A REVIEW OF THE MIDWIFERY LED UNITS IN CHIPPING NORTON

2008-2012

February 2013
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1. Introduction

The Oxford University Hospital NHS Trust made the decision to conduct an extensive review into the Cotswold Maternity Unit following concerns raised through internal monitoring processes about clinical care. The problems related to working practices within the unit, which were not confined to a single issue rather a range of factors which included:

a) A higher than expected transfer rate of women in labour to consultant-led units at the Horton General and John Radcliffe Hospitals.

b) Reports that a certain culture had developed within the unit resulting in difficult relationships amongst the staff, which could have affected the overall quality of care offered to women.

c) A fall in the total number of women choosing to give birth in the unit; 32 women gave birth between April and September 2012.

d) Two couples from Chipping Norton requested a meeting with the newly appointed Head of Midwifery where they expressed concern about decision making, lack of information regarding range of birthing options, and the overall provision of midwifery led care at the Cotswold MU. The Head of Midwifery was informed that 6 other couples with similar concerns had planned to attend but as a group they were very concerned about possible repercussions in the local community if they had come forward to highlight issues to the Trust.

The combination of high transfer rates, a change in choice by local parents, staff attitudes and concerns raised by families with recent experience of the unit resulted in the Trust’s decision to suspend births at the unit and undertake a review. This paper outlines the scope of the review, the methodology and sets out recommendations for change at the Cotswold Maternity Unit.

Background

1. Midwife led units

A midwife led unit is a birthing unit where the woman is cared for exclusively by midwives without the involvement of obstetricians involved in deliveries. Such units may be co-located with Obstetric Units (where both midwives and obstetricians are present and where complex deliveries are managed) or on separate sites. In Oxfordshire there are separate midwife led units at Wallingford, Wantage and Chipping Norton and a co-located unit (Spires) at the John Radcliffe in Oxford. There are obstetric units at the Horton General Hospital in Banbury and the John Radcliffe Hospital in Oxford.

2. History at Chipping Norton

In 2009 the Chipping Norton Maternity Unit (CNMU) moved to a purpose built new unit. This was renamed the Cotswold Maternity Unit (CMU) and was officially opened in 2010 by the Prime Minister. A new clinical manager was appointed in 2010 following a restructure.
2. **Scope of Review**

The review has examined and assessed the management, provision of care, clinical governance systems and processes in place at the Cotswold Maternity Unit to assess the safety, effectiveness and quality of the service. The review covered the period 2008-2012 to encompass an appropriate timescale and thus has reviewed practice at the previous (CNMU) and current midwifery led (CMU) unit.

Terms of Reference were agreed ([Appendix A](#)), and the review included but was not restricted to the following purposes:

1. Evaluate the current governance arrangements to ensure that staff working in the unit comply at all times with those arrangements.

2. Provide assurance to the Trust that clinical practice in the Cotswold Maternity Unit is in line with Directorate and National guidance, as well as Trust policies. This should include examination of: case notes, incident forms, previous complaints and claims, and records of transfers in labour and the early postpartum period.

3. Examine the risk management performance of the unit with particular attention to:
   a. Identification of high-risk patients throughout pregnancy;
   b. Compliance with antenatal guidelines, including whether appropriate and timely referrals have been made to a consultant for an opinion or on-going care;
   c. Management of labour to include care plans, recognition of risk (both mother and baby), and compliance with guidelines regarding transfer to consultant-led care;
   d. Postnatal care including appropriate transfer/discharge of mother and baby.

4. Examine systems for risk management, including incident reporting and investigation, risk assessment, and implementation and monitoring of action plans.

5. Professional supervision including statutory supervision of midwives.

6. Conduct interviews with staff to understand any concerns relating to clinical practice, transfer rates and the reduction in the total number of births.

7. Conduct interviews with key stakeholders and the local population to ensure their involvement and, importantly, understand their issues in relation to the Cotswold Maternity Unit.

8. Identify barriers to good practice where problems are identified.

9. Reinforce and publicise good practice.

10. Investigate the culture of the unit, as well as any underlying problems with relationships amongst staff and the impact on the unit’s effectiveness.
11. Advise on the appropriate service model for the provision of safe, high-quality, effective and accessible midwifery-led care at the Cotswold Maternity Unit.

3. Methodology

In order to fully address the scope of the review and the terms of reference detailed above, a robust structure of interviews, meetings, case reviews and questionnaires were put in place. Given the concerns raised by some individuals about the need for an external rather than an internal review a significant degree of independence was built into every level of the review. The requirement for such independence was discussed at the Oxfordshire Health Overview and Scrutiny Committee (HOSC) at its meeting on 15th November 2012 and final arrangements were subject to the approval of the Chair of HOSC. The elements of independence agreed for the review included:

- All the staff based in the CMU were offered the opportunity to have an external person present during their interview; all declined and were happy to meet to discuss their own personal and professional experiences and views.
- An external facilitator and Chair of MSLC met with the local community at a series of events.
- The PCT Lead and the Head of Midwifery met with the local General Practitioners and Health Visitor.
- Supervisors of Midwives with no involvement in the CMU conducted the case reviews.
- Questionnaires sent to a randomly selected group of women who had received care at the CMU to gain their views.

It was important to ensure the review encompassed an appropriate timescale to determine practice, cultural issues and any changes that had been implemented; a decision was taken to focus on the last 4 years (2008-2012).

The methodology of the review and the independent elements are as follows:

<table>
<thead>
<tr>
<th>Methodology</th>
<th>Number</th>
<th>Actual completed</th>
<th>Independent element</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Meetings with staff</td>
<td>51</td>
<td>41</td>
<td>Staff working in CMU offered the opportunity to have an external person present.</td>
</tr>
<tr>
<td>2 Questionnaires sent to women</td>
<td>200</td>
<td>106</td>
<td>Random selection of notes (A number were returned as the woman was no longer living at the address)</td>
</tr>
<tr>
<td>3 Letters received re the review</td>
<td>5</td>
<td></td>
<td>3 from local women 1 from an observer 1 other</td>
</tr>
<tr>
<td>4 Case note reviews</td>
<td>200</td>
<td>198 (99%)</td>
<td>Random selection of cases. Reviews completed by Supervisors of</td>
</tr>
</tbody>
</table>
### Table

<table>
<thead>
<tr>
<th></th>
<th>Activity Description</th>
<th>Midwives not involved in CMU.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Review of transfers</td>
<td>46</td>
</tr>
<tr>
<td>6</td>
<td>Review of home births</td>
<td>4 246</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consultant Midwives contact with each woman planning to give birth at home.</td>
</tr>
<tr>
<td>7</td>
<td>Questionnaires to GP’s</td>
<td>16 (8 – Banbury area &amp; 8 –CN GP’s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All GP practices in Banbury area.</td>
</tr>
<tr>
<td>8</td>
<td>Meeting with local GP’s and Health Visitor</td>
<td>1 1</td>
</tr>
<tr>
<td>9</td>
<td>Public meetings</td>
<td>6 sessions x 120 places</td>
</tr>
<tr>
<td>10</td>
<td>NCT and MSLC</td>
<td></td>
</tr>
</tbody>
</table>

### 4. Findings

#### 4.1. Meetings with staff

See Appendix B for further analysis

Fifty one members of staff were offered the opportunity to meet with either the Head of Midwifery or Clinical Midwifery Manager. A number of staff did not feel able to comment as they had no dealings with the unit and a number of staff were absent from work during the review period. Forty one staff made an appointment to discuss their views. Staff based in the CMU were offered the opportunity to have an external person present at the meeting but all declined this offer as they were happy to meet with the HOM or clinical manager.

Staff interviewed included those who work/have worked in the CMU, midwives based at the Horton maternity unit, staff from other institutions linked to the unit and midwives based in adjacent community teams. It was important to gain the views of individuals who had personal and professional experience of the unit and some understanding of the clinical practices and culture and could therefore offer ideas for the future of the unit.

The interviews identified issues about culture, management of the current (CMU) and previous (CNMU) units, practice and difference of professional opinion within the units. It is apparent that the 2 units operated very differently. Although many staff had fond memories of the previous unit there were concerns about health and safety because the building was old and tired, staff were isolated and there was a non-inclusive attitude by some individuals. By contrast the CMU is a new
unit but was deemed to be more clinical because of the décor, equipment and layout of the rooms. However the birthing pools were seen as a positive addition. Staff were concerned about lone working especially at night when they attend the unit to care for a woman in labour. There was a concern raised about midwives not working within the European Working Time Directive and there were times that individuals would work for a period of 24 hours to care for women. The review received evidence from a midwife who worked at the previous unit (CNMU) that incident forms were not consistently completed by all staff, i.e. some individuals did not comply with the Trust’s Incident reporting policy.

It was acknowledged that women giving birth and staying postnatally in the previous unit (CNMU) had very good care, often referred to as a ‘gold standard’ but this was in part because women and their babies were able to stay longer than in the other midwifery units within the OUHT. Some midwives felt that the team worked very differently to the rest of the county, the philosophy was to support women to birth normally but this did lead to women being booked inappropriately and risks were not considered. One midwife stated that ‘there seems to be a rule for working for them and another for others. The midwives don’t feel they have to conform to normal working practices. They appear to see postnatal women more frequently even if uncomplicated, like they are able to offer a gold standard service of care in comparison to other groups.’ Another midwife suggested the practices were to ensure ‘normal birth at any cost’. This was a concern for the midwives called in to the unit as they had to care for women who should not have been booked to birth in a standalone midwifery led unit and therefore had to make the decision to transfer the woman to the Horton or the John Radcliffe. This was clearly upsetting for the woman but also caused animosity amongst the midwives. The culture in the new unit is different and this has affected relationships between the staff; it was acknowledged that certain changes could have been managed differently which may have led to better working relationships. However the majority of staff support the clinical manager acknowledging that her style is very different from the previous manager; she is viewed to be very organised, patient orientated, open and ensures the safety of the woman and unborn child is paramount. Staff felt there was a need to improve communication with GP practices, alter deployment of staff to ensure continuity of care and to review the provision of services within the unit.

Generally the staff interviewed were very sad about the situation but were not surprised as they believed the issues in Chipping Norton had been evident for many years. These included practice, inequalities in comparison to other units and lack of governance arrangements. Some staff were critical of senior management as the issues had not been addressed and staff were able to function outwith Trust standards. It was clear to many staff that any new clinical manager introducing change would have problems because of the clash of personnel, personalities and cultures. Staff felt the new manager had little local support in developing the new unit in line with safe and modern midwifery and maternity practice.

The midwives covering from other community teams expressed concern about the isolation of the unit, travelling time when on call and the inequalities of workload between the team based in Chipping Norton and other teams. There were a number of staff who believed the unit was not in the appropriate geographical location, negatively affected other community teams who felt resentful especially when women were booked inappropriately and this in turn affected the safety of women as well as the midwives from other teams. A change in the links to community teams was
seen as a problem; previously the teams from Chipping Norton and Witney worked closely together and the view was that this should be reinstated.

Relationships between some staff in the previous unit (CNMU) and the Horton General Hospital unit were not good. This related to differences in clinical practice, criticism of individuals and their practice and negative information given to women about the wider maternity service.

Staff provided ideas for improvement including; review of on call provision, improved information for women, team building and improved access issues. Many staff highlighted problems with the telephone system and front door bell as both are difficult to hear from all areas/rooms in the unit; this concern related to all staff working in the unit. Support for the team and individuals based in the unit was highlighted and seen as a priority; particularly given the local publicity about a number of midwives.

4.2. Questionnaires sent to women

See Appendix C for a detailed analysis of the questionnaires.

<table>
<thead>
<tr>
<th>Questionnaire</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number distributed</td>
<td>200</td>
</tr>
<tr>
<td>Returned</td>
<td>106</td>
</tr>
<tr>
<td>Returned as ‘no longer at this address’</td>
<td>6</td>
</tr>
<tr>
<td>Other – 1 not sent by OUHT</td>
<td>1</td>
</tr>
<tr>
<td>Questionnaire sent in error to a woman who did not receive care from CMU</td>
<td>1</td>
</tr>
<tr>
<td><strong>Response rate</strong></td>
<td><strong>52%</strong></td>
</tr>
</tbody>
</table>

Resume of 106 responses

One hundred and six women had used the services at CNMU/CMU and of those 90 had booked to give birth there; the remaining 16 were booked for birth elsewhere.

Eleven women gave birth at home, 82 at CNMU/CMU, and the remainder gave birth in other maternity units or were still pregnant.

**Transfer rates from CNMU/CMU**

This may relate to a woman’s different pregnancy and birth. Therefore the numbers do not add up to 106).

a. 84 – No transfer required.
b. 21 – Transfer required.

Reasons for transfer

| • Baby – breathing difficulties x 2. | • Raised Blood pressure post birth. |
| • Breathlessness.                   | • Baby – feeding problems.          |
| • Prolonged second stage of labour. | • Breech presentation,              |
| • 3/4th degree tear x 3             | • Meconium stained liquor although gave birth at CN. |
| • Prolonged rupture of membranes.   | • Fetal heart anomalies.            |
| • Postpartum haemorrhage.           |                                     |
### 2. Suggested changes made by the women who responded to the review

<table>
<thead>
<tr>
<th>Changes Suggested</th>
<th>Changes Suggested</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Open the unit for births.</td>
<td></td>
</tr>
<tr>
<td>• Many respondents suggested the unit should offer the opportunity for women to stay one night.</td>
<td></td>
</tr>
<tr>
<td>• Many respondents offered no changes.</td>
<td></td>
</tr>
<tr>
<td>• Midwives to have more experience of pool births.</td>
<td></td>
</tr>
<tr>
<td>• The unit is concerned with statistics, this is in relation to the under estimation of blood loss.</td>
<td></td>
</tr>
<tr>
<td>• Mats for the birthing rooms.</td>
<td></td>
</tr>
<tr>
<td>• Staffing of the unit.</td>
<td></td>
</tr>
<tr>
<td>• Women in labour not to have to wait in the waiting room.</td>
<td></td>
</tr>
<tr>
<td>• Positive support for home births.</td>
<td></td>
</tr>
<tr>
<td>• Group breast feeding support for mothers, not just 1:1 support.</td>
<td></td>
</tr>
<tr>
<td>• More information/discussion about interventions i.e. Syntometrine.</td>
<td></td>
</tr>
<tr>
<td>• Continuity of care.</td>
<td></td>
</tr>
<tr>
<td>• Improve response times to phone calls.</td>
<td></td>
</tr>
<tr>
<td>• Improve waiting times.</td>
<td></td>
</tr>
<tr>
<td>• Environment – make it more homely.</td>
<td></td>
</tr>
<tr>
<td>• Organisation of the unit i.e. leadership and implementation of processes.</td>
<td></td>
</tr>
<tr>
<td>• Promote the unit locally.</td>
<td></td>
</tr>
<tr>
<td>• Better postnatal care.</td>
<td></td>
</tr>
<tr>
<td>• A better door bell.</td>
<td></td>
</tr>
<tr>
<td>• Improve administrative processes.</td>
<td></td>
</tr>
<tr>
<td>• Improve the telephone system.</td>
<td></td>
</tr>
<tr>
<td>• Better communication between the CMU and the Horton.</td>
<td></td>
</tr>
<tr>
<td>• Improved ventilation in the rooms.</td>
<td></td>
</tr>
<tr>
<td>• Consider the unit is not viable as a place to deliver babies as it is equivalent to giving birth at home. Should be available for antenatal and postnatal care.</td>
<td></td>
</tr>
<tr>
<td>• Comments were made about individual’s members of staff.</td>
<td></td>
</tr>
<tr>
<td>• More birthing rooms.</td>
<td></td>
</tr>
</tbody>
</table>

### 4.3. Letters received regarding the review

One woman who does voluntary work in the north of the county suggested the unit had much potential but a number of changes were required; these included making the unit more homely and removing some of the large pieces of equipment from the birthing rooms. Her view was that many women outside the Chipping Norton area did not consider CMU as an option because of the distance and cross country travel and the fact the unit does not have a unique selling point. She felt most women wishing to have their baby in a midwifery led unit would choose the Spires for two reasons, the close proximity of delivery suite and the option to stay postnatally.

Three women wrote to outline their experiences and to express support for the unit.

One letter offered an opinion on the situation in the previous unit (CNMU) and the comments on the Go petition website.

### 4.4. Case note reviews

**See Appendix D for detailed analysis.**

A notes review was undertaken in January 2013 of a random selection of 200 women who gave birth at CNMU/CMU between 2008 and 2012. This was undertaken as part of the review of the unit, to ensure that safe practice was being maintained and Oxford University Hospital (OUH) guidelines were being followed. The Antenatal and Intrapartum period were looked at specifically. An audit
proforma was designed to encompass Antenatal and Intrapartum Care in the community and at the CNMU/CMU units and completed using the maternal notes. These audit forms were collated and reviewed independently using the 12 questions on the proforma; in total 198 audit proformas were reviewed.

Antenatal assessment
The audit found that 29% of the women had antenatal risk factors at booking and these included a range of medical, obstetric and social issues. There were 8 occasions when a student midwife undertook the booking but no midwife countersigned the entry in the notes; this is not good practice. Eight women (4%) who had a significant obstetric or medical history were deemed to be on the wrong antenatal care pathway and should have been referred to birth in a Consultant Led Unit.

NICE recommends the number of antenatal visits a pregnant woman should receive and 63% of women received the correct number of visits based on their clinical need. Of the women who did not receive the recommended NICE visits, 3 women clearly received between 3-4 too few visits. All 3 were in their first pregnancy, one being a young woman with social issues who should have received extra support. The rest of the women received over and above what is recommended by NICE; these ranged from 1 to 10 extra visits and for over half of these there was no clinical rationale evident for the extra visits.

In only 61% of the notes audited was it noted that a discussion of some description around the place of birth had taken place. There were a variety of ways this was done but the majority appeared to be limited. This is an issue because women and their families should be made aware of the benefits and constraints around birth in a standalone Midwife Led Unit e.g. transfer times to a Consultant led unit.

Intrapartum Assessment
A clinical risk assessment at the onset of labour includes; medical, obstetric and social history, observations of maternal and fetal wellbeing and a recent history of events. The woman should be asked about the frequency of contractions, liquor presence and colour, and fetal movements. This assessment is to ensure that the woman labours and births in what is deemed the safest environment for her and her baby. The audit found that 84% of women had a risk assessment undertaken at the onset of labour.

The OUH Intrapartum Care Guidelines follow the recommendations of NICE to ensure that fetal and maternal well-being is observed throughout labour and birth. The audit found that the Intrapartum Care Guidelines were followed in only 113 cases (57%) However, of the remaining 85 women, 21 had what was described as a rapid birth. Documentation was poor in a number of records.

This audit found clear evidence that a number of midwives working at CNMU/CMU over the last 4 years had not been compliant with local and national guidelines.
4.5. Review of transfers

See Appendix E for detailed analysis.

