Board of Directors Meeting - Open (Thursday 7 April 2022)

Thu 07 April 2022, 01:15 PM - 04:25 PM

WebEx teleconference

NHS
East Kent Hospitals University
NHS Foundation Trust

Agenda

OPENING/STANDING ITEMS

01:15 PM - 01:30 PM
15 min

22/1
Welcome and Apologies for Absence (1:15) 15 mins

To Note *Chairman*

Verbal

01:30 PM - 01:30 PM
0 min

22/2
Confirmation of Quoracy

To Note *Chairman*

Verbal

01:30 PM - 01:30 PM
0 min

22/3
Declaration of Interests

To Note *Chairman*

22-03 - REGISTER 2021-22 V48 - from March 2022.pdf (5 pages)

01:30 PM - 01:30 PM
0 min

22/4
Minutes of Previous meeting held on 10 March 2022

Approval *Chairman*

22-04 - Unconfirmed BoD 10.03.22 Public Minutes.pdf (14 pages)

01:30 PM - 01:30 PM
0 min

22/5
Matters Arising from the Minutes on 10 March 2022

Approval *Chairman*

22-05.1 - Front Sheet Public BoD Action Log.pdf (3 pages)
22-05.2 - Appendix 1 Public Board of Directors Action Log.pdf (1 pages)

01:30 PM - 01:35 PM
5 min

22/6
Chairman's Report (1:30) 5 mins

Information *Chairman*

- 22-06.1 - Chairman Report April 2022 Board Final.pdf (4 pages)
- 22-06.2 - App 1 Chairman Report NEDs commitments.pdf (1 pages)

01:35 PM - 01:45 PM
10 min

22/7
Chief Executive Officer's (CEO's) Report (1:35) 10 mins

Discussion *CEO*

- 22-07 - CEO Report to April Board - FINAL.pdf (4 pages)

CORPORATE REPORTING (COVERING ALL 'WE CARE' STRATEGIC OBJECTIVES)

01:45 PM - 02:15 PM
30 min

22/8
Integrated Performance Report (IPR) (1:45) 30 mins

Discussion *CEO/Executive Team*

- 22-08.1 - IPR Front Sheet April 2022 BoD.pdf (2 pages)
- 22-08.2 - Appendix 1 IPR_v4.3_Feb22_Final.pdf (38 pages)

02:15 PM - 02:20 PM
5 min

22/9
Finance Report (2:15) 5 mins

Information *Director of Finance and Performance*

- **Month 11 Finance Report**

- 22-09.1 - Front Sheet M11 Finance Report Board.pdf (2 pages)
- 22-09.2 - Appendix 1 M11 Finance Report.pdf (27 pages)

02:20 PM - 02:30 PM
10 min

22/10
Board Assurance Framework (BAF) and Corporate Risk Registers (CRR) (2:20) 10 mins

Discussion *Group Company Secretary*

- 22-10.1 - Corporate-BAF Risk Register BOD 30.03.22 v2.pdf (4 pages)
- 22-10.2 - Appendix 1 - BAF 2021-22 30.03.22 v2.pdf (9 pages)
- 22-10.3 - Appendix 2 - CRR 2021-22 30.03.22 v2.pdf (15 pages)

02:30 PM - 02:40 PM
10 min

22/11
Infection Prevention and Control (IPC) Board Assurance Framework (BAF) (2:30) 10 mins

Assurance *Director of IPC*

- IPC Work Plan 2022-23

22-11.1 - Front Sheet IPC BAF 29_03_2022.pdf (2 pages)
22-11.2 - App 1 IPC BAF review V2 29.03.2022.pdf (18 pages)
22-11.3 - Appendix 2 IPC Work Plan 2022-23.pdf (11 pages)

02:40 PM - 02:50 PM
10 min

TEA/COFFEE BREAK 2.40 (10 mins)

OUR PATIENTS OUR QUALITY AND SAFETY

02:50 PM - 03:10 PM
20 min

22/12
Maternity Services: (2:50) 10 mins

Information *Chief Nursing and Midwifery Officer (CNMO)*

- **Clinical Negligence Scheme for Trusts (CNST) - Maternity Incentive Scheme Year 4 - Quarterly Report**

22/12.1
Safety Action 3: Transitional care services to minimise separation of mothers and their babies and to support the recommendations made in the avoiding term admissions into Neonatal Units programme

Information *CNMO / Interim Director of Midwifery*

22-12.1 - CNST SA 3 Transitional Care Report v2 FINAL.pdf (13 pages)

22/12.2
Briefing Note: Findings, conclusions and essential actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (SATH) (3:00) 10 mins

Information *CNMO*

22-12.2.1 - Ockenden Briefing Note OPEN BoD FINAL.pdf (5 pages)
22-12.2.2 - App 1 Final-Ockenden-Report.pdf (250 pages)
22-12.2.3 - App 2 B1523 Ockenden Final report letter NHSE-I 1 April 2022.pdf (3 pages)

03:10 PM - 03:20 PM
10 min

22/13
Chief Medical Officer's Report (3:10) 10 mins

Discussion *Chief Medical Officer (CMO)*

Verbal

REGULATORY AND GOVERNANCE

03:20 PM - 03:30 PM
10 min

22/14
People and Culture Committee (P&CC) - Chair Assurance Report (3:20) 10 mins

Assurance *Chair People and Culture Committee - Stewart Baird*

22-14 - PCC Chair Assurance Report to BoD - 28 March 2022.pdf (2 pages)

03:30 PM - 03:40 PM
10 min

22/15
Finance and Performance Committee (FPC) - Chair Assurance Report (3:30) 10 mins

Approval *Chair Finance and Performance Committee - Nigel Mansley*

- Business Cases (BC)
- Picture Archiving Communication System (PACS) BC
- Bank Rate Enhancements for Nursing September 2021 to March 2022 Post Project BC
- Contract Award for renewal of multifunctional devices

22-15 - FPC Chair Assurance Report BoD Public final.pdf (5 pages)

03:40 PM - 03:50 PM
10 min

22/16
Quality and Safety Committee (Q&SC) - Chair Assurance Report (3:40) 10 mins

Assurance *Chair Quality & Safety Committee - Sarah Dunnett*

22-16 - QSC Assurance Report BoD FINAL.pdf (5 pages)

03:50 PM - 04:00 PM
10 min

22/17
Proposal for Governor attendance at Board Committees (3:50) 10 mins

Approval *Chairman*

22-17.1 - Governor attendance at Board Committees.pdf (3 pages)
22-17.2 - App 1 Proposal Governors attendance Board Committees.pdf (1 pages)

CLOSING MATTERS

04:00 PM - 04:10 PM
10 min

22/18
Any Other Business (4:00) 10 mins

Discussion *All*

Verbal

04:10 PM - 04:25 PM
15 min

22/19
Questions from the Public (4:10) 10 mins

Discussion *All*

Verbal

Date of Next Meeting: Thursday 12 May 2022 at the The Spitfire Ground - Canterbury Cricket Ground

The public will be excluded from the remainder of the meeting due to the confidential nature of the business to be discussed.

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM MARCH 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ANAKWE, RAYMOND	Non-Executive Director	Medical Director and Consultant Trauma and Orthopaedic Surgeon at Imperial College Healthcare NHS Trust **(1)**	1 June 2021 (First term)
ASHMAN, ANDREA	Director of HR and Organisational Development	None **Closed interest** MY Trust (started 11 November 2014/finished 20 July 2020) **(4)**	Appointed 1 September 2019
BAIRD, STEWART	Non-Executive Director	Stone Venture Partners Ltd (started 23 September 2010) **(1)** Stone VP (No 1) Ltd (started 15 August 2017) **(1)** Stone VP (No 2) Ltd (started 1 December 2015) **(1)** Stone VP (No 3) Ltd (started 20 November 2017) **(1)** Hidden Travel Holdings Ltd (started 16 May 2014) **(1)** Hidden Travel Group Ltd (started 15 October 2015) **(1)** Qunifi Holdings Ltd (started 30 November 2017) **(1)** Qunifi Ltd (started 13 February 2015) **(1)** Trustee of Kent Search and Rescue (Lowland) (started 2013) **(4)** **Companies Non-Trading interests** Tempco 0819 Ltd **(1)** Solution Telecom Holdings Ltd **(1)** Qdos Communications Ltd **(1)** Solution Builders Ltd **(1)** Hidden Travel (Flights) Ltd **(1)** Unicus Travel Ventures Ltd **(1)** Pebble Holidays Holdings Ltd **(1)**	1 June 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM MARCH 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
CAVE, PHILIP	Director of Finance and Performance	Wife works as Head of Contracts for Kent and Medway Clinical Commissioning Group (CCG) (started 1 April 2021) **(5)** Interim Managing Director for 2gether Support Solutions **(1)** (started 21 December 2021) **Closed interests** Wife worked as a Senior Manager for Optum, who run the Commissioning Support Unit (CSU) in Kent, which supports the Clinical Commissioning Groups (CCGs) (started 9 October 2017/finished 31 March 2021)	Appointed 9 October 2017
CARLTON, REBECCA	Chief Operating Officer	None	Appointed 16 July 2021
DICKSON, NIALL	Chair	Director, Leeds Castle Enterprises (started 31 May 2012) **(1)** Senior Counsel, Ovid Consulting Ltd (trading as OVID Health Company) (started November 2020) **(1)**	5 April 2021
DUNNETT, SARAH	Non-Executive Director/Senior Independent Director (SID)	Director of Catalyst (London) Ltd **(1)**	1 June 2021 (First term)
FOX, ALISON	Group Company Secretary	Company Secretary, Grabba Enterprises Limited (started 1 December 2020) **(1)** Director, MinervaPro Limited (started 28 November 2021) **(1)**	Appointed 11 November 2013
FULCI, LUISA	Non-Executive Director	Director of Digital, Customer and Commercial Services, Dudley Council (started 6 April 2021) **(1)**	1 April 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM MARCH 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
HOLLAND, CHRISTOPHER	Associate Non-Executive Director	Director of South London Critical Care Ltd **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University and the University of Kent **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services **(5)**	Appointed 13 December 2019
IVANOV, TINA	Director of Quality Governance	None	10 May 2021
MANSLEY, NIGEL	Non-Executive Director	None **Closed interests** Jeris Associates Ltd (started 1 July 2017/finished 26 January 2021) **(1) (2) (3)** Chair, Diocesan Board of Finance (Diocese of Canterbury) (started 22 January 2018/finished 14 July 2021) **(1)**	1 July 2017 (Second term)
MARTIN, REBECCA	Chief Medical Officer	None	Appointed 18 February 2020
OLASODE, OLU	Non-Executive Director	Chief Executive Officer, TL First Consulting (started 9 May 2000) **(1)** Chairman, Integrated Management Group (started 16 March 2001) **(1)** Managing Partner, TL First Accountants Ltd (started 4 January 2006) **(1)** Chairman, ICE Innovation Hub UK (started 11 September 2018) **(1)** Independent Chair, General Purposes and Audit Committee, London Borough of Croydon (started 1 October 2021) **(1)**	1 April 2021 (First term)

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM MARCH 2022

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
OLLIS, JANE	Non-Executive Director	The Heating Hub (started 8 May 2017) **(1)** Non-Executive Director of the Kent Surrey Sussex Academic Health Science Network (AHSN) (started 1 July 2018) **(1)** Founder of MindSpire (started 30 October 2018) **(1)** Non-Executive Director of Community Energy South (started 30 October 2018) **(1)** Vice President of the British Red Cross in Kent (started November 2018) **(4)** Non-Executive Director of 2gether Support Solutions (started 22 May 2019) **(1)** Non-Executive Director of Riding Sunbeams (started February 2020) **(1)**	8 May 2017 (Second term)
SHINGLER, SARAH	Chief Nursing Officer	None	Appointed 7 June 2021
SHUTLER, LIZ	Director of Strategic Development and Capital Planning/Deputy Chief Executive	None	Appointed January 2004
WIGGLESWORTH, NEIL	Director of Infection Prevention and Control	Chair and Director of the International Federation of Infection Control (started 1 January 2018) **(1)** Trustee of the International Federation of Infection Control (started 1 January 2018) **(4)**	15 March 2021
YOST, NATALIE	Director of Communications and Engagement	None	31 May 2016

REGISTER OF DIRECTOR INTERESTS – 2021/22 FROM MARCH 2022

Footnote: All members of the Board of Directors are Trustees of East Kent Hospitals Charity

The Trust has a number of subsidiaries and has nominated individuals as their 'Directors' in line with the subsidiary and associated companies articles of association and shareholder agreements

2gether Support Solutions Limited:
Philip Cave, Nominated Director
Jane Ollis – Non-Executive Director in common/Interim Chair (1 March 2022 to 30 April 2022)
Alison Fox – Nominated Company Secretary

Spencer Private Hospitals:
Stewart Baird – Non-Executive Director in common
Nic Goodger – Nominated Director
Elizabeth Coles – Nominated Director
Alison Fox – Nominated Company Secretary

Categories:

1 Directorships
2 Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS
3 Majority or controlling shareholding
4 Position(s) of authority in a charity or voluntary body
5 Any connection with a voluntary or other body contracting for NHS services
6 Membership of a political party

UNCONFIRMED MINUTES OF THE ONE HUNDRED & SEVENTEENTH MEETING OF THE BOARD OF DIRECTORS
THURSDAY 10 MARCH 2022 AT 1.00 PM
AS A WEBEX TELECONFERENCE

PRESENT:

Mr N Dickson	Chairman	ND
Ms S Acott	Chief Executive Officer (CEO)	SAc
Mr R Anakwe	Non-Executive Director (NED) (by WebEx)	RA
Mrs A Ashman	Director of Human Resources & Organisational Development (DoHR&OD)	AA
Mr S Baird	NED/People & Culture Committee (P&CC) Chair (by WebEx)	SB
Ms R Carlton	Chief Operating Officer (COO)	RC
Mr P Cave	Director of Finance and Performance (DoF&P)	PC
Mr G Dentith	Acting Director of Finance and Performance	GD
Ms S Dunnett	NED/Quality & Safety Committee (Q&SC) Chair (by WebEx)	SD
Ms L Fulci	NED	LF
Mr N Mansley	NED/Finance and Performance Committee (FPC) Chair	NM
Dr R Martin	Chief Medical Officer (CMO)	RM
Dr O Olasode	NED/Integrated Audit and Governance Committee (IAGC) Chair	OO
Mrs J Ollis	NED/Deputy Chairman/Nominations and Remuneration Committee (NRC) Chair/Charitable Funds Committee (CFC) Chair	JO
Mrs S Shingler	Chief Nursing and Midwifery Officer (CNMO)	SSh
Ms L Shutler	Director of Strategic Development and Capital Planning (DSD&CP) /Deputy CEO	LS

ATTENDEES:

Mr G Dentith	Deputy Director of Finance (DDoF)	
Mrs C Drummond	Interim Director of Midwifery (DoM)	CDr
Mrs A Fox	Group Company Secretary (GCS)	AF
Professor C Holland	Associate Non-Executive Director/Dean, Kent & Medway Medical School (KMMS)	CH
Dr T Ivanov	Director of Quality Governance (DoQG)	TI
Ms L White	Deputy Director of Infection Prevention and Control (DDIPC) (for Minute Number 21/141)	LW
Mrs N Yost	Director of Communications and Engagement (DoC&E)	NY

IN ATTENDANCE:

Ms S Hayward-Browne	Business Manager to the Chairman	SH-B
Miss S Robson	Board Support Secretary (Minutes)	SR

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Ms G Oliver	Staff Member
Mrs S Pettifer	Staff Governor
Mrs P Pryer	Member of the Public
Mr P Schofield	Governor - Thanet
Mrs M Smith	Member of the Public
Mrs M Warburton	Governor - Thanet
Professor S Weller	Governor - Universities

MINUTE NO.		ACTION
21/131	**WELCOME AND APOLOGIES FOR ABSENCE** The Chairman welcomed those in attendance. He apologised for not meeting in person noting the decision to hold this virtually due to increased Covid numbers.	

CHAIR'S INITIALS ……

Apologies were received from Dr Neil Wigglesworth (NW), Director of Infection Prevention and Control (DIPC) (non-voting member), noting Lisa White (LW), Deputy DIPC was in attendance on his behalf.

21/132 **CONFIRMATION OF QUORACY**

The Chairman **NOTED** and confirmed the meeting was quorate.

21/133 **DECLARATION OF INTERESTS**

The Board **NOTED** there were no new declarations of interest.

21/134 **MINUTES OF THE PREVIOUS MEETING HELD ON 3 FEBRUARY 2022**

DECISION: The Board of Directors **APPROVED** the minutes of the previous meeting held on 3 February 2022 as an accurate record.

21/135 **MATTERS ARISING FROM THE MINUTES ON 3 FEBRUARY 2022**

Action B/25/21 – Integrated Performance Report (IPR): We Care – falls breakthrough objective
The Board of Directors **NOTED** an update on the ward that had implemented We Care focussing on reduction of falls breakthrough objective and whether a reduction in falls was being maintained, would be provided as part of the IPR discussion later in the meeting.

DECISION: The Board of Directors discussed and **NOTED** the progress updates on the actions from the previous meeting, those for a future meeting, and **APPROVED** the actions recommended for closure.

21/136 **CHAIRMAN'S REPORT**

The Chairman expressed thanks and appreciation to staff in continuing to manage Covid-19 patients, winter demand and operational pressures, as well as leadership support from the Executive Directors, NEDs and senior leaders. He attended a Kent Care Summit the previous week. There was on-going work with the Council of Governors around improving membership and engagement, site visits between NEDs and Governors had restarted. Recruitment to two Governor vacancies for Swale was progressing.

The Board of Directors **NOTED** the contents of the Chairman's report.

21/137 **CHIEF EXECUTIVE'S REPORT**

The CEO highlighted key elements:

- Significant operational pressures, Covid numbers reducing but numbers were fluctuating, with a rise in staff sickness absence;
- Nightingale surge hub at William Harvey Hospital (WHH) stood down, decommissioning and deconstruction commenced, and patient/visitor car park would be resurfaced before being reopened;
- Damian Green, MP, visited the new Intensive Therapy Unit (ITU) at WHH, saw the contrast of a modern ITU in comparison to the unit that had served patients since 1970;
- Research and Innovation (R&I) Catalyst 'Dragon's Den' event held on 10 February 2022, great to see research activity and projects, enthusiasm of staff in R&I, service initiatives and developments.

The CEO thanked the Board, Executive Directors, and all the Trust staff for their support since she had been with the Trust, who were focussed on the priorities for East Kent, and committed caring for patients. She highlighted the particularly difficult period over the last two years managing the pandemic, acknowledging staff had been courageous, hardworking, remained positive during very busy and difficult times, with outstanding commitment to continue to deliver services.

The Board of Directors **NOTED** the Chief Executive's report.

21/138 **INTEGRATED PERFORMANCE REPORT (IPR)**

The DoF&P highlighted:

- Changed format of IPR reflecting feedback from NEDs. True Norths had been expanded providing more detail and reassurance of the actions on a page for these longer term strategic objectives.

The CMO highlighted key points about Mortality metrics:

- On-going monitoring of Trust's mortality data and improvements in respect of Hospital Standardised Mortality Ratio (HSMR);
- Fractured neck of femur pathway area of focus to improve patient outcomes, experience and mortality for frail and vulnerable patients affect by this injury;
- Venous thromboembolism (VTE) assessment compliance deterioration, to be addressed with specific work within the Care Groups led by the Clinical Directors to improve the position of risk assessments.

The CNMO highlighted key points on Harm metrics:

- Total number of harms had fluctuated against the mean and within the normal variation. The reported month's data showed a breach against the upper control limit due to the number of Covid-19 Healthcare Associated Infections (HCAs), each case was a Datix;
- Safe staffing was a contributing factor to patient harms and addressed by the previously approved staffing business case;
- Falls breakthrough objective addressing increased number of falls of which 165 in January 2022. The main contributing area was Emergency Departments (EDs) and Medical Assessment Units (MAUs) with provision of targeted support in these areas. Deep dive undertaken within the wards that had implemented this We Care falls objectives since November 2020, identifying three wards had sustained falls reduction. Remaining wards had reduced falls by 50% but due to increased acuity patients, wave 2, staffing challenges and increased co-hort of mental health patients had been unable to sustain reduction. Overall impact of We Care had shown a positive impact in reducing falls. A falls benchmarking exercise would be undertaken;
- Increase in safeguarding incidents from 12 in December 2021 to 30 in January 2022, due to increased number of mental health patients and those in crisis in the EDs as a place of safety. Reassurance that staff were following the governance process in reporting these incidents to ensure patients and staff safety;
- Increased number of Child and Adolescent Mental Health Service (CAMHS) patients on the wards, due to national shortage of CAMHS beds. Two funded CAMHS mental health nurse posts, one member of staff now in post and other out to advert.

The COO highlighted key points on Trust access standard metrics:

- Risks to the 18 week referral to treatment (RTT) due to the suspension of all but urgent and cancer activity due to the impact of the Omicron variant, position was now improving supported by the relocation of elective and theatre activity that enabled work to continue;
- Long waiters addressed by utilisation of the Independent Sector;
- Use of Vanguard theatres enabling essential works to be undertaken in the Kent & Canterbury Hospital (K&C) theatres allowing continued activity;
- Trust's recovery programme continued as well as planning for April and beyond to resume activity to pre-Covid levels;
- Significant demand and pressure in the EDs, thanks to staff for their hard work and commitment during these challenges to meet demand and treat patients. Continued initiatives in place that included Same Day Emergency Care service in alternative locations and 7 day working pilot across all aspects of services within the hospitals. Focus on Ward to Board rounds creating capacity within the bed base to improve patient flow and reduce patient waits in ED;
- Nursing staffing vacancy challenges particularly at Queen Elizabeth the Queen Mother Hospital (QEQM), with mitigating actions to address this as well as progressing the recruitment plans;
- Increased number of patients with over 21 days length of stay (LoS) impacted by delays in provision of domiciliary care and residential care;
- Cancer activity, need for the provision of additional 24 MRI and 17 CT scans per day, working closely with diagnostics and cancer services to mitigate these pathway risks;
- Improved position with the high demand for endoscopy services.

The DoHR&OD highlighted key points on Staff Turnover (rate) metrics:

- Last 12 month period 1,264 new staff, 803 leavers with a net gain of approximately 400 additional staff;
- Staff turnover and premature turnover continued to be closely monitored with an improved reduction;
- Implementation of a new online staff exit survey;
- Proposal to move staff turnover to a watch metric with focus on a new True North around staff engagement, improving engagement with staff and development of a medical engagement survey.

The DoF&P highlighted key points on the Financial Position metrics:

- Plan to deliver the 2021/22 controlled position;
- 2022/23 financial year would be significantly challenging financially to deliver against budget, impacted by reduction in provision of Covid-19 funding.

The DoSD&CP highlighted key points on the Carbon Footprint and Innovation (virtual outpatients appointments) metrics:

- Investments supporting reduction of Trust's carbon footprint and going forward to be shown in total tonnes identifying the impact of these that included solar panels, combined heat and power against the aimed annual 10% improvement;
- Additional watch metrics to look at use of anaesthetics, medicine waste, NHS fleet and leased vehicles and staff travel;
- Plateaued 40% position with virtual outpatient appointments, improvement against the 1% pre-Covid.

The NEDs acknowledged the nursing staffing recruitment plans and enquired about staffing of the escalation wards. The CNMO stated these were staffed by offering enhanced rates and incentives, with implementation of the Safer Staffing Policy if needed to address staffing challenges and re-distribution of staff to areas as required.

The NEDs enquired about the Trust's percentage of energy capacity provided by the solar panels in comparison against its total energy consumption. The DoSD&CP stated continued work to develop and submit bids for central funding, as well as the importance of engaging with staff on initiatives supporting continued carbon reduction. She highlighted the future increase in energy costs was a real area of concern.

ACTION: Provide the percentage of energy capacity provided by the Trust's solar panels in comparison against its total energy consumption. — DoSD&CP

The Board of Directors considered, discussed and **NOTED** the improved IPR format and the True North and Breakthrough Objectives of the Trust.

21/139 **FINANCE REPORT**

- **MONTH 10 FINANCE REPORT**

The DoF&P noted key points:

- £0.8m surplus position in January 2022, on plan with year-to-date (YTD) position improved to £0.1m deficit and YTD adverse variance remained at £0.3m;
- Continued forecast to achieve break-even position at year end;
- Working on the new financial year planning guidance and developing the Trust's 2022/23 plan;
- Cash balance above plan;
- Capital expenditure against the annual plan was on track to ensure delivery, with weekly meetings monitoring progress and completion of projects;
- Annual accounts audit would commence on 1 April 2022.

The FPC Chair emphasised 2022/23 financial year would be very challenging, with limited funding available for new initiatives and the need to focus on invest to save initiatives. The Chairman noted the added pressure in respect of inflation and the importance of engaging with staff to review potential areas for efficiency savings.

The Board of Directors discussed and **NOTED** Month 10 Finance Report, financial performance and actions being taken to address issues of concern.

21/140 **BOARD ASSURANCE FRAMEWORK (BAF) AND CORPORATE RISK REGISTERS (CRR)**

The GCS highlighted key points:

- Following review of the risks at the Clinical Executive Management Group the previous day:
  - CRR 113 – Insufficient capacity within tier 4 Children and Young People's Mental Health Services (CYPMHS) risk rating not reduced;
  - One of the two new CRR risks related to Datix had not now been added as a risk due to the mitigations in place.

The NEDs acknowledged the good work developing and improving the risk report presented, there remained further work to ensure mitigating actions were reflected and the resulting impact reducing risk scores. It was noted the discussions about the risk registers at the Integrated Audit and Governance Committee and the need to return to three lines of assurance level of risks reporting.

The NEDs enquired about the work with partners to address risk CRR 113 and any lessons learnt. The CNMO reported collaborative partnership working to manage demand, these patients remained in Trust services until availability of a CYPMHS bed. There was also increased numbers of children with eating disorders.

The Board of Directors discussed and **NOTED** the BAF and CRR report.

21/141 **INFECTION PREVENTION AND CONTROL (IPC) BOARD ASSURANCE FRAMEWORK (BAF)**

The DDIPC reported:

- Reduction in Covid numbers, recognition this would fluctuate;
- Increased healthcare associated infection (HCAI) cases due to increased infectiousness of Omicron;
- Trust working closely with 2gether Support Solutions (2gether) on implementation of the 2021 National Standards of Healthcare Cleanliness to achieve full compliance by the October 2022 deadline;
- Change in visiting guidance to be implemented following discussion at Trust's Gold meeting;
- Regional meeting to be held the following week to support systems moving forward on future Covid-19 management as an endemic infection, guidance about mandatory reporting and swabbing.

The Board of Directors discussed and **NOTED** the contents of the IPC BAF report.

21/142 **MATERNITY REGULATORY COMPLIANCE FRAMEWORK:**

21/142.1 **OCKENDEN REVIEW OF MATERNITY SERVICES – ONE YEAR ON PROGRESS REPORT**

The Interim DoM noted:

- Maternity risk assessment reviewed, updated and reported for discussion in detail with progress challenged at the Maternity and Neonatal Assurance Group (MNAG) attended by system partners and observed by Care Quality Commission (CQC) representatives. Trust continued to work closely with the Local Maternity System (LMS);
- Appraisal rates had increased (particularly at WHH) with plans in place to achieve 85% compliance, as well as improving training compliance;
- Gap analysis review and Maternity Voices Partnership (MVP) Chair rating report would support the Trust's improvement plan;
- Progress with implementation of the 7 Immediate and Essential Actions (IEAs) and the plan to ensure full compliance:
  - IEA 1 – Enhanced safety; 100% compliance for CNST year 4 reporting periods;
  - IEA 2 – Listening to women and families; co-produced plan developed with good progress, needed to be fully embedded and remained amber;
  - IEA 6 – Monitoring fetal wellbeing; Leads in place on each of the sites;
  - IEA 7 – Informed consent; good progress to improve compliance.
- Robust workforce plan to recruit additional staff with six monthly update

reports presented to the Board, non-compliant with demonstrating an effective system of clinical workforce planning to the required standard and clarification was being sought on the reasons for this;
- Trust's Maternity Strategy would be reviewed and updated in alignment with its maternity improvement plan;
- Compliance against maternity self-assessment; majority rated green (102 areas), 53 areas rated amber and 3 areas red. Assurance areas requiring attention were being actioned and monitored through the maternity improvement plan.

The NEDs requested clarification on the further improvements in section 6 of the report referenced in the key recommendations as it appeared this section was missing from the report.

ACTION: Clarify the further improvements in section 6 of the report referenced in the key recommendations as it appeared this section was missing from the report. — Interim DoM&G

The NEDs commented it would be beneficial at a future Board meeting to receive an update on progress of the cultural programme and for this to be presented by midwives as well those newly qualified.

DECISION: The Board of Directors:

- Discussed and **NOTED** the Ockenden Review of Maternity Services – One Year On progress report;
- Received **ASSURANCE** that the 10 Safety Actions and 7 IEAs would be met subject to the assessment and assurance provided within the Maternity services assessment and assurance tool;
- **APPROVED** the request for this report, including the completed assurance and assessment tool, review against recommendations from the Kirkup Morecambe Bay investigation report, CQC action plans and update on position against the Maternity Self-Assessment Tool be submitted to the LMNS and Regional Midwifery Officer;
- **SUPPORTED** the broader considerations and the development of further improvements as seen in the report;
- Received **ASSURANCE** that there was an effective process established of ongoing assessment and that the evidence provided was sufficiently robust.

21/143 **MATERNITY SERVICES:**
- **CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST)**

21/143.1 **SAFETY ACTION 6: SAVING BABIES LIVES CARE BUNDLE REPORT**

The Interim DoM reported progress had been good against this National programme improving outcomes for babies, out of the 5 elements 3 were green and 2 amber. Areas of challenge for compliance were CO monitoring at 36 weeks at 76.4% with mitigating actions in place. Two fetal monitoring nurses in place resulting in pathway improvements.

The Chairman noted the improvements in Maternity services, the upcoming completion of the IIEKMS investigation, continued learning and improving as an organisation.

The Board of Directors:

- **NOTED** the content of the Quarterly Saving Babies Lives Care Bundle update report; and

- **NOTED** the identified risk in reaching the required compliance of CO Monitoring at 36 weeks of pregnancy, to the required compliance of 95%, in line with Element 1: Reducing Smoking in Pregnancy, National guidance.

21/144 **CHIEF NURSING AND MIDWIFERY OFFICER (CNMO) – NURSING AND ALLIED HEALTH PROFESSIONALS (AHP) WORKFORCE UPDATE**

The CNMO reported:

- Monthly Safe Staffing reports presented to the Quality & Safety Committee (Q&SC);
- ED safe staffing review commenced, with a focus on QEQM;
- International recruitment pipeline, increased from 30 a month to 40 nurses a month in February 2022, on-boarding process had been updated providing support needed to these staff. As well as OCSE training support, with increased pass results;
- Partnership working with universities and Kent and Medway Medical School (KMMS) in respect of honorary contracts and increased student placements to improve the retention of these staff;
- Increased team supporting apprentices;
- Development of an AHP Strategy scoping the workforce and workforce support that would inform the Trust's 7 day working plan;
- Improvements around governance with workforce data collation;
- Staffing risks managed daily, with clear escalation, and incentives to secure agency staff cover;
- Development of a nursing career framework as well as solutions to workforce gaps and supporting the medical workforce;
- Ward mentoring initiative established by the General and Specialist Medicine (GSM) Head of Nursing supporting international nurses across all Care Groups.

The KMMS Dean welcomed discussions about enhancing roles to support the medical workforce. He noted the positive acknowledgment of the role of AHPs and the development of a strategy, highlighting the importance that this include Physician Assistants and that student placements be fully supported. The CNMO commented a proposal would be presented to the Executive Management Team in the next couple of weeks around additional student support resources. The Board noted positive feedback received from students and trainees.

The Board of Directors:

- **NOTED** the contents of the CNMO Nursing and AHP Workforce update report;
- Received **ASSURANCE** on the progress being made against delivery of the safer staffing business case and the strengthened governance arrangements in place to safely mitigate nurse staffing challenges.

21/145 **CHIEF MEDICAL OFFICER'S (CMO'S) REPORT:**

21/145.1 **LEARNING FROM DEATHS – QUARTER 3 2021/2022**

The CMO highlighted:

- List appended detailing Clinical Directors and Clinical Leads with externally facing roles, and the engagement of Trust's senior clinicians promoting excellence in clinical medicine;

- Growth in medical establishment had resulted in pressures on the appraisal and revalidation team, a key area of focus for improvement working with appraisers and provision of training. Currently appraisals 80% complete or on progress for completion;
- International recruitment of clinicians supported by a welcome to the UK event to be held in next couple of months;
- Clinical Ethics Committee (CEC) currently recruiting with overwhelming staff response applying to become members, these were being reviewed and would ensure representation was inclusive. Trust was now a member of the UK Clinical Ethics Network (UKCEN) that provided members with further educational opportunities;
- King's College London (KCL) School of Medicine Education quality visit held on 24 February 2022, formal feedback would be received in due course. Initial feedback was positive, including students felt welcomed, provision of well-being support, received holistic care, and felt confident to approach leads and trainers to raise any concerns. Student welcome events attended by the CMO and CEO;
- Trust's performance in mortality remained statistically as expected against the National levels with no areas of concern;
- Mortality alerts were reviewed to determine actions required for improvements and learning, with lessons learnt reported to the Q&SC. Timely completion of Structured Judgement Reviews (SJR) compliance fell to 8.82% in Q3 from 13.6% in Q2 as a result of operational pressures. Desktop review being undertaken with recommendations awaited on how to further improve compliance and embed good practice learning from deaths.

DECISION: The Board of Directors:

- Discussed and **NOTED** the CMO's report and the closure of action B/20/21 (appended to report list of Clinical Directors and Clinical Leads with externally facing roles);
- Discussed and **NOTED** the contents of the Learning from Deaths quarter 3 2021/2022 report, the systems in place to regularly review mortality data and perform deep dives into clinical pathways as indicated by the mortality alerts.

