

# **Maternity Services Review**

**The Shrewsbury and Telford Hospital NHS Trust**

## **Report**

**October 2013**

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# Foreword

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This review was commissioned by Shropshire Clinical Commissioning Group (CCG) and Telford and Wrekin Clinical Commissioning Group following concerns over an increased incidence of serious clinical adverse events and the safety of the model of maternity care in Shropshire.

The timescale was extremely challenging and the fact that such a comprehensive report has been produced in a short time is a reflection of the hard work and diligence of all those who have contributed to and produced this report.

I am very grateful, therefore, to everyone involved, particularly the young mums who provided valuable feedback. Special thanks to Mrs Bharti Patel-Smith from Shropshire CCG, Mrs Yvonne Cowie from Staffordshire and Lancashire Commissioning Support Unit and Mrs Cathy Smith, Care Group Director / Head of Midwifery from The Shrewsbury and Telford Hospital NHS Trust, who have been so instrumental in producing this report.

It is clear that Shropshire has a maternity service to be proud of and that the model of service provision is safe and robust and is appropriate for a mixed rural and urban population. There are some concerns expressed in this report and when the recommendations are accepted and implemented, I'm confident that the maternity service will deliver at the highest possible level of safety both for mother and baby.

*Dr Josh Dixey, Secondary Care Consultant on Shropshire CCG Board*

Shropshire Clinical Commissioning Group (CCG) formally became the statutory commissioning body for around 302,000 residents across Shropshire county in April 2013.

By April 2013 the CCG had already embedded its governing principles and vision, encapsulating a commitment to create a local healthcare service founded on compassion and mutual respect; a service that places patient safety, quality of care and patient experience as its first priority. Alongside this, the CCG has committed to growing the leadership, supporting learning across the local health system and using external expertise to improve outcomes for patients.

In May 2013, Shropshire CCG's Governing Body Board commissioned a review of the maternity services which were provided locally through a 'hub and spoke' model.

I am pleased to receive and support the findings of this report of maternity care across the local health economy.

The review was commissioned to focus on patient safety, quality of care, the sustainability of the hub and spoke model and the sustainability of workforce numbers, alongside educational needs, the reporting of serious incidents, patient complaints and review of serious incidents. The review also focussed closely on the areas highlighted by the coroner following the outcome of an inquest into the death of a newborn baby within the county. Importantly, the maternity review board were also asked to seek the opinion of mothers who had received care within the local model, their partners and family members, to ensure that the patient voice was central to the findings.

The work done alongside national experts and local patients has produced a well-balanced, comprehensive report for the CCG Board.

Although the report did not review the impact of public health outcomes, the Board, alongside Shropshire local authority (and in particular public health), remain committed to reducing smoking in pregnancy, improving breastfeeding numbers, exceeding previous flu and rubella vaccination targets in pregnant mothers, and championing mental wellbeing reviews and support, working closely with local health visitors.

On behalf of the CCG Board I would like to thank the staff of The Shrewsbury and Telford Hospital NHS Trust for the support they have given this review, their openness and honesty and the way in which they have constantly embraced the opportunity to learn and improve. And finally to the mothers and family members who have shared their stories and experiences with us and allowed us as commissioners and clinicians the opportunity to improve outcomes for future mothers and babies at our local maternity services.

*Dr Caron Morton, Accountable Officer, Shropshire CCG*

# Executive Summary

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The maternity services review was commissioned by Shropshire and Telford and Wrekin Clinical Commissioning Groups (CCGs) to consider the following areas of concerns:

- Pattern and understanding of serious incidents within maternity services since revised categories of reporting were implemented.
- Issues identified during a high profile inquest in 2012 (relating to a case that occurred in 2009) raising questions about various aspects of maternity care.
- Failure to meet nationally recommended ratio of midwifery supervisors to midwives.
- Ongoing challenges with regard to midwife to birth ratio.

The remit of the review was to identify to the CCG Governing Body Boards the current position regarding the quality and safety of the maternity services provided by The Shrewsbury and Telford Hospital NHS Trust (SaTH) and to make recommendations as appropriate to ensure that this service provides the highest quality and safest care during and after pregnancy in all birth settings.

The review covered the period from 1 April 2012 to 31 March 2013, unless otherwise stated within the report, and assessed five areas as listed below:

1. Service user experience
2. Clinical outcomes indicators and activity data - maternal and neonatal
3. Hub and spoke model
4. Workforce
5. Risk management systems and processes

The review collected and analysed data relating to these areas and where possible benchmarked the data with regional, national or comparator sites. Whilst data and information can give a quantifiable aspect to safety and quality, it was considered that the human aspect was equally important. As such the review also focussed on understanding existing patient experience intelligence; engaging with service users using different methods such as focus groups and online questionnaires; as well as meeting with maternity services staff to get their views. This enabled the review team to get a more rounded view of the maternity service.

The limitations of the review must be noted as it only focussed on the areas of concern as details above, and therefore not all areas of maternity services were assessed.

An objective view was enhanced by including a number of external experts in the Review Team and, in order to further ensure transparency, Internal Audit monitored the process and has given the review a significant assurance rating.

The openness and cooperation of The Shrewsbury and Telford Hospital NHS Trust enabled the review team to complete the review and report to the set timescale and our thanks go out to them.

**The overall findings of the review demonstrate that this is a safe and a good quality service which is delivered in a 'learning organisation'.**

However, it should be noted that any review of such a broad remit inevitably generates many areas for growth and development but this should not detract from the assurance gained through the process that the maternity services are safe and of a good standard in Shropshire. Some of the findings from the report follow.

**Service user experience:** Findings are positive, complimentary and consistently articulated a story of competent services, delivered by competent staff. However 8-10% of the feedback was made up of negative comments, reflecting individual experiences of using maternity services.

**Clinical outcomes indicators and activity data:** The evidence and data collected paints a picture of a unit with a comprehensive set of clinical policies and guidelines in place and which reviews and audits its standard of care on a regular basis. The activity data shows the trust to be a unit with a high level of normal deliveries, and a lower than average rate of Caesarean sections and instrumental deliveries, which suggests a broadly positive outcome for most women. However it is noted that it was not possible to compare the full range of outcomes data as a consequence of suitable benchmarking data not being available. Further work is recommended to undertake a thematic analysis of admissions of term babies to a Neonatal Unit.

**Hub and spoke model:** The review of the hub and spoke model identified a wide range of services provided by the midwife led units (MLU) and concluded that the model of care is deemed to be safe and of a good standard. This is reflected in the feedback from service users, partners and staff and should be used as a stimulus to maximise the use of MLUs. Further work is recommended to promote the MLUs and to understand the monitoring of the rotation programmes for midwives working in MLUs.

**Workforce:** The overall findings demonstrate that a number of staffing issues have been addressed and improved, including the supervisor to midwives ratio and the midwife to birth ratio. There is a business case which, if approved, will enable the trust to continue to move even closer to meeting recommended standards, notwithstanding the challenges faced nationally of recruiting to Consultant Obstetric posts. Although there is a robust training plan there are a number of recommendations to enhance training and increase staff uptake to at least 75% in key topics.

**Risk Management:** This work stream focussed on reviewing the reported serious incidents, incidents and near misses in the period 1 April 2012 to 31 March 2013; associated strategies and policies; clinical governance systems; care pathways which minimise risk; relevant staff availability and training.

The findings highlighted an openness and transparency in reporting and investigation, a culture which has led to a higher reporting of serious incidents than would have been reported elsewhere. Of the 23 serious incidents reported, only seven were considered to be true serious incidents and therefore comparable with similar trusts. There is a robust approach to risk management, clinical governance structures and learning from incidents which suggests a 'learning organisation'. A higher reported rate of unexpected admissions

to the Neonatal Unit when compared to other local units was noted and a thematic analysis by the trust is recommended to understand the reasons for this (which may be due to the diligent reporting).

In summary therefore, the service has been found to be safe and of a good standard. SaTH will continue to build on these standards through the implementation of the recommendations outlined within the report.

The CCG Boards will consider these findings and ensure that a plan is developed, implemented and monitored to address the recommendations as appropriate.

# Recommendations

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Within each work stream there are detailed areas for development. These inform the overall recommendations but both providers and commissioners need to be aware of the detail underpinning each recommendation:

## **Recommendation 1**

### Neonatal Care

- As part of the review it was not possible to gain detailed information on comparator neonatal outcomes other than serious incidents which indicated that the trust had a higher rate of reported unexpected admissions to the Neonatal Unit (NNU). Therefore, a thematic analysis of unexpected admissions of term (37+ completed weeks) babies to the NNU, as reported to STEiS (Strategic Executive Information System), should be undertaken by the trust, in discussion with the commissioners, to understand the reasons for this (which may be due to their diligent reporting).
- Ensure that measures to implement standards for 'Local Neonatal Units' are actioned immediately so that babies less than 27 weeks gestation receive initial stabilisation and intensive care in Shropshire before being transferred to an appropriate unit for ongoing intensive care. Furthermore, reporting mechanisms should be enhanced when there are capacity issues and a process agreed to escalate these to specialised commissioning.
- Implement a strategy to provide midwives working in a MLU or attending homebirths with extended neonatal resuscitation skills (Accredited Neonatal Life Support Training).

## **Recommendation 2**

### Staffordshire, Shropshire and Black Country (SSBC) Newborn and Maternity Network

- Staffordshire, Shropshire and Black Country (SSBC) Newborn and Maternity Network to work with providers to develop, collect and share maternal and neonatal outcome data to aid benchmarking and peer review.

## **Recommendation 3**

### Serious Incidents

- Ensure serious incident reporting is congruent with the National Patient Safety Agency (2010) and NHS England (2013) Serious Incident Framework.
- Continue to enhance the open "relationship aspect" with commissioners about reporting and investigating concerns in the future, in order to enable a conversation to report and clarify concerns before formal procedures are instigated.

#### ***Recommendation 4***

##### Hub and Spoke

- Develop a strategy in conjunction with commissioners to promote and increase the percentage of deliveries in MLUs, thereby creating a thriving service that promotes choice, women-centred care and value for money. This includes the following:
  - Articulate the costs of services / activities provided in each MLU and demonstrate service line reporting.
  - Develop, implement and monitor a systematic and strict rotation and development programme for all midwives.
  - Build on the joint training and pilot the potential of a rolling programme of joint development with WMAS with regard to stabilisation and transportation of mother and/or baby.

#### ***Recommendation 5***

##### Patient and Public Engagement

- Build on the existing partnerships, conduits and systems to triangulate ongoing patient experience feedback to ensure that the 'patient voice' remains at the heart of service review and development.
- Establish a maternity patient and public engagement group as one of many conduits to engage with service users.

# Introduction

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## **Background**

Shropshire and Telford and Wrekin Clinical Commissioning Groups (CCG), as the statutory bodies responsible for commissioning safe, sustainable services for our respective patient population groups, have requested that a formal review of the maternity services across both areas be undertaken.

The remit of the review was to identify to the CCG Governing Body Boards the current position regarding the quality and safety of maternity services, making recommendations as required. This is to ensure that the service provides the **highest quality and safest care during and after pregnancy for mother and baby**.

The scope of the review was to consider the following areas of actual and perceived concerns:

- The pattern and understanding of serious incidents within maternity services since revised categories of reporting were implemented. These are specifically associated with:
  - Concerns about the management of intrauterine growth restriction of the foetus
  - Perceived delays in escalating patient cases for senior advice and support interventions
  - Potential concerns about variations in interpretation of the foetal heart rate
  - Potential concerns about variations in adherence to standard guidance.
- Issues identified during a high profile inquest in 2012 (relating to a case that occurred in 2009) raising questions about:
  - The 'hub and spoke' model of maternity care
  - Decision making with regard to the safe and appropriate transportation of mother and baby (especially in light of the forthcoming hospital reconfiguration)
  - The perceived increased number of serious incidents within maternity services since revised categories were implemented.
- Failure to meet nationally recommended ratio of midwifery supervisors to midwives.
- Ongoing challenges with regard to midwife to birth ratio.

## **Shropshire Maternity Services**

Shropshire Maternity Services currently comprise the following:

- Shrewsbury Consultant Unit (CLU) (Royal Shrewsbury Hospital site)
- The antenatal ward (Royal Shrewsbury Hospital site)
- The postnatal ward (Royal Shrewsbury Hospital site)
- Midwife Led Units (MLU)  
There are five MLUs based in:

- Bridgnorth (Bridgnorth Community Hospital)
- Oswestry (Robert Jones and Agnes Hunt Orthopaedic Hospital)
- Ludlow (Ludlow Community Hospital)
- Telford (Wrekin Unit, Princess Royal Hospital site)
- Shrewsbury (Royal Shrewsbury Hospital site)
- Neonatal Unit (Royal Shrewsbury Hospital site)

The Project Initiation Document (Appendix 1) provides further details of each service area.

During the period 1 April 2012 and 31 March 2013 there were:

- 66,334 community contacts
- 6,624 in-patient spells
- 5,154 births

## ***Review methodology***

The review was wide-ranging and managed through five work streams covering the following areas:

1. Service user experience
2. Clinical outcomes indicators and activity data - maternal and neonatal
3. Hub and spoke model
4. Workforce
5. Risk management

The objectives of the project were to review the areas identified within the five work streams, recommending appropriate action if inadequate standards were identified and highlighting good practice. The aim was to ensure that following the review the CCG Governing Body Boards were assured of the current position regarding the quality and safety of maternity services, and to put forward recommendations which may be required in order to ensure that the service provides the highest quality and safest care during and after pregnancy. The review was able to trigger an immediate quality intervention if areas of patient risk were identified at any stage - it would do so through Shropshire CCG's (as lead CCG for the review) Director of Quality and Safety and Accountable Officer. Further details of the areas covered within the work streams are described within the Project Initiation Document (Appendix 1) and will also be covered in the report.

- ***Phases of work***

The review involved three phases:

- **Phase one: analysis and diagnostic work**

This involved collating all available evidence within each of the five work streams and analysing it against agreed local and national standards and guidelines.

- **Phase two: review and development of recommendations**

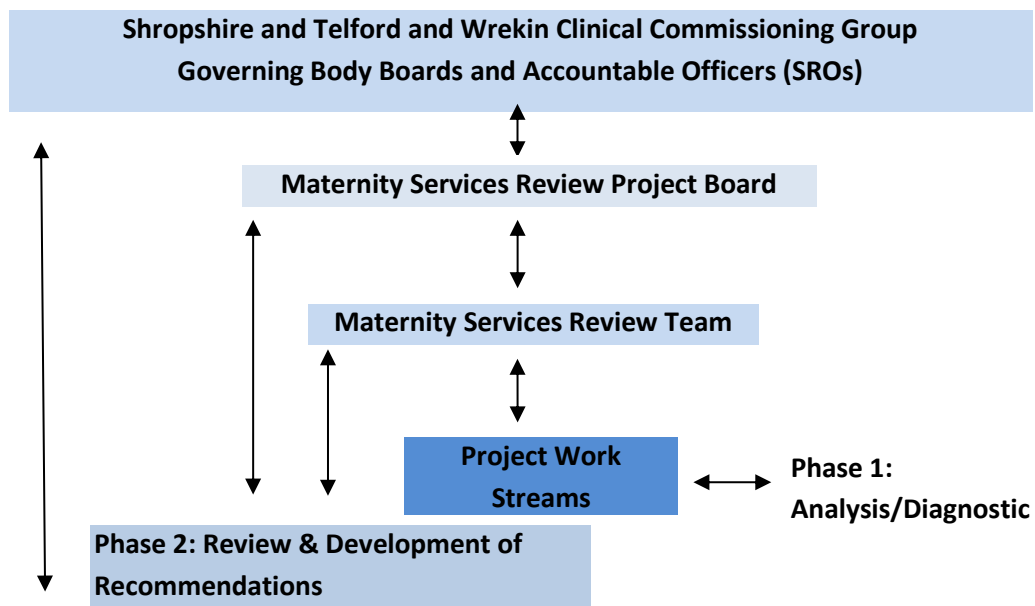
The Maternity Services Review Project Board and Review Team evaluated the outcomes of the analysis and diagnostic work through a joint workshop. This involved mapping out all of the available information in order to formulate a series of conclusions, for future actions based on evidence based best practice.

- **Phase three: performance improvement plan**

A performance improvement and implementation plan will be developed once the final report has been considered by the Shropshire and Telford and Wrekin Clinical Commissioning Groups' Governing Bodies in November 2013.

- **Governance structures**

The structure below identifies the governance for the review and further detail is outlined in the Project Initiation Document (Appendix 1).



**Phase 3: Performance Improvement Plan**

- **Membership of the review**

The membership of each group is detailed in the Project Initiation Document (Appendix 1).

- **External scrutiny**

To ensure a high level of objectivity and transparency it was agreed that external clinicians with expertise in maternity services, both as practising clinicians and nationally recognised experts; Healthwatch; Clinical Networks; the Care Quality Commission and Internal Audit would be part of the process and be involved in different aspects of the review.

- **Evidence**

There is extensive evidence on different aspects of maternity services and this was debated early on in the review process. It was agreed that priority would be given to the following because they are evidence based:

- National Institute for Health and Clinical Excellence (NICE) guidance
- Royal College of Obstetricians and Gynaecologists (RCOG) guidance
- Royal College of Midwives (RCM) guidance
- Staffordshire, Shropshire and Black Country Newborn and Maternity Operational Delivery Network Guidelines

## ***Structure of the report***

This report is structured to consider each of the five work streams in turn, and within each work stream to consider the supporting evidence, emerging themes, areas of good practice, areas for development, conclusions and recommendations.

Finally, overall conclusions have been drawn with supporting recommendations.

# Review Findings

## Work stream 1: Service user experience

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### **Key standards and best practice**

<ul style="list-style-type: none"><li>• <i>The Handbook to the NHS Constitution</i> (2013)</li><li>• NICE (2008) <i>Antenatal Care</i></li><li>• NICE (2012) <i>Patient experience in adult NHS services: improving the experience of care for people using adult NHS services</i></li></ul>
<ol style="list-style-type: none"><li>1. Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.</li><li>2. Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills.</li><li>3. Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.</li><li>4. Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.</li><li>5. Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.</li><li>6. Patients are actively involved in shared decision making and supported by healthcare professionals to make fully informed choices about investigations, treatment and care that reflect what is important to them.</li><li>7. Patients are made aware that they have the right to choose, accept or decline treatment, and these decisions are respected and supported.</li><li>8. Patients are made aware that they can ask for a second opinion.</li><li>9. Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.</li><li>10. Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.</li><li>11. Patients experience continuity of care delivered, whenever possible, by the same healthcare professional or team throughout a single episode of care.</li><li>12. Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals.</li><li>13. Patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care.</li><li>14. Patients are made aware of who to contact, how to contact them and when to make contact about their ongoing healthcare needs.</li></ol>

### **Summary of evidence**

*Equity and Excellence: Liberating the NHS* (2010) states that in order to achieve the best healthcare outcomes, patients' voices should be heard at every level of the service, either through involvement in service development or review of services.

The review of service user experience was underpinned by a detailed Communications and Engagement Plan (Appendix 2) and encompassed both service users and staff. The staff component is included within the Workforce section. In this section the focus is on the service user component and incorporates the views of service users on their experiences of maternity services since 1 April 2012.

The review involved looking at existing patient experience intelligence, alongside creating conduits for feedback such as developing online questionnaires and undertaking focus groups using appreciative inquiry methodology (see Appendix 3 for more information on this).

Social media such as Twitter and Facebook were used to promote the conduits for feedback.

## **Associated strategies, policies, guidance and frameworks**

The table at Appendix 8 outlines the Patient Information Framework (Maternity) supplied by maternity services and comments on compliance.

## **Existing patient experience intelligence**

The purpose of reviewing existing patient experience was to gain some intelligence on how the service was evaluated by service users and their families between 1 April 2012 and 31 March 2013. To gain this intelligence the following areas were considered:

- Feedback on NHS Choices and Patient Opinion websites
- National Maternity Survey 2010 (this was the most recent comprehensive survey available)
- Complaints received about maternity services, including number, themes and outcomes
- Patient Advice and Liaison Service (PALS) contacts regarding maternity services
- Patient information resources
- Service user engagement and involvement
- Other internal activities that enhance service user experience.

- **Feedback on NHS Choices and Patient Opinion websites**

Two comments were posted on NHS Choices and Patient Opinion websites between 1 April 2012 and 31 March 2013 regarding the maternity services provided by The Shrewsbury and Telford Hospital NHS Trust (SaTH). They both related to care received in the Midwife Led Units in Bridgnorth and Ludlow.

*"to round things off were very pleased with the care we received from the time we arrived to the time we left. I would recommend it to any women to have their baby here."*

*"thanks to the kindness and professional competence of the caring staff. Excellent."*

- **National Maternity Survey 2010**

The second national survey of women's experience of maternity care in England took place between April and August 2010. In comparing SaTH's results to other trusts, there were 19 questions suitable for benchmarking where results can be directly attributable to acute trusts rather than primary care trusts (PCTs).

SaTH was placed in the top 20% of all trusts surveyed in six areas:

- The reason for the dating scan was clearly explained
- During labour and birth, women got the pain relief they wanted

- The rating of the care they received during labour and birth
- The length of stay in hospital after the birth was appropriate
- Women were given the information or explanations they needed after the birth of their baby
- Women were treated with kindness and understanding after the birth of their baby

SaTH was placed in the bottom 20% of all trusts for one area only:

- Women were given the choice of having their baby at home

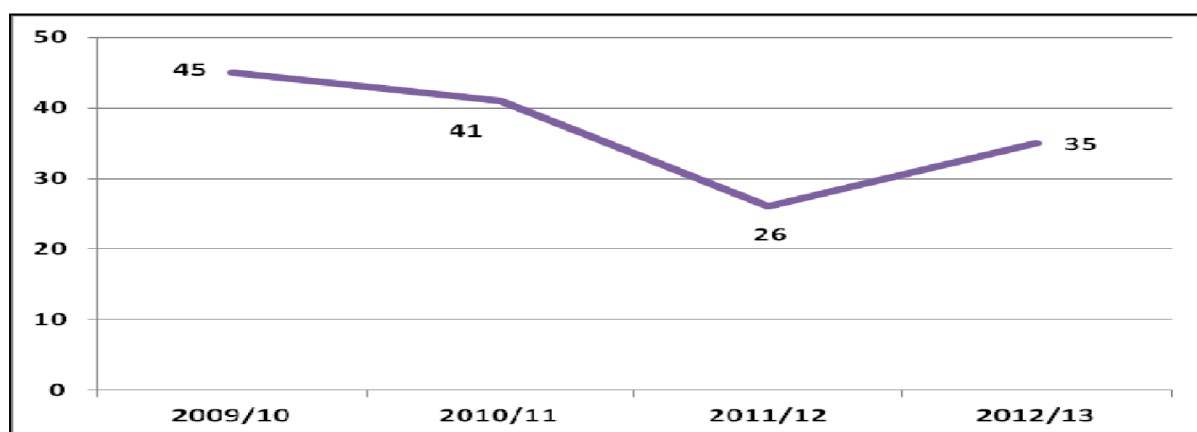
For the remaining 12 questions, the responses placed SaTH in the mid 20% to 80% bracket, indicating that the SaTH's performance was within the normal variation expected and that the trust was not an outlier (either positive or negative) in these areas.

- **Number of complaints, themes, outcomes and trends**

Monitoring trends and patterns in complaints and concerns against providers enables the identification of sub-standard care and facilitates the early detection of systemic problems. Moreover it is important to ensure that the learning from complaints is embedded within the organisation to continually improve services and service user experience.

SaTH's maternity services had 107,345 patient contacts between April 2012 and March 2013. 35 complaints were received during this time, which equates to 0.0003% of contacts generating a complaint. Of the 35 complaints received, 12 were upheld, 8 were partially upheld and 15 were not upheld. The complaint themes centred on 'communications' and 'care given'.

SaTH has the same and comparable routes for patient feedback benchmarked against other trusts nationally (e.g. complaints processes, Patient Advice and Liaison Service (PALS), NHS Choices, Patient Opinion, LINKs (Local Involvement Networks) etc.)

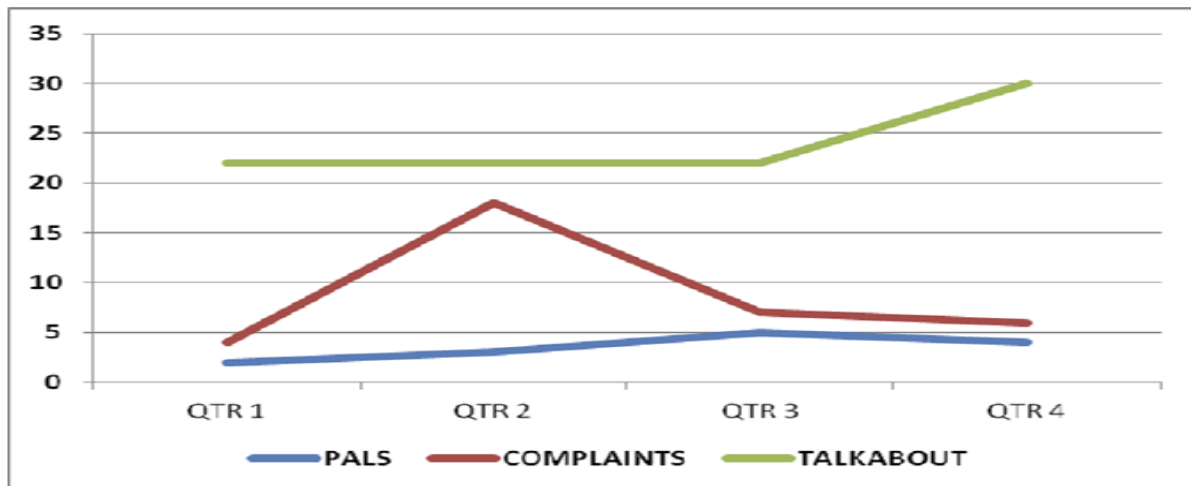


Maternity complaints trend over the last four years.

- **Contact with Patient Advice and Liaison Service (PALS)**

There was a notable decrease in PALS contacts in 2012/13; 14 contacts in comparison to 27 contacts in 2011/12.

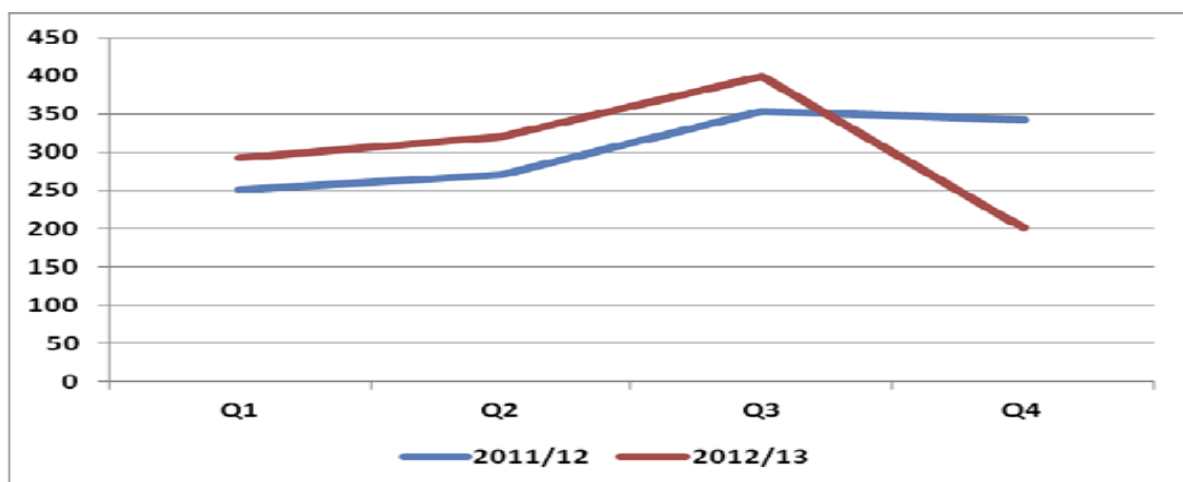
It has been thought that the 'TalkAbout Service' may have had an impact on the number of PALS contacts and complaints as demonstrated in the graph below. The TalkAbout Service offers women the opportunity to discuss their birth experiences with experienced midwives and is valued by women as an opportunity to understand their experiences during pregnancy, labour and birth and any implications for future pregnancies.



TalkAbout Service, PALS and formal complaints in 2012/2013

- **Patient appreciation**

Service user appreciation is the highest compliment for any member of staff and shows how much their hard work is appreciated and therefore motivates them to continue to deliver the best care possible for women. The graph below provides information on the numbers of appreciation contacts and a comparison between 2011/12 and 2012/13. There is a downward trend in quarter 4 (Q4) of 2012/13.



Appreciation contacts 2011/12 and 2012/13

- **Patient information**

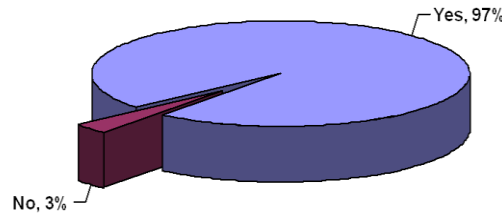
The service provided a wide range of local and national patient information used within the service and a list of the information is included in Appendix 5. Furthermore, there is a process for the development, approval, archiving and dissemination of patient information (the Patient Information Framework, included at Appendix 8).

- **Service user engagement and involvement**

Service user engagement and involvement forms part of the service.

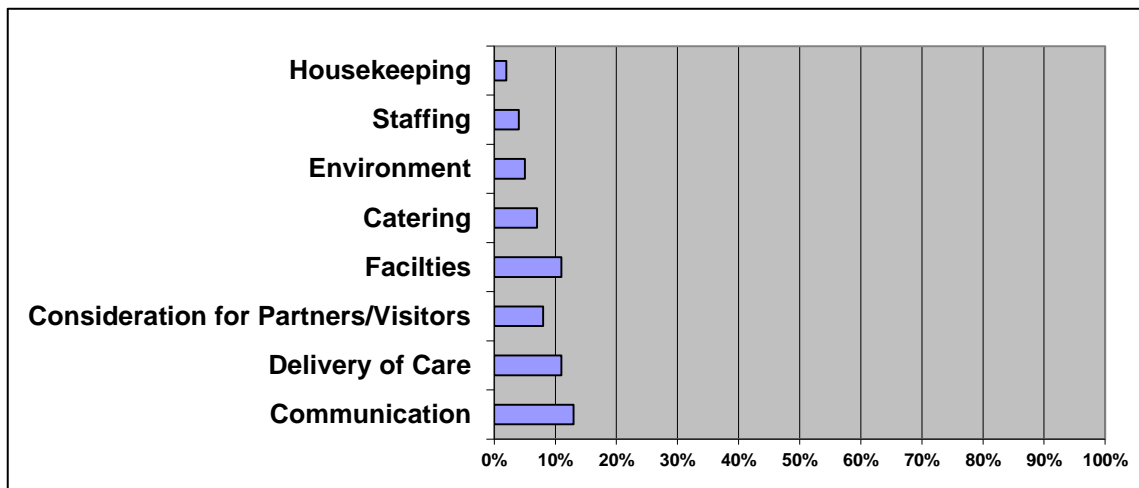
1. A quality assurance questionnaire survey was undertaken between March and April 2012 to assess the level of satisfaction women had with their care during their stay in the Royal Shrewsbury Hospital Maternity Unit (Consultant Unit). Three key questions were asked and the results are outlined in the graphs below:

Q1. Have you been treated with respect since you have been in this department?



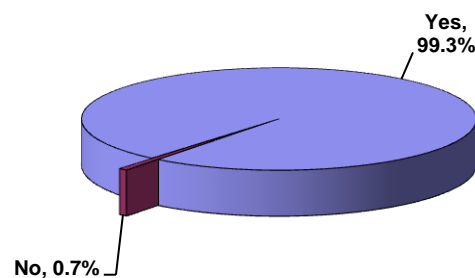
This is an excellent result.

Q2. If there is one thing that could be improved, what would it be?



More than one in ten respondents thought facilities, delivery of care or communication could be improved.

Q3. Would you recommend the SaTH Maternity Services to a friend or relative?



The overall response to the questionnaire was positive and 99.3% of respondents said that they would recommend SaTH Maternity Services to a friend or relative.

2. There has also been ongoing engagement and involvement as part of the maternity services reconfiguration. This information can be accessed at: <http://www.sath.nhs.uk/Future/default.aspx>
3. The Maternity Services Liaison Group has been in place up to March 2013 but is currently not in operation.

## Service user focus groups

A total of 13 service user focus group sessions were scheduled, eight of which were attended. 47 mothers / service users attended in total. Four sessions took into account existing activity and networks and nine bespoke public sessions were set up across Shropshire and in Powys. There was a good 'timing' spread with sessions planned at different times of the day in different locations.

The purpose of the focus groups was to develop a broad 'story based' understanding of user experience; also, we wanted to 'listen' to service users with an emphasis on insights, responses and opinions.

Every focus group was led by an expert independent facilitator, with representation from Healthwatch/ Community Health Council (CHC) and Maternity Services. The additional attendance provided external scrutiny of process as well as assurance to participants of service provider (i.e. SaTH) engagement and involvement in the review.

The focus groups were carried out using appreciative inquiry approach methodology. Information about the structure of the focus groups, including detail on the appreciative inquiry methodology approach, is included at Appendix 3. The areas explored are detailed below and capture themes as well as individual feedback from the focus group participants.

### 1. Choice

What was good?	What was not good?
Where first choice of place of delivery could not be met due to a clinical requirement for urgent intervention to secure a positive outcome, this was accepted by the patient as an informed choice.	In Market Drayton there were strong feelings about choice being denied by the lack of support from midwives to allow expectant mothers to go to Staffordshire to have their baby.
Midwife Led Units (MLUs) offered better and more consistent choices where there was more involvement and time for the patient, stronger relationships, willingness to go the extra mile; whereas the Consultant Led Unit (CLU) 'did' the process to the expectant mothers, treated them like a number and was not "old and homely" like the MLUs were, taking the 'choice' away from patients.	Home birth: the relative power exercised by one midwife in denying this was counteracted by another allowing it, resulting in the experience being very positive for the family concerned. That said, both the new midwife and the original one (who had been against the home birth) failed to administer the blood clotting injection following delivery, resulting in serious complications.

Where choice was fulfilled the experience reported was 'excellent', where there was good support from health professionals, good communication and "fantastic aftercare".	Locality issues around named midwife versus different midwives emerged – this had repercussions around choice as well as the quality and continuity of care, communications, relationship building and the 'mechanistic' approach to appointments.
The aqua-natal sessions were very useful and should be made available across the county (and not just Ludlow).	

## **2. Provision of care/ support from health professionals**

<b>What was good?</b>	<b>What was not good?</b>
An opportunity to extend positive experience presents itself via the same midwife being assigned to the same expectant mother for subsequent pregnancies.	Staff did not take seriously the issues that expectant mothers were raising; in particular midwives did not believe how much pain mums-to-be were in and that there was urgent need for pain relief.
"Completely positive experience throughout." "The breastfeeding support was excellent." These types of positive, complimentary responses were heard at almost all of the eight focus groups that were run.	At the CLU, ringing the buzzer for assistance went unanswered for a long time, was not responded to by qualified staff or was met with unsympathetic care.
The rotational system of midwife working patterns was strongly praised as allowing/ enabling good personal development for staff and an opportunity to share experience for the better care of service users.	'Matter of fact' responses were commonplace (at the CLU as opposed to the MLU) leaving new mums feeling that they were inadequate as they did not know what to do – this was particularly in relation to breastfeeding support.
Several midwives were mentioned by name and praised for providing high quality care and interaction throughout pregnancy, labour and in the post-birth period.	New mothers felt 'abandoned' after giving birth and generally 'isolated' in the busy unit, and new fathers/ family were not allowed to stay to support their partners.
Care and support in emergency situations was second to none and left nothing to chance – this being seen as experts doing their jobs in a committed and competent manner. However, the after-care was not always as good.	One family's experience was so bad that they told us they would not have another baby – not just in the specific consultant-led unit referred to, but a second child per se.
Having a SureStart centre and associated group activity was very beneficial in that it allowed mothers to get support and encouragement from each other within weeks of giving birth.	
The care/ support offered and received from	

health visitors in the Bridgnorth area was “fantastic and well worth having”.	
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### 3. Communication

What was good?	What was not good?
Where communication was good it was very good. In MLUs this was excellent – staff had more one to one time, they had time to explain and discuss things, they went the extra mile and generally demonstrated that they wanted to be in the role they are in.	A very clear message was that new mums did not know about the TalkAbout service at SaTH. This came up at every focus group. Where one new mum did call the service she was contacted six weeks after her initial call on a Saturday morning and asked to attend a session on the following Monday.
All but one participant had received the discharge pack but no one was told about the TalkAbout service at SaTH.	There was very little information on trust websites about Maternity Services so navigating the system became challenging.
Support around breastfeeding was generally very good; however, there was concern expressed around an overly strong influencing approach and the ‘cultural’ expectation to breast feed which made new mums feel uncomfortable.	Issues around contacting care providers (midwives and health visitors) hinged around not having the correct number, not being able to leave messages on answer machines, and the delay in receiving a response. Where this was good, it was exemplary and could not be faulted in any way.
Proactive communication emerged as a strong feature of MLUs, where staff “go the extra mile to make sure you’re kept updated and informed”.	One new mum recounted her experience of the midwife enforcing the ‘requirement’ to breastfeed by physically handling the new mum’s breast in order “to show how it’s done”, without consent, without warning and without consideration for invading personal space.
Antenatal sessions were very good in providing information on a range of concerns and allowed friendships to be formed; they put attendees at ease and allowed the ‘space’ to explore issues in safe environments.	Upon attempting to access notes the response was negative and many processes were listed. Following this hindrance new mothers were told they had to pay per sheet for a copy of their own notes.
	Staff to staff communication emerged several times. In particular there was negative experience around midwives telling expectant mums different things about the same issue; there were also mixed messages around choice of where to give birth. It was felt as though personal opinion dictated this.

Focus group attendees who may still have had outstanding issues about the care they had received had an opportunity to talk to the midwife who attended the focus groups or to the Healthwatch representative. Information was also available about how to access PALS at each focus group.

## **Service user questionnaires**

A service user online survey was set up via the CCGs' websites. The questionnaire enabled responses to be recorded and displayed as percentages and figures, and as comments (results are included at Appendix 4). Broadly speaking, the findings of the focus groups and the online survey complement and support one another. Responses were received from 172 service users.

Some common themes of the survey and focus groups include:

- The vast majority of participants at the focus groups said they had a choice of where to have their baby; in the survey, 85% of respondents reported being offered choice.
- Around the issue of the same 'named' midwife being available throughout a pregnancy, an overwhelming number of focus group participants reported this was *not* the case. In the online survey, only 22% of respondents said they had seen the same midwife throughout pregnancy.
- Every focus group participant reported receiving a purple pregnancy book; in the survey this was reflected by almost 86% saying they *had* received a copy of the book.

Other headlines from the survey:

- Over 59% of respondents felt that 'health professionals worked well together and that care was co-ordinated'.
- 80% of respondents felt that they or their partner/ companion were given enough information to enable them to be involved in decisions about their care.
- After the birth of their baby, only 44% of respondents felt they were 'always' given the information or explanations they needed.
- In regard to the care received in hospital after the birth of their baby and the kindness, dignity and understanding shown by staff, only 58% reported that they 'yes, always' received this.
- 98% of respondents to the online survey took part as a mother.

## **Feedback via a dedicated email address**

A number of written comments (15) were received via a dedicated email address set up for the maternity services review. Just as through the focus groups and the online survey, the majority were positive and complimentary about their experience of Maternity Services, particularly the services provided by Ludlow MLU, experience of home births and of intrapartum care.

## **Themes**

The themes emerging from the various channels of service user experience can be summarised as follows:

- Excellent provision of ‘medical emergency’ care and timely interventions, only to be let down by the aspects of aftercare.
- “CLUs being far too busy to allow a reasonable level of communication between staff and expectant mothers, particularly after birth, leading to feelings of being isolated, abandoned and alone.”
- The measurable difference in experience between users of the MLUs and CLUs across a number of issues – choice, provision of care and communication.

### ***Areas of good practice***

A number of notable areas of good practice are worthy of celebration:

- Excellent technical medical input ‘at the right time’, which is co-ordinated, well communicated and effective.
- The clear merits of “small” locally based services that provide demonstrable advantages over “busy consultant led units” in terms of user experience.
- Excellent, commendable, breastfeeding support which is timely and appreciated.
- Labour ward has introduced a “meet and greet” role within the last 12 months which reduces anxiety for mothers arriving on labour ward and this has been found to be very beneficial.

### ***Areas for development***

- Establish a maternity patient and public engagement group as one of many conduits to engage with service users.
- Stronger emphasis on ‘independent’ engagement, involvement and use of user experience data to strengthen aspects of the service.
- Better marketing/ publicity of the TalkAbout service – perhaps when issuing the information pack to new mums upon discharge.
- Development of a communications and engagement strategy specific to maternity services; this is particularly important in light of the new unit at Telford and the findings of user experience at MLUs.
- Customer care training programme for maternity services staff – good practice would enable actual scenarios from CLUs to be revisited.
- Attention needs to be paid to the requirement of the ‘named midwife’, moving from this concept being nominal to substantive, ensuring that the service aspires to continuity of care for every woman.
- Use the headlines of the survey to consider how some of these elements of the service can be improved.
- Review how to overcome potential feelings of isolation when the new unit opens with individual room settings.
- Continue to explore the use of technology to improve or overcome communications and record keeping issues.
- Use service users to help develop and improve different systems of communications to meet the range of people who access the service.
- Build on the existing partnerships, conduits and systems to triangulate ongoing patient experience feedback to ensure that the ‘patient voice’ remains at the heart of service review and development.

## **Conclusions**

The different channels of capturing service user experience proved to be well utilised and served to produce a range of written and spoken comments.

Where negative aspects of services were shared by users, they tended to be very bad or triggered negative emotive feelings. The negative stories accounted for only 8% - 10% of all the feedback received. Overall around 90% of the service user feedback was positive.

The overall findings of the service user work stream are positive, complimentary and consistently tell a story of competent services, delivered by competent staff – “who bring with them a myriad of personalities” – in different settings.

The good practice needs to be celebrated and maintained. More importantly, the service needs to ensure that measures are put in place to address any cultural and infrastructure-based issues that most likely account for the negative experiences. All services users who have contributed to this review can feel confident that their feedback is being listened to and see how this is impacting on their own care and the care of others.

# Work stream 2: Clinical outcomes indicators and activity data - maternal and neonatal

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## *Key standards and good practice*

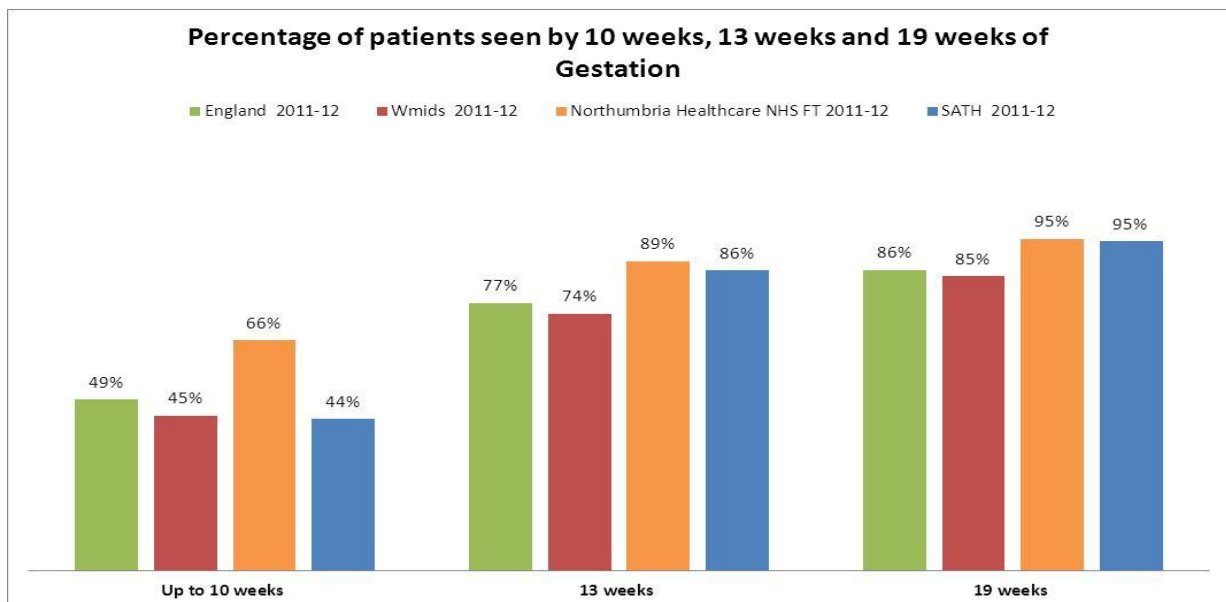
- NICE (2008) *Antenatal Care*
  - RCOG (2011) *High Quality Women's Health Care: A proposal for change*
  - Maternity Matters (2007) *Choice, access and continuity of care in a safe service*
  - NICE (2008) *Diabetes in Pregnancy*
  - NICE (2007) *Intrapartum Care*
  - NICE (2011 modified in 2012) *Caesarean section*
  - NICE (2006) *Routine postnatal care of women and their babies*
1. Antenatal Care Clinical Guideline 62 - Ideally women should have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices, between 10 weeks and 12 weeks and 6 days.
  2. Antenatal Care Clinical Guideline 62 - A schedule of antenatal appointments should be determined by the function of the appointments (nulliparous with an uncomplicated pregnancy, a schedule of 10 appointments / parous with an uncomplicated pregnancy, a schedule of 7 appointments)
  3. Antenatal Care Clinical Guideline 62 / RCOG - Maternity records should be structured, standardised, national maternity records, held by the woman
  4. Maternity matters - Pregnant women have a named midwife throughout their antenatal care
  5. Antenatal Care Clinical Guideline 62 / Diabetes in Pregnancy Clinical Guideline 63 - There are clear referral pathways for pregnant women who require specialist care (obesity, smoking status, gestational diabetes, pre-eclampsia and venous thromboembolism) to be managed and treated by the appropriate teams
  6. Antenatal Care Clinical Guideline 62 - Services are offering foetal screening in accordance with current UK National Screening Committee programmes
  7. Intrapartum Care Clinical Guideline 55 - Discussions with the woman about her chosen place of birth is documented in the hand-held maternity notes
  8. Caesarean section Clinical Guideline 132 - Numbers of planned / elective / on request Caesarean sections
  9. Compare with local / national comparators - Number of births in the Consultant Unit, each midwife led unit and homebirths
  10. Compare with local / national comparators - Number of inductions of labour
  11. Number of normal births
  12. Compare with local / national comparators - Operative vaginal delivery / failed operative vaginal delivery
  13. Compare with local / national comparators - Review of maternal morbidity / maternal mortality
  14. Compare with local / national comparators - Review of neonatal morbidity / neonatal mortality
  15. Evaluation of compliance with Newborn Network: Neonatal Guidelines 2011-13 in relation to NNU transfers
  16. Intrapartum Care Clinical Guideline 55 - A woman in established labour should receive supportive one-to-one care / clinical intervention should not be offered or advised where labour is progressing normally and the woman and baby are well / delay in the established first stage of labour is confirmed in nulliparous women, advice should be sought from an obstetrician and the use of oxytocin should be considered / clinical governance structures are in place to discuss governance issues
  17. Routine postnatal care of women and their babies Clinical Guideline 37 - Immediate postnatal care to be provided in accordance with NICE guidance
  18. Prevalence for breastfeeding at 48 hours
  19. Responses to formal reports of reviews or audits conducted by external / statutory organisation / inquests (e.g. CQC / Network) since April 2012

## Summary of evidence

The areas identified in the clinical outcomes and activity work stream are summarised below in terms of the evidence received, assessment of performance and whether any further work is recommended to be undertaken following this review. Where possible, benchmarking data has also been included. Data has been gathered from a variety of sources, including The Shrewsbury and Telford Hospital NHS Trust (SaTH), the Secondary Uses Service (SUS), Hospital Episode Statistics (HES), the Local Supervising Authority (LSA) for midwives and the Royal College of Obstetricians and Gynaecologists (RCOG).

