The Pennine Acute Hospitals NHS
NHS Trust

Title of Report	Review of Maternity Services
Executive Summary	This is a Survey Report of Maternity Services at Pennine Acute Hospitals Trust
Actions requested	The Board is asked to consider the report and endorse the recommendations.

Corporate Objectives supported by this paper:

- To provide high quality, evidence based, safe services delivered in a personal and compassionate way.
- To engage and support women and families, carers, volunteers, staff, public and communities in our work.
- To drive up quality and performance, reaching all our targets.
- To develop and embed leadership and personal responsibility across the Trust

Risks:

- Adverse clinical effect on the provision of safe, quality compassionate care potentially impacting on outcomes and overall experience for women and their families
- Potential for reputational loss
- Inability to sustain quality and performance.

Public and/or patient involvement:

Resource implications:
The Board need to consider additional funding of midwifery posts.

Communication:
Discussed at Divisional Quality and Performance, Divisional Management Team meeting and Midwifery Staffing Group

Have all implications been considered?	**YES**	**NO**	**N/A**
Assurance	√		
Contract	√		
Equality and Diversity	√		
Financial / Efficiency	√		
HR	√		
Information Governance Assurance	√		
IM&T	√		
Local Delivery Plan / Trust Objectives	√		
National policy / legislation	√		
Sustainability	√		

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Executive Summary

This report provides a current status of the maternity services at Pennine Acute Hospitals Trust. It provides clear factual examples of the poor outcomes for women and babies who experience care within the service and offers examples of how these can be improved.

It describes how the two main hospital sites ROH and NMGH provide care and in what numbers, detailing that more births are on the ROH site, appropriately so because this has the tertiary neonatal service. However, it goes on to describe that ROH has never been effectively established as a high risk site for obstetrics as it should have and as a result risk is unnecessarily spread across both of the units rather than being contained more effectively at ROH. It is clear from the incident profile that the level of risk is greater on the NMGH site.

The report explains that the service is an outlier on a number of important metrics including, severe perineal trauma the result of which presents women with many short and long term health consequences, some of which are life changing. And severe trauma following caesarean section particularly on the NMGH site, this is readily identified through incident reporting where there has been clear evidence of poor decision making which has resulted in significant harm to women.

In terms of medico legal claims the history of these for the service demonstrates real issues relating to the management of women in labour, particularly with regards to interpretation of the electronic recording of the fetal heart rate. This has resulted in high levels of harm for babies in particular, which has significant life-long impact. This has remained a feature of a number of incidents within the service and continued to affect outcomes.

A description of the consultant workforce is presented which has had a heavy reliance on locum medical staff (34%) over many years and is very general in its makeup and lacking specific skills and competencies, the combination of these things has led to untoward outcomes for women. This can been seen through a number of incidents and one in particular at where following surgery a woman was taken back to theatre 3 times but no effective resolution achieved or the diagnosis of faecal peritonitis made, the woman remained in hospital for several months and now has a colostomy. Further examples of this are spread over a number of years and in the recent months, demonstrating an enduring culture

Reports of staffing incidents over the last year are high relating to not enough staff and also poor staff attitude. The effect of reduced staffing numbers has resulted in women not receiving appropriate care and specific issues have related to poor diabetes management, blood sugars, observations where a woman was not

monitored and became very unwell as a result. The effect of poor staffing numbers in clinics has meant that women have had fragmented care, suffered long waits and not had appropriate management one incident identifies that a baby died following birth because the mother was not identified during her antenatal care as being rhesus negative and be given the appropriate treatment to prevent any adverse effects on her baby.

Staff attitude has been a feature of a significant number of incidents from the most basic reports of staff relationship breakdowns resulting in women and their families exposed to unacceptable situations. To an embedded culture of not responding to the needs of vulnerable women in one incident it is clear that the failure of the team to identify her increasing deterioration and hypoxia attributed her behaviour to mental health issues. Failure to respond to deterioration over a period of days resulted in her death from catastrophic haemorrhage. From the RCA it is clear that staff did not build the effective clinical picture from her presenting vital signs and laboratory results, they preferred to focus on the fact that she was demonstrating bizarre behaviour, rather than understand its cause.

A further example of staff attitude and culture has been experienced recently when a woman gave birth to her baby just before the legal age of viability (22 weeks and 6 days), whilst no resuscitation would be offered to an infant of this gestation, compassionate care is essential. However, when the baby was born alive and went on to live for almost two hours, the staff members involved in the care did not find a quiet place to sit with her to nurse her as she died but instead placed her in a Moses basket and left her in the sluice room to die alone.

In understanding the risk and harm that the service is responsible for the report details how this has not been effectively established within the service exemplified by the types of harm outcomes being reported over the previous year which were classed as no harm, and included 3rd/4th degree perineal tears, birth trauma to baby, unexpected death, haemorrhage of greater than 1,500mls, admission to ITU, stillbirth and unplanned hysterectomies.

It is clear from the report that the issues the service face are not new but have been enduring over many years. Attempts to focus on improvement have not challenged or impacted on some of the most fundamental aspects including culture, behaviours, staffing levels and skill mix. There is a need for support from outside of the organisation which is competent and effective to ensure that safe care is provided to women and babies.

Actions required

- Strengthening of leadership within the obstetric consultant workforce, in order to provide visible leaders capable of providing consistent, effective and clinically sound decision making
- Review and establish the consultant workforce substantively so that the reliance on locums is removed enabling it to be based on service need thereby reducing the numbers of generic consultants for those with more specific and focused skills

- Support from experienced midwives particularly on the NMGH site, to strengthen the midwifery staffing arrangements at a senior level to ensure consistent and effective leadership is provided and effective safe clinical decision making is embedded in practice
- Agreement to proceed with recruitment of additional midwifery posts in line with the Birth Rate Plus paper to bring staffing levels to a validated standard and reduce pressures on bank and agency and help to build a substantive and effective workforce
- Ongoing development of the governance processes in order to allow these to grow and embed and demonstrate learning from experience
- Input to support and embed the use of EWS across the service to ensure that a clear unambiguous process is used which provides early recognition of deterioration and enables effective response
- Support a review of, and then monitor against the obstetric and midwifery guidelines to ensure that women and particularly those with high risk pregnancies are correctly identified, provided with effective care and streamed to ROH or another tertiary site
- Review of some of the activity undertaken at Fairfield and Bury to analyse if this could be consolidated on the two main sites in order to increase support to the midwifery workforce
- Agreement to undertake review of ROH maternity services footprint to establish how this can be flexed to accommodate additional capacity