21/146 **POLICIES, GUIDANCE AND CODE OF CONDUCT REVIEW – COUNCIL OF GOVERNORS' RECOMMENDATIONS**

The Chairman reported following review by a Working Group the recommendations proposed for Board approval, noting on-going work with Governors to increase engagement with members, and positive progress building a close working relationship between the Governors and NEDs. It was noted some of the documents were Council owned, Trust owned and jointly owned as detailed below.

DECISION: The Board of Directors **APPROVED** the specific recommendations presented on pages 3 to 6 of the Policies, Guidance and Code of Conduct Review – Council of Governors' Recommendations report summarised below:

Governor Code of conduct (Trust owned document):

- Revise the Code of conduct to:
  - Include Lead Governor in initial discussions when a Governor raises concerns about an aspect of Trust's activity.
  - Align the Governor disqualification criteria to reflect changes to the Constitution.
  - Align the definition of 'Best interests' to reflect the wording in the roles and responsibilities document.

- Amend the text in the Media Policy to reflect that Governors are able to express their personal view as long as it is made clear that this is the case.

Dispute resolution (Jointly owned document):
- Revise the Dispute resolution policy to:
  - Remove 'agreement' from paragraph 2.2 in respect of the effect of recommendations arising from the external review.
  - Re-word paragraph 4.5 to reflect modern technology.
  - Amend paragraph 4.7 for clarity that this agreement of disputes being put in writing.

Managing allegations of a breach of the code of conduct (Jointly owned document):
- Revise the guidance to:
  - Ensure clarity on the process for virtual voting.
  - Include Lead Governor in the process for review of the initial review of Governor complaints (if complaint is about Lead Governor, include the Deputy Lead Governor).
  - Clarity that allegations of a breach can be made by the public and staff.
  - Remove examples of potential breaches.

21/147 **HEALTH AND SAFETY (H&S) AND ESTATES STATUTORY COMPLIANCE UPDATE**

The DoSD&CP noted key points:

- Statutory compliance levels had risen from 69% to 87% currently, anticipated to further improve these to 89% by end of March 2022 and to 95% in 2022/23;
- Review of backlog maintenance priorities for each hospital site, risk scored and ranked into medium, high and urgent priorities;
- Good progress against Health and Safety Toolkit Audit (HASTA) performance, supporting staff to complete these audits, with particular improvement by the Urgent and Emergency Care (UEC) Care Group, currently 87%.

The Board of Directors **NOTED** the Trust's current position in relation to statutory compliance, backlog maintenance, critical infrastructure and progress to date on the H&S Toolkit Audit outcomes.

21/148 **PEOPLE AND CULTURE COMMITTEE (P&CC) – CHAIR ASSURANCE REPORT**

The DoHR&OD on behalf of the P&CC Chair noted:

- Presentation of the Trust's cultural change programme, more work to be done to take this forward around a reinvigorated Equality Diversity and Inclusion (EDI) Strategy;
- Diversity and Culture development session included as part of the 2022/23 Board Development Programme.

The NEDs enquired about the funding for the cultural change programme business case, progress in developing the EDI Strategy and when these would be implemented. The DoHR&OD commented the Strategy was being developed with contribution from the HR team, members of P&CC, staff, staff networks as well as diversity and inclusion Black, Asian and Minority Ethnic (BAME) staff networks. She confirmed a business case would be submitted for consideration for funding allocation and this would be implemented as soon as possible. The Chairman

stated the importance of the incoming CEO being involved in taking this work forward.

DECISION: The Board of Directors:

- **NOTED** the 2 March 2022 P&CC Chair Assurance report;
- **NOTED** the Trust-wide cultural change programme;
- **NOTED** the CNMO Nursing and Allied Health Professional (AHP) update.

21/149 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR ASSURANCE REPORT**

The FPC Chair highlighted key points:

- Trust working on developing its operational plan for 2022/23;
- Recommendation to the Board that a strategic review of the Group structure be undertaken during 2022/23 when the incoming CEO was in post.

DECISION: The Board of Directors:

- **NOTED** the 1 March 2022 FPC Chair Assurance report;
- **NOTED** the Referral to Treatment performance report;
- **NOTED** the Operational Planning Update 2022/23;
- **APPROVED** the recommendation an IPR workshop on the new Statistical Process Control (SPC) charts to the Board (item for Board Development Programme 2022/23);
- **APPROVED** the recommendation the Board undertakes a strategic review of the Group structure during 2022/23;
- **APPROVED** the recommendation that briefings on Commissioning for Quality and Innovation (CQUINs) be provided to the Board and Council of Governors (item for Board Development Programme 2022/23).

21/149.1 **DISCHARGE PROCESS AND CRITERIA TO RESIDE**

The COO highlighted key elements from the report that provided clarification on the discharge pathways and key issues for patients who required support on discharge from Hospital to home or a community setting:

- Process supported by We Care;
- Required partnership working and engagement with system partners to ensure discharge arrangements were robust, effective and any delays were addressed. It was also important to listen to patients and understand their wishes;
- Discharge Lounges were being refurbished to provide comfortable and appropriate environment for patients.

The Chairman enquired whether the process was improving. The COO stated there was good engagement, strong relationships in place with system partners, and the Discharge team actively working with Ward teams. She commented the main area of concern was insufficient domiciliary care provision and during the winter 160 additional beds had been commissioned to address this to maintain flow across the Local Health Economy (LHE).

The CMO highlighted the Modern Ward Rounds that would be key in supporting early discharge, decision making, keeping patients informed as well as their families to be in a better position ready for discharge.

The Board of Directors discussed and **NOTED** the Discharge Process and Criteria to Reside report.

21/149.2 **WAITING LIST OVERVIEW IN CONSIDERATION OF NHS ENGLAND/NHS IMPROVEMENT (NHSE/I) 2022/23 OPERATIONAL AND PLANNING GUIDANCE**

The COO noted:

- Position Referral to Treatment (RTT) waiting times pre-Covid and post-Covid;
- Activity plan for 2022/23 to maximise capacity effectively:
  - Increase new appointments across the system to 110% against 2019/20 activity, minimum target of 104% at Trust level;
  - Reduced follow-up appointment targets of 25% against 2019/20 activity;
  - Increased elective activity across the system to 110% against 2019/20 activity, target of 104% at Trust level;
  - Increased diagnostic activity to a minimum of 120% against 2019/20 activity.

The Board of Directors **NOTED** the Waiting List Overview in Consideration of NHSE/I 2022/23 Operational and Planning Guidance report.

21/150 **QUALITY AND SAFETY COMMITTEE (Q&SC) – CHAIR ASSURANCE REPORT**

The Q&SC Chair highlighted key points:

- The Committee had requested a graph showing a forward projection of demand versus available resource to ensure demand could be met;
- Referral to the P&CC to action the identified limited progress in developing supervision after incidents and the additional changes required to appraisal paperwork;
- Care Groups were in attendance and presented their Governance Reports. The process of assurance was working well, governance discussions were taking place within the Care Groups, improvements had been progressed and it was recognised that more work remained still to be done.

DECISION: The Board of Directors **NOTED** the 1 March 2022 Q&SC Chair Assurance report.

21/151 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR ASSURANCE REPORT**

- **GIFTS, HOSPITALITY AND CONFLICTS OF INTEREST POLICY**

The IAGC Chair noted:

- Approval of the Annual Accounts – 2021/22 Review of Accounting Policies;
- Going concern Review report, requested this was also considered by the Trust's Group subsidiaries;
- Implementation plan of the new accounting standard IFRS16 from April 2022;
- Draft Integrated Governance Guide, requested a governance assurance map be produced detailing the Trust's governance reporting structure that would be presented to the Board once finalised;
- Approval of the updated Gifts, Hospitality and Conflicts of Interest Policy recommended for Board approval;
- Freedom to Speak Up (FTSU) Guardian reports would now be presented to the P&CC.

DECISION: The Board of Directors:

- **NOTED** the 22 February 2022 IAGC Chair Assurance report;
- **APPROVED** the Gifts, Hospitality and Conflicts of Interest Policy.

21/152 **NOMINATIONS AND REMUNERATION COMMITTEE (NRC) – CHAIR ASSURANCE REPORT**

The NRC Chair reported the Council of Governors were progressing the recruitment of a NED to appoint to the current NED vacancy.

The Board of Directors **NOTED** the 8 March 2022 NRC Chair Assurance report.

21/153 **CHARITABLE FUNDS COMMITTEE (CFC) – CHAIR ASSURANCE REPORT**

The CFC Chair commented on the great work of the Charity team and those in the community that continued to support and raise funds for the East Kent Hospitals Charity. It was noted the significant funding from Hornby who had graciously donated profits from sale of NHS branded trains during the pandemic. She highlighted the upcoming events including the Brighton marathon and the Virtual London marathon. The Board would be kept up to date on the identification of a future key fundraising project that the Charity team were in the process of identifying.

The Board of Directors **NOTED** the 8 March 2022 CFC Chair Assurance report.

21/154 **ANY OTHER BUSINESS**

The Chairman wished the CEO all the very best for the future, extended thanks on behalf of the Board, Trust and its staff for her leadership, commitment and hard work over the last four years. The CEO thanked the Board, Executive Directors, Governors and all the Trust staff for their constant support.

21/155 **QUESTIONS FROM THE PUBLIC**

Mrs Warburton raised the Ockenden report in respect of safety compliance and requested assurance the changes had been fully embedded and that these would be sustained. She recognised the hard work in achieving compliance. The CNMO provided assurance that compliance was signed off when robust evidence was provided, audits would continue to ensure sustained compliance that would be overseen by the MNAG.

Mrs Pettifer enquired how many of the reported 165 falls in January 2022 were patient repeat falls (single individual) as it would be useful to see this data included in the IPR to provide a comparison against the total number of falls.

ACTION: Provide the number of patient repeat falls (single individual) within the mitigation narrative section in the IPR to provide comparison against the total number of falls. — CNMO

Mrs Pettifer raised the 107 patients medically fit for discharge, of which 25 were awaiting home support, 56 residential or nursing home support and enquired what support the remaining 26 patients were awaiting. The COO stated these patients included requirements for continuing healthcare, assessment unit support for further rehabilitation and end of life.

The NHSE/I Improvement Director stated her team were working closely with the DoHR&OD on the Trust's cultural change programme supporting with resources to take this programme forward enabling sustained changes.

The Chairman closed the meeting at 4.10 pm.

Date of next meeting in public: Thursday 7 April 2022 at the Spitfire Ground - Canterbury Cricket Ground.

Signature _____

Date _____

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**MATTERS ARISING FROM THE MINUTES ON 10 MARCH 2022**
MEETING DATE:	**7 APRIL 2022**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
APPENDICES:	**APPENDIX 1: ACTIONS TABLE**

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	**Approval**	Information	Assurance	Discussion
Purpose of the Report:	The Board is required to be updated on progress of open actions and to approve the closing of implemented actions.				
Summary of Key Issues:	An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales. The Board is asked to consider and note the progress updates in the attached action log (Appendix 1).				
Key Recommendation(s):	The Board of Directors is asked to discuss and **NOTE** the progress updates on the actions from the previous meeting, those for a future meeting, and **APPROVE** the actions recommended for closure.				

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**

Link to the Board Assurance Framework (BAF):	None	
Link to the Corporate Risk Register (CRR):	None	
Resource:	Y/N	N
Legal and regulatory:	Y/N	N
Subsidiary:	Y/N	N
Assurance Route:		
Previously Considered by:	N/A	

East Kent Hospitals University NHS Foundation Trust

MATTERS ARISING FROM THE MINUTES ON 10 MARCH 2022

1. Purpose of the report

1.1. The Board is required to be updated on progress of open actions and to approve the closing of implemented actions.

2. Background

2.1. An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales.

2.2. The Board is asked to consider and note the progress updates in the attached action log (Appendix 1).

2.3. The Board is asked to consider and approve the actions noted below for closure:

Action No.	Action summary	Target date	Action owner	Status	Latest Progress Note (to include the date of the meeting the action was closed)
B/25/21	Provide an update on the ward that had implemented We Care focussing on the reducing falls breakthrough objective and whether a reduction in falls was being maintained.	Mar-22	Chief Nursing and Midwifery Officer (CNMO)	to Close	Update provided as part of IPR discussion at Board meeting held on 10.03.22. **Action for agreement for closure at 07.04.22 Board meeting**.
B/26/21	Present the IPC work programme to the Board for information once completed.	Apr-22	Director of Infection Prevention and Control (DIPC)	to Close	IPC work plan 2022/23 appended to IPC BAF presented at 07.04.22 Board meeting. **Action for agreement for closure at 07.04.22 Board meeting.**
B/27/21	Provide the percentage of energy capacity provided by the Trust's solar panels in comparison against its total energy consumption.	Apr-22	Director of Strategic Development and Capital Planning (DoSD&CP)	to Close	The solar panels at the William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) will support up to 54% of the site load once operational. Also we know that the collective impact of the solar panels and combined heat and power (CHP) units at QEQM will mean that during the summer months the site will be able to manage 'off grid'. **Action for agreement for closure at 07.04.22 Board meeting**.

B/28/21	Clarify the further improvements in section 6 of the report referenced in the key recommendations as it appeared this section was missing from the report..	Apr-22	Interim Director of Midwifery (DoM)	to Close	Information was included in the report, it was an error within the report there was no section 6. **Action for agreement for closure at 07.04.22 Board meeting**.
B/29/21	Provide the number of patient repeat falls (single individual) within the mitigation narrative section in the IPR to provide comparison against the total number of falls.	Apr-22	CNMO	to Close	Included in IPR presented at 07.04.22 Board meeting. **Action for agreement for closure at 07.04.22 Board meeting**.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST - PUBLIC BOARD								
Action No.	**Date of Meeting**	**Min No.**	**Item**	**Action**	**Target date**	**Action owner**	**Status**	**Progress Note (to include the date of the meeting the action was closed)**
B/25/21	03.02.22	21/119	Integrated Performance Report (IPR)	Provide an update on the ward that had implemented We Care focussing on the reducing falls breakthrough objective and whether a reduction in falls was being maintained.	Mar-22	CNMO	to Close	Update provided as part of IPR discussion at Board meeting held on 10.03.22. **Action for agreement for closure at 07.04.22 Board meeting.**
B/26/21	03.02.22	21/121	Infection Prevention and Control (IPC) Board Assurance Framework (BAF)	Present the IPC work programme to the Board for information once completed.	Apr-22	DIPC	to Close	IPC work plan 2022/23 appended to IPC BAF presented at 07.04.22 Board meeting. **Action for agreement for closure at 07.04.22 Board meeting.**
B/27/21	10.03.22	21/138	Integrated Performance Report (IPR)	Provide the percentage of energy capacity provided by the Trust's solar panels in comparison against its total energy consumption.	Apr-22	DoSD&CP	to Close	The solar panels at the William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) will support up to 54% of the site load once operational. Also we know that the collective impact of the solar panels and combined heat and power (CHP) units at QEQM will mean that during the summer months the site will be able to manage 'off grid'. **Action for agreement for closure at 07.04.22 Board meeting**.
B/28/21	10.03.22	21/142.1	Ockenden Review of Maternity Services - One Year on progress report	Clarify the further improvements in section 6 of the report referenced in the key recommendations as it appeared this section was missing from the report.	Apr-22	Interim DoM	to Close	Information was included in the report, it was an error within the report there was no section 6. **Action for agreement for closure at 07.04.22 Board meeting**.
B/29/21	10.03.22	21/155	Questions from the Public	Provide the number of patient repeat falls (single individual) within the mitigation narrative section in the IPR to provide comparison against the total number of falls.	Apr-22	CNMO	to Close	Included in IPR presented at 07.04.22 Board meeting. **Action for agreement for closure at 07.04.22 Board meeting.**

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**CHAIRMAN'S REPORT**
MEETING DATE:	**7 APRIL 2022**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**CHAIRMAN**
APPENDICES:	**APPENDIX 1: NON-EXECUTIVE DIRECTORS' (NEDs') COMMITMENTS**

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion
Purpose of the Report:	The purpose of this report is to: • Report any decisions taken by the BoD outside of its meeting cycle; • Update the Board on the activities of the Council of Governors (CoG); and • Bring any other significant items of note to the Board's attention.				
Summary of Key Issues:	Update the Board on: • Current Updates/Introduction; • Health Service Journal (HSJ) Provider Summit; • 2gether Support Solutions (2gether) Appointment; • Health and Care Partnership (HCP) Board; • Activity of the CoG; • Consultant Appointments.				
Key Recommendation(s):	The BoD is requested to **NOTE** the contents of this Chairman's report.				

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**
Link to the Board Assurance Framework (BAF):	N/A			
Link to the Corporate Risk Register (CRR):	N/A			
Resource:	~~Y~~/N	N		
Legal and regulatory:	~~Y~~/N	N		
Subsidiary:	~~Y~~/N	N		
Assurance Route:				
Previously Considered by:	N/A			

CHAIRMAN'S REPORT

1. Purpose of the report

To report any decisions taken by the Board of Directors outside of its meeting cycle. Update the Board on the activities of the CoG and to bring any other significant items of note to the Board's attention.

2. Introduction

On behalf of the Board, let me welcome our new Chief Executive, Tracey Fletcher. This is one of the most challenging roles in the NHS but I am confident Tracey will bring the leadership skills, energy and enthusiasm we will need as we continue the drive to transform this organisation and provide the best possible care for our patients and the population of East Kent.

As the Board is well aware, we continue to experience severely increased demand on our services, with our Emergency Departments under enormous pressure. The number of Covid inpatients has been very high at nearly 200 and although this variant mostly causes less serious illness, the impact on staff absence including clinicians, support staff and senior management has been very significant.

The national staff survey has now been published and will be discussed later – although it shows an improved position relative to other trusts in some key areas, the overall scores remain a matter of great concern. All the evidence shows that staff engagement and staff satisfaction scores are critical not just in retention but in the quality of care provided. There is much still for us to do.

I have begun the appraisal process for NEDs and will report to the CoG next month. NHS England/NHS Improvement (NHSE/I) have recently issued guidance which is officially just for non-Foundation Trusts but I hope we will be able to follow this as well. We will also be agreeing NED objectives for 2022/23.

3. HSJ Provider Summit

Last week I attended and spoke at the HSJ Provider Summit which focussed on the opportunities for providers in the system architecture. As we adapt our ways of working to the next phases of the pandemic I hope there will be opportunities for both Executive and NEDs, and other senior leaders in the Trust to take part in and engage more with external organisations, share best practice and find some more time to think strategically.

4. 2gether Appointment

Our Nominations and Remuneration Committee has ratified the appointment of George Jenkins OBE as Chairman of 2gether. George comes to us with a wealth of experience and I am delighted to welcome him to the East Kent family. The Committee also approved any required extension for the Interim Chair, Jane Ollis, on the previously agreed terms. A report will be presented to the next Committee meeting about this virtual decision for formal noting.

5. Health and Care Partnership Board (HCP)

We will be briefing the Board in more detail about the continuing development of the Partnership which I Chair and which we believe will be a critical forum for collaboration across East Kent. We have now agreed a structure which will make sure that our decisions are clinically and professionally led. We will also continue to engage with the Integrated Care Board for Kent and Medway to establish what functions should be operated at this 'place' level. All partners are determined that it will be productive and will develop new ways of working and new interventions focussed around patient and user need. One of our key priorities is workforce and we have now launched our East Kent wide campaign Ready to Care, which is aimed at recruiting to both health and social care.

This is part of a workforce plan the partnership is taking forward which should include a summit later in the year.

At its last meeting the Partnership welcomed Jim Beale the new Director of Adult Social Care for East Kent who gave a frank assessment of the challenges he and his colleagues face. Both in the Partnership and here at the Trust we will be doing everything we can to support Jim and making sure we develop the best possible collaboration between health and social care services.

6. Council of Governors (CoG)

I am sorry to report that Liz Baxter the public Governor for Folkestone & Hythe has stood down for personal reasons which means that we have 3 public Governor vacancies, 1 for Folkestone & Hythe and 2 for Swale. We have begun the election process and hope to have them filled early in June.

The annual election of our Lead and Deputy Lead Governors by Council is also underway – the current terms conclude at the end of May.

The Council's Membership Engagement & Communication Committee has agreed a Membership and Engagement Strategy for the next 5 years. It sets out how we plan to engage our current membership and recruit new members to join. It also considers how we can encourage more members to stand in Governor elections.

A new Policies and Procedures Task & Finish Group is being set up to look at Council processes, which will assist in the day to day running of the Council.

We have completed the Governors' Effectiveness review and the results will be presented to Council in April.

During March I have engaged with Governors in small groups to update them on the situation within the Trust and to hear their views. These types of meetings appear to have been well received as have the regular virtual informal briefs I give to Governors between Council meetings.

I am pleased to report that joint NED and Governor site visits have restarted and a plan of future visits in 2022/23 has been circulated. The aim is to have at least 2 joint visits every month.

The Council's Nominations and Remuneration Committee have taken on an agency to take forward the recruitment for the vacant NED on the Board. It is now at the longlisting stage.

7. Consultant Appointments

NED members of the Board are responsible for chairing Advisory Appointment Committees (AACs) for new substantive Consultant posts. The following panels were chaired:

- Consultant Neurologist – Chaired by Stewart Baird (NED);
- Consultant Diabetes & Endocrinology – Chaired by Sarah Dunnett (NED);
- Consultant Emergency Medicine – Chaired by Professor Chris Holland (Associate NED).

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Non-Executive Directors' (NEDs) Commitments

NEDs March 2022 commitments have included:

Chairman	Chaired meeting of NEDs Meetings with individual NEDs End of year appraisals and objective setting meetings with individual NEDs Meeting with incoming Chief Executive Officer Meetings with Executive Directors Meetings with Lead Governor Meetings with Governors Chaired meetings with Governors Council of Governors Briefing NED We Care Development Session Meeting with Consultant Obstetrics and Gynaecology Meeting with William Harvey Hospital (WHH) Triumvirate Site visit to WHH – Acute Medicine Chaired East Kent Health and Care Partnership (HCP) Board meeting Kent & Medway Chairs meetings Meeting with the Director of Centre for Health Services Studies (CHSS) Health Service Journal Provider Summit

Non-Executive Directors	Meetings with Chairman Meetings with Executive Directors NED We Care Development Session Council of Governors Audit and Governance Committee meeting Joint NED/Governor site visits to WHH Art Work Unveiling at Queen Elizabeth the Queen Mother Hospital Finance and Performance Committee meeting Quality and Safety Committee meeting People and Culture Committee meeting Maternity and Neonatal Assurance Group meeting AAC Panel Chair for Consultant Neurologist AAC Panel Chair for Consultant Diabetes & Endocrinology AAC Panel Chair for Consultant Emergency Medicine NHS Providers NED Induction Event

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**CHIEF EXECUTIVE OFFICER'S (CEO'S) REPORT**
MEETING DATE:	**7 APRIL 2022**
BOARD SPONSOR:	**CEO**
PAPER AUTHOR:	**CEO**
APPENDICES:	**NONE**

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	The CEO provides a monthly report to the BoD providing key updates from within the organisation, NHS Improvement (NHSI), NHS England (NHSE), Department of Health and other key stakeholders.				
Summary of Key Issues:	This report will include a summary of the Clinical Executive Management Group (CEMG) as well as other key activities.				
Key Recommendation(s):	The BoD is requested to **DISCUSS** and **NOTE** the CEO's report.				

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**

Link to the Board Assurance Framework (BAF):	The report links to the corporate and strategic risk registers.	
Link to the Corporate Risk Register (CRR):	The report links to the corporate and strategic risk registers.	
Resource:	~~Y~~/N	No
Legal and regulatory:	~~Y~~/N	No
Subsidiary:	~~Y~~/N	No
Assurance Route:		
Previously Considered by:	N/A	

CEO'S REPORT

1. Purpose of the Report

The CEO provides a monthly report to the Board of Directors providing key updates from within the organisation, NHS Improvement (NHSI), NHS England (NHSE), Department of Health and other key stakeholders.

2. Background

This report will include a summary of the Clinical Executive Management Group (CEMG) as well as other key activities.

3. Clinical Executive Management Group

3.1 Business cases approved or recommended at the 9 March 2022 meeting of the CEMG included:

- Picture Archiving Communication System (PACS), Radiology Information Service (RIS) and Image Archive Systems (VNA) Contract for the Kent and Medway Medical Imaging Consortium (KMMIC).
- Special Care Baby Unit (SCBU) Refurbishment Business Case.

4. Operational Update

4.1 March was a month focussed on re-establishing and increasing our elective activity across all sites as the Trust reset following the Winter Omicron surge. There was some impact on elective activity at the acute sites on days when the hospitals were at capacity, green bed space was re-purposed to support non-elective escalation areas. However, the teams worked hard to ensure this disruption was kept to a minimum.

Diagnostic performance was significantly impacted by staff absence at the start of the year. Performance has improved in February, however, the impact of reduced diagnostic capacity, married with increased demand following public health campaigns, has resulted in the Trust's Cancer Standards falling short of target. Chief Operating Officer, Cancer and Clinical Support Service (CSSD) Senior Leadership teams are engaged in identifying ring fenced capacity (28 CTs and 17 MRIs per day required to achieve 28 day compliance) supported by the Community Diagnostic Centre at Buckland Hospital.

The Care Groups have been continuing to work through their activity plans for 2022/23 with the second submission to the Clinical Commissioning Group (CCG) due on Wednesday 6 April 2022. A key area of focus for this year's activity submission has been opportunity and efficiency. All specialties have been challenged to meet key efficiency targets to support the required 10% growth in activity.

4.2 Nightingale Hub Update

The decommissioning process of the Nightingale Hub is now complete. The dismantlement works were completed on schedule, on Friday 11 March 2022. Once essential repair, maintenance and improvement works to the main visitor car park and the fracture car park are complete on the 31st, staff who were diverted to facilities at Hinx Hill and the Julie Rose stadium, will be able to return to car parking at William Harvey Hospital (WHH).

The Trust was asked to contribute to a Nightingale 'Lessons Learnt' paper submitted by the South East region to NHSE/I, related to the programme of works that was undertaken to support the Nightingale Hub, to establish: what went well, what worked less well, what could be undertaken differently, and what practical and operational changes should be made in the future to embed this learning.

5. Finance Update and Business Planning 2022/23

5.1 The Trust has delivered a surplus of £1.3m to the end of February. It is expected we will breakeven for the 2021/22 financial year, consistent with plan. The Trust continues to work closely with Kent and Medway system partners to develop our operational plan for 2022/23 however, it should be noted that the financial environment is tougher next year, with an increased efficiency ask and a reduction in Covid-19 funding.

6. Infection Prevention and Control

6.1 Covid-19 Update

At the time of writing (28 March 2022) it is clear that the BA.2 sub-variant of Omicron is now dominant across the UK. With the complete lifting of societal restrictions and waning immunity, this has led to some of the highest levels of Covid-19 yet seen in the community. Although community testing is now very limited, Office for National Statistics (ONS) data confirms this. This is reflected in the number of patients in our hospitals who have tested positive for Covid-19 (as well as large numbers attending Emergency Departments and other ambulatory areas). We currently have 201 inpatients, which is more than the peak in May of 2020, though fewer than half of the peak in January 2021. In the majority this is an incidental finding and mortality, morbidity and need for critical care remain low, but the operational pressure created is considerable. There is limited scope for moving to a more 'business as usual' approach to managing Covid-19 until this peak passes.

7. People and Culture Update

7.1 The results of Quarter 4 National Pulse Survey were published this month and showed that the level of staff engagement has remained consistent with the national staff survey results from October 2021. At 6.4 it is a 0.3 increase on the results from 2021. The Board may wish to note that this is currently in line with the national median, also at 6.4. Whilst this represents an increase for our Trust, the national position has deteriorated from 7.1 last year.

The National Staff Survey was published at 09:30 on 30 March 2022. The survey shows an improving position in some key areas, which is positive. However, it also demonstrates that there is considerable work to do with

regard to our ambitions to make our Trust a great place to work. A formal presentation on the survey will be shared with the People and Culture Committee in April.

8. Strategic Update

8.1 New Hospitals Programme

Last Autumn the Trust submitted an expression of interest for £460 million capital investment to the new hospitals programme, seeking vital and long-overdue investment in our hospitals for the long term. A decision on the long listed schemes is expected soon. A successful bid is essential before the NHS can consult on options to transform how our services are delivered in future. In the meantime, we are undertaking due diligence with the construction industry to further test the viability and deliverability of both options. This exploratory process is an important piece of work that will provide an additional assurance test before consultation gets underway.

8.2 Vascular Services

A public consultation on a proposal to improve vascular services in hospitals in East Kent, Medway and Maidstone areas concluded on 15 March 2022. The proposal recommends all inpatient vascular surgery taking place at a single specialist centre at Kent and Canterbury Hospital (K&C) in future, instead of at two hospitals, K&C and Medway. Most care, such as clinics, tests and scans, would continue unchanged at the patient's nearest hospital in Ashford, Canterbury, Margate, Maidstone and Medway. Day surgery would continue at Medway and Canterbury hospitals. Commissioners will consider the consultation feedback, and all other evidence, with a decision expected later this year.

9. Quality Governance

9.1 The review of the complaints/Patient Advice and Liaison Service (PALS) process is nearing completion following the joint Care Group and corporate team workshop. The review has included input from patients/families, as well as feedback from specialist groups such as Kent Association for the Blind. The updated process focuses on a more compassionate and responsive approach, and will be launched on 1 May 2022. The Quality Governance Division restructure consultation completes in April, and there has been significant input and engagement from staff. A Task and Finish group has been established to ensure closure of the backlog of Serious Incidents, and an improved response to new incidents, so that future incidents are managed within set timeframes. The CCG has approved a thematic review approach to Falls and Pressure Ulcers, as well as three other themes, so that 40% of overdue incidents will be closed by June 2022.

10. Conclusion

10.1 The BoD is requested to **DISCUSS** and **NOTE** the CEO's report.

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REPORT TO:	BOARD OF DIRECTORS (BoD)
REPORT TITLE:	INTEGRATED PERFORMANCE REVIEW (IPR)
MEETING DATE:	7 APRIL 2022
BOARD SPONSOR:	DIRECTOR OF FINANCE AND PERFORMANCE
PAPER AUTHOR:	DIRECTOR OF FINANCE AND PERFORMANCE
APPENDICES:	APPENDIX 1: FEBRUARY 2022 IPR

Executive Summary:

Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**

Purpose of the Report:

The Trust has been engaged with a new quality improvement programme called "We Care".

The premise is that the Trust will focus on fewer metrics but in return will expect to see a greater improvement (inch wide, mile deep).

Summary of Key Issues:

The attached IPR is now ordered into the following:

True Norths- These are the Trust wide key strategic objectives which it aims to have significant improvements on over the next 5 years, as these are challenging targets over a number of years it may be that the targets are not met immediately and it is important to look at longer term trajectories. The areas are:

- our **quality and safety.** The two metrics the Trust has chosen to measure against is total harms and mortality rate.
- our **patients.** The four metrics being measured are the Cancer 62-day target, the Accident & Emergency (A&E) 4-hour performance target, the Referral to Treatment (RTT) 18-week target and the Friends and Family recommended %.
- our **people.** The two metrics chosen are staff turnover and staff engagement.
- our **sustainability.** The two metrics chosen to improve are the Trust's financial position and carbon footprint.
- our **future.** The two metrics chosen are the medically fit for discharge % and virtual outpatients usage.

Breakthrough objectives- These are objectives that we are driving over the next year and are looking for rapid improvement. The key areas are:

- **Reducing falls**. The target is to have no more than 100 falls per month, this month there was 147.
- **Reducing deaths from sepsis**. The latest reportable figure of November 2021 shows an improvement in the sepsis/ respiratory Hospital Standardised Mortality Ratio (HSMR) figures of 94.2 this is below our target of 117.
- **Reducing patient time in Emergency Department (ED) once there has been a decision to admit.** Total

East Kent Hospitals University NHS Foundation Trust

	aggregated delays of 907 hours in our ED remains a significant focus and is higher than our 95-hour target. • **Improving theatre capacity.** The lost theatre opportunities in month was 60 which is worse than the 45 target. **Watch Metrics -** these are metrics we are keeping an eye on to ensure they don't deteriorate.
Key Recommendation(s):	To **CONSIDER** and **DISCUSS** the True North and Breakthrough Objectives of the Trust.

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**

Link to the Board Assurance Framework (BAF):	**BAF 32**: There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 34**: Failure to deliver the operational constitutional standards due to the fluctuating nature of the Covid-19 pandemic necessitating a localised directive to prioritise P1 and P2 patients. **BAF 31:** Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements and Covid-19, leading to harm, including death, breaches of externally set objectives, possible regulatory action, prosecution, litigation and reputational damage	
Link to the Corporate Risk Register (CRR):	**CRR 77:** Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 78:** There is a risk that patients do not receive timely access to emergency care within the ED. **Other risks identified not on the CRR:** Risk 1. The scorecard does not capture an accurate view of Performance for the Board. Mitigation 1. We have spent a long time agreeing with the subcommittees the level of detail contained within the scorecard, undertaken the catchball session with the Board and this discussion constitutes the next level of engagement to ensure when we go live the scorecard does accurately reflect performance.	
Resource:	N	
Legal and regulatory:	N	
Subsidiary:	Y	Working through with the subsidiaries their involvement and impact on We Care.
Assurance Route:		
Previously Considered by:	Finance and Performance Committee (FPC) and Quality & Safety Committee (Q&SC) 29 March 2022.	

NHS
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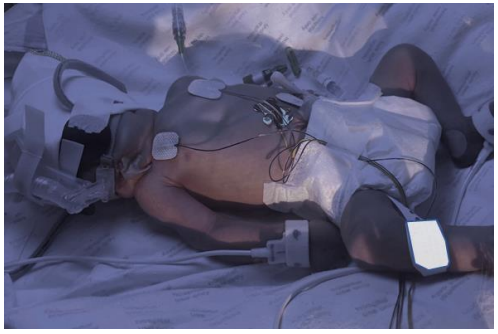
Integrated Performance Report

February 2022







We care

Our vision, mission and values

We care' is how we're working to give great care to every patient, every day. It's about being clear about what we want to focus on and why and supporting staff to make real improvements, by training and coaching everyone to use one standard method to make positive changes.