- **To check that recommended guidance on the time that patients are seen for their first appointment is being followed**

The 2011/12 data is shown below, from which it can be seen that certainly by 12 weeks 6 days, SaTH is ahead of the regional and national comparators. More recent data received from SaTH for 2102/13 shows over 90% of women being seen within 13 weeks. However, the proportion being seen by 10 weeks of gestation has reduced to under 37%, but does not deviate from the achievement of the nationally agreed target for 12 weeks 6 days.



*HES online – number of patients seen within 10 weeks, 13 weeks and 19 weeks of gestation for 2011/12*

### SaTH summary for 2012/13

% of women booked with a gestation of less than:	%
10 weeks 0 days	36.72%
12 weeks and 6 days	90.90%
20 weeks	94.00%

SaTH latest Quarter for percentage of bookings with a gestation of less than 12 weeks 6 days (shown against nationally agreed target)

Expected target (nationally agreed target)	April	May	June	Q1 (YTD)	2012/13
90.00%	89.60%	92.30%	91%	90.80%	90.90%

**Conclusion: SaTH is meeting the national target for booking within 12 weeks 6 days.**

The percentage of women booking by 10 weeks is lower than available comparators, but is within the nationally agreed target for 12 weeks 6 days.

- **The number of women who attend the recommended number of antenatal appointments in line with national guidance is shown below**

Antenatal appointments attended (MLUs only) – 2012/13

Delivery Type	Number of deliveries	Recommended number of appointments	Number within recommended number of appointments	% within recommended number of appointments
Normal Primip - no complications	223	10	176	78.92%
Normal Multip - no complications	739	7	664	89.85%

Evidence from a clinical audit was also provided by SaTH which suggested that from the sample reviewed, at least 92% of women were attending appointments at the appropriate time, with the exception of the 40 week appointment where attendance dropped to 86%, which could possibly be attributed to the women having had their baby.

- **The number of scheduled appointments each woman does not attend**

SaTH did not attend (DNA) rates 2012/13

Obstetrics 1st and F/U		
Total DNAs	Total appointments	DNA rate
1187	35535	3.34%

Midwife Episode		
Total DNAs	Total appointments	DNA rate
1832	65207	2.81%

(Source: SUS, August 2012)

Evidence from an audit of DNAs was also provided by SaTH which concluded that appropriate action was generally being taken when women did not attend. However there were some recommendations made for further audit and for an adjustment to be made to the review process when appointments are missed.

**Conclusion and recommendation: Nearly 90% of multiparous women are having the recommended number of appointments. For primiparous women the figure is currently 79% which needs to be considered by the trust. It has not been possible to**

obtain any benchmarking data for this indicator. DNA rates for both obstetrics and midwife episodes are well below the national average of over 10%, suggesting that this is not a significant issue for the unit. Further assurance is provided by the audit evidence submitted which confirms that attendance is at least as high as suggested by the summary figures above and that DNAs are regularly reviewed by the unit to check that appropriate follow up action was taken.

- ***Patient held records***

A statement was received from SaTH that “All women are provided with hand-held records”, however no further information was received to provide evidence of this. From the survey questionnaire 86% of women confirmed that they had received hand-held records.

- ***Named midwife***

A statement was received from SaTH stating that 60.7% of women had continuity with their community midwife. This is against a target of 75% or greater. Only 22% of respondents to the online survey stated that they had seen the same midwife throughout their pregnancy. This is an area for improvement as continuity of care is a high priority and has been linked directly to successful normal vaginal delivery and breast feeding.

- ***Risk assessment for obesity, smoking status, gestational diabetes, pre-eclampsia and Venous Thromboembolism (VTE)***

Some assurance has been provided by the submission of guidelines and policies covering the above areas. Evidence relating to smoking status and audit of other topics is available.

**Recommendation: It is recommended that the unit’s audit programme should assess compliance with the above policies over the next 12 months.**

- ***Screening data to demonstrate evidence of compliance with national screening committee programme***

SaTH reached the recommended levels of compliance and timeliness in all but two areas; these were:

- Timely referral of women positive for Hepatitis B
- Timeliness of sickle cell and thalassaemia screening

In order to achieve these standards GPs need to refer women before 10 completed weeks of pregnancy.

**Recommendation: Continued monitoring through existing channels of performance against standards.**

- ***Audit information***

A range of audit information is included in Appendix 7.

### ***Activity data***

- ***Number of births***

SaTH birth date (Q1 2013/14, plus 2012/13)

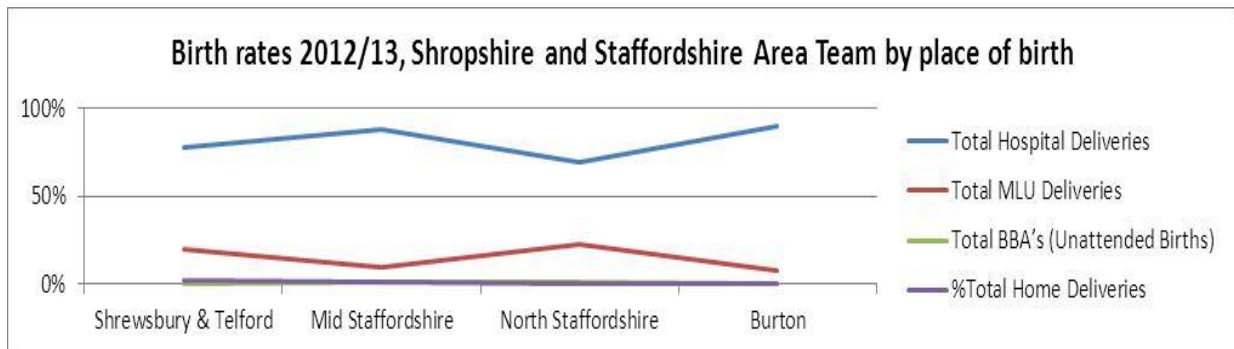
	Descriptor	* Expected target	SaTH				
			April	May	June	Q1	2012/13
Birth rate	% birth in CLU	75%	79.0%	80.8%	80.0%	<b>80.2%</b>	77.8%
	% of births in any MLU	25%	19.2%	16.9%	18.0%	<b>18.0%</b>	20.1%
	% home births	1%	1.0%	2.1%	1.5%	<b>1.5%</b>	1.8%
	% BBA/Other	<1%	0.0%	0.2%	0.5%	<b>0.5%</b>	0.4%

(Source: SaTH) \*Agreed locally.

SaTH data compared to other maternity units in the Local Area Team

	Shrewsbury & Telford	Mid Staffordshire	North Staffordshire	Burton
Total hospital deliveries	77.8%	88.1%	69.1%	90.0%
Total MLU deliveries	20.0%	9.4%	23.0%	7.6%
Total BBAs (unattended births)	0.4%	1.0%	0.9%	0.1%
Total home deliveries	1.8%	1.5%	0.6%	0.6%

(Source: LSA)



LSA data on place of birth over a five year period for consultant and midwife led units

**%Total hospital deliveries**

	2008/09	2009/10	2010/11	2011/12	2012/13
Burton	87.6%	88.0%	90.4%	91.3%	90.0%
Mid Staffordshire	97.5%	82.7%	83.1%	84.3%	88.1%
North Staffordshire	73.1%	78.9%	77.0%	75.9%	69.1%
Shrewsbury & Telford	73.5%	73.5%	73.3%	74.4%	77.8%

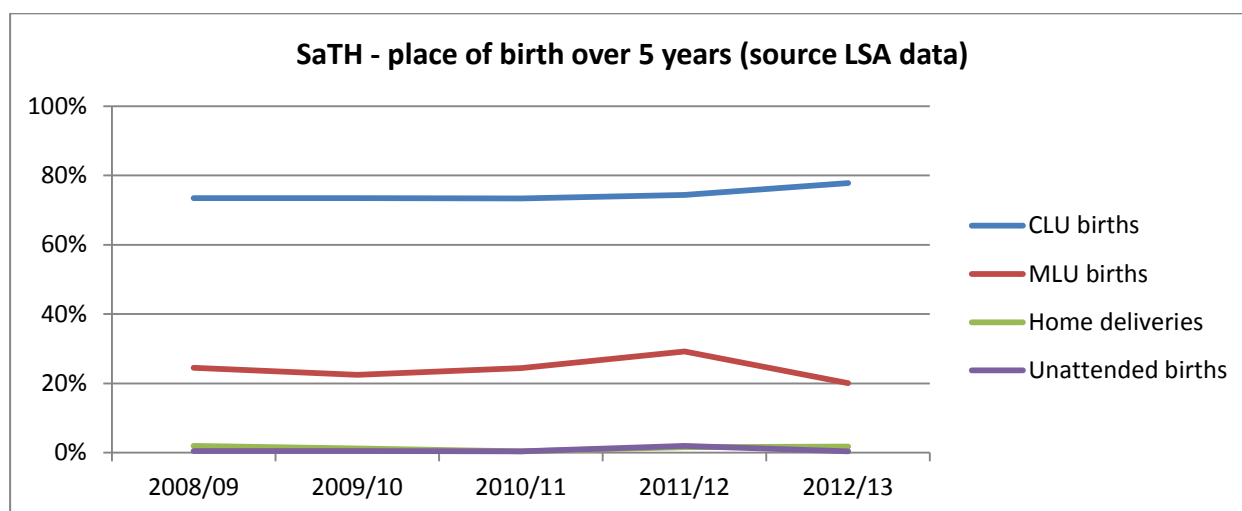
**%Total MLU deliveries**

	2008/09	2009/10	2010/11	2011/12	2012/13
Burton	10.4%	9.9%	8.8%	8.3%	7.6%
Mid Staffordshire	11.8%	13.7%	13.2%	14.5%	9.4%
North Staffordshire	24.2%	20.1%	21.5%	22.3%	23.0%
Shrewsbury & Telford	24.6%	22.5%	24.4%	29.2%	20.0%

*Births at midwife led units in Shropshire for 2012/13*

MLU	Number of admissions	Number of births			Number of other births attended by unit midwives	
		Intended MLU	Women birthed in Unit	Unintentional births (e.g. out of county, concealed pregnancy)	Home confinement	Water
RSH and Community	2492	1111	421	164	21	46
Wrekin and Community	1354	867	401	131	49	57
Oswestry and Community	415	198	72	14	5	0
Ludlow and Community	230	138	71	10	6	4
Bridgnorth and Community	237	175	68	10	6	1

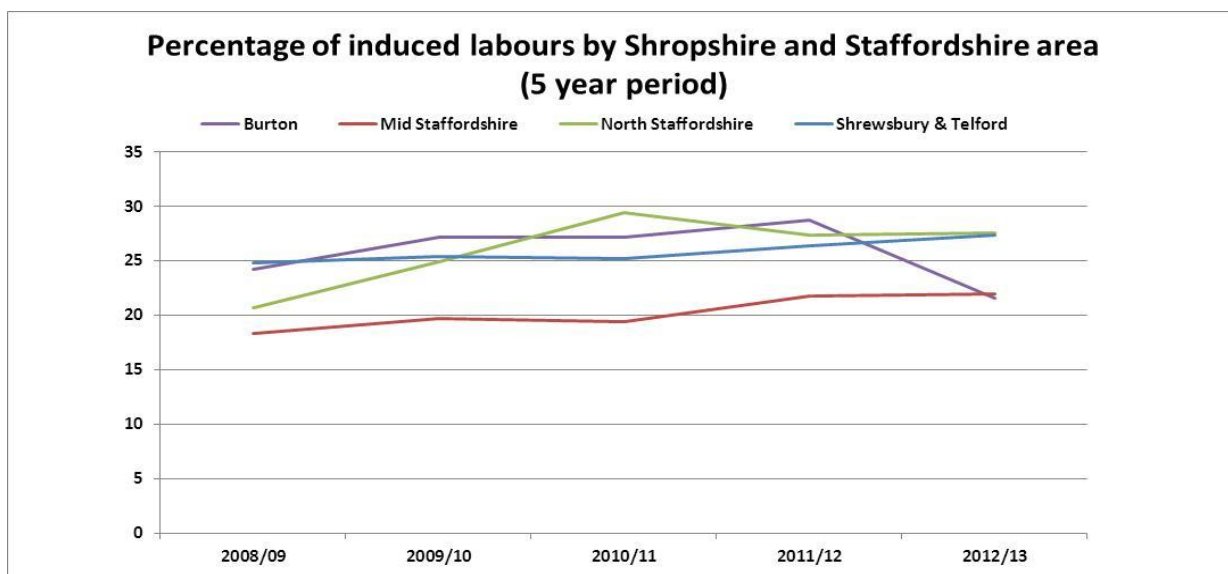
(Source: SaTH)



**Conclusion:** This data provides some contextual information to help interpret some of the subsequent information in this report. Looking at the data over five years, the proportion of births taking place at the consultant led unit has risen during 2012/13 compared to the previous four years, with a corresponding similar reduction in the last 12 months in the proportion being born at a midwife led unit. The total number of births at the MLUs for 2012/13 was just over 1000, representing around 20% of all births at SaTH.

- Induction of labour**

Data was available from both SaTH and the LSA for this area and there is also national comparator data from the RCOG report published in April 2013 which looks back at 2011/12. For 2012/13 the overall induction rate was around 28% of all births. The graph below summarises the data from the LSA over the last five years.



*RCOG figures on induction of labour for 2011/12*

	SaTH rate	National mean	Mean of top 10% of units	Mean of bottom 10% of units
Primips	30.8%	27.5%	38.1%	16.9%
Multips	25.4%	21.4%	29.9%	13.5%

*RCOG figures on the percentage of induced labours resulting in emergency Caesarean section for 2011/12*

	SaTH rate	National mean	Mean of top 10% of units	Mean of bottom 10% of units
Primips	25.0%	30.2%	40.3%	20.4%
Multips	9.1%	13.2%	22.1%	5.8%

**Conclusion: Induction rates have been rising gradually at SaTH over the last few years, a development seen in some of the neighbouring units and also reported as a national trend (NICE, 2008).**

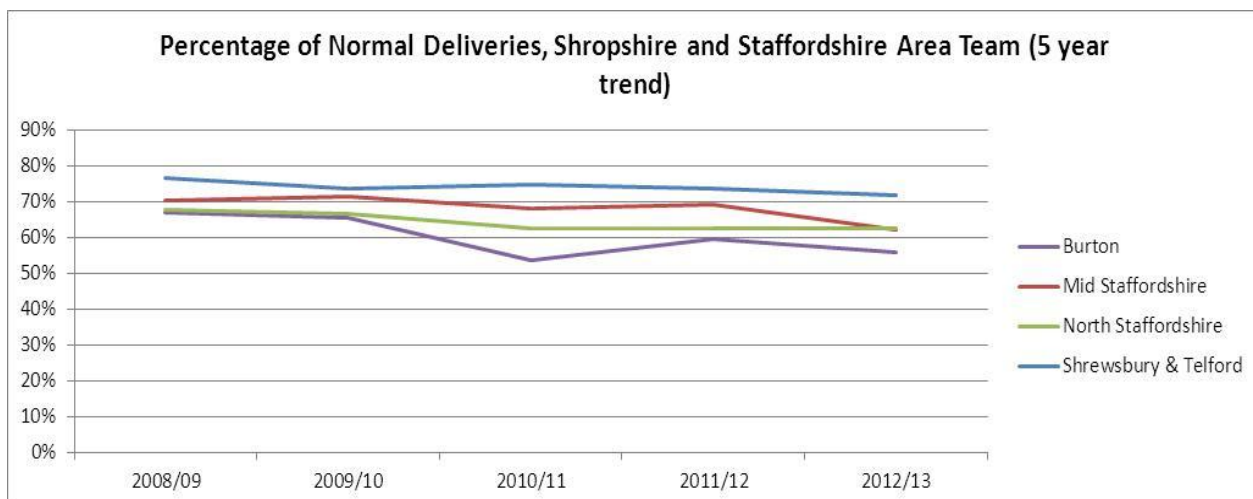
The benchmarking data from the RCOG shows SaTH to be above the national average for both primiparous and multiparous births, but well outside the mean of the top 10% of units. The benchmarking figures for the percentage of induced labours resulting in emergency Caesarean section show SaTH to be well below the national average for this indicator, providing assurance that the decision to induce labour does not appear to be made inappropriately.

- **Method of delivery**

Data from SaTH and the LSA suggests that the normal delivery rate at SaTH was 71.82% for 2012/13. This is also backed up with data for the same period available from SUS. (In England the formal definition of normal labour and birth is delivery without induction, the use of instruments, Caesarean section, episiotomy and without general, spinal or epidural anaesthetic before or during delivery.)

*% normal deliveries over a five year period.*

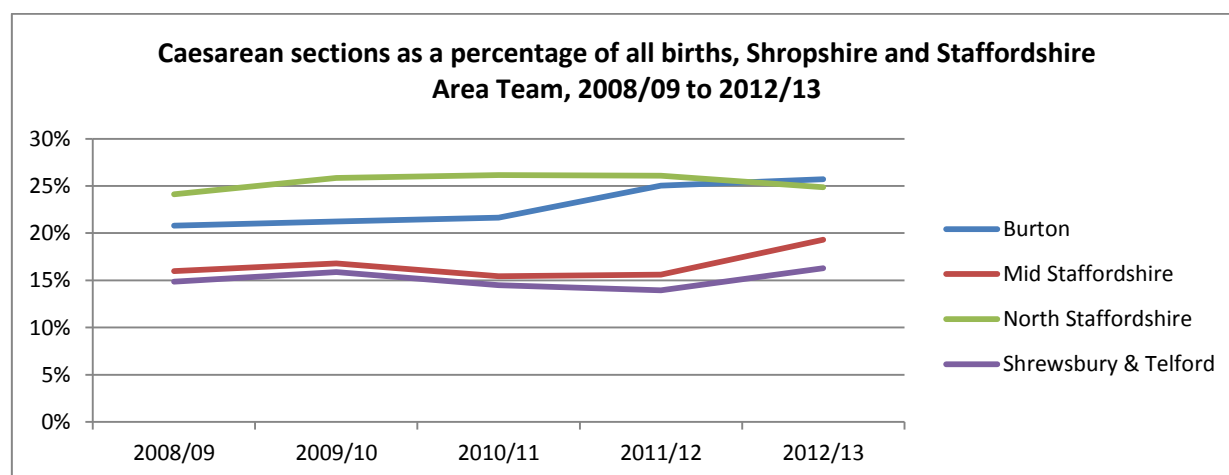
	2008/09	2009/10	2010/11	2011/12	2012/13
Burton	67.00%	65.46%	52.80%	59.50%	55.75%
Mid Staffordshire	70.32%	71.44%	68.10%	69.22%	62.11%
North Staffordshire	67.73%	66.61%	62.70%	62.64%	62.35%
Shrewsbury & Telford	76.79%	73.75%	74.70%	73.67%	71.82%



(Source: LSA)

*% Caesarean section deliveries over five year period*

	2008/09	2009/10	2010/11	2011/12	2012/13
Burton	20.8%	21.3%	21.7%	25.0%	25.7%
Mid Staffordshire	16.0%	16.8%	15.4%	15.6%	19.3%
North Staffordshire	24.1%	25.9%	26.2%	26.1%	24.9%
Shrewsbury & Telford	14.9%	15.9%	14.5%	14.0%	16.3%



(Source: LSA)

Data from the HES online maternity report suggests that the national and West Midlands average for Caesarean sections for 2011/12 was in the region of 25%.

*SaTH Caesarean section – elective/emergency split 2012/13*

Type of delivery	Number of births	% of births	
All Caesareans	839	16.3%	% of Caesareans
Elective Caesarean	437	8.5%	52.1%
Emergency Caesarean	402	7.8%	47.9%

(Source: LSA)

Data provided from SaTH and the LSA suggests that the split between the main delivery methods for 2012/13 is broadly as follows:

Type of delivery %	SaTH
Normal delivery	72.0%
Instrumental delivery	10.8%
Elective Caesarean	8.5%
Emergency Caesarean	7.8%

Comparative data from the RCOG maternity indicators report confirms the finding that the Caesarean section (CS) and instrumental delivery rates are below the national average, as shown by the following:

Indicator	Parity	SaTH rate	National mean	Mean of top 10% of units	Mean of bottom 10% of units
Percentage of spontaneous labours resulting in emergency CS	Primip	7.90%	11.6%	17.20%	7.00%
	Multip	3.90%	6.20%	9.20%	2.90%
Elective CS rate	Primip	0.90%	2.80%	5.00%	1.20%
	Multip	7.90%	12.10%	15.00%	7.20%
Instrumental delivery rate	Primip	19.80%	24.20%	31.80%	16.40%
	Multip	7.30%	7.50%	11.50%	3.80%

The emergency Caesarean section rate is well below the national average and just above the mean of the bottom 10% of units, and for elective sections for primiparous women SaTH is in the lowest 10% of units.

In addition to the above analysis, the SUS data for 2012/13 was used to compare the delivery method of women from Shropshire and Telford who gave birth at a unit outside the county. Whilst the numbers were too small to be able to draw any firm conclusions, the planned Caesarean section rate for this population appears to be higher than the comparable rate at SaTH, at around 13% of all deliveries.

Women from Telford and Shropshire CCGs giving birth outside of Shropshire 2012/13

	Numbers	Percentage
Normal delivery	131	56.7%
Instrumental delivery	38	16.4%
Elective Caesarean	32	13.9%
Emergency Caesarean	30	13.0%
<b>Total births</b>	<b>231</b>	

(Source: LSA)

**Conclusion: SaTH has a lower Caesarean section rate, a lower instrumental delivery rate and a higher proportion of normal deliveries than neighbouring units and also compared to national averages. This is to be regarded as a good outcome for women. Sections 15-18 below explore in more detail maternal and neonatal outcomes post-delivery to ensure no increase in adverse outcomes is being potentiated. This will be explored further in the Risk Management section of the report.**

- Maternal and neonatal outcomes**

Data provided from the SaTH quality dashboard for 2012/13 on numbers of complications as a proportion of all deliveries:

Complication	% of all deliveries
Eclampsia	0.02%
ICU admissions in obstetrics	0.14%
Blood transfusions (4 units)	0.14%
Postpartum hysterectomies	0.00%
Failed instrumental delivery	0.74%
Massive PPH >2L	0.33%
Shoulder dystocia	1.47%
3rd degree Tear	2.29%

It has not been possible to obtain any benchmarking data for maternal outcomes other than that provided within the RCOG report as follows:

Indicator	Parity/ delivery type	SATH rate	National mean	Mean of top 10% of units	Mean of bottom 10% of units
Percentage of attempted instrumental deliveries resulting in emergency CS	All	7.50%	3.10%	7.00%	1.10%
Percentage of instrumental deliveries carried out by vacuum extraction (vacuum : forceps delivery ratio)	All	58.1%	49.3%	72.1%	24.2%
Third and fourth degree perineal tear rate amongst <b>unassisted</b> vaginal deliveries	Primip	4.10%	4.00%	6.80%	2.00%
	Multip	1.30%	1.40%	2.40%	0.60%
Third and fourth degree perineal tear rate amongst <b>assisted</b> vaginal deliveries	Primip	7.30%	6.90%	11.00%	3.00%
	Multip	2.40%	2.50%	4.60%	0.40%
Emergency maternal readmission within 30 days of delivery	Vaginal delivery	0.40%	0.80%	1.60%	0.30%
	CS delivery	1.40%	1.40%	3.40%	0.30%

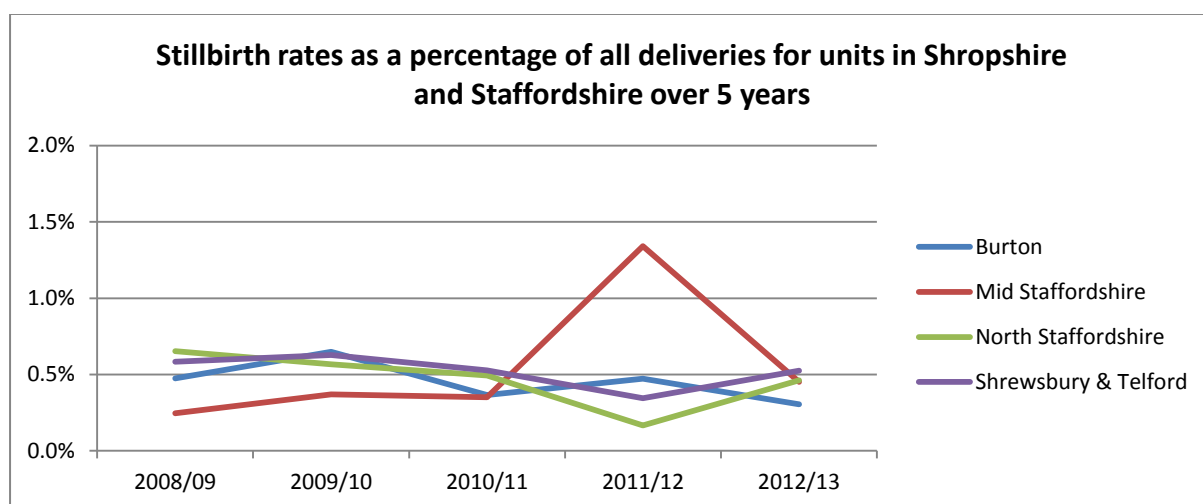
Data provided by SaTH and the LSA stated that there were 26 intrauterine deaths or stillbirths during 2012/3, representing around 0.5% of all deliveries. There were six neonatal deaths within 24 hours of birth, around 0.13% of all deliveries.

The national rate of stillbirths according to the RCOG report is 5.4 per 1000 births (0.5%).

The trend data for stillbirths over five years for SaTH and neighbouring units as collated by the LSA is shown below.

*Stillbirths data for 2008/9 – 2012/13*

	2008/09	2009/10	2010/11	2011/12	2012/13
Burton	0.5%	0.6%	0.4%	0.5%	0.3%
Mid Staffordshire	0.2%	0.4%	0.4%	1.3%	0.5%
North Staffordshire	0.7%	0.6%	0.5%	0.2%	0.5%
Shrewsbury & Telford	0.6%	0.6%	0.5%	0.3%	0.5%



(Source: LSA)

The outcome indicators included in the RCOG report do not generally suggest that outcomes for women giving birth at SaTH are any worse as a consequence of the low Caesarean rate.

The rates of third and fourth degree tears among both assisted and unassisted delivery are very near the national average.

The emergency maternal readmission within 30 days rate is just above the mean of the lowest 10% of units for vaginal births, and the same as the national average for Caesarean births. These are good results.

The only exception to this is the percentage of attempted instrumental deliveries resulting in emergency Caesarean section, where SaTH is above the mean of the top 10% of units, and one of seven hospitals in the country in which the rate was above 6%. This is in the context of a slightly higher than average rate of instrumental deliveries carried out by vacuum extraction but a lower than average instrumental delivery rate overall.

**It is recommended that the failed instrumental rate at SaTH should continue to be closely monitored and further work undertaken to understand the factors that may be contributing to making the unit an outlier for this indicator.**

### ***Neonatal***

This report has been commissioned to look at Maternity Services, with some limited neonatal outcomes. A separate piece of work will need to be undertaken by the trust and reviewed with commissioners as regards to more comprehensive neonatal data.

The next section considers the limited neonatal data which has been gathered during the review.

- ***Neonatal Unit (NNU) transfers***

From data provided by the Staffordshire, Shropshire and Black Country Maternal and Newborn Network, it appears that in 2012/13 there were 427 admissions of term (37+ weeks gestation) babies to the SaTH Neonatal Unit, representing around 8.3% of all deliveries, and just under 10% of estimated term deliveries at SaTH.

- ***Neonatal Unit (NNU) transfers from MLU***

The number of transfers of babies born at Midwife Led Units to the Neonatal Unit during 2012/13 was 34, split between the MLUs as follows:

Unit delivered	Number admitted to NNU	% of births at unit
Bridgnorth MLU	3	4.4%
Ludlow MLU	2	2.8%
Oswestry MLU	2	2.8%
Shrewsbury MLU	21	5.0%
Wrekin MLU	6	1.5%
<b>TOTAL</b>	<b>34</b>	<b>3.3%</b>

**Conclusion: Babies born at MLUs in Shropshire have a lower rate of admission to the Neonatal Unit than the rate for the total number of term babies born at all units in Shropshire (around 10%, see previous section and below).**

- ***Other transfers, not MLU***

Unit Delivered	Number Admitted to NNU	% of births at unit
Shrewsbury Consultant Unit	731	18.1%
BBA (unattended births)	7	33.3%
Home	5	5.5%
Welsh (Wrexham 4 / Cardiff 1)	5	-
<b>TOTAL</b>	<b>748</b>	<b>95.7%</b>

## Total transfers to the NNU - 782

Babies less than 27 weeks gestation receiving NNU care – 23

Babies admitted and transferred out – 53

The Birthplace Study (a national study) showed that for 'low risk' women the risk of an adverse perinatal outcome (intrapartum stillbirth, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome and specified birth related injuries) was low (4.3 events per 1000 births) in all settings. This was also similar for 'low risk' women having their second or subsequent baby. However, the risk of an adverse perinatal outcome is higher for women planning to have their first baby at home (9.3 adverse perinatal outcome events per 1000 planned home births compared with 5.3 per 1000 births for births planned in obstetric (consultant) units). This finding was statistically significant.

- **SaTH neonatal morbidity data 2012/13**

The table below provides information about neonatal morbidity; however it has not been possible to ascertain comparable data within the timescales, although the RCOG recommends that this data should be collected as part of routine monitoring.

Number of cases of meconium aspiration	4
Number of cases of hypoxic encephalopathy	5
Number of transfers (in) during labour and after birth	76
Number of transfers (out) after birth	47

(Source: SaTH data (BadgerNet),2012/13)

- **Other NNU admissions**

Overall numbers of serious incidents related to unexpected admissions to NNU is higher in Shropshire when compared with other sites as outlined in the table below. Therefore it reiterates the need to undertake a thematic analysis of unexpected admissions of term (37+ completed weeks) babies to the NNU by the trust.

This should be considered in the context that the serious incident reporting within SaTH has been more rigorous than many other units report. The review may demonstrate that this accounts for this higher number, but cannot be assumed.

Burton Hospitals NHS Foundation Trust	Mid Staffordshire General Hospitals NHS Foundation Trust	The Shrewsbury and Telford Hospital NHS Trust	University Hospital of North Staffordshire NHS Trust
2	2	8	4

Unexpected admission to NICU (neonatal intensive care unit) / NNU - April 2012–March 2013 (Report from Strategic Executive Information System, STeiS)

- **Babies less than 27 weeks gestation**

It is noted that the NNU in Shrewsbury cared for a number of babies less than 27 weeks gestation. There is evidence that babies born before 27 weeks gestation and those in other

higher risk category groups (e.g. sick, more mature babies requiring prolonged intensive care) should be cared for in few centralised acute centres in order to:

- Ensure that expert and experienced staff treat sufficient numbers of cases to maintain a safe high quality service and move towards the national standards.
- Maximise the use of scarce, expensive resources (staff, facilities and equipment).
- Organise retrieval services across large enough areas to be effective and economic.
- Services and support must be in place for families whose babies are cared for long distances from home.

The NNU in Shrewsbury is categorised as a Local Neonatal Unit and therefore will not be commissioned to provide ongoing intensive care beyond initial stabilisation and intensive care to babies less than 27 weeks gestation (NHS England 2013). Therefore, measures have to be put in place to move towards implementing this immediately.

- ***Prevalence of breastfeeding at birth***

	2008/09	2009/10	2010/11	2011/12	2012/13
Burton	62%	66%	63%	69%	61%
Mid Staffordshire	62%	62%	66%	68%	70%
North Staffordshire	62%	62%	63%	65%	58%
Shrewsbury & Telford	68%	67%	57%	58%	70%

(Source: LSA)

**Conclusion: The rate of initiation of breastfeeding at SaTH improved in 2012/13 from the previous two years, and is not dissimilar to breastfeeding rates at other maternity units in the area, however it is below the national average for 2012/13 of 73.9%. The Q1 figures for 2013/14 suggest that initiation rates have increased to over 70%, so early indications are positive in terms of the 2012/13 rate being exceeded. NB Although there are local and national targets around breastfeeding rates, this must be looked at in the context of choice.**

## ***Audit***

A table of relevant audits and outcomes is included at Appendix 7.

## ***Associated strategies, policies, guidance and frameworks***

The table in Appendix 8 outlines the strategies, policies and procedures supplied by maternity services to inform the review and comments on compliance.

## ***Areas of good practice***

- SaTH is ahead of national and regional comparators for the percentage of women being seen for their first antenatal appointment by 12 weeks and 6 days.
- The recommended number of antenatal appointments are being attended by around 80% of women.
- The DNA level is low, and audits provide evidence that appropriate follow up action is being taken in relation to women who fail to attend maternity appointments.

- Antenatal screening is generally reaching the compliance level specified by the National Screening Committee.
- Breastfeeding rates are showing improvement over the last 15 months.

### **Areas for development**

- As part of the review it was not possible to gain detailed information on comparator neonatal outcomes other than serious incidents which indicated that the Trust had a higher rate of reported unexpected admissions to the Neonatal Unit. Therefore, a thematic analysis of unexpected admissions of term (37+ completed weeks) babies to the NNU, as reported to STeiS, should be undertaken by the Trust, and in discussion with the commissioners to understand the reasons for this (which may be due to their diligent reporting).
- Commence the process of implementing the NHS England NNU care guidelines.
- Ensure that measures to implement standards for 'Local Neonatal Units' are actioned immediately so that babies less than 27 weeks gestation receive initial stabilisation and intensive care in Shropshire before being transferred to an appropriate unit for ongoing intensive care. Furthermore, reporting mechanisms should be enhanced when there are capacity issues and a process agreed to escalate these to specialised commissioning.
- The sourcing of benchmarking data from other organisations to help monitor the rate of adverse maternal and neonatal outcomes. The RCOG report will provide some information but there may be potential for the local neonatal and maternal networks to collect and share this kind of data to aid benchmarking and peer review.
- The monitoring of failed instrumental deliveries – it is recommended that these are subject to review to identify any factors that might be responsible for SaTH having a higher than expected rate for this indicator.
- Continue monitoring through existing channels of performance against standards for all recommended screening tests and implement measures to improve the two areas which are below the recommended level, i.e. Hepatitis B referral and sickle cell / thalassaemia screening. GPs need to ensure that women are referred before the completion of week 10 in order to achieve this.
- The trust should consider how it can work with primiparous women to attend the recommended number of appointments, and implement recommendations from the audit of DNAs.

### **Conclusions**

Evidence and data collected for this part of the review generally paints a picture of a unit with a comprehensive set of clinical policies and guidelines in place and which reviews and audits its standard of care on a regular basis. The activity data shows SaTH to be a unit with a high level of normal deliveries, and a lower than average rate of Caesarean sections and instrumental deliveries, which suggests a broadly positive outcome for most women.

The set of maternal outcomes considered here demonstrate that the low Caesarean and instrumental delivery rates do not appear to put women at any higher risk than at units where intervention rates are higher. However it should be noted that it was not possible to

compare the full range of maternal outcomes as a consequence of suitable benchmarking data not being available.

Similarly, other than looking at the very crude measure of stillbirth rates, it has not been possible to provide full assurance that the low intervention rate is not providing any adverse outcomes for the neonate. It is recommended that work continues to investigate these areas further as stated above.

# Work stream 3: Hub and spoke model

## Key standards and good practice

- NICE (2007) *Intrapartum Care*
  - British Association of Perinatal Medicine: *Neonatal Support for Stand Alone Midwifery Led Units (MLUs), A Framework for Practice*
1. Establish what services are provided in each midwife led unit
  2. Intrapartum Care Clinical Guideline 55 / Neonatal Support for Stand Alone Midwifery Led Units (MLUs) - What operational policies or protocols are in place to manage risk and deal with emergencies e.g. sick babies
  3. Compare with local / national comparators - The number of women who received care in labour in an MLU and then transferred to the Consultant Unit (including in utero and postnatal) / the number of women booked for MLU but transferred who were not in established labour / the reasons for transfer / the number of women who deliver at home and are transferred
  4. Compare with local / national comparators - Neonatal transfers to Neonatal Unit (NNU) from MLUs
  5. Compare with local / national comparators - Mileage, response time and time to transfer to Consultant Unit / Neonatal Unit at RSH from Ludlow, Oswestry, Telford and Bridgnorth MLUs. Include details as above for alternative routes i.e. when primary route is blocked
  6. Intrapartum Care Clinical Guideline 55 - Women should be offered the choice of planning birth at home, in a midwife-led unit or in an obstetric unit
  7. Cost of each MLU per annum to include services and other costs and compare with comparator sites (e.g. rent)
  8. Training - what joint training of midwives and paramedics is in place and how is this done
  9. What clinical governance structures are in place to discuss governance issues in each MLU

## Summary of evidence

There are five Midwife Led Units (MLU) that form the 'spokes' of the maternity services in Shropshire (the Consultant Unit being the 'hub'). The MLUs are located in:

- Bridgnorth (Bridgnorth Community Hospital)
- Oswestry (Robert Jones and Agnes Hunt Orthopaedic Hospital)
- Ludlow (Ludlow Community Hospital)
- Telford (Wrekin Unit, Princess Royal Hospital site)
- Shrewsbury (Royal Shrewsbury Hospital site) - this is an alongside unit (AMU)

All the MLUs are 'free standing' units with the exception of Shrewsbury which is 'alongside' the Consultant Unit.

The MLUs are run by experienced midwives who are available 24 hours a day and are able to give mothers all the support needed during pregnancy, labour and the early days with the baby. There are no obstetric doctors on site but midwives have 24 hour access to consultants and can discuss and refer any problems that arise during pregnancy, labour or post-partum (after birth).

The philosophy of care within MLUs is based on the view that pregnancy and birth are normal physiological processes and women are supported to embrace this view. The environment of MLUs in Shropshire has been described as 'old and homely' by service users who participated in the focus groups which were a fundamental part of this review. There

was also overwhelmingly positive feedback in relation to care women and their partners received during the pregnancy, labour or post-partum period in the MLUs.

In 2005 the government made a commitment to offer women a safe, high quality and accessible service. This meant a choice in place of maternity care and birth. The three choices in place of birth included a home birth, birth in MLUs and birth in an Obstetric Unit (DOH, 2007).

Women choosing to give birth in a Shropshire MLU need to be deemed as 'low risk' pregnancies and meet the NICE intrapartum guideline criteria for 'low risk' birth.

- **Number of deliveries per MLU**

The table below outlines the number of deliveries in the MLUs for the period April 2012 March 2013.

MLU	Number of admissions	Number of births			Number of other births attended by unit midwives	
		Intended MLU	Women birthed in MLU	Unintentional births (e.g. out of county, concealed pregnancy)	Home confinement	Water
RSH and Community	2492	1111	421	164	21	46
Wrekin and Community	1354	867	401	131	49	57
Oswestry and Community	415	198	72	14	5	0
Ludlow and Community	230	138	71	10	6	4
Bridgnorth and Community	237	174	68	10	6	1

The numbers of births are lowest in Bridgnorth, Oswestry and Ludlow and are significantly higher in Telford and Shrewsbury (this is an alongside unit). The low birth rates in the first three MLUs pose questions with regard to midwives working in these units being able to maintain their skills and knowledge, and the value for money of these units.

During the review process it was identified that the Shropshire MLUs provided a wide range of services such as antenatal clinics, scanning clinics, intrapartum and post-partum care and are therefore not just 'birthing centres'. There was a variation in what services each MLU provides and the costs of services across the MLUs were inconsistent. Going forward, under Payment by Results, the commissioners will reimburse providers based on agreed outcomes, quality and women's experience. This will aim to minimise unnecessary interventions across the whole of the maternity pathway. MLUs are best placed to support this; however further work is crucial to define the practicalities of embedding the role of MLUs in the patient pathway and demonstrating value for money.

The matter of midwives being able to maintain their skills and knowledge is difficult to address as there is no national guidance or evidence that identifies the minimum number of births (home births or in a MLU) a midwife has to undertake to maintain competence. There is also no guidance on the minimum number of deliveries that need to be undertaken within a MLU from a point of view of safety and value for money.

To note, the Trust Special Administrator's (TSA) review of the Mid Staffordshire Maternity Services did not recommend a MLU because it was deemed that an average of one birth per day would be too few for midwives to keep their skills up to date.

Notwithstanding the above, there is a rotation programme for midwives in Shropshire from the MLUs into the Consultant Unit. However, the rotation programme needs to be reviewed and made more robust taking into consideration the number of deliveries in each unit. This is also discussed in the Workforce work stream section.

- ***Number of women who received care in labour in an MLU and then transferred to the Consultant Unit***

The table below outlines the number of women who received care in labour in an MLU and then transferred to the Consultant Unit during labour for the period April 2012 to March 2013. The reasons for transfer include: delay in first, second and third stage of labour, epidural request, meconium stained liquor and an abnormal Cardiotocography (CTG).

MLU	Number of transfer during labour	As a % of total number of women who began labour in MLUs
*RSH and Community	163	28%
Wrekin and Community	126	24%
Oswestry and Community	29	29%
Ludlow and Community	21	23%
Bridgnorth and Community	21	24%

\*The RSH MLU is an 'alongside' unit and therefore the thresholds for booking low risk women is lower due to the immediate access to the Obstetric (Consultant) Unit.

The Birthplace Study suggests that there is a higher likelihood of women having their first baby transferring to an Obstetric (Consultant) Unit during labour or shortly after birth. The rate for transferring was 36% if the woman was booked in a 'free standing unit' and 40% in an 'alongside' unit. In women having their second or subsequent babies the transfer rate is 9% if the woman was booked in a 'free standing unit' and 13% in an 'alongside' unit.

The transfer rates in Shropshire range from 23% to 29% which is below the rate indicated by the Birthplace Study. However the local rates do not differentiate between women having their first babies and women having their second or subsequent babies as this information was not available for the review.

- **Number of women booked for MLU but transferred who were not in established labour**

The table below outlines the number of women booked to deliver in a MLU but transferred to a CLU who were not in established labour for the period April 2012 March 2013. The reasons for transfer include: address change, patient preference, unit full, absence of foetal heartbeat, alcohol misuse, bleeding, change to maternal risk, change to foetal risk, cord prolapse, high head, hypertensive disease of pregnancy, malpresentation, poor foetal growth, post term and prolonged rupture of membranes. The transfers are appropriate.

MLU	Number of transfer before labour	As a % of MLU antenatal bookings
RSH and Community	691	47%
Wrekin and Community	471	18%
Oswestry and Community	111	22%
Ludlow and Community	56	17%
Bridgnorth and Community	96	21%

*NB - this refers to number of patients booked in MLU and then transferred to Consultant Unit, it has not been possible to split data into post 37 weeks or prior to reaching term due to category change (as a result of choice, change in risk status etc.)*

- **Neonatal Unit (NNU) transfers from MLU**

This is covered in the clinical outcomes, indicators and activity data – maternal and neonatal work stream section.

- **Transfer distance and times**

As part of the review, the West Midlands Ambulance Service (WMAS) were requested to provide information with regard to transfer times and compliance within the defined timeframes. Women living in rural areas will have concerns around transfer times and this will have an impact on their choice of place of birth. The tables that follow provide contextual information about distance, average travel times and WMAS level of compliance.

The table below shows the distances and average times of transfer from each MLU to the Consultant Unit, Royal Shrewsbury Hospital.

MLU	Distance to Consultant Unit Royal Shrewsbury Hospital	Average journey time to Royal Shrewsbury Hospital
Oswestry	17.8 miles	26 minutes
Ludlow	29.7 miles	42 minutes
Wrekin	18.6 miles	27 minutes
Bridgnorth	23.8 miles	34 minutes

The table below shows average travel times by ambulance from the MLUs as per postcode to the Shrewsbury Hospital. This average is based on the activity for ambulance travel times during 2012/13.

MLU	Number of transfers	Average journey time to Royal Shrewsbury Hospital
Oswestry	36	21 minutes
Ludlow	17	38 minutes
Wrekin	315	23 minutes
Bridgnorth	24	31 minutes

The table below shows the average ambulance response times to the MLUs for April 2012 - March 2013 and the number of transfers.

MLU	Number of transfers	Average overall response time – of the ambulance to the MLU in Minutes
Oswestry	36	19.5 minutes
Ludlow	17	24.8 minutes
Wrekin	320*	12.5 minutes
Bridgnorth	24	19.3 minutes

\*5 transfers went out of county

An audit of transfers between 1 April 2012 and 31 March 2013 was undertaken by maternity services which stated that “in all cases there was appropriate transfer in line with NICE 2007 Intrapartum Guidelines 2007 (IG). Time taken to transfer patient from MLU to CLU at RSH was appropriate.”

- **Joint training programme between MLU staff and ambulance service**

There is ongoing work to bring maternity and ambulance personnel together for more training. There was a Neonatal Stabilisation Programme held in March 2012. There is a joint training session meeting planned for October 2013, with the joint training scheduled to commence before the end of the year.

- **Cost and cost effectiveness**

As custodians of the public purse, Shropshire CCG has a duty to ensure best value when dispensing funds. The resource allocation is finite and consequently requires prudent investment in all areas to ensure the maximum benefit to our patients.

The Governing Body receives regular assurance that all expenditure is made in adherence to the highest professional standards and public accountability from the Chief Finance Officer.

The Birthplace cost effectiveness study evaluated the cost for planned births in four settings. The costs included all resources used, cost of intrapartum care, post-partum care and associated complications. For ‘low risk women’ the cost to the NHS of intrapartum care, post-partum care and associated complications is lower for births planned in a MLU (‘free standing’ or ‘alongside’) compared with birth planned in a Consultant Unit. Furthermore, it was noted that the outcomes for ‘low risk’ women were better in a non-Consultant Unit setting and resulted in a significant increase in ‘normal births’. The Birthplace Study

suggests that all planned births in a non-Consultant Unit led to a reduction in costs because of lower medical intervention resulting in increased ‘normal births’.

In Shropshire only 25% of ‘low risk’ women have their babies in a MLU (‘free standing’ or ‘alongside’). The costs detailed in the tables below indicate that the costs of Shropshire MLU births (based on the information provided) are far higher than detailed in the Birthplace Study. Therefore increasing the number of births in MLUs and maximising capacity within these units will decrease the cost per birth.

### Costs per place of births

- **Birthplace Study costings**

Place of Birth	Birthplace Study costings		Shropshire
	Nulliparous woman	Multiparous woman	
Consultant Unit	£2,075.2	£1,142.4	This level of data was not available from maternity services within the review timeframe
Alongside Midwife Unit	£1,983.1	£991.3	
Free standing Midwife Unit	£1,912.5	£968.9	
Home	£1,793.7	£780.4	

- **Maternity services costings**

Activity	RSH & community	Wrekin & community	Oswestry & community	Ludlow & community	Bridgnorth & community	Oswestry, Ludlow Bridgnorth MLUs totals
Community bookings and antenatal appointments	1486	2685	494	330	457	1281
Number of antenatal follow up attendances	7302	13553	2278	1692	2209	6179
Ward attenders at MLU (excluding bookings and antenatal appointments)	2306	3808	288	195	344	827
Parentcraft classes	303	1951	48	352	572	972
Aquanatal classes	9			304		304
Water birth workshops	0	388				
Breastfeeding workshops	0	714				
Number of in-patient admissions	2492	1354	415	230	237	<b>882</b>
Number of intended births	1111	867	198	138	175	<b>511</b>
Number of births	421	401	72	71	68	<b>211</b>
Unintentional births	164	131	14	10	10	<b>34</b>
Other births/ home confinements	21	49	5	6	6	<b>17</b>
Water births	46	57		4	1	<b>5</b>
Number of women transferred from MLU before labour, including at onset of labour	691	471	111	56	96	<b>263</b>
Number of women transferred from MLU during labour	163	126	29	21	21	<b>71</b>
NNU transfers from MLU to CU	21	6	2	2	3	<b>7</b>
Staffing						
Midwives early	2	long day 2	1	1	1	
Midwives late	2		1	1	1	
Midwives night	2	2	1	1	1	
WSA early	1	long day 1	1	1	1	
WSA late	1		1	1	1	
WSA Night	1	1	1	1	1	
Costs - rent annual			£174,748	£91,527	£66,385	<b>£332,660</b>
Costs - Pay budget annual	£1,313,730	£1,654,319	£626,099	£560,221	£554,723	<b>£1,741,043</b>
Non pay budget annual	£134,694	£107,768	£33,962	£24,105	£16,346	<b>£74,413</b>
<b>Total annual</b>	<b>£1,448,424</b>	<b>£1,762,087</b>	<b>£834,809</b>	<b>£675,853</b>	<b>£637,454</b>	<b>£2,148,116</b>

## ***Audit***

Audit details and outcomes are included at Appendix 7.

