Report Supplementary Materials 6 (17-99-85-supp6).

Maternity safety trajectory included documents

Maternity Safety Trajectory		
Date	**Document**	**Description of Document**
03/2015	Morecambe Bay Investigation Report, Kirkup Independent Investigation	A report of findings from the independent investigation into maternity services at the Morecambe Bay NHS trust. The investigation uncovered several failures within the trust related to inadequate clinical competency, poor interprofessional relationships, and inappropriate and unsafe care. Families of those harmed were invited to attend interviews and panel meetings as observers.
06/2015	Better Leadership for Tomorrow NHS Leadership Review, Lord Rose	A review exploring what is needed to improve and sustain quality leadership in the NHS
06/2015	Perinatal Mortality Surveillance Report, MBRRACE-UK	A document reporting perinatal mortalities for the year 2013
07/2015	Learning Not Blaming, Department of Health	The government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS,' and the Morecambe Bay Investigation
11/2015	New Ambition to Halve Rate of Stillbirths and Infant Deaths, Department of Health	News article from a government website describing the government's ambition to reduce the rate of stillbirths
02/2016	Better Births, National Maternity Review	This document sets out the priorities for maternity services in the UK
03/2016	Saving Babies Lives, NHS England	A care bundle for reducing stillbirth
03/2016	Spotlight on Maternity, NHS England	A document setting out five themes for improving safety in maternity care
10/2016	Safer Maternity Care: Next Steps Toward the National Maternity Ambition, Department of Health	An action plan for setting out the Department of Health's ambitions for improving maternity care safety in the U.K.
12/2016	Preventing Avoidable Harm in Maternity Care, Department of Health	A document explaining the funding/inclusion criteria available for helping reach the national maternity safety ambitions
03/2017	National Guidance on Learning from Deaths, National Quality Board	A Framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths
07/2017	Implementing the Learning From Deaths Framework, NHS Improvement	A resource pack for trust boards and directors for the new Learning from Deaths framework
09/2017	Five Years of Cerebral Palsy Claims, NHS Resolution	A thematic review of compensation claims for cerebral palsy that occurred between 2012 and 2016. Identifies the clinical and non-clinical care issues and system learning opportunities to reduce future harm
10/2017	Each Baby Counts 2015 Report, Royal College of Obstetricians and Gynaecologists	A national quality improvement programme to reduce the number of deaths and disabilities in babies as a result of incidents that occur during labour, with ambition to reduce these by 50% by 2020

11/2017	A Rapid Resolution and Redress Scheme for Severe Avoidable Birth Injury: Government Summary Consultation Response, Department of Health	A report of the public consultation on the parameters of a Rapid Resolution and Redress Scheme to inform policy development
11/2017	Safer Maternity Care: The National Maternity Safety Strategy - Progress and Next Steps, Department of Health	This document reports on progress against the 2016 action plan. It also proposes a number of additional steps to prevent serious incidents in maternity services
12/2017	Implementing Better Births: Continuity of Carer, NHS England	A guide for developing continuity of carer systems in maternity care
02/2018	A guide to support maternity safety champions, NHS Improvement	A guide for maternity safety champions to support them in their role, in using existing safety initiatives to support and lead their teams
05/2018	Spoken communication and patient safety in the NHS, NHS Improvement	Describes facilitators to good communication between patients and providers
11/2018	Each Baby Counts 2018 Progress Report, Royal College of Obstetricians and Gynaecologists	Reports key findings and new recommendations based on the analysis of data relating to the Each Baby Counts quality improvement programme
12/2018	The Maternity Safety Training Fund: An Evaluation, Health and Social Care Evaluations through HEE and University of Cumbria	An evaluation of the impacts and outcomes of the Maternity Safety Training Fund. (Response to Better Births and Maternity transformation programme)
03/2019	Consultation on coronial investigations of stillbirth, HM Government (Ministry of Justice and Department of Health and Social Care)	A consultation documenting seeking views on proposals for introducing coronial investigations of stillbirth cases in England and Wales
03/2019	Learning from deaths: A review of the first year of NHS trusts implementing the national guidance, CQC	A report of interviews and focus groups with inspection staff and specialist advisors involved in inspections. Sought to understand how well Trusts have been implementing national guidance and to identify enablers and barriers to good practice
03/2019	Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality, NHS England	A second version of the saving babies' lives care bundle, which builds on the work of the first to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England
07/2019	The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients, NHS England and NHS Improvement	A document on the NHS' patient safety strategy for improving systems of care and reducing harm
09/2019	The Early Notification scheme progress report: collaboration and improved experience for families, NHS Resolution	Describes the development and progress of the Early Notification scheme to date with an overview of the cases reported in year one from 1 April 2017 to 31 March 2018.
09/2019	Detection of Retained Vaginal Swabs and Tampons Following Childbirth, HSIB	Report and recommendations on avoiding foreign-body retention Never Events after birth
02/2020	East Kent Hospitals University NHS Foundation Trust	Provides an overview of the maternity investigations programme for East Kent Hospitals University NHS Foundation Trust, the

