The Shrewsbury and Telford Hospital NHS Trust

REVIEW OF MATERNITY SERVICES 2007 – 2017

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On behalf of the
Quality and Safety Committee
27th June 2017

FOREWORD

As Chair of The Shrewsbury and Telford Hospital NHS Trust (SaTH)'s Quality and Safety Committee, and amid concerns raised by service users, I have commissioned this report to explore how maternity services have developed over the last decade with the aim of describing what the service looks like, how it is organised and to see how the staff organise themselves around patient safety. I see this report being used to inform the future development of the service in conjunction with the other pieces of work commissioned at the same time. Notably the Secretary of State for Health has commissioned a review of incidents of baby and maternal deaths between 2000 and 2017, which NHS Improvement is taking a leadership role in to ensure the review is independent and will withstand scrutiny. The final piece of work commissioned by the Trust has requested the Royal College of Obstetricians and Gynaecologists undertake a review of current practice. The findings of these three reports will assess the past against the standards of the day, describe the present and provide the best possible chance of learning and improving. This will enable the Maternity Leadership Team and the Trust Board to continue their learning, directly shape the improvement and development of the services for women and most importantly ensure the safety of clinical care.

As a learning organisation I would expect the contents of this report to help staff across the Trust learn from the past and to change the culture of our organisation to ensure we achieve our ultimately allow us to provide the safest and kindest maternity services in the NHS.I am confident that our staff share this ambition for every women who comes to us for care.

Dr David Lee

Chair of the Quality and Safety Committee

PREFACE

Any family anticipating the birth of a baby does so with a range of hopes and aspirations about that experience, whether this is their first baby or a subsequent member of their family. The anticipation and excitement builds during pregnancy right up until the date the baby is born. This should be one of the happiest times of their lives, and thankfully for the majority of families this is true. However, it is evident that this happy outcome isn't always the case; babies are born very prematurely or with congenital problems.

For some unfortunate families the situation is devastating, when the baby dies not long before birth, during the birth or shortly afterwards. Sometimes this is because of a congenital malformation or because of a birth injury, which can be unexpected. Whatever the cause this is by far one of the most tragic events of a family's life, the experience is devastating and unique, the impact can be lifelong. This report serves to understand the potential factors that can affect the safety of the mother and newborn baby and not to minimise the personal impact that any baby death will have.

The staff who work at our hospitals, Midwife-Led units and in the community do so to care for the populations of Shrewsbury, Telford & Wrekin and Mid Wales. They undertake their duties to ensure that women and babies are kept safe, and to practice their chosen profession to the best of their ability. It is our common belief that no-one turns up to work to deliberately cause harm, but by the very nature of the work, with so many human variables involved, occasionally harm will result. Of crucial importance is how the organisation learns and translates this learning into everyday activity to prevent reoccurrence of problems for mothers and/or babies in the future. We often talk about this as a safety culture with the aim of continuous learning. This report is prepared with this in mind, with the key question 'have we learned from past baby deaths and have we improved sufficiently to prevent avoidable death?'

Colin Ovington

Lead Reviewer

EXECUTIVE SUMMARY

This is a structured assessment of maternity services[1] over the decade leading to 2017. The report starts with the notion that a normal pregnancy and childbirth is the expectation for most people in society; however things can go wrong and this is devastating, whether expected or unexpected. The move from what is normal and routine to circumstances when an urgent clinical response is required for a perinatal emergency can develop with quite incredible pace. This statement is true across the NHS, and equally true at SaTH.

The purpose of the report is to describe the journey that the maternity service has been on in terms of quality and safety over the decade from 2007 to 2017. Historically the nature of the trust's business has been less open to public scrutiny than it should have been. This is changing, however there is still much that could be done to strengthen engagement with parents. The service, in keeping with most NHS maternity services, has been too reliant on external assurance (such as CNST assessment or Local Supervising Authority for Midwives) rather than more holistic approaches.

In summary the review demonstrates whether appropriate learning has been embedded and whether there are any gaps remaining in practice, governance and accountability. There are multiple markers in the NHS that have to work cohesively to be able to demonstrate that a service is safe. These will include behaviours, knowledge and insight of professional staff, having the right equipment and numbers of staff and all this needs to operate in an evidence-based framework. A wide range of data and information has been explored along with how this measures up to NHS policy, professional guidelines and other evidence sources to find answers to key questions.

Are our maternity services safe?

- Caesarean section rates are 13-20.2% - this is lower than national level of 25% and is generally believed to be a good indicator of quality and safety.
- Perinatal mortality has fallen since 2009 when the rate was 8.3 deaths per 1,000 live births, to 6.8 in 2015. This is still too high and requires additional action
- Cardiotocograph (CTG) monitoring is one of the most crucial areas of risk management of women and babies in the antenatal and intrapartum period. Learning from Barking Havering and Redbridge Trust, SaTH have put in place a number of actions to promote safer use and interpretation of CTGs.
    - ✓ SaTH have implemented the use of a regular 'fresh eyes' approach which has been shown to reduce the chance of a CTG tracing being misread
    - ✓ There is a programme for staff in maternity to be updated on reading CTG tracings twice a year
    - ✓ An additional full day training session has been put in place to explore the human factors involved and also test the knowledge base of the staff.
    - ✓ CTG machines in the Consultant unit are all the same
    - ✓ New Dawes-Redman machines, which provide automatic interpretation, have been purchased for antenatal assessment areas.
    - ✓ SaTH have appointed a midwife specific to CTG training

[1] Reference to maternity services includes the services organised and delivered by the multidisciplinary team and includes predominantly doctors, midwives and support staff.

- ✓ All delivery suite co-ordinators are trained with additional knowledge and are available 24 hours a day, seven-days-a-week.

- A neonatal stabilisation course (MIST course) is the first such course in England to train midwives, doctors and ambulance crews together
- Standardisation of the neonatal resuscitation equipment across the MLUs has been put in place to ensure all staff are familiar with the lifesaving equipment.
- Twenty-two midwives and five doctors have been trained in Root Cause Analysis (RCA) skills to date.

How we are measuring and know if our service is safe?

- To achieve CNST level 3 (the highest level of achievement possible) there had to be twenty-seven specific guidelines in place
  - ✓ SaTH was one of 74% of trusts to achieve this but only one of 12% to achieve this at level 3
- 155 guidelines are in place and all have been reviewed using up-to-date evidence
  - ✓ Review process in place. 22 guidelines are currently being reviewed and a further 22 will be reviewed before the end of the calendar year (2017)
- There is a programme of clinical audit in place which demonstrates testing of high risk areas of practice.
  - ✓ There is evidence of audit and re-audit of key high risk areas of clinical practice.
  - ✓ There is an average of 24 audits undertaken annually.

How are we engaging with and involving families in investigating incidents?

- The improvement journey of the service includes how user feedback is sought, received and used.
  - ✓ The Maternity Engagement Group is a user group for women, Healthwatch and SaTH staff, to come together to discuss relevant matters on experience, safety and quality of care.
  - ✓ Based on the experience of mothers who have given birth in our services 98.8% say they are likely or extremely likely to recommend the service in the Trust's friends and family test (February 2017)
  - ✓ The maternity service received 47 compliments to every complaint received in recognition of the great care and positive outcome for most women.
- The response rate to the latest patient survey undertaken in 2016 was better than the national performance (46% for SaTH compared to 41% nationally).
  - ✓ The Trust out-performed all other trusts in two questions, one in the labour and birth section, and one in the postnatal section.
  - ✓ Two 'Care in hospital after the birth' questions showed a statistically significant improvement from 2013
  - ✓ Overall, the Trust did not perform worse than other Trusts on any individual questions
- Increased effort is being made by the maternity leadership team to talk with families who've suffered the death of a baby

There is a wider range of information about the service publically available, this is one clear way of expressing a willingness to be open and transparent about the nature of the business in a way that was not so obvious in the past. This change is partly led by the current Board and partly led by the care group leadership team and demonstrates the intention to be open and transparent. Like many parts of the NHS, SaTH used data rather than considering the actions and behaviours necessary to learn from

mistakes. On this particular matter the board has aspirations to learn and promote a culture of leadership and accountability. A trust wide 'Values in Practice'(VIP) agreement is being put in place, very much focused on getting a commitment to the trust's values and leadership programme building on the success in these areas over the last 18 months.

The Trust's partnership with the Virginia Mason Institute, and work on human factors, all point to the learning including 57,000 safer patient journeys since the trust embarked on the partnership work. 1,800 staff have learned about how to improve patient journeys using evidence based methods, which support and empower staff to make changes to create safer more effective environments for our patients.

Based on an assessment of SaTH against these markers it would be fair to conclude that safety in maternity is protected by the efforts of the staff. There are areas of work to develop further including actions to deepen learning from errors, and to continue the journey of becoming more open and transparent. The final action is to create a coordinated approach to the maternity safety improvement plan and engage with the multidisciplinary team, in conjunction with service users, to implement the plan.

CONTENTS

1. INTRODUCTION

Pregnancy and birth are considered to be a normal expectation, however the move from what is normal and routine to circumstances when an urgent clinical response is required for a perinatal emergency can develop with quite incredible pace. The notion of risk for both the expectant mother and / or her unborn baby, or of a new-born baby is something that is the baseline training for obstetricians, midwives and the neonatal team. This is reliant upon being able to identify risk factors or signs and symptoms that demonstrate that something is not normal. Spotlight on Maternity (RCOG, March 2016) directs and challenges organisations and professions on the Government's ambition to reduce by half the rates of still births, neonatal and maternal deaths and intrapartum brain injuries by 2030, but with a demonstrable reduction by 2020. This ambition is set in the context of the UK being ranked 24th out of 49 high income countries for still birth rates, with the UK rate of progress being slower than most. There have been a number of reports about the death of babies at Shrewsbury and Telford Hospital NHS Trust (SaTH) over a period of years. These will be explored more fully by the review commissioned by the Secretary of State for Health with colleagues from NHS Improvement. This report is a review of maternity services between 2007 and 2017 with the aim of describing the quality and safety of the service offered to expectant women and newly born infants. In order to understand the answer there will, by necessity, need to be a definition of what does safety look like, how can it be described, and finally how does the maternity service measure up to these standards and whether there is sufficient being done to achieve the national ambition to reduce avoidable deaths.

Background

The maternity service at Shrewsbury and Telford Hospital NHS Trust (SaTH) has been the focus of much public attention because of concerns raised about the perinatal mortality rate and the specific concerns of newly bereaved parents over a period of years. There have been seventeen reviews undertaken of elements of those concerns, most notably about individual midwives who have been involved in cases. None of these reports state that the maternity service is unsafe and the majority report good practices and no practical problem with supervision structures given the policies that were in operation at that time. A key question for the board and the public is about the safety of the service, and whether the organisation and the staff who provide the service have learned from the mistakes or problems of the past. Finally there are repeated questions about whether the learning has been translated into improvements in the safety and quality of service delivery to women and newly born infants.

