BABY LIFELINE
The Mother and Baby Charity

UNIVERSITY OF Hull

MIND THE GAP

An Investigation into the Training Gap Between NHS Trusts in England

Final report

Baby Lifeline is a UK-based charity which aims to improve outcomes for mothers and babies by providing equipment to maternity units and training to the medical and legal professions. In November 2015 Baby Lifeline sent out Freedom of Information requests to all Trusts in England to gain a better understanding of mandatory and non-mandatory training offered by Trusts, including the governance, available budgets, training topics, and frequency, duration, assessment, and delivery of training. In March 2016 researchers from the University of Hull and Baby Lifeline began to order, analyse, and evaluate the responses received from Trusts. An interim report was published in early April 2016, outlining findings from the responses by 59 Trusts. This report will present the findings from all Trusts who responded to the Freedom of Information request.

The response rate to the Freedom of Information request was good; 132 Trusts were approached, 125 responded to the request. Two Trusts no longer exist and five Trusts did not respond. While the response rate was good, the majority of Trusts responded after the 28-day Freedom of Information request deadline. The quality and quantity of information received varied widely between Trusts. Some provided detailed information about their mandatory and non-mandatory training programme, including a list of topics and the frequency, duration and delivery of each training topic. Other Trusts only responded with a brief list of topics and no further information. It was also evident from the responses that many Trusts did not provide information about all training provided. Some did not include any maternity-specific training, while other Trusts only provided details of training in a maternity context. The information on training budgets is particularly patchy, and many Trusts did not respond to questions relating to training budgets.

Despite these limitations we are able to present some information on the breadth and depth of training provided. A large majority of Trusts provide mandatory training in obstetric emergencies, cardiotocography monitoring, newborn/infant feeding, and antenatal screening. Most mandatory training is provided in-house, most Trusts offer around three to four days of mandatory training per year, and generally require, depending on the topic, annual attendance. While many Trusts ask staff for feedback on training, the quality of the evaluation forms provided by Trusts varied and was, overall superficial in nature.

The most important message though is that training provision varies widely between Trusts in England, in terms of which topics are offered and how they are provided. There is a need for more consistency in the range of topics provided as well as the quality of training. There is also a need for further exploration of mandatory and non-mandatory training offered by Trusts in England, with a view of gathering more complete, reliable and consistent information.

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1. Introduction

1.1 Background

Whilst most births end with a healthy mother and baby, when something does go wrong the impact is distressing, enduring, and extensively felt by associated family members and healthcare professionals. It has been highlighted by recent reports, such as the Perinatal Mortality Surveillance Report by MBRRACE-UK (Manktelow et al 2016), that there is a lack of standardisation in practice across the UK leading to preventable baby deaths. In addition, recent research by the Royal College of Obstetricians and Gynaecologists (RCOG 2016) concluded that 500-800 babies die or acquire severe brain injuries due to something going wrong during labour each year in the UK – this equates more than 1 baby a day as a minimum. A key component of standardizing care and improving outcomes is to provide nationally-implemented, quality education to all healthcare professionals in evidence-based best practice.

1.2 Purpose and aims

Baby Lifeline want to better understand mandatory and non-mandatory training being offered across NHS Trusts; including, the governance, assessment of training provided, topics chosen, budgets allocated, and method of delivery. The aims of the work are to investigate national mandatory and non-mandatory training provision, its consistency across regions and between Trusts, and general attitudes and resource applied to it.

1.3 Methodology

Collection of information

A letter requesting information regarding provision of maternity training (Appendix 1) was sent under the Freedom of Information Act to all English NHS Trusts (n=132). Responses were received in hard copy by post and electronically. Hard copies were scanned and made available as pdf files. All files were separated into responses to the FOI request and additional material. Trusts that had not responded within the specified FOI timeframe were chased by Baby Lifeline.

Sorting and ordering of information

Two databases were set up in Microsoft Excel to capture the information. The first database recorded the responses to the FOI request: person managing the training, use of a training database, link to trust-wide computer system, mandatory training topics, duration of mandatory training, frequency of mandatory training provided, frequency of mandatory training for individuals, method of delivery, providers of mandatory training, use of course assessment form, budgets for mandatory training (including individual budgets for midwives and doctors), non-mandatory training, providers of non-mandatory training, and budget for non-mandatory training (including individual budgets for midwives and doctors). The second database recorded detailed information about training topics for each Trust, including the duration and frequency of topics, staff groups for which training is mandatory, delivery of training, and any further comments. At this point a small number of less-relevant topics (manual handling, fire safety, health and safety etc.) were excluded. In both databases information was entered for each Trust by two researchers based at the University of Hull and one researcher from Baby Lifeline. Some of the information was, if appropriate, coded and entered into SPSS to facilitate descriptive analysis.

Analysis of information

Information for who manages training, training databases and links to the trust-wide computer system, duration and frequency of training, the use of e-Learning and booklets, and providers of mandatory training were summarised and displayed graphically (Sections 3.1 to 3.7). The quality of course assessment forms provided by Trusts was evaluated using a refined version of Kirkpatrick's Classification of Training Evaluation (Bergh, Baloyi & Pattinson 2015) (Section 3.8). This evaluation was carried out by two researchers independently; inter-rater reliability was medium to high.

Information about mandatory and non-mandatory training was entered into a Microsoft Excel spreadsheet, with the training topics, grouped into categories, in the columns and the 125 Trusts which responded in the rows (available as a separate attachment). This spreadsheet was used to calculate the number of mandatory and non-mandatory topics offered by Trusts (Sections 4.1 and 4.2) and the number of topics recommended by the CNST (Section 4.3). In order to assess the relationship between selected mandatory topics provided by Trusts and outcome indicators, correlations were carried out and scatterplots were used to display this information graphically (Section 5). The outcome indicators used were the number of CNST claims per Trust (adjusted for the number of birth per Trust) and stillbirth and neonatal death rates.

2. Response rate and quality of data

2.1 Response rate

Of 132 Freedom of Information requests sent out, 125 Trusts sent back responses. We did not receive a response from 5 Trusts, and 2 Trusts no longer exist. Less than half of the Trusts (49%) that responded did so within the specified 20 working day time limit, and 1 Trust did not date their response at all. 7 Trusts needed to re-contacted in order to supply more detailed or relevant (maternity-specific) information; however, of those Trusts that were not contacted again, many of them did not provide particularly sufficient information.

2.2 Quality of data

Variability in Detail

There was a real variability in detail provided by Trusts; responses ranged from one page to several. In addition, just over half of the respondent Trusts provided supporting documents (51%) with their response.