Clinical and non-clinical incidents are reported using the OUH Clinical Incident reporting system and all transfers from Midwifery Led Units [MLU] and home are reported by midwives.

An audit of all clinical incidents/transfers from CNMU/CMU was undertaken. The review identified that the majority of women transferred from the CNMU/CMU were taken to the Horton Hospital. Where there were neonatal concerns transfer was to the John Radcliffe. All 55 Incident Report forms from 2010, 2011 and 2012 were analysed with the primary aim to assess whether the transfer was appropriate, and also to ascertain if the speed of transfer met locally agreed standards and to identify any recorded delays.

There were a wide variety of reasons for transfer documented in the woman’s notes and there was a notable increase in the transfers from 7.4% of bookings in 2010 to 23.9% in 2012. Some of this could be due to an increased compliance of reporting transfers of care.

The majority of the transfers were during the intrapartum period [67%] and were entirely appropriate to ensure the safety of either mother or baby. Examples included:

- Women who were transferred for failure to progress in 1st and 2nd stage of labour were appropriately transferred for further assessment/review and delivery. The majority of these women required an assisted delivery either by forceps or Emergency Caesarean section.
- There were 3 cases of primary postpartum haemorrhage and these women had initially been supported in having a physiological 3rd stage which was clinically appropriate. One woman was still in the unit – she was appropriately managed and then transferred. One woman had delivered and was discharged home and was later readmitted to the Horton from home.
- Meconium staining in the 1st stage of labour. Out of the 6 cases, 5 were transferred immediately. There was one case where transfer into the ambulance was delayed as the midwives were assessing whether birth was imminent; there was no fetal distress and the woman gave birth in the Horton.
- Fetal distress/decelerations - the Apgar scores for these cases were very good and minimal resuscitation was required.
- Neonatal resuscitation – Of the 6 cases – 4 sets of notes were not available.
- Perineal repair – there were 3 cases where women were transferred, 2 were correctly diagnosed as third degree tears and the third case was a complicated second degree laceration that required a doctor to repair.

Place of birth discussions and use of patient information leaflets were poorly documented in the hand held records. There was evidence in some records that Chipping Norton was the preferred place of birth but there were no discussions to reflect the risks and benefits of an MLU birth.

Over 90% of notes demonstrated clear documentation of the decision time to transfer, ambulance called and arrival at unit.

Documentation of emergency/time critical transfers – 78% of the notes demonstrated which transfer was requested by the midwives. It is essential that midwives document this decision as this will ensure that locally agreed time critical and emergency transfers occur within a set time frame.
The review found that transfers were appropriate and in response to clinical need of either the mother or the baby. However in a number of records documentation was inadequate.

4.6. Review of home births

Four women were planning to give birth at home when the decision was taken to suspend intrapartum care. The Consultant Midwives made contact with the women to ensure they had received all the necessary information and had been assessed appropriately. Three of the women had conversations with the Consultant Midwife, 2 were happy with the information they had received and had no problems and 1 had not planned to give birth at home but did meet with one of the Consultant midwives to discuss her birth plan. One woman had moved out of the area and had decided to give birth elsewhere.

The Consultant Midwives were reassured that the women had received the necessary information and home birth was an appropriate option.

4.7. Questionnaires to GPs

See Appendix F for full analysis of the questionnaires.

Questionnaires
16 questionnaires circulated.
4 questionnaires returned.
25% response rate

The questionnaire revealed that 2 GP practices do not refer women to the CMU, 1 practice refers if clinically indicated and 1 practice offers women this choice but it is rarely accepted. The reasons given included: that the CMU is too far away, that there is another maternity unit in close proximity, that the unit is isolated and travel is required and there is an alternative local maternity unit available for antenatal care.

Positive aspects and concerns raised about the unit included the following:

<table>
<thead>
<tr>
<th>Positive aspects of the CMU</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Excellent reputation.</td>
<td>• Discharge women too quickly which affect breastfeeding and continuity of care.</td>
</tr>
<tr>
<td>o A fabulous facility but need to market the CMU.</td>
<td>• Distance.</td>
</tr>
<tr>
<td>o Good postnatal care and breast feeding advice.</td>
<td>• Women arriving at unit when it is not staffed.</td>
</tr>
<tr>
<td>• Email responses to queries.</td>
<td>• Negative impact on other community areas/teams.</td>
</tr>
<tr>
<td>• Midwife visiting the GP practice.</td>
<td>• Anxiety about primigravid women delivering in the unit.</td>
</tr>
<tr>
<td>• Calm, reassuring and friendly.</td>
<td>• Do not have a personal relationship with the midwives.</td>
</tr>
<tr>
<td></td>
<td>• Poor communication from CMU to the GPs.</td>
</tr>
</tbody>
</table>
4.8. Meeting with local GPs and Health Visitor

See Appendix G for notes of the meeting.

Attended: 3 GPs and I Health Visitor

The impression of those individuals attending the session was that there was a difference between the previous (CNMU) and new (CMU) units. The previous unit provided excellent care to women and the GP surgeries had a regular midwife allocated to provide care to the women. With the new unit there is less midwife cover for the GP surgeries and there was a misconception about whether the unit was open.

Suggested changes

<table>
<thead>
<tr>
<th>• Allow women to stay postnatally – equitable service</th>
<th>• GPs to be updated regarding changes in antenatal care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Baby examinations – midwife</td>
<td>• Local area meetings with midwives and GPs – suggested monthly</td>
</tr>
<tr>
<td>• Consistency – midwives and maternity support workers</td>
<td>• Monthly update from maternity services</td>
</tr>
<tr>
<td>• Continuity of care</td>
<td>• Email GPs about the CMU and any changes</td>
</tr>
<tr>
<td>• Breast feeding support especially from the maternity support workers in the community</td>
<td>• Market the unit</td>
</tr>
</tbody>
</table>

4.9. Public meetings

See Appendix H for detailed notes.

Six sessions were offered and a total of 52 people attended. Thirty six women had attended and/or used the unit, 4 were non users and 12 were would-be users. The review team is grateful to the Chair of the MSLC for agreeing to help distribute the posters advertising the meeting around Chipping Norton.

General impressions of the unit were very positive and comments included: ‘there is a really positive feeling here, I felt like a person here as compared to a battery hen at the hospitals and human care, care everyone should have’. The members of the public attending the meetings identified many positive aspects of the unit; ‘supportive of natural births, it’s a Baby friendly unit, skin to skin and breast feeding encouraged here, purpose build – less hospitalised.’

Concerns about the unit were identified and related to lack of continuity, time to provide care, no midwife trained to undertake baby examinations, lack of support from GP’s, provision of breast feeding support i.e. needs to be offered for groups rather than on an individual basis and all women should be supported to attend. There was a view that staff were working within constraints that affected their ability to do their job. There was a view that there were an increased number of midwives working in the unit who did not share the same ethos as the established team.
Concerns about risk were raised and these included not being able to access the unit during the night and transfer home soon after the birth especially at night. A number of references were made to individual midwives and changes to the provision of home birth equipment causing delays in the arrival of the midwife.

Suggestions to improve the service were highlighted and include:

<table>
<thead>
<tr>
<th>• Continuity of care was deemed to be critical</th>
<th>• Postnatal transfer from another unit</th>
</tr>
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<tbody>
<tr>
<td>• 24 hour provision of experienced midwives</td>
<td>• Option of being able to stay longer</td>
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<tr>
<td>• A commitment to natural birth</td>
<td>• Offer a drop in at the unit – not Wednesday</td>
</tr>
<tr>
<td>• A midwife trained in examination of the new born</td>
<td>• Midwife prescriber</td>
</tr>
<tr>
<td>• Positive publicity about the unit</td>
<td>• Joined up care with the ACE Centre</td>
</tr>
<tr>
<td>• Previous manager to offer advice about the unit</td>
<td>• Health Visitor/Midwife collaboration in the CMU</td>
</tr>
<tr>
<td>• GP’s to distribute leaflets about the unit. The League of Friends have offered to fund the printing of the leaflets</td>
<td>• A Baby Café to be offered in the CMU</td>
</tr>
<tr>
<td>• Offer birth with the option of transfer</td>
<td>• Local midwives</td>
</tr>
<tr>
<td>• Offer classes in the meeting rooms</td>
<td>• Change the chairs and hospital beds</td>
</tr>
<tr>
<td>• Information to be added to the OUH website</td>
<td></td>
</tr>
</tbody>
</table>

A number of comments were made about the review, points were raised about care at the Horton and the John Radcliffe and information was provided about the on-line survey being carried out by the National Childbirth Trust.

The key points from the meetings identified by the facilitators were as follows:

- Continuity of care
- Reduced opening hours = reduced births
- Reduced length of stay – what is the point of going to the CMU if sent home too quickly
- Centre of excellence – want the same level of care
- GPs to support and promote the unit
- Review management style
- Issues about staffing and some individuals

5. National Childbirth Trust (NCT) and Maternity Services Liaison Committee (MSLC)

The Chair of the MSLC collected information from local women about the CMU and this was helpfully forwarded to the Head of Midwifery. The comments were similar to those contained within the returned questionnaires and the discussions at the public sessions. The information is contained in Appendix I.
The NCT conducted an online survey about the CMU and at the point of preparing this report 86 responses had been received. The main themes were that the unit is very valuable with ante and postnatal care considered to be excellent; a key concern was that mothers were not able to stay longer although an extended length of stay was not clinically required.

6. Feedback from HOSC 21st February 2013

Senior staff from OUHT were invited to attend the HOSC meeting on 21st February 2013 to provide a progress report about the review. Appendix J contains a copy of the report.

It was very helpful that members of the local community and representatives from user organisations were present and articulated positive support for the CMU.

Most of the concerns raised have been addressed in this report, however a letter from Oxford Brookes University (OBU) was read out and suggested there had been concerns about the Cotswold Maternity unit and the placement of students. Annual placement reviews are completed and reports circulated by OBU and these concerns had never been raised in the reviews or with the Head of Midwifery. The reports for the last 4 years are contained in Appendix J.

7. Conclusions

The conclusions will be detailed under the ‘purposes of the review’ to provide assurance that the reviewers examined and assessed all aspects of the CNMU/CMU.

7.1. Clinical Governance arrangements

The governance arrangements differed between the CNMU and the CMU and this was related to the culture and management of the units. The previous unit (CNMU) was organised and run as an independent unit which did not link closely with the maternity service or the wider Trust. Despite attempts to change with the move to the CMU the evidence would suggest that the governance arrangements were still not robust and this is supported by comments made by some of the staff working in or linking with the unit.

Clinical governance arrangements were not robust and did not follow OUHT guidelines.

7.2. Clinical practice

The evidence from some of the staff and the women who used the services of the 2 units at Chipping Norton felt that the service the in the previous unit was of a ‘gold standard’, however, this view was not supported by everyone interviewed nor the evidence collected by this review.

One midwife stated that ‘there seems to be a rule for working for them and another for others. The midwives don’t feel they have to conform to normal working practices. They appear to see postnatal women more frequently even if uncomplicated, like they are able to offer a gold standard service of care in comparison to other groups.’ This statement is supported by the findings of the case note review which highlights that not all midwives have been complying with practice guidelines i.e. some women received ten extra antenatal visits despite no clinical rationale.
Certain individuals practice was described as ‘they practice close to the wind’. Staff, women and evidence from the case reviews suggests that not every midwife complied with agreed standards.

*Clinical practice did not comply with OUHT and national guidelines.*

### 7.3. Risk Management performance

There were occasions when women were booked for care and birth at the unit when they did not meet the criteria as they had underlying medical or obstetric problems.

There is evidence that some midwives worked out with the guidelines and examples given highlighted that some woman and babies could have been put at risk. For example babies being kept overnight following meconium stained liquor during labour -the guideline states that these babies should be transferred to a consultant led unit for observation.

There was not a consistent approach to antenatal guidelines. Findings of the audit identified that 4% of women were deemed to be on the wrong antenatal care pathway due to a previous obstetric or medical history and should have been referred to birth in a Consultant Led Unit. NICE recommends the number of antenatal visits a pregnant woman should receive and only 63% of women received the correct number of visits based on their clinical need.

Transfer rates did increase between 2010 and 2012 but the review has identified they were appropriate and related to clinical findings and the need of the woman or her baby. Although upsetting for the woman the midwives should be commended for assessing the clinical situation and thus making the appropriate decision in terms of the safety of mother and baby.

*Clinical Risk management was inadequate.*

### 7.4. Risk Management systems

The review received evidence that some individuals at CNMU did not comply with the Trust Incident reporting polity. The manager in CMU now ensures that incident forms are completed in line with the Trust’s policy and this is evidenced by increased reporting.

*There is evidence of improving risk management procedures.*

### 7.5. Supervision of Midwives

There is little evidence that Supervision of Midwives, under the independent auspices of the Local Supervising Authority (LSA) for Midwives was proactive or had an impact on clinical practice and standards.

### 7.6. Interviews with staff

Interviews with staff revealed both concerns and positives features of the units. Staff stressed the importance of ensuring there is support for those working in the unit and those who attend at night to care for women in labour. Midwives felt that the unit had changed and compliance with agreed midwifery led unit guidelines (which exist to ensure that midwives are not placed in difficult situations especially when they are alone in the unit at night) was now in place.
A culture of bullying was suggested by a number of staff. This related to both CNMU and CMU, in the previous unit some staff were excluded and an ‘elitist’ culture developed. Staff felt that the move to the new unit could have been managed differently to ensure all staff were involved and responsibility for tasks should not have been taken away. These actions led to problems and the development of complex relationships which in turn lead to a breakdown of the team.

There was evidence that team working was poor.

7.7 Interviews with key stakeholders and the local population

As detailed above, and in the appendices, meetings were held with stakeholders and the local population and the findings were generally similar and included: the need for continuity of care, reduced opening hours and changes to the length of postnatal stay led to a reduction in the number of women giving birth in the unit, the differences between CNMU and CMU units, the need for GPs to support and promote the unit, management of the unit and the need to review staffing.

There was evidence of great local support for the unit.  
There was evidence that staff were not following the OUHT discharge procedures.

7.8 Barriers to good practice

The isolation and culture of the previous unit (CNMU) was felt to have a negative effect on individual members of staff. However, the team held regular meetings to discuss individual cases, outcomes and learning which is very good practice and should be commended. The information gathered from such team meetings should feed into the Directorate structure to ensure wider learning.

Isolation of staff.

It was difficult for staff members attending CMU on an irregular basis to gain familiarity with the facilities and other team members.

Further work on team building is required.

7.9 Good practice

Good practice was highlighted by staff, women and through the case reviews. Certain individuals were praised as being professional, always working within guidelines and thus offering safe care and being supportive to colleagues.

There was evidence of excellent practice by some midwives.

7.10 Culture of the 2 units

It is apparent that the two units had very different cultures and previously staff practiced in the ‘Chipping Norton way’; this included practice, working hours and workload which differed from national norms. The culture in the new unit (CMU) is described by most of the staff interviewed as being friendly, supportive and offering a total package of care. However a very few individuals were less positive with one describing the unit as closed which affected trust between staff.

Further work on team building is required.
8. Recommendations

8.1. Clinical Governance arrangements

➢ It is essential that there is a consistent approach across all the midwife led units in Oxfordshire and that all practice in the midwife led units complies with the OUH and National guidelines.

➢ Monitoring must occur in each MLU and monthly meetings should be held to review numbers of births, transfers and cases; senior midwifery staff should be involved in the meetings. These must feed into the Directorate and Divisional governance structures and this will ensure that any concerns are identified quickly and actions taken.

➢ Audits should be undertaken by Supervisors of Midwives to ensure compliance with local and national guidelines and the results presented at the Directorate Governance Committee.

➢ The MLU’s in Oxfordshire should be benchmarked against other units across the UK to offer assurance about practice, guidelines, numbers of births, antenatal and postnatal services.

➢ Regular meetings should be held between CMU staff and local GPs to improve communication and provide information about changes within the unit or local/national guidance.

➢ The senior midwifery management team should provide regular support for all staff in the CMU.

➢ There should be quarterly visits from the Divisional Executive team to meet staff.

➢ The HOM will work closely with the Oxfordshire Commissioning Group to agree reporting structures and provide assurance about the safety of the CMU.

➢ Links should be developed with local user groups to receive feedback about the services provided in the CMU.

8.2. Clinical practice

➢ Managers should ensure all staff are aware of and work within local and national guidelines and this should be monitored through audit and Supervision of Midwives.

➢ Collaboration should be enhanced between OUHT and Oxford Brookes University to ensure excellence in the development of the midwives of the future. The senior midwifery management team should work closely with OBU to ensure OUHT receives regular feedback from the Midwifery Link Lecturers.

➢ The HOM and Lead Midwife for Education should agree formal feedback mechanisms regarding pre and post registration midwifery training.

➢ There must be involvement and support from the Consultant Midwives in the provision of women’s care, especially if women with known obstetric or medical risks request to birth in the CMU.

8.3. Risk Management systems

➢ Every member of staff must report incidents in line with the Trust’s Incident Reporting system; this will be monitored by the Clinical Governance team.

➢ Opportunities for staff to meet with senior management will be put in place and details of how concerns should be escalated highlighted to every member of staff.

➢ Workplace assessments should be completed as appropriate.
8.4. Environment
- The environment within the CMU will be reviewed to make the necessary changes e.g. remove the resuscitaire from the birthing room and relocate to another area within the unit.
- The telephone system must be changed so calls can be heard by all staff wherever they are in the unit.
- The front door bell must be changed so it can be heard by all staff in the unit.

8.5. Women’s expectations
- The OUHT policy for length of stay and discharge procedures should be made clear to women at booking and be consistent in all MLU’s.
- Continuity of care during the antenatal period should be provided as far as possible.
- The provision of antenatal sessions and breastfeeding support should be reviewed because current practice is not using staff resource efficiently and does not provide women with peer support.

8.6. Staff
- The clinical midwifery manager will meet every member of staff working in the CMU to understand their choice of place of work.
- The clinical midwifery manager will review and agree the on call arrangements and links with other community teams.
- Appropriate midwifery cover in GP practices should be provided to improve continuity and communication.
- The clinical midwifery manager will review night time cover within the CMU; considering either an on call system or the employment of individuals on an annualised hours contract.
- Staff must comply with the European Working Time Directive.
- The senior midwifery manager will arrange team building sessions to ensure a cohesive, positive working environment for every member of staff.

