

Independent Review

Homerton University Hospital
NHS Foundation Trust –
Maternity Services

April 2014

Executive Summary

'The Unhappy Midwives' used the pseudonym 'Angela Cartwright' to raise their issues by email correspondence to the Homerton University Hospital NHS Trust (HUHFT or 'the Trust') in June 2012. Initially, in response to the allegations, the Chief Executive convened a review team that included Human Resources, an Obstetric Consultant and union representation. In August 2012 the review team concluded that they were unable to uphold the allegations that had been made by Angela Cartwright.

Dissatisfied with the outcome of the review, Angela Cartwright escalated the concerns to a number of external agencies and by February 2013 informed the newly appointed HUHFT Chief Executive that they intended to launch a petition for a public enquiry. The petition had acquired 52 names by the end of December 2013. Another internal investigation took place in August 2013 led by the newly appointed Chief Nurse. None of the allegations were upheld.

In August 2013 the NHS City and Hackney Clinical Commissioning Group (CCG) requested an independent review and this report contains the conclusions of that review. The CCG defined the terms of reference and agreed these with the Trust Chief Executive. The aim of the review was to provide insight and evidence with regard to the allegations that women had been and are exposed to poor standards of care and that there was a culture of racial discrimination within the HUHFT maternity unit.

The independent review was unable to substantiate any of the allegations made by Angela Cartwright. Two maternal deaths, numerous Datix (a recognised reporting tool within the National Health Service), policies and maternity records were reviewed which did not demonstrate any failings in the standard of care or evidence of racial discrimination. Staff members did not raise any formal complaints to substantiate a culture of poor care and discrimination.

The team makes a number of recommendations in order to offer women and their families a more robust service.

Introduction

In June 2012 a series of anonymous emails were sent to the Chief Executive and the Head of Midwifery (HoM) at Homerton University Hospital Foundation Trust (HUHFT or Trust) raising a number of allegations identifying:

1. Failings in care standards in the maternity unit of HUHFT.
2. Midwives and doctors who were being discriminated against on the grounds of race.

'The Unhappy Midwives' used the pseudonym 'Angela Cartwright' to raise their issues by email correspondence. Angela Cartwright will be used throughout this report to identify the group known as the Unhappy Midwives. Initially, in response to the allegations, the Chief Executive convened a review team in June 2012 that included Trust Human Resources, an Obstetric Consultant and union representation. In August 2012 the review team concluded that they were unable to uphold the allegations that had been made by Angela Cartwright.

Dissatisfied with the outcome of the review, Angela Cartwright escalated the concerns to a number of external agencies and by February 2013 informed the newly appointed Trust Chief Executive that they intended to launch a petition for a public enquiry. The petition had acquired 52 names by the end December 2013.

In August 2013 the newly appointed Trust Chief Nurse produced a report following a review of the processes involved in the investigations of serious incidents (SIs). A Trust Consultant Obstetrician supported the process. The findings at that time were that the investigation processes associated with the incidents identified were robust and for the majority complied with all the elements of good practice identified by NHS recognised systems for the level of investigation required. Two elements were identified as areas for improvement:

1. The involvement of additional external expert scrutiny for level 2 investigations.
2. The provision of training update to all obstetricians and senior midwives involved in SI investigations. It was also suggested that a formal register be set up and maintained by the risk management midwife of all those who had been trained to lead investigations.

In August 2013, NHS City and Hackney Clinical Commissioning Group (CCG) requested an independent review. The CCG defined the terms of reference and agreed these with the Trust Chief Executive. The aim of the review was to provide insight and evidence with regard to the allegations that women had been and are exposed to poor standards of care and that there was a culture of racial discrimination within the HUHFT maternity unit. The CCG sought to agree the terms of reference (TOR) with Angela Cartwright but the Angela Cartwright group felt they could not agree them as they felt the TOR did not go far enough (Appendix One).

The review team consisted of a Lead Midwife for Education (who is also an appointed Supervisor of Midwives), a Head of Midwifery, a Consultant Obstetrician and a Human Resources Advisor.

At an initial meeting at HUHFT, one of the reviewers met with the Trust Chief Nurse to discuss the methodology and conduct of the review. At the meeting the reviewer suggested that all members of staff who had been named in the circulation of emails that had been sent out to external parties needed to be informed. It was also later suggested that the Trust consider informing the Nursing and Midwifery Council (NMC) so that the professional body could be aware of the situation.

