Agenda Item 7.

Walsall Healthcare NHS
NHS Trust

Meeting	Trust Board
Date	2nd July 2014
Title of Paper	Hospital Mortality Update
Lead Director	Mr Amir Khan, Medical Director
Author	Richard Tipper, Patient Safety Project Manager

PURPOSE OF THE PAPER

The paper provides an update for the Trust Board on hospital mortality as per latest published data.

SUMMARY OF THE KEY POINTS

- Improving hospital mortality is one of the Trust's key priorities as set out in the Quality & Safety Strategy.
- Updated HSMR data for month 12 has been delayed as a result of a review of HES data use by the HSCIC.
- It has been advised that the expectation at present will see month 12 data (March 14) and month 1 2014/15 (April 14) published together on July 1st 2014.
- The Hospital Standardised Mortality Rate (HSMR) for the financial year to date (April 2013 – February 2014) 2013 was 86.02 with HSMR for February 2014 at 81.29.
- The Trust's latest available Standardised Hospital Mortality Index (SHMI) Oct 2012 – Sept 2013 is 96 This is marked as "band 2 " which is defined " as expected " this value represents a continued improvement.

RECOMMENDATIONS

1. NOTE the Trust's current hospital mortality rate & associated commentary

LINKS	
• Strategic Objectives	Safe, High Quality Care *(Patient Promise: In Safe Hands)*
• Annual objectives	To reduce hospital mortality rates
• Monitor / CQC / Regulatory Requirements	Mortality rates are reviewed by both CQC and Monitor
IMPACT	
• Patient Experience	
• Quality & Safety	Hospital mortality rate is a key measure of quality and safety of care
• Financial	Resources have been invested in additional consultant and palliative care support
• Workforce	A medical workforce review has been undertaken as part of this plan
• Equality & Diversity	
• Estates	
• IM&T	
• Communications / Engagement	Effective communication will be key to the success of the plan
RISKS • Failure to deliver continued improvements in hospital mortality risks damaging the reputation of the Trust with its stakeholders • Failure to deliver improvements may present a risk to the continued progress of the Trust's Foundation Trust application	
PREVIOUS CONSIDERATION Quality and Safety Committee, 19 June 2014	

Walsall Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD, 2 JULY 2014

MONTHLY MORTALITY REPORT

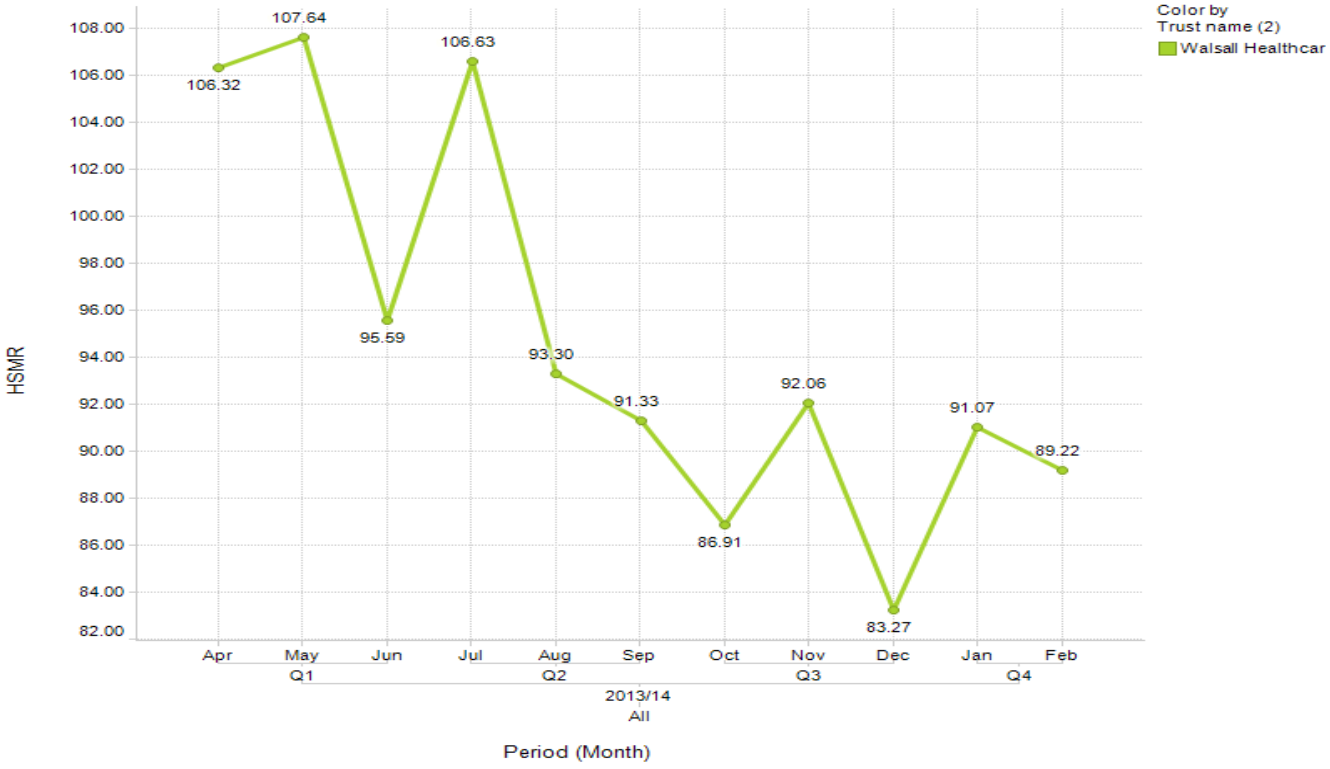
Hospital Standarised Mortality Ratio (HSMR)

