



# **REPORT FOR THE SOLIHULL NHS CARE TRUST PUBLIC BOARD**

## **MATERNITY SERVICES FOR SOLIHULL**

**27 JANUARY 2010**



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## SOLIHULL NHS CARE TRUST PUBLIC BOARD

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### Maternity Services For Solihull

#### 1. Purpose of Report

In 1996 Solihull Hospital developed an obstetric led maternity unit within an unusual model of care as a result of limited paediatric services available. Since June 2009 Solihull NHS Care Trust (SCT) has received a range of reports describing the risks associated with Solihull Maternity Services (SMS) and proposals regarding the future options for service provision. The purpose of this paper is to summarise the current position and how we have arrived at this stage, and to set out the next steps required.

#### 2. Matters for Consideration

##### 2.1 Context

- In 1996 SMS were reconfigured as a response to the withdrawal of paediatric services from Solihull Hospital caused by the deanery denying Solihull training status. For further information please see the attached weblink <http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRSaferChildbirthReport2007.pdf>.

The reconfigured service was possible as a result of a 'special arrangement' being agreed to enable neonatal resuscitation to be delivered by specialist midwives with on call back up from Birmingham Heartlands Hospital (BHH) when no paediatrician was available.

- Since then the selection of appropriate mothers for delivery at Solihull has been by strict criteria, with resuscitation of the neonate being provided by midwives trained as advanced resuscitators of the newborn (ARNB) when it has been required.

In order to continue obstetric services in Solihull some midwives agreed on a voluntary basis to supplement their skill to be able to undertake immediate advanced newborn resuscitation for up to 40 minutes while specialist help came from BHH.

The training was devised in-house (a one week course, experiential learning and annual up-date and preceded the UK Resuscitation Council newborn life support courses. The algorithm and standards the ARNB worked to were all devised in-house mainly by Mike Watkinson. The course was accredited at the University of Central England (now Birmingham City) so if the midwives wished, they could obtain educational credits towards a higher qualification and the concept presented as a



successful model of care at a Royal College of Paediatrics and Child Health (RCPCH) meeting.

A policy of accepting only low risk bookings at Solihull was put in place, with all other bookings being referred to BHH.

This arrangement has worked effectively alongside a fast car system which aims to collect a neonatologist from BHH and take them to Solihull within 30 minutes for medical support when they are required, it should be noted that the fast car has rarely met the required 30 minute standard. This is outside the recommended attendance of access to advanced paediatric resuscitation within 10 minutes.

It was expected that this mode of service delivery would be replicated by other maternity units facing similar pressures as Solihull, however, history has not shown this to have happened. Therefore Solihull's unusual model is now considered by many clinicians to sit outside 'contemporary best practice'.

At Solihull this 10 minute resuscitation is made available from suitably trained midwives with paediatrician on call support.

- Over the last few years, a series of policy documents have been produced seeking to improve both safety of mother and child as well as patient experience of maternity care. These have both responded to and been supplemented by professional guidance aimed at raising standards of safety and professional practice published by different interested professional bodies. These standards provide an important framework for commissioners and providers, but have not always been consistently applied across the country; some are aspirational in nature and therefore need to be considered in the local context, however, the recent letter from South Western Midlands Newborn Network (SWMNN) should be noted (see Appendix 1) with regard to understanding the implementation of aspirational standards.

Key standards which are of concern are the expectation of 60 hour obstetric presence on delivery suite at Good Hope Hospital (GHH) and of 98 hours obstetric presence on delivery suite at BHH, which may be being compromised by the current focus on Solihull (see Appendix 2 Commissioning Strategy for Maternity Services, Birmingham East, North & Solihull Local Health Economy) and

<http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRSaferChildbirthReport2007.pdf>.

### **Resuscitation Council Guidelines 2005**

In 2005 recommendations for resuscitation of a neonate were changed, such recommendations constitute best practice for neonatal resuscitation against which practice will be measured. This change recommended that



endotracheal administration of adrenaline should now be used. Effectively this meant that Umbilical Vein Catheterisation (UVC) became the standard for the administration of adrenaline as part of 'normal' resuscitation.

In 2008 agreement was made with Heart of England Foundation Trust (HoEFT) as part of their risk mitigation plan for the training of midwives with ARNB skills in line with recommendations from the UK Resuscitation Council. They were trained to offer the suite of clinical skills involved in contemporary neonatal resuscitation, whilst they can administer adrenaline via UVC they do not give the range of intravenous medication that full compliance with the guidelines would require. For further information please see <http://www.resus.org.uk/pages/nls.pdf>.

