Hello Shelagh

I have attached our CNST maternity level 3 report following our assessment in June. We were very pleased with the positive feedback we got.

I have also attached the first CTG audit report. This is now carried out each month

Please let me know if you require any further information

Clare Jowett
Head of Governance
The Shrewsbury & Telford Hospital NHS Trust

Tel: 01743 261118
Email: clare.jowett@sath.nhs.uk

Attachments follow this email:

Attachment 1

NHS Litigation Authority

Clinical Negligence Scheme for Trusts

Maternity Risk Management Standards Report of Assessment

Clinical Negligence Scheme for Trusts
Maternity Risk Management Standards
Report of Assessment at Level 3

Trust Name:	Shrewsbury and Telford Hospital NHS Trust		
Trust Contact:	Clare Jowett Head of Clinical Governance	**Trust No:**	T650
Assessor:	K Wynn/E FitzGerald	**Date of Visit:**	18th/19th June 2007
Outcome:	Compliance	**Date of Report:**	20th June 2007
		Reassessment Date:	30th June 2010

Standard	Level 1	Level 2	Level 3	Compliance
1. Organisation	100%	100%	N/A	Yes
2. Learning from Experience	100%	100%	100%	Yes
3. Communication	100%	100%	100%	Yes
4. Clinical Care	100%	100%	100%	Yes
5. Induction, Training and Competence	100%	100%	100%	Yes
6. Health Records	100%	100%	100%	Yes
7. Implementation of Clinical Risk Management	N/A	96%	100%	Yes
8. Staffing Levels	100%	100%	100%	Yes

You will receive a discount from your CNST contribution for next year.

Action Points

Short-term

2.1.1 Adverse incidents and near misses are reported in all areas of the maternity service by all staff groups.

The maternity service provided evidence to demonstrate that incidents are reported across all areas and by all grades of staff. It is also clear that all professional staff are actively encouraged and required to use the incident reporting system. The assessors noted that on several occasions, the incident report forms had not been fully completed, resulting in the potential loss of useful data and learning.
To improve standards in this area, the maternity service may wish to consider providing additional guidance to staff.

5.1.1 All clinical staff attend a specific induction appropriate to the department in which they are working.

The maternity service provided evidence to demonstrate that all grades of staff receive a specific induction appropriate to the department they are working in. A number of key elements were absent from the induction checklists provided, however; evidence concerning the selection process identified that these subjects had been covered. Providing information, such as 'expectations of post' and 'limitations of role' during the selection process only, has the potential for key information being forgotten by the time the member of staff commences work in the department.
Risk management systems in this area, could be enhanced by collating all the relevant information into one comprehensive induction checklist.

Final Comment

The maternity service are to be congratulated for achieving Level 3 compliance with the NHSLA Clinical Negligence Scheme for Trusts Maternity Clinical Risk Management Standards (April 2006) at this assessment.
This result is well deserved as it reflects positively on the enormous amount of work undertaken since the last assessment.
A supportive and learning culture has clearly been established within the maternity service, along with robust risk management systems.
Due to the development of the NHSLA assessment standards the maternity service are advised to visit the NHSLA web site www.nhsla.com regularly and to maintain contact with their risk management assessor to ensure they are kept up to date with the standards and any changes to the assessment process that may affect the maternity service.
In accordance with the new NHSLA scheme rules, the maternity service will be due for assessment in financial quarter one, but no later than 30th June 2010.
I would like to take this opportunity to wish the Trust every success in the future.

Attachment 2

Healthcare Commission
Response to Obstetric Unit Review

Following the receipt of the Healthcare Commission Report (April, 2007), the Trust produced a written response showing compliance with Healthcare Commission requests and ongoing development of its governance activities.

One of the requests of the Healthcare Commission was to receive a copy of the most recent CTG audit undertaken by the Trust. The Department requested more information and clarity of this request and were grateful for the help provided by Shelagh Hawkins during her visit in May 2007. As a result of this advice, monthly audit sessions for CTG traces were initiated in June 2007.

CTG Audit

Methodology

1. Each calendar month 10 sets of casenotes from patients who delivered on the Consultant Obstetric Unit are set aside for investigation.

In order to ensure there is no bias in the selection of cases, the Coding Clerks randomly select 10 sets of casenotes after coding.

2. A proforma was designed to ensure uniformity in assessing the CTG traces and the appropriateness of the staff responses to the traces. (See Enclosure A).

3. The Lead Obstetrician and Senior Midwife for Consultant Unit check through the casenotes, the appropriate CTG traces and decided if the interpretation of the trace and further action was appropriate.

4. The results of the audit will be fed back through the Labour Ward Forum for consideration and any action if necessary.

5. Any failure to interpret a CTG correctly or take appropriate action, or any examples of poor record keeping are reflected back either by the Senior Midwife or the Lead Obstetrician to the individual concerned. If necessary, additional training can then be provided.

Results of June 2007 Audit

- 10 audits on a random sample from 290 births
- 9 audits were satisfactory, both in the interpretation and subsequent action
- 1 audit showed a reduced variability pattern. The midwife took appropriate action but failed to record that she observed the deviation from normal and her response to the deviation. The Senior Midwife interviewed the midwife to explain the issues discovered in the audit.
- Final result = 90% accurate interpretation and action taken