ITEM NO: 4

	Health Select Committee **19th November 2008** **Report from the Director of Policy & Regeneration**
For Action	Wards Affected: ALL
Independent Review of Maternity Services at Northwick Park Hospital	

1.0 Summary

1.1 The independent review of maternity services at Northwick Park Hospital was commissioned following three maternal deaths and two serious untoward incidents in 2007/08. The terms of reference for the review included a full analysis of each of the cases as well as a review of risk management and governance arrangements in the maternity unit. This was to ensure systems remained fit for purpose and provided assurance to the public that the maternity unit working practices and environment were safe for women.

1.2 The review report plus an action plan developed by the North West London NHS Hospitals Trust in response to the findings and recommendations is attached at appendix 1.

2.0 Recommendations

2.1 The Health Select Committee should consider the independent review of maternity services and its findings and question officers from the North West London NHS Hospitals Trust on the progress being made in implementing the action plan arising from the review.

3.0 Detail

3.1 Following three maternal deaths and two serious untoward incidents in 2007/08, the North West London NHS Hospitals Trust commissioned an independent review that considered the root causes 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.

3.2 The review was initiated in April 2008 and completed at the end of June. The main finding from the review panel was that the three maternal deaths and two serious untoward incidents were not the result of deficiencies of care. The review panel also found that:

- 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.

3.3 Areas for improvement in governance systems and maternity care were also identified:

- 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.

3.4 As a result of the review and its findings, the trust has developed an action plan to respond to the review report. The review panel made a series of recommendations (see pages 25 and 26 of the review report) which they believed should be included in the trust action plan.

3.5 The action plan is also included in the report papers and should be the focus of the committee's questions. It is crucial that it is fully implemented and the trust officers should be questioned on the progress in doing this.

3.6 Maternity services at Northwick Park Hospital have been subject of two previous reviews by the Healthcare Commission following 10 maternal deaths between 2002 and 2005. The Healthcare Commission was asked to consider the findings of this report. They are satisfied that previous recommendations have been implemented and do not have any particular areas of concern for patient safety.

4.0 Financial Implications

4.1 None

5.0 Legal Implications

5.1 None

6.0 Diversity Implications

6.1 None

7.0 Staffing/Accommodation Implications (if appropriate)

7.1 None

Background Papers

Appendix 1 - An independent review of serious untoward incidents and clinical governance systems within maternity services at Northwick Park Hospital.

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