The Shrewsbury and Telford Hospital NHS Trust

Paper 12

Reporting to:	**Trust Board – July 2018**
Title	The Royal College of Obstetrics & Gynaecology Reports (RCOG)
Sponsoring Director	Deirdre Fowler – Director of Nursing, Midwifery & Quality.
Author(s)	Jo Banks (Women & Children's Care Group Director)
Previously considered by	N/A
Executive Summary	The RCOG undertook a review of maternity services at the Trust during July 2017. The review was commissioned by the Trust Board to evaluate the culture within the service and to assess the safety and effectiveness of maternity and neonatal services. The purpose of this paper is to update the committee on the progress of actions against the recommendations of the RCOG review; including the addendum to the report received during June 2018.
Strategic Priorities 1. Quality and Safety	☒ **Reduce harm, deliver best clinical outcomes and improve patient experience.** ☒ **Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards** ☐ Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme ☒ **To undertake a review of all current services at specialty level to inform future service and business decisions** ☐ Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme
2. People	☐ Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work
3. Innovation	☒ Support service transformation and increased productivity through technology and continuous improvement strategies
4 Community and Partnership	☐ Develop the principle of 'agency' in our community to support a prevention agenda and improve the health and well-being of the population ☐ Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies
5 Financial Strength: Sustainable Future	☐ Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme
Board Assurance Framework (BAF) Risks	☒ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience ☐ If we do not work with our partners to reduce the number of patients on the **Delayed Transfer of Care** (DTOC) lists, and streamline our internal processes we will not improve our 'simple' discharges. ☐ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff ☐ If we do not achieve safe and efficient **patient flow** and improve our processes and capacity and demand planning then we will fail the national quality and performance standards ☐ If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve ☐ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients

	☐ If we are unable to resolve our (historic) shortfall in **liquidity** and the structural imbalance in the Trust's **Income & Expenditure** position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment
Care Quality Commission (CQC) Domains	☒ Safe ☒ Effective ☒ Caring ☐ Responsive ☐ Well led
☐**Receive** ☒ **Review** ☒ **Note** ☒ **Approve**	**Recommendation** **The Trust Board are asked to note the report.**

Situation

Following receipt of the finalised RCOG report in January 2018, the Trust has received an addendum report following the care group providing evidence of learning and improvement with actions completed against the RCOG report recommendations.

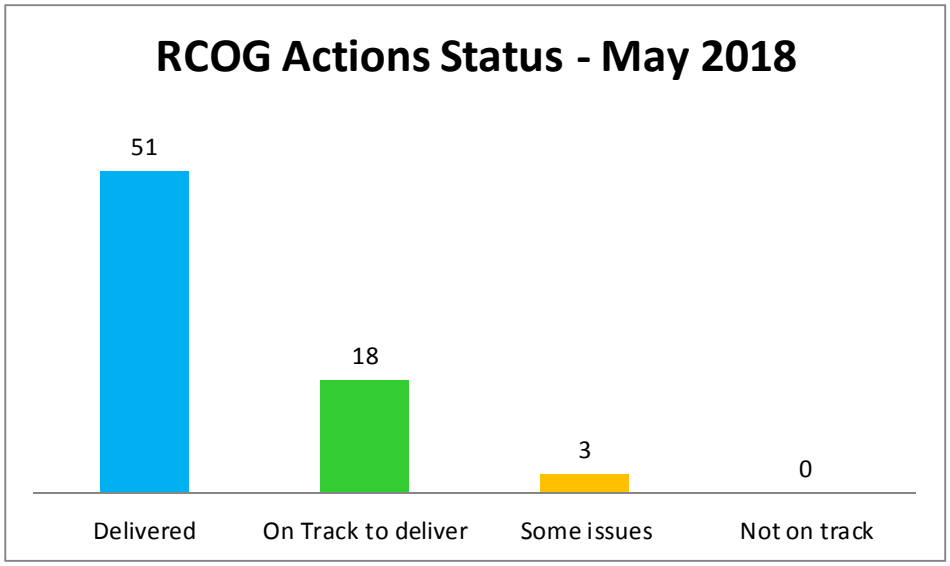
Background

The RCOG undertook a 3 day review of maternity services within the Trust during July 2017; commissioned by the Trust Board to evaluate the culture within the service and to assess the safety and effectiveness of maternity and neonatal services. The team included 7 clinicians who interviewed a broad variety of clinical and non-clinical staff across the care group and relied on 24 care group documents including policies and procedures. The RCOG report findings were received by the Trust during January 2018; followed by a meeting with the RCOG, Care Group leaders and the Director of Nursing Midwifery and Quality on 27th April 2018. The purpose of this meeting was to review improvements and provide evidence of learning and changes to practice against the recommendations within the report.

Assessment

The RCOG report findings recommended 37 overall improvement themes with 72 actions; many of which were in progress at the time of the review visit. Table 1 below provides an update on current progress against actions.

Table 1



The 3 actions relating to “some issues” of completion are within the following themes requiring investment, cross-trust and external influences to the service.

1. Implementation of the local maternity strategic (LMS) plan; led by commissioners.
2. Implementation of the MLU reviews; led by commissioners.
3. Consultant anaesthetic cover of the labour ward in accordance with the 2013 OAA/AAGBI guidelines; requiring investment and on the care group risk register.

The RCOG addendum report was received by the Trust during June 2018 and follows the presentation by the Women and Children's Care Group; shared with the assessors on 27th April 2018. The presentation was an interim report of the progress made in line with the RCOG recommendations.

The key findings below are summarised from the addendum report and relate directly to the RCOG review terms of reference.

1. The Care Group presented a clear update of the work done to date on the models of care for maternity services.

2. The Care Group presented a joint vision for the service which focused on safety and learning.

3. The senior management team have benefited from the teamwork and leadership programmes, with team members working constructively with each other. Leadership and team-working programmes appear to have benefited senior managers with the development of learning and improving culture among staff.

4. Staff engagement in service developments has improved and the blame culture has shifted to a culture of learning and improving.

5. The Care Group has strengthened its risk management structure and governance processes.

6. The Care Group has strengthened the way it investigates clinical incidents and utilises external investigators.

7. The maternity quality performance dashboard has been amended to reflect national quality measures found within guidance.

8. The members of the Women and Children's Care Group conveyed a genuine commitment to improving patient safety and this commitment is reflected in their achievements.

9. The Care Group has clearly worked hard on tackling the concerns raised by the assessors following their site visit in July 2017.

10. The Head of Midwifery should be commended on their current leadership style.

11. All recommendations have been addressed and the majority are now implemented.

12. Despite the continued uncertainty on the maternity model of care and site for the consultant-led maternity and neonatal services, the Care Group remains focused in improving the provision of care within the maternity and neonatal services.

<u>Recommendation</u>

The Board is asked to note the ongoing work to address the actions RCOG identified which the care group is on track to deliver, review, note and approve the report on improvements made by the care group in response to the RCOG review.

REPORT ADDENDUM

Report of the Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust

On 27 April 2018

Contents

1. INTRODUCTION

A review of the maternity services was commissioned in July 2017 by the Trust Board of Shrewsbury and Telford (S&T) Hospital NHS Trust. The review was commissioned to evaluate the prevailing culture within the Women and Children's Care Group, and to identify whether maternity and neonatal services are safe and effective following concern over higher than average perinatal mortality rates. In the subsequent report, the assessors made a number of recommendations based on findings from staff and service user interviews undertaken during the site visit, case reviews and the documentation provided by the Trust.

In February 2018, the Women and Children's Care Group shared with the assessors an interim progress report and on 27 April 2018, during a meeting held at the RCOG, the Care Group had the opportunity to present the progress made in line with the recommendations.

The RCOG agreed that an addendum to the initial report be written by the assessors present.

This addendum report is based on the presentation given by the Care Group members, the action plans based on the recommendations in the initial report and the information shared by the Care Group during the meeting.

2. NAMES OF REVIEW TEAM MEMBERS

Dr Claire Candelier FRCOG, Consultant Obstetrician
Professor Alan Cameron FRCOG (former Vice President, RCOG), Consultant in Maternal Fetal Medicine
Ms Megan Moore, Lay Member
Ms Anna Shasha, Head of Midwifery

3. NAMES OF ATTENDEES FROM RCOG

Mr Edward Morris FRCOG, Vice President Clinical Quality
Ms Anita Dougall, Senior Director Clinical Quality
Ms Louise Thomas, Head of Quality Improvement
Ms Farrah Pradhan, Invited Reviews Manager
Ms Gozde Zorlu, Media and PR Manager

4. NAMES OF ATTENDEES FROM S&T

Ms Jo Banks, Care Group Director, Women's & Children
Ms Deirdre Fowler, Director of Nursing, Midwifery & Quality
Dr Adam Gornall MRCOG, Consultant in Fetomaternal Medicine & Gynaecology and Clinical Director for Maternity
Ms Sarah Jamieson, Head of Midwifery
Ms Joy Oxenham, Quality Improvement and Governance Manager, Women and Childrens Care Group
Mr Andrew Tapp, Medical Director, Women's & Children

Dr Wendy Tyler, Consultant Neonatologist and Clinical Director for Neonatal Governance (at the time of the review)

5. FINDINGS AND CRITICAL APPRAISAL OF EVIDENCE

A. Relating to terms of reference (1):

To review the current obstetric, midwifery and neonatal practice at S&T Hospital NHS Trust in the context of patient safety and to identify any concerns that may prevent staff raising patient safety concerns within the Trust, as well as ensuring the services are well led and the culture supports learning and improvement following incidents.

The Care Group presented a clear update of the work done to date on the models of care for maternity services. The Clinical Commissioning Group (CCG) sought the views of service users during an initial consultation period and then conducted a midwifery-led unit (MLU) review. The CCG proposed model of care is awaiting clinical senate review on the 4th June and after which recommendations will be made to NHSE regarding sign-off . Following sign-off, there will be a public consultation before a definite model of care can be agreed.

The maternity dashboards have been updated and reflect, in greater depth, the activity on all units and incorporate the National Maternity Quality Indicators, run rates (as per learning from the National Maternity and Neonatal Health Safety Collaborative and the Birthrate Plus® acuity tool. The National Maternity and Perinatal Audit (NMPA) clinical indicators are now part of the monthly dashboards and the neonatal dashboards are currently being developed. Evidence of learning from the 2013–15 MBRRACE-UK Perinatal Mortality Surveillance reports was presented to the assessors. Key topics included airway maintenance, medication timing and hypoxic-ischaemic encephalopathy (HIE) stabilisation. Regular training and audit of practice should ensure improved standards are maintained. The number of HIE cases has fallen markedly in 2017, but this fall has not been mirrored by a fall in the stillbirth rate. The Care Group is targeting the four elements of the Saving Babies Lives care bundle to reduce the local stillbirth rate. A smoking cessation midwife is now in post and the Trust has seen a reduction in smoking from 21% to 17% in pregnant women in the Telford and Wrekin CCG area. In January 2018, the launch of 'mama wallets' is helping raise awareness among pregnant women of the importance of detecting and reporting reduced fetal movements.

The Trust should submit data for all the required clinical indicators to the NMPA: data for induction of labour; early elective section between 37^{+0} and 38^{+6} weeks of gestation; small-for-gestational-age (less than the 10th centile) baby born at or after 40 weeks gestation; and low Apgar score less than 7 at 5 minutes. These data were not submitted for the 2017 audit report based on births between 1 April 2015 and 31 March 2016. The Care Group has agreed to include clinical indicators, such as induction of labour, in their audit programme where they are outliers.

B. Relating to terms of reference (2):

To review the current provision of care within the maternity and neonatal services in relation to national standards.

The maternity dashboard now indicates maternity and sick leave, the use of bank staff, transfer rates and reasons for transfer from MLUs. The ratio of midwife to mother is 1:29. The dashboard is discussed at relevant meetings and shared with all. Redistribution of midwifery staff has allowed the merger of the day assessment unit and triage at the consultant-led site enabling provision of a 24 hour service.

The neonatal guidelines remain separate from the regional network (West Midlands) guidelines but incorporate network guidance wherever possible. Any deviation from the West Midlands guideline is acknowledged in the guideline. Local guidelines are revised every 3 years, or sooner if there is a change in practice or new guidance published.

The Maternity Voices Group has replaced the Maternity Engagement Group and the revised terms of reference now include service user engagement in obstetric guideline development.

C. Relating to terms of reference (3):

To review the current midwifery, obstetric and neonatal workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.

Further to the CCG MLU review and the 2017 Birthrate Plus® data, the proposed model of care is currently awaiting sign-off from NHS England. This model is based on one consultant-led site, one co-located MLU, and one stand-alone MLU with other MLUs providing antenatal care, including scanning and fetal monitoring. Due to low staffing levels, inpatient services (intrapartum and postnatal) at the three smaller MLUs (Bridgnorth, Oswestry and Ludlow) were suspended on 1 July 2017 for an initial period of 6 months. Services at these MLUs resumed for the month of January 2018, but since February 2018, the closure of one or more of the MLU's unit has been reinstated to maintain a safe level of care for labouring women. The decision as to which unit closes will depend on planned births. Women and staff will be given prior warning: approximately 2 to 4 weeks in advance. Since the assessor's visit in July 2017, midwifery staff morale has improved and this improvement is reflected in the fall in sickness rate. The Care Group is justifiably proud that the postnatal ward at the Princess Royal Hospital has recently achieved Diamond Exemplar status.

Progress is being made with the maternity actions from the Clinical Negligence Scheme for Trusts incentive scheme. The Band 7 labour ward coordinator is supernumerary, but only approximately 50% of the time. This shortfall is now included as a red flag in the escalation policy. It is hoped that the extension of the triage service from 12 hours to 24 hours will reduce the number of episodes when the coordinator is not supernumerary. The six professional midwifery advocates have completed the bridging training and the plan is for them to attend a training course in line with the A-EQUIP model recommendations. The risk management midwife post has been reinstated and reports directly to the Care Group Director but is professionally responsible to the Head of Midwifery. The planned appointment of a consultant obstetrician with a special interest in risk management should benefit the Quality Improvement and Governance Team. This appointment should not be taken as an opportunity for other consultants to abrogate their own risk management responsibilities. Although the neonatal staffing issue has not improved since the review, the current medical and advanced neonatal nurse practitioners rotas have been viewed favourably in the Neonatal Critical Care Peer Review, which took place in January 2018. Staffing is monitored via the risk register and annual audits. There are occasions when consultant neonatologists are called in out of hours to perform registrar duties and the assessors were assured that this did not impact significantly with their daily duties.

D. Relating to terms of reference (4):

To review the working culture within the maternity and neonatal services, including relationships and communication between healthcare professionals.

The Care Group presented a joint vision for the service which focused on safety and learning. The senior management team appears to have benefited from the teamwork and leadership programmes, with team members working constructively with each other. Staff engagement in service developments has improved and the blame culture has shifted to a culture of learning and improving. The regular quality improvement newsletter written by the Risk Management Midwife encompasses good practice feedback and learning from clinical incidents, and has been well received by the staff. The Head of Midwifery also provides a regular update.

The assessors were disappointed to learn that consultant anaesthetic cover of the labour ward remains non-compliant with the 2013 Obstetric Anaesthetists' Association/Association of Anaesthetists of Great Britain and Ireland guidelines for obstetric anaesthesia. As a basic minimum, there must be 12 consultant sessions per week to cover emergency work separate from scheduled activities. Regular audits undertaken on consultant anaesthetic presence for elective, emergency and out of hours work showed only 50% cover. There appears to be a reluctance by the anaesthetic department in addressing this safety issue. The unit is fortunate to have a team of experienced specialty and associate specialist tier 2 doctors who cover the labour ward 24/7. However, the deficiency in the consultant anaesthetic workforce on the labour ward is concerning as the number of pregnant women with risk factors, such as obesity, increasing maternal age and medical conditions, is increasing. The Care Group is regularly reporting this non-compliance to their Risk Register Group with escalation to scheduled care. The assessors recommend Trust Board engagement to help resolve these issues.

