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The Pennine Acute Hospitals NHS Trust

Title of Report	Maternity Services Review and Improvement Plan

Submitted to	Joint Health Overview and Scrutiny Committee
Date	5 January 2016

Executive Summary	This report provides details of: the external review of Maternity Services that the Trust commissioned in 2014; the resulting development of the maternity improvement plan; and the wider review of Maternity Services.
Actions requested	The Committee is asked to consider and discuss the contents of the paper.

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Maternity Services Review

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1. Introduction and Context

Following the appointment of the new Chief Executive in April 2014 and prior to a full review of the Trust Serious Incident (SI) policy and processes, a system was introduced whereby all SIs were notified to the Chief Executive and executives within 24 hours and discussed at the newly formed 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 no stone was left unturned an external review of nine incidents which had occurred within maternity services (6 neonatal and 3 maternal deaths) over the period January 2013 to July 2014 was commissioned. These figures 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 external review team consisted of a Senior Midwife and an Obstetrician external to the Trust.

The terms of reference extended beyond a review of the serious incidents themselves, however, in the first instance the reviewers concentrated on these. The findings and recommendations of the external review report are appended. To reflect our duty of care to the individuals' involved and following discussion with the families concerned, data which could be identifiable at a patient level has been redacted to ensure compliance with our duty of confidentiality to our patients.

2. The Maternity Review and Subsequent Improvement Plan

The findings of the review of the nine incidents demonstrated that, whilst the maternal deaths did not appear to be the result of deficiencies in care, further scrutiny and improvement was required from the review of the neonatal deaths. The key themes identified in the external review were:

- Clinical Risk Management
- Clinical Leadership
- Obesity Management
- Serious Incident Investigations.

The external review report is available on the Trust's internet at http://www.pat.nhs.uk/quality-and-performance/Maternity%20Review/Maternity%20External%20Review%20TB%20June%2015.pdf

An initial improvement plan was developed, incorporating the recommendations from the external review that the Trust had commissioned. The improvement plan is available on the Trust's internet at http://www.pat.nhs.uk/quality-and-performance/maternity-services-review.htm

On 1 April 2015 the Trust convened the Pennine Acute Trust (PAT) Incident Management Group (IMG) in response to the External Review of Maternity Services. The Trust established the IMG to oversee the management and assurance of the issues arising, to ensure a fully coordinated approach, inviting key partners (NHS England, Clinical Commissioning Group Quality Leads, Trust Development Authority, Care Quality Commission) to be members. The terms of reference agreed were to:

- Agree an understanding of the issues identified;
- Agree any gaps in assurance;
- Agree the scope of the Trust Improvement Plan;
- Agree the process for disclosure;
- Agree the scope of any further review;
- Allocation and clarification of responsibilities

The PAT Chief Nurse co-chairs this meeting with an external partner, Stuart North, Chief Officer, Bury CCG.

NHS England Sub-regional team held a single item Quality Surveillance Group (QSG) on 14 April 2015 to discuss the external review. External partners (TDA, CCGs and CQC) were invited to attend the QSG to feedback any issues / concerns that they had in relation to the Trust's maternity services. The Trust was also invited to present to the QSG feedback on action taken to date and assurance that the services were safe.

The outcome of the QSG held to discuss the external review of maternity services at PAT was that all parties were confident that the maternity services at PAT were safe. They were further assured by the collaborative approach being taken with regard to overseeing the improvement plan, delivered via the Incident Management Group (IMG). No additional monitoring was put in place from NHS England.

The Trust had put in place a disclosure and communication plan to ensure that key groups and individuals were informed of the report findings and resulting improvement work required. This included informing the families, the coroner, Healthwatch, MPs and other key stakeholders. Communicating with the families, in a sensitive way, was the key aspect of the disclosure and communications plan. However, before the plan could be delivered and families contacted the local media received communication about the external review from an unknown source and informed the Trust of their intention to publish the details. The Trust did make contact with the families where possible ahead of the media publication, and since then the Chief Nurse has contacted all of the ten families involved, inviting them to meet with her if they wished. To date, the Chief Nurse has met with a number of the families and has reiterated the offer to meet with the remaining families, if they wish. The Trust has given its heartfelt condolences and sincere apologies to all of the families involved.