8.7. Supervision of Midwives
- Supervisors of Midwives should monitor practice, ensure staff are aware of guidelines and monitor compliance.
- Supervisors of Midwives should provide updates for staff on the importance of contemporaneous record keeping, audit and feedback through the Divisional governance structures.
- The Midwives Rules and Standards 2012 should be discussed with every midwife during their annual review meeting to ensure all staff are aware of their professional responsibilities, in line with the Nursing and Midwifery Council. (see Appendix K)

8.8. Appropriate service model at the Cotswold Maternity Unit
The Cotswold Maternity unit is highly valued by the local community and is an important part of the OUHT strategy to deliver care as close to home as is appropriate. There is a need to review the staffing within the unit, their roles and responsibilities and the links to other community teams in
order to ensure appropriate cover and service provision; this is underway. In order to be safe and deliver high quality care all Oxfordshire MLUs should adhere to the same standards and follow OUHT and national guidelines. Under this structure the CMU will fully reopen and provide antenatal, intrapartum and postnatal care to the population of Chipping Norton and surrounding areas.

The Trust is committed to maintaining safe maternity services throughout the county. In order to maintain safe and sustainable clinical viability the number of births at the CMU needs to grow substantially, a birth rate of 150 – 200 per annum would ensure a sustainable unit. The Trust will work with local stakeholders, General Practitioners and local commissioners to ensure the population of Chipping Norton and the surroundings areas are fully informed about the CMU and the services that can be provided locally in the context of modern midwifery care. The outcomes will be closely monitored by the OUHT and commissioners.

9. Conclusion and Actions

The review has found that there were significant concerns associated with the choice of patient pathways, clinical governance and cultural problems at Chipping Norton over a number of years. In the context of the issues received by service users and staff it was appropriate to suspend births at the unit. A timeline for the implementation of the recommendations outlined in Section 8 will need to be developed by the Division and approved by the Director of Clinical Services. It is anticipated that this can be completed and agreed by 31 April 2013 and subject to this being achieved the CMU should re-open for births on 1 July 2013.

The Trust Board is asked to:

- Receive the review and consider the recommendations set out in Section 8
- Support the timeline for the provision of the action plan and proposal to re-open the CMU for births from the 1 July 2013
- Agree that the action plan and progress against the plan will be considered at the June 2013 Trust Board meeting at which the final decision on the timing of the opening of the CMU will be determined

Jane Hervé
Head of Midwifery
## APPENDICES

### A – K

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<td>see attached</td>
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Appendix A

Oxford University Hospitals NHS

REVIEW OF THE COTSWOLD MATERNITY UNIT

Terms of Reference

Rationale for Review

Concerns have been raised through internal monitoring processes about clinical care at the Cotswold Maternity Unit. The problems, which have recently come to the attention of the Maternity Services Liaison Committee, mainly relate to working practices within the unit, not to a single incident:

e) There is a higher than expected transfer rate of women in labour to consultant-led units at the Horton General and John Radcliffe Hospitals.

f) It appears that a certain culture has developed within the unit resulting in difficult relationships amongst the staff, which may have affected the overall quality of care offered to women.

Over the same period, there has been a fall in the total number of women choosing to deliver in the unit; in fact, in the last 6 months only 32 women have delivered there. These issues considered together are worrying because of the possibility that they are somehow linked by common factors. Therefore, the Trust has decided to conduct an extensive review into the Cotswold Maternity Unit.

Scope of Review

The review will examine and assess the management, provision of care, clinical governance systems and processes in place at the Cotswold Maternity Unit to ensure the safety, effectiveness and quality of the service. Recommendations for change and how it should be implemented will be made where appropriate.

The review will include (but will not necessarily be restricted to) the following purposes:

12. Evaluate the current governance arrangements to ensure that staff working in the unit comply at all times with those arrangements.

13. Provide assurance to the Trust that clinical practice in the Cotswold Maternity Unit is in line with Directorate and National guidance, as well as Trust policies. This should include examination of: case notes, incident forms, previous complaints and claims, and records of transfers in labour and the early postpartum period.

14. Examine the risk management performance of the unit with particular attention to:
   a. Identification of high-risk patients throughout pregnancy;
b. Compliance with antenatal guidelines, including whether appropriate and timely referrals have been made to a consultant for an opinion or on-going care;

c. Management of labour to include care plans, recognition of risk (both mother and baby), and compliance with guidelines regarding transfer to consultant-led care;

d. Postnatal care including appropriate transfer/discharge of mother and baby.

15. Examine systems for risk management, including incident reporting and investigation, risk assessment, and implementation and monitoring of action plans.

16. Professional supervision including statutory supervision of midwives.

17. Conduct interviews with staff to understand any concerns relating to clinical practice, transfer rates and the reduction in the total number of births.

18. Conduct interviews with key stakeholders and the local population to ensure their involvement and, importantly, understand their issues in relation to the Cotswold Maternity Unit.

19. Identify barriers to good practice where problems are identified.

20. Reinforce and publicise good practice.

21. Investigate the culture of the unit, as well as any underlying problems with relationships amongst staff and the impact on the unit’s effectiveness.

22. Advise on the appropriate service model for the provision of safe, high-quality, effective and accessible midwifery-led care at the Cotswold Maternity Unit.

Timescale for Review and Reporting

The review will start in November 2012 and be completed within a 12 week period.

The outcome of the review will initially be considered by the Children’s and Women’s Divisional Executive before being presented to the Director of Clinical Services and Chief Nurse.

The review will be led by Jane Hervé, Head of Midwifery with appropriate support from the PCT and other agencies.

Paul Brennan
Director of Clinical Services
29 October 2012
1. **Number of staff interviewed.**

41 Staff were interviewed as part of the review. 51 were offered the opportunity to meet with the Head of Midwifery or Clinical Manager but 10 declined as they either did not feel they could comment as they had not had any contact with the 2 units or were off sick during the time of the review.

2. **Time worked in the unit**

Staff who had links with the unit were offered the opportunity to be involved and these included midwives and midwifery support workers who had worked in either unit in Chipping Norton, community midwives, midwives from the Horton Hospital in Banbury and lecturers from Oxford Brookes. The rationale for this decision was to ensure staff who had links with the unit, worked as part of the team, those staff who covered when on call or cared for women who had been transferred from CNMU or CMU were able to provide evidence to the review.

3. **Impression of the units**

Staff had very different views of the units but generally there was a feeling that the two units were very different and each unit had positive and negative aspects.

There were concerns raised about the isolation of the units and this was a safety issue for the women and the midwives. One midwife suggested that the units are *‘a long way from help’*. Staff felt safer in the CNMU as the elderly care ward was very close and would offer help if necessary.

Some staff felt there were inequalities in service provision and resources, with the units in Chipping Norton having more resources. The quietness of the units was also raised as an issue. The term ‘gold standard of care’ was mentioned and deemed to be frustrating for other staff who are not able to provide this level of service because of their caseloads.

The CNMU unit was felt to more homely, very relaxed and a *‘birthplace’*. There were other concerns i.e. health and safety and environmental issues. These included security, effects on the elderly care ward, problems with maintenance and parking. One midwife suggested *‘the unit was tired out and needed a lot of work to make it hygienic and functional’*. The 6 bedded ward was deemed to be more positive than the single rooms in the CMU as women are more isolated. It was seen as self-contained unit with one individual suggesting *‘it was an independent unit i.e. not*
tethered by the NHS’. One member of staff suggested the unit ‘could not have lasted as it was not run as a business; it was a matter of time before anything happened i.e. too many hours worked.’

The CMU is deemed to be a lovely facility, more clinical and therefore needs to be more homely. The change in the length of postnatal length of staff has affected the numbers of women choosing to give birth in the unit. Lack of piped Entonox was mentioned as a difficulty as canisters have to be used; these are bulky. It was suggested that ‘student midwives have had a mixed experience although on the whole positive’.

Relationships between staff were identified as an issue. The staff in CNMU were described as friendly by a few individual’s, others mentioned a ‘click’, midwives working in isolation and on call midwives not wanting to work in the units for a variety of reasons. These related to isolation of the unit, being treated like a student, a very untidy and disorganised place. The team in CNMU were described as ‘longstanding, strong and committed to making the unit work.’

Staff based in the Horton Maternity units explained there had been communication issues previously and an ‘us and them’ situation.

Management of the 2 units was highlighted by a number of staff and the differences of style by the individuals managing and leading the CNMU and CMU. The styles were described by many individuals interviewed; both styles have had impacted on the organisation of the units and the staff. (The details have been withheld as they will attributable to individuals)

The birthing pools are seen as a positive.

The negative effects on other community teams and midwives was identified by a number of staff. Changes in workload and community areas is seen as a way to increase the births but has affected the focus of the team based in the CMU.

One individual summed up the situation by stating that ‘the CMU is a positive unit for both women and staff but has been spoilt by the events of the last year although this is an underlying longstanding problem that has not been addressed.’

4. Positive aspects

• Generally staff felt that the unit was positive and offered a good service to women during the antenatal, intrapartum and postnatal periods. The provision of a midwifery led service was seen as very positive.

• Staff mentioned a number of individuals who were very good practitioners, experienced and made safe decisions.

• The fact staff have time was highlighted and the provision of 1:1 care in labour was positive.

• Teamwork was mentioned as a positive in both units.

• Normality and the birthing pools.

• Organisation of the CMU.

• CNMU – ‘passionate individuals about normality, enabling women to give birth. However became isolated and not balanced to appropriate need’. Offered ‘exclusive care and handpicked certain women’.

• The development of the Maternity Support Worker role in the CMU.
• Changes to the establishments and individual staff were identified as a positive by some staff.
• CNMU – a good reputation, familiar and a ‘family tradition’ as mother and grandmothers gave birth in the unit. 24 hour service.
• CNMU – dinner and babysitting service offered to couples before they went home.
• CMU – parking.
• A local unit.

5. Concerns about the units

The issues raised can be classified under the following categories:

<table>
<thead>
<tr>
<th>Culture</th>
<th>Practice</th>
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<tbody>
<tr>
<td>Longstanding, undermining.</td>
<td>Delays in care i.e. transfers</td>
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<tr>
<td>Underhand practices towards staff</td>
<td>Concerns about some individuals practice</td>
</tr>
<tr>
<td>Not allowing access to a room when called as the second midwife</td>
<td>Lack of basic emergency care i.e. IV cannulation</td>
</tr>
<tr>
<td>Midwives do not give a positive impression of the Horton – this set up barriers</td>
<td>Delays in transfers</td>
</tr>
<tr>
<td>1:1 care to the exclusion of other midwives</td>
<td>On calls affect the other community teams i.e. continuity of care</td>
</tr>
<tr>
<td>Midwives give false expectations of possible outcomes</td>
<td>Not able to adopt the 1:1 care model</td>
</tr>
<tr>
<td>Essence of Chipping Norton has gone</td>
<td>Pushing boundaries to achieve normal birth</td>
</tr>
<tr>
<td>Team working – not so cohesive</td>
<td>Inequalities in workload</td>
</tr>
<tr>
<td>A lot of history – situation could have been predicted</td>
<td>Inequalities in service provision</td>
</tr>
<tr>
<td>Loss of postnatal stay has affected the unit</td>
<td>Different practices from other community teams</td>
</tr>
<tr>
<td></td>
<td>Postnatal care is poor</td>
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<table>
<thead>
<tr>
<th>Environment</th>
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</thead>
<tbody>
<tr>
<td>Training</td>
</tr>
<tr>
<td>Staff must be trained in obstetric emergencies</td>
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<tr>
<td>MSW training no longer in place</td>
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<tr>
<th>Governance/Safety</th>
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<tbody>
<tr>
<td>Staff issues</td>
</tr>
<tr>
<td>Recruitment affected as midwives do not want to work in Chipping Norton</td>
</tr>
<tr>
<td>Feel much happier being called into the JR or HMH</td>
</tr>
<tr>
<td>On calls affect family life</td>
</tr>
<tr>
<td>Feel vulnerable especially as ‘tucked away’</td>
</tr>
<tr>
<td>Would prefer to look after women at home</td>
</tr>
<tr>
<td>Withdrawing the MSW’s at night</td>
</tr>
<tr>
<td>Information about the unit being discussed outside – related to specific staff members</td>
</tr>
<tr>
<td>Reorganisation of Band 7’s caused major problems amongst individuals</td>
</tr>
</tbody>
</table>
The Facebook campaign and the effects on staff

Reopening the unit without addressing concerns about on calls and the impact on other community teams

Staff being stopped in the street by the public suggesting they have lost their job

Management have a responsibility

CNMU – a difficult team to manage, led to infighting

Transfer rates up due to midwives not feeling confident and isolation of unit

Some of the individuals are bigger than the unit

CNMU – Fire exit left open and used by staff and visitors to access the unit

Lack of management support for the clinical manager during a very difficult transition

Unit governed by risk management

Lack of backup at night

A number of staff suggested it was a very sad situation that should have been addressed 4-5 years ago meaning that the situation would not have deteriorated so badly.

6. Compliance with clinical governance arrangements

The issues raised can be classified under the following categories:

<table>
<thead>
<tr>
<th>Culture</th>
<th>Practice</th>
<th>Governance/Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working relationships between staff at CNMU/CMU and the Horton</td>
<td>Rotational MW’s are more proactive and follow guidelines.</td>
<td>Some women were supported after discussion with a SOM/Consultant Obstetrician.</td>
</tr>
<tr>
<td>Tension between the ‘old and the new’.</td>
<td>Lack of handover.</td>
<td>Not all women are appropriate for birth in CNMU/CMU i.e. woman with a high BMI.</td>
</tr>
<tr>
<td>‘The group’ were openly critical of any midwife who transferred a woman.</td>
<td>Clinical assessments not completed for all women.</td>
<td>Individuals did not put anyone’s life in danger.</td>
</tr>
<tr>
<td>Not all staff involved i.e. midwives and MSW’s.</td>
<td>Consultant midwife has instigated a positive change.</td>
<td>Women not informed about risks.</td>
</tr>
<tr>
<td>Testing</td>
<td>Some midwives stayed in the unit for 24 hours.</td>
<td>In the past ‘rules were bent’.</td>
</tr>
<tr>
<td>No concerns from students.</td>
<td></td>
<td>Women had not been given information about risks.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incident forms now completed.</td>
</tr>
</tbody>
</table>

7. Practice within guidelines

It was highlighted by a number of staff that guidelines were not always followed by every individual midwife; this led to other midwives having to deal with the consequences. Some individuals were described as practicing their own way and excluding others. This caused upset between the ‘old and the new’.

Non-compliance with NMC guidelines i.e. record keeping.
There were concerns about practice and the suggestions that boundaries were ‘pushed’ so women could birth in the CNMU.

A number of individual midwives were singled out as working professionally and offering safe care.

Acknowledged by individual staff that some women were accommodated in the CNMU who were outwith the guidelines to prevent them birthing at home alone.

It was suggested that CNMU midwives were involved in writing the midwifery led guidelines.

Generally the opinion of the most staff is there is better compliance in CMU.

8. Suggested changes

<table>
<thead>
<tr>
<th>• Management support</th>
<th>• Move the unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Build a cohesive team</td>
<td>• Close the unit</td>
</tr>
<tr>
<td>• Rotate staff to CMU</td>
<td>• Appropriate selection of women booking to birth in the unit</td>
</tr>
<tr>
<td>• Ensure women are appropriately prepared</td>
<td>• Exclude a number of individuals</td>
</tr>
<tr>
<td>• Staff the unit with experienced MSW’s</td>
<td>• Antenatal and postnatal service only</td>
</tr>
<tr>
<td>• Review the on call provision</td>
<td>• Neighbourhood midwives</td>
</tr>
<tr>
<td>• Review workloads</td>
<td>• A complete change of personnel</td>
</tr>
<tr>
<td>• Cohesive working – CMU, community teams and the Horton Maternity Unit</td>
<td>• Change the environment</td>
</tr>
<tr>
<td>• Staff training – Obstetric emergencies</td>
<td>• Team meetings to address any concerns/honesty</td>
</tr>
<tr>
<td>• Improve front door bell and telephone</td>
<td>• Increase the number of births</td>
</tr>
<tr>
<td>• Case review meetings</td>
<td>• Improve continuity of care</td>
</tr>
<tr>
<td>• Avoid lone working</td>
<td>• Review postnatal stay</td>
</tr>
<tr>
<td>• Review shift patterns</td>
<td>• Improve timekeeping</td>
</tr>
<tr>
<td>• Market the unit</td>
<td>•</td>
</tr>
</tbody>
</table>

9. Culture

<table>
<thead>
<tr>
<th>• Different in both units</th>
<th>• Old unit - sinister</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Issues led to disharmony</td>
<td>• Exist on another plane</td>
</tr>
<tr>
<td>• Women first, midwives supported each other – an ‘organic’ management style</td>
<td>• Supportive culture now</td>
</tr>
<tr>
<td>• More organised</td>
<td>• Openness, comradeship</td>
</tr>
<tr>
<td>• Different management styles have led to difficulties with some individuals</td>
<td>• Closed and therefore dangerous</td>
</tr>
<tr>
<td>• Very different approach to birth – failure to recognise deviations/proactive approach to managing women</td>
<td>• The different philosophies undermined individuals and caused major problems</td>
</tr>
<tr>
<td>• Has been unhappiness/unrest</td>
<td>• Generally happy</td>
</tr>
<tr>
<td>• Having a figurehead that steers the unit</td>
<td>• Insular, defensive and a sense of</td>
</tr>
<tr>
<td>grandeur</td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td></td>
</tr>
<tr>
<td>• Defensive because of on-going issues</td>
<td></td>
</tr>
<tr>
<td>• Previously – very unhealthy culture</td>
<td></td>
</tr>
<tr>
<td>• Passionate about normal birth</td>
<td></td>
</tr>
</tbody>
</table>
RESULTS OF THE QUESTIONNAIRES - WOMEN

1. Questionnaires

200 questionnaires distributed
106 Returned
6 returned as ‘no longer at this address’
1 other questionnaire returned (not one of the 200 sent)
1 questionnaire sent to a woman who did not receive care from CMU

52% response rate

Resume of 107 responses

3. Used the services of CMU/CN.
   a. 107 women had used the services of the units

4. Booked to give birth in CMU
   a. 91 women - had booked
   b. 16 women – not booked

5. Gave birth
   a. 11 – Home
   b. 1 – still pregnant
   c. 11 – had given birth to their babies in a variety of units inc CMU
   d. 2 – John Radcliffe
   e. 82 – CMU/CN

6. Provision of information
   a. Yes – 91
   b. No/Mixed – 16

Comments:
Home birth suggested rather than birth in MLU.
More information about the facilities would have been beneficial.
Not in terms of risks at CN.
Transfer times explained but risks were left for you to infer.
Midwife assumed the mother would have her baby at the Horton Maternity Unit.
GP’s not supportive.
Strong bias to the CMU and felt slightly coerced.
Thought an ambulance was based at CMU.
Research it myself.
Information mainly provided by the NCT.
Pressure to have baby in hospital and only get information they choose to give you as steer in a certain direction.
Unit not advertised enough.
No one gave concrete evidence or discussed risks.
Options not discussed.
Made decision to have a home birth although did not feel fully supported by the midwife.
Not informed the unit was closed due to an infestation.

