NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

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[redacted]

PRIVATE & CONFIDENTIAL
Mr P Nieto
HM Area Coroner for Derby and Derbyshire
St Katherine's House
St Mary's Warf
Mansfield Road
Derby, DE1 3TQ

11 May 2023

Dear Sir

I am writing in response to the Regulation 28 Report dated 16 March 2023, following the Inquest into Mrs Walker's sad death.

I firstly want to begin by offering my sincere condolences to Mrs Walker's family and give an assurance that the Trust has taken significant steps to address the concerns that you raised.

I note that you have identified two broad areas of concerns relating to governance processes relating to clinical guidelines and equipment. Please find enclosed commentary that I have prepared to given assurance around the actions taken as a result of Mrs Walker's death and following the Prevention of Future Death Report.

By way of further assurance, the Trust has retained 360 Assurance to audit the measures taken by the Trust, which will include an audit of the following:

- the structure, roles, responsibilities, attendance and reporting arrangements
- the quality of the minutes and actions including scrutiny and challenge regarding risks, issues and concerns including documentation of these, responsibilities and escalation
- a review of the functioning and effectiveness of the Maternity Services Risk and Governance Strategy
- the effectiveness of the governance across all sites with equal consideration being given to risks, issues and concerns across all sites.

The Trust is committed to transforming our maternity services. The Trust's Improvement Action Plan covers the steps we need to take to improve our compliance against Saving Babies' Lives, Ockenden recommendations, the maternity incentive scheme, locally agreed from actions and recent external reviews of our service. Having everything in one place means we can prioritise, track and measure progress, and clearly hold ourselves to account on when we are going to deliver each action within it. To support this, we will be implementing a project

management approach to make sure workstreams are coordinated, and that we use all opportunities to engage with staff and service users.

Within the Local Maternity and Neonatal System (LMNS) the Trust reports to the Perinatal Quality and Safety Group (PQSF) each month to ensure accountability for the quality and sustainability of services alongside transformation and improvement activity. The PQSG escalate issues, concerns and risks to the ICS or regional governance structures.

Furthermore, the Trust Board has approved and are investing in additional staffing in maternity to the value of £500k to strengthen leadership and governance to support safe care.

I hope that this response demonstrates that the Trust are committed to learning from Mrs Walker's death and to improving care for our future patients.

Yours sincerely

[redacted]
Chief Executive