The advice to inform staff was taken on board, further to seeking advice from the Trust's legal advisors, and all staff named in the Angela Cartwright campaign were contacted and invited to a meeting to inform them of how they had been named. A Trust consultant midwife and the Associate Workforce Director were identified to lead this piece of work with administrative support to arrange individual appointments for staff. In the claims 56 members of staff were named in a various ways as victims, perpetrators or witnesses. Staff who attended the meetings were advised of the correspondence undertaken by Angela Cartwright and were presented with redacted transcripts of the email(s) within which they had been named. Staff were given the opportunity to discuss any issues that arose and were signposted to a number of sources of support, which included the counselling services, a Supervisor of Midwives network and Trade Union representative.

By mid-December 2013 thirty-four members of the original 56 staff had made contact with the Trust team. Twenty-seven staff accepted the invitation and attended an individual meeting. Each meeting was scheduled for approximately thirty minutes. Further appointments were scheduled for 2014 for those who were unable to attend due to annual leave or other commitments.

A number of those midwives who attended the meeting already had a level of awareness about the issues raised by Angela Cartwright mainly as a result of the Chief Executive's email of 7th June 2013 to all members of maternity staff. Staff responded in a number of ways including surprise, dismissal, anger, distress and anxiety. The majority of those who attended the meeting did not recognise the allegations made (whether as a perpetrator or as a victim) nor the culture of the maternity unit that had been described. Many of the staff commented on the destructive nature of such a campaign. A final report is to be submitted to the CCG by the Trust when all the staff meetings will have been completed. In early January 2014 the Chief Nurse confirmed that the Trust had not informed the NMC.

The Independent Review Team

The review team was chosen to reflect the skills required for the review and consisted of experienced senior midwives with remits within education, supervision of midwifery, and management, a Consultant Obstetrician and a senior Human Resources Officer. All members of the team were recruited from outside the London area. The review commenced in October 2013.

Methodology

The review team analysed the various incidents which were identified by Angela Cartwright and sought to identify the cases so that they could be independently reviewed. The methodology used was a structured and systematic approach using a selection of research tools in order to ensure triangulation of evidence for the review.

This included:

- Personnel: Discussions with the HoM, Maternity Clinical Risk Manager the Contact Supervisor of Midwives and the Local Supervising Authority Midwifery Officer (LSAMO). A meeting was also arranged with Angela Cartwright who sent an intermediary.
- Governance: Review of Trust policies, clinical guidelines / protocols, workforce statistics and other supporting information undertaken through table top review and electronically.
- Process: An initial meeting with the CCG was held; the team then met with the Trust Chief Nursing Officer and the HUHFT HoM. At the meetings there was agreement that all documents and interview requests would be submitted by the review team to members of the senior team. Contact with clinical staff would only occur if necessary and with the full knowledge of the Trust senior team with acknowledgment of the staff meetings that were to be arranged. From the outset, the review team was cognisant that the process would be difficult for staff. The review team therefore chose not to question staff, some of whom were unaware that their names had been circulated to the public.

Background

The HUHFT maternity services serve a population of 250,000. It is part of the North East London (NEL) maternity activity reconfiguration, attracting increased bookings from Waltham Forest. 5,300 babies are born at HUHFT per annum; the population covers a diverse ethnic and cultural mix. This is also reflected in the staff profile described later in this document.

The maternity services were successful in securing funds from the Department of Health's £26 million project, to improve birthing environments in January 2013. The monies were used to improve the birth centre rooms, delivery rooms, birth pools and antenatal facilities.

The CCG re-established its Maternity Services Liaison Committee (MSLC) in 2013 and 100 applications were received to join the MSLC as user representatives.

Midwifery Staffing

Although Angela Cartwright did not focus on staffing issues at HUHFT, the review team felt that it was pertinent to consider midwifery staffing in order to assess whether there were any obvious deficits. The Trust HoM was open about their staffing establishment and made themselves available to assist the reviewers and ensured that all the documents that were requested were accessible.

The HUHFT commissioned a birth rate plus assessment of maternity staffing. Birth rate plus is the most recognised and recommended workforce planning system based on the principle of providing one to one care during labour and delivery to all women with additional midwife hours for women in the higher clinical need categories (Ball and Washbrook 1996). The assessment, which was carried out in 2010, found no shortfall in staffing based on bands 3-8 with a total staffing establishment of 187.61 whole time equivalents (WTE) giving a midwife to birth ratio of 1: 29.6 WTEs. The maternity unit has been closed on two occasions due to capacity issues and the supervisory team was actively involved in the process.

In September 2013 the maternity services approved staffing levels and the Contingency Planning and Closure of the Unit guideline was updated and approved until October 2016. This document is multi professional and clearly sets out the required staffing levels, escalation in periods of unexpected workload and closure of the unit in exceptional circumstances.

