Health and Social Services Scrutiny and Performance Panel
29th January 2016

Agenda Item No.

Title of the Report:

Walsall Review into Perinatal and Infant Mortality and update on multidisciplinary action plan

Ward(s); All

Portfolios: Councillor Martin (Public Health)

Executive Summary:

Infant mortality is a sensitive indicator of the overall health of a population, providing a measure of the well-being of infants, children and pregnant women and reflects the levels of deprivation in an area.

In recognition that Walsall's infant mortality rate (6.8 per 1000 live births) is significantly higher than regional (5.4 per 1000 live births) and national rates (4.1 per 1000 live births), Walsall Public Health commissioned a deep dive review into the causes of infant mortality from the Perinatal Institute in 2014.

This review covered perinatal and infant deaths over a four year period between 2010 and 2014. It was completed in 2015 and identified a number of key learning points and recommendations for improvement for Walsall Healthcare Trust, the Walsall Clinical Commissioning Group and Public Health services as outlined in the attached report.

Following the completion of the review, a joint action plan has been developed by Walsall Healthcare Trust, Walsall CCG and Walsall Public Health to address the recommendations of the report.

Reason for scrutiny:

The reduction in infant mortality and ensuring the wellbeing of infants and children is a key issue for Walsall Borough Council and partner agencies. This report aims to;

- Enable the panel to scrutinise recommendations, actions and progress to date.
- Keep the panel informed of work that is being done to reduce infant mortality and improve the health of children.

Recommendations:

That: The Health and Social Services Scrutiny and Performance Panel note this report and continue to monitor progress towards the reduction in infant mortality in Walsall.

Background papers:

Appendix 1: Review of Perinatal & Infant Deaths and Maternity Care in Walsall - Report to Walsall Borough Council (26 November 2015)

Appendix 2: Joint stakeholder action plan following the Perinatal Institute Review of Perinatal and Infant Deaths and Maternity Care in Walsall

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Review of Perinatal & Infant Deaths and Maternity Care in Walsall

Report Summary

26 November 2015

Introduction

A Confidential Enquiry was commissioned by Walsall Borough Council to investigate the standard of care of stillbirths, neonatal and infant deaths which occurred in Walsall between 2010 and 2014. The Enquiry was undertaken by the Perinatal Institute, a national not-for-profit organisation specialising in the improvements of the quality and safety of care for mothers and babies. This document is a summary of the key points of the report; the full report is available on request from Walsall Public Health (publichealth@walsall.gov.uk or Tel 01922 653747).

Walsall

Perinatal and infant mortality in Walsall is above the regional and national average. In part, this is considered to be due to a relatively high degree of poverty and social deprivation, as well as other factors which represent increased risk, such as smoking, obesity, and consanguinity.

Maternity care is provided by Walsall Healthcare NHS Trust, with a consultant led unit and a free standing midwifery led unit (MLU). Neonatal care is provided by a local neonatal unit (LNU), with a Newborn Network linked neonatal intensive care unit (NICU) at Wolverhampton.

Case reviews

We undertook a confidential case reviews of 66 deaths which had occurred in Walsall between April 2010 and March 2014. These included 42 stillbirths, 16 neonatal deaths and 8 sudden unexplained deaths in infancy (SUDIs or 'cot deaths'). All cases had identifiable details removed and were examined by independent experts in a structured manner using the Perinatal Institute's software application called SCOR ('standardised clinical outcome review').

Standard of care

The findings were seen within the overall context of a busy NHS hospital, where the care of most pregnancies lead to a satisfactory outcome, despite the challenges of the local maternity population.

The review found examples of good practice as well as instances where care was below an acceptable standard, which was thought to have potentially contributed to the death in a proportion of cases. It was considered that optimal care may have resulted in better outcomes in 18 of the 42 stillbirths (43%), and in 5 of the 16 neonatal deaths (31%) examined.

While a clear source for concern, such figures are in keeping with the findings from the West Midlands confidential enquiries previously undertaken by the Perinatal Institute [1], and the findings of the recently published national report by MBRRACE on stillbirths at term [2]. In each report, over half of the deaths examined had substandard care which was considered to have contributed to the outcome. It was also observed that most of the deaths following substandard care in Walsall had occurred during the first half of the 4 year period studied, with evidence that improvements had been put in place during this period.