HSMR for the financial year commencing April 2013 is 86.02. For the most recent published month (February 2014), HSMR is reported as 81.29. Figure 2 below shows the HSMR by month over the year as being broadly consistent at or under 85 for the previous 6-7 months. Figure 3 demonstrates the Trust is predicted to have a rebased HSMR of 96. The crude rate for all admissions is 1.68% for FYTD.

HES data updates for March 2014 has been delayed by the HSCIC due to a review of their data reporting procedures. It has been advised to expect publication of March and April 14 mortality data on July 1st.

A full reflection of the HSMR dashboard is attached to this report as appendix 1.

Figure 1 – HSMR for FYTD April 2013 to February 2014 HED



HED have published updated data updated for Month 11 as above which showed the trust HSMR for February as 89.22 compared to 81.29 by Dr Foster. The discrepancy is due to HED rebasing HSMR on a monthly basis rather than annually.

Summary Hospital-Level Mortality Indicator (SHMI)

SHMI for the period October 2012 – September 2013 shows SHMI as 0.96 which is banded as level 2 "as expected. Publication of the next data series for the period January 2013 to December 2013 will be published in July 2014. This publication identified that 27.07% of deaths in this period had input from the palliative care team which equated to 1.38% of all spells. Figure 2 below shows the Trust SHMI plotted since 2010 which shows the overall reduction in SHMI over this 3 year period. Figure 3 shows the most prevalent diagnosis for these cases.

Figure 2 – SHMI for 3 year period.

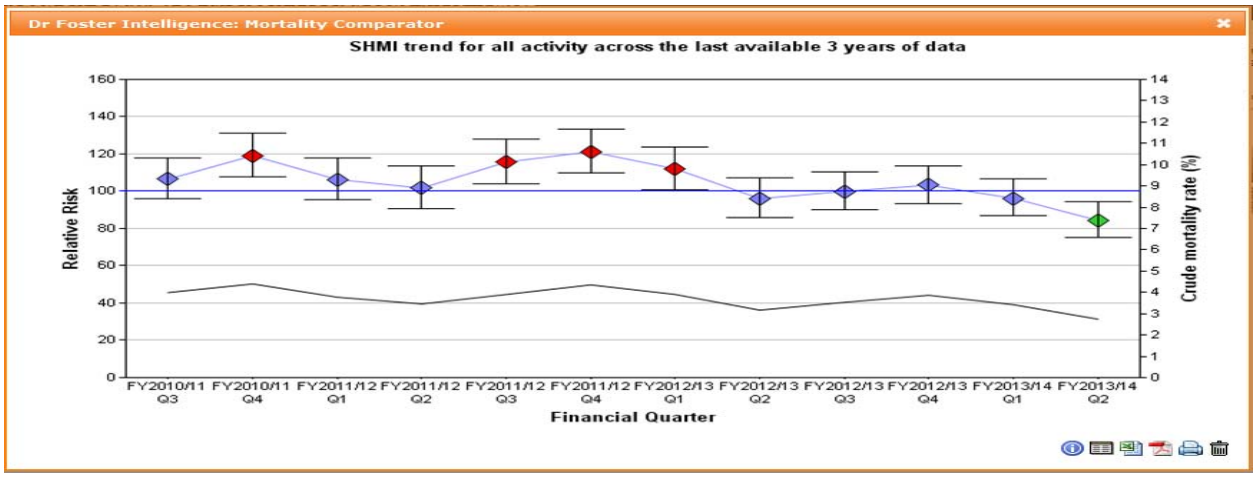
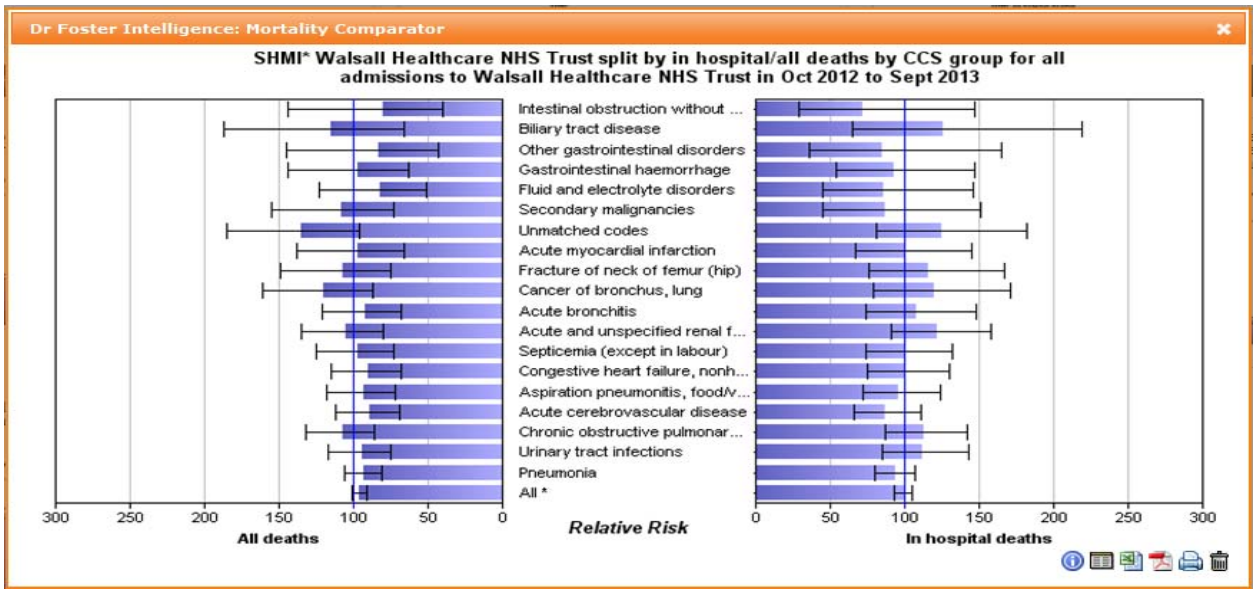