Minimal midwifery staffing levels are clear and the Safer Childbirth (Royal College of Obstetrics and Gynaecology (RCOG) 2007) recommendations have been clearly considered in the document. The guideline is appended with a clear monitoring tool and demonstrates that the maternity staffing can be clearly reviewed. The document refers for the need to increase the Consultant presence on the labour ward from the current 80 hours per week to 98 hours as recommended by the RCOG and a business case to address the short fall is planned.

During the review it was noted that HUHFT has developed a home birth team that is separate to the community midwifery team. This is an innovative approach that supports women's choice in place of birth in line with Maternity Matters (Department of Health 2007) recommendations.

Maternity Survey

The Picker Institute Europe – Making Patients Views Count Maternity Survey 2013 for HUHFT was published in October 2013. The results of the survey were shared with the reviewers and an action plan to address changes to the scores is to be undertaken by the HUHFT team. The survey revealed that the Trust demonstrated no significant difference in 16 questions that had been posed in the 2010 survey. However, compared to other Trusts, HUHFT was significantly worse in 14 questions. The midwifery team has completed an action plan, which is available and therefore this will not be considered further as it is outside the scope of this report.

Statutory Supervision

The manner in which Statutory Supervision has been enacted within HUHFT was assessed. The last two Local Supervising Authority (LSA) annual audit reports from 18th April 2012 and 18th April 2013 were reviewed and both the Contact Supervisor and the LSAMO shared information openly when requested and made themselves accessible to the review team.

There are twelve Supervisor of Midwives (SoMs) at the Trust (including the HoM). Two of those SoMs were on leave of absence at the time of the review. There is a high ratio of supervisees to supervisors of midwives. The LSA recommended ratio is 1: 15 (NMC 2012). The SoMs at HUHFT have been working to a ratio of 1:22. In order to mitigate against this, in the 2013 annual audit, the LSAMO suggested the appointment of a full time SoM. The Trust recruited an external SoM following the LSA annual review in April 2013, who carries a case load of 15 midwives, reducing the ratio to 1:17. A further reduction in the ratio is being planned, as one midwife is in the process of undertaking the POSOM programme and funding has been secured for three further student supervisor of midwives in April 2014. A business case to appoint a full time SoM is currently under consideration. SoMs are selected as recommended by the LSAMO forum with self or peer nomination and a ballot process. There are currently no supervisory investigations in progress at HUHFT; however, one SoM is supporting another Trust in a SoM investigation. Given the low numbers of SoMs at HUHFT currently, this could be considered inappropriate.

The Contact Supervisor confirmed that seven SoMs had completed root cause analysis (RCA) training and seven had completed the LSA Fitness to Practice Master Class. SoMs attend round table meetings, which form part of RCA analysis, and SoMs use 'Guideline P' (an investigation decision tool for supervision in midwifery) to decide whether an investigation is required. This is an example of good practice.

The review team had intended to undertake an anonymous survey of midwives to gain the midwives views of the maternity services and the Trust. However, having prepared an on-line survey ready for use the team was informed that an anonymous survey had already been completed around statutory supervision. The final report is awaited.

The Contact SoM stated that the supervisory team has "a very open relationship with the LSAMO" and this was corroborated by the LSAMO, who also described the culture of supervision within the HUHFT as "supportive but limited due to the current ratios". There have been no issues raised through the supervisory process around staffing issues, bullying or harassment, but the Contact SoM advised that the survey of staff should identify any issues. The reviewers noted that the process for tracking individual members of staff who may be involved in more than one incident should be reviewed and that there needs to be a robust follow through of the supervisory process. An increase in the number of SoMs would go some way to addressing this issue.

LSA Annual Audit

The review team accessed the LSA annual reports and contacted the LSAMO, who described the team as, “small but motivated and committed”, and stated that recommendations had been made for the reduction in the supervisor to supervisee ratio, particularly by employing a full time SoM, as other London hospitals have done. The LSA commented that the SoMs should work more closely with the Maternity Risk team to ensure that midwives are aware of the difference between supervisory investigations and risk management investigations.

Recommendations in this section:

- SoMs should work more closely with the Maternity Risk team to ensure that midwives are aware of the difference between supervisory investigations and risk management investigations (recommendation made by LSAMO in the annual audit), however minutes of the Supervisors of Midwives meetings demonstrate that this has commenced and therefore should continue to strengthen.
- The number of SoMs needs to be increased as a matter of urgency. Although three POSOMs commenced the programme on 1st April. This will not address the high SoM to supervisee ratio until late 2014.
- In April 2013 the LSA recommended that a full time supervisor should be appointed. This should be done as a matter of urgency to ensure effective supervision.
- The SoMs at HUHFT should not be involved in external supervisory reviews until such time that the ratios are at least 1:15.