Incomplete Data

Almost all of the Trusts did not give a full list of what they provide as part of their mandatory and non-mandatory training in maternity. The Perinatal Institute have made available a list of Trusts that have implemented the Growth Assessment Protocol (GAP) (last updated June 2016). They noted that 76% of Trusts have implemented the GAP; however, our data shows only 23% of Trusts provide training in this area (not necessarily just GAP). Whilst we understand that external training is provided nationally, most Trusts have stated that they do not mandate external training; therefore, this suggests this data is missing from Trust responses.

In addition, many Trusts have not specified that they provide or mandate training in a number of areas that are pertinent to obstetrics and midwifery; for example, maternity skills and drills (n=113 (111 mandatory)), CTG training (n=103 (102 mandatory)), and neonatal resuscitation (n=102 (98 mandatory)) (see Table 1). Some Trusts did not respond to the questions regarding maternity-specific training, and only Trust training; 80% of the data for the 'duration of the training' was used for analysis due to the rest of the data not referring to maternity training.

Unclear Responses

In addition to data not being provided, some data provided is unclear and cannot be analysed; for example, almost a third of Trusts did not provide a clear response to whether their training database was linked to a Trust-wide computer system (Figure 2). The duration of training for 14% of Trusts was also unclear (Figure 3).

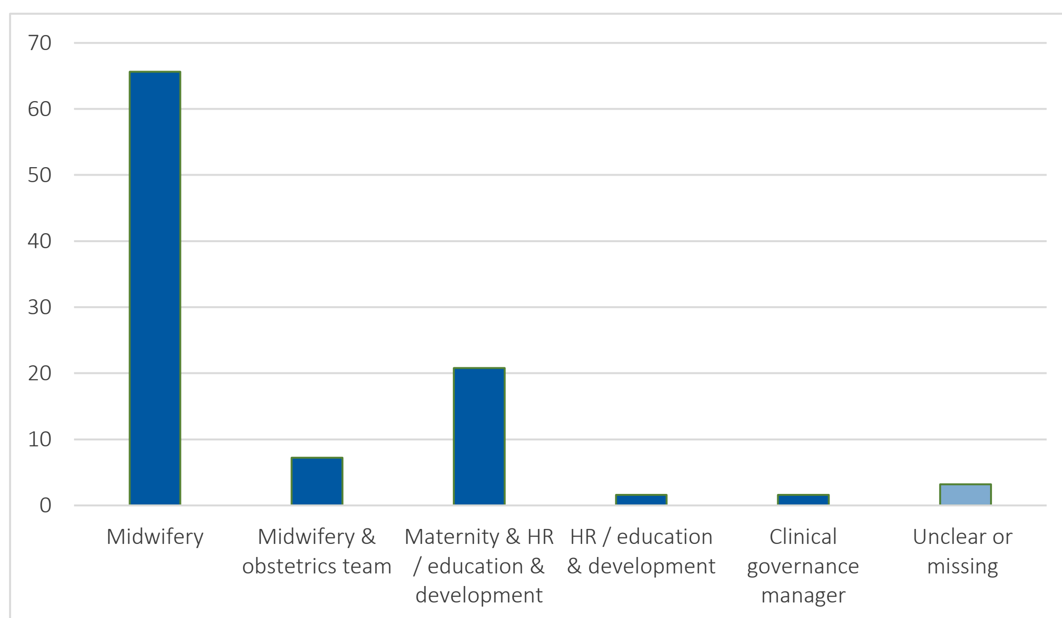
Many Trusts for 'frequency of mandatory training' did not discriminate clearly between how frequently staff are mandated to attend training, and how frequently the training is provided. Many only providing a response for how frequently the staff were mandated to attend. The data for the frequency of provision was often the same as mandated attendance, or not supplied.

3. Summary of data

3.1 Who manages mandatory maternity training?

Figure 1 shows who manages mandatory maternity training. In the majority of Trusts, mandatory maternity training is managed by either one or two specialist midwives (practice development midwives, professional development midwife) or a team of midwives. In a small percentage of Trusts mandatory maternity training is managed by a midwifery and obstetrics team. In just over 20%, training is managed jointly by maternity and Human Resources / education and development. In only a few Trusts training is managed by HR / education and development or the clinical governance manager. The information provided by several Trusts was not clear. In addition, some Trusts may have responded in terms of Trust-wide mandatory training (not just maternity-specific), which is more likely to be managed by HR; consequently these figures may be misleading. Nevertheless, it is clear that in the majority of Trusts maternity-specific mandatory training is managed at least partly from within midwifery.

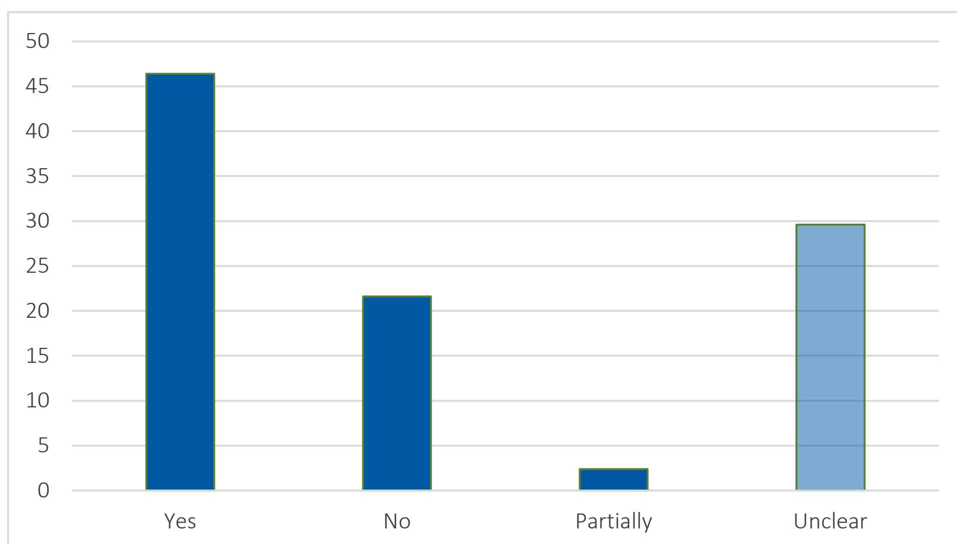
Figure 1. Who manages mandatory maternity training (%)



3.2 Training database

All Trusts used a database to keep track of maternity-specific mandatory training. In almost half of the Trusts this database was linked to a Trust-wide computer system (Figure 2), while for 20% of Trusts this is not the case. However, many of the responses to this question were not clear. In many cases it was unclear whether the maternity training database linked directly to the Trust-wide system or whether data had to be added manually. Several Trusts stated that they were in the process of linking the training database to the Trust-wide computer system, so it is likely that in the future more and more Trusts will directly link the training database into the Trust-wide system.

