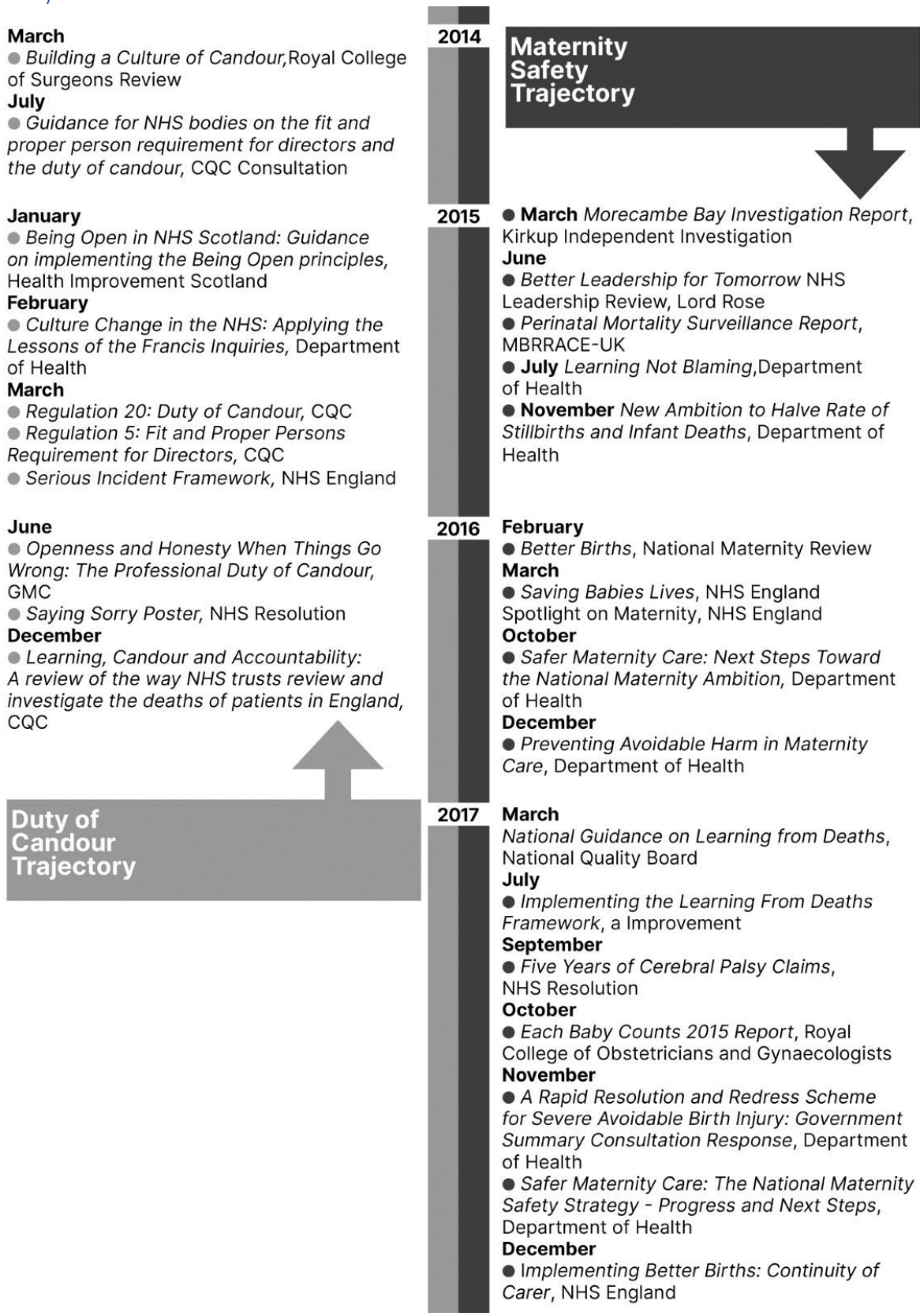
Report Supplementary Materials 4 (17-99-85-supp4)