Purpose

The purpose of this report is to describe the journey that the maternity service has been on in terms of quality and safety over the decade from 2007 to 2017. The review will demonstrate

how conclusions are drawn, whether appropriate learning has been driven into the service and whether there are any gaps remaining in practice, governance and accountability.

Out of Scope

This report will not deal with individual cases where a baby has died and is not intended to overlap or duplicate the work being undertaken in the two reviews taking place concurrently. The first is commissioned by the Secretary of State for Health to review the serious incidents that have occurred between 2000 and 2017 in maternity. The second has been commissioned by the Trust to explore current practice in obstetrics and maternity to be undertaken jointly by the Royal College of Obstetricians and Gynaecologists (RCOG).

2. METHODOLOGY

This report will draw upon a number of data sources to arrive at conclusions; where possible they will be triangulated and benchmarked to national norms and to expected standards. This report does not generate new data, however if there are gaps in data, this will be stated and a conclusion drawn about the effect on governance of maternity as a system. Ease of data retrieval will also be an indicator of governance maturity albeit subjective in nature. In scientific terms the data will be both qualitative and quantitative, both necessitating differing ways of analysis to draw conclusions. Gathering this resource of information and data will help:

- Explore normal procedures and processes over time
- Explore incidents and key learning and actions taken, and evidence of assurance and continuity, identify any gaps
- Explore standards of decision-making, models of empowerment
- Explore how women (partners/husbands) are involved in key decisions
- Review key documents about the nature of the service
- Interview key personnel in order to build a common organisational understanding and history

Questions that must be addressed

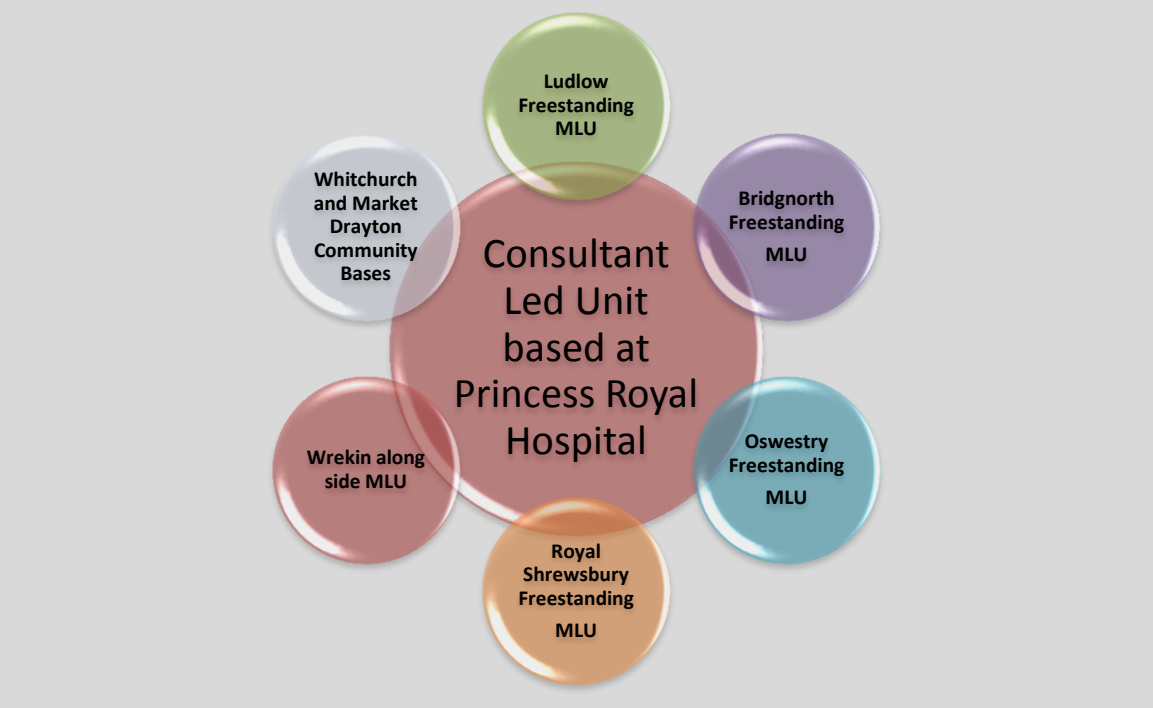
The approach is to look to sources of information and data to test what is factually known about the service is going to help address key questions:

- Is the maternity service safe?
- How we are measuring and know if our service is safe?
- What we are doing now about patient safety?
- How are we measuring and know if we are learning?
- How are we engaging with and involving families in investigating incidents?
- How we compare to other NHS providers?

3. DESCRIPTION OF THE SERVICE

The maternity service is described using a hub and spoke model, the hub being the consultant unit with five spokes, the maternity led units (MLU), Diagram 1. The model has been in place since 1974, however there have been changes with the move of the consultant unit from the Royal Shrewsbury Hospital (RSH) to the Princess Royal Hospital (PRH) in Telford into a purpose built unit in 2014. Midwifery led units can be described as 'freestanding' when they are geographically distant to the consultant unit and operate in isolation with operating protocols in place for those rare occasions when assistance is required for the care of the mother or baby, or both. The 'alongside' units are on the same site as the consultant unit, making it efficient to get assistance if events don't go to the desired or expected plan of care. All units operate as one cohesive whole, with both symbiotic and synergistic relationships to one another. The MLUs operate to care for women who have low risk pregnancies, those who are less likely to have complications during or immediately after the intrapartum period. Community midwifery teams also operate from each of the MLUs and in addition from a community bases at Whitchurch and Market Drayton.

Diagram 1. Hub and Spoke Model of Maternity Care



Each part of the service is made up of a variable number of wards and departments, these are described in table 1

Table 1 – Description of wards and areas of maternity services[2]

Ward/Area	Midwifery and Support Staff
Antenatal Ward 13 beds Triage – 4 beds 1 bereavement suite	2 midwives 1 WSA
PRH ultrasound scan	2 midwives
PRH Day assessment unit	1 midwives 1 WSA
PRH antenatal clinic	2 midwives 2 WSA
Triage	2 midwives 1 WSA
Delivery Suite 13 beds 2 theatres plus recovery 1 bereavement room 1 pool room	7 midwives 2 WSA
Postnatal Ward 23 beds Transitional Care incorporated	3 midwives 3 WSA
Wrekin (Alongside) Midwife Led Unit 13 beds 4 labour rooms/pool room	2 midwives and 1 on-call 1 WSA
Ludlow (Freestanding) Midwife Led Unit 4 beds 1 labour room 1 pool room	1 midwives and 1 on-call 1 WSA
Oswestry (Freestanding) Midwife Led Unit 6 beds 2 labour room/pool room	1 midwives and 1 on-call 1 WSA
RSH ante natal clinic	2 midwives 2 WSA
RSH – ultrasound scan	4 midwives
RSH (Freestanding) Midwife Led Unit 13 beds (inc Day Antenatal Unit) 3 labour rooms/pool room	1 midwives and 1 on-call 1 WSA
Bridgnorth (Freestanding) Midwife Led Unit 4 beds 1-2 labour rooms/pool room	1 midwives and 1 on-call 1 WSA
Whitchurch & Market Drayton And MLU Community Bases	20 midwives

[2] Midwives on duty are supported by midwifery leaders and managers and specialist midwives who cover across all areas

Midwifery team

The midwifery staffing of the service in 2017 is as follows:

Staff	WTE
Midwives	153.78 WTE
Women's Service Assistant's	79.79 WTE
Assurance/Patient Experience	3.0 WTE
Information Team	2.2WTE
Specialist Midwives	7.6 WTE
Ultrasound Midwives	11.72WTE
Managers	12.0WTE (of which 3.2 WTE clinical)

Table 2. Whole time equivalent midwifery and support staff

The midwives undertake a rotation across services in order to keep skills contemporaneous in each area of midwifery practice. The consultant led unit (CLU) is a place where normal midwifery can take place; if there are known risks the plan of care to deliver the baby will be assigned to the CLU in preference to anywhere else in the service in order to mitigate against risk factors. Choice is a very important aspect of the service and despite operating a tiered service some women will still make a choice to deliver their baby contrary to the advice of professional staff and choose to book at a MLU or even a home birth sometimes with known risk factors. The safety of care for all women is paramount, when absolutely necessary and on a risk based assessment of circumstances, the MLUs will be temporarily closed to ensure that staffing of the highest risk areas is the priority, notably the CLU. The variables that will confound staffing of all parts of the service is the unexpected unavailability of staff in combination with those variables which are known but to some degree uncontrollable. Short and long term sick leave can be managed, but difficult to control, and is 4.85% with a target to reduce this to 3.39%. Special leave for on the day unexpected eventualities which is completely uncontrollable, maternity leave which is 2.37% in the 2015/16 financial year compared to 8% in the year prior. Study and training activities are planned, but are compounded by uncontrollable variables. The vacancy rate has been consistent at 3% over a number of years, which is low compared to some nursing services in the trust. These are just examples and not meant to be a comprehensive list, but it should give the reader an understanding of the day-to-day management difficulties in maintaining staffing to the full complement.

Within the midwifery team are a number of leadership, management and specialist functions; these are fairly standard in maternity services across the country and are an invaluable source for the development of services for women, and crucially for keeping the midwifery team up-to-date with current practice in a number of areas. The team at SaTH consists of;

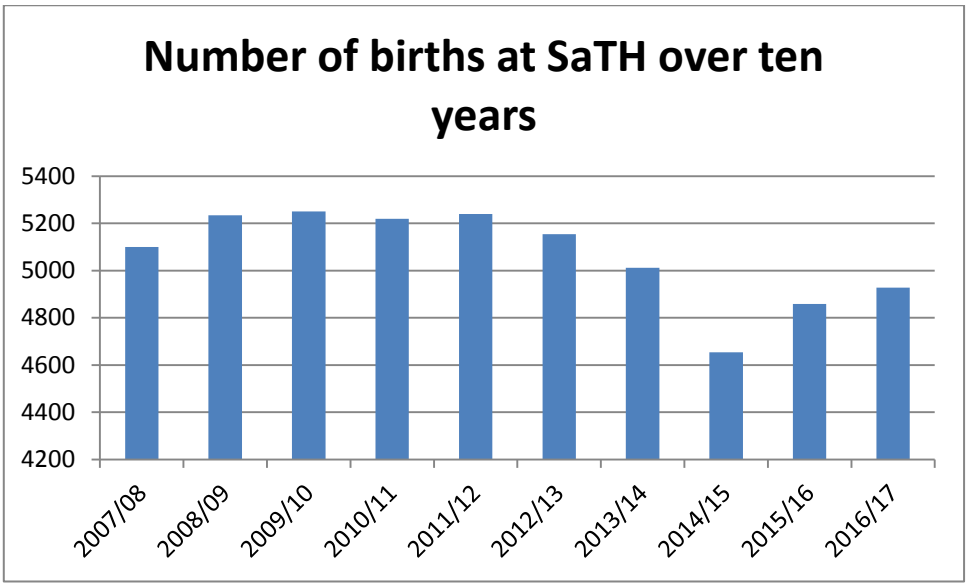
- Head of Midwifery
- Deputy Head of Midwifery
- Lead Midwife for Consultant Unit
- Lead Midwife for Community and MLUs
- Specialist Midwife Roles:
    - Bereavement
    - Improving Women's Health (vulnerable women)
    - Feeding
    - Safeguarding
    - Information Systems
    - Guidelines
    - Screening
    - Education
    - Public Health

The Medical Team

There are 12 consultant medical staff that undertake care in obstetrics, some of whom also practice gynaecology, supported by a team of middle grade and junior medical staff. There is a small number of locum staff at all levels who fill gaps on the rota mostly because of vacancies, not uncommon in the current NHS.