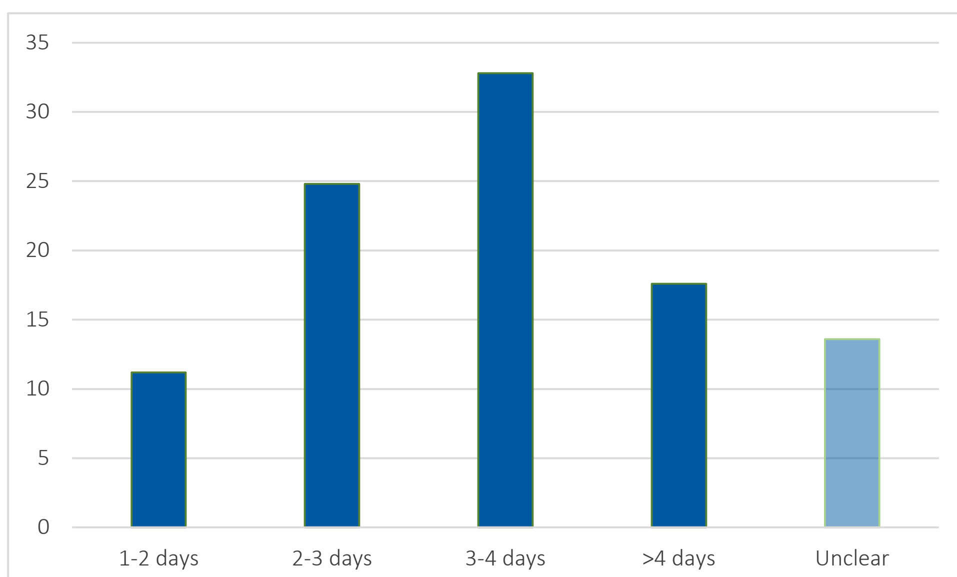
Figure 2. Training database linked to Trust-wide computer system (%)



3.3 Duration of mandatory training

Figure 3 shows an estimate of the number of days spent on mandatory training each year. The information from many Trusts was not clear enough to include, and even those Trusts who provided a clear response did not necessarily distinguish between general Trust mandatory training, maternity-specific mandatory training and Trust-wide statutory training. This figure therefore only gives an indication of the duration of maternity-specific mandatory training. Most Trusts provided 3 to 4 days of mandatory training each year and it is clear that there is considerable variation between Trusts.

Figure 3. Duration of mandatory training per year (%)



3.4 Frequency of mandatory training

Not all Trusts provided information about how frequently staff are required to attend training. Overall, the majority of maternity-specific mandatory training needs to be completed annually. Only a few Trusts disclosed how frequently training is offered; this varied from almost monthly to several times a year or annually.

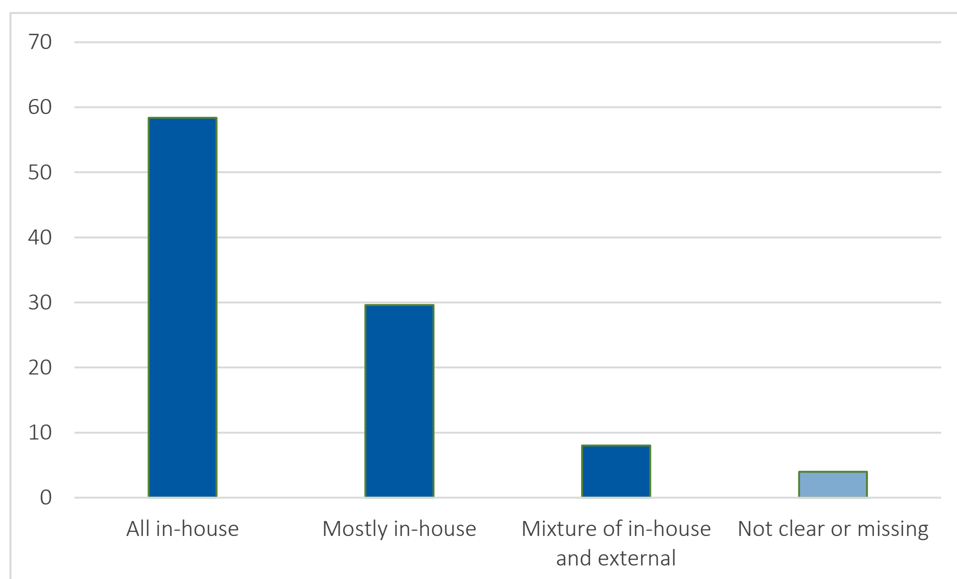
3.5 E-Learning and booklets

Almost 38% of Trusts used eLearning (or in some cases workbooks/booklets) for some of their training; a further 15% used e-Learning for a small proportion of training (i.e. just one or two topics). The K2 online cardiotocography (CTG) training was one of the most common e-Learning packages. Almost 30% of Trusts did not list any training by e-Learning and almost 18% of Trusts did not provide the relevant information. It is likely that not all Trusts have provided comprehensive information and that the proportion of Trusts using e-Learning is higher than stated here. It is clear that e-Learning is commonly used and that this varies from Trust to Trust: while some deliver most of their training in a classroom/face-to-face setting, others provide a large proportion of training as e-Learning.

3.6 Who provides mandatory maternity training?

For the majority of Trusts, mandatory maternity training is provided in-house (Figure 4). In about a third of Trusts training is mostly in-house with some external providers and in 10% of all Trusts training is a mixture of in-house and externally provided. However, many Trusts use external e-Learning, such as K2 for CTG training, but while some include this as externally provided training others do not; consequently these figures might be misleading. Nevertheless, it is clear that on the whole mandatory maternity-specific training is largely provided in-house.

Figure 4. Who provides mandatory maternity training (%)



3.7 Training budgets

The information on budgets was very incomplete; many Trusts did not respond at all or their response was unclear. More than half the Trusts stated that there was no specific budget for mandatory training, with most giving as a reason that mandatory training was provided in-house. About a third of these said that individuals could apply for funding to attend external courses. About a third of Trusts gave an unclear response or did not respond at all to this question. Only 13 Trusts clearly stated that they had a specific budget for mandatory maternity training. No Trust provided information on individual training budgets for midwives. Individual training budgets for doctors seem to be more common and 16 Trusts provided a figure for an annual budget. This ranged from £300 to £1345 annually, with a mean of just under £790.