1. Introduction

The purpose of this report is to provide the Trust Board with a current status report of the maternity service following the external review in March 2015 and the informal feedback from the CQC visit in February 2016.
The report contains recommendations to improve safety, quality, performance, and women (and families) and staff experience, in order improve care and outcomes and build sustainability.
A number of challenges have been identified within the Division in relation to safe staffing levels in both medical and midwifery staffing.
An additional paper has been submitted to the Board requesting investment in Midwifery staffing this is mentioned in this report but not in depth.
The data is presented for PAT combined, and NMGH and ROH separately where possible to provide the most informative picture.

2. Overview of the Service

There are maternity/gynaecology services on each of the 4 sites in Pennine, Acute Hospitals Trust (PAT), at Fairfield General and Bury these are all outpatient based and comprise, Antenatal Day Case Units, Early Pregnancy/Gynaecology Assessment Unit and Out Patient Clinics for both Antenatal and Gynaecology. The main acute sites are at North Manchester General and The Royal Oldham.

In 2015 9,587 women gave birth across the 2 acute sites. In addition there is a large community service where community midwives provide antenatal and postnatal care in homes, clinics, children's centres and at Fairfield General Hospital and Rochdale Hospital. Approximately 2140 women receive

antenatal and postnatal care but do not give birth in at PAT this disproportionately impacts on NMGH community midwives (NMGH n=1900; ROH n=240).

NMGH and ROH comprise both inpatient and outpatient maternity services, the current bed base are reflected in the table below.

Site	Birth Centre	Post Natal	Antenatal	Labour	AND U	Triage
NMGH	5	28	23	12*	4	3
ROH	5	29	24	12*	3	5
Total	10	57	47	24	7	8

*Labour beds at NMGH include 1 High Dependency bed & 1 Bereavement Room and ROH includes 2 High Dependency beds

ROH is the tertiary referral centre for neonatal care. As a result women who have complications which may influence the baby's need for tertiary neonatal care are seen at ROH. However, many of these women have high risk maternal factors. Although not technically classified as a tertiary referral maternity service it is by default functioning as one clinically.

ROH does have problems with challenges with capacity; it has the highest birth numbers and should be able to accommodate more women with higher risk pregnancies, as the tertiary neonatal service is on site. However, over the past three months the service has had to divert women away to NMGH because of lack of bed stock. This situation presents unacceptable risk to the women and does not enable them to give birth in the safest place for themselves or their babies.

Women who attend NMGH for Obstetric and Gynaecology services come from an environment of significant social variance and deprivation with the associated complexities of a high risk population and accompanying physical, psychological and emotional co-morbidities e.g. High BMI, diabetes.

Therefore drawing conclusions about the level of complexity and risk, based on the technical classifications of both hospitals is not helpful or accurate.

The distribution of the numbers of women giving birth is shown in table1.

Table 1 Births by Place of birth

Site	Birth Centre	Home birth	Hospital Birth	**Total**
ROH	940	186	4025	**5151**
NMGH	730	76	3630	**4436**
Total	**1670**	**262**	**7655**	**9587**

Midwifery Led Care

Both NMGH and ROH have thriving birth centres alongside their hospital service providing midwifery led care, including water birth, in non-technical environments. Ensuring women have choice in the place of birth and the type of care they receive is a marker for high quality maternity care and reflected in NICE guidance.

The planned home birth rate is below national average at NMGH but higher at ROH (table 2).

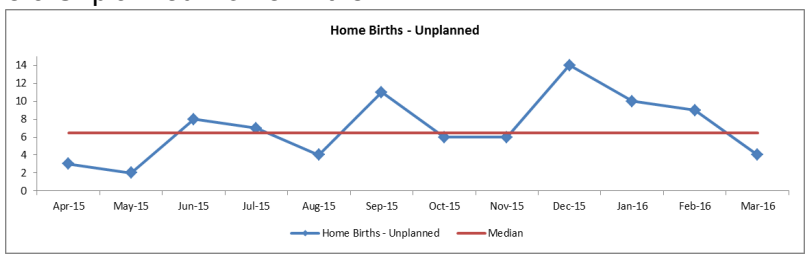
Table 2 Planned Home Birth distribution

PAT	NMGH	ROH	National Average
1.8%	0.8%	2.7%	2.3%

Unplanned homebirth

Unplanned homebirths are monitored and shared through the maternity dashboard; they can represent a marker of lack of access to appropriate care and a marker of poor quality care. From December to February 2015 there was an increase in unplanned home births but this was not statistically significant. A deep dive has been carried out which did not identify any significant themes and this increase has not continued.

Table 3 Unplanned Home Births



3. Complexity and Clinical Outcomes

The maternity dashboard monitors a range of clinical outcomes and trends across the whole maternity service and is available on the Trust's intranet. The data shown below is taken from the 1st April 2015-31st March 2016 dashboard.

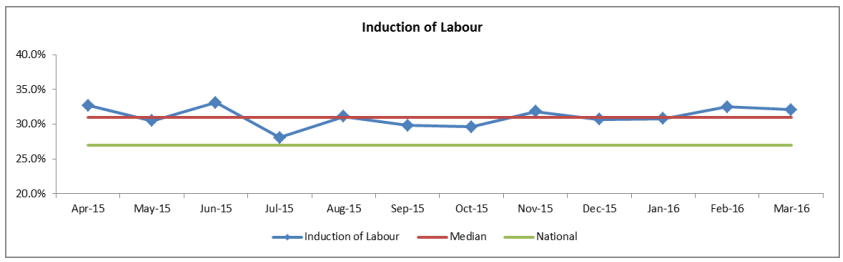
Caesarean section

The caesarean section rate for PAT 26% is similar to the national average of 26.2%. It is slightly higher at ROH (27.5%) than NMGH (25%) this is probably reflective of the case mix.