We know that frontline staff are best placed to know what needs to change. We've seen real success through initiatives like 'Listening into Action', 'We said, we did', and 'I can'.

'We care' is a bigger version of this – it's the new philosophy and new way of working for East Kent Hospitals. It's about empowering frontline staff to lead improvements day-to-day.

It's a key part of our improvement journey – it's how we're going to achieve our vision of great healthcare from great people for every patient, every time.

For 'We care' to be effective, we need to be clear about what we are going to focus on – too many projects will dilute our efforts.

For the next five years, our focus centres on five "True North" themes. These are the Trust-wide key strategic objectives which it aims to significantly improve over the next 5 years:

- our **patients**
- our **people**
- our **future**
- our **sustainability**
- our **quality and safety**

True North metrics, once achieved, indicate a high performing organisation.

What is the Integrated Performance Report (IPR)?

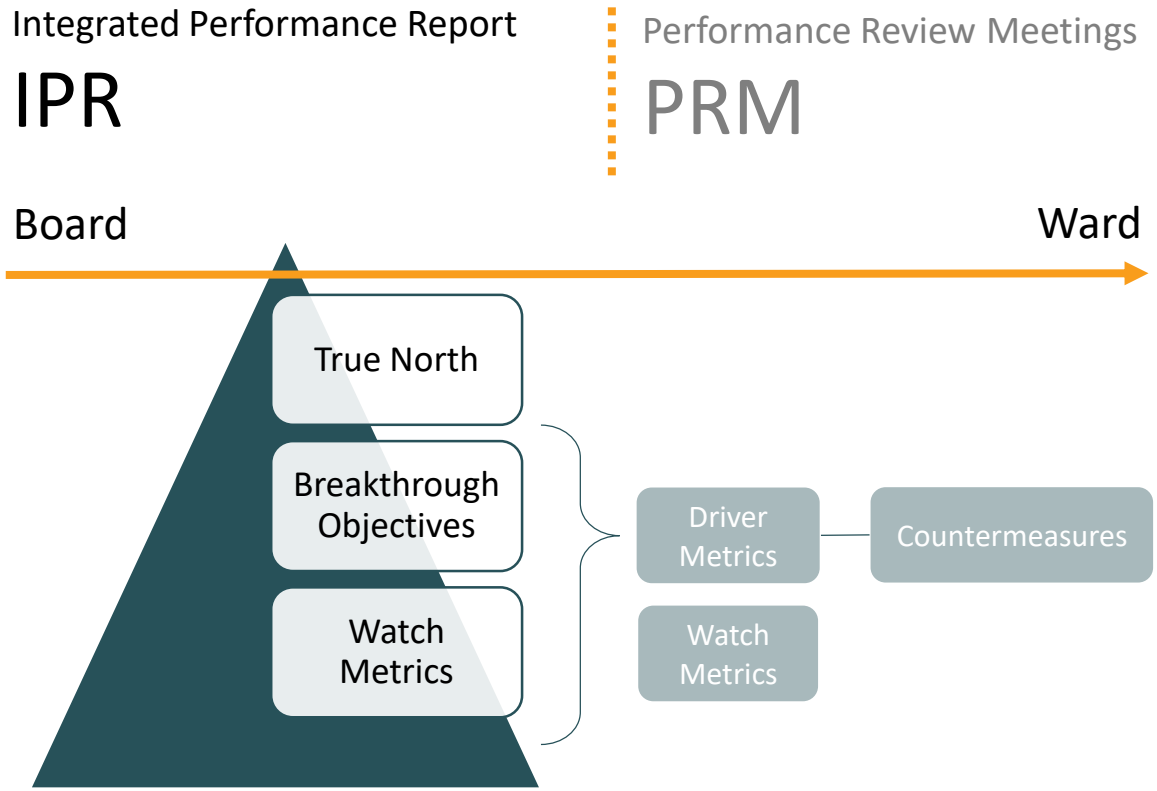
To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year. These are the "breakthrough" objectives that we are driving over the next year and are looking for rapid improvement.

- Reducing falls
- Reducing healthcare acquired infections
- Reducing deaths from sepsis/respiratory failure
- Improving theatre capacity
- Reducing patient time in ED once there has been a decision to admit.

We have chosen these five objectives using data to see where focusing our efforts will make the biggest improvement. We'll use data to measure how much we're making a difference.

Frontline teams will lead improvements supported by our Improvement Office, which will provide the training and tools they need. Our Executive Directors will set the priorities and coach leaders in how to support change. Our corporate teams will work with frontline teams to tackle organisation-wide improvements.

We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our improvement journey.



The IPR forms the summary view of Organisational Performance against these five overarching themes and the five objectives we have chosen to focus on in 2020/21. It is a blended approach of business rules and statistical tests to ensure key indicators known as driver and watch metrics, continue to be appropriately monitored.

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

The 'We Care' methodology incorporates the use of SPC Charts alongside the use of Business Rules to identify common cause and special cause variations and uses **NHS Improvement** SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor.

The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

If data point falls outside these levels, an investigation would be triggered.

It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons

Variation			Assurance		
	H L	H L	?	P	F
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Where to find them

What are the Business Rules?

Breakthrough objectives will drive us to achieve our "True North" (strategic) goals, and are our focus for this year.
These metrics have a challenging improvement target and the scorecard will show as red until the final goal is achieved when it then turns green. Once achieved a further more stretching target may be set to drive further improvement, turning the metric back to red, or a different metric is chosen.

Metrics that are not included in the above are placed on a watch list, where a threshold is set by the organisation and monitored. More of these metrics should appear green and remain so. Watch Metrics are metrics we are keeping an eye on to ensure they don't deteriorate.

Business rules work in conjunction with SPC alerts to provide a prompt to take a specific action.

This approach allows the organisation to take a measured response to natural variation and aims to avoid investigation into every metric every month, supporting the inch wide mile deep philosophy.

The IPR will provide a summary view across all True North metrics, detailed performance, actions and risks for Breakthrough Objectives (driver) and a summary explanation for any alerting watch metrics using the business rules as shown here as a trigger.

#	Rule	Suggested rule
1	**Driver** is **green** for reporting period	Share success and move on
2	**Driver** is **green** for six reporting periods	Discussion: 1. Switch to watch metric 2. Increase target
3	**Driver** is **red** for 1 reporting periods (e.g. 1 month)	Share top contributing reason, and the amount this contributor impacts the metric
4	**Driver** is **red** for 2 reporting periods	Produce Countermeasure summary
5	**Watch** is **red** for 4 months	Discussion: 1. Switch to driver metric (replace driver metric into watch metric) 2. Reduce threshold
6	**Watch** is out of control limit for 1 month	Share top contributing reason (e.g. special / significant event)

Our quality and safety

Our quality and safety

Rebecca Martin

Mortality (HSMR)

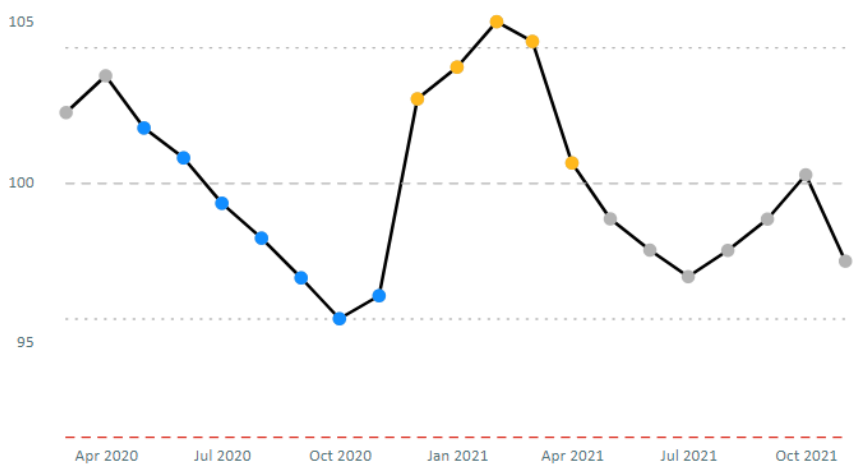
Mortality metrics are complex but monitored and reported nationally as one of many quality indicators of hospital performance. While they should not be taken in isolation they can be a signal that attention is needed for some areas of care and this can be used to focus improvement in patient pathways.

Our aim is to reduce mortality and be in the top 20% of all Trusts for the lowest mortality rates in 5 to 10 years. We have set our threshold for our rolling 12 month HSMR to be below 90 by January 2027 to demonstrate achievement of our ambition.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
104.3	100.6	98.8	97.8	97.0	97.8	98.8	100.2	97.5			

Variation indicates consistently falling short of the target	Common cause (no significant change)	Flag Description No Special Cause Flags

XMR Run Chart



What the chart tells us

The Trust HSMR has been improving since the end of the second Covid-19 wave in March 2021 and now sitting above the lower control limit shows common cause variation. The metric demonstrates a 12 month rolling position to November 2021 which is the last data release.
There have been no new mortality alerts since last report.

Intervention and Planned Impact

Interventions planned to drive our improvement are:

- Breakthrough Objective focussed on improving outcome for patients admitted to our hospitals with sepsis or respiratory failure as their admission diagnosis. This has reached its target of and is detailed on slide 8. Following review of improvement priorities for 2022/23 the breakthrough objective will be closed and activity monitored through monthly Mortality Steering and Surveillance Group.
- The fracture Neck of Femur pathway is being revised to improve outcomes for this group of patients and this is reported as a driver metric for Surgery and Anaesthetic Care group . We are analysed of the impact of reducing our current HSMR for fractured neck of femur from 118 to 100 on the overarching metric to give us an reduction of 2 points on overarching HSMR. A TPIP will be launched for 2022/23 to support driving this at WHH and QEQM sites
- The Trust has commissioned a desktop review of our mortality review processes through the NHSIE Better Tomorrow team. Feedback has been received and recommendations reviewed.
- A focussed review of patients with healthcare associated Covid-19 is being undertaken to identify any additional learning and will be presented to Q&SC in May 2022.

Risks/Mitigations

The impact of Covid-19 on national mortality surveillance is a risk although the baseline appears to have settled which is sustained will give a clearer impact of improvement activity.

20/21 breakthrough objective

Sepsis & Respiratory Failure (Composite HSMR)

Sepsis and respiratory failure have consistently triggered as primary diagnostic categories making the greatest contribution to the Trust's HSMR over the last few years. We believe that understanding and acting on the drivers behind this performance will help us provide a safer service for our patients.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
130.9	125.2	116.3	109.8	105.9	100.9	100.2	100.7	94.2			

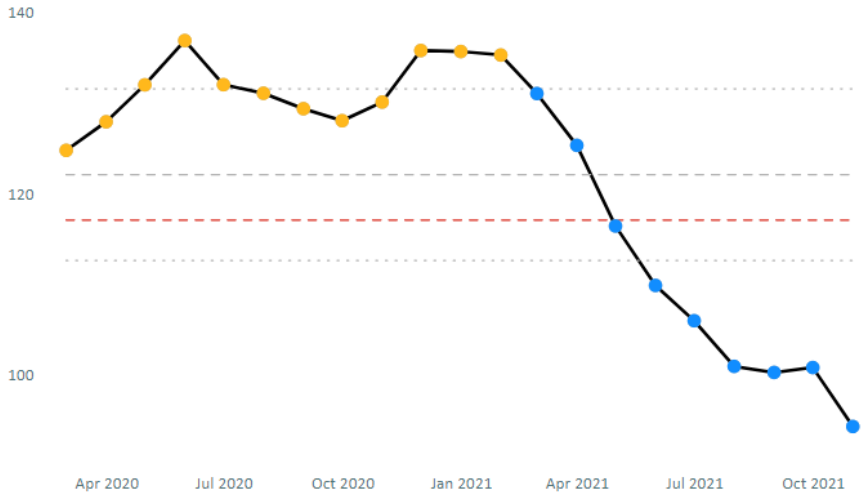
Variation indicates inconsistently passing and falling short of the target

Special cause of improving nature or lower pressure due to lower values

Flag Description

Below Mean Run Group
Astronomical Point
Two Out Of Three Beyond Tw...

XMR Run Chart



What the chart tells us

The Trust composite HSMR began to rise at the beginning of the global C-19 pandemic peaking around June '20. The rolling 12 month position dropped slightly following the first wave, peaking again following the second wave in early '21. Since this the rolling 12 month performance has consistently improved, achieving threshold in May '21. Performance has been sustained below threshold up to and including the most recent data point in November '21.

Intervention and Planned Impact

The improvement tool used to investigate this breakthrough objective has focused on 3 areas with a 4th being identified via a national mortality alert in November 2020; Recognition, escalation and response to the deteriorating patient, Advance care planning, Learning from deaths and harm & Excess mortality in hip fracture patients.

Interventions over the last 30 days;

- Seabathing ward is now re-established as hip fracture ward at QE
- Sepsis treatment bundle has been widely shared with clinical teams. The digital enablement plan is on track for reporting in April '21

Interventions planned for the next 30 days

- This breakthrough objective and driver meeting needs to be handed over to a business-as-usual process. Options have been discussed and a preferred option identified. Handover is in progress.

Risks/Mitigations

There are currently no considered risks with this breakthrough objective.

Our quality and safety

Sarah Shingler

The True North target is to achieve zero avoidable harm within 5-10 years. Our calculation includes incidents with harm or those that have the potential to lead to harm and aggregates the following;

- Falls, Pressure Ulcers, C Difficile (in-hospital), E.Coli (in-hospital), Covid Infections (in-hospital), Nutrition Incidents, Medication Errors

The effects of patient safety incidents go beyond the impact of the physical injury itself. Patients and their families can feel let down by those they trusted, and the incident may also lead to further unnecessary pain and additional therapy, or operative procedures and additional time in hospital or under community care.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
477	381	431	453	510	456	445	444	461	512	668	603

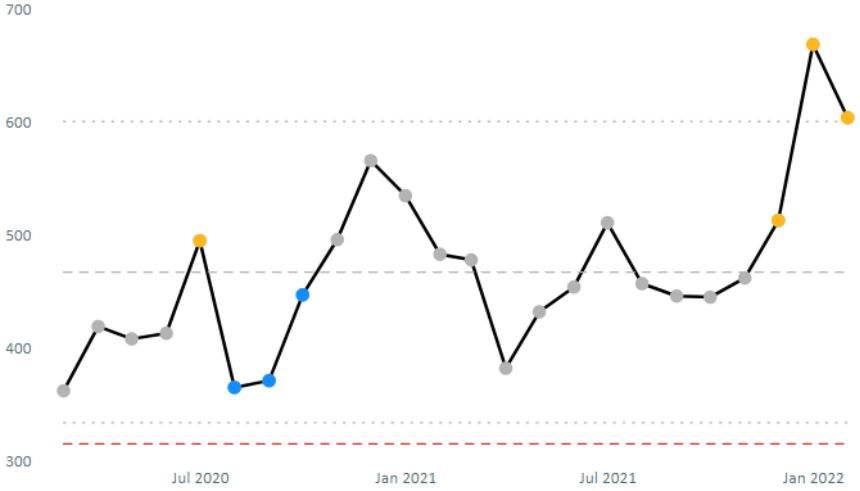
Variation indicates consistently falling short of the target

Special cause of concerning nature or higher pressure due to higher values

Flag Description

Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The number of total harms has been fluctuating around the mean and within normal variation for the period since February 2020.
The most recent month's data point is now just meeting the upper control limit on the SPC chart, this increase is driven by the number of C-19 HCAI infections in February '22.
We have seen a reduction in falls and pressure ulcers (category 2,3,4) through February 22.

Intervention and Planned Impact

Safe staffing is a major factor contributing to patient harms, we are now beginning to see a direct correlation between low staffing levels and harm. A business case has been approved and recruitment pipeline in place. We expect to see a demonstrable change in staffing levels from June '22 onwards, being fully established by January '23.

Terms of Reference and membership have recently been refreshed for the pressure ulcer and falls multi disciplinary team (MDT) steering groups, both chaired by the Site Director of Nursing. Oversight of progress is reported through the Fundamentals of Care Committee with exception reporting into Quality & Safety Committee (QSC).

An improvement plan is in place for nutrition, falls and pressure ulcer care.

Risks/Mitigations

- Fundamentals of Care training and We Care meetings recommenced Feb 22
- Temporary staffing strategies in place to support QEQM ED and AMUs and other wards where staffing is significantly compromised and where enhanced care is required.
- Ward leaders and Matrons out on the floor supporting ward teams, increasing oversight that risk assessment and falls/pressure strategies are being used.

20/21 breakthrough objective

Falls

Analysis shows that falls are currently the greatest contributor to harm events. Currently 45% of falls are reported as not resulting in harm and 54% of falls are reported as resulting in low harm. The assessment of falls is not currently standardised across the Trust.

Any fall can leave patients and their families feeling let down by those they trusted, with the potential need for further therapy, pain, operative procedures or additional time under community care or in hospital. All can impact long term outcome.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
112	102	104	132	140	132	146	146	134	151	164	147

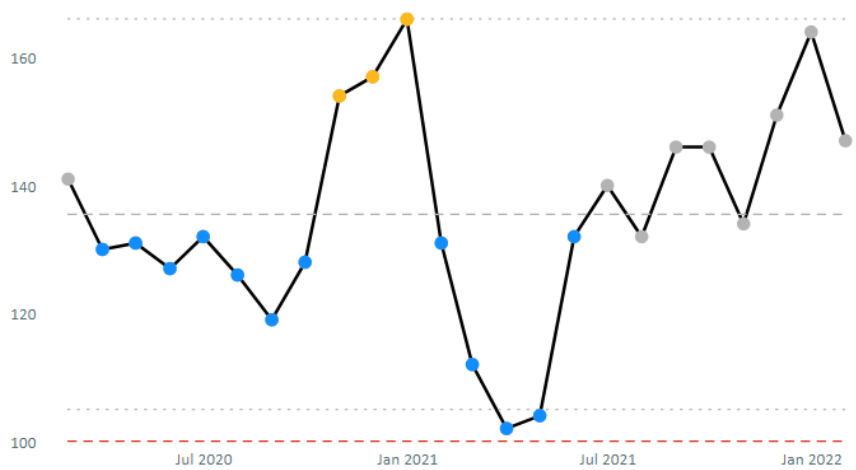
Variation indicates consistently falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The number of falls in February across the Trust was 147. The number had plateaued between Jun to Nov '21 during a period of intensive focus on harm reduction from falls, by wards/care groups and driver meetings. In Dec/Jan operational pressures around hospital flow increased, with additional escalation areas opened. Attendance at the driver meetings reduced to allow that focus. The driver meetings and focus on Falls A3s has now recommenced, with a subsequent improvement seen.
Harm reported in Feb 22: 1 severe, 3 moderate, 143 low/no harm events.
Areas of high numbers of falls include Cambridge L, Quex, Clarke and Sandwich wards.

Intervention and Planned Impact

- The 'Falls Yellow Kits' are now in use in the UEC care group at WHH and QEQM. The pilot predicted their impact would be greater identification and visibility of patients at high risk of falls, with a significant reduction in falls across UEC (up to 20 fewer falls per month) which continues into the ward admission. The corporate falls team have been assisting in identifying high risk patients in ED at WHH. This will be rolled out at QEQM with the new band 4 who commenced this week. In recent weeks 50 patients have been identified, with only 1 subsequent fall amongst these patients. A combination of the yellow kits and greater corporate falls team input, continues to result in a significant reduction in numbers of falls across the UEC care group (despite on-going capacity challenges).
- Camb M1 have now completed their Falls A3 and can demonstrate a 50% reduction in ward falls.
- The wards identified above as having high numbers of falls are receiving intensive support from the corporate falls team, to help identify areas of improvement.

Risks/Mitigations

When the BO is closed there is a risk that a lack of focus on falls improvement will result in the local teams not feeling empowered to make the local changes they wish to implement. The CNMO has agreed that the fortnightly, matron led meetings will continue as business as usual to mitigate this risk and will feed into the wider fundamentals of care work which will focus on reducing all harm moderate and above.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Harm Events	W4		Covid-19 HCAI		1	15	35	178	138
	W4		Nutrition Incidents		60	61	68	66	76
	W4		Serious Incidents		18	35	24	21	18

Covid-19 HCAI

The Omicron variant surge presented new and complex challenges, with increased transmissibility compared with Delta (circa X3) and the original Covid-19 virus (circa X10). In common with other trusts locally and nationally there have been a number of outbreaks and clusters of HCAI cases. A second smaller surge in February, as predicted, has seen lower but still significant numbers of HCAI cases. Conversely mortality and morbidity appear to be very much reduced in all cases; many cases are incidental findings in patients presenting for other reasons.

Nutrition Incidents

Short staffing on wards clearly has an impact on omissions in care. It is expected that datix numbers will increase over the next few months, consideration is being given as to whether we need to raise the threshold again.

Increased incidents relating to Parenteral Nutrition line infection risks are currently undergoing greater scrutiny and will be reviewed at the next IPC Committee.

Food and drink incidents relate to delays in meal provision and poor mouthcare, action is being undertaken by 2GSS and Clinical Teams.

Increased incidents for incomplete documentation for NG tubes, food and fluid charts has been raised with care groups.

All of the above issues are raised with HoNs and are being taken to the Care Group Governance meetings over the next four weeks to agree plans of action. Outputs will be overseen by the FOC Committee.

Serious Incidents

SI's have decreased and the categories of SI's reported are more widespread, with less falls and Pressure ulcers this month. Covid outbreaks (4) and delays to treatment/response/diagnosis (5) are the main contributory categories. There were 3 allegations of abuse which are being investigated.

Our patients

Our patients

Rebecca Carlton

Trust Access Standards: 18wk Referral to Treatment

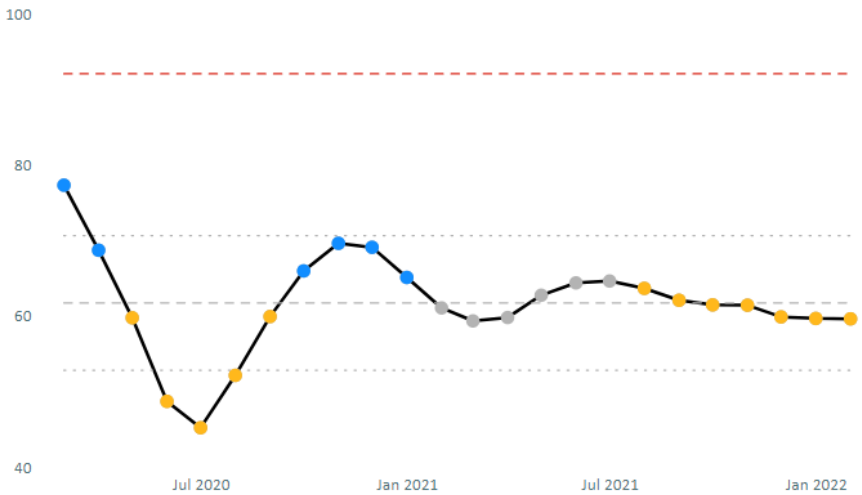
The National RTT Standard is to achieve a maximum of 18 weeks wait from GP referral to 1st definitive treatment for every patient. It is a priority to ensure patients have access to timely care whilst also reflecting patient choice regarding timing and place of treatment.

Performance has been adversely affected by the global pandemic and as we enter our recovery phase we are committed to improving our elective waiting times moving towards delivery of the constitutional standard. As part of the 'sustaining access' Strategic Initiative early work has commenced with system partners regarding demand management, pathway design, and an early focus on waiting times for 1st Outpatient Appointment.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
59.3%	59.7%	62.7%	64.3%	64.5%	63.6%	62.0%	61.4%	61.3%	59.8%	59.6%	59.5%

F	L	Flag Description
Variation indicates consistently falling short of the target	Special cause of concerning nature or higher pressure due to lower values	Descending Run Group

XMR Run Chart



What the chart tells us

Performance reduced rapidly at the beginning of the pandemic with the lowest performance occurring in July 2020. During the initial elective recovery phase in spring/summer 2020 performance improved, dipping to a lesser extent during waves two and three. Performance is demonstrating a special cause variation of a decreasing nature over the last 6 months with performance now below the mean for the period.

Intervention and Planned Impact

- 2022/23 Business planning underway with care groups to focus on increased activity to reduce the waiting lists and treat long waiting patients. Key actions include:
- Actual Theatre Utilisation 85%
- Reduction of cancellations on the day
- Reduction in OPD DNA's
- Contracts to continue use of the IS and West Kent Shared PTL being finalised to assist with treating our long waiting patients.
- Updated Access Policy approved at CEMG. Teams reminded to follow the access policy to ensure that we have the right patients on the waiting list and we manage patients according to the policy. It is anticipated that we will see an increase in the number of patients removed or placed on active monitoring as they are unfit for surgery.
- TIF submission for continuation of the Vanguard theatre/ or alternative to the system to support elective activity at Kent and Canterbury Hospital.

Risks/Mitigations

- Increased number of patients testing positive to Covid leading to cancellations on the day and 1-3 days prior to admission.
- Increased number of staff testing positive to Covid impacting on available staffed theatre sessions.
- Increased number of Covid positive patients on all sites impacting on bed availability.

20/21 breakthrough objective

Theatre Session Opportunity

Efficient use of our theatre complex is key to maximising the throughput of routine elective care.
It is imperative that elective surgery deferred during the global pandemic is prioritised alongside Cancer and urgent operative needs to minimise any harm to our patients and reduce our overall waiting times for elective surgery.

Ensuring that the theatre capacity we have available is utilised in the most efficient manner will allow for subsequent decisions regarding any residual capacity deficits and new ways of working.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
38	26	17	23	39	51	48	39	38	52	54	60

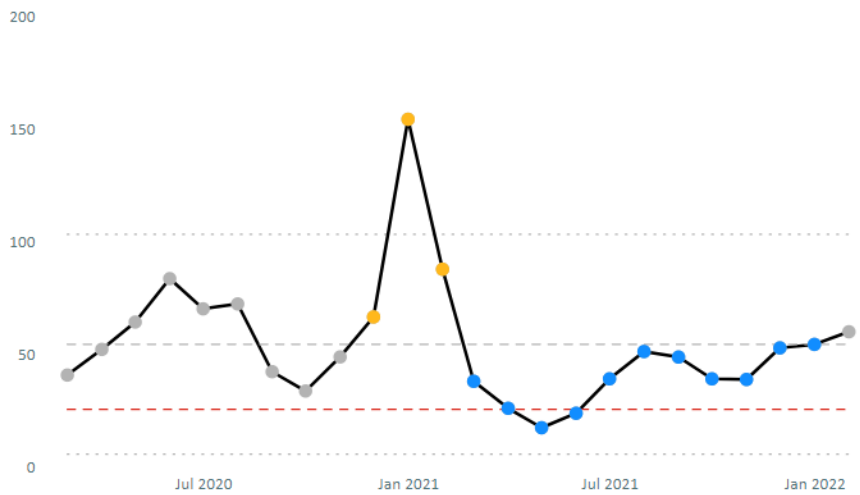
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

Current performance shows an opportunity of 60 sessions of theatre capacity available an increase on the previous month. Review of the data identifies that the opportunity is made up of :
36 cancelled sessions,12 sessions related to early finishes ,5 sessions related to turnaround times, 4 due to late starts and 3 due to cancellations on the day. This data is being validated as the theatre moves do not appear to have been actioned correctly on Theatre man.

Intervention and Planned Impact

- The EOC has been returned to Orthopaedics and joint replacements are now being booked to ensure long waiting patients are treated.
- Ensuring lists are booked to 95% with an actual theatre utilisation of 85% - this has been included as part of the business planning process and is an objective for each care group. It is expected that this increased actual utilisation will support delivery of the 104% activity plans.
- Breakthrough meeting restarted to ensure focus on minimising opportunity and improving utilisation.
- Care groups asked to return to pre-Covid avg cases per list to improve productivity and utilisation.
- Care groups have been asked to work with pre-op to reduce the number of cancellations on the day but noted that the patients that cancel 1-3 days before surgery are having an impact on the ability to fully utilise theatre lists. Patients are unwilling to self isolate without confirmation of surgery.

Risks/Mitigations

- Winter pressures remain a challenge impacting on availability of green beds.
- Short notice patient cancellations due to Covid-19 impacting ability to fully utilise theatre lists.
- Green bed availability at QEQM remains a challenge and will require support around creating a green ward and / or how we use Spencer beds.
- Breakdown / Replacement of essential theatre estates will reduce available capacity- where planned we are reallocating sessions where possible. However we are experiencing a number of repairs that require urgent attention leading to lost capacity.

Our patients

Rebecca Carlton

Trust Access Standards: ED Compliance

The National 4 Hour Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at the Emergency Department where clinically appropriate.

Performance has been adversely affected by year on year increases in emergency presentation to our acute sites. The global pandemic has created additional pressures in terms of managing infection and maintaining social distance.

Significant investment has been made into expanding our emergency departments and to recruitment to our nursing teams to provide enhanced patient pathways improving both quality of care and experience and this work is ongoing.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
81.9%	81.8%	81.3%	77.1%	73.8%	73.4%	73.2%	70.4%	70.6%	70.3%	70.1%	72.0%

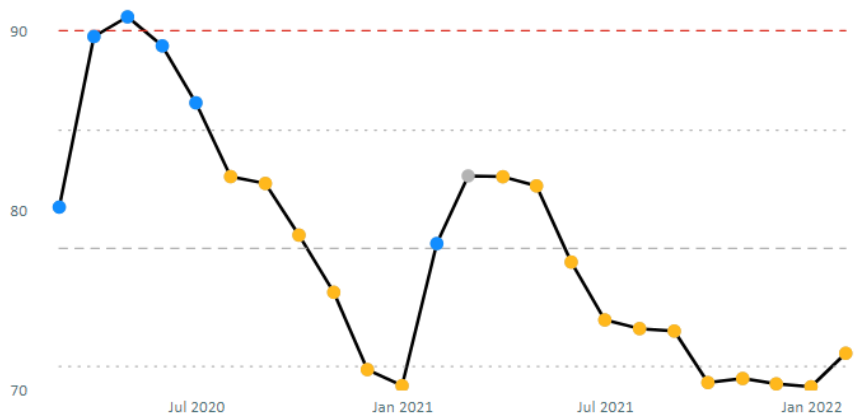
Variation indicates consistently falling short of the target

Special cause of concerning nature or higher pressure due to lower values

Flag Description

Below Mean Run Group Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

ED performance has improved to 72% in February 2022. Performance improved during Wave 1 of the pandemic due to a reduction in attendances. Performance dipped as demand increased and Wave 2 began. Performance improved in early 2021 until Wave 3 began, elective services restarted and brought with it the increased IPC challenges of managing increased patient contacts and 'Green' pathway elective patients. Winter 2021/22 saw a stabilisation of ED performance in the mid 70's%, together with increased challenge in managing increased Covid patients, Covid contacts and staff sickness.

Intervention and Planned Impact

- ED Restart programme to focus on achieving 80% performance against the 4 hour standard by the end of February 2022 did see an improvement in performance. Focus on patient flow continues to be the highest priority daily.
- ECIST are supporting a review of the Acute Medical Model at WHH to reduce the length of stay to <48 hours.
- Plans to implement the principles of the Modern Board Round and Criteria to Reside are being progressed with clinical champions identified and launch dates agreed for March.
- In February the WHH SDEC service was temporarily transferred to Out Patients, building on the success of the Paula Carr pilot and reducing over crowing in ED.
- Increased operational support in ED 7/7 with a focus on patient flow.

Risks/Mitigations

- Nursing vacancy, particularly at QEQMH – Continued mitigation via a senior nurses being rostered to direct clinical care, Pool Nursing rota is seeing increased uptake.
- Increasing number of patients with a LOS of >21 days due to insufficient PW1 (domiciliary care) and PW3 (residential/nursing home care) awaiting supported discharge. – mitigation continued via whole system working to escalate issues and commission appropriate capacity.

20/21 breakthrough objective

ED Aggregated Patient Delay

Long waits across our Emergency Departments (ED) have been a challenge to the organisation for several years, extending length of stay in ED is often a consequence of reduced bed availability for specialist ward areas and admissions.

It is recognised that extended stays in ED can have an impact on patient outcomes. It is a priority for the organisation to reduce time between the decision to admit a patient in ED and the transfer of the patient to a ward environment. We are making this an area of clinical and operational focus to drive down the wait times, improve flow and the standard of care for our patients.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
385	311	353	475	644	664	647	797	873	875	903	907

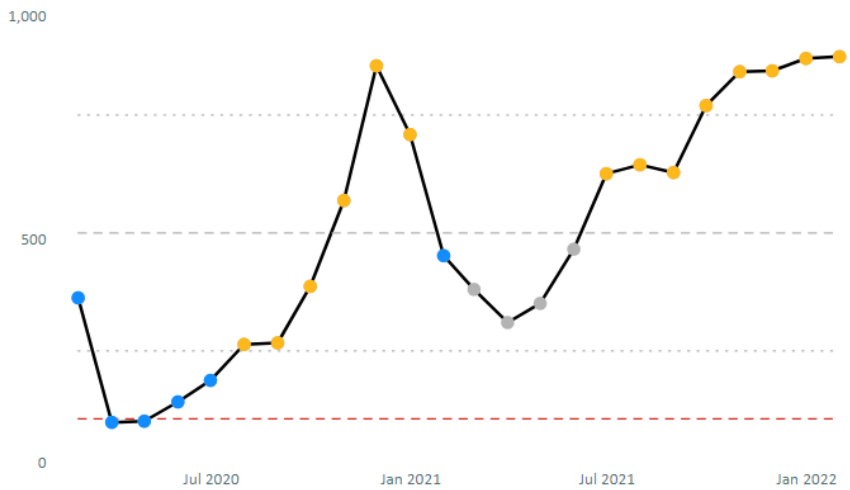
F — Variation indicates consistently falling short of the target

H — Special cause of concerning nature or higher pressure due to higher values

Flag Description

Above Mean Run Group
Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

At the start of the pandemic when attendances reduced the aggregated time a patient waited to be transferred to a hospital bed was low and achieved the internally agreed standard. As demand has increased to above normal levels performance has deteriorated. Covid Waves have had an impact on performance. This metric is heavily influenced by bed availability on main wards, which has been a consistent challenge throughout the pandemic due to an increase in the number of patients who no longer meet the criteria to reside in hospital, lack of external capacity, balancing IPC requirements to transfer patients to the correct ward and managing contact patients who become Covid post admission (not hospital acquired).