Activity

Maternity services generally get described by a number of statistics. The first is numbers of babies born. This number fluctuates year on year (graph 1.) however the overall numbers have decreased from 2007(5100) to 2017(4978) with a peak in 2009/10 of 5250 births and the fewest number of babies born in 2014/15, (4654). Safety of the service is then measured by the number of complicated deliveries, be they instrumental (forceps or Ventouse) or via caesarean section (LSCS), and also by the number of babies that survive. Much of this detail is captured in morbidity and mortality statistics. At SaTH there has been a constantly low rate of LSCS (11 to 16%), much fewer than the national average of 23%, this is generally believed to be a good indicator of quality and safety. The numbers of babies born by instrumental delivery varies between 8.52% and 12.33%. It must be remembered that every time we add an intervention into the birthing process, which will done to address a risk factor(s) we essentially put in an additional but different risk factor into the equation.



Graph 1. Births over ten years at SaTH

4. LEADERSHIP

Within the last twelve months there have been changes in the senior leadership team in Women and Children's Services, which brings with it fresh foresight, energy and ideas about improvements in the service. Leaders set the tone of the culture within a service, however it also has to be recognised that the body of staff also set a cultural and social norm particularly in a large team such as a midwifery service, in this sense culture is defined by the values of the staff which may not entirely be identical to the stated values of the organisation. Long standing relationships between staff over many years helps to cement the social norms of a team, often described as 'the way we do things around here'. National Advisory Group (August 2013, p6) assert a deep seated belief,

> *"the vast majority of staff wish to do a good job, to reduce suffering and to be proud of their work. Good people can fail to meet patients' needs when their working conditions do not provide them with the conditions for success."*

This is a crucial factor and foundation stone from which to develop learning and support staff to develop and improve, to hold to account and to justify blame.

> *"Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction."* (ibid p6)

This statement is targeted towards system leaders and governments; however the principles apply at trust and at care group level and drives us to be proportionate when things don't go well. In making this statement it is incumbent then to focus on what are the ingredients that make the working conditions needed for success, or what are the elements that will drive the culture of the organisation or team.

Culture

(NHS Improvement, September 2016) discuss the five key elements that make up high quality care cultures, on which team members working together will lead to a collective leadership culture.

1. Vision and values
2. Goals and performance
3. Support and Compassion
4. Learning and innovation
5. Teamwork

Sat behind these are ten leadership behaviours (Table 3); together these elements can create a place that is more positive, able to learn and able to improve, a place where less may go wrong. Experience tells us that 'leaders' will often espouse these cultural elements and leadership behaviours; however the evidence is that the lived behaviours don't always align to the aspiration. Role modelling becomes skewed and the body of staff socialise into defensive or protective behaviours, sometimes for their patients and sometimes for themselves.

1. Facilitating shared agreement about direction, priorities and objectives	2. Encouraging pride, positivity and identity in the team/organisation
3. Ensuring effective performance	4. Ensuring necessary resources are available and used well
5. Modelling support and compassion	6. Valuing diversity and fairness
7. Enabling learning and innovation	8. Helping people grow and lead
9. Building cohesive and effective team working	10. Building partnerships between teams, departments and organisations

Table 3 – Leadership behaviours for high quality care. (NHS Improvement, September 2016)

It is difficult to apply this model to history at SaTH as leaders change – that is the people themselves move on, or that they stay but learn contemporaneous leadership methods. It is, however, pertinent to describe leadership by the lived experience of staff and patients, this will tell us something about how things were and whether there is any discernable change.

> "*Demonstrating and living the values through behaviour is fundamental. In poorly performing NHS organisations, senior leaders ignored staff concerns, avoided discussing workload pressures and paid little attention to addressing systematic problems such as interdepartmental conflict. This created a negative unspoken message about what was valued and how staff should behave, and thus undermined organisational performance"* (NHS Improvement, September 2016, p 152)

Patient Experience

The experience of women who use maternity services is a key marker of quality and safety. The national survey is conducted anonymously by a third party and carries with it a high level of independence. How SaTH manage complaints is equally important as it will also give an impression about how we consider matters that don't go as planned or as women would anticipate. The degree of compassion and empathy is as important to addressing the areas of concern raised by women. The maternity survey is not undertaken every year, starting in 2007 through to 2015 there have been four completed. The response rate to the latest survey undertaken in 2016 to assess the previous year was better than the national (46% for SaTH compared to 41% nationally). For most indicators SaTH sits in the middle territory, with only a few notable exceptions. The Trust outperformed all other trusts in two labour and birth questions and one postnatal question. Two 'Care in hospital after the birth' questions showed a statistically significant improvement from 2013 and three 'Staff' questions showed a statistically significant decline from 2013. Overall, the Trust did not perform worse than other Trusts on any individual questions. While this demonstrates a move in a positive direction, there is still much that could be done to promote the women's experience.

Negative experiences recorded in complaints identify that most occur during the intrapartum part of the maternity pathway.

> *A good working relationship between the multidisciplinary team (midwives, medical, ancillary, managerial staff) and the women in their care is crucial to ensure optimal birth outcomes. This is best achieved with a team approach, based on mutual respect, a shared philosophy of care and a clear organisational structure for both midwives and medical staff with explicit and transparent lines of communication. Clear, accurate and respectful communication between all team members and each discipline is essential, as well as with women and their families.* (RCOG et al, 2007pp10)

Analysis of complaints at SaTH demonstrates correlation between some of the indicators as indicated in table 4 below:

Primary indicator	Correlates with secondary complaint indicators
Inadequate staffing	concerns about quality of care
Ignored or dismissed	receiving insufficient communication
Attitude of staff	being upset/distressed and also with insufficient communication
Inadequate care	delays in care, pain and being ignored
Conflicting advice	feelings of upset / distress, delays, inadequate care, and feelings of being ignored / dismissed.
Conflicting advice	perceptions of 'Inadequate care' and delays
Feelings of upset / distress	feelings of pain
Fear or worry	upset / distress, pain and insufficient communication
Being ignored or dismissed	perceptions of inadequate care and feelings of upset / distress and pain
Insufficient communication	feelings of upset / distress and ignored/dismissed

Table 4 correlation between primary complaint indicators and other issues raised in the same complaints letter.

There are much less formal methods for building insight into the compliments received in maternity care. These do normally run to over a thousand per year which includes many thank you cards, letters and gifts of appreciation for the care given to women and their families. In 2012 there was a ratio of 47 compliments for every complaint received (41 complaints and 1927 compliments). In the same time frame a Quality Assurance Survey was undertaken, 97% of women felt that they had been treated with respect whilst being cared for by the Maternity Services team and an outstanding 99.3% of women would recommend the Maternity Services to a friend or relative.

It is important to demonstrate that having received both positive and negative feedback that the service leadership take the learning and translate key areas into actions which improve and make care standards sustainable. This includes continuing the journey to receive feedback. The Maternity Engagement Group is a user group for women Healthwatch and SaTH staff, to come together to discuss relevant matters to the safety and quality of care. This group has been in existence for some considerable time, however attendance is variable and consequently has an underutilised powerbase, and will require co-ordinated effort to make the mechanism more robust. There have been, and will continue to be, a range of other service specific business meetings with a range of stakeholders, however it is crucial that open dialogue is developed and maintained with families who feel that care hasn't been as good as expected, or where something went wrong, including on rare occasions the death of a baby. There is an effort being made by the leadership team to do this with historical cases of baby deaths, this is to be encouraged and supported, and become a natural way of showing compassion and empathy for the distress that families go through. This level of transparency and openness will also be highly

regarded by any family who makes a complaint and consideration should be given to using the same mechanism as a standard.

Staff Experience

Undertaking a staff survey is also a national requirement, again the survey is undertaken by a third party and done anonymously. Most results haven't changed over a number of years. We know that better engaged and empowered staff are more likely to help make improvements. The percentage of staff reporting better communication between senior management and the staff has improved from 17% in 2011 to 31% in 2016, and those able to contribute towards improvement has gone up from 52% to 77% in the same time frame. This is an encouraging move but still has some way to go. The next indicator of openness is whether the staff feel they are able to report incidents. Interestingly the service was advised in 2014 that they were reporting too many incidents having made a significant improvement in the years that led to this point, the numbers reported have subsequently dropped down. Reporting incidents and errors is seen as an external marker of whether an organisation is open to learning. Kelly et al, (2017) talk eloquently about learning from excellence being equally as important as learning from incidents and errors, this is a significant part of encouraging and supporting staff to be the improvement change agents required to keep services contemporaneous and even leading the way. Inventively they have taken the Serious Incident Report Investigation (SIRI) acronym and reversed it to imply Improving Resilience, Inspiring Success (IRIS) as a means of engaging staff to report positive excellence on the incident reporting system in addition to reporting incidents. This is something to consider, enabling a comprehensive method of taking learning into clinical practice. Most organisations only consider learning from negative events and arguably miss at least half of the opportunity to improve quality and safety.

Openness and transparency

Incident reporting, investigating, and undertaking root cause analysis (RCA) are expected behaviours however these in isolation do not orchestrate organisational learning; other behaviours are required. The openness of the governance team to allow staff access to the range of information amassed by them, and for staff to be more involved in the finalisation of analysis and conclusions would move the service further forward. There has been to some degree an air of protecting information, with information going into the governance team and decisions being made that don't involve investigating officers, (IO) or indeed allow IOs access to key documents. The other interesting behaviour is that many documents are individually pass worded, this mechanism has a place, however from experience this is quite unusual for the type of work produced via the governance team in other parts of the NHS.

Leadership and management are two separate and distinct activities Lunenburg (2011). The common narrative is about control at varying levels in the service over a long period of years, which focuses on getting things done and hasn't been about looking upward and outward to see what could be done differently.