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1. Confidential Enquiries – West Midlands Perinatal Institute 2007-2011 www.pi.nhs.uk/pnm/clinicaloutcomereviews/index.htm
2. Perinatal Confidential Enquiries – MBRRACE-UK 2015 www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Perinatal%20Report%202015.pdf

Learning points and recommendations

The full report sets out the main themes and learning points derived from the confidential case reviews. Based on these, the Perinatal Institute and its clinical advisors formulated a set of recommendations. We list here three of the key recommendations for each of the organisations which are tasked with the care of mothers and infants Walsall.

1. Key recommendations to Walsall Healthcare NHS Trust

- Many of the deaths had fetal growth problems which had not been recognised. There was a need for improving the monitoring of fetal growth, with standardised measurement of fundal height (the size of the womb), supported by regular ultrasound scans in pregnancies where the baby was at increased risk.

- Neonatal care was not always well co-ordinated, and lacking clearly stated plans of care. Collaboration with the neonatal intensive care unit (NICU) required improvement, to be helped by full implementation of Newborn Network guidance for the transfer of sick babies.

- There is a need for standardised in house examination of all baby deaths, combined with independent peer review, to help understand what has gone wrong and to develop action plans for prevention.

2. Key recommendations to the Newborn Network

- Review of neonatal cases suggest a need to clarify transfer protocols within the network
- It is suggested that the network help to standardise assessment and management of all newborn babies, and support professional development
- It should also support ongoing peer review of deaths at Network level

3. Key recommendations to the Walsall Clinical Commissioning Group

- Commissioning of services needs to consider the requirements of the local maternity population
- Sufficient ultrasound resources need to be made available for the assessment of babies' growth, according to national guidelines
- The Trust should be given resources for a dedicated bereavement service, to optimise the care of women and families who have had a perinatal loss

4. Key recommendations to Walsall Metropolitan Borough Council and Public Health

- Promote public health messages relating to maternity care, including smoking and obesity
- Promote education on awareness of risks of cot death (SUDI), including factors such as co-sleeping, alcohol, smoking, and babies with intrauterine growth restriction
- Help ensure good service provision in all areas, including those with high social deprivation

Feedback

The findings and recommendations have been discussed with the respective organisations, and have been widely welcomed. The NHS Trust representatives were able to point out that a number of learning points have already been recognised and appropriate steps taken. A detailed action plan is being drawn up by Walsall Borough Council, Walsall Clinical Commissioning Group and Walsall Healthcare Trust and to address all issues raised in the report.

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Walsall Healthcare NHS
NHS Trust

Appendix 2

Title:	**Joint stakeholder action plan following the Perinatal Institutes Infant mortality review of the Walsall Healthcare NHS Trust.**
Date :	**11th November**
Version :	**Draft V 0.1 WHT actions only May 2015** **Draft V 0.2 WHT amendments May/June 2015** **Draft V 0.3 WHT draft shared with other stakeholders June 2015** **Draft V 0.4 stakeholders agreed a joint plan July 2015** **Draft V 0.5 Joint actions included, plan shared with all stakeholders July 2015** **Draft V 0.6 amendments at IMIB Agust 2015** **Draft V 0.7 RAG rating key added 11.08.2015** **Updated plan V0.8 27.08.15** **Updated plan V 0.9 28.09.15** **Updated plan V10.0 19.10.15** **Updated plan V11.0 27.10.15** **Updated plan V 12.0 (11.11.15)**

Rag Rating Key (CQC standard)

RED		**Not commenced**
AMBER		**Commenced**
GREEN		**On target**
Black		**Completed**

