FINAL REPORT

March 31 2010
Amended June 30 2010
Amended August 6 2010

Review of Maternity Services in University Hospitals of Morecambe Bay NHS Trust

Professor Dame Pauline Fielding DBE, Yana Richens, Professor Andrew Calder
1. INTRODUCTION

This review of maternity services was commissioned by the Chief Executive with the support of the trust board following five unconnected serious untoward incidents (SUIs) at Furness General Hospital (FGH) during 2008. It was not the purpose of the review to reinvestigate these incidents. The most high profile (referred to as Baby T) was the subject of legal proceedings concluded some time ago. Professional midwifery proceedings are still ongoing with the Nurses and Midwives Council. The Baby T incident concerned the death of a baby from septicaemia 9 days after birth. The other incidents consisted of a stillbirth associated with shoulder dystocia, two maternal deaths and death of a woman resulting from complications of laparoscopy. The trust and Local Supervisory Authority (LSA) investigations had already reported and this review was aimed at determining the direction of further improvement of the service.

2. EXECUTIVE SUMMARY

The review team recognised that recent adverse clinical events, whilst unconnected, at FGH had had a profound negative impact on staff morale both in Barrow and across the trust. The apparent ‘cluster’ of these episodes appeared to the review team to have been coincidental rather than evidence of serious dysfunction. That said, the need to improve several aspects of the maternity service, already acknowledged in external and internal investigations, should be seen as a positive opportunity for constructive developments.

We found that the trust has made considerable progress in addressing the issues which were highlighted as a result of the SUIs. Maternity services within a newly formed Family Services Division are in the midst of much change. The financial circumstances of the trust mean that all services must be economical as well as safe and effective. A clinical governance structure within the Family Services Division is needed which will give due emphasis to all aspects and not just risk management. The Birthrate Plus report will need to be interpreted and implemented in the light of more clinical and cost effective ways of providing services. Key to all these endeavours is a requirement for staff of all disciplines to co-operate in working
together harmoniously and for management and staff to develop a greater degree of trust in their relationship. In particular the need to devote careful and detailed attention to matters including the structure of all categories of staffing, recruitment and training and, most importantly, leadership, should be seen as paramount. The arrangements for clinical governance should be seen as a particular priority and efforts should continue to improve the day to day interaction of staff with the object of imbuing a spirit of common purpose and pride in the service.

Specific attention should be directed to those disadvantaged sections of the community who would benefit from specially tailored care provision. Other issues deserving of attention include the best use of precious resources and the physical environments in which the service will in future be delivered.

3. TERMS OF REFERENCE

The following terms of reference were agreed with the trust:

- To provide further assurance that the trust has addressed any issues highlighted by its review of maternal and infant deaths in the areas relating to patient safety, patient experience, clinical effectiveness and team working and that it has robust practices, procedures, management and leadership in place to ensure good outcomes for patients accessing its maternity services.
- To review current practice, procedures and management in respect of the key areas through to board level with a view to recommending actions which will improve the service to the best standard possible.
- To review cross bay practice in respect of the key areas with a view to ensuring that there are common standards and procedures in place.
- To consider and review any other relevant matters that may arise from the above stages.
- To provide expert advice on the Family Services’ Division’s proposals and governance arrangements associated with new models of care for the future.
4. ARRANGEMENTS FOR THE REVIEW
The review team comprised of two clinical experts – a consultant midwife and consultant obstetrician and gynaecologist – led by a health service manager. Biographies of the team members can be seen in Appendix 1.
The team conducted 30 formal interviews with 44 members of staff. Interviews were also conducted with the LSA officer for the Strategic Health Authority and with a non-executive director of the trust. Informal discussions were held with a number of staff whilst visiting the three sites as well as with five users of the service. Site visits were undertaken at all three sites. Numerous documents were requested and consulted – these can be seen in Appendix 2.