7. Impression of the unit
   a. 11 – Not applicable
   b. 13- Mixed or negative comments

**Comments:**
Gave birth at home but attended the unit for PN checks – unit seemed extremely busy.
The new unit is a bit more clinical but still has a relaxed and friendly feel.
Positive comments but post birth the administration was a little bit chaotic.
En suite amazing – if they could actually be used ofe overnight care for the first few nights.
Old unit very dated and old fashioned x 4 comments.
Disappointed with the time it took to open up the unit.
Running of the unit seemed disorganised and routines not in place.
The ability to stay longer than 2/3 hours would be preferred.
Concerns about care i.e. having to get out of the pool, second stage of labour and feeling
my blood loss was underestimated.
Was not as I expected or as good as I was expecting; disappointed.
Care when giving birth was poor.

c. 83 – Positive comments

**Comments:**
Excellent, brilliant, relaxed.
Staff very friendly, amazing and supportive.
Rooms with birthing pool.
Like a hotel with staffing to match.
Fabulous facilities.
Clean, lovely atmosphere.
Professional and knowledgeable staff.
Home from home.
Very well run and organised.
Very impressed with the care and service received.
A number of staff were mentioned as making a positive difference to the woman’s birth experience.

8. Reason for transfer
   a. 85 – No transfer required.
   b. 22 – Transfer required.
Reasons for transfer:
Baby – breathing difficulties x 2.
Breathlessness.
Prolonged second stage of labour.
3/4th degree tear x 3
Prolonged rupture of membranes.
Postpartum haemorrhage.
Raised Blood pressure post birth.
Baby – feeding problems.
Breech presentation,
Meconium stained liquor although gave birth at CN.
Fetal heart anomalies.
Jaundice.

9. Positive aspects of the CMU/CN

Comments:
Less medical atmosphere.
Pool.
Midwives with expertise in natural childbirth.
Facilities.
1:1 care.
Open door to return for advice.
Patient focussed and treated as an individual.
Empower you to give birth.
Staff, facilities, atmosphere.
Local facility.
Baby needed to be observed due to meconium in labour, able to stay in CMU.
Size of the unit.
Wealth of the experience amongst the midwives.
Postnatal care and Breastfeeding support.
Individual staff are mentioned as offering positive care.
Only women In the unit so privacy and dignity supported.
One woman did not have any positive experiences.

10. Concerns

Comments:
Most respondents did not have any concerns at all.
Lack of communication – re unit being closed because of an infestation.
Breast feeding problem not spotted earlier and no advice on expressing. Poor communication between feeding specialist and midwives.
The whispering campaign directed at particular midwives at the unit by mothers who may not have had the birth experience they wanted and want to blame someone for this. I was horrified to hear of names being flung about in the public arena.
Women having to go home soon after the birth, this was mentioned by 11 women.
Concerned would have to go to the JR.
Incorrect information re the availability of the on call midwife.
The unit is not promoted enough.
2nd midwife arrived after the birth.
Isolated unit and transfer times x 6.
One midwife did not show empathy or respect.
Long wait for paperwork.
Waiting time for antenatal appointment.
Midwives did not hear the emergency bell, were with another woman in labour.
Staffing.
Lack of continuity of antenatal care.
Baby details recorded incorrectly.
Access to unit at night, especially as on call midwives may take time to get to the unit.
I was left too long in labour and should have been referred to Banbury.
Midwife spent a lot of time filling in forms and using the computer, affected 1:1 care.
Baby moved to another room while the mother was having a shower.
No ‘gas and air’ available.
Advice from GP re place of birth.
Inappropriate comments made by one midwife.
General comment about lack of follow up care of women who have sustained perineal trauma.
Concerns that one member of staff did not know how to use a piece of equipment adequately.
A lottery about who delivered our baby. This woman made reference to a number of staff in both a positive and negative manner.

11. Suggested changes

Comments:
The majority of respondents suggested the unit should reopen.
Many respondents suggested the unit should offer the opportunity for women to stay one night.
Many respondents offered no changes.
Midwives to have more experience of pool births.
The unit is concerned with statistics, this is in relation to the under estimation of blood loss.
More birthing rooms.
Continuity of care.
Mats for the birthing rooms.
Staffing of the unit.
Women in labour not to have to wait in the waiting room.
Positive support for home births.
Group breast feeding support for mothers, not just 1:1 support.
More information/discussion about interventions i.e. Syntometrine.
Improve response times to phone calls.
Improve waiting times.
Environment – make it more homely.
Organisation of the unit i.e. leadership and implementation of processes.
Promote the unit locally.
Better postnatal care.
A better door bell.
Improve administrative processes.
Improve the telephone system.
Better communication between the CMU and the Horton.
Improved ventilation in the rooms.
Consider the unit is not viable as a place to deliver babies as it is equivalent to giving birth at home. Should be available for antenatal and postnatal care.
Comments were made about individual’s members of staff.
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Introduction
A notes review was undertaken January 2013 of a selection of women who gave birth at the Cotswold Midwifery Led Unit (CMLU) in Chipping Norton within the calendar years 2008 and 2012.

This was undertaken as part of an internal review of the unit, to ensure that safe practice is maintained and Oxford University Hospital (OUH) guidelines followed. The areas that were specifically looked at were the Antenatal and Intrapartum period.

Methodology
Two hundred sets of notes were selected from women who birthed at the Cotswold Midwifery Led Unit in Chipping Norton over a period of 4 years. Fifty sets of notes were randomly chosen from each year.

A group of midwife auditors were randomly selected from the OUH Trust to complete an audit proforma of 12 questions for a selected amount of notes. The majority of these auditors were Supervisors of Midwives (excluding any supervisors who worked at the CMLU). Questions were chosen to encompass Antenatal and Intrapartum Care in the community and at the CMLU. The notes were reviewed in the paper format and occasionally Electronic Patient Records (EPR) had been used but were not accessed for the audit.

These audit forms were collated and reviewed independently using an excel spread sheet and formatting. They were reviewed using the 12 questions on the Proforma. In total 198 audit proformas were reviewed.

Where a percentage does not add up to 100%, this is due to the fact that the audit proforma was either missing the information required or the auditor had not found the answer to the question in the maternal hand held records.

Results
Parity
The % of women who gave birth at the CMLU by parity is displayed in the table below.

<table>
<thead>
<tr>
<th>Parity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>34%</td>
</tr>
<tr>
<td>1</td>
<td>41%</td>
</tr>
</tbody>
</table>
### Antenatal Assessment

**Risk Factors Identified at Booking**

Out of the 198 women 29% of them were stated to have antenatal risk factors identified at booking. These included a range of medical, mental health, previous obstetric history and social issues. The table below highlights some of the reasons for a Consultant referral.

<table>
<thead>
<tr>
<th>Past/current Medical History</th>
<th>Cervical laser treatment, Thyroid Conditions, Asthmatic, Raised/Low BMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past/current Mental Health History</td>
<td>Depression</td>
</tr>
<tr>
<td>Previous Obstetric History</td>
<td>Previous baby IUGR, Previous GBS, Grand Multiparous, PPH, Maternal Age, Previous preterm labour, Cholestasis, previous baby &gt;4.5kgs</td>
</tr>
<tr>
<td>Social Issues</td>
<td>Teenage pregnancy, concealed pregnancy,</td>
</tr>
</tbody>
</table>

There were eight occasions where student midwives undertook the booking visit but no midwife countersigned the entry.

**Midwife/Consultant Antenatal Care Pathway**

Out of the women booked to birth at CMLU, 12% were referred to a consultant for an opinion. The majority of the time it was documented that the Consultant was happy for the woman to birth at the CMLU and the woman was transferred back to Midwifery Led Care where appropriate. There were only 2 women who were referred to a Consultant where it was thought to be the wrong pathway. One woman had a Clomid induced pregnancy and the other no risk factors identified.

There were 5 women on the Midwife Led Antenatal Care Pathway who should have been referred to a Consultant for the following reasons:

- Previous PPH and urinary retention
- Sherman's Disease
• Previous heavy bleeding postnatally and family history of heart problems
• Grand multiparous
• Depression currently on medication

In total 4% of women were deemed to be on the wrong Antenatal Care Pathway.

**NICE Recommended Visits**

NICE recommends that every primigravida should receive ten visits throughout the antenatal period and a multiparous woman six. There were 63% of women who received the correct amount of visits as per NICE.

Of the women who did not receive the recommended NICE visits, 3 women clearly received between 3-4 too few visits. All 3 were primigravida and one was a teenage pregnancy with social issues. Some other women received too few visits due to transferring their care from other areas late on in pregnancy.

The rest of the women received over and above what is recommended by NICE. These ranged from one extra visit to ten and for over half of these no rational was evident for the extra visits. The rest were due to a variety of reasons including:

• Raised Blood Pressure
• Echogenic Bowel noted
• Small for Gestational Age

**Place of Birth Discussion**

In 61% of the notes audited it was noted that a discussion of some description around the place of birth had taken place. There were a variety of ways this was done but the majority appeared to be limited. In some cases it was just a tick in the box "birth place discussed" or "Chipping Norton" and a tick next to it. These "discussions" were often identified at booking and no place of birth appeared to be reviewed further along in the pregnancy. In some cases a discussion was clearly documented but the risks and benefits including transfer times and what would instigate a transfer were omitted. In the cases where women were Consultant Led Care the only mention of the birth in the CMLU was by the Consultant agreeing it.
Intrapartum Assessment

Clinical Risk Assessment at the Onset of Labour
A clinical risk assessment at the onset of labour includes; medical, obstetric and social history, observations of maternal and fetal wellbeing and a recent history of events. The woman should be asked about the frequency of contractions, liquor presence and colour, and fetal movements. Any deviations from the normal require referral to an obstetrician. (clinical risk assessment in labour guideline). This will ensure that the woman labours and births in what is deemed the safest environment for her and her baby.

Within this audit it was noted that 84% of women during this time frame, had a risk assessment undertaken at the onset of labour. Out of the women who did not appear to have had a risk assessment performed the following were done in part or missing:

- Maternal Observations
- Palpation
- Urine Analysis
- Noting of Fetal Movements
- Colour of the liquor or if membranes intact or not
- Risk factors present i.e. risk of PPH or previous PPH

It was noted in ten women within this review, that they either had a "rapid birth" or the baby was Born Before Arrival (BBA).

Intrapartum Care Guidelines Followed
The OUH Intrapartum Care Guidelines, follow the recommendations of NICE to ensure that fetal and maternal well-being is observed throughout labour and birth. The percentage of women who had the Intrapartum Care Guidelines followed in their labour was 57%.

The majority of the reasons for this lower percentage was to do with the following not being documented as per the OUH Intrapartum Care Guidelines:

- FHR not being recorded every 15minutes in the first stage
- FHR not being recorded every 5 minutes in the second stage
• Maternal observations (Temperature, Pulse, Blood Pressure) not being recorded every hour (pulse) or 4 hours (BP and Temperature)
• Pool Temperature not monitored hourly and also women entering the pool too hot (38.0 degrees C) or giving birth at a temperature too low (35.0 degrees C). In a significant amount of cases the pool temperature was never documented
• Meconium noted and no transfer arranged in time (1.5 hours from noting to birth)
• Delay in commencing partogram
• Noting what is established labour (one woman 6 cm and had early labour observations)
• Plans not written with deviation from normal e.g. Abnormal FHR, Abnormal maternal temperature, slow progress of multiparous, prolonged 2nd stage
• Limited bladder care noted throughout labour and no voids measured

Twenty one of these women where it was deemed that the OUH Intrapartum Care Guidelines were not followed, had what was described as a rapid birth or BBA. From what could be interpreted via the audit forms it was felt that generally retrospective entries in these cases could be improved.

**Detailed Discussion re Transfer when a Deviation from the Normal Birth Pathway was Identified**

There were 10% of the women who were deemed to require transfer from CMLU to a Consultant Led Unit either the John Radcliffe or Horton General. Out of these, seven women/babies were actually transferred to a Consultant Led Unit for the following reasons:

**Neonatal**

• No respiratory effort
• Slow to regular respirations
• Low apgar score
• Grunting
• Low temperature and no breast feeding support overnight
Maternal

- Post Partum Haemorrhage (PPH)
- 3rd degree tear repair

The other women were Intrapartum arranged transfers but gave birth on the unit prior to transfer. The actual documented detailed discussion regarding the transfer/plan of care appeared to be lacking in a number of cases, only 6% of the 10% had this noted.

Second Midwife Called for Delivery

Where possible a second midwife should be present for a birth to assist with any maternal or neonatal resuscitation that may be required. In 74% of the cases a second midwife was called prior to the birth of the baby. The reasons for not calling a second midwife were as follows:

<table>
<thead>
<tr>
<th>Reason</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid Birth</td>
<td>4</td>
</tr>
<tr>
<td>No reason given</td>
<td>12</td>
</tr>
<tr>
<td>Student Midwife</td>
<td>7</td>
</tr>
<tr>
<td>Other - MSW present/early shift MW due to arrive</td>
<td>3</td>
</tr>
</tbody>
</table>

Fetal Weight and Apgar Score

The average fetal weight over all of the cases reviewed was 3595g. Thirty three (17%) babies in the audit weighed over 4000g and fourteen (7%) weighed under 3000g.

Apgar Score

<table>
<thead>
<tr>
<th>Score Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>10, 10, 10</td>
<td>119</td>
</tr>
<tr>
<td>At 1 minute &lt; 10 but &gt; 5</td>
<td>62</td>
</tr>
<tr>
<td>At 1 minute ≤ 5</td>
<td>6</td>
</tr>
<tr>
<td>None Recorded</td>
<td>11</td>
</tr>
</tbody>
</table>

The lowest Apgar score recorded at ten minutes was seven.
Other Comments
There was a box on the audit proforma that allowed the auditor to make additional comments. In this box was noted good practice, good documentation and areas that might be improved upon. Some of these areas were:

- Consultant input required even though midwife retrieved and reviewed POH in old notes
- Several women booked at Horton and John Radcliffe with no note of wishing to birth at CMLU
- Retrospective entries should be encouraged
- Women left sometimes when inappropriate for stage of labour e.g.
  - Midwife advised woman to go for a walk outside (returned 1 hour - 8cm)
  - Left woman in pool for 20 minutes alone close to 2nd stage to talk to another woman in labour on the phone
  - Handed over to a midwife 2 minutes prior to vertex visible to see an antenatal woman.
- Lack of evidence of planning and following up risk factors - one woman had raised BP but no plan written and no repeat BP noted
- Non suturing of perineum - discussion of risks and benefits of this, plus current national guidance with women not documented
## Recommendations

<table>
<thead>
<tr>
<th>Noted Issue</th>
<th>Recommendation</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students: No Countersigning for Student Midwives booking histories Used as the 2nd midwife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of Documented discussions re place of birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To ensure the correct AN pathway is chosen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Risk Assessment at the Onset of labour not always noted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrapartum Care Guidelines not followed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• FHR in 1st and 2nd stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maternal observations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pool Temperature</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Meconium stained liquor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Delay in commencing partogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Clearly identifying established labour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Plans of care in the normal and deviation from normal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bladder care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tears left un-sutured - no risks/benefits/national guidance discussion noted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retrospective Note Entry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detailed discussion of plan for transfer and rationale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not all births have the presence of a 2nd midwife at births on an MLU or at Home</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix E

1. Review of transfers from Chipping Norton Midwifery Led Unit
2. [2010-2012]

3. Background

Clinical and non-clinical incidents are reported to the Risk Management team using the Oxford University Hospital Clinical Incident forms. All transfers from Midwifery Led Units [MLU] and Homebirths are required to be reported using paper forms/DATIX. The majority of the transfers from the MLU were taken to the Horton Hospital and where required to the John Radcliffe Unit. The transfers to the John Radcliffe were for neonatal concerns.

An audit of all clinical incidents/transfers was undertaken in response to the temporary closure of the Chipping Norton Midwifery Led Unit.

4. Methodology

All the Incident Report forms from 2010, 2011 and 2012 were obtained from the Risk Coordinator. There were a total of 55 forms. The breakdown from each year is detailed in Table 1:

<table>
<thead>
<tr>
<th>Year</th>
<th>Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>8</td>
</tr>
<tr>
<td>2011</td>
<td>19</td>
</tr>
<tr>
<td>2012</td>
<td>28</td>
</tr>
</tbody>
</table>

Table 1

The maternity hand held records and EPR were accessed to provide information on antenatal, intrapartum and immediate postnatal care. An audit proforma was developed to capture the required information [Appendix 1]. The primary aim of the audit was to review if the transfer from Chipping Norton Midwifery Led Unit was appropriate, if the speed of transfer met locally agreed standards and any delays recoded.
Additional information included:

- Booked for midwifery or consultant led care
- Documentation of discussions in the antenatal period including: place of birth and any patient information leaflets given to enable women to make informed decisions including risks and benefit
- Midwife at onset of labour and point of transfer
- Documentation for the reasons for transfer and discussion with woman and family
- Maternal and fetal outcomes

5. Results

There was a wide variety of the reasons for transfer documented. These have been broken down by each year.

Table 2

<table>
<thead>
<tr>
<th>Reason</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meconium staining 1st stage</td>
<td>1</td>
</tr>
<tr>
<td>In utero transfer in 1st stage for failure to progress</td>
<td>2</td>
</tr>
<tr>
<td>Breech presentation 1st stage</td>
<td>2</td>
</tr>
<tr>
<td>PPH</td>
<td>2</td>
</tr>
<tr>
<td>Resuscitation of baby</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 3

<table>
<thead>
<tr>
<th>Reason</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary PPH</td>
<td>1</td>
</tr>
<tr>
<td>In utero transfer in 1st stage</td>
<td>6</td>
</tr>
<tr>
<td>Meconium staining in utero transfer in 1st stage</td>
<td>2</td>
</tr>
<tr>
<td>Suturing</td>
<td>1</td>
</tr>
<tr>
<td>PPH 1st stage labour</td>
<td>1</td>
</tr>
<tr>
<td>Resuscitation of baby</td>
<td>1</td>
</tr>
<tr>
<td>Epidural Request</td>
<td>3</td>
</tr>
<tr>
<td>Repair of 3rd degree</td>
<td>1</td>
</tr>
<tr>
<td>Maternal tachycardia</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
6. Transfer Rates

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total deliveries</td>
<td>121</td>
<td>80</td>
<td>117</td>
</tr>
<tr>
<td>Number of reported transfers</td>
<td>9</td>
<td>19</td>
<td>28</td>
</tr>
<tr>
<td>Transfer rate</td>
<td>7.4%</td>
<td>23.7%</td>
<td>23.9%</td>
</tr>
</tbody>
</table>

There has been a notable increase in the transfers from 2010 to 2012. This could be due to an increased compliance of reporting these incidents.