### Safer Childbirth

Published in October 2007 by The Royal Colleges of Obstetricians and Gynaecologists, Midwives, Paediatrics and Child Health and Anaesthetists. This document outlines the minimum standards for the organisation and delivery of care in labour; the following standards are relevant to the current discussion around Solihull Maternity Unit (SMU). **(The numbering below references the appropriate sections in the Safer Childbirth document):**

- 3.6.2 Minimum standards with respect to the immediate care of the newborn require that basic life support skills should be available wherever a baby is born, and this will be provided in the instance by midwives.
- 3.6.3 In addition in a hospital setting, the birth of a preterm, ill or congenitally abnormal baby may occur and thus there must be immediate, on site availability of clinicians (doctors, advanced neonatal nurse practitioners or midwives) with advanced neonatal life support skills (including endotracheal intubation). The failure to provide this level of support may result in unfavourable outcomes and will fall below an acceptable standard of care. Paediatric staff must be competent in neonatal life support as described in section 4.4.
- 4.4.1 The on site clinicians must have access to senior colleagues who have advanced skills for immediate advice and urgent attendance (within 10 minutes) when required. When general consultant paediatricians cover the labour ward, they must be trained and regularly assessed as competent in neonatal advanced life support through attendance at a recognised course.
- 4.4.2 Consultant Paediatricians: 24 hour availability of a consultant paediatrician (or equivalent non consultant career grade doctor) trained and assessed as competent in advanced neonatal life support, who can attend within 30 minutes. (Required for level 1 – Neonatal Special Care).



Please see attached website for further information:

<http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRSaferChildbirthReport2007.pdf>

### **NICE Intrapartum Care Guidelines June 2008**

<http://guidance.nice.org.uk/CG55/Guidance/pdf/English>

The SWMNN state that in their view (as documented in their letter of 8 December 2009 (Appendix 1)) the current service being provided at Solihull does not meet these standards.

### **Maternity Standards 2008**

Published to produce a single, comprehensive set of standards to cover every step of the pathway of care for women from pre-pregnancy through to the transition to infancy and parenthood. They were jointly agreed by The Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health and the Royal College of Anaesthetists.

Standard 13.2 All consultant-led obstetric units should have a named consultant paediatrician who has responsibility and a special interest in neonatology. For further information please see attached website:

<http://www.rcog.org.uk/files/rcog-corp/uploaded-files/WPRMaternityStandards2008.pdf>

## **2.2 First Significant Clinical Event**

### **2003**

A post term mother was induced after a complicated delivery, two trained ARNBs commenced resuscitation to the neonate including giving adrenaline via the endotracheal tube. The paediatric team arrived approx 40 - 45 minutes after delivery and an improved heart rate was obtained briefly but ultimately resuscitation efforts were discontinued and the baby died.

The Route Cause Analysis (RCA) found no deficits in obstetric care and a cause of death of intrapartum hypoxia. There was a delay in obtaining a blue light vehicle for the BHH team. The resuscitation in Solihull by ARNB and anaesthetist proceeded logically but the improvement gained by the neonatal specialist registrar on arrival simply by reintubation and bag ventilation raised the question as to the effectiveness of the earlier ventilation. The report concluded that it was unknown whether earlier paediatric presence would have affected outcome.

## 2007

The coroner noted the death and an inquest was held in 2007. This found that on balance the child might have been more effectively resuscitated if a paediatrician had been available on site immediately and the coroner attached a rule 43 letter in which he raised concerns as to the safety of Solihull Hospital as a low-risk obstetric unit. In the Coroner's letter to the National Patient Safety Agency he stated "I am a lawyer and I have no medical training, expertise or experience. I express no view as to whether the maternity unit should continue on the present basis because I am not competent to make such a decision. However, I do believe that this is a matter which should be considered by those appropriately qualified to take responsibility." The letter was copied to various organisations for comment regarding the appropriateness of the provision.

A response was received jointly from the British Association of Perinatal Medicine (BAPM) and RCPCH (see Appendix 3). Their conclusion was that current services exposed babies delivered at Solihull Hospital by either emergency caesarean section or instrumental delivery to significant risk and the Trust (HoEFT) "may be considered to be failing in its duty of care"

Two options were proposed:

- Solihull provide competent staff on each shift who can provide high quality neonatal life support; or
- Obstetric cover be withdrawn and Solihull become a midwifery-led unit.