5. FINDINGS
All recommendations are highlighted in bold throughout the text.

The Maternity Service
Maternity care is provided across the trust area of responsibility in three hospital settings which provide inpatient maternity care. The largest of these is in Lancaster (RLI) with a smaller specialist unit in Barrow in Furness (FGH) as well as a midwifery led unit in Kendal (Helme Chase). The first of these might be regarded as the most conventional being comparable to many middle sized specialist units up and down the country. Nevertheless, the RLI unit experiences problems of staffing and has a relatively low rate of incident reporting. Further investigation would be needed to determine if this low rate of reporting is reflective of a low rate of adverse incidents.

The Kendal unit is popular and well supported by the local community. The rate of transfers (to RLI) resulting from antenatal or intrapartum complications is comparatively high and the facility, which has a strong middle class bias, may be seen as something of a luxury with mothers remaining as inpatients for longer than is the norm nowadays (including some who transfer back from RLI after delivery where in most other services they would go home).

The unit in Barrow in Furness (FGH) has been the site of the cluster of a number of adverse outcomes and these have been the subject of much negative publicity in the
local media. The unit serves a community with high rates of social exclusion due to unemployment, poverty, social deprivation, immigration, drug addiction and obesity. The hospital facilities are not entirely fit for purpose, particularly with respect to the labour ward environment and the distance of theatres, and compare unfavourably with others in the trust. The trust is considering how to address this in terms of the wider capital programme. There is a stable cadre of experienced nursing and midwifery staff but, perhaps because of the unit’s geographical location which places it in the most remote and inaccessible corner of the trust’s catchment area, the trust has found it increasingly difficult to attract and appoint high calibre staff of all types. The staff working at FGH have found conditions to be challenging in the last few years.

For these reasons the morale of the staff in the maternity service has been badly affected. Relations between different categories of the staff and between staff and management have suffered within an atmosphere which at times may have embodied a “blame culture”.

Previous Investigations

Internal audit reported on the investigations following the Serious Untoward Incidents in July 2009. Recommendations were followed up in a Sustainability Plan which was requested by the Care Quality Commission (CQC) following the 2007 report into maternity services and which was reported most recently to the CQC in January 2010. This demonstrates that all recommendations have either been implemented or are in the process of being implemented i.e. are ongoing.

However, the review team had some concerns regarding the continuing audit of implementation. During one of the site visits it became apparent that a complaint (which had not been logged in the formal complaint system) concerned the syringe feeding of a baby. This practice had been denounced during a previous investigation and yet had still happened on this occasion.

- All clinical practice issues highlighted as a result of investigations should be built into a continuing audit programme.
Patient Safety

Incident Reporting

All staff interviewed were aware of the system for incident reporting and most had some experience of this. The arrangements for root cause analysis, reporting upwards and feedback to staff were robust and are to be commended. All incidents are fed through to midwifery supervisors in real time so that supervisors are aware of potential problems. Medical and midwifery staff seemed to be well acquainted with the online system and with the arrangements for root cause analysis and feedback.

However, the review team learned that non-supervisory midwifery managers were not always aware of practice requirements of individual midwives if supervisors had chosen not to divulge this information. In one extreme case, this resulted in a manager being unaware of a midwife from another trust working under supervision in the clinical area. There was also a lack of clarity about which issues should be dealt with under supervision and which under management procedures.

- Management and supervisors of midwives must agree on criteria for dealing with staff following incidents.

Low Risk Acceptance Criteria

At Helme Chase, the review team were concerned that the criteria for acceptance were not being followed. This had resulted in some high risk women delivering there at risk to the mother and baby and to the unit’s reputation. The existence of a disclaimer form is worrying suggesting that high risk women are being accepted if they are willing to sign a disclaimer.

- Acceptance criteria for delivery at Helme Chase must be adhered to.
- The use of a disclaimer form should cease.
• The trust should undertake an audit of cases at Helme Chase to understand the circumstances in which the acceptance criteria has not been met. The audit should also examine reasons for transfer.

