An independent review of serious untoward incidents and clinical governance systems within maternity services at Northwick Park Hospital

16 September 2008

Contents

About this report		**3**
Foreword		**4**
Executive summary		**5**
1.	Background	**7**
2.	Review panel, process and terms of reference	**8**
3.	Summary of five serious untoward incidents	**9**
4.	Overall conclusions from the review of five serious untoward incidents	**15**
5.	Review of governance arrangements	**17**
6.	Application of the risk management framework	**20**
7.	Professional supervision	**22**
8.	Participation in Trust governance and risk procedures	**23**
9.	Barriers to good practice	**23**
10.	Areas of good practice	**24**
11.	Key recommendations	**25**
12.	Summary	**27**
Appendices		
Appendix one: References		**28**
Appendix two: Terms of reference		**29**
Appendix three: Biographies of the panel		**32**
Appendix four: Summary of response from the Healthcare Commission		**33**
Appendix five: Draft action plan by The North West London Hospitals NHS Trust in response to recommendations		**34**

About this report

This report presents the findings and conclusions of an independent review into clinical governance arrangements within maternity services at The North West London Hospitals NHS Trust.

The report has only been altered where it was necessary to remove information to protect the confidentiality of patients and to ensure it makes sense to the reader.

This report therefore does not provide the full specific clinical details of the three maternal deaths which took place during 2007/08 or the two serious untoward incidents (SUIs) that occurred at the Trust during this time. However it does include a summary of each case and overall conclusions of the review panel.

This report includes a summary of the response to the report from the Healthcare Commission (appendix four). It also includes an action plan which has been developed by the Trust in response to the recommendations made by the review panel and the Healthcare Commission (appendix five).

Foreword

As the independent Chair of the panel, I am pleased to present this report which details the findings of an independent expert panel into the safety of working practices within the maternity unit of The North West London Hospitals NHS Trust.

In April 2008, following three maternal deaths and two other untoward incidents in the past year within its maternity unit, The North West London Hospitals NHS Trust Board instigated a review to undertake a full analysis of the cases. The terms of reference also included a review of wider issues of risk management and governance arrangements in the unit to ensure they remained fit for purpose and provided assurance for the public as to safe working practices and environment for women.

Whilst undertaking our investigations both I and my colleagues on the panel were ever mindful of the tragic nature of the circumstances which prompted this review and we wish to express our sincere condolences to the families for the loss of their loved one.

I am grateful for the time and expertise of the whole panel and in particular to the external experts who reviewed and scrutinised the evidence and assisted in providing the analysis and conclusions laid out in this report.

It is my belief that the findings of this report provide an accurate reflection of both the good practice established in the maternity unit since special measures were put in place and subsequently lifted, whilst also recognising the need for continuous improvement in providing the safest care possible for women and babies.

Ms Ann Groves

Chair of the Review Panel

Executive summary

In April 2008, following three maternal deaths in one year and two other serious untoward incidents (SUIs) in its maternity unit, The North West London Hospitals NHS Trust (NWLH) initiated an independent review into the root cause of the incidents, the appropriateness of the maternity unit's governance systems and their application (including risk identification, risk management, incident reporting and review, multidisciplinary working, leadership and professional supervision) barriers to good practice and areas of excellent practice.

In consultation with NHS London and the Healthcare Commission (HCC) an investigating panel was convened. This was chaired by a non-executive board member of Harrow Primary Care Trust (PCT) and included an executive member of Brent PCT, a Professor of Obstetrics (nominated by the Royal College of Obstetricians and Gynaecologists), a Professor of Midwifery and a Supervisor of Midwives (recommended by the Local Supervising Authority). They were supported by the Medical Director, Director of Nursing and Midwifery and Assistant Director of Integrated Governance of the Trust.

Having agreed the terms of reference, the panel reviewed the following evidence:

- The Trust's SUI policy

- The SUI reports and action plans

- Chronologies of a series of other serious incidents

- Maternity clinical governance records, including policies, organisation charts, attendance records, minutes and action plans.

External experts also conducted interviews with staff groups including midwives working in the hospital and community settings, senior midwives, supervisors of midwives and consultant obstetricians, paediatricians and anaesthetists. The findings of the review were mapped against the HCC recommendations (July 2005; 8, 45-51).

The work of the panel was completed on 24 June 2008. The findings of the review were:

- The maternal deaths and incidents were not the result of deficiencies of care.

- Standards of care when a woman is admitted to the delivery suite are well above average.

- Incident reporting and investigation systems are of a high quality.

- There are examples of excellent practice which should be widely disseminated.

- Governance systems are fit for purpose and generally well applied.

Areas for further improvement in governance systems and maternity care were identified. The latter may have influenced the timeliness of treatment in some of the cases. To produce further reductions in risk for the large proportion of vulnerable and high risk women attending the unit some essential recommendations are made.

These include:

- Better delivery of antenatal care in the community by an expanded team of community midwives, ensuring that all women have equitable standards of antenatal care including appropriate access to obstetric and midwifery services, particularly those most vulnerable.

- Optimising antenatal care of high risk women by applying best practice guidelines (including monitoring the effectiveness of the 'did not attend' policy) and implementing recommendations of the National Institute for Health and Clinical Excellence (NICE) guidelines 2006 for the care of women in the postnatal period, strengthening leadership skills and inter-professional and inter-specialty communication.

- Providing better opportunities for multidisciplinary learning from incidents.

- Reviewing assurance processes in the governance framework.

The panel has provided a list of essential requirements which should be incorporated into any action plan generated by the Trust in response to this review.

1. Background

A previous investigation by the Trust, following a series of maternal deaths between April 2002 and April 2005, was followed by a detailed enquiry by the Healthcare Commission (Healthcare Commission; Review of Maternity Services provided by The North West London Hospitals NHS Trust, July 2005).

This enquiry resulted in the development of an action plan which led to major improvements in staffing levels, physical environment and governance arrangements within maternity services at Northwick Park Hospital.

The Healthcare Commission's final report in August 2006 (Healthcare Commission; Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, The North West London Hospitals NHS Trust, between April 2002 and April 2005, p107) acknowledged the progress made by the Trust in providing a better and safer service for women, detailing 13 specific areas where improvements had been achieved.

The action plan was fully implemented under the supervision of the Healthcare Commission and the then North West London Strategic Health Authority. All stakeholders had confidence in the outcome and external surveillance (special measures) was removed in September 2006.

During the investigation and the implementation of the action plan, no further maternal deaths occurred in the unit. When three further deaths occurred during 2007/08, the Trust Board recognised its responsibility to re-examine the governance and practice of maternity care in order to reassure the public and the families of the women involved that they could have confidence in the safety of the service.

It was also recognised that this concerned other parties, including the Healthcare Commission, NHS London and Brent and Harrow PCTs and the Local Supervisory Authority (LSA). In consultation with these partners it was agreed that the enquiry was necessary and that it should be independent of the Trust. It was agreed that external professional experts should be invited to review the evidence and advise the panel on the current fitness for purpose of the governance arrangements of the maternity unit. The panel would also advise whether improvements in practice and governance should be made and endorse any elements of good practice which were discovered.

2. Review panel, process and terms of reference

The investigation was conducted by an independent panel chaired by a Non-Executive member of Harrow PCT (Ms Ann Groves).

It included:

- Professor of Midwifery (Professor Jacqueline Dunkley-Bent)
- Supervisor of Midwives (Ms Cathy Rogers) nominated by NHS London
- Professor of Obstetrics (Professor James Drife) nominated by the Royal College of Obstetricians and Gynaecologists
- Executive Member of Brent PCT (Ms Thirza Sawtell).

They were supported by the Trust's Medical Director (Mr Michael Burke) Director of Nursing and Midwifery (Ms Elizabeth Robb) and Assistant Director for Integrated Governance (Ms Catherine Thorne). Biographies of panel members are included in appendix one.

