Agenda item 11

Health and Wellbeing Board
24 January 2014

MATERNITY SERVICES REVIEW

Responsible Officer Dr Caron Morton, Accountable Officer Shropshire CCG
Email: cmorton@nhs.net Tel: (01743) 277580

1. Summary

The maternity services review was commissioned by Shropshire and Telford and Wrekin Clinical Commissioning Groups (CCG) to consider the following areas of concerns:

- Pattern and understanding of serious incidents within maternity services since revised categories of reporting were implemented.
- Issues identified during a high profile inquest in 2012 (relating to a case that occurred in 2009) raising questions about various aspects of maternity care.
- Failure to meet the national recommended ratio of midwifery supervisors to midwives.
- Ongoing challenges with regard to midwife to birth ratio.

The report provides the outcomes of the maternity services review (Appendix I).

1.1 Key Points

Process

- There has been considerable involvement of services users / partners in this review process and this has provided a wealth of information on service user experience as reflected in the report.
- Involvement of external clinical experts and scrutiny from other stakeholders has been central to the review process. Clinical experts included obstetricians, neonatologist and midwives. Other stakeholders included representation from Healthwatch, Internal Audit Care Quality Commission, Local Supervising Authority, Staffordshire, Shropshire & Black Country (SSBC) Newborn & Maternity Network and NHS England.

2. Recommendations

- To receive this report.
- To note the recommendations to Shropshire CCG Governing Body Board which were presented to the Board on 11 December 2013 and approved.

REPORT

3. Risk Assessment and Opportunities Appraisal
(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

As documented in the report.

4. Financial Implications

This review focussed on the quality and safety of maternity services but indeed there are financial implications that needs be considered in the future commissioning of maternity services.

5. Background

Outlined within the summary.

6. Additional Information

As documented in the report.

7. Conclusions

Outputs of the review

- The report concludes that the hub and spoke model of maternity service is safe and of good quality, however there are areas for improvement and recommendations have been made to address these areas.

- The concerns relating to the high number of reported serious incidents during 2012/13 was due to diligent reporting and the review process has identified that only 7 incidents out of the 23 were considered to be true serious incidents and therefore comparable with similar trusts

- Staffing issues have been improved and addressed, including midwife supervisor to midwife ratios and midwife to birth ratios.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) Included within the Maternity Services Review Report**.**
Cabinet Member (Portfolio Holder) Cllr Karen Calder
Local Member All
Appendices Appendix I – Maternity Services Review Report