

By email and post

Private & Confidential

Mr Tom Taylor
Chief Executive
Shrewsbury and Telford Hospitals NHS Trust
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XQ

18th April 2007

Reference: 0159/PP

Dear Mr Taylor

I am writing to inform you that the Healthcare Commission has completed its consideration of the concerns regarding the obstetric service at the Royal Shrewsbury Hospital. I would like to sincerely apologise for the delay in writing to you with the outcome of these enquiries.

The Healthcare Commission initially received concerns in March 2006 in connection with the injury caused to the babies of [REDACTED] (November 2004) and [REDACTED] (December 2004). The allegations raised with the Healthcare Commission were as follows:

- Alleged failure of staff to recognise and act upon poor Cardiotocograph (CTG) tracings
- Non-adherence to the National Institute of Health and Clinical Excellence (NICE) guidelines
- Lack of/inappropriate staff training

As you are aware, following the review of documentation from various sources, discussion with Commission staff and an independent midwifery adviser, it was decided that the Commission would visit the maternity service to interview relevant staff and seek clarification regarding the following outstanding concerns:

- Risk Management Systems (including incident reporting, root cause analysis, actions plans, follow-up and learning from incidents)
- How policies and procedures are rolled out to staff and embedded in practice
- Clinical Governance
- Transfers from the Wrekin Unit to the Royal Shrewsbury Hospital

The Healthcare Commission has not conducted a formal investigation, but has made preliminary enquiries in order to establish what (if any) risk there is to the safety of patients and to decide the appropriate course of action.

After carefully reviewing information provided by the trust and its staff, and other relevant information, we are now in a position to feed back on the outcome of our work.

Initial concerns

Alleged failure of staff to recognise and act upon poor Cardiotocograph (CTG) tracings

Following the two cases referred to above, the Investigation Team were informed that the trust reflected on CTG interpretation and training issues and these were acted on by Dr Mahejar. It is encouraging to hear that Dr Mahejar conducts regular CTG training sessions with consultants using anonymised CTG tracings to aid learning.

It is noted that the trust reviewed the two incidents for any trends and identified that the same clinicians were not involved. To satisfy itself that incidents involving the reading and interpretation of CTGs are not repetitive and that learning is taking place, the Commission would like to receive a copy of the most recent CTG audit undertaken by the trust.

Non-adherence to NICE guidelines

The Commission is satisfied that the trust now benchmarks itself against NICE guidance and that it is trying to take a more proactive approach to risk management (including reviewing National Patient Safety Agency (NPSA) advice and other relevant reports).

The Investigation Team heard that the trust maternity guidelines are produced in line with national guidance and are ratified by the labour ward forum and governance group. It is also noted that the Local Supervisory Authority is ensuring that NICE guidelines are communicated to midwives and embedded in practice.

During the Commission's visit to the maternity unit it was encouraging to hear from staff that the unit aims to leave women as long as possible before providing the option of a Caesarean, which is in line with NICE guidance. It is noted that BirthChoice UK statistics show that the trusts' Caesarean rate was 14% in 2005, which is significantly below the UK national average of 23.2%.

Lack of/inappropriate staff training

At the time of its visit, the Commission heard that there were thirteen midwifery supervisors and three midwifery managers in post. The ratio of supervisors to midwives was 1:17, however, the trust had recently appointed additional supervisors, which would help to increase the amount of monthly supervision received by the midwives.

The supervisors are involved in incident investigations and they sit on the governance and clinical risk meetings, which aids learning from incidents and cascading information to the midwives.

The Investigation Team note that skills drills training is coordinated so that all midwives can attend, and generic mandatory training is held at either the Shrewsbury or Telford site. The Commission recommends that the impact of

skills drills training on patient care should be evaluated. It is also encouraging to hear that the attendance of staff at mandatory training is monitored and forms part of appraisal and supervisory sessions.

Outstanding concerns

Risk Management Systems (including incident reporting, root cause analysis, actions plans, follow-up and learning from incidents)

During interviews, the Investigation Team heard that the trusts' previous view was to only investigate incidents if a complaint was lodged or litigation was initiated, and this was evident in the cases of the babies of [REDACTED] and [REDACTED]. The Commission is pleased to hear that complaints and/or litigation is no longer the trust's driver for investigating an incident, with all incidents now investigated, presented to clinical governance meetings, lessons learnt and audits undertaken.

The trust states that the handling of risk has improved greatly since the appointment of a clinical risk adviser, although additional resource is required permanently in maternity to enable risk to be managed in a robust manner within office hours.

