Oxford University Hospitals NHS
NHS Trust

Paper Number

Health Overview and Scrutiny Committee meeting: 21 February 2013

Title	**Progress report on the review of the Cotswold Maternity Unit**

Status	A paper for noting by members of HOSC outlining the review of the Cotswold Maternity Unit (CMU) and the proposed way forward.
History	Follow up report following the presentation at the HOSC meeting on 15 November 2012.

Board Lead(s)	Sir Jonathan Michael, Chief Executive			
Key purpose	Strategy	**Assurance**	Policy	Performance

Progress report on the review of the Cotswold Maternity Unit (CMU)

Introduction

1. At the HOSC meeting held on 15 November 2012 members of the Oxford University Hospitals NHS Trust were given the opportunity to explain the decision to temporarily suspend births at the Cotswold Maternity Unit, Chipping Norton. A number of issues had been raised and these concerns had been identified through internal monitoring processes, the staff and via the Maternity Services Liaison Committee. The issues mainly related to working practices within the unit and not to one single incident. Higher than expected transfer rates and falling numbers of births had been noted and it was felt this may indicate an underlying problem.

2. The decision was taken to suspend the births, while maintaining the other components of the service, during the time the review was undertaken; the rationale for this decision was to enable the Trust to properly support the staff and mothers during this review. It was acknowledged that it would be a difficult time for all concerned and it was important not to add extra pressure on the staff in the unit which may then impact on the outcomes for women and their babies.

Review process

3. The scope of the review included (but was not necessarily restricted to) the following purposes:

   3.1 Evaluate the current governance arrangements to ensure that staff working in the unit comply at all times with those arrangements.

   3.2 Provide assurance to the Trust that clinical practice in the Cotswold Maternity Unit is in line with Directorate and National guidance, as well as Trust policies. This should include examination of: case notes, incident forms, previous complaints and claims, and records of transfers in labour and the early postnatal period.

   3.3 Examine the risk management performance of the unit with particular attention to:

      a. Identification of high-risk patients throughout pregnancy;

      b. Compliance with antenatal guidelines, including whether appropriate and timely referrals have been made to a consultant for an opinion or on-going care;

      c. Management of labour to include care plans, recognition of risk (both mother and baby), and compliance with guidelines regarding transfer to consultant-led care;

      d. Postnatal care including appropriate transfer/discharge of mother and baby.

   3.4 Examine systems for risk management, including incident reporting and investigation, risk assessment, and implementation and monitoring of action plans.

   3.5 Advise on professional supervision including statutory supervision of midwives.

   3.6 Conduct interviews with staff to understand any concerns relating to clinical practice, transfer rates and the reduction in the total number of births.

3.7 Conduct interviews with key stakeholders and the local population to ensure their involvement and, importantly, understand their issues in relation to the Cotswold Maternity Unit.

3.8 Identify barriers to good practice where problems are identified.

3.9 Reinforce and publicise good practice.

3.10 Investigate the culture of the unit, as well as any underlying problems with relationships amongst staff and the impact on the unit's effectiveness.

3.11 Advise on the appropriate service model for the provision of safe, high-quality, effective and accessible midwifery-led care at the Cotswold Maternity Unit.

4. The OUHT was explicit at the outset of the review that the intention was to reopen the unit once any recommendations highlighted through the review had been implemented and provided assurance to HOSC at the previous meeting as to this commitment. We would wish to reiterate that again in this progress report.

Process

5. In order to fully address the scope of the review and the purposes detailed above, a robust structure of interviews, meetings, case reviews and questionnaires were put in place. Given the concerns raised by some individuals about the need for an external rather than an internal review a degree of independence was built into every level of the review. Independence included:

- At HOSC's recommendation all the staff based in the CMU were offered the opportunity to have an external person present during their interview; all declined and were happy to meet to discuss their own personal and professional experiences and views.
- An external facilitator and Chair of MSLC met with the local community at a series of events.
- The PCT Lead and the Head of Midwifery met with the local General Practitioners and Health Visitors.
- Supervisors of Midwives with no involvement in the CMU conducted the case reviews.
- Questionnaires sent to a randomly selected group of women who have received care at the CMU to gain their views.

6. It was important to ensure the review encompassed an appropriate timescale to determine practice, cultural issues and any changes that have been implemented; the decision was taken to focus on the last 4 years. (2008 -2012)

7. The steps taken and the independent elements are as follows:

Specific review	Number	Actual completed	Independent element
Meetings with staff	51	36	Staff working in CMU offered the opportunity to have an external person present.
Questionnaires sent to women	200	94	Random selection of notes

Letters received re the review	4		2 from local women 1 from an observer 1 other
Case note reviews	200	200 (100%)	Random selection of cases. Reviews completed by Supervisors of Midwives not involved in CMU.
Review of transfers	46	46	
Review of home births	4	2	Consultant Midwives contact with each woman planning to give birth at home.
Questionnaires to GP's	16 (8 – Banbury area & 8 –CN GP's	4	All GP practices in Banbury area.
Meeting with local GP's and Health Visitor	1	1	PCT Lead
Public meetings	6 sessions x 120 places	6 sessions held and 52 people attended	External facilitator and Chair of MSLC
NCT and MSLC			Feedback received.

Emerging themes

8. Whilst acknowledging further analysis and review is required, the review has identified the following themes:

- Local women and their families are supportive of the Cotswold Maternity unit and want it to be available for the full range of services.
- An analysis of recent transfers has shown that these were entirely appropriate and done to ensure the safety of the mother and baby. It appears that some staff have recently been more cautious when working in the CMU because of the prevailing culture of the unit; this is related to the fact that the team was not operating in a unified and cohesive basis.
- The need to agree and implement an effective discharge policy.
- The need for midwives and local General Practitioners to work closely together to support each other in the care of pregnant women and to collaborate in the on-going development of the unit.
- The need agree staffing ratios and the appropriate skill mix to provide the service at the CMU.
- A number of concerns have been raised by staff who have been on the periphery of the units at Chipping Norton; these relate to the culture and the difficulties this has caused between groups of staff. This will be addressed in the main report.

- The need to review the working arrangements to ensure continuity and provision of midwifery care.
- The importance of promoting the service by working closely with the local community, GPs and other key stakeholders to build up support for the CMU and thus encourage and support women who want to birth in the standalone midwifery unit.

Next steps

9. Given the level of information obtained as part of the review it is important to ensure time is given to an effective analysis of the data and provide robust evidence to underpin the recommendations about the future of the unit. This will include a detailed analysis of the individual staff meetings and completed questionnaires from the women and GPs, and evaluation of the audit of the 200 case notes. It is imperative that the detail is analysed in such a way to address the purposes of the review and to fully address any concerns or deviations from practice.

10. The need to ensure that the outcome of the review is robust and comprehensive must be balanced with the desire of the local community and the Trust to reopen the unit at the earliest appropriate time. A timetable has, therefore, been agreed to ensure the final report is completed by the end of February 2013 for consideration by the Trust Board on 13 March 2013.

Timescales

Work plan	**Timescale**
Analysis of all data collected.	Mid February 2013
Report writing	Complete end February 2013
Agree action plan	13 March 2013
Open Cotswold Maternity Unit	To be agreed

Conclusion

11. HOSC is asked to note this progress report and the emerging themes.

Jane Hervé,
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Director of Planning and Information

11 February 2013