Staff shortages at Royal Lancaster Infirmary (RLI)

Staffing shortages were mentioned more frequently at RLI than at the other two sites. This concern is also reflected in the LSA Audit (2009). The Birthrate Plus report has identified the required WTEs for the activities of supervision, senior midwifery management, governance and risk, Baby Friendly Initiative, antenatal screening, consultant midwifery, and practice development in addition to clinical care. It has also made some recommendations for adjustments to skill mix to facilitate the recruitment of maternity support workers to undertake some of the clinical care.

• The trust should now identify how to achieve the recommended staffing levels and skill mix within a reasonable timescale.

Provision and Staffing of Theatres at FGH

At FGH midwives and medical staff reported concerns with the provision of theatres. These are at some distance from the labour ward and can result in an undignified journey for the woman in an emergency situation. One possible solution, albeit a temporary expedient, might be to reinstate the room originally intended as a theatre on the labour ward which is currently used by junior doctors. It is appreciated that this area was previously considered less than ideal to serve all the needs of an obstetric theatre and if this view persists then a different solution should be sought.

Elective caesarean sections are carried out on Tuesdays – normally 3 per week. In normal daytime hours, an emergency caesarean section may have to wait until staff are freed up from an orthopaedic list. This has taken as long as 2 hours from decision to delivery on occasions. However, the main concern of staff is with the arrangements for out of hours staffing. There are no dedicated theatre staff in the
evening. There is an anaesthetist on call from home but other staff have to be called in and several telephone calls may have to be made before a team is assembled. During the night two members of staff often have to leave the labour ward to transfer a woman to theatre, leaving the labour ward short staffed. The review team were told of an occasion when staff arrived at theatre with a woman only to find the doors of the theatre locked and no team present. Also at FGH there is no provision of piped Entonox in the labour ward.

Midwifery staff do not have access to a room in which to take their breaks and currently eat lunch and take coffee breaks at the nurses’ station. This creates a poor impression to visitors.

The review team formed the view that short term steps to address these concerns by modification of existing premises could improve matters but that in the longer term a more radical redesign and reprovision of a labour ward/theatre complex should be undertaken.

- The provision of a theatre and piped Entonox for the labour ward at FGH should be reviewed.
- Arrangements should be made for an on call theatre rota.
- Consideration should be given to training maternity care assistants to assist in theatres.
- A solution should be found for the provision of a coffee room for midwifery staff.
Consultant paediatrician cover

The review team learned that whilst there is a paediatric service on both RLI and FGH sites, there are no dedicated sessions for the neonatal units. However, the trust has recently taken a wider multidisciplinary approach to paediatrics which should improve the service across the trust.

- **Consideration should be given to ensuring that an appropriate paediatrician in each of the two specialist units should have dedicated sessions for the neonatal units.**

Patient experience

Systems for gathering information about patient experience are not well developed. However, there are positive moves to talk with mothers in children’s centres – the midwifery strategy aims to increase the use of these centres for community based antenatal and postnatal care. There is a group for teenage mothers in FGH and a Listen to Mother service on each site. The Maternity Services Liaison Committees (led by the Primary Care Trust) are not active but during on-site visits the review team found that mothers generally reported a positive experience of the service. Information for women about supervision is displayed at each site and notice boards provide contact details of supervisors. Even so, it is apparent from the LSA Audit (2009) that women do not always access this information. There is a PALS service on each site.

There appears to be a relatively low number of formal complaints but the review team had some concerns that not all complaints were logged on the formal system and there appeared to be no systematic data collection and hence learning from informal complaints. A new Head of Patient Experience has recently taken up post in the trust.

The roll out of the productive ward project includes a patient survey. Results from this at RLI show great appreciation of the staff with minor comments about the food and lighting.
The midwifery strategy has a theme about listening to patients and several strands of activity which are aimed at improving the patient experience.

- Now that a Head of Patient Experience is in post, the trust should consider how to co-ordinate and formalise systems for measuring the quality of patient experience in maternity services.
- The Head of Patient Experience should work with the Family Services Directorate as a matter of priority.
- Staff should be reminded that all complaints must be logged appropriately.
- The trust should develop a system for encouraging the capture of both formal and informal complaints.