2.1 Process of the investigation

The process of the investigation included:

1. Examination of the complete records of five cases (three cases of maternal death and two others).

2. Examination of serious untoward incidents (SUI) reports on seven recent cases of major obstetric haemorrhage (MOH).

3. Examination of clinical risk management group minutes during 2007, maternity governance board minutes, reports for patient safety committee from maternity, reports to clinical governance committee from maternity, five SUI reports and action plans, the maternity escalation policy, organisational chart and staff establishment figures.

4. Review of the Local Supervision Strategy.

5. Examination of relevant clinical guidelines.

6. Visits to Northwick Park Hospital on 24 June (Professor Drife) and on 20 June (Professor Dunkley-Bent and Ms Rogers) when departmental visits were made and semi-structured interviews conducted with representative groups of midwives, obstetricians, paediatricians, anaesthetists and maternity managers.

2.2 Terms of reference

The agreed terms of reference of the review panel are included in appendix two.

3. Summary of five serious untoward incidents

The complete notes of the three women who died during 2007/08 and of two non-fatal serious untoward incidents in the maternity unit were examined by the review panel.

The case histories are described in detail in the Trust's serious untoward incident reports and in the full report produced by the review panel. Abbreviated summaries of all five cases are given below and include conclusions of the review panel in each case. For the purposes of this document and in order to protect the confidentiality of patients they are published as woman A, B, C, D and E.

3.1 Three maternal deaths

3.1.1 An abbreviated case summary of woman A

Woman A was a 25 year old mother of two with a Body Mass Index (BMI) of 40 and a previous history of poor attendance at antenatal clinics.

She booked for antenatal care at 10 weeks and was referred to a consultant obstetrician because of her high-risk status (due to her BMI). She did not attend the consultant clinic.

At 34 weeks of pregnancy she experienced abdominal pain and was admitted to Northwick Park Hospital. She was seen by a consultant and discharged home with an appointment to attend the hospital's clinic in two weeks' time. She did not attend this or other antenatal appointments.

At 40 weeks (expected date of delivery) of her pregnancy, woman A was admitted into hospital with suspected onset of labour but this was not the case and she was sent home. Four days past her expected date of delivery she was admitted into hospital in labour and gave birth shortly afterwards.

After the birth, swabs were taken which showed the presence of beta haemolytic streptococci (a type of infection). The baby was treated with antibiotics and three days after delivery she was discharged home. A referral was made to the health visitor in view of the patient's vulnerable status.

On day 21 after delivery of her baby, an ambulance was called because of hyperventilation problems over the previous few days. Woman A had a cardiac arrest and died in the ambulance. Post mortem examination showed that she died from pulmonary embolism.

Conclusion of review panel

Woman A was appropriately managed and current standards of care were correctly applied. Nevertheless her case highlights ways in which care could be improved – both locally, with more attention paid to non-attendees for antenatal care, and

nationally, with improved guidelines on thromboprophylaxis (blood thinning drugs to prevent blood clots)*.

The deficiencies in antenatal care were identified in the Trust's action plan (09.03.2008) and are being addressed by the recruitment of 20 community midwives and the transfer of antenatal care to the community midwifery service managed by the Trust.

The panel recommends that the organisation of this expanded team should take account of the special needs of the community, for example by establishing a team for vulnerable women. NICE (2006) recommended that all women should be given information on warning signs and symptoms of postnatal morbidity and this practice should be adopted by the maternity unit.

*Current Royal College of Obstetricians and Gynaecologists (RCOG) guidelines on thromboprophylaxis do not differentiate between obesity and morbid obesity.

3.1.2 An abbreviated case summary – woman B

Woman B was a 39 year old expecting her first baby with a two year history of infertility. She booked at 11 weeks of pregnancy and had an amniocentesis performed at 17 weeks.

She was seen routinely by the midwives and at 34 weeks she was admitted to hospital with antepartum haemorrhage (vaginal bleeding). This settled quickly and a scan showed no placental abnormality. She was discharged and attended the hospital antenatal clinic a week later.

At 36 weeks she was again admitted to hospital with a small antepartum haemorrhage. An examination was carried out which showed that the bleeding was not caused by problems with the placenta.

Two weeks later she was seen by a GP at term and no abnormalities were noted. She was asked to return in a week.

Six days later she phoned the delivery suite at 12.53 and was admitted to the delivery suite at approximately 14.00 with constant abdominal pain and having not felt the baby move since the previous night. Twenty minutes later woman B had a seizure. Emergency procedures were correctly followed. A consultant obstetrician was present immediately along with other obstetric and midwifery staff. Magnesium sulphate was given and a consultant anaesthetist was called and attended promptly. An emergency caesarean section was carried out and a baby girl was delivered at 15.01.

Woman B suffered massive haemorrhage. Despite the resuscitation team's attempts to resuscitate she died. After post mortem examination the cause of death was given as amniotic fluid embolism (AFE).

Conclusions of panel

Amniotic fluid embolism (AFE) is a rare complication that cannot be predicted or prevented and it is hard to see how the fatal outcome in woman B's case could have been avoided. Nevertheless two episodes of mild bleeding in the last weeks of pregnancy should have reclassified her as a high-risk case.

AFE was the cause of 17 maternal deaths in the UK in 2003-2005 [1]. There is no specific treatment for AFE other than general resuscitatory measures and the condition has a high mortality rate. It cannot be predicted and over the years the search for specific risk factors has been frustratingly inconclusive.

When woman B had a seizure she was immediately attended to by a consultant obstetrician and promptly delivered by emergency caesarean section. This was appropriate management. It was reasonable to assume initially that the cause of the seizure was eclampsia, as AFE usually presents with collapse and torrential bleeding.

Administration of magnesium sulphate did not make any difference to the outcome. AFE tends to occur during labour and in woman B's case it could have occurred whenever she went into labour. Her collapse could not have been predicted and could not have been treated more promptly. There is no clear lesson that can be drawn about how her death could have been prevented.

3.1.3 An abbreviated case summary – woman C

Woman C was a 28 year old who had arrived in the UK from Afghanistan at the very beginning of her pregnancy. Her first language was not English and an interpreter was required.

Her care started at another London hospital at 7 weeks pregnancy because of vaginal bleeding and again at 17 weeks pregnancy with urinary tract symptoms. She was discharged and advised to ask her GP to refer her for antenatal care. As woman C told the hospital that she had not been resident in the UK for long, staff advised her to contact social services and they referred her to the community midwives.

Woman C was then seen by a midwife at Northwick Park Hospital at 28, 30 and 32 weeks' pregnancy. No abnormalities were noted. At 39 weeks the midwife found that patient C's blood pressure was higher than at booking (26 weeks) and she had facial oedema (swelling) which can be an indication of pre-eclampsia.

The next day (one day before expected date of delivery) her blood pressure was higher and she had proteinuria (protein in urine). A decision was made to induce labour when the delivery suite was able to accommodate her. She was transferred the next day and induction started the following day.

Woman C had a natural delivery of baby girl at 02.25 the next morning. Immediately after delivery vaginal bleeding was noted from the vaginal wall and the registrar was asked to review her. Vaginal tears were sutured in theatre by the consultant. It was

noted that there was difficulty in accessing all the tears, and a vaginal pack was inserted. Woman C had sudden severe diarrhoea around this time. The vaginal pack was removed later that day and woman C was transferred to the high dependency unit (HDU) on the delivery suite. She was regularly reviewed.

Early in the morning of day four, woman C collapsed and a diagnosis of toxic shock was made. Resuscitation was started and woman C was transferred to the Intensive Care Unit (ITU).

The cause of her collapse was found to be necrotizing fasciitis with an extended spectrum beta-lactamase E-Coli (this is a bacterium highly resistant to antibiotics). At autopsy the sutured vaginal tear was noted to be delicate. There was destruction of the tissues between the vagina and the rectum which could have been due to the infection or possibly birth trauma.