Policy Review Timeline of Identified Documents



2018

February

- *A guide to support maternity safety champions*, NHS Improvement

May

- *Spoken communication and patient safety in the NHS*, NHS Improvement

November

- *Each Baby Counts 2018 Progress Report*, Royal College of Obstetricians and Gynaecologists

December

- *The Maternity Safety Training Fund: An Evaluation*, Health and Social Care Evaluations through HEE and University of Cumbria

2019

March

- *Consultation on coronial investigations of stillbirth*, HM Government (Ministry of Justice and Department of Health and Social Care)
- *Learning from deaths: A review of the first year of NHS trusts implementing the national guidance*, CQC
- *Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality*, NHS England

July

- T*he NHS Patient Safety Strategy: Safer culture, safer systems, safer patients*, NHS England and NHS Improvement

September

- *The Early Notification scheme progress report: collaboration and improved experience for families*, NHS Resolution
- *Detection of Retained Vaginal Swabs and Tampons Following Childbirth,* HSIB

2020

February

- *East Kent Hospitals University NHS Foundation Trust HSIB summary report*, HSIB
- *Maternity incentive scheme year three – summary of changes*, NHS Resolution
- *Maternity incentive scheme – year three*, NHS Resolution (full report)

March

- *Better Births Four Years On: A review of progress*, NHS England and NHS Improvement
- *Each Baby Counts Progress Report 2017*, Royal College of Obstetricians and Gynaecologists
- *Each Baby Counts Progress Report 2018*, Royal College of Obstetricians and Gynaecologists
- *Patient Safety Incident Response Framework 2020: An introductory framework for implementation by nationally appointed early adopters*, NHS England and NHS Improvement

References

1. Care Quality Commission. Regulation 20: Duty of Candour. Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare. In: Care Quality Commission, editor. The Health and Social Care Act 2008 (Regulated Activities); 2014.

2. Care Quality Commission. Guidance for NHS Bodies on the Fit and Proper Person Requirement for Directors and the Duty of Candour. 2014.

3. Dalton D, Williams N. Building a Culture of Candour: A Review of the Threshold for the Duty of Candour and of the Incentives for Care Organisations to Be Candid. In: Surgeons RCo, editor.; 2014.

4. Care Quality Commission. Regulation 5: Fit and Proper Persons Requirement 2015.

5. Department of Health. Culture Change in the NHS: Applying the Lessons of the Francis Inquiries. In: Health Do, editor.; 2015.

6. Department of Health. Learning Not Blaming. In: Health Do, editor.; 2015.

7. Healthcare Improvement Scotland. Being Open NHS Scotland: Guidance on Implementing the Being Open Principles. 2015.

8. Kirkup B. The Report of the Morecambe Bay Investigation, 2015.

9. Manktelow BN, Smith LK, Evans TA, et al. Perinatal Mortality Surveillance Report: UK Perinatal Deaths for Births from January to December 2013. In: MBRRACE-UK, editor.: Department of Health Sciences, University of Leicester; 2015.

10. NHS England. Serious Incident Framework: Supporting Learning to Prevent Recurrence. In: Domain PS, editor.; 2015.

11. Nursing and Midwifery Council a, General Medical Council. Openness and Honesty When Things Go Wrong: The Professional Duty of Candour. 2015.

12. Rose L. Better Leadership for Tomorrow: NHS Leadership Review. In: Health Do, editor.; 2015.

13. UK Government. New Ambition to Halve Rate of Stillbirths and Infant Deaths. In: Care DoHaS, editor.: UK Government; 2015.

14. Care Quality Commission. Learning, Candour and Accountability: a review of the ways that NHS trusts review and investigate the deaths of patients in England2016. (accessed.

15. Department of Health. Safer Maternity Care: Next Steps Towards the National Maternity Ambition. In: Team DoHMSP, editor. gov.uk; 2016.

16. Department of Health. Preventing Avoidable Harm in Maternity Care: Department of Health Capital Fund 2015-16. In: Health Do, editor. gov.uk; 2016.

17. NHS England. Saving Babies Lives: A Care Bundle for Reducing Stillbirth. In: Unit ACP, editor.; 2016.

18. Department of Health. Safer Maternity Care: The National Maternity Safety Strategy-Progress and Next Steps. In: Health Do, editor. London; 2017.