## ***Associated strategies, policies, guidance and frameworks***

The table in Appendix 8 outlines the strategies, policies and procedures supplied by maternity services to inform the review and comments on compliance.

## ***Areas of good practice***

- There is evidence that 'low risk' women birthing in the MLU ('free standing or 'alongside') are less likely to have avoidable interventions, and have good outcomes.
- MLUs provide another option for place of birth.
- There is support for MLUs from the wider multidisciplinary maternity team which is central to providing a safe and high quality service.
- MLUs are popular with women who have given birth or received care in one and state that it feels more homely and that they feel more supported there.

## ***Areas for development***

- Develop a strategy in conjunction with commissioners to promote and increase the number of deliveries in MLUs, thereby creating a thriving service that promotes choice, women centred care and value for money. This includes the following:
  - Articulate costs of services / activities provided in each MLU and demonstrate service line reporting.
  - Develop, implement and monitor a systematic and strict rotation and development programme for all midwives.
  - Build on the joint training and pilot the potential of a rolling programme of joint development with WMAS with regard to stabilisation and transportation of mother and/or baby.
- Implement a marketing campaign to promote MLUs once a better understanding is gained about the potential service users, demographics and geography issues that may have an impact on choice of birth in a MLU (e.g. distance to a Consultant Unit) and how these can be mitigated.
- Promote and increase the number of deliveries in MLUs, thereby creating a thriving service that promotes choice, women centred care, value for money and ongoing workforce capability and capacity.
- Consider becoming a pilot site for 'costing sites' as noted by the LSA local lead.
- Ensure that the time for ambulance response relates to an ambulance and not a car or motorbike which is inappropriate to undertake a transfer. Further clarification to be sought from WMAS.
- Ensure that specific targets are set and monitored for response to maternal transfer requests by WMAS.

## ***Conclusions***

The hub and spoke model of care in Shropshire is deemed to be safe and of a good standard and this is reflected in the feedback from service users, partners and staff. This should be used as a stimulus to maximise the MLUs. There is a significant piece of work to be undertaken in promoting the MLUs and creating a thriving and vibrant service, alongside understanding the monitoring of rotation programmes for midwives working in the MLUs.

# Work stream 4: Workforce

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## **Key standards and good practice**

- RCOG (2007) *Safer Childbirth*
- NHS Litigation Authority (2013) *Clinical Negligence Scheme for Trusts, Maternity Clinical Risk Management Standards*
- NICE (2007) *Intrapartum Care*
- Nursing and Midwifery Council (2012) *Midwives rules and standards*
- King's Fund (2011) *Staffing in Maternity Units. Getting the right people in the right place at the right time*
- Department of Health (2003) *Report to the Department of Health Children's Taskforce from the Maternal and Neonatal Workforce*

1. Safer Childbirth / Clinical Negligence Scheme for Trusts, Maternity Clinical Risk Management Standards - Review of midwifery, obstetric and anaesthetic staffing level compliance with good practice or evidence of working towards good practice
2. Intrapartum Care Clinical Guideline 55 - Midwives' competence in the early recognition of severely ill pregnant women who require immediate and appropriate multidisciplinary specialist care / electronic foetal monitoring / use of oxytocins / management of intrauterine growth restriction of the foetus
3. Clinical Negligence Scheme for Trusts, Maternity Clinical Risk Management Standards - Midwife vacancies and attrition rate and its impact on services to include long term retention and recruitment of staff
4. Midwives rules and standards - Ratio of midwife supervisors to midwives / numbers of midwives who have had an annual review / preceptorship programme for newly qualified midwives
5. Clinical Negligence Scheme for Trusts, Maternity Clinical Risk Management Standards - Education and training programme attendance / records of mandatory training areas and percentage trained against each area
6. Hearing the views of staff - Feedback from staff focus groups
7. Birthrate plus - Workforce planning

## **Summary of evidence**

The workforce is key to the delivery of effective, efficient and safe services and staff need to be supported by adequate support, training and policies/procedures/guidelines in order to fulfil their role.

This section identifies the various aspects which support the maternity services workforce to provide a quality and safe service and some of the specific standards which should be met, or for the organisation to be working towards achieving.

## **Staff feedback**

### **Focus group sessions**

Focus group sessions were carried out at the five Midwife Led Units (Bridgnorth, Ludlow, Oswestry, Wrekin and Shrewsbury), the Consultant Unit at RSH, and at Newtown and Welshpool in Powys. The size of the groups varied at each location, depending upon the availability of staff. The structure of the sessions was consistent, with a facilitator (independent of SaTH) who led discussions with an initial focus on what was seen as positive and good practice within maternity services, then also asking for views on areas that could be improved from a staff perspective.

The feedback from these sessions has been collated and themed and is included at Appendix 6. A summary of the main themes is included below. Where themes were similar across all areas these are grouped together as 'all units', where themes were similar across all the MLUs these are grouped together as 'MLUs'. Themes and comments that are particular to the Consultant Unit (CLU) and the Shrewsbury MLU (due to it being an alongside unit rather than a peripheral (free standing) unit) are listed separately. The feedback from Powys is listed separately.

- **Shropshire**

What works well	Areas for improvement / concerns
<p>General (CLU)</p> <ul style="list-style-type: none"> <li>- Patient care of a good, consistent standard</li> <li>- Patient to nurse ratio is good</li> <li>- Very high standard from well-trained midwives</li> <li>- Not many emergency transfers in labour</li> <li>- Positive about bereavement service</li> </ul> <p>General (MLUs)</p> <ul style="list-style-type: none"> <li>- Staff are passionate about and proud of their units</li> <li>- Staff consider the MLUs essential and the hub and spoke model unique and a 'privilege'</li> <li>- 'Midwifery care in Shropshire is fantastic'</li> <li>- Good links between MLUs and Consultant Unit – MLUs help take the pressure off the Consultant Unit</li> <li>- Standalone units promote the normality of birth</li> </ul>	<p>General (CLU)</p> <ul style="list-style-type: none"> <li>- Patient care impacted on by staff shortages, lack of time</li> <li>- Quite a high induction rate (24%) – slightly higher than national average</li> </ul> <p>General (MLUs)</p> <ul style="list-style-type: none"> <li>- One suggestion that if there was access to a wider range of pain relief in the latent phase of labour, some transfers could possibly be avoided</li> <li>- Women sometimes disappointed that they cannot be booked to deliver at the MLU, but it is for clinical reasons and would not be appropriate</li> </ul> <p>General (Shrewsbury MLU)</p> <ul style="list-style-type: none"> <li>- Postnatal ladies do not get the care they should and discharge themselves as there is no support</li> </ul>
<p>Access and choice (MLUs)</p> <ul style="list-style-type: none"> <li>- MLUs a good resource, offer women choice</li> <li>- Flexible - mums know they can ask to be seen even if it is a full clinic</li> <li>- If patient is not able to get to clinic the midwife will telephone them to make sure they are alright</li> <li>- Shropshire massive area to cover, nice to have smaller units to work in</li> </ul>	<p>Access and choice (Shrewsbury MLU)</p> <ul style="list-style-type: none"> <li>- A patient was denied a homebirth because the midwife who was on call was taken to ward 20 (delivery suite)</li> </ul>
<p>Team working (all units)</p> <ul style="list-style-type: none"> <li>- Very good team work, supportive of each other, get on well, mutual respect</li> <li>- Integrated service, staff know one another as they move about</li> <li>- Great deal of team cooperation to ensure the Consultant Unit can remain safe, a lot</li> </ul>	<p>Workload (all units)</p> <ul style="list-style-type: none"> <li>- Paperwork / workload levels going up and up</li> <li>- A lot of expectations</li> <li>- Notes demand much more time now, more staff required if good record keeping to be maintained</li> </ul>

<p>of goodwill and flexibility (e.g. on call system)</p> <ul style="list-style-type: none"> <li>- Praise for Healthcare Assistants (HCAs) and Women's Services Assistants (WSAs) – invaluable help and support</li> </ul> <p>Team working (MLUs)</p> <ul style="list-style-type: none"> <li>- Staff work well together, help each other out and share jobs so multi-skilled and kept up to date</li> <li>- Good communication</li> </ul>	
<p>Staffing (CLU)</p> <ul style="list-style-type: none"> <li>- Increase of medical staff has made a big difference</li> <li>- If unit busy during the night, on call midwives pulled in</li> <li>- Use of bank midwives – valuable service</li> </ul> <p>Staffing (all units)</p> <ul style="list-style-type: none"> <li>- Positive about rotation system – keeps skills up to date and appreciation of all areas of the service</li> <li>- Staff work really hard, help each other out, regularly stay later than shift</li> </ul> <p>Staffing (Shrewsbury MLU)</p> <ul style="list-style-type: none"> <li>- Midwives changed to a 12 hour shift, means you get a good break and not overworked</li> </ul>	<p>Staffing (CLU)</p> <ul style="list-style-type: none"> <li>- Issue with general lack of staff</li> <li>- Need to call on other areas which then impacts on their service</li> <li>- Suggestion to possibly see postnatal clinics introduced (towards end of 10 days) – reduce time spent travelling by community midwives</li> <li>- If on call midwives called in every night, can be a problem as they still have to do their day shifts</li> <li>- Looked at having an on call midwife for 24 hour cover. Funding means this has been put on hold</li> </ul> <p>Staffing (MLUs)</p> <ul style="list-style-type: none"> <li>- Units can sometimes be short-staffed, particularly when staff are asked to cover shifts at RSH at short notice – on call midwife is then called in to cover the unit</li> <li>- Bridgnorth lost 56 midwife hours a week when new unit opened in 2006, units getting busier</li> <li>- Apprehension (Bridgnorth) about big changes coming up with staff rotating. Feeling that perhaps consideration could be given to rotating those near to retirement, continue to update their skills by spending time at Shrewsbury</li> </ul> <p>Staffing (Shrewsbury MLU)</p> <ul style="list-style-type: none"> <li>- General lack of staff</li> <li>- No guidance on rotas</li> <li>- Management could look at the individual skills, i.e. some people would prefer to work permanent nights</li> <li>- Currently different shift hours and patterns –</li> </ul>

	<p>once move to Telford, everyone should do same 12 hour shifts and make it more consistent and people would feel better</p> <ul style="list-style-type: none"> <li>- MLU midwives frequently taken to ward 20 – can impact on MLU, MLU midwives miss breaks</li> <li>- When they look at numbers of patients they only look at who is in, not those potentially coming in or the phone calls the unit receives</li> <li>- No paediatricians at the weekend (paediatricians are on call)</li> </ul>
<p>Support and supervision (all units)</p> <ul style="list-style-type: none"> <li>- Good support and supervision</li> <li>- Very good mentoring service to students</li> </ul> <p>Skills and training (all units)</p> <ul style="list-style-type: none"> <li>- Positive about training – protected time</li> <li>- Rotation of midwives – seen as very good as no one gets too settled in one area, skills kept up to date</li> </ul> <p>Skills and training (MLUs)</p> <ul style="list-style-type: none"> <li>- Midwives are able to practise their art and midwifery skills rather than ‘obstetric nursing’</li> <li>- Training / emergency days / neonatal resuscitation / two midwifery study days per year / statutory training / drills for emergency procedures</li> <li>- Additional training for a number of midwives (Wrekin) in neonatal examination of newborn, means they can go out and carry out the examination which is only available 9-5 at RSH</li> </ul>	<p>Support and supervision (CLU)</p> <ul style="list-style-type: none"> <li>- Lack of time and capacity for mentoring and support for students</li> <li>- People not putting themselves forward as mentors, will be a problem in the future</li> <li>- Issues re supernumerary hours – should be protected period of training for newly qualified midwives</li> </ul> <p>Support and supervision (Shrewsbury MLU)</p> <ul style="list-style-type: none"> <li>- Concern among newly qualified midwives about being pulled onto ward 20 and not being familiar with procedures</li> </ul> <p>Skills and training (Shrewsbury MLU)</p> <ul style="list-style-type: none"> <li>- Due to shortage of staff, only get to go on mandatory training</li> </ul>
<p>Governance (all units)</p> <ul style="list-style-type: none"> <li>- Staff feel supported by clinical governance <ul style="list-style-type: none"> <li>- very thorough case review process, supportive process, part of culture</li> </ul> </li> <li>- Risk assessment at all stages is instinctive</li> </ul> <p>Governance (CLU)</p> <ul style="list-style-type: none"> <li>- Consultant now visits antenatal and postnatal wards twice a day to get awareness of any high risk cases or any risks developing</li> <li>- Audit very good and very complete, staff involved</li> </ul>	<p>Governance (CLU)</p> <ul style="list-style-type: none"> <li>- Guidelines sometimes seen as too prescriptive – ideal is best care without going overboard</li> </ul>

<ul style="list-style-type: none"> <li>- Governance meetings well attended and useful, good decisions made, good structure</li> </ul> <p>Governance (MLUs)</p> <ul style="list-style-type: none"> <li>- Staff follow pathways in the case of emergencies – not a feeling of isolation, well trained and confident</li> </ul>	
<p>Information sharing (all units)</p> <ul style="list-style-type: none"> <li>- Good process for information sharing</li> <li>- Positive about Medway (new maternity information system)</li> </ul>	<p>Information sharing (all units)</p> <ul style="list-style-type: none"> <li>- Medway (patient information system) – looking for funding for digital pens and addition hardware to support use in the community</li> </ul> <p>Information sharing (Shrewsbury MLU)</p> <ul style="list-style-type: none"> <li>- Lots of memos but hard to get the time to read them, always receiving lots of updates</li> </ul>
<p>Patient feedback (all units)</p> <ul style="list-style-type: none"> <li>- A lot of compliments, thank you cards etc. received</li> <li>- Friends and Family Test recently implemented, good to get immediate feedback</li> </ul>	<p>Patient feedback (Shrewsbury MLU)</p> <ul style="list-style-type: none"> <li>- Receive verbal complaints where patients are told they can go, but are then kept waiting because either staff have been called away to ward 20 or another patient who is about to deliver comes to the unit</li> <li>- Patients who are postnatal cannot see who is going into the labour ward, think the nurses are just sitting in the office</li> <li>- Expectations of patients are very high and more education is needed around what to expect</li> </ul>
<p>Community-based (MLUs)</p> <ul style="list-style-type: none"> <li>- Clinics, classes held locally and/or on site - particularly important in rural areas where transport is an issue</li> <li>- Mothers who don't necessarily go to parentcraft (e.g. younger mothers, more socially disadvantaged) get the extra support postnatally</li> <li>- Family-centred and local, community-based</li> </ul>	
<p>Environment (MLUs)</p> <ul style="list-style-type: none"> <li>- Friendly, 'home from home'</li> <li>- Relaxed, supportive, safe, reassuring, give women confidence</li> </ul>	<p>Environment (MLUs)</p> <ul style="list-style-type: none"> <li>- Some units would like more funding to be able to further enhance the environment</li> </ul>
<p>Continuity / dedicated time (MLUs)</p> <ul style="list-style-type: none"> <li>- Good quality, dedicated, continuity of care</li> <li>- Midwives work on the units and in the community, deliver antenatal and postnatal care – see women through the whole process, so women tend to get to know all</li> </ul>	

<p>the staff well (particularly on smaller units)</p> <ul style="list-style-type: none"> <li>- Team working – share patients, swap patients if they know patients they have seen before</li> </ul> <p>(Peripheral units)</p> <ul style="list-style-type: none"> <li>- Extra time for women – can rest, get extra support following the birth, ask questions, talk through concerns, not rushed</li> </ul>	
<p>Breastfeeding support (MLUs)</p> <ul style="list-style-type: none"> <li>- All midwives and support staff trained to same level in breastfeeding support</li> </ul>	<p>Breastfeeding support (Shrewsbury MLU)</p> <ul style="list-style-type: none"> <li>- Need consistency around breastfeeding support</li> <li>- Patients go home because they cannot get to see anyone, then they need help later on at home</li> </ul>
<p>Services and facilities (MLUs)</p> <ul style="list-style-type: none"> <li>- Facilities that promote natural childbirth, normality of birth</li> <li>- Consultant clinics, day assessment unit (PANDA)</li> <li>- Scanning, available in community at Sutton Hill (Wrekin)</li> <li>- Triage service for different clinics and specialities (RSH and Wrekin)</li> <li>- Early pregnancy service Monday-Friday for two hours (Wrekin)</li> <li>- External support and specialist advice available, e.g. diabetes, mental health (RSH, Wrekin)</li> <li>- Translation service</li> </ul>	<p>Services and facilities (MLUs)</p> <ul style="list-style-type: none"> <li>- Would like more funding for more equipment / facilities (e.g. for antenatal classes, birthing couches)</li> <li>- Would like longer hours for consultant clinics and day assessment unit (Wrekin)</li> <li>- Lack of space and equipment in 'community room' at Wrekin</li> <li>- High demand for clinics and classes – could do with longer / more sessions to reduce waiting times</li> <li>- Ludlow – existing facility needs some cosmetic updating</li> </ul> <p>(Shrewsbury MLU)</p> <ul style="list-style-type: none"> <li>- Would be useful to see if women attending parent classes stop at home longer before coming to hospital</li> <li>- Need more resources about home births Need someone who is trained in hypno-birthing</li> <li>- Aqua-natal classes no longer exist</li> <li>- Resources and facilities need improving</li> </ul>
	<p>Move of services to Telford (MLUs)</p> <ul style="list-style-type: none"> <li>- Concerns in some (not all) of the MLUs due to increased distance/travel time, issues with transport links</li> <li>- Feel the care for those in most need will be compromised</li> <li>- More women could choose to deliver out of county (Hereford / Wrexham)</li> </ul> <p>Move of services to Telford (Shrewsbury MLU)</p> <ul style="list-style-type: none"> <li>- Midwives not happy, majority live in</li> </ul>

	<p>Shrewsbury</p> <ul style="list-style-type: none"> <li>- Patients opting for home births</li> <li>- Service for Welsh patients not as good</li> <li>- Patients who did not know much about it are terrified of having their babies in Telford, too far</li> </ul>
	<p>Ambulance response times</p> <ul style="list-style-type: none"> <li>- Ongoing issues in some areas</li> <li>- WMAS not always familiar with local area</li> <li>- Paramedic sometimes sent on bike / by car – ambulance is what is needed</li> </ul>

- **Powys**

<b>What works well</b>	<b>Areas for improvement / concerns</b>
<p>Triage Midwife</p> <ul style="list-style-type: none"> <li>- Excellent services</li> <li>- Efficient and helpful</li> </ul>	<p>Transferring women</p> <ul style="list-style-type: none"> <li>- Getting better but some challenges in relation to perceived negative attitudes and communications when midwives want to transfer women</li> </ul>
	<p>Postnatal Plan</p> <ul style="list-style-type: none"> <li>- Where women have other conditions, e.g. high BP, the discharge plan is not completed and therefore makes it difficult both for midwives and GP to understand the ongoing plan of care for the woman</li> </ul>
	<p>Antenatal</p> <ul style="list-style-type: none"> <li>- There is a perception that antenatal clinics on a Friday feel rushed</li> <li>- Women’s experience of the scan appointment is not always positive, however it is perceived that this is improving</li> <li>- When women are seen at SaTH antenatal clinics the documentation does not always clearly document place of birth following the consultation with the obstetrician and this then needs to be chased up by the midwives</li> </ul>

- ***Semi-structured interviews with medical staff at Shrewsbury***

As well as the focus group sessions, semi-structured interviews were carried out with medical staff at Shrewsbury by an external Obstetrician. The themes from these interviews were similar to those listed above (more detail is included at Appendix 6) and the summary and his recommendations are repeated below:

**Summary**

- “It would appear that this is a very vibrant unit which functions to a high level.

- The staff members interviewed are all enthusiastic champions of their service and have a genuine pride in it.
- The governance systems in place appear to be functioning and appropriate for the needs of the service.
- There are clear indications that there is an open culture with a desire to learn from incidents and other outcome measures.
- Evidence of constant service reviews and improvements were described.
- The move to Telford is seen as a positive development.
- The likely pressures for future workforce needs have been considered and are under review. The move to a more Consultant delivered obstetric service is recognised.
- The Midwifery Led Units are regarded as a safe and effective part of the overall maternity service.
- The Midwifery workforce and the level of their practice is valued by Obstetricians, Paediatricians and Doctors in Training.
- The unit is actively working towards the achievement of CNST Level 3.
- I heard no evidence to suggest that there are any deficiencies in the systems required to monitor the safety and quality of the service.”

- ***Other feedback received***

Other feedback, received via the dedicated maternity services review email address, also addressed similar themes to those described above. Additional points were made as follows:

- When the maternity units at Chester and Wrexham close to new patient admissions, the Royal Shrewsbury maternity unit takes on their care. This increase in patient admissions on the Consultant delivery suite and Midwife Led Unit leads to a significant increase in the work load. Stress levels for staff, patients and their relatives are also increased during this time. When the other hospitals shut the increase in the work load makes the risk of less than excellent care given to the patients more likely to happen.
- The midwives working on the community have a very heavy workload, which has increased over the past few years.
- The wish for more home births requires the community midwifery staff to do more frequent on-calls, which means fewer midwives are available to do clinics and home visits if they have been called out to a home birth.
- When the maternity Consultant Unit relocates to Telford it will leave the county west of Shrewsbury with little cover for maternity service requirements, whilst the east of the county already has access to care in Wolverhampton, Birmingham and Stoke-on-Trent.
- The de-skilling of clinicians
- The lack of communication between midwives and GPs. (This has also been raised with the CCG as a potential risk now that midwives only write in the midwifery notes and not in the practice notes.)
- Who actions blood results like FBCs.
- Whether or not to use notifications electronically.
- Insufficient communication between gynaecology and obstetrics.

## *Training and development*

- *Education and training programmes attendance*

The SaTH training needs analysis is an appendix to the Maternity Services Training Guideline; it is comprehensive and includes mental health training for midwives. It indicates the type and frequency of training as well as identifying which groups of staff need to undertake the training. This training includes some skills drills and live drills training and more formal training. Some training is provided in multi-disciplinary team (MDT) sessions. There is bi-monthly monitoring of training.

There is ongoing work to bring maternity and ambulance personnel together for more training. There was a Neonatal Stabilisation Programme held in March 2012. There is a joint training session meeting planned for October 2013 and joint training will follow before the end of the year.

It would be useful for the training needs analysis to identify specific staff in all sections rather than identifying RP (relevant professional) in some as this is open to misinterpretation.

A query was raised at the workshop on 18 September 2013, about limitation of some training such as PROMPT to non-permanent doctors. PROMPT (PRactical Obstetric Multi-Professional Training) is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working. SaTH have identified that this training was recent and has begun with this group, but as the programme rolls out it will encompass other staff including midwives and doctors.

- *Records of mandatory training areas and percentage trained against each area*

The Maternity Mandatory Training Progress report (August 2013) demonstrates that, apart from new / update training planned over 2013, the staff training had achieved over 75% attendance (in a rolling 12 month period or 24 months for biennial training) in most of the key areas. This being so, there are a number of topics which still need to attain this level. Since this is mandatory training it should be expected that most of the topics should be nearer to 100% and many are, but not all. This is monitored every two months by the trust and relevant reminders are sent to managers to follow up.

Without looking at individual records where training has not been completed, it is difficult to say whether there are differences in training achievement by site. Those on maternity leave, long term sick leave and unpaid leave are not included in the statistics.

The training progress report does not identify all of the training and a percentage trained, and does not include the specifics for the RPs (relevant professionals). Where training is mandatory this should be monitored for all training topics and groups of staff.

**Note:** It has been identified by SaTH that in the lower uptake areas, these figures include those who do not need the training rather than measuring against the cohort that do. It is suggested that to get an accurate picture of the true percentage trained, this should be amended to identify only the percentage of those who require the training.

The training progress report identifies the following for specific training as mentioned above for midwives:

- MEWS training (the early recognition of severely ill women) - 89%
- Electronic foetal monitoring updates - 79%
- Customised foetal growth – new / update training planned for 2013 - 46%

Mandatory training and updates are covered in the midwife's annual supervisory review. Mandatory training has to be completed prior to their submission of their annual Intention to Practice (ITP), which has to be signed by their supervisor of midwives, to the regulatory body. This should ensure that all midwives have completed all mandatory training and whether there are any development requirements.

Training for midwives in the community / MLU should be up to date in all areas as they are often working in isolation and away from immediate consultant obstetric / paediatric support. Training should be monitored so that it can be demonstrated that all staff remain current in essential training.

The service user experience work stream identified that there should be some greater emphasis on communications and customer care training and that this should include doctors.

## ***Staffing and leadership***

- ***Review of midwifery, obstetric and anaesthetic staffing level compliance with good practice or evidence of working towards good practice***

There is a Strategy for Staffing Levels for maternity services:

- Midwifery and support staff
- Obstetricians
- Obstetric Anaesthetists and Assistants

There is an Insufficient Staffing Contingency Plan for:

- Midwifery
- Anaesthetics
- Obstetricians

There is a Maternity Escalation Policy which is invoked when shifts cannot be covered and there are safety implications.

- ***Audits***

Annual staffing audits are undertaken and include:

- A staffing level audit for Midwifery (October 2012)
- An audit of labour ward cover (Obstetrics) (October 2011 – October 2012)
- An audit of labour ward cover (Anaesthetists) (October 2011 - October 2012)

These can be found at Appendix 7 and demonstrate that there is some shortfall in staffing which would be addressed if the Business Case as described below is approved and implemented. The audit demonstrates that the anaesthetic cover is greatly improved.

- **Business Case**

In addition there is a Business Case: Enhancing Quality and Safety in Obstetrics, dated 21 May 2013, which builds on a previous Business Case dated 2010 (some of which has already been implemented). The Business Case will support SaTH's assessment against NHS Litigation Authority Maternity Standards by showing commitment to increasing:

- Appropriate medical staffing (obstetric)
- Midwife to birth ratio (see below)
- Appropriate obstetric theatre staffing

- **Crude ratio of birth to WTE (whole time equivalent) midwives**

	2008/9	2009/10	2010/11	2011/12	2012/13
Burton	36.8	34.45	32.4	32.34	30.2
Mid Staffordshire	34.8	28.0	24.5	22.8	27.2
North Staffordshire	33.5	28.82	31.6	32.21	30.8
Shrewsbury & Telford	33.0	29.57	27.1	30.0	28.6

(Source: LSA)

**Note:** Minimum midwife to woman ratio (Safer Childbirth RCOG / CNST standard 1) is 1:28 for a safe level of service to ensure the capacity to achieve one to one care in labour. The midwifery total care ratios for services with more complex case mix must be determined locally after case mix (social and clinical determinants) and external workload assessment is done; this may mean a lower midwife to woman ratio up to 1:25.

If approved, the Business Case will address the recommendation for separate anaesthetic cover to critical care and obstetric services made in the West Midlands Quality Review Service (WMQRS) report.

If the Business Case is approved, the workforce will be increased by:

- 5.24 WTE Midwives
- 5 WTE Consultant Obstetricians
- Theatre staffing will be increased as per options (several options are offered).

- **Review of staffing documents – midwifery and support staff**

The documents relating to midwifery and support staff were reviewed by an external midwife and they appear to be robust, with adequate monitoring, systems for maintaining staffing levels and audit, with instigation of the Maternity Escalation Policy when necessary.

#### Points for further clarification / action

- The minimum midwife levels stated in the Business Case (page 19) uses 1:28 and 1:35 (RCM staffing standard in maternity services) which is different to the Safer Childbirth criteria which is referenced in the CNST standards. This needs to be updated along with further analysis of midwifery staffing requirements to meet CNST standards and the Business Case updated as necessary.

- **Review of staffing documents – medical**

The documents relating to medical staff were reviewed by the external Obstetrician and it was found that they “All appear to describe well thought through plans with options to achieve their implementation. These describe a state of service design and pressures which are common across current UK practice.”

The Obstetricians’ contract includes a statement that they will be expected to reside within 30 minutes or 10 miles by road of the base hospital whilst on call, which is in line with the national recommendation.

- **Midwife vacancies and attrition rate and its impact on services to include long term retention and recruitment of staff**

Midwifery collated averages for 2011/12	
Vacancy rate	9%
Sickness rate	3%
Maternity leave	4%
Staff attending occupational health for work related stress for the period 28.02.13 to 19.08.13	<5 (Includes self referrals and management referrals. Appointments from 1 to 6 per person in this period)

SaTH have identified that they do not have problems in recruiting or retaining midwifery staff and have a stable workforce. There is a mix of opinion as to whether the transfer of services to PRH from RSH in 2014 is good or bad and the potential impact on staffing should be considered.

- **Ratio of midwife supervisors to midwives**

	2008/09	2009/10	2010/11	2011/12	2012/13
Burton	12.9	12.0	12.0	11.9	12.5
Mid Staffordshire	13.4	15.4	14.2	13.3	13.8
North Staffordshire	13.1	16.4	12.7	13.0	14.2
Shrewsbury & Telford	16.7	17.5	21.3	21.3	16.3

(Source: Five year collation of LSA workforce and clinical data 2008/9 – 2012/13 for Shropshire and Staffordshire Area Team (LSA))

The ratio of supervisors to midwives was seen as an issue for the period 2010/12 and as a result of the implementation of a contingency plan had reduced to 16.3. SaTH now advise that the current rate is 14.5 and they are attaining the LSA requirement of not exceeding 1:15. Supervisors of midwives now have more midwives to supervise and have been allocated more time to do so. As can be seen from the table above this is a great improvement on previous years.

- **Numbers of midwives who have had an annual review**

Supervisor of midwives (SOM) documentation for the annual reviews is specific to Labour Ward, MLU, Scanning and Antenatal, and there is also a generic document. All midwives have had an annual review and have completed and submitted their ITP documentation.

- **Preceptorship programme for newly qualified midwives**

There is a 12 month preceptorship programme in place for all newly qualified midwives, with placements on both the consultant labour ward and MLU (RSH or PRH). It identifies skills, objectives, core competencies and support, training needs / action plans to achieve these.

- **Education**

A document confirming NMC revalidation has been received as well as a copy of the educational audit. Both had some commendations and recommendations for maternity services.

**Commendations included:**

- Ludlow MLU for high quality women-centred practice.
- Whitchurch Community Midwifery on their induction pack for new staff and students and a student induction pack.

**Recommendations included:**

- Ludlow, RSH Community Midwifery and Wrekin MLU regarding mentors attending annual updates.
- Wrekin to explore ways of formalising service user feedback on student performance.

- **Student evaluations**

Feedback was mostly positive.

## **Areas of good practice**

- Medical staffing is as good as it gets without additional funding being made available.
- One to one midwife care in labour is now achieved throughout the county.
- Midwife recruitment and retention - no problems have been experienced in Shropshire to date.
- A robust training programme is in place and has a variety of training methodologies including skills drills and MDT training.
- Lots of positive feedback was received from staff about the integrated service.
- Staff are very positive about the integrated service and how it works, although they can become frustrated when they have to move mid shift.
- The rotation system helps staff to see the service through the eyes of staff in different areas and to appreciate challenges and rewards.
- Midwifery staff require more skills updates / training than other healthcare professions which is not covered in the budget or cover. SaTH have innovative ways to overcome this such as evening meetings with a meal and update – addressing issues / interest / needs.

## **Associated strategies, policies, guidance and frameworks**

The table in Appendix 8 outlines the strategies, policies and procedures supplied by maternity services to inform the review and comments on compliance.

## Areas for development

- Rotation of midwives – there should be a regular robust rotation programme. This is currently under review by SaTH. A small group of staff may need to be addressed.

### Staffing

- Need to identify whether suitable medical staff are available in order to ensure that adequate medical staff are available for recruitment – within financial constraints. This is against a backdrop of a shortage of Obstetric consultants – as identified to the team during the review.
- The minimum midwife levels stated in the Business Case (page 19) uses 1:28 and 1:35 (RCM staffing standard in maternity services) which is different to the Safer Childbirth criteria which is referenced in the CNST standards. This needs to be updated along with further analysis of midwifery staffing requirements to meet this standard, and the Business Case updated as necessary.
- Implement any aspects of the Business Case as may be approved in order to increase staffing and move closer to attaining external standards.

### Education and development

- Implement a strategy to provide midwives working in a MLU or attending home births with extended neonatal resuscitation skills (Accredited Neonatal Life Support Training).
- Education to include more soft skills training in communications and customer care, and for this to include doctors.
- To take action to increase mandatory training uptake to at least 75% and to aim for higher levels.
- To consider how training is reported and amend this to identify the percentage of staff who have been trained as a percentage of those who require the training, rather than as a percentage of the total for that staff group (i.e. including those who do not require training).
- Continue to roll out the PROMPT training for all staff as appropriate.
- Continue to identify innovative ways of addressing the lack of training allocated time and budget.
- Within the training needs analysis, consider identifying specific staff in all sections rather than identifying RP (relevant professional) in some, as this is open to misinterpretation.
- Monitor training attendance so that it can be demonstrated that measures are in place to enable **all** MLU/Community staff to remain current in essential training.
- Develop, implement and monitor a systematic and strict rotation and development programme for all midwives.
- Build on the joint training and pilot the potential of a rolling programme of joint development with WMAS with regard to stabilisation and transportation of mother and/or baby.

### **Recommendations from semi-structured interviews with medical staff**

- The CCG review process should include direct contact with clinicians to seek evidence of governance arrangements.

- The CCG review should seek evidence from the CNST submission process to assure itself of the governance systems in place.
- The CCG should regard as a high priority placing a senior clinician as a standing member within the governance structure of the maternity service.
- This service is likely to grow and will need the support of the commissioning body in the future.
- Consideration should be given to providing training in the management of Obstetric Emergencies and Resuscitation of the newborn in a standard way across the whole service.

## Conclusions

From the workshop which considered an overview of data and information, and from overall findings:

- 168 hours Consultant presence on Labour Ward remains an aspiration now due to funding and there are challenges in recruiting Obstetricians nationally.
- Units are dominated by trainees; achieving 'Safer Childbirth' standards is impossible. This is as good as it gets without appropriate funding and availability of additional doctors to recruit.
- There is a challenge in medical recruitment, and there is a need to make sure jobs are diverse and interesting. Support is required in continuing to aspire to meet the recommended standards.
- The numbers of consultants have increased recently and there is a Business Case which if approved will increase these again.
- Aspirations are based on funding being released. A Business Case has been developed and is awaiting approval.
- One to one midwife care in labour and supervisor to midwife ratios have both improved.
- Recruitment of midwives is not considered an issue by SaTH currently.
- Training – there is a robust training profile, but this has a greater demand on midwives' time than other clinical groups such as nurses, but the cover allocated is the same across these professions.
- Rotation of midwives is a potential issue – some midwives are not rotating as they should be and this needs to be addressed; there is a need to understand responsibilities. This is currently recognised as an issue and is being addressed by SaTH.
- Negative feedback has been received in regard to perceived staff shortages.
- Training needs to have a greater emphasis on communication and customer care, i.e. the softer skills. Positive feedback included a statement that it is like an A&E and the workforce has to flex to meet the demands.

# Work stream 5: Risk management

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## Key standards and good practice

- NHS Litigation Authority (2013) *Clinical Negligence Scheme for Trusts, Maternity Clinical Risk Management Standards*
- NICE (2007) *Intrapartum Care*
- NICE (2006) *Routine postnatal care of women and their babies*
- King's Fund (2011) *Improving safety in maternity services*
- Royal College of Anaesthetists 2011
- NICE Quality Standard (2010) *Specialist neonatal care*

1. Clinical Negligence Scheme for Trusts, Maternity Clinical Risk Management Standards - Standard 1 Criterion 1 - Demonstrate implementation of an approved maternity service risk management strategy detailing the maternity service's leadership arrangements for the management of risk.
2. Clinical Negligence Scheme for Trusts, Maternity Clinical Risk Management Standards - Standard 1 Criterion 8 - Embedding the learning ('ward to board') following the root cause analysis.
3. Intrapartum Care Clinical Guideline 55 - Clear pathways and guidelines are in place to minimise risks.
4. Clinical Negligence Scheme for Trusts, Maternity Clinical Risk Management Standards - Standard 3 - The national modified early obstetric warning score (MEOWS) tool is used to identify women with potentially serious medical conditions who require immediate and appropriate multidisciplinary specialist care.
5. Routine postnatal care of women and their babies Clinical Guideline 37.
6. Specialist neonatal care (QS4) - Patients within their health economy are covered by perinatal network guidelines and care pathways for transfer for special, high-dependency, intensive and surgical care.

## Summary of evidence

Patient safety is a fundamental dimension of quality and should be at the heart of every person providing and commissioning services in the NHS. Service providers should have in place processes that enable early detection of failings and put in place actions to address sub-standard care. Alongside other factors such as regulations, a risk management framework supports organisations to put in place processes to minimise risk and acts as a valuable tool for learning lessons, leading to improvements in service provision.

One of the areas of concerns and a trigger for this review was a high number of reported serious incidents between 1 March 2012 and 31 March 2013. In the review of 'risk management' a broad spectrum of areas was considered to gain a robust understanding and enable triangulation within the review process. The areas considered included:

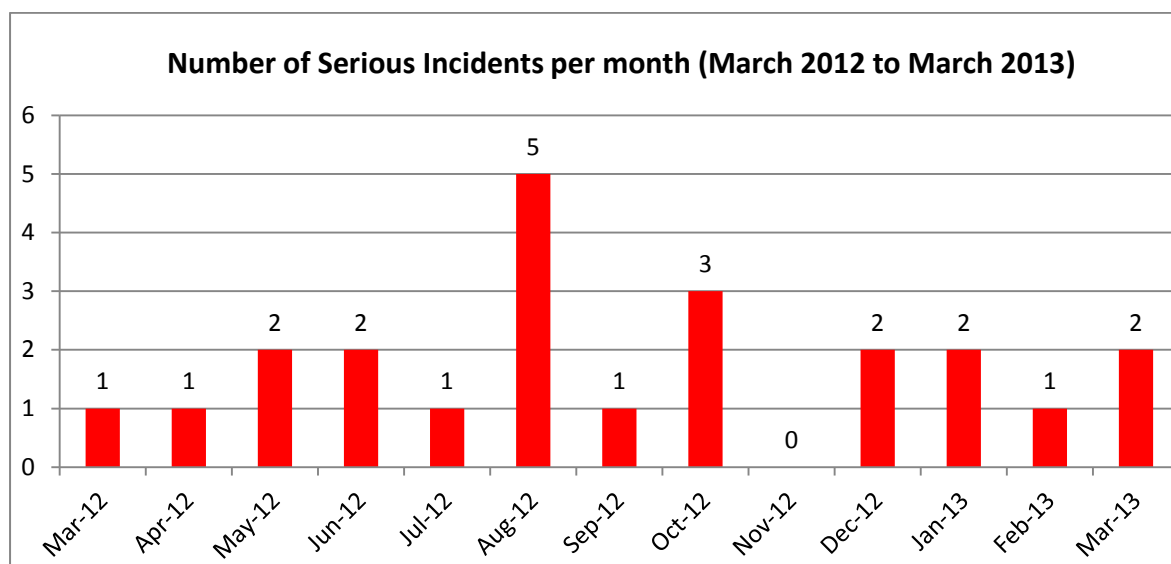
- Associated strategies and policies
- Number and category of serious incidents and root cause analysis reports
- Incidents and near misses by locations
- Clinical governance systems and processes for identifying, assessing and managing risks effectively (assessing and managing maternal risk is covered in the Clinical Outcomes and Activity Data work stream section)
- Intrapartum pathways of care that minimise risk

- Audit reports – when transfer was indicated but did not occur (this data is not available, see audit report); the time taken to see an obstetrician or neonatologist; the time from admission to birth once transferred; numbers of women booked, being admitted to, being transferred from, and giving birth in each place of birth and to include maternal and neonatal outcomes – see also the sections on Clinical Outcomes and Activity and Hub and Spoke
- The availability of a midwife labour ward co-ordinator, to be present on duty on the labour ward 24 hours a day, seven days a week and be supernumerary to midwives providing 1:1 care
- Obstetric (Consultant) Units have 24 hour availability of a health professional fully trained in newborn life support (neonatal resuscitation) and stabilisation who is able to provide immediate advice and attendance
- A midwife taking charge of a delivery in any birth setting is trained and competent in neonatal life support (neonatal resuscitation)
- Observations of the newborn and current clinical skills in recognising the need to seek advice for the unwell neonate
- Evidence for reducing the incidence and impact of post natal depression

### Serious incidents

23 'serious incidents' were reported in the period March 2012 to March 2013. The criteria for reporting serious incidents was based on the West Midland Strategic Health Authority criteria which were broader than those in the National Patient Safety Agency (2010) and NHS England (2013) Serious Incident Framework.

The chart below provides information on the monthly numbers of these serious incidents.



### Data from NHS England

There have been 112 recorded maternity serious incidents over the last two and a half years across Burton, Mid Staffordshire, University Hospital North Staffordshire (UHNS) and SaTH.

Serious incidents fall into the following categories:

- Maternity Services
- Maternity Services - Intrapartum death
- Maternity Services - Intrauterine death
- Maternity Services - Maternal death
- Maternity Services - Maternal unplanned admission to ITU
- Maternity Services - Unexpected admission to NICU (neonatal intensive care unit)
- Maternity Services - Unexpected neonatal death

The highest incident type is unexpected admission to a NNU / Neonatal Intensive Care Unit (NICU) with 44 over the last two and a half years. The Shrewsbury and Telford Hospital Trust has the highest reported number of unexpected admissions to NNU as reported to STEiS, at 26 from the above group. This number also means that they subsequently have the highest number of incidents overall.

Further investigation into understanding why SaTH is the highest in this category, and thus overall, should be carried out. This may be attributed to the reporting criteria as evidenced elsewhere, but cannot be assumed.

- **Review of the serious incidents by external experts**

#### **Breakdown of the 23 reported serious incidents**

The table below provides an overview of all the incidents reported as 'serious'. The external experts reviewed the serious incidents, root cause analyses and action plans and reported that **seven** out of the 23 serious incidents reported would actually meet the criteria for serious incidents as outlined by the National Patient Safety Agency (2010) and NHS England (2013). A rate of seven serious incidents is comparable with other sites with a similar number of births.

Incidents	Total	True serious incidents	Not serious incidents	Antenatal Screening incidents
Serious incidents reported	23	7	9	7
<b>Of the serious incidents reported</b>				
<b>Types of serious incident</b>			<b>Types of incident classed as non-serious</b>	
Admission to NNU			Antenatal screening	
Neonatal death			Admission to NNU	
Intrapartum death			Neonatal death	
			Intrapartum death	

The external experts identified that a number of the serious incidents had not been closed. It was also identified that the approved timescale for closure was exceeded in some cases. This has now been addressed with all cases now closed. The external experts highlighted the need to ensure that serious incidents are closed within the timescale with follow through of action plans. It is recognised that there may be circumstances where the incident cannot be closed in the timescale but in this case there should be a process for applying for an extension. It was also identified that the CCG did not hold the latest root cause analysis

(RCA) documents and that there needed to be a request made to SaTH for closure reports. The CCG had not requested final closure reports; this has now been addressed.

Furthermore it was suggested that the risk management training should be reviewed to ensure that all managers and staff have a robust understanding of the methodology and requirements of completing risk assessments and that all root cause analyses and serious incidents are signed off by a senior manager before closure within the STeiS timescales.

The diligent reporting by SaTH is to be commended, but a system which reports in a standardised way which can be benchmarked with other similar trusts would be beneficial.

### **Learning and improving from these Incidents**

Further to local investigation of these serious incidents (and subsequently some non-serious / screening incidents) learning has been shared.

From the 23 serious incidents reported, a factor which arose more than once (<5) involved Cardiotocography (CTG) misinterpretation. It should be noted that this is a very low percentage when considered alongside the circa 30,000 CTGs completed annually. This does not detract from its importance and training in this topic is mandatory and is also covered in the supervisory annual review.

Following the seven screening incidents, a comprehensive review was undertaken. The Shrewsbury and Telford Hospital NHS Trust has been commended on their honesty in reporting screening incidents and this has led to learning, not just for the trust but other trusts within the region. Several areas of good practice were identified as well as an action plan implemented following the 'failsafe' visit. It was concluded at this review that Shropshire are not outliers in the number or themes of the screening incidents that have been reported on STeiS.

The learning from each incident has led to robust processes being put in place to ensure that every women/neonate that enters the screening pathway receives a result; this is reflected in the trust's antenatal screening guideline.

- ***Incidents and near misses***

Datix is a voluntary reporting system and as such the diligence of reporting of incidents and near misses may account for some variations across locations, but should not automatically be assumed. This may also account for some discrepancies when cross checking with mandatory reporting systems.

It should also be noted that the category / sub categories have changed recently which needs to be considered when comparing reports for different time periods.

The table below uses information from the Datix report and it should be noted that the reporting period is not standard across locations and this should be considered when comparing data.

Maternity reported incidents on Datix by MLU / CLU 2012-2013 (incomplete year for some sites)

Location	Annual Births	Report period in months	Incidents in report period	Incidents in report period as a percentage of births
Ludlow MLU	71	8 months	4	5.63%
Oswestry MLU	72	10 months	10	13.8%
Shrewsbury MLU	421	11 months	27	6.4%
Wrekin MLU	401	11 months	10	2.49%
Shrewsbury CLU (wards 18, 19 & 20)	4030	12 months	288	7.15%
<b>Total</b>	<b>4995</b>		<b>339</b>	<b>6.79%</b>

**N.B.** Bridgnorth MLU - No maternity categories used and therefore not included in the above table.

The higher percentages for the CLU are to be expected since this is where any high risk pregnancies would be managed and delivered, and similarly for Shrewsbury MLU as this is an alongside MLU and would have a lower threshold than for those MLUs which are free standing.

Maternity patient safety episodes (PSE) by main maternity related category - April 2012 to March 2013 as reported on Datix

Category	Total	Total as a percentage of births
<b>Births – including home births</b>	<b>5154</b>	<b>100%</b>
Intrapartum	135	2.62%
Neonatal	118	2.29%
Other maternal obstetric incidents	83	1.61%
Postpartum	13	0.25%
Perinatal and maternal mortality	8	0.16%
Maternity complications	6	0.12%
Antenatal	2	0.04%
Delivery using more than one instrument	39	0.76%
<b>Total main maternity related incidents</b>	<b>404</b>	<b>7.84%</b>
<b>Other incidents</b>	<b>646</b>	<b>12.53%</b>
<b>Total</b>	<b>1050</b>	<b>20.37%</b>

Maternity PSE by severity of harm April 2012 to March 2013 as reported on Datix

Severity of harm	Total
Near miss / no harm	680
Short term harm requiring further medical treatment or procedure	238
Minimal harm requiring first aid or minor treatment	123
Death	5*
Permanent or long term harm	4
<b>Total</b>	<b>1050</b>

\*Severity of harm is used for the outcome of the incident and therefore death is used when this is the outcome of the incident, if death is not related to the incident then it is not used.

The totals in the above table have not been considered as a percentage of births as this would not give a true reflection of activity within maternity services as the incidents reported will include many which are not related to the pregnancy / birth itself. It can be noted however that the majority of these incidents resulted in no harm or short term harm.