Conclusions of the panel

The external panel concluded that woman C's care was of a good standard once the client was referred to Northwick Park and that the overall quality of care by community midwives in the antenatal period was high.

However, woman C's difficulties with antenatal care before 28 weeks' pregnancy are very concerning. There seems to have been a lack of understanding of, or response to, the needs of asylum seekers who are known to be a high-risk group. However, this was not the fault of Northwick Park Hospital.

The panel also noted that interpreters were used appropriately throughout and that midwifery plans of care were generally of a commendable standard. During labour her care was made difficult by the need for interpreters but these were provided.

The cause of her vaginal tears is unclear. They were repaired in the standard way by a consultant. The reason for her infection is also unclear but may be related to diarrhoea around the time of delivery. There were no clear signs of sepsis or toxaemia until day four, when she suffered rapid collapse, as can occur with overwhelming infection. The panel cannot identify any clear deficiencies in her care in hospital.

3.2 Non-fatal cases

3.2.1 An abbreviated case summary – woman D

Woman D was a 36 year old Black African (Somali) with three children and had booked late for antenatal care in this pregnancy because she had been out of the UK.

At 23 weeks' pregnancy she was referred urgently to Northwick Park Hospital by her GP. She was seen and booked at 26 weeks of pregnancy. It was noted that she had

a history of intrauterine growth retardation (a condition where a baby's growth slows or ceases) and she was therefore referred to a consultant clinic.

At 29 weeks' pregnancy, woman D was admitted to the delivery suite feeling unwell (cough and high temperature). She was started on antibiotics and the next day was seen by a consultant obstetrician, referred to the chest physicians and the Infectious Diseases Team with suspected tuberculosis (TB).

She remained in hospital for five days. The diagnosis of TB remained uncertain. She was then discharged home.

After three days, woman D was admitted to the delivery suite. Abnormal liver function tests were noted. She was admitted to the antenatal ward and transferred to the Infectious Diseases Unit the next day where she stayed for 10 days, when she was discharged on anti-tuberculosis treatment.

The following day woman D was admitted via A&E with vomiting and diarrhoea. She was assessed and restarted on anti-TB treatment and was later discharged home.

At 36 weeks of pregnancy woman D was admitted in labour. She was jaundiced and unwell. It was noted that there was a need to rule out fatty liver of pregnancy (a rare but serious complication of pregnancy). The consultant was informed. Woman D went on to have a normal delivery of a girl.

At 05.45 on the day of delivery she was reviewed by the physicians and the differential diagnosis included isoniazid (TB drug) induced fatty liver or possible fatty liver of pregnancy. Woman D was transferred to the liver unit at another London Hospital. She had a liver transplant and has survived. Liver histology revealed inflammatory changes but a specific cause for her liver failure was not revealed.

The SUI investigation received an expert opinion from a consultant in infectious diseases who did not feel that the TB drugs were solely to blame for her liver failure, and did not feel that there was any substandard management.

Conclusions of the panel

This case demonstrates the need for a robust routine system of communication between obstetrics and other specialties in the hospital. It should not be necessary to have to try to invent such a system on a case-by-case basis when it is required. This has been recognised in the Trust's action plan.

The external panel recommended the need for integrated care pathways of women requiring multidisciplinary input which was recommended by the internal SUI panel.

The panel also commended the team for systems and processes that were clearly evident and support safety in practice such as the risk factor assessment sheet completed on booking with recommended care pathways, the quality of midwifery admission reviews and management plans.

3.2.2 An abbreviated case summary – woman E

Woman E was booked at 16 weeks of pregnancy. She was under the care of a consultant and was expecting twins.

At 32 weeks of pregnancy woman E was admitted to the delivery suite because of concern that she was going into labour.

Woman E's pains settled and she was discharged home the next day after being seen by a consultant. Within the next six days, woman E was admitted to the delivery suite three times. On the last of these admissions she was transferred to a postnatal ward and was seen by the midwife and the obstetric senior house officer.

Later that evening her membranes ruptured and woman E was admitted to the delivery suite. It became clear that delivery would be very difficult. Woman E was seen by a consultant obstetrician and caesarean section was recommended and agreed to. The caesarean section was carried out and two babies were delivered. Woman E was stabilised and transferred to the Intensive Care Unit.

Conclusions of the panel

This was an extremely challenging and unusual case. Nevertheless more could have been done in terms of contingency planning and multidisciplinary discussion in early pregnancy.

The case highlights the need for a clear leadership role on the part of a consultant obstetrician who would initiate such discussion and be responsible for a detailed plan of management. The external review panel of this case made a number of comments about the high standards of midwifery practice throughout this woman's care including the comprehensive booking history taken and management plan made in view of risks identified, and the plan of care following this woman's admission to hospital at 33 weeks.

Notable aspects of midwifery practice identified by the panel were the:

- Attempts made to involve client in all aspects of decision making
- Non-judgemental attitude
- Kindness and respect
- Quality of communication
- Level of support given.

4. Overall conclusions from the review of the five serious untoward incidents

The five serious untoward incidents which the review examined have some factors in common. They were all high risk cases; four of the women were non-Caucasian and in four cases communication was difficult for language, cultural or clinical reasons. The fact that they were all high risk cases highlights the need not only for meticulous risk assessment as early as possible in each pregnancy and equity of access to midwifery services but also for continuing this risk assessment in the postnatal period, and for increased consultant obstetrician input into antenatal care.

There were no deficiencies in care in relation to the application of national guidelines. Care on the delivery suite was of a high standard, with better than average consultant involvement and excellent plans of care by midwives following antenatal admission. Processes for logging calls to the labour ward were good and supervisors of midwives were appropriately informed. Nevertheless, with the exception of one case, supervisors of midwives were not subsequently engaged with the serious untoward incident (SUI) panel investigation. This was evident from the terms of reference of the SUI panel and minutes of meetings.

None of the deaths or SUIs could have been prevented by better attention to current guidelines or protocols. In the three fatal cases, however, there were opportunities for better high-level clinical care in interpreting and reacting to apparently “minor” symptoms. Consultant obstetrician involvement in these cases was limited to the labour ward and was much less before or after the intrapartum period (during delivery).

The non-fatal SUIs revealed deficiencies in communication and co-ordination between obstetrics and other specialties in the hospital. The cases focus attention on the antenatal care of high-risk women. When high risk is recognised, there needs to be clear leadership from a named consultant obstetrician. This role requires hands-on involvement and can be time consuming, and it is important that this development does not put at risk the high standards of consultant involvement in the labour ward.

The cases reveal that the unit often runs at full capacity which can result in delays in women been seen and assessed in a timely manner on labour ward, in induction of labour and pressure to discharge from postnatal and inappropriate use of high dependency unit (HDU) beds.

The consultant obstetrician rounds did not routinely include a review of all patients physically placed on HDU. The obstetrician focused on those high risk cases that had been referred to them by the midwives. This could lead to some patients placed on HDU being overlooked but the Trust has adopted new working practices to prevent this. All patients who are physically placed on HDU are now reviewed on a daily basis by the consultant obstetrician.

The external panel also found evidence of strong leadership by labour ward coordinators and supervisors of midwives. The strategy for supervision is clearly articulated and reflective of current challenges, nevertheless the interface between

the supervisory framework and the clinical governance framework needs to be further strengthened and a supervisor of midwives should be appropriately represented at the Trust's risk management meetings and be included as a key member of an SUI panel.

5. Review of governance arrangements

5.1 Current governance arrangements

Analysis of the serious incidents gave reassurance that the deaths were probably unavoidable. However, the cases demonstrated factors which have the potential to increase risk for women who are already high risk and/or vulnerable. These include individual performance, team working and leadership (particularly in relation to inter-professional and inter-specialty working), implementation of good practice guidelines, community care and capacity and demand management.