3.8 Course assessment forms

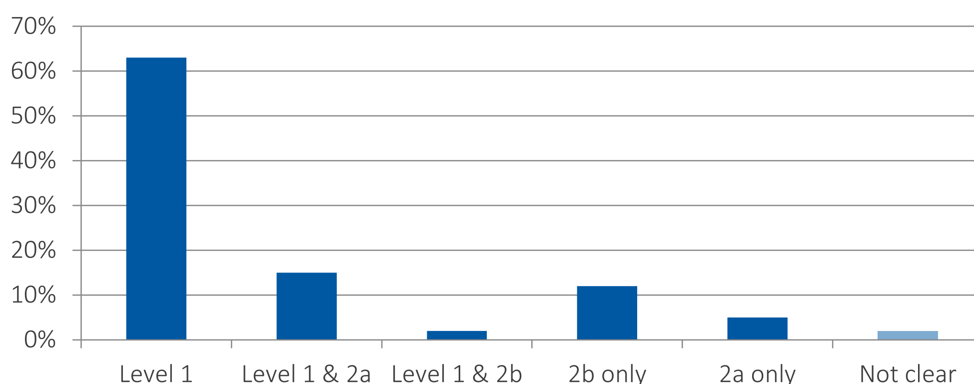
Around 70% of Trusts said that they use course assessment forms to evaluate at least some of their training courses, while 24% do not evaluate training and the responses for the remaining Trusts are unclear or missing. A third of Trusts provided an example of evaluative methods used pre and post course. In order to apply meaning to the quality and type of assessment used, a refined version of Kirkpatrick's Classification of Training Evaluation was used (Bergh, Baloyi & Pattinson 2015; Kirkpatrick 1998). This refined version outlines 4 levels of classification, and further sub-levels to 2 and 4. As no Trusts provided examples that surpassed the first two levels of classification, we will outline the sublevels for 2 only.

Level 1: Post-course delegate satisfaction
Level 2: Knowledge and skills Learned
- 2a) Changes in attitudes or perceptions
- 2b) Knowledge
- 2c) Skills

Level 3: Application to clinical practice
Level 4: Effect on clinical outcomes

As Trusts tended to use more than one type of evaluative method, we have categorised the classifications into 'Majority' (Figure 5) for the most utilised method and 'Other' (Figure 6) for other methods apparent but used less frequently. It has also been identified whether the Trust provided evaluation forms at all, and for all specified topics (Figure 7) – this could signify a lack of assessment for some topics.

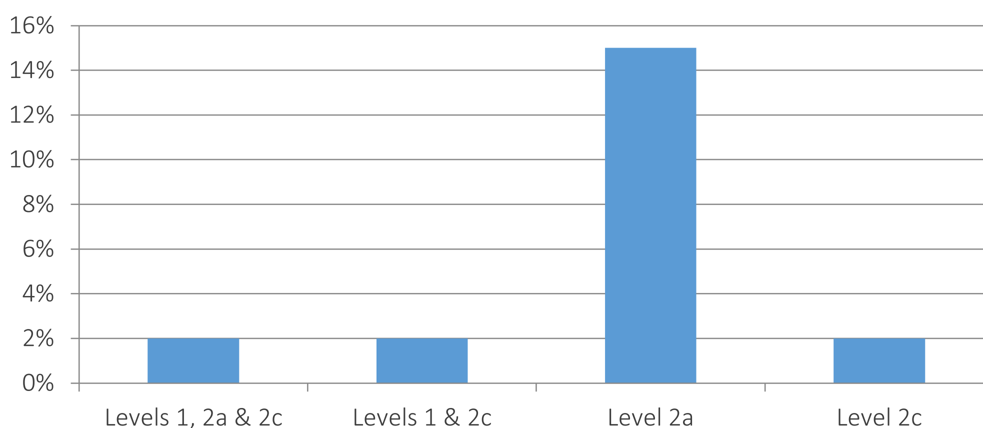
Figure 5. Kirkpatrick Classification level for majority of evaluative methods



The majority of Trusts (63%) only measured post-course satisfaction of delegates as an evaluative method, with some Trusts coupling this with changes in perception and attitude (15%) and 1 Trust also evaluating skill. Some Trusts only provided examples of knowledge and skills assessment (17%). Other levels that were identified within the methods provided. The majority also identified changes in attitudes or perceptions (15%), and 3 Trusts also assessed skill (Level 2c). The majority of Trusts did not provide any examples of evaluative methods used for their training (77%). Of those that did provide examples, 22% did not provide examples for all topics they listed, and 6% of Trusts provided examples of evaluation for all topics specified.

What can be deduced from the above data is that there is no standard form of assessment used generally across Trusts, and no standard form of assessment across topics. The majority of Trusts do evaluate their training; however, it is not clear whether this assessment is provided across all topics. There is clearly a need for improvement in the evaluation of training.

Figure 6. Other identified Kirkpatrick Classification levels of evaluation



4. Training topics

4.1 Non-mandatory topics

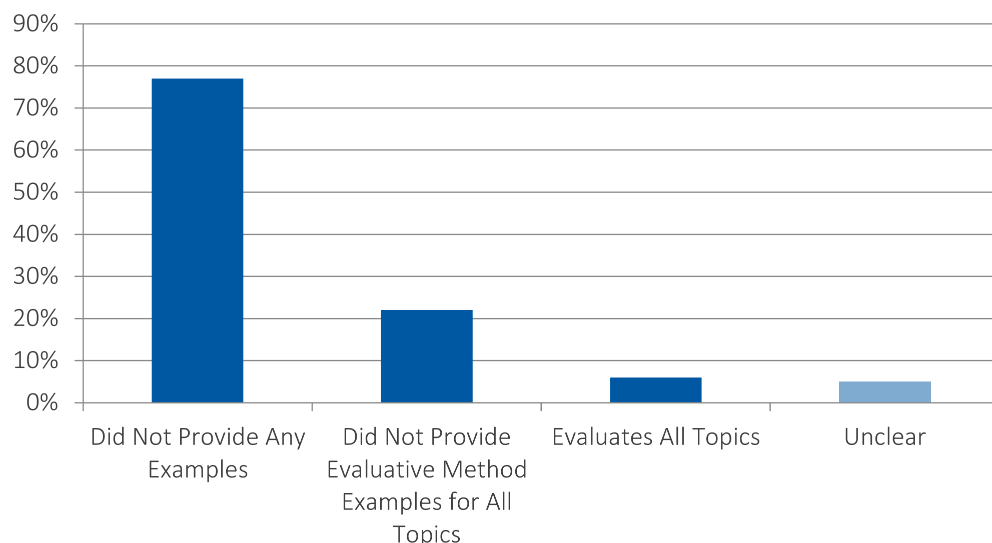
Not all Trusts provided information about the non-mandatory maternity-specific training they offered. In most Trusts non-mandatory training changed from year to year, often in response to specific policies or incidents. Some obstetric emergency topics were listed as non-mandatory, including high dependency care / care of the severely ill woman, sepsis, teamwork & communication; a minority of Trusts also listed skills and drills and neonatal resuscitation as non-mandatory (Table 1). Some Trusts offered non-mandatory CTG sessions in addition to mandatory ones and in some Trusts some topics relating to intrapartum and immediate postpartum care were non-mandatory. Perinatal mental health, bereavement and various public health courses were amongst the most commonly offered non-mandatory training courses. However, as with mandatory training, it is likely that the information from many Trusts is incomplete.

