17-0434 FOI Request: Deaths in Maternity Units

1 The exact number of deaths over the last three years.

The below information is based on calendar years and is the information we have available. Please note the following definitions that have been used to provide this data.

- A stillbirth is a baby born dead after 24 completed weeks of pregnancy.
- A neonatal death is a live born baby who died before 28 completed days after birth

Maternal deaths can be categorised in three main different ways:

- A direct maternal death is one that is the result of a complication of the pregnancy, delivery, or management of the two
- An indirect maternal death is one that is a pregnancy-related death in a patient with a pre-existing or newly developed health problem unrelated to pregnancy (for example cardiovascular disease that may complicate or be aggravated by pregnancy)
- An accidental, incidental, or non-obstetrical maternal death is one un-related to a pregnancy.

For the purpose of this question we have included links to MBRRACE reports:

2014:
https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK-PMS-Report-2014.pdf

2015:
https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK-PMS-Report-2015%20FINAL%20FULL%20REPORT.pdf

2016:
https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Perinatal%20Surveillance%20Full%20Report%20for%202016%20-%20June%202018.pdf

2. How many took place at each of the major hospitals in Shrewsbury & Telford

The maternal death sadly occurred at our Royal Shrewsbury Hospital site. The coroner's report following the inquest was natural causes, and it has *not* been indicated as an avoidable death.

This data is not recorded in this way centrally for stillbirths and neonatal deaths. This information was taken from our central records system, which just gives the date of death not the location. Such information could only be obtained by manual review of maternity medical records and therefore the cost of complying with the request would significantly exceed the appropriate limit as set out in Section 12 of the Freedom of Information

3. The total number of births over the last three years

This is already available on our website:

https://www.sath.nhs.uk/wp-content/uploads/2016/08/Maternity-Birth-data-2008-to-201617-projected.pdf

4. The total number of births in local hospital maternity units such as Ludlow Hospital

This is already available on our website:

https://www.sath.nhs.uk/wp-content/uploads/2016/08/Maternity-Birth-data-2008-to-201617-projected.pdf

5. The recommended guidelines for staffing in each maternity unit in Shropshire including senior members of staff.

Our Birth to Midwife Ratio is in line with national NICE and Royal College guidance, Safer Childbirth/Birthrate Plus (1:30). This guidance can be found here **https://www.nice.org.uk/guidance/ng4/resources/birthrate-plus-workforce-planning-methodology-and-birthrate-plus-intrapartum-acuity-tool-2546353549**

and here **https://www.rcoa.ac.uk/system/files/PUB-Safer_Childbirth.pdf**

Details of our staffing are published here

https://www.sath.nhs.uk/about-us/our-performance/safe-staffing/

A review of nurse / midwifery staffing is contained in this board paper:

https://www.sath.nhs.uk/wp-content/uploads/2016/09/160929-Trust-Performance-Report.pdf

6. The actual number of staff in each maternity unit.

This shows the number of midwifery staff due to be on each shift at each location. The table below shows the actual number of staff on duty at any one time during a shift at each of our units. The low numbers in our midwifery led units reflect the number of births they support and are in line with safe staffing guidance as outlined above.

	Shift	On call
Delivery Suite	7	-
Antenatal Ward	2	-
Postnatal Ward	3	-
Wrekin MLU	2	1
RSH MLU	1	1
Bridgnorth MLU	1	1
Oswestry MLU	1	1
Ludlow MLU	1	1
Total	**18**	**5**