*Maternity PSE by sub category April 2012 to March 2013 as reported on Datix*

<b>Sub Category</b>	<b>Total</b>	<b>Total as a percentage of births</b>
<b>Births – including home births</b>	<b>5154</b>	<b>100%</b>
Maternal haemorrhage	74	1.46%
Shoulder dystocia	53	1.03%
Apgar	51	0.99%
3 <sup>rd</sup> / 4 <sup>th</sup> degree tears	50	0.97%
Unexpected admission to NNU	39	0.76%
Unplanned home birth or en route to hospital	25	0.49%
Suturing problem	13	0.25%
Other birth trauma	11	0.21%
Other categories with < 10 incidents	49	0.95%
<b>Total</b>	<b>365</b>	<b>7.08%</b>

**Trend in patient safety incidents 2011/12 – 2012/13**

The general trend for 2012/13 was for incidents to be greater than in the previous year. For the final quarter of 2012/13 the numbers have reduced below those of the previous year. This trend should be monitored and any peaks investigated.

Total patient incidents for 2012/13 were 1050 and for 2011/12 were 1010.

**Disseminating learning points**

Disseminating the learning points is covered in a number of documents including the Procedure for the Reporting and Investigation of Incidents, Complaints and Claims, Standard Operating Procedure for the management of SUIs (Serious Untoward Incidents) and Serious Adverse Events, and the Learning from Adverse Events Policy (incidents, complaints and claims).

Section 9 of the Learning from Adverse Events Policy (incidents, complaints and claims) covers learning and improving as a result of adverse incidents in depth. All patient safety incidents are reported to the National Patient Safety Agency (NPSA) and to the National Reporting and Learning System (NRLS). This section adequately identifies how local, organisational and cross-organisational learning is fulfilled.

**Detail of the sharing of learning**

Patient Safety Advisors and Health and Safety Advisors review incidents stored on the central database. Trends and the number and severity of incidents are reported to the relevant governance structures within the centres, and trends are reported quarterly to the Health, Safety and Security Committee.

All patient safety incidents are uploaded onto the National Reporting and Learning System (NRLS) which allows key problems and trends to be identified nationally. Thus national alerts can be issued informing safety within organisations at a national level, rather than just a local level.

Learning from serious incidents on a wider scale would be achieved by raising the event with the Strategic Health Authority (now the responsibility of the NHS England Area Team) within two working days, which should be updated within one week and the final report should be available within 45 working days. Any learning points which may be relevant to other trusts within the West Midlands area will then be disseminated.

The Trust Board and Hospital Executive Committee are provided with information regarding any ongoing serious incident that is being investigated.

Learning from incidents is shared with staff at all levels within the organisation via (for example):

- Items in the staff newsletter
- Team/ department/ taskforce meetings
- Face to face contact
- Shared learning through Centre Chiefs Governance Structures
- Any changes in procedures or practice recommended following investigations will be monitored and the results fed back to the staff involved.

More specifically the extract from Learning from Adverse Events Policy (incidents, complaints and claims) below identifies more detail:

“Lessons learned are communicated via a range of media:

- PALS and complaints quarterly reports which are reported to committees of the Board and to risk, PPI and/or governance groups.
- The High Risk Scrutiny Group reviews SIs and other adverse events to inform discussion of key risks facing the trust
- Inclusion of articles on incident reporting in Team Brief and other staff newsletters
- Distribution of SI reports to Centre management teams
- Personal feedback on incidents
- Quality Account
- Infection control newsletter
- Patient Safety Alerts
- Monthly SI updates to the PCTs (will now be CCGs)
- Newsletters
- Risk management initiatives promotional material.
- Clinical audit
- Training sessions
- Chairman’s Awards and learning events

Members of the Safety Teams and the Patient Services Manager are to attend Centre and speciality meetings to ensure sharing of information, collaborative working, and to help effect change when the need is identified. Lessons learnt and changes in practice are also communicated to staff via governance training programmes, including induction.”

### **Women and Children's Care Group specific**

Within the Maternity Service's Risk Management Strategy, section 9.4 covers processes for learning from experience relating specifically to the Women and Children's Care Group and in addition to the above includes:

- Care Group Board receiving reports
- Cases / incidents selected for review at Governance Group meetings, with actions / learning opportunities identified and monitored through the group. Where a comprehensive review will aid understanding and learning, a case review is requested
- Where relevant, cases are presented at MDT updates
- Perinatal Mortality meetings enable review and learning from perinatal deaths
- A synopsis is included in MAGNETS (midwifery supervision, audit, governance, news, education, training and safety)
- Reports are produced and discussed at governance groups and circulated via the internet.

The process for disseminating learning to individuals, and assuring their understanding, is not explicit, especially within the Midwife Led Units. Being explicit with regard to dissemination will enhance this strategy. It should not be assumed that staff read distributed documents.

### **Examples of dissemination of learning from incidents**

Examples of how the learning is disseminated were received and included minutes from Governance meetings, screenshots of Serious Incident Feedback (SIF) reports circulated and newsletters.

#### **• *Clinical Governance structures***

Clinical Governance is the responsibility of all levels of staff. For some this may be reporting incidents, producing or monitoring reports, or reading, understanding and implementing information which is cascaded about changes to policy / procedure or shared learning.

The formal outline structure is highlighted below:

- **Tier 1:** This is the highest level – the Trust Board.
- **Tier 2:** There are seven committees which include a Non Executive Director (NED) member and one (Hospital Executive Committee) which does not. The seven committees include: Risk; Finance; Clinical Quality and Safety; Charitable Funds; Remuneration; Audit; and Workforce.
- **Tier 3:** There are 11 existing / proposed new committees / groups. Those which report to the Clinical Quality and Safety Committee are: Clinical Governance Executive; Infection Control Committee; Patient Engagement and Improvement Panel and Clinical Audit Committee. Those which report to the Risk Committee are the Health, Safety and Security Committee; and the Operational Risk Group (Tier 4).
- **Tier 4:** At this tier there are 11 groups and committees which report to the Clinical Governance Executive as follows: Operational Risk Group (also reports to the Risk Committee at Tier 2); Nursing and Midwifery Forum; Medical Records Committee; Local Safeguarding Committee; Blood Transfusion Committee; Resuscitation Committee;

Drugs and Therapeutics Committee; Safe Medication Practice Group; Organ Donation Group and the Mortality Group.

- **Below Tier 4** there are several Centre Governance meetings. A list of 19 maternity risk management groups is included in the Maternity Services Risk Management Strategy at section 10.

- ***Dedicated midwife coordinator on labour ward***

The ward 20 rota includes all band 7s, all of which are labour ward co-ordinators. For each shift there is an identified labour ward coordinator, however during busy times these individuals may have to undertake clinical work and / or activate the escalation policy.

- ***Obstetric units have 24 hour availability of a health professional fully trained in newborn life support (neonatal resuscitation) and stabilisation who is able to provide immediate advice and attendance***

There are three tiers of neonatal staff available, supported by the labour ward coordinator and midwives 24 hours a day.

- ***A midwife attending a delivery in any birth setting is trained and competent in neonatal life support (neonatal resuscitation)***

This is mandatory training for midwives and training requirements (see Workforce work stream section) are checked at the annual supervisory review. Since the monitoring of mandatory training indicates that not all midwives have up to date training it is not possible to state whether this is met. If those without up to date training are rostered to be with another midwife to take charge of the delivery then this would comply.

- ***Observations of newborn and skill to recognise unwell neonate***

Observations of the newborn are outlined in the document 'Neonatal Care' – see Appendix 8.

- ***Mental Health***

Mental health training is included in the Training Needs Analysis and is monitored bi-monthly along with other training.

- ***Rule 43 responses from SaTH and WMAS***

Further to the tragic death of a baby four years ago and the subsequent inquest in December 2012, a 'Rule 43 Maternity Services' was issued by the Coroner to SaTH and to WMAS.

## **SaTH**

This looked at three main areas for the Trust:

- The decision to allow the mother to deliver at the MLU
- Post-delivery complications which arose
- The information chain

A report has been received from SaTH which identifies reported actions completed / ongoing and are included in the table below:

Guidance in relation to Reduced Foetal Movement was updated in line with Royal College of Obstetricians and Gynaecologists publication in 2011. <b>Completed.</b>
Continued support to provide enhanced resuscitation training for midwives. Local guidelines have been reviewed by the Consultant Neonatologist. All midwives attend an annual in house training update. <b>Completed.</b>
Training facilitator handbook has been updated. <b>Completed.</b>
Midwives working within the community settings have been given priority for attendance at external, enhanced resuscitation training. <b>Completed</b>
The service was granted a financial educational award to further enhance skills to stabilise sick newborn babies prior to transfer to NNU. <b>Training completed March 2012.</b>
Local guidance has been updated to draw midwives' attention to the possible significance of a large placenta. It has also been strengthened to ensure midwives are aware of the importance to transfer when circumstances no longer remain normal. <b>Completed.</b>
Audits of record keeping in Ludlow have taken place and are satisfactory. <b>Completed.</b>
The trust is working with the ambulance service with regards to transfer of pre-term and neonate babies. <b>Ongoing working group meetings.</b>

## **WMAS**

The Coroner identified failings in the information chain. Although he identified all individuals had undoubtedly done the best they could, they were in fact acting in isolation from each other with incomplete information and this resulted in breaks in the chain.

Whilst outside of the scope of the Rule 43, the Coroner also raised the family's concerns regarding a lack of family liaison immediately following the incident and during their ongoing involvement with both trusts.

### **Actions taken include:**

The introduction of a Family Liaison Officer scheme.

WMAS have corresponded since April 2013 with Shropshire providers to ensure that joint training with paramedics and midwives takes place. WMAS Head of Education and Training and Head of Clinical Practice are currently working with partner providers to ensure this joint training takes place.

WMAS has also arranged Neonatal Life Support training with the Neonatal Transport Consultant for the West Midlands Neonatal Transfer Service, to commence during 2013/14. This will complement the mandatory training that is already embedded within WMAS

As part of the Southern West Midlands Network scrutiny of WMAS, the Neonatal Transport Consultant for the West Midlands Neonatal Transfer Service was also instrumental in reviewing the use of Air Ambulance for transferring of neonates.

## **Audit**

Audits and findings are noted in the table at Appendix 7.

## **Associated strategies, policies, guidance and frameworks**

The table in Appendix 8 outlines the strategies, policies and procedures supplied by maternity services to inform the review and comments on compliance.

## **Areas of good practice**

- Openness and transparency in reporting and investigation, although this has led to a higher reporting of serious incidents than would have been reported elsewhere.
- Transparency in sharing SIs, as part of root cause analysis.
- Commissioners are invited to be involved.
- Celebration of good practice and participation – Midwife Led Units.
- All maternity sonographers are midwives at SaTH.
- There is a strong audit culture within maternity services.

## **Areas for development**

- Continue the good practice around transparency and reporting, but develop a reporting system which meets the needs of the trust and can also be used to compare like for like data with other trusts, e.g. ensuring that serious incident reporting is congruent with the National Patient Safety Agency (2010) and NHS England (2013) Serious Incident Framework.
- Continue to enhance the “relationship aspect” with Commissioners about reporting and investigating concerns in the future, in order for a conversation to take place to report and clarify the concerns before formal procedures are instigated.
- The recommendations made by SaTH from the audits they have undertaken and reviewed as part of this process are endorsed – see Appendix 7.
- Commissioners to regularly review the flow of data through quality meetings and to agree the assurance information required to ensure the dashboard meets requirements and how learning from SIs are put in practice.
- Agree a common framework for compliance with criteria agreed through ‘heads of midwifery’, Director of Nursing/NHS England.
- Regular review of assurance data/information to CCGs with SaTH reviewing existing mechanisms, and scrutinise under and over reporting (e.g. dashboard).
- Review policies and procedures, and in particular the Serious Incident Policy, to make sure they are user friendly, e.g. a shorter policy with appendices – see guidance from the external risk expert.
- Review risk management training and ensure all managers and staff understand the methodology and requirements of completing risk assessments.

- Employ a system where extensions need to be applied for to extend the timescales for RCAs where they cannot be met.
- Consider tracking that the dissemination of learning from incidents and policy / procedure changes and understanding exists at the level of the individual.

## **Conclusions**

- This serious incident reporting criteria is not congruent with the National Patient Safety Agency (2010) and NHS England (2013) Serious Incident Framework. Nonetheless, this must not be perceived as a negative action as it highlights diligence in reporting.
- True serious incidents are congruent with other units.
- Unexpected admissions to NNU appear to be higher than expected when compared to other local trust serious incidents reported on STeiS.
- There appears to be a robust approach to risk management, clinical governance structures and learning from incidents which suggests a learning organisation. However it may be prudent to consider tracking that the dissemination of learning from incidents and policy / procedure changes and understanding exists at the level of the individual.

# Conclusions

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The maternity services review was commissioned by Shropshire and Telford and Wrekin Clinical Commissioning Groups (CCGs) to consider the following areas of perceived concerns:

- Pattern and understanding of serious incidents within maternity services since revised categories of reporting were implemented.
- Issues identified during a high profile inquest in 2012 (relating to a case that occurred in 2009) raising questions about various aspects of maternity care.
- Failure to meet the nationally recommended ratio of midwifery supervisors to midwives.
- Ongoing challenges with regard to midwife to birth ratio.

The maternity service review outputs indicate that 90-92% of service users are positive about their experience of using maternity services in Shropshire. However, against the backdrop of rising demand, increasing complexity and changes in demographics, commissioners needed to be assured that the provider could sustain and improve this level of service user satisfaction, address the 8-10% negative comments, maintain safety and continue to develop a service that is fit for the future.

This review provides assurances that the maternity services are safe and of a good standard in Shropshire, however there are areas for further development.

Overall, service user experience is positive. The clinical outcomes for mothers and babies, based on the limited available clinical data, are good. However, further work is necessary to review neonatal admissions, work towards compliance with the NHS England guidelines for Neonatal Unit (NNU) care and work together with the Staffordshire, Shropshire and Black Country (SSBC) Newborn and Maternity Network to develop benchmarks for measuring maternal and neonatal outcomes.

The 'hub and spoke' model is greatly valued by service users. The service providers must build on this, thereby creating a thriving service that promotes safety and quality, choice, women-centred care, value for money and ongoing workforce capability and capacity. Effort must also focus on creating confidence with regard to the safe transfer of women and alleviating anxiety for those women who choose to book in a MLU and then need to be transferred to the Consultant Unit.

There are current workforce issues, especially in relation to obstetricians; however this is a national challenge due to the limited pool of obstetricians. Having said this, the numbers of consultants have increased recently and there is a business case which, if approved, will increase these again. Recruitment of midwives is not considered an issue currently and the service is working towards recruiting their full complement and is supported by a business case pending approval. One to one midwife care in labour and supervisor to midwife ratios have both improved.

The service operates an open approach in reporting serious incidents and their reporting thresholds are lower than the serious incident reporting criteria of the National Patient Safety

Agency (2010) and NHS England (2013) Serious Incident Framework. Nonetheless, this is not to be perceived as a negative action as it highlights diligence in reporting. There is a demonstrable willingness to learn and a determination to put things right for those individuals who have suffered and to ensure that the incident is not repeated.

Any review of such a broad remit inevitably generates many areas for growth and development but this should not detract from the assurance gained through the process that the maternity services are safe and of a good standard in Shropshire.

# References

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## Service User Experience

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# Glossary/abbreviations

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ACCEPT	Tool used to ensure consistent approach to the documentation for the transfer of care
AMU	Alongside Maternity Unit
BBA	Born Before Arrival (emergency/unattended births)
CCG	Clinical Commissioning Group
CHC	Community Health Council
CLU	Consultant Led Unit
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CS	Caesarean Section
CSU	Commissioning Support Unit
CTG	Cardiotocography (technical means of recording the foetal heartbeat)
DNA	Did not attend
FBC	Full Blood Count
F/U	Follow up
HES	Hospital Episode Statistics
HDU	High Dependency Unit
ICU/ITU	Intensive Care Unit/Intensive Therapy Unit
LAT	Local Area Team
LSA	Local Supervising Authority
LSCS	Lower Section Caesarean Section
MAGNETS	Midwifery Supervision, Audit, Governance, News, Education, Training & Safety
MDT	Multi-Disciplinary Team
MEOWS	Modified Early Obstetric Warning Score
MLU	Midwife Led Unit
MULTIP	A pregnant woman who has already had one 'successful' pregnancy/ multiparous

Neo-NEWS	Neo-Natal Early Warning Scores
NED	Non-Executive Director
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Health and Clinical Excellence
NICU	Neonatal Intensive Care Unit
NNU	Neonatal Unit
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
PALS	Patient Advice and Liaison Service
PID	Project Initiation Document
PRIMIP	First time mother
PROMPT	Practical Obstetric Multi-Professional Training
PSE	Patient Safety Episode
PCT	Primary Care Trust
PRH	Princess Royal Hospital
RCA	Root Cause Analysis
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians and Gynaecologists
RP	Relevant Professional
RSH	Royal Shrewsbury Hospital
SaTH	The Shrewsbury and Telford Hospital NHS Trust
SBAR	Tool used to ensure consistent approach to the documentation for the transfer of care
SI/SUI	Serious Incident/Serious Untoward Incident
SOM	Supervisor of Midwives
STeIS	Strategic Executive Information System
SUS	Secondary Uses Services

TSA	Trust Special Administrators
Q	Quarter
UK	United Kingdom
VTE	Venous Thromboembolism
WMQRS	West Midlands Quality Review Service
WTE	Whole Time Equivalent

# Key acknowledgements

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- Appendix 2 - Communications and engagement strategy
- Appendix 3 - Appreciative Inquiry: an approach to seek feedback from maternity services service users
- Appendix 4a - Service user online survey questionnaire
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- Appendix 7 - Audits reviewed and findings
- Appendix 8 - Associated strategies, policies, guidance and frameworks



*Telford and Wrekin  
Clinical Commissioning Group*



*Shropshire  
Clinical Commissioning Group*

## **Maternity Services Review**

# **PROJECT INITIATION DOCUMENT**

**FINAL 29.07.13 (updated 29.08.13)**

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## 1. Introduction

Shropshire and Telford and Wrekin Clinical Commissioning Groups (CCG), as the statutory bodies responsible for commissioning safe, sustainable services for our respective patient population groups, have requested that a formal review of the maternity services across both areas be undertaken.

The remit of the review will be to identify to the CCG Governing Body Boards the current position re the quality and safety of maternity services, making recommendations as required, in order to ensure that the service provides the **highest quality and safest care during and after pregnancy**. It will also review the sustainability of the hub and spoke model going forward.

Sustainability will be classified into quality, performance and stewardship of public resources. The review will assess areas such as long term retention and recruitment of staff, staff satisfaction, patient experience, access and choice as well as quality and safety.

Both CCGs need to satisfy their statutory duties alongside planning for the future, and approach this project with the understanding that there is support for the current model as long as it meets the criteria outlined.

### 1.1 Background

A review of maternity services at The Shrewsbury and Telford Hospital NHS Trust has been commissioned by the Governing Bodies of Shropshire and Telford and Wrekin CCGs, with the support of the Shropshire and Staffordshire Local Area Team (NHS England), to ensure the delivery of the best possible care now and in the future.

The review has been commissioned to focus on the following:

- Recent high profile inquest raising questions about the:
  - 'hub and spoke' model of midwifery care
  - decision making process with regard to safe and appropriate transportation of mother and baby (especially in light of the forthcoming hospital reconfiguration)
- Pattern and understanding of serious incidents within maternity services since revised categories of reporting implemented. Specifically associated with:
  - Potential concerns about the management of intrauterine growth restriction of the foetus
  - Perceived delays in escalating patient cases for specialist interventions
  - Potential concerns about variations in interpretation of the foetal heart rate
  - Potential concerns about variations in adherence to standard guidance, including the use of oxytocins
- Failure to meet nationally recommended midwifery supervisor/midwife ratio
- Ongoing challenges with regard to midwife/birth ratio

## **1.2 Shropshire Maternity Services**

Shropshire Maternity Services currently comprise the following:

- *Shrewsbury Consultant Unit (Royal Shrewsbury Hospital site)*

Women with complicated pregnancies, such as those with an existing medical problem, or who may need additional monitoring during labour, or whose labour is being induced, are advised to give birth on the Shrewsbury Consultant Unit. If any problems are experienced during labour, obstetric and neonatal teams are available 24 hours a day on site.

Although the anaesthetic team is not based on the labour ward, if there is a need for regional or general anaesthesia, the anaesthetist will be contacted and will attend according to the urgency.

- *The antenatal ward (Royal Shrewsbury Hospital site)*

This ward offers inpatient antenatal care to women with medical and obstetric problems such as raised blood pressure or diabetes. The midwives regularly liaise with other specialities within the hospital, and consultant teams from the medical and surgical centres visit as required. Induction of labour also takes place on this ward.

- *The postnatal ward (Royal Shrewsbury Hospital site)*

This ward cares for women requiring consultant postnatal care after normal and assisted deliveries. The ward also cares for women whose babies are on the Neonatal Unit.

- *Midwife Led Units (MLU)*

There are five MLUs based in:

- Bridgnorth (Bridgnorth Community Hospital)
- Oswestry (Robert Jones and Agnes Hunt Orthopaedic Hospital)
- Ludlow (Ludlow Community Hospital)
- Telford (Princess Royal Hospital site)
- Shrewsbury (Royal Shrewsbury Hospital site)

The MLUs are run by experienced midwives who are available 24 hours a day and are able to give mothers all the support needed during pregnancy, labour and the early days with the baby. There are no obstetric doctors on site but midwives have 24 hour access to consultants and can discuss and refer any problems that arise during pregnancy, labour or post-partum.

- *Neonatal Unit (Royal Shrewsbury Hospital site)*

The local neonatal unit provides care to premature and sick babies.

## **1.3 Plans for Reconfiguration**

From summer 2014, women who need a consultant-led delivery will give birth at the new Women and Children's Unit at the Princess Royal Hospital, Telford. This includes women who are expecting twins, women with diabetes, women who have previously had caesareans, women whose babies are in a breech position and women whose babies are premature.

The main reason for this change is that the existing maternity building at the Royal Shrewsbury Hospital does not comply with structural building standards. It is in a poor state and the CCGs cannot accept that this can be the base for maternity and children's services in the long term. The unsuitability of the site has also been highlighted by the Care Quality Commission. A number of options have been considered through the formal Phase 1 reconfiguration programme of The Shrewsbury and Telford Hospital NHS Trust. The only way that safe and sustainable maternity services could be secured for Shropshire, Telford and Wrekin and mid Wales was to transfer consultant-led maternity services to Telford on the Princess Royal Hospital site.

Women having a low-risk pregnancy will still be able to choose as per their constitutional rights to have their baby:

- At home
- At one of the community midwife-led units at Bridgnorth, Ludlow and Oswestry
- At the midwife-led unit at the Princess Royal Hospital, Telford, or Royal Shrewsbury Hospital (RSH) (which will be refurbished and relocated in 2014).
- At one of the midwife-led units run by Powys Teaching Health Board
- In the new Women and Children's Unit at the Princess Royal Hospital, Telford from 2014

Antenatal appointments and scans will continue to take place as they do now across all sites.

The Trust indicates that if a woman or baby develops complications during or after labour, at home or at one of the midwife led units, they will be quickly and safely transferred to the consultant-led unit / NNU at the Princess Royal Hospital, just as women and babies are currently transferred to Royal Shrewsbury Hospital. The Ambulance Services will undertake the transportation of women and babies.

#### ***1.4 Objectives of Project***

The objectives of the project are to review the areas listed in **Appendix A** highlighting good practice and recommending appropriate action if inadequate standards are identified. The aim is to ensure that following the review the CCG Governing Body Boards are assured of the current position re: the quality and safety of maternity services, and any recommendations which may be required in order to ensure that the service provides the ***highest quality and safest care during and after pregnancy***, including:

##### **Patient safety and high quality care**

- Services deliver high quality and safe care in all environments (including the hub and spoke model).
- There is promotion of normal birth.
- There is cooperation through maternity networks to ensure local patterns of services meet women's needs and expectations.
- There is benchmarking against national, regional and comparator populations.
- Services are working towards complying with national standards (e.g. National Patient Safety Agency) and benchmarks.
- There is compliance with the toolkit for neonatal services.
- There are risk management systems and processes in place, including a learning environment.

- The safe and timely transfer and transportation of women and / or neonates who develop complications during and /or after labour at home or at one of the midwife led units.

### **Workforce**

- There is adequate staffing and a skill mix and deployment that ensure that midwives are able to deliver continuity of antenatal and postnatal care.
- There is achievement of 1:1 care and continuity in labour, measured through using agreed tools such as the National Patient Safety Agency (NPSA) score card.
- Midwifery staffing ratios achieve a minimum of one midwife to 30 births, across all birth settings.
- The obstetric unit is staffed to provide appropriate obstetric consultant presence on the labour ward.
- Obstetric units have 24 hour availability of a health professional trained in neonatal resuscitation and stabilisation who is able to provide immediate advice and attendance.
- There is one supervisor of midwives to every 15 WTE midwives.
- Ensure that midwives undertake a supervisory annual review to ensure safe practice.
- All midwives have current clinical skills in recognising, and the need to seek advice for, the unwell neonate.

### **Education and patient pathways**

- Services are working towards all relevant National Institute for Health and Clinical Excellence (NICE) guidelines / national standards.
- Any midwife as the main healthcare professional at delivery, regardless of setting, is trained and competent in resuscitation of the newborn (NLS).

### **Patient choice and experience**

- There is evidence of access to all types of intrapartum care: homebirth, midwife-led environments and obstetric-led environments.
- Services deliver improved continuity of care, choice (in line with the NHS Constitution), access and productivity.
- There is evidence of a range of models of antenatal and postnatal care including individual and group sessions, in and out of hours availability.
- Patients are advised appropriately, as required, of recommendations to birth at a consultant led unit or midwife led unit on the same site, with adequate documentation where the patient refuses.

### **Hub and Spoke Model**

- Consider the sustainability of the hub and spoke model using data obtained during the review based on: quality, performance and stewardship of public resources.

## ***1.5 Authority for the Project***

This project has been authorised by the Governing Bodies of Shropshire and Telford and Wrekin CCGs, with the support of the Shropshire and Staffordshire Local Area Team (NHS England).

## 2. Project Definition

### 2.1 Key Deliverables

The key deliverables for the project will include, but are not limited to:

#### **Patient Safety and High Quality Care**

##### ***Clinical Outcomes Indicators***

- Analysis of all appropriate data and reports to review compliance with relevant national standards, guidance and benchmarks e.g. National Institute for Health and Clinical Excellence (NICE) standards.
- Comparison of data against national, regional and comparable provider's data.
- A review of whether 1:1 care and continuity in labour is achieved.
- A review to ascertain that there is promotion of normal birth.
- A review of the level of cooperation through maternity networks to ensure local patterns of services meets women's needs and expectations.

##### **To Include: *Activity - Data***

- Scheduled bookings
- Instrumental vaginal delivery (forceps and ventouse)
- Caesarean sections (planned and emergency)
- Midwives undertake a supervisory annual review to ensure fitness to practice.

##### ***Clinical Outcomes Indicators***

- Maternal morbidity
- Eclampsia
- ICU admissions in obstetrics
- Blood transfusions (4 units of blood)
- Postpartum hysterectomies

##### ***Neonatal Morbidity***

- A review of the 24 hour availability, on obstetric units, of a health professional trained in neonatal resuscitation, stabilisation and who is able to provide immediate advice and attendance.
- A review of compliance with the toolkit for neonatal services.
- A review of whether midwives have current clinical skills in recognising, and the need to seek advice for, the unwell neonate.

##### **To include:**

- Number of cases of meconium aspiration
- Number of cases of hypoxic encephalopathy
- Neonatal deaths
- NNU transfers (other than planned or for prematurity) from MLUs and CLUs

##### ***Hub and Spoke Model***

- A review of the safety and quality of services in all environments (including the hub and spoke model and transportation of women / neonates from a MLU to the consultant / neonatal unit during or after labour).

- A review of whether continuity of care, choice and access is available in line with the NHS Constitution.
- A review of whether there is evidence of access to all types of intrapartum care: homebirth, midwife-led environments and consultant-led environments.
- Ensure that midwives undertake a supervisory annual review to ensure safe practice.

**To Include:**

- Review of the 'hub and spoke' model of care, especially in light of the reconfiguration plans
- Review of the functions of the MLU
- Number of deliveries per MLU – per month / per annum
- Ambulance response time and alternative routes – distance and times from MLU to consultant unit.
- Mileage and time to transfer to consultant unit / neonatal unit from MLUs and time to pick up when remote.
- Patient choice, does the current model favour care closer to home model, and the impact of this on women who do not wish to deliver in a MLU?
- Identification of the current costs of the hub and spoke services
- Maternal transfer (including in-utero)
- Neonatal transfers to neonatal unit from MLUs and consultant unit
- Number of deliveries en route
- Criteria for booking in an MLU
- Look at midwifery competencies rather than number of deliveries per midwife
- Are pathways in place for changes in circumstances and what are they? Who, what, why, how?
- Criteria for neonatal transfer and who transfers – how, how many?
- Is there joint training of midwives and paramedics and how is this done?
- Number and type (short / long) of booking at MLU per month / annum
- What are the challenges of PBR for provider services?

**Workforce**

**Staffing**

- An analysis of staffing, education, training and support, skills, skill mix and the deployment of staff to ensure that midwives are able to deliver continuity of antenatal and postnatal care.
- An analysis of midwifery staffing ratios across all birth settings.
- A review of appropriate obstetric consultant presence on the labour ward.
- A review of whether any midwife as the main healthcare professional at delivery, regardless of setting, is trained and competent in resuscitation of the newborn (NLS).
- A review of access to supervisors of midwives.
- A review of whether midwives have current clinical skills in recognising, and the need to seek advice for, the unwell neonate.
- A review of anaesthetist availability to the labour ward.

**To Include:**

- Midwife/birth ratio
- Provision of appropriate anaesthetist cover to labour ward
- Appropriate consultant cover on labour ward and physical presence

- Midwives' competence in the:
  - appropriate management of intrauterine growth restriction of the foetus
  - timely escalation of problems to senior input (decision making thresholds utilised in order to establish whether the mother / baby required consultant-led care)
  - interpretation of the foetal heart rate
  - appropriate use of oxytocins
  - appropriate observations of the newborn
- Midwife vacancies and attrition rate and its impact on services to include long term retention and recruitment of staff. Attrition agreed as: midwives appointed but not working for any reason
- The ratio of midwife supervisors to midwives
- Does every student get a sign-off mentor, how many sign-off mentors are there and are the same mentors used each time or does it vary across those available.
- Understand the skills and competences of midwives
- Any midwife as the main healthcare professional at delivery, regardless of setting, is trained and competent in resuscitation of the newborn (NLS).
- All midwives have current clinical skills in recognising, and the need to seek advice for, the unwell neonate
- Education and training programmes - attendance
- Appraisals and personal development plans
- The views of frontline staff, including the staff survey
- Identify if there are any business cases, including any in development, for changes to staff numbers

### **Risk Management**

- A review of the risk management systems and processes, including how the learning points from incidents are implemented and monitored.
- A review of compliance with NPSA requirements.
- A review of NHSLA (CNST for maternity) compliance.
- Review of serious incidents – external view

### **To Include:**

- The impact of 'ward to board' learning
- Systems and processes for learning from adverse serious incidents and events
- Systems and processes for identifying, assessing and managing risks and their effectiveness
- Number of serious incidents, incidents and near misses
- Failed instrumental delivery
- Massive Postpartum Haemorrhage >2L
- Shoulder dystocia
- 3rd-degree tear

### **Patient choice and experience**

#### ***Service User Experience***

- A review of patient choice and experience through analysis of existing surveys and undertaking further engagement activities with service users.

**To include:**

- Arrangement for delivering service user focussed pathways of care, including promoting access and continuity of care
- Complaints – number of complaints / those upheld
- Views of service users through focus groups around the catchment area
- Feedback from Primary Care on service
- Compliments received
- Advice given re: birthing unit and when circumstances change
- Action taken following comments and suggestions received

**2.2 Constraints**

The constraints on this project are as follows:

- **Capacity**
  - This is an extensive review of maternity services and appropriate capacity and expertise are required to support this review.
- **Resources**
  - Securing resource for effective project infrastructure; careful consideration will be given to the priorities of the review within the proposed timeframe.
- **Political**
  - This review will be undertaken within the backdrop of the implementation of the hospital reconfiguration plans and therefore can potentially undermine the decisions associated with these plans.
  - The ability to encourage the public, including vulnerable and marginalised groups, to be involved and ensure their contributions are valued.
  - The active support and involvement of the key partner organisations.
- **Timeframes**
  - The identification of, and protected time commitment from, key leads and members of the Project Teams.

**2.3 Assumptions**

The project is predicated on the following assumptions:

- The adequate resourcing of the review.
- Appropriate expertise to undertake the review.
- Engagement, commitment and transparency within the review processes of all stakeholders.
- Implementation of recommendations following the review.

**2.4 Exclusions**

There are no specific areas that are excluded from this project unless they fall outside of the remit described in the PID.

**2.5 Interfaces**

The other projects and pieces of work that interface with this project are:

- Ambulance services review by the West Midlands Ambulance Services

- The implementation plan of the 2014 reconfiguration of services.
- Rule 43 letters from the Coroner to SaTH.
- Maternity and Children’s Clinical Network
- Neonatal Network – pathways going forward.
- Clinical Quality Review.
- Local Supervisory Authority review.
- Ambulances Services Review - Wales

## **2.6 External Dependencies**

The project is externally dependent on the following:

- Communications and engagement plan that defines engagement with the various stakeholders.
- The contribution from external experts to maintain impartiality of the review.

## **2.7 Tolerances**

Any excursion from the remit / objectives as identified in this document to be agreed by the Maternity Services Review Project Board.

## **2.8 Benefits**

The review has the potential to assure, and / or make recommendations if required which if implemented as necessary will generate, the following benefits:

- Access to high quality services evidenced by the delivery of local and national standards.
- Services that are based on the needs of the population and promote continuity of care, choice and access.
- Services which are safe in all environments.
- Services which are evidence-based and effective.
- A service that is sustainable – in clinical, operational and financial terms.
- Services that support the development of, and provide appropriate access to supervision for, staff.
- Services that build upon previous and current stakeholder engagement.
- The reinforcement and sharing of good practice.

## **2.9 Cost Headings**

The initial costs for this project are:

<b>Area</b>	<b>Cost</b>
<b>Project Board</b>	
Administration support	£8,000.00
Expert knowledge	£20,000.00
<b>Patients Panel/Survey work</b>	£1,000.00
External facilitator	
<b>Project Manager</b>	£12,000.00
<b>Review Team</b>	

Data Analyst Risk Manager Expert knowledge	£7,000.00
<b>Miscellaneous</b> Adverts, meeting venues, catering, legal fees, travel and expenses	£2,000.00
<b>Contingency</b>	£10,000
<b>Total Cost</b>	£60,000.00

All costs will be incurred in the timeframe for the project. There are no capital or revenue costs attached to the project.

Should any further skill or expertise be required to deliver the project objectives, these will be put to the Project Board for their decision.

It is proposed that the costs of the maternity review will be shared between Shropshire CCG and Telford and Wrekin CCG.

### 3. Approach and Plan

#### 3.1 Approach

The review will ensure that appropriate data is collected, analysed and compared against national standards and guidance. It will also benchmark against national and regional data as well as that of similar units.

The results of the individual workstreams will be drawn together and discussed at a joint Project Board / Review Team workshop. Conclusions and recommendations will then be identified which will be incorporated into a final report.

The scope of the review involves three phases:

#### **Phase One: Analysis and Diagnostic Work to be completed by 17.09.13.**

This will include 5 work streams as follows:

1. Clinical Outcomes Indicators and Activity Data - Maternal and Neonatal
2. Hub and Spoke Model
3. Workforce
4. Risk management
5. Service User Experience

Terms of reference for the work streams including membership, remit and responsibilities can be found at appendices D, E, F, G, H,

Analysis and Diagnostic Work to be completed by **17.09.13.**

#### **Phase Two: Review and Development of Recommendations**

1. The maternity Services Review Project Board and Review Team will evaluate the outcomes of the analysis and diagnostic work streams through a joint workshop, mapping out all the available information in order to formulate a series of conclusions, for future actions based on evidence based best practice – **18.09.13.**

2. Report compiled for final approval by the Maternity Services Review Project Board – **mid October 2013.**
3. The report to be shared with Senior Responsible Owners – before **31.10.13.**
4. Report to be presented to the relevant Governing Body Boards **November 2013.**
5. Serious concerns / recommendations, if identified, will be escalated as and when they occur.

### Phase Three – Performance Improvement Plan

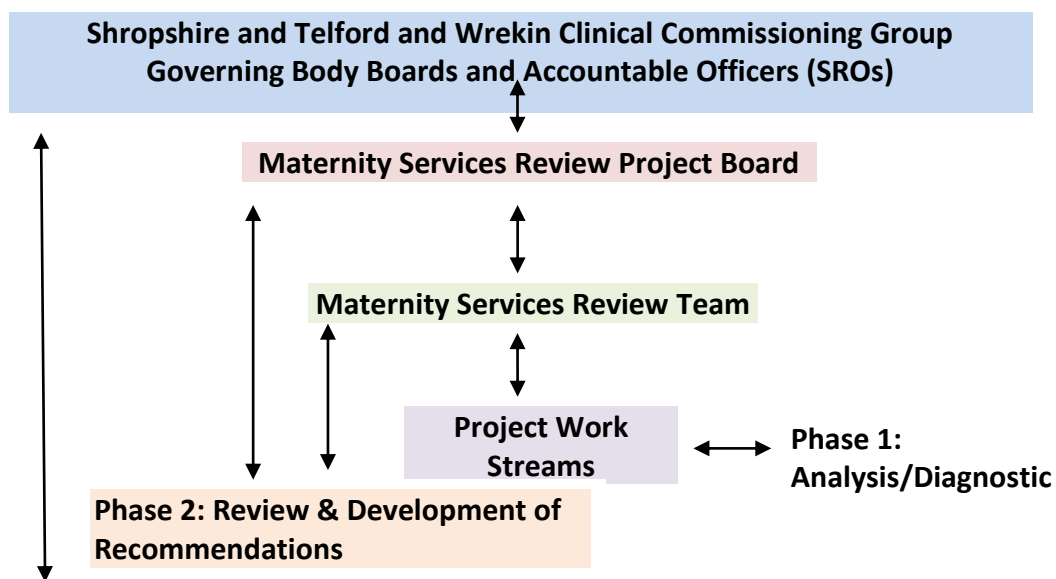
1. Development of a performance improvement plan and implementation – **November 2013.**

### 3.2 Initial Project Plan/Milestones

As above

## 4. Project Organisation Structure / Governance

The structure below identifies the governance for the review, and there follows key roles and responsibilities for individuals and groups. Terms of Reference for the Project Board, Review Team and work streams are included in the appendices. Please see diagram below:



**Phase 3: Performance Improvement Plan**

### 4.1 Senior Responsible Owner

The Senior Responsible Owner for the project is the Accountable Officer, Shropshire CCG, and the Accountable Officer, Telford and Wrekin CCG.

The key roles and responsibilities are:

- To read the final report and agree a way forward
- To receive and action escalations from the Project Board when conflict arises beyond their scope.

## ***4.2 Project Lead***

The Project Lead is the Director of Governance and Involvement, Shropshire CCG, supported by a Project Manager.

The key roles and responsibilities are:

- Oversight of the project.
- To manage the Project Manager

## ***4.3 Project Manager***

The project manager is seconded from the Staffordshire and Lancashire CSU.

The key roles and responsibilities are:

- Ensuring that the project is completed to budget, on schedule, and within scope
- Managing co-ordination of the partners and working groups engaged in the project work
- Detailed project planning and control including:
  - Developing and maintaining a detailed project plan
  - Managing project deliverables in line with the project plan
  - Recording and managing project issues / risks
  - Managing project scope and change control and escalating issues / risks where necessary
  - Monitoring project progress and performance

## ***4.4 Maternity Services Review Project Board***

The key roles and responsibilities are:

- Approval of a detailed Project Initiation Document
- Agreeing the composition of the Project Review Team
- Ensuring effective project delivery, including the provision of regular progress reports to key stakeholders
- Approval of a final report, to be presented to a joint meeting of the Shropshire and Telford and Wrekin CCG Governing Bodies no later than **31 October 2013**.
- Advise and support as required and unblock where issues / conflicts arise.
- Escalate to the Accountable Officers where there are conflicts which cannot be unblocked at this level.

The Terms of Reference are attached at **Appendix B**.

## ***4.5 Maternity Services Review Team***

The key roles and responsibilities are to:

- Ensure effective project delivery, including the provision of 6 weekly progress reports to the Project Board.
- Agree the membership, terms of reference and work of the 5 Work Stream Groups.
- Ensure effective delivery of work stream outputs.
- Advise and support work streams as necessary and unblock where issues / conflicts arise.
- Communications:

- Update the rolling Forward Press Plan in order to promote all events and activities via local newspapers and radio.
- Produce copy for an e-bulletin to go out following each meeting.
- On-going engagement of our MPs, including circulation of the e-bulletin
- Approval of documents before presentation at Project Board for example: Communications and Engagement Strategy; finance papers; project plan; risk register / issue log; exception reports; escalation reports; recommendations.
- Approval of a final report, to be presented to the Project Board **mid October 2013**.
- Escalate to the Project Board where there are conflicts which cannot be unblocked at this level.

The Terms of Reference are attached at **Appendix C**

#### ***4.6 Maternity Services Review Work Streams***

There are 5 work streams which will undertake analysis and diagnostic work to be completed by **17.09.13**. These are as follows:

1. Clinical Outcomes Indicators and Activity Data - Maternal and Neonatal
2. Hub and Spoke Model
3. Workforce
4. Risk management
5. Service User Experience

Terms of reference for the 5 work streams including membership, remit and responsibilities can be found at **appendices D, E, F, G and H**

#### ***4.7 Project Filing Structure***

The electronic project files will be kept in the CCG PA shared folder.

### **5. Communication and Stakeholders**

#### ***5.1 Communication method***

A communications and engagement strategy / plan will be produced, implemented and regularly updated as part of this project. This section shows any planned communications at the time of writing the PID.

It will be for each stakeholder / organisation involved to set out:

- Key message(s) for each stakeholder (or group of stakeholders)
- Frequency of contact (e.g. day / week / month)
- Channel for communication (e.g. meeting, e-mail, formal report or presentation etc.)
- How to obtain feedback / input from stakeholders into the project work
- Responsibility for the delivery of communication

#### ***5.2 Stakeholders***

Stakeholders are listed in the Communications and Engagement Strategy

## 6. Reporting Cycle

### *6.1 Project Initiation*

The project will formally start when the Senior Responsible Officer (SRO) and Maternity Services Review Project Board have approved this project initiation document.

### *6.2 Reporting Periods*

**The project work streams will** produce three weekly reports for the duration of the project to the Maternity Services Review Team. See terms of reference.

**The Maternity Services Review Team will produce an 'overview'** report for all Maternity Services Review Project Board meetings (6 weekly), accompanied by minutes of the previous meeting and an action note setting out any commitments undertaken by project streams and progress against this. See terms of reference.

**The Maternity Services Review Project Board will** report to the Governing Body Boards bi-monthly. See Terms of Reference.

### *6.3 Exception Reporting*

Exception reporting will be carried out by the Project Manager as required.

### *6.4 Project Issues*

Project issues may be raised by anyone with an interest in the project at any time. The Project Manager will manage the issue log.

### *6.5 End Project Notification*

The project will be formally closed by the SRO and the Maternity Services Review Project Board following Phase 3 when a Performance Improvement Plan is in place.

## 7. Risk Assessment

The risks relevant to the project are contained in the initial risk log. The Project Manager will manage the risk log.

## **Appendix A: Areas for Review to include, but not restricted to:**

### **Patient safety and high quality care**

#### ***Clinical Outcomes Indicators***

- Analysis of all appropriate data and reports to review compliance with relevant national standards, guidance and benchmarks e.g. National Institute for Health and Clinical Excellence (NICE) standards.
- Comparison of data against national, regional and comparable provider's data.
- A review of whether 1:1 care and continuity in labour is achieved.
- A review to ascertain that there is promotion of normal birth.
- A review of the level of cooperation through maternity networks to ensure local patterns of services meets women's needs and expectations.

#### **To Include: *Activity - Data***

- Scheduled bookings
- Instrumental vaginal delivery (forceps and ventouse)
- Caesarean sections (planned and emergency)
- Midwives undertake a supervisory annual review to ensure fitness to practice.

#### ***Clinical Outcomes Indicators***

- Maternal morbidity
- Eclampsia
- ICU admissions in obstetrics
- Blood transfusions (4 units of blood)
- Postpartum hysterectomies

#### ***Neonatal Morbidity***

- Obstetric units have 24 hour availability of a health professional trained in neonatal resuscitation and stabilisation who is able to provide immediate advice and attendance
- A review of compliance with the toolkit for neonatal services.
- A review of whether midwives have current clinical skills in recognising, and the need to seek advice for, the unwell neonate.
- A review of whether any midwife as the main healthcare professional at delivery, regardless of setting, is trained and competent in resuscitation of the newborn (NLS).

#### **To include:**

- Number of cases of meconium aspiration
- Number of cases of hypoxic encephalopathy
- Neonatal deaths
- NNU transfers (other than planned or for prematurity) from MLUs and CLUs

#### ***Hub and Spoke Model***

- A review of the safety and quality of services in all environments (including the hub and spoke model and transportation of women / neonates from a MLU to the consultant / neonatal unit during or after labour).

- A review of whether continuity of care, choice and access is available in line with the NHS Constitution.
- A review of whether there is evidence of access to all types of intrapartum care: homebirth, midwife-led environments and consultant-led environments.
- Ensure that midwives undertake a supervisory annual review to ensure safe practice.

**To Include:**

- Review of the 'hub and spoke' model of care, especially in light of the reconfiguration plans
- Review of the functions of the MLU
- Number of deliveries per MLU – per month / per annum
- Ambulance response time and alternative routes – distance and times from MLU to CLU.
- Mileage and time to transfer to CLU / neonatal unit from MLUs and time to pick up when remote.
- Patient choice, does the current model favour care closer to home model, and the impact of this on women who do not wish to deliver in a MLU?
- Identification of the current costs of the hub and spoke services
- Maternal transfer (including in-utero)
- Neonatal transfers to NNU from MLUs and CLUs by unit
- Number of deliveries en route
- Criteria for booking in an MLU
- Look at midwifery competencies rather than number of deliveries per midwife
- Are pathways in place for changes in circumstances and what are they? Who, what, why, how?
- Criteria for neonatal transfer and who transfers – how, how many?
- Is there joint training of midwives and paramedics and how is this done?
- Number and type (short / long) of booking at MLU per month / annum
- What are the challenges of PBR for provider services?

**Workforce**

***Staffing***

- An analysis of staffing, education, training and support, skills, skill mix and the deployment of staff to ensure that midwives are able to deliver continuity of antenatal and postnatal care.
- An analysis of midwifery staffing ratios across all birth settings.
- A review of appropriate obstetric consultant presence on the labour ward.
- A review of whether any midwife as the main healthcare professional at delivery, regardless of setting, is trained and competent in resuscitation of the newborn (NLS).
- A review of access to supervisors of midwives.
- A review of whether midwives have current clinical skills in recognising, and the need to seek advice for, the unwell neonate.
- A review of anaesthetist availability to the labour ward.