Intervention and Planned Impact

- To increase the number of patients discharged by midday each day to 30% of total discharges. Current performance is 14.7% at WHH and 16.9% at QEQMH.
- Senior ED management rota continues to provide increased leadership at weekends/evenings.
- Achieve a maximum 48 hour LOS on Acute Medical Unit (AMU) which will enable patients to be transferred from ED for assessment.
- Increase the number of patients streamed to SDEC pathways, including direct access for SECAMB.
- Working with LHE to escalate patients who no longer meet the criteria to reside (NLFTR) and are delayed for PW1, PW2 and PW3. Chief Operating Officer is involved in daily meetings to escalate operational delays and monthly meetings to engage with LHE re commissioning appropriate capacity for local population. Simple discharges are also an area of focus.

Risks/Mitigations

- LOS on AMU is >48 hours due to lack of timely bed capacity on wards. Mitigation: to implement 'Modern Ward Round' to maximise morning discharge and reduce LOS.
- The number of patients who are NLFTR in hospital is reducing capacity on wards. Mitigation: Continue to work with LHE to increase community capacity across PW1,2 &3.
- PW0/Simple discharges are delayed due to internal delays in pathways. Mitigation: Daily review of diagnostic requests in place with a senior review of CT/MRI to ensure clinically urgent.
- Increase in Covid Inpatients and the effect of Covid sickness on staffing is having an adverse impact on the length of time patients spend in ED.

Our patients

Rebecca Carlton

Trust Access Standards: Cancer 62day

The National 62 Day Referral to Treatment requires all patients to receive treatment for Cancer within 62 days from GP referral. The standard exists to ensure patients are seen diagnosed and treated as soon as possible to promote the best possible outcome for all patients on a cancer pathway.

The Trust is committed to reducing the time to diagnose and treat patients. Throughout the pandemic the Trust has prioritised and maintained access for all cancer patients improving our overall performance.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
81.5%	86.7%	83.3%	82.2%	82.5%	80.7%	78.8%	79.3%	84.3%	78.0%	75.8%	70.1%

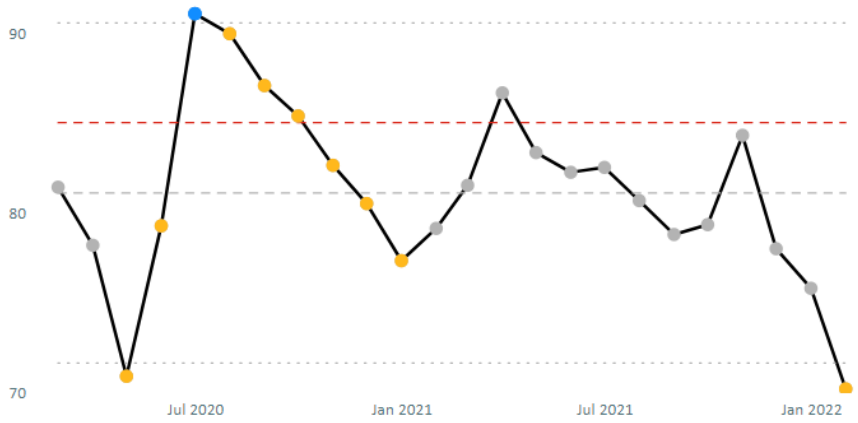
Variation indicates inconsistently passing and falling short of the target

Special cause of concerning nature or higher pressure due to lower values

Flag Description

Astronomical Point

XMR Run Chart



What the chart tells us

Performance increased significantly following the prioritisation of Cancer pathways at the beginning of the pandemic achieving the standard for four consecutive months. With the exception of May 2020 all data points fall within control limits. Performance began to dip during the first recovery phase as demand into the Trust began to resume normal levels. The target has been met 5 times in the last 20 months and was narrowly missed, post validation, in November 21. Although the performance has deteriorated Kent and Medway Cancer Alliance continued to record the lowest back log of all cancer Alliances, East Kent Hospitals is the largest contributor to this.

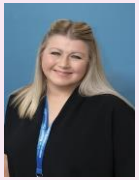
Intervention and Planned Impact

- Using the patient tracking list (PTL) review each pathway for every patient ensuring an optimal plan is in place to improve patient experience. This is supported by CNS clinical oversight
- All surgical patients escalated at point of known surgical intervention request. Processes to highlight all breach dates to the relevant teams to ensure patients are booked within breach. This will strengthen working relationships between the Cancer Care Groups and other Clinical Care Groups leading to an improvement in tumour site performance.
- Continue to work closely with lead CNSs to maximise learning and reduce waiting times for patients
- Restore face to face out-patient appointments where appropriate and continue reviews of current clinic capacity and support provision to ensure consistency on each site where appropriate

Risks/Mitigations

One of the biggest issues to delivery of the cancer standards is the availability of ring-fenced capacity for MRI and CT scans impacting the cancer pathway. This is being mitigated with support from the Clinical Support Services Care Group who are working up a plan to reduce diagnostic wait times.

Our patients



Sarah Shingler

Patient Experience (FFT)

The Family and Friends Test is a national measure which confirms how likely patients are to recommend the Trust as a place for treatment. This data collection incorporates a scale for quantitative analysis and an area for free text comments and is gathered on a monthly basis.

The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall recommended score together, we have therefore added completion rates as watch metrics to our overall scorecard.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
93.3%	91.7%	90.8%	90.5%	91.2%	91.8%	91.8%	91.4%	91.8%	92.7%	93.3%	92.1%

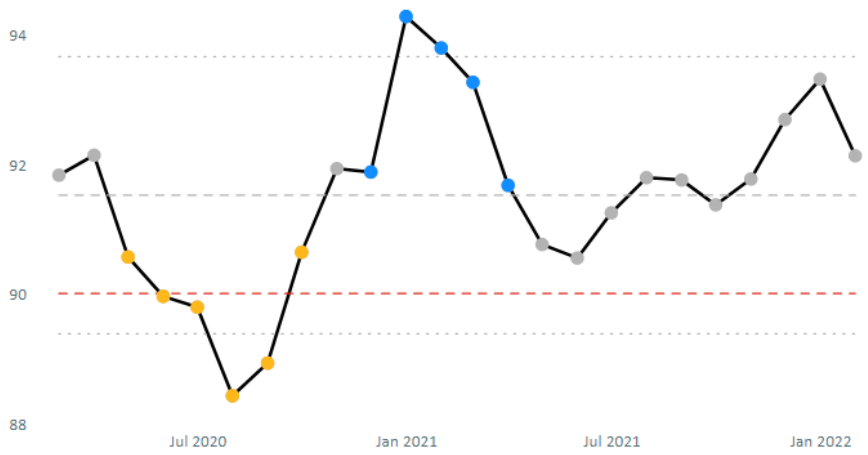
Variation indicates inconsistently passing and falling short of the target

Common cause (no significant change)

Flag Description

No Special Cause Flags

XMR Run Chart



What the chart tells us

The Trust has achieved the threshold target of 90% consistently since October '20 for patients who would recommend the Trust as a place for treatment. Performance peaked in Jan/Feb '21 outperforming the upper control limit for the period. However, recent performance shows that this improvement has not been sustained, although remaining above the upper control limit – there is still deterioration from January position.

Intervention and Planned Impact

The True North for Our Patients has been recently reviewed; moving forwards in addition to FFT the breakthrough objective will focus on ten questions from the in-patient experience survey. Alongside this the ward accreditation project commences roll out in April '21. All in-patient adult wards will complete 50 in-patient surveys per month, with ward leaders and matrons having responsibility and oversight for addressing concerns and driving improvements. This will link into the We Care improvement work.

The Patient Voice and Involvement Strategy has been approved. A business case to resource the Patient Voice team has now been approved, with recruitment commencing.

Maternity patient experience project 'Your Voice is Heard' commences April 22, ambition to capture feedback from every woman who gives birth in one of our units (6000 births per year)

Risks/Mitigations

If culture and behaviours do not change there is a risk that patient experience does not improve or deteriorates further, placing the Trust at increased risk of CQC regulatory action and reputational damage.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Cancer 62d			Cancer 2ww Performance		93.0%	98.0%	97.7%	96.6%	96.6%
	W4		Cancer 28d Performance		75.0%	69.8%	66.5%	62.6%	70.8%
	W4		Radiology Diags vs Plan		Traj.	16,239	14,957	15,774	15,433
	W4		Endoscopy vs Plan		Traj.	1,368	1,044	1,262	1,396
RTT - 18 Weeks			RTT 52w Breaches		Traj.	4,695	4,475	4,327	3,891
	W4		DM01 Compliance		75.0%	73.3%	65.7%	62.3%	68.0%
	W4		RTT 35w Waiters (w/o TCIs)		8,500	8,894	9,315	9,826	9,514
	W4		RTT OP Booking Breaches		14,000	17,976	19,440	19,193	19,696
	W4		Elective Admissions vs Plan		Traj.	6,183	5,275	5,189	5,603
ED Compliance	W4		Time in Department over 12 Hrs		6.0%	9.8%	9.6%	9.5%	9.2%
	W4		Clinician First Seen within 1h		50.0%	38.1%	38.6%	37.7%	36.0%
	W4		Super Stranded >21D		75	139	151	186	172
	W4		Discharges by Midday		15.0%	13.0%	14.4%	14.1%	14.8%
	W4		NEL Admissions vs Plan		Traj.	6,548	6,265	6,495	6,125
FFT			FFT ED Response Rate		12.0%	12.5%	12.4%	13.2%	14.8%
	W4		FFT Maternity Response Rate		18.0%	4.4%	3.9%	3.8%	10.4%
	W4		Complaint Response		90.0%	23.9%	27.3%	21.9%	12.3%
			PALS Enquiries		550	619	526	677	748

Cancer

28 and 62 day performance has deteriorated in month due to delays in diagnostics, particularly radiology. Actions include Medical Director engagement with Radiology leads to identify ring fenced capacity to reduce waiting times. This will positively impact on 28 and 62 day compliance.

RTT 18 Weeks

The number of 35wk patients undated increased due to the planned reduction in operating capacity in January to mitigate Wave 3 of Covid-19. Following the restart of elective surgery in February performance has begin to improve as predicted.

ED Compliance

Clinical Assessment within 1hr is a driver for the UEC Care Group in order to improve patient experience and ensure compliance with the 12 hour total time in ED metric.

Super stranded patients are being actively managed via regular calls with the local health economy however, of note, the winter plan modelling was based on a maximum number of 130 long stay patients. This is an external capacity issue in the main.

FFT

Maternity; The appropriate touch point times when the FFT questions will be asked during pregnancy have been agreed and the numerator and denominator has been adjusted to reflect the agreement. This was put in place mid February therefore improvement is expected in next round of reporting. Although some improvement seen in month

EDs: both EDs were extremely challenged throughout December and January, with overcrowding and long waits. FFT data triangulates with PALS concerns and formal complaints received during this period.

Our people


Our patients
Our people
Our future
Our sustainability
Our quality and safety

Our people

Andrea Ashman

Staff Turnover (rate)

The annual turnover rate provides us with a high-level overview of Trust health. Workforce retention is a top priority across the NHS. High turnover rates are typically associated with increased recruitment and training costs, low morale and reduced performance levels.

Our aim is to achieve and maintain a 10% staff turnover rate.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
9.3%	9.6%	10.1%	10.5%	10.8%	10.9%	11.2%	11.6%	12.0%	12.2%	12.3%	12.6%

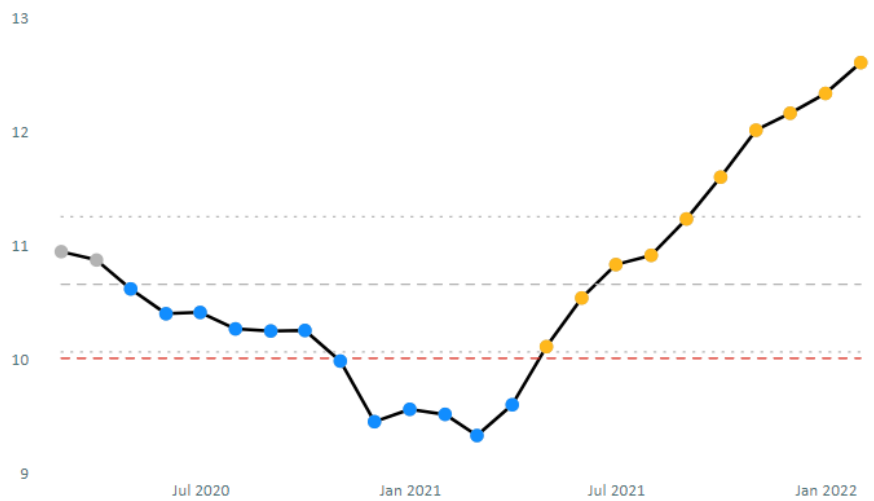
F — Variation indicates consistently falling short of the target

H — Special cause of concerning nature or higher pressure due to higher values

Flag Description

Above Mean Run Group
Astronomical Point
Ascending Run Group
Two Out Of Three Beyond Tw...

XMR Run Chart



What the chart tells us

Total turnover, when measured as a rolling 12-month average, has risen for an eleventh month in succession and remains above the True North target (10%) at 12.6% (February 2022). It is however important to share that total turnover has actually been improving in real-terms since September 2021 and compares favourably against the South East turnover average of 14.3%. Total turnover, measured in-month, has now improved in four of the last five months and currently sits at 11.27% -the lowest it has been this year. Staff Nurses continue to represent our primary leaver group (193 leavers in 12 months) and so work to drive improvement continues against local, regional and national priorities

Interventions and Planned Impact

Five top turnover areas have been identified: Theatres, KCH, Critical Care, WHH, Pharmacy Clinical Services, Pharmacy Operational Services.

Work is already underway providing wellbeing support into Theatres, Critical Care and Accident & Emergency areas (across all sites). Action plans are also being refined in these areas following the release of National Staff Survey data at Directorate level. Engagement has also taken place with respective leads and Business Partners to better understand the challenges within our Pharmacy Clinical & Operational Services. Turnover in this area appears to have been a direct result of the mandatory Covid-vaccination announcement by the Government (now rescinded). Respective support was offered in this space.

Risks/Mitigations

The drive for increased recruitment will address staffing shortfalls however the strong correlation between high volume recruitment and turnover is evident. Continued and intensive onboarding work, led by East Kent Hospitals, is taking place with our regional colleagues across the Kent & Medway system. This includes the development of a new starter feedback platform, onboarding champion roles and system-wide onboarding checklists and communications

Our people

Andrea Ashman

Staff Engagement (score)

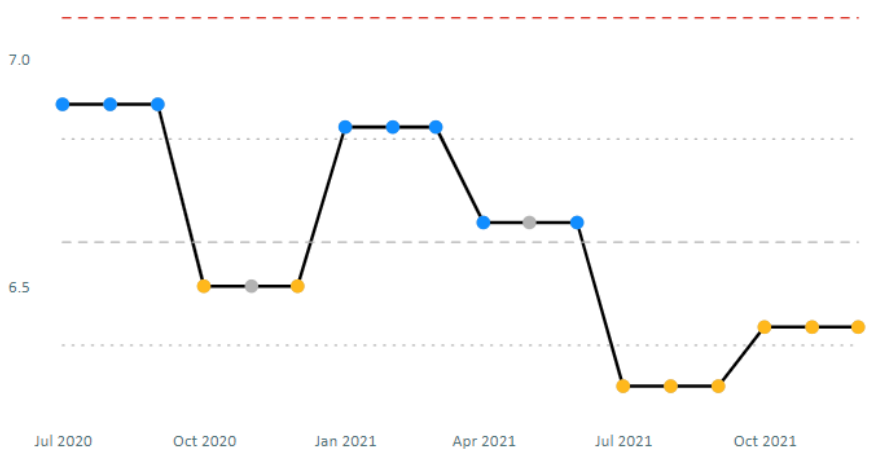
Staff satisfaction levels are amongst the bottom 20% across the country, which can lead to difficulty in recruitment and retention. The annual national staff survey is used to give an indication of staff engagement. We will be monitoring this at quarterly intervals throughout the year via the staff friends and family test.

Our aim is to improve our staff engagement score as demonstrated in the annual staff survey.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
6.9	6.6	6.6	6.6	6.3	6.3	6.3	6.4	6.4	6.4		

F	L	Flag Description
Variation indicates consistently falling short of the target	Special cause of concerning nature or higher pressure due to lower values	Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

Since July 2020 the data has broadly been following a downward trend with quarter two 21/22 data falling below the lower control limit of the SPC chart.
The most recent data returns just within control limits but remains well below mean performance and is consistently missing the desired threshold.

Interventions and Planned Impact

A programme of work has commenced including the establishment of 'Involvement' as a breakthrough objective under Staff Engagement as agreed by the board last month.
A comprehensive overview of the current position was provided at the People and Culture Committee in January. No further data on our overall position is released due to the National Staff Survey embargo, but a report of the survey and associated findings will be provided to the People & Culture committee at the next available opportunity upon lifting of the embargo (30/03/22 09:30hrs).
In the interim considerable work has been undertaken to understand the 2021 National Staff Survey results and to use this evidence-base to refine action plans across each of our Care Groups. The analysis is largely complete and Care Group Triumvirates are now meeting with our Staff Experience Team and developing focussed actions plans to drive improvement. Work is also underway with our Chief Medical Officer as we begin to commission a 5-year plan around Medical Engagement, specifically aligned with the Medical Engagement Scale. Initial conversations have taken place and local questions are being developed based on respective need for local intelligence. A provider recommended by NHSE/I is being considered and timescales for implementation, to drive a 5 year plan of sustained improvement

Risks/Mitigations

The National Quarterly Pulse Survey data for Q4 has been received this month and shows a consistent position since October. True North for engagement is to be supported by a breakthrough objective on Involvement. A dashboard to display the NSS results in a more discoverable and accessible way is being developed using the latest data and information to help drive concerted and consistent action at-pace, identify areas of best-practice and to act in a timely manner on concerns raised.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Staff Turnover Rate	W4		Vacancy Rate		9.0%	9.3%	9.9%	9.3%	12.7%
	W4		Staff Turnover: HCA		13.5%	13.6%	13.5%	14.3%	14.1%
	W4		Staff Turnover: Nursing		10.0%	12.0%	11.7%	11.7%	11.8%

Staff Turnover

Total turnover measured in-month (12.76%) has risen for the first time since September 2021 despite following a promising downward trend for three consecutive months. This appears to be driven primarily by premature and nurse turnover.

The change in turnover this month correlates very strongly with an almost trebling in recruitment from 78 joiners in December to 194 joiners in January

Nurse turnover remains above the alerting threshold (10%) and although there have been promising signs of improvement throughout the last 5 months, this has risen in January following the turnover of almost 20 nurses.

There is recognition that Staff Nurses continue to represent our primary leaver group (154 leavers this year)

Healthcare Assistant turnover remains stable at just under 15%. Substantial growth has been seen nationally as colleagues were able to seek alternative employment, but this continues to be blunted locally by continued support activity in the form of the 'Ready to Care' programme.

Our sustainability

Our sustainability

Phil Cave

Financial Position (I&E Margin)

Whilst there has been a significant financial deficit over the last 3 years at the Trust, in the current year a breakeven position was delivered. This metric will measure us against our long term aim to maintain a breakeven position. The impact of Covid-19 has paused the NHS business planning process nationally and has limited the ability of the Trust to hit its cost efficiency targets.

Our aim is to achieve and sustain a break even financial position.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
-0.007	-0.548	-0.438	0.030	0.024	0.042	0.021	-1.494	-0.996	-0.941	-0.090	1.307

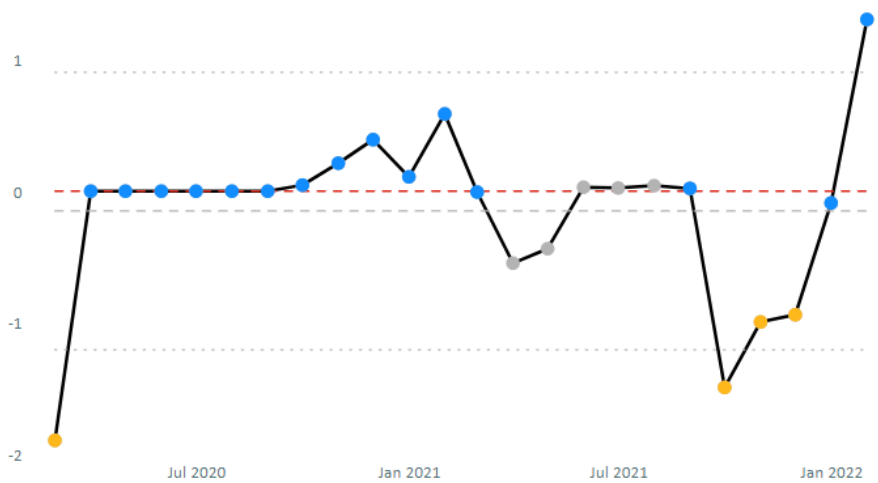
Variation indicates inconsistently passing and falling short of the target

Special cause of improving nature or lower pressure due to higher values

Flag Description

Outside Moving Range Limit
Astronomical Point
Two Out Of Three Beyond Tw...

XMR Run Chart



What the chart tells us

Since April 2020 the Trust's I&E margin has been broadly achieving a breakeven position. The data for the second half of the 2021/22 financial year (H2) has fallen below the mean but remains within common cause variation. As long as the threshold remains within common cause variation the Trust cannot be sure of consistently hitting the target. This month the surplus generated of £1.3m is above the control limits but is broadly a positive movement.

Interventions and Planned Impact

The Trust has a surplus position which is driven by less than expected service development costs.

The Trust is working with the regional Kent & Medway system partners and NHSEI to ensure we are appropriately reimbursed for any unavoidable costs and additional funding has been agreed for the increase in patients seen through the emergency department.

The Trust is forecasting to deliver a breakeven for the second half of the 2021/22 financial year which would mean a breakeven position for the full 2021/22 financial year consistent with the plan and threshold.

Risks/Mitigations

The main risks relate to continued additional costs due to treating patients with Covid-19 and reduced capacity to treat elective patients.

The mitigating actions are to continue to work with system partners to ensure appropriate reimbursement of costs and continue to reduce discretionary costs where appropriate to appropriately reflect the volume of patients we are treating.

Our sustainability

Liz Shutler

Carbon Footprint (CO2e)

Implementing environmentally sustainable principles and reducing the Trust's greenhouse gas emissions adds value to our patients and reflects the ethics of our staff. The national requirement is for the Trust to be net zero for the emissions it controls by 2040 (80% by 2028 to 2032). Being environmentally sustainable is therefore a key element of our Trust's True North.

The Trust's carbon emissions are made up of direct emissions i.e. natural gas; indirect and direct emissions i.e. electricity consumption, waste, water and steam usage. It is these areas we will be focussing on improving over the coming five to ten years, although as metrics are developed we will add in other scope one, two and three measures such as travel, freight transport and food and catering.

Our aim is to reduce the net emissions controlled by the Trust directly by 50% by 2025/26.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
57.34	54.35	47.80	38.27	36.74	39.60	39.77	43.52	60.90	60.34	65.53	

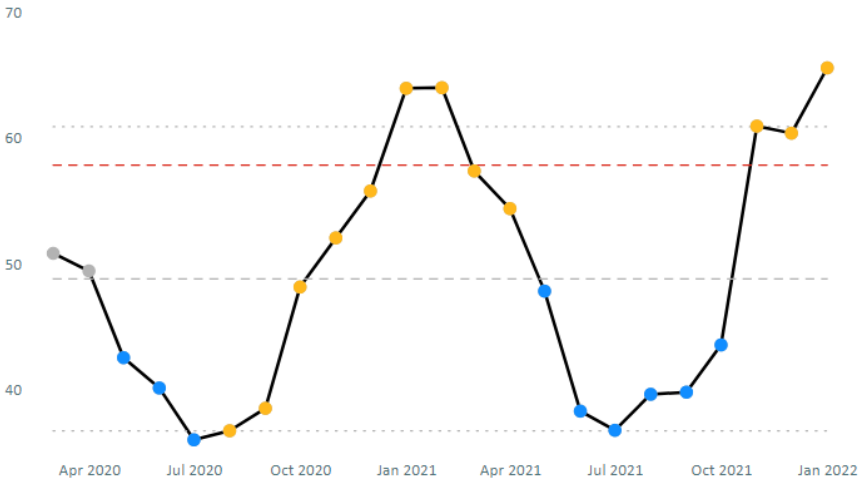
Variation indicates inconsistently passing and falling short of the target

Special cause of concerning nature or higher pressure due to higher values

Flag Description

Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

There is a clear seasonal effect to the Trust's Carbon Footprint as demonstrated in the chart. In the main, the position remains below the threshold with the exception of the winter months.

The January position is above the threshold of 60 and is above the same period last year.

Interventions and Planned Impact

The Trust is working with Breathe Energy to recommend opportunities for a continuing programme of carbon reduction and to bid, on the Trust's behalf, for central monies to enable long term carbon reduction as part of the Public Sector Decarbonisation Scheme. Schemes are currently being developed and analysed to determine the carbon reduction savings.

In addition to electricity, gas, waste and steam, work is ongoing to include additional data and measures aligned to NHSE/I's report "Delivering a Net Zero NHS". Those currently being explored include: Anaesthetics Usage; Medicines Waste; NHS Fleet and leased vehicles; and Staff Travel. Electric vehicle charging points have been installed at QEQM and implementation is planned at WHH and K&C in 2022.

A Joint Carbon Reduction Steering Group is in place which includes representatives from both the Trust and 2gether Support Solutions.

Risks/Mitigations

- Appropriate funding to trigger significant change is not available.
- Potentially lack of behaviour change and culture in the organisation to promote net zero carbon target.
- Due to the backlog maintenance programme and age of the estates we will have inefficient use of energy.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Financial Position	W4		Total Pay		0.0%	-1.5%	-1.2%	-1.2%	-1.3%
Carbon Footprint			CO2e Gas (tonnes/day)		38.19	33.96	36.48	41.49	

Total Pay

The pay position is adverse to plan due to higher than planned usage of temporary staffing primarily to backfill staff who were either sick or isolating due to Covid-19 Omicron variant. It is proposed that the pay metric is not promoted to a driver metric at this time as the financial plan and pay expenditure budget will be reset in April due to the start of the new financial year. Additionally, the Trust Board has approved a breakthrough objective in 2022/23 of agency expenditure which will monitor this position.

Carbon Footprint

Gas tonnage per day is alerting due to the latest data points breaching the upper control limits of the SPC chart. This is due to the seasonality of the metric and high usage during the winter months, we would envisage a reduction as we head into spring and therefore do not at this time consider that this metric should be promoted to a driver metric.

Our future


Our patients
Our people
Our future
Our sustainability
Our quality and safety

Our future

Rebecca Carlton

Not fit to reside (pats/day)

We have embedded the recording of criteria to reside (C2R) via daily board rounds through the course of the pandemic, this enables us to identify patients who no longer need to reside in hospital. As such this allows us to easily identify the ongoing support and care patients need to facilitate discharge.

Patients are delayed in hospital awaiting a supported discharge which may be Domiciliary care such as a Care Package, discharge to a Community Hospital for rehabilitation or discharge to a nursing or residential home. There may also be patients delayed for internal reasons, such as a diagnostic test or a change in clinical condition.

The Trust works closely with local health economy (LHE) stakeholders to ensure that external capacity is sufficient to meet the needs of the local population. This includes reviewing the available out of Hospital capacity and ensuring patients are reviewed daily for timely discharge.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
206.5	220.2	223.2	297.1	309.9	299.6	303.0	299.5	332.0	346.2	314.3	320.4

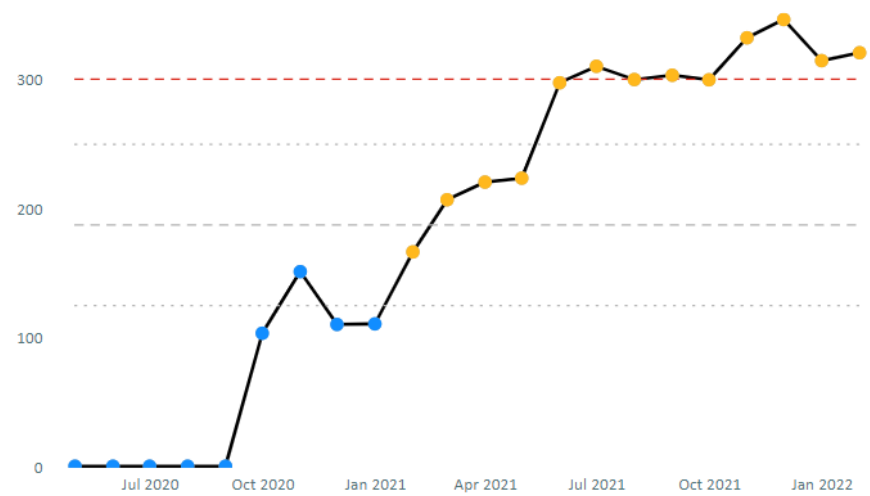
P — Variation indicates consistently passing the target

H — Special cause of concerning nature or higher pressure due to higher values

Flag Description

Above Mean Run Group
Astronomical Point
Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

The number of patients who are no longer meet the criteria to reside (C2R) in hospital is increasing however this chart also reflects improved data capture since the inception of C2R. In June '21 the levels stabilised at approx. 300 patients. A more recent increase to 346 occurred during the Covid-19 third wave due to insufficient capacity available outside of secondary care. February 22 has seen an increase in the number of Covid and Contact presentations which can be more complex to discharge due to lack of designated Covid bed capacity.

Intervention and Planned Impact

- Continuing to work very closely with the local health economy (LHE), meeting 3 times p/w, inclusive of KCHFT, KCC, CCG, Hospice and Mental Health Trust colleagues ensure appropriate capacity is available externally to meet the discharge needs of our local population.
- Weekly MDT meeting with a Consultant lead, Matrons, Ward Managers, Senior Therapist and members of the Discharge Team to review all patients with a LOS >7d to confirm patients pathway is optimal and reduce risk of internal and external delays.
- Daily board rounds include documentation of the C2R category, reported daily within Trust &LHE.
- ECIST support to launch and embed 'Modern Ward Round' document. Clinical champions identified who will provide cascade training to each ward.
- Refocus of patient PTL and recording of C2R categories on board rounds, including identifying discharges for next 24 hours and weekends.

Risks/Mitigations

- Insufficient external capacity, particularly in PW1, PW2 and PW3 to meet patients needs; Mitigation is to work through the LHE to highlight capacity to be commissioned.
- Patients and their families decline to be discharged into an alternative discharge pathway; Mitigation is to provide every patient with a letter from the CMO and CNO confirming discharge arrangements and also to ensure that Matrons are involved in discussions with families to support.

Our future

Liz Shutler

Innovation (Virtual OP Apps)

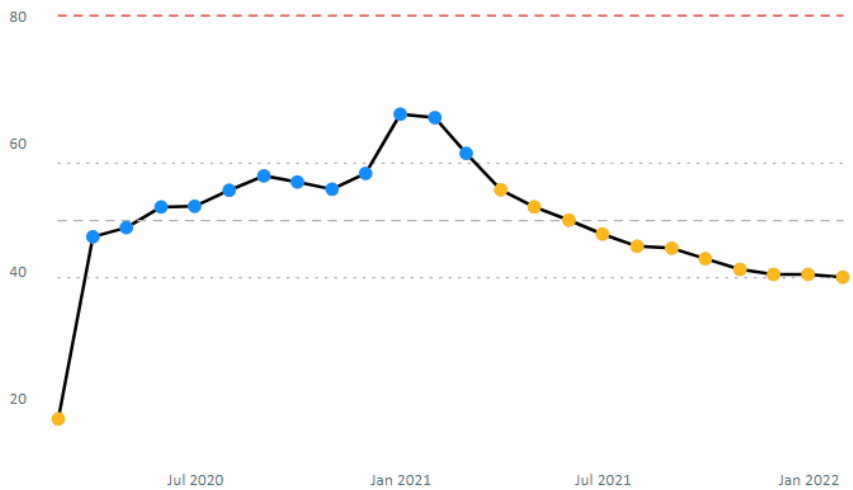
The current process for achieving innovation at the Trust is cumbersome and untimely. A cultural shift needs to take place using IT as a key enabler to drive the process. Outpatients are working towards the targets set by our commissioners of at least 25% of all patient appointments and 60% of all follow ups to be conducted virtually, where clinically appropriate, and to that end we have developed an enhanced engagement plan to encourage the shift from face to face to virtual mediums such as phone and telemedicine.

Our aim is to increase the use of technology and innovation in the delivery of high quality care for the EK population.

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
58.4%	52.7%	50.0%	47.9%	45.7%	43.8%	43.5%	41.9%	40.2%	39.4%	39.4%	39.0%

F Variation indicates consistently falling short of the target	L Special cause of concerning nature or higher pressure due to lower values	Flag Description Below Mean Run Group Two Out Of Three Beyond Two Sigma Group

XMR Run Chart



What the chart tells us

Performance has remained static with a very slight downward trend within a few percentage points over the last six months. Performance for February 2022 is at 39.0% which is below our revised threshold of 50%.

Nationally the target is for 25% of all outpatients to be via telemedicine and our current position shows we achieve this, with first appointments at 33.0% and follow-up appointments at 41.5%. The Trust has the highest level of achievement within Kent and Medway

Intervention and Planned Impact

The Outpatient Transformation Steering Group has reviewed the national benchmarking data and the Trust is currently 23rd in the rankings for delivery within the benchmarked data. Following discussion and review of individual specialty data, it was felt reasonable to aspire to move into the top 10 providers by setting a new threshold of 50%.

