East Kent Hospitals Update for Health Overview and Scrutiny Committee

Maternity services

1 Introduction

1.1 As a result of concerns about our maternity service, NHS England and NHS Improvement have commissioned an independent review into the service. The review will be led by Dr Bill Kirkup.

1.2 NHS England and NHS Improvement have also provided a package of support from the NHS Maternity Support Programme, which includes a team of national experts working alongside our maternity teams.

1.3 The Trust has also set up an externally-chaired Board sub-committee, chaired by consultant in Obstetrics and Gynaecology Mr Des Holden, to oversee seven key areas of work.

2 Background

2.1 In January this year, the inquest was held into the tragic death of baby Harry Richford. Baby Harry died in November 2017. The Trust wholeheartedly apologises for its failings in Harry's care and fully accepts the Coroner's conclusion and recommendations.

2.2 Since the inquest further families have raised concerns. The Trust is taking these concerns extremely seriously and has apologised to all those families for whom we could have done things differently. While a number of changes have been made to our service over recent years, we recognise that the scale of change needed in our maternity service has not taken place quickly enough.

2.3 In February 2020 the minister for patient safety, Nadine Dorries MP, asked both the CQC and the Healthcare Safety Investigation Branch (the organisation that investigates maternity incidents in all NHS Trusts) to provide a report on the Trust's maternity service.

2.4 Following these reports, Nadine Dorries announced that NHS England and NHS Improvement are commissioning an independent review. This review will provide an independent look-back, in partnership with affected families, of potentially avoidable or preventable deaths of babies in east Kent and will be led by Dr Bill Kirkup.

2.5 England's Chief Midwifery Officer, Jacqueline Dunkley-Bent, and the Regional Chief Nurse, have visited east Kent in recent weeks to provide assurance about the service we are providing now.

2.6 The Trust has already implemented a number of actions to improve safety. It has created and filled several specialist midwife posts. Safety huddles, where safety issues are regularly and frequently discussed, have been embedded across the Trust to anticipate problems before they occur, and multi-disciplinary teams work collaboratively and effectively within these huddles. And a protocol is in place to ensure that fetal heart rate recording is subject to a 'fresh eyes' check by another member of staff.

2.7 The Trust has also developed its approach to working with families in the sad case of a death, to ensure that it always provides a point of contact and that it includes and involves families in its investigations of these incidents, from the moment a serious incident occurs.

3. Timeline

3.1 In 2015, the Trust commissioned the Royal College of Obstetricians and Gynaecologists to review maternity services. In 2016, the Trust received this report, which identified areas of concerns and made a number of recommendations for action. The Trust began a number of changes to improve the safety and experience of women and their families, which included:

- Adding more consultants, auditing senior clinician oversight of births at our hospitals and increasing the hours some consultants worked
- New standards for obstetric care on our labour wards
- Comprehensive training for all maternity staff on identifying and safely supporting difficult births
- Investing in more maternity and neonatal equipment.

3.2 In 2017, the maternity team launched an improvement programme called BESTT (Birthing Excellence Success Through Teamwork), through which staff work with women to continuously improve maternity services. This has led to improvements such as fetal monitoring and obstetrics emergency training and the introduction of bereavement midwives and bereavement suites in both hospital sites.

3.3 The Trust's initial investigation into the death of Harry Richford, and subsequent independent reviews commissioned in 2018 by the new Head of Midwifery, found that further changes needed to be made to the maternity service. Since that time the service has:

- Implemented a more comprehensive way of monitoring babies' heart rate during labour, in line with best practice
- Improved the way we recruit, assess, support and supervise our temporary / locum doctors
- Put a comprehensive training programme in place for staff involved in identifying and safely supporting difficult births, including neonatal resuscitation and complex caesarean sections, including simulation training, plus training to improve communication, team working, recognising when a patient is deteriorating and escalation to senior clinicians

- Fully implemented labour ward safety huddles – whole team conversations focused on patients and care priorities - that take place four times a day, every day of the week
- Strengthened the leadership in midwifery, in addition to the new Head of Midwifery appointed in 2018 supported by two site-based deputies; a new clinical lead for obstetrics was appointed in 2019 supported by new site-based leads.
- Introduction of physiology–based cardiotocographic (CTG) interpretation and improved focus based on the best practice St Georges' Model.

3.4 The Trust also restructured the service in 2018 into a clinically led service to provide more senior clinical support and oversight of the service.

4. What is happening next

4.1 The Trust welcomes the independent review being led by Dr Bill Kirkup, and we continue to work with the Care Quality Commission, the Healthcare Safety Investigation Branch, NHS England and NHS Improvement to improve services for families in East Kent.

4.2 Collaboration with the NHS Maternity Support Programme, which includes support from a Director of Midwifery from a Trust rated 'Outstanding' by the CQC; consultant obstetricians and consultant paediatricians, one specialising in neonatology, is supporting our teams to make rapid and sustainable improvements to our service.

4.3 A new Trust board sub-committee, chaired by Mr Des Holden, is overseeing seven task and finish groups that will:

- Review the Royal College of Obstetricians and Gynaecologists report undertaken in 2015;
- Review the BESTT programme;
- Establish a process to implement, embed and assure the Coroner's recommendations;
- Carry out a review of obstetric and paediatric medical job plans;
- Carry out a review of Serious Incidents and investigations and their actions
- Review data available on our maternity services
- Review Paediatric Emergency Department oversight.

4.4 The practical changes in our maternity service continue. For example we have implemented centralised CTG monitoring, which will allow continuous fetal monitoring to be displayed on monitors in the labour wards' midwifery stations and viewed by consultants elsewhere in the hospital or on call at home. This means staff can immediately be alerted to a potential problem and on call doctors will be able to provide expert opinion straight away, wherever they are.

4.5 We are also recruiting six more consultants to extend and further improve the presence on our labour wards.

4.6 The CQC undertook an unannounced inspection of the maternity service in January 2020. The initial feedback to the Trust has been discussed at the Trust's Board of Directors public meeting and is available on the Trust's website. The full report is expected in the Spring.

5. Conclusion

5.1 East Kent Hospitals University NHS Foundation Trust recognises that in recent years it has let down a number of families and has not always delivered the high-quality maternity care that local residents have a right to expect. We apologise unreservedly for our failings in this respect and we are determined to improve our maternity service in the weeks and months ahead.

5.2 We have already made a number of improvements in our maternity service. However, we absolutely recognise the need to do more and the need to make further improvements as rapidly as possible.

5.3 The Trust has made clear that it welcomes the support it is currently receiving from a number of independent, senior, maternity clinicians from outside of East Kent and it welcomes too the independent review being undertaken by Dr Bill Kirkup.

5.4 The Trust Board is determined that working together with the executive leadership, Trust clinicians and external advisers, it must and will ensure the development of a maternity service that our local residents and our local representatives can all be truly proud of.

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