Gloucestershire Hospitals
NHS Foundation Trust

1. BBC Panorama documentary on maternity services

Background

A BBC Panorama documentary was broadcast on Monday 29 January, which focused on the Trust's maternity services. The programme included three very tragic deaths of a mother and two babies in our hospitals, as well as exploring the national and local challenge in recruitment and staffing. The documentary also focused on the impact on staff experience, where some staff felt unable to speak up about safety concerns or felt that they were not listed to, particularly in relation to the two baby deaths in 2019 and 2020.

Our maternity services continue to go through a transformation process and as a Trust we are determined to learn and change when things go wrong. The tragic cases highlighted took place between 2019 to 2021 and each one was independently investigated. As a result of those investigations, and the Care Quality Commission's (CQC) inspections, we have already made significant improvements to our maternity services.

The Trust's response

The Panorama programme made for very difficult viewing and the Trust has reiterated its apology for failings experienced by those individuals who suffered tragic losses while in our care.

What would be different if you received care today?

The Trust understands that expectant mothers, family members and the community more broadly may be anxious following the broadcast of Panorama. However, the Trust have made extensive changes and improvements over the last 18 months or so as part of the wider journey of improvement underway. Service users are safe in the hands of the Trust's highly skilled midwives and obstetricians. Some of the changes and the care that you would expect today includes:

- A new and expanded senior leadership team
- The Trust have increased the number of midwives and doctors into the service to support women and babies
- Worked with staff to focus on patient safety, learning and continuous improvement
- Introduced a new consultant midwife role, strengthening midwifery oversight of midwifery-led care
- Ongoing recruiting and retention programme to reduce vacancies and turnover
- Introduced a 'Place of birth risk assessment' to prevent delays in accessing urgent care if required

- Three daily safety briefings to review staffing, workload and labour inductions - ensuring concerns are addressed immediately
- Strengthened our internal Freedom to Speak Up service
- Provided a range of support for staff, including wellbeing and psychological services, peer to peer networks, and safety champions.

The changes made in maternity services have been driven by staff, working closely with families and communities, to ensure everyone has a voice so that the best and safest care is provided.

Staffing levels and continued investment in midwifery

Since April 2020, the Trust has invested an additional £1.8 million to increase maternity staffing, including obstetricians, consultants, administration support and the number of midwives working in the department has increased from 242.99 (2020) to 263.77 (December 2023). Between September and December 2023, the Trust welcomed 19 new midwives into the service, this is reflected within the December 2023 figure (offset by staff leaving the service – primarily for career development).

Across the whole of maternity services there has been additional recruitment and in April 2020 there were 389.84 whole-time equivalent (wte) contracted staff in post, which has increased to 430.73wte by November 2023. The Trust expects to have 271.1 midwives in post by July 2024, based on new starters and prediction around leavers and international recruits.

The vacancy rate for clinically delivering midwives in the Trust has dropped from 15% in the summer 2023 to 7.85% December 2023. With our continued focus on recruitment and retention of midwives we predict that this vacancy rate will reduce to 5.3% by July 2024.

Since April 2020, two additional obstetric consultant roles have been established. There are a further three obstetricians joining the service between April 2024 and August 2024.

MBRRACE: Maternal death rates

As part of the documentary the BBC claimed that the Trust had a maternal death rate that was twice the national average. That was not correct and something that the national experts in maternal and neonatal deaths at Oxford University (MBRRACE) and the Local Maternity and Neonatal System, independently reviewed. They are clear that the data for Gloucestershire is in line with the national average and was not statistically significantly different from the UK rate.

MBRRACE also issued a statement as they were concerned about how the data was being interpreted and noted that “trends in maternal death rates would not be apparent with small amounts of data covering shorter periods of time, or covering individual hospitals or regions”. MBRRACE Statement on Maternal Death Data

Next steps

The Trust is committed to learning from the tragic cases and will be engaging with the Maternity Improvement Advisor from NHSE and system partners to commission an external party comprising clinicians to look at the mortality issues raised to offer a further deep dive and objective review. How we respond to issues of safety at the department and at the wider Trust level is an important lesson for all of our services. The Trust must develop an open and listening culture that supports staff to speak up and be listened to on issues of patient safety.