Category	Leadership	Management
Thinking Process	Focuses on people Looks outward	Focuses on things Looks inward
Goal Setting	Articulates a vision Creates the future Sees the forest	Executes plans Improves the present Sees the trees
Employee Relations	Empowers Colleagues Trusts and develops	Controls Subordinates Directs and coordinates
Operation	Does the right things Creates change Serves subordinates	Does things right Manages change Serves superordinate's
Governance	Uses influence Uses conflict Acts decisively	Uses authority Avoids conflict Acts responsibly

Table 5. Comparisons between Leadership and Management (Lunenburg 2011)

The team have been managed on a hierarchical basis, not uncommon in the NHS, however passing responsibilities up the line within the service, but not outside the service, has meant that control has been within the gift of a limited number of managers. Managers concentrated on doing things right, and policies were created for the relevant areas of practice which helped the service achieve accreditation against Clinical Negligence Scheme for Trusts (CNST). To their credit they achieved this to the highest level attainable. Policies had to meet certain criteria and be up to date with current national guidance or policy.

The change in the senior team in the last year has seen some change to the governance arrangement, they are working to proactively be more open and transparent about the service; additional and external scrutiny of the service at the same time has created a degree of inevitable transparency. More and more the dialogue is about the people (staff and the women who use the service), attempts to influence staff rather than control, and to create the right climate for change across the team. It would seem that the right ingredients are being brought to bear. There is a planned area of work on culture within the service which is likely to be a springboard to galvanise the move in thinking required of a contemporary public service; and to some degree what the public are asking of the service.

SaTH maternity service is supported by good people, the right culture is needed to empower them all to be able to do the right things at the right time to promote active learning and prevent harm from occurring.

5. CARE GROUP GOVERNANCE INFRASTRUCTURE

According to a written submission from the Department of Health, 'clinical guidelines have now become a routine part of practice'. Clinicians will agree that this has been the case for many years however, the evidence base to support guidelines has become more robust. However, Safer Childbirth suggests that only 74% of trusts had all 27 maternity guidelines in place, with some units having as few as 10 in place (RCOG et al 2007). SaTH demonstrated that they had these in place as part of the CNST assessments undertaken on a number of occasions.

Recommendations which fall from this work include:

- Maternity services need a single set of evidence-based guidelines that are backed by professional organisations, NICE and other organisations.
- Staff in all disciplines should be encouraged to familiarise themselves with using guidelines in a local setting and should be trained to use the relevant protocols.

At SaTH there is a Maternity Guidelines Group which is a sub-group of the Labour Ward Forum (LWF) and Maternity Governance Group (MGG) who ensures a systematic approach to the development and archiving of robust evidence-based multi-disciplinary clinical guidance. The group have agreed Terms of Reference, minutes of meetings and provide feedback to the LWF and MGG.

The Maternity Guidelines Group has responsibility for bi-annual review and distribution of Labour Ward Protocols and Maternity Guidelines for Practice. At the point of checking 22 of the 155 guidelines are due a review and a further 22 will require a review before the end of the calendar year (2017) with a plan of work for key individuals and the group to ensure that the documents are contemporaneous and ratified. The group monitor a cycle of audit of relevant clinical guidance, ensuring where appropriate, a guideline is audited 3 yearly.

The Guidelines Midwife and the Antenatal Triage and Support Midwife are responsible for joint co-ordination of a planned review and distribution cycle of maternity guidelines for practice. The Lead Midwife for Inpatient Services and Lead Obstetrician are responsible for a planned cycle of review and distribution for Labour Ward Protocols.

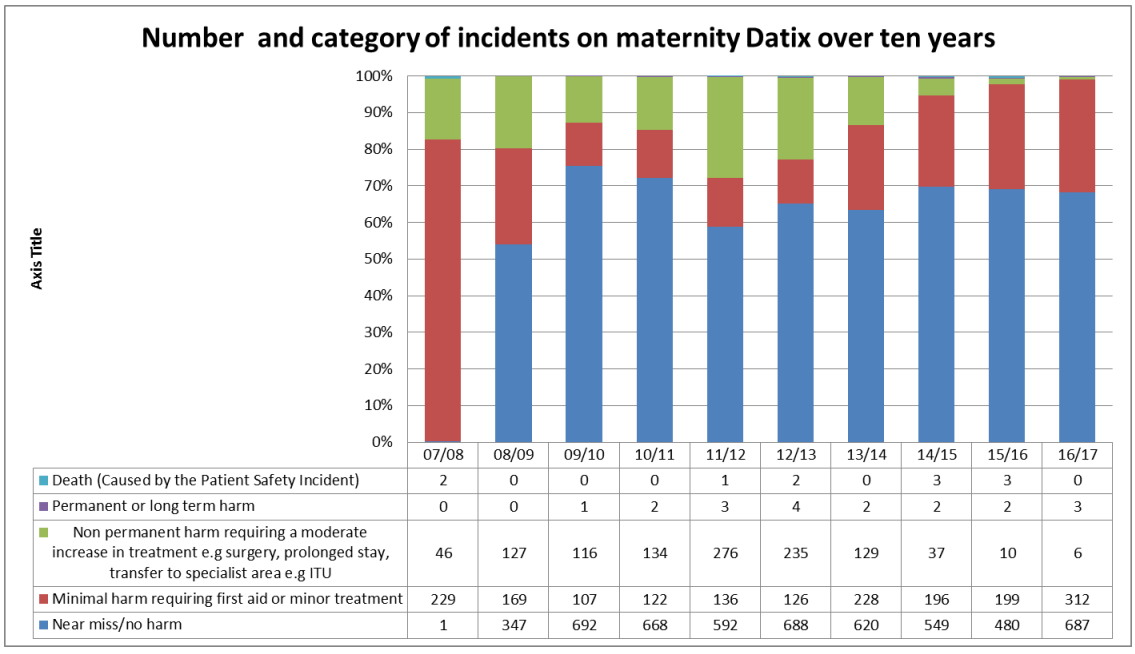
The Trust is corporately informed of guidelines that are developed within the Care Group. Once developed, the guideline is distributed as widely as possible using various methods, and sits on the intranet document library list and available to all staff. The comprehensive range of 155 guidelines that are in place to help inform clinical practice and promote patient safety is available at appendix 2.[3]

[3] Appendix 2 - Policies ,procedures and guideline have been divided into general, ante natal, intrapartum and post natal to reflect the maternity pathway and to understand which documents relate to patient safety at the different stages.

Clinical teams as a natural way of working generate policies and undertake clinical audit activity as a means of directing the standards expected and testing them to see if they are applied in practice. Within maternity this is equally true and as a high risk specialty the processes are embedded historically. Appendix 3 gives a list of policies and appendix 4 a list of clinical audit activity over ten years. For ease both of these lists have been divided into general, antenatal, intrapartum and postnatal elements, to reflect the pathway of care and also to give an impression of how the team are managing risk. It can also be identified from the list of audits that there are some in higher risk categories that are repeated several times, which is good practice and demonstrates the full audit cycle. On average the team are undertaking 28 audits per year, in subjects which are relevant to the services offered.

Pathway section	Guidelines	Audits over ten years
General and process	50	78
Antenatal	46	56
Intrapartum	37	109
Postnatal	18	41

Table 6. Numbers of Clinical Policies and Guidelines in place and the numbers of audits undertaken over the ten year period of this review.



	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17
Death (Caused by the Patient Safety Incident)	2	0	0	0	1	2	0	3	3	0
Permanent or long term harm	0	0	1	2	3	4	2	2	2	3
Non permanent harm requiring a moderate increase in treatment e.g surgery, prolonged stay, transfer to specialist area e.g ITU	46	127	116	134	276	235	129	37	10	6
Minimal harm requiring first aid or minor treatment	229	169	107	122	136	126	228	196	199	312
Near miss/no harm	1	347	692	668	592	688	620	549	480	687

Graph 2. Categories of incidents reported on Datix over ten years

Annual summary data of graph 2 is given in table 7. Incident reporting occurs in two major ways internally on Datix, an electronic system for recording and managing incidents and the following processes. The second way is on a national reporting system called Strategic Executive Information System (StEIS) available to CCGs, NHS Improvement and NHS England. These two mechanisms are not aligned with one another with the result that there is a varied level of understanding about the number of incidents both internal to SaTH and the external world of the NHS.

Year	No of incidents
2007/08	948
2008/09	880
2009/10	919
2010/11	1067
2011/12	1009
2012/13	1055
2013/14	979
2014/15	787
2015/16	694
2016/17	1008

Table 7. Numbers of incidents recorded on Datix by year

6. SAFETY IMPROVEMENT PLAN

Safety of maternity services for women is addressed via a number of initiatives and policy directions. 'Spotlight on Maternity', contributing to the Government's national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030 (NHSE, March 2016) takes the learning from a number of sources and in the *'fresh spirit of openness, improved learning, greater transparency and a renewed focus on working together'* aims to make long term significant changes and improvements to prevent deaths in maternity services; for mothers, and their babies. The response of SaTH, following the national methodology was to create a bespoke plan with actions which will make a real difference to mothers and their babies.

The national ambition in summary is

> *"to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030, with a 20% reduction by 2020."* (NHSE, March 2016)

The reasons for this initiative are in a large part due to the numbers of deaths over recent years across the country and the slow progress being made to reduce these numbers in comparison to other high income nations. The second factor is that variation in death rates across England cannot be fully explained by exploring known risk factors. There is however, evidence to demonstrate that focused effort or a 'spotlight' on a pathway of care like maternity can have a positive impact, (NHSE March 2016).

There are five areas of focus

1. Focus on leadership: create strong leadership for maternity systems at every level.
2. Focus on learning and best practice: identify and share best practice, and learn from investigations.
3. Focus on teams: prioritise and invest in the capability and skills of the maternity workforce and promote effective multi-professional team working.
4. Focus on data: improve data collection and linkages between maternity and other clinical data sets, to enable benchmarking and drive a continuous focus on prevention and quality.
5. Focus on innovation: create space for accelerated improvement and innovation at local level.

National reports into still births and deaths in infancy have described suboptimal care in 75% of all intrapartum related deaths. This is often the result of failure by clinical staff to recognise a problem and take the consequent actions. How members of the multidisciplinary team relate to one another and communicate is often at the root of the problem, RCOG et al (2007) pp3. The RCOG go on to describe (ibid, pp12) how maternity units need to respond when incidents do happen using recognised root cause analysis tools and methods. Staff need to be trained in the use of these tools in order to create the best opportunity to learn and have a risk management policy which identifies triggers and indicators to help guide them. Finally to test out how these mechanisms work there should be audit undertaken on subjects that will help the staff understand more fully their role in patent safety related to emergency caesarean section, and neonatal indicators, such as delayed or failed resuscitation.

