Title of Report	Maternity Services Review Report and Improvement Plan
Executive Summary	The 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 governance and monitoring arrangements in place within the Trust and external to the Trust.
Actions requested	The Board of Directors are asked to note and discuss this report and the proposed publication.

Risks
As noted on the strategic risk register - Service failure affecting individual patients, regulatory involvement and / or reputational damage arising from failure to fully implement, to a level which meets the assurance needs of the Board and Commissioners, the improvement plan arising from the external review of maternity services.

Public and/or patient involvement:
The families have been contacted to ensure awareness of the publication of this report and the Chief Nurse has met with and continues to offer to meet the families.

Resource implications:
No resource implications specifically outlined within this paper.

Communication:
External Review Report and Improvement Plan to be published on the Trust website following the Board meeting.

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	√		

Name	Gill Harris
Job Title	Chief Nurse
Date	June 2015
Email	Gill.Harris@pat.nhs.uk

Maternity Services Review Report and Improvement Plan

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 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) over the period January 2013 to July 2014. 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 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. This is to ensure maintenance of 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 appended to this paper (Appendix 1).

An initial improvement plan was developed, incorporating the recommendations from the external review that the Trust had commissioned. The improvement plan is appended to this paper (Appendix 2).

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, 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 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, 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 NHSE. 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, and actions have been agreed under each of these headings.

A Maternity oversight meeting is in place within the Trust, chaired by the Chief Nurse, which meets weekly, ahead of the IMG. Progress and evidence of the improvement plan is monitored and reported internally to Trust Quality & Performance Committee and external assurance is given via IMG.

4. Further Improvement Work

The Trust has signed up to be one of the pilot sites for the Perinatal Institute on the Saving Babies' Lives programme SaBiNE Project (Saving babies in North England). Professor

Jason Gardosi and his team at The Perinatal Institute were awarded the 2015 British Medical Journal (BMJ) Award for Clinical Leadership for its work in preventing babies dying before birth, also known as stillbirth prevention. Their pioneering work led to the first reduction of stillbirths in England for 20 years, and England stillbirth rates are now at their lowest ever levels.

The Pennine Acute Hospitals NHS Trust and local patients are now set to benefit from the expertise of The Perinatal Institute in this area. The Trust and the Perinatal Institute are set to launch the implementation of the SaBINE project across our maternity services at North Manchester General Hospital and The Royal Oldham Hospital.

This will look to introduce a care bundle in our maternity services, looking at the following elements:

- Reducing smoking in pregnancy
- Foetal growth surveillance
- Reduced foetal movements
- Effective foetal monitoring in labour

One of the major actions in the Trust's Improvement Plan has been to agree a shared learning arrangement with The Newcastle upon Tyne University Hospitals NHS Foundation Trust. This programme will be led by the Trust's Chief Nurse. This is an important and positive partnership that sits very well within the context of the national maternity review announced by NHS England in May 2015 and reflects a key recommendation from the Kirkup review into Morecambe Bay.

The Trust has also been successful in a bid to the NHS Litigation Authority, as part of the Sign Up to Safety Campaign, to introduce a central Cardio-tocographs CTG electronic monitoring system, which will support and enhance interpretation of the CTG allowing the midwife to escalate the recognition of the deterioration of foetal wellbeing to the shift co-ordinator and the senior medical team. This work is also underway.

5. Conclusion

The Trust has put an improvement plan in place in maternity services, following an external review, commissioned by the Trust in 2014. The findings of the report have been shared with the families and key stakeholders and the improvement plan is being monitored internally and externally to the Trust.

The Board of Directors are asked to note and discuss this report and the proposed publication.

Gill Harris
Chief Nurse

June 2015