E. Relating to terms of reference (5):

To review the processes for escalation from MLUs to consultant-led units.

A review had been undertaken of the manager on-call rota and the rota is now working better. The escalation policy is firmly in place and was referred to on many occasions, particularly during times when an MLU is closed and services are diverted to another unit.

F. Relating to terms of reference (6):

To review approaches to monitoring fetal heart rates and acting upon abnormal traces, to describe how this relates to established best practice and make any recommendations for improvement.

Staff feedback has shown that the twice-weekly cardiotocography (CTG) meetings held on the labour ward are valued, but has highlighted difficulties in regular attendance. The plan is for daily CTG review meetings once the centralised monitoring system becomes operational in May 2018. This system, with ready access to both real-time and archived traces, will facilitate these training and teaching sessions. An audit of CTGs in the second stage of labour is in progress; findings are to be presented in June 2018. The Care Group aims to

improve CTG analysis in their quest to reduce intrapartum stillbirth rates. The group should continue to ensure all key staff attain annual competency on CTG interpretation and use the interventions recommended in the Saving Babies Lives care bundle (such as using a buddy system for the review of CTGs, use of stickers and using an escalation protocol).

G. Relating to terms of reference (7):

To review the root cause analysis (RCA) investigation process; how serious incidents (SI) are identified, reported and investigated within the maternity services; how recommendations from investigations are acted upon by the maternity services; and how processes ensure sharing of learning among clinical staff, senior management and stakeholders.

The Care Group has strengthened its risk management structure. There are regular workshops for RCA training and although the consultant body attendance at these workshops remains low, there is now a wider pool of RCA-trained investigators. Risk management meetings are held once weekly, as opposed to once monthly, with a weekly review of all Datix reports. Rapid review meetings are also held once weekly and are executive led. Leadership and team-working programmes appear to have benefited senior managers with the development of a learning and improving culture among staff. The Patient Safety Value Stream (Virginia Mason Institute), initially commenced on the antenatal ward, is in the process of being rolled out on the other wards. Safety huddles occur twice daily on the antenatal, postnatal and labour wards on the consultant-led unit as well as on the Wrekin MLU. The Datix incidents of the day are discussed during these meetings. Staff are encouraged to talk with non-Care Group guardians (values guardians) should they wish to discuss concerns. The 2018 staff survey has shown a marked improvement in the staff engagement score.

The Care Group has strengthened the way it investigates clinical incidents. RCA investigations follow the NHS Improvement SI Framework. The increased frequency of rapid review and executive review meetings has facilitated adherence to timeframes with an escalation process if there is slippage. An external investigator participates in all high-profile or high-risk incidents. Since the assessors' visit, both SI reviews gained input from external investigators. Measures have been taken to improve staff feedback and learning from incidents, for example, staff are no longer able to opt-out from receiving feedback when they complete a Datix, and it is a fixed agenda item for all SI and high risk cases at ward meetings. The Head of Midwifery writes a newsletter to staff and this bulletin includes an update on clinical incidents.

During their visit to the RCOG on 27 April 2018, the assessors reviewed two investigation reports. One followed the NHS Improvement SI Framework and had clear action plans, specific directives and timescales. The RCA investigation was completed in a timely manner; some action plans are ongoing and all but one recommendation had completion of action by date to be achieved. Repeated attempts at engaging the family had been unsuccessful in this investigation and the attempts were clearly documented in the report. Arrangements for shared learning were also documented. The second report was a 61-page document written by Consequence UK (an independent investigation company). This report appears to have been written primarily for the family of the deceased and specifically addresses the issues of concern they had raised. Recommendations were made, but the action plan constructed by the Care Group to address concerns raised by the unnamed report author was not included in the documents received by the assessors.

H. Relating to terms of reference (8):

To review the education and supervision of obstetric and paediatric trainees, including consultant accessibility and presence on the delivery suite and neonatal unit as per national standards recommendations in the context of providing a safe and efficient service.

The British Association of Perinatal Medicine recommendations for medical and neonatal nursing staffing on the neonatal unit are yet to be achieved, but this is not viewed as a safety issue by the Care Group due to the current level of activity on the neonatal unit. Trainees are considered to be getting enough experience and benefit from simulation training and are encouraged to participate in the neonatal stabilisation courses run for midwives in MLUs. Since the initial review, the Care Group has developed a faculty of PROMPT trainers to facilitate both medical and midwifery staff getting hands-on training in the management of obstetric emergencies. Staff attend annually during their working hours.

A logbook is kept on the labour ward alongside the multidisciplinary handover documentation and consultants are expected to sign this log to confirm their attendance when called.

I. Findings from the service user perspective

Women booked and due to give birth in an MLU subsequently closed to deliveries are contacted directly by the MLU team. Regular updates on the affected MLUs are placed on social media, in the press and on the Trust website.

The Care Group acknowledged that Maternity Voices service user representatives should be recompensed for their travel and childcare expenses. The assessors were told that expenses were paid at last month's meeting.

It is recommended that the Trust continues to engage service users fully and appropriately on the proposed new model of care via the new Maternity Voices (previously Maternity Engagement Group), the Local Maternity System (LMS), the program board and its work streams, and continue to raise awareness about this so that a range of key stakeholders are involved.

The Trust should continue to develop and exploit its social media platforms to engage with service users more widely, using appropriate professional media support and the community engagement facilitator.

The development of a variety of antenatal education and support, including a new parent craft app and 'women and friends' group, is encouraging and it is recommended that this be continued.

6. CONCLUSIONS

The members of the Women and Children's Care Group present at the meeting held on 27 April 2018 conveyed a genuine commitment to improving patient safety and this commitment is reflected in their achievements. The Care Group has clearly worked hard on tackling the concerns raised by the assessors following their site visit in July 2017. All recommendations have been addressed and the majority are now implemented. The Head of Midwifery should be commended on their current leadership style and appears to have pulled the team together. Despite the continued uncertainty on model of care and site for the consultant-led maternity and neonatal services, the Care Group remains focused in improving provision of care within the maternity and neonatal services.

REPORT

Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust

On 12–14 July 2017

Contents

1. EXECUTIVE SUMMARY

This review of maternity services was commissioned by the Trust Board of Shrewsbury and Telford Hospital (SaTH) NHS Trust to evaluate the prevailing culture within the Women and Children's Care Group, and whether maternity and neonatal services were safe and effective following concern over higher than average perinatal mortality rates. Actions have been put in place by the Care Group to address deficiencies in the interpretation of fetal monitoring. Staffing levels across the maternity units have led to a temporary suspension (July–September 2017) of inpatient intrapartum and postnatal care in the three smaller midwifery-led units (MLUs). The assessors were asked to critically evaluate the investigation process of serious incidents (SIs). During the 3-day visit, interviews were conducted with members of staff and service users.

The assessors found that staff were extremely caring and there was a genuine desire to provide the best possible care for women across the MLUs and the consultant-led unit (CLU). There was a culture of working together, with staff supporting each other during a period of prolonged scrutiny and negative media, which has led to low morale among the midwifery and medical workforce. There was a cohesive consultant body with evidence of strong leadership. Communication channels between the CLU and the neonatal unit (NNU) were strong. Trainees valued the training and supervision offered by the consultants. The service users interviewed reported an overall positive experience of the maternity services.

Despite a falling birthrate in the MLUs and workforce planning, staffing has favoured MLUs, areas with low birth activity and acuity, rather than the CLU, the area with the highest activity and acuity. The sustainability of safely staffing five MLUs across the Trust is being reviewed by the local commissioners. The Care Group should now present to the Trust Board a viable workforce plan supported by the April 2017 Birthrate Plus® data.

The current SI investigation process is complex and fails to adhere to recommended timescales. The process would be strengthened by a risk management midwife and a risk management obstetrician and a small team of root cause analysis (RCA) trained investigators. Involvement of external investigators in all SIs would strengthen the quality assurance and consistency of the incident investigation process. The culture of shared learning from SI investigations was not apparent. It is unclear to many of the clinical staff who is responsible for SI management within the Trust management team.

The perinatal mortality rates have remained above average compared with rates in similar trusts. Although the neonatal deaths in 2013 and 2014 were presented within the Care Group with a list of learning points, the assessors did not see evidence of action plans and resulting changes in practice. The latest 2015 MBRRACE data should generate action plans as well as learning points in order to improve perinatal mortality rates.

The newly-appointed Care Group Director and Head of Midwifery should work constructively together to develop a service embedded in a safety and learning culture.

The assessors have made recommendations which they hope will be constructive, and help to improve the care provided to women and their babies.

2. INTRODUCTION

The Trust commissioned the Royal College of Obstetricians and Gynaecologists (RCOG) to review current practice within their maternity services and to evaluate whether their maternity services are safe and effective. This review has been requested following concern over higher than average perinatal mortality rates. The Trust has recognised deficiencies, such as interpretation of fetal monitoring, and put in place actions to address these deficiencies. While a Care Quality Commission (CQC) inspection in 2014 gave an overall rating of 'good' to the maternity and gynaecology services, the services at the Princess Royal Hospital (PRH), Telford, were rated as 'requires improvement' under the safety domain, with concerns raised about the staffing levels in maternity and incident reporting – specifically consistency in reporting, categorisation and giving staff feedback. A further CQC inspection took place in 2016, with the report published on 16 August 2017. The Chair of SaTH NHS Trust commissioned a review of the development of maternity services in the Trust over the decade leading up to 2017. This report was published on 27 June 2017 and was made available to the review team.

Two other reviews are taking place concurrently at the Trust. A review of the MLUs requested by the local Clinical Commissioning Groups (CCGs) is due to report in autumn 2017. At the request of an independent inquiry by the Secretary of State, NHS Improvement is conducting a review of the quality of investigations and implementation of their recommendations, pertaining to a number of SIs that occurred between 2000 and 2017.

4. TERMS OF REFERENCE

1. To review the current obstetric, midwifery and neonatal practices at SaTH NHS Trust in the context of patient safety, identifying any problems that may prevent staff raising patient safety concerns within the Trust, as well as ensuring the services are well led and the culture supports learning and improvement following incidents.
2. To review the current provision of care within the maternity and neonatal services in relation to national standards (National Institute of Health and Care Excellence [NICE], RCOG, Royal College of Paediatrics and Child Health [RCPCH], British Association of Perinatal Medicine [BAPM] and The Royal College Of Midwives).
3. To review the current midwifery, obstetric and neonatal workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.
4. To review the working culture within the maternity and neonatal services, including relationships and communication between healthcare professionals.
5. To review the processes for escalation from MLUs to the CLU.
6. To review approaches to monitoring fetal heart rates and acting upon abnormal traces, to describe how this relates to established best practice and make any recommendations for improvement.
7. To review the RCA investigation process, how SIs are identified, reported and investigated within the maternity services, how recommendations from investigations are acted upon by the maternity services, and how processes ensure sharing of learning among clinical staff, senior management and stakeholders.
8. To review the education and supervision of obstetric and paediatric trainees, including consultant accessibility and presence on the delivery suite/NNU as per national standards recommendations, in the context of providing a safe and efficient service.
9. To make recommendations based on the findings of the review.

5. CONTEXT

The SaTH NHS Trust is the main provider of district general hospital services for nearly half a million people residing in Shropshire, Telford and Wrekin and mid-Wales. The maternity services are hospital and community-based. The hospital services consist of one CLU sited at the PRH, which opened in September 2014, and five MLUs. The Wrekin MLU is located at the PRH site and the other four MLUs are freestanding – Royal Shrewsbury, Oswestry, Ludlow and Bridgnorth. In addition, there are community-based services provided by Powys Healthcare that are sited in Newtown and Welshpool.

The CLU currently has 12 consultants responsible for labour ward cover, with on-site consultant presence 78.5 hours per week (Monday–Friday 08:30–21:00, Saturday and Sunday 08:00–16:00). The middle tier rota is staffed by Specialist Trainees Years 3–7 (ST3–ST7) and Specialty and Associate Specialist (SAS) doctors on a one in six rota for 4 weeknights and on a one in seven rota for 3 weeknights; the junior tier rota is staffed by ST1, ST2 and GP trainees on a one in seven rota. The labour ward has 13 rooms, one pool room and one bereavement room. There are two dedicated

obstetric theatres, with a separate recovery area. An elective caesarean section list runs three mornings a week and is staffed separately from the on-call rota. The antenatal ward has 13 beds, the postnatal ward 23 beds (with one bay specifically for transitional care babies) and a bereavement suite. There is a four-bed triage unit, open between 08:00 and 20:00. The CLU offers specialist maternal medicine antenatal clinics, led by two maternal and fetal medicine consultants and a consultant obstetrician. The majority of antenatal and postnatal care is provided within the community setting by the MLUs and community-based midwives in conjunction with GPs and where appropriate consultant obstetricians. Each woman is risk assessed and a plan of care developed. There are additional specialist clinics for perinatal mental health, infectious diseases, external cephalic version/breech, bereavement and anaesthesia. For the year 2016/17, there were 4194 births on the CLU. The total number of births across the Trust for 2016/17 was 4928.

The NNU at the PRH is designated as a level 2 local neonatal unit (LNU) and is part of the Staffordshire, Shropshire and Black Country Newborn and Maternity Network. Neonatal care in the PRH has three tier rotas: resident tier one, resident tier two and tier three consultant on call. Current neonatal configuration is three special care cots; three high dependency cots; and 16 intensive care cots. Previously, the neonatal unit was classed as a neonatal intensive care unit but was reclassified as a LNU in 2014.

The Wrekin MLU at the PRH has 13 beds and four labour rooms and one pool room. For the year 2016/17, there were 337 births (6.8%). The freestanding MLU at the Royal Shrewsbury Hospital has 13 beds, including a day assessment unit, three labour rooms and one pool room. For the year 2016/17, there were 142 births (2.9%). The freestanding MLU at Bridgnorth has four beds and one to two labour/pool rooms. For the year 2016/17, there were 77 births (1.6%). The freestanding MLU at Oswestry has six beds and two labour/pool rooms. For the year 2016/17, there were 52 births (1.1%). The freestanding MLU at Ludlow has four beds, one labour room and one pool room. For the year 2016/17, there were 36 births (0.7%). There were 64 (1.3%) planned home deliveries in 2016/17.

Due to low staffing levels, inpatient services (intrapartum and postnatal) have been suspended since 1 July 2017 at the three smaller MLUs of Bridgnorth, Oswestry and Ludlow. The MLUs have cardiotocograph (CTG) monitors for undertaking 20-minute tracings during pregnancy, which are faxed to the PRH for review by medical staff. The assessors were told these monitors were not to be used for women labouring in MLUs.

6. CONSULTANT STAFFING

Please see Appendix 15.1 for further information.

7. DESCRIPTION OF REVIEW PROCESS AND SITES VISITED

The Women and Children's Care Group Medical Director of SaTH contacted the RCOG. Following this request, seven assessors were selected with relevant experience related to the terms of reference.