They also advised that a process for reviewing all events for babies requiring advanced resuscitation should be put in place to satisfy themselves that standards for the resuscitation and stabilisation of the newborn over the first postnatal hours is being met.

We have not seen any response from the National Patient Safety Agency.

In July 2008 a risk assessment and recommendations to mitigate the risk were adopted by HoEFT and SCT. They identified the following potential risks and developed an action plan with the aim of mitigating the concerns raised.

### Risks

- Babies care compromised due to not following current recommended resuscitation standards of giving adrenaline via UVC at Solihull site. (It was estimated that approximately 2 babies a year will require adrenaline and this will now be administered via UVC).
- Staff competencies are not maintained due to infrequency of use of techniques on Solihull site.

- Liabilities from not following Safer Childbirth recommendations.
- BHH is a level 3 unit and treats babies of all gestations who could be put at risk if there is decreased capacity for neonatologist input when staff attend Solihull Hospital (approximately once a week).
- Babies requiring complex treatment could be compromised due to delay in the transfer to an appropriate Neonatal Unit (appendix 4).

### **The Mitigation plan**

- Recruitment of experienced '405' trained nursing staff (i.e. nurses skilled at providing intensive care to newborns and who can support first line resuscitators) to work at Solihull Hospital. Initially 07:30 – 21:00 with aim for 24/7 cover by June 2009. For a range of reasons, 24/7 cover has not been achieved consistently.
- Provision of an improved fast car facility for urgent transport of paediatric staff to Solihull Hospital as necessary. This has been problematic to achieve.
- Augmentation of skills of midwives with ARNB skills in line with recommendations from the UK Resuscitation Council. While ARNBs have been trained to offer the suite of clinical skills involved in contemporary neonatal resuscitation, they do not give the range of intravenous medication that full compliance with the guidelines would require.
- Increasing midwifery numbers to five per shift at Solihull.
- Developing a business case for providing paediatric doctors on site 24 hours a day at Solihull.
- Clarification that the booklet given to all pregnant mothers clearly states that there is no paediatric cover at Solihull.
- Training of some nurses at Solihull Hospital to become Advanced Neonatal Nurse Practitioners.

### **Second Significant Clinical Event**

Implementation was in progress when on the 29 September 2008 a further significant incident occurred.

Paediatric cover was requested at 22:39 by Solihull Hospital following delivery of a distressed infant by emergency caesarean, the team arrived 41 minutes after being called. The baby required advanced resuscitation and stabilisation and at 02:00 a pneumothorax was diagnosed requiring the on call consultant general paediatrician to attend to assist with the placing of a chest drain. The



baby arrived back at BHH at 07:10 on 30 September 2008 having been successfully resuscitated and stabilised.

### **Third Significant Clinical Event**

During the same time period the Neonatal Unit (NNU) team were asked to attend the delivery of 27 week premature twins at the BHH site. The team had returned to BHH shortly after the birth of the first twin (who was born at 07:05). Obstetric care management issues meant that the delivery of the second twin was delayed (07:59). The first twin survived, but the second died approximately 40 hours after birth despite intensive care.

The RCA found the main concern to have been the management of the second twin during labour. A general paediatric registrar had initiated resuscitation of this twin and had been supported by a consultant neonatologist within 10 minutes.

As yet neither NHS Birmingham East and North (BEN) nor SCT have received a final report on this incident, and have not therefore been able to sign off action plans to prevent recurrence. However, this incident raised significant concern in the Trust's ability to safely and effectively serve its whole population.

The second and third events occurred shortly after the correspondence was received from the Coroner concerning the first event, but 5 years after the original incident had occurred. In response BEN as co-ordinating commissioner, established a maternity service review group, chaired by Nicola Bengé (Director of Health Improvement, BEN) with representation from SCT and HoEFT. The group now reports to the Clinical Quality Review Group established in January 2009.

In October 2008 SCT requested information from HoEFT with regard to the two neonatal deaths and a meeting between HoEFT and SCT chief executives Mark Goldman and Sally Burton occurred on 12 December 2008. A proposal was made for consultants to sleep in at Solihull on a voluntary and interim basis to reduce the risk of non availability of an advanced resuscitator within 10 minutes. The following was agreed:

- To commission a strategic review of maternity services at Solihull taking account of services provided across the West Midlands.
- Assess the viability of a plan to provide paediatric cover 24/7 at Solihull Hospital as an interim measure.
- Ensure that Clinical Quality Review meetings involve SCT.
- Monitor the measures being taken and provide appropriate advanced resuscitation at SMU.