The Commission is satisfied that the trust now uses the NPSA's root cause analysis tool to investigate incidents (utilising an investigation protocol) and also keeps a record of all actions from prenatal mortality meetings, so that there is an audit trail of any recommendations and the progress made. It is also encouraging that in January 2006 the maternity service set up a complication register so that any trends in incidents involving consultants can be easily identified and prompt action taken if required.

It is noted that action and feedback from incidents has been a challenge due to the geography of the trust, but the Commission is encouraged to hear that the trust has established a tracking system for the recommendations from incidents which ensures that the loop is closed on the implementation of all actions and that these are monitored by the Obstetric Clinical Risk Group. However, the trust need to improve the quality of the action plans resulting from clinical incident cases and high risk case reviews, i.e. the actions need to be clearly measurable, the accountable person named and they should have timescales.

How policies and procedures are rolled out to staff and embedded in practice

Several policies and procedures were overdue for review at the time of the Commission's visit and so it is recommended that they be revised as soon as possible in line with national guidelines (if not already done). The trust should ensure that all staff are clear about revisions to policies; the CRAWL magazine, which has received positive feedback from staff, would seem to be a good mechanism for this.

Clinical Governance

The Commission was told that previously clinical governance had been neglected by the trust, but that the structure was being revised and the trust was moving towards integrated governance. The Commission supports this move, as the new structure will result in halving the number of committees;

having clearer reporting lines; and monthly clinical governance meetings will be established. The Commission understands that the revised structure was due for consultation in October 2006 and would appreciate receiving a copy of the final structure for information.

Transfers from the Wrekin Unit to the Royal Shrewsbury Hospital

The Commission was encouraged to see that lessons have been learnt and some good work has taken place in relation to midwifery practices and transfer practices between the Wrekin unit and the Royal Shrewsbury Hospital. This includes the rotation of staff between Shrewsbury, Telford and the Wrekin unit; the inclusion of national guidelines in managing the latent stage of labour and the Midwifery Manager at the Wrekin Unit attending business meetings, senior midwife meetings and case review meetings to ensure that all staff at the Wrekin unit are aware of changes to policy and practice.

In summary, based on the findings above, the Commission has concluded that the concerns do not meet the Commission's criteria for investigation. However, improvement is required in the areas mentioned and so the Commission will monitor implementation in these areas until it is satisfied that sufficient progress has been made. These findings will be considered as part of the trusts' 2007 Annual Health Check.

The recommendations are attached as Annex A. The Investigation Team has now concluded its involvement in these matters, and the Healthcare Commission Regional Team will monitor these actions and progress reports should be sent to Liz Oxford, Senior Assessment Manager at:
liz.oxford@healthcarecommsision.org.uk

I would like to thank you and your staff for the assistance provided to the Healthcare Commission throughout our consideration of these matters.

If you would like to discuss the content of this letter in more detail, please do not hesitate to contact me on 020 7448 4518 or at:
paula.palmer@healthcarecommission.org.uk

Yours sincerely

Paula Palmer
Investigation Officer

cc. Mr Jonathon Lloyd - Head of Performance - West Midlands SHA
Sarah Seaholme – Investigation Manager – Healthcare Commission
Andrea Gordon – Area Manager – Healthcare Commission
Liz Oxford – Senior Assessment Manager - Healthcare Commission

Annex A**Case: [0159/1PP]**

To: Shrewsbury and Telford Hospitals NHS Trust

Re: Concerns raised regarding the obstetric service at the Royal Shrewsbury Hospital

Recommendations
CTG
The trust should send a copy of the latest CTG audit to the Commission and ensure that staff are aware of it for their learning. Trends, learning and improvements should be identified and acted upon.
Lack of/inappropriate staff training
Skills drills training programmes should be evaluated and revised where necessary.
Risk Management Systems (including incident reporting, root cause analysis, actions plans, follow-up and learning from incidents)
The trust needs to improve the quality of the action plans resulting from clinical incident cases and high risk case reviews, i.e. the actions need to be clearly measurable, the accountable person named and they should have timescales.
How policies and procedures are rolled out to staff and embedded in practice
Policies and procedures should be reviewed in a timely manner, in line with national guidance, and staff should be clear of any revisions.
Clinical Governance
The trust should share its revised Clinical Governance structure with the Commission.
Clinical Risk Adviser
The trust should consider the need for permanent additional resource for the Clinical Risk Adviser for the Children and Maternity Service