The assessors requested specific information and data from the Trust which was received prior to the review. On 7 June 2017, the lead assessor and the Invited Reviews Manager met the Chief Executive, the Medical Director, the Care Group Medical Director, the Head of Midwifery, the Clinical Director for Maternity and the Clinical Director for Neonates, with the Personal Assistant to the Care Group Medical Director in attendance. This meeting offered the opportunity to discuss further the context of the review and the requirements for the on-site visit. A short tour of the CLU was given by the Care Group Medical Director to the visitors.

On the morning of Wednesday 12 July 2017, following an assessors' meeting, there was a site visit of the CLU, the NNU and the Wrekin MLU at the PRH. After this, the interviews commenced in accordance with the schedule. The assessors divided into two groups: one of which visited the MLUs at Shrewsbury and Oswestry, while the other continued interviews and reviewed the records for three SIs chosen by the Trust. On Thursday 13 July and Friday 14 July 2017, interviews continued and some of the assessors visited an antenatal clinic at the PRH where they interviewed patients and families, as well as two service user representatives from the Shrewsbury and Telford Maternity Engagement Group (MEG). On Friday lunchtime, some of the assessors spoke with a group of midwives attending a study day.

Verbal feedback to the Medical Director, Director of Nursing, Care Group Medical Director, Care Group Director and Head of Midwifery was given by the review team at the end of the visit.

The visit timetable along with name of interviewees can be found in Appendix 15.2. The Trust Patient Safety Manager and the Clinical Director for maternity were interviewed by telephone by the lead assessor on 7 August and 14 August 2017 respectively.

Following interviews and gathering of documents, the evidence was reviewed and this report was prepared.

8. DOCUMENTATION SOUGHT FROM THE TRUST

The documentation detailed below was received (the list is not exhaustive):

- Management structure of the service and overview
- Operational policy for the maternity services, all sites
- Escalation policy
- Job plan, job description for Head of Midwifery
- RCOG specialty department visit completed questionnaire
- RCOG clinical indicators project – *Patterns of Maternity Care in English NHS Hospitals 2013/14*, maternity national results August 2015
- CCG improvement and assessment framework 2016/17
- Women and Children's Business Planning – workshop 3

- Patient feedback survey
- Patient experience and engagement strategy
- MEG meeting minutes, 27 July 2016, 5 November 2016 and 10 February 2017
- Maternity clinical dashboards 2016/17 and 2017 to date
- Unit closures in 2016, 2017 to date
- Birthrate Plus® report – April 2017
- Statutory and mandatory training report 2017, including staff appraisals
- Clinical governance for medical staff
- Agenda of Obstetrics and Gynaecology Governance Feedback meetings for 2016 and 2017 to date
- Standard operating procedures for investigating incidents, version 1, 2014
- Women and Children's Care Group Risk Management Strategy, version 1, 2014
- Clinical incident/near-miss reporting and investigation policy (including SI and never events), version 1.3, 2016
- Risk management strategy, version 14, June 2017
- Guideline for managers and employees involved in adverse events
- Thematic analysis of SI RCA obstetrics/neonatology FY 2014/15 – FY 2015/16
- Term admissions to NNU
- MBRRACE 2013 and 2014 Neonatal Deaths, Trust mortality meeting 6 March 2017
- Audit and monitoring programme, June 2017
- Audit reports completed and presented in 2015/16, and currently being undertaken
- Guideline Antenatal Electronic Fetal Monitoring, version 1.3, 2016
- Standard operating procedures for auscultation of antenatal fetal heart rate, 2016
- Care in labour on consultant unit, version 4.7, 20 April 2017
- Application to maternity safety training fund for 2016/17
- Maternity department sign up to safety plan
- Implementation of national guidance within the neonatal services
- NHS England review of babies born at 27 weeks and under between 1 April 2014 and 21 September 2015
- Obstetric training programs for trainees and permanent medical staff
- PMET (Postgraduate Medical Education and Training) review findings summary obstetrics and gynaecology, 3 April 2014
- PMET review findings summary paediatrics, 16 November 2015
- Policy for whistleblowing, version 4.2, June 2013
- Review of maternity services 2007–17, 27 June 2017
- Proposed transitional model of midwifery-led care across Shropshire, 29 June 2017
- Ward to Board survey, August 2016–April 2017, Midwifery Care–Patient Experience
- Overview of maternity services report, Head of Midwifery, March 2017
- Neonatal care pathways 2015, Staffordshire, Shropshire and Black Country Newborn and Maternity Network

- Email communication from Dr Sanjeev Deshpande (consultant neonatologist) and Ms Samantha Davies (Neonatal Unit Manager) in reference to neonatal medical and nursing standards.

9. SYNOPSIS OF INDEX CASES AND INTERVIEWS

Relating to Terms of Reference (7):

To review the RCA investigation process, how SIs are identified, reported and investigated within the maternity services, how recommendations from investigations are acted upon by the maternity services, and how processes ensure sharing of learning among clinical staff, senior management and stakeholders.

Three cases selected by the Trust were reviewed by three of the assessors. The RCA final reports and executive summary were not available to the assessors, who were told these reports were still being completed. The assessors had access to the notes/minutes from the multidisciplinary team (MDT) meeting, statements, guidelines, correspondence with the family and medical records.

9.1 CASE REVIEWS

Case 1 background

A 33-year-old woman was booked for delivery on the CLU. In 2007, she had a spontaneous vaginal delivery at 42 weeks gestation of a baby weighing 3.9 kg. In 2008, she required an emergency caesarean section for suspected fetal compromise at 42 weeks of gestation, infant birthweight 3.95 kg. The plan for her third birth was for a vaginal delivery. Her antenatal care was shared with the Powys community midwives. Her BMI (body mass index) at booking was 43.5 kg/m^2. She had a normal oral glucose tolerance test and reassuring ultrasound growth scans at 31^{+0} weeks and 35^{+0} weeks of gestation. In October 2016, at term, she was seen at the antenatal day assessment unit following a road traffic accident. The CTG trace was reassuring. Twelve days later, at term^{+12}, her labour was induced following the diagnosis of an intrauterine death. The next day, she delivered a female infant, birthweight 2.82 kg (below the first customised growth centile). The cord was noted to be wrapped four times tightly around the neck. Post-mortem examination was declined. Placental examination revealed a small placenta consistent with fetal growth restriction. The pathologist's impression was that the intrauterine death was a consequence of an acute umbilical cord entanglement complication.

Rigour of RCA investigation:

a. Evidence of appropriate multidisciplinary involvement

The investigation was led by the Patient Safety Team Manager. The team was multidisciplinary and consisted of 13 members. Nine written statements, seven from midwifery staff and two from medical staff (ST5 and SAS doctors) were in the investigation bundle.

b. Adequate timeframe

The incident was reported on day 2, with an investigation opened on day 10. The Patient Experience Lead met with the parents on day 26. The parents were to meet with the Head of Midwifery and the Care Group Medical Director once the investigation was completed and to have a separate meeting with the Clinical Director in obstetrics to discuss placental histology. The SI meeting appears to have taken place on day 107. Over 6 months after the stillbirth, the parents met with the Head of Midwifery, Care Group Medical Director, Patient Experience Lead, Patient Safety Team Manager, a Senior Manager and a lead midwife. The LSA (Local Supervising Authorities) report was completed on day 125. At the time of this review, 8 months after the stillbirth, the final RCA investigation report was still outstanding and no draft form was made available to the assessors. This timeframe was thought to be unacceptable considering the impact of this case.

c. Identification of all issues

The root cause was attributed to the nuchal umbilical cord. There were missed opportunities to identify a low birthweight fetus during the antenatal period and this was identified by the investigation team as a contributory factor. When the woman attended the antenatal day assessment unit following the road traffic accident, the symphysis fundal height was measured but was not plotted on the customised growth chart. Had this been done, static growth would probably have been identified, an ultrasound scan requested and, more than likely, early delivery would have been advised. This failing in care provision by the midwife instigated a supervisory investigation. The two care providers, SaTH and Powys maternity services, followed differing growth monitoring guidance and this was listed as a contributory factor. The limitation of accurately estimating fetal weight in obese women was not seen as a contributory factor by the investigation team. At the 35^{+0} weeks gestation scan, the estimated fetal weight was just below the 50^{th} centile (2.78 kg), yet at birth the weight was below the 1^{st} centile (2.82 kg). A nuchal cord is associated with intrapartum complications rather than with fetal growth restriction. The LSA investigation was comprehensive and identified key factors of care contributing to the poor outcome, including the failure to measure and plot the symphysis fundal height on the customised growth chart at all visits. Midwifery reflection and training needs were recommended in the action plan.

d. Action plans with specific directives, timescales, and evidence of achievement

The final report was not available to the assessors. The action plan listed in the meeting report is, except for referral to supervision, not signed off as completed. There was no evidence presented within the action plan of discussions taking place at board level.

e. Incident discussed at appropriate meetings

The assessors cannot comment on this as the final report was not seen.

f. Evidence lessons have been learnt by midwives and medical staff

Item 2 of the action plan states that 'staff involved to be aware of outcome of investigation and learning from identified lessons', but this is not signed off as completed. The midwife referred for supervision appears to have reflected on her clinical practice and was advised to attend Growth Assessment Protocol (GAP) training. The assessors cannot comment further on this as the final report was not seen.

g. Comments

The RCA report was still outstanding 8 months after the SI investigation was opened. Although the parents were seen 3 weeks after the loss of their baby by the Patient Experience Lead, it took over 6 months for the meeting to discuss the investigation findings to take place. Such a delay is unacceptable. Duty of candour and lessons learnt should feature separately in the report and not form part of the action plan. RAG (Red, Amber or Green) ratings for progress against timeframes would be useful indicators on the action plan. This should apply to the process of all SI investigations. Failure to adhere to set timelines and reasons for delay should be documented in the action plan report. The 2016 Trust clinical incident/near-miss reporting and investigation policy stipulates that SI/high risk case reviews/RCA investigations should be completed within 35 days, to allow a further 10 working days for internal validation, with final sign-off by 45 working days. No reason for the delay was apparent.

The RCA investigation team should consist of a small number of suitably selected members with appropriate training and be led by a director level chair. It is good practice to include an external expert opinion in SI inquiries to ensure a robust unbiased investigation. The current practice of sending minutes of the RCA meeting to all team members for comments causes long delays particularly when there is a large number attending the meeting.

Case 2 background

An 18-year-old woman was booked for midwifery-led care. She had previously had a spontaneous vaginal delivery at term of a baby weighing 3.83 kg. She was known to be a group B streptococcus carrier in her previous pregnancy. At 31^{+2} weeks of gestation she was seen in triage complaining of abdominal pain and vaginal bleeding. A CTG trace was normal. She was discharged home. At 32 weeks of gestation, she attended triage complaining of a headache and reduced fetal movements. She was hypertensive and there was a 3+ protein level in her urine. The CTG trace was normal. After review by a ST2, she was discharged home. She returned the following day with an eclamptic fit and an in utero fetal death was diagnosed.

Rigour of RCA investigation:

a. Evidence of appropriate multidisciplinary involvement

The investigation team included the Head of Midwifery, the Deputy Head of Midwifery, team leaders, managers, the Patient Experience Lead, an obstetric consultant and trainee, the Clinical Director for Obstetrics and the Care Group Medical Director.

b. Adequate timeframe

A rapid review was held 3 days after the incident occurred. The SI meeting was held 3 months and 25 days later. The final RCA investigation report was not available to the assessors 6 months after the incident.

c. Identification of all issues

Lack of knowledge of the trainee was identified, as was the failure by the midwives to take appropriate action when the woman attended triage at 32 weeks of gestation. There were no systems failures identified as part of the investigation. The opinion of an external expert was sought regarding the failure of the computerised CTG to identify a pre-terminal trace. His opinion was that the investigation should focus on the mismanagement of pre-eclampsia which resulted in a stillbirth and not on the CTG interpretation.

d. Action plans with specific directives, timescales, and evidence of achievement

The final report was not available to the assessors. The action plan listed in the meeting report was nonspecific with actions such as 'share report widely' and 'learn from events'. There was no documentation that action plans had been completed. There were recommendations for individual learning, but no recommendations for system changes to help prevent further similar incidents in the future.

e. Incident discussed at appropriate meetings

The assessors cannot comment on this as the final report was not seen.

f. Evidence lessons have been learnt by midwives and medical staff

Learning points were identified for key individuals. However, there was no evidence of widespread learning.

g. Comments

The CTG trace was grossly abnormal. There was a failure by the staff involved to recognise this pre-terminal CTG trace. The staff involved appeared to have relied upon the computerised CTG interpretation programme 'Dawes Redman criteria', which reported that the criteria had been met. Urgent senior review should have been sought. The investigation focused on learning needs for individuals who had failed to interpret the CTG trace correctly and to recognise and manage severe pre-eclampsia appropriately. The main root cause was, in the opinion of the assessors, a system

failure: lack of a policy that requires senior review of a woman in these specific circumstances presenting to triage prior to discharge. The lack of change in process is likely to expose both service users and staff members to the risk of similar problems in the future. Urgent review of triage guidelines is recommended to address this issue.

Case 3

This was the case of a Romanian woman who spoke no English. Serial ultrasound assessments had revealed a large for gestational age fetus (above the 95th centile). The woman entered spontaneous labour at 39^{+5} weeks of gestation and was admitted to hospital at 3 cm cervical dilatation. Labour augmentation was required. There was anticipation of the potential for shoulder dystocia. Registrar assistance was requested for the delivery. The baby weighed 3.64 kg and had Apgar scores 1/1, 5/5 and 7/10. The cord pH was 7.22 and base excess –4.2 mmol/l. The baby was found to have Erb's palsy and has subsequently required paediatric neurology and plastic surgery at Birmingham Children's Hospital. The case was only classed as a serious clinical incident following the receipt of the discharge letter from Birmingham.

Comments

The SI investigation was completed after 2 months. This was after the neonatal discharge summary from Birmingham Children's Hospital was received and the extent of the injury was ascertained. There was no external input, the report was mainly a descriptive timeline and the focus was on the individual obstetric clinician. The case was discussed at the monthly governance meeting, but evidence of learning was not apparent.

9.2 INTERVIEWS

By the nature of this review process, a significant amount of the information received is based on personal opinion. It is the role of the assessment team to ensure that when any findings are made, they are supported by a range of sources and do not only present an individual's view. For emphasis, direct quotations are sometimes used, but are set within a broader context.

Relating to Terms of Reference (1):

To review the current obstetric, midwifery and neonatal practices at SaTH NHS Trust in the context of patient safety, identifying any problems that may prevent staff raising patient safety concerns within the Trust, as well as ensuring the services are well led and the culture supports learning and improvement following incidents.

In the interviewee's opinion, are there any issues within the Trust which may prevent staff raising concerns about patient safety?

Staff were unaware of any issues within the Trust that would prevent them from raising concerns about patient safety.

If you had any concerns about patient safety, what would you do?

Staff were aware of how to escalate appropriately. The Care Group Medical Director, the Head of Midwifery and the Clinical Directors across the Care Group were all seen as approachable with an open door policy regarding patient safety concerns. Staff would initially approach their line manager if they felt there was a problem with patient safety. The Care Group had no whistleblowing champion but this was not perceived as an issue of concern.

Relating to Terms of Reference (2):

To review the current provision of care within the maternity and neonatal services in relation to national standards.

How did the interviewees describe the department's standard of practice, supported by examples?

The department's standard of care was perceived as being good/excellent. There was a labour ward handover of care that occurred twice daily at 08:30hr and 20:30hr supplemented by a further handover at 17:00hr for the oncoming night resident/non-resident consultant. There was a separate NNU handover taking place at the same time. Monday–Friday, after the morning handover, the on-call consultant neonatologist and NNU co-ordinator attend the labour ward after their ward round on the NNU. The quality of the handover on the labour ward was dependent on the leaders. Consultants with a main interest in obstetrics were perceived as being more proactive on the labour ward than consultants with a major interest in gynaecology.