4.2 Mandatory topics

The majority of Trusts covered most of the topics related to obstetric emergencies, such as skills and drills, newborn and maternal resuscitation and early recognition of severely ill women (Table 1). Thirty-two Trusts stated that they provide multi-disciplinary skills and drills training. It is very likely that more Trusts provide this training, but they did not explicitly provide this information. Most Trusts also had mandatory training in CTG. It is likely that these topics were mandatory in all Trusts but have not been reported as such in the responses. Infant feeding was mandatory in a majority of Trusts, but newborn screening and examination of the newborn was only covered by 50 and 38 Trusts (24 mandatory) respectively. Of the topics relating to intrapartum and immediate postpartum care, perineal care was the most frequent mandatory topic.

4.3 CNST recommendations

Figure 7 Evaluative method examples provided



The Clinical Negligence Scheme for Trusts (CNST) recommended a set of minimum risk management training to be included in Trusts' training needs analyses (CNST 2013), including:

- Emergency / skills & drills training (cord prolapse, shoulder dystocia, vaginal breech, antepartum and postpartum haemorrhage, eclampsia)
- Continuous electronic fetal monitoring
- Early recognition of severely ill pregnant women
- Maternal resuscitation
- Assessment and management of all types of perineal trauma
- Maternal antenatal screening tests
- Mental health training
- Newborn life support
- Newborn feeding
- Full physical examination of the newborn
- Care of women following operative interventions

Based on the information received from the Trusts, the majority of Trusts provided between five and seven of these eleven topics as mandatory training (Figure 8). Four Trusts (3.2%) offered all eleven topics. However, due to the lack of consistent information we cannot comment on the quality of this training, which is likely to vary considerably between Trusts.

Table 1. Number of Trusts covering each topic (only topics covered by at least five Trusts are included)

	Number of Trusts providing topic	
Topic	**Mandatory**	**Non-mandatory**
Maternity skills & drills	111	2
CTG	102	1
Newborn / infant feeding	100	1
Neonatal resuscitation / life support	98	4
Antenatal screening	94	0
Mentor/assessor update	77	4
Maternal resuscitation/collapse	68	2
Perineal care (assessment, management)	63	12
Perinatal mental health	54	12
Sepsis	50	3
Newborn screening	50	0
Early warning systems	44	0
Care of the severely ill woman & high dependency care	35	6
Teamwork and communication (obstetric emergencies)	28	3
Record keeping and accountability	28	0
Epidural/anaesthetic	27	4
Conflict resolution	26	1
Growth assessment protocols (GAP)	25	4
Smoking cessation	25	1
Examination of the newborn	24	14
Supervisor of midwives course	21	8
Diabetes in pregnancy	21	7
Bereavement	19	11
Risk management/awareness	19	0
Venous thromboembolism	19	2

Female genital mutilation	14	0
Promoting normality in childbirth	13	5
Care following operative interventions	13	2
Domestic abuse	12	1
Obesity	11	2
Intermittent auscultation	11	0
Hypertension in pregnancy	10	3
Anti-D	8	0
Complaints	8	0
Consent	7	0
Substance misuse	6	2
Public health courses	6	1
Revalidation	6	0
Patient group directives	6	0
Hypnobirthing, aromatherapy, active birth, complementary therapies	5	5
Learning from risk, patient experience and clinical incidents	5	0
Well/unwell baby /newborn care	5	0
Water birth / pool drill	4	5
Human factors	4	3
Leadership and innovative	2	4

Figure 8. Number of CNST-recommended topics provided by Trusts as mandatory

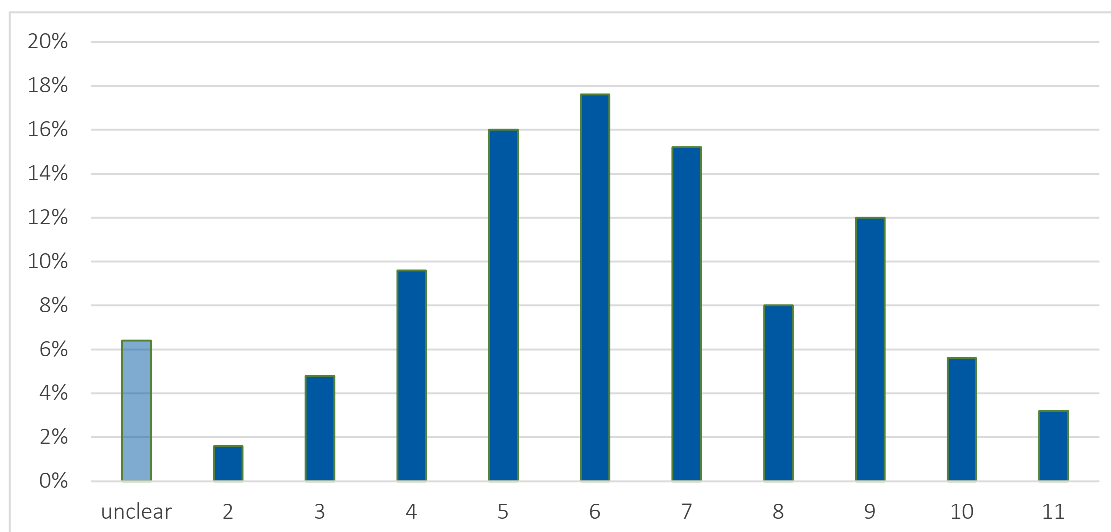


Table 2. Mean number of CNST-recommended topics provided by Trusts by region

Region	Mean number of topics
North West	6.9
North East	6.6
East of England	6.5
Yorkshire and Humber	6.5
London	6.4
West Midlands	5.8
South East	5.7
South West	5.1
East Midlands	5.0
South Central	4.4

4.4 National and training programmes

A number of Trusts used a range of national or regional training programmes (Table 3). It is very likely that in reality the information received from Trusts is not complete, and highlights lucidly one of the potential issues of quality. One example of this would be the GAP/GROW programme; according to a list published on the Perinatal Institute website, 93 of the 125 Trusts included in this evaluation have implemented the GAP/GROW programme, yet only 20 have stated this in their response to the FOI. Whilst we have not sought to validate this list with the Perinatal Institute, this does appear a striking difference.

