East Kent Hospitals Update for Health Overview and Scrutiny Committee

Maternity Services Update: September 2020

1. Introduction

1.1 The Trust takes concerns raised about the safety and quality of its maternity services extremely seriously. We recognise that we have not always provided the right standard of care to every woman and baby and we apologise unreservedly to families for whom we could have done things differently.

1.2 While a number of improvements have been made to the Trust's maternity service over recent years, we recognise the scale of change needed has not taken place quickly enough.

1.3 The Trust is taking all necessary steps to improve services and we are determined to provide an excellent standard of care to every mother and child who uses our maternity service. We will not rest until we, our patients, the public and our regulators are all confident we are doing so.

2. Care Quality Commission inspection

2.1 Following a Care Quality Commission (CQC) inspection of the Trust's maternity services in January, the service was rated as 'good' for effectiveness, care and responsiveness and 'requires improvement' for leadership and safety.

2.2 The service retained its rating as 'requires improvement' overall. 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.

2.3 The reports, published in May, found that the Trust had:

- 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,
- implemented learning to improve safety for women and babies following investigations into serious incidents found in maternity service, and
- strengthened the way in which the leadership team had communicated incidents with families following serious incidents.

2.4 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.

2.5 The areas requiring improvement were primarily in the new antenatal triage at QEQM Hospital and day care services at William Harvey Hospital which are used to assess and monitor women experiencing pain or symptoms from 16 weeks of pregnancy.

Action taken

2.6 Actions taken by the Trust include:

- improvements to standard operating procedures within the new antenatal triage service, including guidelines for risk assessment and escalation,
- introduction of a nationally recommended safety communication system called 'Situation, Background, Assessment and Recommendation' (SBAR) for all women presenting to triage,
- investing in the Maternity Information System so the service can use further digital recording throughout pregnancy and birth, and
- improved midwifery staffing and increased senior doctor throughout the day in the Antenatal day care service.

2.7 To date, 75% of the improvement actions within the Trust's action plan that responds to the CQC's visit have been completed, 11% are complete but awaiting formal provision of evidence, and 14% are in progress but are still within the planned timescales for delivery.

Areas highlighted as improvements, good or outstanding practice

2.8 The CQC highlighted the following improvements and areas of good or outstanding practice 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 practice to ensure that 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 had been strengthened, and
- the service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

2.9 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.

Recruitment

2.10 The Trust has successfully recruited four additional consultant obstetricians to QEQM Hospital and nine at William Harvey Hospital this year. This has enabled a significant increase in consultant presence on the labour wards, ensuring doctors have no other conflicting duties.

2.11 Consultant presence has been extended until 10pm on site at QEQM Hospital, with an on call from home overnight. Consultant presence has been extended to 24/7 on site at the William Harvey Hospital. This unit receives a greater number of births and takes the known complex deliveries due to the presence of the Neonatal Intensive Care Unit (NICU).

2.12 There has also been a significant expansion of senior midwifery roles and recruitment allowing extra experience and supernumerary oversight on both labour wards for more hours, and enhanced teaching in relation to fetal monitoring.

2.13 The Trust has also strengthened the clinical leadership of the service by creating a separate Clinical Director for Women's Health (previously combined with Children's Health) and made further investments in senior clinical leadership roles, including an additional site lead for obstetrics at each QEQM and William Harvey hospitals and governance roles.

3. Learning and Review Committee

3.1 A Trust board sub-committee, chaired by a senior clinician external to the Trust (Mr Des Holden, Consultant in Obstetrics and Gynaecology) was set up by the Trust in February in response to serious concerns raised about the quality and safety, and the experience of a number of families who had used maternity and neonatal services.

3.2 As part of its work, the Committee oversaw the following key areas of work:

- 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" in line with the Coroner's recommendations, and
- reviewing data available on maternity services in east Kent.

3.3 The Committee reported monthly to the Trust Board and produced its final report to the Board in July.

3.4 **Coroner's recommendations**: The Chair of the Committee reported that all of the Coroner's recommendations had or were being implemented. These changes significantly increase oversight of staffing, governance around training and competencies and team working within the labour ward environment. A new locum policy has been adopted by the Trust and its compliance will be audited.

3.5 **RCOG report**: The Committee took a robust approach to objectively and comprehensively examining the evidence, to determine if the recommendations had been met and sustained. The Committee felt there was not sufficient evidence available to demonstrate that all 23 recommendations in the report could be shown to have been completed. 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.

3.6 **BESTT Review**: The Birthing Excellence Success Through Teamwork (BESTT) improvement programme, launched in 2017, resulted in a significant investment into staffing, equipment, education, learning and digital innovation. Moving forward the BESTT Programme is focussed on developing and delivering a new maternity strategy, in line with the National Maternity Strategy (Better Births, 2017), the National Maternity Transformation Programme and the NHS Long Term Plan (2019).

3.7 **Data Review**: The Trust has commissioned Imperial College's Neonatal Research Group to undertake a review of the rate of neonatal encephalopathy at the Trust.

3.8 The Committee also considered whether the information presented to Trust Board and its sub-committees could be improved in relation to maternity and neonatal services to improve assurance on the safety and quality of the services.

3.9 NHS Digital and the National Clinical Director for Maternity are developing a new maternity dashboard, recognising that many in use across the country at present contain metrics that have not evolved over many years. The Trust is exploring the possibility of being an early adopter of the new national dashboard.

Integrated Action Plan

3.10 An integrated action plan to address the remaining improvement actions that require implementation is in development. The plan brings together recommendations from RCOG, CQC, Healthcare Safety Investigation Branch, the Coroner and commissioners, into this single action plan for the improvement of maternity services.

3.11 Implementation of this plan will be overseen by the Trust's Maternity Oversight Committee, chaired by a Non-Executive Director, demonstrating the Trust Board's commitment to maternity improvement. Committee members include representatives from the maternity service, NHS England and Improvement, Kent and Medway CCG, the East Kent Maternity Voices Partnership and Healthwatch.

3.12 Progress will be monitored by the Trust's Quality Committee and reported monthly to the Trust Board, to give assurance that all work stated as complete or in progress is being delivered and embedded.

3.13 The plan will be updated to any actions arising from the independent investigation into maternity services led by Dr Kirkup (Section 4).

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

4. Independent Investigation

4.1 In February 2020 the Minister for Patient Safety, Nadine Dorries, announced that NHS England and NHS Improvement were commissioning an independent investigation into the maternity and neonatal services provided by the Trust.

4.2 The investigation is being led by Dr Bill Kirkup supported by a panel of experts in obstetrics, midwifery, neonatal medicine, clinical governance and information management. Full details are on the investigation's website.

4.3 The investigation has started by meeting with families and a panel of experts. The panel is working with families to agree its terms of reference. The investigation expects to report in 2021.

4.4 The Trust has welcomed the independent investigation and is doing everything in its power to assist and support the investigation. The Trust is being supported in this programme of work through the appointment of a Maternity Services Strategic Programme Director, accountable to the Trust Board.