The department was viewed as a good place to work, with friendly staff, a supportive team and no barriers between consultants and junior staff. Consultants encouraged trainees to participate in guideline development. The trainees' timetable was well organised. Doctors had the opportunity to develop their personal practice even when not on a training scheme.

When poor practice was identified, measures were put in place to rectify this. For example, failure to use continuous fetal heart rate monitoring and misinterpretation of the CTG trace was addressed with increased training using the K2 CTG package and with the instigation of multidisciplinary twice-weekly CTG reviews on the labour ward.

Since the investigation ordered by the Secretary of State, staff were anxious about making errors and frequently asked medical staff for reassurance. There was a constant fear of being blamed when things went wrong. Midwives were reluctant to book women for delivery on a MLU and would try to find risk factors to avoid this choice.

How did the interviewees think that the department keeps up-to-date?

The department held in-house clinical meetings, such as monthly perinatal morbidity and mortality meetings, monthly clinical governance feedback meetings, monthly audit meetings and mandatory training days to keep up-to-date. The monthly clinical governance meetings focus on the five domains of the Care Quality Commission reports. If staff cannot attend the meetings, the ward leaders would disseminate learning to their staff.

There was an active training programme with a wide range of Advanced Training Skills Modules (ATSMs) offered to trainees and SAS doctors; the regional PROMPT (PRactical Obstetric Multi-Professional Training) and ROBuST (RCOG Operative Vaginal Birth Simulation Training) courses are held on site and facilitated by the consultants. The anaesthetic department runs multidisciplinary drills twice-yearly in the simulation laboratory. The neonatal team has developed the MIST (The Midwifery Identification, Stabilisation and Transfer of the Sick Newborn) course, based on the Scottish Neonatal Stabilisation course and designed for units in remote and rural areas, for training of midwives in the MLUs. There is a secretary, a Band 7 Midwife with fulltime responsibility for coordinating midwifery training as well as collating evidence of attendance. She also supports evidence attendance of Doctors. Neonatology Staff have a Band 7 Practice development nurse to support and coordinate training.

How effectively does the department use national guidelines in the management of patients?

Since achieving Clinical Negligence Scheme for Trusts (CNST) level 3 for maternity standards, the interviewees considered that the guideline process was well embedded in the unit. New NICE guidance was benchmarked and reasons for noncompliance would be communicated to the Trust board. The unit was currently working towards compliance with the recommendations of the 2013 RCOG Green-top Guideline No. 31 *Small-for-Gestational Age Fetus, Investigation and Management*. The department now uses GAP with customised fetal growth charts. There is a guideline lead for obstetrics and a lead for gynaecology, although there had been a period without an obstetric guideline lead because no recognition for this work was in the job plan allocation. This has since been addressed. Staff are sent an email about any new/revised guidelines. Not all obstetric consultants follow the guidelines and that was viewed as acceptable as long as the reasons for deviation from guidelines were explained and documented. Some of the NNU guidelines differed from The Staffordshire, Shropshire and Black Country Newborn Network (SSBCNN) Neonatal network guidance. It was felt by some consultants that the department should use the regional network guidelines. There was a delay in updating all guidelines due to the increased demands caused by the current reviews.

<u>Relating to Terms of Reference (3):</u>

To review the current midwifery, obstetric and neonatal workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.

What, in the interviewee's opinion, are the department's strengths, supported by examples of good practice and good patient care?

The departments were perceived as friendly and cohesive units with a good working relationship between the midwifery, obstetric and neonatal staff. The departments valued education and supported trainees. While under significant scrutiny, the department remained resilient. The Clinical Directors were considered as being able to turn around any crisis. Midwives and doctors would challenge one another in a professional and positive manner and were committed to change. The NNU was perceived as a good unit on the neonatal network and consultants wanted to work here. The paediatric trainees receive monthly simulation training and receive good support from the advanced

neonatal nurse practitioners and consultants when stepping up to the middle grade rota on the NNU. There was a good working relationship within the obstetrics and gynaecology consultant body and between obstetricians and neonatologists.

What, in the interviewee's opinion, are the department's weaknesses, again supported by examples?

Current morale among the midwifery workforce was very low. There were not enough midwifery staff to support the MLUs. Birthrate Plus® had indicated that the service required an additional 10 midwives and 16 maternity support workers. The midwifery workforce no longer work extra shifts due to the stress of working in the current climate within the Trust. There was a high vacancy rate and sickness rate among midwives. The risk management structure was perceived as weak and lacking a midwife risk manager. Managers were constantly firefighting. The manager on-call rota required managers to deal with clinical areas they had no experience with and this caused a high level of anxiety among managers. Interviewees gave examples of paediatric managers having to deal with labour ward crises, usually because of staffing shortages. A midwifery manager would be able to help with the clinical workload. Some staff were reluctant to contact the on-call manager as they were perceived by them as not supportive. The obstetrics and gynaecology consultant workforce was felt to be inadequate. It was felt that with two to three more consultant obstetricians this would enable obstetrics on-call duties to be separate from gynaecology. There was a perception that the department did not value obstetrics as much as gynaecology, with obstetrics treated as second rate.

The department struggled with junior medical staff recruitment. The six deanery posts were rarely filled and there was a reliance on overseas doctors. It was challenging to train these doctors to the level required to work on the middle grade rota in the short period of time available. There were often gaps in the middle grade rota. Covering clinics/theatre on different sites a sizeable distance from each other was challenging.

There was tension between the SaTH anaesthetists with respect to providing on-call cover for the maternity unit in Telford. The obstetric lead anaesthetist had no labour ward on-call in Telford. The anaesthetic body appeared to want obstetrics to move back to Shrewsbury.

There remained a sense of disappointment from some members of the neonatal team of the downgrading from regional neonatal intensive care unit to LNU in 2014. High rates of perinatal mortality reported in previous years had been noted by the departments. A report into management of extreme preterm infants at the NNU was made available to the review team and subsequent new Neonatal Network guidelines were issued in 2015. The neonatal team felt there had been a lot of change over the years and, at times, the team felt unsupported by the management team.

In the interviewee's opinion, are there any organisational issues which might contribute to the way the department performs?

The Trust Board are based in Shrewsbury and this was thought by some to explain their lack of presence in Telford during the current difficult climate. Although it was acknowledged by interviewees that the Trust had initially tried to offer support; the Board is perceived as not being supportive of maternity staff. Staff have felt unable to defend themselves to the media with no apparent support

from the Trust. Staff frequently had to relive the past because of media coverage and the ongoing investigation and could not move onwards. The culture was now very defensive and not focused on the learning process as it had been previously. Staff now have to write a lot more statements than they used to after incidents. There were staff cliques among midwifery staff based at the CLU and among midwifery staff at the MLUs, with a resulting rift between hospital and community staff.

The Head of Midwifery has planned to undertake a review of the midwifery structure since January 2017, but this has proven difficult in light of the workload generated by the investigations of historic cases.

There was a lack of resources to organise a weekly risk management meeting. The current process of incident reporting was felt to be suboptimal with the Head of Midwifery not part of the process. Midwifery and medical staff have no time allocated time for RCA investigations. There was a reluctance among medical staff to obtain RCA training as they would then have to take part in RCA investigations. This was putting more pressure on the Clinical Directors to lead investigations.

There were not enough resources to safely staff the CLU and five MLUs. This had led to repeated MLU closures over the last few months. The labour ward coordinators have to care for women during their shift, as well as perform their coordinator duties. Midwives scrub for emergency caesarean sections, further depleting the numbers available for women in labour. Triage is not open 24/7 and this places added pressure on labour ward staff.

With the ending of midwifery supervision, Professional Midwifery Advocates (PMAs) have been identified but, to date, have not received training and do not have a contract.

There was difficulty in filling gaps in the middle grade obstetrics and gynaecology rotas.

The NNU team were part of the local neonatal network. They used the regional network guidance for admission criteria and transfer criteria for their patients.

Relating to Terms of Reference (4):

To review the working culture within the maternity and neonatal services, including relationships and communication between healthcare professionals.

How do doctors and midwives communicate with patients, each other and colleagues?

Communication was good at management level. All consultants covering labour ward were approachable. Obstetricians were perceived as more hands-on and were more visible on the labour ward than gynaecologists. Trainees did not feel intimidated by midwives and regularly discussed care plans with the labour ward coordinator. There was a good relationship between the consultant on-call and the labour ward coordinator.

The quality of handovers across the unit was viewed as being directly linked to clinical incidents/complaints. Quality of handover was thought to depend on leadership of the staff on duty at the time. Communication issues between patients and midwives have been a recurrent theme in

clinical incidents. The Care Group has worked with the Virginia Mason Institute on the role of human factors in incidents in order to improve the patient experience.

The neonatologists work closely with the obstetricians; their relationship was described by both teams as cordial and professional. The maternal fetal medicine consultants and neonatologists meet monthly to discuss the women with high-risk pregnancies.

Overall communication between service users and staff was felt to be good. Service users and their families interviewed at an antenatal clinic at Telford about their current antenatal and previous birth experiences reported staff as being responsive to their needs. However, there was no awareness reported by these service users of the quarterly held MEG meetings and this was perceived as a procedural group rather than an engagement group.

How does the department work as a team, using formal and informal mechanisms?

There were times when pregnant women with complex needs requested to give birth on a MLU against professional advice. The consultants and midwives worked together under such circumstances to meet the women's needs. The consultant body was perceived as a cohesive unit. There was always someone willing to help if needed. Consultants sharing one open-plan office has helped communication channels among the consultants.

There have been recent changes at senior management level with new appointments for the Care Group Director, Head of Midwifery and Director of Nursing posts. The Head of Midwifery is very visible, seen on the wards and felt to be approachable. Despite the recent negative scrutiny from the media that has demoralised a lot of midwives, the team spirit remains. Repeated closures of the MLUs have unsettled the community midwives. There is a rift between on-call and hospital-based staff, with the on-call midwives feeling pressured to cover the CLU at the detriment of MLU service provision, a primary contributory factor being poor workforce planning.

In the interviewee's opinion, how does the department respond in an emergency?

The management of obstetric emergencies was deemed to be consistently responsive. Out-of-hours obstetricians and anaesthetists come in when requested. SIM (Simulation-based Immersive Medical) training in the management of obstetric emergencies was valued and was thought to prompt a quicker response in real-life emergencies, as well as facilitate teamwork.

The neonatal team were felt to respond well to neonatal emergencies and receive simulation training as part of routine neonatal teaching.

<u>Relating to Terms of Reference (5):</u>

To review the processes for escalation from MLUs to the CLU.

What is the interviewee's opinion of the escalation process from MLUs to the CLU?

Interviewees were of the opinion that there were not enough resources to support staff in the MLUs. Moreover, they felt that the CLU needed more investment; high-risk cases were on the labour ward and midwives working in the unit were stretched. Midwives would no longer cover extra shifts

because of the added stress as a result of media coverage and investigations, and this had led to repeated MLU closures over the past months. The escalation policy was used to maintain safety of services with escalation taking place nearly every day. Ward managers were continually having to cover clinical shifts. There were on average five midwives off sick daily. The sickness rate was higher in the MLUs than in the CLU. Staff were perceived to be working in the wrong places and were not working where most of the births took place; at the PRH.

Since 1 July 2017, the smaller MLU of Ludlow, Bridgnorth and Oswestry had been closed to inpatient and overnight care provision for at least 3 months. The unit will remain closed until the findings of the CCG-led review of the MLUs are released in September 2017. Antenatal care is still being provided there by community and MLU-based staff.

The MIST course, based on the Scottish Neonatal Stabilisation course, has been introduced for midwifery staff in the MLUs by members of the neonatal team. On the whole the consultant neonatal team had few dealings with midwifery staff in the MLUs.

Relating to Terms of Reference (6):

To review approaches to monitoring fetal heart rates and acting upon abnormal traces, to describe how this relates to established best practice and make any recommendations for improvement.

When did you last attend CTG training? Have you completed the K2 training tool?

Although it was acknowledged that there had been a number of claims relating to CTG misinterpretation, the view of some was that these events were not a problem particular to the unit, but were a universal problem in obstetrics. The medical and midwifery staff interviewed said they were up-to-date with mandatory CTG training. The standard of training was perceived as good. Most of the staff had started the electronic K2 fetal monitoring package but few had completed the whole package. The assessors were told that this electronic training was usually done by staff in their own time or when their workload permitted. Midwives could claim time for 1 day to undertake the training but completing the whole package took much longer. Student midwives could not access the K2 package. The Band 7 midwives had attended a CTG Masterclass held in London. The attendance at the recently established twice-weekly review of CTG traces on the labour ward was reported as good, with staff making an effort to attend if possible. Views differed among interviewees on whether it was appropriate for staff in MLUs to undertake antenatal CTG traces, which would then be faxed to the CLU for review. The planned central monitoring system on the labour ward was perceived favourably as long as it was used correctly.

Relating to Terms of Reference (7):

To review the RCA investigation process, how SIs are identified, reported and investigated within the maternity services, how recommendations from investigations are acted upon by the maternity services, and how processes ensure sharing of learning among clinical staff, senior management and stakeholders.

How are SIs identified, reported, investigated and recommendations disseminated to staff? Are the processes to ensure shared learning robust?

Datix® (patient safety software) was the main method used to report an incident and all staff were encouraged to use it. Due to the current clinical workload, staff felt they did not have the time to complete Datix® entries. There was no systematic structure to Datix® reviews. Line managers review and investigate their own Datix® incidents. There was a perception that some Datix® reports were ignored by Datix® incident reviewers. There was a need for more transparency on the process of Datix® review. The review team were told of the need to appoint to the vacant post of risk management midwife (Band 8A). There were no resources to hold weekly risk management meetings. It was felt that incidents should be directly reported to the Head of Midwifery instead of the current practice of copying in the HoM. Currently they are reported to the Care Group Director (a managerial role) and/or the Director of Nursing. A robust risk management structure was lacking, with the managers seen as constantly firefighting.

Some SIs were identified because of a complaint or an unplanned admission to the NNU. A rapid response planning meeting occurred within 2 working days of notification of an incident and this rapid review was particular to the Care Group. Investigations were managed within the Care Group, with support from the Patient Safety Officer who sat outside the Care Group. It was thought by many interviewees that the investigation should be led by the Patient Safety Officer and not by the Care Group. The Trust should invest in their Patient Safety Team. This had been raised at the Clinical Governance meetings but there was resistance. Across the Trust, the risk management team in the Women and Children's Care Group was perceived as stronger than risk management teams in other Care Groups. No other Care Group had an assurance team led by a Patient Experience Lead. Many interviewees wanted a risk management midwife and a weekly risk management meeting.

The assessors were told that SI investigation processes needed streamlining, there were too many steps and the whole process was too lengthy. RCA investigations were more defensive and were not as focused on the learning processes as they used to be. There was a wish to involve external investigators; the 'fresh eyes' approach from another Trust would be very helpful. Interviewees who had worked on investigations with external input had found a much higher standard of investigation than those kept in-house. A small number of doctors and midwives were trained as RCA investigators. It was felt that there was a need for more trained investigators and a tighter team. In the past RCA investigations have been described as being substandard. It was thought that getting the right team at the onset would reduce the need for changes/add-ons, further meetings between investigators and would, ultimately, shorten the current lengthy timescale. Medical staff tended to rely on the Clinical Director in obstetrics to do the bulk of RCA investigations. Staff needed time allocated in their job plans for partaking in reviews. Midwives had no protected time for reviews so the specialist midwives tended to perform these investigations.