Induction of Labour

The induction of labour rate is higher than the national average (27%) for PAT at 31% (NMGH 30% and ROH 32% 2015-16). The new reduced fetal movement guideline brought in as a result of the National Saving Babies Lives Care Bundle has slightly increased the induction of labour rate in the first quarter of this financial year, although it is not statistically significant yet. This increase is likely to be sustained and possibly increase further (PAT 31.4%, NMGH 31.4% ROH 32.3%).

Table 4 Induction of labour

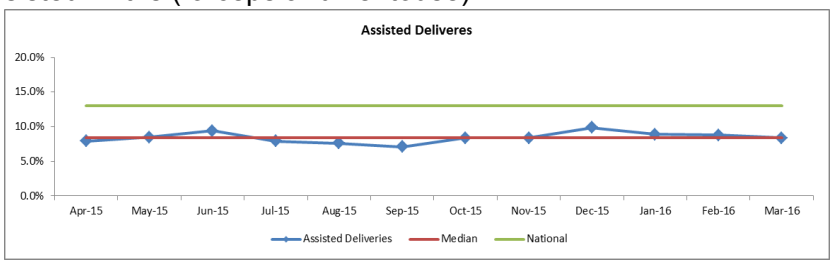


The rising induction of labour rates is of particular significance at PAT as there is an already higher than average conversion rate from induction to instrumental and caesarean section when compared to other Trusts of similar size and demographic (HSCIC data 2015).

Assisted births (Forceps and Ventouse)

The assisted birth rate is below the national average of 12.9 % (PAT 8.4%, NMGH 8.6% ROH 8.3%). This difference is partly accounted for by the higher than average normal birth rate which is for PAT 64% compared to national average 61% (NMGH 66.2% ROH 63%). This indicates that more women are having a caesarean section rather than an assisted vaginal birth than might happen in other maternity services.

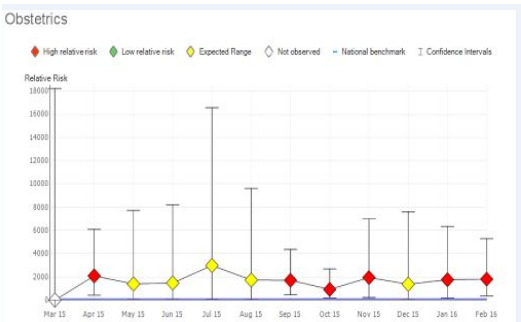
Table 5 Assisted Births (forceps and ventouse)

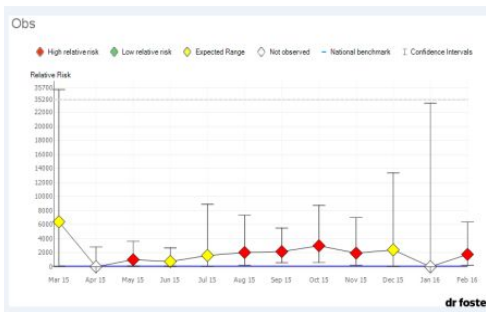


4. Dr Foster Harm Profile

The use of Dr Foster data is not embedded within the service a review of this highlights key areas of focus.

The HSMR data for obstetric services is shown below it shows that both ROH and NMGH have a level of high relative risk for 6 months of the previous year.





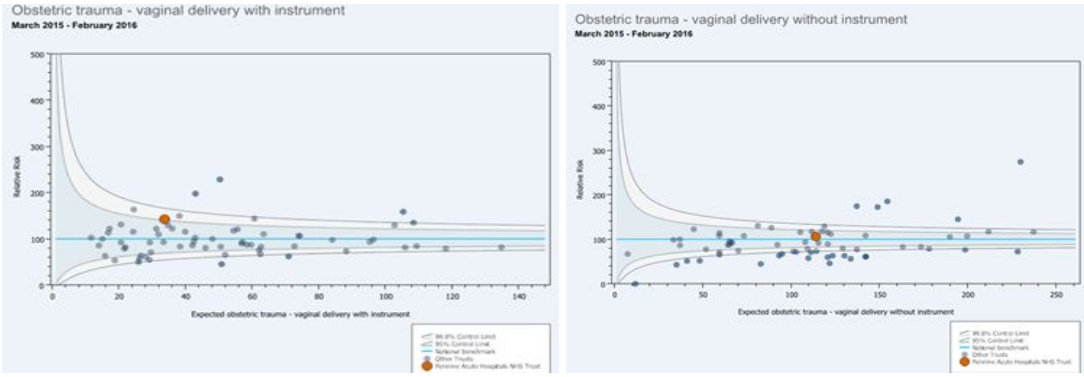
HSMR ROH HSMR NMGH

Severe Perineal Trauma

Dr Foster has identified that ROH and NMGH are both above average for reporting severe perineal trauma (third and fourth degree tears).
Severe perineal trauma is a complex harm to understand and there are a number of factors to consider including the reporting rates, the identification of perineal trauma alongside clinical skills and decision making.
Severe perineal trauma is associated with other harms such as post-partum pain, haemorrhage and infection and both short and long term incontinence for women. These additional co-morbidities increase the harm experienced by women and may be avoidable in some cases.

