Homerton University Hospital NHS
NHS Foundation Trust

Homerton University Hospital NHS Foundation Trust
Hackney College
Defoe Building, Room 10
50 Hoxton street
N1 6LP

2nd December 2015

Dear Sir/Madam,

Ref: FOI 2132

Thank you for your recent Freedom of Information follow-up request and associated queries regarding the Trust's Maternity service and Equality & Safety monitoring.

The Trust can provide the following information:

1. Race Equality assessment

I am concerned to hear that the Trust has not carried out any structured Equality Assessment of its maternity services since 2012. This is despite whistleblowers raising very serious concerns of harmful racial discrimination against both staff and patients. I do not understand how the Trust made claims that it investigated these concerns and found no evidence of racial discrimination, if no structured assessment of all the facts had taken place.

Please disclose any past reports about Race Equality in Homerton maternity services, including any external feedback. I understand that at least one organisation was engaged to address Race concerns prior to 2012.

Please disclose if the Trust has benchmarked the clinical outcomes in its maternity services against comparator trusts with similarly diverse and deprived populations.

Please disclose the reports and results of any such benchmarking exercise, and please disclose which comparator Trusts were referenced.

We are unclear what you mean by an Equality Assessment. Our policies have an Equality Impact Assessment when they are adopted. We are also not clear which concerns you are referring to. The allegations of racism raised by the 'Unhappy Midwives' were considered by the investigation commissioned by City and Hackney CCG and found to be unwarranted. We are not aware of any organisation 'engaged to address Race concerns'. The Trust's clinical outcomes are benchmarked in the annual Embrace report, which is in the public domain.

2. Identifying Links Between Serious Incidents

The Trust has declined an analysis of whether serious incidents have clustered around individual staff, and the ethnicity of such

staff, on grounds of cost exemption.

This implies that the Trust has not fully investigated:

• The Unhappy Midwives' concerns that serious incidents were clustering around particular staff.

• The Unhappy Midwives' concerns that white staff were preferentially treated, were less likely to be held to account for unsafe practice and thus continued to cause further patient harm.

Of concern is the fact that the Trust has been repeatedly advised to proactively search for links between serious incidents, both by the CCG's 2013 review of Homerton maternity services, and most recently by the CQC.

The CCG review report stated:

"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 17 August 2015 CQC inspection report of Homerton maternity specifically advised HUHFT to review the staff involved in incidents, as a potential common factor:

"All five maternal deaths had been or were in progress of being investigated and action plans developed. Investigations looked at individual deaths and there had been no mapping of the deaths, to consider whether time of day, day of the week, staff involved, agency/ locum usage, number of staff on duty, equipment used or other factors had been a consideration of potential impact. While it was noted that the action plans developed had elements of crossover they had not been merged to form one unified action plan"

It seems to me that instead of declining to carry out an analysis now on grounds of cost, the Trust ought to have carried out the requested analysis long ago for reasons of patient safety and Safeguarding.

I also understand that as HUHFT operates the DATIX incident reporting system, searching for staff linked to incident clusters should not be an onerous task.

I am concerned that the Trust is resisting analysis. I ask you to review this for the sake of patients and transparency, and I ask that an analysis is carried out.

The Trust has reviewed 5 maternal deaths since 2013—.There were no common themes of the same individual members of staff directly involved in the care of the five women, except very senior staff who were in a couple of cases called to provide further advice. The Trust has strengthened the process for recording the identity of all staff involved in incidents. We have reviewed this element of your request further with regard to mapping staff names against all previous serious maternity incidents recorded on Datix. Whilst we do use the Datix system to record all serious incidents, until recently, the identities of staff involved in a serious incident were not systematically uploaded onto Datix. Consequently, to provide this data would require reviewing and reinvestigating each individual incident to attempt to identify those staff who had been involved.

The cost of locating, retrieving and extracting the requested information would greatly exceed the current cost limit under section 12 of the Freedom of Information act, currently set at £450, and we are therefore applying this exemption. More importantly, this would be logistically extremely difficult and time-consuming and would take an enormous amount of staff time away from direct clinical care.

3. Full Capture of Data on Deaths

There have been concerns that there were more than 5 Homerton maternal deaths, because Homerton maternity patients may have been taken to other hospitals.

It is relevant to note that CQC recently reported that it found not all incidents in Homerton maternity were reported.

Please could the Trust advise what mechanisms it has for establishing whether any maternity patients under Homerton's care have died in the community or at other hospitals.

When a maternal death (ie the death of a woman within 12 months after delivery) occurs in another hospital the hospital providing care for the patient would communicate the death to the organisation where the mother gave birth, as occurred in two of the five maternal deaths. There is an expectation that Homerton would be notified of the death of any mother or mother-to-be by the hospital where the woman had been treated.

Where there is the death of a Homerton mother in the community (ie at home), Homerton may be contacted by the Coroner or external bodies, for example the CCG, regarding the death.

Irrespective of where the information regarding the maternal death comes from, the Trust's incident management process is followed. This includes the logging of the incident on the Trust's electronic incident management system, Datix, the holding of

a Serious Incident Review Meeting to establish the facts and level of investigation required.

4. Ethnicity Breakdown on Deaths

The Trust has given me combined figures for the ethnicity of all the patients who died.

Please provide separate ethnicity breakdowns for both maternal deaths and baby deaths.

Please refer to the below table.

Ethnicity - Maternal & Neonatal Deaths 2012 to 2015	Neonatal	Maternal
Asian or Asian British Indian	1	0
Asian or Asian British Pakistani	0	1
Black or Black British African	6	1
Black or Black British Caribbean	0	3
Black or Black British Other	1	0
White British	3	1
White Other	4	0

5. Reporting and investigation of an incident flagged by the Unhappy Midwives

I understand that the Unhappy Midwives raised a specific concern that a mother suffered a subarachnoid haemorrhage (a very serious form of stroke) that they believed was due to poor management of the patient's high blood pressure by a white midwife. It is not clear to me if this stroke was counted in the list of serious incidents that has been supplied by HUHFT.

Please advise whether this reported incident of stroke is included in the data.

Please advise if the Unhappy Midwives' concerns about this incident were investigated.

Due to the personal sensitive nature of the above question, we have applied an exemption under section 41 of the Freedom of Information Act, (Information provided in confidence) and is applicable whereby the person providing the information would have a reasonable expectation to that information being kept confidential.

Furthermore, under section 41(1)(b) of the Freedom of Information Act, releasing this information would constitute an actionable breach of confidence and result in a potential claim being made against the Trust.

If you have any queries about this response please contact the information governance manager at foi@homerton.nhs.uk , in the first instance. If, following that, you still have any concerns, you may contact the Information Commissioner either by letter, FOI/EIR Complaints resolution, Wycliffe House, Water Lane, Wilmslow, Cheshire SM9 5AF, or by email www.informationcommissioner.gov.uk to take them further.

Yours sincerely

Mike Dunne
Information Governance Manager/Deputy Calidcott Guardian