Identification of specific incidents

The review team attempted to identify specific incidents that had been outlined by Angela Cartwright. The Trust Chief Nurse / Director of Governance undertook a review of the cases highlighted by the Angela Cartwright in August 2013 to determine whether there had been a robust investigation and to assess the internal process for investigating the cases. The report commissioned by the Chief Nurse contained comments from one of the Trust Consultants who stated, "I can confirm that all the cases have been properly and fairly investigated, appropriate conclusions drawn and appropriate steps taken to improve patient safety". They further stated that, "I can find no evidence of racial discrimination in the way the cases have been handled".

Angela Cartwright made a number of allegations in her correspondences. Although Angela Cartwright did not give patient identifiable information, the review team was able to match DATIX reports to the scenarios described in Angela Cartwright's allegations from the description of alleged incidents and staff named. At the meeting with the intermediary the reviewers went through each allegation with the intermediary to confirm the accuracy of the correspondence and to give the intermediary an opportunity to give further evidence to uphold or strengthen the allegation. No further evidence has been submitted.

The review team investigated each case in detail and reached conclusions on the care provided and on any wider lessons. As the review of each case involved patient identifiable and clinical information the individual case conclusions have not been included in this version of the report. They have however been shared with the Chief Nurse and Medical Director of HUHFT.

In total 11 allegations about clinical care were identified and investigated and a further 1 allegation could not be identified.

27 allegations relating to staff / recruitment and selection issues were made – 11 of these were able to be identified and were investigated.

There were two maternal deaths during 2013 and these were reviewed by the Consultant Obstetrician who was part of the review team. These maternal deaths were shared with the review team by the Trust even though they were outside of the original remit of the review, in the spirit of the Trust being open. The review team was reasonably confident that management throughout pregnancy, postpartum and intensive care was consistent with standard obstetric practice and could not identify any major areas where practice could have been improved.

The conclusions and recommendations resulting from the review of the cases are detailed below:

- It was found that all the Datix reviewed had been investigated, but they did not include a round table discussion that involved all the relevant clinicians. It is essential that a clinician who has undergone training should chair all RCAs and that all clinicians involved in significant incidents (SIs) should be invited to participate. This will enable the team to identify the root causes but it would also serve as a debrief opportunity for the staff and enable them to contribute in the implementation and monitoring of action points.
- There was evidence that 125 people within the organisation have been trained to conduct RCAs (it is not clear if all of the staff are still employed by the Trust). Of these, eight are midwives employed within the organisation and only five of those are reported to have undertaken investigations. The reviewers believe that an increase in these numbers will benefit the organisation.
- The quality of the person leading a RCA round table event cannot be underestimated and robust training and support in conducting the RCA is vital to elicit the facts and support those involved in an SI. During the course of the review the Risk Manager has given assurance that more staff are to be trained in leading RCAs and that these proceedings will be conducted in an open forum where staff will be able to voice their account of events. The reviewers have not observed the conduct of RCA meetings. There were no obstetricians identified on the RCA trained staff list. This should be addressed urgently as all of the comprehensive reports have involved a Consultant Obstetrician.
- In some of the Datix reviewed there appeared to have been a delay in conducting the investigation or in writing up the reports. The Clinical Risk Manager was aware of this issue and was taking action to address this issue.

Conclusion

The allegations made by Angela Cartwright suggested that there were failings in the care standards in the maternity unit of the HUHFT and that midwives and doctors who were being discriminated against on the grounds of race. The evidence suggests that there were no complaints made by staff to support these allegations. Indeed, only one individual felt sufficiently concerned to make a formal complaint. The review found evidence that policies are in place to enable staff to raise concerns formally without fear of reprisal.

The review was unable to substantiate any of the allegations made by Angela Cartwright. Two maternal deaths and numerous Datix, policies and records were reviewed which did not demonstrate any failings in the standard of care or evidence of racial discrimination.

The investigation and implementation of actions for the specific serious incident cases outlined by Angela Cartwright

An email was sent to Angela Cartwright inviting the group to attend a meeting with two members of the independent review team. The team set aside two days on the weekend of 26-27th October 2013 to accommodate the midwives and to assure them that their anonymity would be protected. Angela Cartwright contacted the team and agreed to meet through an intermediary that they needed to source before the meeting. Angela Cartwright contacted the review team on 27th October at 13.00 hours by email and informed the team that they had found an intermediary who would be able to attend at 17.00 hours.