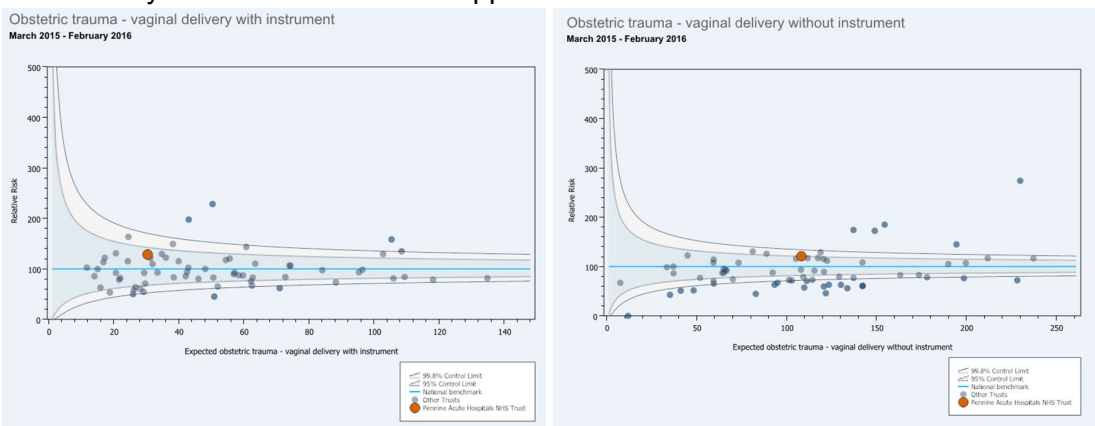
Severe Perineal Trauma-ROH

ROH is alerting at the upper limit for reporting severe perineal trauma associated with instrumental vaginal birth (forceps and ventouse). ROH are also above national average for reporting severe perineal trauma in spontaneous birth.



Severe Perineal Trauma-NMGH

At NMGH there is a higher than national average for severe perineal trauma associated with instrumental vaginal birth, but it is within the upper limit. Whereas the severe perineal trauma rate for birth without instrumentation which is usually facilitated by the midwives is at the upper limit.

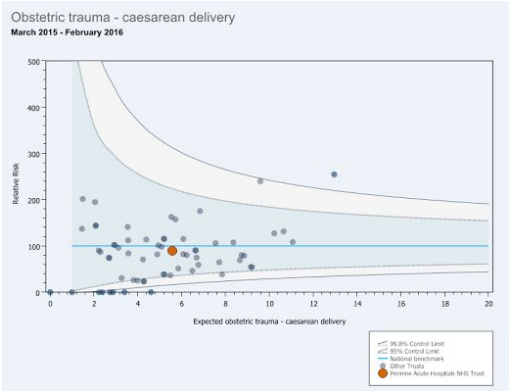


Severe Trauma at Caesarean

Dr Foster reports that there are two contrasting pictures between the sites for severe trauma at caesarean section. With the level of trauma at ROH being lower than the national average whilst that at NMGH it is significantly higher.

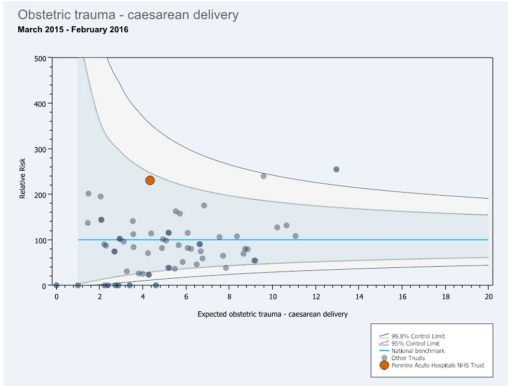
Severe Trauma at Caesarean – ROH

At ROH the incidence of trauma at Caesarean is lower than national average.



Severe Trauma at Caesarean NMGH

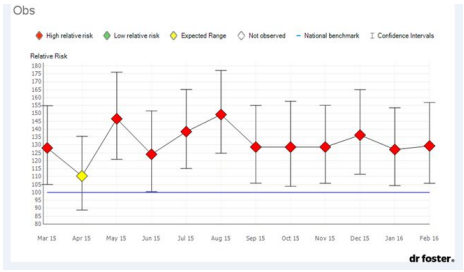
At NMGH the obstetric trauma at Caesarean is concerning being both above the national average and also considerably higher than all other Trusts of similar size, although it remains just within the upper limits for alerting.



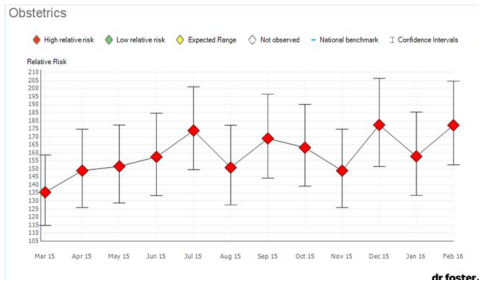
Length of Stay (LOS)

Both ROH and NMGH are alerting for increased LOS for the year 2015/16. The underlying causes of this need further exploration in order to understand are women remaining in hospital longer for clinical reasons because of case mix or because of associated complications as outlined in the harm profile or is it cultural, system error or administrative causes. Long LOS is costly for PAT, impacts on capacity and flow and disrupts family normalisation. This is also important to consider when the

maternity services are escalating capacity issues and diverting women to different sites. Understanding LOS and what is driving this will be crucial when reviewing capacity and demand needs and when considering the movement of any Consultants from NMGH to ROH to achieve the 168 hours labour ward cover.



LOS NMGH



LOS ROH

5. Patient Safety

In December 2011 PAT achieved level 1 NHSLA accreditation and in January 2012 the Maternity service achieved CNST level 1, at that time and to achieve the lowest level i.e. level 1 was predominantly a paper based review. As part of the CNST feedback three areas were noted as requiring additional attention:

- Process for immediately escalating risk management issues from the high risk clinical areas to maternity service managers and then to board level
- Frequency of audit of health records
- Labour ward staffing – particularly with regard to leadership and roles

It is noteworthy that these three issues identified in 2012 are still features within the incidents which are being reviewed within the service.

It is acknowledged that there has been a poor incident reporting culture within the service. Incident reporting as part of good governance arrangements has been promoted to increase reporting over the past year and more recently this has been being even more actively encouraged and supported. From reviewing the incident reporting system it is apparent that significant numbers of incidents have been graded at low levels of harm, despite poor outcomes e.g. Stillbirth, Severe PPH, damage/loss of uterus. However, increasing numbers of incidents are now being reported and there is some evidence that staff are improving in their assessment of harm caused when submitting these.