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
Trust Maternity recommendations:						
a) Increase awareness of importance of antenatal assessment and clear, individualised care plans reflecting medical, obstetric and social risk factors	The maternity service to review its current processes of antenatal risk assessment using the maternity pathway	A Mulay L Fitzsimons	September	Apr 2016	• Quarterly audits using Badgernet, for compliance to pathway • Q1 audit to be available for September meeting	
b) Ensure all staff are trained in antenatal surveillance of foetal growth and the appropriate referral pathways and establishing rolling audit of performance (SGA/FGR detection rates)	• Midwifery service to review of the current programme of training in place • Medical staff to undertake GAP training. Ongoing mandatory training delivered on monthly basis • Mandatory E-Learning package introduced for Midwifery and medical staff • Access to e-learning packages for all medical staff • Develop a database for missed IUGR cases for further scrutiny	A Mulay K Palmer Dee Perkins	26 Aug 15	31 Mar 16	July GAP e-learning 70% July mandatory training 88% Figures due to A/L and a number of staff on maternity leave Update for September 2015 GAP training up to 81%	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
	• Review data quality within GAP data entry by the service	J Adams	26 Aug 15	31 Mar 16	Qtrly report from P.I. to be distributed to Women's Care Group and shared with Infant mortality Improvement Board (IMIB)	
	• Ultrasonography audit of practices to be undertaken on rolling programme of audit	J Hannon A Mulay	28 Oct 15	31 Mar 16	• Audit process agreed sample audit due Sep/ Oct • audit assigned to business manager October 2015	
c) Ensure ongoing training in intrapartum surveillance, CTG interpretation and timely escalation of problems	• Maternity service to ensure all staff attends annual Mandatory CTG training • Records will be available via the TNA • Quarterly reports to Maternity Risk Group and within the annual training report for maternity services	Dee Perkins Matrons Mrs Mulay Karen Palmer	26 Aug 15	31 Mar 16	CTG training figures update: September 90% October 89% Training records are available	
d) Establish a dedicated diabetes in pregnancy service including a diabetes specialist midwife post	• Maternity services to collaboratively scope current service provision against national guidance best practice in relation to pathways	A Mulay K Palmer D Osborne U Viswanathan	September (update on progress of report)	31 Mar 16	Scoping exercise across the west midlands Heads of Midwifery group established that this is not a model across all units. (2 out of 10 have a dedicated	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
	• Any recommendations to be agreed in partnership with CCG and Public Health and escalated to Divisional Quality Team				diabetic midwife). The model favoured is the model at Walsall with a multidisciplinary team approach. NICE guidance does not advocate a specialist midwife but insists on the MDT Completed September 2015	
e) Establish a post of a bereavement service with specialist bereavement midwife	• Maternity services to collaboratively scope current service provision against national guidance best practice in relation to pathways. • Any recommendations to be agreed in partnership with CCG and Public Health and escalated to Divisional Quality Team	A Mulay K Palmer D Osborne U Viswanathan	September (update on progress of report)	31 Mar 16	CCG pathway lead has commenced literature search  Bereavement Care Review-DO-221015.dc KP to include the role in the JD of 3 midwives that are currently the bereavement team Debbie to be the lead co-ordinator Evidence of policies/JD update needed	
f) Use the regional	• Maternity services to review	C Hollington	30 Sep 15	July 2015	• Current practice and	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
perinatal pathology service for placental histology	current service agreements with regional laboratories. • Maternity services to review pathway for transfer of specimens to regional laboratory with local histopathology services				pathway reviewed • Service Level Agreement already in place • Process for transfer of specimens agreed • Service to be fully operational 01 September. This is in operation	
g) Ensure clear and contemporaneous record keeping at all times	• Maternity service to undertake an annual audit of health care records completion. Findings to be presented to Women's services Quality team • Maternity service to continue to complete stress testing of documentation quality. Escalation of findings to the Maternity Risk Group	K Palmer J Adams	30 Sep 15	31 Mar 16	• Audit completed April 2014-15 • Audit results to be shared with IMIB • Monthly stress testing in place by the service presented to Maternity Risk Group and Maternity Task and Finish Group. Report for September meeting **Report available**	
Additional Maternity services actions:						
h) Draft report findings to be shared with medical Obstetric and Neonatal Consultants	Report to be emailed to all Walsall Obstetric Consultants, Neonatal Consultants and senior Midwives	K Palmer A Mulay		Jun 15	Circulated to all leads by KP and AM	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
and Midwifery senior Midwives						
i) Maternity services requested to meet with Perinatal Institute to agree grading of CESDI 3 cases	Meeting to be arranged for review of the data collection and records of CESDI level 3 cases with the Perinatal Institute team, Walsall Midwifery and Obstetric representation, Public Health representations and independent Obstetric Consultant	A Mulay K Palmer C Hollington	31st July 2015 31/07/15	08/05/15- Meeting undertaken at PI 20/07/15	Meeting was undertaken on 08/05/15 at the Perinatal institute – Cases classified as CESDI 3 reviewed. The service agreed with these grading's in these cases. Summary report produced for Medical Director 20/07/15	
j) Maternity services wish to review cases graded at level 2 CESDI for lessons learnt and cross referencing to own local reviews	Mrs Mulay and C Hollington to review these notes against local reviews and identify any areas of concern	A Mulay C Hollington	26 Aug 15	30 Sep	Case review complete	