Table 3. National and regional training programmes

Training programme	Number of Trusts	Organisation
GAP/GROW	20	Perinatal Institute
PROMPT	22	PROMPT Maternity Foundation
K2 Perinatal Training Programme	25	K2 Medical Systems
NIPE	10	Public Health England
ALSO	6	ALSO UK
YMET	5	Yorkshire & Humber Clinical Skills Network
MOET	3	Advanced Life Support Group
ALERT	3	ALERT

GAP: Growth Assessment Protocol; GROW: Gestation Related Optimal Weight; PROMPT: PRactical Obstetric Multi-Professional Training; NIPE: Newborn and Infant Physical Examination; ALSO: Advanced Life Support in Obstetrics; YMET: Yorkshire Maternal Emergencies Training; MOET: Multidisciplinary Obstetrics Emergency Training; ALERT: Acute Life-threatening Events Recognition and Treatment

5. Outcome indicators

Implementing training is directly linked to improved safety of women and babies (King's Fund 2008). Ideally, a score would have assigned to each Trust to indicate the breadth and quality of training provision. However, this was not possible with the available information. Where possible, we therefore explored the maternity-specific mandatory training topics for each Trust against the number and nature of CNST recommended topics (that is, the 11 CNST standard topics listed in Section 4.3), in order to determine if adherence or non-adherence to the recommended topics had any impact upon outcomes. Whilst we acknowledged that failings in care can result in multiple adverse outcomes for mothers and babies, we selected 3 specific outcomes to focus upon for the purposes of this work. These were:

1. the rate of CNST claims associated with childbirth per Trust
2. the stillbirth rate for each Trust
3. the neonatal death rate for each Trust

Figures for CNST claims were taken from the NHSLA (2015) and stillbirth and neonatal death rates from the MBRRACE report for 2014 (Manktelow et al 2016). Spearman rank correlations were run to test relationships between the number of CNST training topics and the stillbirth rate, neonatal death rate, and the CNST claims rate. No correlation was found for any of the relationships. Scatter graphs were completed to illustrate these relationships graphically (Figures 9, 10, 11). These graphs also illustrate the lack of a relationship between the variables. However, it is important to bear in mind that the information for training topics is incomplete and therefore unreliable. Furthermore, these topics were listed for each Trust as long as they had been mentioned in the FOI response; we do however lack reliable information about the quality of training for each topic. For example, while one Trust may cover a topic in an interactive workshop lasting several hours, another may only require half an hour e-Learning. As this information is lacking for many training courses, all were captured within the same composite measure irrespective of this lack of detail, which to some extent is methodologically flawed as we are not necessarily comparing like with like. Better information about training topics, including evidence to facilitate robust quality assessment, is necessary in order to reliably compare training provision to outcome indicators. We were also unable to account for the size of the Trust within this analysis, which is likely to have some impact on the outcome measures utilised.

Further analyses were carried out to explore the impact of specific multi-professional emergency training courses on the stillbirth rate, neonatal death rate and CNST claims per 1000 births. Twenty-two Trusts said in their responses that they used PROPMT training; for ALSO and YMET this figure was six and five respectively. As assumptions of normality were not met for any of the variables, Mann-Whitney U tests were carried out as non-parametric alternatives to test for significant differences between Trusts offering these courses and those who do not. No significant differences were found between Trusts with and without PROMPT training with regards to impact on the stillbirth rate, neonatal death rate and CNST claims per 1000 births. As too few Trusts offered ALSO and YMET training, separate analyses were not carried out for these courses. Instead, further Mann-Whitney U tests were carried out to compare Trusts who offer PROMPT, ALSO and/or YMET training and those who do not. No significant differences were found for any of the three outcome variables.