This section of the report examines the suitability of the maternity unit's clinical governance framework to mitigate risk in such cases and whether it is being appropriately applied.

The review of the investigation process of the five cases detailed above demonstrate that investigation processes are commensurate with the clinical governance framework.

5.2 Risk management

5.2.1 Identification of high risk patients in antenatal care

The unit has a high incidence of high risk cases (55-60%). There is a good system for assessing and recording risk at booking. However, the need is not only for identification of such patients but for a system that maximises consultant input into their care, not only in formulating management plans which may involve other specialties, but also in making clinical decisions which require an experienced doctor and demand higher standards than the application of guidelines.

5.2.2 Recent incidents of major obstetric haemorrhage

In a recent national survey in Scotland [1] the frequency of major obstetric haemorrhage (>2.5 litres) was 1 in 273 pregnancies, which would mean around 20 cases per year in Northwick Park Hospital. The actual numbers over the last two years are around 35 cases per year.

The panel feel that this reflects the high-risk population served and not any deficiency in clinical care. A 'massive obstetric haemorrhage' (MOH) protocol exists and 'skills and drills' training is in place. On the evidence of recent incidents, the MOH protocol works well and has saved lives in a number of cases.

5.2.3 Risk management protocols in antenatal care

Procedures for women who do not attend appointments should involve more than writing to the patient or the GP and may be labour intensive for community midwives. They are important because patients who fail to attend are generally at high risk. More resource may be required.

The obstetricians have an “obstetric clinical care plan” which can be filled in for individual cases and is very helpful in listing staff contact numbers but it does not make clear who is in overall charge of the case. It could usefully be revised. Much of the antenatal care is being provided by GPs and it is difficult to communicate with such a disparate group.

One of the obstetricians commented that “only the keen GPs” will turn up to talks and lectures and of course this is a universal problem. Particular efforts must be made to ensure that protocols, especially those on risk assessment, are shared with GPs. In other parts of the UK a high proportion of antenatal care is provided by midwives, who in general are good at identifying and referring high risk patients, though continuing monitoring and discussion are required.

Within the hospital, multidisciplinary and cross-specialty working is an essential part of high-risk care and liaison is necessary with specialties that normally have little to do with antenatal care. Rightly or wrongly the consultant obstetricians feel that they are resented when they involve other specialties in difficult cases. This feeling, if it does indeed exist, may be there for historic reasons and must be tackled. A network of named consultant contacts in other specialties is one possible option. Leadership training for consultant obstetricians is another. These SUIs have highlighted the importance of multidisciplinary and cross-specialty care. Organising this effectively requires leadership and accountability.

5.2.4 Management of labour

The panel formed the impression that this is now a major strength of Northwick Park Hospital. The number of midwives per shift is good and the consultant presence is also good. The consultants are experienced in labour ward work and proud of their service and tend to work beyond their official hours.

Adjustments could be made to allow smoother running of the elective caesarean section lists which are scheduled to start at the same time as the consultant’s major hand over meeting. This must be resolved. The system of consultants being on-call for 24 hours has some advantages but also has disadvantages in terms of continuity of care, as management plans may change from one 24-hour period to the next. A system of being on-call during the daytime for a working week at a time might reduce this problem.

5.2.5 Postnatal care including discharge procedures

Investigations of these SUIs and information received from staff raised a number of concerns about capacity on the labour ward. Staff reported that there are many occasions when women have to wait for either a bed or a midwife to assess them on admission. The staff perception was one of enormous pressure on the postnatal wards to transfer women to the community, often leaving them worried about the quality of postnatal care they gave. Indeed, the senior team noted that in the past one of their main concerns was whether they had enough staff; this concern has now been replaced with whether they have enough beds.

Throughout the country, postnatal wards are overcrowded and there is pressure to get women home as soon as possible. This is frequently due to reductions in bed numbers after over-optimistic expectations for reducing length of stay. The problem has not been solved by streamlining discharge procedures despite continuing efforts to do so. It is important to take a realistic view of this problem, based on actual experience rather than on national 'norms' or targets. A full postnatal ward often results in blocking of beds in the delivery suite, including the recovery area and the high dependency unit. Therefore, NICE guidelines on informing all women on warning symptoms and signs of serious postnatal morbidity should be adopted at once.

6. Application of the risk management framework

The risk management framework was mapped against the HCC recommendations.

The findings were as follows:

- Good evidence of team work as well as obstetric involvement was found.
- There is a need to review whether the unit is accepting women when capacity/ staffing is stretched.
- The panel were unable to determine from records reviewed the quality of support by supervisors of midwives (SOM) in these cases (but other evidence suggests SOM support is generally good).
- Guidelines reviewed were of a good standard, easy to follow and appropriately referenced.
- Good systems are in place to enable effective communication for women who do not speak English.
- Documentation of care by midwifery and obstetric staff is generally of a very high standard.
- Investigation processes are thorough; statements are requested from all involved parties.
- Terms of reference of SUI (serious untoward incident) panels are clear.
- Involvement of supervisors of midwives in SUI investigations needs strengthening.
- There is a tendency in SUI investigations to focus more on the actions of individual practitioners as opposed to establishing root causes.
- There is evidence of strong leadership in management and midwifery.

In relation to SUI reports, it is likely that investigations do, in fact, follow a root cause analysis protocol but this is not fully reflected in the report to the Board. SUI procedures should include a more thorough review of the nature of community midwifery care and health visitor involvement. The development and management of action plans need some attention with regards to more detail, completion of all categories and measurable outcomes that reflect the seriousness of the cases.

Implementation of NICE postnatal guidelines is recommended in relation to providing all women with information regarding the signs and symptoms of major morbidities and actions thereafter.

Supervisors of midwives need to form part of the core SUI panel. SUIs are intensively investigated but these reviews do not involve multidisciplinary meetings of

clinical staff. A comment was made to the panel that each specialty investigates each incident but there is insufficient cross-specialty discussion. There is a need to recognise that incident reviews should involve clinicians at least as much as managers who specialise in risk management. There is a well-recognised technique for doing this, in the form of “facility-based incident reviews” which are being promoted in many countries by the World Health Organisation (WHO) “Making Pregnancy Safer” initiative [3] but paradoxically are not widely practised in this country, where review meetings have tended to focus on cases of perinatal mortality or criterion-based audit. Such review meetings should be a matter of regular routine, not a response to incidents as and when they occur, and should involve multidisciplinary discussion among midwives and doctors of all specialties involved.

Minutes of the clinical risk management group in places lack logical flow. Minutes of the clinical risk management group demonstrate that risk reporting and management processes are in place. Areas of concern that relate to the findings of this review include a lack of follow-up of actions proposed, anomalies regarding actions, anomalies regarding implementation and review of findings.

Whilst the review suggests there is room for improvement in multidisciplinary working, communication, record keeping, medicine management, senior clinicians identified as the lead in complex cases, care pathways, capacity issues, skill mix and adherence to policy and guidelines unless clinical situations dictate they need to be improved, there is no suggestion that weaknesses in any of these areas lead directly to the adverse incidents.

The recommendations and actions already identified and those in progress of being developed by the Trust will improve these issues identified by the review panel.

7. Professional supervision

Due to time constraints, the panel did not have the opportunity to speak privately with junior doctors but gained the impression that they are closely supervised and indeed their complaint would tend to be that if anything they are not allowed enough independence.

There are two registrars on duty at night but they have to cover both obstetrics and gynaecology. During the day, gynaecological clinics are held in the Central Middlesex Hospital but at night all gynaecological emergencies are admitted to Northwick Park, which means that the on-call team is often stretched.

As junior doctors' hours are reduced in line with the European Working Time Directive this problem will get worse, and there is unlikely to be any change in the trend for juniors to be less experienced than they were in the past. The consultants would like more registrars (or sub-consultant grade doctors) to strengthen the rota.