HCC E-clinic roll out has commenced with no reported issues, with full completion by end of March 2022.

Updated Telemedicine SOP has been completed and is expected to be ratified by April 2022.

Further engagement with specialties to improve telemedicine usage will commence in March 2022 following the deployment of E-Clinic

Care Groups are liaising with other providers to identify best practice opportunities

Risks/Mitigations

- Lack of clinical /operational buy in.
- More patients are being brought back to face-to-face appointments.
- Manual allocation of appointments in E-clinic is needed until the technical solution is in place to auto allocate in June 2022.
- To mitigate the above, an enhanced engagement plan and focused project work, champions and advocates for virtual consultations are being put in place.

Alerting watch metrics

Supporting metrics that have either;

- Been red for 4+ months (OR)
- Breached the upper or lower SPC control limit

True North Domain	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Innovation			Virtual OP Appts - First		25.0%	32.0%	31.0%	33.4%	33.0%
			Virtual OP Appts - Follow Up		25.0%	43.8%	43.0%	41.9%	41.5%

Virtual Appointments

Both virtual outpatient metrics are alerting due to the latest data points breaching the lower control limits of the SPC charts. Following the high performance in the percentage of virtual outpatient appointments carried out during the pandemic, levels are now beginning to stabilise to what we feel is a clinically appropriate level. The percentage achievement remains above the national threshold of 25% and the Trust continues to be the highest performer in the Kent & Medway region. At this point we do not feel it is appropriate to drive any further improvement in this metric.

Appendix 1
Non-Alerting Watch Metrics

East Kent Hospitals University NHS Foundation Trust

True North Domain	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Harm Events	W		52w Severe Harm Review		0	0	0	0	0
	W		Medication Errors; All		110	187	191	200	179
	W		Medication Errors; Severity C+		1	2	0	1	3
	W		Pressure Ulcers: Cat 2		32	39	33	33	26
	W		Pressure Ulcers: Cat 3 & 4		3	0	1	1	1
	W		Pressure Ulcers: DTI		10	6	5	8	11
	W		Pressure Ulcers: Unstageable		10	5	10	7	11
	W		IPC: Audits Composite		80.0%	87.5%	87.4%	87.6%	87.7%
	W		VTE Assessment Compliance		90.0%	92.2%	92.1%	91.2%	91.7%
	W		Safeguarding Incidents		20	17	7	14	18
	W		IP Spells with 3+ Ward Moves		500	505	474	497	540
	W		Clinical Incidents		2,500	2,208	1,998	2,291	1,896
	W		Never Events		0	0	0	0	0
	W		Maternity Serious Incidents		2	2	1	1	1
Mortality	W		Extended Perinatal Mortality		6.32	5.47	5.47	4.63	4.77

True North Domain	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Cancer 62d	W		Cancer 31d Performance		96.0%	97.9%	97.9%	97.2%	98.4%
RTT - 18 Weeks	W		OPA vs Plan		Traj.	63,756	54,196	55,755	52,503
ED Compliance	W		A&E Atts vs Plan		Traj.	21,408	19,760	20,262	19,687
	W		Unplanned Re-attendance ED		10.0%	9.0%	10.3%	9.6%	10.6%
	W		NEL Readmissions		15.0%	10.0%	11.2%	11.5%	10.4%
	W		Stroke Ward within 4 Hours		50.0%	60.9%	73.3%	58.7%	63.0%
FFT	W		FFT IP Response Rate		15.0%	17.2%	17.2%	16.5%	18.1%
	W		FFT DC Response Rate		27.0%	26.2%	26.6%	28.3%	30.1%
	W		FFT OP Response Rate		17.0%	15.9%	17.8%	18.5%	18.4%
	W		Complaints		100	103	60	72	86
	W		Mixed Sex Breaches		500	289	69	129	126

True North Domain	BR	Flag	KPI	SPC	Thres.	Nov-21	Dec-21	Jan-22	Feb-22
Staff Turnover Rate	W		Premature Turnover Rate		25.0%	19.3%	19.3%	19.9%	19.6%
Staff Engagement	W		Sickness		5.0%	4.8%	5.4%	6.0%	
	W		Appraisals Compliance		73.0%	78.1%	76.9%	77.1%	77.8%
	W		Statutory Training		91.0%	90.3%	91.6%	91.9%	91.6%
	W		Safeguarding Children Training		85.0%	90.6%	91.2%	91.3%	91.3%
Financial Position	W		Premium Pay		Traj.	7,255	6,441	7,168	7,403
	W		Non Pay		0.0%	0.1%	-0.2%	-0.2%	-0.5%
Carbon Footprint	W		CO2e Electricity (tonnes/day)		18.00	15.42	13.38	13.23	
	W		CO2e Water (tonnes/day)		0.55	0.23	0.13	0.22	
	W		CO2e Steam (tonnes/day)		9.21	11.08	10.12	10.39	

Appendix 2
Trust Priority Improvement Projects

NHS
East Kent
Hospitals University
NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
Accommodation Strategy	Phil Cave	To enhance the functionality, experience and investment opportunities in the staff and student non-clinical estate at K&C, WHH and QEQM.	May 2022	• Delay due to growth in scope of project. • Training Hub facility secured at East Kent College and proposal put forward for central management. • Integrated Education Strategy proposal presented to Integrated Education Board. • Project Lead and Team identified to take forward next stage of space utilisation review. • Demand modelling being reviewed to support the need for additional residential accommodation	• Implement Project Team to progress space utilisation review. • Continue to explore options for education and training space to complement EKC model. Progress the central management team proposal. • Progress review of demand modelling to secure additional residential accommodation.
Job Planning (Trust wide)	Rebecca Martin	To ensure every substantive SAS and Consultant doctor has a signed job plan on the e-job system, that accurately reflects their workload	April 2022	• LNC was delayed until April 4th 2022: Aim is to present changes following discussion at previous LNC and approve • Infographics now updated on the first Tuesday of each month and will be displayed on the email signatures of the Revalidation PM and TPIP SRO • CMO webpage to be expanded to include a job planning section which will display advice and key information .	• Review contract for e-Job plan to understand period of time left and to plan a system review as necessary • Review current license capacity and apply for an increase in licenses as required • Onboard admin support, recently recruited into the CMO team, to support Job planning project manager in releasing capacity to focus on improvement workstreams
Safe & Effective Discharge	Rebecca Carlton	All patients discharged have an accurate EDN completed and appropriately authorised in a timely fashion	May 2022	• Director of Pharmacy has reviewed recent data relating to EDN completion and has included patient stories, to support clinician engagement. • Mr Shah (Consultant Surgeon) has shared his teams progress on Kings B ward, and the benefits timely EDN completion is having	• Five wards prioritised to support improvement (CoE team coaching provided). • Share learning from Mr Shah's team. • Clinician engagement and ownership will be the focus

Appendix 2
Trust Priority Improvement Projects

NHS
East Kent
Hospitals University
NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date	Progress in last 30 days	Progress in next 30 days
Governance of Clinical Guidelines	Tina Ivanov	To have a central repository of for all clinical guidelines	Jan 2022	• The process of reviewing MicroGuide vs 4 policy and 4 action is in progress. • No date has been confirmed with regards version 2 of 4 policy. • Mike Bedford is addressing choice of MicroGuide	• Meetings with Clin Directors in progress • Continue to chase comments re Clinical Guidelines Policy • Awaiting confirmation of funding for Band 6 post
Improving End of Life Care	Sarah Shingler	Deteriorating patients who's death can be recognised in a timely way enabling better care in the right place at the right time this will also improve HSMR, reduce unnecessary use of hospital resource, increase personalised care planning	TBC Scoping as new project	• Collect and collate the data for analysis and discussion • Engaging Care group stakeholders	• Continue to engage stakeholders and implement countermeasures as per A3
National & Local Clinical Audit	Rebecca Martin	An agreed vison, roles & responsibilities of an audit lead. To have 75% of all audits that are effectively managed within each of the Care groups (Must do's - nationally dictated, Local audits requested by local Commissions)	April 2022	• Clinical Audit team to clarify any remaining areas for improvement against the problem statement. • Commence drafting a TPIP Closure Request as relevant	• Recruit to post, as currently no SRO attached to this TPIP. • Clinical Audit team continue to work with Care Groups regarding their compliance
Safeguarding	Sarah Shingler	Assessment of Mental Health risk to determine the level of support required carried out for 100% of patients	Dec 2021	• Communicate changes to Enhanced Observation tools and audits • Communicate roles and responsibilities around safeguarding • Produce first dashboard report on Information Portal • Focussed work at QEQM to reduce KASAFs	• Safeguarding team to draft a TPIP Closure Request, to enable the progress to continue as Business as Usual (delayed 1 month due to SLT revised agenda)

Appendix 2
Completed Trust Priority Improvement Projects

NHS
East Kent
Hospitals University
NHS Foundation Trust

Project Name	Exec Sponsor	Intended Deliverables	Expected Completion Date
CITO Management	Liz Shutler	To replace WINDIP with an EDM which will meet the needs of users, support the Trust's Electronic Patient Record objectives and the rollout of Sunrise by providing scanning capability for documentation which has yet to be or cannot be directly captured or integrated into Sunrise EPR	Jan 2022
ITU Expansion	Liz Shutler	Expanded 24 bed Critical Care unit operational for patients to be admitted	Feb 2022 - BAU
ED Expansion	Liz Shutler	Expansion to current ED footprints to enable provision of 'Emergency Village / Same Day Emergency Care' facilities	Dec 2023 - BAU
Sepsis Audit tool	Sarah Shingler	Ensure the correct sepsis audit tool is used for the right people at the right time, initial threshold 85% completion	Complete
Hospital Out of Hours	Rebecca Martin	Provision of a Hospital out of Hours Team to ensure timely response & co-ordination to Deteriorating Patients	Complete
Falls on Datix	Sarah Shingler	Improved data quality of reporting of falls on Datix ensure high quality accurate reporting	Complete

Appendix 3: Glossary of Terms

Term	Description
A3 Thinking Tool	Is an approach to thinking through a problem to inform the development of a solution. A3 also refers to the paper size used to set out a full problem-solving cycle. The A3 is a visual and communication tool which consists of (8) steps, each having a list of guiding questions which the user(s) work through (not all questions may be relevant). Staff should feel sure each step is fully explored before moving on to the next. The A3 Thinking Tool tells a story so should be displayed where all staff can see it.
Breakthrough Objectives	3-5 specific goals identified from True North. Breakthrough Objectives are operational in nature and recognised as a clear business problem. Breakthrough Objectives are shared across the organisation. Significant improvement is expected over a 12 month period.
Business Rules	A set of rules used to determine how performance of metrics and projects on a scorecard are discussed in the Care Groups Monthly Performance Review Meetings.
Catchball	A formal open conversation between two or more people (usually managers) held annually to agree the next financial year's objectives and targets. However, a 6 monthly informal conversation to ensure alignment of priorities is encouraged to take place. The aims of a Catchball conversation are to: (1) reach agreement on each item on a Scorecard e.g. driver metrics, watch metrics tolerance levels, corporate/ improvement projects. (2) Agree which projects can be deselected. (3) Set out Business Rules which will govern the process moving forward.
Corporate Projects	Are specific to the organisation and identified by senior leaders as 'no choice priority projects'. They may require the involvement of more than one business unit, are complex and/or require significant capital investment. Corporate Projects are often too big for continuous daily improvement but some aspect(s) of them may be achieved through a local project workstream.
Countermeasure	An action taken to prevent a problem from continuing/occurring in a process.
Countermeasure Summary	A document that summarises an A3 Thinking Tool. It is presented at monthly Performance Review Meetings when the relevant business rules apply.

Appendix 3: Glossary of Terms

Term	Description
Driver Lane	A visual tool containing specific driver metric information taken from the A3 (e.g. problem statement, data, contributing factors, 3 C's or Action Plan). The driver lane information is discussed every day at the improvement huddle and in more detail at weekly Care Group driver meetings and Monthly Performance Review Meetings. The structure of a driver lane is the same as the structure of a countermeasure summary.
Driver Meetings	Driver Meetings are weekly meetings that inform the Care Group of progress against driver metrics on their scorecard. Having a strong awareness of how driver metrics are progressing is vital for continuous improvement. Driver meetings also enable efficient information flow. They are a way of checking progress to plan.
Driver Metrics	Driver Metrics are closely aligned with True North. They are specific metrics that Care Group's choose to actively work on to "drive" improvement in order to achieve a target (e.g. 'reduce 30 day readmissions by 50%' or 'eliminate all avoidable surgical site infections'). Each Care Group should aim to have no more than 5 Driver Metrics.
Gemba Walk	'Gemba' means 'the actual place'. The purpose of a Gemba Walk is to enable leaders and managers to observe the actual work process, engage with employees, gain knowledge about the work process and explore opportunities for continuous improvement. It is important those carrying out the Gemba Walk respect the workers by asking open ended questions and lead with curiosity.
Huddles (Improvement Huddle) Boards	Huddle or Improvement Boards are a visual display and communication tool. Essentially they are a large white board which has 9 specific sections. The Huddle or Improvement Boards are the daily focal point for improvement meetings where staff have the opportunity to identify, prioritise and action daily improvement ideas linked to organisational priorities (True North). The Huddle or Improvement Board requires its own Standard Work document to ensure it is used effectively. The aims of the Huddle/Improvement board includes: 1. help staff focus on small issues 2. prioritise the action(s) 3. gives staff ownership of the action (improvement)
PDSA Cycle (Plan Do Study Act)	PDSA Cycle is a scientific method of defining problems, developing theories, planning and trying them, observing the results and acting on what is learnt. It typically requires some investigation and can take a few weeks to implement the ongoing cycle of improvement.
Performance Board	Performance boards are a form of visual management that provide focus on the process made. It makes it easy to compare 'expected versus actual performance'. Performance Boards focus on larger issues than a Huddle Board, e.g. patient discharges by 10:00am. They help drive improvement forward and generate conversation e.g.: 1. when action is required because performance has dropped 2. what the top 3 contributing problems might be 3. what is being done to improve performance

Appendix 3: Glossary of Terms

Term	Description
Scorecard	The Scorecard is a visual management tool that lists the measures and projects a ward or department is required to achieve. These measures/projects are aligned to True North. The purposes of a Scorecard include: 1. Makes strategy a continual and viable process that everybody engages with 2. focuses on key measurements 3. reflect the organization's mission and strategies 4. provide a quick but comprehensive picture of the organization's health
Standard Work	Standard work is a written document outlining step by step instructions for completing a task or meeting using 'best practice' methods. Standard Work should be shared to ensure staff are trained in performing the task/meeting. The document should also be regularly reviewed and updated.
Strategy Deployment	Strategy Deployment is a planning process which gives long term direction to a complex organisation. It identifies a small number of strategic priorities by using an inch wide mile deep mindset and cascades these priorities through the organisation.
Strategy Deployment Matrix	A resource planning tool. It allows you to see horizontal and vertical resource commitments of your teams which ensures no team is overloaded.
Strategic Initiatives	'Must Do' 'Can't Fail' initiatives for the organisation to drive forward and support delivery of True North. These programmes of work are normally over a 3-5 year delivery time frame. Ideally these should be limited to 2-3. Initiatives are necessary to implement strategy and the way leaders expect to improve True North metrics over time (3-5 years).
Structured Verbal Update	Verbal update that follows Standard Work. It is given at Performance Review Meetings when the relevant business rules apply.
Tolerance Level	These levels are used if a 'Watch Metric' is **red** against the target but the gap between current performance and the target is small or within the metrics process control limits (check SPC chart). A Tolerance Level can be applied against the metric meaning as long as the metrics' performance does not fall below the Tolerance Level the Care Group will continue watching the metric.
True North	True North captures the few selected organisation wide priorities and goals that guide all its improvement work. True North can be developed by the Trust's Executive team in consultation with many stakeholders. The performance of the True North metrics against targets is an indicator of the health of the organisation.
Watch metrics	Watch metrics are measures that are being watched or monitored for adverse trends. There are no specific improvement activities or A3s in progress to improve performance.

NHS
East Kent
Hospitals University
NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**MONTH 11 FINANCE REPORT**
MEETING DATE:	**7 APRIL 2022**
BOARD SPONSOR:	**DIRECTOR OF FINANCE AND PERFORMANCE**
PAPER AUTHOR:	**REPORTING ACCOUNTANT**
APPENDICES:	**APPENDIX 1: M11 FINANCE REPORT**

Executive Summary:

Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion

Purpose of the Report:

The report is to update the Board on the current financial performance and actions being taken to address issues of concern.

Summary of Key Issues:

The Trust delivered a £1.4m surplus position in February resulting in a £1m favourable variance against plan year to date. The favourable variance is driven by additional income over plan of £3m due to a combination of Covid-19 income of £1.1m, education and training income and Ockenden maternity funding totalling £0.7m. Additional income support was also received from Kent & Medway Clinical Commissioning Group (CCG). These were offset by £0.9m overspend on pay predominantly relating to permanent staffing following an increase of 130 Whole Time Equivalent (WTE) contracted staff.

Due to the on-going Covid-19 pandemic, the traditional NHS funding and administration process remains suspended in 2021/22, with fixed funding arrangements at a System level (Kent & Medway Integrated Care System (ICS)) split into two halves of the year: April to September 2021 (H1) and October to March 2022 (H2). The financial plan for the second half of the year (H2) is to achieve an Income & Expenditure (I&E) breakeven position to bring the full year I&E plan to breakeven. The plan was submitted to NHS England/NHS Improvement (NHSE/I) in November following confirmation of the available funding consisting of baseline funding consistent with H1 and additional funding through the Elective Recovery Fund (ERF), subject to meeting the required activity thresholds and gateways.

The Trust continues to forecast a break-even position at year end.

	This Month			Year to Date		
£'000	Plan	Actual	Variance	Plan	Actual	Variance
EKHUFT Income	70,316	73,315	2,999	743,569	750,342	6,773
EKHUFT Employee Expenses	(41,446)	(42,316)	(870)	(445,344)	(451,031)	(5,687)
EKHUFT Non-Employee Expenses	(28,808)	(29,818)	(1,011)	(298,695)	(299,783)	(1,088)
EKHUFT Financial Position	**62**	**1,180**	**1,119**	**(469)**	**(472)**	**(3)**
Spencer Performance After Tax	(15)	19	34	165	97	(67)
2gether Performance After Tax	0	294	294	0	1,559	1,559
Rephasing/Rounding Adjustment	15	(118)	(133)	717	(118)	(835)
Consolidated I&E Position (pre Technical adjs)	**62**	**1,375**	**1,314**	**413**	**1,067**	**654**
Technical Adjustments	(35)	22	57	(141)	240	381
Consolidated I&E Position (incl Top Up)	**27**	**1,397**	**1,371**	**272**	**1,307**	**1,035**

The Trust has identified £2.7m of additional costs due to Covid-19 in February which brings the year-to-date total to £20.6m. In-envelope spend

	being £0.6m and £2.5m greater than plan in month and H2 Year to Date (YTD). The ERF methodology has changed for H2, and is now based on monthly Referral to Treatment (RTT) completed pathway submissions instead of elective activity levels. £6.7m has been included for H2 performance, which is below planned levels as most elective activity was cancelled due to the surge in Covid-19 patients and increased emergency demand. Planning guidance for the new financial year 2022/23 was received in December 2021 and the Trust has agreed a draft financial plan with our commissioners which has been submitted to the national team. The plan for 2022/23 is a £22m deficit position which includes a challenging efficiency target of £30m.
Key Recommendation(s):	The BoD is asked to review and **NOTE** the financial performance and actions being taken to address issues of concern.

Implications:				
Links to 'We Care' Strategic Objectives: **Healthy finances:** Having Healthy Finances by providing better, more effective patient care that makes resources go further				
Our patients	Our people	Our future	**Our sustainability**	Our quality and safety
Link to the Board Assurance Framework (BAF):	**BAF 38:** Failure to deliver the financial breakeven position of the Trust as requested by NHSE/I may result in the Trust not having adequate cash to continue adequate operations of the organisation, potentially make poor financial decisions which will result in reputational damage and non-compliance with regulators.			
Link to the Corporate Risk Register (CRR):	None			
Resource:	N	Key financial decisions and actions may be taken on the basis of this report		
Legal and regulatory:	N			
Subsidiary:	N			
Assurance Route:				
Previously Considered by:	Finance and Performance Committee (FPC) 29 March 2022.			

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2021/22

February 2022

Director of Finance and Performance Management
Philip Cave

Contents and Appendices

Month 11 (February) 2021/22

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Executive Summary
Month 11 (February) 2021/22

Executive Summary

The Trust delivered a £1.4m surplus position in February resulting in a £1m favourable variance against plan year to date. The favourable variance is driven by additional income over plan of £3m due to above plan Covid-19 income of £1.1m and above plan education and training income and Ockenden maternity funding totalling £0.7m. Additional income support was also received from Kent & Medway CCG. These were offset by £0.9m overspend on pay predominantly relating to permanent staffing following an increase of 130 wte contracted staff.

Due to the on-going Covid-19 pandemic, the traditional NHS funding and administration process remains suspended in 2021/22, with fixed funding arrangements at a System level (Kent & Medway ICS) split into two halves of the year: April to September 2021 (H1) and October to March 2022 (H2).

The financial plan for the second half of the year (H2) is to achieve an I&E breakeven position to bring the full year I&E plan to breakeven. The plan was submitted to NHSEI in November following confirmation of the available funding consisting of baseline funding consistent with H1 and additional funding through the Elective Recovery Fund (ERF), subject to meeting the required activity thresholds and gateways.

The Trust continues to forecast a break even position at year end.

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The Trust has identified £2.7m of additional costs due to Covid-19 in February which brings the year-to-date total to £20.6m. In-envelope spend being £0.6m and £2.5m greater than plan in month and H2 YTD.

The Elective Recovery Funding (ERF) methodology has changed for H2, and is now based on monthly RTT completed pathway submissions instead of elective activity levels. £6.7m has been included for H2 performance, which is below planned levels as most elective activity was cancelled due to the surge in Covid-19 patients and increased emergency demand.

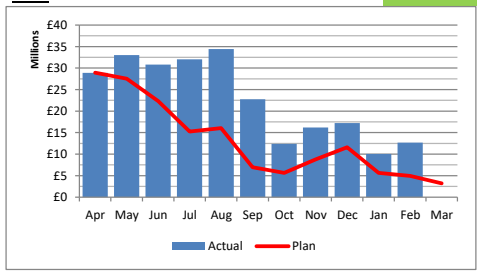
Planning guidance for the new financial year 2022/23 was received in December 2021 and the Trust has agreed a draft financial plan with our commissioners which has been submitted to the national team. The plan for 22-23 is a £22m deficit position which includes a challenging efficiency target of £30m.

Income and Expenditure G

In February, the Trust delivered a surplus of £1.4m which is £1m ahead of plan. The Trust has recognised the agreed level of income for Q3 for our ERF funding allocation from the Kent & Medway ICS system, however due to the surge in demand for emergency beds the Trust did not earn the planned level of ERF funding in either January or February. However, the Trust has received support from commissioners to fund the shortfall in ERF income as well as additional support to cover the unplanned running costs caused by the Trust's use of Spencer Private Hospital beds at both QEQM and WHH.

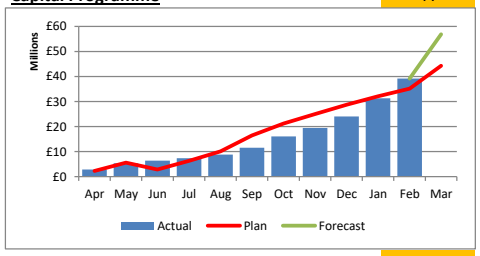
The Trust's forecast continues to demonstrate a break-even position at year end.
The major risk to the achievement of breakeven is the ability to reduce covid expenditure whilst we continue to bed on average circa 150 covid patients. We have therefore continued to utilise Spencer Private Hospital (SPH) beds resulting in increased costs for the group as SPH are unable to generate any income from elective inpatient activity. Along with this we continue to experience high levels of staff sickness which necessitates back fill via bank and agency.

Cash G



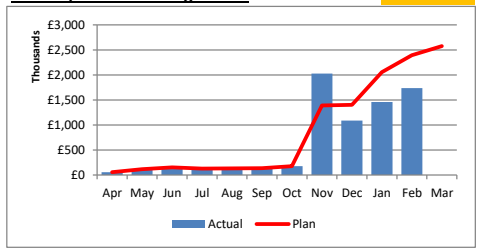
The Trust's cash balance at the end of February was £12.7m which was £7.8m above the plan but a significant drop from the March 20/21 year-end closing balance of £68m due to a combination of capital payments clearing creditor balances and the reversal of the NHSE/I block payment on account to cover anticipated operational costs in advance.

Capital Programme A



Total capital expenditure at the end of February was £39.1m which was £4m above our internal Trust plan.
The capital plan has been re-phased following a detailed assessment of deliverability. Progress against this plan is being managed by weekly meetings led by the Deputy CEO to ensure the Trust delivers in line with this.

Cost Improvement Programme A



In light of the national directive to focus on the operational response to Covid-19 EKHUFT has a reduced ability to make efficiency savings. The Trust delivered £1.7m of savings in February which brought the YTD position to £7.2m which was £0.9m behind the planned level.

Income and Expenditure Summary

Month 11 (February) 2021/22

Unconsolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Electives	7,791	7,019	(772)	85,697	74,381	(11,316)	93,488
Non-Electives	16,198	16,643	445	178,178	197,975	19,796	194,376
Accident and Emergency	3,101	3,211	111	34,108	39,294	5,186	37,208
Outpatients	8,139	7,971	(168)	89,526	88,350	(1,176)	97,665
High Cost Drugs	4,013	3,886	(128)	42,797	43,396	599	46,810
Private Patients	24	11	(13)	300	224	(76)	324
Other NHS Clinical Income	26,825	28,666	1,841	263,643	255,623	(8,019)	290,381
Other Clinical Income	108	85	(23)	1,485	1,190	(295)	1,593
Total Income from Patient Care Activities	**66,198**	**67,491**	**1,293**	**695,734**	**700,433**	**4,699**	**761,847**
Other Operating Income	4,118	5,823	1,705	47,835	49,908	2,073	51,952
Total Income	**70,316**	**73,315**	**2,999**	**743,569**	**750,342**	**6,773**	**813,799**
Expenditure							
Substantive Staff	(36,073)	(36,514)	(441)	(389,877)	(390,413)	(536)	(425,980)
Bank	(2,651)	(2,889)	(238)	(23,702)	(28,481)	(4,779)	(26,353)
Agency	(2,722)	(2,912)	(190)	(31,765)	(32,137)	(371)	(34,487)
Total Employee Expenses	**(41,446)**	**(42,316)**	**(870)**	**(445,344)**	**(451,031)**	**(5,687)**	**(486,820)**
Other Operating Expenses	(27,967)	(28,886)	(919)	(289,321)	(290,543)	(1,222)	(317,468)
Total Operating Expenditure	**(69,413)**	**(71,202)**	**(1,789)**	**(734,665)**	**(741,574)**	**(6,909)**	**(804,288)**
Non Operating Expenses	(841)	(932)	(91)	(9,373)	(9,240)	133	(10,214)
Income and Expenditure Surplus/(Deficit)	**62**	**1,180**	**1,119**	**(469)**	**(472)**	**(3)**	**(704)**

Consolidated	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Income from Patient Care Activities	67,342	67,401	59	709,991	710,458	467
Other Operating Income	4,498	4,697	199	50,920	47,674	(3,246)
Total Income	**71,840**	**72,098**	**258**	**760,911**	**758,132**	**(2,779)**
Expenditure						-
Employee Expenses	(45,042)	(46,189)	(1,147)	(480,559)	(490,721)	(10,162)
Other Operating Expenses	(25,802)	(23,544)	2,258	(269,887)	(256,916)	12,971
Total Expenditure	**(70,844)**	**(69,733)**	**1,111**	**(750,446)**	**(747,637)**	**2,809**
Non-Operating Expenses	(934)	(990)	(56)	(10,052)	(9,428)	624
Income and Expenditure Surplus/(Deficit)	**62**	**1,375**	**1,313**	**413**	**1,067**	**654**

Income from Patient Care Activities

The H1 and H2 21/22 Covid-19 finance regime has remained largely as set out in October 2020. Allocated payments support Group income at a level which allow delivery of a break-even position.

During M8 the nationally mandated revised H2 plan was submitted by all Trusts incorporating changes such as ERF funding and the 3% pay award. For H2 the pay award has been funded in full at the same £6.2m value as H1, however, the National and ICS efficiencies and a reduction for Covid-19 funding resulted in a monthly increase of £0.3m compared to £1.0m per month in H1.

The ERF methodology changed in H2 and is now based on monthly RTT completed pathway submissions instead of activity levels. To adjust for this change in methodology the baseline target has also been adjusted to 89% of the completed pathways delivered in 19/20. Further to this, the Trust has secured £8.4m of guaranteed ERF+ funding, the minimum level of ERF income in H2.

The YTD planned TIF fund income of £3.5m in M11 has not been received due to a delay in it commencing. This is offset with an underperformance in expenditure.

The Commissioner allocated payments have been rolled over from the previous year with the changes that were implemented in the last half of the year, which are:

A budget of £2.8m per month to cover Covid-19 costs, Top up funding of £4.0m and an additional £3.5m of growth funding. The growth funding no longer includes CCG invoices from Spencer Private Hospitals, but does include the UTCs. All these payments are being commissioned by Kent and Medway CCG.

Other Operating Income and Expenditure

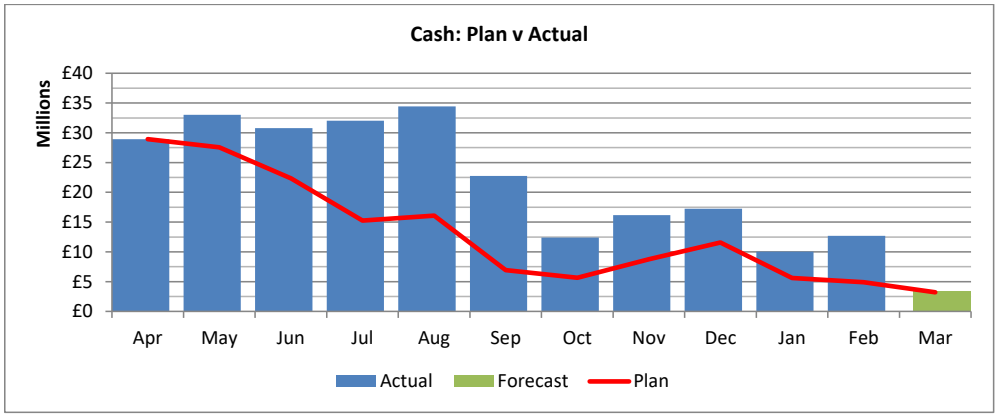
Other operating income is favourable to plan in February by £1.7m and by £2.1m YTD. The in-month variance is driven mainly by above plan Covid-19 income of £1.1m and above plan education and training income and Ockenden maternity funding totalling £0.7m. YTD, Harmonia Village income is adverse to plan by £1.1m, offset by a favourable variance on education and training income, sale of Beautiful Information and Covid-19 income totalling £3.1m.

Total operating expenditure is adverse to plan in February by £1.8m and by £6.9m YTD. Covid-19 expenditure stands at £2.7m in month and £20.6m YTD, with in-envelope spend being £1.4 m and £0.6m greater than plan in month and £2.5m greater than H2 plan YTD.

Employee expenses performance is adverse to plan in February by £0.9m and adverse to plan by £5.7m YTD (1.28%). Expenditure relating to all Covid-19 pay streams is £1.0m in month and £11.4m YTD. Total expenditure on pay in February was £42.3m, an increase of £0.5m when compared to January, predominantly relating to permanent staffing following an increase of 130 wte contracted staff. Expenditure on bank and agency staff increased by £0.1m.

Other operating expenditure is adverse to plan in February by £0.9m and adverse to plan by £1.2m YTD (0.42%). Expenditure on all Covid-19 non-pay streams is £1.7m in month and £9.2m YTD. Despite increased spend in February, referrals to the Independent Sector remain significantly below plan at £0.7m in month and £7.5m YTD, offset by spend on contracted out medical services in UTCs originally planned as pay which causes a technical overspend of £3.5m YTD and drugs which are adverse to plan by £3.9m YTD. In month £1.6m of Computer Purchases and been moved from Revenue to Capital.

Actual expenditure on non-pay in February was £26.4m, a reduction of £1.4m when compared to January.



Unconsolidated Cash balance was £12.7m at the end of February 22, £7.8m above plan.

Cash receipts in month totalled £70.6m (£6.4m above plan)

Block payments were received on the 15th of the month: £49.3m from K&M CCG and £13.2m from NHS England. These receipts were as per the notified H2 figures, but a combined £3.2m above initial plan.

Other NHS Receipts were £0.8m above plan.

No VAT reclaim was received in month (£2.5m below plan)

Health Education England receipts were £4.4m above plan. (receipt in the plan for March)

Other receipts were £0.5m above plan

Cash payments in month totalled £68.0m (£3.0m above plan)

Creditor payment runs including Capital payments were £22.8m (£5.8m above plan).

Payments to 2gether Support Solutions were £8.7m (£4.3m below plan)

Payroll was £36.3m (£1.5m above plan).

2021/22 Plan

Plan assumptions for 2021/22 were based on the I&E plan for H1. It was initially planned that contract values for H2 would remain consistent with H1 for cash purposes.

Whilst the 2021/22 plan will require strict cash management to eliminate risks towards the end of the year, there is no expected requirement for any additional revenue funding.

H2 block payments have been reforecast in line with details received from NHS Kent & Medway CCG. Forecasting has been reviewed further following the completion of the H2 plan, and will be continually monitored.

Creditor Management

Cash planning in late March/early April showed areas of high risk around Month 6. To reduce this risk, the Trust reverted back to pay invoices to 30-day terms from 1st April 2021.