3. Governance and Monitoring

The Trust has developed a comprehensive improvement plan which responds to the review findings, but also incorporates wider learning opportunities following publication of the Kirkup Review into Morecambe Bay Trust (March 2015), as well as other internal learning from service feedback. The plan was developed and owned by the staff within maternity services; it was formally approved by the IMG on 26 May 2015 and has since been shared with NHS England. It was noted by the IMG that the action plan reflected a desire for continuous and responsive improvement and as such may change to reflect emerging best practice or new developments. The format is aligned to the CQC five domains of Safety, Effectiveness,

Caring, Responsiveness and Well Led. Actions have been agreed under each of these headings.

4. Further Improvement Work

In support of the improvement plan a number of service improvements have been initiated. To support the development of the improvement plan a 'buddying' system with Newcastle was facilitated by our Chief Nurse. The Senior Team visited Newcastle in July 2015. This was a very positive visit where clinical relationships were developed and good practice shared. Since the visit we have adopted from the Newcastle Unit:

- Midwifery Preceptorship Package (Now live)
- Development of Band 7 Labour Ward Practitioner (Launch in January 2016)
- Development of Clinical Passports Bands 5-6
- Newcastle will also facilitate a review of a Serious Incident as an external reviewer if required

Development of the improvement plan was progressed. Table (1) demonstrates some examples of improvements implemented to date.

Service Improvement	Impact on Women and Families
Opportunity: Support early recovery for women having elective caesareans *How:* A rapid process improvement workshop with wide staff engagement was held to review the management of elective caesarean section list and patient after care *Improvement:* Long day elective lists at ROH have started with NMGH expected to start mid-January to maximise use of theatre time. The enhanced recovery pathway to improve women's experiences and enable early transfer home is being piloted at ROH with a plan to roll out to NMGH once finalised.	• Will improve the satisfaction of the woman and her partner • Streamline the service by reducing delays and cancellations
Opportunity: Review guidelines following new guidance publication *How:* Clinical review of all Trust guidance and assessment of new national guidance to ensure practice is compliant with new guidance. *Improvement:* Changes in the following guidelines to improve care given • Revised instrumental delivery guideline (Consultants presence now mandated), • raised Body Mass Index (BMI) guideline, • birth centre operational policy, • labour and birth guideline • induction of labour guideline • escalation and divert policy • Antenatal Day Unit (ANDU) attendances for	• Ensure women receive safe care, changes to guidelines based on review of Serious Incidents, Coroner's recommendations and new NICE guidance. Patient care follows national guidance. • Compliance against the instrumental delivery guideline; early warning score, raised BMI guideline, birth centre policy to ensure that the changes in policy to deliver high quality safe care are being embedded has

Service Improvement	Impact on Women and Families
reduced foetal movements on non-in-patient sites e.g. Referral to anaesthetists guideline • Recognition and management of the ill pregnant woman including early warning score	been audited. • Women with reduced foetal movements are now directed straight to the maternity sites where there is direct access to obstetric care and emergency facilities to expedite the birth of the baby should the Cardiotoco-graph (CTG) indicate this is necessary to reduce delay in transfer from the peripheral ANDU's and improve outcome.
Opportunity: Improve the reporting, management and sharing of learning from incidents to improve care for all patients. *How:* Trust wide review of incident reporting and management Policies. *Improvement:* A new SI policy was implemented emphasising duty of candour. Root Cause Analysis training for staff was provided to support high quality incident investigation that includes cross site, multidisciplinary investigations	• Learn from incidents that have occurred • Improve the quality of care • Maintain the safety of women and their babies • Identify risks and have appropriate management plans in place to manage the risks. • For duty of candour - involve and co-operate with women and families, in an open and honest way about potential or actual harm and actions required to improve safety and standards of care.
Opportunity: Improve equipment to support patient monitoring *How:* Investment in new equipment and replacement programme. Successful bid for external funding for new monitoring equipment *Improvement:* 15 new CTG monitors purchased with a rolling replacement program established	• Able to monitor women appropriately
Opportunity: Review staffing levels and skill mix *How:* External benchmarking undertaken for staffing levels and skill mix of clinical teams *Improvement:* Staffing levels and clinical roles improved leading to 40 WTE maternity support workers employed	• Release midwifery time to care • Improve staff to patient ratios to provide more support to patients
Opportunity: Improve training and support for clinical teams	• Patient care improved through consistent practice