The test of the patient safety plan at SaTH is whether it addresses the right matters and whether there has been any progress with implementation. Within the service there have been a number of plans to improve patient safety; they range from one which is very specific following an incident through to a wider ranging plan signed up to as part of the national sign up to safety initiative in Maternity. It would be a fair assessment to suggest that staff have become overwhelmed by the number of different plans that exist. One patient safety plan should exist which concentrates on key areas of risk, and with a robust engagement plan to galvanise the whole of the maternity and obstetric team. This would be the one plan that all staff should be able to talk about and know what they are doing to help improve patient safety. In general terms when incidents occur they will happen as a result of known areas of risk, with some exceptions. When this happens the safety plan will need testing to ensure that it is driving the right improvement and not merely re-doing the same things. To achieve this, root cause analysis (RCA) has to be robust, and involve a cause and effect analysis of behaviours and reasons using recognised tools such as those described by the National Patient Safety Agency e.g. five why? or fishbone diagram or other methods designed to elicit a deeper understanding. This latter stage is the most important in terms of finding the learning that could drive improvement.

True learning

There are a number of reasons for incident reporting, the first is to recognise the problem, the second is to catalogue the event, the third is to stimulate investigation. Most systems in the NHS capture these elements well. The penultimate reason is about learning, which can be at a number of levels from individual to pan-organisational; the final reason is to prevent the risk of recurrence. The timeliness of every stage is crucial if learning is to make a true difference, with this we have to consider the notion of communication and dissemination of information and how best to do this for maximum effect, this will vary depending the specific nature of individual incidents. Describing the changes and improvements required and placing them into a plan however is not sufficient, there needs to be a test of whether the plan has made any difference, which is where the subject matter of an annual plan of clinical audit should keep a focus.

The definition of what learning is important should be a multidisciplinary activity and occasionally will require peer review to add in a layer of challenge to any localised assumptions and draws upon a wider sphere of professionalism and experience. This co-production model can and should engage with patients as a test of whether the actions prescribed are fitting for the incident; this isn't about the patient being the expert on maternity, but by being an expert in the receipt of care and treatment. Some organisations have invited patients to return to the service to be part of the team to help test out the impact after a period of change has taken place, some patients want a follow-up conversation for professional staff to check out with the patient that they are satisfied that we have taken their concern seriously. In all circumstances it should be the wish of professional staff to do the right thing by the individual patient and not a one approach to fit all.

Actions in a safety plan need to be behaviourally stated, putting an expectation on the actions individual staff will take and can demonstrate to staff that they have a part to play. This may seem quite obvious, however time and time again we hear of actions been directed at specific individuals which focuses on correcting performance of that one person, when in reality the subject requires sharing between many others. Specific actions need also to draw upon best practice and an evidence base, and where this doesn't exist then a robust rationale stated.

Prevention is the best medicine

'Sign up to safety' clearly isn't about correcting problems and incidents, but about trying to prevent these from occurring. The nature of the SaTH plan does both, like other maternity services across the England and Wales. By doing so the plan is attempting to pull in the learning from past incidents and to make sense of these in a proactive way to prevent reoccurrence. How we monitor women at the riskiest times is key to preventing negative consequences, the learning about this is plentiful across the NHS inclusive of historical problems at SaTH. There have been notable improvements to CTG monitoring in parts of the NHS where problems existed (Lintern, 2017).

Key learning	SaTH Actions 2017
Central CTG monitoring and review by different staff every hour.	Purchased CTG telemetry and archiving software and hardware which will allow for review of CTG traces remotely whist a woman is in labour. Maternity have installed all the connectivity and servers. Maternity need to make a final decision regarding which monitors to use. Once decided it is planned to be in place by the autumn.
An eight hour e-learning programme with staff given a day off to complete it. **Doctors and midwives are not allowed on the labour ward until they complete the training.**	SaTH have purchased the K2 training tool, recently all doctors have completed it. All doctors will complete as part of their induction in August. All delivery suite midwives are expected to complete it.
Weekly multidisciplinary CTG meetings for staff to discuss cases.	SaTH hold twice weekly MDT meetings to discuss CTGs on Delivery Suite.
Annual mandatory training on CTG that staff must pass.	All staff attend a session on NICE guidance and then sit a test afterwards. K2 are working on a better assessment tool and SaTH are in discussion with them on this.
Replacing four different types of CTG equipment with one single system.	Throughout the Consultant unit SaTH only use the same Huntleigh CTG monitors.
Multidisciplinary simulation training.	SaTH ran a Collective Leadership course around CTG training to look at the Human Factors involved. Also run a monthly MDT training for all skills and this includes CTG drills. SaTH are developing a Maternity training Faculty in which we will have dedicated trainers embarking on a comprehensive training schedule including CTG. All aspects of training including CTG training will be regularly assessed and monitored. The training needs will be driven by risk assessment within the department, in accordance with national guidance.

Table 8. Additional actions undertaken to improve CTGs

At SaTH the maternity team are taking the learning acquired from other parts of the NHS to ensure we are implementing the elements of the plan that made the big improvement and where necessary extending the elements of the plan further. So for example, rather than just employing one midwife to lead training on CTG, SaTH are doing the same but also ensuring that all delivery suite co-ordinators are trained with additional knowledge so that the skill is available 24 hours a day, every day of the year and not simply reliant on one person. Additional actions are included in table 8.

One of the largest areas of error within obstetrics is the misinterpretation of cardiotocographs (CTGs). SaTH have endorsed the use of a regular 'fresh eyes' approach which has been shown to reduce the chance of the tracing being misread by using additional reviewers without disturbing

the woman in labour. In addition, staff have been trained in the use of Dawes-Redman antenatal CTG analysis; and the service is in the process of buying additional machines to support this. The collected activities will improve the insight and accuracy that all of the multidisciplinary team will have in reading and interpreting CTG recordings.

Key safety developments

Over the past eight years maternity services within the Trust have undertaken a number of safety improvement developments to support the delivery of the safest care possible to women and their families within Shropshire. A longer list of improvements is given at appendix 4.

- An enhanced programme for the detection of growth restriction based on the GROW programme was introduced and the Saving Babies Lives care bundle embedded into the maternity safety strategy. The result of this is that the team have greater awareness of risk factors and put in place necessary precautions to safeguard the birth of a baby with growth restriction.

- Between 2009 and 2015 there has been a fall in the UK perinatal mortality rate and following analysis of data; within the Trust in 2009 the rate was above the UK average. By 2012 this had fallen to the national average. By 2015 the perinatal mortality rate has improved since 2009, however is still above the average and requires additional learning and actions to improve further. Since 2016, in line with recent CQC recommendations; maternity services analyses all perinatal deaths using a standardised tool to assess any developing trends. Following the announcement that MBBRACE are to develop a standardised national tool the maternity leads approached the organisation offering help to support the development of the tool and be a test site. Likewise, within the local network we have helped to develop links with other units by developing a system for external scrutiny of perinatal cases where the cause of death is unclear or there is variation in opinion within the service.

- Maternal mortality is both rare and extremely distressing. Over the past few years the department has worked hard on managing maternal sepsis as the leading direct cause of maternal death. All staff have received specific training in the recognition and treatment of sepsis alongside the use of a trigger symbol to denote the commencement of the golden hour for treatment. It is expected that this early intervention of sepsis will reduce the problems that very few women suffer completely. In most recent MBRRACE report cardiac disease is now the leading cause of maternal death.

- Maternity services successfully bid for and joined wave 2 of the National Maternal and Neonatal Health Safety Collaborative. This looks to be a comprehensive initiative that will allow maternity services to work in partnership through 2017 with other similar Trusts in order to improve patient safety and learn together.

- In 2015/6, maternity services ran a series of workshops, in conjunction with BPP University, for all levels of staff within the unit. The workshops aimed to improve collective leadership

across the department with the introduction of a 'safety pause' in which members of the team were asked to speak out if they had concerns regarding safety. The staff members were also given instruction on enhanced communication and human factors and how they can impact upon safety. Since the workshops we have worked with BPP to evaluate the impact by analysing complaints. This found that the number of instances where communication was cited as an issue has reduced from 57 in 2013/14 to 27 in 2015/16 – a reduction of 53%. A significant reduction was also noted in the level of complaints regarding the attitude of staff – a reduction of 50% compared to 2013/14. As a result of this improvement the service are planning to extend the training using part of the recent funding received from Health Education England as part of the NHS Improvement Collaborative.

• Since moving to PRH, the maternity department has developed a new maternity triage system. The unit was one of 3 units in the West Midlands to trial the newly developed Birmingham Symptom Specific Obstetric Triage system (BSOTS). The trial was conducted within NIHR and results are to be published in the near future. The department was able to successfully replicate the system and the team was highly commended by the trial team from Birmingham for its successful implementation. The impact of this is to have a co-ordinated and comprehensive risk assessment of women in the antenatal phase when they are worrying about a variety of symptoms such as reduced fetal movements. This will help identify problems at the earliest possible time and for relevant treatment plans to be put in place.

• The maternity unit always works very closely with the neonatal department, particularly around patient safety. After the death of a baby at one of the MLUs a stabilisation course was developed (MIST course). This course, based upon a similar course in Scotland is the first in England. The whole day course is run in conjunction with West Midlands Ambulance Service (WMAS) and West Midlands Neonatal Transport Service (WMNTS) and is structured as a life support course with a mixture of lectures, skills stations and scenarios. All community midwives attend every 4 years in addition to undertaking the UK NLS Resuscitation Course. Each course also has four paramedics in attendance, mostly from WMAS but now also from Powys along with midwives from Powys. The neonatal department has been among the first in the West Midlands to commence neonatal simulation training using electronic manikins (purchased with charitable donations) in a purpose built simulation room. The feedback from the course has been excellent and the course has been presented at the British Association of Perinatal Medicine.

• Along with developments in neonatal training there has been a significant investment in equipment in order to ensure that each MLU across the county has the same equipment as each other and the Consultant Unit, such as resuscitaires, transfer pods, resuscitation kits, stabilisation kits, and transfer kits. Charitable bids in 2016 enabled the purchase of portable saturation devices specifically for neonatal use to be available for transportation; which are unavailable for many similar units across the country.

- As part of the Trust Friends and Family test, maternity services continues to record a high level of service user respondents (February 2017 - 98.8%) that state that they are likely or extremely likely to recommend the service/care they received.

7. CONCLUSION

There are multiple markers in the NHS that have to work cohesively to be able to demonstrate that a service is safe. These will include behaviours, knowledge and insight of professional staff, having the right equipment and numbers of staff and all this needs to operate in a framework of an evidence base. A wide range of data and information has been explored along with how this measures up to NHS policy, professional guidelines and other evidence sources to find answers to key questions.

What is very evident from the work undertaken is that there is a high degree of energy to provide safe maternity services from a dedicated team, the comment about good people come to work to do good things is very genuine. The vast majority of women who use the service have told us how much they appreciate what is done with them and for them. Despite recognised and real critique of the service, and critique of colleagues who were part of the maternity team, the staff are showing professional resilience, but with some degree of wear and tear. Staff talk about historical cases where babies or mothers have died, and are genuinely distressed when things go wrong.