**To Include:**

- Midwife/birth ratio

- Provision of appropriate anaesthetist cover to labour ward
- Appropriate consultant cover on labour ward and physical presence
- Midwives' competence in the:
  - appropriate management of intrauterine growth restriction of the foetus
  - timely escalation of problems to senior input (decision making thresholds utilised in order to establish whether the mother / baby required consultant-led care)
  - interpretation of the foetal heart rate
  - appropriate use of oxytocins
  - appropriate observations of the newborn
- Midwife vacancies and attrition rate and its impact on services to include long term retention and recruitment of staff. Attrition agreed as: midwives appointed but not working for any reason
- The ratio of midwife supervisors to midwives
- Does every student get a sign-off mentor, how many sign-off mentors are there and are the same mentors used each time or does it vary across those available.
- Understand the skills and competences of midwives
- Any midwife as the main healthcare professional at delivery, regardless of setting, should be trained and competent in resuscitation of the newborn (NLS).
- All midwives have current clinical skills in recognising, and the need to seek advice for, the unwell neonate
- Education and training programmes - attendance
- Appraisals and personal development plans
- The views of frontline staff, including the staff survey
- Identify if there are any business cases, including any in development for changes to staff numbers

### **Risk management**

- A review of the risk management systems and processes, including how the learning points from incidents are implemented and monitored.
- A review of compliance with NPSA requirements.
- A review of NHSLA (CNST for maternity) compliance.
- Review of serious incidents – external view

### **To Include:**

- The impact of 'ward to board' learning
- Systems and processes for learning from adverse serious incidents and events
- Systems and processes for identifying, assessing and managing risks and their effectiveness
- Number of serious incidents, incidents and near misses
- Failed instrumental delivery
- Massive Postpartum Haemorrhage >2L
- Shoulder dystocia
- 3rd-degree tear

## **Patient choice and experience**

### ***Service User Experience***

- A review of patient choice and experience through analysis of existing surveys and undertaking further engagement activities with service users.

#### **To include:**

- Arrangement for delivering service user focussed pathways of care, including promoting access and continuity of care
- Complaints – number of complaints / those upheld
- Views of service users through focus groups around the catchment area
- Feedback from Primary Care on service
- Compliments received
- Advice given re: birthing unit and when circumstances change
- Action taken following comments and suggestions received

## *Appendix B: Terms of Reference for Maternity Services Review Board*

### **Terms of Reference Maternity Services Review Project Board**

#### **1. Introduction**

A review of maternity services at The Shrewsbury and Telford Hospital NHS Trust has been commissioned by the Governing Bodies of Shropshire and Telford and Wrekin CCGs, with the support of the Shropshire and Staffordshire Local Area Team, to ensure the delivery of the best possible care now and in the future.

#### **2. Membership**

- Chair
- Director of Nursing, Patient Safety and Experience (Shropshire and Telford and Wrekin CCGs)
- Director of Governance and Involvement (Shropshire CCG – Project and Review Team Lead)
- Healthwatch (Shropshire and Telford and Wrekin)
- Assistant Director of Nursing (NHS England Area Team)
- External Experts, to include Lead Midwife and Obstetrician, (with experience of ‘hub and spoke’ models)
- Directors of Public Health (Shropshire and Telford and Wrekin)
- Consultant Obstetrician (SaTH)
- Head of Midwifery (SaTH)
- CCG Clinicians
- Representation from Mental Health, South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- Representation from the Powys Local Health Board
- Representation from West Midlands Ambulance Services
- Representation from the Maternity and Children’s Strategic Clinical Network (SCN), West Midlands
- Project Manager - CSU

#### **3. Secretary**

Secretarial support will be provided by the CCG

#### **4. Quorum**

The quorum for the meeting will be as follows:

- Chair
- Director of Nursing, Patient Safety and Experience (Shropshire or Telford and Wrekin CCGs)

- Director of Governance and Involvement (Shropshire CCG – Project and Review Team Lead)
- Healthwatch (Shropshire and Telford and Wrekin)
- Assistant Director of Nursing (NHS England Area Team) unless Director of Nursing, Patient Safety and Experience (Shropshire CCG) is in attendance
- Consultant Obstetrician (SaTH) or Head of Midwifery (SaTH)
- CCG Clinician
- Representation from the Powys Local Health Board
- Representation from West Midlands Ambulance Services

## **5. Frequency and notice of meetings**

- Six weekly meetings

## **6. Remit and responsibilities of the Maternity Services Review Project Board**

- Approval of a detailed Project Initiation Document
- Agreeing the composition of the Project Review Team
- Ensuring effective project delivery, including the provision of regular progress reports to key stakeholders
- Approval of a final report, to be presented to a joint meeting of the Shropshire and Telford and Wrekin CCG Governing Bodies no later than 31 October 2013.
- Advise and support as required and unblock where issues / conflicts arise.
- Escalate to the Accountable Officers where there are conflicts which cannot be unblocked at this level.

## **7. Governance / reporting arrangements**

Maternity Services Review Project Board will report directly to the relevant Governing Body Board bi-monthly to include:

- A summary of progress overall
- Serious issues and risks, if escalated to the Board for their attention and action
- Exception reporting on costs / other issues
- A summary of progress against project work streams

The Project Board will receive 6 weekly reports from the Maternity Services Review Team.

## **8. Revision of Terms of Reference**

These terms of reference will be updated if and when required during the project.

## **9. Terms of Reference Approval**

These terms of reference were approved by the Maternity Services Review Project Board [24.07.13]

## ***Appendix C: Terms of Reference – Maternity Services Review Team***

### **Terms of Reference Maternity Services Review Team**

#### **1. Introduction**

A review of maternity services at The Shrewsbury and Telford Hospital NHS Trust has been commissioned by the Governing Bodies of Shropshire and Telford and Wrekin CCGs, with the support of the Shropshire and Staffordshire Local Area Team, to ensure the delivery of the best possible care now and in the future.

#### **2. Membership**

- Director of Governance and Involvement, Shropshire CCG (also Chair)
- Project Manager, Commissioning Support Unit
- External Experts, to include Lead Midwife and Obstetrician, (with experience of hub and spoke' models)
- Data analyst, Commissioning Support Unit
- Local Supervisory Authority Representative
- Patient and Public Engagement Leads, Shropshire and Telford & Wrekin
- Communications Lead, Commissioning Support Unit
- Newborn and Maternity Operational Delivery Network, representative
- CNST lead midwife, or representative – SaTH
- Patient experience midwife – SaTH
- Safeguarding lead – Shropshire CCG
- Finance representative, Shropshire CCG
- Public Health representatives (Shropshire and Telford & Wrekin)

#### **3. Secretary**

Secretarial support will be provided from the CCG

#### **4. Quorum**

The quorum will be as follows: External Midwife, External Obstetrician, Chair, Project Manager, Communications Lead, Data Analyst, a SaTH representative and Engagement Lead.

If the quorum is not met then the meeting will go ahead but no decisions will be made until the membership has had an opportunity to contribute to the discussions via email.

#### **5. Frequency and notice of meetings**

Six weekly meetings

## **6. Remit and responsibilities of the Maternity Services Review Team**

- Ensure effective project delivery, including the provision of 6 weekly progress reports to the Project Board. This may involve remote work / virtual meetings in order to meet timescales. Email correspondence will be used to ensure members are updated as appropriate.
- Agree the membership, terms of reference, work and priorities of the 5 Work Stream Groups.
- Ensure effective delivery of work stream outputs.
- Advise and support work streams as necessary and unblock where issues / conflicts arise.

### **Communications**

- Update the rolling Forward Press Plan in order to promote all events and activities via local newspapers and radio.
- Produce copy for an e-bulletin to go out following each meeting.
- On-going engagement of our MPs, including circulation of the e-bulletin
- Approval of documents before presentation at Project Board for example: Communications and Engagement Strategy; finance papers; project plan; risk register / issue log; exception reports; escalation reports; recommendations.
- Approval of a final report, to be presented to the Project Board mid October 2013.
- Escalate to the Project Board where there are conflicts which cannot be unblocked at this level.

## **7. Governance / reporting arrangements**

The Maternity Services Review Team reports directly to the Maternity Services Review Project Board.

The Maternity Services Review Team will produce an 'overview' report for all Maternity Services Review Project Board meetings (6 weekly), accompanied by minutes of the previous meeting and an action note setting out any commitments undertaken by work stream groups and progress against this. This will highlight:

- A summary of progress overall
- Serious issues and risks, if escalated to the Review Team for their attention and action
- Exception and / or escalation reporting on costs / other issues
- A summary of progress against project work streams.

The Review Team will receive 3 weekly reports from each of the 5 work stream groups.

## **8. Revision of Terms of Reference**

These terms of reference will be updated if and when required during the project.

## **9. Terms of Reference Approval**

These terms of reference were approved by the Maternity Services Review Project Board [24.07.13]

## ***Appendix D: Terms of Reference – Work Stream 1***

### **Terms of Reference Work Stream 1 Clinical Outcomes Indicators and Activity Data – Maternal and Neonatal**

#### **1. Introduction**

A review of maternity services at The Shrewsbury and Telford Hospital NHS Trust has been commissioned by the Governing Bodies of Shropshire and Telford and Wrekin CCGs, with the support of the Shropshire and Staffordshire Local Area Team, to ensure the delivery of the best possible care now and in the future.

#### **2. Membership**

- Director of Governance and Involvement (Shropshire CCG – Project and Review Team Lead)
- Project Manager, Commissioning Support Unit
- External Midwife
- External Obstetrician
- Data Analyst, Commissioning Support Unit
- Representative from Maternity Services
- Representatives from Newborn and Maternity Operational Delivery Network
- Safeguarding Children and Young People Representative

#### **3. Secretary**

Secretarial support will be provided by the CCG.

#### **4. Quorum**

The meeting will be quorate if the Chair or Project Manager is present and one other member i.e. Data analyst. Meetings will go ahead without full membership but no decisions will be made until the membership has had an opportunity to contribute to the discussions via email.

#### **5. Frequency and notice of meetings**

- Three weekly meetings

#### **6. Remit and responsibilities of the work stream**

Remote work / virtual meetings may be required in order to meet timescales. Email correspondence will be used to ensure members are updated as appropriate.

#### ***Clinical Outcomes Indicators***

- Analysis of all appropriate data and reports to review compliance with relevant national standards, guidance and benchmarks e.g. National Institute for Health and Clinical Excellence (NICE) standards
- Comparison of data against national, regional and comparable provider's data.
- A review of whether 1:1 care and continuity in labour is achieved.
- A review to ascertain that there is appropriate promotion of normal birth.
- A review of the level of cooperation through maternity networks to ensure local patterns of services meet women's needs and expectations.

***To Include:***

***Activity - Data***

- Scheduled bookings
- Instrumental vaginal delivery (forceps and ventouse)
- Caesarean sections (planned and emergency)
- Midwives undertake a supervisory annual review to ensure fitness to practice.

***Clinical Outcomes Indicators***

- Maternal morbidity
- Eclampsia
- ICU admissions in obstetrics
- Blood transfusions (4 units of blood)
- Postpartum hysterectomies

***Neonatal Morbidity***

- Obstetric units have 24 hour availability of a health professional trained in neonatal resuscitation and stabilisation who is able to provide immediate advice and attendance
- A review of compliance with standards for neonatal services.
- A review of whether midwives have current clinical skills in recognising, and the need to seek advice for, the unwell neonate.

***To include:***

- Number of cases of meconium aspiration
- Number of cases of hypoxic encephalopathy
- Neonatal deaths
- NNU transfers (other than planned or for prematurity) from MLUs and CLUs
- Any midwife as the main healthcare professional at delivery, regardless of setting, should be trained and competent in resuscitation of the newborn (NLS).

**7. Governance / reporting arrangements**

The work stream group reports directly to the Maternity Services Review Team.

The work stream will produce an 'overview' report 3 weekly for the Maternity Services Review Team which will include an action note setting out any commitments undertaken by the group and progress against this. This will document the following:

- Highlights of activities undertaken and completed in the reporting period

- Tasks to be progressed in the next period
- Progress against milestone dates as identified in the project plan
- Early warning of issues / risks and actions in hand to address them
- Exception and / or escalation reporting
- Escalate to the Review Team where there are conflicts which cannot be unblocked at this level.

#### **8. Revision of Terms of Reference**

These terms of reference will be updated if and when required during the project.

#### **9. Terms of Reference Approval**

These terms of reference were approved by the Maternity Services Project Board [24.07.13]

## *Appendix E: Terms of Reference – Work Stream 2*

### **Terms of Reference Work Stream 2 Hub and Spoke Model**

#### **1. Introduction**

A review of maternity services at The Shrewsbury and Telford Hospital NHS Trust has been commissioned by the Governing Bodies of Shropshire and Telford and Wrekin CCGs, with the support of the Shropshire and Staffordshire Local Area Team, to ensure the delivery of the best possible care now and in the future.

#### **2. Membership**

- Director of Governance and Involvement (Shropshire CCG – Project and Review Team Lead)
- Project Manager, Commissioning Support Unit
- External Midwife
- External Obstetrician
- Data Analyst, Commissioning Support Unit
- Representative from Maternity Services
- Representative from the Newborn and Maternity Operational Delivery Network
- Ambulance services expertise
- Finance expertise, Shropshire CCG

#### **3. Secretary**

Secretarial support will be provided by the CCG.

#### **4. Quorum**

The meeting will be quorate if the Chair or Project Manager is present and one other member i.e. Data analyst. Meetings will go ahead without full membership but no decisions will be made until the membership has had an opportunity to contribute to the discussions via email.

#### **5. Frequency and notice of meetings**

- Three weekly meetings

#### **6. Remit and responsibilities of the work stream**

Remote work / virtual meetings may be required in order to meet timescales. Email correspondence will be used to ensure members are updated as appropriate.

- A review of the safety and quality of services in all environments (including the hub and spoke model and transportation of women / neonates from a MLU to the consultant / neonatal unit during or after labour).
- A review of whether continuity of care, choice and access is available in line with the NHS Constitution.
- A review of whether there is evidence of access to all types of intrapartum care: homebirth, midwife-led environments and consultant-led environments.
- Ensure that midwives undertake a supervisory annual review to ensure safe practice.

**To Include:**

- Review of the 'hub and spoke' model of care, especially in light of the reconfiguration plans
- Review of the functions of the MLU
- Number of deliveries per MLU – per month / per annum
- Ambulance response time and alternative routes – distance and times from MLU to CLU.
- Mileage and time to transfer to CLU / neonatal unit from MLUs and time to pick up when remote.
- Patient choice, does the current model favour care closer to home model, and the impact of this on women who do not wish to deliver in a MLU?
- Identification of the current costs of the hub and spoke services
- Maternal transfer (including in-utero)
- Neonatal transfers to NNU from MLUs and CLUs by unit
- Number of deliveries en route
- Criteria for booking in an MLU
- Look at midwifery competencies rather than number of deliveries per midwife
- Are pathways in place for changes in circumstances and what are they? Who, what, why, how?
- Criteria for neonatal transfer and who transfers – how, how many?
- Is there joint training of midwives and paramedics and how is this done?
- Number and type (short / long) of booking at MLU per month / annum
- What are the challenges of PBR for provider services?

**7. Governance / reporting arrangements**

The work stream group reports directly to the Maternity Services Review Team.

The work stream will produce an 'overview' report 3 weekly for the Maternity Services Review Team which will include an action note setting out any commitments undertaken by the group and progress against this. This will document the following:

- Highlights of activities undertaken and completed in the reporting period
- Tasks to be progressed in the next period
- Progress against milestone dates as identified in the project plan
- Early warning of issues / risks and actions in hand to address them
- Exception and / or escalation reporting

Escalate to the Review Team where there are conflicts which cannot be unblocked at this level.

#### **8. Revision of Terms of Reference**

These terms of reference will be updated if and when required during the project.

#### **9. Terms of Reference Approval**

These terms of reference were approved by the Maternity Services Project Board [24.07.13]

## **Appendix F: Terms of Reference – Work Stream 3**

### **Terms of Reference Work Stream 3 Workforce**

#### **1. Introduction**

A review of maternity services at The Shrewsbury and Telford Hospital NHS Trust has been commissioned by the Governing Bodies of Shropshire and Telford and Wrekin CCGs, with the support of the Shropshire and Staffordshire Local Area Team, to ensure the delivery of the best possible care now and in the future.

#### **2. Membership**

- Director of Governance and Involvement (Shropshire CCG – Project and Review Team Lead)
- Project Manager, Commissioning Support Unit
- External Midwife
- External Obstetrician
- Data Analyst , Commissioning Support Unit
- Local Supervising Authority (LSA) representative
- University representative
- Representative from maternity services

#### **3. Secretary**

Secretarial support will be provided by the CCG.

#### **4. Quorum**

The meeting will be quorate if the Chair or Project Manager is present and one other member i.e. Data analyst. Meetings will go ahead without full membership but no decisions will be made until the membership has had an opportunity to contribute to the discussions via email.

#### **5. Frequency and notice of meetings**

- Three weekly meetings

#### **6. Remit and responsibilities of the work stream**

Remote work / virtual meetings may be required in order to meet timescales. Email correspondence will be used to ensure members are updated as appropriate.

- An analysis of staffing, education, training and support, skills, skill mix and the deployment of staff to ensure that midwives are able to deliver continuity of antenatal and postnatal care.
- An analysis of midwifery staffing ratios across all birth settings.

- A review of appropriate obstetric consultant presence on the labour ward.
- A review of whether any midwife as the main healthcare professional at delivery, regardless of setting, should be trained and competent in resuscitation of the newborn (NLS).
  - A review of access to supervisors of midwives.
  - A review of whether midwives have current clinical skills in recognising, and the need to seek advice for, the unwell neonate.
  - A review of anaesthetist availability to the labour ward.

**To Include:**

- Midwife/birth ratio
- Provision of appropriate anaesthetist cover to labour ward
- Appropriate consultant cover on labour ward and physical presence
- Midwives' competence in the:
  - appropriate management of intrauterine growth restriction of the foetus
  - timely escalation of problems to senior input (decision making thresholds utilised in order to establish whether the mother / baby required consultant-led care)
  - interpretation of the foetal heart rate
  - appropriate use of oxytocins
  - appropriate observations of the newborn
- Midwife vacancies and attrition rate and its impact on services to include long term retention and recruitment of staff. Attrition agreed as: midwives appointed but not working for any reason
- The ratio of midwife supervisors to midwives
- Does every student get a sign-off mentor, how many sign-off mentors are there and are the same mentors used each time or does it vary across those available
- Understand the skills and competences of midwives
- Any midwife as the main healthcare professional at delivery, regardless of setting, should be trained and competent in resuscitation of the newborn (NLS).
- All midwives have current clinical skills in recognising, and the need to seek advice for, the unwell neonate
- Education and training programmes - attendance
- Appraisals and personal development plans
- The views of frontline staff, including the staff survey
- Identify if there are any business cases, including those in development, for changes to staff numbers

**7. Governance / reporting arrangements**

The work stream group reports directly to the Maternity Services Review Team.

The work stream will produce an 'overview' report 3 weekly for the Maternity Services Review Team which will include an action note setting out any commitments undertaken by the group and progress against this. This will document the following:

- Highlights of activities undertaken and completed in the reporting period

- Tasks to be progressed in the next period
- Progress against milestone dates as identified in the project plan
- Early warning of issues / risks and actions in hand to address them
- Exception and / or escalation reporting

Escalate to the Review Team where there are conflicts which cannot be unblocked at this level.

#### **8. Revision of Terms of Reference**

These terms of reference will be updated if and when required during the project.

#### **9. Terms of Reference Approval**

These terms of reference were approved by the Maternity Services Project Board [24.07.13]

## **Appendix G: Terms of Reference – Work Stream 4**

### **Terms of Reference Work Stream 4 Risk Management**

#### **1. Introduction**

A review of maternity services at The Shrewsbury and Telford Hospital NHS Trust has been commissioned by the Governing Bodies of Shropshire and Telford and Wrekin CCGs, with the support of the Shropshire and Staffordshire Local Area Team, to ensure the delivery of the best possible care now and in the future.

#### **2. Membership**

- Director of Governance and Involvement (Shropshire CCG – Project and Review Team Lead)
- Project Manager, Commissioning Support Unit
- External Midwife
- External Obstetrician
- Data Analyst, Commissioning Support Unit
- Representative from Maternity Services - SaTH
- Risk Management Expert, Commissioning Support Unit

#### **3. Secretary**

Secretarial support will be provided by the CCG.

#### **4. Quorum**

The meeting will be quorate if the Chair or Project Manager is present and one other member i.e. Data analyst. Meetings will go ahead without full membership but no decisions will be made until the membership has had an opportunity to contribute to the discussions via email.

#### **5. Frequency and notice of meetings**

- Three weekly meetings

#### **6. Remit and responsibilities of the work stream**

Remote work / virtual meetings may be required in order to meet timescales. Email correspondence will be used to ensure members are updated as appropriate.

#### **Risk management**

- A review of the risk management systems and processes, including how the learning points from incidents are implemented and monitored.
- A review of compliance with NPSA requirements.
- A review of NHSLA (CNST for maternity) compliance.

- Review of serious incidents – external view

**To Include:**

- The impact of 'ward to board' learning
- Systems and processes for learning from adverse serious incidents and events
- Systems and processes for identifying, assessing and managing risks and their effectiveness
- Number of serious incidents, incidents and near misses
- Failed instrumental delivery
- Massive Postpartum Haemorrhage >2L
- Shoulder dystocia
- 3rd-degree tear

**7. Governance / reporting arrangements**

The work stream group reports directly to the Maternity Services Review Team.

The work stream will produce an 'overview' report 3 weekly for the Maternity Services Review Team which will include an action note setting out any commitments undertaken by the group and progress against this. This will document the following:

- Highlights of activities undertaken and completed in the reporting period
- Tasks to be progressed in the next period
- Progress against milestone dates as identified in the project plan
- Early warning of issues / risks and actions in hand to address them
- Exception and / or escalation reporting

Escalate to the Review Team where there are conflicts which cannot be unblocked at this level.

**8. Revision of Terms of Reference**

These terms of reference will be updated if and when required during the project.

**9. Terms of Reference Approval**

These terms of reference were approved by the Maternity Services Project Board [24.07.13]

## **Appendix H: Terms of Reference – Work Stream 5**

### **Terms of Reference Work Stream 5 Service User Experience**

#### **1. Introduction**

A review of maternity services at The Shrewsbury and Telford Hospital NHS Trust has been commissioned by the Governing Bodies of Shropshire and Telford and Wrekin CCGs, with the support of the Shropshire and Staffordshire Local Area Team, to ensure the delivery of the best possible care now and in the future.

#### **2. Membership**

- Director of Governance and Involvement (Shropshire CCG – Project and Review Team Lead)
- Project Manager, Commissioning Support Unit
- Independent facilitator for engagement activities
- Healthwatch (Shropshire and Telford & Wrekin)
- Patient and Public Engagement leads (Shropshire and Telford & Wrekin)
- Community Health Council (Powys / Montgomeryshire)
- Communications Lead, Commissioning Support Unit
- Data analyst, Commissioning Support Unit
- External Appreciative Inquiry Facilitator
- Patient Experience Midwife Lead, SaTH

#### **3. Secretary**

Secretarial support will be provided by the CCG.

#### **4. Quorum**

The meeting will be quorate if the Chair or Project Manager is present and one other member. Meetings will go ahead without full membership but no decisions will be made until the membership has had an opportunity to contribute to the discussions via email.

#### **5. Frequency and notice of meetings**

- Three weekly meetings

#### **6. Remit and responsibilities of work stream**

Remote work / virtual meetings may be required in order to meet timescales. Email correspondence will be used to ensure members are updated as appropriate.

## **Patient choice and experience**

### ***Service User Experience***

- A review of patient choice and experience through analysis of existing surveys and undertaking further engagement activities with service users.

#### **To include:**

- Arrangement for delivering service user focussed pathways of care, including promoting access and continuity of care
- Complaints – number of complaints / those upheld
- Views of service users through focus groups around the catchment area
- Feedback from Primary Care on service
- Compliments received
- Advice given re: birthing unit and when circumstances change
- Action taken following comments and suggestions received

## **7. Governance / reporting arrangements**

The work stream group reports directly to the Maternity Services Review Team.

The work stream will produce an 'overview' report 3 weekly for the Maternity Services Review Team which will include an action note setting out any commitments undertaken by the group and progress against this. This will document the following:

- Highlights of activities undertaken and completed in the reporting period
- Tasks to be progressed in the next period
- Progress against milestone dates as identified in the project plan
- Early warning of issues / risks and actions in hand to address them
- Exception and / or escalation reporting

Escalate to the Review Team where there are conflicts which cannot be unblocked at this level.

## **8. Revision of Terms of Reference**

These terms of reference will be updated if and when required during the project.

## **9. Terms of Reference Approval**

These terms of reference were approved by the Maternity Services Project Board [24.07.13]



*Telford and Wrekin  
Clinical Commissioning Group*



*Shropshire  
Clinical Commissioning Group*

# **Maternity Services Review**

## **Communications and Engagement Strategy**

Created: V2 04/07/13 S. Venables  
V3 16/07/13 B Patel-Smith  
V4 22/07/13 B Patel-Smith  
V5 30.07.13 Y Cowie

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# 1 INTRODUCTION

Shropshire and Telford and Wrekin Clinical Commissioning Groups (CCGs), as the statutory bodies responsible for commissioning safe, sustainable services for our respective patient population groups, have requested that a formal review of the maternity services at the Shrewsbury and Telford Hospital NHS Trust be undertaken.

The remit of the review will be to identify to the CCG Governing Body Boards the current position regarding the quality and safety of maternity services, making recommendations as required, in order to ensure that the service provides the highest quality and safest care to mothers and their babies. It will also review the sustainability of the hub and spoke model going forward.

This Communications and Engagement Strategy has been developed to ensure that robust communications and engagement activities are undertaken at each of the three stages of the review outlined in the Project Initiation Document:

- Phase 1: Analysis/diagnostic work - to be completed by 17 September 2013
- Phase 2: Review and Development of recommendations – report compiled for final approval by the Maternity Services Review Project Board – mid October 2013
- Phase 3: Performance Improvement Plan – development of performance improvement plan and implementation – November 2013

This strategy has been developed in conjunction with the Maternity Services Review Project Initiation Document and outlines the activities that will be undertaken locally to inform, involve and receive service user experiences and support meeting the objectives of the project.

It also outlines other activities to be implemented to ensure that communications and engagement is open, transparent and inclusive.

Overall control and monitoring of the Communications and Engagement Strategy will be overseen by:

- The Maternity Review Team
- Service User experience workstream

## 2. SITUATIONAL ANALYSIS

A review of maternity services at The Shrewsbury and Telford Hospital Trust has been commissioned by the Governing Bodies of Shropshire and Telford and Wrekin CCGs, with the support of the Shropshire and Staffordshire Area Team (NHS England) to ensure the delivery of the best possible care now, and in the future.

The rationale for the review is based on:

- Recent high profile inquest raising questions about the:
  - 'Hub and spoke' model of midwifery care
  - Decision making process with regard to safe and appropriate transportation of mother and baby (especially in light of the forthcoming hospital reconfiguration)

- Pattern and understanding of serious incidents within maternity services since revised categories of reporting implemented. Specifically associated with:
  - Potential concerns about the management of intrauterine growth restriction of foetus
  - Perceived delays in escalating patient cases for specialist interventions
  - Potential concerns about variations in interpretation of the foetal heart rate
  - Potential concerns about variations in adherence to standard guidance, including the use of oxytocins
- Failure to meet nationally recommended midwifery supervisor/midwife ratio
- Ongoing challenges with regard to midwife/birth ratio

The Project Initiation Document for the Maternity Services Review outlines what the maternity services currently comprises of and takes account of changes which have previously been consulted and agreed and come into force in Summer 2014. Broadly current services are:

- Shrewsbury Consultant Unit (Royal Shrewsbury Hospital site)
- The antenatal ward (Royal Shrewsbury Hospital site)
- The postnatal ward (Royal Shrewsbury Hospital site)
- Midwife Led Units (Bridgnorth Community Hospital; Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry; Ludlow Community Hospital; Princess Royal Hospital, Telford; Royal Shrewsbury Hospital)
- Neonatal Unit (Royal Shrewsbury Hospital site)
- From summer 2014, women who need a consultant-led delivery will give birth at a new Women and Children's Unit at the Princess Royal Hospital Telford which will replace the existing maternity building at Royal Shrewsbury Hospital

### **Duty to engage**

In accordance with our legal duties under the NHS Act 2006, the Equality Act 2010 and the NHS Constitution 2012 we are committed through our systematic involvement and engagement methods to ensure that patients and the public are at the heart of all we do.

Under Section 242(1B) of the NHS Act (2006), we are required to ensure that the public and our patients are informed and involved in the following areas:

- In planning the provision of services
- In the development and consideration of proposals for change in the way services are provided
- In any decisions to be made affecting the operation of services

We also have a legal duty under the Equality Act (2010) to eliminate inequality and discrimination on the grounds of race and ethnic group, age, gender, disability, faith and sexual orientation.

The NHS constitution adheres to the ideals of the NHS Constitution (2012), which sets out the principles, rights and values of the NHS in England.

The NHS Constitution includes pledges linked to patient and public engagement, specifically:

- Information provision to support choice
- Ensuring involvement in service planning and redesign

- Responsibilities to patients including the provision of feedback

This review involves many stakeholders which have been outlined in the Stakeholder Analysis (Appendix 1). All communications and engagement must be targeted and appropriate as well as being open and honest and responsive to the needs of our whole community, with specific reference to the most 'unheard voices' and 'hard to reach communities'. In developing our communication channels we have been conscious of our need to engage effectively with the different communities and groups of people within our population including the nine protected groups covered by the Equality Act (2010) as well as vulnerable or marginalised groups.

### 3. OBJECTIVES

The overall objectives of this strategy are:

- To support through consistent communications and engagement the delivery of the overall objective of this review
- To work in partnership with organisations including Healthwatch in both Telford and Wrekin and Shropshire and the Community Health Councils (CHC) in Powys. This is to promote collaboration, effective engagement and have well informed stakeholders who are and able to express views and experiences and ensure external scrutiny of the project
- To ensure clinical engagement in the review across all stakeholders
- To have a community that is engaged and is aware of how they can get involved and express their views
- To ensure that communications are open, clear, concise, transparent and timely
- To manage the risk of negative publicity by ensuring that messages are backed up by facts – not anecdotal evidence

### 4 KEY MESSAGES

Clear messages will be used to convey the objectives and essence of this review and stimulate engagement. It is important that we reflect these key messages in all our communications and engagement with our key stakeholders to ensure a consistent approach.

- We are committed to putting patients and service users at the heart of everything that we do
- We value the patient/service user voice and will work in partnership to review maternity services
- We are dedicated to working with our health care professionals and clinicians in the planning and provision of health services, in collaborative ways
- We want safe, sustainable maternity services for our patients – we will do this through recognition of current good practice and using this as a platform to build on
- We want to give our population services of the highest quality, providing the safest care to mothers and their babies
- We want maternity services to be based on the needs of the population and provide continuity of care, choice and access
- We want maternity services to be provided in a safe environment
- We want to ensure that we have a workforce that is professional and competent

## Tone of voice

We want to be inclusive, transparent and accessible and professional in all our communications and engagement activity.

## 5. STRATEGY

### Targeting and segmentation

We have considered who needs to be involved and engaged at various levels of the review and undertaken a Stakeholder Analysis (**Appendix 1**).

The mapping and segmentation for the Stakeholder Analysis will help the Maternity Services Review Team to consider the:

- Messages to communicate and the objectives of the messages
- Strategy by which we wish to reach the target audience
- Tactics for reaching them, to be selective in the approach
- Timescale in which to work, and to hit trigger points
- Resources that we have to reach the target audiences (either individually, or collectively if we choose to work in partnership with other organisations)

### Positioning

The Maternity Services Review Team recognise that we need to position this review and the communications and engagement using a number of strategies in order to raise awareness enhance perceptions and stimulate interest and dialogue. Positioning will be based on:

- **Quality and Safety:** Quality of insight and knowledge, quality and safety of sustainable commissioned maternity services and quality of governance
- **Attributes/features:** Collaboration, care, genuine leadership, innovation, clinically led, quality driven, partnership orientated, respectful, amicable, tolerant, understanding, learning, ethical, transparent and honest
- **Customer Benefits:** Responsive, service user focused putting them at the heart of decision making process through true involvement and continuous improvement; choice of service user to take up their constitutional right to have their baby at a place of their choosing, where it is safe to do so
- **Use and application** – Safe, high quality, knowledgeable workforce, patient exercising choice

### Public and Patient Engagement Strategy

Involving our service users and wider stakeholders is imperative to the project and is embedded into our objectives.

The Service User Experience work stream is tasked with focusing on the 'service user experience' including:

- Patient Opinion Website
- NHS Choices Website and Patient Opinion

- CCG websites
- CQC Maternity Services Review
- Compliments
- Local audits or surveys
- Complaints / PALs
- National Patient Survey on Maternity Services, 2010
- Insight Report
- Focus groups

### ***Focus Groups***

We will be holding a series of service user focus group meetings across Telford and Wrekin, Shropshire and Powys (see Appendix 2) during phase 1 of this review. We will widely publicise these events using channels identified in this document. These events will be led by an external facilitator and are open to any member of the community who wish to provide comment on the maternity services.

To ensure external scrutiny of the project the focus groups will be attended by Healthwatch for Telford and Wrekin, Shropshire and CHC for Powys.

We will also offer to attend meetings of established groups to present the review and run specific focus groups.

### ***Digital channels***

Research shows us that the 16 – 24 year old age group and the 25 – 44 year old age groups has high usage of websites and social media with the 25 – 44 year old age groups particularly using websites as a tool to access information, communicate and manage their lives. Other areas have successfully used Facebook to communicate and engage on maternity services and we propose to adopt this media, along with Twitter. We will ensure that any off-line communications and engagement also drives traffic through to Facebook and Twitter.

We will implement approaches to manage the feedback and ensure that we engage in a dialogue. We will also ensure that Facebook and Twitter is driven from the 2 CCG websites and access is also linked to partner sites to encourage more usage which we will monitor closely.

We will also set up an on-line survey to enable people who can't attend a focus group to feedback their views

Digital communications will run through phase 1, 2 and 3 of this review.

We will set up visitor tracking and utilise the Google Analytical Evaluation and monitoring to assess use of website and make adjustments to ensure improved us.

### **Press/PR strategy**

The Maternity Services Review Team appreciates that any review brings with it differing opinions and views. Working in highly political environment the NHS is strongly influenced by national and local policy and decision making, legislation, funding and local lobbying.

A press and media protocol (Appendix 3] has been established which exists to ensure that all media enquiries are handled in the same way, regardless of their point of entry into various local organisations and at what level. It is essential that the protocol is followed to ensure that consistent messages are delivered and that communication is evidenced based and not based on anecdotal feedback.

A rolling Forward Press Plan will be established for the duration of the review covering phases 1, 2 and 3, which include all proactive media opportunities and reactive issues which will be implemented on a week by week basis. The Plan will be updated by the Maternity Services Review Team. We will ensure that all events and activities are promoted via local newspapers and radio.

We will expand our reach of media opportunities to include local magazines, newsletters and websites and distribute articles to be featured.

We have established public and patient engagement structures and partnerships including our two local HealthWatch organisations. We will ensure that we establish an e-bulletin which will be distributed after each meeting of the Maternity Services Review Team to ensure that our stakeholders are kept apprised of the progress of the review and are away of forthcoming activities.

### **Public Affairs strategy**

On-going communications and reports will be presented to the joint Overview and Scrutiny Committee to ensure that they are fully appraised and engaged in the review process.

On-going engagement of our MPs will be undertaken by members of the Maternity Services Review Team and we will ensure that the e-bulletin is also circulated to MPs to enable them to keep their constituents informed.

The two CCGs are active members of the Health and Wellbeing Board. We will ensure that the review is a regular feature of the board meeting.

### **Health professionals**

It is important that all relevant health care professionals are engaged and involved in this review both as a member of the workforce, but as a patient and also someone who influences service users.

We will coordinate drop-in sessions, in Shrewsbury, Oswestry, Bridgnorth and Telford for relevant health professional at phase 1 of this review to hear views, opinions and experiences and gather data and then provide feedback.

## **6. CONTROL AND MONITORING**

Within Appendix 2 of this strategy we have outlined our tactics and actions to be undertaken to a set timescale.

The output control measures are also linked either to a work measurement e.g. number of press releases issued or activities undertaken.

The outputs of this Strategy will be reported to the Service User Experience Workstream (5) that reports directly to the Maternity Services Review Team.

The Workstream will produce an ‘overview’ report every 3 weeks for the Maternity Services Review Team. The report will include an action note setting out any commitments undertaken by the group and progress against this. This will document the following:

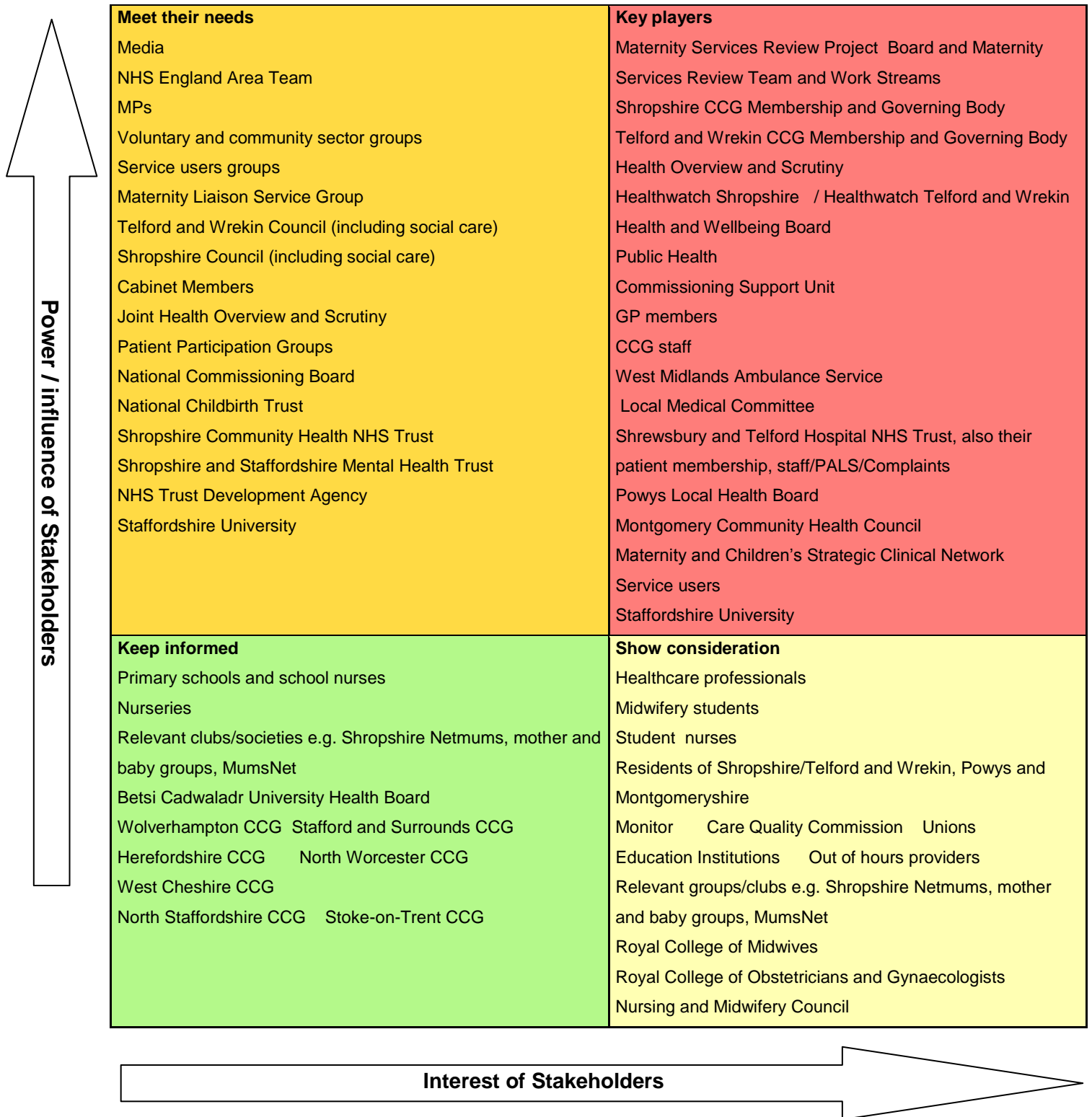
- Highlights of activities undertaken and completed in the reporting period
- Tasks to be progress in the next period
- Progress against milestone dates as identified in the project plan
- Early warning of issues/risks and actions in hand to address them
- Exceptions and/or escalation reporting

## Risks

There are key risks associated with the communications and engagement of the Maternity Services Review (scale of 1-5, 5 being most likely):

Risk description	Likelihood	Severity	Mitigation
Disengagement of key stakeholders	1	5	Review communications and engagement strategy
Negative feedback from lobbyist direct or via media	3	5	On-going communications with lobbyists. Use of key spokespeople to challenge misconceptions Meeting set up with local journalists
Negative feedback from attendees at events	3	2	Use of HealthWatch to act as independent body to record feedback Patient stories shared with audience and through media
Petition raised	1	3	Set up meeting with key petition organisers to either mitigate risk of petition or establish dialogue
Negative feedback from local politicians	2	3	Communication pre-engagement to discuss review
Negative comments relating to communications and the ability to be involved	1	5	Use wider networks to support delivery of message. Enhance communications throughout engagement process
Review undertaken within the backdrop of the implementation of the hospital reconfiguration and therefore can potentially undermine the decisions associated with these plans	2	3	Ensure that communications of the drop projects differentiates the work
Disengagement of staff	1	5	Ensure regular internal communications are maintained Ensure staff have an opportunity to feedback through staff drop in sessions
Vulnerable groups feel marginalised or contributions are not valued	2	4	Enhance communications with vulnerable groups and utilised
Disengagement of staff	1	5	Ensure adequate engagement and involvement of staff. Seek views and keep updated

# Appendix 1 Stakeholder Analysis



## Appendix 2

# TACTICS AND ACTION

Our implementation plan set out activities to be undertaken and the phases of the review they will be undertaken.