Running parallel to this but not directly linked is a Local Maternity and Neonatal System (LMNS) review led by the new Chief Nursing Officer of the Integrated Care Board and Chair of the LMNS, Marie Crofts. In particular the review will look at key priorities, transformational work and action plans currently underway to ensure these are aligned to strategic priorities.

Conclusion

The Trust is deeply sorry that failings in its care led to these tragic deaths and how devastating this has been for those families. We are determined to learn and change when things go wrong. While significant improvements have been made, in commissioning a further review of maternal and neonatal deaths we will enhance the Trust's understanding which will help inform and strengthen the safety culture and ways of working.

2. National Maternity Survey

The Care Quality Commission (CQC) published results of its national maternity survey last month (February). The national survey highlights women's and families' views on all aspects of their maternity care from the first time they see a clinician or midwife, through to the care provided at home in the weeks following the arrival of their baby.

The survey took place in February 2023 and asked women about their experiences of care at three different stages of their maternity journey – antenatal care, labour and birth and postnatal care – and 230 people who accessed maternity care at Gloucestershire Hospitals took part.

The Trust was rated particularly highly for the following areas:

- Partners or someone else involved in the service user's care were able to stay with them as much as they wanted during their stay in the hospital
- Women and birthing people could see or speak to a midwife as much as they wanted during their care after birth
- During antenatal check-ups, people were given enough information from either a midwife or doctor to help decide where to have their baby

- Women and their supporters were not left alone by midwives or doctors at times when it worried them during labour and birth
- People felt that if they raised a concern during labour and birth, it was taken seriously.

Meanwhile, the Trust was rated less highly for the following areas:

- Being given appropriate information and advice on the risks associated with an induced labour, before being induced
- Being provided with relevant information, support and advice about feeding their baby, both during pregnancy and after the birth of their baby.

The Trust welcomes the annual CQC Maternity Survey as it enables independent feedback about where the service users think outstanding care is being provided, and areas in which improvement is required.

The full results for England are available on the CQC website.

3. Stroud Maternity Unit & Aveta Birthing Unit

3.1 Stroud Maternity Unit

The Trust's Chief Executive Officer, Kevin McNamara, met with Parliamentary Under Secretary, Maria Caulfield, Stroud MP, Siobhan Bailey, Chairman of the Health Scrutiny Committee, Cllr Andrew Gravells as well as senior representatives from the Care Quality Commission (CQC) and the Nursing and Midwifery Council (NMC) to discuss the ongoing temporary closure of postnatal beds at Stroud Maternity Unit (SMU).

The six postnatal beds have been closed since September 2022 and midwifery staff have been centralised at the Gloucestershire Royal Hospital to ensure safe staffing levels, and, in particular, one-to-one care in labour and birth.

The Trust welcomed the opportunity to meet with key partners as part of a constructive meeting to discuss the challenges facing maternity services and although good progress has been made in terms of recruitment, there is still more to do to ensure safe staffing levels are achieved to enable the reopening of post-natal beds in Stroud.

The Trust continues to work openly with partners as well as staff on long-term, sustainable solutions.

3.2 Aveta Birthing Unit

To ensure safe staffing levels the Trust temporarily closed the Aveta Birth Unit at Cheltenham to

labour and new births in 2022. This has enabled maternity services to centralise midwives at the Gloucestershire Royal Hospital and to ensure one-to-one care, a key safety standard, in labour and new births. The Trust has seen the benefit of this approach with the CQC acknowledging that 99% of new births now receive this kind of care and there's a determination to achieve 100%.

The Trust continues to successfully recruit new midwives and obstetricians to the service and this has been linked to further service improvements.

As a result, the Trust continues to work closely with system partners on how service provision can be re-opened safely in the future in Cheltenham and Stroud.