19. Department of Health. A Rapid Resolution and Redress Scheme for Severe Avoidable Birth Injury: Government Summary and Consultation Response. In: Department of Health: Resolution PE, and Maternity Team, editor. gov.uk; 2017.

20. Magro M. Five years of cerebral palsy claims: A thematic review of NHS Resolution data, 2017.

21. National Quality Board. National Guidance on Learning from Deaths. In: Board NQ, editor. gov.uk; 2017.

22. NHS England. Implementing Better Births: Continuity of Carer. 2017.

23. NHS Improvement. Implementing Learning from Deaths: Key Requirements for Trust Boards. In: Health Do, editor.; 2017.

24. NHS Resolution. Saying Sorry Poster. In: Resolution N, editor.; 2017.

25. Royal College of Obstetricians & Gynaecologists. Each Baby Counts: 2015 Full Report 2017.

26. Grimwood T, Snell L. The Maternity Safety Training Fund: An Evaluation. In: England HE, editor.; 2018.

27. NHS Improvement. A Guide to Support Maternity Safety Champions. In: Health Do, editor. gov.uk; 2018.

28. Care Quality Commission. Learning From Deaths. A review of the first year of NHS trusts implementing the national guidance, 2019.

29. Health Safety Investigation Branch. Detection of Retained Vaginal Swabs and Tampons Following Childbirth. In: HSIB, editor.; 2019.

30. HM Government. Consultation on coronial investigations of stillbirths. In: Coroners B, Cremation, and Inquires Policy Team, editor. London; 2019.

31. Iedema R, Greenhalgh T, Russell J, et al. Spoken communication and patient safety: a new direction for healthcare communication policy, research, education and practice? BMJ Open Quality 2019; 8(3): e000742.

32. NHS England. Saving Babies' Lives- Version Two: A Care Bundle for Reducing Perinatal Mortality. In: Programme MT, editor.; 2019.

33. NHS England and NHS Improvement. National Patient Safety Strategy. 2019. https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/2019). Accessed 1 June 2021.

34. NHS Resolution. The Early Notification scheme progress report: collaboration and improved experience for families, 2019.

35. Health Safety Investigation Branch. East Kent Hospitals University NHS Foundation Trust. In: HSIB, editor.; 2020.

36. Health Safety Investigation Branch. Summary of Themes Arising from the Health Safety Investigation Branch Maternity Programme (NLR). In: HSIB, editor.; 2020.

37. Health Safety Investigation Branch. National Learning Report: Sever brain injury, early neonatal death, and intrapartum stillbirth associated with group B streptococcus infection. In: HSIB, editor.; 2020.

38. Health Safety Investigation Branch. National Learning Report Neonatal collapse alongside skin-to-skin contact. In: HSIB, editor.; 2020.

39. Health Safety Investigation Branch. Delays to intrapartum intervention once fetal compromise is suspected. In: HSIB, editor.; 2020.

40. Healthcare Safety Investigation Branch. Giving Families a Voice: HSIB's approach to patient and family engagement during investigations: Independent Report by the Healthcare Safety Investigation Branch, 2020.

41. NHS England, NHS Improvement. Better Births- Four Years On: A Review of Progress. 2020.

42. NHS England, NHS Improvement. Maternity and Neonatal Safety Champions Toolkit. 2020.

43. NHS Resolution. Maternity Incentive Scheme Year Three- Summary of Changes, 2020.

44. NHS Resolution. Maternity Incentive Scheme Year 3, 2020.

45. Ockenden D. Emerging Findings and Recommendations from the Independent Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust, 2020.

46. Royal College of Obstetricians and Gynaecologists. Each Baby Counts Progress Report 2018. In: RCOG, editor.; 2020.

47. Royal College of Obstetricians and Gynaecologists. Each Baby Counts Progress Report. In: RCOG, editor. London; 2020.

48. NHS England, NHS Improvement. https://www.england.nhs.uk/patient-safety/incident-response-framework. 2021. Accessed 1 June 2021.

49. Ockenden D. Findings, Conclusions, and Essential Actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust, 2022.