East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**16 JULY 2020**
REPORT TITLE:	**FINAL REPORT FROM THE LEARNING AND REVIEW COMMITTEE (LRC) - MATERNITY**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**INDEPENDENT CHAIR – LRC**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: LRC – MATERNITY REPORT** **APPENDIX 2: TERMS OF REFERENCE (ToR) MATERNITY OVERSIGHT COMMITTEE**

BACKGROUND AND EXECUTIVE SUMMARY

The LRC has agreed with Ursula Marsh (Head of Midwifery) that she will develop an overarching action and audit programme on behalf of the committee that can be used by the Trust Quality Committee (QC) to give assurance that all work stated as complete or in progress is being delivered. This action plan is well underway and I have seen an initial draft. As it is also dealing with actions relating to other reports the Trust has received it will be necessary for action plans relating to the specific work of the LRC to form a sub-report so that these actions do not get lost and be seen through to completion. Going forward the Committee will be chaired by Jane Ollis, Non-Executive Director of the Trust. The ToR for this Maternity Oversight Committee are attached for approval.

The sub-report will include all the actions underpinning the response to HM Coroner with respect to the inquest held for Harry Richford, unresolved or newly appropriate actions from the look back at the Royal College of Obstetrics and Gynaecology Report (RCOG), and actions relating to the review of perinatal mortality, including the work Imperial College has been asked to complete. The report will include who the name of the person accountable for the action, the timescale for completion and the evidence that will be supplied to show completion and that the change of practice where appropriate is embedded. The programme of work will need to be modified to include improvement in relation to the independent review led by Dr Kirkup.

At the request of the LRC Dr Rebecca Martin, Medical Director, looked at the output from the RCOG look back workstream, led by Ms Zoe Woodward and has concluded that it is not possible to evidence all actions from that report as having been completed. 23 recommendations were made by the RCOG. When the available evidence was reviewed the LRC concluded there was sufficient evidence that 2 recommendations had been met, that 11 had been partially met. For some of the recommendations where evidence weas insufficient, the LRC agreed that this applied beyond the women and children's care group.

Having reviewed perinatal mortality data in relation to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) up to 2017, and then using a similar methodology, the LRC heard that the number of still births has fallen, and is below that expected for the average similar unit as ranked by MBRRACE, but the number of babies born alive and subsequently dying in 2019 would put EKHUFT above the average (as compared to the most recently available MBRRACE mean). Imperial College London's Neonatal Research Group have already agreed to look at the rate of neonatal encephalopathy in the Trust and will be asked to look at neonatal mortality to help with insight and subsequent action plan.

Although agreed with NHS England/NHS Improvement (NHSE/I) that workforce would not be a focus for the LRC, during the life of the committee the Trust has successfully recruited several obstetric consultants and also increased its senior midwifery staffing and recruited bereavement midwives. All these appointments are important in delivering the strategy of safe and effective, and well evaluated care that puts women using the service and their babies at the heart of service decisions.

The new maternity strategy is in development and will set the direction the service wants to go, with better births and the NHS long term plan at its heart. It will take the learning from Healthcare Safety Investigation Branch (HSIB), Care Quality Commission (CQC), and the Independent Review led by Dr Bill Kirkup and translate this through priorities for improvement into better outcomes for mothers and babies. The Birthing Excellence Success Through Teamwork (BESTT) programme will be the vehicle for the delivery of this strategy. The QC, an assurance sub-committee of the Board will receive the evidence that change initiatives and actions from the plans to address internal and external reports have been carried out. This evidence must feature audits performed with a frequency that provides assurance change has been made and is embedded.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	CRR77: Women may receive sub-optimal quality of care and poor patient experience in our maternity services.
LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	CRR77: Women may receive sub-optimal quality of care and poor patient experience in our maternity services.
RESOURCE IMPLICATIONS:	It is likely there will be resource implications from the action plan, and resources have already been found particularly in relation to staffing enhancement.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	None

PRIVACY IMPACT ASSESSMENT: *NO*	**EQUALITY IMPACT ASSESSMENT:** *NO*

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to:

- discuss and **NOTE** the report; and
- **APPROVE** the Maternity Oversight Committee ToR.

