Monitor, the Department of Health. |
| **36** | The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. Whilst we do not absolve Trusts from responsibility for prioritising limited capability safely and effectively, we recommend that the Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. Action: the Department of Health. |
| **37** | Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. Action: the Department of Health. |
| **38** | Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. Action: NHS England. |
| **39** | There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. Action: the Department of Health. |
| **40** | Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. Action: the Department of Health |
| **41** | We were concerned by the ad hoc nature and variable quality of the numerous external reviews of services that were carried out at the University Hospitals of Morecambe Bay NHS Foundation Trust. We recommend that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. Action: the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives. |
| **42** | We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. Action: the Care Quality Commission, Monitor. |
| **43** | We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, *High Quality Care for All* , and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. Action: NHS England, the Department of Health. |
| **44** | This Investigation was hampered at the outset by the lack of an established framework covering such matters as access to documents, the duty of staff and former staff to cooperate, and the legal basis for handling evidence. These obstacles were overcome, but the need to do this from scratch each time an investigation of this format is set up is unnecessarily time-consuming. We believe that this is an effective investigation format that is capable of getting to the bottom of significant service and organisational problems without the need for a much more expensive, time-consuming and disruptive public inquiry. This being so, we believe that there is considerable merit in establishing a proper framework, if necessary statutory, on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current |