Direct Dial/Ext: 03000 416512
e-mail: kay.goldsmith@kent.gov.uk
Ask for: Kay Goldsmith
Date: 20 July 2020

Dear Member

HEALTH OVERVIEW AND SCRUTINY COMMITTEE - WEDNESDAY, 22 JULY 2020

I enclose, for consideration at the Wednesday, 22 July 2020 meeting of the Health Overview and Scrutiny Committee, the following report that that has been updated since the agenda was printed. For ease of reference, the updated section is under heading 5 "Learning & Review Committee." The rest of the report is as previously published.

Agenda Item No

12 **East Kent Hospitals University NHS Foundation Trust - Maternity Services (written item)** **(Pages 1 - 4)**

Yours sincerely

Benjamin Watts
General Counsel

This page is intentionally left blank

East Kent Hospitals Update for Health Overview and Scrutiny Committee

Maternity Services Update

1. Care Quality Commission Inspection

1.1 The Care Quality Commission carried out an unannounced inspection of maternity services at Queen Elizabeth The Queen Mother Hospital, Margate, and William Harvey Hospital, Ashford, on 22 and 23 January 2020, along with a further unannounced visit to the hospitals on 4 and 5 February 2020.

1.2 The CQC rated East Kent Hospitals' maternity service as 'good' for effectiveness, care and responsiveness and 'requires improvement' for leadership and safety.

1.3 The maternity service retained its rating as 'requires improvement' overall, while the service at Queen Elizabeth The Queen Mother Hospital, Margate, was upgraded to 'good' for 'Responsive', which means services are organised in a way that meets women's needs.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

1.4 The CQC inspections took place after concerns were raised about the safety of maternity services at the Trust, including the inquest this January into the death of baby Harry Richford, who died at Queen Elizabeth The Queen Mother Hospital in 2017, and a number of families coming forward.

1.5 The CQC's said the Trust:

- Implemented processes to make sure patient safety was at the centre of women's care.
- Provided care and treatment based on national guidance and evidence-based practice.
- Following the investigations into serious incidents found the maternity service implemented learning to improve safety for women and babies.
- And the head of midwifery and senior maternity leadership had strengthened the way in which they communicated incidents with families following serious incidents.

1.6 However, the CQC cited a number of areas requiring improvement and issued two Requirement Notices, relating to improvements needed with regard to the governance and the provision of the safe care and treatment.

1.7 The areas requiring improvement were primarily in the hospital's new antenatal triage and day care services used to assess and monitor women experiencing pain or symptoms from 16 weeks of pregnancy.

2. Action taken

2.1 The CQC gives immediate feedback following inspections, so that areas needing improvement can be addressed without delay. Action the Trust has taken against specific areas in the CQC's findings include:

2.2 Standard operating procedures within the new antenatal triage service, including guidelines for risk assessment and escalation - the CQC found these were not always followed within the triage service, which meant the necessary care and treatment were not always identified quickly. The CQC found these guidelines were being followed on the hospitals' labour and post-labour wards. The CQC found staff in day care did not always report incidents, which meant managers could be unaware of avoidable events on the unit.

- Since the CQC's inspection, the service has begun using the nationally-recommended safety communication system called 'Situation, Background, Assessment and Recommendation' (SBAR) for all women presenting to triage. The Trust has also recently appointed a Maternity Governance Lead to co-ordinate the review and improvement of the service's internal governance processes and improve reporting of incidents.

2.3 Antenatal documentation – this was not always clear or up-to-date, because 50% of records were stored digitally and 50% were hand written. The CQC found documentation was well kept and detailed on the labour and post-labour wards.

- The Trust is investing in the Maternity Information System, which is supplied by an external provider, so the Trust can begin using further digital recording throughout pregnancy and birth as soon as the technology becomes available.

2.4 Long waits and limited senior doctor cover in the hospitals' antenatal day care service.

- The Trust has since changed the midwifery rota to improve midwifery staffing levels in the antenatal triage and day care service and has increased the senior doctor presence throughout the day. Additional consultants have been recruited, which will ensure continued senior doctor presence.

- Since the CQC's inspection, the service has included all waiting times on the electronic patient records, reported them in the care group quality and risk report, and introduced a weekly review by a senior midwife.

2.5 At William Harvey Hospital, the inspection team found cleaning checks were out of date on some equipment in the antenatal and day care service. The cleaning checks are now being monitored regularly.