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Learning and Review Committee – Maternity

Report to Trust Board – 16 July 2020

The Learning and Review Committee (LRC) was set up by EKHFT as a 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 and had experienced tragedies including stillbirths (the death of a child while still in the womb) and the deaths of babies soon after birth. This committee and its remit were discussed with NHS England (NHSE) in view of the pending decision to be taken within the Department of Health and Social Care (DoHSC) to hold an Independent Enquiry. NHSE supported the remit of the committee to:

- look at trust response to previous Royal College reports (Royal College of Obstetrics and Gynaecology, 2016; Royal College of Paediatrics and Child Health, 2015);
- consider whether the work of the Birthing Excellence Success Through Teamwork (BESTT) improvement programme was aligned with available evidence relating to the serious incidents in maternity and neonatal services;
- help ensure the Trust response to HM Coroner findings in relation to baby Harry Richford was comprehensive and did not make unsafe assumptions from previous reports and improvement work;
- consider 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;
- hear from the workstream working to deliver a sustainable and improved workforce deployment plan for medical staff.

Since the committee was convened the Trust and the Country have been dealing with the COVID-19 pandemic and the independent enquiry commissioned by DoHSC and led by Dr Bill Kirkup has begun.

This is my final report to the Board in relation to the original remit. The committee will continue, and support delivery of a strategy for the care centre, and an over-arching plan of actions relating to the workstreams above, actions that are required from the Care Quality Commission (CQC) and Healthcare Safety Investigation Branch (HSIB) reports, and actions from Dr Kirkup's review. Going forward the committee will be chaired by Jane Ollis, Non-Executive Director of the Trust.

Response to HM Coroner inquest into the death of Harry Richford

The LRC met 6 times. Initially as has been previously reported the committee's work focused on the reply to HM Coroner's letter relating to the death of Harry Richford and making the changes that were required. One recommendation was not for the Trust, but all the recommendations made to the Trust have either been done or are in the process of being done.

These changes will significantly increase oversight of staffing, governance around training and competencies and team working within the labour ward environment, but only if they are embraced and owned by all members of the multi-disciplinary team. The Board, or its Quality sub-committee should seek to be assured that the changes have been made and are sticking. For example, locum doctors working overnight within the obstetric department

should have a written review of their work made by the consultant on-call with them. A file on the departmental drive has been set up for these references to be collected. This is a change of process that was made in April and is easily auditable. The LRC recommends auditing this process quarterly, which will demonstrate to the department that the change is important and not aspirational. The Board and the Quality Committee (QC) should decide whether audits and their presentation are the right periodicity. I believe there is an advantage of each constituency (clinicians, care centre, senior management and board) owning the process and the outcomes delivered.

Royal College of Obstetricians and Gynaecologists (RCOG) report 2015

The workstream looking at the recommendations made by the RCOG in their report to the Trust in 2015 was led by Miss Zoe Woodward, Consultant in O&G. The methodology for this work was to identify every recommendation, decide as a group whether the recommendation had been actioned and identify evidence that supported the view. The evidence was an important element in concluding whether or not the LRC was assured. The LRC realised that it would be difficult to review the evidence for each recommendation at virtual meetings and agreed that Dr Rebecca Martin, Medical Director, who is relatively new in post and new to the Trust, would work with this workstream, review evidence, and present their findings to the LRC.

The LRC received the final report from this workstream on 23 June 2020. The report was presented by the Medical Director and was caveated that with significant changes in leadership over the interim period since the report was received it was difficult to track actions and evidence. However, she stated and the LRC accepted her reasoning that where evidence couldn't be found, or where review of on-going evidence (for instance minutes of committees tasked with keeping policies consistent with national guidance, completion of investigations into clinical incidents in a timely way) gave concern, these recommendations could not be described as met. The LRC was told whether each recommendation was met, partially met or not met. Where the recommendation was deemed not to have been met there was a further sub-division as to whether the evidence considered was for the care group of women and children's, or for the wider Trust.

Of 23 recommendations the LRC accepted that two were met, 11 were partially met, and for 10 there was either no evidence of delivering the recommendation, or available evidence suggested it had not been delivered. The committee heard that where the recommendations had not been met, this applied at the level of the care group for six recommendations and at Trust level for four. For recommendations that were partially met this evidence applied at Trust level for seven recommendations and at care group level for four.