In the terms of reference to this piece of work a number of questions were posed one of the key questions is; how we are measuring and know if our service is safe? and, what we are doing now about patient safety? Throughout the report there has been an attempt to find supporting evidence both from literature, professional guidelines and NHS policy and to test how this is applied in the real life setting at SaTH. What is very clear is that there has been a huge amount of work undertaken to improve patient safety, and to maintain systems of safety. Like many parts of the NHS, SaTH used data rather than considering the actions and behaviours necessary to learn from mistakes. Notwithstanding the importance of systems of governance, (of which there is critique and room to be more transparency and engagement, both of staff and patients), the capture and analysis of incidents also requires further work, to be less descriptive and more analytical of root causes and to seek out true learning.

Leadership plays a great part of running the service on a day-to-day basis, and also the focus and drive to improve. There has been a change to leadership which is seen as a good thing, however the team are unpicking many years of management which, historically had tighter controls than contemporary leadership theory would promote. The cultural journey that the whole of the maternity team will need to undertake is the thing that is quite likely to be very testing for individual members and will need a high level of coaching and support. On this particular matter the board has aspirations to learn and promote a culture of leadership and accountability. A trust wide 'Values in Practice'(VIP) agreement is being put in place, very much focused on getting

a commitment to the trusts values and leadership programme building on the success in these areas over the last 18 months.

The effort around safety planning, be that about individual incidents or about the wider 'sign up to safety' plan need better co-ordination, the expression 'grip, focus and pace' are apt. Few staff know about all the action plans that are in place. There should be a drive to put all patient safety actions into one plan against a framework that makes sense to the staff who run the service. Staff should be able to talk about what they are personally involved with in regard to patient safety with great ease; it's not always about correcting the past and is future focused on preventing problems. There has to be affirmative action to create a coordinated approach to the maternity safety improvement plan together with engagement of the multidisciplinary team in conjunction with service users in its implementation.

Learning is the key to improving, if we don't analyse effectively, we don't find out about the things that really need to change. Consideration needs to be given to the tools used to achieve this and a better description of behavioural changes required across the service to effect change. The potential is there in the team, they are good people, support, encouragement, coaching, and direction focused on what is important will help the team to do the right things to make the biggest difference to ensure that maternity services at SaTH is the safest and kindest.

Based on an assessment of the SaTH against the range of safety markers it would be fair to conclude that safety in maternity is protected by the efforts of the staff and supported by leaders. There are areas of work to develop safety further including actions to deepen learning from errors, and to continue the journey of becoming more open and transparent. The final action is to create a coordinated approach to the maternity safety improvement plan and engagement of the multidisciplinary team in conjunction with service users in its implementation.

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RECOMMENDATIONS

	Recommended Actions
1.	To share and publish the report, within the maternity service, with commissioners and local stakeholders.
2.	Triangulate the findings of the report with those of the Secretary of State review being undertaken by NHS Improvement, and also the commissioned review by the Royal College of Obstetricians and Gynaecologists.
3.	Pull together one safety plan and ensure that all staff in maternity has access to it, and understand their role in implementing preventative as well as reactive safety arrangements. The plan should draw from the Trust's 'sign up to safety' model and pull actions from clinical incidents into one comprehensive plan.
4.	Ensure that the governance arrangements in maternity are more transparent and open, engaging staff from across the service, and encouraging staff to own incidents and complaints rather than funnelling everything to a small dedicated team.
5.	Explore better ways of learning from incidents and errors, analysing the root cause of incidents using national tools in order to promote deeper learning and identification of actions that will make a difference to patent safety and prevent harm.
6.	Consider better ways of engaging peers from neighbouring trusts to help with detailed review of incidents and identification of learning.
7.	Ensure that there is a way of identifying clinical audit activity against the key areas of risk within the service
8.	Strengthen the review process for guidelines and protocols is sufficiently forward-looking to prevent policies and guidelines from going beyond their review dates
9.	Improve staff engagement, involvement and leadership across maternity services equipping staff with contemporary tools and techniques to promote an empowered staff group who are competent in critical risk management, decision making and deeper levels of learning about what is crucial for individual patient needs
10.	Care Group Leaders to engage in phase one of the leadership academy to understand Multidisciplinary leadership development, from an organisational perspective to making a difference with individual team members, involving and empowering staff
11.	Investigate individual stillbirths and neonatal deaths using a standardised process, advocating for families, involving patients and using an independent multidisciplinary peer review mechanism
12.	Take learning from other parts of the NHS to promote learning from good practice and engage staff to report positive excellence in a similar way to reporting incidents and errors.

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Appendix 1 - **Terms of reference**

Safety of Maternity services 2001 – 2017

This document sets out the terms of reference for a review of maternity services between 2007 and 2017 with the aim of describing the quality and safety of the service offered to expectant women and newly born infants.

Background

The maternity service at Shrewsbury and Telford Hospital NHS Trust has been the focus of much public attention because of concerns raised about the perinatal mortality rate and the specific concerns of newly bereaved parents over a period of years. There have been seventeen reviews undertaken of elements of those concerns, most notably about individual midwives who have been involved in cases. A key question for the board and the public is about the safety of the service, and whether the organisation and the staff who people the service have learned from the mistakes or problems of the past. Finally there are repeated questions about whether the learning has been translated into improvements in the safety and quality of service delivery to women and newly born infants.

Purpose

The purpose of this review is to describe the journey that the maternity service has been on in terms of quality and safety over the decade from 2007 to 2017. The review will demonstrate how conclusions are drawn, whether appropriate learning has been driven into the service and whether there are any gaps remaining in practice, governance and accountability.

Scope

- Conduct interviews with key personnel to establish facts and sources of evidence-based data
- Source relevant records and documents to inform the review
- Produce a final report of findings and advisory recommendations

Out of Scope

This review will not overlap or duplicate the work being undertaken in the two reviews taking place concurrently; the first is commissioned by the Secretary of State for Health to review the serious incidents that have occurred between 2000 and 2017 in maternity. The second has been commissioned by the Trust to explore current practice in obstetrics and maternity.

Objectives

For each of the objectives this view would describe:

- the current state of play supported by data and where possible benchmarked
- the 10 years leading up to today's position
- key learning from that journey and remaining areas for improvement.

Describe the safety of the Trust's maternity services over the defined time period

Assess the Trusts clinical governance and assurance practice in relation to maternity

Define the framework of accountability and how this has changed and developed, making suggestions about adding strength to the current framework if necessary

Key deliverable

- Produce a descriptive report with recommendations
- Develop standards by which the board hold the organisation to account and publish them in the website
- Set all in the context of an objective of being top quartile for safety
- To advise an assurance framework for quality and safety, which may be transferrable to the rest of the organisation

Methodology

Explore normal procedures and processes over time

Explore incidents and key learning and actions taken, and evidence of assurance and continuity, identify any gaps

Explore standards of decision making, models of empowerment

Explore how women (partners/husbands) are involved in key decisions

Review key documents about the nature of the service

Interview key personnel in order to build a common organisational understanding and history

Timescales

Who	What	When
Email to stakeholders	Draft terms of reference to approval stakeholders	10th May 2017
Executive team meeting	Inform the Executive team about the scope of the work	10th May 2017
Care group Management Team	Formally inform the care Group about the scope of the work	10th May 2017
Quality and Safety Committee	Terms of reference for information	17th May 2017
Executive team meeting	Update on progress	14th June 2017
Quality and Safety Committee	Penultimate draft report	21st June 2017
Stakeholder Event	Q&S committee to host an event with stakeholders to discuss the report findings	27th June 2017
Trust Board	To receive advisory recommendations	29th June 2017

Appendix 2. **Guidelines Used to Direct Care and Patient Safety in Maternity**

GENERAL MATERNITY POLICIES, PROCEDURES & GUIDELINE		
Anaphylactic reaction - maternity		**Obsteric Anaesthetic High Risk Clinic Referral SOP**
Booking for Maternity Care (inc Referral for Care)		On-call for Clinical Midwifery
Concealed Pregnancy - (includes management for women who are booked elsewhere)		Operational Policiy for Actue Maternity Services
Confirming a Viable Pregnancy with Coil In Situ		Operational Policy for Antenatal Ward and Obstetric Triage Area (Mat003)
Escalation of Maternity Services (Mat042)		Operational Policy for Bridgnorth Midwife Led Unit (Mat008)
Ex-utero Exception Reporting		Operational Policy for Delivery Suite
Fetal Loss		Operational Policy for Ludlow Midwife Led Unit (Mat009)
Feticide - Role of the US Sonographer		Operational Policy for Oswestry Midwife Led Unit (Mat010)
Feticide - The role of the midwife sonographer in assisting with feticide		Operational Policy for Postnatal Ward on Consultant Unit
Feto-Maternal Specialist Consultant Ultrasound Scan Referral		Operational Policy for Shrewsbury Midwife Led Unit (Mat007)
Guideline Development Framework - Maternity		Operational Policy for Wrekin Midwife Led Unit (Mat006)
High Risk Results		Patient Information Framework (Maternity) - Writing, approving, archiving and disseminating
HIV infection in pregnancy		Staffing arrangements for MLU's during transfer of mother or baby
Internal Rotation Update SOP (Maternity Management)		Standard operating procedures for intraoperative cell salvage in obstetric surgery (TX008)
Investigating Incidents (SOP)		Strategy for Staffing Levels - Midwifery and Support Staff
Labour Ward Staffing Strategy		Strategy for Staffing Levels - Obstetric Anaesthetists and their Assistants
Maternity Information System		Strategy for Staffing Levels – Obstetricians
Maternity Notes - SOP		Surrogacy
Maternity Records		Teenage Pregnancy
MDT Referral Pathway (Women's Services)		Telephone Contact Sheet, Maternity - Standard Operating Procedure
MRSA management in maternity		Transfer of a Woman in Antenatal, Intrapartum & Postnatal Period
Multiple Pregnancy & Birth		Unplanned Downtime (Maternity Information Systems)
Obesity - Management of Pregnant Women with a Raised BMI at Initial Consultation		Venous Thromboembolism (maternity)
Obs & Gynae General Surgery - Risk of Bowel Injury SOP		Viable Pregnancy Management
Monitoring/Audit Procedure - Women and Children's Care Group		Vitamin K administration