**Clinical Effectiveness**

The review team learned that the process for the development of clinical guidelines or implementation process of national (e.g. NICE guidelines) rests with the maternity risk management committee. However this process appeared to be random, and individuals who were charged with this responsibility were not always clear why they had been nominated to undertake this task. The individual would be given the task to write a clinical guideline. The guidelines are then returned to the risk management group for ratification. There does not appear to any multidisciplinary or multisite involvement in this process. This is leading to a lack of ownership of guidelines. Guidelines are then put online for staff to access and feature in the 6 monthly obstetric updates and in a newsletter. There are paper copies on the wards and designated members of staff are responsible for folder management. There is no document control system in place in the trust.

Certain new processes that have been put into place such as the paediatric alert form and the traffic light systems are definite improvements. However, despite the existence of guidelines, the review team found some evidence of lack of consistency
in both consultant and midwifery practice when it came to using the clinical guidelines and evidence based care pathways. For example, at FGH consultants have different preferences for Clexane regimes during the antenatal and postnatal period. At RLI there is a care pathway for women with mental health problems, however the team were informed that this was not yet available at FGH. It was also reported that observations for meconium stained liquor were not undertaken or recorded at Helme Chase. As this is a sign of fetal distress during labour, in these instances the woman may need to escalate from low to high risk care

- The trust should develop a system for the development and implementation and monitoring of clinical guidelines across all three sites.

- All clinical guidelines/protocols should be applied consistently across the service where appropriate and should be subject to regular audit.

- The trust should implement a system of document control and ensure that guidelines and protocols are regularly reviewed and updated.

Patient records were inspected as part of the review (n=9 at each site). The general impression was that notes are being completed by midwives and dated and signed with a legible signature. This was not always the case for medical staff, notably at FGH. The review team found evidence of medical staff not undertaking ward rounds at the allotted time on labour ward. Several midwives also commented that whilst they had undergone training in the new hand held notes they did not find these easy to complete and that there was no consultation prior to implementation.

- Medical staff should be reminded of the importance of signing notes legibly and timing the entries. The next audit of clinical records should include this item.
The review team have some concern about the use of the Fetal Assessment Unit at FGH. The unit closes at 1600 hours but staff feel that there is more demand between 1700 and 2000 hours. During this time, women attend the Labour Ward which puts additional pressure on staff there.

- **The trust should review the use of the Fetal Assessment service and produce clear guidelines for how the service should operate across the trust.**

Because of the particular challenges which arise in the Barrow in Furness area from what might generally be described as socio-economic problems, there would seem to be a need for antenatal services specifically tailored to the needs of those disadvantaged mothers. Ideally, this would be in the form of a dedicated and geographically accessible antenatal clinic within Barrow itself rather than requiring the mothers to travel to FGH. The review team were told that a new antenatal clinic has recently been established without evidence of established clinical need. This appears to be a poor use of resources when there may be more needy communities to serve. Also because of the issues in Barrow, there would seem to be a need for a public health strategy around some of the factors which impact on maternal health. There are currently no specialist midwives in this area. Currently there are midwives who are working through Sure Start centres and the team witnessed excellent practice with teenage mothers. Staff highlighted that the area had problems with substance misuse and alcohol abuse, although there were no specialist services for this group of high risk women.

- **The provision of community clinics should be reviewed with the aim of directing resources to the neediest areas.**

- **The trust should initiate discussions with the primary care trust to develop a strategy for improving maternal health in Barrow.**
The review team also learned that women at FGH, even though identified as low risk, are registered under consultant care when admitted in labour. The review team were told that the computer system does not allow registering under midwife only care, the consequence of which is to increase the number of women registered under a consultant.

The review team were encouraged to see the development of GURU – an online system to track key clinical indicators. This is now present across the service but not all wards have data population at present. This appears to be a helpful tool which deserves wider publicity.

**Team working**

It was clear from most of our interviews that team working is dysfunctional in some parts of the maternity service. Whilst this is apparent in all professional groups, it is particularly evident in relation to medical staff.