## Maternity Services Review

The first phase of the work has been to establish the actual level of risk associated with the current model of service at Solihull. The group commissioned an external safety review of SMU to assess current risk (Stage 1 review) by 'Improvement and Facilitation Solutions' (see Appendix 5). The findings of this review were that the current provision for neonatal emergencies is inadequate against the most recent national clinical standards. The current service is stretched to its limit at Solihull in terms of safe provision for current capacity and demand, and is under significant and increasing pressure across the Trust. This review also noted that this was a long standing issue at Solihull, characterised by polarised views amongst the workforce who deliver the service. This suggested clear presence of risk, but assessment as to level of severity is hampered by a lack of reliable data, disjointed governance processes and inadequate multidisciplinary team working.

The results of the review led to a recognition by all organisations, that there was a need to review the future service configuration in line with national professional standards to safeguard the safety of women and children using this service.

In June 2009 a second stage option appraisal was commissioned and completed by August 2009 (see Appendix 6). It considered six options and concluded that the existing service could not continue, strengthening the existing services would require recruitment of staff that are not available and establishment of a middle grade paediatric rota which is not practically possible. Its preferred option was the establishment of a midwife led unit at Solihull.

It was agreed over the summer of 2009 that there was a need to consult publicly on the long term configuration of the maternity service at the Solihull site and preparation was made by the maternity services group to augment this public process with a pre-consultation event with key stakeholders to help shape the future direction of formal consultation over maternity services for Solihull.

The pre-consultation event held in October 2009 identified strong public opinion for the development of different options on which to consult (than those identified in the stage 2 options appraisal) including proposals as to how to maintain services on Solihull site and the joint trusts agreed to review this (see Appendix 7).

HoEFT also reported that staff were leaving because of the current model of care citing the cases of at least 3 midwives and a consultant neonatologist who had or were in the process of moving to neighbouring units.

In November 2009 all three boards agreed to a review of all available information and data using a standard risk assessment framework with the view to determining if the service needs urgent change or can be sustained whilst longer term solutions are found. This risk assessment was difficult to carry out due to lack of site specific data (see Appendix 8).

**The joint risk assessment** was presented to the SCT Board in November 2009. It suggested that a rapid closure of the SMU without adequate development of a safe alternative was likely to constitute a higher risk than maintaining existing services with patches in place. It also highlighted a level of conflicting views between the different assessments, with HoEFT unable to agree the risk assessment that was taken to the three Boards as they did not consider it sufficiently and accurately articulated the risk from their organisation's perspective.

The Boards therefore agreed to a further piece of work to test some of the assumptions within the risk analysis and fully understand the views of clinicians in order to draw a final conclusion to this work. Agreement was made for the CEOs with their clinical leads to meet key clinical groups to investigate further within 'a select committee' approach in order to try and understand the level of risk better.

In November 2009, The **NHS Gateway** team visited to review whether the economy was ready to go out to consultation and advised that we were not (see Appendix 9).

This was further verified by the December 2009 National Clinical Advisory Team (NCAT) visit report which stated "In conclusion, we did not feel that the PCT is ready to go out to consultation on the options for the SMU" (see Appendix 10).

A full chronology of events up until 12 January 2010 is included at Appendix 11.

### 3. **Current Position**

For some time, HoEFT have been warning that they have concerns that they will be unlikely to be able to sustain the current mitigation patches to maternity services at Solihull:

21 May 2009 ARNBs expressed concerns to HoEFT management about providing cover for Solihull.

14 July 2009 HoEFT report to maternity review steering group that ARNBs have confirmed their intent to withdraw cover on 1 August 2009.



20 July 2009 HoEFT management met with ARNBs and agreement was reached to continue their cover to allow consultation to occur with expectation that temporary cover can stop April 2010.

The HoEFT clinical staff have been expressing that they are not prepared to continue to provide this cover to the Solihull unit beyond April 2010 as operating outside “contemporary best practice” has been placing an excessive personal and professional burden on themselves whilst increasing pressure on other parts of the system. This has become more of an issue over the last couple of months given the delay in the formal public Consultation on future options for service provision, and likelihood that the implementation of a longer term sustainable service model will not be achieved much before the autumn of 2010.