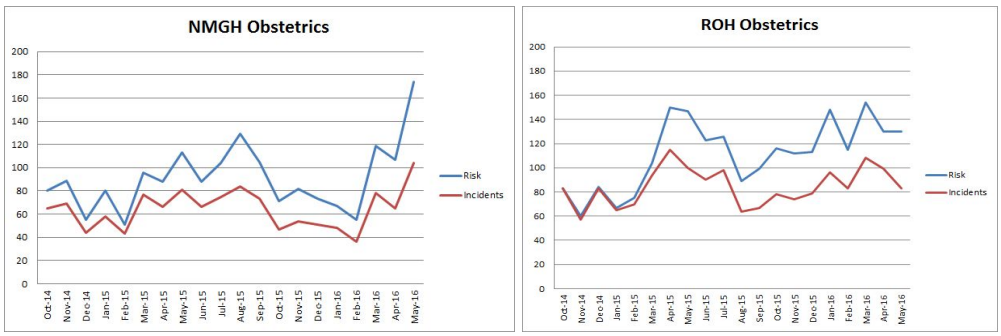
In the reporting period from 2014 to now there were 865 No or Minimal harm incidents reported which included categories of incident which one would anticipate a greater risk level assessment attributed to them due to their potential or actual seriousness. These include surgical failures, unexpected deaths or transfers to ITU, and hospital acquired injuries - See table below

Causes	A - No Harm	B - Low(Minimal Harm	Grand Total
3rd & 4th Degree Tears	33	59	92
Anaesthetic Complications	2	6	8
Antepartum Haemorrhage	8	2	10
Apgar @ 5 Mins <6	5	6	11
Birth Trauma To Baby	6	26	32
Cord PH <7.1	47	46	93
Death - Unanticipated/unexpected	2		2
Delay In Transfer Into/out Of Theatre	10	3	13
Delivery Not On Labour Ward	33	3	36
Failed Forceps/Ventouse	4	5	9
Failed Instrumental Delivery Going To Section	3	2	5
Failed/Delayed Diagnosis	8	7	15
Failure To Rec. Complication During Care	1		1
Failure To Recognise Or Escalate Acute Illness		1	1
Fetal Laceration At Caesarean Section		3	3
Hospital Acquired Colonisation/Infection	2	3	5
Incorrect/Inappropriate Procedure Performed	10	3	13
ITU Admission (Maternity)	4	4	8
Late Foetal Loss	9	3	12
Maternal Death	3		3
Neonatal Death	19		19
Post Partum Haemorrhage > 1500 Mls	110	123	233
Pre Eclampsia/Eclampsia	10	2	12
Pressure Ulcer (Hosp Acquired) Unstageable		1	1
Pressure Ulcer Grade 2 (Hosp Acquired)		6	6
Return To Theatre	1	1	2
Return To Theatre (Maternity)	1		1
Ruptured Uterus	3	4	7
Shoulder Dystocia	66	35	101
Stillbirth < 500g	9		9
Stillbirth > 500g	48	7	55
Suspected Deep Tissue Injury (Hosp Acq)		1	1
Trauma To Bladder Or Organs	3	4	7
Undiagnosed Breech	18	6	24
Undiagnosed Fetal Abnormality	1	1	2
Unexpected Transfer To ITU/HDU	9	2	11
Unplanned Hysterectomy	2		2
Grand Total	**490**	**375**	**865**

This demonstrates further a history of poor assessment and reporting of harm and a culture where there was reluctance to learn from incidents and have opportunities put in place actions to reduce recurrence.

The general level of incidents reporting and risk in maternity services has increased monthly at both sites over the past few months (Divisional Governance Report May 2016) (See Chart 5). This is more acute at NMGH and appears to be stabilising at ROH.

Risks and Incidents



From a thematic perspective the analysis of the most frequently occurring incidents over the preceding year are:

- Staffing
- Massive Postpartum Haemorrhage (PPH >1500mls)
- Unexpected transfer to neonatal unit
- Severe perineal trauma
- Stillbirth

Perineal trauma is featuring on both the Dr Foster harm profile and in the most commonly reported incidents. However, trauma at caesarean section reporting is noted to be generally low within PAT incident reporting as is the level of harm believed to be caused, despite the profile described in the Dr Foster report. This may well indicate that the assessment of risk and harm is inconsistent.

There are currently reviews being undertaken on PPH, unexpected transfers to the neonatal unit and perineal trauma.

The local audit report for Stillbirths for 2015 showed a number of concerning features relating to some of the poor outcomes. Further work is being undertaken to understand this in more detail.

6. Governance Processes

Lack of a clear and transparent governance structure and processes has inhibited learning from clinical incidents and this is likely to have affected the incident profile adversely.

Clinical incident reviews have shown repetitive features emerging including poor clinical decision making, lack of clear care management plans, concerns over team working, poor communication (including handover of care) and lack of effective leadership. These issues are negatively impacting on clinical outcomes, the experience of women and their families, and also staff experience.

There has been a strengthening of governance arrangements within the Division over the preceding 6 months, with a number of new appointments focusing on specific elements within the assurance framework. In addition since the 1st April 2016 the framework for governance has been made more robust by the implementation of processes to ensure greater oversight and transparency within the Division, with a clear auditable trail of decision making. These arrangements include support from senior professional and medical leaders within the service.

There have been 437 incidents reported against Obstetrics and Gynaecology since 1st April 2016. There are 12 of these in obstetrics which are currently being reviewed, all of these are either having concise or full RCA's (NMGH 8 and ROH 4) against the categories below which represent poor outcomes for women and babies, and common sources of litigation.

Serious Incident Type	NMGH	ROH
Cord PH <7.1		1
Maternal Death	1	
Neonatal Death	1	1
Post Partum Haemorrhage > 1500 Mls	2	
Retained Foreign Object Post Op	1	
Stillbirth > 500g	2	1
Unexpected Transfer To Neonatal Unit	1	1

In April 2016 there were 565 incidents still open on the Safeguard system which were not classed as SI's, as part of the review process which has been put in place many of these have been validated and closed, there are still 34 in progress 26 NMGH and ROH 8, the process continues to investigate and close these, a number have converted into higher risk incidents as part of this review. Below is a summary:

Cause	N.M.G.H.	R.O.H.
Apgar @ 5 Mins <6	1	
Birth Trauma To Baby		1
Communication Issue Outside Immediate Team	1	
Delay In Treatment/Care	2	1
Documentation Issue	1	
Failure To Follow Guideline/protocol/policy	1	
ITU Admission (Maternity)	1	
Late Foetal Loss	2	
Medication Prescribing Error	1	
Misdiagnosis Of Antenatal/postnatal Screening	1	
Post Partum Haemorrhage > 1500 Mls	3	1
Readmission - Other	1	
RESP - Other Airway	1	
Ruptured Uterus		1
Shoulder Dystocia	3	
Staffing Levels		1
Stillbirth > 500g	3	2
Trauma To Bladder Or Organs	1	
Unexpected Transfer To Neonatal Unit	1	
Unplanned Hysterectomy	2	1

7. Complaints

The profile of complaints over the preceding 3 years has not altered significantly with the same numbers being received as well as similar themes being raised in the same volume. The chart below shows the Safeguard complaint categories for these for Obstetrics and Gynaecology by site:

	Gynae	Gynae	Obstetrics	Obstetrics
Complaint Categories	**N.M.G.H.**	**R.O.H.**	**N.M.G.H.**	**R.O.H.**
All Aspects Of Clinical Treatment	12	30	29	46
Failure To Follow Agreed Procedure	1	1	2	7
Comm/information To Patients	2	4		2
Attitude Of Staff	4	2	2	
Trust Admin/Policies/Procedures Including Patient	1		1	4
Values and Behaviours (Staff)	1		1	1
Admission, Discharge&Transfer		2	1	
Other		1		1
Appointments, Delay/Canc O/P		1		
Privacy, Dignity & Wellbeing (PDW)				1
Staff Numbers		1		1
Access to Treatment or Drugs	1			
Grand Total 100	**22**	**42**	**36**	**63**

8. Medico Legal Claims

For the period April 10 to March 2015 Pennine Acute Trusts received the highest number of both Clinical Negligence Scheme for Trusts (CNST) and Risk Pooling Scheme for Trust Claims. The NHSLA made the highest number of pay outs on behalf of PAT. And PATs contribution was also the highest in the group.

The number of claims notified at PAT has been consistently higher than all but one of its comparators in terms of size of income and multiple sites (Heart of England Trust) in the last 5 years. In 2014/15 PAT had the highest number of claims notified of any of its comparators.

Within PAT, Obstetrics was the source for 11% claims overall but accounted for 38% damages paid out by specialty. Obstetrics was responsible for 44% of the total value of claims (total value includes total value of amount paid in damages, claimant costs, defence costs, and for open claims the estimated value of the claim at the time of data collection).

Pennine Acute Trust Claims Profile

Area	**No. of Claims**	**Value**
PAT	534	£57,935,714.98
Obstetrics Total	67	£25,666,834.00
Obstetrics Claims break down by value and volume		
Obstetrics > £1 M	4	£19,450,000.00

Area	**No. of Claims**	**Value**	**% of Total**
PAT	534	£57,935,714.98	
Obstetrics Total	67	£25,666,834.00	44%
Obstetrics Claims Breakdown by Value and Volume			

Obstetrics > £1 M	4	£19,450,000.00	33%
Obstetrics < £1 M	63	£6,216,834.00	11%

Failure to monitor appropriately in labour

This area of significant claims for PAT focused particularly CTG interpretation; this has also been identified through inquests, incident reviews and sign up to safety as a key area of concern for patient safety and is the highest cause of high volume high value claims.

High Volume High Value Obstetric Claims		
Cause of Claim	**No. of claims**	**Value**
Failure to monitor 1st stage labour	1	£6,050,000.00
Failure to respond to abnormal FHHR	1	£6,050,000.00
Failure to monitor 2nd stage labour	1	£6,050,000.00
Medication errors	1	£1,300,000.00

The Trust has been successful in obtaining funding from the NHSLA to support the implementation of an electronic CTG alerting and recording tool, work towards implementing this is underway.

9. Corners Inquest Findings

In the current calendar year there are a number of cases which have either taken place or are scheduled to come before the Coroner.

The table below shows the outcomes and main findings for the service:

Incident date	Outcome	Notable features	Coroners Status
23rd April 2013	Maternal death on postnatal ward **ROH**	Family still in contact with service and working through areas of concern relating to care.	Death by Natural causes
20th March 2015	Maternal death in theatre during spinal anaesthetic @ **NMGH**	Post Mortem reports death as amniotic fluid embolism alongside coronary artery atheroma with severe stenosis.	Death by Coronary artery atheroma with severe stenosis
1st June 2015	Neonatal death on postnatal ward **NMGH**	Concerns about care provided to mother – not screened for Group B Streptococcus and missed opportunity to treat baby	Listed for 20th June

17th November 2011	Neonatal death following vaginal birth at **ROH**	Concerns about care in labour and decisions made about mode of birth	Listed for 29th June
11th October 2015	Maternal death @ 23 plus weeks of pregnancy at **NMGH**	Concerns about care provided, delay in diagnosis, failure to respond to deteriorating clinical presentation. Cause of death - Placental abruption and coronary artery atheroma with severe stenosis	Not yet listed

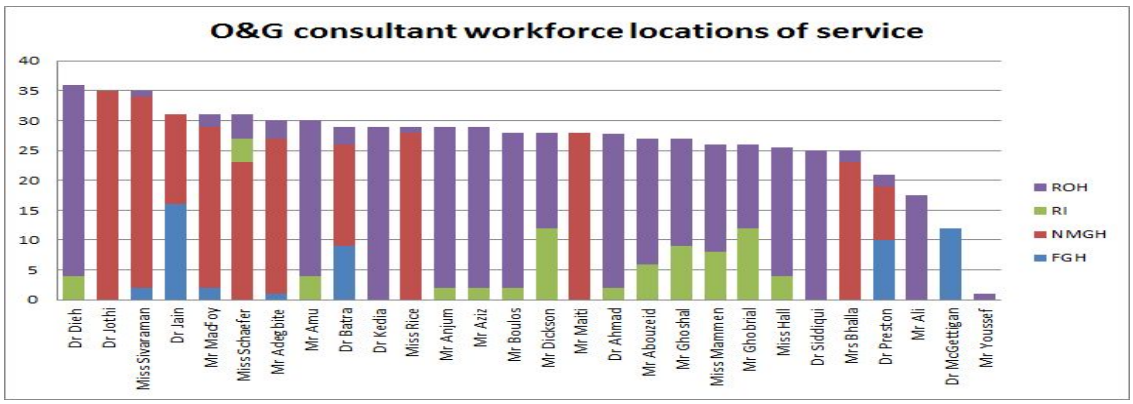
10. Workforce

Medical

The CQC raised concerns about the high reliance on locum medical staff and commented that leadership in the service was deficient.