The legacy of the Serious Untoward Incidents has not helped here – the review team heard that relationships between obstetricians and paediatricians at FGH is improving but there is still much more that needs to be done. The consultant obstetricians in the trust did not present as a cohesive group with common aims, agreed approaches to the provision of services and productive ways of working together. They were preoccupied with their own agendas and reported little confidence in the clinical leadership. Interviews and observations in the course of our fieldwork suggested that there was an unhelpful division between consultants working at RLI and that levels of commitment to obstetrics differed amongst those providing both obstetric and gynaecology services.

The review team learned that multidisciplinary ward rounds do not take place on the labour ward at FGH. This is a missed opportunity for the development of strong teamwork which is compounded by the lack of availability of shared space for breaks and teaching.
The review team recognised that there was a challenging set of circumstances in which management still had to establish a common culture, structure and systems within which good practice could flourish across the sites. There was evidence of efforts to address this disunity by making opportunities for staff to meet together but the local geography militates against this. There is scope for a determined effort at FGH to arrange regular and accessible clinical discussion meetings which the obstetric, paediatric, midwifery, nursing and other relevant staff would be able to (and expected to) attend.

There is also a history of poor relationships between midwives and neonatal staff although this was felt to be improving. However, midwives at FGH are concerned that disagreements between paediatricians and obstetricians as to whether high risk women should be transferred prior to delivery increases the pressure on staffing.

The trust has recently introduced some action learning for senior managers and clinicians. This should prove helpful in establishing roles and relationships in the new structure and could be rolled out to some advantage.

The use of maternity care assistants differs across the three sites. At Helme Chase and at FGH, care assistants provide postnatal and community support for women and undertake Guthrie tests. We have some concerns about the support and training for care assistants who provide postnatal care to women in areas of social deprivation such as Barrow.

- **Multidisciplinary ward rounds should be introduced as a matter of priority on labour wards.** This will provide the opportunity for discussion on what has happened overnight, what activity is expected during the day, whether the right staff are available and what can be done if they are not.
• Key staff from clinical teams must be identified and supported to undertake development programmes in clinical leadership. The clinical leads in each unit must put in place regular (weekly) fora for clinical conferences, guideline discussions, perinatal reviews etc and strive to ensure that all types and grades of staff are aware of them, able to attend and encouraged to see them as an essential component of their working week. Such leadership must foster an atmosphere of engagement within which the whole team of staff are able to pull in the same direction towards providing the best possible service.

• The trust should identify and designate shared space for medical and midwifery staff which can be used for breaks and teaching.

• The trust should develop common job descriptions for maternity care assistants.

Clinical Governance

It became apparent during the course of the interviews that there is little understanding of the concept of clinical governance. Staff were, rightly, very focussed on managing risk and arrangements in the division were directed to this end. There was less emphasis on other aspects of clinical governance such as clinical audit, education and training, research and development, clinical effectiveness. Whilst the review team heard of some activity in most of these areas, at mandatory study days and audit days, the divisional structure did not co-ordinate these in a logical manner and staff did not view these as being part of clinical governance. In part, this may be due to the recent history of the division in being part of a larger surgical division but it is something which needs to be addressed in setting up a governance structure for Family Services. The trust at large has a comprehensive committee structure within which clinical governance appears to work effectively. We are concerned that the draft terms of reference for the Family Services Clinical Governance Group show the group receiving a wide range of information, the relevance of some items not being immediately apparent e.g. Oncology Report, Tissue Viability Report. This committee needs to have a very clear focus on the various aspects of clinical governance and seek information which
will enable members to discharge their responsibilities rather than gathering together existing data which does not address the core pillars of clinical governance adequately.

Training opportunities for midwives are seen to be somewhat problematic with training budgets cut and difficulties in releasing midwifery staff for non-statutory training. Maternity care assistants reported good training opportunities and felt well supported in their roles. The current arrangements for postgraduate training and the education of medical undergraduates appear to be very satisfactory and indeed deserve to be commended. Junior medical staff commented that whilst facilities for audit were excellent, they were not encouraged to undertake audits themselves.