The HoEFT Chair, Mr Clive Wilkinson, requested an urgent meeting on 4 December 2009 attended by all three chairs as well as Mark Goldman, Ian Cunliffe, Mandy Sunderland, Ann Keogh, Patrick Brooke, Nicola Bengé, Eamonn Kelly and HoEFT lawyers. It heard from Beachcroft LLP that they had advised the HoEFT board of a significant legal risk including corporate manslaughter should an incident occur at Solihull even with existing mitigation actions in place. This was discussed and agreement was made to note HoEFT's advice but to continue with the previously agreed “select committee approach”. Agreement was also made that risk would be unacceptable without existing risk mitigation patches in place.

**The Select Committee style meeting** was held on 9 December 2009 at which Mark Goldman, Sophia Christie, Claire Molloy, Nicola Bengé and Patrick Brooke had the opportunity to hear reports and ask questions from clinicians representing the SWMNN, Anaesthetists, Obstetricians, Paediatricians and Midwives currently supporting mitigation (see Appendix 12 - Interview of Clinicians). It was concluded that the existing service is able to operate to a level of safety as a result of the risk mitigation patches, however, it is not meeting best practice and even with the patches is extremely fragile, with sustainability of the unit being dependent on the good will of the clinicians. Clinicians shared their professional perception of risk even though the hard data makes it difficult to verify their anecdotal experience through Clinical Governance monitoring.

- Anaesthetists expressed concerns that they should ideally have a dedicated anaesthetist available to cover maternity (Maternity standards 2008).
- The SWMNN reaffirmed their views as documented in their letter of 8 December 2009 (Appendix 1) in which they state: The current service being provided at Solihull does not meet the above standards (referring to NICE intrapartum care guidelines, Maternity Standards 2008 and Safer Childbirth 2007) which have been designed to ensure units deliver a safe service. As a network we understand some of these



- standards may be seen as aspirational..... but support for babies born in unexpectedly poor condition who require resuscitation is a basic right which is not currently available in Solihull.
- Obstetricians expressed concerns that increased numbers of deliveries occurring at Solihull had not been matched by the necessary staffing or support services.
- Paediatricians were able to provide advanced resuscitation support but that was only because they had previously had neonatal experience. They also expressed that they could not continue to provide the level of cover required long term.
- Midwives were mixed in their views and although they were providing advance neonatal resuscitation including UVC they would not feel able to do this without on call neonatologist/paediatrician support.

Agreement was subsequently made for Chief Executives and the SHA to meet to discuss how to manage this on 4 January 2010.

#### 4. HoEFT's Proposal

At the meeting on 4 January 2010 with Commissioners and the SHA, HoEFT advised that they had reached a point at which they needed to move forward with changes to maternity services across sites in preparation for SMU's 'patches' becoming unsustainable post April 2010, as is expected.

Due to the risk to patient safety of maintaining services on the Solihull site (with risk mitigation patches in place) is considered less than the risk of a rapid less controlled move of deliveries to another site (such as would result from immediate closure of Solihull's maternity unit) it is considered that the safest option will be to keep the SMU open until alternative capacity has been developed and is operational.

HoEFT predict that they will be unable to maintain patches beyond April 2010 and when patches fail the unit will be considered unsafe to continue to operate.

They therefore proposed the following **interim** solution:

- Immediate development of an attached MLU on the BHH site – this should be operational within approximately 12 weeks.
- Once an attached MLU is available deliveries will be shifted from Solihull to other sites (principally BHH).
- The SMU to close briefly and then reopen as a standalone MLU.

- Development of elective Gynaecology Services at Solihull with a full gynaecology ward including specialist nurses and a dedicated gynaecology theatre.

## 5. Consultation

At present both NCAT and Gateway have advised that commissioners and providers are not ready to go out to public consultation.

Interim solutions will need to remain in place until a full consultation process has occurred.

Commissioners need to use the next few months to ready themselves for consultation with the aim to go out to full public consultation within 2010.

The West Midlands Strategic Health Authority (SHA) with SCT have appointed Mr John MacDonald to support commissioners to ready themselves for and to carry out a full consultation.