Figure 9. Training score vs stillbirth rate

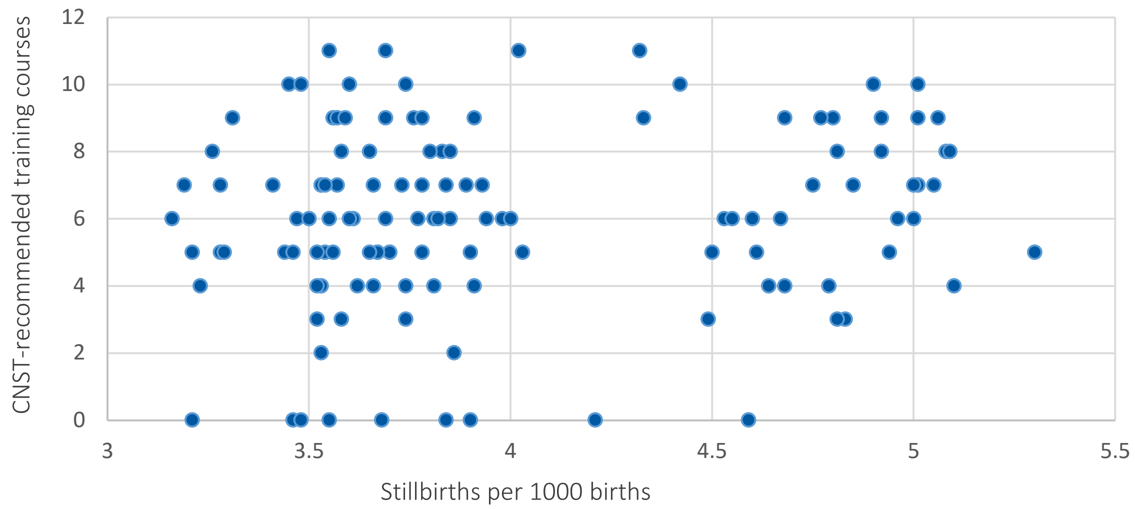


Figure 10. Training score vs neonatal death rate

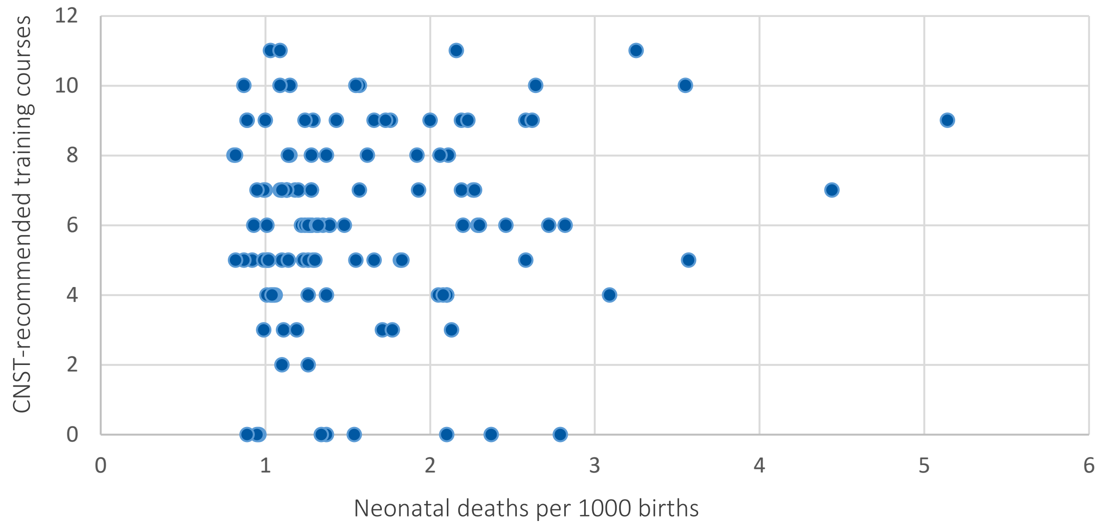
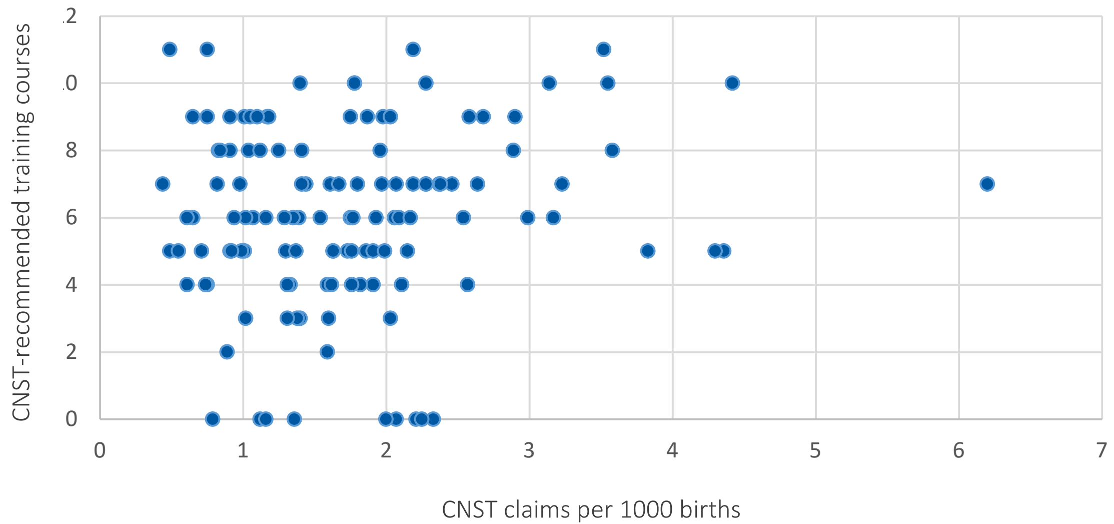


Figure 11. Training score vs CNST claims per 1000 births



6. Limitations

The Freedom of Information Act (FOIA) is a powerful tool for in that it allows FOI access to data that can be subject to analysis without the constraints of ethical approval and governance processes. There are however some limitations to this method of data collection (Savage and Hyde 2014). This in turn can impact on the quality of study findings. The shortcomings of this study are mainly related to the information that was available through the FOI request. Consequently, and similarly to the preliminary report, we have found that the limitations to this work can be categorised under the following headings:

Maternity team as a whole

We are confident that many of the responses were not representative of the maternity unit as a whole. Research and anecdotal evidence suggests that mandatory training updates for clinical staff tend to be delivered by a broad range of health professionals and practitioners, right across the multi professional team, and this approach to training has become an important feature of many organisations. However, the responses to the FOI request suggests that the majority of responses were only concerned with the training which was delivered by the midwifery team, and therefore there is much more data to be obtained with respect to this aspect of the enquiry. Conversely, responses from some Trusts seem to have been completed without any input from members of the maternity/obstetric team and focus only on trust-wide mandatory training, rather than maternity-specific topics.

Clarity of response

Lack of clarity in responses has meant that in many cases it has been difficult to infer conclusions. In some cases it appears that questions were interpreted differently by Trusts; this may be partly due to the way the original FOI was written. It is important to note that in some cases, an inadequate response may in itself, serve as data (Savage and Hyde 2014) as the quality and comprehensiveness of the response may allow inferences about attitudes to training.

Level of detail

The variability in detail across the questions meant that points of analysis were not captured in some responses; for example, some Trusts did not supply information about the duration of courses/topics and some only provided it for certain topics. Many Trusts only provided a list of topics, often very brief, without any further information about frequency, duration and delivery of training or about which staff groups should attend. On the other hand, some Trusts provided extensive details about training, including documents such as Training Needs Analyses and training programmes. This could infer a greater investment in and priority for training within those Trusts, but due to the data issues overall can only be conjecture.

Terminology

Many professions have a tendency to use jargon and abbreviations that can be impenetrable to outsiders. Healthcare is no exception to this. For example, we found that within the responses there were 25 different titles used for the question relating to who manages the training. During the data analysis period we have spent some time gaining an understanding of specific terms and grouping subjects together that we felt were similar in nature but had different titles.