Midwives at RLI commented that they would like to undertake training to do the paediatric checks prior to mother and baby being discharged. Currently this is done by junior medical staff but pressure of work means that discharge is often delayed until a doctor is available.

The establishment of the GURU system at ward level is a promising feature of what could be a robust bottom-up clinical governance structure. Also the maternity dashboard will contribute to the data set for clinical governance.

- The clinical governance structure for the new division should ensure that clinical audit, education and training, research and development and clinical effectiveness sit alongside risk management in contributing to clinical governance arrangements.
- Training opportunities for midwives should be reviewed with a view to ensuring appropriate professional development.
- Training for Maternity Support Workers to assist at caesarean sections should be undertaken in order to sustain the flow of emergency services at weekends.
- Information from the GURU system and from the maternity quality dashboard should be allowed to feed into the division’s governance arrangements.
Midwifery Supervision

It was apparent during most of the interviews that there is a lack of common understanding of the role of the Supervisor at all levels of the organisation. This matter has a troubled history in the events which followed the SUI of Baby T but is not entirely related to this incident.

The review team found evidence of inappropriate use of supervisors to manage staffing shortages and no clear guidance on when it would be appropriate to contact a supervisor. It was evident that relationships between midwives and senior managers had been damaged by the fallout from the incident but that this was gradually improving with some trust being restored.

There is currently one supervisor for each site on call out of hours. This seems to be an unnecessary use of resources and encourages inappropriate use of the supervisor of midwives.

- There needs to be clear guidance of what circumstances need a supervisor’s input displayed at ward level.
- A Supervisor of Midwives should not be on call when they are not on duty.
- There should only be one Supervisor of Midwives on call for the trust at any one time.

Management Structure

The change of divisional affiliation from one which combined maternity alongside surgery to a more rational structure for family services should improve matters considerably. It is clear from the minutes of the old divisional structure that surgical
issues predominated in discussions. However, the review team understood that administrative resources to support the new division have not been transferred and this will inevitably delay the new structure from bedding down.

Strong clinical leadership of the new division will be crucial to its success. The review team are of the view that it is highly desirable in succession planning to seek to appoint a new consultant with defined responsibility for leading the service as Associate Medical Director when the current incumbent retires. Such an individual, ideally coming from outwith the trust and therefore free of any RLI/FGH bias, would preferably have a strong obstetric (feto-maternal) profile, something which will complement the existing staffing structure at FGH.

**Future Service Structure**

At the time of this review, the division was still considering its future structure and thoughts of new models of care awaited the Birthrate Plus report on midwifery staffing. However, the review team did discuss the potential shape of future services with a number of staff as follows.

It is clear that the Helme Chase Midwifery led unit provides excellent facilities for both in and out of area women. Staff did express concerns that the unit is periodically under threat due to the relatively low number of births. The review team felt that this unit could offer either a case-loading or a domino (domiciliary in and out) service which would maximise efficiency. These systems are described in Appendix 3. The unit did in the past have a maternity assistant on duty at night but this was discontinued to make savings. This has lead to some resentment amongst the care assistants as the ward is now staffed by two midwives at night with a third on call.

The review team were surprised to learn of postnatal transfers back into Helme Chase from RLI and FGH. This seems a poor use of resources when women, if deemed fit, could be discharged home rather than being transferred for convalescence.
The availability of midwife led care, because of the geography of the service, is really not an option for women in Morecambe. Staff were mindful of this and several midwives expressed the desire for a midwife led unit in RLI.