k) Maternity services to review all term stillbirth cases which occurred in 2014. Any trends identified to be actioned appropriately	Review of term (> 37/40) 2014 Stillbirths to be undertaken	A Mulay K Palmer C Hollington	31st July 2015	Completed 13/07/15	• Report from MMBRACE received – reviewed report completed and presented at July 2015 Serious Incident Committee meeting	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
			31 Aug 15		Report shared, including all associated actions /learning points	
l) Review of maternal records identified the documentation of foetal movement pattern discussions was not always evident in the records	• This is now a field within Badgernet for completion at all antenatal assessments • Scoping exercise completed of information and resources available in different languages completed • 4 Common languages in Walsall Translated- Polish, Czech, Punjabi, Urdu. • Arrangements for proof reading and checking in progress	A Mulay K Palmer C Hollington S Thomas A Mulay C Hollington	30 Jun 2015 30 Sep 2015	30 Jun 2015	• Qtrly stress testing of the documentation within Badgernet • Audit to be presented to the IMIB	
Neonatal recommendations:						
a) Consultant paediatrician needs to have overall responsibility for the management of each neonatal case ensuring teams understand individual plans of care	Consultant paediatrician's presence mandatory for deliveries at <28 weeks- to be added to local clinical guideline. Neonatal department is actively engaging with "Supporting the sick neonates" programme. Simulation	Dr Muhammad Dr Krishnamurthy	30th November 2015		Local guidelines reviewed_ neonatal Resuscitation and Pre-term labour management Neonatal resuscitation- requires amendment. Amendment undertaken to the preterm management guideline in line with	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
	training to be commenced with the service.		31st Dec 2015 30th September 2015		Neonatal guideline contents The Neonatal service is actively engaging with "Supporting the sick neonates" programme. 3 Consultant Neonatologist are allocated to attend on 5th October 2015 Peer review meeting commenced- First meeting held 29th May 2015. 7 attendees. 2nd meeting 2nd October	
b) Ensure adherence to protocol re transfer of preterm infants	The neonatal service is to adhere to local and Network guidance in relation to the transfer of the preterm Neonate: 1) All babies <28 weeks are transferred out either in-utero or ex-utero. 2) if a cot is not available within the network, it is escalated to consultant obstetricians and	Dr Bhaduri Dr Muhammad Dr Krishnamurthy	31st December 2015		. This is now being undertaken. May need an audit to look at current practice	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
	neonatologists both here and at the tertiary unit Staff to incident report when compliance not achieved					
c) Enhanced communication and cooperation with level 3 (NICU): interactions and outcomes of transfer requests should be recorded to allow audit and review	• The neonatal service is to adhere to local and Network guidance in relation to the transfer of the preterm Neonate • Staff to incident report when compliance not achieved • Neonatal peer review meetings on a quarterly basis	Dr Muhammad Dr Krishnamurthy J Adams	31st January 2016 31st January 2016		Development in areas within the network undertaken to date: 1) New preterm SROM pathway in trial with New Cross Hospital 2) Communication between Walsall NNU and New Cross at least once a week, recorded and audited Neonatal and Obstetric services to develop a pathway defining communication and documentation requirements in relation to transfer of pre-term infants and communication with level 3 units Added to maternity Dashboard, Added to the presentation of data at the	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
			30th August 2015		monthly Morbidity/mortality meeting from August 2015	
d) Growth status of neonates at delivery should be assessed using customised centiles consistent with obstetric and midwifery policy	The maternity service to review current practices in the use of customised centile charts for the plotting of fundal height growth in pregnancy and birth weight following birth in line with best practice recommendations	K Palmer A Mulay	30 Jun 2015	In place since Oct 2014	The Walsall maternity services use the customised growth charts package for the plotting of fundal height measurements in pregnancy and since October 2014 birth weight following birth	
	System to be set in place so information about growth status of neonates at delivery is passed to the Health Visiting Team for ongoing monitoring when required Health Visitors to be provided with customised growth charts when required	K Palmer Matrons J Nembhard	Aug 15	Dec 15	From the 9th of November all growth charts of IUGR babies will be included in the 'red book' on discharge for the Health visitors GP's are notified of SGA babies via the discharge summary	
Additional locally agreed actions for Neonatology						
e) Review of Neonatal death cases to be undertaken by the	• Review of Neonatal death cases to be undertaken by the service to identify any	Dr Muhammad Dr Krishnamurthy		31 Jul 15	Review complete	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
service to identify any areas for learning and lessons learnt with a focus on Clinical Leadership at neonatal resuscitation	areas for learning and lessons learnt with a focus on Clinical Leadership at neonatal resuscitation.					
f) Service requires the purchase of a video laryngoscope to assist in difficult resuscitation of neonates	• Clinical Director/ Divisional director to purchase equipment required.	Dr Bhaduri Q Zada		30 Jun 15	The video laryngoscope was delivered to NNU 14.1015. Staff are having training on 30/10/15 from medical rep	
	• The neonatal service to develop a difficult intubation kit and provide pathway and Standing operating procedure for staff.				We have a difficult airway kit now within our resus equipment. The SOP Pathway is ready awaiting further input from ENT and anaesthetists and ratification through governance	
Trust General recommendations:						