The outstanding actions needed to address recommendations not fully implemented, but that remain relevant within the women and children's care centre, will be incorporated into the overarching action plan referred to at the last Board, with the evidence required to show implementation (and thereby support audit and assurance) detailed against each. Some of these actions have already been taken, as the plan will show. The need then becomes one of audit with a frequency that mitigates risk of change not becoming embedded.

However, the LRC heard that for some of the recommendations the evidence to show compliance is required more widely across other care groups, and at operational committees within the Trust. This is outside the remit of the women and children's care centre's action plan. For this reason, the QC should agree the recommendations the Medical Director

makes for wider assurance and the evidence that will be required for the Trust Board to be assured.

Birthing Excellence Support Through Teamwork (BESTT) and Maternity Strategy

The aims of the BESTT programme have been discussed at previous Board meetings as has the desire the team leading the programme had for clarity on its role going forward and relationship to service strategy. This has now been clarified within the care group, and its new clinical leadership.

The strategy has been developed outside the LRC process, but the first draft has been presented at the most recent LRC meeting on 23 June 2020. This strategy sets the outcomes and experience of women who are using the service and the staff working in it at the heart of its ambition. It references the goals of the NHS Long Term Strategy (2019) and Better Births: improving outcomes of Maternity services in England (2016). It makes the link between inequality during pregnancy and birth, and long-term inequality of opportunity and health. A re-launched BESTT programme will enable delivery of the strategy and focus on outcomes on the journey to a 50% reduction in perinatal mortality and morbidity by 2025.

Perinatal Mortality

The Trust has seen a decline in stillbirth rates on available national databases in line with the mean for the country. Going forward the care group will use the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) methodology and look at still birth rates every month and as a three-month rolling rate. This augments the review and analysis of every single baby that is stillborn.

The most recent available MBRRACE data is for 2017. For that year neonatal mortality above which a unit hosting a level 3 special care baby service would be given a red rating was 2.19 deaths/1000 live births. For 2017 the EKUHFT rate was 2.84/1000. Crude neonatal mortality for 2018 was 1.69/1000, and for 2019 was 2.97/1000 (these rates are unadjusted against MBRRACE data). There is speculation that more babies are being born prematurely nationally and locally, and small changes in the number of babies who die has a significant effect on rates (the number of neonatal deaths that would be average in a year for a hospital delivering 7000 babies is 15), as do changes in the number of in utero and ex utero transfers into and out of the hospital between maternity units. The Trust is judged green for stillbirths and this may have an effect on the neonatal mortality rate if babies that might previously have been stillborn are now born alive. In addition there were twice as many babies born with congenital abnormalities in 2019 than in 2018.

This is a complex situation and with the national dataset lagging behind individual trust data it is difficult to compare with others or understand any anomalies in recording and submitting data. The Trust may want to consider commissioning a report from the MBRRACE-UK team to provide an independent commentary upon neonatal mortality for East Kent and whether there has been an observed increase in neonatal mortality in trusts which have seen a decline in stillbirth rate. In addition, the Neonatal Data Analysis Unit, part of Imperial College London's Neonatal Medicine Research Group may also be able to provide an additional source of independent mortality analysis.

National audits have suggested the Trust has a higher rate of neonatal encephalopathy, but a lower rate of babies judged to be at risk of this at five minutes of life than is average for England. This is an anomaly that Imperial College London's Neonatal Medicine Research group are looking at and their report is expected imminently.

A number of actions within the integrated action plan for maternity relate to perinatal mortality and morbidity. External review of babies who are part of the perinatal mortality, whether from Imperial as suggested above, or as part of the local maternity system as referenced in the Medical Director's RCOG paper (recommendation 9) would aid not just Board assurance, but departmental learning and the implementation of the maternity strategy which is pledging a reduction in mortality of 50%. I have not looked at clinical records of babies who have died, partly because of the restrictions imposed through Covid, but mostly because this will be done by the Independent Investigation led by Dr Kirkup. This analysis will also be very valuable in understanding and learning.

The Board will need to set the aspiration of the service. Present available data suggests that in comparison with other level 3 units mortality sits above average, either within the expected range or just above the expected range. Through as great as possible understanding of the reasons for the death of every baby who passes away, a better chance of implementing change that helps reach the 50% reduction in babies dying will follow.