The obstetrics and gynaecology consultant body consists of 26.55 w.t.e of which 9 w.t.e or 34% are locums, a number of these have significant tenure within PAT. As a result of this there are gaps in the specialised roles within the consultant body including fetal maternal medicine. The consultants work mainly on one site with a number providing multiple site cover as part of their job plans, the chart below shows the spread of this.

O&G Consultant DCC and On Call cover



There have been noted to be a number of challenges within the workforce and a history of recourse to adversarial resolution of issues, including job planning, including progress to Employment Tribunal. A number of the consultants also have restrictions on their practice.

The CQC assessment in February 2016 raised concerns about the level of consultant support particularly to the labour wards, and advised that these should be based on the RCOG and RCM Safer Childbirth (2008) recommendations.

Currently both sites have 130 Consultant Hours per week. The CQC recommend that NMGH reduce to 98 hours per week (appropriate for less than 4000 births per year) and ROH increase to 168 hours week (appropriate for more than 6000 births per year). It is possible to do this by transferring two of the consultants from NMGH to ROH. However, this does provide significant challenges as there are gaps in the junior medical staff tiers which would challenge the ability to provide a robust rota particularly at NMGH.

In order to achieve the required levels of births to a maximum of 4000 per year at NMGH would involve deflecting approximately 400-500 women. If they were to be directed to ROH it would commensurately increase the numbers of births at ROH by the same amount. However, it cannot be guaranteed that the flows would align to this and a separate piece of work is under way to focus on this specifically, and additional capacity would be required in terms of estates to accommodate these births.

This could also improve safety if the high risk women currently receiving care at NMGH e.g. diabetic women and those with increased BMI's transfer to ROH with its tertiary neonatal unit.

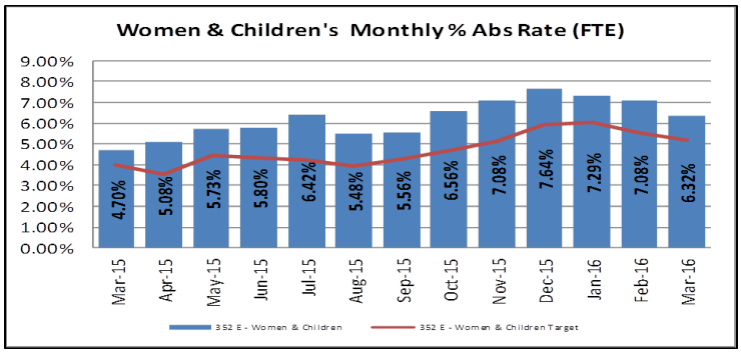
This transfer of consultant cover and clinical activity needs to consider a number of factors including the:

- CQC recommendation that 168 hours of support has to be in place by August 2016
- Potential to destabilise NMGH site by moving Consultant cover
- The need to have additional junior medical staff at NMGH
- Level of risk currently within the service
- Need for increased estates capacity at ROH to facilitate women being transferred from NMGH
- Design of the service model provision across the sites
- Employee responsibilities to NHS locum staffing
- Potential requirement for consultation process

Midwifery staffing

The CQC also raised significant concerns regarding leadership of the service as well as commenting on a bullying culture and staffing, in particular the midwife to birth ratio. A request had already been made by the Chief Nurse to undertake the Birth Rate Plus assessment in the service and this work was underway. This paper has been submitted to the Board for consideration, and demonstrates that there is a requirement for investment in additional midwifery posts.

There are also challenges within the midwifery workforce in relation to posts which have not been recruited to (30 w.t.e) as well as recent resignations (circa 10 w.t.e). In addition the sickness absence rate is at 6% and has regularly been higher over the preceding months.



Recruitment is progressing and has been largely successful but many of the recruits are newly qualified midwives and will not complete training until September.

11. Staff and Patient Experience

Women and Families Experiences of Care

The Division are committed to improving the experience of Women and families and staff. Engagement and co-creation of maternity care pathways is central to creating a safe, accessible, compassionate and responsive, woman and family centred maternity service. Currently the experience and clinical outcomes of care is highly variable.

There are still some women and families that do not feel that they have been cared for in a way that would make them feel safe, listened to and valued and yet we have many women having great clinical outcomes and a personal experience of high quality, compassionate care in PAT on both sites. However this contrast with the 99 complaints received over the last 15 months 77 of which were directly related to care received.

Maternity Listening and Action Group (MLAG).

In October 2015 PAT established a Maternity Services Liaison Committee now known as the Maternity Listening and Action Group. This meets regularly, actions are documented and followed up and always begins with stories of women and families experiences.

Staff survey

The Division's staff survey results indicate poor staff engagement; particularly in relation to the following areas which also indicate give concern current staffing levels and an indication of the level of clinical risk the division is facing. These include:

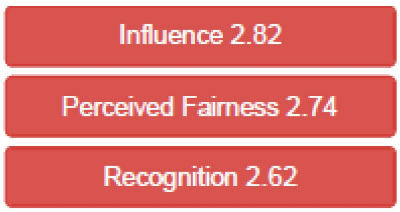
- In the last month saw errors/near misses/incidents that could hurt patients
- Cannot meet conflicting demands on my time at work
- Not enough staff at organisation to do my job properly
- Unable to provide the care I aspire to
- Staff are dissatisfied with opportunities for flexible working patterns

- Organisation does not treat fairly staff involved in errors

Many of the above themes correlate to the division's quality and safety trends observed over the previous 12 months relating to serious incidents, coroners inquests and complaints.

Triangulation of governance data, qualitative feedback from staff and engagement indicators (sickness absence and attrition trends) strongly suggests that cultural changes to improve staff engagement are needed.