7. Reasons for transfer

The majority of the transfers were during the intrapartum period [67%]

<table>
<thead>
<tr>
<th>Intrapartum Events</th>
<th>Post Natal</th>
<th>Neonatal</th>
</tr>
</thead>
<tbody>
<tr>
<td>In utero transfer in 1st stage for failure to progress</td>
<td>Secondary PPH</td>
<td>Meconium at birth transfer for fetal observations</td>
</tr>
<tr>
<td>Meconium staining 1st stage</td>
<td>Retained placenta</td>
<td>Resuscitation of baby</td>
</tr>
<tr>
<td>In utero transfer in 2nd stage for failure to progress</td>
<td>PPH</td>
<td></td>
</tr>
<tr>
<td>Breech presentation 1st stage</td>
<td>Repair of 3rd degree tear</td>
<td></td>
</tr>
<tr>
<td>Fetal distress - decelerations</td>
<td>Perineal Suturing</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td>Advised to birth at HGH due to risk factors, given conflicting advice *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APH 1st stage labour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epidural request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal tachycardia</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*This transfer was excluded as this woman had known identified risk factors and was advised against delivery in the MLU. There was a detailed birth plan in place by the Consultant midwife which was secured in the hand held records. This woman opted to stay at home but was subsequently transferred into the Horton during the intrapartum period.

- Women who were transferred for failure to progress in 1st and 2nd stage of labour were appropriately transferred for further assessment/review and delivery. The majority of these women required an assisted delivery either by Neville Barnes Forceps or Emergency Caesarean section. There was 1 case where there would appear to have been a differing of opinions as to the onset of established labour, one midwife documented in the hand held records that: *I would dispute established labour at 4am. Not ever really established labour at 09.00hrs. So therefore amended partogram Mrs X was in 'latent phase' establishing at 11.00 am'. Retrospective entries into hand held records should state facts and not opinions and this documentation does not reflect good practice.
- Meconium staining in the 1st stage of labour. Out of the 6 cases, 5 women were transferred immediately. There was one case where transfer into the ambulance was delayed as the midwives were assessing whether delivery was imminent. There was no fetal distress and delivery was completed in the Horton. There was no delay in decision making for transfer for any of the cases when meconium was identified in labour.
- Transfer for fetal distress/decelerations: The apgars scores for these cases were very good and minimal resuscitation was required. The category of transfer was not always documented in the records and therefore auditing the agreed local timeframes for this clinical condition/event is difficult.
- There were 3 cases of primary postpartum haemorrhage. Two cases were well managed using appropriate medication. There was 1 case where IV ergometrine would have been more appropriate then IM. All women initially had a physiological 3rd stage which was appropriate for these low risk women. Two women had a secondary PPH. One woman was still in the unit – she was appropriately managed and then transferred. One woman had delivered and was discharged home and was readmitted to the Horton from home.
- Neonatal resuscitation – Of the 6 cases – 4 sets of notes were not available. The 2 cases that were reviewed:
  1. The women arrived into the unit in advanced 2nd stage of labour and delivered within 2 minutes of arrival. The documentation of the apgars scores is conflicting. The attending midwife has hand written the scores differently in the notes and then documented on EPR different scores. There was documentation in the hand held records to show that this had been discussed with delivery suite at the JR as the midwife has recorded that the baby was feeding well and would be observed in the unit overnight. There were no baby observations documented in the hand held records/EPR of apex, respiration rate or temperature. If there are any on-going baby concerns/observations required the most appropriate place would be the
Consultant led Unit, as a baby who collapses needs access to the paediatric team for on-going support and this is only available in the Consultant led unit.

2. This baby was delivered in the Chipping Norton Unit with apgars of 4,7,9. Sternal recession noted along with labour respirations, basic resuscitation initiated and transfer to JR SCBU for further assessment. Baby admitted and observation and antibiotics. Good resuscitation from team at Chipping Norton and ambulance response time of 1 hour.

- Perineal repair – There were 3 cases where women were transferred, 2 were correctly diagnosed as third degree tears and the third case was a complicated second degree laceration that required a doctor to repair.
- There were 4 cases of undiagnosed breech deliveries – 2 were diagnosed during labour and appropriately transferred to the Consultant unit and were delivered by Caesarean section with good apgars. Two vaginal deliveries were precipitate [1 baby required resuscitation and transfer to the Consultant unit] the other baby required stimulation and oxygen therapy.

8. **Missing data**

There were 4 sets of notes not available in 2012, 2 sets in 2011 and 1 set in 2010. The total number of notes that were audited was 48. The missing data accounts for 12% of data.

9. **Documentation of place of birth**

Place of birth discussions and patient information leaflets were poorly documented in the hand held records. There was evidence in some records that Chipping Norton was the place of birth but there were no discussions to reflect the risks and benefits of a MLU delivery. The women who were booked to deliver at the unit were mainly low risk women on the midwifery led pathway. Where there were identified medical problems an opinion was sought from the medical staff to determine place of birth.

10. **Time Critical and Emergency Transfers**

Over 90% of notes demonstrated clear documentation of the decision time to transfer, ambulance called and arrival at unit. However, documentation of whether an emergency or time critical transfers had been requested was seen in only 78% of the notes. This is essential for the midwives to document this as this will ensure that locally agreed time critical and emergency transfers occur within a set time frame.

11. **Ambulance Transfer forms**

The OUH have implemented an Ambulance Transfer form that has to be completed by staff initiating a transfer from the community setting. One copy has to be filed in the hand held notes and the other has to be returned to Risk Coordinators. There were only 2 forms found in the hand held records. This ensures that detailed handover of care are undertaken between health professionals.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time-Critical Transfer</td>
<td>The next available ambulance will be directed for the transfer</td>
</tr>
<tr>
<td>Emergency Transfer</td>
<td>An ambulance will be sent within 1 hour</td>
</tr>
</tbody>
</table>
12. **Recommendations**

1. **Issue Identified:** There was poor documentation that the place of birth had been discussed in detail with woman and their families

   **Recommendation:** The patient information leaflet regarding ‘Planning a birth at home or midwife led unit’ needs to be discussed and documented in the notes that the risks and benefits of place of birth have been fully discussed

2. **Issue identified:** Poor documentation of time critical and emergency transfers

   **Recommendations:** Discussion at team meetings and regular audits by teams to discuss transfers and monitor transfers

3. **Issue identified:** Limited documentation of discussion with parents regarding reasons for transfer to Consultant led unit.

   **Recommendation:** Point 3 to be discussed to staff and team meetings. De-briefing with parents in the postnatal period

4. **Issue identified:** Definition of established labour

   **Recommendation:** Discussion with Consultant Midwife to agree definition

5. **Issue identified:** Poor use of the Ambulance Transfer form

   **Recommendation:** Point 5 needs to be discussed at team meetings
## Appendix 1

### Audit Tool

<table>
<thead>
<tr>
<th>Stickie Label</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Year delivered and transferred</td>
<td></td>
</tr>
<tr>
<td>Incident number</td>
<td></td>
</tr>
<tr>
<td>Incident details [from Incident form]</td>
<td></td>
</tr>
<tr>
<td><strong>Review points</strong></td>
<td></td>
</tr>
<tr>
<td>Ambulance Transfer form present</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Low Risk</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Place of Birth discussed</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Patient information leaflet given</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Midwife at onset of labour</td>
<td></td>
</tr>
<tr>
<td>Midwife at point of transfer</td>
<td></td>
</tr>
<tr>
<td>Identified reason for transfer</td>
<td></td>
</tr>
<tr>
<td>Emergency or Time Critical Transfer</td>
<td></td>
</tr>
<tr>
<td>Ambulance Call</td>
<td></td>
</tr>
<tr>
<td>Ambulance Arrive</td>
<td></td>
</tr>
<tr>
<td>Ambulance arrive at Unit [Consultant unit]</td>
<td></td>
</tr>
<tr>
<td>Total time [minutes]</td>
<td></td>
</tr>
<tr>
<td>Time reviewed by medical staff</td>
<td></td>
</tr>
<tr>
<td>Outcome</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2

South Central Ambulance Service NHS

Emergency Inter-Hospital Transfers Flow Chart for Acute Trusts

All requests for Emergency Inter-hospital transfer must be requested by a clinician with appropriate clinical knowledge using the agreed terminology for either a 'time critical (emergency)' transfer or an 'emergency transfer' as defined below. To speak to Oxon/ Bucks Emergency Operations Centre please use the following number 08457 395494 - the details of the transfer will be taken and logged by a call taker and then passed to the Clinical Support Desk Clinician or Duty Manager who will discuss the case and arrange the next available Ambulance.

Examples of clinical conditions meriting the next available ambulance for IMMEDIATE inter-hospital transfer:

- Primary or rescue cardiac angioplasty (PCI)
- Vascular emergencies – ruptured abdominal or thoracic aortic aneurysm or aortic dissection / transection
- Immediate cardiothoracic surgery for stab/gunshot wound or emergency cardiac surgery
- Major trauma management (e.g. transfer of severely injured to a regional trauma unit)
- Paediatric sepsis when retrieval service is not available
- Neurosurgical transfer for evacuation of inter-cranial haematoma, management of sub-arachnoid haemorrhage or neurosurgical intensive care
- Transfer from midwifery led Unit to Obstetric Delivery suite for fetal or neonatal distress / anti-partum or post partum haemorrhage or maternal or neonatal medical emergency.
- Stroke treatment if within 2 hours of onset of symptoms (and not provided on site)

Examples of clinical conditions or circumstances that require inter-hospital transfer within 1 hour:

- Direct ITU admission from ED/ward/operating theatre
- Transfer between CCU/ITU/HDU
- Cauda equina and isolated spinal cord compression
- New onset acute limb ischaemia (suspected ilio-femoral embolism)
- Limb threatening injury
- In-utero transfers in labour
- MLU to Obstetric Unit for epidural / failure to progress
- Oxygen dependent adults and children
- Emergency renal dialysis
- Testicular torsion
- Patients on infusions/monitors/sedation that can’t be switched off for transfer
- Sudden loss of vision
- ENT emergency (Airway compromise / haemorrhage)
- Ill patient in non-acute hospital site requiring transfer

Is there any other significant clinical reason for the transfer?

Refer to hospital PTS provider

Request a **TIME CRITICAL TRANSFER**
The patient and HCP escort must be ready for transfer when the crew arrive

Request an **EMERGENCY TRANSFER**
The patient & HCP escort must be ready for transfer when the crew arrive

Considered on a case-by-case request by the CSD desk

John Black  Fizz Thompson  Luc Stephens
Medical Director  Executive Director of Patient Care  Interim Director of EOC

16 March 2010

53
RESULTS OF QUESTIONNARIES RECEIVED FROM GP’S

1. Questionnaires

16 questionnaires circulated.
4 questionnaires returned.
25% response rate

2. Results

2 GP practices do not refer women to the CMU.
1 practice refers if clinically indicated.
1 practice offers but rarely accepted.

3. Rationale for response

- The CMU is too far away.
- Another maternity unit in close proximity.
- Isolated and travel required.
- Local maternity unit available for antenatal care.

4. Impression of CMU

Remote and away from key services.
GP’s have little direct contact with the unit.
A difference noted between the old and new
-Midwife cover in GP surgeries.
-Provision of care in part due to misperception about whether the unit was open.

5. Positive aspects of the CMU

- Excellent reputation.
  - A fabulous facility but need to market the CMU.
  - Good postnatal care and breast feeding advice.
- Email responses to queries.
- Midwife visiting the GP practice.
- Calm, reassuring and friendly.

6. Concerns

- Discharge women too quickly which affect breastfeeding and continuity of care.
- Distance.
- Women arriving at unit when it is not staffed.
- Negative impact on other community areas/teams.
• Anxiety about primips delivering in the unit.
• Do not have a personal relationship with the midwives.
• Poor communication from CMU to the GP’s.

7. **Compliance with clinical governance, guidelines and culture of the unit.**

Unable to comment except one practice suggested the culture of the CMU is ‘low tech, friendly and a home from home facility’.
Appendix G

Oxford University Hospitals
NHS Trust

Cotswold Maternity Review

Meeting with the GP’s

Tuesday 22 January 2013

In attendance
3 GP’s
1 Health Visitor
Sarah Breton
Jane Hervé

All GP’s are involved in the routine antenatal care of pregnant women.

Impression of the unit:
➢ A very big difference in the old and new units

Old
➢ Provision of excellent care to mothers and babies
➢ Regular midwife allocated to GP surgery

New
➢ Less midwife cover at GP’s i.e. Charlbury surgery previously had one day a week but is now four hours a fortnight
➢ There has been a misperception about whether the unit was open

Positives
➢ A fabulous facility
➢ Need to market the CMU

Concerns
➢ Inconsistent care with a different midwife
➢ Poor communication from CMU to GP surgeries
➢ Communication breakdown between midwives / health visitors / GP’s
➢ Women discharged sooner now, unlike the old unit and this adversely affects breastfeeding
➢ Continuity of care is not good
Suggested changes:
- Allow women to stay postnatally – equitable service
- Baby examinations - midwife
- Consistency - midwives and maternity support workers
- Continuity of care
- Breastfeeding support especially from the maternity support workers in the community
- GP updated regarding changes in antenatal care i.e. clotting, GTT etc
- Local area meetings with midwives and GP’s every four weeks
- Monthly update from maternity services
- Email GP’s about the CMU and any changes

Other comments:
- Women’s Health Physiotherapist – very poor service / non-existent service
- One GP does not know the names of any midwives in the CMU
- Patients request – remind women about pelvic floor exercises antenatally
- Develop 4D scanner private service
Appendix H

COTSWOLD MATERNITY UNIT REVIEW
15TH AND 16TH JANUARY 2013
Facilitated by Pat Moss and Jennifer Lanham

This part of the Review was based on the following questions:

1. Have you used, or intend to use, the Unit?
2. What is your impression of the Unit and how would you describe the culture of the unit?
3. What are the positive aspects of the Unit?
4. What, if any, concerns have you about the Unit?
5. Do you have any concerns re: identification of risk?
6. Could you suggest any changes that would improve/restore trust in the service?

Six sessions were offered and a total of 52 people attended.

Q.1 Have you used, or intend to use the Unit?
- 36 women had attended and/or used the Unit
- 4 were non-users
- 12 were would be users.

Q.2 What is your impression of the Unit and how would you describe the culture of the Unit?
- A much more personal experience and after-care is offered.
- It’s a valuable, local resource.
- There’s a feeling of empowerment here, they were supportive of my wishes.
- There’s a really positive feeling here.
- Marvellous, brilliant, outstanding, the support was over and above anything I’d imagined. (Spring 2010)
- I had total confidence in the Unit and felt in safe hands.
- So much support given.
- The Unit offered continuity of care.
- Clear ethos here about empowering women.
- There’s such a difference between a community mid-wife and a hospital based mid-wife and there’s a commitment here to a mid-wife led unit.
- It was a role-model for other maternity units.
  Mothers talked through the options here vs Horton ‘Must do’ attitude
- My midwives at the old unit were experienced, caring, friends… supportive professionals who were very passionate but not irresponsible.
- I felt like a person here as compared to a ‘battery hen’ at the hospitals
- Personal experience for the most personal experience of your life vs delivery by a ‘faceless person’
- Human care. Care everyone should have.
- A model for what the NHS is aiming for.
• Flagship unit with lovely midwives.
• Encouragement and empathy offered here.

Q.3 What are the positive aspects of the Unit?
• Local birth helps avoid intervention.
• Supportive of natural births.
• Water birth – ‘I caught my baby’ – it’s a sanctuary here. (August 2011)
• People came to meet me as I arrived – so welcoming – like being met by your Mum.
• The parking here is wonderful – no worries about having money for it either.
• It’s a ‘Baby Friendly’ Unit, skin on skin and breastfeeding encouraged here.
• I had a home-birth, but the mid-wife stayed for almost four hours, making sure everything was OK.
• Great support with breast feeding
• Purpose built – less hospitalised.
• I was transferred to the Horton, but the local midwife and a student mid-wife travelled with me and stayed with.
• Out of five births (at multiple facilities), it was the best birth experience I had.
• The continuity of care with the midwives, no monetary amount can be put on the importance of this.
• People here take the time to understand – we called Care Assistant ‘Auntie’.
• The Unit is what women want.
• I would love to be able to come here.
• Welcomed here in Saturday mornings – fantastic.
• Long-term health benefits in being so less stressed here.
• I’d studied Hypnotherapy and found it really beneficial for me and was supported by the unit
• I had three days stay at the old unit while my milk came in. It was brilliant and very important as I had no experience with babies and no family to support me. Care led to 12 months of successful breast feeding.
• Three births here (2009, 2010, 2012) and had the same midwife – brilliant. When she left the care here changed.

Q.4 What, if any, concerns have you about the Unit?
• There are some very experienced midwives here but they are not allowed to do their jobs – it’s like their hands are tied behind their backs.
• Poor management. ‘Staff seemed scared of management’
• The fact that two mid-wives have now left has contributed greatly to the lack of confidence in the Unit.
• The new staff appears to be afraid of the management and they are working to different constraints that are not allowing them to do their jobs as they’d like to.
• The new chairs are uncomfortable for new Mothers – why weren’t people asked what they wanted?
• Midwives attending home births now seem to have limited time.
• Lack of continuity – I’ve seen five GPs and see a mid-wife every other appointment
• GPs not supportive of births at unit. Recommend hospitals over MLU or home birth
• Anger at choice being taken away.
• The JR is double the distance from Chipping Norton and the traffic can be dreadful.
• The service being offered has now changed – Mothers can’t be referred back for immediate care.
• I go to Baby cafes in Oxford because I find them to be more supportive. At the MLU I was put in a room on my own as was another woman who was in for breast feeding support. I felt it would have been better to have been with other mums.
• Some Mothers coming back to the Unit for breast feeding support are made to feel that they shouldn’t be coming back, with comments such as ‘you’ve been discharged – go and see a Health Visitor’ – “you shouldn’t be coming back here” but we want to come back where we feel safe and unwelcome. ‘It was a huge rejection’
• Continuity is not always offered – we see different midwives a lot of the time.
• This Unit is only as good as its leader – it needs someone who isn’t defensive – is the leadership here threatened by other organizations coming here? If there is defensiveness from the top, then it will never work.
• Change in attitude ‘pop in’ if you’re concerned vs ‘wait, wait, wait’.
• Call forwarding for care (unit was closed) an issue in labour. ‘I had to wait an hour to come in. Almost made me cry’
• Far too many midwives coming who don’t share the same ethos – probably excellent midwives, but more used to hospital led deliveries. More anxious and probably transfer more.
• Going into hospital will not maximise my desire for a natural birth.
• The whole place has changed in the past two years.
• The Unit has lost its new baby checks facility
• Poor communication to mothers i.e. fly infestation at unit and more recently with the review.
• Currently does not foster continuity of care
• The old core team ‘exuded confidence’, had ‘core beliefs and principles’

Q5 Do you have any concerns re: identification of risk?
• Increase in post-natal depression – is there a link between excellence of care or lack of it, and post-natal depression.
• The same symptoms that would make you be referred elsewhere would enable you to give birth at home – why the referral?
• The level of care was far less.
• I had to wait an hour outside for the unit to open.
• The conversation with the GPs has been about what could go wrong – even being low-risk, my GP said I should have my baby in hospital.
• Three out of the four GPs I’ve seen have said to go into hospital – the GPs do not have confidence in the Unit.
• The GPs are scare-mongering
• There’s a hard of hearing member of staff who couldn’t offer a full service.
• Being told you’d got to go home after two hours – sometimes in the early hours of the morning – women at JR and Horton not sent home – why here?
• The wording of the policy about going home doesn’t help – it makes Mothers feel pressured to go home. My letter says eight times ‘go home’. Not good for a first time mum.
• I had to wait an hour for the midwife to get here – scary.
• Kit used to be left at expectant Mother’s houses for home births – now midwives have to call into the Unit to pick up the kit. Why? Creates a delay. First midwife arrived 20 minutes
before baby because she had to collect kit, second midwife made it four minutes before the baby.