During the course of the meeting the original allegations made by the midwives in the email dated 27th June 2012 formed the basis of the discussion. The intermediary was asked if they were aware of any further evidence that could substantiate the original allegations. The intermediary said that they would approach the Angela Cartwright to see if any further information was forthcoming.

The intermediary stated that the issue of racial discrimination was not to be considered by the review team as it was to be reviewed by another organisation. The intermediary was asked if they were happy that the independent review was being conducted appropriately. The response was positive and they confirmed that they had no further questions of the review team. The intermediary was unable to provide further information at the time of the interview and after three hours left the meeting. Throughout the meeting the intermediary handled their mobile phone. During the meeting the intermediary talked about their own personal circumstances. The intermediary informed the reviewers that at least eleven practitioners had been referred to the NMC. The intermediary provided no new information to the investigation.

The following day (28th October 2013) an email was received that had been sent at 03.36 hours to a number of individuals external to the case expressing concern over the qualifications and character of the reviewers. Angela Cartwright referred one of the reviewers to the regulatory body (Nursing and Midwifery Council).

The reviewers focused the investigation in an attempt to reveal any of the specific incidents highlighted by Angela Cartwright.

One of the allegations made by Angela Cartwright was that the Homerton does not have a robust system to link individual cases and identify and investigate any common issues or themes which emerge about either individual or clinical practice.

These cases were reviewed by the review team and their recommendations and conclusions are:

- The Homerton should put in place a system to identify and understand any common issues or themes across different incidents relating to either clinical or individual practice so that any necessary actions can be taken to address the issues raised and ensure that there is appropriate follow through of the supervisory process.

The culture within the maternity unit for reporting serious incidents and evidence of wider learning from the incidents.

The Risk Manager supplied the reviewers with all the Datix forms, statements and concise and comprehensive investigation reports requested. They have a good knowledge of the cases and their outcome and were able to provide information around the incidents. The progression in the investigations from 2009 to 2013 was evidenced in the way that the chronologies had improved along with the comprehensive investigation reports. The area that the reviewers felt was most lacking was in the setting up of round table multi professional meetings to share learning in order to implement robust action plans. The HUHFT team has embedded a 'Friday meeting' for the multi professional team to share and learn from cases, however this does not replace the RCA process for specific serious incidents (SIs). The Risk Manager was clear that table-top meetings with the multi professional teams had commenced in order to improve the management of SI's.

The process for investigations is via the Datix system and there is evidence that it is widely used. The three levels of RCA investigation guidance has been implemented and used within the maternity service which is good practice. However, between 2009 and 2013 there is evidence that demonstrates that incidents occurred, the guidance was followed, but the cases were not referred to management or supervision for further scrutiny that may have enabled the service to detect themes with incidents or individuals involved.

In many organisations there are Corporate Significant Incident Group meetings that include Chief Executives who review SIs and ensure that the investigations and reports are robust and complete. The process ensures that all action plans have a nominated lead to implement them in a timely manner and to review completed action plans to ensure that the loop is closed. It may also reveal themes and patterns that may not be easily discerned when the incidents are reviewed by a number of different individuals.

Recommendation:

The Trust should consider the development of a Corporate Significant Incident Group or similar meeting to review all SIs and to ensure that a nominated lead implements and reviews the action plan in a timely manner.

Trust policies and the handling of the original case.

In June 2012 the CEO took on board the allegation made by Angela Cartwright and asked for an internal review. The internal group was unable to uphold the allegations made. Once midwives had been named within the allegations it would have been appropriate to inform the individuals. This may have reduced the stress amongst staff in 2013 when they were eventually informed.

The newly appointed Chief Nurse reviewed the SI investigation process in August 2013. The review concluded that the investigations were generally carried out in a robust and thorough manner using recognised tools. In the main, the reviewers found that the majority of the previous investigations were robust. However, further scrutiny by the external team into some cases demonstrated that there have been issues that could have been addressed more thoroughly. It would have been more appropriate had Angela Cartwright reported the numerous allegations at the time of the incidents to enable contemporaneous investigation and action to occur if it had been found necessary. All registered practitioners have a duty to report any concerns or incidents as they occur for the safety of their patients and colleagues. The number of allegations rendered the review a lengthy and challenging process.

