Maternity Services – Briefing for Local Authorities & HOSCs

1. Background

The Pennine Acute Hospitals NHS Trust provides inpatient maternity services from North Manchester General Hospital and The Royal Oldham Hospital. Approximately 10,000 babies are delivered per year across these two dedicated multi-million pound purpose-built women and children's units.

Following the appointment of the Trust's new Chief Executive in April 2014, and prior to a full review of the Trust's serious incident policy and processes, a system was introduced whereby all SUIs (serious untoward incidents) were notified to the Chief Executive and Executive Directors within 24 hours and discussed at the Senior Management Team (SMT) on a weekly basis. This ensured the Trust could take any immediate corrective action required and reduce risk. This process highlighted several incidents within maternity services. The incidents reported were reviewed through the Trust's own root cause analysis and serious incident processes and any immediate improvements or actions required were implemented. However, to ensure that we left no stone unturned we commissioned an external review of nine incidents which had occurred within maternity services (6 neonatal and 3 maternal deaths). These should be seen in the context of approximately 10,000 births in a year between The Royal Oldham Hospital and North Manchester General Hospital (including home births).

The terms of reference for the review were agreed by the SMT and the Trust Board of Directors.

2. Review Findings

In summary, the findings of the external review were:

- The population of women cared for at Pennine Acute Trust is diverse and challenging and includes a significant number of high risk and vulnerable women.
- There are clearly areas of good practice which are appropriately noted and acknowledged and which should be widely shared.
- The three maternal deaths did not appear to be the result of deficiencies in care.
- The serious incidents were thoroughly and comprehensively reviewed by the Trust and there was a clear, honest and open approach to identifying failings.

3. Recommendations

There were twelve recommendations made within the review, which are outlined below:

1. Staffing issues where safety is compromised must be appropriately escalated, and must include involvement of the duty Supervisor of Midwives.

2. Managers must ensure that the process for escalating concerns is clear.

3. The process for employing and managing locum doctors should be reviewed.

4. The directorate should review its management of obesity in pregnancy, labour and the postnatal period, and that guidelines are appropriately implemented.

5. All serious incident reports should be 'quality checked' before submission, to ensure that the root cause clearly established.

6. Recommendations made by the serious incident review panel must be clear and unambiguous.

7. Where individual failings have been identified, the reports must demonstrate that training / educational needs have been considered.

8. Senior managers must ensure that training / educational needs are addressed where leadership has failed.

9. Serious incident reviews must be signed off by a nominated senior manager from the appropriate specialty.

10. The directorate should ensure that all mandatory training is up to date for all disciplines of staff, including record keeping and interpretation of CTG.

11. All available methods should be used to ensure that standards of documentation are improved where necessary.

12. The Trust must be assured that a robust system is in place to ensure the regular and timely review, implementation and audit of guidelines in accordance with Trust policy.

Whilst many areas identified for improvement by the external reviewers had already been addressed, further scrutiny and improvement is required around some areas of clinical risk management, clinical leadership, obesity management and serious incident investigations. It is important to note that the Trust did not wait for the external review before taking action to reduce risk and improve services. In addition, the Trust also commissioned a review of staffing levels.

4. Improvement Plan

A comprehensive improvement plan was developed to address the issues identified in the external review. The implementation of the improvement plan for our maternity services is being led by our Chief Nurse and Acting Medical Director and individual actions are being put in place by a whole team of doctors, midwives staff and managers. Implementation is being overseen by the maternity incident management group.

5. Communication and Engagement

The Trust was very conscious of the need to ensure that the families of the cases reviewed were informed first and that discussions were held in a sensitive and supportive manner. Plans were being developed so that these discussions could be held with the families. However, the content of the external review was disclosed, by an unknown source, to the media before the plans to meet with the families could be put into place. The press (Manchester Evening News) only gave the Trust 24 hours to make contact with the families before they published the story. This was an inadequate period of time for meaningful communication. We were only able to make telephone contact with the families and alert them to the fact that there had been a review undertaken and offer them the opportunity to meet with us.

Since publication of the review we have now put in place a full communication and disclosure plan and have maintained contact with those families who have indicated a desire for contact. We have shared the relevant section of the external review report which concerns their loved one with those families who have requested to receive it. The Trust is also supporting staff to ensure they are kept informed and updated about the review and outcomes. We have also communicated with the relevant health bodies including our four local Clinical Commissioning Groups, NHS England, the Trust Development Authority and the Care Quality Commission.