Paediatrics

Dr Tina Sajjanhar, an experienced senior Paediatric consultant from Lewisham is supporting the Trust in these areas at the request of NHSE/NHS Improvement (NHSI) and her work has commenced after an initial Covid–related delay. It is important that either the continuing LRC, or the QC receives updates from this work and where actions are required, these are owned and held to account appropriately.

Dashboard

NHS Digital (NHSD) and the National Clinical Director (NCD) for Maternity are working on a new dashboard for maternity, recognising that many of the dashboards in use at present contain metrics that whilst easily recorded have not evolved over many years. I believe the Tommy's campaign are also funding work in this area. Matthew Jolly (NCD for Maternity) says the dashboard they are working on has been delayed by Covid but will feature a mix of hard data points and soft intelligence. I have written to NHSD and Matthew and suggested the Trust would be willing to be an early adopter of the new dashboard. It is impossible to know whether this will meet the needs of the Trust and its Board and it may be that the new dashboard would require tailoring to some of the specific challenges that recent national reports, the independent review, and the maternity strategy have underlined for the Trust. Where process metrics are recorded it will be important to understand the confidence in their association with outcomes. In general it is outcomes that matter to the public and process metrics are often not good surrogates for outcome and can give misleading reassurance.

Workforce

Although workforce plans were originally in the remit of the LRC, early discussion with NHSE/I suggested they would be supporting this work stream. Nonetheless the care group have been very successful in recruiting to an expanded consultant workforce, allowing a significant increase in consultant obstetrician presence on the labour ward, with no conflicting duties in hours, and with sustainable 24/7 presence for the William Harvey Hospital (WHH) site, and 87+hours presence on the Queen Elizabeth the Queen Mother Hospital (QEQMH) site following Covid (both sites are working with maximum labour ward presence during the changed working patterns of the first wave of Covid infection). There has also been a significant expansion of senior midwifery roles and recruitment allowing extra experience on both labour wards for more hours, and enhanced teaching in relation to fetal monitoring.

Conclusions

The LRC was asked to receive the output from several workstreams set up as a consequence of public confidence in the maternity and neonatal service, and public scrutiny. Some of the workstreams have been looked at and supported outside the LRC, and have been assisted by NHSE/I (paediatrics, work force).

The workstreams that have been reported to the Board since April have been well led by clinicians who are passionate about their service, passionate about a multi-disciplinary approach, and want to work in and deliver a service that is valued by the public who use it. This is true of the work that has gone into service change and response to HM Coroner and in understanding the actions taken after the RCOG report in 2015, and where the Trust is today in relation to those recommendations. It is also at the heart of the cultural and improvement work that underpins the BESTT programme.

The senior leadership team within the care centre is finalising both the overarching action plan for the work that still needs to be completed (although many actions have already been taken) and the evidence that will be required within the service and at Board sub-committee level to provide insight and assurance. It is also finalising its strategy for progressing work that has come from this process, and from reports received from CQC, NHSE/I and from HSIB. The BESTT programme will become the delivery vehicle for this strategy but will need support from the care centre and from the Executive. The strategy and the BESTT programme priorities will also need to incorporate the output and learning for the independent review commissioned by the DoHSC.

It is important that the on-going work within the service prioritises outcomes and seeks out opportunities to demonstrate improvement. For instance, catastrophic events are fortunately infrequent, but low level and no harm incidents are more common in all services, as are near misses. These provide a greater number of opportunities for learning, and a transition from infrequent, formal teaching sessions to daily consideration of things that went well, or less well, or where incidents were averted are likely to have cultural benefit as well as impact on actual events. As the Medical Director has also suggested there are methodologies available for investigating incidents which have a greater chance of being able to demonstrate learning. Previous reports to the Board have emphasized the value of adopting one of these methodologies. It is also important that poor behaviour from anyone in the multi-disciplinary team is not tolerated and the confidence within the team that this is so has significant room for improvement.

For the Board and its QC it is important that they have an action plan that is owned by the service and by the Executive Management Team, has appropriate time scales for delivery and named people who are accountable and is told the evidence that will be collected and available to show delivery. The QC must then hold the service to account for delivering. When the holding to account is visible and supportive it will help the leadership in the service to deliver and to raise concerns when they can't.

Dr Des Holden

8 July 2020