- The trust should consider the introduction of a Case loading or a Domino service at Helme Chase.
- The trust should reconsider the practice of readmitting women for feeding support and convalescence to Helme Chase.
- The trust should discuss the future model of service across the trust with commissioners in order to clarify how this impacts on maternity services and workforce plans.
APPENDIX 1

Biographies of Review Team Members

Dame Pauline Fielding completed her nurse training at Bury and Fairfield School of Nursing in 1966. She continued with clinical work as a District Nurse in Manchester until the birth of the first of her two children. On returning to work part time, she completed a degree in Psychology at Southampton University and, with a research fellowship from the Department of Health, completed a PhD in 1982. Clinical posts followed as a ward sister and then Director of Clinical Nursing Research at The Middlesex Hospital, London. A move into management ensued with the posts of Nursing Director at Whipps Cross Hospital and then Chief Nurse in Waltham Forest Health Authority. Dame Pauline was the first Nursing Director of Forest Healthcare Trust and subsequently held the post of Nursing Director at what is now known as Lancashire Teaching Hospitals NHS Trust. Since retiring from full time NHS work in 2002 Dame Pauline has been a Clinical Advisor to the Healthcare Commission now the Care Quality Commission and has undertaken a number of investigations and clinical governance reviews. She has also conducted independent reviews for NHS North West and other authorities and has served on a number of national committees. She has acted as an expert witness in a number of cases. Dame Pauline was made a Dame commander of the Order of the British Empire in 1999 for her services to nursing and is an honorary professor at the University of Central Lancashire. Dame Pauline received an honorary doctorate from Southampton University in 2001.

Yana Richens is a Consultant Midwife and supervisor of Midwives at University College Hospital, London. She has a wide range of clinical experience as a nurse and a midwife, both in acute and community settings. Yana was a member of both the Department of Health steering for Making a Difference for midwives in 1999 and the external working group for the maternity module of the National Service Framework in 2004. She is a member of the Chief Nursing Officer’s national advisory group, providing specialist advice on black and ethnic minority issues in the
NHS and was the first midwife to be awarded the prestigious Mary Seacole Fellowship to undertake a study of women of Pakistani origin within UK maternity services. Yana was a member of the NICE guideline development group for the puerperal/perinatal mental health guideline and is currently a member of the guideline for women with complex social problems. She is co-editor of the British Journal of Midwifery and consultant editor of the African Journal of Midwifery. She co-founded the Female Genital Mutilation Clinical Guideline group which has just produced a teaching DVD for midwives and obstetricians on how to perform a deinfibulation. Her current interests are obesity and pregnancy, perineal trauma and access to maternity care for ethnic minority women. She has published extensively and spoken at national and international conferences.

Andrew Alexander Calder was born in Aberdeen, Scotland and was educated at Glasgow Academy and the Glasgow University Medical School. After completing his basic specialist training in Glasgow Teaching Hospitals he was for three years Clinical Research Fellow in the Nuffield Department of Obstetrics and Gynaecology at the University of Oxford. After clinical academic posts at Glasgow Royal Maternity Hospital he was appointed in 1986 to the Chair of Obstetrics and Gynaecology in the University of Edinburgh and Consultant in the Edinburgh Royal Infirmary. He is a former Chairman of The Academy of Royal Colleges and Faculties in Scotland and Vice Dean of the Edinburgh Medical School, and Head of the Division of Reproductive and Developmental Sciences based at the Queen’s Medical Research Institute and the Royal Infirmary of Edinburgh. He is Director of the Jennifer Brown Research Laboratory and Co-Director of the Tommy’s Centre for Maternal and Fetal Health Research. He retired from his clinical chair in July 2009 when he became Honorary Assistant Principal (Reproductive Health) in the University.
Appendix 2

Documents seen include the following:

Divisional Senior Management Team Meeting minutes for 2009
Surgery, Critical Care and Family Services Divisional meeting minutes for 2009
Clinical Quality and Safety Committee minutes for 2009
Integrated Risk Sub-Committee minutes for 2009
Clinical Audit and Effectiveness Committee minutes for 2009
Patient Service and Experience Sub-Committee minutes for 2009
Infection Prevention and control Committee minutes for 2009
Labour Ward Forum minutes for 2009
Helme Chase Staff Meeting minutes for 2009
FGH Maternity Advisory Group minutes 22 January 2009