<i>When</i>	<i>Stakeholder/ group/ Audience</i>	<i>What</i>	<i>What does good look like</i>	<i>Lead</i>	<i>Status/Update</i>
Phase 1 by 15/07/13	All audiences	<p>Explore with partners all communications and engagement activity and agree leads and coordinators for all activities</p> <p>Explore the support of NHS England advisory teams in the engagement process (former supports - National Clinical Advisory Team and Gateway Team)</p> <p>Pay attention to networks of patient and public networks so as to build on existing communications and engagement activity</p>	Coordinated approach to Review by partners	S Venables	Complete
05/07/13		<p>Agree how the information gathered via websites, Facebook, complaints etc. and the focus groups will be collated and who is responsible for this collation, analysis, evaluation and reporting and ensure external scrutiny</p> <p><b>Review existing service user feedback:</b>            Patient Opinion Website            NHS Choices Website and Patient Opinion            CCG websites            CQC Maternity Services Review            Compliments            Local audits or surveys            Complaints / PALs            National Patient Survey on Maternity Services, 2010            Insight Report            Focus groups</p>	All partners aware of role and external scrutiny and governance in place	B Patel- Smith and B Singh Rai	75% complete

06/08/13	Overview and Scrutiny (Telford and Wrekin and Shropshire)	Attend Overview and Scrutiny Committee in both areas of county to present the proposed Review. Coordinate regular updates in line with requires of the committee	Informed and engaged Overview and Scrutiny	B Patel-Smith and C Morris	Meeting 05.08.13.
Updated to 14.09.13 Phase 1	Service users and relevant representatives groups	<p>Coordinate 8 focus groups across Telford and Wrekin, Shropshire and Powys.</p> <p>Promote on-line and off-line through press, by invitation, in newsletters, through relevant groups including SaTH patient membership. Set up additional focus group with organisations who specifically wish for bespoke, specific, focus group.</p> <p>Ensure that focus groups are coordinated with all other work including survey to ensure consistent approach, which will be facilitated by an independent person</p>	<p>Aim for 20 people attending each meeting. Community aware of review and ways that they can be involved</p> <p>All questions coordinated and consistent feedback achieved</p>	B Patel-Smith and B Singh Rai	
Updated to 14.09.13 Phase 1 and 3	All audiences	Coordinate Maternity Services Review page on Facebook linked to CCG websites and partner websites	People aware of review, information shared and dialogue generated and feedback received from 50 people	S Venables, K Higgins and S Smith	
Updated to 14.09.13  14.09.13	All audiences	<p>Coordinate online survey created to allow people unable to attend events to contribute to review</p> <p>Utilise facebook and twitter to support marketing and awareness of the survey</p> <p>Develop report</p>	More people involved in the review and expressing views with the aim that 60 people completing survey	S Venables and B Singh Rai	
By 19/07/13	Nine protected groups and vulnerable communities	Consider how the input of the most 'unheard' and 'hard to reach' communities will be secured. These groups may include Polish, Bengali and Gypsy and Traveller communities.		B Patel-Smith and B Singh Rai	Complete

Updated to 09.08.13  Phase 1 and 3	All audiences	Maternity Services Review information created on 2 x CCG websites and SaTH website with links to partner websites. Information to include details of review, events, links to on-line survey, Facebook, Q&A	Informed community with knowledge of how to get involved in the review	S Venables	
Ongoing to link to events  Phase 1 and 3	All audiences	Collate and produce proactive press releases to support reputation management in line with press protocols	At least 3 press releases per month	S Venables	
Updated to 02.08.13	CCGs/ SaTH/Maternity Services Review Team	Establish key media spokespeople for the Review.  Ensure that information, press releases etc are shared with the nominated spokesperson in a timely manner.	Media spokespeople identified and confident and well briefed in undertaking media interviews representing the Maternity Services Review Team	S Venables  S Smith	Media spokes person agreed - either B Patel -Smith / Caron Morton  Awaiting Telford link
Updated to 09.08.13	Journalists	Meetings and/or regular communications established with journalists to develop ongoing relationships and communicate review	Enhanced working relationships around Maternity Review	S Venables	
Updated to 09.08.13	All audiences	Widen media database and target appropriate local magazines and newsletter with relevant articles and features, including Trust and Patient newsletters	Better informed local residents	S Venables	
After each meeting of project team  Next due w/c 29.07.13	All audiences	Develop, collate and distribute an e-bulletin to distribute after each meeting the Project Board  Link this to the Facebook page, CCG websites, existing patient databases (as appropriate), and new contacts emerging from this review  Use twitter to signpost and raise awareness	Production of 3 bulletins  Ensure that all audiences are up-to-date with the progress of the review	S Venables  Jenny Fullard	

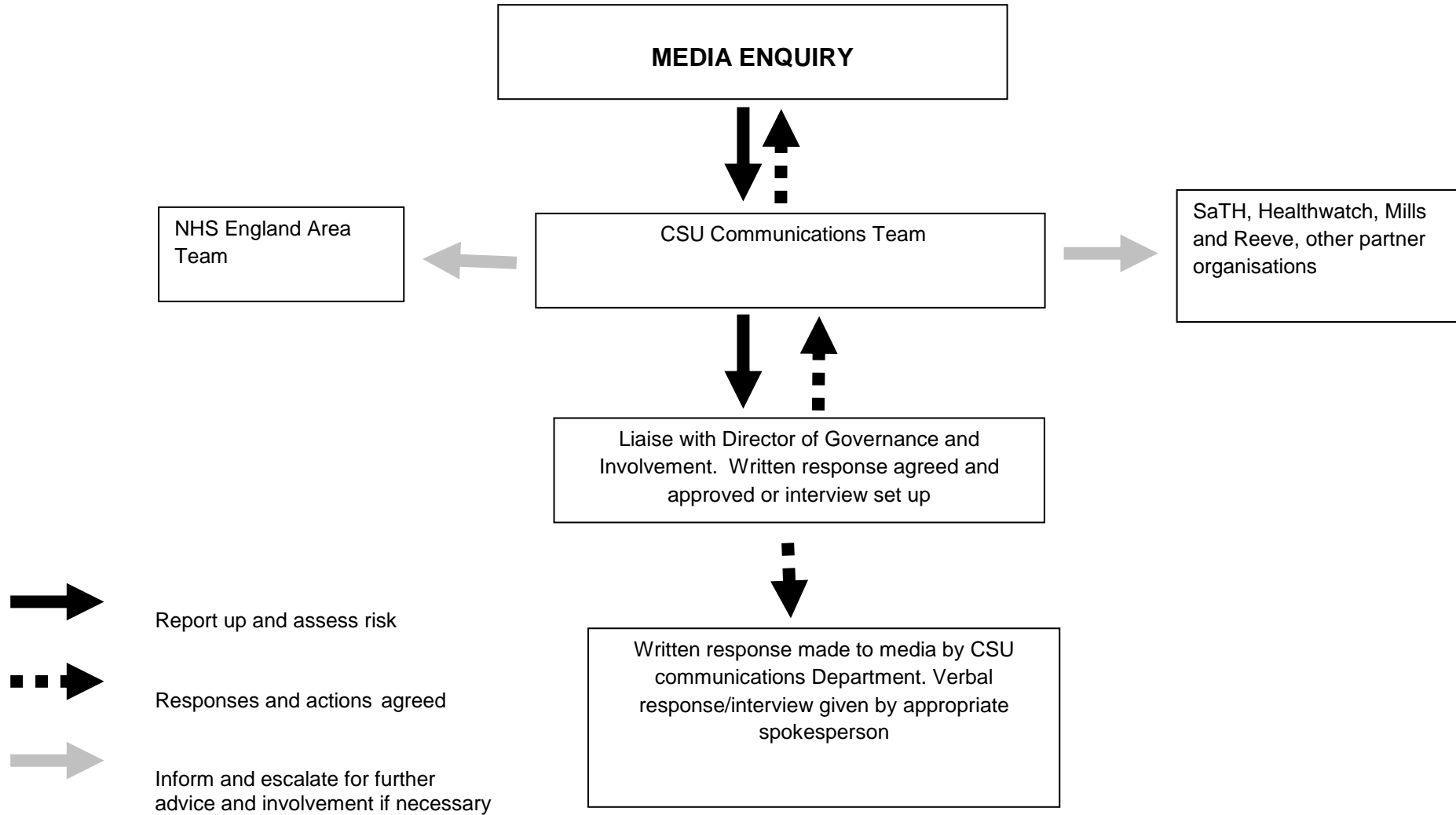
Updated to 09.08.13	PPGs, Shropshire Patient Group, Telford and Wrekin Round Table, SaTH membership, HealthWatch	Work with established community and voluntary groups to identify opportunities to do individual presentations to their communities/groups.  Be clear at the outset what we are presenting, when and how.  Collate results	Aim for 20-30 people attending each meeting. Community aware of review and ways that they can be involved	B Patel-Smith, K Higgins, S Smith and B Singh Rai	Presentation to the Shropshire Patients Group on 16/07/13
!4.09.13					
09/08/13	Health and Wellbeing Board	Report on regular basis the progress of the review, utilising a range of tools and techniques including verbal feedback, presentations, distribution of the reporting pro-forma etc	Well informed Health and Wellbeing Board and representative organisations	B Patel-Smith and C Morris	Shrops – paper presented.  Need to identify if Telford completed
Updated to 09.08.13	MPs & Assembly Members in Wales	Set up regular communications with local MPs to keep them apprised of the review and outputs	Well informed MPs & Assembly Members able to inform constituents	S Venables	
08.08.13		Identify names from CHC		Y Cowie	
Updated to 09.08.13	Health professionals	Work with provider organisations to set up either focus groups, or 1:1 interviews, with a cross section of staff specifically for health professionals to inform the review process via sound engagement and involvement  Set up drop in sessions  Develop and make available questionnaire for staff  Collate results	Aim for 20 health professionals people attending each workshop and informed of the details of the review and involved	C Smith and B Patel-Smith  As above  S. Venables / Y Cowie	
Set up by 19/07/13	Voluntary and community sector working with vulnerable and protected groups	Review the existing communication and engagement networks of the participating organizations to establish how best to engage the most 'unheard' and 'hard to reach voices' in the review process  Use the framework of the nine protected characteristics of The Equality Act (2010) as a guide	Inclusive engagement of all areas of the community	B Patel-Smith, K Higgins, S Smith and B Singh Rai	On-going

On-going	All audiences	Report on regular basis to the Project Board and CCG Governing Body at Board meetings	Well informed Project Board and Governing Body	B Patel-Smith and C Morris	On-going
On-going Following the end of the review and report accepted / recommendations in place	All audiences	Agree mechanism and then arrange to feedback results of maternity services review and /or individual parts of the review to participants, focus groups, staff, public and stakeholders etc	Those who are interested are aware of the results of the review	Communications Team	

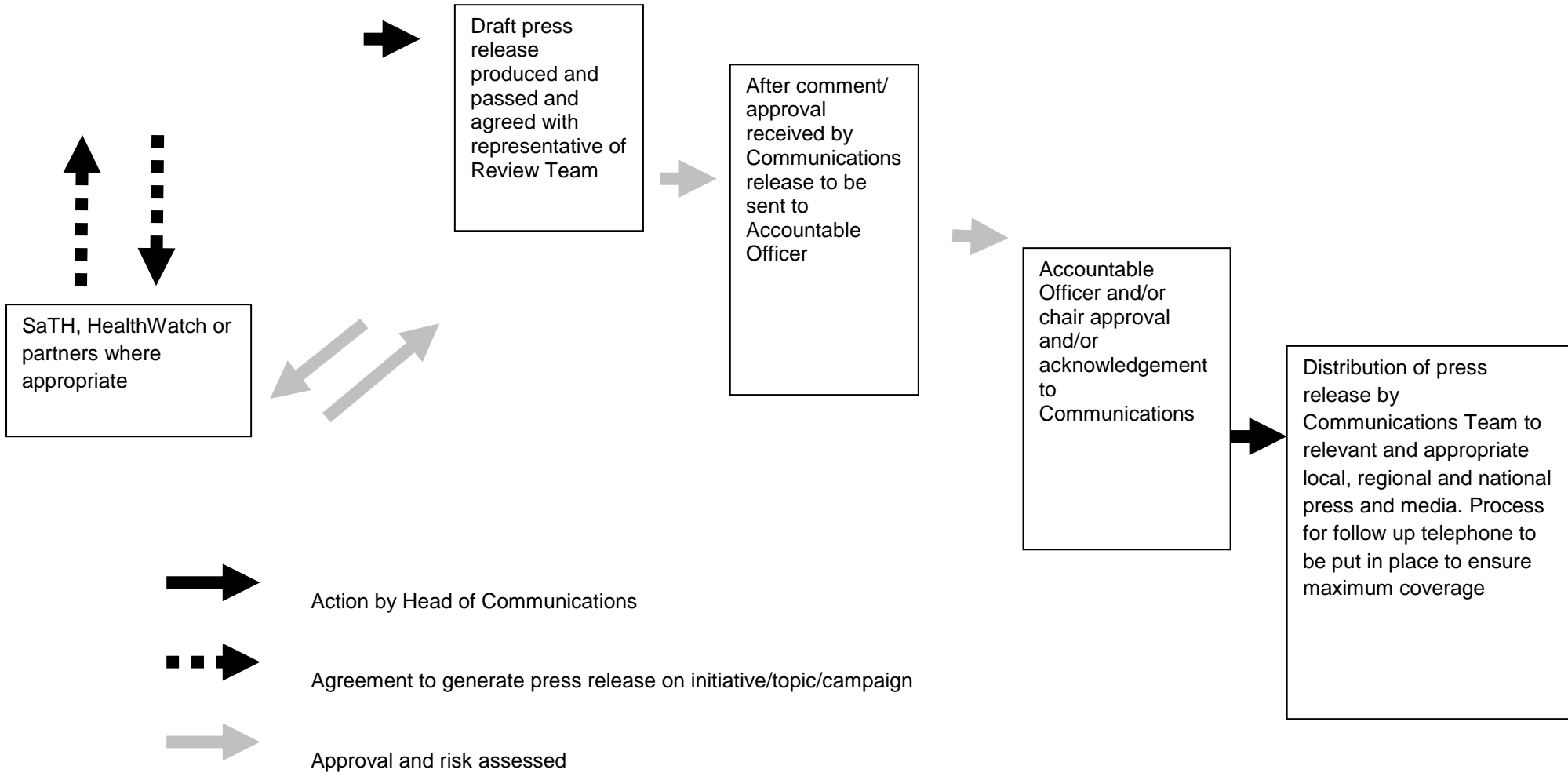
Appendix 3

# Media Handling Protocol

- reactive response to enquiries from the media



- **proactive generation and approval of press releases**



### **Appreciative Inquiry: an approach to seek feedback from maternity services service users**

#### **Background and Context:**

Shropshire and Telford and Wrekin Clinical Commissioning Groups (CCGs), as the statutory bodies responsible for commissioning safe, sustainable services for our respective patient population groups, have requested that a formal review of the maternity services at the Shrewsbury and Telford Hospital NHS Trust be undertaken.

The remit of the review will be to identify to the CCG Governing Body Boards the current position regarding the quality and safety of maternity services, making recommendations as required, in order to ensure that the service provides the highest quality and safest care to mothers and their babies. It will also review the sustainability of the hub and spoke model going forward.

#### **Our Proposal/ Approach:**

The approach will entail an Independent officer and expert facilitator (Balraj Singh Rai) leading the User Experience workstream of the Maternity Services Review in order to ensure consistency of approach at different stages of the process and total objectivity in the data collection, its subsequent analysis and presentation back to the commissioning bodies.

This approach is a development process or philosophy that engages individuals within organisational systems. In the case of this review this will be Maternity Services in the geographical areas covered by the two Clinical Commissioning Groups above.

AI is based on the assumption that an organisation/ service which inquires into problems or difficult situations will keep finding more of the same! However, an organisation which tries to appreciate what is already good / best in itself will find and discover more and more of what is positive and can be built on. In addition, it is an approach that is conducive to collaboration and engagement from the outset, together with ownership of the 'solution' or final goal.

Appreciative Inquiry involves a particular way of asking questions and envisioning the future that fosters positive relationships and builds on the basic goodness in a person, a situation, an organisation or a service. In so doing, it enhances a system's capacity for transformational change via strong, meaningful collaboration and a 'stake' in the future.

Appreciative Inquiry utilises a cycle of 4 short processes focusing on:

1. Discover: The identification of organisational processes that already work well.
2. Dream: The envisioning of processes that would work well in the future.
3. Design: Planning and prioritising processes that would work well.
4. Destiny (or Deliver): The implementation (execution) of the proposed design.

The basic idea is to build organisations and services around what is good and what works, rather than trying to fix what does not work. It is the opposite of problem solving. Instead of focusing on gaps and inadequacies to remediate skills or practices, AI focuses on how to create more of the exceptional performance that is occurring. It opens the door to a universe of possibilities, since the work doesn't stop when a particular issue is solved but rather focuses on "What is the best we can be?" The approach acknowledges the contribution of individuals, in order to increase trust and organisational alignment. The method aims to create meaning by drawing from actual stories of concrete successes in current and recent practice, and sets thinking in motion for a better future.

As noted above, "AI ...fosters positive relationships and builds on the basic goodness in a person, or a situation ..." The principles behind A.I. are based in the rapidly developing science of Positive Psychology: the idea of building on strength, rather than just focusing on faults and weakness is a powerful idea in use in mentoring programs, and in coaching dynamics, and one that unilaterally 'gels' and cements collective action for the betterment of all stakeholders.

In this way, AI will be an ideal, effective and timely approach to utilise on the Maternity Services review in order to fine tune and tailor the implementation of the crucial data collection; it will be particularly valuable to start with a positive point and remind ourselves of the value building on the "good" parts of the existing service.

Balraj will facilitate collective, open and honest discussions with a range of service users and carers from across the geographical area on a 'focus group' basis. For these sessions, an appropriate room will be required. Each discussion is likely to last between 1 hour and 1.5 hours.

Administrative support is also required to record each dialogue session and support the subsequent write up.

### **Session Structure:**

Each focus group will be facilitated using the same structure in order to ensure consistency, namely:

- Welcome, thank you, introductions, the 'why' we are here and ground rules
- 'Engagement' question – designed to be open ended and to allow each participant to respond
- 'Exploration' questions\* – designed to encourage discussion based on the following broad themes, which will be based on the principles of appreciative inquiry whereby the starting point is one of a good experience, of what worked well and of positivity in user experience

1. Choice

2. Support from health professionals/ provision of care (this will include breastfeeding support)

3. Communication

4. Overall experience

It is possible that **not** all the themes will be covered to the same level of detail in every focus group – the facilitated approach via a single facilitator will allow this to be managed effectively.

- 'Exit' question – designed to encourage participants to share anything they have not had a chance to in the focus group
- An outline of what will happen next in the review process

Each focus group will be lead by the Independent facilitator, with representation from Healthwatch/ CHC and Maternity Services. The aim of the additional attendance is to provide external 'scrutiny' of process and assurance to attendees of service provider engagement and involvement in the review.

## Shropshire, Telford and Wrekin Maternity Services Review Survey 2013

### What was good and what can we improve?

Please take a moment to tell us what was good about your experience of using the maternity services in Shropshire, Telford and Wrekin and what was not so good to help us improve.

#### General

Where were/ are you booked in to deliver your baby?

- In hospital, at the Shrewsbury Consultant Unit  
In a midwife led unit
- Ludlow,
  - Bridgnorth,
  - Oswestry,
  - Shrewsbury,
  - Telford and Wrekin
- Powys  
 At home  
 Other.....

Where was your baby born

- In hospital, at the Shrewsbury Consultant Unit  
In a midwife led unit
- Ludlow,
  - Bridgnorth,
  - Oswestry,
  - Shrewsbury,
  - Telford and Wrekin
- Powys  
 At home  
 Baby not delivered yet  
 Other.....

How old is your baby/ when is your baby due?

If you used/are using midwifery services in Powys, please only complete the questions relating to the care you received in Shropshire, Telford and Wrekin.

#### Care while you were pregnant

Roughly how many weeks pregnant were you when you had your 'booking' appointment (issued with your pregnancy notes/purple book)?

- When I was 0 to 7 weeks pregnant  
 When I was 8 or 9 weeks pregnant  
 When I was 10 or 11 weeks pregnant  
 When I was 12 weeks pregnant  
 When I was 13 or more weeks pregnant  
 Don't know / Can't remember

Were you offered any of the following choices about where to have your baby? (Select all that apply)

- I was offered a choice of hospitals  
 I was offered a choice of giving birth in a midwife led unit or birth centre  
 I was offered a choice of giving birth in a consultant led unit  
 I was offered a choice of giving birth at home  
 I was not offered any choices  
 I had no choices due to medical reasons  
 Don't know/Can't remember

Did you get enough information from either a midwife or doctor to help you decide where to have your baby?

- Yes, definitely
- Yes, to some extent
- No
- No, but I did not need this information
- Don't know / Can't remember

If you saw a midwife for your antenatal checkups, did you see the same one every time?

- Yes
- Yes, but would have preferred not to
- No, but I wanted to
- No, but I did not mind
- I only saw a midwife once
- I did not see a midwife
- Don't know / Can't remember

Thinking about your antenatal care, were you involved enough in decisions about your care?

- Yes, always
- Yes, sometimes
- No
- I did not want / need to be involved
- Don't know / Can't remember

### Your labour and the birth of your baby

Did you have confidence and trust in the staff caring for you during your labour and birth?

- Yes, definitely
- Yes, to some extent
- No
- Don't know / Can't remember

Did you feel that these health professionals worked well together and that your care was co-ordinated?

- Yes, definitely
- Yes, to some extent
- No
- Don't know / Can't remember

Did you get enough information from a midwife or doctor if the choice of where to have your baby was changed during pregnancy?

- Yes, definitely
- Yes, to some extent
- No
- Do not know / Can't remember
- Not applicable

Were you given a copy of the pregnancy notes/purple book?

- Yes
- No
- No, I already had one
- Don't know / Can't remember

During your pregnancy, did you attend any antenatal classes provided by the NHS?

- Yes
- No, I was not offered any classes
- No, they were all booked up
- No, I attended other antenatal classes (e.g. NCT)
- No, I did not need to attend the classes
- No, I did not attend for some other reason

How many health professionals looked after you during your labour?

- 1 health professional
- 2 or 3 health professionals
- 4 or 5 health professionals
- 6 or more health professionals
- Don't know/Can't remember

Thinking about the care during labour and birth, were you and/or your partner/companion given enough information to enable you to be involved in decisions about your care?

- Yes, definitely
- Yes, to some extent
- No
- Don't know / Can't remember

During your pregnancy, what type of pain relief did you plan to use when giving birth? (Select all that apply)

- Natural methods (e.g. hypnosis, breathing, massage)
- Water or a birthing pool
- TENS machine (with pads on your back)
- Gas and air (breathing through a mask)
- Injection of pethidine or a similar painkiller
- Epidural (injection in your back, given by an anaesthetist)
- I did not want to use pain relief
- I had not decided

Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?

- Yes
- Yes, but I did not want this
- No
- No, but this was not possible for medical reasons
- I did not want skin to skin contact with my baby

### Care in hospital after the birth of your baby

How long did you stay in hospital after your baby was born?

- Up to 12 hours
- More than 12 hours but less than 24 hours
- 1 to 2 days
- 3 to 4 days
- 5 or more days

Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness, dignity and understanding?

- Yes, always
- Yes, sometimes
- No
- Don't know / Can't remember

### Breastfeeding

During your pregnancy did midwives provide relevant information about feeding your baby?

- Yes, definitely
- Yes, to some extent
- No
- I did not want/need this information
- Don't know / Can't remember

During your labour were you able to use your choice of pain relief that you had planned?

- Yes
- No, I did not use pain relief
- No, I was advised to change my choice for medical reasons
- No, my choice was not available
- No, I changed my mind
- I did not have a plan

If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?

- Yes
- No
- They did not want to be involved
- I did not want them to be involved
- I did not have a partner or a companion with me

Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?

- Yes, always
- Yes, sometimes
- No
- Don't know / Can't remember

Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?

- Yes, always
- Yes, sometimes
- No
- I did not want/need this
- Don't know / Can't remember

Would you recommend this service to your friends and family? Please score between 1 and 10 (1 being you would definitely recommend and 10 being you would definitely not recommend)

1..... 10  
Would definitely recommend Would definitely **not** recommend

Is your feedback on maternity services as a:

- Mother
- Partner
- Family member
- Other \_\_\_\_\_

**Ethnicity**

What is your ethnic group? (**Cross ONE box only**)

**WHITE**

- English / Welsh / Scottish / Northern Irish / British
- Irish
- Gypsy or Irish Traveller [ ]
- Any other white background, (Please write in box)

**MIXED / MULTIPLE ETHNIC GROUPS**

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed / multiple ethnic background, (Please write in box) [ ]

**ASIAN / ASIAN BRITISH**

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background, (Please write in box) [ ]

**BLACK / AFRICAN / CARIBBEAN / BLACK BRITISH**

- African
- Caribbean
- Any other Black / African / Caribbean background, (Please write in box) [ ]

**OTHER ETHNIC GROUP**

- Arab [ ]
- Any other ethnic group, (Please write in box) [ ]

**Any additional comments**

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If you would like to know more about the review or would like to receive a copy of the review findings, please email [maternityreview@shropshireccg.nhs.uk](mailto:maternityreview@shropshireccg.nhs.uk) or call 01743 277580.

If you would like to raise an individual concern or complaint about the treatment you received, please contact our Patient Advice service on 0800 030 4563.










*Thank you for your participation.*

Acknowledgement: This questionnaire is based on the 'Women's Experience of Maternity Care' questionnaires conducted in 2010 and 2013 by the CQC. These questions have been used with the permission of the CQC.

## General

Where were/are you booked in to deliver your baby?		Response Percent	Response Total
In hospital, at the Shrewsbury Consultant Unit		31.33%	52
In a midwife led unit:		0%	0
a) Ludlow		11.45%	19
b) Bridgnorth		4.82%	8
c) Oswestry		4.22%	7
d) Shrewsbury		25.3%	42
e) Telford and Wrekin		12.65%	21
Powys		0%	0
At home		6.02%	10
Other		4.22%	7

Total # of respondents 172.  
Statistics based on 166 respondents; 0 filtered; 6 skipped.

Where was your baby born?		Response Percent	Response Total
In hospital, at the Shrewsbury Consultant Unit		54.12%	92
In a Midwife led unit:		0%	0
a) Ludlow		10%	17
b) Bridgnorth		1.77%	3
c) Oswestry		0.59%	1
d) Shrewsbury		20%	34
e) Telford and Wrekin		4.12%	7
Powys		0%	0
At home		2.94%	5
Baby not delivered yet		1.77%	3
Other		4.71%	8

Total # of respondents 172.  
Statistics based on 170 respondents; 0 filtered; 2 skipped.

How old is your baby/when is your baby due?		Response Total
		170

Total # of respondents 172.  
Statistics based on 170 respondents; 0 filtered; 2 skipped.

If you used/are using midwifery services in Powys, please only complete the questions relating to the care you received in Shropshire, Telford and Wrekin

Care while you were pregnant

Roughly how many weeks pregnant were you when you had your 'booking' appointment (the appointment where you were given your pregnancy notes/purple book)?	Response Percent	Response Total
When I was 0 to 7 weeks pregnant	12.05%	20
When I was 8 or 9 weeks pregnant	30.12%	50
When I was 10 or 11 weeks pregnant	34.94%	58
When I was 12 weeks pregnant	10.84%	18
When I was 13 or more weeks pregnant	4.22%	7
Don't know / Can't remember	7.83%	13






Total # of respondents 172.  
Statistics based on 166 respondents; 0 filtered; 6 skipped.



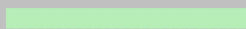



Were you offered any of the following choices about where to have your baby? (Select all that apply)	Response Percent	Response Total
I was offered a choice of hospitals	44.58%	74
I was offered a choice of giving birth in a midwife led unit or birth centre	36.75%	61
I was offered a choice of giving birth in a consultant led unit	24.1%	40
I was offered a choice of giving birth at home	25.9%	43
I was not offered any choices	15.06%	25
I had no choices due to medical reasons	21.08%	35
Don't know / Can't remember	3.01%	5





Total # of respondents 172.  
Statistics based on 166 respondents; 0 filtered; 6 skipped.





Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	Response Percent	Response Total
Yes, definitely	34.76%	57
Yes, to some extent	31.1%	51
No	14.02%	23
No, but I did not need this information	19.51%	32
Don't know / Can't remember	0.61%	1







Total # of respondents 172.  
Statistics based on 164 respondents; 0 filtered; 8 skipped.


Did you get enough information from a midwife or doctor if the choice of where to have your baby was changed during the pregnancy?		Response Percent	Response Total
Yes, definitely		22.56%	37
Yes, to some extent		15.24%	25
No		14.02%	23
Don't know / Can't remember		0.61%	1
Not applicable		47.56%	78
Total # of respondents 172. Statistics based on 164 respondents; 0 filtered; 8 skipped.			






If you saw a midwife for your antenatal checkups, did you see the same one every time?		Response Percent	Response Total
Yes		22.89%	38
Yes, but would have preferred not to		1.81%	3
No, but I wanted to		31.93%	53
No, but I did not mind		40.96%	68
I only saw a midwife once		1.81%	3
I did not see a midwife		0%	0
Don't know / Can't remember		0.6%	1
Total # of respondents 172. Statistics based on 166 respondents; 0 filtered; 6 skipped.			





Were you given a copy of the pregnancy notes/purple book?		Response Percent	Response Total
Yes		88.55%	147
No		7.83%	13
No, I already had one		1.21%	2
Don't know / Can't remember		2.41%	4
Total # of respondents 172. Statistics based on 166 respondents; 0 filtered; 6 skipped.			




Thinking about your antenatal care, were you involved enough in decisions about your care?		Response Percent	Response Total
Yes, always		55.76%	92
Yes, sometimes		32.12%	53
No		10.91%	18
I did not want / need to be involved		0%	0
Don't know / Can't remember		1.21%	2
Total # of respondents 172. Statistics based on 165 respondents; 0 filtered; 7 skipped.			

During your pregnancy, did you attend any antenatal classes provided by the NHS?		Response Percent	Response Total
Yes		58.68%	98
No, I was not offered any classes		8.98%	15
No, they were all booked up		1.8%	3
No, I attended other antenatal classes (e.g. NCT)		8.38%	14
No, I did not need to attend the classes		13.77%	23
No, I did not attend for some other reasons		8.38%	14
Total # of respondents 172.			
Statistics based on 167 respondents; 0 filtered; 5 skipped.			









Your labour and the birth of your baby			
Did you have confidence and trust in the staff caring for you during your labour and birth?		Response Percent	Response Total
Yes, definitely		62.65%	104
Yes, to some extent		22.29%	37
No		15.06%	25
Don't know / Can't remember		0%	0
Total # of respondents 172.			
Statistics based on 166 respondents; 0 filtered; 6 skipped.			

How many health professionals looked after you during your labour?		Response Percent	Response Total
1 Health Professional		13.94%	23
2 or 3 Health Professionals		41.82%	69
4 or 5 Health Professionals		20.61%	34
6 or more Health Professionals		21.82%	36
Don't know / Can't remember		1.82%	3
Total # of respondents 172.			
Statistics based on 165 respondents; 0 filtered; 7 skipped.			







Did you feel that these health professionals worked well together and that your care was co-ordinated?		Response Percent	Response Total
Yes, definitely		59.04%	98
Yes, to some extent		21.69%	36
No		16.87%	28
Don't know / Can't remember		2.41%	4
Total # of respondents 172.			
Statistics based on 166 respondents; 0 filtered; 6 skipped.			

Thinking about the care during labour and birth, were you and/or your partner/companion given enough information to enable you to be involved in decisions about your care?		Response Percent	Response Total
Yes, definitely		53.89%	90
Yes, to some extent		26.35%	44
No		19.76%	33
Don't know / Can't remember		0%	0




Total # of respondents 172.  
Statistics based on 167 respondents; 0 filtered; 5 skipped.




During your pregnancy, what type of pain relief did you plan to use when giving birth? (Select all that apply)		Response Percent	Response Total
Natural methods (e.g. hypnosis, breathing, massage)		30.54%	51
Water or a birthing pool		17.37%	29
TENS machine (with pads on your back)		28.14%	47
Gas and air (breathing through a mask)		73.65%	123
Injection of pethidine or a similar painkiller		23.35%	39
Epidural (injection in your back, given by an anaesthetist)		18.56%	31
I did not want to use pain relief		3.59%	6
I had not decided		9.58%	16

Total # of respondents 172.  
Statistics based on 167 respondents; 0 filtered; 5 skipped.






During your labour were you able to use your choice of pain relief that you had planned?		Response Percent	Response Total
Yes		56.29%	94
No, I did not use pain relief		4.79%	8
No, I was advised to change my choice for medical reasons		13.17%	22
No, my choice was not available		10.78%	18
No, I changed my mind		5.39%	9
I did not have a plan		9.58%	16





Total # of respondents 172.  
Statistics based on 167 respondents; 0 filtered; 5 skipped.

Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?		Response Percent	Response Total
Yes		86.31%	145
Yes, but I did not want this		0%	0
No		5.95%	10
No, but this was not possible for medical reasons		7.74%	13
I did not want skin to skin contact with my baby		0%	0
Total # of respondents 172. Statistics based on 168 respondents; 0 filtered; 4 skipped.			

If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?		Response Percent	Response Total
Yes		84.94%	141
No		14.46%	24
They did not want to be involved		0%	0
I did not want them to be involved		0%	0
I did not have a partner or a companion with me		0.6%	1
Total # of respondents 172. Statistics based on 166 respondents; 0 filtered; 6 skipped.			

#### Care in hospital after the birth of your baby

How long did you stay in hospital after your baby was born?		Response Percent	Response Total
Up to 12 hours		11.04%	18
More than 12 hours but less than 24 hours		10.43%	17
1 to 2 days		21.47%	35
3 to 4 days		38.04%	62
5 or more days		19.02%	31
Total # of respondents 172. Statistics based on 163 respondents; 0 filtered; 9 skipped.			

Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?		Response Percent	Response Total
Yes, always		43.83%	71
Yes, sometimes		32.72%	53
No		22.84%	37
Don't know / Can't remember		0.62%	1
Total # of respondents 172. Statistics based on 162 respondents; 0 filtered; 10 skipped.			

Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness, dignity and understanding?		Response Percent	Response Total
Yes, always		58.28%	95
Yes, sometimes		26.99%	44
No		14.72%	24
Don't know / Can't remember		0%	0

Total # of respondents 172.  
Statistics based on 163 respondents; 0 filtered; 9 skipped.

**Breastfeeding**

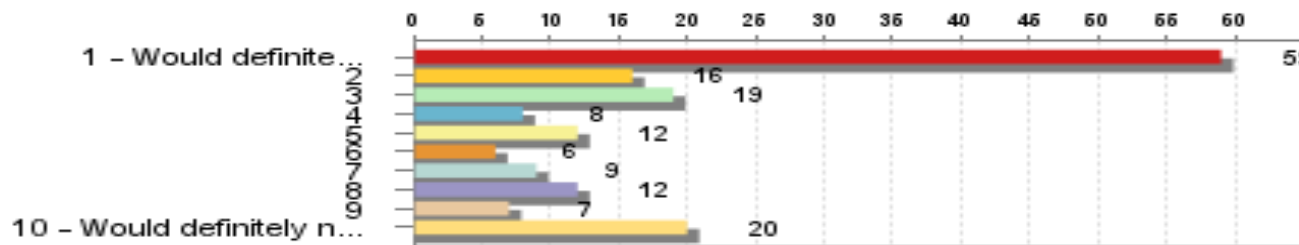
During your pregnancy did midwives provide relevant information about feeding your baby?		Response Percent	Response Total
Yes, definitely		50.3%	84
Yes, to some extent		29.94%	50
No		11.98%	20
I did not want/need this information		7.78%	13
Don't know / Can't remember		0%	0

Total # of respondents 172.  
Statistics based on 167 respondents; 0 filtered; 5 skipped.





Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?		Response Percent	Response Total
Yes, always		50.6%	84
Yes, sometimes		25.9%	43
No		17.47%	29
I did not want/need this		6.02%	10
Don't know / Can't remember		0%	0

Total # of respondents 172.  
Statistics based on 166 respondents; 0 filtered; 6 skipped.




Would you recommend this service to your friends and family? Please score between 1 and 10 (1 being you would definitely recommend and 10 being you would definitely not recommend)



Total # of respondents 172.  
Statistics based on 168 respondents; 0 filtered; 4 skipped.

Is your feedback on maternity services as a:		Response Percent	Response Total
Mother		97.65%	166
Partner		1.18%	2
Family Member		0.59%	1
Other		0.59%	1

Total # of respondents 172.  
Statistics based on 170 respondents; 0 filtered; 2 skipped.

Ethnicity			
What is your ethnic group (Select ONE box only)		Response Percent	Response Total
White		0%	0
English / Welsh / Scottish / Northern Irish / British		98.82%	167
Irish		0.59%	1
Gypsy or Irish Traveller		0%	0
Any other white background, (PLEASE WRITE IN BOX)		0.59%	1

Total # of respondents 172.  
Statistics based on 169 respondents; 0 filtered; 3 skipped.

MIXED / MULTIPLE ETHNIC GROUPS		Response Percent	Response Total
White and Black Caribbean		0%	0
White and Black African		100%	1
White and Asian		0%	0
Any other mixed / multiple ethnic background (PLEASE WRITE IN BOX)		0%	0
			Total # of respondents 172. Statistics based on 1 respondents; 0 filtered; 171 skipped.

ASIAN / ASIAN BRITISH		Response Percent	Response Total
Indian		0%	0
Pakistani		0%	0
Bangladeshi		0%	0
Chinese		0%	0
Any other Asian background (PLEASE WRITE IN BOX)		0%	0
			Total # of respondents 172. Statistics based on 0 respondents; 0 filtered; 172 skipped.

BLACK / AFRICAN / CARIBBEAN / BLACK BRITISH		Response Percent	Response Total
African		0%	0
Caribbean		0%	0
Any other Black / African / Caribbean background (PLEASE WRITE IN BOX)		0%	0
			Total # of respondents 172. Statistics based on 0 respondents; 0 filtered; 172 skipped.

OTHER ETHNIC GROUP		Response Percent	Response Total
Arab		0%	0
Any other ethnic group (PLEASE WRITE IN BOX)		0%	0
			Total # of respondents 172. Statistics based on 0 respondents; 0 filtered; 172 skipped.

Any additional comments		Response Total	
		113	
			Total # of respondents 172. Statistics based on 113 respondents; 0 filtered; 59 skipped.

## Shropshire, Telford and Wrekin Maternity Services Review Survey 2013

### Any additional comments from online questionnaire survey

*NB Any names and identifying information have been removed. Otherwise comments are exactly as submitted. A total of 113 survey respondents provided comments.*

Responses
<p>My community midwife changed surgery while I was pregnant, which is why I didn't always see the same one. I wasn't able to use the birthing pool as planned for medical reasons, but still managed to give birth using the other planned methods of pain relief. I was very happy with the care received. I felt very comfortable with the care given on the MLU. There was a delay when I needed to be transferred to the consultant unit and I found the staff there (at the delivery and the one who did the stitches) a bit brusque and with a slightly negative attitude perhaps towards the midwife who came with me from the MLU. Back on the ward afterwards I always felt that I was treated with dignity and respect and my questions were always answered. There was inconsistent advice around breastfeeding but I don't know how you avoid this when staff have their own personal experiences, work-related experiences and official training to draw on, and when every mother and baby is different. It is an extremely emotive subject. It does concern me slightly that if I had another baby and needed to be transferred late on again, the consultant unit is likely to be in Telford by then. But I suppose I could choose to plan to deliver there. Overall, extremely happy with the maternity services I have experienced.</p>
<p>Aftercare In Hospital was awful if you decided not to breastfeed unhelpful and rude left within 6 hrs wd have left sooner if i Cd</p>
<p>My main criticism of the whole experience was with the post natal care and the fact that every time a midwife came to the house after the birth, it was someone different. At the time, my baby was very jaundiced and I was having difficulties producing enough milk and I constantly received conflicting advice from the midwives which was unhelpful. The prenatal care was superb through seeing the same midwife and it would be incredibly helpful if that same midwife could continue with the post natal care.</p>
<p>My waters broke at 34 weeks and my baby was delivered by emergency c-section at 36+5. My baby was delivered in Shrewsbury. I transferred to Bridgnorth and then back to Shrewsbury for medical reasons. The staff at both hospitals were exceptional and I could not have asked for better care. I had and still have complete faith in them and absolute gratitude for looking after me and my precious baby so well. The staff at both hospitals really cared - and welcomed me into the world of motherhood with compassion and a genuine interest in my baby. Please don't cut the services of these amazing staff, they are a credit to the NHS.</p>
<p>Bridgnorth is an absolutely lovely maternity unit with great staff. It is a perfect place to give birth, so relaxed and you do not feel like a number or on a conveyer belt.</p>
<p>The care we had was excellent - the midwives acted swiftly to save my daughter's life, as did the neonatal ward in Shrewsbury. They informed us about what they were doing and were honest but not disheartening. We cannot thank them all enough, as well as the MLU staff who housed and fed us whilst our daughter was being treated. The service we received was superlative.</p>

My consultant was appalling. Made me very nervous and very unhelpful! No information given when questions were asked throughout my pregnancy and was told to refer to the purple folder if i had any questions. One if the midwives from Bridgnorth was outstanding i believe her name is xxx.

Having experienced a full-term still birth a year earlier, our care was exceptional and we felt supported throughout.

during the delivery my partner felt very supported as there was an "older" male student midwife present.

Had a great experience, xxx the midwife in Shrewsbury consultant unit was wonderful. The transferral back to Bridgnorth and the care received there was brilliant, felt really looked after.

We planned to give birth at Gobowen/Oswestry but due to difficulties were transferred to Shrewsbury. The care received during labour was great at both places however the after care when we transferred back to Gobowen was incredible. This midwife led unit is a huge positive to the care/advice/information and support received. My wife was able to rest for the first time after giving birth and felt very well supported to do so. The staff, atmosphere and general 'feel' of Gobowen was brilliant and cannot be praised highly enough.

i think the care you recieve within the wards are extremely good - sometimes overbaring with information (when you have 2 other children) you dont need all the information of "how to" do things thrown at you. the nurses/midwives/consultants etc are great - the only thing that i found irritating was the fact you were forever waiting for the "paperwork" to realease you - every time ive had a baby - after being given the nodd tht you can go home, 4 hours plus waiting for doctors to finalise the papers etc so you can leave

The care at RSH Maternity and Ludlow Maternity Units was outstanding. They were fantastic. The health visitors were terrible- unhelpful, poorly informed and contradictory of each other, and told me, a mother who ended up with PND, to 'take a walk and I'd feel better.' They were terrible. However, the midwives at Ludlow and the community midwife from Shrewsbury who visited me in Bishops Castle were extremely helpful and supportive throughout and were even there via phone for me to contact post-natally when my husband and I needed advice and support that we didn't receive from the health visitors. I can't praise the midwives enough!!

I have birth in Shrewsbury then transferred to Ludlow for a few days. I cannot express how fantastic every single member of staff were. I had an amazing midwife in labour, she couldn't have been better. Then back in Ludlow I can't explain how brilliant everyone was to me. I felt so supported and still do. They helped me establish breastfeeding and gain confidence as a first time mum. The care really blew me away.

Ludlow Maternity provided a fantastic service when i had both of my children. If we lost the unit im sure that post natal depression would rise dramatically as we would be nearly 30 miles from another hospital therefore patients would come home early and family members are less likely to visit.

I gave birth at home and then developed what was eventually diagnosed as thrombophelbitis. This led to me being send to hospital, and mis-diagnosed. It wasn't until I saw my GP that I correctly diagnosed and treated a week later, I was told by the GP that this only happens after child birth - which begs the question "why didn't the postnatal ward know what was wrong with me?"

Amazing care at Bridgnorth. At Shrewsbury never saw the same midwife twice in 5day stay! They were all great but so busy that I didn't feel I had the necessary support with breast feeding until I had to really push for help. Would be good to have some consistency in care.

I was brought in to get induced on the tuesday and i didnt have my baby untill the thursday. I think when they brought me into induce me they should have sorted it out properly so that i was induced that day and had the baby by either that night or the next day not two days later then i kept being told they were bringing me to the labour ward this never happened i was told that about 10 times over the period of which i stayed, also on the ward the food they provided for a pregnant woman was not up to standard they offer you just a baked potato with nothing on it just plain. However when i went to the labour ward on the early hours off thursday morning they were fabulous especially the midwife who delivered my baby, xxx i think her name was. I couldnt have done the labour without her support she was fantastic from the start. I havent a bad thing to say about my time on the labour ward but the mlu unit would need to get a grip and get more alert about situations.

I had wonderful care throughout pregnancy, labour and after my baby was born. I was able to spend a few days recuperating at the Wrekin Maternity Unit after leaving Shrewsbury and received great support from all the staff.

Only one giving birth at the wrekin yet after labour I was put on ward around 4 am. Not offered any toast or food after labour. Even in the morning around 9 am no one had come to see me so had to buzz and ask for breakfast! Little things like that make such a difference to a mother whos had a tiring birth. You need refuelling! I had a HCA come to see me mainly on the ward even though I was the only patient but would've preferred a midwife. In the end I felt lonely on the ward so I left at lunch.

All of the staff involved in my care both during my pregnancy and in labour were excellent. The midwife who dealt with my labour was first rate. However it was obvious that the staff were under unreasonable pressure as the ward was understaffed.

Overall the care I received throughout was excellent, especially my community midwife and the midwives during labour both on the MLU and consultant unit. The healthcare assistants were also brilliant. Breastfeeding was difficult but I had ample support both in hospital and in the community. Health visiting has also been great and seemed to pick up the baton from the midwives seamlessly. My only negative experience was the one day antenatal class held at RSH. As it was our only shot at antenatal class (we had not left sufficient time for the weekly ones) I was hoping for a well structured succinct day advising us on what to expect and some tips/techniques on how to cope with labour. Both my husband and I came away sorely disappointed, unprepared and as a result mildly anxious. We ended up going privately (just for a few hours and had a much more satisfying experience, so I think it is possible in the time given!). This was in contrast to the excellent Breastfeeding classes held by xxx which stood me in good stead. Overall a big thank you!

Community midwife xxx was amazing throughout pregnancy. Sensible advice and filled me with confidence. Accepted follow through care from third year midwifery student xxx who was also amazing throughout pregnancy, labour and birth and aftercare. xxx was the senior midwife who was also at my birth, again really supportive . Dr xxx delivered my baby via ventouse very gently and expertly. xxx was midwife who helped with the resuss team for baby and also took care of me after my time in theatre as I ended up there having manual removal of placenta. Again looked after exceptionally by xxx, the anaesthetists and consultant who removed my placenta with great expertise.. I did not feel in control of decisions being made about how baby was delivered and things happened fast during delivery so what was happening wasn't explained fully. Although xxx student midwife saw me after the birth said if we had any questions about the birth she would talk us through

them. Community midwife xxx saw me with student for 13 days after birth. Exceptional support and advice given. Thank you to everyone involved in the birth of my baby girl.

Xxx's breastfeeding workshop is a must for any new mum wanting to breastfeed! My only dilemma has been since I am based at raf Shawbury and my doctor is there, I had a fantastic midwife, xxx. But because I live in wem, I had lots of different midwives where I would of liked to stay with xxx.

I was induced at 40+9 at 10am Thursday morning my partner was sent home at 8.30pm leaving me to labor over night on my own (not my choice) my partner was called in at 4am Friday morning to chaos! By the time I was taken to delivery I was verging on my body pushing. Not me actually doing it. Midwives were on handover meaning I had numerous ones in and out. My labor seemed very rushed! The midwives I did have were amazing at their job and the student midwife xxx who delivered my daughter was amazing. I just felt that some continuity would give new mother to be some reassurance. Also having to change wards. Daily was a pain too. Once delivered you should be allowed to settle in and enjoy your new arrival with out the disturbance of moving wards. I was moved 3 times after delivery. Overall my experience was good but if these things had not have happened it could have been better. I also would have liked to have seen one midwife all way through and have a copy of my maternity notes.

There were a few members of staff that really let the maternity unit team down with the way that they dealt with me during/after labour. But most of the staff, particularly during labour were absolutely great and very supportive. A couple of the things that I was not happy with were that when going in to be induced I was told that the registrar was going to give me an examination to see how far along I was but he then gave me a sweep (I didn't know this at the time) which is of course quite painful and distressing when you don't know what is going on. I only found out later when a midwife told me why it was so painful. I dont think any procedure should be done without the patients knowledge and consent. The same person later during my labour made some decisions about how to handle my diabetes that didn't make sense to us and my fiance had to explain why my treatment should be changed. It was changed as my fiance suggested eventually but they pretended to have come to decision miraculously themselves. One midwife on the consultant unit after birth seemed very unsupportive and critical of how I was trying to feed my baby (I struggled for some time with latching on) I feel that sometimes the staff feel so overworked and stressed that they forget what a powerful position that they are in and the things they say and do have a huge affect on new mothers who already feel vunerable and insecure. I was told during labour that I would almost certainly need a cesarean due to the high risk factor of being diabetic and having twins. At the last minute I was advised that a natural birth would be what we aimed for and ended up in labour for almost 24hours (whilst ill) and having a cesarean in the end anyway. I knew I should hae had a cesarean and think it would have saved the NHS some time and money to just book patients like myslef in for a cesarean if this is the safer option. There were many many mebers of staff who were excellent, the junior midwives and experienced midwives during labour were fantastic, xxx the breastfeeding consultant is an assest to your team and really helped me.

During my stay after the boys were born, I found the midwives and healthcare assistants were excellent. I didn't think some of the doctors were as good, their people skills were not great!! I was lucky in having twins and having a relatively easy birth. I was amazed that a maternity ward could be short staffed. In my room there was a sign stating if I was unhappy with the cleanliness of the room, to report this to the midwives....now they seemed busy and overstretched enough!! There was a cleaner but I think she was on set hours, so really only had time to change and empty bins, I was in one room for four nights and the floor was never cleaned!!!! All in all I had a positive experience, but I was lucky.

care at RSH not good during L & D (induction). told not in labour for hours (when I could feel pain), partner attempted to be sent home whilst I was in advanced labour, then taken to Labour ward 9cm dilated in a lot of discomfort. Care at PRH outstanding, cant thank them enough.

It would be helpful if antenatal appointments took into consideration those who work and work some distance from their GP, especially as Shropshire is a rural county. My GP offers appointments 10am - 12pm once a week. Clearly I am entitled to time off work for antenatal appointments, but these times made it very difficult for me to meet the needs of the service that I run. The midwife who runs our local clinic ended up making appointments for me out of clinic time and elsewhere in order to try and accommodate my needs. I know she does this for many clients in a similar position. It would be helpful if clinic times were reviewed or a service was available to allow early morning or later afternoon/evening appointments. The experience I had at RSH consultant unit was patchy. The post natal care on the ward was sadly very lacking in many areas. Communication from the staff was very poor and two of the midwives who cared for me did not appear to know what care I and my baby needed. The post natal information given is good, however something more explanatory would help to eliminate some of this confusion that arose. For example including a brief, easy to understand, information leaflet about how you are cared for post nately would be good. Also being given this information in advance of labour and delivery would be helpful in order to allow the ,other/ partner feel involved and in control at a very destabilising and vulnerable time. I also think it would be incredibly helpful for the antenatal ward team to be provided with customer service training. Protected meal times should be reviewed. I understand and wholeheartedly agree with the concept however the rationale behind protected mealtimes is to allow the patient to eat uninterrupted. For the first few weeks of my child's life, eating uninterrupted was only achieved if she was asleep or my husband provided her care whilst I was eating. The former was unachievable in hospital due to set meal times not necessarily coinciding with a sleeping child. The latter was also not achievable due to partners being asked to leave for one hour at meal times. This is not well thought out or logical. I ate one handed, with difficulty, whilst trying to nurse my child. If my husband were allowed to be with me, then he could have nursed the child or fed me or cut my food up for me. This rule seemed to me to be indicative of policy being implemented without consideration of the service needs of the user.

The maternity staff at RSH were excellent and I cannot fault the support I had from them whilst getting to grips with breastfeeding my baby in hospital.

My midwife did not respect my choices at telford and Wrekin hospital, such as small things like do I want the radio on when I replied no she put it on anyway, she seemed lazy and very bossy. She did not read my birthing plan therefore I was constantly asked questions and she did not tell me the sex or weight of my baby. I had to be taken by ambulance to Shrewsbury where the midwife did not even know how to secure the car seat in the ambulance. I had to do it. I was the only person in the unit on the day of my babies arrival yet no family were allowed to even sit in the visitors room, they were made to stand outside in the rain. My overall experience of labour was shadowed by this midwife. My baby had a bowel movement as he was delivered yet this was still on me and my son when we arrived at Shrewsbury. To say I was embarrassed was an understatement. I also had to give birth in a examination room as she couldn't be bothered to clean the normal room. I thank her my son was delivered healthy but not for her attitude.

All the midwives that I received support from during my first and second pregnancy were extremely helpful and people that you could put your full confidence in. This issue with support is following this period of care, when you are back at home. Health visitor, community support is where I feel services could be improved

My labour was generally a positive experience but my biggest disappointment was the fact that in the 4 days in hospital I saw many different midwives and so it was difficult to explain things to different people all of the time. No one came to weigh my son day three, I had to ask a midwife for this to be done. I was made to feel like a bad mother as my son had lost 10% of his body weight, the midwife who dealt told me I should be feeding every 3 hours, If she had bothered to sit and talk through my feeding chart she would have seen I was feeding at that point every 2hours. Was told to go on the breast pump with No explanation, the hca hooked me up, I felt quite degraded at this. As this was happening at change over the new staff had no idea what was going on, as no one had explained anything to me I couldn't say why I was on the pump to the new staff. I was eventually then taken off the pump by the night staff as they felt I was feeding well on my own. In my opinion it would have been nice as a first time mum for someone to sit with me and have discussed my feeding chart rather than making me feel like I wasn't feeding my son right. I can see why so many women are put off. My experience of breast feeding wasn't a very positive one in hospital. I also didn't understand why at meal times my husband had to leave, if my son was settled on my son I don't see why he couldn't stay with my son. My son had to be out into his cot moved into the dining area where he cried and I had to leave my meal and not finish it, made no sense. Community midwives were brilliant but would have preferred to have seen the same one each appointment (4 times had a different one) water birth should be promoted more.