- I had a midwife who was hard of hearing – I didn’t feel safe with her. Details were missed in my notes because she didn’t hear. It could have been vital details like allergies that were missed.
- A hard of hearing midwife couldn’t hear my baby’s heart-beat – it really scared me. What safe-guards are there in place?
- I would not allow the hard of hearing midwife to deliver my baby.
- The hard of hearing midwife misses a lot of stuff – she doesn’t always know that you’re talking/screaming at her.
- The unit changed drastically with decreased stay and no transfers for after care. Women being sent home in the middle of the night. I felt vulnerable.
- One mum stated that she had no skin on skin, no checks (wee etc) before leaving, and felt pressurised to go home quickly.
- My midwife was constantly negative about my choice for a home birth. JR obstetrician was pro homebirth. Having 90% in favour and one ‘significant midwife’ against doesn’t work
- GPs and midwives not communicating effectively. Issue of iron, prescriptions, and birth options.

Q.6 **Could you suggest any changes that would improve the service?**

- Continuity of care was discussed as critical to success at every session.
- Experienced community midwives absolutely essential – with 24 hours provision.
- There’s discussion on Facebook about a particular individual, if she’s to remain, how will the OUH Trust support her as they would any other member of staff?
- A commitment to natural births essential.
- A midwife to do new baby checks is needed here.
- Positive publicity about the Unit is needed to regain confidence.
- Continuity of care – how long post natal should midwives be able to visit?
- Bring back the lady who used to run the Unit (possibly in an Advisory role) and regain confidence.
- GPs could give out leaflets promoting the Unit – (the League of Friends would give financial support for the printing of such leaflets).
- GPs should be factual – and let women make their own decision. Statistically low risk and only fifteen minutes from Banbury.
- Midwives being allowed to do their job – and not just pre, post and home visits.
- Why not be able give birth here as before and then be transferred only if necessary?
- I would wish to be transferred back to the Unit as soon as possible if I had given birth somewhere else.
- The option of being able to stay longer – breast feeding can still be difficult with second and third babies.
- Health Visitors run a drop-in in the centre of Chipping Norton on Wednesday mornings – could something be offered at the Unit on another day?
- Prescribing midwife on the staff please.
- Encourage joined-up care with the ACE Centre Parent Craft.
• Could Health Visitors attend the Unit, possibly once a week, to work alongside midwives to offer advice re: breast feeding and feeding generally? It would ease the transition from midwife care to health visitor and build trust.
• Could a Baby Cafe be offered in the two meeting rooms – it’s a perfect place and the car parking is excellent and easy for Mothers with babies.
• Could there be a bank of local midwives who could get to homes as soon as possible and not be brought in from outlying areas? This would offer continuity of care.
• Hospital style beds not good.
• Lovely experience here – but told to leave three hours afterwards. Previously I’d been able to stay here longer. (April 2011)
• Breast feeding clinics/parent craft classes for second births too please – Saturday sessions not open to second time Mothers – why?
• More staff needed here. And needs to be open 24/7.
• Support, education, and cooperation from GPs important.
• Get midwives who did baby checks back.
• Offer more classes in meeting rooms.
• ‘Bring back midwives, without them there is no trust’

**General questions asked:**

- Why invest money in 2011 without the available funds to keep it running?
- Will the Unit reopen by March?
- When it reopens, will it be made public as to what has changed?
- The Council’s Legal Department said that the NHS has to answer the questions put to them. Will a public response be made?
- Why can’t we visit the JR? I have no concept of what it’s like there. The DVD about it glosses over the fund side of having a baby. Surely it’s my right to be able to visit – it would influence my decision.
- Will the reasons for the closure be made public?
- Are the staff that raised concerns being supported?
- Why has the transfer rate gone up?
- What staffing changes have occurred between 2009 and 2011 that may have a bearing on the number of births here?
- Why were Mothers asked to leave after two hours?
- Why is the Unit not open 24/7?
- Why is their strict criteria regarding iron levels, blood pressure etc. for giving birth at the Unit, yet Mothers with the same symptoms would be allowed to give birth at home?
- Why is the Unit closed yet the same midwives are delivering at home in the community?
- Please could it be made public the members of the Review Panel, together with their job titles and how independent are they?
- Are they looking at the general transfer rate verses individual staff transfer rates? Can prior decisions regarding midwives be rescinded?

**General comments made about the Review**

- Why was so little notice given about the meetings?
- Why was there so little publicity about the public sessions?
- Three month timescale needs clarification.
• Pregnant women need a time-scale as to when the Unit is to reopen.
• There’s been nothing in the Chipping Norton Newsletter about the Review.
• The powers that be want to close the Unit because it will enable them to expand the care home.
• The service has deliberately been changed – sources tell us that the OUH never wanted a maternity unit in this building.
• Nothing on the OUH website about the Review.
• The petition names the two people concerned.
• People in Glos. were not told about the consultation/review – it should have been more broadly advertised.

Comments relating to care at the Horton/JR:
• I felt abandoned on the Ward – the midwife was lovely but post natal was hellish. (2009).
• I spent five nights at The Horton and found it so stressful.
• No-one told me that Mothers have to go and collect their own food at The Horton – I was in pain and found this stressful.
• I was told the Horton was not a B & B.
• I had a really awful time at The Horton – I managed to transfer to Chipping Norton.
• Whole birthing experience dreadful – my husband was not allowed to stay with me because I was put on the post-natal ward and the hospital wanted £150 for a private room.
• Mums very unhappy about female only wards. Want fathers to be allowed to stay overnight. Felt abandoned.
• Felt guilty to press the button for help.
• I had a spinal block and when I asked for help with my bleeding was given stuff to mop it up myself. I cleaned it up and threw it on the floor because there was no place to put it. I felt abandoned.
• The JR is a processing factory

Feedback given about an on-going on-line survey being carried out by NCT:
• 86 responses to date.
• Unit considered hugely valuable, with ante and post natal care considered to be excellent. Major problem about not being able to stay longer.

Issues raised and changes needed:
• Lack of communication about length of closure
• NCT would appreciate more input
• NCT wanted to know more about what’s gone on.

Comment from Facilitators: Could the OUH put an update of the Review on the OUH website (pertaining to time-scales etc.) as expectant Mothers are anxious to know whether or not they are going to be able to give birth at the Unit.

Pat Moss Jennifer Lanham
Facilitator Facilitator
January 2013 January 2013
Appendix I

Examples from the Maternity Services Liaison Committee

Cotswold Maternity Unit Birth Experiences

To whom it may concern,

I have been privileged to have both of my children in Chipping Norton, my first (Aug 2010) at the old hospital and my second at CMU (Aug 2012). Both experiences however, were very different.

With my first (Aug 2010) I felt I was empowered by the midwifes to have my son naturally without and intervention. The care both before and after the birth was outstanding.

My partner and I were fortunate, prior to the birth of my first baby, to attend the 'parent craft' at the old hospital which was taken by xxx. She was inspirational and gave us the confidence to have the baby at the old hospital which was exactly what we'd wanted.

I stayed in hospital approximately 10 hours after my first child was born and was cared for by xxx. Again her support with breast feeding and care she showed was outstanding.

My birthing experience in 2012 was very different and my concerns are as follows:

• our anti natal appointment were with a number of different midwifes.

• having spoken to a midwife at the unit to inform them I was in established labour and felt I needed to come in, I was told to wait another hour before calling again.

• we waited another hour by which time the contractions were 3 in 10 mins and I was anxious to get to the CMU. We called again and was phoned back by a midwife who told us she lived in Stow and it would be at least 30mins before she would be able to get to the unit.

• we arrived at the time specified 10.10pm and at 10.25pm our baby was born. We didn't make it into the birthing pool which was my preference, and I felt cheated that I gave birth to my daughter in the consultation room.

• I only had one midwife, my partner had to assist. The second was called and told not to come as the baby had arrived.

• I had, and quote from my notes a ‘perineum 2nd degree tear’ and was sutured with vicryl. This was carried out WITHOUT anaesthetic. I was told that if I wanted anaesthetic I would need to have my feet in stirrups and it would take much longer. The offer of anaesthetic was said in a way which made me feel it would be an inconvenience to have it. This was a traumatic experience and one I have been left worrying about.

• we were left to bond with the baby in the birthing pool for some time before moving to a side room. I don't remember being asked if I'd passed urine before I was discharged. Approximately 2 hours later the midwife told us we could go home if we wanted to. Again, this was phrased in a way that left us feeling, if we stayed we'd be inconveniencing the midwife and the support lady. We left the unit, still shaking and in shock from what had been a very traumatic birth.
I felt my wish to have a natural child birth in a relaxed supportive and caring midwife led unit was taken from me.

I support the CMU and feel it offers a much needed and valued service but some changes need to be made to restore the trust and outstanding reputation the unit once had.

Dear Jennifer Lanham,

I believe that you are Chair of the Maternity Services Liaison Committee so I would like to send you my thoughts about xxx, one of the Chipping Norton midwives who has recently had her career placed in turmoil for reasons beyond her control and which I believe have been unjust because of her well-known totally reliable personality.

However, may I once again say how much I respect xxx for her consistent professionalism, kindness, caring nature, passion for looking after those in need of her help and excellent skills, ultra-efficiency, good parenting, love of serving our local community in her spare time, honesty and total trustworthiness.

I have known xxx for many years and have seen how well she organises people in a lovely, gentle but business like way at meetings which she has conducted, sticking to the point and therefore being an excellent time manager. I like the way she speaks out according to her conscience about things that are in need of change. She is a very practical person who will quite rightly do things to improve a situation that is in need of improvement (rather than being negligent by saying or doing nothing). These are all the qualities the best type of leader should have.

I cannot believe for one moment that the disgraceful way in which xxx has been treated in her place of work has been justifiable.

Many years ago I was transferred to Chipping Norton Maternity wing after giving birth to my two children and found the ward a wonderfully happy and safe environment because of the commitment of all the staff there at the time. This fond memory has been shattered by the current problems caused by bad decision-makers there now who would appear not to listen to the truth or even to know xxx enough to see what an honour and a great privilege it actually is to work beside her. I hope they come to their senses to realise the huge mistake they have just made in causing havoc to the career of a highly successful midwife who has worked there with the huge respect of many, many families over the years, along with the disservice to the rest of our community by preventing other mothers-to-be and their babies from having such a wonderful, caring and conscientious midwife in xxx to care for them when they are in need of her!

I do not know the other midwife who has been placed in a similar position to xxx, but having seen what has sadly happened to xxx so utterly unfairly I cannot but believe that she also has suffered a huge injustice at the hands of people who should not be let loose in the nursing profession.

We should all be extremely grateful for their loyal service to us all and supportive of xxx and
her suffering colleague when so much of their excellent work is the fruit of their own personal selflessness.

Please pass this message on to anyone if you think it could be of some help.

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I was unable to attend the Cotswold Maternity Unit Review last week, but would like to share my experience and thoughts about the unit.

When I moved to this area in July 2000, I was expecting my third child the following month. I arranged to meet the midwife assigned to our local surgery ahead of our move, in order to ensure more continuity in my antenatal treatment and this worked well. I scheduled appointments to coincide with trips to the village to supervise work being carried out on the house in advance of our move.

As my first two deliveries were very straightforward and my third pregnancy was another healthy one, the midwife urged me strongly to go to Chippy hospital (Cotswold Maternity Unity) for this delivery. Countless young mothers in the area regaled me with tales of what a wonderful facility it was and how lucky we were to have it.

My second delivery (in London) was a very fast one, in fact it was so quick that there wasn't enough time for an epidural, which I'd had with my first. Consequently, I was given entonox during the delivery and local anaesthetic for an episiotomy afterwards. Based on this experience, I was very keen to ensure that suitable pain relief would be available at the Chippy hospital. I made a point of clarifying this with the midwife at each visit, asking her what pain relief options were available to me. I was reassured several times, told of the range of pharmaceutical pain relief that would be available and that the midwives would be able to administer them.

My actual experience of the unit was wholly disappointing. When I presented at the hospital, the admitting midwife insisted that I had come in too early and suggested that my husband take me home. After my speedy second delivery, I didn't want to risk a write-up in the Oxford Times about the baby delivered on the A361 somewhere between Shipton under Wychwood and Chipping Norton, so decided to stay put. As the contractions were getting more intense, I asked the midwife for pain relief medication. She suggested I roll on an inflatable ball in the mothers' room. I tried this for a little while and found that it really wasn't doing the trick, so asked again for medication, to which the response was, "why don't you try a nice warm bath?". Well, there wasn't time for the bath to finish running, as my beautiful daughter, xxx, was delivered
approximately 35 minutes after I first arrived at the hospital. Unfortunately, when she was exiting the birth canal, xxx had her arm extended above her head and her elbow sticking out, which meant for a painful delivery and a significant amount of tearing in my perineum. Consequently, the stitching up afterwards took longer than the actual delivery and the midwife, who was xxx, commented "I've never seen anything like this before." Not very reassuring.

As you might imagine, I experienced significant pain after the delivery, probably as a result largely of the tearing and subsequent stitches. When I asked for a codeine-based pain killer, which I had been given following my first and second deliveries, I was offered a choice of paracetamol or ibuprofen. When neither of these made a significant impact on the pain, I asked again for something stronger, but was refused.

I spent two miserable nights on the ward, watching women arrive from the JR who had come to recuperate in Chippy. Our meals were served on a long refectory-style table which stretched down the middle of the ward, and the food was diabolical = nothing like the lovely home-cooked meals previous patients had described being served.

In addition to the dismissive attitude of the midwives, I found the other staff also very unfriendly, lacking the simple courtesy of a hello or good morning/afternoon when they entered the ward to clean or serve a meal.

From the comments I still hear whenever the topic turns to the Chippy Maternity Unit, I would imagine that the bulk of the feedback you are hearing is overwhelmingly glowing and positive. I am delighted that so many women have had pleasant experiences at Chippy, but thought it important for what I can only guess is the minority voice to be heard as well. I think the biggest cause of my dissatisfaction was around the fact that I felt I had been misled. I later came to learn that the unit prides itself on non-intervention and natural deliveries, which explained my treatment. Had I been told this up front, rather than being led to believe that it was simply a small maternity unit with no hidden agenda, I feel that I would have been able to make a more informed choice.

For the delivery of my fourth child, in 2004, after my experience at Chippy I chose to go to the JR and it was absolutely faultless. There were complications in the delivery (placenta previa), which were potentially quite serious. In contrast to my experience at Chippy, whilst at the JR I felt that I was in safe hands, surrounded by practitioners who were experienced, skilled and focused on the health and well-being of me and my baby. My fear is that, had I gone to Chippy, my condition would have been diagnosed as a bit of
I attended the 10.30am open session on Tuesday morning at the Cotswold maternity unit. I have 1 negative and 1 positive experience that I wanted to share with you about the midwives.

I don't know if this is relevant, but due to the trust's secrecy about what they are doing we can only read between the lines and provide the experiences that we believe to be relevant.

After the birth of my first daughter in April 2009, I attended the old Chippy maternity unit for a postnatal check up. The midwife on duty was xxx, xxx was the only midwife on duty during my visit. My daughter had started to look jaundiced and xxx needed to take a blood sample from my daughter’s heel to send off for testing. While previous midwives had warmed my daughter's foot in their hands when taking a blood, xxx decided to put my week old daughter’s foot in a Lukewarm pot of water. She then said to leave it for a few minutes, but she then proceeded to leave the room to take another appointment with another woman for at least 20 mins. Returning only after I went to see what was happening. In the meantime, my daughter’s foot was colder than it was before we started and she was now crying. During the appointment, my husband and I gave xxx lots of information about our daughter’s condition and weren’t sure if she was ignoring us or what was going on. We also asked xxx many questions and got no response. It was only after leaving the hospital and discussing the appointment with my husband, that we both came to the conclusion on our own that xxx was hard of hearing.

Although, I have no issue with any individual’s disabilities, I do think it wrong if someone working in a medical environment doesn't make it known to patients in their care that they lip read. Particularly when lives depend on their decisions.

I know this is only a minor incident, however it did influence my opinion of the unit and I did choose to see other midwives in preference to xxx after this incident. It also made my husband and I hope that xxx wouldn't be the midwife on duty when I went into labour with my second daughter in July 2011.

I would also like to share my positive experience of the unit. xxx delivered my second daughter at the unit in July 2011 and I can not speak highly enough of her dedication and professionalism. I was very relieved when I knew xxx was on duty, as I knew I would be in safe hands. I found her an extremely dedicated and enthusiastic individual, who believed deeply in the ethos of natural birth and every woman’s right to choice. I have been saddened to hear of her removal from the unit and I personally feel it a travesty that women are being denied the care of such a skilled and experienced midwife. Should the time come that we have another addition to our family, I would certainly hope to be lucky enough to have xxx deliver our next baby.
I think the trust should be ashamed of the fact that in under 2 years they have taken a country leading midwife unit and through their mismanagement destroyed its reputation. I fully support the reopening of the unit as soon as possible and I think the trust owes it to our community to genuinely support its reopening and fully publicise the outcome of the review as well publicly announce what changes have been made.

We would like it to be put on record to the trust that we don't believe that this review has the best intentions for the unit, the mothers of our community and clearly not the experienced midwives who have devoted their lives and reputations to the unit. They have shown themselves to be incompetent and not worthy of managing such a fantastic unit. The outcome can clearly not remain private as they are a public body and they are responsible to the public.

I hope this information is of help, if you would like any more information then please feel free to get back to us. If there is a more appropriate way for some of this information to be conveyed to the trust please can you let me know.

To help inform the current review of the Chipping Norton Maternity Unit I want to register my gratitude to Chippy staff for the level of care and support they provided me in summer 2012. Whilst my medical history prevented me from being able to give birth at the unit, CNMU midwives provided me with both antenatal and postnatal care after the birth of my daughter in September 2012. The unit is a valuable resource to local women in that it provides antenatal and postnatal services all under one roof whilst maintaining a caring and supportive environment, something which I think is critical for women both in the run up and immediate weeks after giving birth.