9 April 2009
Local SOM meeting minutes for 2009
Extraordinary Local SOM Meeting minutes 20 April 2009
Cross Bay Supervisors Meeting minutes 15 July 2009
Contact Supervisors of Midwives Meeting minutes 7 October 2009
Cross Bay supervisors Extraordinary Meeting minutes 12 January 2009
Senior Midwives Meeting minutes for 2009
Clinical Records Group Meeting minutes for 2009
Divisional Governance Meeting minutes for 2009
FGH Clinical Incident Group Meeting minutes for 2009
Helme Chase Clinical Incident Group Meeting minutes 11 March 2009

3 June 2009
RLI Clinical Incident Group Meeting minutes for 2009
Maternity Risk Management Steering Group minutes for 2009
Working Group Combined NT Screening minutes for 2009
North Lancashire Maternity Services Commissioning Group minutes for 2009
Children, Young People and Maternity Strategy Group minutes 26 May 2009

22 September 2009
Maternity Services User Involvement Plan 22 April 2009
Discussion document to trust board proposing this review (undated)
Maternity Complaints report 1 April 2008 to 31 March 2009
Midwifery Action Plan 2009-2012
Birthrate Plus Summary of Data and Recommendations 25 January 2010-03-01
Foetal Assessment Unit Attendees
Property Appraisal: Labour Ward FGH 17 September 2009
Obstetric Dashboard Draft
Enhanced Vigilance Neonatal Observation Chart
Maternity Services Newsletter January 2010-03-01
Maternity Risk Management Strategy 2008/9
Maternity Training Policy June 2007
Local Workplace Induction Checklist
Guideline Proforma
Staff Induction Policy 2009-2011
FGH Medical Staff in Training Induction Programme (FY1/FY2/SHO) August 2009
FGH Medical Staff in Training Induction Programme (SpR) August 2009
RLI Support Worker Induction Programme August 2007
RLI Midwife Induction Programme July 2007

North West LSA Annual Report to the NMC on the Statutory Supervision of Midwives and Midwifery Practice, 2008-2009
LSA Audit Report for Morecambe Bay NHS Trust 2008 and 2009
North West LSA Annual Statistics for the Year Ending 2008 and 2009
NPSA Organisation Patient Safety Incident Report
Healthcare Commission Review of Maternity Services 2007
Healthcare Commission Action Plan Review June 2009
Appendix 3

**Case loading** is a flexible, autonomous system which could work well at Helme Chase. Groups of 4-6 WTE midwives would deliver approximately 40 women per year for each WTE midwife. Case loading requires the midwife to become effective in time management, understand accountability and be an effective communicator. The hours may not be regular and so can fit very well into family life. Part time midwives share a case load with another part time midwife and midwives work in whole time equivalent partnerships where possible. This ensures that women get to know at least two midwives reasonably well and the others will be familiar to her. Each group provides ways for midwives to meet their group colleague’s caseload women at, for example, parent craft classes or drop in clinics.

Case loading midwives work flexibly. They keep their own diary sheets up to date and follow their own women through care. When women need to be handed over to another group practice midwife, the midwife does this personally. Midwives do not need to come into the base daily. The time is used effectively to see women at convenient times. The case load midwife will follow their own/group practice women into the unit for birth or will take responsibility for home birth.

All antenatal care should be provided by the known group practice midwives. Shared antenatal care with GPs if appropriate or requested by the woman can still take place in a community setting. The case load midwife remains the named midwife. When women are transferred for care to the obstetric teams the responsibility for intrapartum care and postnatal discharge also transfers.

Women are discharged from the birth centre and the postnatal wards by their group practice midwives. A plan for care is in place before the woman leaves the hospital and contact is possible via the on call system at night. Case loaded women should contact their group direct if they need assistance.
A DOMINO system would mean that the unit is staffed by a maternity care assistant when there are no labouring women present. Midwives would not be required for postnatal women either. When a woman goes into labour, she calls the unit and the maternity care assistant contacts the midwife who goes to assess the woman at home, bringing her in to the unit for delivery.