Payments to creditors were brought back from 30 days to 23 days in June and then further brought back to 16 days on the 23rd September. On the 21st October the Trust brought creditor days back to 9 days, and in November the Trust brought terms back to the 7-day target. Timing of expected receipts in the month mean that payment terms may be moved as required on a weekly basis to ensure the Trust maintains a positive balance.

At the end of February 2021, the Trust was recording 55 creditor days (Calculated as invoiced creditors at 28th February/ Forecast non-pay expenditure x 365).

Income from Patient Care Activities

Month 11 (February) 2021/22

Trust Income Plan	Trust Actual Income	Income Variance
£695.735m	£700.433m	£4.699m

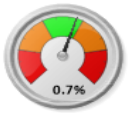
2021/22 - Month 11 Model

East Kent Hospitals University NHS Foundation Trust

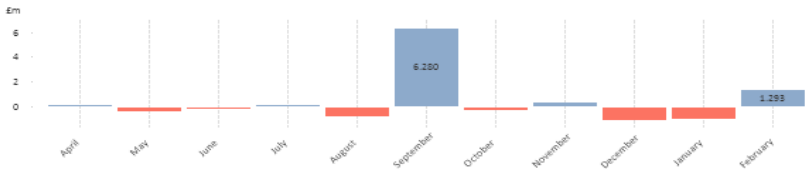
Summary	Year to Date Plan	Year to Date Actual	Year to Date Variance	This Month vs. Run Rate Actual	Run Rate to date	Var to M10
1 Total Non Elective Spells	178.2	198.0	19.8	16.5	18.1	(1.6)
2 Accident & Emergency	34.1	39.3	5.2	3.2	3.6	(0.4)
3 Total Elective Spells	85.7	74.4	(11.3)	7.0	6.7	0.3
4a New Outpatient Attendances	40.4	38.4	(2.0)	3.5	3.5	(0.0)
4b Outpatient Follow Up Attendances	49.1	50.0	0.9	4.3	4.6	(0.3)
5 Other Cost Per Case	149.1	140.9	(8.3)	12.2	12.9	(0.7)
6 Block Agreements	21.4	20.8	(0.6)	1.9	1.9	(0.0)
7 Income Additional to PbR	119.5	129.2	9.7	21.1	10.8	10.3
8 Risks and Adjustments	(0.0)	(6.1)	(6.1)	(5.1)	(0.1)	(5.0)
9a Elective Recovery Fund	18.3	15.7	(2.5)	2.8	1.3	1.5
9c Adjust Prior Month Reported Position	-	-	-	0.0	(0.0)	0.0
Grand Total	**695.7**	**700.4**	**4.7**	**67.5**	**63.3**	**4.2**

Commissioner Group	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	Annual Plan
Kent and Medway CCG	54.6	50.5	(4.1)	575.6	577.4	1.7	630.1
NHS England SS	8.0	8.1	0.1	87.4	90.9	3.5	95.4
Public Health & Secondary Dental	1.3	1.4	0.1	14.2	15.0	0.8	15.5
Cancer Drugs Fund and Hep C	0.9	0.4	(0.5)	6.9	5.7	(1.2)	7.9
Other Organisations	0.4	0.3	(0.1)	4.7	3.7	(1.0)	5.1
Prior Year Income	0.6	6.5	5.9	2.5	3.8	1.3	3.1
NHS England - Other	0.2	(0.0)	(0.2)	2.4	(0.0)	(2.4)	2.6
Out of Area CCGs	0.2	0.2	0.0	1.9	2.0	0.1	2.1
NHS England - Rechargeable Drugs	-	0.1	0.1	-	1.9	1.9	-
	66.2	**67.5**	**1.3**	**695.7**	**700.4**	**4.7**	**761.8**

Total Income Var

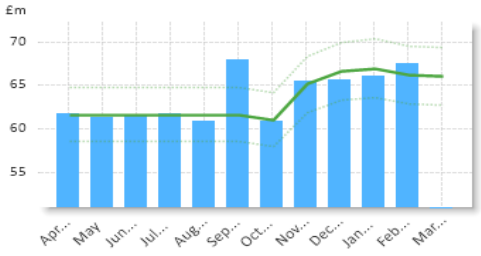


Income Variance

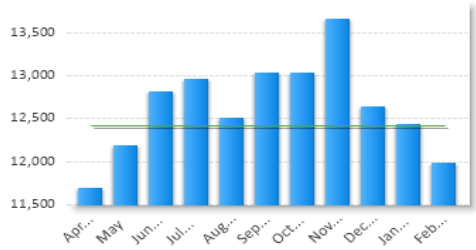


Care Group Income £m	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	Annual Plan
Cancer Services	4.3	4.3	0.0	47.1	47.1	0.0	51.3
Central	15.5	16.8	1.3	138.0	142.7	4.7	153.4
Child Health	3.5	3.5	(0.0)	38.7	38.7	(0.0)	42.2
Clinical Support Services	5.1	5.1	(0.0)	56.2	56.2	(0.0)	61.3
General and Specialist Medicine	12.7	12.7	(0.0)	139.4	139.4	0.0	152.0
Surgery - Head and neck, Breast Surgery a...	3.6	3.6	(0.0)	40.0	40.0	(0.0)	43.7
Surgery and Anaesthetics	10.0	10.0	0.0	110.1	110.1	0.0	120.1
Urgent and Emergency Care	7.6	7.6	0.0	84.1	84.1	0.0	91.7
Womens Health	3.8	3.8	0.0	42.2	42.2	0.0	46.1
	66.2	**67.5**	**1.3**	**695.7**	**700.4**	**4.7**	**761.8**

Income by Month



Monthly WAU - vs Plan



Almost all Income for H1 and H2 has been set by NHSE/I and allocated to commissioners at a level of £46.3m per month due to the Covid-19 finance regime. The significant favourable variance is due to the backdated funding of £6.2m paid in M6 to cover the 3% staff pay award which wasn't planned. From M7 onwards the staff pay award of 3% is offset by efficiency savings and Covid-19 funding reduction, which increases the monthly income by £0.3m.

In addition, £9.6m per month consisting of Covid-19 and other top-ups are being paid by Kent and Medway CCG and are fixed. The elements are Covid-19 funding and support £3.0m, Central Top-Up £4.0m and Growth of £3.5m, including the CCG-funded elements of the new UTCs.

The YTD Elective Recovery Funding (ERF) is £15.7m. This is primarily below planned levels due to the H1 revised target of 95% which came into effect from 1st July. From M7 the baseline and performance has changed to be measured against RTT completed pathways instead of against pure activity. As part of this change the target has also been updated to 89%.

The variable element of High Cost drugs with NHS England is currently £0.6m over plan. However, this is cost neutral as these are pass through costs and the Trust's expenditure is also higher.

NHSE High Cost Devices are paid as pass through costs under the visible cost model, meaning income and expenditure balance off. From the start of December, the vascular stents have been added to the visible cost model.

There are small variances present in Private, Overseas, Compensation Recovery Unit and Provider to Provider income.

Activity

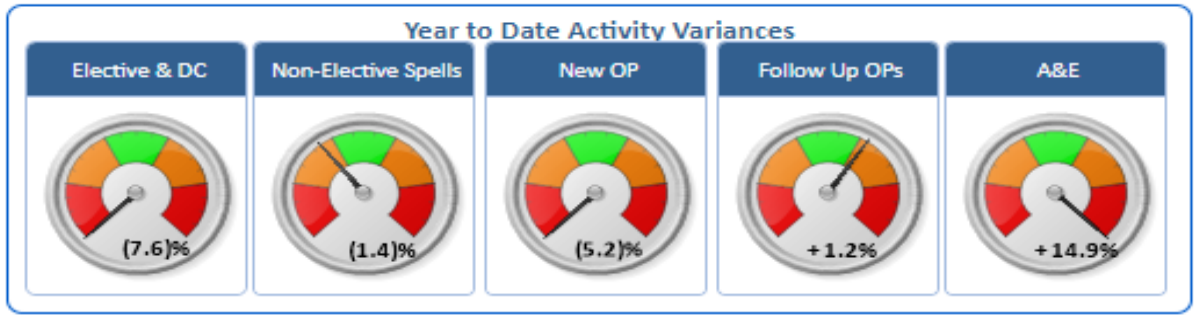
Month 11 (February) 2021/22

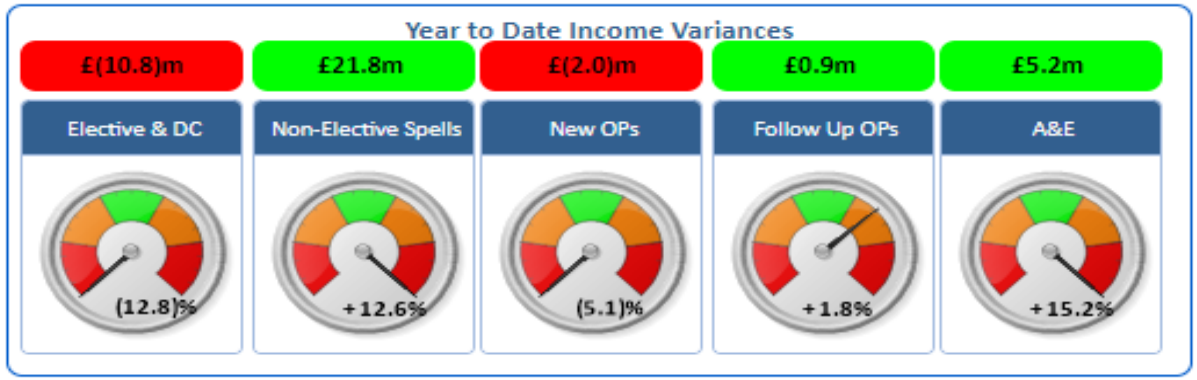
Trust Income Plan	Trust Actual Income	Income Variance
£695.735m	£700.433m	£4.699m

2021/22 - Month 11

East Kent Hospitals University NHS
NHS Foundation Trust

	Year to Date Activity			Year to Date Income £m			Average Tariffs	
Point of Delivery	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual
1a Total Non Elective Spells	80,169	79,029	(1,140)	£172.6 m	£194.3 m	£21.8 m	£2,153	£2,459
2 Accident & Emergency	211,959	243,593	31,634	£34.1 m	£39.3 m	£5.2 m	£161	£161
3a Total Elective Spells	81,374	75,227	(6,147)	£84.9 m	£74.1 m	£(10.8)m	£1,043	£984
4a New Outpatient Attendances	223,653	211,939	(11,714)	£40.4 m	£38.4 m	£(2.0)m	£181	£181
4b Outpatient Follow Up Attendances	494,176	500,314	6,138	£49.1 m	£50.0 m	£0.9 m	£99	£100





The activity plan for 21/22 has been based on Pre-Covid-19 19/20 actuals and is phased in 12ths.

The Trust has been paid £4.8m for the Elective Recovery Fund in H1. The Q3 value is expected to be £1.1m over the fixed ERF+ value of £4.2m. No Additional ERF funding has been accrued in February above the fixed ERF+ value.

Outpatients have operated at 6% under planned levels in February. YTD Outpatients are 2% over plan.

Elective inpatient activity has underperformed by 3% against plan in February. YTD Electives are 8% under plan.

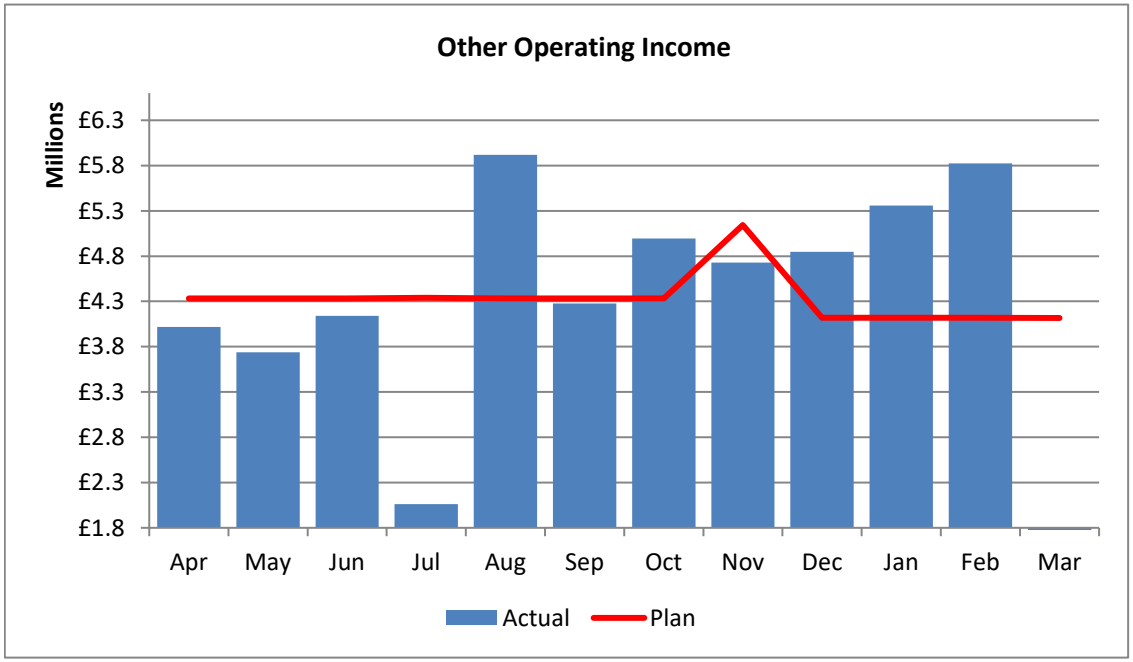
The level of A&E attendance continues to run an overperformance against plan. Activity in February is 2% over plan, with YTD activity showing 15% over plan.

Non-Elective activity in month is 10% under plan, however the case mix is richer with income being 3% over plan. This is in line with the YTD position where activity is 1% under plan, but income is 13% over plan. This is being driven by an increase in longer stay admissions.

Other Operating Income

Month 11 (February) 2021/22

Other Operating Income	This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Non-patient care services	2,016	2,307	291	21,122	20,603	(519)	23,137
Research and development	226	325	99	2,305	2,304	(2)	2,531
Education and Training	1,178	1,583	406	14,439	16,585	2,146	15,615
Car Parking income	105	80	(25)	1,082	1,107	25	1,186
Staff accommodation rental	171	148	(23)	2,036	1,759	(277)	2,206
Property rental (not lease income)				8		(8)	8
Cash donations / grants for the purchase of capital assets	81	65	(16)	825	707	(118)	906
Charitable and other contributions to expenditure	15	15	()	165	157	(8)	180
Other	327	1,300	973	5,853	6,686	833	6,181
Total	**4,118**	**5,823**	**1,705**	**47,835**	**49,908**	**2,073**	**51,952**
			41.41%			4.33%	
			Favourable			Favourable	



Other operating income is favourable to plan in February by £1.7m and by £2.1m YTD. The in-month variance is driven mainly by above plan Covid-19 income of £1.1m inclusive of the Nightingale surge hub and above plan education and training income of £0.4m. Ockenden maternity funding and a favourable position on research and development income totalling £0.4m is offset by below plan income for the Harmonia Village of £0.1m.

YTD, Harmonia Village income is adverse to plan by £1.1m. This is offset by a favourable variance on Education and Training income of £2.1m, sale of Beautiful Information £0.6m and Covid-19 income, which is now favourable to plan by £0.4m

Employee Expenses
Month 11 (February) 2021/22

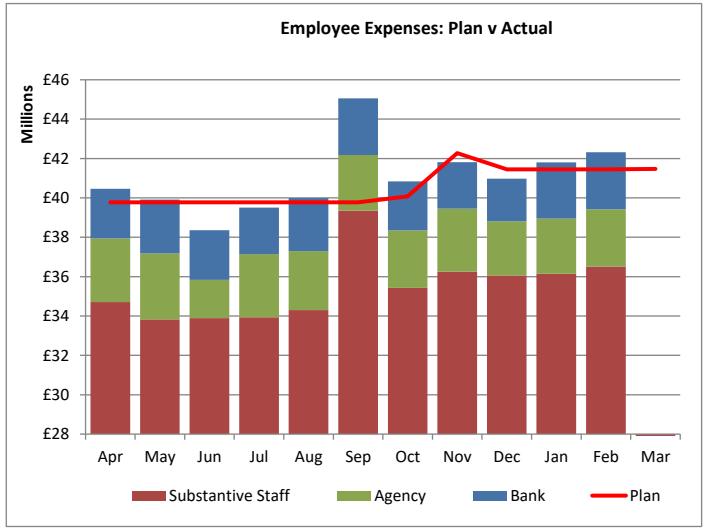
Employee Expenses	WTE This Month			This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Permanent Staff										
Medical and Dental	1,360	1,299	62	(11,557)	(11,066)	491	(123,938)	(120,747)	3,191	(135,495)
Nurses and Midwives	3,275	2,590	684	(10,053)	(10,400)	(347)	(108,045)	(108,431)	(386)	(118,128)
Scientific, Therapeutic and Technical	1,662	1,554	109	(5,366)	(5,555)	(189)	(59,017)	(59,837)	(819)	(64,384)
Admin and Clerical	1,742	1,486	256	(3,565)	(3,498)	67	(38,706)	(38,290)	416	(42,270)
Other Pay	1,773	1,507	266	(5,063)	(5,038)	24	(54,740)	(53,480)	1,261	(59,803)
Permanent Staff Total	**9,811**	**8,435**	**1,376**	**(35,604)**	**(35,558)**	**46**	**(384,447)**	**(380,784)**	**3,663**	**(420,080)**
Waiting List Payments										
Medical and Dental	0	0	0	(248)	(449)	(201)	(2,154)	(4,002)	(1,849)	(2,401)
Waiting List Payments Total	**0**	**0**	**0**	**(248)**	**(449)**	**(201)**	**(2,154)**	**(4,002)**	**(1,849)**	**(2,401)**
Medical Locums/Short Sessions										
Medical and Dental	5	41	(35)	(222)	(508)	(286)	(3,277)	(5,627)	(2,351)	(3,498)
Medical Locums/Short Sessions Total	**5**	**41**	**(35)**	**(222)**	**(508)**	**(286)**	**(3,277)**	**(5,627)**	**(2,351)**	**(3,498)**
Substantive	**9,816**	**8,476**	**1,340**	**(36,073)**	**(36,514)**	**(441)**	**(389,877)**	**(390,413)**	**(536)**	**(425,980)**
Bank										
Medical and Dental	0	31	(31)	(308)	(374)	(66)	(3,654)	(3,590)	65	(3,962)
Nurses and Midwives	55	285	(230)	(1,202)	(1,406)	(205)	(10,882)	(13,387)	(2,506)	(12,083)
Scientific, Therapeutic and Technical	1	3	(2)	(11)	(11)		(153)	(90)	63	(164)
Admin and Clerical	13	73	(60)	(131)	(202)	(70)	(1,440)	(2,096)	(656)	(1,571)
Other Pay	32	276	(245)	(999)	(897)	102	(7,573)	(9,317)	(1,745)	(8,571)
Bank Total	**100**	**667**	**(567)**	**(2,651)**	**(2,889)**	**(238)**	**(23,702)**	**(28,481)**	**(4,779)**	**(26,353)**
Agency										
Medical and Dental	3	48	(45)	(1,259)	(929)	329	(18,469)	(11,381)	7,088	(19,728)
Nurses and Midwives	41	173	(133)	(951)	(901)	50	(8,244)	(11,860)	(3,616)	(9,195)
Scientific, Therapeutic and Technical	0	0	0	(18)		18	(162)	(191)	(29)	(180)
Admin and Clerical	0	1	(1)	(1)	(12)	(11)	(8)	(69)	(61)	(8)
Other Pay	2	40	(38)	(110)	(154)	(44)	(587)	(758)	(172)	(697)
Agency Total	**46**	**263**	**(217)**	**(2,338)**	**(1,996)**	**342**	**(27,469)**	**(24,259)**	**3,211**	**(29,808)**
Direct Engagement - Agency										
Medical and Dental	5	71	(66)	(384)	(911)	(527)	(3,807)	(7,805)	(3,998)	(4,191)
Scientific, Therapeutic and Technical	0	1	(1)		(5)	(5)	(489)	(73)	416	(489)
Direct Engagement - Agency Total	**5**	**72**	**(67)**	**(384)**	**(916)**	**(532)**	**(4,296)**	**(7,878)**	**(3,582)**	**(4,680)**
Agency	**51**	**335**	**(284)**	**(2,722)**	**(2,912)**	**(190)**	**(31,765)**	**(32,137)**	**(371)**	**(34,487)**
Total	**9,968**	**9,478**	**490**	**(41,446)**	**(42,316)**	**(870)**	**(445,344)**	**(451,031)**	**(5,687)**	**(486,820)**
						-2.10%			-1.28%	
						Adverse			Adverse	

Employee expenses performance is adverse to plan in February by £0.9m and adverse to plan by £5.7m YTD (1.28%). Expenditure relating to all Covid-19 pay streams is £1.0m in month and £11.4m YTD.

Total expenditure on pay in February was £42.3m, an increase of £0.5m when compared to January, predominantly relating to permanent staffing (mainly Consultant grade) and overtime costs which increased by £0.4m. Substantive staff contracted wte increased by approximately 130 compared with staff in post in January. Expenditure on bank and agency staff increased by £0.1m.

Expenditure on all substantive staff is adverse to plan in February by £0.4m and by £0.5m YTD.

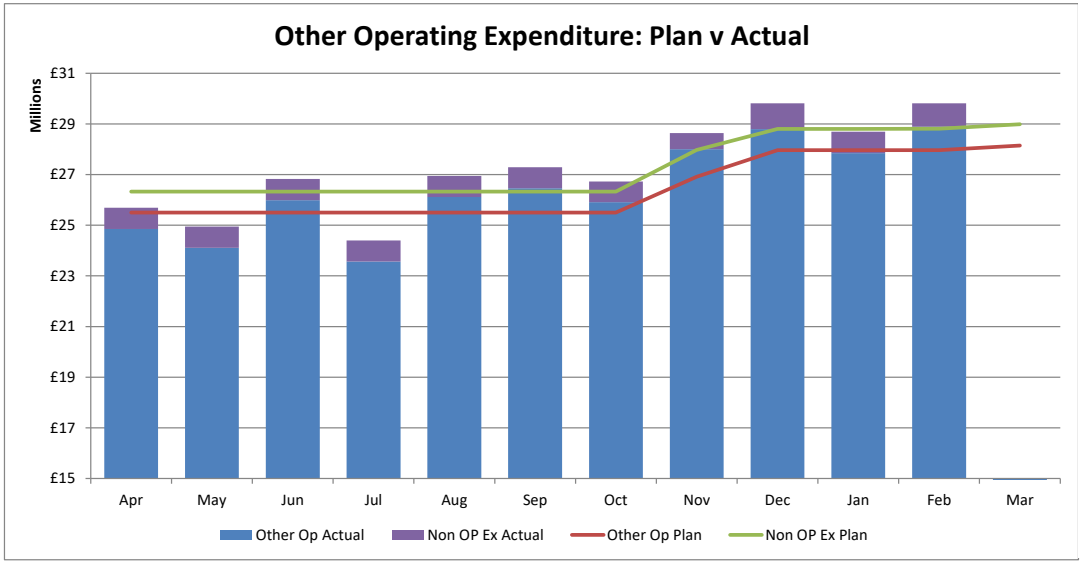
Expenditure on bank and agency staff combined is adverse to plan in February by £0.4m and by £5.2m YTD.



Other Operating Expenditure

Month 11 (February) 2021/22

£000	This Month Plan	This Month Actual	This Month Var.	Year to Date Plan	Year to Date Actual	Year to Date Var.	Annual Plan
Drugs	(6,326)	(6,332)	(5)	(68,364)	(72,257)	(3,893)	(74,690)
Clinical Supplies and Services - Clinical	(3,272)	(3,355)	(83)	(31,975)	(33,816)	(1,841)	(35,248)
Supplies and Services - Non-Clinical	(9,220)	(9,143)	77	(103,959)	(99,269)	4,690	(113,237)
Non Executive Directors	(17)	(16)	1	(191)	(214)	(22)	(208)
Purchase of Healthcare	(2,388)	(1,718)	671	(15,068)	(7,551)	7,517	(17,456)
Education & Training	(171)	(424)	(253)	(2,110)	(3,083)	(974)	(2,281)
Consultancy	(70)	(37)	33	(629)	(501)	128	(699)
Premises	(1,072)	45	1,117	(11,422)	(11,489)	(67)	(12,494)
Clinical Negligence	(2,330)	(2,194)	136	(25,625)	(25,474)	152	(27,955)
Transport	(251)	(294)	(43)	(2,546)	(2,722)	(175)	(2,797)
Establishment	(336)	(374)	(38)	(3,488)	(4,214)	(727)	(3,823)
Other	(771)	(3,117)	(2,346)	(5,692)	(11,913)	(6,222)	(6,580)
Depreciation & Amortisation-Owned Assets	(1,743)	(1,928)	(185)	(18,253)	(18,040)	213	(20,001)
Total Other Operating Expenditure	**(27,967)**	**(28,886)**	**(919)**	**(289,321)**	**(290,543)**	**(1,222)**	**(317,468)**
Profit/Loss on Asset Disposals		**(123)**	**(123)**		**(250)**	**(250)**	
PDC Dividend	(742)	(769)	(27)	(8,590)	(8,459)	131	(9,332)
Interest Receivable	186	187	1	2,049	2,056	8	2,235
Interest Payable	(285)	(227)	58	(2,832)	(2,587)	245	(3,117)
Total Non Operating Expenditure	**(841)**	**(932)**	**(91)**	**(9,373)**	**(9,240)**	**133**	**(10,214)**
Total Expenditure	**(28,808)**	**(29,818)**	**(1,011)**	**(298,695)**	**(299,783)**	**(1,088)**	**(327,683)**



Other operating expenditure is adverse to plan in February by £0.9m and adverse to plan by £1.2m YTD (0.42%). Expenditure on all Covid-19 non-pay streams is £1.7m in month and £9.2m YTD.

Drug spend is marginally breakeven against plan in February and adverse to plan by £3.9m YTD. Drugs historically classed as rechargeable are adverse to plan in February by £0.1m, and by £4.1m YTD. All other drugs are favourable to plan by £0.1m in month and by £0.2m YTD.

Supplies and services - clinical are adverse to plan in February by £0.1m and by £1.8m YTD. In month, referred diagnostics and scanning services are showing an adverse variance of £0.7m, predominantly due to outsourced MRI and CT services (MRI previously sourced via the OHF contract). This overspend against plan is offset by favourable variances on Covid-19 testing reagents, equipment maintenance and above plan savings totalling £0.6m. YTD, expenditure reclassified from non-clinical supplies causes a technical overspend against the Trust's original plan of £3.4m, visible cost model items are overspent by £1.1m, scanning services are overspent by £1.4m and pathology reagents are overspent by £0.5m. These overspends are offset by underspends on Covid-19 testing reagents, prostheses, equipment maintenance and theatre consumables totalling £4.6m.

Supplies and services - non-clinical are favourable to plan in February by £0.1m and favourable to plan by £4.7m YTD. The in-month variance is driven by a favourable variance on the OHF contract of £0.8m, predominantly relating to MRI scanning services now being commissioned directly and showing against clinical supplies, offset by slippage against CIP targets of £0.7m in month and £1.8m YTD. YTD, expenditure reclassified to clinical supplies causes a technical underspend of £3.4m with the remainder of the YTD variance mainly relating to slippage on anticipated CCN's to the OHF contract in prior months and MRI scanning now classified as clinical supplies expenditure.

Purchase of healthcare from the independent sector including the use of Spencer beds is favourable to plan in month by £0.7m and by £7.5m YTD. The outsourcing of activity to the independent sector remains below plan.

Premises are favourable in month by £1.2m in month and adverse £0.1m YTD. In month the variance reflects the reclassification of £1.6m of computer equipment and software cost out of revenue expenditure and into capital expenditure.

Other expenditure is adverse to plan in February by £2.3m and by £6.2m YTD. In month, the variance relates mainly to legal costs which are adverse to plan by £2.0m following a provision in February of £1.9m. Outsourced medical services originally planned as pay expenditure account for £3.5m of the adverse variance YTD. Overspends on legal costs, staff permits, security services and hospitality totalling £3.6m YTD are offset by a favourable position of £1.8m on provisions against bad debt.

Depreciation was marginally above plan in month and favourable to plan by £0.2m YTD.

Actual expenditure on other operating expenditure in February was £26.4m, a reduction of £1.4m when compared to January. The underlying reduction relates to the reclassification of £1.6m of computer equipment and software cost as referenced in Premises.

Cost Improvement Summary

Month 11 (February) 2021/22

Delivery Summary	This Month			Year to Date			Forecast	
Programme Themes £000	Plan	Actual	Variance	Plan	Actual	Variance	Outturn	Variance
Agency	1,369	646	(723)	3,949	3,288	(661)	4,989	(450)
Bank	-	-	-	-	-	-	-	-
Workforce	20	12	(7)	199	169	(31)	205	(14)
Outpatients	-	-	-	-	-	-	-	-
Procurement	25	27	2	273	336	64	355	58
Medicines Value	-	-	-	-	-	-	-	-
Theatres	-	-	-	-	-	-	-	-
Care Group Schemes *	317	154	(164)	1,677	1,091	(586)	1,694	(300)
Sub-total	**1,731**	**839**	**(892)**	**6,098**	**4,884**	**(1,215)**	**7,244**	**(707)**
Central	665	898	233	2,052	2,331	279	3,156	381
Grand Total	**2,395**	**1,737**	**(658)**	**8,150**	**7,215**	**(935)**	**10,400**	**(326)**

* Smaller divisional schemes not allocated to a work stream

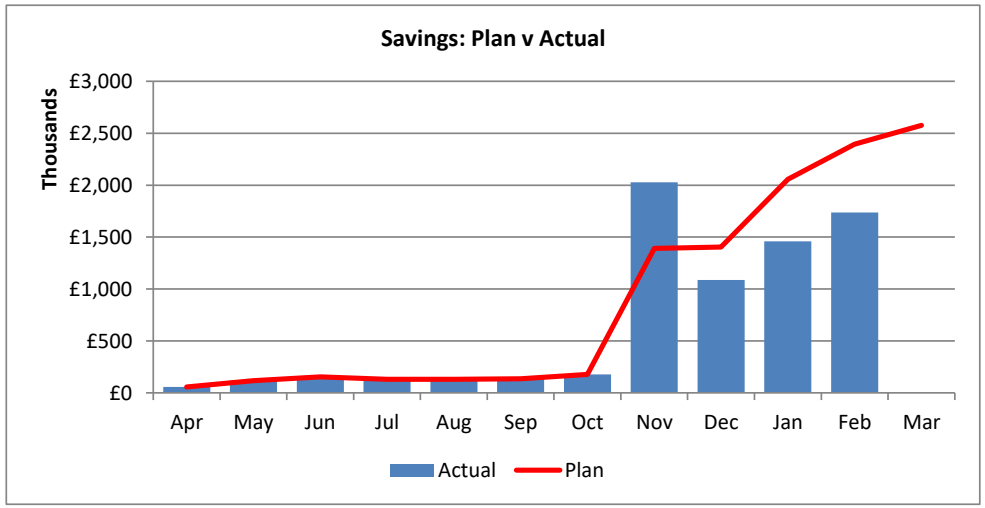
Delivered £000		
Month	Target	Actual
April	57	57
May	118	118
June	154	154
July	130	130
August	131	131
September	135	135
October	178	178
November	1,390	2,027
December	1,404	1,088
January	2,057	1,459
February	2,395	1,737
March	2,576	
	10,726	**7,215**

Savings and Efficiencies

The agreed savings plan for H2 is £10m. The savings achieved in February of £1.7m was below the plan of £2.4m. The in month shortfall relates to timing of efficiencies yet to be identified. The YTD delivery is below plan with the FOT £0.3m below the targeted value. There is a FOT risk of £2.0m in unidentified efficiencies.

Recurrent savings in January amounted to £0.85m, with £0.88m being on a non-recurrent basis.

A pipeline of ideas has been developed as the basis for delivery of the 2022-23 efficiency programme. Currently the shortfall is circa £12.5m compared to the indicative target.



Capital Expenditure
Month 11 (February) 2021/22

Capital Programme	Annual	Annual	Year to Date		
£000	Plan	Forecast	Plan	Actual	Variance
ED Expansion WHH	10,647	5,991	6,534	4,973	1,561
ED Expansion QEQM	10,295	5,508	6,437	4,163	2,274
ED Expansion Other	2,058	1,648	1,764	595	1,169
Energy Performance Contract (EPC - Breathe)	1,710	2,310	1,710	1,938	(228)
Mammography equipment - 2 x rooms K&C	130	508	130	508	(378)
Electronic Medical Record (T3 'Sunrise' system)	780	779	780	1,067	(287)
Cardiac Catheter Lab QEQM	1,198	1,150	1,198	929	269
Installation of replacement MRI - QEQM	740	779	740	780	(40)
New Interventional Radiology (IR) suite - K&C	2,850	3,000	2,850	2,676	174
Endovascular theatre (EVT) kit installation - K&C	880	30	680	15	665
Clinical Trials Unit	1,600	807	1,475	557	918
Community Diagnostic Hub - BHD		3,609		782	(782)
MDG - Medical equipment replacement (<£250k per item)	1,500	2,322	1,500	1,337	163
IDG - IT hardware/ systems replacement	1,000	1,750	1,000	2,470	(1,470)
2Gether Support Solutions	350	350	350	118	232
Spencer Private Hospitals	150	170	150	66	84
PEIC - Backlog maintenance/ Patient environment improvement	3,000	3,100	2,667	1,434	1,232
ITU Expansion - 24 bed Unit WHH	2,530	4,938	2,530	4,973	(2,443)
East Kent Transformation Programme	200	196	200	139	61
Donated Assets	900	900	800	548	252
K&M ICS Prioritisation	1,178	600	1,059	432	627
Restore and Recovery	588	397	588	259	329
Elective Orthopaedics		2,582		2,548	(2,548)
ED Enabling Works - PEIC		2,939		1,696	(1,696)
ED Enabling Works - IDG		800		101	(101)
Pathology - Home reporting, iRefer, Image Sharing		864		502	(502)
Pathology - Order Comms, Digital Path, POCT		2,411			
TIF - Estates		1,372		829	(829)
TIF - Digital		1,728		380	(380)
All Other		3,898		2,328	(2,328)
	44,284	**57,437**	**35,141**	**39,143**	**(4,002)**

Funded By:		
Depreciation	19,206	19,206
Grants and Donations	900	1,115
Public Dividend Capital	24,178	36,866
In-year disposals	0	250
	44,284	**57,437**

Summary Capital Spend Position - February 2022

The Group gross capital year-to-date spend to the end of February is £39.1m, against an internal capital re-phased plan year-to-date of £35.1m, representing a £4m overspend. This is aligned with the planning expectations, given the significant capital approved in addition to what was included in the April2021 Capital Plan submitted to NHSE/I.