Selection and Recruitment

Angela Cartwright made several allegations in relation to the process involved in the selection and recruitment of staff. The team sought to review the policies and processes. The reviewers examined the allegations made as well as the appropriate policies and found:

- Robust selection and interview processes were undertaken. The HoM, a Consultant Obstetrician, Consultant Midwife and a HR Advisor interviewed candidates. A scoring system was applied and the successful candidate scored most favourably. The interview record forms give clear indication of the performance of each candidate.
- The Trust has a number of policies and procedures which support the employee relations environment. During the review a number of HR policies were examined which were found to offer clear advice to both managers and staff. However, it was noted that some policies were in draft format. The Trust need to determine a system to ensure that policies are updated and finalised in a timely manner.

Racial Discrimination

Angela Cartwright suggested that a culture of racial discrimination exists within HUHFT. Upon reviewing the senior midwifery team it was found that there are:

Band Seven Midwives

Midwives	Black (%) *	White (%)
Community (13)	55	45
Specialists (16)	50	50
Delivery Suite Co-coordinators (9)	55	45
Antenatal Clinic team leader (1)	-	100
Ward team leaders (2)	100	-

Band Eight Midwives

Midwives	Black (%)*	White (%)
Head of Midwifery	100	-
Others	45	55

* Black includes black African, black British, black Caribbean & Asian

The reviewers believe that the ethnic mix of midwifery staff at a senior level reflects the population that the HUHFT serves. Angela Cartwright cited over twenty black and minority ethnic midwives in the original allegations of June 2012. Only one individual raised a formal complaint but has since resigned their post from the Trust.

A bullying and harassment policy is available to staff. At the time of the review the policy was due for update and the content was appropriate. The HR department was able to advise that when policies are made available or are updated, they are announced at the team brief that is held monthly and then this information should then be cascaded to all teams within the Trust. When policies become available they are uploaded onto the intranet and staff receive an email informing them of the action.

Recommendations:

- There should be a mechanism to ensure that policies are updated in a timely manner.

Conclusion

Recruitment and selection processes were found to be robust and supported by clear policies. Staff members did not raise any complaints to substantiate a culture of poor care and discrimination.

Good Practice

The maternity unit at HUHFT demonstrated a number of good practices, which include:

- HUHFT has developed a home birth team that is separate to community midwifery and supports the choice agenda for women. The home birth team has been reconfigured and an audit of the team has been undertaken and action plan implemented.
- A birth rate plus assessment was undertaken in 2010 that confirmed a midwife to birth ratio of 1:29.
- When mothers are booked for a home birth they are offered the opportunity to 'Meet your Midwives'. The meetings have a number of benefits for the mothers and the midwives and allow for a full discussion of the care available to women and enables women to discuss any areas of anxiety.
- There is a team of specialists who are available to the team and mothers to support the care and a maternity helpline.
- SoMs use 'Guideline P' (an investigation decision tool for supervision in midwifery) to decide whether an investigation is required.
- The three levels of RCA investigation guidance have been implemented and used within the maternity service.

Conclusion

It is evident that the nature of the campaign conducted by Angela Cartwright has been widespread and of concern across the health economy. It has been a difficult time for all members of staff within the maternity services of HUHFT. The allegations made by Angela Cartwright were numerous, but due to the brevity of information it was difficult to investigate all of the allegations thoroughly. The meeting with the intermediary produced no further information to assist the review.

It was clear from the outset that the Trust Senior Management team understood the serious nature of the allegations. However, it would have given more assurance if parties external to the organisation had carried out the initial review. This may have concluded the situation earlier and decreased the upset and anxiety experienced by the staff. The HoM, the Risk Manager and Contact Supervisor of Midwives have acted with candour throughout the review and have assisted the proceedings by supplying all items of information and evidence requested in a timely manner.

The reviewers were keen not to cause further upset or disruption to the service and chose not to question staff, some of whom were unaware that their names had been circulated to the public. Staff who were met about the allegations reported that they did not recognise the allegations that had been made nor the culture of the maternity unit that had been described.

The allegations made by Angela Cartwright suggested that there were failings in the care standards in the maternity unit of the HUHFT and that midwives and doctors who were being discriminated against on the grounds of race. The evidence suggests that there were no complaints made by staff to support these allegations. Indeed, only one individual felt sufficiently concerned to make a formal complaint. The review found evidence that policies are in place to enable staff to raise concerns formally without fear of reprisal.

The review was unable to substantiate any of the allegations made by Angela Cartwright. Two maternal deaths and numerous Datix, policies and records were reviewed which did not demonstrate any failings in the standard of care or evidence of racial discrimination. Recruitment and selection processes were found to be robust and supported by clear policies. Staff members did not raise any complaints to substantiate a culture of poor care and discrimination.