A better option would be the appointment of more consultants, as the obstetric service across the UK is becoming increasingly consultant-delivered. The consultants regard it as normal to stay in the hospital well beyond their official hours and unlike junior staff do not have free time built into their job plans after their night on-call. This work pattern should not be allowed to obscure a need for more consultants. This requires monitoring and discussion.

Supervision of midwives is mentioned in several places in the report. The strategy for supervision is clearly articulated and reflects current challenges. At present the ratio of supervisors of midwives to midwives has fallen below the Trust's target ratio of 1:15.

Strategies to achieve a ratio of 1:15 require urgent attention. In all cases the on-call supervisors of midwives was appropriately informed and the maternal death policy was followed. Nevertheless, as previously discussed, supervisors of midwives are not normally included in the SUI panel investigation. This needs to be addressed.

The quality of the midwifery records, as discussed throughout this report, clearly reflects the leadership and commitment of the supervisors of midwives team and is to be credited.

The SUI investigation demonstrates that capacity is a real issue for the Trust and supervisors of midwives need to be assured that the safety of mothers and babies are not being compromised by increased demand on the service. The Trust needs to ensure that supervisors of midwives are appropriately engaged with and in any plans to increase the workload in the maternity unit.

8. Participation in Trust governance and risk procedures

The importance of these procedures is recognised by staff but they feel there are now too many "high level" procedures. Devolving responsibility for some functions may be desirable. The Trust should review whether the current committee structure provides full assurance to the maternity unit managers and to the Trust Board.

9. Barriers to good practice

A high proportion of antenatal care is provided by general practitioners (GPs) and many of these work in single-handed practices – a pattern that GPs have moved away from in most parts of the country. Although the obstetricians feel they are readily accessible should questions arise, this pattern of care provides challenges in identifying women who should be classed as high risk and in identifying complications at an early stage.

In many parts of the country, midwives now play a major role in providing antenatal care. The numbers of community midwives in the Trust's area is low and although a substantial number of new posts have been funded, recruitment is difficult, particularly of experienced midwives. This is a problem all over the country but is not helped by the continuing negative publicity locally. If the recruitment plan is successful, the transfer of antenatal care in Brent to the community midwifery service managed by the Trust should improve the service.

The national move towards midwife-delivered antenatal care has led to a general reduction in training and updates for GPs who still deliver this service. There has been little written about GP antenatal care since the mid-1990s [4].

Space in the antenatal clinic is limited and this should be reviewed.

The delivery suite is of good size but pressure of beds in the postnatal ward can lead to a "back-up" of patients.

Some recruitment difficulties are due to the ongoing effects of negative publicity and efforts must be made to counteract this. Also, it is not easy from a financial point of view to work as a consultant obstetrician in London without private gynaecological practice. In order to improve recruitment and retention of consultants, the Trust may wish to consider this issue.

Inter-specialty communication has also been affected by the bad publicity focussed on the maternity unit.

10. Areas of good practice

The review identified the following:

- Incident reporting and investigation are thorough. Two of the external experts reviewed seven incident reports of cases of major obstetric haemorrhage and were impressed with their clarity and conclusions.

- The refurbishment of the delivery suite has resulted in a pleasant working environment with a good physical appearance and rooms of a very satisfactory size.

- The atmosphere is relaxed and friendly, with good relationships between midwifery and medical staff.

- Interpreters are available.

- There is dedicated teaching of undergraduates and the feedback from them is excellent.

- There is good supervision of postgraduate trainees, who appreciate the wide range of clinical experience in the hospital.

- Consultant staffing of the labour ward is well above average in terms of the number of consultant hours and the fact that two consultants are present during the day. Consultant numbers are much better than they were, in line with previously accepted standards. One consultant per 500 deliveries used to be the accepted norm but nowadays many hospitals are increasing consultant numbers well beyond this formula. With the high proportion of high-risk women attending Northwick Park this may be necessary for the reasons given above.

- The consultant obstetricians are providing a good service, in spite of the pressures they are under from the high-risk population and the constant negative attention of the media, both local and national. Their dedication is impressive. The panel felt, however, that they need some support in developing leadership skills in relation to multi-specialty working.

- The panel feels that, in general, the risk assessment process with reminders to staff on management options should be considered excellent and should be widely disseminated. The quality of GP referral letters in the cases of woman C and woman A was of a very high standard. Midwifery management plans are commendable. Strategies that have facilitated the achievement of such standards require sharing. The quality of guidelines to support the delivery of care is of a high standard. There is an excellent process for logging calls on labour ward.

- There is evidence of strong leadership by labour ward co-ordinators and supervisors of midwives. The strategy for supervision is clearly articulated and reflective of current challenges. The interface between the supervisory framework and the clinical governance framework could be further strengthened.

11. Key recommendations

The panel anticipates that the Trust will wish to devise and implement an action plan as a result of this report. The existing management team is, in the panel's view, capable of taking forward the next steps.

The panel recommends that the following items should be essential components of the plan:

- Implementation of NICE postnatal guidelines at once.
- A review of community care packages and primary care involvement with a view to ensure an equitable service for all women, targeting services toward the most vulnerable.
- Dissemination of exemplars of good practice.
- Direct access to a midwife (embracing the Maternity Matters choice agenda deliverable by 2009) requiring implementation of the Trust's plan to recruit an extra 20 community midwives and, therefore, maintenance of an appropriate ratio of supervisors to midwives.
- Standardised multidisciplinary referral tool/information commonly referred to as the booking letter sent from GP to the antenatal clinic to be implemented in accordance with confidential enquiries.
- Medicine management (study day for all staff members).
- Mandatory continued professional development (CPD) for GPs who provide maternity care.
- There should be a focus on antenatal care with regard to the identification and care of high risk cases and establishing multidisciplinary care plans for them.
- The consultant obstetricians have a high level of clinical skills and experience but may need support in developing leadership skills.
- Recruitment of two more consultant obstetricians is underway and the need for leadership skills should be borne in mind during this process.
- An aggressive publicity drive is recommended to inform the local community and the rest of the hospital about the clear improvements in the maternity service.
- Urgent strategies to address concern about delays between arrival on the delivery suite and assessment/admission which was borne out in the review of some of these cases and interviews with staff.

- Reviewing the Risk Management Policy to ensure that supervisors of midwives are appropriately represented in the Trust's clinical governance frameworks.

- Clinical Risk Management Group to implement a tighter process to ensure actions are followed through to implementation and to provide assurance of compliance.

12. Summary

The recent cluster of maternal deaths at Northwick Park Hospital is not the result of deficiencies of care. Standards of care on the delivery suite are now well above average and the staff are to be congratulated on raising standards and morale during a very challenging period of change.

Incident reporting and investigation systems are of high quality and have identified the next steps in making further improvements to the overall quality of care.

The population of women cared for at Northwick Park Hospital includes a high proportion of vulnerable and high-risk women. It has become clear that the focus now needs to be on identifying and supporting such women early in pregnancy. This will involve the improvement of existing care plans and encouraging and empowering consultant obstetricians to take the lead, when appropriate, in co-ordinating multi-specialty working. It is important that such further initiatives do not reduce the consultant presence on the delivery suite.

The high standards achieved in the hospital need to be recognised and publicised. It is clear that the service has been transformed but the staff still feel pressurised by misperceptions from the local and national media and even, regrettably, from other specialties within the hospital. Publicity is required to remedy this.

Appendix one: References

1. Lewis, G (ed) 2007. The Confidential Enquiry into Maternal and Child Health (CEMACH). *Saving Mothers' Lives*: reviewing maternal deaths to make motherhood safer (2003-2005). The Seventh Report on Confidential Enquiries in the United Kingdom. London CEMACH.

2. Knight M, Kurinczuk JJ, Spark P, Brocklehurst P. United Kingdom Obstetric Surveillance System (UKOSS) Annual Report 2007. Oxford: National Perinatal Epidemiology Unit.