As part of my antenatal care I had my 36, 40, 41 week check ups at the unit. All of the midwives I met were reassuring, listened to my concerns as a prospective first-time mum, and offered plenty of advice. As my due date came and went I became increasingly anxious that I would end up being induced, something which I really wanted to avoid at all costs. The midwives at the CNMU understood my desire to have a natural low tech birth and did everything they could to help nature takes its course. I felt listened to at all times and as a result was offered (and accepted) three stretch and sweeps. With my induction date looming my final stretch and sweep was carried out by xxx who was excellent. I was also particularly impressed by xxx (who although incredibly busy) picked up on my anxiety at my first stretch and sweep and found the time to do some breathing exercises which me to help me relax. Thanks to care I received at Chippy I got my wish and following a straight forward 12-hour labour gave birth to my daughter on xxx September 2012 (I avoided being induced by a day).

Whilst fortunate enough to have had a very easy labour I found the first couple of weeks after the birth of my daughter very stressful due to breastfeeding difficulties. Once again staff at the CNMU came to my rescue and I visited the unit several times to get advice. The care and emotional support I received from xxx was fantastic and really helped me through a very low period. Nothing was too much trouble for her and although very busy with the phone ringing off the hook she was incredibly generous with her time.

In the sprawl of the NHS it is very easy for maternity services to become impersonalised with
little or no continuity of care. Chipping Norton is the complete opposite in that it offers a safe haven for women when they are at their most vulnerable. I personally found great comfort in knowing I could ring Chippy staff at anytime and that I was being cared for by ladies dedicated to their profession.

I had my second son in July this year at the JR in Oxford but was cared for before and after the birth by the Midwives at the Cotswold Maternity Unit in Chipping Norton Hospital and have mostly wonderful and positive things to say about the Midwives and other staff who work there.

My first baby was born in 2010 and my plan was to have him in Chipping Norton but he was breech and my waters broke when I was 36 weeks so I had to have an emergency c-section at the JR. Because of this I couldn’t have my second baby in Chipping Norton as I had to be monitored throughout the birth. But if I had had a choice I would have loved to have had both babies in Chipping Norton as I always felt completely comfortable and welcome by the midwives there.

My Midwife was xxx and she was so wonderful the first time around that I requested her to be my Midwife again for my second baby this year. She always made me feel at ease and was very supportive. If I had any worries about my pregnancy I could talk to her about them in confidence and was always reassured.

I also was being cared for by a student midwife called xxx and she was also incredibly supportive.

I also felt really supported after my baby was born. He had slight jaundice so I had to make quite a few visits to the maternity unit for his Billie Ruben levels to be checked and also went for my scheduled checks, again, I was made to feel very comfortable and welcome.
The only slight negative experience I had was in my home visit; the day after I came home from the JR I was expecting a call from the Midwives to say when they were coming over, but the Midwife that visited didn’t call she just turned up and I was still in bed, which I felt a bit uncomfortable about. I think her name was xxx. I had not ever seen her before and although she did answer the questions I had efficiently she was on her way to the clinic in Charlbury so I felt slightly rushed and flustered when she left as there were things I had forgotten to ask.

Overall my experience of the midwives in Chipping Norton was extremely positive, especially the relationship I have developed with xxx, which has inspired me to look into training to become a midwife myself when my baby is a bit bigger.

I give my permission for the MSLC to use my story as an example and I am happy to be contacted by the review committee to answer any questions they may have about my experiences at the Cotswold Maternity Unit in Chipping Norton Hospital.

I have heard the news about Chipping Norton Maternity Unit, and am really upset that such a fantastic service has had to be suspended. You have asked for feedback about the Unit and the midwives there. I had very lovely experiences with all the midwives at Chipping Norton - xxx, xxx, xxx and xxx - all absolutely brilliant, supportive, reassuring and calming.

Of course, at the time that xxx was born Chipping Norton Maternity Unit was still based in the old building, but my experiences of their services was extremely positive. Ultimately I didn't have xxx at Chipping Norton, because we were advised by xxx, I think) that his heart rate was slowing, so we were sent to the Horton Hospital for monitoring. Whilst I really wanted to have xxx in Chippy, I had to act on xxx advice. Once I was at the Horton and my waters had broken, there wasn't anyway that I was going to get back in the car to come back to Chippy! What was lovely was that xxx came to the hospital later
to find out how we were getting on!

I also did some private hypnobirthing sessions with xxx, and these worked absolutely brilliantly for me. I found it really very refreshing to hear and see DVDs of women who were birthing their babies naturally and without any pain relief. The thought of having an epidural really terrified me, so it was fantastic to hear some really positive stories and birth experiences in the run up to having a baby myself. When you are pregnant, people are all too willing to tell you how painful it can be, and that can exacerbate the feeling of panic and anxiety in the run up to the onset of labour - but just a change of mindset - to the 'I can do this' and learning to relax can make all the difference. What a shame these classes are not made available by the NHS.

Perhaps I am someone who would have given birth easily anyway, but having so far only had one baby I have no other comparison. Using techniques that xxx taught me, I was able to be totally relaxed and calm and mentally prepared for the birth. The end result of which was that I was able to give birth to xxx with absolutely no pain relief whatsoever (other than being in a water). My midwife at the Horton Hospital, xxx told me that 'she had never seen a birth like it!'

After xxx' arrival, xxx was the midwife who came to visit me at home. She very quickly figured out that my whole family had descended on our small house, so quietly she said to me 'You have a lot of visitors downstairs .... do you want me to say something to them to encourage them not to outstay their welcome' (or something to that effect)... and as she was leaving she brilliantly handled the situation and said something that I think made everyone realise that I needed some rest! It was a huge relief to me when they all left!

In the early days, I had some breastfeeding issues, and the midwives declared that xxx wasn't putting on enough weight. I have to admit, I was an emotional wreck at the time and I felt that I was a little bit 'hijacked' by the breastfeeding 'gestapo' and they kept me & xxx at the hospital all day with a breast pump to try and increase my milk supply. Looking back, it was the right thing to do, and I ended up feeding xxx until his first birthday, but at the time I was very close to opting for formula!

Once xxx had arrived, I spoke to xxx over the phone a couple of times in a state of mild panic when xxx had his first temperature and NHS Direct were 'ringing me back', and both times she was very calm and reassuring and gave me some very sensible answers and solutions.
Overall, I think it would be a great shame if the Chipping Norton Maternity Unit was not re-opened for births again, I believe it is an invaluable resource, and I think many women would miss it if they found themselves having to go to Banbury or Oxford for their ante and post natal appointments.

If you would like to get in touch with me again, or need any additional information, please let me know.

I am writing to give my feedback on the Chipping Norton MLU. I used this service in April 2010 for the birth of my first child. My husband and I could not fault the service provided by xxx and xxx. I was allowed to labour in any way I wanted to and made to feel completely comfortable.

My labour and delivery were quite straightforward, if a bit quick towards the end, but I did not feel anxious at any point and was taken care of. I was allowed to stay for the day following my late night delivery and was given good feeding advice which meant that my daughter and I established fantastic breast feeding which continued for 9 months.

I have always recommended the unit to my friends and have planned to have my subsequent deliveries (whenever that maybe) at the unit. I can say strongly enough how disappointing and upsetting it would be if the service was to be withdrawn. It is my strong belief that the community should do everything possible to maintain this valuable and highly regarded service.

Our first child, xxx, was born at the old Unit in 2004. I received antenatal care from xxx via the doctor’s surgery in Hook Norton (which was easy for me to get to as I live in Hooky) and felt extremely well supported throughout. xxx and I were convinced that the Horton would be our first choice for the birth, until we visited Chippy! The calm, assured atmosphere was amazing and we were imbued with confidence that our baby and I would be in the hands of experienced midwives who would support our choice for a natural birth. xxx ran the excellent Parent Craft Classes (awful name though!) which we found very helpful. We gained a clear understanding of what natural birth involved, the interventions that are available and what was involved in breastfeeding. Throughout the antenatal care, xxx felt he was included too and that his views were respected. He found it extremely valuable to understand more about the interventions so that he could support me if we were unable to give birth in Chippy for any reason.

When I went into labour with xxx, we went to the Unit and saw xxx She suggested we should wait at home for a bit longer but made it absolutely clear that she would be waiting for us to come back and that we were to get in touch straight away if we were concerned about anything. We went back to the Unit at about 10 pm and xxx provided incredible support throughout the night. xxx had such faith in her that he was prepared to go into the lounge to get some rest, confident that I would be looked after properly. At one point I got frightened and she immediately engaged with me to understand my fear and reassure me that I could do it. She even stayed on after xxx arrived the next
morning and together they helped me through a rather awkward delivery (albeit with a fairly large episiotomy). I am convinced that without such wonderful, strong, supportive midwives and the consistency of care during labour, I would have struggled to give birth naturally.

After xxx was born, I stayed in the Unit for 5 days and received amazing help with breastfeeding (day and night). It wasn’t easy at first but the boundless patience and incredible knowledge of the entire team helped us enormously. xxx (and all my other children) were exclusively breastfed for 6 months and then continued to breastfeed until they were at least 14 months old. I felt pretty bruised and sore after his birth and the benefits of having support to cope with visits to the loo, or having someone to run a bath for me, were immeasurable. Like many first time parents, we were pretty overwhelmed by the birth and the enormity of coping with a new baby. The entire team made us feel amazingly well cared for and provided support that simply wasn’t available to us anywhere else. I wouldn’t be at all surprised to find that post-natal depression rates were much lower among Chippy mums who received this support – I’ve certainly spoken to many mothers who believe that the Unit made a huge difference to their mental health after their babies were born.

Our 3 younger children were all born at home and xxx provided excellent antenatal care (again at Hook Norton surgery) during these pregnancies. She was reassuring but also honest when it came to any difficulties that cropped up and she always made sure we understood the answers to our questions. Her calm, confident approach was fantastic. Our second midwife for xxx (2007) and xxx (2009) births was xxx. xxx was officially our second midwife for xxx (2011) birth but she didn’t arrive until after xxx was delivered. Our home births were amazing experiences! It was such a wonderful thing to happen and we feel deeply privileged. xxx was absolutely superb on each occasion. She adapted to the situation, remained unflustered (even as the snow poured down during xxx birth so she almost needed to be towed off the farm!) and it felt like having a member of the family with us. It is impossible to quantify the benefits but our homebirths gave the older children the chance to see a baby being born and gain the understanding that this is a perfectly natural process. The new born baby instantly became part of the family, as far as the older children were concerned and this helped us all adapt to having a new arrival in the house.

Sadly, over the course of our 3 homebirths, we noticed a significant decrease in the amount of support we received after the birth. This wasn’t a big problem to us as we felt reasonably confident by that stage. However, we would have felt very different if the care levels had been at 2011 levels when we’d had either xxx (2004) or xxx (2007). The decline in support is a huge shame. We all know about the benefits of breastfeeding and how much support is sometimes needed. A crying baby (or crying mummy) can’t wait until the next timeslot to see a breastfeeding counsellor. Equally, fewer checks on mothers must increase the risks.

As you can see, we had wonderful experiences with the Chippy midwives and have sung their praises for many years. I had fairly limited interactions with xxx and xxx but they didn’t strike me as being anywhere close to the calibre of the people we dealt with in the past (the whole team, not just the midwives I’ve named). It is a tragedy to see the Unit in such a terrible state. After the move to the amazing new facilities, xxx and I were suspicious that the Unit would be run down and the building handed over to something more profitable or more glamorous than natural birth. We sincerely hope that there isn’t some awful ulterior motive behind the recent events at the Unit.
I’m sorry this is so long but I wanted to try to put over just how amazing the Chippy midwives and the team used to be. I hope this will be of some help for you in building the case with xxx to investigate the current problems (and the chain of events which led us to this point) and restoring the incredible service for future parents.

My baby was born in February 2011. I live near Witney, so my midwives fell under the Witney area. In my eyes, my experience with Chipping Norton Hospital & Midwives didn’t come soon enough. I wish the Midwife appointments had started earlier in my pregnancy rather than on the birth date. My experience is across both hospitals, that is the old Chipping Norton War Memorial Hospital & the new Chipping Norton Hospital, Cotswold Maternity Unit.

I was the last Mum to give birth at the Old Hospital. My Midwives for the delivery of my daughter were xxx & xxx. I can actually say that if/when I have another baby, I would hope to have xxx & xxx again. From the minute I arrived at the hospital, they made me feel calm, relaxed & I knew I was in capable hands. They were extremely supportive of my decision to have a water birth without the need for any medical intervention/drugs. Xxx went out of her way to ensure consistency of Midwife throughout the whole birth process. She was meant to have clocked off mid-process but stayed on knowing it was the right thing for me. This surely goes to show xxx has the best interests of Mums in labour at heart. My daughter was delivered at Chipping Norton Hospital without the need for a transfer to a Consultant-led hospital. The duration of labour was a grand total of 7 hours & 32 minutes.

The hospital was quiet when we were there, it was a Sunday morning. xxx eventually managed to clock off & finish her shift. We were offered to stay in the hospital for the remainder of the day, to help with breast-feeding & rest. That evening, no midwives planned to be present in the hospital, so if I wanted to stay, they would have had to call a midwife in. We chose to go home at around 7pm.

My experience of the new hospital lies solely through the need for breast feeding support. The support I received matched my desire to breast feed – it was something I really wanted to do. I was invited to go to the hospital for whole mornings, so the breastfeeding counsellors could help with a number of feeds that day. They suggested I pack a lunch so I didn’t have to hurry off. Each time I attended the hospital, I was given a private room, to relax in & feed my daughter. As I had my fair share of problems in this area, I spent many a day popping over to Chipping Norton for help. Each time, the breast feeding counsellors made me feel very welcome & went out of their way to help & suggest variations of feeding. As a result, I was successful in breast feeding my daughter for over 12 months. I only wish I could remember the names of these counsellors as they deserve a mention!

In conclusion, I would love to have the opportunity to have another birthing experience with the Chipping Norton Midwives. As I mentioned at the start, I would prefer the relationship to start earlier in the pregnancy. I therefore do hope that you manage to get to a place in your analysis where you find confidence in what the hospital is trying to achieve & certainly what xxx & xxx have tried to achieve for those mums that choose a midwife led experience. There is a lack of choice in my area for midwife led births. I also think you should include in your analysis, the education of natural birthing & reaching pregnant Mums at an early stage. It was something I had my heart set on from the outset & so shaped my mindset accordingly. To give birth in a consultant led hospital would have been my worst nightmare. But a lot of Mums are scared of not having consultants to
hand, hence their birth plan choice. Inevitably, this will affect birthing numbers at hospitals such as Chipping Norton. I, for one, felt the NCT classes I attended did not provide anywhere close to sufficient support in natural birth/midwife-led birthing experiences.

Please re-open the Chipping Norton Midwife led hospital at your earliest convenience, so other mums can experience what I have.

I was supported for the last 3 months of my pregnancy by midwives from the Cotswold Maternity Unit at Woodstock Surgery. My midwife was xxx. I was always extremely impressed with the level of care and information provided by xxx. Through that 3rd trimester she was always very thorough at every appointment and despite being extremely busy always made sure I had time to ask any questions and discuss issues such as my choice of location for the birth of my first baby, techniques through labour and minor health issues in the later stages of pregnancy. As I came to the end of my pregnancy and became overdue she was very helpful in explaining all the options available to us in terms of moving towards induction, providing advice on actions we could take to try and start labour and gave me extremely strong support in a very stressful time. I always felt extremely pleased with the care provided by xxx and trusted her judgement in all aspects of my pregnancy.

After the birth of our son in July 2012 at the Delivery Suite in the JR, we were visited by xxx on our first day at home. I was impressed with her care and focus on us as new parents within what was evidently a very busy day for her as the midwife on home visits. She gave us reassurance on medical issues for both our baby and myself a day after birth, completed all the checks required thoroughly and answered all the questions we had as new parents.

Over the next 10 days we visited the Cotswold Maternity Unit for all our new baby checks and for support from the health care workers, such as bathing our baby and advice on breast feeding. We were pleased and confident in all the advice and help given over this time and found the unit a welcoming and positive environment to visit.

As a new mother in her first pregnancy I was very impressed with the care I received through the Cotswold Maternity Unit and especially in the work of xxx as my midwife.

I write in response to an email from xxx (below). I have very little experience of the Cotswold Maternity Unit but I hope what little I have may be of help.

I had my baby xxx on xxx Feb 2012 at The Spires within the John Radcliffe Hospital. I wanted to have my baby at The Cotswold Maternity Unit, and visited prior to the birth the discuss procedures etc with the midwives there. I don’t remember names (I spoke to 2 midwives), but they were utterly professional, friendly and gave me every confidence in their abilities and passion for the care of mothers and babies. My husband and
I came away with the following impressions:

Absolute confidence in the midwives
An impression that the midwives had to be of a certain level of experience in order to work there
A confidence in their procedures should an emergency situation arise
An impression that they appreciated the importance of the support of the father
An impression that I would simply not be permitted to give birth there if the risks were too high
An impression that they avoided sending women to hospital if possible – this came across as a positive element, and they were proud of their low hospital transfer rates. I liked this as I wanted to avoid being “shipped off to hospital” if possible (as it happened, I had a haemorrhage and would have gone there away).

I was unable to use the Unit for my son’s birth because it was closed that day. I was told they had had an insect infestation and there had been a problem with the insecticides used.

I have been evangelical about the Unit after the birth of my daughter xxx there on xxx of June this year. xxx is our second child and having had our first child in London where I received varying standards of care before my son’s birth we have been well aware of how lucky we are to have such a fantastic service on our doorstep.

In the lead-up to the birth I received a good level of care (always professional and caring) from the midwives I saw (xxx and I’m afraid I can’t remember the name of the others) before xxx birth and felt very strongly that I wanted to have my baby at the Unit. My husband and I were given the chance to look around the unit to prepare ourselves better which enabled us to prepare and to look forward to the experience together.

As for the birth itself, I was very keen that it would be a completely different experience to my first pregnancy (which was traumatic and where my wishes were completely disregarded) - thankfully the experience I received in Chippy was the polar opposite and I was bowled over by the level of personal care that I received there. As soon as we called xxx up to say we were coming in, we were made to feel like individuals "we’ll get the bath running for you then" which immediately made us feel special and looked after before we’d even got in the car! xxx, the student midwife came out to greet us at the Unit and took us upstairs. We arrived and were treated like royalty! xxx was our midwife and was utterly brilliant. She took time to
listen to our wishes, read our birth plan and guided us through the experience according to those wishes. We were hugely impressed with her attentiveness and her immediate understanding that it was important to us to have a very different experience to our son's birth and to retain as much control of our situation as possible. She kept us calm and enabled us to use the techniques that we had been practicing from a Natal Hypnotherapy cd. I readily placed all my trust in her and drew great strength from her during each contraction. Shortly before our daughter was born she said to me "you can do it this time" and it will always stick with me because at that key moment she understood exactly what was important to me and the doubts that I had about my own ability - it was precisely what I needed to hear and I am very grateful that she enabled us to have a beautiful water birth that exorcised a good deal of the trauma from the birth of my son in London.