Trainees and medical staff got feedback on SIs/high risk case reviews by attending the monthly Clinical Governance meetings. It was difficult for midwives and nurses to attend these meetings. Other methods used to give staff feedback were through ward meetings, emails and patient safety bulletins. Staff were unaware of a risk newsletter. The review team were told that staff did not have the time to attend Clinical Governance meetings or read emails regarding governance issues.

Relating to Terms of Reference (8):

To review the education and supervision of obstetric and paediatric trainees, including consultant accessibility and presence on the delivery suite/NNU as per national standards recommendations, in the context of providing a safe and efficient service.

How is supervision of STs organised?

The assessors interviewed two obstetrics/gynaecology STs, one neonatal trainee and one obstetrics/gynaecology SAS doctor. The college tutors for obstetrics/gynaecology and paediatrics were also interviewed, as well as the Head of Undergraduate Training.

Medical students complete a 6-week block in obstetrics and gynaecology. The assessors were told that medical students' feedback was very good and the students thought the placement was well-organised. Labour ward midwives were very helpful to medical students. Trainees commented on the robust departmental induction programme, which included the management of acute obstetric emergencies (PROMPT course). The obstetrics/gynaecology trainees felt well supported by the consultants who readily attend if required out-of-hours. Consultants who live in Shrewsbury usually stay in hospital accommodation when on-call for ready availability. Consultants were on the delivery suite during the day and would complete workplace-based assessments with the trainees. Trainees partake in guideline development and senior trainees lead on the twice-weekly CTG reviews. Trainees were allocated an educational supervisor and, if applicable, an ATSM supervisor. The scope of ATSMs offered was good. Trainees want to rotate to Telford, despite its distance from Birmingham. SaTH had a reputation of being a sound educational department. Senior trainees were encouraged to partake in clinical incident investigations. Trainees got feedback on high risk case reviews/SIs at the monthly Clinical Governance meetings. Since the recent adverse media, the trainees have found that midwives have asked doctors for assistance more and have needed more support than previously. The obstetrics/gynaecology SAS doctor felt well supported by consultant colleagues and the Trust SAS tutor. Funding for study leave was available. Career development was encouraged and the job plan reflected special skills acquired during training.

The NNU provided training for paediatrics and core neonatal medicine. The consultants were felt to be quite supportive. The review team were informed that recent General Medical Council (GMC) national training survey showed no reds or ambers after having flagged 'inadequate experience' in the past few years. The review team made the Trust management team aware of an incident, highlighted by a member of the neonatal staff, when there was perceived difficulty in getting the on-call neonatal consultant to attend the NNU. This incident was promptly addressed by management.

The findings of the 2017 GMC national training survey report confirmed that SaTH was highly rated by obstetrics/gynaecology and paediatric trainees. The obstetrics/gynaecology trainees highly rated the indicators 'clinical supervision' and 'clinical supervision out of hours'. The paediatric trainees highly rated the indicators 'educational governance' and 'supportive environment' (significantly positive compared with the national average).

Other notable comments

Student midwives

The assessors interviewed five student midwives and the Midwifery Lead for Education at the University of Stafford. The students were very positive about their placements and wanted to work in the organisation. The preceptorship programme for newly-appointed/qualified midwives was highly rated. The student midwives enjoyed the exposure to MLUs and learning how antenatal/intrapartum care was provided in different settings. Staff were supportive and the obstetricians were approachable and willing to teach. There were no hierarchical issues on the labour ward. Although the student midwives did not have access to the K2 CTG training package, they observed and received CTG training at the University. There were good links between the University and the Trust.

Midwives focus group

There were overwhelming feelings of worry, being under constant scrutiny and being terrified of things going wrong at work. Not knowing when the Secretary of State investigation would end was very stressful. Trust investigations were known to take a very long time, with up to 360 days being quoted. Community midwives expressed anxiety about having to come to work not knowing where they would be working. They felt well supported on the labour ward but were out of their comfort zone. The midwives were seen to provide strong support for each other.

Service user feedback from interviews

Nine service users and their families agreed to be interviewed prior to their antenatal appointments at the PRH. Two of the nine women were primigravida, the other seven women had given birth previously between one and six times. The women were asked about their antenatal experience during their current pregnancy and any previous experiences of SaTH maternity services. They were all questioned about a range of issues drawn from the terms of reference from the patient perspective and their answers are reported below.

Their overall experience including quality of maternity care, patient choice, location of maternity services, breastfeeding, feelings of safety and antenatal education:

- One woman who had birthed previously at the Telford CLU said “it was really good.”
- A woman reported that face-to-face “antenatal classes have stopped for everyone, it’s all online now”; another woman (primigravida) said she was “just given a phone number on a piece of paper about this” by a Ludlow midwife; one expectant first-time dad said the online course was “helpful but a bit patronising.”
- One woman said she “can’t fault it” about her current antenatal care at Telford and “they do listen”.
- One father-to-be, and a father of five, whose partner had birthed previously in both Shrewsbury and Telford said “there’s not enough support for dads”, another (expectant first-time dad) said that he felt “included”.
- One mother who had previously birthed with twins at Telford said she “didn’t have help to express” and that she “buzzed ten times but the HCA [healthcare assistant] was too busy.”

- One mother said she had been allowed to stay at a SaTH MLU until she "had sorted her breastfeeding out".
- One woman (primigravida) said that the SaTH Pregnancy Health Record was "helpful", another primigravida said no-one had explained her notes to her.
- One woman reported that she "hadn't considered an MLU" due to her risk factors, having been induced three times previously.
- One woman said she had most antenatal appointments at Bridgnorth MLU and that it was "good there".
- One woman (Ludlow) said her blood had been sent unlabelled and that "only one out of all my scheduled appointments had been kept in Ludlow", her appointments had been "on schedule and all good in Telford."
- One woman who had just moved from London reported finding care "too interventionist" at Telford and that it was "OTT", but she did "feel safe and listened to", she also reported being surprised at having to pay at SaTH to find out the sex of her baby.
- None of the women or their family members had heard of the Maternity Engagement Group.

Timely and sufficient access to appropriate staff:

- One woman who had previously birthed and been transferred from an MLU to the CLU within SaTH said she had "one midwife during labour."
- One woman reported difficulty getting an initial midwife appointment via her GP practice.
- One woman reported no access to the quit smoking service despite being a smoker, and maternity services having known of her pregnancy for 15 weeks.
- One woman (primigravida) said of her experience of Telford antenatal care that "it seems very busy" but "the midwives are lovely and you don't feel you're troubling them."
- One primigravida said "it has been ok" about her antenatal care in Ludlow and "good" now she is at Telford, but that when she had to phone Ludlow MLU "no-one said who to contact" and there was no appropriate answerphone message about this. She further reported that she "wouldn't have considered Ludlow MLU to give birth" after this, despite "wanting to be in a local place", nor would she consider a homebirth as her "home was too far away from hospital" and that Ludlow MLU seems "a zombie hospital" and that she had not received "any letter, text or phone call about what was going on."

Communication with staff:

- A woman under consultant-led care who had also birthed previously in both Shrewbury and Telford reported that staff were "responsive to questions."
- One woman booked into the Telford CLU said "everyone is really helpful."

Their access to and experience of appropriate fetal monitoring and escalation as required:

- One woman reported having come in for fetal monitoring and that it "was fine."
- One primigravida said when she had reported concerns about fetal movements she was told to come straight in, "had half an hour's monitoring and was seen by both a midwife and a doctor" and was told "if you're not happy, phone again or come in."

Interview with MEG service user representatives at the PRH, Telford

Two service user representatives from MEG were interviewed. They had both experienced Shrewsbury and Telford midwifery-led and consultant-led care.

They both reported overall positive experiences of SaTH maternity services.

- "I am happy with how I was dealt with."
- "It was a positive experience, can never fault it."
- They both reported feeling "safe".
- One service user said she understood it was difficult for SaTH to "balance safety with providing quality and local services."

They reported several concerns about maternity services from personal experience and from their MEG engagement including:

- quality of postnatal care
- having access to an option near home for recovery time post-birth
- concerns that staff were "firefighting", one representative said they were "short-staffed" the other that services "were fully-stretched".
- "that MEG was somewhat procedural and not really an engagement group as such".

Regarding breastfeeding, one reported good breastfeeding support, the other representative felt it was lacking.

They mentioned the public concern around the future of the three MLUs in Bridgnorth, Ludlow and Oswestry, including the public petition with 4500 signatures and the three Facebook groups. One of the representatives had actually set up the Save Oswestry MLU Facebook group, which has 1970 members. The other Facebook groups are Save Ludlow MLU (2109 members) and Save Bridgnorth MLU (1299 members).

10. FINDINGS AND CRITICAL APPRAISAL OF EVIDENCE

Overview of current maternity and neonatal services

Relating to Terms of Reference (1):

To review the current obstetric, midwifery and neonatal practices at SaTH NHS Trust in the context of patient safety, identifying any problems that may prevent staff raising patient safety concerns within the Trust, as well as ensuring the services are well led and the culture supports learning and improvement following incidents

Background

Over the past decade, the Women and Children's Care Group have contributed to a number of initiatives to improve patient safety. The perinatal mortality rate has fallen in line with the rest of the UK but remains above average compared with the rate in similar trusts.

Findings from documentation provided by the Trust and from interviews

Staff felt able to raise concerns about patient safety and felt well supported by the management team. The management team were seen as approachable. Trainees valued the quality of supervision given by consultants. The consultant body provided 78.5 hours on-site cover of the labour ward.

A series of measures have been implemented across the MLUs to optimise the standard of neonatal resuscitation. Midwives working in MLUs undertake an accredited neonatal life support course every 4 years, in addition to mandatory yearly neonatal life support training. Neonatal resuscitation equipment has been standardised across the MLUs.

The MBRRACE-UK Perinatal Mortality Surveillance Report published 22 June 2017 for the period January–December 2015 reported a stabilised and adjusted stillbirth rate of 3.86 (3.11–5.27), which is average (3.81 for the comparator group). The neonatal stabilised and adjusted loss rate was 2.03 (1.18–3.33), 1.39 for comparator group, and the extended perinatal stabilised and adjusted loss rate was 6.01 (5.13–7.68), 5.19 for the comparator group – more than 10% higher than the group average. For the period January–December 2014, the SaTH NHS Trust was 10% higher than the group average, with a 1.34 neonatal mortality rate and a 5.39 extended perinatal mortality rate. Following the last MBRRACE report, no presentation with proposed action plans has been made to the Trust Board. Perinatal deaths are reviewed using a standardised tool. In line with the recommendations of the RCOG Quality Improvement Programme *Each Baby Counts*, an external panel member is invited to all neonatal death reviews.

Patient experience

A range of maternity service documentation relating to patient experience was reviewed as within the scope of the Terms of Reference. The significant findings are outlined below.

The Ward to Board (August 2016–April 2017) Midwifery Care–Patient Experience survey reported an improving maternity ward return rate of around 85% in April 2017 from a low of just below 60% in October 2016 across all maternity wards. The RAG ratings indicated 100% positive responses on issues such as being treated with dignity and respect, feeling safe, being listened to and staff professionalism. Shrewsbury MLU was amber flagged with 88% of women reporting being treated with kindness and compassion; Telford postnatal ward was amber flagged at 88% for seeing staff clean their hands; Telford antenatal ward was red flagged at 67% for women reporting seeing doctors as much as you needed to and the same ward was amber flagged at 83% for reports of women feeling doctors listened to them.

The January 2017 Matron Quality Review (January–December 2016), with a reporting rate in the MLUs varying between just below 40% to 58%, had 100% of patients at all MLUs reporting feeling "being treated with compassion", with the exception of Shrewsbury at 81%; 100% of patients at all MLUs reported feeling safe; in terms of responsiveness, 100% of patients at all MLUs said their call buzzer was answered, with the exception of Oswestry at 50%.

The SaTH Maternity Patient Experience, Q1 (April–June 2017) saw a sharp increase on the same quarter for 2016 in complaints – 15 formal complaints, two informal complaints compared with 6 and 2 respectively. The highest proportion of complaints related to the care received during the antenatal, intrapartum and postnatal periods (ten), with an additional five being for mismanagement or communication. Of respondents in both April and May 2017, 100% would recommend the maternity care provided across all SaTH maternity wards.

In the March 2017 *Overview of maternity services* report, the Head of Midwifery highlighted a downward trend in births in the MLUs with 14% of activity (including homebirths) in comparison with 2008/9 when MLU births accounted for 26% of the overall activity. Just over half of reported complaints were regarding clinical care and management of the delivery.

Conclusion

A presentation of MBRRACE 2013 and 2014 neonatal deaths was made on 6 March 2017 at the Trust's mortality meeting. Lists of learning points against perinatal hypoxia, prematurity complications, sepsis and congenital anomalies were tabled. Despite these recommendations there was no action plan with an allocated person responsible and timeline for achievement. The assessors have not seen the evidence that practice changed as a result of this presentation. Neonatal and perinatal mortality rates will not improve until areas of poor/substandard care are addressed.

Recent patient experience feedback on SaTH maternity services has on the whole been positive. Women reported feeling confident, had trust in the staff and valued their professionalism. The CLU facilities at the PRH were highly rated by the service users, unlike the MLU facilities that felt very dated. Women were critical of the distance to the CLU and a lack of continuity with midwifery care. Although the majority of low risk women (95.2%) felt they could make an informed choice about where to give birth, a significant number (43.1%) felt they were given no choice on location of antenatal visits. Current trends indicate a shift from births in MLUs to the CLU at the PRH since its opening in September 2014.

Relating to Terms of Reference (2):

To review the current provision of care within the maternity and neonatal services in relation to national standards.

Background

In 2014, the maternity services at SaTH NHS Trust achieved level 3 in the CNST maternity clinical risk management standards. NHS Improvement is currently reviewing the quality of investigations and implementation of recommendations in a number of SIs that occurred from 2000 to date.

Findings from documentation provided by the Trust and from interviews

Due to time constraints, the assessors were unable to access the intranet maternity guidelines but were told systems were in place to ensure guidelines were developed and revised in accordance with best evidence-based practice and in a robust fashion as necessary to secure a level 3 CNST assessment.

Assessors were told of delays in updating guidelines, a consequence of the demands made on the Guidelines Group by the current internal and external reviews in progress. In the Trust *Review of maternity services 2007–17* report, it was stated that there was a guideline review process in place. The Maternity Guidelines Group was responsible for a biannual review and distribution of protocols/guidelines and monitoring with 3-yearly audits of appropriate guidelines. SaTH was currently working towards compliance with the recommendations of the 2013 RCOG Green-top Guideline No. 31 *Small-for-Gestational Age Fetus, Investigation and Management*. The department now uses GAP with customised fetal growth charts to reduce their stillbirth rate. The main reason mentioned for noncompliance with NICE guidance was a lack of resources and this was fed back to the Trust Board. There is a Guidelines midwife who chairs the Maternity Guideline Group meetings and who attends the Maternity Governance meetings where guidelines are ratified. There are two Clinical Guideline leads, one for obstetrics and one for gynaecology. SaTH participates in national audits such as the National Pregnancy in Diabetes audit. The neonatal team stated they followed national guidance when available and were using regional network guidance for agreed policies for extremely preterm infants, infants with significant congenital anomalies or antenatally-diagnosed cardiac anomalies.