Figure 3 – SHMI by diagnosis group



Reviews

Reviews undertaken by Mr T Muscroft and Dr T Constable in respect to deaths in April / May will be presented to the mortality meeting a summary is contained within the meeting minutes.

Reviews of hospital deaths continue to be conducted by Consultants with results and feedback to be presented back into care group meetings for action. A revised divisional and

care group level mortality report will be received from May which will support these groups in identifying trends and target areas of concern for decisive action or escalation.

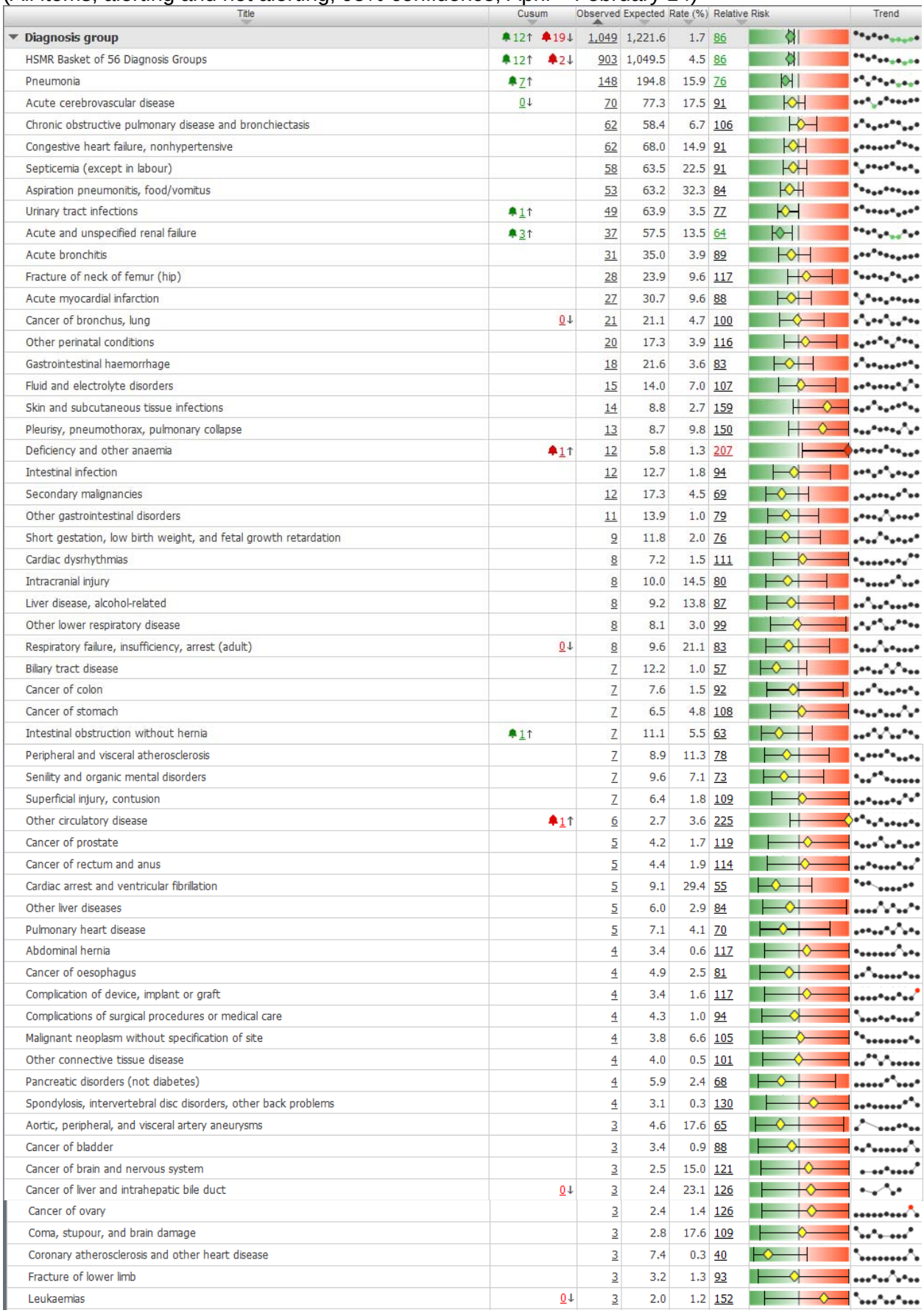
Data & commentary contained within this report will be presented to the Mortality Review Group 6th July 2014 and confirmed by the Medical Director:

Signed:

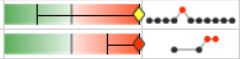
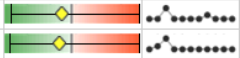
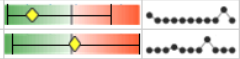
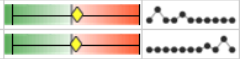
Amir Khan Medical Director Date: 6th / July / 2014

Appendix 1 – Dashboard

(All items, alerting and not alerting, 95% confidence, April – February 14)



Title	Cusum	Observed	Expected	Rate (%)	Relative Risk	Trend
Diagnosis group	12↑ 19↓	1,049	1,221.6	1.7	86	
HSMR Basket of 56 Diagnosis Groups	12↑ 2↓	903	1,049.5	4.5	86	
Pneumonia	7↑	148	194.8	15.9	76	
Acute cerebrovascular disease	0↓	70	77.3	17.5	91	
Chronic obstructive pulmonary disease and bronchiectasis		62	58.4	6.7	106	
Congestive heart failure, nonhypertensive		62	68.0	14.9	91	
Septicemia (except in labour)		58	63.5	22.5	91	
Aspiration pneumonitis, food/vomitus		53	63.2	32.3	84	
Urinary tract infections	1↑	49	63.9	3.5	77	
Acute and unspecified renal failure	3↑	37	57.5	13.5	64	
Acute bronchitis		31	35.0	3.9	89	
Fracture of neck of femur (hip)		28	23.9	9.6	117	
Acute myocardial infarction		27	30.7	9.6	88	
Cancer of bronchus, lung	0↓	21	21.1	4.7	100	
Other perinatal conditions		20	17.3	3.9	116	
Gastrointestinal haemorrhage		18	21.6	3.6	83	
Fluid and electrolyte disorders		15	14.0	7.0	107	
Skin and subcutaneous tissue infections		14	8.8	2.7	159	
Pleurisy, pneumothorax, pulmonary collapse		13	8.7	9.8	150	
Deficiency and other anaemia	1↑	12	5.8	1.3	207	
Intestinal infection		12	12.7	1.8	94	
Secondary malignancies		12	17.3	4.5	69	
Other gastrointestinal disorders		11	13.9	1.0	79	
Short gestation, low birth weight, and fetal growth retardation		9	11.8	2.0	76	
Cardiac dysrhythmias		8	7.2	1.5	111	
Intracranial injury		8	10.0	14.5	80	
Liver disease, alcohol-related		8	9.2	13.8	87	
Other lower respiratory disease		8	8.1	3.0	99	
Respiratory failure, insufficiency, arrest (adult)	0↓	8	9.6	21.1	83	
Biliary tract disease		7	12.2	1.0	57	
Cancer of colon		7	7.6	1.5	92	
Cancer of stomach		7	6.5	4.8	108	
Intestinal obstruction without hernia	1↑	7	11.1	5.5	63	
Peripheral and visceral atherosclerosis		7	8.9	11.3	78	
Senility and organic mental disorders		7	9.6	7.1	73	
Superficial injury, contusion		7	6.4	1.8	109	
Other circulatory disease	1↑	6	2.7	3.6	225	
Cancer of prostate		5	4.2	1.7	119	
Cancer of rectum and anus		5	4.4	1.9	114	
Cardiac arrest and ventricular fibrillation		5	9.1	29.4	55	
Other liver diseases		5	6.0	2.9	84	
Pulmonary heart disease		5	7.1	4.1	70	
Abdominal hernia		4	3.4	0.6	117	
Cancer of oesophagus		4	4.9	2.5	81	
Complication of device, implant or graft		4	3.4	1.6	117	
Complications of surgical procedures or medical care		4	4.3	1.0	94	
Malignant neoplasm without specification of site		4	3.8	6.6	105	
Other connective tissue disease		4	4.0	0.5	101	
Pancreatic disorders (not diabetes)		4	5.9	2.4	68	
Spondylosis, intervertebral disc disorders, other back problems		4	3.1	0.3	130	
Aortic, peripheral, and visceral artery aneurysms		3	4.6	17.6	65	
Cancer of bladder		3	3.4	0.9	88	
Cancer of brain and nervous system		3	2.5	15.0	121	
Cancer of liver and intrahepatic bile duct	0↓	3	2.4	23.1	126	
Cancer of ovary		3	2.4	1.4	126	
Coma, stupour, and brain damage		3	2.8	17.6	109	
Coronary atherosclerosis and other heart disease		3	7.4	0.3	40	
Fracture of lower limb		3	3.2	1.3	93	
Leukaemias	0↓	3	2.0	1.2	152	