- Since 2017, many changes had been put in place within the maternity service, including a new leadership team, a staff training programme and new equipment. Following its inspection, the CQC recognised that leaders had improved the governance processes throughout the service with support from partner organisations. It found 'effective structures, systems and processes to support delivery of the maternity service'.

3. Areas highlighted as improvements, good or outstanding practice

3.1 The CQC found:

- Staff monitored the effectiveness of care and treatment and used their findings to make improvements and achieve good outcomes for women.

- Staff worked well together for the benefit of women.
- The Trust had reviewed its escalation process and implemented processes to make sure patient safety was at the centre of women's care, and safety huddles, on-call medics, and the centralised fetal monitoring system would ensure that escalation processes were strengthened.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

3.2 Improvements noted by the CQC following their previous inspection in 2018 included:

- Scanning all women at 36 weeks of pregnancy to reduce the incidence of birth complications, caesarean sections, breech birth and pre-term babies, in line with best practice
- Women receive one-to-one care during childbirth
- Midwifery staffing levels had improved and were safe and in line with national guidance
- Strengthened clinical leadership.

3.3 Inspectors also found areas of 'outstanding practice', including the Trust's state-of-the-art simulation training equipment, which allows all staff exposure to simulated 'real life' emergency situations for life-saving training, and providing wraps to help new mums give 'skin to skin' care when breastfeeding their babies.

You can read the reports in full on the Care Quality Commission website

4. Maternity Services Independent Investigation

4.1 In February 2020 the government health minister, Nadine Dorries MP, announced that NHS England and NHS Improvement were commissioning an independent investigation into the maternity and neonatal services provided by East Kent University NHS Foundation Trust. The investigation is being led by Dr Bill Kirkup and is expected to cover the period since 2009. Dr Kirkup expects to report in 2021.

4.2 A panel of clinical experts has been appointed to assist Dr Kirkup and an investigation support team is being put in place. The support team is being led by Mr Ken Sutton, Secretary to the investigation, and his assistant, Ann Ridley, both of whom have worked with Dr Kirkup previously.

4.3 Full details of the panel and support team are available on the investigation's website. Dr Bill Kirkup has started his investigation by meeting with families and a panel of experts. The panel is working with families to agree its terms of reference.

4.4 The Trust has welcomed this independent investigation and is doing everything it can to assist Dr Kirkup and his panel.

5. Learning and Review Committee

5.1 A Trust board sub-committee, chaired by a senior clinician external to the Trust, consultant in Obstetrics and Gynaecology Mr Des Holden, was set up by the Trust in February to oversee a number of task and finish groups.

5.2 These included to implement, embed and assure the Coroner's recommendations following the inquest of baby Harry Richford; to robustly scrutinise the Trust's response to the Royal College of Obstetricians and Gynaecologists (RCOG) report undertaken in 2015; reviewing the Trust's maternity improvement programme "BESTT"; and reviewing data available on maternity services in east Kent.

5.3 The Learning and Review Committee has been reporting to the Trust Board on a monthly basis and produced its final report to the Board in July.

5.4 The Chair of the Committee reported that all of the coroner's recommendations had or were being implemented.

5.5 However, in objectively and comprehensively examining the evidence, the committee felt there was not sufficient evidence available to demonstrate that each of the 23 recommendations in the RCOG report had been completed.

5.6 The review considered that 13 of the recommendations had been met or partially met, but that for 10 of the recommendations, there was insufficient evidence available to demonstrate that the recommendation had been delivered.

5.7 This robust approach, and close down, of the current 'discovery phase' of the work of the committee will enable the Trust to move to further implementation and embedding of the changes resulting from the task and finish groups.

5.7 The Chair of the committee has commissioned an integrated action plan to address the remaining tasks, themes and actions that require implementation. All the recommendations from the RCOG report, the CQC report and from elsewhere are being incorporated into this single Integrated Improvement Programme for maternity.

5.8 The implementation of this plan will be overseen by a working group chaired by a Non-Executive Director of the Trust as a demonstration of the Trust board's commitment to maternity improvement. Implementation will be monitored by the Trust's Quality Committee which reports in public to the Board of Directors.

5.4 The Trust Board is determined to ensure continuous improvement in maternity services and that it must and will ensure the delivery of a maternity service that our local residents and our local representatives can all be truly proud of.

July 2020