The maternity clinical dashboards have thresholds and targets set. Transfer rates from individual MLUs to the CLU do not feature on the main dashboard although this data is collected. The Wrekin MLU dashboard features transfer rates, birth outcomes and maternal and fetal outcomes. Dashboards for the other MLUs were not seen. RAG ratings for 2017 indicate a high induction rate and high incidence of third- and fourth-degree perineal tears in primigravida having an assisted vaginal delivery. The RCOG clinical indicators project *Patterns of Maternity Care in English NHS Hospitals 2013/14*, published in March 2016, has highlighted the Trust as an outlier for induced labours (40.2%, national mean 31.1%), proportion of deliveries requiring an instrument in multiparous women (9.7%, national mean 7.6%), proportion of episiotomy procedures in multiparous women (11.3%, national mean 9.3%), proportion of third- and fourth- degree perineal tears among assisted vaginal deliveries in primiparous women (10.3%, national mean 7.3%). The assessors were not told of action plans made

as a result of these findings. The caesarean section rates – 14.1% for primiparous (national mean 22.3%), 19.1% for multiparous women (national mean 21.8%) – and vaginal births following a primary caesarean section (33.2%, national mean 27.0%) are low and high respectively, compared to national means.

Conclusion

From the evidence provided, local obstetric guidelines were in line with best evidence-based practice and national guidance. Staff were allowed to deviate from local guidelines as long as they could justify their reasons for doing so. The Baseline Assessment Tool for each new NICE obstetric guideline was used to identify noncompliance and to establish an action plan to facilitate eventual compliance. The assessors found no evidence that women's views were reflected in the guideline development process. Staff were aware when guidelines were updated as they were emailed revisions and new guidance. The audit programme should incorporate projects to address the clinical indicators of maternity care where the Trust is an outlier, for example the high induction of labour rate and high rate of third/fourth-degree perineal tears in primigravida.

Relating to Terms of Reference (3):

To review the current midwifery, obstetric and neonatal workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.

Background

Midwifery staffing numbers was highlighted as a main area of concern in the 2015 CQC report. The CLU at the PRH was often unable to care for labouring women due to lack of staff. Community staff covering the MLUs were called in at short notice to staff the CLU. Due to poor workforce planning, current staffing allocation favours MLUs, which are the areas with low birth activity and acuity, rather than the CLU, the area with the highest activity and acuity.

Findings from documentation provided by Trust and from interviews

The Trust is in the process of developing a new model of care. Consideration is being given to the development of a 'transfer lounge' in the hospital setting prior to women and their babies being transferred to the care of the community midwifery service. The alongside MLU appears to be used as an overflow for the hospital maternity service, with postnatal women being transferred to the MLU due to the lack of available postnatal beds. Given that the MLUs are no longer accommodating postnatal women there may be postnatal capacity issues that appear to be impacting on the alongside MLU.

All the staff spoken to state that there was a shortage of staff and that morale was low. Staff felt that this had not been acknowledged and that they should receive positive rather than constant negative feedback. A Birthrate Plus® review of the midwifery staffing was completed in April 2017. Due to media attention there has been a 30% reduction in the number of the current midwives willing to undertake additional shifts. Since 1 July 2017 there has been a redistribution of staff from the MLUs to

CLU. The service has not developed a paper for the Board with regards to the additional midwifery staff required for the current clinical activity and case mix based on the Birthrate Plus® findings.

Added pressure was put on midwifery staff by not knowing where they would be working until they arrived for their shift. For some, having to work on the CLU labour ward, an environment they had not worked in for many years, caused great anxiety. All interviewed staff were tired of the relentless scrutiny and would like to be able to move the service forward.

The interviewed student midwives were all very positive about their training experience at the Trust. They were hoping to be able to gain employment as midwives at the end of their training. The response to vacancies has reduced since the media attention.

The obstetric staffing rota is compliant with current obstetric staffing level recommendations. Twelve consultants partake in the labour ward cover providing 78.5 hours on site, with the rest on-call for just over 4000 births per year. Consultants are on site from 08:30–21:00 Monday–Friday and 08:00–16:00 Saturday and Sunday. Consultants lead the rounds on the labour ward, review women, make care plans and readily attend when requested out of hours.

The NNU based at the PRH, Telford, has three level 1 cots, three level 2 cots and 16 level 3 cots. The staffing levels are registered on the Trust's risk register for two areas, the neonatal nurse staffing ratios and the single tier 2 doctors covering both general paediatrics and neonatology between 23:00 and 08:00. The assessors were told that the current neonatal nurse complement was below the BAPM recommended levels. Current staffing levels of neonatal nurses were felt to be at 90% of BAPM recommendations. There was no problem with recruitment of neonatal nursing staff though. The NNU employed seven whole time equivalent (WTE) advanced neonatal nurse practitioners with 1½ working on the tier 2 medical rota and 5½ (5.64 WTE) working on the tier 1 medical rota.

Medical staffing of the NNU was provided by three tiers of staff: tier 1 and tier 2 resident with consultant neonatologist/neonatal paediatrician on-call from home.

Conclusion

The assessors viewed the allocation of the workforce across the sites as a patient safety issue. Community midwives were regularly transferred from the community to provide intrapartum care on the labour ward, a high risk area where they felt vulnerable. The labour ward coordinator was rarely supernumerary due to staffing shortages. Midwives have to scrub for emergency caesarean sections further depleting staffing on the labour ward at the CLU. There should be a supernumerary Band 7 leader on each shift. Workforce indicators should feature on the maternity dashboards. The establishment of a weekly-held risk management meeting, with good attendance from the medical staff and midwifery managers/team leaders, where incident investigations and action plans can be discussed would strengthen the current governance structure. The disbandment of midwifery supervision was seen as a cost saving to managers, but there appeared to be no job specification or remuneration agreed for the seven PMAs.

The department is reliant on its SAS workforce to provide its middle grade rota of one in six for 4 week nights and one in seven for 3 week nights. Of concern is that one or two SAS doctors will be leaving and, if not replaced, this will impact on the ST's training if trainees have to cover the rota gaps.

The consultant anaesthetists are noncompliant with the 2013 Obstetric Anaesthetists' Association/Association of Anaesthetists of Great Britain & Ireland (OAA/AAGBI) guidelines for obstetric anaesthesia, which recommend there must be 12 consultant anaesthetist sessions per week to cover emergency work on the delivery suite.

The LNU at the PRH is recognised by the West Midlands Deanery as a training unit for core neonatal trainees. Medical staffing meets BAPM standards at tier 1; BAPM would recommend that a LNU that regularly provides intensive care should have separate tier 1 and tier 2 rotas for neonatal care – this is currently not met; at consultant level BAPM recommendations are for a minimum of seven consultants – however, the PRH has split neonatal and paediatric rotas with six consultants providing neonatal care only on call.

Relating to Terms of Reference (4):

To review the working culture within the maternity and neonatal services, including relationships and communication between healthcare professionals.

There was a culture of working together, with staff supporting each other. Once qualified, student midwives wanted to work at SaTH and trainees in obstetrics and gynaecology were delighted to rotate back during their years in training. There were no perceived barriers to communication between specialties. Shortage in staffing meant that the community midwives were regularly called into work on the labour ward at the PRH caring for women with high-risk pregnancies and this impacted on their work duties in the community. The neonatal team felt they had no problems in recruiting nursing staff. The recent scrutiny and negative media has impacted greatly on staff morale and wellbeing. Staff have been instructed not to comment on the allegations being made in the press/media. Midwives gave examples of having to ask family members to undertake normal tasks, such as shopping, in case they were accosted in the supermarket and other public places. Staff would like support from Trust executives and to see them in the maternity clinical settings. Despite feeling isolated and unsupported by senior management, staff are extremely supportive of each other. All interviewed staff felt that they would be unable to have closure until the current NHS Improvement review was over.

Relating to Terms of Reference (5):

To review the processes for escalation from MLUs to the CLU.

Steps have been taken to maintain safety of maternity services by temporarily suspending inpatient intrapartum and postnatal care at Ludlow, Oswestry and Bridgnorth MLU. The recommendations of the forthcoming review of the MLUs led by the local CCGs are awaited by the Trust. In the meantime, a response to the Birthrate Plus® review released in April 2017 should be developed without further delay.

Relating to Terms of Reference (6):

To review approaches to monitoring fetal heart rates and acting upon abnormal traces, to describe how this relates to established best practice and make any recommendations for improvement.

Background

In response to a number of incidents relating to lack of use of electronic fetal monitoring (EFM) and misinterpretation of CTG traces, the Care Group has made a number of recommendations. In their 2016 'Sign up to Safety' plan, the Care Group aimed to reduce the number of harmful incidents due to the misinterpretation of CTGs by 50%.

Findings from interviews

Midwifery and medical staff appeared committed to the changes and increased training put in place regarding EFM. The e-learning for K2 CTG package was viewed favourably, although staff struggled to complete the training within the 1 day allocated time and most had to complete in their own time. Staff are expected to complete key identified components of K2 annually and this is monitored by the band 7 Education Midwife.

There were labour ward staff that had not completed their training. In addition to the e-learning package there is a well-established consultant-led annual teaching session on NICE guidance for CTGs. The recently introduced twice-weekly CTG meetings on the labour ward to discuss cases are well attended, with midwifery and obstetric staff attending when duties allow. Staff need to attend at least ten sessions annually (Trust recommendations). Centralised CTG monitoring on the labour ward was keenly awaited. The plan is for all CTG traces to be reviewed at each handover by all staff on duty, in addition to hourly reviews by the labour ward coordinator and the obstetric team on-call. It was hoped that this practice would embed the 'fresh eyes approach' recommended by NICE. Labour ward coordinators are attending a CTG masterclass to facilitate training on the labour ward. A series of collective leadership courses looking at human factors involved in CTG assessment have been held by the Trust.

Conclusion

The use of a centralised monitoring system on the labour ward, with a formal hourly review of all CTGs by senior midwifery and obstetric staff, supplemented by CTG reviews at staff handover, is a positive step towards reducing the risk of intrapartum CTG misinterpretation. Twice-weekly multidisciplinary reviews of cases should offer staff the opportunity to discuss overall care management as well as reviewing individual CTG traces. An interviewee commented that there should be no escalation with CTG traces as the on-site consultant should be there regularly reviewing all traces, as opposed to the current practice of only escalating once an abnormality has been recognised by a midwife and trainee. Centralised monitoring should facilitate this. Training of staff includes a competence assessment with the e-learning EFM package. The unit plans to analyse trends in admissions to the NNU of babies with intrapartum CTG abnormalities. The CLU now uses one monitoring system as opposed to four different types. The antenatal day assessment units in Telford and Shrewsbury use the Dawes Redman system for antenatal CTG interpretation with plans for all MLUs to use this system. While computerised CTG analysis avoids subjective visual interpretation, this system should be used appropriately and is not a predictive test of fetal compromise, as demonstrated by the second SI case reviewed by the assessors.

<u>Relating to Terms of Reference (7):</u>

To review the RCA investigation process, how SIs are identified, reported and investigated within the maternity services, how recommendations from investigations are acted upon by the maternity services, and how processes ensure sharing of learning among clinical staff, senior management and stakeholders.

Background

A 2015 independent review of a 2009 SI was critical of the Trust's clinical governance processes in place at the time which failed to investigate a neonatal death through a robust managerial investigation. The review acknowledged that, as a result of lessons learnt, the Trust's clinical governance and complaints processes have strengthened, with evidence of clinical governance becoming embedded within maternity services.

Findings from RCA Investigation Reports on three specific cases

The assessors did not see the RCA investigation reports, only timelines and action plans. A copy of a 'Root Cause Analysis – Investigation' pro forma was seen but this document did not appear to follow the NHS England national reporting templates for SIs. There was evidence of appropriate multidisciplinary involvement in the investigations, although the team was excessively large and it was felt such a large team would add little or no benefit to the investigation process. The opinion of an independent expert was not sought in any of the cases. The assessors felt that not all factors were investigated, with a failure in identifying the actual root cause. The focus was mainly on individual failings and learning needs rather than

on system failures. Action plans did have specific directives and timescales, but there was little evidence of achievements. Reasons for nonadherence to timescales were not documented. The involvement of the women and their partners in the investigation process was unclear. There was no documentation on whether women were offered a copy of either the final RCA investigation report or the Executive Summary report.

Findings from interviews

It was apparent from the interviews that identification and reporting of incidents relied on individuals, with no robust system in place for cross-referencing of incidents reported against information recorded on the maternity information system. Team leaders reviewed Datix® incidents and decided whether or not to recommend investigation. The assessors felt this approach was too subjective, with the temptation not to investigate incidents occurring on your own patch. Appointing a risk management midwife and a risk management obstetrician should make identification and reporting of incidents more objective. Line management of the risk team should be via the Head of Midwifery and Clinical Directors as opposed to the current practice of reporting to the Care Group Director and/or the Director of Nursing. The frequency of risk management meetings should be increased from monthly to weekly. The investigation pathway needs streamlining with a smaller investigation team where all members are RCA trained. The practice of having external input for high risk case reviews/SIs, a regular event in neonatal RCA investigations, should occur in obstetric reviews thus strengthening the quality of the review. Due to the current pressures on the Care Group, the Trust Patient Safety Manager writes the SI/high risk case reviews investigation reports with no 'fresh eyes' review. In the past, she was able to critique reports as she was not their author. It is inappropriate for all SI reports to be written by the same investigator and a wider pool of RCA trained investigators should be used to carry out this task. The most frequently mentioned way medical staff found out about SI was by attending the monthly Clinical Governance meetings. Lead midwives, ward managers would find out at the monthly maternity governance meetings and then cascade any learning down to their own staff. Other methods such as Patient Safety Bulletins, ward notices and e-mails, were mentioned but did not seem regularly accessed by the interviewees.

Conclusion

The Women and Children's Care Group has its own 'Risk Management Strategy' separate from the Trust's 'Risk Management Strategy' and a 'Standard Operating Policy' for investigating incidents. The assessors felt that investigation processes would be strengthened by the appointment of both a risk management midwife and a risk management obstetrician which would reduce the risk of inappropriate action following a Datix® report. The RCA-trained investigators need recognition in their job plan for these investigations. The culture of learning from incident investigations was not apparent. Investigations were perceived as another thankless task to participate in. External investigators should participate in all high risk case reviews and SIs – their input would make the investigation more open, robust and strengthened. For a RCA investigation to be of benefit, a trained multidisciplinary team needs to address the root causes, to challenge existing practices, to write a report with clear action plans, specific directives and timescales. Timeframes should be adhered to with an escalation process if there is slippage. The Care Group should have some acknowledgment of Trust Board scrutiny and this should be cascaded back to the team. NHS England national reporting templates should be used to facilitate a consistently high standard in all investigations.

Relating to Terms of Reference (8):

To review the education and supervision of obstetric and paediatric trainees, including consultant accessibility and presence on the delivery suite/NNU as per national standards recommendations, in the context of providing a safe and efficient service.

Background

The 2014 PMET review findings summary for the obstetrics and gynaecology specialty commented on the strong ethos of training for the maternity unit and how trainees felt well supported by the consultants. However, there was a need for the Trust to integrate clinical governance into learning outcomes for trainees, to ensure that there were clear and robust mechanisms in place to learn from clinical incidents, and that any learning points were clearly disseminated to trainees appropriately.