Other endocrine disorders		3	2.0	3.5	151	
Other non-traumatic joint disorders		3	1.6	0.8	184	
Residual codes, unclassified		3	4.3	0.6	70	
Anal and rectal conditions	2↑	2	0.5	0.5	434	
Intrauterine hypoxia and birth asphyxia	2↑	2	0.1	33.3	1,352	
Other infections, including parasitic	2↑	2	0.5	13.3	429	
Other diseases of bladder and urethra	1↑	2	0.8	0.9	245	
Paralysis	1↑	2	0.6	8.7	309	
Abdominal pain		2	2.3	0.2	87	
Cancer of breast		2	2.4	0.2	84	
Cancer of head and neck		2	0.8	2.7	235	
Diabetes mellitus with complications		2	2.9	1.6	69	
Diverticulosis and diverticulitis		2	4.5	0.4	44	
Fracture of upper limb		2	1.9	0.6	106	
Gastroduodenal ulcer (except haemorrhage)		2	1.8	1.3	109	
Genitourinary symptoms and ill-defined conditions		2	1.8	0.2	109	
Oesophageal disorders		2	1.9	0.3	105	
Other and ill-defined heart disease		2	1.2	5.6	168	
Other diseases of kidney and ureters		2	1.0	2.7	197	
Other hereditary and degenerative nervous system conditions		2	1.3	6.1	151	
Other inflammatory condition of skin	0↓	2	1.3	0.9	156	
Other nutritional, endocrine, and metabolic disorders		2	3.3	0.3	60	
Peritonitis and intestinal abscess		2	1.5	12.5	133	
Shock		2	1.3	100.0	159	
Syncope		2	2.5	0.5	81	
Calculus of urinary tract	1↑	1	0.2	0.3	665	
Cancer of thyroid	1↑	1	0.1	16.7	1,328	
Cancer, other respiratory and intrathoracic	1↑	1	0.3	3.0	359	
Headache, including migraine	1↑	1	0.2	0.3	603	
Inflammatory conditions of male genital organs	1↑	1	0.1	1.1	793	
Multiple myeloma	1	1	0.7	0.4	150	
Other upper respiratory infections	1↑	1	0.3	0.4	302	
Regional enteritis and ulcerative colitis	1↑	1	0.3	0.2	307	
Thyroid disorders	1↓	1	0.5	2.2	203	
Cancer of kidney and renal pelvis		1	2.0	3.3	50	
Cancer of other GI organs, peritoneum	0↓	1	1.8	1.6	56	
Cancer of pancreas		1	3.7	1.3	27	
Cancer, other and unspecified primary		1	0.6	14.3	160	
Cardiac and circulatory congenital anomalies		1	0.7	7.7	141	
Chronic renal failure		1	2.9	7.1	34	
Coagulation and haemorrhagic disorders		1	1.6	1.0	61	
Conduction disorders		1	2.4	0.8	41	
Crushing injury or internal injury		1	1.9	0.8	54	
Epilepsy, convulsions		1	3.3	0.3	30	
Heart valve disorders		1	1.3	1.0	75	
Infective arthritis and osteomyelitis		1	1.5	1.8	65	
Multiple sclerosis		1	0.5	4.8	211	
Mycoses		1	0.1	5.6	1,164	
Neoplasms of unspecified nature or uncertain behavior		1	2.1	0.5	47	
Non-Hodgkin's lymphoma		1	1.0	0.6	101	
Noninfectious gastroenteritis		1	0.4	0.7	279	
Nonspecific chest pain		1	1.3	0.1	77	
Open wounds of head, neck, and trunk		1	1.8	1.0	55	
Osteoarthritis		1	1.7	0.1	59	
Other congenital anomalies	0↓	1	0.9	1.4	118	
Other disorders of stomach and duodenum		1	1.5	0.3	66	
Other fractures		1	5.0	0.8	20	
Other nervous system disorders		1	3.2	0.4	31	
Other upper respiratory disease		1	2.9	0.3	35	
Pathological fracture		1	0.7	4.3	145	

