NHS
The Shrewsbury and
Telford Hospital
NHS Trust

29 June 2017

Dear patient

I am writing to let you know that we have today (29 June 2017) published a report of a review we have carried out into our maternity services. I wanted to ensure that, as somebody using the service; you had some context to the review and knew where to find a copy. I also want to assure you of our commitment to providing the very best maternity services for local women and their partners.

Every year the Trust delivers more than 4,500 babies. We want to give the safest and kindest care to all the women and babies we look after. We strive every day to meet this ambition, and mostly do deliver on it, but we know we don't always get it right, every time, for every family. Most of the time birth is a normal and natural event, but sadly sometimes things can go badly wrong with a lasting impact for all involved. As a Trust, we have committed to making sure we learn from every incident where we know we could have done things better. We recognise we haven't always done that as well as we might have in the past.

To continue our learning and to meet our ambition to provide the safest and kindest care, we have carried out this internal review. It looks back over the past ten years and seeks to determine the quality and safety of our services, and whether we have learnt from mistakes in the past. We want to identify where we can improve our current ways of working to help us be the very best we can be for the families we support and care for.

We are publishing this review tomorrow and sharing it with people who use the service, our staff and local communities, so we can start putting its recommendations in place as soon as possible. We are determined to do this with openness and transparency, and to be a continuously learning organisation.

We are expecting publication of two independent reviews into our maternity service in the autumn. However, we have chosen not to delay publication of our internal review because we want to act on the recommendations in our review and make improvements as soon as we can.

Together the three reviews will give us a full picture of our maternity services:

- our internal review looks back over the last 10 years at our culture, systems and processes and how far they support safety, openness and learning
- a look-back by our regulator, NHS Improvement, at the individual investigations carried out in the past for 22 babies and three mothers, establishing learning from these
- at our request, a review of current practice and learning in our service by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

We want to make sure as many people as possible can access these reports, the issues they raise and our response to them. You will be able to see the reports and our responses to them as soon as they

are published, from the maternity services section of our website. This can be accessed via our homepage www.sath.nhs.uk.

We are building upon our candour and transparency of recent years to be more open and accountable than in the past and believe this is critical if we are to continuously learn and improve.

We are sorry when we don't meet the high standards of care we set for ourselves. We want to get our care right for each and every woman and baby, and are committed to nothing less. When things go wrong we want to learn and promote a culture of accountability not blame. We want to support our staff to deliver the sort of care they would want for themselves and their own families and friends.

However, I do want to reassure you about the care you can expect from the Trust. We have a team of committed doctors, midwives and other health professionals who provide high quality care day in, day out. While we recognise we still have areas of improvement:

- Perinatal deaths (stillbirths plus neonatal deaths) have fallen since 2009 when it was recorded at a crude rate of 8.3 deaths per 1000 live births to 7.01 in 2015. We recognise this is still high and are working hard to reduce this further
- We have made a determined effort to improve cardiotocograph (CTG) monitoring (where our midwives and doctors monitor foetal heartbeat before a baby is born) with significant improvements made which include regular training and investment in equipment to promote safer use and interpretation
- A low rate of births in our service (13-21.8%) are by caesarean section which is lower than the national average (25%) and is widely believed to be a good indicator of quality and safety within services
- We have standardised neonatal resuscitation equipment (for babies within the first 28 days of life) across the midwife-led units to ensure all staff are familiar with the lifesaving equipment wherever they are caring for babies
- 98.8% of mothers (who have given birth using our services) say they are likely or extremely likely to recommend the service and care they received in the Trust's friends and family test (Feb 2017).

We are committed to making further improvements and learning the lessons of the past to make sure we deliver better, safer services for local women and families in the future. Once again, I would like to assure you of our determination to provide the kindest and safest care to you and your family.

Yours faithfully

Simon Wright
Chief Executive