There are some areas within HUHFT maternity services that should be improved as a result of the findings of the review in order to offer women and their families a more robust service. These include:

- SoMs should work more closely with the Maternity Risk team to ensure that midwives are aware of the difference between supervisory investigations and risk management investigations. Recent evidence demonstrates that this has already commenced and needs to be further strengthened.
- The numbers of SoMs need to be increased as a matter of urgency. Although three midwives commence the preparation of supervisor of midwives programme in April, this will not address the high SoM to supervisee ratio until late 2014. In April 2013 the LSA recommended that a full time supervisor

should be appointed. This should be done as a matter of urgency to ensure effective supervision.

- It was found that all Datix were investigated, but they did not include a round table discussion that involved all the relevant clinicians. It is essential that a clinician who has undergone training should chair all RCAs and that all clinicians involved in significant incidents (SIs) should be invited to participate. This will enable the team to identify the root causes but it would also serve as a debrief opportunity for the staff and enable them to contribute in the implementation and monitoring of action points. There is evidence that this has commenced and is being embedded in the maternity services.
- There is evidence that 125 people within the organisation have been trained to conduct RCAs (it is not clear if all of the staff are still employed by the Trust). Of these, eight are midwives employed within the organisation and only five of those are reported to have undertaken investigations. The reviewers believe that an increase in these numbers will benefit the organisation.
- The quality of the person leading a RCA round table event cannot be underestimated and robust training and support in conducting the RCA is vital to elicit the facts and support those involved in an SI. During the course of the review the Risk Manager has given assurance that more staff are to be trained in leading RCAs and that these proceedings will be conducted in an open forum where staff will be able to voice their account of events. There were no obstetricians identified on the RCA trained staff list. This should be addressed urgently as all of the comprehensive reports have involved a Consultant Obstetrician.
- The SoMs at HUHFT should not be involved in external supervisory reviews until such time that the ratios are at least 1:15.
- A robust system for supervision and risk management is essential in order to identify those staff who are involved in multiple serious incidents to give reassurance that practice is in line with national standards.
- In some of the Datix reviewed there appeared to have been a delay in conducting the investigation or in writing up the reports. The Clinical Risk Manager was aware of this issue and was taking action to address this issue.
- The Trust should put in place a system to identify and understand any common issues or themes across different incidents relating to either clinical or individual practice so that any necessary actions can be taken to address the issues raised and ensure that there is appropriate follow through of the supervisory process.
- The Trust has a number of policies and procedures that support the employee relations environment. During the review a number of HR policies were examined which were found to offer clear advice to both managers and staff. However, it was noted that some policies were in draft format. The Trust need to determine a system to ensure that policies are updated in a timely manner.
- In at least three cases that were reviewed the statements described missing equipment or inadequate rooms that could have an impact on the care provided. This issue should be addressed with immediate effect.

Homerton University Hospital NHS Foundation Trust Response to the Independent Review of HUHFT Maternity Services April 2014

Homerton University Hospital NHS Foundation Trust takes the raising of any concerns around the quality of its services very seriously. Although the Trust had already carried out two internal reviews covering this issue, the Trust welcomed the proposal by the Clinical Commissioning Group to undertake an external review. The review focussed on the issues and concerns raised by the anonymous group calling themselves “the unhappy midwives” and referred to in the review as “Angela Cartwright”.

The Trust has cooperated fully with the requirements of the review and in line with our principles of openness and transparency shared the results of the previous internal reviews as well as any details requested about the incidents, with the review team.

During the period over which these anonymous concerns have been raised (June 2012 onwards), the Trust has made considerable effort to contact the individual or individuals behind them in order to understand what assurance and response was required. This has never been successful.

The Trust is happy to see that the independent review was unable to substantiate any of the allegations made by “Angela Cartwright”. This is also the case with the CQC inspection report 2014 and the London Supervisor of Midwives review 2013. The CQC undertook a comprehensive inspection in February which included maternity services and the report was published on 22nd April 2014. As part of our continuing goal to improve the quality of care provided by our maternity service we will ensure that the recommendations of the review are given full consideration and action taken where it is required.

It is hoped that the publication of this report will finally allow the Trust to close this issue which has led to considerable strain on the maternity department and individual senior midwives and clinicians within it.

CCG Comment

The CCG has discussed with the Trust their detailed action plans in relation to each recommendation in the report and will continue to monitor the implementation plans.

The CCG is satisfied with the detailed actions and responses of the Trust to this report.