Procedure group	10↑ 12↓	519	588.1	1.3	88	
Diagnostic imaging (except heart)	9↑	154	243.4	3.9	63	
Rest of Respiratory (diagnostic/minor)	1↑	65	47.6	28.5	137	
External resuscitation		43	37.2	43.0	116	
Urethral catheterisation of bladder	1↓	42	53.8	7.4	78	
Diagnostic imaging of heart		28	26.5	5.8	106	
Rest of Arteries and veins (diagnostic/minor)	1↓	20	12.4	2.4	161	
Diagnostic endoscopic procedures on upper GI tract		18	18.1	0.7	100	
Excision of colon and/or rectum		15	13.0	6.9	116	
Therapeutic endoscopic procedures on upper GI tract		11	18.3	4.1	60	
Other drainage of peritoneal cavity		10	9.8	5.7	102	
Rest of Miscellaneous operations	3↑	9	2.3	0.5	398	
Rest of Soft tissue (diagnostic/minor)		9	9.2	8.7	97	
Therapeutic operations on jejunum and ileum		8	6.4	8.9	125	
Head of femur replacement		7	9.2	4.9	76	
Reduction of fracture of neck of femur		7	5.0	8.3	141	
Rest of Arteries and veins		6	6.4	10.7	94	
High-cost drugs		5	3.0	0.3	169	
Cardiac pacemaker or defibrillator introduced through the vein		4	2.7	1.5	151	
Percutaneous puncture of kidney		4	2.5	12.5	158	
Reduction of fracture of bone (upper/lower limb)		4	3.9	0.9	102	
Rest of Soft tissue		4	5.4	1.4	74	
Compensation for renal failure	1↓	3	1.1	37.5	268	
Rest of Heart	1↑	3	1.3	23.1	237	
Rest of Lower GI		3	2.0	1.1	148	
Diagnostic endoscopic retrograde exam of bile duct and pancreatic duct	2↑	2	0.5	14.3	413	
Rest of Bone	1↑	2	0.5	0.6	406	
Diagnostic endoscopic examination of lower respiratory tract		2	2.1	0.7	96	
Diagnostic endoscopic procedures on lower GI tract		2	3.2	0.1	63	
Diagnostic spinal puncture		2	3.9	0.8	52	
Liver biopsy		2	0.9	7.1	213	
Rest of Nervous system		2	0.8	3.0	238	
Rest of Skin		2	2.0	0.7	100	
Rest of Urinary		2	0.7	1.3	278	
Therapeutic endoscopic procedures on biliary tract		2	3.9	1.1	51	
Therapeutic endoscopic procedures on ureter	1↑	1	0.5	0.5	184	
Therapeutic transluminal operations on vein	1↑	1	0.1	100.0	711	
Contrast radiology or catheterisation of heart		1	3.3	0.1	31	
Diagnostic endoscopic examination of bladder		1	0.6	0.1	159	
Diagnostic puncture of bone		1	0.7	20.0	154	
Inguinal hernia		1	0.4	0.4	248	
Invalid, method and site codes		1	0.7	1.7	149	
Knee replacement		1	0.4	0.3	224	
Other excision of gall bladder		1	0.6	4.3	181	
Puncture of joint		1	1.2	0.3	84	
Rehabilitation		1	0.2	9.1	543	
Rest of Joint		1	1.1	0.3	92	
Rest of Mouth		1	0.3	0.6	343	
Rest of Respiratory		1	1.8	0.7	54	
Rest of Upper GI		1	1.0	1.3	101	
Therapeutic endoscopic procedures on lower GI tract		1	0.5	0.2	193	
Total excision of spleen		1	0.2	33.3	415	

Walsall Healthcare NHS Trust

Agenda item 7.

Meeting	Trust Board
Date	Wednesday 2nd July 2014
Title of Paper	Independent External Review outcome regarding the retention of Foetal Remains
Lead Director	Jayne Tunstall - Chief Operating Officer
Author	Debbie Hill – Operational Delivery Manager and Jayne Tunstall – Chief Operating Officer

PURPOSE OF THE PAPER

To provide the Board with the findings of the External Review recently carried out and the Action Plan developed in order to address the findings and recommendations relating to the delay in the sensitive disposal of foetal remains that were held within the Mortuary.

SUMMARY OF THE KEY POINTS

- An External review has been carried out and the findings outlined in the report. Main findings are:

  Overall, the review findings identified multifactorial reasons for the backlog of foetal remains

  - Inadequate leadership and management in 2 departments
  - Failure to ensure the provision of mandatory, risk management and policy training for staff in all areas involved in this process.
  - Fundamental weaknesses in the governance and management of risk concerning the backlog of foetal remains and therefore no escalation to Executives or the Board
  - A significant gap in the provision of a comprehensive bereavement service
  - Historical practices and processes in place and not reviewed

- Trust has carried out 81 of the 86 cremations with 3 burials being organised
- The remaining 2 have separate arrangements agreed

RECOMMENDATIONS

To NOTE the Report and the findings from the External Recommendations.

LINKS	
Strategic Objectives	First Class Experience, Safe high quality services, Engaged and empowered workforce, Good use of resources, Integrated care and Effective NHS FT
Annual objectives	None
Monitor / CQC / Reg Requirements	None
IMPACT	
Patient Experience	It is vital that the standard of care and quality of service is maintained even during the most challenging of situations.
Quality & Safety	To ensure quality is maintained at all times and ensure dignified actions are taken as part of the events recorded within this report.
Financial	Not reviewed as part of this briefing paper.
Workforce	Support and leadership has been provided throughout this sequence of events and continue to be closely monitored.
Equality & Diversity	N/A
Estates and Facilities	N/A
IM&T	N/A
Comms/Engagement	N/A

RISKS

Assurance is being provided that the risk of this occurring again is at an absolute minimum with the production and implementation of new, updated policies and procedures to avoid a further system failure in the future

PREVIOUS CONSIDERATION

Updates and discussion has previously been held in several forums.