## 6. Governance

**The Governance processes set out below are currently being developed and the following should be read as a draft proposal pending agreement.**

### **Consultation over future maternity services for Solihull**

Developing and consulting on the long term future of maternity services for the people of Solihull. In taking forward this work it is important that there is clear local leadership provided by SCT which has the statutory responsibility for commissioning services for their population. This currently operates through a shared commissioning agreement with BEN who act as 'the co-ordinating commissioner'; however it is proposed that it will be led by SCT with governance provided by a new maternity strategy group chaired by Claire Molloy.

### **Monitoring of interim service change**

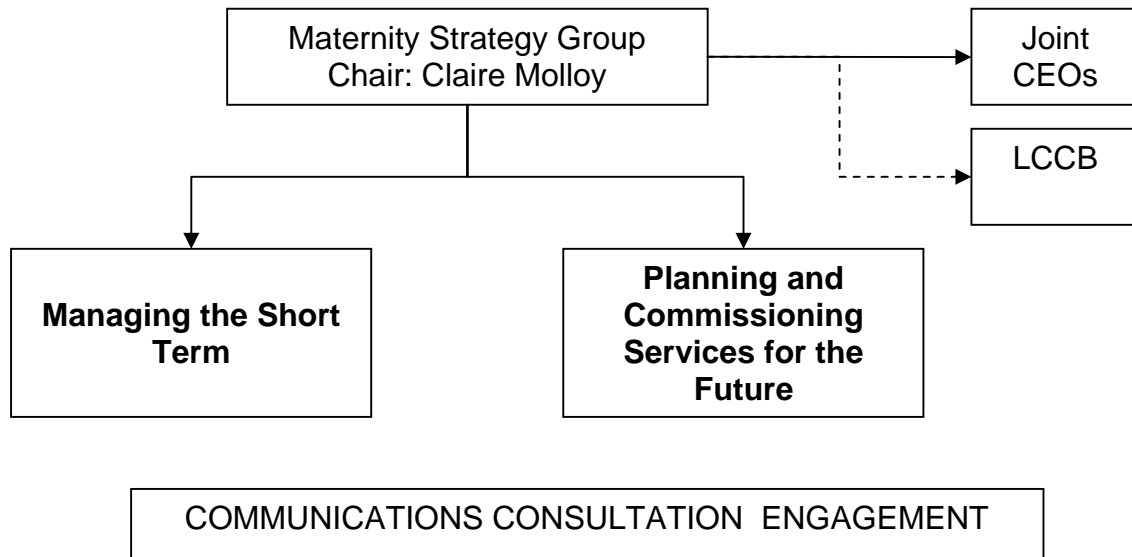
Managing the short term situation, in particular ensuring that the case for change at this time is clear, that interim arrangements are robust, that mothers, the public and other key stakeholders are fully aware of the changes to the service and the changes are explained to local politicians. It is proposed that governance is provided by the new maternity strategy group chaired by Claire Molloy, with leadership still to be fully agreed.

### **Wider PAN Birmingham, Solihull and Sandwell maternity review.**

It is recognised that changes to the services at Solihull will impact on other services both within Birmingham and neighbouring towns such as Warwick and Redditch. Discussions will therefore need to occur with the existing review group to ensure that these discussions are coordinated within the larger health economy picture.

For these reasons and after discussions between SCT, BEN and SHA the Maternity Review Group stood itself down on 15 January 2010 and a new group will be established to take forward the work. Initial membership and links for this group are summarised below:

A detailed work programme will need to be agreed as a matter of urgency and this is currently underway.



### Resources

It has been agreed that John MacDonald a former CEO with significant experience of leading service reconfiguration will be appointed to:

- Support, provide advice and report to the Chief Executive, SCT.
- As Programme Director, John will develop the overall programme plan, provide advice and support to key directors and managers, monitor activities and provide regular progress reports to the Chief Executive, SCT, liaise with key stakeholders as appropriate.

It has also been agreed that specialist media and communications skills will need to be procured and SCT is already in the process of this procurement.

**7. Implications (Including Financial, Consultation, Equalities, HR and Legal)**

- Interim closure of the SMU pending consultation is likely to lead to significant political challenge.
- Possible shared legal risk with HoEFT and BEN if a significant patient incident occurs at Solihull site, this could include 'corporate manslaughter' particularly if service is allowed to operate without risk mitigation patches in place.
- Risk of significant reputational damage.
- Successful consultation will require an increase in capacity, principally in terms of senior leadership.
- Financial cost of increased communications support.

**8. Recommendations**

The SCT Board is asked to:

- Note the current position.
- Consider and approve next steps.

Dr Patrick Brooke  
21 January 2010