Findings from interviews

The assessors interviewed two obstetrics and gynaecology STs, one SAS doctor and the college tutor. The interviewed trainees and SAS doctor felt well supported by the consultants during and out of working hours. The trainees were very positive about their induction, with mandatory skills drills part of the programme. Their training needs were met and consultants were proactive in engaging in their portfolio. Trainees were encouraged to partake in guideline development and, when feasible, senior trainees led the twice-weekly CTG review meetings. The senior trainee interviewed was currently partaking in a high risk case review. The trainees have protected time to attend the monthly clinical governance feedback meetings during which SIs/high risk case reviews are presented. New NICE guidance, changes in guidelines and policies are also discussed during this meeting. The monthly perinatal morbidity meetings offer trainees further opportunities for learning from clinical practice. Paediatric trainees wish to come to PRH for their neonatal training.

Conclusion

The latest GMC national training survey report provides evidence of the high standard of education, training and supervision offered by the maternity unit to its trainees in both obstetrics and gynaecology, and paediatrics. There is good multidisciplinary working between medical, midwifery and nursing staff. The maternity unit has incorporated clinical governance into learning outcomes for its trainees.

11. CONCLUSIONS

Strengths of the maternity services

New build CLU at the PRH.

Training centre for PROMPT and ROBuST courses.

Introduction of a neonatal stabilisation course (MIST) for MLUs based on the Scottish Neonatal Stabilisation course.

Induction programme for trainees.

Monthly obstetrics and gynaecology governance feedback meetings for medical staff with protected time.

Cohesive obstetrics and gynaecology consultant body with strong leadership.

Good support between consultants, junior doctors and midwives.

Good communication between CLU and NNU.

Low caesarean section rate 14.1% for primiparous women (22.3% national mean) and 19.1% for multiparous women (21.8% national mean) - RCOG clinical indicators project *Patterns of Maternity Care in English NHS Hospitals 2013/14*.

High proportion of vaginal births following a primary caesarean section 33.2% (27.0% national mean) - RCOG clinical indicators project *Patterns of Maternity Care in English NHS Hospitals 2013/14*.

Good reported overall experiences of maternity services by service users interviewed.

Weaknesses of the maternity services

High midwifery sickness rate.

Noncompliance with the 2013 OAA/AAGBI guidelines for obstetric anaesthesia – 'as a basic minimum there must be 12 consultant sessions per week to cover emergency work on delivery suite.'

Vacant midwifery risk management lead post (risk management midwife accountable to the Head of Midwifery).

Lack of a risk lead for obstetrics.

Current midwifery staffing model does not meet the service demands, which is predominantly within the CLU.

Absence of a supernumerary Band 7 labour ward coordinator on every shift.

Triage service not operational 24/7.

Midwives scrubbing for emergency caesarean sections.

Distance between co-located MLU and CLU at the PRH.

MLU used as overflow for hospital maternity service at the PRH.

Low morale among the midwifery and medical workforce.

Shortage of middle grade doctors to cover obstetric on call rota.

One obstetrics and gynaecology consultant on long term sick leave.

Trust risk register for neonatal nursing staff levels and overnight tier 2 medical staffing on the NNU, which is currently shared with general paediatrics.

Processes for SI investigations are complex, fail to meet timescales, with little evidence of widespread learning from incidents. Many of the interviewed staff were unclear who, at Trust management level, was responsible for clinical governance for SI investigations.

Lack of external expert opinion for high risk case reviews and SI investigations.

Lack of effective engagement with service users via the MEG.

Continuing uncertainty on whether consultant-led maternity services and neonatal care would return to Shrewsbury where they had been based until comparatively recently.

Continuing sense of loss of neonatal intensive care unit status within the local neonatal network.

12. RECOMMENDATIONS

Relating to Terms of Reference (1):

To review the current obstetric, midwifery and neonatal practices at SaTH NHS Trust in the context of patient safety, identifying any problems that may prevent staff raising patient safety concerns within the Trust, as well as ensuring the services are well led and the culture supports learning and improvement following incidents.

12.1 The transfer of postnatal women from the labour ward/postnatal ward on the CLU to the Wrekin MLU should be monitored to ensure the MLU is not being used as an overflow for the hospital-based maternity service.

12.2 Following the suspension of postnatal inpatient facilities at the Ludlow, Oswestry and Bridgnorth MLU, postnatal capacity and length of stay in the other units should be reviewed. SaTH should consider alternative ways of providing postnatal care nearer to home for women living in or near Ludlow, Oswestry and Bridgnorth.

12.3 The Trust should address the 10% higher than group average neonatal and extended perinatal mortality rates reported in the last two MBRRACE-UK Perinatal Mortality Surveillance Reports for the periods January–December 2015 and January–December 2014. The deaths should be reviewed and resulting action plans need to be achieved within a defined timescale with evidence of shared learning and practice change.

12.4 The Trust should audit its practice in the clinical indicators ranked as outliers in the 2016 RCOG *Patterns of Maternity Care in English NHS Hospitals 2013/14* and *The National Perinatal and Mortality Audit* *http://www.maternityaudit.org.uk/pages/home*

Relating to Terms of Reference (2):

To review the current provision of care within the maternity and neonatal services in relation to national standards.

12.5 The maternity dashboard should indicate the actual mother to midwife ratio. Currently indicated is the establishment of midwives which fails to record maternity and sick leave and usage of bank/agency staff.

12.6 The maternity clinical dashboards should include transfer rates and reasons for transfer from each MLU to the CLU, with each MLU having its own birth, maternal and fetal outcomes.

12.7 The antenatal triage service should be provided on a 24/7 basis to ensure non-labouring women are not admitted to the labour ward in the hospital setting.

12.8 The neonatal guidelines should follow the regional network guidelines whenever possible. Deviation should have a clear local rationale and must be reviewed on an annual basis.

12.9 Involve service users via the MEG and other platforms on developing the Baseline Assessment Tool for each new NICE obstetric guideline.

Relating to Terms of Reference (3):

To review the current midwifery, obstetric and neonatal workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.

12.10 The Care Group should formulate a comprehensive workforce plan, supported by the latest Birthrate Plus® data, for presentation to the Trust Board. This plan should include the skill mix required on all sites. Skill mix requirements will depend on the services offered at each MLU and at the CLU.

12.11 The Band 7 labour ward coordinator should be supernumerary. A shortfall in this standard should constitute a 'red flag' staffing alert and trigger a review through the Care Group governance structure.

12.12 The PMAs should receive PMA training, have a PMA job profile and be allocated time in their job plan as recommended in the 2017 NHS England *A-EQUIP a model of clinical midwifery supervision* document (A-EQUIP: an acronym for Advocating for Education and QUality ImProvement).

12.13 The Trust should invest in the Care Group Patient Safety Team. The risk management midwife post removed in 2015 should be reinstated at the same banding. This midwife should be accountable to the Head of Midwifery. The Safety Team would benefit from having among its members a risk management consultant obstetrician.

12.14 Neonatal staffing issues highlighted and already on the Trust's risk register need to be addressed.

Relating to Terms of Reference (4):

To review the working culture within the maternity and neonatal services, including relationships and communication between healthcare professionals.

12.15 The new senior management team in the Care Group, namely the Care Group Director and the Head of Midwifery, need to clarify their roles in order to work effectively together to develop a vision for the service centred on safety and learning. Once developed, the vision needs to be embedded within the service so that all staff are aware of the direction of travel.

12.16 The Head of Midwifery would benefit from a mentor to provide guidance and support during her first years in post.

12.17 Consultant anaesthetic cover of the labour ward should be in accordance with the 2013 OAA/AAGBI guidelines for obstetric anaesthesia.

12.18 Increase staff awareness of examples of good practice identified through patient experience surveys/reports. This would improve staff morale and consistency of care through maternity services.

Relating to Terms of Reference (5):

To review the processes for escalation from MLUs to the CLU.

12.19 There should be a review of the manager on call rota arrangements in relation to the escalation policy. Clear guidance on accountability should be reflected in the plan to ensure a safe, effective care provision.

12.20 Monitoring of the escalation processes should be evident at the monthly Care Group clinical governance meetings.

Relating to Terms of Reference (6):

To review approaches to monitoring fetal heart rates and acting upon abnormal traces, to describe how this relates to established best practice and make any recommendations for improvement.

12.21 Staff feedback on the benefits of the twice-weekly CTG meetings held on the labour ward should be sought.

12.22 Trends in incidents involving EFM misinterpretation should be analysed once the centralised monitoring system is in use.

Relating to Terms of Reference (7):

To review the RCA investigation process, how SIs are identified, reported and investigated within the maternity services, how recommendations from investigations are acted upon by the maternity services, and how processes ensure sharing of learning among clinical staff, senior management and stakeholders.

12.23 The frequency of risk management meetings should be increased from monthly to weekly.

12.24 The review team advise that over reliance on one individual, such as the Patient Safety Lead, to oversee the timeline and process should be avoided. A wider pool of RCA-trained investigators should be used to carry out this task.

12.25 SI reporting should follow the NHS Improvement Serious Incident Framework (https://improvement.nhs.uk/resources/serious-incident-framework/)

12.26 There should be promotion of independent external review and the request for invited review with all SIs and high risk case reviews. Doing this portrays a culture of openness and willingness to learn from tragic events.

12.27 For a RCA investigation to be of benefit, a trained multidisciplinary team needs to address root causes, to challenge existing practice, to write a report with clear action plans, specific directives and timescales. Timeframes should be adhered to with an escalation process if there is slippage.

12.28 The Patient Safety Team should ensure that final reports are circulated to all staff. Evidence obtained from interviews suggests that shared learning from action plans was mainly obtained by staff attending the clinical governance feedback meetings.

12.29 All medical staff should be reminded of their legal responsibility to legibly date and sign each entry, along with a printed signature and their GMC registration number.

12.30 The Trust should inform the parents of any local review taking place and invite them to contribute in accordance with their wishes.

Relating to Terms of Reference (8):

To review the education and supervision of obstetric and paediatric trainees, including consultant accessibility and presence on the delivery suite/NNU as per national standards recommendations, in the context of providing a safe and efficient service.

12.31 The review team suggest that a logbook of all requests for consultant attendance, with reason for attendance, time of request and time of arrival onto the unit.

Recommendations from the service user perspective

12.32 During the current closures of Ludlow, Oswestry and Bridgnorth MLU, it is essential to keep service users informed, with answer machines providing contact names and numbers, on where and how services are provided. Regular updates should also be performed.

12.33 The Trust management should review and enhance MEG awareness through raising its profile. The Trust should consider rebranding as Maternity Voices in accordance with Better Births. https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

12.34 The Trust management should consider engaging service users via social media, drawing upon the professional expertise of communication and social media advisors. This would access the untapped source of the vast majority of women who are unable to attend the MEG meetings in person, many of whom are on Facebook and other social media platforms.

12.35 The Trust management should consider paying travel and childcare expenses to all MEG service user representatives.

12.36 The Trust management should review the effectiveness of online antenatal education provision, especially for first-time parents.

12.37 The Trust management should review the consistency and quality of breastfeeding support and the availability of trained staff for this across all SaTH sites.

14. BIOGRAPHIES

Obstetric and Gynaecology Assessor Lead – Dr Claire Candelier FRCOG

Claire has worked as a consultant obstetrician and gynaecologist at Stockport NHS Foundation Trust since 1997. She is currently the college tutor having previously held the post from 2000–05. She was the Clinical Director for obstetrics and gynaecology from 2003 to 2010. Claire has been the Obstetric Lead since 1997. Claire has provided expert reports and opinions since 2010. Her current college activities are examiner for the MRCOG Part 2 examination and assessor for individual performance and service reviews.

Claire obtained a degree in medicine and surgery at Sheffield University in 1981. She is a Fellow of the RCOG since 2003, having obtained her membership in 1986. Claire obtained her doctorate in medicine in 1994 and has worked for the NHS for 35 years.

Obstetric Assessor - Professor Alan Cameron MD FRCOG

Alan has been a consultant obstetrician in Glasgow for 25 years. He undertook his subspeciality training in maternal fetal medicine at the University of Calgary, Alberta, Canada. After this he was appointed lecturer in the Department of Obstetrics and Gynaecology in Glasgow. He has retained an active research profile and he was rewarded with an Honorary Professorship from the University of Glasgow in 2007. His main research interests are in prenatal diagnosis and fetal therapy. He was the Scottish Members representative on RCOG Council from 1996–2002 and was President of the British Maternal and Fetal Medicine Society from 2005–08.

As a former Chair of the RCOG/Royal College of Radiologists Standing Joint Committee he helped develop the current RCOG ultrasound training modules. In 2008 he was elected as the Scottish Fellows representative on RCOG Council and was re-elected in 2011. He chaired the Scottish Committee of the RCOG from 2009–13. He is the RCOG representative on the UK National Screening Committee and is involved in various projects with the Fetal Anomaly Screening Programme. He was the local President when the European Board of Obstetrics and Gynaecology took place in Glasgow in 2014.

From 2013–16 he was Vice President for Clinical Quality at the RCOG. He was the co-principal investigator of the flagship RCOG project ‘Each Baby Counts’ and was Senior Clinical Adviser to the Lindsay Stewart Centre at the RCOG.

Obstetric Assessor – Dr Colette Sparey MRCOG

Colette is a consultant obstetrician working for the Leeds Teaching Hospitals NHS Trust and has been in post since 1999. She has subspecialty accreditation in maternal and fetal medicine and has an active fetal medicine practice. Her main area of interest is intrapartum care and she continues to work in this acute area of maternity services at the Leeds General Infirmary.

Colette is currently the Subspecialty Training Programme Supervisor for subspecialty training in maternal and fetal medicine in Leeds and is an RCOG assessor for this training programme.

Colette has had a number of managerial roles in the Leeds Teaching Hospitals NHS Trust.

- Labour Ward Lead 1999–2005
- Specialty Lead for obstetrics 2005–07
- Clinical Director for obstetrics and gynaecology 2007–16

She has been involved in the risk management team at Leeds throughout her time as a consultant and has chaired governance groups at specialty and directorate levels.

Colette is a Special Advisor for the Care Quality Commission and has taken part in a number of inspections in acute NHS Trusts and has previously been a member of the Yorkshire & Humber Maternity Strategic Clinical Network and Clinical Expert Group.

Neonatology Assessor – Dr David Millar MB MRCP FRCPCH

David has been a consultant neonatologist since 2006. David trained in paediatrics and neonatology in Northern Ireland and Scotland. He completed a Perinatal–Neonatal Fellowship in Canada prior to returning to the UK.

Following time as a RCPCH tutor; David was elected Regional Advisor (RCPCH) in 2014. He is currently Regional Lead for RCPCH in Northern Ireland.

David was appointed inaugural Clinical Information Lead for the Neonatal Network Northern Ireland, as well as Chair of the Neonatal Intensive Care Outcomes, Research & Evaluation (NICORE) in 2013. During David's 3 years in post he has helped the Network benchmark internationally through the Vermont Oxford Network.

David is currently the Irish Representative for the BAPM and sits on the BAPM Executive. He attends the steering group for Neonatal Mortality Reviews, which is setting standards for reviews throughout the UK. David chairs the BAPM working group working on neonatal terms for SNOMED-CT (Systematized Nomenclature of Medicine – Clinical Terms) and sits on the BAPM working group for information sharing with parents (consent).

From May 2015, David has sat on an expert panel for the Care Quality Commission conducting a thematic neonatal enquiry into different areas, covering topics such as: communication; multidisciplinary working; and clinical management in the areas of fetal medicine, neonatology, paediatric nephrology and respiratory paediatrics.