7. Conclusions

Despite the great variability in the quality and detail of information provided by Trusts, it is possible to draw some conclusions from this evaluation. It is apparent that the variety of maternity-related training topics varies across Trusts in England. There are also differences in which topics are considered mandatory or non-mandatory. While obstetric emergencies, CTG, infant feeding, and antenatal screening are covered by most Trusts, this does not appear to be the case for other topics. About a quarter of Trusts stated that they offered multi-disciplinary, team-approach skills and drills training (though the real figure is likely to be higher), which may be particularly effective in managing or preventing emergencies (Bergh, Baloyi & Pattinson 2015; Siassakos et al 2013). A number of Trusts use national training programmes, which would suggest a higher degree of standardisation.

The quality of training also seems to vary and there is a range of methods of training delivery and duration of training for individual topics. On the whole, there is a lack of standardisation of the range of topics, duration, frequency and delivery training, and monitoring and evaluation of training. Many Trusts appear to rely heavily on e-learning. What also stands out is that the majority of Trusts do not have dedicated budgets for this training.

Due to the lack of consistency in responses and the variability of information provided, any conclusions from this FOI request need to be treated with caution. However, the findings clearly suggest that provision of maternity training and the quality of provided training is inconsistent across Trusts in England and as such this report lends support to calls for an improvement and standardisation of the provision and quality of training in line with King's Fund recommendations.

While Baby Lifeline recognises the financial and time pressures on maternity services, adequate training is important to ensure the safety of mothers and babies. Baby Lifeline is in an ideal position to fill this 'training gap', as the organisation provides standardised high quality training with subsidised attendance, with an emphasis on leadership and human factors and the aim of developing champions to promote high quality training.

8. Recommendations for future work

Considering the inconsistent and variable information obtained from this FOI request, lessons have been learnt regarding the construction of the FOI request itself. We recommend that a potential further FOI project is more targeted and concise in the formulation of the request. This could be done, for example, by providing Trusts with a list of more focused maternity-specific topics and asking them to indicate whether they provide this topic (mandatory or non-mandatory), how long is spent on topic, how frequently staff need to attend training, which staff groups are included, and how the training is delivered and evaluated. Repeating the FOI request would also allow assessment of any changes in training provision over time.

Obtaining more comprehensive information from all Trusts would enable a more reliable evaluation of training provision as well as comparison to CNST claims, stillbirth rate and neonatal death rate, and other outcome indicators. Currently, the lack of correlations between training and outcome indicators is difficult to interpret. While the lack of correlations might be due to the low quality of the training, it could also be due to the lack of reliable information on which the Trusts' 'training score' was based (which does not include a measure of the quality of this training).

Furthermore, the process of evaluating information received in response to this FOI request has made it clear that sorting and analysing this information requires a considerable amount of time. It would, therefore, be advisable to seek funding for any potential further project in this area.

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Appendix 1: FOI request letter

Baby Lifeline
The Granary, Fernhill Court
Balsall Street East, Balsall Common.
CV7 7FR
Tel: 01676 534 671
Fax: 01676 535 645
Email: info@babylifeline.org.uk
Web: www.babylifeline.org.uk
Company Registered No. 2661760. Registered Charity No. 1006457. Limited by Guarantee.

Please copy to all Heads of Midwifery & Clinical Directors in your Trust

«CEO»
Chief Executive

«PTNR_DESC»
«ADDRESS1»
«ADDRESS2»
«ADDRESS3»
«TOWN», «COUNTY»
«POSTCODE»

25th November 2015

Dear Sirs,

REQUEST PURSUANT TO FREEDOM OF INFORMATION ACT 2000

We write to request information from your Trust pursuant to the Freedom of Information Act 2000.

As you may be aware Baby Lifeline is a charity supporting the care of pregnant women and newborn babies all over the UK and worldwide. As part of our goal of promoting high standards of care and safety for all mothers and babies, Baby Lifeline provides very highly specialised training for midwives and obstetricians designed and presented by leading specialists in their fields. Baby Lifeline aims to work with healthcare providers in order to ensure that appropriate training is accessible to all. The Maternity Review is likely to emphasise that “those who work together should train together” and the importance of team working and a common philosophy.

We are sending this letter in order to obtain information about training programmes offered and supported in-house and areas that would be welcomed from external agencies.

Please be aware that any data produced will always be anonymised.

The health and safety of mothers and babies is paramount for us all. With this in mind, we would be grateful if you would provide us with responses to the following questions:-

1. WITH RESPECT TO MANDATORY MATERNITY TRAINING

1.1 Who manages training? A practice development midwife or the HR department?

1.2 Do you keep a database tracking training? If so, is this part of a trust-wide computer system?

1.3 Which topics do you identify as requiring mandatory maternity training?

1.4 What is the duration of your training? That is, what number of hours and/or sessions of training do you provide per topic?

1.5 How frequently is the training provided per topic?

1.6 How frequently do you mandate that individual staff should attend for re-training? By which method do you deliver this training?

1.7 Is this training provided in-house or do you use external providers?

1.8 Do you use a course assessment form? Yes / No

[If yes - please would you provide us with your course assessment form]

1.9 Do you offer a budget for mandatory training for attendance at external courses for:

Midwives	Yes / No	Individual annual budget = £
Trained doctors	Yes / No	Individual annual budget = £

1.10 Please confirm if you do not have access to data about Q1.9

2. WITH RESPECT TO NON-MANDATORY MATERNITY TRAINING

2.1 Do you have any specific non-mandatory training programmes?

2.2 Do you provide any non-mandatory training relevant to obstetrics within the Trust?

2.3 If so, is this training provided in-house or do you use external providers?

2.4 Do you offer a budget for non-mandatory training for attendance at external courses for:

Midwives	Yes / No	Individual annual budget = £
Trained doctors	Yes / No	Individual annual budget = £

2.5 Please confirm if you do not have access to data about Q2.4

The completion and receipt of the requested information will be much appreciated, and we ask that you confirm who will be dealing with this letter so that we may have a point of contact. Once we have received all responses, personal data will be fed back to you along with the anonymised national data.

We look forward to hearing from you within 28 days of the date of this letter.

Yours faithfully,

BABY LIFELINE

Appendix 2: Acronyms

ALERT	Acute Life-threatening Events Recognition and Treatment
ALSO	Advanced Life Support in Obstetrics
BBL	Baby Lifeline
CNST	Clinical Negligence Scheme for Trusts
CTG	Cardiotocography
FOI	Freedom of Information
GROW	Gestation Related Optimal Weight
GAP	Growth Assessment Protocols
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MOET	Managing Obstetric Emergencies and Trauma
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NIPE	Newborn and Infant Physical Examination
PROMPT	PRactical Obstetric Multi-Professional Training
RCOG	Royal College of Obstetricians and Gynaecologists