I felt that my concerns during LABOUR where not addressed, that I was made to have a natural birth when an emergency c section was more appropriate just so they didn't dent their pressious natural birth rate target. I felt like I was on a butcher's slab. And to find ten days late that I had two serious infections was disgusting. I do not rate Shrewsbury maternity unit and would not recommend them

Yes- I had primary tokophobia during pregnancy. None of the consultants particularly dr xxx took any notice of this or even seemed aware of the condition. I had a horrendous nerve racking pregnancy due to this and as a result I went to have my baby in stoke on Trent where I was treated much better. I requested a c section at Shrewsbury but, despite current NICE guidelines, was unable to have one even though i suffered from a recognised condition. Therefore I was not able to have my baby in Telford and Shrewsbury hospitals which is disgusting as I have lived here for many years. I am a victim of your primary aim to cut c section rates at the expense of mothers safety. Shocking.

I would like to say that during my pregnancy I saw at least 8 different midwives at me monthly and fortnightly appointments also during my labour the midwife I saw gave the impression that I was being dramatic and sent me homemhoweve when I returned to the hospital 5 hours later and she checked me and saw felt my babies head then it was too late for any pain relief accept gas and air but the the midwife was brilliantm also following the birth og my son all the midwives and support staff in the hospital were amazingm however the support during my labour and antenatal care wasn't great•

Home birth was firstly met with putting off techniques for first birth. I think that it was only because I was adamant that I wanted a home birth that I got it, it was not really discussed as option on booking in. Second time around very supportive. Aftercare of homebirth first time around was not great in that midwives seemed to leave very quickly. I had trouble establishing feeding and sent to shrewsbury for help which was useless as quite rightly midwives were dealing with more complicated birth issues. Then I was sent you bridgnorth where care was excellent and I felt extremely supported. Please retain midwife led units and encourage home births where appropriate. Can there be better links with local NCT branches please?

I was admitted to antenatal, labour & post natal wards at shrewsbury hospital aswell as my

baby spending 6wks in neonatal. The staff are stretched and over worked, trying their best to tend to all patients & sometimes needs, support etc not being met because of this.

I was very pleased with my antenatal care from my community midwife and all the staff on the antenatal/ labour & postnatal wards. However, I was seen in the consultant clinic from 28 weeks and found these appointments very frustrated and that I was treated as a number or a combination of symptoms rather than a person. It felt like a conveyor belt and during my last consultant appt before delivering my twins I was reduced to tears as my questions/ queries & fears were not listened to or taken seriously.

My birth experience was truly magical. I look back with pride and happiness. The midwives at RSH are absolutely fantastic ladies.

the care during my short labour was great, had a lovely midwife who I could recommend. however post natal care on the ward was non existent, as a first time mom with a prem baby in a hot cot next to me I needed reassurance, explanations, and just general advice on how to look after him, I couldn't make it to the antenatal classes as I had been admitted into a different hospital. I had him in the night and I was told off by day staff for not waking my newborn up enough times for a feed and for not filling out a feed chart which I had not been shown. I was not even aware that I was allowed to take him out of the cot to cuddle etc. I was having difficulty with breast feeding when I asked for help I was told that the breast feeding specialist is on the rounds and would be with me soon, she never showed up but me and my son figured it out eventually. the other annoying thing is that my son had to have blood tests taken before feeds however my partner spent 2hours chasing staff asking if it was ok to feed him or did they want to do the test which was 1.5hrs overdue , I couldn't cope seeing my son crying for food so I fed him, only to be criticised by staff saying that we may have delayed treatment by not waiting for his tests to be done. Having worked in the Sath NHS trust for a few years I understand that the ward was busy and staff were probably over stretched but the level of care was very poor on the ward.

There was a definite need for more consistent advice re breast feeding Lots of confusing messages from ward midwifed community m w etc Need for more postnatal breast feeding support groups etc

I felt the midwives were stretched to their limits and could not give the care that was needed to each new mother. I ended up having an emergency c-section so could not feed, change, clean up or comfort my baby afterwards as I could not pick him up without the help of the midwife in getting him out and it made me quite on edge knowing i needed to buzz for someone and then having to wait for someone to help me pick up my screaming son. I was quite traumatised by the c-section and felt that maybe some kind of counsellor would have been a great help in the days that I was actually in hospital. Also I started breastfeeding and would have loved to carry on but received mixed "ways" of breastfeeding by different people which just left me confused. And if someone had explained that I could have gone to one of the midwife led units after for a few days and that I would have received help with my son and proper support on breast feeding then maybe things would have been different. The care I received during labour and birth was fantastic but the aftercare I thought was not very good at all just due to being understaffed???

I had to really push to be allowed a home birth as my BMI was around 35. It was finally agreed I could have one but a consequence of this was that I was then cancelled from the gestational diabetes test that I was supposed to take. This meant that if it was there (likely as I had an 11 lb 11 oz baby) it was not picked up in my pregnancy and no action was taken. I had an emergency c section which a root cause analysis showed should have been prioritised earlier because the doctor looking after me was new, relatively inexperienced and didn't get consultant advice early enough. My baby was in neo natal for 7 days and I post pat

rum haemorrhaged. The care we both received was excellent and I am so grateful for the professionalism and love given by the staff, however, things could have been different if action had been taken earlier. I have faith that the care plan for my next baby will address all these issues. I am a strong supporter of the NHS as a free and independent body.

I would really like to have a further opportunity to discuss my experience as a patient on the consultant led ward in Shrewsbury. I had a great experience of labour and that staff during the birth were amazing, however my experience afterwards was awful and really made what should have been a special time really difficult for me. Antenatal care was also good, despite having to see lots of different midwives.

I had a c-section and don't think this is covered in this questionnaire. I would say the pre-natal and birthing care was very good but that once I had the baby the staff were brilliant but there was not enough of them. I think if there could be a focus on wellbeing after the birth i.e. the use of specialist holistic therapists who could offer things like reflexology and massage to mum teach them how to massage baby etc. I used this after I developed PND and was a huge help and think that sort of focus on wellbeing been available earlier I would have fared much better with my mood and acted as a preventative method to stop further referral to other support services which became necessary due to that. Also quite often mums just want someone to talk to pass them something etc when they are stuck in bed after c-section and having some additional contact with a holistic therapist would have been a great help.

Shrewsbury consultant labour unit and ward 19 were fantastic with good staff who knew their job. Telford unit very unsure about; too many text book opinions from staff with seemingly no experience, nice place but staffing and advice leaves much to be desired.

The support, treatment and advice that I received at Wrekin maternity unit was excellent, our midwife was outstanding and I was kept informed of every development during the birth. Much better than my first experience of labour at RSH a few years ago.

My personal experience of the staff on Ward 19 at Shrewsbury Hospital was exceptional. Despite particularly busy periods they were always on hand and willing to give as much or a little time as needed. I was particularly grateful for the care and attention in the early hours of the morning when trying to establish feeding, and the dignity at which the staff dealt with my blood loss. I have, in the three weeks since giving birth been in regular contact with lactation experts (xxx and xxx) who have also been exceptional in their assistance with ensuring my ability to breastfeed effectively. The staff in short have been wonderful, and work tirelessly, often in demanding circumstances. I have nothing but positive things to say about the care I was given during my labour and subsequent stay in hospital.

My experience is biased as I had a particularly poor elderly midwife who told me I wasn't trying hard enough, after a 20-hour labour this was not what I wanted to hear nor did I like the "we are too busy for an epidural", I was then taken to the consultant ward anyway for a forceps delivery. I received a midwife visit to my bed after my husband requested it. I appreciate that the ward was busy but my care was pretty poor. I am disgusted to learn that now you will have to travel to Telford to a consultant ward. How appalling.

I had an awful experience giving birth, the midwife was horrible to me I felt I got no support. Afterwards in the ward I got no help with breast feeding, I was desperate too but had trouble getting my daughter latched on. No one checked to see if we were ok feeding it was only after I got distressed on the second day that they tried to 'help' my daughter still wouldn't latch so I got told I was starving her and I will not be able to breast feed so give her formula. I also got told if I didn't give her formula she would be re-admitted for weight loss as she was a small baby. 15 months on and I feel so let down, I often cry at the lack of care.

I had my baby in telford but was rushed to Shrewsbury hospital after I had my son with complications with myself. The staff at both hospitals were fantastic and saved my life. Thank you

I think you need to review your IVF policy as you are at odds with neighbouring areas and NICE guidelines - your rationing of care has cost us £13,000 so far even though i already pay about that much every year in tax for the NHS, its a terrible affliction and should have more support and priority

my scoring is for the time i spent in shrewsbury hospital. my time in ludlow hosp would rate 10/10 on all levels. i would not be able to feed baby myself without their support.

it would be helpful if this survey also looked at other services including screening tests and scanning, which is all an essential part of the maternity experience

Sometimes it felt like that breast feeding was being pushed in our faces all the time. We researched our options and made informed decisions but still when it was not possible for me to breast feed the pressure continued. As soon as my daughter was given a bottle 36hrs after born and trying to breast feed all the support from healthcare professionals seemed to stop. I understand the benefits of breast feeding however I do feel that the progression should respect our decisions and provide the same level of support whether the baby is on breast or bottle. During labour it also felt like they were not explaining what was happening but just sitting in corner writing notes, then when i experienced complications with post bleeding very little information was given to myself or my partner who go essentially shoved in a corner holding a new born baby for the first time. More information needs to be given to help partners understanding in what's happening. I appreciate that sometimes at the time it's not always possible but it should be considered as it added extra anxiety to the situation not knowing what was going on

I already knew I wanted to give birth in Ludlow so the Midwife was happy with that choice after my booking in appointment showed no reason why I couldn't. I already knew the choices but wanted Ludlow, although a birthing pool would be nice for baby number 2!! I found breast feeding a struggle to begin but was encouraged by all the staff, although maybe a little more explanation to first time mums as to what to expect, I was told it shouldn't hurt but it really does (for some it's fine pretty much straight away) for a good few weeks, sometimes still now! Which made me worry something was wrong. And really explain how every day is different until the milk really starts flowing as often I thought something was wrong. Now I know, I'll happily try again. Generally the support was fantastic though. The unit was like home from home, my midwife who delivered was superb. It was clean and tidy, comfy and welcoming. My baby boy is happy and healthy thanks to the staff at Ludlow. A very happy mum and dad!! :)

I decided on Wrexham as very little information was given to about the service offered at Gobowen ( I live in Oswestry) I'm not sure I would of chosen Gobowen as I like the reassurance of consultants on hand (who I'd did need as I went to theatre in the end) however more info on Gobowen should be provided to promote it. The service at Gobowen when I returned for 3 nights was excellent. The midwives are wonderful. The parent craft sessions run by xxx were also excellent. I could not of coped with labour and the first few weeks of motherhood without the knowledge from class and social group I met. Please please keep these running. Not seeing the same midwife or couple of mid wife's is very poor. I saw a different mid wife every time I had an appointment. Hey don't know you. Can't judge how your coping and it feels very impersonal. I system of seeing 1 or 2 mid wife's would be much better.

I gave birth at Ludlow maternity and ALL of the staff who work there are fantastic and we

could not fault anything they did. They were all very helpful and kind throughout the pregnancy and during labour. The after care is brilliant at Ludlow and it is important that this service remains. Shortly after giving birth I had we had to go to Shrewsbury Hospital due to my blood pressure being too high. I understand that Shrewsbury is a much busier hospital but I did not feel as well looked after during my stay there - support wise. I did not see a midwife for a while once I was on the main ward and not having a changed a nappy before I wanted some support whilst doing this and I when I looked for someone I could not find anyone to ask. If I did not have the option to go to Ludlow hospital before returning home I dont think I would have stayed in shrewsbury very long at all, which would have meant returning home too soon. The staff at Shrewsbury were very kind and friendly, but due to it being a much busier hospital I understand that the support cant be the same as Ludlow.

This was my second birth at the RSH midwife led unit. Both times I requested a water birth - but both times this was not made available to me. The first time, I am aware that my labour progressed much much quicker than was expected, and there was not time to fill the birthing pool. This was not the case this second time (xxxx) though, and I am not sure why a water birth was not made available to me. Mid wives very kind and efficient. However, the consultant care for my baby boy - born with a still unspecified mark on his face - was not handled well. A registrar and another Dr came to see me at 2am and 4 am respectively in the morning. (My baby boy born at 3:30pm.) Have no idea why the times for this were so late at night. Both times I and my baby were woken up to be seen by the night Doctors. This was not ideal after a day of labouring, and when the matter was so obviously not seen as urgent. (Otherwise why wait nearly 12 hours?) I was breast feeding, and excellent support given. I saw a much younder mother (aged 17) not being given the support she was requesting to bottle feed though. I felt there was poor follow up community mid wife care at home afterwards. I had breast oedema, and although I received excellent care when I was sent back to hospital maybe a week later to help deal with this, there was not the support from the community midwives who visited at home to help solve this that I would have wished. It took several days for the problem to be diagnosed, and for it to be arranged that I go back to hospital for a day to be helped/shown how to massage this out. When back in the MLU, the support on how to solve this breast oedema was excellent. Overall, my birth experiences were positive, and the hospital midwives were excellent. On a different note, I think your survey a bit misleading though - I think some respondents may think the MLUs are all in hospitals (Ludlow, Shrewsbury, Brignorth) so may tick the first box if they had a birth in the RSH, even if in the MLU. Also, the pain relief options for me - a water birth was requested - there was not the option to say that this never really materialised for my xxxx birth, although I am not sure why! In terms of ante natal classes too - was never told about the free antenatal classes on offer from NHS, so first time round did NCT. Didn't plan on doing any ante natal classes for my second baby. But think your survey question is misleading. How many people I wonder did NCT antenatal classes as they were not told about the free NHS ones?!

The service still isn't patient orientated, it's what fits in for the department. The registrar assigned to me, needs a better bed side manner, she was patronising & was openly rude to the anaesthetist. After my epidural I was taken in to theatre with no explanation as to why I couldn't carry on pushing in the room. Communication wasn't good @ this time! She talked about me to members of staff stating I hadn't pushed for very long, when I had actually been pushing for an hour & had been in labour for 14 hours by this time. Before the epidural was administered, she asked me to promise to push after it had been done & not just give up! I wanted a natural delivery, so for me to ask for an epidural meant that I could no longer cope with the pain, my baby was back-to-back & I was tired. This registrar isn't a consultant & her importance isn't above the care of a patient or her colleagues. The whole maternity service needs to be much more welcoming, be prepared to listen to the women & work as a team.

The support & care both my husband & I received from Ludlow Maternity Unit throughout both of my pregnancies/births was fantastic. Aftercare outstanding - especially help to

establish breastfeeding. Could not fault in any way.

During my labour I felt each individual member of staff did their utmost to help me, but there were too few of them. As a result I felt there was little continuity of care, and I was often just left alone for long periods of time which was frightening, especially as I found it difficult to speak and voice any concerns while labouring.

I was transferred to the Oswestry midwife led unit, 3 days after the birth of my baby and cannot recommend highly enough the care and kindness I received there, this was in stark contrast to the treatment I received in Shrewsbury.

Fantastic service provided at Ludlow maternity, I would strongly recommend to any of my friends and family!! All the staff including ancillary nurses need a pat on the back!!

My labour didn't go to plan I think a de-brief should've been offered as soon as possible afterwards that would've been really beneficial to me and other mothers I have spoken to since. Working with a smaller team of midwives would I think be better in all I must of been cared for by 20+ different midwives throughout the pregnancy. Care given after my baby was born could not be faulted in anyway especially at Ludlow I would've struggled to breastfeed if it wasn't for the support and help from the staff at Ludlow.

The midwife who was present when I actually gave birth was considerably unprofessional with some of her comments about me. I also felt very rushed, and was bundled out of the room to shower, it was not a gentle experience. If I give birth again I plan to do so at home with my dignity intact without the midwife's comment about my pubic hair. I will be sending a letter to PALS about my experience. The post natal community 'care' provided is shockingly bad.

keep services in shrewsbury

I had a terrible time due to a lack of effective communication between staff due to their workload. Individually staff worked very hard but they were simply too busy to provide effective care at a busy time. During induction I had terrible sickness and being a diabetic I was at risk and had a hypo. The Dr did not tell the midwives I had not had the anti sickness he only inserted the fitting, I kept vomiting and becoming worse and then suddenly after my husband complained I was given the anti sickness medication and was able to stabilise. Everyone was too busy to look after me. It was too busy for my waters to be broken so I was induced again. I was left traumatised after 3 days of being induced, 20 hours of labour and an emergency c section. My baby then had jaundice which was only spotted once I was transferred to Telford as it was quieter and they took proper care of us both. I cried when I was forced to return to Shrewsbury for my baby to be treated for jaundice. I was diabetic and had been told I would have a separate room- I did not and was on a ward with noisy women unable to rest after my ordeal. I really struggled and was not helped until I went briefly to Telford which felt like a sanctuary by comparison. This should have been a magical time for me but it was traumatic instead. The whole hospital experience before my labour had been efficient and reassuring.

Both of my children were delivered at Ludlow hospital and I received all antenatal care at Ludlow (other than ultrasound scans) for both pregnancies. I would like to compliment the staff at Ludlow on the outstanding care provided. All staff I encountered were extremely kind, caring and patient and I had excellent one to one care during the labour. After my babies were born the staff were particularly helpful in supporting me to breastfeed despite this being very difficult to achieve. Without their practical support I doubt either children would have been breastfed. I feel very lucky to have received labour and postnatal care in such a supportive environment with really personal and attentive care. However, the physical

surroundings at Ludlow are very poor and money should be spent on improving the building - so much energy and therefore money must be unnecessarily wasted heating the building. Even simple draught-proofing would make a big difference!! I feel strongly that full midwife-lead maternity services in Ludlow should continue as it is an excellent unit and I would not have wished to have been forced to travel to Shrewsbury. The thought of undertaking such a long journey when in severe pain in labour is just awful, would have increased my anxiety levels and I believe would put mothers and babies at increased risk. The practicalities of travelling such a long distance and being potentially sent home again (I returned home for a time during labour with both children), or having my partner sent home, are worrying. I also doubt that mothers, particularly the most vulnerable, would attend necessary antenatal appointments if they had to travel a long distance. I would certainly think twice! Please continue to support Ludlow maternity unit and invest in the building and its facilities - I would have loved to have been able to have a water birth for instance.

In shrewsbury I wasn't given any advice after the birth on what to do not even skin to skin. also had the smallest amount of help to breast feed which I strongly wanted to do, but instead they took my baby off me and bottle fed him, angry is not the word!

I had an elective c section this time, following 2 previous difficult deliveries

I found the care at Shrewsbury appalling. Unprofessional, uncaring and chaotic. I saw 8 different midwives pre birth all of whom stressed how busy they were to me. I am having another baby and dreading the birth. My husband after the dismissive way he was treated last time is also dreading it. Lots needs to change in regard to the professional standards of the midwives. They use the old building and workload as an excuse for their sloppy approach to patients and fathers. Many changes in their attitude needed.

The care I received during my labour was mixed. When my waters initially broke on the Friday am we went to Telford to be checked and was told to go home and keep active and return later that day to see how things had progressed. When we returned later that day I was examined and told things were progressing, there was some concern over babies erratic hb but that settled. We were advised to go home get my bags etc and make our way to Shrewsbury in the next few hours. On arriving at Shrewsbury there were further concerns over babies hb and we were kept waiting for a dr to examine me for several hours. We were then sent home (as there were no beds on the consultant unit) after midnight that night despite me having painful contractions and told to return the next morning for 7am to be induced if things hadn't sped up by then. On returning home I spent the rest of the night in extreme pain that I couldn't handle anymore and we went back at 6am. We were booked in and waited all day then to be examined and get a slot to be induced which finally started at about 15.30. I then ended up with an emergency c-section later that night due to serious concerns that evening over babies hb. I do wonder if this emergency section could have been prevented but that is something we will never know. The care we received once I had started to be induced and during my established labour and delivery was fantastic. Can't fault the midwives or the theatre team at all for this. It was a very scary experience for both myself and my husband but we were confident in the hands of the staff. Once I was transferred onto the ward afterwards though the care was awful. Short staff, no one came when baby was crying, I rang the bell as baby crying and I couldn't get to as had section and couldn't move. Very upsetting for a first time mum. The ward was so short staffed it was crazy. One of the midwives who was on duty the one night was in tears talking to me as she was run ragged and was trying to do her job but was physically unable to keep up with the demand. Very poor aftercare. I tried bf but baby was so hungry and I was so tired, when asking to give baby formula initially I was refused and told to continue. In the end one midwife on the 3rd night was so understanding and gave my daughter a bottle. we both had a settled few hours sleep for the first time in days... with the right support and staff with the time this could all have been avoided.

Fortunately I had researched A LOT before getting pregnant with my son following difficulties in my previous birth. I had contact with the Supervisor of Midwives throughout as I planned a homebirth against medical advice. The Supervisors were brilliant. The question about how many midwives I saw doesn't allow for the fact that community midwives that I saw worked in a team of 3 so I saw just those through my pregnancy. The MW attending me at home in the mid-stages of labour gave me a cervical sweep WITHOUT consent 'whilst she was there' as she was checking my dilation. All of the information about home birth, about the fact I could decline VEs or other tests, interventions and procedures was all from research I did myself - none of this is available from the NHS information given to women. Some women believe they HAVE to be induced as this is the impression they are given by the Midwives, as well as believing that they HAVE to give birth in a certain unit, and that they HAVE to undergo tests such as blood tests. I declined the 12 week blood tests and was given grief about it for several weeks, some HCPs believing that the results must have been mislaid and needed doing again rather than refused.

I gave birth in Walsall but live in Telford and all my post natal care was carried out in Telford.

I feel that it would be useful if NHS staff would advise mums of other ways of treating colic. Through a friend I have found out about Cranial Osteopathy and this is what has helped with my baby's colic. I wish I'd heard of it sooner, it seems to be something most mums find out via word of mouth from friends, rather than from health professionals.

I was induced at 7.30pm at night (with gell) and not checked until I asked to be examined at 1am. I was told that I was making a fuss and not in labour. I was made to feel like a nuisance and left to get on with it in the induction ward. I was found after hand over fully dilated and told to call my husband, who nearly missed the birth. When I actually got into the labour ward the care was fantastic but the midwife on night duty on the induction ward (xxx) was nothing short of neglectful and incompetent. This experience has made me question having another baby in shrewsbury. I would rather pay to be treated privately (if available) than have to set foot in shrewsbury maternity ever again.

I found both antenatal and maternity care to be inconsistent. Breastfeeding advice at RSH was appalling - frankly I was glad to go home. However, care in the delivery suite was fantastic and I couldn't fault it but the rest of the provision needs seriously overhauling.

I found the pre natal care with community midwife (xxx) excellent. It was thorough, supportive and caring. Neo natal support after birth was exceptional. Tests and care given were excellent. I could not fault either of these services and feel I received the best possible care. The care on the post natal ward was good if a little disjointed. Midwives were clearly busy and did not have time to build any relationship with mums and if I wanted help (ie with feeding) I always had to ask. There are no notes with you for the midwives to write down what they advised you, so I found during difficulties I initially had with breast feeding, that different midwives gave me different and conflicting advice on what to do. In my difficulties I felt I didn't get enough support despite asking for it, which resulted in my baby being dehydrated (it was an exceptional hot period) the individual midwives were all very competent and kind but they system didn't support them.

Most of the time everyone at maternity unit treated me with kindness and compassion. I had a very positive experience and felt safe in their hands. Only one midwife in ward 19 was short with me after giving birth the next day over whether i needed pain relief as i was not quick enough to make a decision and i felt her manner was very abrupt. She said well do you want it yes or no? However she did not reflect the majority of staff who were very kind helpful and encouraging.i felt very safe at shrewsbury and feel very strongly tha that consultancy led unit should stay there -the county town!

I had a terrible experience & ended up being treated for post traumatic stress following this birth ahead of my second child. I felt frightened & not listened too during the birth & was "cared" for by a rude uncaring doctor.

I have spent 6 hours in hospital after delivering my 1st baby. Have no support and havent seen midwife after delivery. Baby was checked by doctor few hours after to decided if I can move hospitals closer to home town, but I was asked if I want to go home instead. I couldnt rest after delivery (14 hours). Postnatal rooms werent available for me so I was moved to normal ward with broken BP machine what was bipping every time I moved. After delivery curtain around my bed i've pulled to have some privacy with my husband was constantly opened by health care and i was exposed to all visitors-MY CHILD WAS 3 HOURES OLD!!! I am sorry i didnt claim compensation for this horrid experiences.

I was left alone for 4 hour periods during labour, including straight after we were told cord prolapse was possible. I did not want the midwife to keep leaving the room, especially for such long periods.

I stayed in Ludlow Hospital after having my baby in Hereford and the level of care there was fabulous. I recommend it widely as do my friends. There is one poor member fo the team there, xxx who lets the rest down. Her reputation precedes her and more experienced mothers will leave the hospital if they know she is coming onto shift. I left the hospital with my newborn baby in hysterical tears because of her. So unfortunate as the rest of the staff are outstanding in their field. I will return to Ludlow with future children but will ensure I avoid that woman being on shift.

After a vry difficult labour and a lengthy repair procedure, The staff on the ward at Shrewsbury were unhelpful and unkind to the point I asked to be moved to another hospital as my daughter did not feed for 24 hours. They were insistent that I breast feed but I physically couldn't. They wold not accept this and I have suffered a lot of emotional trauma because of this. Labour staff and operating staff were amazing and Oswestry were fantastic.

I cannot fault the care that i received during my labour. I was induced as my baby was overdue and this process what not fully explained to me. During the later stages of labour I developed complications and my husband commented that he was not informed of what was happening. This would have been useful and reassuring. I found the after care that i received on the consulting ward to be totally inadequate. There needs to be much improvement with their discharge of vulnerable and high risks patients as I was sent to MLU with very low iron levels and a ill baby. This resulted in us being transferred back to Shrewsbury where the care i received was again inadequate. The ward i was on was very busy and the staff were obviously very busy, This I feel is in part the main reason for failings at this hospital.

My experiences were polarised . Superb antenatal mw and consultant input, poor intrapartum care, excellent postnatal care. I felt traumatised by my birth experience (4th time) but feel this was down to poor individual professional attitude rather than universally poor care on the unit.

I think that the protected meal times excluding fathers from the ward for mulitple times during the day is entirely inappriate. This will becom emore important when everything moves to telford and some fathers will have further to travel. Other hospitals have father access 9-9. This is how it should be, the next day I was so exhausted I wanted my husband with me all day to help with the baby so I could recover more easily.

The care and support provided at Ludlow MLU was excellent during my pregnancy, labour

and aftercare. it gave me the confidence needed as a first time mum. I struggled with breast feeding and would have given up if it wasn't for the support and encouragement provided by the midwives and staff. I can't stress enough how fantastic and valuable the service is at Ludlow MLU.

I was admitted for an induction and the midwife on the antenatal ward provided very little 'care'. She was busy / not interested and I was in a lot of pain (no pain relief other than 2 paracetamol was offered). I was finally rushed to the labour ward about 10mins before my baby was born. My experience would mean I would not recommend Shrewsbury hospital.

Labour staff and aftercare was faultless. But over crowding was a big issue at Shrewsbury, I had to wait for a week in the hospital for a slot to be induced. There was a waiting list and no room in the delivery suits. While waiting on the ward to be induced staff seemed over stretched and once my labour started I was in pain for longer than I should have been as gas and air was not used on the ward and I had to wait for a delivery room to come free. I quickly transferred back to Telford Hospital after the birth and this was lovely unit very calm atmosphere.

Post natal facilities not good with twins i.e. private room far too small, little help from midwives, too strict on visiting hours for partner

The care we received at Ludlow Hospital with our first baby was second to none. Our second baby is due in November and have received the same level of care during this pregnancy and look forward to delivering there again.

I think it is poor that people of Powys are expected to travel further for such services. More travel time for people who pay their taxes the same as in England, Scotland and NI. Treated as second class citizens - discriminated for being Welsh.

Didn't really see much of the midwives post natively as they were at full capacity delivering babies. As it was my third child I was ok on my own to get on with caring for my son but had it been my first I would have been a little lost. My labour was induced and some of the midwives ante-natally were not as helpful as perhaps could have been during induction process but I understand probably due to work pressures.

I was a 'High Risk' patient. I had so much support from my Consultant and other staff members.

The Midwifery service in Shrewsbury I feel is brilliant. My Midwife xxx delivered my first child at home 5 years ago and so I felt very relaxed to have her as my midwife again this time. Throughout the pregnancy she was very informative and extremely lovely and when I went into labour and xxx turned up with another equally lovely midwife xxx I felt so relaxed with them there and felt confident my baby and I were in safe hands. Everything went smoothly and it was all thanks to these 2 amazingly lovely brilliant midwives who are a credit to the team. Also when I did have to call into the hosp for a check up re my waters the midwives I saw there were also very lovely.

There was no continuity of care offered - which resulted in clear indicators that mine was not a low risk pregnancy being missed. There was a lack of training of midwives who failed to react appropriately at various points before and during my labour and following my baby's birth which could have prevented my daughter's avoidable death. There was no care plan in place following her death leaving me and my family without support. The failings were comprehensive and catastrophic and to this day not one midwife has been disciplined and no one has apologised to me or my husband for the avoidable death of our daughter. The complaints system you have in place is utterly useless and the harm done through the gross

communications we have received regularly from the Trust involved have compounded the damage caused by our daughter's death. All in all your service was appalling - and according to the fact that the CCG's own risk rating of the maternity service is now extreme, the service has not improved since 2009.

My daughter died due to grossly negligent care by numerous health care professionals - as was proven during her inquest. Clinicians breached multiple Trust, NMC and national (NICE) guidelines and policies - even a requirement to offer basic care was a complete failure - our daughter was left alone in a cold cot, with respiratory distress, in a hypothermic state and was discovered collapsed by a healthcare auxiliary due to the fact that the sole midwife on duty was undertaking 'routine duties'. Midwives, senior clinicians and managers grossly failed my daughter in the basic duty of care that she should have been afforded. Even when it was recognised that she was unwell, further delays caused her to suffer needlessly. Maternity services at SATH are a complete disgrace – and even more so, due to the fact that not one midwife, clinician or manager has been investigated or removed from post. Where is the accountability in this failed service? A service, that by the CCG's very own ratings system is currently ranked 'extreme' in terms of risk to its' users. Action needs to be taken to address the cover ups and failings at all levels ... we have a constitutional right to be afforded safe services which we pay for. The CCG has a constitutional right to purchase only safe services.

I found the care i recieved at Bridgnorth maternity hospital absolutley fantastic, outstanding. Could not fault at all. My first born here and I felt supported through out. Second pregnancy was through Shrewsbury where I was induced, and I was appaled at the difference in the standard of care. I was left in a ward from a Sunday morning until a Tuesday morning when I was able to go down to the delievery room, due to there being no room available, nobody informed me of this when I was induced, and with another child at home, childcare was very difficult. I was also just left with being told I could be sent down at any time. No one in Shrewsbury had been informed of my SPD in preganancy, which caused pains during labour. After delievery we were left on our own to bond, but we were not informed, just felt abandoned, I was attached to a drip from being induced, I could not move off the bed, and then we had problems with my babies breathing, where my partner had to run outside and it took quiet some time for assistance to come into the room, this was then a health care assistant, rather than a GP or midwife. A frightening experience, and one that was totally different to the experience I had had with my first born at Bridgnorth. With my second child, we had two midwives during the labour, the first one had not broken my waters, and had said she had, and left me to wait three hours, and then had not passed on relevant information to the second midwife, which they openley discussed and slated to us as patients. I felt it was very unprofessional and frightened me as a mother to put my care of my unborn child and myself in the hands of individuals who lacked professionalism. Bridgnorth maternity has my best ratings, Shrewsbury by far was not at a standard I felt it should have been at.

I had my 1st baby in Worcester hospital and had a bad experience so decided to have my second baby at home which was a fantastic experience which I am so proud of. Please ensure there are always enough midwives on call so that women who want to are able to have a homebirth as it is a million times better than being in hospital.

I was booked to go into Shrewsbury to be induced with twins at 38 weeks. Whilst on the ward, I found the midwives to be excellent. However, the ward itself seemed to be run by auxillary nurses - who only seemed concerned as to whether the cup of teas my husband was making in the kitchen were for me and not for him!! My husband was treated like an inconvenience by the aux nurses not like an excited father to be. I was top of the list to go onto the labour ward for three days, and in the end they had to sneak me on at 6am so as the day staff couldn't refuse me. The midwives and doctors on the labour ward, we could not

fault. We both felt we could trust them to look after us, my care and our babies care once born. They kept us up to date at all times and allowed us to make our decisions. They even allowed my husband to make a cup of tea and gave him something to eat!!! Once I delivered our babies and was ready to go onto the post natal ward from recovery, again my husband was treated as a nobody. It was 8am and they told my husband to wheel the crib to the doors of the ward, leave them there and go home. My husband asked if he could just see that we were all settled safely on the ward before he went home to get some sleep. He was told no, he was not allowed on and that he will have to wait until later to see us all again. I was so upset that he was treated like this, as were both still on such a high. Again this was all done by aux nurses!! Once i was on the post natal ward, again the midwives were excellent but felt I couldn't ask any questions or ask for help as they seemed to be running round like headless chickens!! Because of our experience, on the monday I asked to be transferred to Oswestry and they agreed. I had only been there half an hour and had more help than i had in all the time i was in Shrewsbury (6 days). If I had another baby, I would definately try to have it in Oswestry and would only recommend Shrewsbury if they had to have their babies there and not by choice. Shrewsbury need to get the wards run by midwives / nurses again - not by auxillary nurses or tea ladies as my husband called them. Shrewsbury could learn alot from Oswestry about care / help and wards with proper nurses on. Even though I think it is a shame that maternity services are moving to Telford soon, I can quite understand as Shrewsbury is dirty, scruffy and outdated.

My placenta was left in me for 3/4 days after giving birth when it fell out of me whilst climbing my stairs. My blood pressure was checked in hospital and it was high, I was told by the midwife she would come back in an hour to check it again she never came back my blood pressure was not checked again . A student midwife delivered my son whilst being over seen by a qualified midwife. The midwife who did a homevisit confirmed I had passed a placenta I have never forgotten this experience in 9 years.

The whole experience of labour and the birth was horrific. The midwife was horrible, the on call consultant was bad tempered, the anaesthetist put the epidural needle in the wrong place, I had forceps and ended up with 3rd degree tears and was cut too far into my back passage. It was awful, as a result I vowed to never have another baby as I just couldn't cope with that again. Sorry to be so negative, but nearly 5 years later I still cry about it!

All the staff are fantastic at the telford MLU. We had lots of support and advice. The unit was very clean and the food was good. The treatment we had was first class.

I was transferred from Shrewsbury to Worcester as there were no nicu cots when my waters broke at 34+5 weeks. I am very thankful I was transferred as my son only had feeding problems and jaundice and not breathing or temperature problems. We were therefore kept together on transitional care unit whilst he was Ng fed and had light treatment. If he was born in Shrewsbury he would have gone to nicu which would have severely affected our bonding and my experience of birth and the first few weeks. I was involved in the empire study and the midwives involved in that were excellent too.

Horrible experience at Shrewsbury, rude midwives, no help with breastfeeding. Husband ignored and made to feel in the way. They need a major overhaul of staff not the infrastructure. They need re-training in compassion and basic care.

I received shropshire midwife health checks during my pregnancy but then chose Newcross to have my baby predominantly because of geography in that it was closest to where I live and I was hugely impressed by their new MLU which I'd seen during a tour. I transferred from Newcross to Bridgenorth MLU after the birth of my baby for 48 hours of much needed convalescence. The care and support I received there was second to none I couldn't fault it and recommend it to everyone.

Had to have an emergency c section and the staff were fantastic. Considering how busy they are they do a great job.

I have had 3 babies in last 3.5 years. 1st and 3rd born at Ludlow. 2nd born Hereford due to low-lying placenta but returned within 12 hours to Ludlow. All antenatal care at Ludlow, attended antenatal classes at Ludlow for 1st baby. Stayed in Ludlow 7 days with 1st baby, and 3 days with 2nd and 3rd. Care before birth, during and after fantastic at Ludlow. Relaxed, professional and kind care made whole process as calm and natural as possible. Stayed in for one week with 1st baby as found breastfeeding very difficult: constant help and advice during this week enabled me to feed all three babies. I would not have achieved breastfeeding success at home as home-visiting midwives could not have helped every couple hours, 24 hours a day. I recommend Ludlow Maternity Hospital to every mother-to-be I know as the Hospital's care and kindness are exceptionally good and a credit to the staff who work there.

I felt the midwives were unprofessional and rude. The ward was cramped and at visiting time stunk of smoke, it was horrible. I had no help with feeding and consequently felt really alone. I thought midwives would be kind and they weren't a bit, they just kept telling me how busy they were. I don't want to have another baby at Shrewsbury.

The Midwives xxx and xxx present during my labour and birth and shortly after were superb, couldn't have asked for any better care, support, respecting of my wishes To use hypnobirthing. The ladies all looking after me and baby xxxx as I stayed in hospital for several days were brilliant.all the staff. Including the ladies in the green uniforms were Always there to help me. Was a lovely supportive clean and caring place to be with responsive proactively given care couldn't have asked for more, especially being away from My family and having my first baby.

## Maternity Patient Information Leaflets

*All leaflets are the most recent version available. External leaflets are subject to change according to availability*

### **Antenatal Pack 1 – Given at booking to all women except those looked after by Teenage Identified Midwives (TIMS)**

Leaflet	Source
Pregnancy Health Record and Patient Information Booklet	SaTH
Screening tests for you and your baby	NSC
Mother's Guide to Breastfeeding	mothersguide.co.uk
Baby on the way, quit today + Smokefree card	DH
Being a parent starts right now	DH
Parents guide to money	Money Advice Service
Healthy Start –Free milk, fruit, vitamins	DH
Fit for Pregnancy	ACPWH
Whooping Cough and Pregnancy	DH

### **Antenatal Pack 2 – Given at booking to women looked after by Teenage Identified Midwives (TIMS)**

Leaflet	Source
Pregnancy Health Record and Patient Information Booklet	SaTH
Screening tests for you and your baby	NSC
Mother's Guide to Breastfeeding	mothersguide.co.uk
Baby on the way, quit today + Smokefree card	DH
Being a parent starts right now	DH
Parents guide to money	Money Advice Service
Healthy Start –Free milk, fruit, vitamins	DH
Fit for Pregnancy	ACPWH
Whooping Cough and Pregnancy	DH
Teenage Identified Midwives	Shropshire Council/SaTH
Respect Yourself	Shropshire Council
Bump to Baby (Shropshire only)	Shropshire Council
Becoming a Dad	Shropshire Council
Family Information Service	Shropshire Council
Bubbalicious card	bubbalicious.co.uk
Why weight mums and Nova training (T&W only)	T&W Council

### **Mid-trimester Pack – given 24 to 28 weeks**

Leaflet	Source
Fit for birth	ACPWH
How active is your baby?	SaTH

**Postnatal Pack 1 – Given after birth to all women who are giving their babies breastmilk only**

<b>Leaflet</b>	<b>Source</b>
After the birth – caring for yourself and your baby	SaTH
Off to the best start	DH
Sterilising feeding equipment	UNICEF
Fit for the future	ACPWH
Screening tests for your baby	NSC
Expanded newborn screening test (until pilot ends March 2014)	NHS, National Institute for Health Research

**Postnatal Pack 2 – Given after birth to all women who are giving their babies formula milk or are mixed feeding**

<b>Leaflet</b>	<b>Source</b>
After the birth – caring for yourself and your baby	SaTH
Off to the best start	DH
Sterilising feeding equipment	UNICEF
Fit for the future	ACPWH
Screening tests for your baby	NSC
Expanded newborn screening test (until pilot ends March 2014)	NHS, National Institute for Health Research
Bottle feeding guide	DH

**Additional leaflets available on the SaTH intranet – to be given as required**

*All leaflets produced by SaTH unless indicated as RCOG*

<ul style="list-style-type: none"> <li>▪ Air Travel in Pregnancy (RCOG)</li> <li>▪ Amniocentesis</li> <li>▪ Breech Baby</li> <li>▪ BMI – Raised</li> <li>▪ Chronic Villus Sampling – CVS</li> <li>▪ Elective Caesarean Section</li> <li>▪ Emergency Caesarean Section</li> <li>▪ Glucose Tolerance test (GTT)</li> <li>▪ How Active is Your Baby?</li> <li>▪ Home Birth</li> <li>▪ Hyperemesis</li> <li>▪ Information for Partners Staying on Ward 18</li> <li>▪ Iron Transfusion Letter</li> <li>▪ Induction of Labour</li> <li>▪ Large Baby</li> <li>▪ Loss before 24 Weeks</li> <li>▪ Multiple Pregnancy</li> <li>▪ Obstetric Cholestasis (RCOG)</li> <li>▪ Pelvic Girdle Pain</li> <li>▪ Preterm prelabour rupture of membranes before 24 Weeks</li> <li>▪ Preterm prelabour rupture of membranes between 24 and 37 Weeks</li> </ul>	<ul style="list-style-type: none"> <li>▪ Prelabour rupture of membranes after 37 Weeks</li> <li>▪ Pre-Eclampsia (RCOG)</li> <li>▪ Post Dural Puncture Headache</li> <li>▪ Reduced Movements Flyer</li> <li>▪ Rubella and Pregnancy (MMR)</li> <li>▪ Shoulder Dystocia (RCOG)</li> <li>▪ Sterilisation (RCOG)</li> <li>▪ Supervisors of Midwives</li> <li>▪ Stillbirth and Neonatal Death</li> <li>▪ The Loss of Your Baby Before Birth</li> <li>▪ Talk-About Service Leaflet</li> <li>▪ Venous Thrombosis</li> <li>▪ Vitamin K Consent form (Arabic)</li> <li>▪ Vitamin K Leaflet (Arabic)</li> <li>▪ Vitamin K Consent Form (Polish)</li> <li>▪ Vitamin K Leaflet (Polish)</li> <li>▪ Vitamin K Consent Form (Slovakian)</li> <li>▪ Vitamin K Leaflet (Slovakian)</li> <li>▪ Vitamin K Consent Form (English)</li> <li>▪ VBAC – Vaginal Birth After Caesarean Section</li> <li>▪ Water Birth</li> </ul>
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## Workforce Feedback

## 1. Staff focus group sessions – collated feedback (summarised and themed)

- **Consultant Unit (Shrewsbury)** – views contributed by 11 members of staff

Good Practice	Challenges / Concerns
<p>Patient care</p> <ul style="list-style-type: none"> <li>- Patient care of a good, consistent standard</li> <li>- Patient to nurse ratio is good</li> <li>- Very high standard from well-trained midwives</li> <li>- Women's Service Assistants (WSA) do a lot of the patient contact</li> <li>- Not many emergency transfers in labour</li> </ul>	<ul style="list-style-type: none"> <li>- Impacted on by staff shortages, lack of time</li> <li>- Quite a high induction rate (24%) – slightly higher than national average</li> </ul>
<p>Team working</p> <ul style="list-style-type: none"> <li>- Very good team work, supportive of each other, get on well</li> <li>- Locum has described it as the 'best unit'</li> <li>- Community midwives know they can ring for advice</li> <li>- Integrated service, staff know one another as they move about</li> <li>- Great deal of team cooperation to ensure the consultant unit can remain safe, a lot of goodwill and flexibility</li> <li>- Midwives will speak up and challenge doctors on behalf of the patient if necessary</li> <li>- All consultants very approachable, mutual respect</li> <li>- Very supportive of peers</li> </ul>	
<p>Staff / staffing</p> <ul style="list-style-type: none"> <li>- Consultant unit very busy, 'full on'</li> <li>- 24/7 service, on call rota for midwives after hours</li> <li>- Very positive about the WSAs – numbers have increased which has had an impact, they do a great job</li> <li>- Increase of medical staff has made a big difference</li> </ul>	<ul style="list-style-type: none"> <li>- Issue with general lack of staff – sometimes one coordinator and 4 midwives, need 7 members of staff to run safely</li> <li>- Need to call on other areas which then impacts on their service</li> </ul> <p><b>Possible solution</b></p> <ul style="list-style-type: none"> <li>- Suggestion to possibly see postnatal clinics introduced (towards end of 10 days) – reduce time spent travelling by community midwives</li> </ul>
<p>Training / support / supervision</p> <ul style="list-style-type: none"> <li>- Learning organisation</li> <li>- Good support and supervision</li> <li>- Training sometimes slips due to clinical need, but there is protected time for training and any slippage is quickly addressed</li> <li>- Training is targeted and flexible</li> <li>- Obstetrics training – excellent support from the consultant</li> <li>- Rotation of midwives – seen as very good as no</li> </ul>	<ul style="list-style-type: none"> <li>- Lack of time for mentoring and support for students</li> <li>- Workload makes it difficult to offer appropriate training and support to students</li> <li>- Workload for mentors set to increase, stressful role</li> <li>- People not putting themselves forward as mentors, will be a problem when current mentors start leaving</li> <li>- Issues re supernumerary hours – newly</li> </ul>

<p>one gets too settled in one area, skills kept up to date</p>	<p>qualified midwives should not be relied upon to take on the same workload as other midwives (relied on when staff shortages), should be protected period of training</p>
<p><b>Governance</b></p> <ul style="list-style-type: none"> <li>- Consultant now visits antenatal and postnatal wards twice a day to get awareness of any high risk cases or any risks developing – now see high risk patients proactively</li> <li>- Audit very good and very complete, can look at comparisons and seeing improvements</li> <li>- Involvement of staff to ensure recommendations are feasible</li> <li>- Guideline midwives – clinical input into guidelines, works well</li> <li>- Governance meetings well attended and useful, good decisions made, good structure</li> <li>- Staff feel supported by clinical governance</li> <li>- Very thorough case review process, supportive process, part of culture</li> <li>- SI reviews – well attended, interesting, supportive, not accusatory, a ‘what can we learn from this?’ attitude</li> <li>- Risk assessment at all stages is instinctive</li> <li>- CNST assessment in March 2014 (level 3) – record keeping has improved</li> </ul>	<ul style="list-style-type: none"> <li>- Guidelines sometimes seen as too prescriptive – ideal is best care without going overboard</li> </ul>
<p><b>Bereavement service</b></p> <ul style="list-style-type: none"> <li>- Developed following complaints about lack of care etc. a few years ago</li> <li>- Complaints have reduced considerably</li> <li>- Post mortem uptake has increased</li> <li>- Provides reassurance for both mums and midwives</li> <li>- Midwives have access to support / counselling also</li> </ul>	
<p><b>On call system</b></p> <ul style="list-style-type: none"> <li>- If unit busy during the night, on call midwives pulled in</li> <li>- Use of bank midwives – valuable service</li> </ul>	<ul style="list-style-type: none"> <li>- If on call midwives called in every night, can be a problem as they still have to do their day shifts</li> <li>- Early shift sickness can be a problem</li> <li>- Looked at having an on call midwife for 24 hour cover. Funding means this has been put on hold</li> </ul>
<p><b>Information sharing</b></p> <ul style="list-style-type: none"> <li>- Good process</li> <li>- Risk newsletters, ward books, information on intranet, case review synopsis displayed in all offices</li> <li>- Senior midwives meeting, ward meetings</li> <li>- Individual staff responsibility to access information</li> </ul>	
<p><b>Patient feedback</b></p> <ul style="list-style-type: none"> <li>- Complaints vs compliments ratio is good – number of compliments received not an actual reflection as lots of verbal thank yous and gifts (patient appreciation forms completed when</li> </ul>	

gifts received) - Friends and Family test recently introduced, sent out to women when they have gone home or given out by ward clerk	
Use of data - Improved data flows in last 3 years, improved management decisions, KPIs and patient flow - Improved booking figures - Monthly dashboard, information disseminated at all levels, colour coded to highlight potential issues - Positive about Medway (new maternity information system)	- Medway – phased implementation, missing area is community – looking for funding for digital pens and addition hardware
	Workload / paperwork - Paperwork / workload levels going up and up - A lot of expectations, an issue in other areas also - Notes demand much more time now, more staff required of good record keeping to be maintained
	Other - Constant scrutiny – time consuming, unsettling and demoralising, not helpful to have to defend Shropshire’s approach