In the days following my daughter's birth I always felt very welcome back at the Unit and found the staff very helpful, attentive and interested in my baby and supporting us. It would be a travesty for a service like this to shut - I strongly believe that it was the level of care that enabled me to have such a positive experience.

I hope that this is helpful and please don't hesitate to contact me if you need any further information.

Dear Sarah / Maternity Services Liaison Committee,

I heard that you are collecting stories about birth experiences from mothers and thought you might be interested in the attached letter which I sent to the acting head of midwifery following the birth of my son in March 2011.

My antenatal care was provided by xxx, whom I thought was very good. Admittedly I had a completely uncomplicated labour, but I very much appreciated her approach of offering me choices (for example about scans, blood tests etc) rather than telling me what I would have.

The main midwife I had for the delivery was xxx, who was really fantastic. I had not met her before but I completely trusted her and felt that she was there just as much as I needed, without being at all intrusive. I particularly appreciated that she knew about hypnobirthing which was something I had read about and practised, and was able to recognise what I wanted without me having to explain. I managed to have a completely drug free delivery, and felt supported and in control throughout (although not without pain!).

xxx and another midwife joined for the final part of the delivery and xxx took over to do my sutures and provide aftercare when xxx went off shift. She appeared competent and friendly, but it was her question about "what were my plans" regarding going home, her manner, and her mention that they did not routinely offer people to stay in out-of-hours that made me feel that I should go home straight away, which I very much regret. xxx was also there on several of my visits over the next few days to establish breastfeeding, and I had the impression that she thought we were too slow in seeking help with feeding and had allowed the baby to dehydrate and become drowsy, which of course we felt terrible about. Having said that, we did successfully establish breastfeeding with the help of xxx and other midwives.
(including xxx - I think she is a midwifery assistant of some kind, she was really
great: positive and kind).

I did receive a reply to my letter of complaint, which said that the staff were under the
impression that it was our own wish to be discharged and that we would have been
welcome to stay. I feel sure that they would have agreed if we had insisted on
staying, but I didn't want to be the cause of them having to stay at work overnight if
that was not routine.

Dear MSLC
I would like to provide you with feedback on my experience with the Chipping Norton
Maternity Unit, where I went to give birth to my son in June 2012.
This is my first baby and I chose to go to Chipping Norton because I wanted to be in
an environment that I felt comfortable with during labour and also wanted to use a
birthing pool. My husband and I had looked around the unit previously and agreed
that it would be the nicest place for us to be.
My birth was relatively quick; I arrived at the unit at about 1pm and gave birth at
about 5.30pm. The midwives who looked after me were xxx and xxx. xxx was on
call from Bicester.
My husband and I were both impressed that we had at least one person with us all
the time, and felt that we were extremely well looked after. xxx was especially good
and I don't think I would have had such a great birth experience had she not been so
supportive.
After the birth we learned that xxx, one of the midwives who looked after me, was
hard of hearing. It would have been helpful to have known this during labour
because I sometimes felt that I wasn't being listened to and got a bit frustrated at
times. This is not a complaint but something that might be helpful for other mothers
in labour in the future.
I had stitches and this procedure took a while. Once this was done the midwives
started to discharge us. I understand that there was a new computer system in
place which they were struggling with and therefore it took a few hours for me to be
discharged. I also had not passed any urine and was encouraged to drink lots so
that they could send me home. We were eventually discharged at 11.30pm, almost
as soon as I had been to the toilet. I do feel that this was too late at night to be
sending us home, especially with a first baby, and it did knock my confidence with
the baby for the first couple of days as I had been left alone without being guided on
how to do anything for my baby until a midwife visited the next day. Before we had
decided to use Chipping Norton we were aware that we may not be able to stay
overnight but I was under the impression that we would be kept in if I gave birth in
the evening or at night. Perhaps I had misunderstood. This is the only complaint I
have with the otherwise fantastic service we received.
I was shocked to hear that births had been suspended at the unit and feel sad for
those who were hoping to use it as they will certainly miss out on a lovely birth
experience.
I would recommend the unit to other expectant mothers, however I would strongly
suggest that they gave consideration to the fact that they are likely to come home the
same day. Had I realised what this would be like in reality, I think I might have
decided to go to the Spires unit at the JR instead. I will also bear this in mind for my
next children. If the unit offered an overnight stay after giving birth, especially for
new mothers, as a matter of course I would not hesitate to use the unit again. I give permission for the MSLC to use the content of my email in the review of Chipping Norton Maternity Unit should they so wish. I am also happy to be contacted by the review committee. xxx has my contact detail
### Progress report on the review of the Cotswold Maternity Unit

#### Status
A paper for noting by members of HOSC outlining the review of the Cotswold Maternity Unit (CMU) and the proposed way forward.

#### History
Follow up report following the presentation at the HOSC meeting on 15 November 2012.

<table>
<thead>
<tr>
<th>Board Lead(s)</th>
<th>Sir Jonathan Michael, Chief Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key purpose</td>
<td>Strategy</td>
</tr>
</tbody>
</table>
Progress report on the review of the Cotswold Maternity Unit (CMU)

Introduction

1. At the HOSC meeting held on 15 November 2012 members of the Oxford University Hospitals NHS Trust were given the opportunity to explain the decision to temporarily suspend births at the Cotswold Maternity Unit, Chipping Norton. A number of issues had been raised and these concerns had been identified through internal monitoring processes, the staff and via the Maternity Services Liaison Committee. The issues mainly related to working practices within the unit and not to one single incident. Higher than expected transfer rates and falling numbers of births had been noted and it was felt this may indicate an underlying problem.

2. The decision was taken to suspend the births, while maintaining the other components of the service, during the time the review was undertaken; the rationale for this decision was to enable the Trust to properly support the staff and mothers during this review. It was acknowledged that it would be a difficult time for all concerned and it was important not to add extra pressure on the staff in the unit which may then impact on the outcomes for women and their babies.

Review process

3. The scope of the review included (but was not necessarily restricted to) the following purposes:

3.1 Evaluate the current governance arrangements to ensure that staff working in the unit comply at all times with those arrangements.

3.2 Provide assurance to the Trust that clinical practice in the Cotswold Maternity Unit is in line with Directorate and National guidance, as well as Trust policies. This should include examination of: case notes, incident forms, previous complaints and claims, and records of transfers in labour and the early postnatal period.

3.3 Examine the risk management performance of the unit with particular attention to:

a. Identification of high-risk patients throughout pregnancy;

b. Compliance with antenatal guidelines, including whether appropriate and timely referrals have been made to a consultant for an opinion or on-going care;

c. Management of labour to include care plans, recognition of risk (both mother and baby), and compliance with guidelines regarding transfer to consultant-led care;

d. Postnatal care including appropriate transfer/discharge of mother and baby.

3.4 Examine systems for risk management, including incident reporting and investigation, risk assessment, and implementation and monitoring of action plans.

3.5 Advise on professional supervision including statutory supervision of midwives.
3.6 Conduct interviews with staff to understand any concerns relating to clinical practice, transfer rates and the reduction in the total number of births.

3.7 Conduct interviews with key stakeholders and the local population to ensure their involvement and, importantly, understand their issues in relation to the Cotswold Maternity Unit.

3.8 Identify barriers to good practice where problems are identified.

3.9 Reinforce and publicise good practice.

3.10 Investigate the culture of the unit, as well as any underlying problems with relationships amongst staff and the impact on the unit’s effectiveness.

3.11 Advise on the appropriate service model for the provision of safe, high-quality, effective and accessible midwifery-led care at the Cotswold Maternity Unit.

4. The OUHT was explicit at the outset of the review that the intention was to reopen the unit once any recommendations highlighted through the review had been implemented and provided assurance to HOSC at the previous meeting as to this commitment. We would wish to reiterate that again in this progress report.

Process

5. In order to fully address the scope of the review and the purposes detailed above, a robust structure of interviews, meetings, case reviews and questionnaires were put in place. Given the concerns raised by some individuals about the need for an external rather than an internal review a degree of independence was built into every level of the review. Independence included:

- At HOSC’s recommendation all the staff based in the CMU were offered the opportunity to have an external person present during their interview; all declined and were happy to meet to discuss their own personal and professional experiences and views.
- An external facilitator and Chair of MSLC met with the local community at a series of events.
- The PCT Lead and the Head of Midwifery met with the local General Practitioners and Health Visitors.
- Supervisors of Midwives with no involvement in the CMU conducted the case reviews.
- Questionnaires sent to a randomly selected group of women who have received care at the CMU to gain their views.

6. It was important to ensure the review encompassed an appropriate timescale to determine practice, cultural issues and any changes that have been implemented; the decision was taken to focus on the last 4 years. (2008 -2012)
7. The steps taken and the independent elements are as follows:

<table>
<thead>
<tr>
<th>Specific review</th>
<th>Number</th>
<th>Actual completed</th>
<th>Independent element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meetings with staff</td>
<td>51</td>
<td>36</td>
<td>Staff working in CMU offered the opportunity to have an external person present.</td>
</tr>
<tr>
<td>Questionnaires sent to women</td>
<td>200</td>
<td>94</td>
<td>Random selection of notes</td>
</tr>
</tbody>
</table>

| Letters received re the review | 4 | 2 from local women 1 from an observer 1 other |
| Case note reviews | 200 | 200 (100%) | Random selection of cases. Reviews completed by Supervisors of Midwives not involved in CMU. |
| Review of transfers | 46 | 46 |
| Review of home births | 4 | 2 | Consultant Midwives contact with each woman planning to give birth at home. |
| Questionnaires to GP’s | 16 (8 – Banbury area & 8 –CN GP’s) | 4 | All GP practices in Banbury area. |
| Meeting with local GP’s and Health Visitor | 1 | 1 | PCT Lead |
| Public meetings | 6 sessions x 120 places | 6 sessions held and 52 people attended | External facilitator and Chair of MSLC |
| NCT and MSLC | | | Feedback received. |

**Emerging themes**

8. Whilst acknowledging further analysis and review is required, the review has identified the following themes:

- Local women and their families are supportive of the Cotswold Maternity unit and want it to be available for the full range of services.
- An analysis of recent transfers has shown that these were entirely appropriate and done to ensure the safety of the mother and baby. It
appears that some staff have recently been more cautious when working in the CMU because of the prevailing culture of the unit; this is related to the fact that the team was not operating in a unified and cohesive basis.

- The need to agree and implement an effective discharge policy.
- The need for midwives and local General Practitioners to work closely together to support each other in the care of pregnant women and to collaborate in the on-going development of the unit.
- The need agree staffing ratios and the appropriate skill mix to provide the service at the CMU.
- A number of concerns have been raised by staff who have been on the periphery of the units at Chipping Norton; these relate to the culture and the difficulties this has caused between groups of staff. This will be addressed in the main report.
- The need to review the working arrangements to ensure continuity and provision of midwifery care.
- The importance of promoting the service by working closely with the local community, GPs and other key stakeholders to build up support for the CMU and thus encourage and support women who want to birth in the standalone midwifery unit.

Next steps

9. Given the level of information obtained as part of the review it is important to ensure time is given to an effective analysis of the data and provide robust evidence to underpin the recommendations about the future of the unit. This will include a detailed analysis of the individual staff meetings and completed questionnaires from the women and GPs, and evaluation of the audit of the 200 case notes. It is imperative that the detail is analysed in such a way to address the purposes of the review and to fully address any concerns or deviations from practice.

10. The need to ensure that the outcome of the review is robust and comprehensive must be balanced with the desire of the local community and the Trust to reopen the unit at the earliest appropriate time. A timetable has, therefore, been agreed to ensure the final report is completed by the end of February 2013 for consideration by the Trust Board on 13 March 2013.

Timescales

<table>
<thead>
<tr>
<th>Work plan</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analysis of all data collected.</td>
<td>Mid February 2013</td>
</tr>
<tr>
<td>Report writing</td>
<td>Complete end February 2013</td>
</tr>
<tr>
<td>Agree action plan</td>
<td>13 March 2013</td>
</tr>
<tr>
<td>Open Cotswold Maternity Unit</td>
<td>To be agreed</td>
</tr>
</tbody>
</table>
Conclusion

11. HOSC is asked to note this progress report and the emerging themes.

Jane Hervé,
Head of Midwifery

Andrew Stevens
Director of Planning and Information

11 February 2013
# 1. Placement profile.

**Demographic information about the service.**

- **To be updated annually, at the time of the Audit, by the Practice manager/Departmental Head/ Nominated Practice Representative, and agreed with the link lecturer**
- **This information will be entered on a database in the placement unit, and an annual print out provided for updating.**

**Demographic information continued**

<table>
<thead>
<tr>
<th></th>
<th>Name of ward/department/residence/ health centre/ service/team</th>
<th>The Cotswold Maternity Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Site Address Telephone number Fax number E-mail address</td>
<td>The Cotswold Maternity Unit Russell Way Off London Road Chipping Norton OX7 5FA Tel: 01608 648222 Fax: 01608 648223 <a href="mailto:chippingnortonmidwives@orh.nhs.uk">chippingnortonmidwives@orh.nhs.uk</a></td>
</tr>
<tr>
<td>3.</td>
<td>Clinical Manager. Name, Title and Tel. number</td>
<td>XXX Team Leader 01608 648222 XXX</td>
</tr>
<tr>
<td>4.</td>
<td>Nominated link lecturer or School link, base, and contact number.</td>
<td>XXX Senior Midwifery Lecturer School of Health and Social Care, room MRAG/61, Marston campus Tel: XXX Email: XXX</td>
</tr>
<tr>
<td>5.</td>
<td>Public Transport / parking</td>
<td>Available although most students live locally</td>
</tr>
<tr>
<td>6.</td>
<td>Describe the service provided, &amp; the Client groups for whom it is provided</td>
<td>Antenatal, intrapartum and postnatal care, including antenatal education and breast feeding support (drop in clinic every day)</td>
</tr>
<tr>
<td>7.</td>
<td>Number of in patient beds, or places, if relevant, or daily attendance’s/visits</td>
<td>6 beds comprising: 2 birthing rooms with pools 1 clinic room 1 multi-use room 2 postnatal rooms All rooms have en-suite facilities</td>
</tr>
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<td></td>
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</tr>
<tr>
<td>8.</td>
<td>Style of work organisation of the service provided E.g. teams, key workers</td>
<td>Midwifery led care with some caseloding and operate a flexible on call system.</td>
</tr>
<tr>
<td>9.</td>
<td>Usual working days, shift patterns and times, meal breaks.</td>
<td>8am – 4pm 2pm – 10pm On calls 8pm – 8am</td>
</tr>
<tr>
<td>10.</td>
<td>Style of dress expected of student (e.g. uniform, casual, jeans acceptable)</td>
<td>Smart casual professional dress, no jeans or jewellery Name badge essential</td>
</tr>
<tr>
<td>11.</td>
<td>Are changing facilities available in the FMU? If not, where are the nearest?</td>
<td>Staff changing room available if required</td>
</tr>
<tr>
<td>12.</td>
<td>Learning resources available on site (e.g. literature, computers, videos etc.) Access to libraries</td>
<td>Journals, databases (for example, MIDIRS, Cochrane library) computers, DVDs, books Can access OBU intranet (online journal access include: BrJ of MW, Birth, J MW &amp; Women’s Health, Midwifery). Team and students can access Cairns as well as OBU and the Horton library.</td>
</tr>
<tr>
<td>13.</td>
<td>Particular areas of expertise and interests, which you would wish students to observe and learn from</td>
<td>Core of MWs who have expertise in home and FMU birth. Breastfeeding support and education. Antenatal education Hypno-birthing</td>
</tr>
<tr>
<td>14.</td>
<td>Areas of expertise / innovation / practice development focus</td>
<td>Global Baby Friendly award, resulting in speciality focus Promote community birth (FMU, home) as appropriate Examination of the newborn Midwifery link for pregnant teenagers</td>
</tr>
<tr>
<td>15.</td>
<td>Are there examples of research/evidence-based practice?</td>
<td>Continuous review of practice with reflection and discussion if change considered appropriate</td>
</tr>
<tr>
<td>16.</td>
<td>Philosophy of Unit</td>
<td>Reviewed 2011 and available.</td>
</tr>
<tr>
<td>17.</td>
<td>Additional Comments</td>
<td>Concerted effort is planned over the next 12 months to raise the profile of the unit to encourage women from the wider community to choose TCMU as their place of birth.</td>
</tr>
<tr>
<td>18.</td>
<td>Placement Category (To be added by placement unit staff)</td>
<td></td>
</tr>
</tbody>
</table>
## Placement Audit Action Plan for the Cotswold Maternity Unit 2011-12

<table>
<thead>
<tr>
<th>What action has been identified?</th>
<th>How will this be achieved?</th>
<th>Who will take responsibility for ensuring actioned?</th>
<th>Date to be reviewed / completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update welcome pack for students</td>
<td>New pack to reflect change of the Midwifery unit’s location and OBU faculty changes</td>
<td>xxx in liaison with xxx</td>
<td>Mid October 2011</td>
</tr>
<tr>
<td>Chipping Norton team’s caseload is increasing since the opening of the new unit, which should</td>
<td>Mentors to ensure that they provide all aspects of ante, intra and postnatal care for mother and their babies as required for student competencies</td>
<td>Chipping Norton midwives, MCAs. xxx</td>
<td>Lead midwife xxx to monitor in liaison with link lecturer.</td>
</tr>
<tr>
<td>optimise the student experience, including continuity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bicester and Horton based MWs will be working a rota alongside the Ch.N team with the aim of</td>
<td>Bicester and Horton MWs allocated shifts in the MW unit</td>
<td>xxx in liaison with the Horton</td>
<td>Review student intrapartum experiences across Ch N, Bicester and Horton 2012.</td>
</tr>
<tr>
<td>strengthening the team to increase caseload and continuity access for a wider range of women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promote greater use of the new unit</td>
<td>Produce a colour leaflet of the new unit for women and disseminate widely</td>
<td>xxx in liaison with the team</td>
<td>End 2011</td>
</tr>
<tr>
<td>Promote greater use of the new unit</td>
<td>Explore the feasibility of re-introducing AN refresher class for multiparous women</td>
<td>xxx in liaison with the team</td>
<td>End 2011</td>
</tr>
</tbody>
</table>

Please use reverse of sheet for any comments

Name of team: The Cotswold Maternity Unit

Date: 26_09_11 ........................

Signed: Trust Representative: xxx, lead midwife, Chipping Norton.

Review Date: September 2012.

Link Lecturer: XXX