The staff pulse check survey had some of the poorest return rates from W&C and has highlighted maternity as having more negatively reported areas requiring improvements across significant domains, than other Divisions.



In addition the friends and family test and the "would you recommend" question responses also are some of the lowest in the Trust (see below).

Friends and Family Test

- 42.86% of staff would be happy with the standard of care provided by the trust if a friend or relative needed treatment
- 35.71% of staff would recommend the Trust as a place to work

Staff Side Feedback on Midwifery

Feedback from nursing and midwifery unions suggest that staff are unhappy and feeling unsupported because of

- Staffing levels – increasing stress about not being able to deliver good quality care and having to be moved to cover areas which are short staffed to ensure safety.
- Uncertainty surrounding the 'Single Site' outcomes specifically for NMGH
- Staff attrition due to increasing retirement, lack of professional development including problems with and support in particular support for newly qualified midwives and preceptorship.
- Poor skill mix in midwives as a result of experienced midwives retiring, leaving, and new recruits being mostly newly qualified. Batch recruitment happens due to University course structure in October and March which puts added pressure on the experienced midwives (particularly in October) and especially in the absence of an education team and strong management support structure.
- Incidents of bullying
- Shifts with staffing levels being reduced is increasing stress
- Changes in Governance and the way in which incidents are investigated has also had an impact on staff as although it is well established in other maternity units the full RCA reviews are relatively new to PAT.

12. External Review

The Chief Nurse requested an external review on maternity services in April 2015 which resulted in key themes being identified and recommendations made from which the maternity improvement plan was put into place, the themes identified were:

Clinical leadership within both the medical and midwifery teams exemplified by:

- Handover both quality, attendance and timeliness
- Poor communication
- Lack of clear clinical decision making
- Team working issues
- Equipment investment and culture of caring for it

In addition there are distinct clinical areas which need attention these are

- Early Warning Score remains an on-going issue in clinical incidents. Management of PPH
- Prevention of stillbirth
- Unexpected admissions to the neonatal unit
- Diabetes Care
- High Risk Women - identified need for a stronger leadership and management structure across the disciplines.
- Lack of Woman centred care

There were 12 key recommendations made which were:

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 all its management of obesity in pregnancy, labour and the postnatal period, and that guidelines are appropriately implemented.
5. All serious incidents should be quality checked before submission, to ensure 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 speciality.
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 regular and timely review, implementation and audit of guidelines in accordance with Trust policy.

As work has progressed on the maternity improvement plan another section was introduced called '**new additions'**. This section is still being added to and currently has 28 completed actions with evidence and 23 of these have evidence logged.

As most of the original actions are now complete the maternity improvement plan is going to be re-launched in a different format to re-energise staff engagement and new project manager has been appointed to support.

Look-back exercise
As part of the review a recommendation was made to look at a number of historic cases over the past 3 years. This identified that a number of these (34) had not been effectively investigated and resource and support has been put in place to ensure that this is remedied. There are currently 24 still in progress and there are worrying repetitive themes emerging including:

Monitoring
- Basic completion of vital signs to establish patient's baseline not undertaken
- EWS having incorrect scoring giving false assurance leading to delays in intervention
- Failures to carry out fluid balance monitoring this is significant where women have had estimated large volume PV bleeding
- Poor use of SBAR (neonatal and children's) in order to alert other members of the clinical team about deterioration

Communication
- Generally poor documentation
- Illegibility of signature/position
- Insufficient key pathological results not checked
- Critical information missing or not recorded in the patient records to enable safe continuity of care

Human factors
- Rigid mind set with a tendency to see patient's condition as uncomplicated
- Group influence where junior staff have a tendency to defer to more senior opinion or are overruled
- Normed practice in not following guidelines

Safety culture
- Poor rule compliance
- Lack of risk management plans when patient begins to deteriorate and no clarity in when nursing/midwifery staff in particular need to escalate
- Toleration, poor awareness or inadequate adherence to Trust practice
- Disempowerment of staff to escalate issues or take action

Externally imported risks

- Agency use particularly around medical staff handovers and no monitoring of establishing competency
- Poor agency ordering and monitoring systems which have large numbers of vacancies going unfilled

Team

- Leadership - several patients did not have continuity of lead clinician and there was a lack of ownership with cross site working adding to this complication
- Poor inter-professional challenge in many of the incidents the nursing/ midwifery staff had concerns but did not seem to push for senior or multidisciplinary reviews

13. Conclusion

The paper outlines a number of notable features which have adversely affected clinical outcomes for women and babies within the maternity services at PAT, alongside the identification of weaknesses within the governance processes and how these have.

It describes that despite an external review taking place and significant actions being undertaken these have not affected positively on the culture within the service or made improvements in clinical outcomes, or the care for mothers and babies.

Over the last few months actions have been taken to build a profile of risk related issues for the service and where possible mitigate these by putting in remediating strategies. However, in the medium to longer term additional actions are needed including:

- Strengthening of leadership within the obstetric consultant workforce, in order to provide visible leaders capable of providing consistent and clinically sound decision making.
- Review and establish the consultant workforce substantively so that the reliance on locums is irradiated enabling it to be based on service need thereby reducing the numbers of generic consultants with those with more specific and focused skills.
- Support from experienced midwives particularly on the NMGH site, to strengthen the midwifery staffing arrangements at a senior level to ensure consistent and effective leadership is provided and effective safe clinical decision making is embedded in practice
- Agreement to proceed with recruitment of additional midwifery posts in line with the Birth Rate Plus paper to bring staffing levels to a validated standard and reduce pressures on bank and agency and help to build a substantive and effective workforce
- Ongoing development of the governance processes in order to allow these to grow and embed
- Input to support and embed the use of EWS across the service to ensure that a clear unambiguous process is used which provides early recognition of deterioration and enables effective response

- Support a review of, and then monitor against the obstetric guidelines to ensure that women and particularly those with high risk pregnancies are correctly identified, provided effective care and streamed to ROH or another tertiary site
- Review of some of the activity undertaken at Fairfield and Bury to analyse if this could be consolidated on the two main sites in order to increase support to the midwifery workforce
- Agreement to undertake review of ROH maternity services footprint to establish how this can be flexed to accommodate additional capacity