3. World Health Organisation Department of Reproductive Health and Research. 2004. *Beyond the Numbers*: reviewing maternal deaths and complications to make pregnancy safer. Geneva: World Health Organisation.

4. Neilson J. Antenatal care on trial (editorial). BMJ 1996; 312: 524-5. NICE CG37 Postnatal Care: Routine Postnatal Care of Women and their Babies (July 2006).

5. Healthcare Commission: Review of Maternity Services provided by The North West London Hospitals NHS Trust (July 2005).

6. Healthcare Commission: Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, The North West London Hospitals NHS Trust, between April 2002 and April 2005 (August 2006).

Appendix two: Terms of reference

The terms of reference of the review and the constitution of the independent review panel are included below.

Background

The Maternity Unit at Northwick Park Hospital has seen a £19m investment in facilities and a complete overhaul of its clinical governance arrangements since the Healthcare Commission's review into the 10 maternal deaths which occurred between 2002 and 2005. This resulted in 'special measures', which were placed on the Trust by the Secretary of State for Health, being lifted 18 months ago in September 2006.

Rationale for Review

The Trust has had three maternal deaths since special measures were lifted. These occurred on 5 June 2007, 18 September 2007 and 20 March 2008.

The first two cases have been subject to full SUI investigations and referred to the Coroner which is normal practice. The cause of death in these two cases was pulmonary embolism and amniotic fluid embolism respectively and they are reported to be two of the leading causes of maternal death as set out in the Savings Mothers' Lives report CEMACH 2007. The third maternal death was being investigated at the time of initiation of the review. The Strategic Health Authority has been fully briefed.

In order to assure the Board that there is no common link between these maternal deaths, the Trust instigated an additional review of all three cases to review underlying trends. Also, given that it is 18 months since Special Measures status was lifted, it is the right time for the Trust to undertake a review of the governance processes within the Maternity Unit.

This Review is also important for the Trust at this time as birth activity has increased to 5,200 per year, almost 10% above our capacity at the time the action plan was agreed. This increased activity was planned and implemented with the full agreement of the Healthcare Commission, Primary Care Trust partners and the National Clinical Governance Support Team in recognition that our governance systems were robust enough to support this work load. However, demand for maternity services is increasing and the Trust needs to assess whether it will be able to expand its service further. This review will help to inform this decision-making process.

Scope of Review

This review will examine and make an assessment of the management, provision and quality of healthcare, incorporating clinical governance systems and processes in place in The North West London Hospitals NHS Trust's Maternity Service to ensure the safety, effectiveness, quality and appropriateness of the services. This will include (but will not necessarily be restricted to) the following purposes:

- To carry out a root-cause analysis of all recent SUIs to establish whether there are common underlying performance or system weaknesses which might predispose to further incidents.
- To review current governance arrangements against the HCC action plan to determine whether they are still fit for purpose (particularly in respect of multidisciplinary working) and, if not, how they might be modified.
- To examine the risk management performance of the unit with particular attention to:-
    a. Identification of high risk patients in antenatal care
    b. Compliance with risk management protocols in antenatal care (DNA procedures, written care plans, multidisciplinary care, cross speciality care, leadership and accountability)
    c. Management of labour (care plans, recognition of risk as in failure to progress, foetal distress and major obstetric haemorrhage (MOH), protocols for escalation of care)
    d. Postnatal care including healthcare acquired infections (HCAI) protocols and discharge procedures.
- To examine overall systems for risk management, including incident reporting and investigation, risk assessment and implementation and monitoring of action plans.
- Multidisciplinary incident review and governance meetings.
- Professional supervision including statutory supervision of midwives.
- Participation in Trust governance and risk procedures.
- Where problems are identified, to identify barriers to good practice.
- Where good practice is identified, to reinforce, reward and publicise it.

Timescale for Review

The review will start at the end of April. A draft report will be submitted by the end of June 2008 with a final report by the end of July 2008.

Reporting Process

The written report will be first considered at the Private Part of the Trust Board.

Appendix three: Biographies of the panel

Chair of the review panel, Ms Ann Groves
Non Executive Director of Harrow Primary Care Trust

Ms Groves has worked as a systems specialist at Kodak in Harrow for more than thirty years. She was a magistrate for 25 years and a local councillor for 16 years. She is also an ex-mayor of Harrow. She has been a non-executive board member of Harrow PCT for three years. She is also chairman of Age Concern Harrow, Alzheimer's Society Harrow and Hillingdon Branch and Harrow Association of Disabled People. She is a member of the Harrow Strategic Partnership Executive.

Professor James Drife (MD FRCOG FRCPE FRCSE HonFCOGSA)
Department of Paediatrics, Obstetrics and Gynaecology
University of Leeds, UK

Professor Drife is a professor and NHS consultant in obstetrics and gynaecology in Leeds and a former vice-president of the Royal College of Obstetricians and Gynaecologists. He has been a member of the General Medical Council and of the UKCC Midwifery Committee, and chairman of the Association of Professors of Obstetrics and Gynaecology. He has been a national assessor for the UK Confidential Enquiries into Maternal Deaths since 1992. He was a member of the Chief Medical Officer's Expert Group on Learning from Experience, whose report was published as *An Organisation with a Memory*. He is a consultant to the World Health Organisation's *Making Pregnancy Safer* initiative. He writes regularly for the BMJ and is Co-Editor-in-Chief of the *European Journal of Obstetrics, Gynaecology and Reproductive Biology.*

Professor Jacqueline Dunkley-Bent
Professor of Midwifery at South Bank University

Professor Dunkley-Bent has vast experience in maternity care both from a clinical and managerial perspective. She has worked within primary and secondary health care settings since 1985. The roles she has undertaken include: Head of Midwifery and Gynaecology at Guy's & St Thomas' NHS Foundation Trust in South East London, Consultant Midwife Public Health, trauma counselling for childbearing women, Senior Lecturer and Curriculum Leader at Middlesex University in North London.

She has published a range of articles, contributed five chapters to books in the last five years and authored her own book. At Guy's and St Thomas' she maintained and managed a budget in excess of £20 million, leading a maternity unit toward achieving CNST level three and achieving the highest Healthcare Commission review for maternity services in London whilst working as Head of Midwifery. She recently participated in the Pan London review of maternity services and acts as an expert witness for the claimant. She is currently employed by London South Bank University and takes a lead role in ensuring that education is responsive to the changing needs of healthcare provision and reflected as such in education provision. In addition she advises the chief nurse at NHS London on maternity matters.

Ms Cathy Rogers
Consultant Midwife

Ms Rogers is a consultant midwife at Barnet and Chase Farm Hospitals NHS Trust and a supervisor of midwives. She is also a Senior Lecturer at the University of Hertfordshire where she co-leads on the preparation programme for supervisors of midwives. She co-led the development of the first Masters programme for the prepartion of supervisors of midwives in the United Kingdom. She has contributed widely on developments both in the education and practice of midwifery and midwifery supervison. She was regional assessor for CESDI as well as consultant midwife representative on the National Patient Safety Agency. She has published widely and presented at many conferences nationally. She is also an expert witness in midwifery.

Appendix four: Response to the review report from the Healthcare Commission

The Trust received comments on the draft report from the Healthcare Commission in a letter dated 22 July 2008. The Healthcare Commission's **overall comments** on the report are as follows:

1. The Commission is satisfied, overall, that a reasonable and thorough approach has been taken in the preparation of the report.

2. We consider that the report sets out clearly the circumstances leading to the five incidents and has logically come to its conclusions that whilst the review exposed a small number of weaknesses in the system, these were not significant to the eventual outcome of the incidents.

3. We are also satisfied that the key recommendations are reasonable and appropriate, in the light of the findings contained in the report. The Trust will undoubtedly be in the process of considering how best to implement these recommendations and I should be grateful if you would send written details of the Trust's proposed actions as soon as these are available.