Midwifery Assessor – Ms Anna Shasha RM

Anna has been a midwife since 1986 and has had a variety of posts including Community Midwife, Senior Midwife for antenatal and postnatal area, Community Midwifery Manager and then Head of Midwifery since 2001. She has worked mostly in the London region and then moved to the East of England to become Head of Midwifery at Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust, in 2010. Her post is wide and varied – she manages and leads 180 WTE midwives, 40 WTE nurses, 30-plus 40 WTE support staff. She is passionate about MDT working, always looking at delivering effective support and training to all. Anna enjoys meeting the women and getting their views and is keen that all voices are heard.

Anna served as a board member at the Royal College of Midwives 4 years ago and this gave her insight to the workings of a large organisation outside the NHS, while still embedded within the NHS.

Midwifery Assessor – Ms Suzanne Truttero MBA LLB ADM RM RN

Having trained at The Royal London Hospital, Suzanne qualified as a midwife before undertaking an Advanced Diploma in Midwifery at Surrey University and then attaining the Risk Management Diploma. She has practised in hospital, community and educational environments predominately in the London area over many years, and held senior management roles in several large acute hospitals.

With a specific interest and proven track record in risk assessment and management, Suzanne was appointed Risk Manager of five central London hospitals, with the responsibility for establishing a governance structure for the organisation, investigating clinical incidents, and putting in place robust action plans in order to ensure compliance on behalf of the Trust Board. Suzanne is an experienced Director of Women's Services (maternity, gynaecology and children's) and held the position of Midwifery Officer for London responsible for the regulation of 5000+ midwives and the inspection of over 30 maternity services over a period of 10 years. More recently, she was the Midwifery Advisor to the Department of Health, and a key member of the National Clinical Advisory Team reviewing maternity services across England. She was the Midwifery Advisor to the team that reviewed the maternity services across Dublin, and is currently a Specialist Advisor and Bank Inspector for the Care Quality Commission.

Suzanne holds an MBA from Warwick University and a Law degree from the University of London.

Lay Assessor – Ms Megan Moore

Megan has been working in service development within the NHS and health charities since 2003. Prior to this she was a workforce trainer in the university sector, changing careers when she had children. Her main areas of interest are service reviews, strategy and workforce development. Megan has an MBA, specialising in Change Management.

Megan has commissioned maternity services in Oxfordshire, leading its Maternity Programme Board to undertake reviews of service configuration and performance monitoring, as well as collaborating with the local Maternity Services Liaison Committee to enhance representation of women's views. She has also worked extensively in workforce development and the commissioning and development of services for long-term conditions and disabilities. This has included the review of diabetes services, HIV services, sensory needs provision and advocating improved disability access.

Alongside her career, Megan has undertaken a range of voluntary activities including involvement in local maternity user groups, leading women's health projects in a Cape Town settlement and advocacy as a Citizens Advice assessor. Megan has two children, one at primary and one at secondary school.

15. APPENDIX

15.1 RCOG SPECIALTY DEPARTMENT VISIT

Please can the Departmental leads complete this questionnaire, which will give concise background information, and return to the lead assessor or the review 2 weeks before visit.

Please attach diagrams of departmental management structure, meetings and flow of reporting. Also dashboard of clinical activity.

Medical staffing:

Consultants	**WTE (total number)**	**Junior staff/trainees**	**WTE (total number)**
Obstetrics only	0	FY2	2
Gynaecology only	1	GP ST	4
Combined	12	ST1/2	3
	Name	ST3–5	1 Maternity leave; 1 FT; 1 80%
Labour ward lead	Michele Mohajer/Nibedan Biswas	ST6/7	1 FT; 1 80%
Fetal medicine lead	Adam Gornall	Permanent specialty	SAS: 5 FT; 1 part time AS:2
Gynaecology lead	Martyn Underwood	Long-term locum	1 ST5 for maternity leave 2 consultants commence of 10 July 2017 (1 for leaving consultant; 1 conversion of SAS post)
Oncology lead	Nick Reed	Others – MTI	1
Colposcopy lead	Martyn Underwood/Jill Blackmore		
Other leads	Bernie Bentick (fertility)		
	Richard Foon (urogyne)		
	Sheena Hodgett (obs guideline)		
	Richard Foon (college tutor)		

How many hours of consultant labour ward cover/week? Resident 08:30–21:00 Mon–Fri; 08:00-16:00 Sat and Sun = 78.5 Hours

Does consultant on call/labour ward also cover gynaecology? NO

Junior tier rota: 1 in 7 Banding: …….

Middle tier rota: 1 in 6 (4.6 plus 1 SAS doctor) 4 nights of the week.

3 nights of the week covered 1 in 7 by 3

SAS doctors each with set night

Banding: …….

Third tier (if applicable) rota: N/A

Who is on third tier live in rota? No tier 3 at junior level

If a consultant – is there another consultant on call from home? YES, two consultants always non-resident on call. Four consultants resident on site when non-resident on call for obstetrics in view of distance and time of travel from home since move of W&C centre in September 2014.

Number of live in doctors on call: At consultant level: **Weekday:** resident consultant gynaecology 08:00–17:00; resident consultant obstetrics 08:30–21:00. Non-resident 1st on consultant and 2nd on consultant. **Weekend:** Resident 1st on consultant 08:00–16:00, and then non-resident supported by second on consultant non-resident.

E.g. Weekday	*1 registrar obstetrics* *1 registrar gynaecology*	*1 junior obstetrics* *1 junior gynaecology*
Weekday	1 Tier 2 (registrar) labour ward 1 Tier 2 obstetrics triage; obstetrics day assessment unit; gynaecology	1 Tier 1 (SHO) obstetrics; 1 Tier 1 gynaecology; 1 FY gynaecology
Weekday night	1 Tier 2	1 Tier 1
Weekend day	1 Tier 2	1 Tier 1
Weekend night	1 Tier 2	1 Tier 1

Times of on call handover: MDT labour ward handover: 08:30 and 20:30. Further handover at 17:00 for oncoming night resident/non-resident consultant.

Is there a specific consultant to do antenatal ward round on weekdays? YES the consultant covering the Labour Ward conducts antenatal ward rounds 7 days per week.

Is there a gynaecology consultant on call with no other routine duties? YES

Who does the gynaecology ward round? On call gynaecology consultant weekdays; 1st on consultant weekends.

Midwifery:

Head of Midwifery:	Sarah Jamieson
Deputy Head of Midwifery:	Anthea Gregory-Page
How many senior Midwives & roles?	Wendy Cutchie: Lead for Community Maggie Kennerley: Lead for Acute Unit and Outpatient services Joy Oxenham: Patient Experience Lead Midwife Sharon Magrath: Safety Guarding Lead Midwife Melanie Stubbs: Medway Lead Midwife Michelle Powell: Public Support Specialist Midwife Jan Baker: Antenatal Screening Specialist Midwife Karen Butterill: Improving Women's Health Specialist Midwife Karen Henderson: Education Specialist Midwife Sandra Umataliev: Infant Feeding Specialist Midwife Jan Latham: Bereavement Specialist Midwife Jacqui Bolton/Paula Pryce: Guideline Specialist Midwife Jill Whitaker: Delivery Suite Manager Claire Murgatroyd: Antenatal Ward Manager Annette Barton: Postnatal Ward Manager Julia Brookes: Outpatients Manager Beverley Montague: Bridgnorth MLU and Ludlow MLU Manager Louise Watkins: Wrekin MLU Manager Louise Norton: Oswestry MLU, Whitchurch MLU, and Market Drayton MLU Manager Judith Adams: Royal Shrewsbury Hospital MLU Manager Judith Ockenden: Patient Experience Advisor
How many Supervisors of Midwives:	7 – Midwifery Advocates
Midwife : Birth ratio	

Management:

SDU Lead (name)	Jo Banks
Governance Leads:	Obstetrics: Adam Gornall Gynaecology: Martyn Underwood Neonatology: Wendy Tyler Paediatrics: Tabitha Parsons
Obstetrician	Adam Gornall
Midwifery	Patient Experience Lead: Joy Oxenham
Gynaecologist	Martyn Underwood
Departmental Managers: numbers and roles	Tina Kirby: Business Manager Abbey Milner: Assistant Business Manager Melissa Matthews: Acting Administration Manager Lynn Atkin: Lead Nurse Finance Link: Steve Williams HR Business Partner: Laura Kavanagh Communications Link: John Kirk

List departmental management/clinical meetings:

Meeting	**Who attends**	**Frequency**	**Reports to:**
E.g.: Perinatal morbidity	*All obstetricians and neonatologists*	*1st Tuesday lunchtime of month*	*SDU business meeting*
Perinatal mortality	Obstetricians, neonatologists, perinatal pathologist, bereavement midwife	Weeks 1 and 5 of 8-week cycle Friday pm	Maternity Governance
Gynae-oncology MDT	Gynae-oncology resident consultants; visiting gynae-oncology consultants; oncology; histology; radiology consultants; specialist nurses; tracker	Every Wednesday	
Maternity governance	Obstetrician, Head of Midwifery, Deputy Head of Midwifery, Lead Midwives, Ward	4-weekly	Care Group Board

	Managers, Business Manager, Patient Safety Lead, Assurance Team, Medway, Patient Experience Lead		
Gynaecology governance	Gynaecology Lead, Lead Nurse, Ward Managers, Patient Safety, Patient Experience, Audit Lead, Assurance Lead, Patient Experience Lead	Monthly	Care Group Board
Maternity business	Business Manager, Obstetrics Lead, Finance Link, HR Link, Ward Managers, Lead Midwives	Every 3rd Friday	Care Group Board
Gynaecology business	Business Manager, Lead Nurse, Gynaecology Lead, Finance Link, HR Link, EPAS	4 Weekly	Care Group Board
Clinical governance feedback	All medical staff timetabled	Week 4 and 8 in 8-week cycle. Monday pm	Feedback from Governance Obs and Gynae
NICU Mortality Morbidity Meetings	Nursing and Medical Staff from Royal Stoke and SaTH	Every other Month	Neonatal and Maternity Clinical Governance

Clinical governance structure:

To coordinate and implement the monitoring and review of risk incidents and governance initiatives with regard to obstetrics, gynaecology and fertility in accordance with the risk management strategy (Women & Children's services).

Allocated managers:

List meeting structure	**List pathway of an incident report**
	See documents attached  SOP Investigating Incidents (015) 21 3 :
	 Risk Management.pdf

	Clinical Incident near-miss reporting a
	Risk Management Strategy v14 June 17

Do the trainees attend a clinical governance meeting? YES

If not – how do lessons learnt get disseminated to medical staff?

To midwifery staff:

Beds/activity:

Number of beds/rooms:		
Labour ward	13 delivery rooms	
Triage	15 including treatment room	
Obs / HDU on labour ward	0	
Antenatal and postnatal	13 + 23	
Standalone birth centre	Royal Shrewsbury Hospital – 13 + 2 delivery Oswestry – 6+2 delivery Ludlow- 4 + 2 delivery Bridgnorth – 4 + 2 delivery	
On-site birth centre	13 + 4 delivery	
Gynaecology ward	12	
Number of staffed labour ward only theatres		(insert hours)
Weekdays	08:30–12:30 x 3 days	12 hours
Out-of-hours	None, separately staffed save 24/7 anaesthetic cover	

15.2 VISIT TIMETABLE

SaTH RCOG Invited Review - Timetable

Wednesday 12 July Seminar Rooms 1&2 W&C Centre PRH	
0800-0900	Assessors Meeting
0900-0945	Tour of Wrekin MLU and Consultant Unit
0945-1015	Edwin Borman Medical Director
1015-1045	Andrew Tapp Obstetrician Gynaecologist W&C Care Group Medical Director
1045-100	Mid Morning break
10-45-1130	Maggie Kennerley - Lead Midwife for Acute and Outpatient Service
1130-1200	Dr Nibedan Biswas Consultant Obstetrician Gynaecologist - Labour Ward Lead
1200-1230	Dr Guy Calcott O&G Trainee ST4 and Dr Maimoona Afzal O&G Trainee ST 2
1230-1300	Jan Latham - Bereavement Midwife
1300 - 1330	Lunch
1330 - 1700	Tour and visit of Oswestry MLU and Shrewsbury MLU - Louise Norton Midwife - manager of Oswestry MLU
1330-1400	Dr Koottalai Srinivasan - Respiratory Consultant - Head of Undergraduate training
1400-1430	Mr Andrew Sizer - Consultant in Reproductive Medicine and Surgery - College Tutor for O&G
1430-1500	Rachel Lloyd - Assurance Team Officer

Thursday 13 July Meeting Room 2 and 4 - Admin Hub PRH	
0830-0900	Martyn Underwood - Consultant Obstetrician Gynaecologist - Clinical Director for Gynaecology
0900-0930	Tina Kirby - W&C Business Manager
0930-1000	Band 7 Midwives Louise Haywood, Rachel Downes, Beccy Davies
1000-1030	Jo Banks - W&C Care Group Medical Director
1030-1045	Mid Morning Break
1045-1115	Lorien Branfield - Labour Ward Anaesthetic Lead Consultant
1115-1145	MEG Representatives - Hannah Wood - Service User and Liz Grayston
1145-1215	Beverley Montague - Manager for Bridgnorth and Ludlow MLUs - Midwife
1215-1245	Wendy Cutchie - Lead Midwife for Community Services
1245-1315	Lunch Break
1315-1345	Dr Sanjeev Deshpande - Consultant Neonatologist - Clincal Director for Neonataology - Business
1345-1415	Dr Wendy Tyler - Consultant Neonatologist - Clinical Director for Neonatology - Governance
1415-1445	Samantha Davies -Neonatal Lead Nurse
1445-1500	Mid Afternoon Break
1500-1530	Claire Murgatroyd - Antenatal Ward and Triage Manager - Midwife and Lead Midwife Advocate
1500-1530	Dr Ari Kannivelu - Paediatric Consultant - Paediatric College Tutor
1590-1600	Dr Banchhita Sahu - Consultant Obstetrician Gynaecologist
1600-1630	Dr Sheena Hodgett - Consultant Obstetrician Gynaecologist and Dr Michele Mohajer - Consultant Obstetrician Gynaecologist

Friday 14 July Meetings Rooms 2 & 4 - Admin Hub PRH	
0830-0900	Dr Dimitris Papoutsis - O&G SAS
0900-0930	Sarah Jamieson - Head of Midwifery - Midwife
0900-9030	Anthea Gregory-Page - Deputy Head of Midwifery - Midwife
0930-1000	Deirdre Fowler - Director of Nursing, Midwifery and Quality
1000-1030	Annette Barton - Postnatal Ward Manager - Midwife
1030-1045	Mid Morning Break
1045-1115	Jill Whitaker - Labour Ward Manager - Midwife
1115-1145	Traci Hudson Lead for Education Stafford Uni- Midwifery. Students: Sophie Whitaker, Kate O'Donnell, Mazeda Khanam
1145-1215	Specialist Midwives: Judith Ockenden - Patient Experience Advisor; Fiona McAree Medway Midwife, Melanie Stubbs Medway Midwife, Jan Baker Screening Coordinator Midwife; Karen Henderson - Clinical Education Midwife
1215-1245	Band 6 Midwives - Sue Robb and Karen Pearce
1245-1315	Lunch Break
1100-1130	Dr Shiva Shankar - Consultant Neonataologist
1130	Dr Davina Kenyon-Blaire - Neonatal Trainee
1200	Advanced Neonatal Nurse Practitioners Sarah Kirk
1230	Neonatal Nurses
1345-1315	Lunch Break
1314-1445	Assessors Meeting
1445-1500	Mid Afternoon Break
1500-1530	Feedback Edwin Borman, Andrew Tapp, Jo Banks, Deirdre Fowler