ANTE NATAL POLICES, PROCEDURES & GUIDELINES		
Amniocentesis - Role of the Midwife Sonographer Assisting the Fetal Medicine Specialist		**Hypertensive Disorders of Pregnancy in the Antepartum, Intrapartum and Postnatal Period**
Antenatal Fetal Monitoring		Latent phase of labour
Antenatal Inpatient Care		Management of Intrahepatic Cholestasis of Pregnancy (ICP) (including pruritus) SOP
Antenatal Screening for Down's, Edward's and Patau's Syndrome		Macrosomia - management of suspected fetal macrosomia
Antenatal Screening for Sickle Cell and Thalassaemia (Haemoglobinopathies)		Management of Genital Herpes in Pregnancy
AntePartum Haemorrhage Management		Management of patients using an insulin pump (CSII) in pregnancy
Anti D Prophylaxis in Early Pregnancy		Maternity Ultrasound Department Management of Fetal Death in utero SOP
Cardiac Disease in Pregnancy		Mental Health – Antenatal and Postnatal
Care of Women in Labour on Consultant Unit		Obstetric Cholestasis and Associated Liver Disorders in Pregnancy
Chicken Pox and Shingles in Pregnancy		Place of Birth or Mode of Delivery against Professional Advice
Chorionic Villus Sampling - Role of the Midwife Sonographer Assisting the Fetal Medicine Specialist		PPROM - Preterm Pre-Labour Rupture of Membranes
Clinical Risk Assessment (Antenatal)		Pre-eclampsia - severe
Colostrum - antenatal collection & storage of colostrum for babies who have the potential to have feeding difficulties		Reduced Fetal Movements
Dating Scan/Nuchal Translucency Screening		Routine 18+0 - 20+6 weeks Fetal Anomaly Scan
Diabetes - Gestational Diabetes - screening		Rubella - Antenatal Screening
Diabetes - Pre existing and Gestational (care in antenatal, intrapartum, postnatal period)		Screening - antenatal (maternal) including processing of test results
Early Warning Score - Early Recognition of the Severely Ill Woman (MEWS)		Sepsis - Related to the Antenatal, Intrapartum and Postnatal Period.
Eclampsia Management		Smoking in Pregnancy and the Postnatal Period
ED Management of PV Bleeding or Abdominal Pain in Early Pregnancy		Substance misuse in women during their pregnancy
Group B Strep - Prevention of Early Onset (Maternity)		Suspected Placenta Praevia & Suspected Placenta Praevia Accreta (131)
Hyperemesis Gravidarum & Nausea and Vomiting in Pregnancy		Syphilis - antenatal screening
Ultrasound Management of Multiple Pregnancy		Third Trimester Ultrasound Scan Referral

INTRAPARTUM POLICES, PROCEDURES & GUIDELINES

Care of Women in Labour on Consultant Unit		Maternal Collapse
Breech Presentation		Maternal Death
Brow Presentation - Standard Operating Procedure		Maternal Transfers from Wrekin MLU to Consultant Unit
Caesarean Section - Emergency		Meconium Liquor at Delivery
Cord Prolapse		Obstetric & peri-partum referral - emergency department
Difficult Airways Management in the Obstetric Patient (previously "Failed Intubation")		Operative Vaginal Delivery
Elective Caesarean Section. (Including Booking process, risk assessment and SOP)		Perinatal Palliative Care
Epidurals - Caring for women in labour with patient controlled epidural analgesia (PCEAs)		Perineal Trauma
Face Presentation- In Labour (Standard Operating Procedure)		Perineal Trauma - Management of 3rd & 4th Degree Tears
Fetal Blood Sampling		Placenta - Standard Operating Procedure
Fetal Bradycardia in Pregnancy		Pre-Term Labour - Diagnosis and Management
Fetal Heart - Auscultation of the Fetal Heart inc Irregular heart rate SOP		PROM - Prelabour Rupture of Membranes at Term
Fetal Heart - Electronic Fetal Monitoring - continuous		Resuscitaton of the Newborn on Delivery Suite
Home Birth SOP		Retained Placenta Management
Induction of Labour		Shoulder Dystocia
Inflatable birth pool SOP		SOTS: Symptom Specific Obstetric Triage System
Intrapartum Care on MLU or Home Birth		Upper Limb Birth Trauma (inc. Brachial Plexus Injury)
Vitamin K in the Newborn		VBAC - Vaginal Birth After Caesarean Section
Waterbirth - Use of Pool for Labour & Birth		

POST NATAL POLICES, PROCEDURES & GUIDELINES
Anti-D for Rh-D negative women (maternity)
Bladder Care - Postnatal Management
Cleaning Breastmilk Expressing Equipment SOP
Consultant Postnatal Transfer to MLUs
Dealing with the death of a baby
Group B Streptococcal Disease-Management. - Babies Born to Women with Risk Factors
Management of Urological Injury - Obstetric and Gynaecological Surgery
Perineal Trauma Clinic SOP
Postnatal Care
Postnatal Pre-eclampsia Clinic (referral and management)
Postpartum Obstetric Haemorrhage Management
Recognising & Stabilising the Sick Newborn in Midwifery Led Units (MLU) & attended Home Births
SOP Preterm Thermoregulation on Delivery Suite
SOP Procedure for Cleaning Incubator
SOP Procedure for Cleaning Respiratory Breathing Devices
SOP Procedure for General Cleaning of Equipment (Monitors, phototherapy lamps, milk warmers breast pumps, intravenous pump stands)
SOP Using Expressed Breast Milk for Oral Mouth Care
Transport Arrangements for the Movement of a Sick Newborn into Hospital from Home or a Midwife Led Unit

Appendix 3 **Clinical Audit Programme**

Antenatal Audits
Venous Thromboembolism
Pre-existing Diabetes
Obesity
Clinical Risk Assessment (Antenatal)
Patient information
Maternal Antenatal Screening Tests
Mental Health
Referral when Fetal Abnormality Detected
Clinical Risk Assessment (Antenatal)
Severely Ill Pregnant Women
Severely Ill Pregnancy Women
Correct application of screening guideline - Gestation diabetes
Mental Health
Recording of and plotting of Symphisis Fundal Height
SGA/IUGR
Antenatal observations (inpatient)
Mental Health
Antenatal Maternal and Fetal Observations (Inpatient)
Management of APH
Monitoring of RFM - number of women who did/did not require further action
IOL as a result of reduced fetal movements
Identification and action on the Sepsis pathway
Clinical risk assessment booking and antenatal
Estimated Fetal Weight (re-audit)
Detection and follow up depression during Pregnancy
Pregnancy in women with Epilepsy
Rubella Audit 2006
Obese patient in obstetrics and gynaecology
Teenage Pregnancies
Down Syndrome - 10 year audit
Fetal abnormalities in Shropshire 2006
Rubella audit (Antenatal screening) (re-audit)
Severe hypertension management (pre-eclampsia)
Eclampsia 2008 (re-audit)
Multiple pregnancies management (re-audit)
DOH Risk Assessment audit for VTE - Obs and Gynae
Rubella audit 2009 (Antenatal screening) (re-audit)
CEMACH Obesity in Pregnancy
Puerperal psychosis admissions
Patients having baby with unidentified IUGR at or after 40 wks
Women who decline blood products
Eclampsia 2010

Breech presentation at term
Women with venous thromboembolism in pregnancy and the puerperium
Women's experience of ANC journey
Interhospital transfers in Obs and Gynae (CNST)
Estimated Fetal Weight (re-audit)
National Diabetes in Pregnancy (NPID) Audit
Anaemia in Pregnancy
Hypertension in pregnancy – CG107
Pregnancy (rhesus negative women) - routine anti-D (review) - TAG156
Breech and ECV re-audit
Estimated Fetal Weight (re-audit)
Multiple pregnancy - QS46
Puerperal Psychosis Admissions (Brockington Unit) Re-audit

Intrapartum Audits
Labour Ward staffing
Care of women in labour
Intermittent Auscultation
Continuous Electronic Fetal Monitoring
Fetal Blood Sampling
Use of Oxytocin
Caesarean Section
Induction of Labour
Severely Ill Pregnant Women
High Dependency Care
Vaginal Birth after Caesarean Section
Severe Pre-eclampsia
Eclampsia 2013
Operative Vaginal Delivery
Multiple Pregnancy and Birth
Perineal Trauma 2013
Shoulder Dystocia 2013
Clinical Risk Assessment (Labour)
Handover of Care (Onsite)
Maternal Transfer by Ambulance
Non-Obstetric Emergency Care
Care of women in labour
Intermittent Auscultation
Continuous Electronic Fetal Monitoring
Caesarean Section
Severely Ill Pregnant Women
Vaginal Birth after Caesarean Section
Eclampsia 2014

Operative Vaginal Delivery
Multiple Pregnancy and Birth
Shoulder Dystocia 2014
Maternal Transfer by Ambulance
Severely Ill Pregnant Women
Multiple Pregnancy and Birth
Clinical Risk Assessment (Labour)
SOP - Elective CS
SOP - Membrane sweep
SOP - Fluid balance
SOP - Face and Brow presentation
Shoulder Dystocia
Emergency Caesarean Section
Emergency Caesarean Section
Transfers by Ambulance
Care of women in labour on MLU
Delay in 2nd Stage of Labour
Electronic Fetal Monitoring (Escalation)
Electronic Fetal Monitoring (Maternal pulse/Fetal Heart Rate)
Fetal Blood Sampling
Electronic Fetal Monitoring (CTG Documentation)
Management of breech presentation pathway
LSCS Categorisation and time to delivery
Handover of care - Labour ward
Handover of care - Midwifery
Transfer of care onsite
Transfer of care by ambulance
Shoulder Dystocia
Vaginal birth after Caesarean Section
Multiple pregnancy
Risk assessment on admission to Community services in labour
Perineal repairs - existing practice (re-audit)
3rd and 4th degree tears and postnatal management (re-audit)
Primary Indications for Caesarean Sections
Obstetric Cardiac Arrest
Obese patient in obstetrics and gynaecology
Shoulder dystocia (re-audit)
Pregnancy following 3rd and 4th Degree Tears
Blood transfusions in obstetrics
Use of blood transfusion on labour ward
Intrapartum fetal injuries
Deliveries with sequential instrumentation
Eclampsia 2008 (re-audit)
Shoulder Dystocia (re-audit)
Prophylactic antibiotics in caesarean section (re-audit)
Auscultation of fetal heart and continuous EFM

Perineal Repairs, re-audit of existing practice
VBAC Audit 2009 (interdistrict)
Massive Obstetric Haemorrhage - 2008 (re-audit)
Shoulder dystocia - documentation and outcome
Trial of assisted vaginal delivery
Emergency Caesarean Section
Obstetric haemorrhage
Operative vaginal delivery
Eclampsia 2010
Vaginal Birth After Caesarean Section (CNST)
Shoulder Dystocia (re-audit)
NHSLA Obstetrics Consent 2010 (re-audit)
Fetal Blood Sampling (re-audit) (CNST)
Fetal Blood Sampling
Outcome of trial of instrumental delivery 2011 (interdistrict)
Breech presentation at term
Severe Pre-Eclampsia 2011 (CNST)
Management of 3rd and 4th degree tears 2011 (CNST)
Fetal Blood Sampling (re-audit)
NHSLA Consent Obstetrics RSH Oct-11
Water pool use 2013 (re-audit)
Induction of labour - CG70 (review only, not audit)
Management of retained placenta
Term breech management
Caesarean Section – a 5 year review
Caesarean section : timing of antibiotic administration (NICE CG132)
Management, complications and success rates of patients of previous caesarean section
Breech and ECV re-audit
Caesarean section : maternal request for caesarean section (NICE CG132)
Caesarean section : mother-to-child transmission of HIV (NICE CG132)
Caesarean section : morbidly adherent placenta (NICE CG132)
Estimated Fetal Weight (re-audit)
Use of blood transfusion on labour ward re-audit
Incidence of 3rd-4th degree perineal tears
Induction of labour - CG70