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
a) Implement a self-sustaining process of standardised reviews of all perinatal deaths to allow ongoing learning from adverse outcomes and facilitate prevention	• The maternity services will implement the use of the Perinatal Institutes standardised review of perinatal deaths- SCOR • SCOR will be used as tool all cases of perinatal mortality within the maternity and neonatal service	A Mulay K Palmer C Hollington F Botfield			• Meeting held in April 2015 with IT team to inform on adoption of SCOR • Awaiting implementation. Escalated to Executive Team Jun/Jul 15 The SCOR software was awaiting an update. It is now ready and the CD, risk manager, HoM and matron for delivery are receiving training on the 4th November 2015	
Maternal and New-born network recommendations:						
a) Clarify transfer protocols between local neonatal unit(LNU) and neonatal intensive care unit (NICU) : facilitate collaboration	• Adhere to the network guidelines and incident report when unable to comply	Dr Muhammad Dr Krishnamurthy			• Audit individualised cases when policy not adhered too • We are now transferring • all babies <28 weeks in or ex-utero • Exception reports will be completed for all transfers that are not accepted due to	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
					capacity issues	
b) Help standardise assessment and management of neonates	• Adhere to the network policies and guidelines and ensure all clinicians have access to local guidelines	Dr Muhammad Dr Krishnamurthy			All guidelines are now on the Trusts intranet and easily accessible to all clinicians	
c) Provide support mechanisms for the professional development and maintenance of competence and expertise of medical staff at LNUs and special care units through collaborative learning and working	• Shared training programmes	Dr Muhammad Dr Krishnamurthy			This is the same as action point a on the neonatal part of the action plan.. in addition there are discussions with New Cross regarding 'sharing' consultants for 1 session per week to share learning	
d) Facilitate and standardised peer review of adverse outcomes and network level	• Data is currently submitted to the Network of all poor outcomes for discussion/ trend analysis and shared learning across the network				• Quarterly submission of data to the Neonatal network in place	
Clinical Commissioning group recommendations:						
a) Provide oversight and quality assurance for antenatal risk	• Paediatric and Maternity Programme board to receive pathway alignment	Diane Osborne Sally Roberts Wendy	Sep 15	Oct 15	CCG Pathway lead has undertaken a snap shot audit via Badger-net of risk	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
assessment as key determinant for the maternity payment pathway, allowing for prevalent medical, obstetric and social circumstances of the maternity population	data quarterly • Maternity services to audit the quality of the risk assessment annually • Maternity service to provide evidence of increased patient pathway activity for those on intermediate and intensive pathways • CCG Pathway lead to review all pathways in line with NICE	Godwin			assessments and pathway alignment. No issues were evident Evidence of increased patient pathway activity was seen Nice guidance is adhered to where appropriate, and formalised within the service specification	
b) Ensure sufficient resources are available for foetal growth assessment by ultrasound, according to RCOG and NHS England commission guidance	• CCG Pathway lead to scope current provision (needs assessment in respect of increasing birth rate, and sonographer capacity) • CCG pathway lead to research RCOG/NICE/Best practice	Diane Osborne Sally Roberts Wendy Godwin	Sep 15	Oct 15	CCG lead has met with the superintendent Sonographer and findings will be discussed Lead sonographer suggested that currently there are no capacity issues. Early scans are more timely, freeing up slots for scans and reducing re-scans If the Trust move to 2 weekly scans for all high risk and SGA, capacity will be an issue WHT to undertake an audit to identify the extent of the	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
					increased capacity if the recommendations are followed KP to discuss with sonographer lead access to Badger and other points **(date needed)**	