References

Ball J.A. & Washbrook (1996) Birthrate Plus; A Framework for Workforce Planning and Decision Making for Midwifery Services. Books for Midwives Press, Elsevier Press.

Department of Health (2007) Maternity matters: Choice, Services and the Continuity of Care in a Safe Service. DH, London.

Nursing and Midwifery Council (2012) Midwives Rules and Standards. Nursing and Midwifery Council. London.

Royal College of Obstetricians and Gynaecologists 2007 Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. RCOG Press at the Royal College of Obstetricians and Gynaecologists, London.

Appendix One - Terms of Reference for investigation into maternity concerns raised as a consequence of anonymous emails from the group known as “unhappy midwives” at the Homerton University Hospital NHS Foundation Trust

Context

Concerns were raised by the “unhappy midwives” via email to the Homerton University Hospital NHS Foundation Trust (HUHFT or ‘Trust’) in 2012. The concerns were fully investigated by the Trust. The “unhappy midwives” continued to raise concerns and about the investigation the Trust had undertaken. This first came to the attention of the commissioners in 2013. The NHS City and Hackney Clinical Commissioning Group (CH CCG), as lead commissioner has agreed with the Trust and the “unhappy midwives” to lead an independent investigation into the concerns raised.

The investigation

The investigation will be undertaken independently. An experienced midwife, accompanied by a second midwife, a human resources professional and an obstetrician are asked to investigate the issues raised by the Unhappy midwives campaign which may impact on the care of women and babies. The Terms of Reference for the investigation are outlined below and will be shared with the Trust and the “unhappy midwives”. The investigation is anticipated to commence in September 2013 and will be written up and shared with the stakeholders upon completion.

Terms of Reference

- To identify the specific serious incident cases from the information provided in the emails from the “unhappy midwives”;
- To review the reporting, investigation and implementation of actions associated with the specific serious incident cases outlined from the emails from the “unhappy midwives”;
- To review the reporting and management culture within the maternity unit for dealing with serious incidents, including process for investigation, discipline of tracking and completing actions and sharing wider learning from the incidents with staff;
- To make recommendations associated with addressing any improvement areas identified.

Other areas to consider including in investigation:

- Confirm how the Trust applied its policies and procedures in the handling of the original case.

Thursday 19th September 2013

Appendix two - Documentation reviewed and Contacts

Policies

- Access to Professional Education policy (Draft, due for review May 2014)
- Bullying and Harassment policy (Due for Review March 2012)
- Flexible Working policy (due for Review March 2012)
- Performance and Appraisal policy (due for review July 2015)
- Recruitment and Selection policy (due for review July 2015)
- Serious Incidents/Root Cause Analysis Investigations policy (due for review October 2015)

Documents and reports

- Birthrate Plus, Evidence based rations for Midwifery Workforce Planning. Homerton University Hospital Foundation Trust April 2010
- Care Quality Commission Inspection Report (April 2013)
- Interview Record Form for Band 8A Delivery Suite Matron 2nd November – 12th November 2010
- Interview Agenda for Band 7 posts in March 2012 and Band 7 job description
- Interview and candidate responses for Band 7 posts
- Local Supervising Authority. Annual Audit Report Monitoring the Standards of Supervision & Midwifery Practice. The Homerton Hospitals NHS Foundation Trust. 18th April 2012 Maternity Investigation status report (SI &RCA) 20/7/12
- Local Supervising Authority. Annual Audit Report Monitoring the Standards of Supervision & Midwifery Practice. The Homerton Hospitals NHS Foundation Trust. 18th April 2013
- Minutes of Supervisors of midwives meetings 20/7/12. 15/6/12
- Project 1014/133 Home birth audit and reconfiguration
- Maternity Services approved staffing levels, contingency planning, closure of the unit
- Notes of Matrons Meeting – 7/10/2013
- Panel responses and scoring for Band 7 posts in March 2012
- The Picker Institute Europe – Making Patients Views Count Maternity Survey 2013
- HUHFT Supervision of Midwives Survey 2013

Contacts

- Chief Nurse, Homerton University Hospital NHS Foundation Trust
- Contact Supervisor of Midwives, Homerton University Hospital NHS Foundation Trust
- Clinical Risk Manager, Homerton University Hospitals NHS Foundation Trust
- City and Hackney Clinical Commissioning Group
- Head of Employee Relations, Homerton University Hospital NHS Foundation Trust
- Head of Midwifery, Homerton University Hospital NHS Foundation Trust
- Intermediary acting on behalf of Angela Cartwright
- Local Supervisory Authority Midwifery Officer (London)