Postnatal Audits
Post Partum Haemorrhage 2013
Newborn Life Support
Admission to Neonatal Unit
Immediate Care of the Newborn
Newborn feeding

Examination of the Newborn
Bladder Care
Support for Parents
Postnatal care
Recovery
Monitoring of Term admissions to Neonatal unit 2013
Monitoring of Stillbirths 2013
Post Partum Haemorrhage 2014
Newborn Life Support
Newborn feeding
Monitoring of Term admissions to Neonatal unit 2014
Monitoring of Stillbirths 2014
SOP - Newborn security
SOP - Neonatal alert
Immediate Care of the Newborn
Postnatal Observations Maternal and Neonatal
Bladder Care
Home births - first postnatal visit
Risk assessment and discharge planning
Massive PPH
Newborn examination
Discharge processes
Stillbirths
Mortality W and C
Term admissions to NNU
Post-Natal pre-eclampsia Clinic at RSH
Puerperal psychosis admissions
Puerperal psychosis admissions
National Maternity Survey 2010
UNICEF Baby Friendly Initiative Stage 3 Accreditation
Primary PPH Audit
MBRACE 2015 (Maternal, Newborn and infant clinical outcome review programme)
National Maternity Survey 2015
Frenulotomy service
Puerperal Psychosis Admissions (Brockington Unit) Re-audit
National Maternity Survey 2017

General and Process Audits
Risk management strategy (Organisation)
Risk management strategy (Leadership)
Staffing levels (Midwifery and Nursing)
Staffing levels (Obstetricians)
Staffing levels (Anaesthetists)

Maternity Records
Incidents complaints and claims
Training Needs Analysis
Skills and Drills
Booking Appointments
Missed Appointments
Risk management strategy (Organisation)
Risk management strategy (Leadership)
Staffing levels (Midwifery and Nursing)
Staffing levels (Obstetricians)
Staffing levels (Anaesthetists)
Labour Ward staffing
Maternity Records
Patient information
Labour Ward staffing
Staff survey - Identification and correct monitoring of Maternal Pulse/Fetal Heart
Telephone contact in the antenatal/intrapartum/postnatal period
Record keeping within Pregnancy Health Records
Estimated Fetal Weight (re-audit)
Severe Maternal Morbidity
Detection and follow up depression during Pregnancy
Pregnancy in women with Epilepsy
Rubella Audit 2006
Obstetric Cardiac Arrest
Obese patient in obstetrics and gynecology
Blood transfusions in obstetrics
Teenage Pregnancies
Down Syndrome - 10 year audit
Fetal abnormalities in Shropshire 2006
Intrapartum fetal injuries
CNST Obstetrics Casenotes (re-audit)
Rubella audit (Antenatal screening) (re-audit)
NHSLA Obstetric Consent 2008 (re-audit)
Drug Misuse in Pregnancy
Prescription Documentation Audit - Obstetrics and Gynaecology (sept 09)
DOH Risk Assessment audit for VTE - Obs and Gynae
Rubella audit 2009 (Antenatal screening) (re-audit)
CEMACH Obesity in Pregnancy
Puerperal psychosis admissions
Obs and Gynae stamp audit (Jan-10)
Patients having baby with unidentified IUGR at or after 40 wks
Prescription Documentation Audit - Obstetrics and Gynaecology (Jan 10)
Use of SSRIs in pregnancy and their effect on the neonate
Women who decline blood products
GMC Number audit

National Maternity Survey 2010
NHSLA Obstetrics Consent 2010 (re-audit)
Women with venous thromboembolism in pregnancy and the puerperium
GMC Number audit - Obstetrics and Gynaecology (Oct-11)
Prescription Documentation Audit - Obstetrics and Gynaecology (Oct-11)
NHSLA Consent Obstetrics RSH Oct-11
Interhospital transfers in Obs and Gynae (CNST)
Prescription Documentation Audit - Obstetrics and Gynaecology (Oct-12)
Stamp audit - Obstetrics and Gynaecology (Oct-12)
NHSLA Casenote Obstetrics 2013
National Maternity Survey 2013
National Diabetes in Pregnancy (NPID) Audit
Preview Trial
Drug Misuse in Pregnancy (re-audit)
Prescription Documentation Audit - Obstetrics and Gynaecology (Oct-13)
Stamp audit - Obstetrics and Gynaecology (Oct-13)
Anaemia in Pregnancy
UNICEF Baby Friendly Initiative Stage 3 Accreditation
Maternity Safeguarding Record Keeping audit
Stamp audit - Obstetrics and Gynaecology (Oct-14)
MBRACE 2015 (Maternal, Newborn and infant clinical outcome review programme)
NHSLA Casenote Obstetrics 2015
Prescription Documentation Audit - Obstetrics and Gynaecology 2015
National Maternity Survey 2015
Drug Misuse in Pregnancy
NHSLA Casenote Obstetrics 2016
Puerpurel Psychosis Admissions (Brockington Unit) Re-audit
National Maternity Survey 2017

Appendix 4 **Key Improvements and Achievements**

- A joint mental health service began for women with mental health issues
- Specialist Midwife post has been funded for improving women's health
- Promotion of normal childbirth - A number of presentations have been written and presented to both internal and external agencies promoting the midwife led units
- Promotion of midwife led units in a variety of settings including the RCM conference 2013 - 2105
- Intrapartum care of a woman on a midwife led unit or home birth guideline developed.
- 2009 (May) Ambulance obstetric emergency procedures, shared with the Trust
- Operational policies for all midwife led units were first developed in 2007, by 2015 Operational policies for all midwife led units and consultant unit services are now updated and visible on the SaTH intranet
- New staff orientation to a midwife led unit proforma developed
- Neonatal Life Support Course (Accredited): Midwives that are working in a midwife led unit on community now undertake this course every four years, in addition to the Neonatal Life Support they currently receive on the mandatory training days
- Annual rotation of midwives - process updated
- Appointment of ward managers
- SBAR transfer form developed
- The maternal and neonatal transfer guidelines have been developed and updated 12 times
- Development of the bereavement service – Specialist Midwife for Bereavement
- Clinical risk assessment guideline revised and updated
- Neonatal Stabilisation Training
- The Midwifery Guidelines continue to be developed and updated in all areas of practice in line with National Guidelines and NICE Quality standards. Guideline midwives work collaboratively with regional obstetric network groups on development of guidelines
- Introduction and promotion sepsis guideline
- The Newborn Early Warning System (NEWS) was developed in 2013 – enhanced observations for at risk babies were introduced
- Maternity Early Warning Score (MEWS) was fully revised in 2014 following recommendations from CNST level 3
- Obstetric skills drills introduced
- Development of triage cards/checklist for midwives to support conversation about breast feeding support and assessment of neonatal health
- Standardised check list for homebirth equipment to also include after the birth booklet and prompt card
- Piloted the Birmingham Symptom Specific Obstetric Triage system (BSOTS)
- Collective Leadership training
- BBP School of Health
- PAUSE training- sign up to safety
- CQC presentation to staff
- Commenced a new Frenulotomy service Jan 2016 by Lactation Consultant Midwife / Specialist Midwife in Infant feeding
- New Tongue Tie Guideline
- Hosted Public Health Study day with Multi-disciplinary stakeholders (Jan 2016)

- Presentation to the Child death overview and Scrutiny Panel (CDOP) February 2016
- Marketing Women and Children's Services to the Oswestry health Forum led by Owen Patterson
- Newborn Stabilisation Training course
- Saving Babies Lives presentation delivered to the CQRM group
- MBRRACE Presentation delivered to CQRM Board April 2016
- CQC Inpatient Survey Presentation delivered to CQRM
- Workshops for staff on
- Reports, Investigations, Inquests – what you need to know- staff workshop
- Baby Friendly visit for full accreditation assessment
- Baby Friendly Full Accreditation Award
- Maternity Survey updated and revised
- Hosted a Royal College of Midwives study day – learning Lessons from Kirkup (April 2016)
- Better Births Hot topic presentation April 2016
- Models of Care Staff Workshop
- Mary Seacole Leadership – Successful scholarship application
- New resuscitation mannequins purchased for all Midwife led Units
- New Hospital model from Community model for Hearing Screening
- New born Stabilization kits for the Midwife led units x 5
- Benchmark of National maternity review
- Training Self Directed Learning package
- Epidural and recovery skills
- Massimo neonatal portable pulse oximeter requested through Walker Trust funds for all MLU's- ordered and Massimo neonatal portable pulse oximeter requested through Walker Trust funds for all MLU's- ordered
- VIP awards – Highly Commended Individual for the Frenulotomy Service
- Care with Confidence Awards 2016 Nomination (Telford and Wrekin CCG)
- End of Life Project Group – Team of the Year SaTH VIP Awards 2016
- Top Triage Manager for implementation of the Birmingham Symptom Specific Obstetric Triage Service BSOTS
- Supervision Model -Action Plan and proposals for Supervision going forward New Model of Supervision to be launched
- New Women and Children's Leadership structure September 2016
- New Head of Midwifery appointed (external appointment)
- New Care Group Director appointed
- RCM accredited 'Tell it Right, Start it Right' Down's Syndrome Association study day
- GAP training - Perinatal Institute
- Commencement of K2 CTG training package
- Gifts of Remembrance
- Bereavement photography course funded by 4louis, organised and hosted by SaTH
- Safeguarding Supervision Training undertaken x 10 Midwives
- Midwifery Rotation SOP
- Implementation of RED FLAG events and updating of guideline
- Consultant Unit Paper (part of models of care)
- Improving Maternity Services Paper (updated and rebranded)
- Better Birth early adopters proposal
- Thematic Analysis of SI's fed back to Commissioners and very well received

- Launched the Exemplar Ward Programme Nov 2016 –pilot sight
- Maternity Safety Training Bid (successful in the bid - £60k of maternity safety training funding awarded to Trust - HEE)
- Maternity Improvement Plan (patient specific) – in conjunction with patient and with oversight by the Trust Board and DON
- Better Births Conference - chaired by Baroness Cumberlege – February 2017
- Birthrights Training – February 2017
- Safety Improvement Plan (developed – will be published when approved by Trust)
- Sign up to Safety Funding
- Saving Babies Lives Care Bundle
- Delloite Governance Processes Audit
- Caring for You Campaign – RCM
- Escalation Policy reviewed and updated
- Standardised Clinical Outcome Reviews (SCOR)
- Water birth Study day (Sept 2017) run by Diane Garland
- Public Health Midwife – new post – recently appointed
- Birthrate Plus full review of workforce – results due April 2017