	HSIB summary report, HSIB	found safety risks, and the engagement and escalation taken in response
02/2020	Maternity incentive scheme year three – summary of changes, NHS Resolution	A summary of the changes made to the scheme- no changes noted related to families
02/2020	Maternity incentive scheme – year three, NHS Resolution (full report)	Guidance on the Maternity Incentive Scheme and actions that must be taken to meet the requirements for the scheme
03/2020	Better Births Four Years On: A review of progress, NHS England and NHS Improvement	A report on the progress of Better Births Maternity Transformation Programme four years in
03/2020	Each Baby Counts Progress Report 2017, Royal College of Obstetricians and Gynaecologists	This report presents key findings and recommendations from each baby counts from 2017
03/2020	Each Baby Counts Progress Report 2018, Royal College of Obstetricians and Gynaecologists	This report presents key findings and recommendations from each baby counts from 2018
03/2020	Patient Safety Incident Response Framework 2020: An introductory framework for implementation by nationally appointed early adopters, NHS England and NHS Improvement	Provides guidance on cultures, systems, and behaviours necessary to respond to patient safety incidents to promote learning and improvement; replaces the Serious Incident Framework
03/2020	Summary of Themes arising from the Healthcare Safety Investigation Branch Maternity Programme (NLR), HSIB	General document about work and themes arising from HSIB investigations
07/2020	National Learning Report Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection, HSIB	Investigation into babies born with Group B strep
08/2020	National Learning Report Neonatal collapse alongside skin-to-skin contact, HSIB	A report on Sudden unexpected postnatal collapse
09/2020	National Learning Report Giving families a voice: HSIB's approach to patient and family engagement during investigations, HSIB	A report sharing HSIB's approach to family involvement and engagement
09/2020	Maternity and Neonatal Safety Champions Toolkit, NHS England and NHS Improvement	A toolkit for champions to describe their role and responsibilities
11/2020	Delays to intrapartum intervention once fetal compromise is suspected, HSIB	A report on delays to intrapartum intervention when foetal compromise is suspected
12/2020	Emerging Findings and Recommendations from the	A preliminary report of findings from the independent investigation into maternity services at Shrewsbury and Telford

	Independent Review of Maternity Services At The Shrewsbury and Telford Hospital NHS Trust, Ockenden	hospital NHS Trust. The investigation uncovered a number of failures within the trust related to inadequate clinical competency, poor interprofessional relationships, and inappropriate and unsafe care
06/2021	The safety of maternity services in England, House of Commons Health and Social Care Committee	An inquiry report that considers the safety of maternity services in England. The report covers safe staffing, learning from incidents, and providing safe and personalised care for mothers and babies.
03/2022	Findings, Conclusions, and Essential Actions From the Independent Review of Maternity Services At The Shrewsbury and Telford Hospital NHS Trust, Ockenden	The final Ockenden report, which builds upon the emerging findings from 2020 and suggests further areas of focus for improving maternity care in the Trust and within England

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