1. Introduction & Background

In February 2014, the Trust undertook a detailed audit in response to a Freedom of Information Request and it became apparent that a total of 86 foetal tissue remains were stored in the mortuary. The gestation period of the remains ranged from 5 to 21 weeks.

Following discovery of the above information, a range of activities were undertaken by the Trust namely: an incident report to the Human Tissue Authority, immediate informal meetings held and the establishment of an FOI Project Group chaired by the Chief Executive, which addressed and controlled all key aspects of the issue including the Media.

As part of the work, in March 2014, the Trust carried out an internal investigation into 86 Foetal Remains that had been held in the Mortuary for a considerable time.

The HTA issued a statement on 18th March 2014 - "the hospital reported the incident to us as soon as it was discovered and has carried out an internal investigation promptly and in a transparent manner."

There was already pre-arranged and scheduled HTA inspection (not connected with the foetal remains issue) undertaken in the Mortuary on 25.3.14 in respect of compliance with the Human Tissue Authority minimum standards and they produced their Report in relation to that that can be found on their website – http://www.hta.gov.uk/db/documents/2014-03-25 12102 Manor Hospital inspection report – Final.pdf

As part of the Trusts internal investigation that was carried out, a Report was produced. This identified several key findings;

- A serious failure in administrative systems which ensure safe and timely disposal of foetal remains
- Policies that were live in the Trust relating to Foetal Tissue and the Disposal of Foetal Tissues were past their review dates
- Management oversight had failed in some departments of the organisation which were responsible for the safe and timely disposal of Foetal remains

2. Key Actions taken following the Internal Investigation

The FOI Project Group which oversaw the internal investigation held their final meeting on Tuesday 1st April 2014, 9 days after the letter from Bruce Keogh

was received by the Trust. At this point in time, the FOI Group had set out key actions. These included:

Action 1 *Complete the internal report for the HTA*

The report was completed and sent to the HTA (Human Tissue Authority) for information on 12th March 2014.

Action 2 *Provide the support and leadership required to the General Office in the absence of their line manager*

An interim Team Manager was put into place who has now reviewed the processes and arrangements regarding foetal remains funerals. The Disposal of Foetal Remains Policy will reflect all changes made to processes.

Action 3 *Review and update all policies relating to the disposal of Foetal Remains and Products of Conception*

Work is continuing with all stakeholders to finalise the Trusts Policy on The Disposal of Foetal Remains. This work has included a complete review of all documentation used as well as the requirement for a training programme for staff to be developed.

A governance structure has also been introduced to ensure that no foetal remain is disposed of earlier than 28 days of "the event" and no longer than 2 months in usual circumstances. This ensures that mothers can have time to make an informed decision of what they would like to do with their baby. The 28 days is allowing a period of time for the mother should they change their mind.

Action 4 *Provide a safe and dignified cremation or burial of the 86 remains, ensuring the wishes of all parents involved are adhered to from intelligence that has been gathered on each foetus throughout this process*

Since Tuesday 15th April, 81 cremations have been carried out with the final cremations held on Tuesday 3rd June 2014 which will leave 4 foetal remains of the 86 still in the Mortuary.

3 of the 4 that remain in the Mortuary are for burials which are currently being arranged as per the mother's wishes.
None of the mothers wanted to be in attendance at the time of the burials.

1 of the 86 remains was collected by the mother in May 2014. The Trust policy for this has also been previously reviewed and has confirmed to be robust in its processes when dealing with such cases.

The one remaining foetus is to remain in the Mortuary for the foreseeable future. The mother contacted the Trust and instructed that it was not moved until further notice from her. To date, instruction has not yet been received from her. The Mortuary are absolutely clear to keep it safe until the mother states what her wishes are. Each month there is a process in place to confirm the foetus remains in the mortuary.

Action 5 *Support any parent that has been affected by the retention of the Foetal Remains*

Since the "111" hotline closed, neither the Trust nor "111" services have received any more calls from concerned or distressed mothers.

Action 6 *Respond to Bruce Keoghs letter and implement directive.*

In response to Sir Bruce Keoghs letter, the Trust has worked to produce and apply interim updated new guidance for the disposal of foetal remains and products of conception and arrangements have now been put into place to ensure ALL products are cremated unless the mother indicates otherwise

Action 7 *Support the Teams and Departments involved in the system failure.*

Support has been provided to departments and teams involved in the system failure, whilst we are working with them to produce new guidelines and updated Standard Operating Procedures for their departments

Action 8 *A training plan needs to be developed that reflects the policies and procedures that will explain all the standard operating procedures clearly to the teams and what is required from each of them.*

Staff have been informed around the interim changes in the process / procedure to be followed and once the Policy has been ratified and the Action Plan approved, a full training programme will be required to be developed and rolled out promptly.