- **Powys** – views contributed by 6 members of staff

<b>Good Practice</b>	<b>Challenges</b>
Triage Midwife - Excellent services - Efficient and helpful	Transferring women - Getting better but some challenges in relation to perceived negative attitudes and communications when midwives want to transfer women  <b>Possible solution</b> Would SaTH staff consider having a joint development event / liaison group?
	Post Natal Plan - Where women have other conditions, e.g. high BP, the discharge plan is not completed and therefore makes it difficult both for midwives and GP to understand the on-going plan of care for the woman  <b>Possible solution</b> Encourage the completion of the post natal discharge summary so that midwives and GPs can safely provide on-going care for women
	Antenatal - There is a perception that antenatal clinics on a Friday feel rushed - Women’s experience of the scan appointment is

	<p>not always positive, however it is perceived that this is improving</p> <ul style="list-style-type: none"> <li>- When women are seen at SaTH antenatal clinics the documentation does not always clearly document place of birth following the consultation with the obstetrician and this then needs to be chased up by the midwives</li> </ul>
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- **Midwife Led Units (MLUs) – outlying units (Wrekin, Bridgnorth, Oswestry, Ludlow)** – views contributed by 22 members of staff across the units (5-6 at each)

Good Practice	Challenges
<p>General positive comments</p> <ul style="list-style-type: none"> <li>- Staff are passionate about and proud of their units, enjoy their jobs</li> <li>- Staff consider the MLUs essential, lucky to have them</li> <li>- Staff consider the hub and spoke model 'lovely and unique to Shropshire' – feel very privileged</li> <li>- 'Midwifery care in Shropshire is fantastic'</li> <li>- Good resource, offers women choice</li> <li>- Good links between MLUs and consultant unit</li> <li>- Standalone units promote the normality of birth</li> <li>- Take pressure off Shrewsbury</li> </ul>	
<p>Community based</p> <ul style="list-style-type: none"> <li>- Antenatal and postnatal care, low risk straightforward births, transfers from consultant unit for immediate postnatal care</li> <li>- Clinics, classes held locally and/or on site</li> <li>- Particularly important in rural areas where transport is an issue</li> <li>- Mothers who don't necessarily go to parentcraft (e.g. younger mothers, more socially disadvantaged) get the extra support postnatally</li> <li>- Local to the towns, people take ownership</li> <li>- Good reputation, word of mouth, appreciated by the local community, some women travel in from elsewhere</li> <li>- Family-centred and local – inclusion of whole family in the process, support to fathers</li> <li>- Integration with other services in the community</li> <li>- Bridgnorth – good relationship with hospital League of Friends</li> <li>- Local jobs for midwives who live in the area</li> </ul>	<ul style="list-style-type: none"> <li>- One suggestion that if there was access to a wider range of pain relief in the latent phase of labour, some transfers could possibly be avoided</li> </ul>
<p>Environment</p> <ul style="list-style-type: none"> <li>- Friendly, 'home from home'</li> <li>- Relaxed, supportive, safe, reassuring, give women confidence</li> </ul>	<ul style="list-style-type: none"> <li>- Some units would like more funding to be able to further enhance the environment</li> </ul>
<p>Continuity and dedicated care</p> <ul style="list-style-type: none"> <li>- Good quality care</li> <li>- Small teams – midwives work on the unit and in the community, deliver antenatal and postnatal</li> </ul>	<ul style="list-style-type: none"> <li>- Lots of examples of good practice have been passed to the communications team for acknowledgement (staff newsletter, Chairman's</li> </ul>

<p>care – see women through the whole process</p> <ul style="list-style-type: none"> <li>- Women tend to get to know all the staff well (particularly on smaller units) so likely to know the midwife at delivery (not guaranteed)</li> <li>- Good communication and handover with health visitors</li> <li>- Good links and support from social services if extra support needed (Wrekin)</li> <li>- Extra time for women – can rest, get extra support following the birth, not rushed</li> <li>- Team work flexibly to accommodate mothers who need extra help</li> <li>- Efforts made to maintain continuity of midwife for those in special situation or who have extra needs</li> <li>- Support available 24/7 (drop in / over the phone), nothing too much trouble</li> <li>- Units provide a known point of contact for women in early stages of labour, even for women booked to deliver at consultant unit</li> <li>- More time than larger units following the birth to offer advice, talk through concerns</li> <li>- Women can come back to the unit if they are having any problems or need extra support (e.g. breastfeeding) – reassurance from staff and other mothers</li> <li>- Women are the focus at the unit - ‘given time and love and care here’, ‘women are nurtured’</li> <li>- Staff ‘go the extra mile’ – e.g. follow up phone calls to ask how a scan went, explanation of which service is the most appropriate and why (part of triage service at Wrekin)</li> </ul>	<p>award) but not progressed which can be disheartening (Wrekin)</p> <ul style="list-style-type: none"> <li>- Women sometimes disappointed that they cannot be booked to deliver at the MLU, but it is for clinical reasons and would not be appropriate</li> </ul>
<p>Team working / staffing</p> <ul style="list-style-type: none"> <li>- Staff work well together, help each other out and share jobs so multi-skilled and kept up to date</li> <li>- ‘Midwives care for each other so they can care for the mothers’</li> <li>- Good communication</li> <li>- Second midwife is now called to be present for second stage of labour – if necessary on call midwife called in after hours</li> <li>- On call system – not part of contracts, a lot of goodwill</li> <li>- Praise for HCAs/WCAs – invaluable help and support</li> </ul>	<ul style="list-style-type: none"> <li>- Units can sometimes be short-staffed, particularly when staff are asked to cover shifts at RSH at short notice – on call midwife is then called in to cover the unit</li> <li>- Bridgnorth lost 56 midwife hours a week when new unit opened in 2006, units getting busier</li> </ul>
<p>Skills and training</p> <ul style="list-style-type: none"> <li>- Midwives are able to practise their art and midwifery skills rather than obstetric nursing</li> <li>- Highly skilled, experienced professionals</li> <li>- Should be enough time for staff to keep up to date with training</li> <li>- Midwives rotate around the county and update on the consultant unit at RSH</li> <li>- Training / emergency days / neonatal</li> </ul>	<ul style="list-style-type: none"> <li>- Concern (Bridgnorth) about big changes coming up with staff rotating – some apprehension. Feeling that perhaps consideration could be given to rotating those near to retirement, continue to update their skills by spending time at Shrewsbury</li> </ul>

<p>resuscitation / 2 midwifery study days per year / statutory training / drills for emergency procedures</p> <ul style="list-style-type: none"> <li>- Additional training for a number of midwives (Wrekin) in neonatal examination of newborn, means they can go out and carry out the examination which is only available 9-5 at RSH</li> <li>- Very good mentoring service to students</li> </ul>	
<p>Breastfeeding support</p> <ul style="list-style-type: none"> <li>- All midwives and support staff trained to same level in breastfeeding support</li> <li>- More time following delivery for support, women gain confidence</li> <li>- 24/7 support available</li> <li>- Lactation consultants</li> <li>- SaTH going for 'baby friendly' accreditation</li> </ul>	
<p>Services / facilities / clinics</p> <ul style="list-style-type: none"> <li>- Facilities that promote natural childbirth, normality</li> <li>- New birthing pool at Oswestry and plan to have birthing pool 'in a box' at Bridgnorth – hope to attract more women</li> <li>- Home birth option</li> <li>- Water birth option (some units)</li> <li>- Antenatal classes, breastfeeding workshops, clinics</li> <li>- Consultant clinics, day assessment unit (PANDA/WANDA)</li> <li>- Scanning, available in community at Sutton Hill (Wrekin)</li> <li>- Triage service for different clinics and specialities (RSH and Wrekin)</li> <li>- Early pregnancy service Mon-Fri for 2 hours (Wrekin)</li> <li>- External support and specialist advice available, e.g. diabetes, mental health (RSH, Wrekin)</li> <li>- Translation service</li> </ul>	<ul style="list-style-type: none"> <li>- Would like more funding for more equipment / facilities (e.g. for antenatal classes, birthing couches)</li> <li>- More room / storage required (Bridgnorth), especially for equipment on clinic days</li> <li>- Stock could be improved</li> <li>- Would like longer hours for consultant clinics and day assessment unit (Wrekin)</li> <li>- Lack of space and equipment in 'community room' at Wrekin</li> <li>- High demand for clinics and classes – could do with longer / more sessions to reduce waiting times</li> </ul>
<p>Supervision / support</p> <ul style="list-style-type: none"> <li>- Teams very supportive of one another</li> <li>- Supervisor of midwives not on all sites but always on call access, very helpful, put themselves out</li> <li>- Support available at RSH and felt to be accessible</li> <li>- Approachable higher managers</li> <li>- Good supervision, appraisal</li> </ul>	
<p>Information sharing</p> <ul style="list-style-type: none"> <li>- Information displayed and available</li> <li>- Positive re Medway computer system</li> </ul>	<ul style="list-style-type: none"> <li>- A lot of time spent doing paperwork</li> <li>- Request for amount of paperwork to be reviewed so more time can be spent clinically looking after patients</li> </ul>
<p>Governance / reflective practice</p> <ul style="list-style-type: none"> <li>- Reflect on successes of emergency deliveries – look at what was good and what could have been done better</li> </ul>	

<ul style="list-style-type: none"> <li>- CNST training ongoing</li> <li>- Staff follow pathways in the case of emergencies – not a feeling of isolation, well trained and confident</li> <li>- Staff do their best to avoid incidents, systems are reviewed and best practice promoted</li> </ul>	
<p>Patient feedback</p> <ul style="list-style-type: none"> <li>- Very positive feedback received</li> <li>- Friends and Family test – positive, immediate feedback for staff</li> </ul>	
<p>Other comments</p> <ul style="list-style-type: none"> <li>- MLUs promote the normality of birth</li> <li>- Good food</li> </ul>	<ul style="list-style-type: none"> <li>- One comment (Bridgnorth) that all day visiting hours is too long, not enough time for mothers to rest</li> </ul>
	<p>Move of services to Telford</p> <ul style="list-style-type: none"> <li>- Concerns in some (not all) of the MLUs due to increased distance/travel time, issues with transport links</li> <li>- Feel the care for those in most need will be compromised</li> <li>- More women could choose to deliver out of county (Hereford / Wrexham)</li> <li>- If women choose to go out of county, what impact will that have financially on SaTH?</li> </ul>
	<p>Ambulance response times</p> <ul style="list-style-type: none"> <li>- Ongoing issues in some areas, due to geography</li> <li>- WMAS not always familiar with the local area</li> <li>- Paramedic sometimes sent on bike / by car – ambulance is what is needed</li> </ul>
	<p>Facilities</p> <ul style="list-style-type: none"> <li>- Ludlow – existing facility needs some cosmetic updating now doubts over new build</li> </ul>
	<p>Maternity services review</p> <ul style="list-style-type: none"> <li>- Not well publicised</li> <li>- Risk of feedback from public sessions not being fair / balanced</li> <li>- Cost of review – will there be enough feedback to justify the cost, what will happen with the findings, how to ensure value for money?</li> <li>- Concern that there is an agenda nationally to move to only having alongside units</li> </ul>

- **Midwife Led Unit – alongside unit (Shrewsbury)** – views contributed by 11 members of staff

<b>Good Practice</b>	<b>Challenges</b>
<p>General positive comments</p> <ul style="list-style-type: none"> <li>- Nice option to have low risk units to deliver in</li> <li>- Love working in Shropshire. Great team, supportive and help each other out</li> </ul>	<ul style="list-style-type: none"> <li>- Most of the time everything is wonderful, there is just the odd day when it is not</li> </ul>
<p>Community based</p> <ul style="list-style-type: none"> <li>- Community clinics are a base for the families, important for the communities</li> </ul>	

<p>Access and choice</p> <ul style="list-style-type: none"> <li>- Mums know they can ask to be seen even if it is a full clinic, ring up PANDA and generally they will be seen</li> <li>- If patient is not able to get to clinic the midwife will telephone then to make sure they are alright</li> <li>- Hub and spoke model is good and gives more choices to patients</li> <li>- Shropshire massive area to cover, nice to have smaller units to work in</li> <li>- Midwives rotate between different areas</li> </ul>	<ul style="list-style-type: none"> <li>- Patients get upset if they don't meet the criteria to deliver at Oswestry</li> </ul>
<p>Team working</p> <ul style="list-style-type: none"> <li>- Community staff work closely with the midwife unit</li> <li>- Midwives prepared to rotate to help</li> <li>- Lots of camaraderie and help each other out</li> <li>- Brilliant team, share knowledge</li> <li>- Discharges are done together so that patients are not sitting around waiting to see the consultant</li> </ul>	
<p>Staffing</p> <ul style="list-style-type: none"> <li>- All staff work really hard. Staff who should work until 4pm nearly always stop until 6pm. Some staff will attend night births after being on duty all day</li> <li>- Midwives changed to a 12 hour shift, means you get a good break and not overworked</li> </ul>	<ul style="list-style-type: none"> <li>- Need more staff, struggle due to holidays and sickness</li> <li>- No guidance on rotas – can be unsettling to some midwives if they change what they are used to and they are taken out of their comfort area</li> <li>- Management could look at the individual skills, i.e. some people would prefer to work permanent nights, some midwives cannot do that</li> <li>- Hospital based midwives could change to do the same 12 hour shifts, currently conflicting hours</li> <li>- Once move to Telford, everyone should do same 12 hour shifts and make it more consistent and people would feel better. They would have good breaks and better rest periods, especially if covering a large area</li> <li>- Midwives can get confused when they move from MLU to ward 20 where there is different shift patterns and rotas – difficult to slot into working pattern. There is an e-rota but it is not used, need to be something in place that helps</li> <li>- Midwives are taken to ward 20 from the MLU because they are short, then that leaves the MLU short staffed</li> <li>- Postnatal ladies do not get the care they should and discharge themselves as there is no support</li> <li>- If patients are brought over from Telford and there is no one here, then they will ask that Telford midwife to stay – that has a knock-on effect and leaves Telford short</li> <li>- A patient was denied a homebirth because the</li> </ul>

	<p>midwife who was on call was taken to ward 20</p> <ul style="list-style-type: none"> <li>- MLU midwives are taken onto ward 20 all the time, which means they are spread thinly because of the low risk</li> <li>- Midwives end up covering ward 20 so that staff can have breaks but then the MLU midwives end up not having a break – happening frequently</li> <li>- When they look at numbers of patients they only look at who is in, not those potentially coming in or the phone calls the unit receives. They have taken both midwives before and there is nothing coming back the other way</li> <li>- Should be an escalation policy when midwives being used from the MLU to go to ward 20</li> <li>- No paediatricians at the weekend so the midwives do a lot of their own examinations before discharge</li> <li>- Patients are going home without nursery examinations and being told to come back the following day or they are seen in the community, but that then impacts on the work the community midwives are doing</li> </ul>
<p>Continuity of care</p> <ul style="list-style-type: none"> <li>- Good continuity in the community – mums get to know their midwives</li> <li>- Work in a team – share patients and will pass known patients on to other members of the team, swap patients if they know patients they have seen before</li> <li>- Stick to the 3 in their team – massive continuity, midwives enjoy getting to know the patients well</li> <li>- Good relationship with patients</li> <li>- Continuity very important – patients will tell you things because you know them, if you always do the patient’s growth measuring you know if something is not right</li> </ul>	<ul style="list-style-type: none"> <li>- Odd comments from patients asking ‘when will I see my midwife?’ as seen by someone else due to leave</li> </ul>
<p>Clinics / services / facilities</p> <ul style="list-style-type: none"> <li>- Parentcraft – feedback great</li> <li>- Home births</li> </ul>	<ul style="list-style-type: none"> <li>- Parent classes started by midwives –waiting list of patients waiting to attend and no funding</li> <li>- Would like to audit whether the things taught at parentcraft are useful</li> <li>- Would be useful to see if women attending classes stop at home longer before coming to hospital – some patients have up to 3 false alarms thinking they are in labour then need to see the consultant. Unsure of what labour is, they need to be told what to expect. Numbers of false alarms should then come down</li> <li>- Parentcraft classes need to be funded for 2 midwives to attend</li> <li>- Need more resources about home births – patients do not read the information in the purple book</li> <li>- Would prefer to have 2 midwives at a home</li> </ul>

	<p>birth</p> <ul style="list-style-type: none"> <li>- Need someone who is trained in hypno-birthing</li> <li>- Aqua-natal classes no longer exist, patients frequently ask for it, was somewhere patients could relax and have social interaction</li> <li>- There are small rooms and facilities are an issue. Suturing post-delivery, there is no overhead light, use a torch</li> <li>- Resources should be improved</li> <li>- The pool is not very good</li> <li>- If we are offering home births make sure it is a good service and the staff are available</li> </ul>
<p>Breastfeeding support</p> <ul style="list-style-type: none"> <li>- Trust is well staffed with lactation consultants</li> <li>- Breastfeeding clinic in Telford very structured</li> </ul>	<ul style="list-style-type: none"> <li>- Need consistency around breastfeeding support. Needs to be the same at RSH as it is in Telford. RSH clinic very ad hoc</li> <li>- Patients go home because they cannot get to see anyone, then they need help later on at home</li> </ul>
<p>Skills and knowledge</p> <ul style="list-style-type: none"> <li>- Very up to date</li> </ul>	<ul style="list-style-type: none"> <li>- The passion is there but there is not enough staff</li> <li>- Midwives do an awful lot under the circumstances, you wouldn't do the job if you weren't passionate</li> </ul>
<p>Governance</p> <ul style="list-style-type: none"> <li>- Proactive in implementing new guidelines very smoothly and quickly</li> </ul>	
<p>Information sharing</p> <ul style="list-style-type: none"> <li>- Good at sharing knowledge</li> </ul>	<ul style="list-style-type: none"> <li>- Too much paperwork</li> <li>- Too much towards CNST, not a fair balance. Physical checks take time to complete but the paperwork takes longer</li> </ul>
<p>Patient feedback</p> <ul style="list-style-type: none"> <li>- Patients like that midwives can request a scan and don't have to wait to see a consultant</li> <li>- Every day a card is received. Students also get presents and cards from patients</li> <li>- Patients feel the MLU should be bigger and not an add on. It used to be a whole ward</li> <li>- Rarely receive complaints, patients very happy</li> <li>- Most patients are really grateful for what you have given them and enjoy the experience</li> </ul>	<ul style="list-style-type: none"> <li>- Receive verbal complaints where patients are told they can go, but are then kept waiting because either staff have been called away to ward 20 or another patient who is about to deliver comes to the unit</li> <li>- It is difficult to give patients exactly what they want</li> <li>- Patients who are postnatal cannot see who is going into the labour ward, think the nurses are just sitting in the office</li> <li>- Expectations of patients are very high and more education is needed around what to expect</li> </ul>
<p>Training</p> <ul style="list-style-type: none"> <li>- Training held locally in SECC</li> <li>- Managers will chase up the midwives if they have not attended</li> <li>- If too many members of staff go on a study day then someone can be asked to come to work</li> <li>- Information from the mandatory days is fed back to other staff members</li> </ul>	<ul style="list-style-type: none"> <li>- Due to shortage of staff, only get to go on mandatory training</li> <li>- Lots of memos but hard to get the time to read them, always receiving lots of updates</li> </ul>

Supervision and support	<ul style="list-style-type: none"> <li>- Newly qualified midwives are worried they will be pulled onto ward 20 and they will not know where things are or procedures. They say they will get support but that doesn't happen as they are too busy</li> <li>- If you ask ward 20 to do a home delivery or water birth they say no as they are not trained</li> </ul>
<p>Anecdotal comparison to elsewhere</p> <ul style="list-style-type: none"> <li>- Chlamydia testing under 25s not done in other areas</li> <li>- Women who have given birth in other areas like the hub and spoke model</li> <li>- Patient moved up from London, 'stunned how good the care is here in Shropshire', expected to wait longer in clinics before being seen</li> <li>- Patient had birth at same time as sister in London – patient had more midwife visits than sister, sister had to travel into London for check ups</li> <li>- In Liverpool, one large maternity unit – patients discharged after 6 hours, not breastfeeding support. Newly qualified midwives moving from Liverpool to other areas</li> <li>- Women who have babies in city hospitals and then come to Shropshire see a bit difference. A lot of places do not have postnatal discharges, but they then have to go into a clinic</li> </ul>	<ul style="list-style-type: none"> <li>- The service we offer should be a good service, it should be a home from home</li> <li>- Good example is the Serenity Suite in Birmingham – we need the funding to be able to do it</li> </ul>
	<p>Move to Telford</p> <ul style="list-style-type: none"> <li>- Midwives not happy, majority live in Shrewsbury</li> <li>- Patients who live in Welshpool are concerned, they are moving to Wrexham as they have opened up an MLU</li> <li>- Patients opting for home births</li> <li>- Service for Welsh patients not as good</li> <li>- Staff can currently walk to work in bad weather, doesn't take long to get to RSH in an emergency. If they were phoned to go to Telford they wouldn't do it</li> <li>- Patients who did not know much about it are terrified of having their babies in Telford, too far</li> <li>- Just beginning to hear about the move to Telford</li> <li>- No explanation is being given to patients</li> <li>- If the consultant unit is moved from RSH, then it would be an ambulance journey to Telford</li> <li>- Don't want to be in Telford, want to be in Shrewsbury</li> </ul>
	<p>Maternity services review</p> <ul style="list-style-type: none"> <li>- How are we getting feedback from those women who can't get in touch – single mums who cannot get to focus groups, those who don't attend breastfeeding groups / mums groups?</li> <li>- How do we stop those negative stories from</li> </ul>

	<p>patients who have unrealistic expectations?  - Patients will say something because they have had a problem. Lots of patients will turn up to say things didn't go well rather than if things went well</p>
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**2. Semi-structured interviews with medical staff at Shrewsbury**

Carried out by Dr Dave Evans, FRCOG, consultant obstetrician and gynaecologist and medical director at Northumbria NHS Foundation Trust on 29 August 2013.

Met with four members of the consultant obstetric staff and the Clinical Director, two obstetric trainees and two consultants in neonatal paediatrics.

**Awareness of review:** All permanent staff were aware that the CCG review was taking place though no one was able to describe an understanding of why the review had been initiated. No one had been asked to take part or provide evidence to the review until this meeting.

**Governance:** All believed that the department functioned well, had good systems of governance, a very open culture and learned from reviews of critical incidents. They described good systems for sharing learning across the whole range of clinical staff including staff from peripheral units.

**High reporting unit for critical incidents:** There had been a decision made by the department to aim to be a high reporting unit in terms of critical incidents. They were aware that this may make them appear to be an outlier but felt that this was a demonstration of their openness and their willingness to learn. They felt that the investigation process was open and trusted by all staff. The completion of outcome implementation was supported by the Trust's systems. They also described a parallel system in place for reviewing incidents which did not meet the criteria for central referral. The feedback from both of these systems was used in governance and learning events. It was acknowledged that the time which was devoted to investigating these incidents may be becoming excessive in terms of the learning which was generated.

**Information sharing / data monitoring:** The MEDWAY data collecting system is in the process of installation with Intra-partum and Post-natal components in place and the Ante-natal part soon to be installed. As described this will give a level of data capture and an ability to monitor the performance of units – including the MLUs – and also individual clinicians. This will provide a monitoring system to support detailed scrutiny of specific incidents and also trends in practice and outcomes. It will provide supporting data for performance reviews, safety monitoring and individual appraisal.

**Adherence to guidance:** They believe the unit worked well to national guidelines and was actively moving towards achieving CNST level three. They did acknowledge that in some cases this meant that small changes could not currently be made as they were attempting to demonstrate a whole year's embedded practise of the existing system. This was not viewed to be a major problem.

**Internal communication:** All parties described excellent communication between staff, between different parts of the unit and between peripheral units and the main site.

**Support for MLUs:** All spoke at length in support of the peripheral MLUs and the important role they performed. No clinical concerns were raised at all. All felt that the system was well managed and the staff appropriately trained. The rotation of midwifery staff was described as a positive feature which allowed maintenance of skills.

**Team working:** Good examples of team working were given and people described a very close and supportive culture. All described the upset which had been felt in the unit by publicity of recent cases in the local media.

**Emergency response:** They felt the department responded well to emergencies. Trainees described a good level of training and support for their performance in emergency situations and the use of training drills. 84 hour dedicated Consultant Delivery Suite time with no other commitments was now embedded. 40 hours of cover for Gynaecological emergencies was also provided.

**Midwifery workforce:** All parties recognise the stability of the midwifery workforce as being a major positive factor contributing to the working of the department and also its supportive environment. The trainees describe the midwives working to a very high level of independent practice which they felt was appropriate and allowed them to concentrate on cases which better required their attention.

**Staffing:** Work force planning had included a recent expansion of consultant numbers and an investment in non-consultant career grade doctors. They were described as a reliable and skilled workforce. They were said to have good development and career progression opportunities. It was recognised that as this group got older, they were unlikely to be replaced. All parties recognise that this was not a long-term solution to providing skilled obstetricians 24 hours a day and there had been active consideration of moving towards resident consultants on-call. It was felt with the imminent move that the timing was not right at present but there was a commitment to revisit this in the future and clear expressions that the future work force was almost certain to involve 24 hour resident consultant cover. Currently all consultants work in both Obstetrics and Gynaecology, it was recognised that in future many consultants are unlikely to work in this way. Wherever possible, internal cover for absence was sought to reduce the reliance on external locum staff as this was recognised as being an area of clinical risk.

**External communication:** In terms of external communication all had described how in the past a standing invitation to a clinical member of the PCT to attend departmental governance meetings had not been taken up. There was an expression that in the future they would hope that a clinical member of the CCG would be able to join in this function as they feel this would allow them to demonstrate their systems in action and give assurance to the CCG.

**Reconfiguration of hospital services:** There was a clear appreciation of the risks to the service. The move to Telford was viewed very positively, however this will leave

the obstetric unit distant from some of the services which occasionally are required to provide support. It was felt that overall the direction of the Trust would mean that over the coming years more services would move to the Telford site and although this was viewed as a short-term clinical risk, in the long-term they felt comfortable that this would be accommodated. Currently the benefits of the move were felt to far outweigh this risk.

**Workforce:** There was a description of speciality services being under significant clinical pressure and struggling to meet waiting times. There was a clear understanding of the need to reconsider work force planning for the future and a commitment to do this.

It was felt that the new Telford hospital was likely to see an increase in births as a consequence of re-organisation elsewhere in the Midlands, in particular the Stafford area. This was seen as a potential risk in terms of times when local units close to admissions and diversions are required. It was also described as an opportunity to increase the size of the service generating the need for further developments.

**Shrewsbury site facilities:** Concerns were expressed as to the possible future developments on the Shrewsbury site after the move. The current environment was described as wholly inadequate for the future. The limitations of the site, current buildings and the availability of financial support were all described as risks. The future development of other services particularly Fertility were seen as being vulnerable because of this. All described great clinical potential.

**Training unit:** The trainees describe this as being a popular unit, they felt well supported, were given good training and had good opportunities to develop clinical skills. They described the rota arrangements as good and allowing for a good spread of clinical involvement. One trainee had chosen to return for a second year because of this. The unit was described as being serially a high performer in both the GMC and Deanery Trainee Satisfaction Surveys.

**Team working:** The Paediatricians spoke in support of the MLUs and had no clinical concerns. They described excellent working relationships and communication with the obstetric team.

**Audit/training:** They described a recent audit of resuscitation equipment available across the service and also of the level of training. This was due for re-audit later this year to assess the move towards standardisation. They described recent support from the Trust to allow a team from Scotland, skilled in supporting the transfer of infants from remote units to visit and provide a training day for MLU staff and also paramedics. This was described as having been a great success.

**Neonatal unit status:** Concern was expressed about any possible change in status of the neonatal unit leading to a loss of skills by the medical team. The possibility of rotation to other units to maintain skills was viewed as a positive option.

### **Summary**

It would appear that this is a very vibrant unit which functions to a high level.

The staff members interviewed are all enthusiastic champions of their service and have a genuine pride in it.

The governance systems in place appear to be functioning and appropriate for the needs of the service.

There are clear indications that there is an open culture with a desire to learn from incidents and other outcome measures.

Evidence of constant service reviews and improvements were described.

The move to Telford is seen as a positive development.

The likely pressures for future workforce needs have been considered and are under review. The move to a more Consultant delivered obstetric service is recognised.

The Midwifery Led Units are regarded as a safe and effective part of the overall maternity service.

The Midwifery workforce and the level of their practice is valued by Obstetricians, Paediatricians and Doctors in Training.

The unit is actively working towards the achievement of CNST Level 3.

I heard no evidence to suggest that there are any deficiencies in the systems required to monitor the safety and quality of the service.

### **Recommendations**

1. The CCG review process should include direct contact with clinicians to seek evidence of Governance arrangements.
2. The CCG review should seek evidence from the CNST submission process to assure itself of the Governance systems in place.
3. The CCG should regard as a high priority placing a senior clinician as a standing member within the governance structure of the maternity service.
4. This service is likely to grow and will need the support of the Commissioning body in the future.
5. Consideration should be given to providing training in the management of Obstetric Emergencies and Resuscitation of the newborn in a standard way across the whole service.

### **3. Telford and Wrekin GP feedback**

- The de skilling of clinicians
- The lack of communication between midwives and GPs
- Who actions blood results like FBCs

- Whether or not to use notifications electronically
- Insufficient communication between gynaecology and obstetrics

#### **4. Feedback received via the dedicated maternity services review email address**

1. When the maternity units at Chester and Wrexham close to new patient admissions, the Royal Shrewsbury maternity unit takes on their care. This increase in patient admissions on the Consultant delivery suite and midwife led unit leads to a significant increase in the work load. Stress levels for staff, patients and their relatives are also increased during this time. During the 10 years I have worked at the hospital I have never known the maternity hospital to shut but we are all aware that when the other hospitals shut the increase in the work load makes the risk of less than excellent care given to the patients more likely to happen.
2. The midwives working on the community have a very heavy workload, which has increased over the past few years due to an increase in the number of ladies booking and requiring ante-natal care. The practice for ladies and their babies to be discharged earlier from the consultant and midwife led units following delivery has also added to the community workload.
3. The wish for more home births requires the community midwifery staff to do more frequent on-calls, which can mean that not sufficient midwives are available to do clinics and home visits if they have been called out to a home birth.
4. I believe that the care the ladies in Shropshire receive is of a high standard, due in no small part to the dedication and diligence of all the staff within the Trust.
5. I would like to point out that when the Maternity consultant unit relocates to Telford it will leave the county west of Shrewsbury with little cover for maternity service requirements, whilst the east of the county already has access to care in Wolverhampton, Birmingham and Stoke on Trent.

## Audits Reviewed and Findings

Audit	Findings
<b>Service User</b>	
Antenatal information pilot audit results 2012	<p>Results of audits of Antenatal Patient Information provided to women at booking to test the process, guideline and audit pro-forma. November 2012 to October 2013 SaTH are carrying out the 'Main' audit of 52+ cases (in line with CNST sample requirements) of patients who booked with the SaTH Maternity service.</p> <p>Figures below show a total of 16 (100%) compliant cases for the pilot audit. The current compliance for this year's audit is 25/28 (89%).</p> <p>The process for recording the provision of Antenatal Information is documenting this in the Maternity Information System. In all cases audited (Pilot Audit and Main Audit) patients were given the appropriate pack. (Pack 1 to all patients other than those booked for TIMs care whom are provided with Pack 2).</p>
<b>Clinical Outcomes</b>	
Clinical Risk assessment Antenatal (no date) - 70 cases	<p>Conclusions</p> <ul style="list-style-type: none"> <li>• Clinical Risk Assessments are being carried out in line with the care pathway for timing of risk assessments. <ul style="list-style-type: none"> <li>– &gt;90% of appointments other than 40wk for High risk and or Nulliparous women (86%)</li> <li>– As a result of these risk assessments care pathways are being changed accordingly.</li> </ul> </li> <li>• 100% of women who required referral to triage were referred and a triage plan was documented in the case notes.</li> <li>• 33/34 patients who required referral to Consultant had a Consultant Antenatal clinic appointment made.</li> <li>• Identification for appropriate place of birth was identified and documented in 100% of cases</li> </ul> <p>Discussion</p> <ul style="list-style-type: none"> <li>• Further analysis of areas where non compliance was identified will be carried out in order to ascertain reason and impact on clinical care.</li> <li>• The management plans of the ten women who moved from Low to High Risk care pathway will be reviewed</li> </ul>

<p>Missed appointments (April 2012 – March 2013) – 27 cases. Re non-compliance with specified auditable standards</p>	<p>Non Compliancy</p> <ul style="list-style-type: none"> <li>• One case review not evident by Lead Midwife- Guideline has redefined this role</li> <li>• One case not referred to safeguarding Midwife- which requires follow up</li> <li>• 2 cases whereby DNA Checklist not filed in the notes</li> </ul> <p>Discussion points</p> <ul style="list-style-type: none"> <li>• Appropriate to have more involvement of the Ward Manager rather than Lead Midwife being responsible for review of notes</li> <li>• Lead Midwife to be accessed for escalation issues and ?facilitate Governance review</li> </ul> <p>Conclusions</p> <ul style="list-style-type: none"> <li>• Overall compliance appears to be good in relation using the missed appointment tick list and Roles &amp; Responsibilities</li> </ul> <p>Recommendations</p> <ul style="list-style-type: none"> <li>• Ward Managers to have more of authority in following through and reviewing the notes when there is a third DNA, rather than the Lead Midwife.</li> <li>• To re-audit the above process in 12 months time to review if new process is effective</li> </ul>
<p>Low risk care pathway (2006) Audit of 187 women from 2005 – Wrekin</p>	<p>Conclusions</p> <ul style="list-style-type: none"> <li>• 796 received – 666 continued on care pathway</li> <li>• Effective triage by Midwives</li> <li>• No adverse maternal / fetal outcomes</li> <li>• Evident that woman do need longer in the</li> </ul> <p>First stage: Primigravida = 13hrs 5 mins Multigravida = 8 hrs 26 mins Second stage: Primigravida = 1 hr 33 mins Multigravida = 4 mins</p> <p>Recommendations</p> <ul style="list-style-type: none"> <li>• Continue with using low risk care pathway at MLUs</li> <li>• Consider it's use for low risk woman on Consultant unit</li> <li>• Continue to monitor maternal and foetal outcomes</li> </ul>
<p><b>Hub &amp; Spoke</b></p>	
<p>Maternal transfer by ambulance (2013) Number = 12 purpose sample, 61 sets of case notes (160 annual transfers) Excludes RSH MLU</p>	<p>Conclusions</p> <ul style="list-style-type: none"> <li>• Overall compliance appears to be good in relation to documentation requirements of each staff group when transferring women in to the Hospital from Community / Midwife Led Unit during the Intrapartum period</li> </ul>

as no ambulance involved.	<p>Recommendations</p> <ul style="list-style-type: none"> <li>• Devise standardised Doctors Letter, based on SBAR</li> <li>• Amend in utero transfer tick list to incorporate time of hand over of care and any significant events / care during transfer</li> <li>• Re-educate staff on the importance of full completion of the form</li> <li>• Re-educate staff on the importance of full completion of the correct form</li> <li>• Follow-up of individuals where form incomplete / not completed / used incorrect form</li> </ul>
<b>Workforce</b>	
A staffing level audit for Midwifery (October 2012)	<ul style="list-style-type: none"> <li>• Identified a deficit of 5.00 WTE midwives against RCM recommended staffing levels. It should be noted that 5.6 WTE clinical midwifery hours are currently allocated to theatre coverage. These duties are in addition to those normally expected of clinical midwives. There was also a deficit of specialist roles of 2.58 WTE (N.B. 5.6 WTE clinical).</li> </ul>
An audit of labour ward cover (1 <sup>st</sup> October 2011 – October 2012) to determine staffing levels (Obstetricians) in line with Safer Childbirth (RCOG 2007).	<ul style="list-style-type: none"> <li>• This audit demonstrated a shortfall in middle grade x2 and consultant presence on Labour Ward. Further to the 2010 Business Case 3 consultants were appointed which goes some way to meeting the standards, but it has been identified that there is still a shortfall. The audit demonstrates that options have been explored and introduced in the form of a 'new Middle Grade rota supplying twilight cover between 16:00 and 23:00. The model of dual Middle Grades 24/7 is being readdressed because of recruitment difficulties and an updated Business Plan to supply 24/7 Consultant presence on Labour Ward with the continuation of single tier Middle Grade cover proposed. Although this falls short of the RCOG standards it does mean that 2 doctors with decision making in operative capacity will be available 24/7'.</li> </ul>
An audit of labour ward cover (Anaesthetists) (October 2011 - October 2012) to determine staffing levels (Anaesthetists) in line with Safer Childbirth (RCOG 2007).	<ul style="list-style-type: none"> <li>• This demonstrated a shortfall for consultant weekday sessions and consultant cover for elective lower section caesarean sections (LSCS). The conclusions were that there was 100% coverage of out of hours work and that all shortfalls as above were resolved by using specialty doctors (24%) or senior Specialist Trainee Doctors (6%). Cover for Elective LSCS</li> </ul>

	<p>sessions have been resolved by prospective consultant cover and where not possible Specialty Doctors or Senior Specialty Trainee Doctors were used. Resident Middle Grade rota now in place since 31.10.11 resulting in separate 24 hour resident on-call rota for labour ward. One labour ward session a week not covered by consultant due to recent restructuring within the anaesthetic department'. The one consultant labour ward session requiring cover was proposed in a business plan and was approved with recruitment in progress at the time of writing the audit report.</p>
<p><b>Risk Management</b></p>	
<p>Audit of incidents, complaints &amp; claims October 2012- May 2013 This focusses on completion of documentation for serious incidents to assess compliance with specified auditable standards i.e. Standard 1: Criterion 8 Arrangements for ensuring that all SUIs undergo a RCA, involving as appropriate unbiased external input*. Arrangements for ensuring that lessons learned from all incidents, complaints and claims are actively disseminated to all staff.</p>	<p>Note: Date within aims and objectives is incorrect (October – September 13 – see title page) similarly footer identifies 'audit of patient information – August 2013'. Results: 11 of the 12 (92%) were fully compliant against all categories. The 12<sup>th</sup> was non-compliant against category 1: the initial review planning meeting was not held within 2 days due to clinical staff failure to escalate as an SI. Conclusions: Processes are in place and working to immediately identify, report, investigate and learn from serious incidents within maternity services. The non-compliance identifies the need to reinforce the need to escalate serious incidents. In mitigation this was a relatively new reporting category and the incident was reported under the incident reporting system rather than SI system Action: September 20113 – Clarification of the definition of 'External Input' and of 'Commissioner Involvement' – meeting to be held to confirm definition and review Risk Management Strategy.</p>
<p>Audit of maternal transfer by ambulance (2013) Sample period May 2012-April 2013 Part 1 (identifying documentation requirements of each staff group when undertaking in-utero transfer) – Number = 12 purpose sample, Part 2 (Process for identifying the documentation requirements of each staff</p>	<p>Discussion points: Indicate that not all forms / letters were completed adequately and there were differences in the forms used, with some missing from case notes. Some of this may be attributed to format and non-standardisation and process. Compliance ranged from 75% - 100%.  Results – The SBAR Tool was used for HDU transfers, maternal transfers by ambulance but not for this criterion as a local tool was used. However since January 2013, SBAR is now the only handover tool and is used in all areas. Documentation has been modified to reflect this.</p>

<p>group when transferring women to hospital from the community / MLU during the intrapartum period) -61 sets of case notes (160 annual transfers) Excludes RSH MLU as no ambulance involved.</p> <p>(Criterion: Locally or nationally developed tools to ensure a consistent approach to the documentation of the transfer of care, for example SBAR / ACCEPT)</p>	<p>Conclusions</p> <p>Overall compliance appears to be good in relation to documentation requirements of each staff group when transferring women in to the Hospital from Community / Midwife Led Unit during the Intrapartum period</p> <p>Recommendations</p> <p>Part 1</p> <ul style="list-style-type: none"> <li>• Devise standardised Doctors Letter, based on SBAR</li> <li>• Amend in utero transfer tick list to incorporate time of hand over of care and any significant events / care during transfer</li> <li>• Re-educate staff on the importance of full completion of the form</li> </ul> <p>Part 2</p> <ul style="list-style-type: none"> <li>• Re-educate staff on the importance of full completion of the correct form</li> <li>• Follow-up of individuals where form incomplete / not completed / used incorrect form</li> </ul>
<p>Audit of transfers* 1<sup>st</sup> April 2012 – March 2013. A randomised sample of 11 women who had undergone in-utero transfers – 1% of total transfers from all units</p>	<p>In all cases there was appropriate transfer in line with NICE 2007 Intrapartum Guidelines 2007(IG). Time taken to transfer patient from MLU to CLU at RSH was appropriate. Time that patient was seen by an Obstetrician or Neonatologist varied from 0 minutes to 55 minutes – no set time in NICE IG 2007.</p> <p>Conclusion: Demonstrates good level of compliance in relation to transfer of patient for appropriate reasons in line with NICE standards 2007 and with speed of transfer and the amount of time undertaken to be seen by Obstetrician or Neonatologist.</p> <p>Recommendations: Add times of transfer, arrival time and time to seen by Obstetrician or Neonatologist to Maternity Community Dashboard.</p>
<p>*Does not include circumstances where transfer was indicated but did not happen. This is audited continuously by the Maternity Community Dashboard and where necessary is taken through the Governance process. Does not include time to birth following transfer.</p>	

### Associated Strategies, Policies, Guidance and Frameworks

The table below outlines the strategies, policies and procedures supplied by maternity services to inform the review and comments on compliance.

Document	Comments on compliance	comments
<b>Service User Experience</b>		
Patient Information Framework (Maternity). Writing, approving, archiving and disseminating	The framework outlines the process by which patient information is produced and controlled, in order to give patients and their families the literature they are entitled to as stated in the NHS Constitution (2013)	
Patient Information Guideline	Clear guideline describing what information should be shared at the various stages of pregnancy.	
<b>Hub &amp; Spoke</b>		
Clinical Risk Assessment (Antenatal)	Clear guideline based on evidence.	<b>Also relates to Risk Management</b>
Place or Mode of Birth against Professional Advice	Clear guideline based on evidence and legal implications.	<b>Also relates to Risk Management</b>
Intrapartum Care On a Midwife Led Unit or Homebirth	Comprehensive guideline based on evidence.	
Transfer (by Ambulance) of a Woman in the Antenatal, Intrapartum and Postnatal Period	Clear guideline based on evidence.	<b>Also relates to Risk Management</b>
Transport Arrangements for the Movement of a Sick Newborn into Hospital from Home or a Midwife Led Unit	Policy reviewed in June 2013, based on audit requirements of the CNST standards.	<b>Also relates to Risk Management</b>
Maternity Early Warning Score - Early	Comprehensive guideline based on evidence.	<b>Also relates to Risk Management</b>

Recognition of the Severely Ill Woman		
<b>Clinical Outcomes</b>		
Strategy for Staffing Levels - Obstetricians	Clear guideline and congruent with CNST level three standards.	<b>Also relates to workforce</b>
Strategy for Staffing Levels – Midwifery and Support Staff	Clear guideline and congruent with CNST level three standards.	
Strategy for Staffing Levels – Obstetric Anaesthetists and Assistants	Clear guideline and congruent with CNST level three standards.	
Antenatal Screening – The process, review and communications of screening results	Clear guideline congruent with NICE and National Screening Committee guidance	<b>Also relates to Risk Management</b>
Venous Thromboembolism	Clear guideline congruent with NICE and CEMACH guidance	
Gestational Diabetes Screening	Clear guideline congruent with NICE recommendations	
Diabetes – Antenatal Care for Women with Pre-Existing Diabetes	Clear guideline congruent with NICE and CNST requirements	
Pre-eclampsia – severe	Clear guideline congruent with RCOG recommendations and CNST requirements	
Smoking in Pregnancy and the Postnatal Period	Clear guideline congruent with NICE recommendations / other royal college guidance	
Operative Vaginal Delivery	Clear guideline congruent with RCOG recommendations and CNST requirements	
Caesarean Section – Emergency	Clear guideline congruent with NICE recommendations	
Elective Caesarean Section	Clear guideline congruent with NICE recommendations, however does not include	

	'choice'	
Care in Labour on consultant Unit	Clear guideline based on NICE and RCOG guidance. Clear reference to other associated guidance.	<b>Also relates to risk management</b>
All Postnatal Care In Hospital/MLU or Community	Clear guideline congruent with NICE recommendations and CNST requirements	
Neonatal Unit Admissions	These two documents may benefit from being combined to maximise the impact of the contents	
Admissions to the Neonatal Unit		
Transitional Care	This policy still appears to be in draft.	
Newborn Feeding	Clear guideline congruent with NICE recommendations and CNST requirements	
Neonatal Jaundice Maternity Guideline	Clear guideline congruent with NICE guidelines.	
Neonatal Care (including Neonatal Thermoregulation, hypoglycaemia and the Neonatal Hypoglycaemia Guideline as Appendix 1)	Clear guideline which includes observations of the newborn.	
<b>Workforce</b>		
Please refer to earlier sections for documents which overlap work streams		
Midwifery Preceptorship Programme	Clear programme. However it would be helpful to have documented how compliance with this programme will be monitored.	<b>Also relates to Risk Management</b>
SaTH NHS Trust Maternity Services Training Guideline (includes the Training Needs Analysis as an	Covers all professional groups. Clear outline of processes for identifying various training needs.	<b>Also relates to Risk Management</b>

Appendix)		
Escalation Policy	Clear guideline identifying when and how to escalate staffing issues	<b>Also relates to Risk Management</b>
<p><b>Risk Management</b></p> <p>Please refer to earlier sections for documents which overlap work streams</p>		
Maternity Service's Risk Management Strategy Version 6	Clear strategy describing structures, roles and processes including governance groups and governance roles. However, the process for dissemination of learning to individuals, and assuring their understanding, is not explicit and especially within the Midwife Led Units. Being explicit with regard to dissemination will enhance this strategy.	
Serious Incident Policy CG04	<p>Includes Maternity Categories to be reported on UNIFY/STEIS.</p> <p>However, maternity services have been using the criteria used in the West Midlands which have a lower threshold of reporting serious incidents. Therefore the reported numbers of serious incidents are higher than other comparable trust with similar number of births. The higher reporting should be perceived as positive.</p> <p><b>N.B.</b> Flow chart p35 of SI policy seems to have the learning element missing, but is indicated in the title.</p> <p>It is noted that the policy is currently being updated.</p>	
Procedure for the Reporting and Investigation of	A clear guideline which includes disseminating the learning.	

Incidents, Complaints and Claims		
Monitoring and Audit policy (Maternity)	Clear guideline.	
Auscultation	Clear guidelines in their own right but may be helpful to consider having an overarching document that includes both guidelines.	
Electronic foetal monitoring - continuous		
Enhanced observations of babies with Neo NEWS on postnatal wards/MLU	New guidance but still has comments. Needs to be finalised and approved.	
Guideline, protocol and policy development framework – maternity	Clear framework that supports the development, approval and dissemination of guidelines, protocols and policies.	
Escalation policy	Clear guidelines on when and how to escalate staffing issues	
Dealing with referrals of babies for intensive care	This policy is inappropriate as the Neonatal Unit is a 'Local' unit rather than intensive care unit.	
High dependency care	Clear guideline based on CMACE guidance and CNST requirements.	
Third trimester ultrasound scan referral	New and clear guideline.	
Booking for midwifery care – including referral for care	Clear guideline based on CMACE guidance and CNST requirements.	
Use of oxytocin in labour	Guideline based on CNST requirements. Need to review the section on training as training on oxytocin is not covered as mandatory training.	
Learning from adverse events Policy (incidents, complaints and claims) CG09	Section 9 covers learning and improving as a result of adverse incidents. All patient safety incidents are reported to the NPSA and to the National	

	<p>Reporting and Learning System.</p> <p>This section adequately identifies how local, organisational and cross-organisational learning is fulfilled. This document is due to be updated.</p>	
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