Service Improvement	Impact on Women and Families
*How: F*ull time Supervisor of Midwives role implemented *Improvement*: Support and improve midwifery practice	and clinical supervision
Opportunity: Clear escalation processes and early intervention *How:* Escalation and divert policy implemented with ward rounds, escalation of red flags. Ensure timely escalation and senior review and action of issues. The frequency of diverts is also monitored on the maternity dashboard and an after action review is carried out after to ensure that we learn from events improve our services where possible to reduce the need for divert in the future. Foetal monitoring, early warning score, foetal growth and obstetric emergency training monitored monthly *Improvement*: Patients receive the right care and the right time from the right clinician	• Patients receive the right care at the right time from the right clinician
Opportunity: Proactive monitoring of service *How:* The maternity dashboard has been reviewed and expanded to incorporate key metrics. We have established the accepted parameters and identified margins for becoming red, amber and green. We are in the process of developing run charts for each indicator to sit on the Rag rated dashboard so we can identify statistically significant trends and changes both positive and negative to help us continuously measure for improvement. *Improvement:* Proactive identification of changes in performance	• Supports consistent care and reduces clinical variation.
Opportunity: Ensure consistent pathways across the trust including bereavement services, antenatal and post natal services. *How:* Clinically led reviews of pathways to standardise care. Workshops held to review existing pathways and identify improvements. *Improvement:* Consistent pathways will reduce variation in care delivery and streamline processes for women and families leading to increased access and reduced waiting times. Women and families will also better understand what care they can expect to receive and what choices are available to them.	• Bereavement facilities improved to ensure sensitive environment for women & families and that communication between the professionals involved in supporting a bereaved family is clearer including communication with primary care. • Consistent pathways will increase access, reduce waiting times and standardise care.
Opportunity: Involving patients, carers and families	• Services are personal to the

Service Improvement	Impact on Women and Families
in service improvements *How:* Established a Pennine Acute Hospitals Footprint Maternity Listening and Action Group to ensure women and family views are listened to and fed directly back to maternity services in strategy, service development, service redesign and improving the overall experience of care. *Improvement*: Patient centred care designed by patients and for patients.	communities we serve
Opportunity: Participate in the 'Saving Babies Lives' programme and learn from national good practice *How:* The Trust continues to implement the 'Saving Babies' Lives programme. There has been significant progress made in the training of staff to produce birth centile charts that determine if the baby is smaller than expected and whether this had been identified in pregnancy. *Improvement:* Improved detection of small for gestational age babies enabling appropriate responses.	• Monitoring babies during pregnancy reduces the number of still births and early neonatal deaths

5. Workforce Developments

The development of the Maternity Improvement Plan has become the foundation for further developments within the Directorate.

Following the Birthrate+ review the Trust Board supported and invested in 40 additional Health Care Assistants (HCA) Bands 2 – 4. This provided a real opportunity to enable midwives to have more contact time with women. There was a significant recruitment drive over a number of days and 40 additional HCA's were recruited. A number of the new staff are undertaking the 'Health Care Certificate' which has enabled our new staff to provide a caring quality service.

These additional staff have also enabled the Maternity Matrons to review how best to utilise this additional workforce.

The In Patient Matron has developed a 'Discharge Team' within the postnatal area at North Manchester. The Team carries out the following duties:

- Full handover with Shift Leader on the Postnatal Ward
- Retrieve women from the Labour Ward, settle them into the postnatal ward, and plan with the women and family an expected date and time of discharge
- Facilitate the discharge by ensuring any Take Home prescriptions are ready, any follow up appointments made and they have received information on Public Health e.g. smoking, feeding, co-sleeping, immunisation etc
- Once the work is complete they will visit the Antenatal and Labour Wards to assist and facilitate discharges
- Enter data on the Maternity IT system

- **All** of their work is supervised by the Shift Leader of the Postnatal Ward

This initiative has only been in place for eight weeks but has had an immediate impact on patient satisfaction and has been well received by the midwives in all areas. It is anticipated that this will have a positive impact on the length of stay and this information is captured on the Maternity Dashboard and will be rolled out to the Royal Oldham site.

6. Engagement and Staff

The Division recognise that the key to going forward is continuing engagement with our staff on all levels. Following the weekly Improvement Plan 'Three Key' messages are circulated to all the clinical areas and uploaded on the intranet. The Divisional Director of Midwifery has held a listening meeting which has now evolved into the 'Big Conversation'; staff choose the topic and this provides an opportunity for staff to raise concern or ideas and the opportunity for staff to assist in taking their services forward.

7. Conclusion

The external review of maternity services demonstrated the need for significant change and enhanced clinical ownership and leadership in the way our services were clinically and operationally managed and delivered. The Trust has responded to this challenge focussing on the needs and safety of our women and their families to drive forward service improvements. This journey continues. However our services have improved and the Trust is confident that they will continue to do so.

8. Recommendations

The Joint Health and Overview Scrutiny Committee are asked to note the contents of this report.