The month 11 YTD position of £39.14m is, however, £18.3m below the year-end forecast of £57.4m, as a significant portion of the 21/22 Capital Programme was concentrated in M12, given the late notice of some of the main funding streams, along with operational pressures driven by the current economic climate, increased delivery times and global supply shortages for both materials and finished products.

New funding approved:

• **Diagnostics Digital Capability** - the Trust signed the letter of Agreement for an award of £2.4m in November 2021, for the delivery of:

- GP and Community Order Communications;

- Digital Pathology; and

- Point of Care Testing (POCT)

The associated MOU confirming the PDC Central Funding has now been received and signed by the Trust in February 2022;

• **Frontline Digitisation** - the Trust received confirmation in December 2021 that was successful in securing circa £1m funding for the associated bid submitted and IDG was approved to proceed to implementation on this basis;

The associated MOU confirming the PDC Central Funding has now been received and signed by the Trust in February 2022;

• **Unify Tech Funding** – Digital Maternity Awards – the Trust received and signed the MOU for the associated £0.02m in February 2022;

• **Imaging Academies** – workstations – The Trust received and signed the MOU for the associated £0.03m in February 2022;

Risk Management

2021/22 Capital Programme – Year-end position

The 2021/22 year-end forecast position of £57.4m presented in this report includes an additional £1.36m funding gap offset by a portfolio of risks amounting to £2.3m (detailed in the report submitted to the Strategic Capital Planning and Performance Committee), which are being actively managed over the coming weeks to deliver a balanced programme.

Delivery of GP Order Comms is also a high-risk programme, representing a further risk of up to £2.3m. Whilst this is outside our control as the scheme is an ICS initiative the Trust is hosting for the system, we are working closely with colleagues from the K&M ICS, to actively manage this risk.

ED Expansion - Funding

In the absence of a variation letter to the original £23m MOU for 2021/22, the Trust had been asked by the regional NHSE/I team and the K&M ICS to fully utilise the PDC amount awarded and to stay true to the agreed CDEL limit. The Trust had therefore reported on this basis in the M10 PFR a reduced internally generated capital of £4m with the new total being £15.2m, the £4m representing the agreed share of UEC PDC to be overspent by other organisations in the ICS so that capital is balanced at a Kent & Medway system level.

However, a subsequent decision by the DHSC in February 2022 to decline the request to fund alternative schemes from the planned UEC slippage, which has since been reversed and the DHSC have confirmed individual MOUs will be issued to each individual organisation, up to the level of funding agreed.

The Trust has therefore reported in the M11 PFR a fully utilised internally generated capital and an under-utilised UEC PDC funding of £4m, corresponding to the UEC PDC balance other K&M ICS organisations will be spending in 21/22.

An MOU variation letter citing the revised UEC PDC funding of £19m to be utilised by EKHUFT in 2021/22 is yet to be received.

Emergency PDC Cash Application

Following a corresponding CDEL allocation by the K&M ICS, the Trust applied for £3.2m of Emergency PDC funding in November 2021.

Whilst the final deadline to submit a drawing request was the 8th March 2022, the Trust is yet to receive the associated MOU, despite informal confirmation from the regional NHSE/I colleagues earlier in the year that the application was successful.

2021/22 Funding and Associated MOUs

In 2021/22, The Trust received a number of MOUs incorrectly citing capital in excess of the amounts expected, primarily revolving around the Targeted Investment Fund (TIF), for both Estates and Digital. This issue has also been raised by a number of other Trusts.

The advice from the Regional NHSE/I colleagues and K&M ICS was to sign the MOUs and only draw down up to the level of funding required, given it was unlikely that variation letters could be issued on time and the Trust was at risk of missing out the funding opportunity altogether.

The Trust has therefore agreed with the proposed approach and submitted the signed MOUs in February 2022.

Statement of Financial Position

Month 11 (February) 2021/22

£000	Opening	To Date	Movement	
Non-Current Assets	**392,497**	**411,343**	**18,847**	▲
Current Assets				
Inventories	4,198	5,944	1,746	▲
Trade and Other Receivables	31,065	35,475	4,409	▲
Assets Held For Sale			-	
Cash and Cash Equivalents	67,943	12,700	(55,244)	▼
Total Current Assets	**103,207**	**54,118**	**(49,088)**	▼
Current Liabilities				
Payables	(36,206)	(43,010)	(6,804)	▲
Accruals and Deferred Income	(83,474)	(49,096)	34,377	▼
Provisions	(3,826)	(4,247)	(421)	▲
Borrowing		(551)	(551)	▲
Net Current Assets	**(20,299)**	**(42,786)**	**(22,488)**	▼
Non Current Liabilities				
Provisions	(3,171)	(3,060)	111	▼
Long Term Debt	(87,360)	(80,527)	6,833	▼
Total Assets Employed	**281,666**	**284,970**	**3,303**	▲
Financed by Taxpayers Equity				
Public Dividend Capital	394,480	398,255	3,775	▲
Retained Earnings	(172,005)	(172,477)	(472)	▼
Revaluation Reserve	59,191	59,191	-	
Total Taxpayers' Equity	**281,666**	**284,970**	**3,303**	▲

Non-Current asset values reflect in-year additions (including donated assets) less depreciation charges. Non-Current assets also includes the loan and equity that finances 2gether Support Solutions.

Trust closing cash balances for February was £12.7m (£10m in January) £7.8m above plan. See cash report for further details.

Initial planning shows a potential Income and Expenditure deficit for 2023/24, which means the Group is likely to require borrowing during the year to support cash.

Trade and other receivables have increased from the 2020/21 opening position by £4.4m (£2.9m increase in January), the increase this month being driven by increases in NHS Debtors.

Payables have increased by £6.8m YTD (£1.3m increase in January) - the majority of which relates to invoices from 2gether Support Solutions.

£441k capital related PDC was drawn in month, with a potential £24m to be received in March

The large decrease in accruals and deferred income relate to year-end activity not being replicated in November.

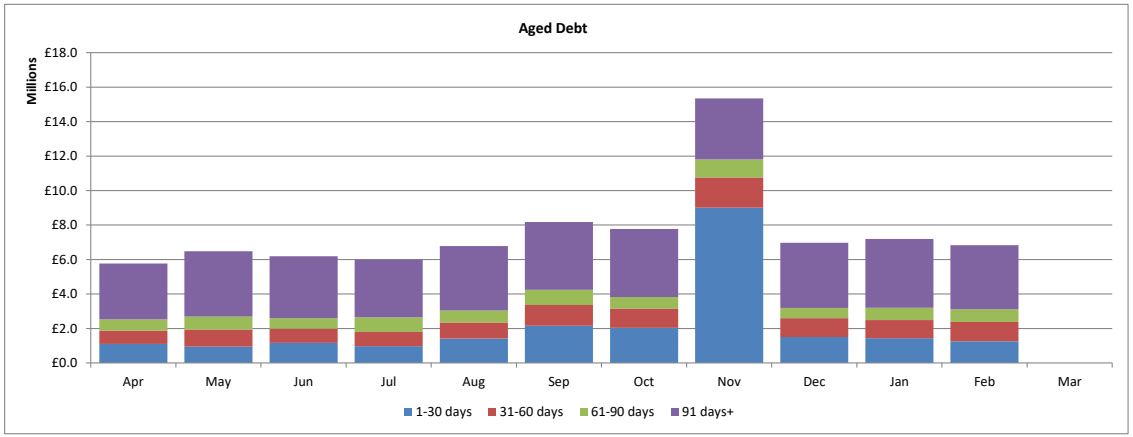
The long-term debt entry relates to the long-term finance lease debtor with 2gether. The movement in Retained earnings reflects the year-to-date unadjusted deficit.

Working Capital

Month 11 (February) 2021/22

Top ten debtor balances outstanding as at 28/02/2022

Debtor Name	Current	1+	31+	61+	91+	Total
NHS KENT AND MEDWAY CCG	9,761	94	92			9,947
SPENCER PRIVATE HOSPITALS LIMITED	797	5	389	346	1,017	2,554
2GETHER SUPPORT SOLUTIONS LTD	860	557	40	35	196	1,687
MEDWAY NHS FOUNDATION TRUST	52	50	125	28	532	788
KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	318	257			0	575
DARTFORD AND GRAVESHAM NHS TRUST	73	8	168	12	103	364
NHS ENGLAND SOUTH EAST COMMISSIONING HUB (14G)	334			3		337
KINGS COLLEGE HOSPITAL NHS FOUNDATION TRUST	25	109			139	272
PHILIPS RESPIRONICS				245		245
DANSAC LIMITED	107		107			214
Total	**12,328**	**1,079**	**921**	**667**	**1,987**	**16,982**



Total invoiced debtors have increased from the opening position of £8.2m by £11.6m to £19.8m (of which £13.0m is current debt)

At 28th February there were 3 debtors owing over £1m.

- 2gether Support Solutions owe £1.7m (£0.9m is current)
- Spencer Private Hospitals owe £2.6m. (£0.8m is current) The Trust is working with subsidiaries to bring reciprocal balances down.
- NHS Kent & Medway CCG owe £9.9m, of which, £9.8m is current debt.

Top ten creditor balances outstanding as at 28/02/2022

Supplier Name	Current	1+	31+	61+	91+	Total
2gether Support Solutions Ltd		6,885	5,762	352	108	13,107
Other Creditors	2,692	526	666	509	1,025	5,417
Spencer Private Hospitals Ltd		856	68	69	405	1,397
CDW	647	43	52		22	763
Medway NHS Foundation Trust (RPA)	166	12	7	2	574	761
Maidstone & Tunbridge Wells NHS Trust (RWF)	470			180	43	692
NHS Business Services Authority Prescription Pricing Division		266	284		1	551
NES Holdings (UK) Ltd	51		255	75	10	390
Abbott Laboratories Ltd	226	125				351
Alliance Healthcare (Distribution) Ltd	307			9		316
	4,558	**8,712**	**7,094**	**1,195**	**2,187**	**23,746**

Better Payment Practice Code	Last Year YTD Number	Last Year YTD £'000	This Year YTD Number	This Year YTD £'000
Non NHS				
Total bills paid in the year	57,064	460,732	64,057	527,716
Total bills paid within target	51,973	411,498	59,332	481,609
Percentage of bills paid within target	**91.1%**	**89.3%**	**92.6%**	**91.3%**
NHS				
Total bills paid in the year	2,691	41,092	2,550	11,131
Total bills paid within target	1,970	35,778	1,988	8,619
Percentage of bills paid within target	**73.2%**	**87.1%**	**78.0%**	**77.4%**
Total				
Total bills paid in the year	59,755	501,824	66,607	538,847
Total bills paid within target	53,943	447,276	61,320	490,228
Percentage of bills paid within target	**90.3%**	**89.1%**	**92.1%**	**91.0%**

Invoiced creditors have increased by £3.6m from the opening position to £23.7m.

19% relates to current invoices with 9% or £2.2m over 90 days.

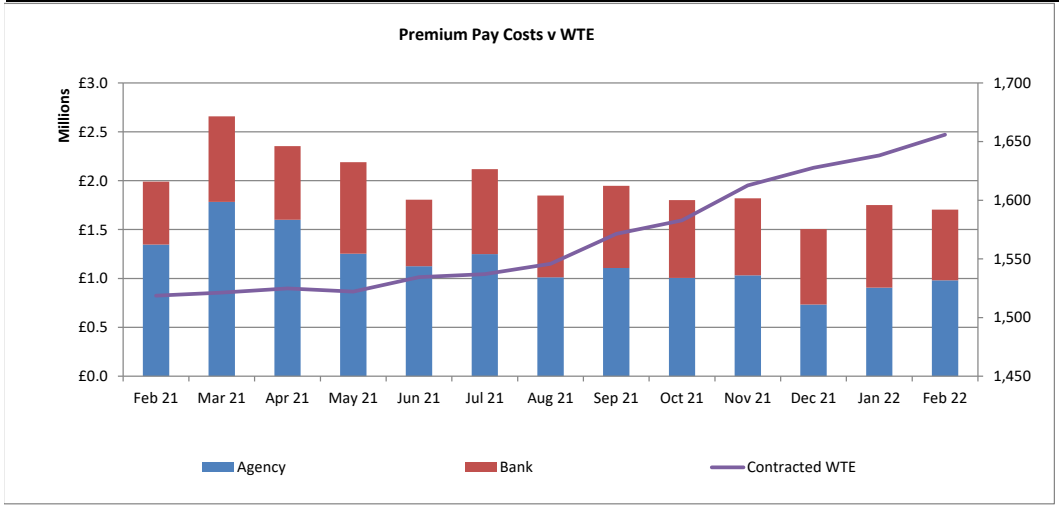
Over 90 days NHS creditors have increased by 55k:

- Kent Community Health NHS Foundation Trust (RYY) - £74k
- Medway NHS Foundation Trust (RPA) - (£15k)
- Royal Brompton And Harefield NHS Foundation Trust (RT3) - (£47k)
- The Royal Wolverhampton Hospitals NHS Trust (RL4) - £13k
- Guys & St Thomas NHS Foundation Trust (RJ1) - £40k

General and Specialist Medicine

Month 11 (February) 2021/22

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,747	1,654	(93)	19,214	17,649	(1,566)
Non-Electives	5,978	6,820	842	65,756	79,043	13,287
Accident and Emergency						
Outpatients	1,993	2,104	111	21,924	22,129	205
High Cost Drugs	845	650	(195)	9,293	9,466	173
Private Patients	0	1	1	0	17	17
Other NHS Clinical Income	2,107	1,439	(667)	23,176	10,995	(12,180)
Other Clinical Income	0	1	1	0	64	64
Total Income from Patient Care Activities	**12,669**	**12,669**		**139,363**	**139,363**	
Other Operating Income	138	45	(93)	2,115	1,019	(1,096)
Total Income	**12,807**	**12,714**	**(93)**	**141,478**	**140,383**	**(1,096)**
Expenditure						
Substantive Staff	(7,437)	(6,769)	669	(76,081)	(69,859)	6,222
Bank	(490)	(724)	(234)	(5,408)	(8,846)	(3,439)
Agency	(589)	(981)	(392)	(7,625)	(12,000)	(4,376)
Total Employee Expenses	**(8,516)**	**(8,473)**	**43**	**(89,113)**	**(90,706)**	**(1,593)**
Purchase of Healthcare	(377)	(223)	154	(2,576)	(2,177)	399
Supplies and Services Clinical	(824)	(723)	100	(10,675)	(10,663)	12
Supplies and Services General	(51)	(33)	18	(619)	(304)	315
Drugs	(1,120)	(1,098)	22	(12,651)	(12,600)	51
All Other, incl Transport	(128)	(207)	(80)	(1,774)	(2,566)	(793)
Total Operating Expenditure	**(11,016)**	**(10,758)**	**258**	**(117,408)**	**(119,017)**	**(1,609)**
Contribution	**1,792**	**1,956**	**165**	**24,071**	**21,366**	**(2,705)**



The Care Group financial position improved by £0.2m in January to £2.7m adverse to plan YTD. Income is £1.1m adverse to plan due to Harmonia being temporarily suspended (offset by £0.9m underspend on pay), expenditure is adverse by £1.6m primarily due to ward costs of premium pay and additional staffing. Underlying costs are increasing due to nursing recruitment, enabling patient safety, and for elective and diagnostic recovery.

Clinical Income:

Clinical Income is on-plan in line with Covid-19 reporting; the income position is reduced by £12m YTD, predominantly due to an overperformance on NEL of £13.3m. Elective and outpatients were on plan for February but £1.4m adverse YTD due to prior month flow and capacity restraints. Activity in some specialities is restricted due to capacity constraints, however these are easing, including Renal (phased implementation of dialysis business case in progress) and Cardiology (temporary closure of Cath lab at QEQM now reopened, and decreased referrals), or by lack of availability of consumables, specifically in Respiratory.

Other Income:

Plans to secure a partner for Harmonia are in contract negotiation stages.

Pay:

February pay is on plan (£1.6m adverse YTD), the driver being premium pay pressures to maintain safe ward staffing levels, manage outliers and front door pressures, and address the activity backlog. The run rate is consistent with prior months; there is an underlying trend of increased pay cost, particularly in Nursing/HCA through implementation of the Safer Staffing Business Case. Agency spend at £1m is consistent with the average spend, of which Consultant spend is a consistent £0.6m but with some contracts ending in Q1. Covid-19 pay costs have reduced slightly to £0.2m and are £0.3m favourable YTD.

Non-Pay:

Non-Pay is £0.2m favourable this month due to lower usage of endoscopy Insourcing, and underspends on Cardiology consumables and Respiratory devices following higher purchases in January.

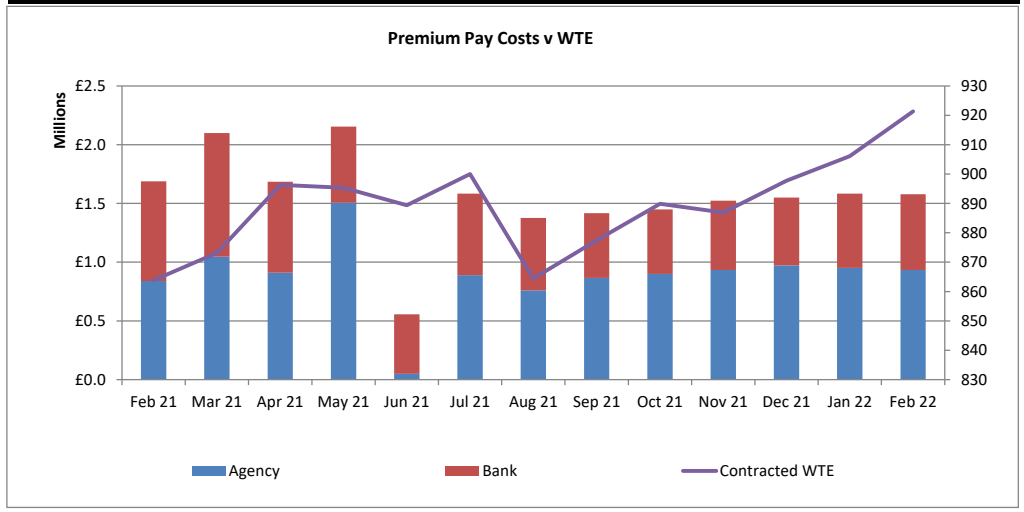
Covid-19:

Covid-19 costs of £0.2m were incurred in February, a decrease but still higher than the recent average and £0.1m above plan. The cumulative position is £3.3m spend, which is £0.3m favourable YTD.

Prepared by: Joanne Smith
Reviewed by: Richard Kingston & Wasique Chaudry

Urgent and Emergency Care
Month 11 (February) 2021/22

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	123	121	(2)	1,350	957	(393)
Non-Electives	4,265	3,910	(354)	46,914	45,965	(949)
Accident and Emergency	3,101	3,211	111	34,108	39,294	5,186
Outpatients	56	56	()	614	623	9
High Cost Drugs	1	8	7	6	96	91
Private Patients						
Other NHS Clinical Income	(1)	263	264	(7)	(3,840)	(3,833)
Other Clinical Income	98	73	(25)	1,078	966	(112)
Total Income from Patient Care Activities	**7,642**	**7,642**	**()**	**84,062**	**84,062**	**()**
Other Operating Income	(1)	6	7	1	78	77
Total Income	**7,641**	**7,648**	**7**	**84,062**	**84,140**	**77**
Expenditure						
Substantive Staff	(4,333)	(4,270)	63	(46,150)	(46,009)	141
Bank	(408)	(645)	(237)	(4,646)	(6,785)	(2,139)
Agency	(827)	(934)	(107)	(9,540)	(9,672)	(132)
Total Employee Expenses	**(5,568)**	**(5,849)**	**(281)**	**(60,336)**	**(62,466)**	**(2,130)**
Purchase of Healthcare						
Supplies and Services Clinical	(163)	(155)	8	(1,754)	(1,837)	(83)
Supplies and Services General	(18)	(67)	(50)	(208)	(273)	(65)
Drugs	(143)	(180)	(37)	(1,658)	(2,035)	(377)
All Other, incl Transport	(749)	(648)	101	(7,948)	(7,695)	253
Total Operating Expenditure	**(6,641)**	**(6,899)**	**(258)**	**(71,904)**	**(74,307)**	**(2,403)**
Contribution	**1,001**	**749**	**(252)**	**12,158**	**9,833**	**(2,325)**



The Care Group's position was £0.25m adverse in February, driven mainly by pay overspends associated with activity levels being significantly ahead of plan.

Income:

February's attendances were 2% (400) above plan. Actual attendances are averaging 22,100 per month this year and are persistently exceeding pre-Covid-19 levels (when activity was averaging 20,000 attendances a month in 19/20). Added to this, the general acuity of patients attending is more complex and more patients are requiring support with mental health conditions. OPEL (Operational Pressures Escalation Levels) 4 has often been applied and reflects current pressures. Consequently, the overall adjustment required to counter the overperformance is £3.8m YTD.

Employee Expenses:

Pay was £0.28m overspent in February and continues on an upward trajectory. Although overall actual pay expenditure was £0.04m lower than last month, it is £0.19m higher than the average for the year, driven mainly by an increase in substantive pay.

Substantive costs have largely risen due to recruitment successes, particularly for HCAs/Nurses. Contracted staff increased by 15 from last month and are 30 staff higher than the average for the year.

Although premium pay costs (agency, bank, locum and overtime) were £0.04m lower than last month, they are £0.06m higher than the average for the year. Decreases this month are split between agency and medical locum spend. The rise over the year is mostly linked to the staffing of additional escalation areas/beds on the ED floor and AMU/SDEC; escalated rates/incentives to ensure minimum staffing during peak times and additional cover to provide some resilience in the team due to Covid-19 illness/contact isolation.

Covid-19 costs totalled £0.21m in February. This was £0.03m lower than last month but £0.08m higher than the allocation, thereby causing a pressure on the budget. Covid-19 budget allocations have now been capped at September levels (£0.13m per month).

Acute Junior Dr costs have also increased over funded levels over the last two years. Approximately 70% of these costs relate to GSM services (e.g. Stroke cover at KCH, Oxford, Cambridge M1 and Kings D2 ward cover) and are therefore outside of the Care Group's control.

Other Operating Expenditure:

Non-pay was £0.02m favourable to plan in February. Actual costs were £0.03m lower than the average for the year and is thought to be due to the shorter month.

Other pressures are due to 2gether recharges for ad hoc security/cleaning costs.

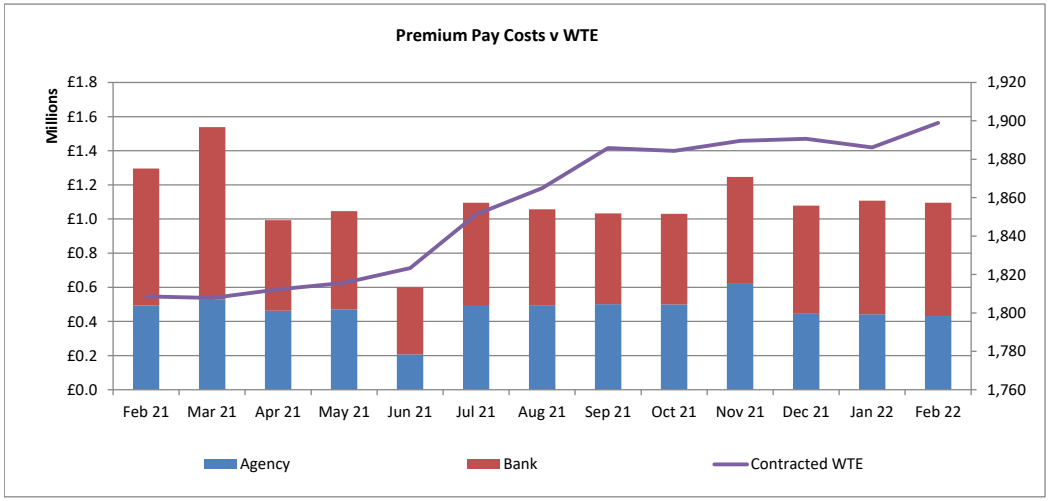
Cleaning/housekeeping/porterage costs were particularly high in February. A further piece of work is being undertaken to fully understand the nature of these ad hoc charges; if the need is expected to be recurrent; and ultimately if contracted hours need to be re-addressed.

CIPs:

A small amount of savings was recognised this month. Focus is now moving into identifying savings opportunities for 2022/23.

Prepared by: Stephen Lazell
Reviewed by: David Bogard & Hillary Mitchell

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	3,601	2,877	(724)	39,610	30,896	(8,715)
Non-Electives	3,326	3,388	61	36,589	42,671	6,083
Accident and Emergency						
Outpatients	1,436	1,254	(183)	15,801	14,729	(1,072)
High Cost Drugs	27	47	20	295	361	66
Private Patients	0	1	1	0	143	143
Other NHS Clinical Income	1,617	2,431	814	17,787	21,203	3,417
Other Clinical Income	0	10	10	0	80	80
Total Income from Patient Care Activities	**10,007**	**10,008**		**110,082**	**110,084**	**2**
Other Operating Income	89	100	10	734	850	116
Total Income	**10,096**	**10,107**	**11**	**110,816**	**110,934**	**118**
Expenditure						
Substantive Staff	(8,391)	(8,243)	148	(89,734)	(89,954)	(220)
Bank	(357)	(664)	(307)	(3,627)	(6,310)	(2,684)
Agency	(260)	(431)	(171)	(3,242)	(5,073)	(1,831)
Total Employee Expenses	**(9,009)**	**(9,338)**	**(329)**	**(96,602)**	**(101,337)**	**(4,735)**
Purchase of Healthcare	()	(1)	()	(2)	(3)	(1)
Supplies and Services Clinical	(1,749)	(1,419)	330	(19,093)	(17,634)	1,459
Supplies and Services General	(52)	(46)	6	(570)	(560)	9
Drugs	(404)	(382)	22	(4,202)	(4,183)	19
All Other, incl Transport	(235)	(291)	(56)	(2,438)	(2,645)	(207)
Total Operating Expenditure	**(11,449)**	**(11,477)**	**(28)**	**(122,906)**	**(126,362)**	**(3,456)**
Contribution	**(1,352)**	**(1,369)**	**(17)**	**(12,090)**	**(15,428)**	**(3,338)**



The Care Group is £3.3m adverse to plan YTD, no change from last month.

Income:

SLA Income has been adjusted YTD to break-even by £2.8m, for the impact of Covid-19.

Elective income is adverse £8.7m YTD and Outpatients £1.1m YTD. As expected both underperformed considerably in February with the continued impact of the new Covid-19 variant on non-urgent patient activity.

4 R plans had been developed for all specialties to deliver activity and reduce waiting times in line with National guidance, however risks of Theatre & Bed capacity remain limiting factors notwithstanding the additional impact of the new Covid-19 variant.

Non-Elective income however continues to overperform and is favourable YTD by £6.1m.

Pay:

Pay is adverse £4.7m YTD.

Both Bank (£2.7m) and Agency (£1.8m) are overspent YTD mainly due to increased Nursing to support additional workloads from Covid-19 patient pathway changes, 4 R plans and cover for sickness & vacancies.

Non-Pay:

Non-Pay is favourable £1.3m YTD, with underspends on clinical supplies from reduced patient activity.

Covid-19:

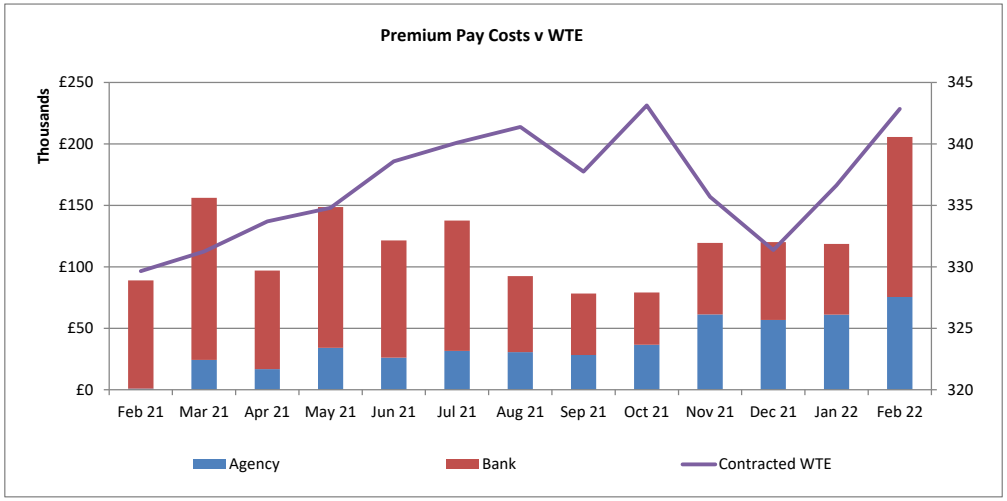
Covid-19 additional costs incurred of £2.8m are in the above, with all but £0.4m funded. The costs mainly relate to temporary staffing for the additional workforce requirements of pathway changes incurred supporting Critical Care services & emergency wards and also backfilling of staff.

Prepared by: James Isard
Reviewed by: Sue Travis

Surgery - Head and neck, Breast Surgery and Dermatology

Month 11 (February) 2021/22

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,244	1,215	(29)	13,679	13,080	(599)
Non-Electives	167	146	(21)	1,837	1,656	(180)
Accident and Emergency						
Outpatients	1,912	1,814	(98)	21,032	19,782	(1,250)
High Cost Drugs	249	132	(117)	2,738	3,297	560
Private Patients	0	9	9	0	45	45
Other NHS Clinical Income	69	325	256	761	2,182	1,422
Other Clinical Income	0	0	0	0	2	2
Total Income from Patient Care Activities	**3,640**	**3,640**		**40,045**	**40,045**	
Other Operating Income	10	7	(4)	114	105	(9)
Total Income	**3,651**	**3,647**	**(4)**	**40,159**	**40,150**	**(9)**
Expenditure						
Substantive Staff	(1,735)	(1,713)	22	(18,580)	(18,441)	139
Bank	(67)	(130)	(63)	(999)	(860)	139
Agency	(9)	(76)	(67)	(114)	(459)	(345)
Total Employee Expenses	**(1,811)**	**(1,919)**	**(108)**	**(19,693)**	**(19,759)**	**(67)**
Purchase of Healthcare	(49)	(58)	(9)	(540)	(625)	(85)
Supplies and Services Clinical	(131)	(117)	13	(1,140)	(1,015)	126
Supplies and Services General	(1)	(4)	(2)	(12)	(23)	(11)
Drugs	(369)	(336)	33	(4,754)	(4,831)	(77)
All Other, incl Transport	(11)	(46)	(34)	(403)	(400)	4
Total Operating Expenditure	**(2,372)**	**(2,480)**	**(107)**	**(26,542)**	**(26,653)**	**(111)**
Contribution	**1,278**	**1,167**	**(111)**	**13,617**	**13,498**	**(120)**



The Care Group is £0.1m adverse to plan YTD, all attributable to an adverse position in the current month from staffing costs.

Income:

SLA Income has been adjusted YTD to break-even by £1.0m, for the impact of Covid-19.

Elective income is £0.6m adverse YTD and Outpatients £1.3m adverse YTD. As expected both underperformed in February with the continued impact on patient activity of the new Covid-19 variant.

4 R plans were in place for most specialties to deliver activity in H2. However, Theatre capacity/outpatient clinic room capacity & staffing remain limiting factors notwithstanding the additional impact of the new Covid-19 variant.

Non-Elective income is adverse YTD by £0.2m.

Pay:

Pay is adverse by £0.07m YTD.

Substantive & Bank staff are underspent almost offsetting the Agency overspend (£0.3m YTD) for Medical Staffing to cover vacancies and support RTT improvements.

Non-Pay:

Non-Pay is adverse by £0.04m YTD.

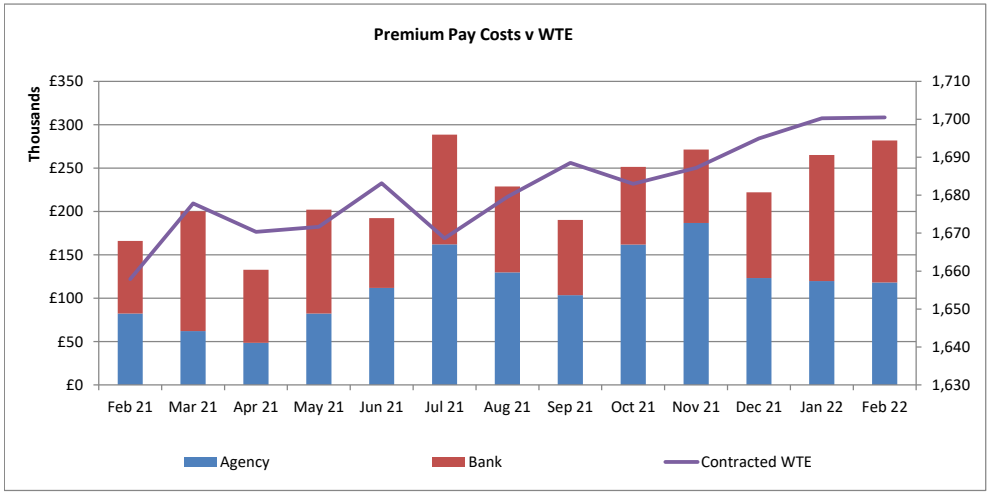
Underspends on clinical supplies and services offsetting increased AMD patient costs for Drugs and Spencer Hospitals service.