4. We have noted the areas of good practice highlighted in the report and substantial improvements since the Commission's investigations were undertaken. We recognise the effort and commitment that the trust has shown in rising to meet the significant challenges with which it was faced.

5. Whilst the report highlights several areas where the care could be improved, we do not have any area of particular concern regarding the safety of patients, or failure by the Trust to implement our previous recommendations.

6. It is our understanding that a number of community midwives were to be recruited by the Trust to look after deprived women in the community including refugees and those who do not speak English. We would appreciate an update of progress with this recruitment.

Other more specific points on the individual cases were also made and these have been incorporated into the Trust's action plan. See appendix five.

Appendix five: Draft action plan by The North West London Hospitals NHS Trust in response to recommendations

1. Purpose

This paper provides a detailed action plan in response to the review of maternity services at Northwick Park Hospital which was completed in July 2008. Implementation of this action plan will be monitored by the Trust Board.

2. Background

In April 2008, following three maternal deaths in one year and two other serious untoward incidents (SUIs) in its maternity unit, The North West London Hospitals NHS Trust (NWLH) initiated an independent review into the root cause of the incidents, the appropriateness of the maternity unit's governance systems and their application (including risk identification, risk management, incident reporting and review, multidisciplinary working, leadership and professional supervision), barriers to good practice and areas of excellent practice.

In consultation with NHS London and the Healthcare Commission (HCC) an investigating panel was convened. This was chaired by a non-executive board member of Harrow Primary Care Trust (PCT) and included an executive member of Brent PCT, a Professor of Obstetrics (nominated by the Royal College of Obstetricians and Gynaecologists), a Professor of Midwifery and a Supervisor of Midwives (recommended by the Local Supervising Authority). They were supported by the Medical Director, Director of Nursing and Midwifery and Assistant Director of Integrated Governance of the Trust.

The report was reviewed and endorsed by the Healthcare Commission and NHS London. The additional recommendations made by both organisations have been included within this action plan.

3. Overview of Key Findings

The work of the panel was completed on 24 June 2008. The findings of the review were:

- The maternal deaths and incidents were not the result of deficiencies of care
- Standards of care when the client is admitted to the delivery suite are well above average
- Incident reporting and investigation systems are of a high quality
- There are example of excellent practice which should be widely disseminated
- Governance systems are fit for purpose and generally well applied.

The Healthcare Commission noted that although the review 'exposed a small number of weaknesses in the system, these were not significant to the eventual outcome of the incidents'. They also noted the areas of good practice highlighted in the report and the substantial improvements since the Commission's investigations were undertaken. They go on to recognise the effort and commitment that the Trust has shown in rising to meet the significant challenges with which it faced. The HCC states in its letter to the Trust that it does not have any area of particular concern regarding the safety of patients.

The Review Panel and the HCC identify a number of areas of action which will further strengthen the service in the future. These are the subject of the targeted action plan.

4. Action Plan

The attached action plan documents the details of the recommendations that have been made by the report and the actions being taken. It not only highlights the key recommendations, but also identifies actions that arise as a consequence of comments/observations made throughout the main body of the report. It is important to recognise that many actions have already been taken by the maternity department, and the unit continues to develop and to respond to other national drivers such as the national Healthcare Commission Maternity Services Review (2007).

5. Monitoring Arrangements

The action plan will be implemented by the Maternity Management Team, supported by the executive lead for maternity services. The Maternity Governance Board is the local framework in place to provide quality assurance in the maternity services and links directly to the Trust Clinical Governance Committee. Implementation will be monitored by the Trust Board and an update will be provided by the Chief Executive to the London Strategic Health Authority (NHS London) and the Healthcare Commission on progress. A letter will be sent to the HCC providing assurance on recruitment, the action plan and the changes that have been made to the high dependency unit (HDU).

IMMEDIATE ACTIONS (OCTOBER - NOVEMBER 2008)

Key Recommendation	Ref*	Actions	Lead	Outcomes	Timescale	Progress
Implementation of NICE Postnatal Guidelines (2006).	P35	• Update current Postnatal Guideline to ensure compliance with NICE. • Ratification by Guidelines Group.	Clinical Director (CD) & Head of Midwifery	Postnatal guideline compliant with NICE Guidance.	Sept 08	**COMPLETE** Postnatal guideline updated/ ratified 8 Sept 2008
Postnatal capacity can be a barrier to good practice leading to a 'back up of patients'.	P32	• Review of postnatal capacity undertaken and impact of new MLU modeled. • Developed role of Bed Manager to focus on flow of patients.	Head of Midwifery/ General Manager	Bed Manager midwife in post. No IOL delays. Capacity on delivery suite.	-	**COMPLETE**
Adjustments could be made to allow smoother running of the elective caesarean section lists.	P25	• Start times reviewed. • Consultant allocated for elective lists.	Clinical Director	C-Section list commence on time.	-	**COMPLETE**
Use the Maternity Dashboard.	HCC	• Dashboard already in place (developed by NWLH). Also under further development in 2008/09.	Maternity Mgt Team	Close monitoring of activity and clinical outcomes.	-	**COMPLETE** Joint Maternity Review Group with PCTs established
Assurance that GPs concerned in cases will receive appropriate feedback involving the PCTs as appropriate.	HCC	• Discuss with PCT Medical Director & Chief Executive. • Consider wider learning for all GPs via GP forums.	PCT (Medical Director(s) /CEO)	GPs received feedback.	Oct 08	
Urgent strategies to address concern about delays between arrival on delivery suite and assessment/admission.	P35	• Expansion of triage facilities. • Review and update triage guidelines. • Opening of co-located midwifery led unit to reduce demand on delivery suite.	Head of Midwifery General Manager	Timely and appropriate assessment of women on arrival to delivery suite.	Nov 08 Oct 08 Complete	Works currently out to tender. Triage guidelines in draft form
HDU working practices to be reviewed and new practices adopted to ensure patients not overlooked.	HCC	• Consultant Obstetrician HDU Lead to be put in place. • Ward round to include HDU every day.	Head of Midwifery/ CD	HDU beds appropriately used. Daily review of all patients on HDU.	Complete	**COMPLETE**

Key Recommendation	Ref	Actions	Lead	Outcomes	Timescale	Progress
High risk assessment should trigger a specific care pathway with clearly set out processes and checks.	HCC & SHA	• Affix prominent coloured sticker to hand held maternity notes to raise awareness of risks present. • Adapt care plan proforma to have named obstetrician who will ensure consultant obstetrician involvement in high risk women throughout the continuum of pregnancy and postpartum period. • A copy of the care plan filed on delivery suite. • Review processes for high risk case (social & medical) communication.	General Manager Clinical Director CD/Head of Midwifery CD/Head of Midwifery	High risk women identified and managed appropriately with care plans in place. Vulnerable Women's Guideline updated. At least one MDT meeting/ consultation for all cases.	Nov 08 Oct 08 Complete Oct 08	Care plan proforma in place – to be updated
There should be a focus on antenatal care with regard to the identification and care of high risk cases and establishing multidisciplinary care plans for them / optimising antenatal care of high risk women by applying best practice guidelines.	P35, P5 & HCC & SHA	• Review antenatal guidelines to ensure robust process for identification and care of high risk women. • Review antenatal risk assessment form to develop an enhanced document for cumulative scores for increasing risk. • Consider a tracking mechanism using community midwives to visit women who do not attend their antenatal clinic. • Audit effectiveness of the DNA policy. • Review communication & GP involvement for DNAs.	CD/Head of Midwifery Head of Midwifery/ General Manager Head of Midwifery	Antenatal guidelines updated. Risk assessment form updated. Review tracking mechanism for DNA. Audit undertaken & actions identified. GPs involved when women DNA and support process.	Oct 08 Nov 08 Nov 08 Nov 08	Drafted; pending presentation to the Maternity Governance Board
Consider use of a tracking board in delivery suite to track women who have been transferred to another department.	SHA	• Outliers board to be created on delivery suite.	Head of Midwifery	Tracking in place & appropriate input given.	Complete – in place since Feb 08	**COMPLETE**