c) Allocate funding for a dedicated bereavement service to optimise the care of women and families who have had a perinatal loss	• CCG Pathway lead to scope current provision (service available, policy, complaints, compliments etc) • CCG pathway lead to research RCOG/NICE/Best practice • CCG pathway lead to share findings and make recommendation to the Board	Diane Osborne Sally Roberts Wendy Godwin	Sept 15		CCG pathway lead has commenced literature search  Bereavement Care Review-DO-221015.dc KP to include the role in the JD of 3 midwives that are currently the bereavement team Debbie to be the lead coordinator Evidence of policies/JD update needed	
d) Support implementation of standardised reviews	• CCG pathway lead to monitor the progress of the implementation of SCOR	Diane Osborne Sally Roberts Wendy			**See Trust General Recommendation point a)**	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
of adverse incidents	• Pathway lead to meet with WHCT quality lead monthly for progress report/update and to provide advise/support	Godwin				
Walsall Council and Public Health recommendations: All actions to be agreed by Improvement Board and PH programme board Actions also appear in PH Contract Performance Management Remedial Action Plan reporting to Public Health Programme Board						
a) Promote public health messages relating to maternity care , including smoking and obesity	• Walsall Momma's resources produced around SIDs messages; disseminated to midwives and health visitors Evaluation to take place with 100 women to identify impact of Walsall Mommas film on behaviour and awareness	U Viswanathan Esther Higdon		Oct 2015	Evaluation in progress Film available for use by midwives, health visitors, children's centres and smoking cessation in pregnancy team To investigate buying a DVD player/film loop for the antenatal clinic so this film can be shown **Film publicised on WHT and WBC websites**	
	• Audit of smoking in pregnancy. Findings shared with wider partnership and recommendations set in place e.g. Midwives to discuss implications of smoking in pregnancy at each appointment	U Viswanathan Teresa Maillard		Aug 2015	Recommendations set in place Opt out emphasised Smoking cessation services accessing opt out referrals from BadgerNet Audit underway to identify midwives that are failing to	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
					send the referral Smoking cessation lead is also auditing and following up women who are missed **Referral data being analysed by Public Health and WHT** **PH to meet with the team**	
	• Increased emphasis on increasing referrals to the smoking in pregnancy service • Expectation of commissioners that there is an increased smoking referral to service uptake ratio	U Viswanathan Paulette Myers Esther Higdon Lifestyle Service		Oct 2015	• Reported KPIs • August 2015 saw a reduction in women smoking at time of delivery to 8.9% from 14% in August 2014 • **Continue to work with midwifery service and smoking cessation service to increase referrals** **PH to seek further reassurance from midwives**	
	• Subject to positive evaluation of Walsall Mommas, to develop a film around foetal movements in pregnancy	U Viswanathan Esther Higdon CDT		Feb 2016	• **Production of new film set in place around foetal movement** • Film produced and circulated • Awaiting evaluation	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
	• Increased emphasis on increasing Healthy Start vitamin uptake during pregnancy and post birth • Increased uptake of healthy start vitamins in children with focus on Vitamin D intake	Uma Viswanathan/ Midwifery service/Health Visiting service		On going	• Increase demonstrated through reported KPIs • To investigate a universal offer • Venues have increased to access vitamins and make them more available • From October 2015. A system has been set in place so pharmacies can order vitamins directly from the NHS supply chain thereby improve access and uptake • 17 new venues offering Healthy Start across Walsall taking total number of outlets to 43 • Investigate offering Healthy Start universally at a cost of £36k pa. Risk; funding availabilty • Are HV and MW aware • Uptake still very poor • EH to look further at solutions • EH to provide	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
					information for midwives to give out at booking	
	• Increase number of women maintaining a healthy weight in pregnancy	U Viswanathan Midwifery service HV service		On going	• MaEYS team in place offering support for weight management • Increase demonstrated through reported KPIs of women not increasing their weight beyond recommended limits • Health visitors supporting messages at 28 week antenatal check • Qtr 1 2015/16 106 women being supported • Work with MAEYs team to increase numbers worked with	