6. Media Interest

Following disclosure, by an unknown source, of the content of the external review to the media, the Manchester Evening News (MEN) carried the story over the Easter weekend (3 April 2015). The story was subsequently reported in a number of national newspapers and on the BBC and ITV regional news bulletins. A follow-up piece was covered in the MEN on 18 April 2015 covering an apology by the Trust to those families involved in the review where mistakes and the standards of care fell short of what is expected.

Below is a copy of the statement which the Trust has provided to the media. This is also available on the Trust website at www.pat.nhs.uk

Trust press statement

Gill Harris, Chief Nurse at The Pennine Acute Hospitals NHS Trust, said:
"Childbirth is a life changing event for any women and their family. Obstetric care is considered high risk, particularly for some women, and by its nature unpredictable. However, as midwives, doctors and healthcare professionals it is our job to ensure we minimise the chance of avoidable harm to provide the safest care for women and their babies and an experience that meets their expectations.

"For this reason, we believe that it was right and responsible for the Trust to commission an external review, in addition to our own internal reviews, to look at the details and circumstances surrounding a small number of maternity cases at our hospitals, to leave no stone unturned and to learn any lessons as well as ensure any mistakes are not repeated. We did not wait for the external review to make improvements to our care as we aim to be an organisation that continually learns and improves.

“We are always keen to learn from others to improve the care our staff provides and so we are also working with another large hospital trust outside of Greater Manchester to share learning across our two organisations. We know we can learn from other hospitals as we develop our services and equally other Trusts can learn from us.

“Where the Trust has made mistakes and the standards of care have fallen short of what both our staff and patients expect, we are deeply sorry and are committed to learning and improving all aspects of care we provide. We will work closely with individual families concerned to ensure we learn from their experiences and are also working closely and collaboratively with our local commissioners and partners in acting on the outcomes of both our internal and external reviews. We are committed to being open and transparent to patients, the public and with our staff. We are committed to using this feedback to help us achieve the highest standards of maternity care.

"We deliver around 10,000 babies each year at our maternity units at The Royal Oldham Hospital and North Manchester General Hospital and I would like to reassure the public that our maternity services at our hospitals are safe. If any expectant mother has a concern then they should contact and speak in confidence with their designated midwife.”

7. Scrutiny and Assurance

As a result of the media interest NHS England held a Quality Scrutiny Group on 16 April 2015. This meeting comprised senior representatives from NHS England, the four local Clinical Commissioning Groups, the Trust Development Authority and the Care Quality Commission. As a result of that meeting NHS England confirmed that they were assured that the Trust's maternity services are safe. Specifically NHS England wrote to the Trust on 24 April 2015 stating that the clear process of managing the matters arising from the external review report will be through the Trust's maternity incident management group and that the group will be co-chaired by the Trust's Chief Nurse and by a CCG Chief Officer. The letter went on to state that this would be the process for assuring the quality and safety of maternity services in the Trust.

The Trust's maternity incident management group meets every fortnight. As stated above, it is co-chaired by Gill Harris, Chief Nurse and Stuart North, Chief Officer of Bury CCG. A number of senior Trust staff and representatives of our four local CCGs, the TDA and NHS England are members of the group. The external representatives provide a high level of scrutiny of the actions being undertaken by the Trust and the CCG representatives report back to their own governing bodies.

One of the major actions in the Trust's Improvement Plan has been to agree partnership working with staff from The Newcastle upon Tyne Hospitals NHS Foundation Trust (which has a highly respected maternity service) who have agreed to take part in a shared learning arrangement ("twinning") across the two organisations. This programme will be led by the Trust's Chief Nurse. This is a really important and positive partnership that sits very well within the context of the national maternity review announced by NHS England last month.

The Care Quality Commission produces data on perinatal mortality ratios. The CQC's latest analysis shows the Trust is not an outlier for perinatal mortality rates and that perinatal mortality ratios at the Trust are similar to expected.

8. Advice for patients/public

The Trust delivers 10,000 babies each year at its purpose-built maternity units at North Manchester General Hospital and The Royal Oldham Hospital, including our specialist Level 2 (high dependency special care baby unit) and Level 3 (neonatal intensive care unit).

The Trust is keen to reassure existing patients (pregnant women), their families, and the general public that the Trust's maternity services are safe.

If any expectant mother, partner or family member has a concern or any questions, they should contact their designated midwife in confidence to discuss further.

The Trust is planning to publish the final improvement plan in the coming weeks after input from the families involved, Trust medical and midwifery staff and partner agencies.

Information about this review and maternity services in general is available for patients and the general public on the Trust website at www.pat.nhs.uk .

Andrew Lynn
Head of Communication
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