SHORT TERM ACTIONS – BY JANUARY 2009 (within 4 months)						
Key Recommendation	**Ref**	**Actions**	**Lead**	**Outcomes**	**Timescale**	**Progress**
Review the Risk Management Policy to ensure that supervisors of midwives (SOMs) are appropriately represented in the Trust clinical governance frameworks.	P36	• Review Trust's Risk Management Policy to ensure SOMs are appropriately represented. • SOMs to be involved in the review of all Grade 4, 5 & SUI incidents.	Assistant Director of Integrated Govern-ance	SOMs are appropriately represented at appropriate governance forums.	Nov 08	
Standardised multidisciplinary referral tool/information commonly referred to as the booking letter sent from GP to the antenatal clinic to be implemented in accordance with confidential enquiries.	P35 & HCC	• Review proformas against recommendations. • Discuss with local units the use of same booking form. • Undertake audit of GP use. • Engage with GPs to clarify level of their involvement so they can use the risk alert system for referral to specialist care and assist in following up non-attenders.	Head of Midwifery Matron for Commun-ity & PCT Leads	Antenatal Booking Proforma compliant with national confidential enquiries. GPs using proforma and clear understanding of risk alert system.	Nov 08 Nov 08 Jan 09	GP Antenatal booking proforma in place
Consider multi-disciplinary clinics using a list of named consultants and physicians so that the obstetrician in charge of the case can contact the named physician to review the case together and develop an individual plan of management.	HCC	• Draw up list by specialty. • Discussion to be held at Grand Round and broader forum by Medical Director and Chief Executive to support maternity services.	Medical Director & CDs	List of contacts in place. Used by obstetricians in high risk management cases.	Jan 09	
A review of community care packages and primary care involvement with a view to ensuring an equitable service for all women, targeting services toward the most vulnerable.	P35	• Review to be undertaken. • Develop multidisciplinary integrated care pathway for vulnerable women. • Training programme for midwives in use of the CAF.	Head of Midwifery & Lead midwife for safe-guarding	Community care packages developed for vulnerable women.	Nov 08 Nov 08	Vulnerable women guideline ratified Sept 2007
Consider the development of a multidisciplinary perinatal mental health service.	SHA	• Business case for joint clinics to be developed. • Protocols to be reviewed and updated on the intranet.	Head of Midwifery/ General Manager	Joint clinics in place. Protocols updated.	Dec 08 Sept 08	

MEDIUM TERM – WITHIN THE NEXT 6 MONTHS (BY FEBRUARY 2009)						
Key Recommendation	**Ref**	**Actions**	**Lead**	**Outcomes**	**Timescale**	**Progress**
Dissemination of exemplars of good practice.	P35	• Launch of RCOG Maternity Standards-NHSLA Standards (local). • Grand round for dissemination of key messages within Trust.	Maternity Mgt Team	Organisational learning disseminated to the wider community.	Sept 08 Dec 08	Agenda and guest DH speaker
Medicine management (study day for all staff members).	P35	• Medical staff - Incorporate into Friday teaching programme. • Midwives and nursing staff – Incorporate into mandatory training.	Clinical Director, Head of Midwifery & Gynae & SOMs	All staff receive annual updates on medicines management.	Jan 09	
Publicity drive is recommended to inform the local community & the rest of the hospital about the clear improvements in the maternity service (HCC).	P35	• Development of a robust communications strategy in conjunction with key stakeholders (i.e. NMC, SHA, LSA, PCTs, TVU). • Official Unit opening following completed refurbishment to include keynote speakers.	Maternity Mgt Team Chief Executive	Inform Trust and local community of improvements. Opening takes place.	Nov 08 By Dec 08	
Maintenance of an appropriate ratio of supervisors to midwives.	P35	• Ongoing liaison and engagement with LSAMO to identify appropriate support from available SOMs regionally. • Two student SOMs in training with guaranteed slots for approved courses. • Ongoing monitoring of SOM ratio on maternity clinical scorecard.	SOMs, Head of Midwifery & LSAMO	Achieve ratio of 1:15 as per National Midwifery Council (NMC) guidance.	Ongoing	Appointment of two SOMs on consult-ancy basis LASMO support increasing midwives in training Remuner-ation package for SOM activities

Key Recommendation	Ref	Actions	Lead	Outcomes	Timescale	Progress
The consultant obstetricians have a high level of clinical skills and experience but may need support in developing leadership skills.	P35	• Reinforce consultant lead roles within the department via Job Plan process. • Undertake a training needs analysis via job planning review process. • Develop bespoke package for development of leadership competencies and skills. • Consider leadership skills as core competency for two new consultant obstetrician posts.	CD & Assistant Director of Oper-ations (ADO) CEO & CD	Clear leads in place. Training needs identified and packages to meet needs in place. Leadership skills tested at interview.	Oct 08 Dec 08 Nov 08	Job plan reviews underway Interviews Nov 08
Clinical Risk Management Group to implement a tighter process to ensure actions are followed through to implementation and to provide assurance of compliance.	P36	• Recruit substantive Maternity Risk Manager. • Update Maternity Risk Management Strategy. • Development of a rolling action plan incorporating all actions identified following multidisciplinary risk review. • Schedule quarterly review by Maternity Governance Board to provide assurance of compliance. • Review of Maternity Governance membership to ensure assurance between the Maternity Governance Board and Maternity Clinical Risk Group.	Head of Midwifery CD & Clinical Risk Manager	Robust process in place to ensure actions are implemented, thereby closing the loop. Audit of implementation in place.	Dec 08	Risk Manager post out to advert Drafted pending presentation to the Maternity Governance Board

LONGER TERM – BY AUGUST 2009 (MAY TAKE 6-9 MONTHS TO CREATE FACTORS REQUIRED FOR CHANGE)						
Key Recommendation	**Ref**	**Actions**	**Lead**	**Outcomes**	**Timescale**	**Progress**
Review of antenatal clinic space.	P32	• Review of needs undertaken. • Identify space within current block.	General Manager	Review complete. Proposals for improvement.	Dec 08	Review of needs commenced.
Consultants on-call. Consider a system of being on-call during the daytime for a working week at a time.	P25	• Consider appointment of two new consultants.	CD/ Delivery Suite Lead	Rotas reviewed to maximise continuity of care.	Dec 08	
Continuous professional development for GPs who provide maternity care.	P35 & SHA	• Develop programme with PCT lead(s).	PCT Leads/ CD	Programme in place. GPs receive updates on current practice.	Apr 09	PCT to lead in conjunction with Trust.
Direct access to a midwife (embracing the Maternity Matters choice agenda deliverable by 2009).	P35	• Implement integrated midwifery model of care with integrated team development. • Recruit extra 20 community midwives.	Head of Midwifery & ADO	Direct access to midwife. Meeting Maternity Matters choice agenda. Midwives recruited.	Apr 09	Integrated model developed and agreed with Brent & Harrow PCTs. Implement-ation schedule agreed.

*page reference refers to the review panel's full report, not the public version.

Key

IOL	Induction of labour
MLU	Midwifery Led Unit
HDU	High Dependency Unit
MDT	Multidisciplinary Team
DNA	Did not attend
SOMs	Supervisors of midwives
LSAMO	Local Supervisory Authority Midwifery Officer
CAF	Common Assessment Framework
CEO	Chief Executive Officer
TVU	Thames Valley University
RCOG	Royal College of Obstetricians and Gynaecologists
NHSLA	NHS Litigation Authority

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The North West London Hospitals NHS Trust, Northwick Park and St Mark’s Hospitals, Watford Road, Harrow, HA1 3UJ. Tel: 020 8869 3232.
www.nwlh.nhs.uk