Growth status of neonates at delivery assessed and shared with Health Visiting service (as per page 8 WHT action)	• Ensure Health Visitors use Badgernet to identify those babies who are born at a low birth weight • Health Visitors to share this information with GPs	U Viswanathan/ Esther Higdon Midwifery service HV service	December 2015	March 2016	• Health Visitors accessing BadgerNet and viewing womens records • Process to share with GPs to be discussed	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
					• (see Neonatal recommendation d - From the 9th of November all growth charts of IUGR babies will be included in the 'red book' on discharge for the Health visitors	
b) Promote education on SIDS awareness including co sleeping, alcohol, smoking, restricted foetal growth	• Walsall Momma's resources produced; disseminated to midwives and health visitors, smoking cessation team and Children's Centres. Resource evaluated	U Viswanathan Esther Higdon		October 2015	• Walsall Mommas evaluation in progress • Film distributed	
	• Continued support for smoking in pregnancy inc. continuation of CQUIN emphasis on repeat referrals to smoking cessation support	U Viswanathan Paulette Myers Midwifery service HV service		on-going	• Badgernet reporting • HV and smoking cessation team KPI reports	
	• Children's Centres using Public health transformation funding, integrated 0-5 service model and Health Visiting service to raise awareness of safe sleeping	U Viswanathan Sue Morgan and Children's Centre leads		Mar 2016	• KPI reporting • Children's Centres monitoring engagement with target groups – currently 62%. To raise to 70%	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
	through Walsall Mommas film and other campaigns. • Emphasis placed on targeting most deprived communities				**Risk; less staffing capacity in Children's Centres and reduced venues due to funding cuts**	
c) Maintain clear pathways for interagency working with high risk families	• Integrated 0-5 service between Children's Centres and health visitors set in place • Align the teenage pregnancy strategy and action plan to reduce teenage pregnancy	UV/Children's Services/ EH/SM/JN		Mar 2016	• Evaluation of model and data sharing • Health Visitor representative on all Children's Centre Advisory Boards • Teenage pregnancy strategy in place and actions being worked towards to reduce teenage pregnancy • Sharing meetings taking place • Ante natal pathways to be strengthened • Knowledge of social issues to be accurate	
d) Ensure feedback from Child Death Overview Panel reviews are shared with all agencies involved in the care		U Viswanathan			• Process for sharing CDOP reviews is in place • Process supported by Dr Thomas	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
					• ToR for CDOP revised	
e) Address service provision within areas of high deprivation	• Focus on support to priority areas through Children's Centres and Health Visiting service			On going	• Transformation funding for Children's Centres KPI reporting • HV KPI reporting and proportionate allocation of HV teams to areas of need set in place using benson Wintere tool which takes deprivation into account • CC redesign focussing services on deprivation and focussing services towards target groups • Breastfeeding support targeted at Quintiles 1 and 2	
Walsall Council and Public Health additional actions :						
f) Ensure infant mortality remains a priority for CYPPB and HWB	• HWB task group established and actions taken forward • Regular reports to CYPPB	U Viswanathan Esther Higdon		March 2016	• HWB task and Finish group meeting held 17th August 2015. • To investigate and set recommendations around 5 themes – lifestyle, demographics,	

Issues/Findings	Actions	Lead for action	Review date	Completion Date	Progress to date	Status R.A.G.
					healthcare, wider determinants and Emotional health and Wellbeing. 3 meeting to be held reviewing above themes over next 5 months	
g) PI summary report circulated for wider distribution		U Viswanathan Kathryn Halford Sally Roberts		Sep 2015	• To investigate duty of candour with Richard Kirby. Report to go to WHT Private Board October 2015 and to CCG and WHT Public Boards November 2015 • Meetings taking place between 3 Communication teams to ensure a coordinated response • Report circulated more widely	