Action 9 *Commission an external, independent investigation on what happened and to provide recommendations for the Trust going forward*

This review was carried out April / May 2014 by Buckley-Gray Consultancy Ltd and their Report, (See Appendix 1), identifies the findings and recommendations as detailed below:

3.0 External Independent Management Review Report Findings

3.1 Key Messages

- The Trust is committed to providing a good experience for the mothers, parents and families who use this service
- Their aim is to deliver high quality care
- The Trust is consistent in their approach in taking active measures to immediately resolve identified issues
- Overall, the review findings identified multifactorial reasons for the backlog of foetal remains

3.2 Key Factors that contributed to this incident

- Historical practices and processes in place due to the absence of a robust Trust wide current policy that clearly defines the roles and responsibilities of all departments involved in the pathway
- Inadequate leadership and management in the general office and to a lesser extent the mortuary
- Fundamental weaknesses in the governance and management of risk concerning the backlog of foetal remains and therefore no escalation to Executive Directors and / or the Board.
- Clinical practice at the procedure stage needs reviewing to ensure compliance with clinical policy
- Failure to ensure the provision of mandatory, risk management and policy training for staff in all areas involved in this process.

- A significant gap in the provision of a comprehensive bereavement service

3.3 The Report's Concluding Remarks

There is evidence that the Trust has implemented a strong governance framework, however, there was no complete oversight of the system or rigorous facilitation for the timely disposal of foetal remains. Moreover, the processes in place for the governance of quality are not entirely embedded within the organisation. It would appear that some members of staff didn't entirely understand their responsibilities of compliance.

Sustainability of the necessary changes will be crucial to maintain sound systems of control, effective improvements in risk management, assurance and continuous quality improvements of this service.

4.0 Action Plan to address Findings

Appendix 2 details the Action Plan that encompasses all of the recommendations and actions identified within the External Report, it should be noted that a number of actions were identified in the initial Internal Investigation Report and they have been / are being implemented already.

A summary of the actions to be implemented are detailed below:

- Implementation of comprehensive Trust wide Policies and Procedures in respect of the dignified disposal of all Foetal Remains
- Continue to address the leadership and management issues in the general office and monitor closely.
- Review Mortuary management systems. Put measures in place to address the shortfall in appraisals / IPDR and regular communication meetings in order to proactively resolve any concerns.
- Assess any development needs of staff in both Mortuary and General Office in terms of exercising good judgement of taking ownership and realistic steps to address the known issues surrounding the disposal of foetal remains.
- All Staff should be clear on what is expected of them and be in a position to take ownership of issues, provide robust decision making and accurate assurance on the provision of services for the disposal of foetal remains.

- Ensure there is a robust process for the escalation of concerns to alert Divisional Directors and Executives enabling the Board to have insight into key risks. Include in the appropriate Trust Policy.
- Mortuary and Pathology Service meetings accurately record minutes of meetings to reflect accurately the discussions held.
- Ensure clinical involvement at Pathology Quality Team meetings.
- Clinicians to revisit compliance with clinical aspects of the Policy
- All staff in General Office to complete Mandatory and Policy Training and for an assessment around their requirements for incident reporting and Risk Management training and ensure attendance
- Clinical Support Service staff to be given training and support on risk management which includes Serious Incident Reporting and the Quality and Safety Strategy
- All staff should understand risk management processes, they should be systematic and owned at the right levels.
- Review the Bereavement Service provided by the Trust
- A process be developed within the Mortuary and Clinical Services Division to escalate delays in any funerals being arranged
- Seek feedback specifically from this cohort of patients in relation to their experience and review and consider any appropriate action required as part of normal patent experience reviews.

5. Governance / Monitoring Process

There is a process in place whereby the Mortuary will hold their Team Meeting and will escalate any issues or where remains have been held for longer than the Policy stipulates. A clinical Incident Form will also be completed and investigated.

The escalation processes within the Mortuary, General Office, Delivery Suite and Gynae Departments will be produced, agreed and effectively communicated so that any issue in relation to foetal remains will be discussed in the appropriate Meeting / Committee and then escalated to the Divisional Teams and onto Executive Officers

The Womens and Childrens Division will lead and oversee the implementation of the whole Action Plan, ensuring Monthly meetings are held in order to monitor implementation. This will be chaired by the WCSS Divisional Director.

Kathryn Halford will be the Executive Lead upon the departure of the Chief Operating Officer Jayne Tunstall and progress will be reviewed at Quality and Safety Committee on a Quarterly basis.

6. Outstanding issues

It has been fully recognised by the HTA, that further clarity is required by Sir Bruce Keogh to understand the criteria going forward of what should be buried, cremated or incinerated. Until that time however, the Trust will ensure that ALL foetal remains and products of conception are disposed of in a dignified manner as per confirmation with HTA.

The final draft of the Disposal of Foetal Remains policy will be ready for ratification in the next month detailing exactly the process to be followed by teams in relation to foetal remains.

7. Conclusion

The issue around the inappropriate retention of the foetal remains is nearing its conclusion with 81 cremations completed.

The Trust has taken very seriously the situation and has taken actions to strengthen the processes and systems prior to the External Report being published.

The Action Plan now developed from the External Review recommendations will be implemented at pace in order to ensure the risk of such an incident happening again is mitigated.