Covid-19:

Covid-19 additional costs of £0.05m have been funded in the above and relate mostly to temporary staffing.

Prepared by: James Isard
Reviewed by: Sarah Hyett

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	77	55	(22)	843	536	(307)
Non-Electives	10	5	(5)	106	14	(92)
Accident and Emergency						
Outpatients	856	662	(195)	9,420	7,383	(2,038)
High Cost Drugs	1,422	1,309	(113)	15,643	15,494	(148)
Private Patients	0	0	0	0	18	18
Other NHS Clinical Income	2,747	3,080	334	30,214	32,781	2,567
Other Clinical Income	0			0	1	1
Total Income from Patient Care Activities	**5,111**	**5,111**	**()**	**56,226**	**56,226**	
Other Operating Income	739	817	77	8,392	8,115	(278)
Total Income	**5,851**	**5,928**	**77**	**64,618**	**64,341**	**(277)**
Expenditure						
Substantive Staff	(6,181)	(6,222)	(41)	(67,042)	(66,627)	415
Bank	(66)	(164)	(97)	(631)	(1,179)	(548)
Agency	(185)	(118)	67	(2,043)	(1,348)	695
Total Employee Expenses	**(6,433)**	**(6,504)**	**(71)**	**(69,715)**	**(69,154)**	**561**
Purchase of Healthcare	(22)	(7)	15	(244)	(47)	197
Supplies and Services Clinical	(2,744)	(2,773)	(29)	(29,091)	(28,397)	694
Supplies and Services General	(24)	(39)	(15)	(167)	(161)	6
Drugs	(1,826)	(1,718)	108	(19,570)	(19,119)	452
All Other, incl Transport	(266)	(361)	(95)	(2,969)	(3,281)	(311)
Total Operating Expenditure	**(11,315)**	**(11,401)**	**(86)**	**(121,757)**	**(120,158)**	**1,598**
Contribution	**(5,464)**	**(5,473)**	**(9)**	**(57,138)**	**(55,818)**	**1,321**



The CSS Care Group maintained the overall position this month.

Income:

The Top-up adjustment to meet the main patient care income plan was low this month at £0.1m reflecting an increase in Homecare drugs reimbursement which was at year to date trend level at £1.4m. There was a reduction in direct access and GUM pathology tests reflecting the fewer days in February, however Radiology direct access and unbundled imaging was on par with January. Therapies outpatients activity was overall similar to last month - 1,778 attendances below plan (24%). The total Top-up adjustment for the year is now £2.9m.

Pay:

There was an overspend on pay in February (£0.07m) and an increase in run rate due to increased enhancements paid reflecting more weekend working (Trust pilot) and WLI payments increases. Radiology overtime and waiting list costs continue to be the main drivers of the overspend, the Radiology department is now overspent on pay budget £0.1m in Month and £1.3m year to date. This is offset by Pathology who are still carrying significant vacancies and are in receipt of out of envelope Covid funding. Therapies are carrying 32 WTE vacancies at Month 11 and have an underspend of £0.4m year to date, these vacancies are in active recruitment. Therapies are currently utilising overtime to support 7 Day services.

Non-Pay:

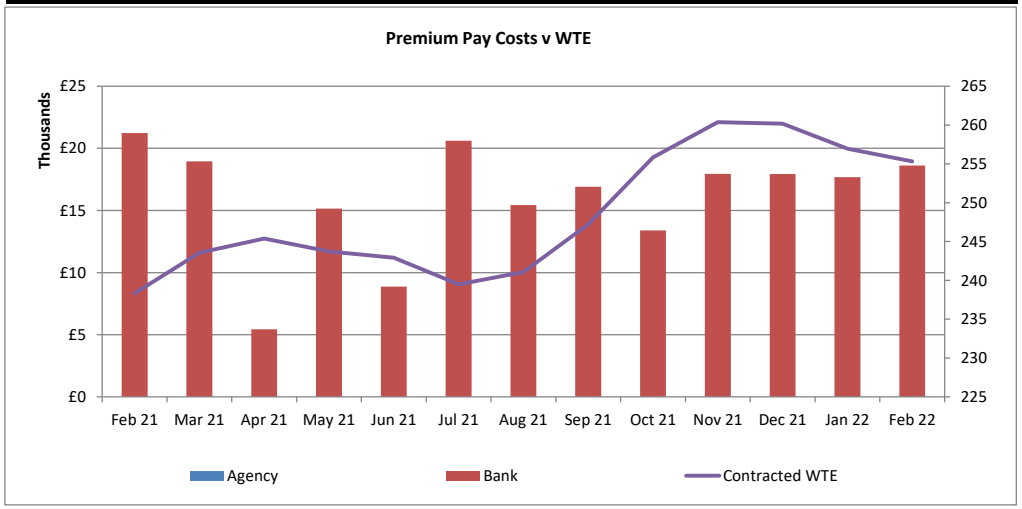
There was an increase in Non-pay expenditure in February mainly reflecting the increased rechargeable Homecare drugs costs and also Radiology non-pay expenditure, mainly CDC funded scanning capacity. The overall overspend was minimal across the Care Group. The pathology department received some over consumption charges against its Immunology budget for reagents supplied through the managed service contract with Genmed. There was also additional spend on building work providing additional security including enhanced CCTV to the Mortuary and Histopathology.

Covid-19:

Inside-envelope Covid-19 expenditure costs in February were higher than last month with the recognition of MRI outsourcing increases. Total year to date £1.4m. Outside Envelope costs (Covid-19 testing) were slightly less than last month (£0.4m). Year to date Outside Envelope costs now total £2.75m. Income loss impact is now £3.6m in CSS including patient care income.

Prepared by: Vivienne Bertram
Reviewed by: Heather Munro

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	390	517	126	4,295	5,654	1,358
Non-Electives	26	4	(22)	283	341	59
Accident and Emergency						
Outpatients	846	1,046	200	9,302	12,446	3,144
High Cost Drugs	2,251	2,399	148	24,762	26,560	1,798
Private Patients						
Other NHS Clinical Income	765	313	(453)	8,420	2,047	(6,373)
Other Clinical Income	0			0	14	14
Total Income from Patient Care Activities	**4,278**	**4,278**		**47,060**	**47,060**	
Other Operating Income	102	93	(9)	1,094	1,041	(53)
Total Income	**4,380**	**4,371**	**(9)**	**48,155**	**48,102**	**(53)**
Expenditure						
Substantive Staff	(1,028)	(985)	43	(10,764)	(10,617)	147
Bank	(13)	(19)	(5)	(147)	(168)	(21)
Agency	()	0		(4)	0	4
Total Employee Expenses	**(1,042)**	**(1,004)**	**38**	**(10,916)**	**(10,785)**	**131**
Purchase of Healthcare	()	(2)	(2)	(4)	(10)	(7)
Supplies and Services Clinical	(223)	(200)	23	(2,473)	(2,295)	178
Supplies and Services General	(5)	(6)	(2)	(50)	(82)	(32)
Drugs	(2,343)	(2,362)	(19)	(27,265)	(27,404)	(139)
All Other, incl Transport	(44)	(52)	(8)	(496)	(488)	7
Total Operating Expenditure	**(3,657)**	**(3,626)**	**31**	**(41,203)**	**(41,065)**	**138**
Contribution	**723**	**745**	**23**	**6,952**	**7,037**	**85**



The CCHH care group maintained its small surplus in February. Patient activity continues to exceed the plan.

Income:

The total year to date adjustment to plan is now £7.4m reflecting the overperformance in Clinical Oncology, Clinical Haematology and Anti-coagulation this year, including corresponding High cost drugs recharges. Activity across the specialties was lower than in January unsurprisingly as February is a short month.

Employee Expenses:

Pay costs increased in February very slightly. Premium pay breached the low threshold, however pay cost was within budget overall. Medical staff costs had a small overspend this month which was offset by underspends another staff types. Agency cost remains zero for this financial year.

Other Operating Expenditure:

Non-Pay is underspent this month and YTD. 91% of non-pay in this Care Group is drugs costs, which are overspending reflecting the increase in activity this year.

Covid-19:

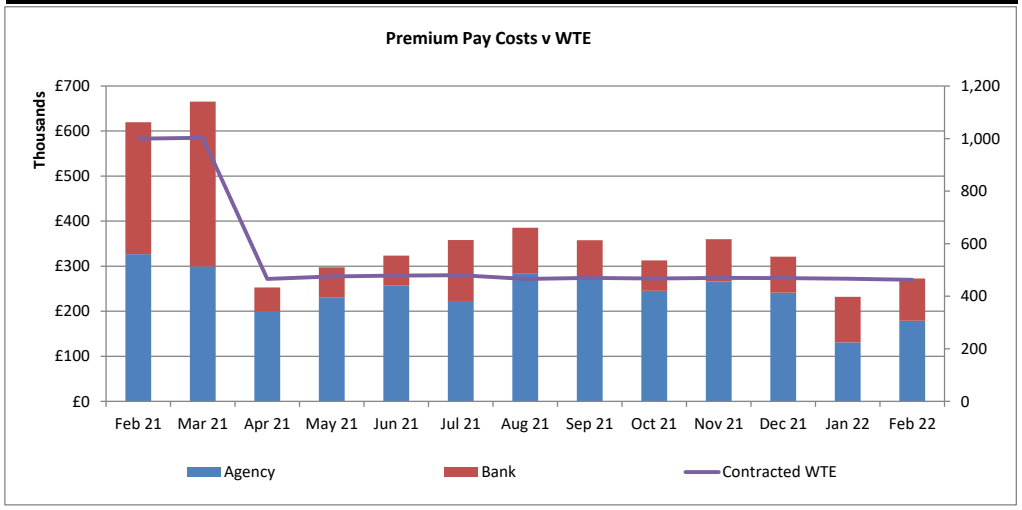
There were some admin and clerical and very low nursing pay costs recorded as Covid-19 costs in January. Total Covid-19 costs claimed remains minimal at £0.03m, with £0.01m for overtime utilised for the patient vaccination programme, rechargeable to NHSE/I as it is an 'Outside of Envelope' cost and the balance for additional staffing costs.

Prepared by: Vivienne Bertram
Reviewed by: Sarah Collins

Child Health

Month 11 (February) 2021/22

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	99	76	(23)	1,087	620	(466)
Non-Electives	664	458	(205)	7,299	5,931	(1,367)
Accident and Emergency						
Outpatients	651	616	(35)	7,160	6,771	(389)
High Cost Drugs	33	12	(21)	366	273	(93)
Private Patients						
Other NHS Clinical Income	2,071	2,355	284	22,786	25,098	2,312
Other Clinical Income	0	0	0	0	4	4
Total Income from Patient Care Activities	**3,518**	**3,518**		**38,697**	**38,697**	
Other Operating Income	71	74	3	835	833	(2)
Total Income	**3,589**	**3,592**	**3**	**39,532**	**39,530**	**(2)**
Expenditure						
Substantive Staff	(2,435)	(2,255)	180	(26,659)	(24,604)	2,055
Bank	(43)	(94)	(51)	(492)	(941)	(449)
Agency	(126)	(179)	(53)	(1,486)	(2,533)	(1,046)
Total Employee Expenses	**(2,604)**	**(2,527)**	**76**	**(28,637)**	**(28,078)**	**559**
Purchase of Healthcare	0	(1)	(1)	0	(6)	(6)
Supplies and Services Clinical	(112)	(94)	17	(1,473)	(1,665)	(191)
Supplies and Services General	(3)	(14)	(11)	(56)	(96)	(40)
Drugs	(98)	(101)	(3)	(1,183)	(1,205)	(22)
All Other, incl Transport	(35)	(68)	(33)	(475)	(687)	(212)
Total Operating Expenditure	**(2,851)**	**(2,805)**	**46**	**(31,824)**	**(31,737)**	**87**
Contribution	**738**	**787**	**49**	**7,708**	**7,793**	**86**



The Care Group's position was £0.05m favourable in February.

Income:

The Covid-19 adjustment to bring income up to breakeven was £0.95m in February and is £7.6m YTD. There are continued signs that activity is increasing in some areas, particularly across outpatients, however overall activity is still well below plan.

Employee Expenses:

Pay was underspent by £0.08m in February. Overall pay actuals were slightly lower than last month and the average for the year.

Substantive pay costs were £0.04m lower than last month but are £0.04m higher than average.

Conversely, premium pay cost (agency, bank, locum overtime) increased (by £0.04m) on last month but are £0.06m lower than the average. In other words, despite the uptick in premium pay costs in February, an increasing trend in substantive pay is being offset by reductions in premium pay. Premium pay decreased primarily because of lower medical agency costs, at both acute sites due to consultant and middle grade recruitment.

Covid-19 expenditure (£0.03m) was comparable to last month and is equal to the allocation. Covid-19 budget allocations have now been capped at September levels (£0.03m per month).

In previous months, unused paediatric business case funding was returned to central reserves. However, given the level of medical temporary staffing expenditure YTD, to cover vacancies, there is insufficient capacity within the position to continue to do this.

Other Operating Expenditure:

Non-Pay was £0.03m overspent in February. Actuals costs decreased significantly, by £0.06m compared the average for the year and is thought to be due to the shorter month.

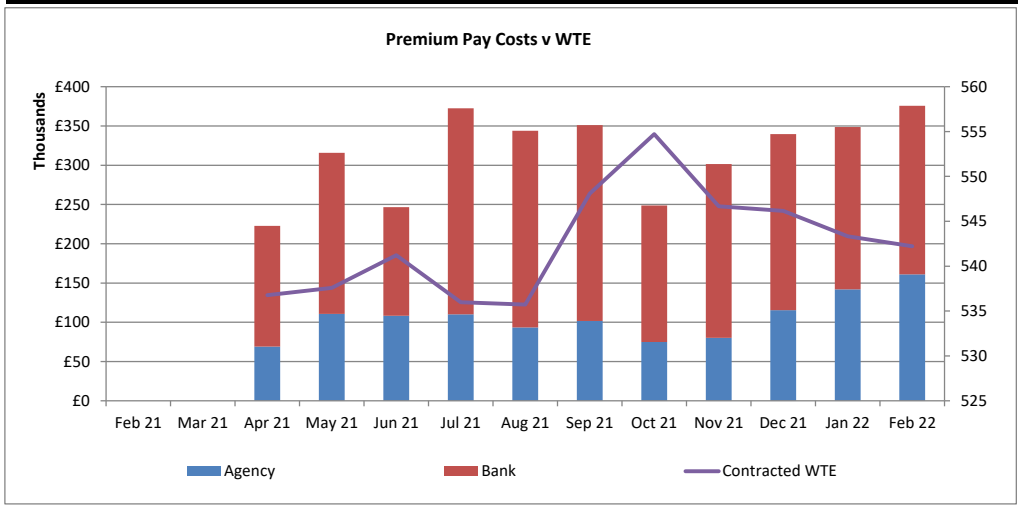
CIPs:

A small amount of non-recurrent pay savings relating to vacancies have been recognised this month. Focus is now moving into identifying savings opportunities for 2022/23.

Prepared by: Stephen Lazell
Reviewed by: Karen Costello

Women's Health
Month 11 (February) 2021/22

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	511	506	(5)	5,620	4,990	(630)
Non-Electives	1,763	1,913	150	19,396	22,353	2,957
Accident and Emergency						
Outpatients	389	419	31	4,274	4,489	215
High Cost Drugs	11	8	(4)	126	13	(114)
Private Patients						
Other NHS Clinical Income	1,163	992	(172)	12,797	10,327	(2,470)
Other Clinical Income	0	0	0	0	42	42
Total Income from Patient Care Activities	**3,838**	**3,838**	**()**	**42,213**	**42,213**	**()**
Other Operating Income	467	379	(88)	1,285	868	(417)
Total Income	**4,305**	**4,216**	**(88)**	**43,498**	**43,081**	**(417)**
Expenditure						
Substantive Staff	(2,722)	(2,486)	236	(28,012)	(26,878)	1,133
Bank	(164)	(215)	(50)	(1,981)	(2,301)	(319)
Agency	(62)	(161)	(99)	(712)	(1,166)	(454)
Total Employee Expenses	**(2,949)**	**(2,861)**	**88**	**(30,705)**	**(30,345)**	**360**
Purchase of Healthcare	(1)	(1)	()	(13)	(13)	1
Supplies and Services Clinical	(130)	(93)	37	(1,478)	(1,398)	80
Supplies and Services General	(4)	(5)	()	(48)	(35)	13
Drugs	(96)	(103)	(7)	(981)	(951)	30
All Other, incl Transport	(61)	(75)	(14)	(571)	(592)	(22)
Total Operating Expenditure	**(3,241)**	**(3,139)**	**102**	**(33,796)**	**(33,334)**	**462**
Contribution	**1,063**	**1,078**	**14**	**9,702**	**9,747**	**45**



The Care Group's position was £0.01m favourable to plan in February.

Income:

Women's Health activity returned to performing above plan in February, primarily due to higher non-elective (NEL) activity. There has been a sustained increase in NEL short stay activity since the Women's Health Suite in Ashford was opened, and also an increase in QEQM Gynaecology Assessment Unit (GAU) activity. Outpatient attendances and elective/day case activity have also been rising as part of Restore & Recovery efforts.

Consequently, the Covid-19 adjustment to bring income up to breakeven was £0.25m in February and is £3.2m for the YTD.

Central NHSEI Ockenden maternity funding continues to be phased into the budget - £1.0m of funding has been allocated to the Trust for 2021/22, with £1.5m expected for 2022/23.

Employee Expenses:

Pay was £0.1m favourable to plan in February, primarily due to Ockenden funding being added to the budget - although this is largely offset in 'other operating income'.

Pay actuals were £0.1m higher than last month and are £0.12m higher than the average for the year. The increase in month has been largely driven within substantive pay. This is because an increase in medical arrears accruals were made in February, with some arrears covering several years.

Following a reduction in medical locum costs, overall premium pay (agency, bank, locum overtime) actually decreased slightly compared to last month but are £0.4m higher than the average for the year.

After a fall in bank costs last month due to shift incentives being reduced, costs returned to near average levels for the year. Midwifery sickness and maternity leave is affecting the Care Group's ability to reduce nursing temporary staffing costs.

Medical agency costs are also increasing, particularly at QEQM, to cover vacancies and sickness leading to on call rota gaps.

Covid-19 expenditure (£0.08m) was comparable to last month but is £0.03m higher than the allocation, thereby causing a pressure on the budget. Covid-19 budget allocations have now been capped at September levels (£0.05m per month).

Other Operating Expenditure:

Non-Pay was slightly underspent in February. Actual expenditure was marginally higher than average due to a spike in minor build work expenses. However, costs are currently being contained within the overall budget.

CIPs:

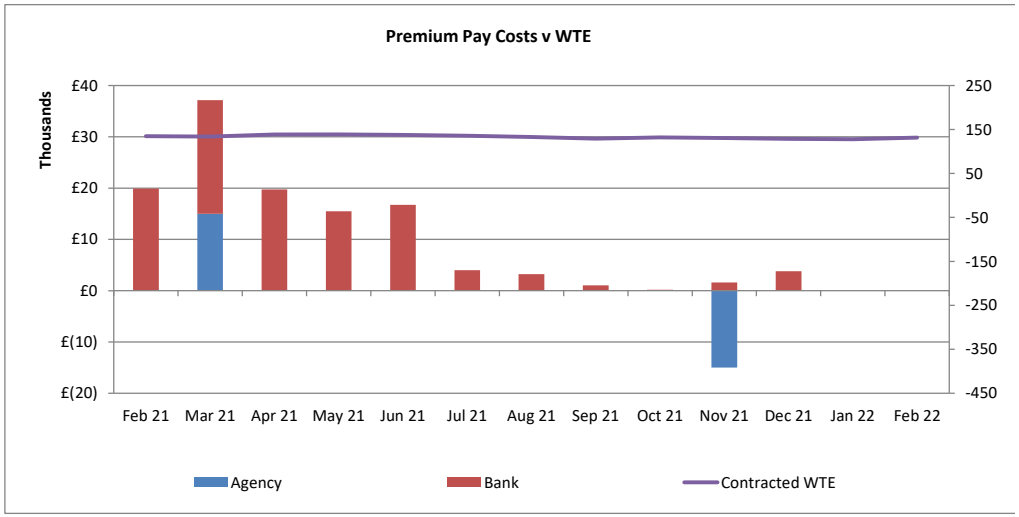
A small amount of non-recurrent pay savings relating to vacancies have been recognised this month. Focus is now moving into identifying savings opportunities for 2022/23 with efforts centred on CNST and reducing premium pay.

Prepared by: Stephen Lazell
Reviewed by: Tori Harrison

Strategic Development and Capital Planning

Month 11 (February) 2021/22

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Non Patient Care Services	110	103	(8)	581	613	32
Car Parking	99	176	77	1,088	1,203	115
Staff Accommodation	197	148	(49)	2,151	1,764	(387)
All Other Income	178	167	(11)	1,867	1,857	(9)
Total Income	**584**	**594**	**10**	**5,687**	**5,438**	**(249)**
Expenditure						
Substantive Staff	(594)	(539)	55	(6,494)	(5,911)	583
Bank	(33)	0	33	(357)	(66)	292
Agency	0	0	0	0	15	15
Total Employee Expenses	**(627)**	**(539)**	**88**	**(6,852)**	**(5,962)**	**890**
Supplies and Services General	(4,665)	(4,658)	7	(50,496)	(50,438)	58
Establishment	(132)	(136)	(4)	(1,436)	(1,813)	(377)
Premises and Rates	(250)	(249)	1	(2,752)	(2,739)	13
Premises Other	(1,028)	(971)	57	(9,154)	(9,158)	(4)
Transport	(21)	(12)	10	(233)	(151)	83
Education and Training	(14)	(4)	10	(158)	(61)	97
All Other	(51)	(56)	(5)	(179)	(135)	44
Total Operating Expenditure	**(6,788)**	**(6,624)**	**164**	**(71,260)**	**(70,457)**	**803**
Contribution	**(6,204)**	**(6,030)**	**174**	**(65,574)**	**(65,019)**	**555**



Strategic Development and Capital Planning is favourable to budget by £0.55m YTD as at the end of February.

Income:

Income is favourable £0.01m in month and adverse £0.2m YTD. Car parking income is favourable £0.08m in month and favourable £0.1m YTD, this is net of the Covid-19 top up which was based on month 12. IT income is adverse in month £0.02m and £0.03m favourable YTD. The favourable position is due to Covid-19 certificate project income, there are non-pay costs which offset this. Accommodation is adverse £0.05m in month and £0.4m YTD. However, this needs to be looked at in conjunction with internal recharges for overseas nursing accommodation which is £0.3m favourable YTD resulting in a net position of adverse against plan of £0.12m, occupancy levels influenced by Covid-19 and overseas nurses' bookings.

Pay:

Pay is favourable £0.1m in month and £0.9m favourable YTD. Facilities favourable £0.03m in month and £0.33m favourable YTD which is attributable to inter site transfers, a review has been carried out on this service and it has now ceased. Strategic Development £0.01m favourable in month and £0.11m YTD due to 3 WTE vacant posts which are out to recruit/have been recruited into and awaiting to start. This has been reconciled and agreed with the department. IT favourable £0.04m in month and £0.46m YTD. There are 15.25 WTE vacancies in IT, this has reduced by 3 WTE since last month. These represent 83% of the total vacancies of SD&CP and these relate to the Electronic Medical Records Project and the project change team.

Non-Pay:

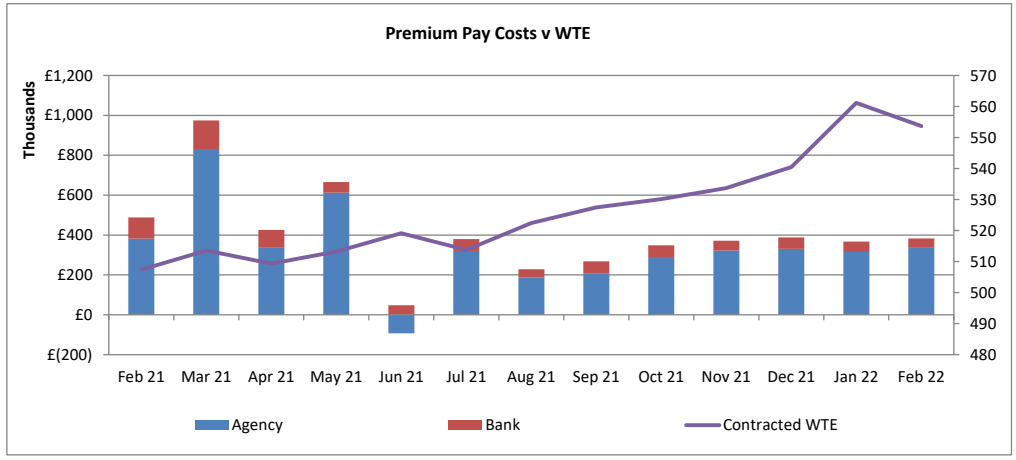
Non-Pay is favourable £0.08m in month and £0.09m adverse YTD.

Utilities adverse in month £0.04m and £0.52m adverse YTD. However, it needs to be noted the budget profile is in 12ths and has not been changed to account for seasonality. Gas is adverse £0.3m, electricity £0.24m of which the majority relates to WHH, these variances are being investigated in conjunction with the Energy and Sustainability Engineer with regards to price and activity.

Patient's Travelling Expenses were favourable £5k in month and £0.06m YTD. Rent/Hire Premises is £0.26m favourable YTD but needs to be looked at in conjunction with the accommodation income as stated above.

There are various under and overspends that are not that material but are still being monitored with departmental leads.

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Non Patient Care Services	225	360	135	1,281	1,570	289
Research and Innovation	332	312	(20)	2,352	2,220	(132)
Education and Training Income	1,595	1,514	(82)	14,621	14,899	278
Staff Accommodation	0	0	0	0	(5)	(5)
All Other Income	665	28	(637)	1,355	889	(466)
Total Income	**2,818**	**2,213**	**(604)**	**19,609**	**19,573**	**(36)**
Expenditure						
Substantive Staff	(2,778)	(2,630)	148	(28,843)	(27,918)	924
Bank	(22)	(47)	(26)	(279)	(609)	(331)
Agency	(18)	(336)	(318)	(41)	(3,169)	(3,128)
Total Employee Expenses	**(2,818)**	**(3,013)**	**(196)**	**(29,162)**	**(31,696)**	**(2,534)**
Supplies and Services General	(155)	(185)	(30)	(863)	(1,482)	(618)
Establishment	(162)	(97)	65	(836)	(1,071)	(235)
Premises and Rates	(4)	(12)	(8)	(42)	(71)	(28)
Premises Other	(910)	(946)	(36)	(2,569)	(3,342)	(773)
Transport	(45)	(47)	(3)	(435)	(436)	(1)
Clinical Negligence	(2,328)	(2,328)	()	(25,608)	(25,608)	()
Education and Training	(437)	(406)	31	(2,921)	(2,804)	117
All Other	(2,408)	(2,236)	172	(13,834)	(10,797)	3,037
Total Operating Expenditure	**(9,266)**	**(9,269)**	**(3)**	**(76,271)**	**(77,305)**	**(1,034)**
Contribution	**(6,449)**	**(7,056)**	**(607)**	**(56,662)**	**(57,732)**	**(1,070)**



The Corporate position is adverse £0.6m in month and £1m adverse YTD. The position in month is due to sale of EKBI the income was received last month but the budget adjust to reflect savings has been actioned this month. The YTD position is made up as follows: Clinical Quality & Patient Safety (CQ&PS) favourable £0.3m, HR favourable £0.1m, Finance favourable £0.2m, Operations adverse £2.4m (Covid-19), Trust Board favourable £0.3m, PGME and R&I favourable £0.4m.

Income:

Income is adverse £0.6m in month and £0.03m YTD.

The position in month is due to budget adjustment relating to the sale of EKBI as mentioned above.

Pay:

Pay is adverse £0.2m in month and adverse £2.5m YTD. This is mostly attributable to Covid-19 which is adverse £0.4m in month and £3.9m YTD. The funding envelope is held in non-pay, therefore, subjectively the total variance seems higher. The charges from 2gether are currently being reconciled and potential exit strategies being discussed on a weekly basis. The meet and greet teams have now ceased.

The adverse Covid-19 variances are partly offset by vacancies/underspends in other Corporate areas. CQ&PS adverse £0.04m in month/adverse £0.012m YTD, HR favourable £0.06m in month/£0.37m YTD, Finance favourable £0.06m in month/favourable £0.25m YTD, Trust Board £0.06m favourable in month/£0.6m YTD respectively. All posts being reviewed and monitored especially against business case allocations.

Non-Pay:

Non-Pay is favourable £0.2m in month and £1.5m favourable YTD.

CQ&PS adverse £0.03m in month and favourable £0.03m YTD.

HR favourable £0.06m in month and adverse £0.22m YTD. The position in month is due to advertising. YTD is mainly due to work permits for overseas nurses as well and budget phased in 12ths. Forecast on permits is to come back in line in future months due to decreased activity, this is to be reviewed in light of current months activity.

Finance breakeven in month and adverse £0.6m YTD, minor adverse and favourable variances.

Trust Board favourable £0.01m in month and adverse £0.35m YTD. The position YTD is mainly due to legal fees £0.26m adverse - monitoring with department is ongoing as part of forecast process.

Operations favourable £0.02m month and favourable £2.2m YTD due to Covid-19 underspends against the non-pay allocation which, at present, being used to offset the shortfall in pay. The total Covid-19 envelope income, pay and non-pay is £2m adverse YTD, as stated before reviews of all Covid-19 expenditure are being carried out to ascertain ongoing requirements.

Summary Profit & Loss February 2022 and Outturn Forecast

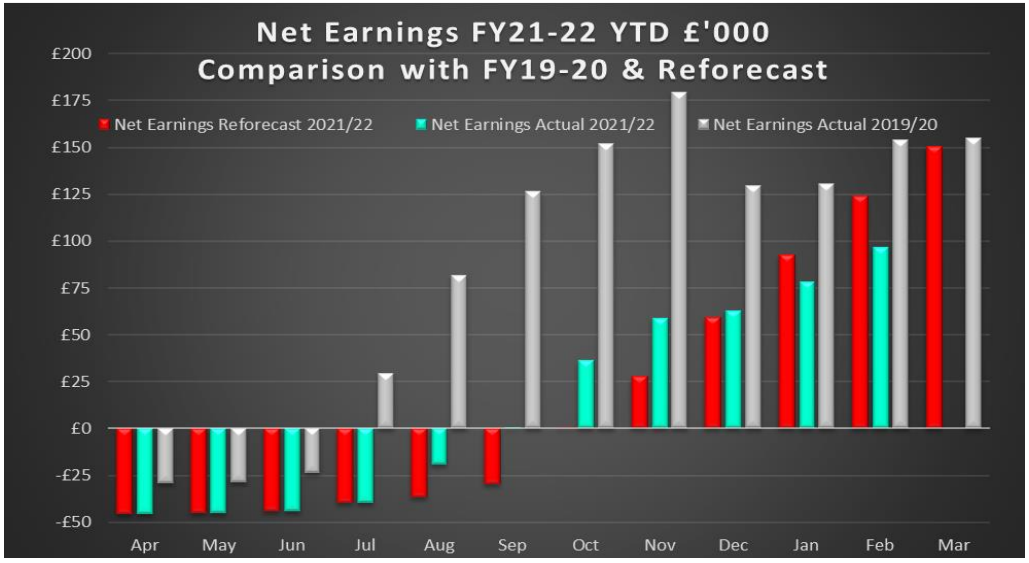
£'000s	Month			YTD			Full Year 2020-21		
	Actual	Budget	Variance	Actual	Budget	Variance	Outturn	Budget	Variance
Income	1,131	1,337	(206)	14,004	15,415	(1,411)	14,641	16,855	(2,214)
Pay	(605)	(674)	69	(6,826)	(7,615)	788	(7,136)	(8,313)	1,176
Non Pay	(339)	(554)	216	(5,429)	(6,188)	759	(5,675)	(6,759)	1,083
Other Costs	(164)	(122)	(42)	(1,627)	(1,346)	(281)	(1,701)	(1,468)	(233)
Operating Profit	23	(13)	37	122	267	(145)	128	316	(188)
OP %	*2.1%*	*-1.0%*	*-17.8%*	*0.9%*	*1.7%*	*10.3%*	*0.9%*	*1.9%*	*8.5%*
Interest Receivable							0		
Interest Expense	(1)	(3)	2	(2)	(31)	29	(2)	(33)	31
Net Profit before Tax	23	(16)	39	120	236	(116)	125	282	(157)
NPBT %	*2.0%*	*-1.2%*	*-18.8%*	*0.9%*	*1.5%*	*8.2%*	*0.9%*	*1.7%*	*7.1%*
Tax	(4)	1	(5)	(23)	(71)	49	(24)	(83)	59
Net Profit after Tax	19	(15)	34	97	165	(67)	102	200	(98)
NPAT %	*1.6%*	*-1.1%*	*-16.4%*	*0.7%*	*1.1%*	*4.8%*	*0.7%*	*1.2%*	*4.4%*

Salient comments on month / YTD results:

During this financial year we have seen significantly reduced theatre activity in comparison to pre-Covid-19 levels, due to a number of constraining factors and despite demand from both private and NHS patients.

With the Covid-19 situation worsening in early 2022 beds at both sites have been reserved for EKHUFT patients with theatre access unavailable. This has had a significant impact on the P&L, with the previously forecast profits for the last quarter of the year revised to a breakeven position.

We foresee a swift return to profitability once theatres are again made available as demand for both NHS and private surgeries remain strong.



Summary Profit & Loss February 2022

£'000s	Month			YTD			Full Year 2021-22		
	Actual	Prior Year	Variance	Actual	Prior Year	Variance	Forecast	Prior Year	Variance
Income	15,668	12,399	3,268	138,865	120,825	18,041	160,754	113,604	47,150
Costs	(15,323)	(12,269)	(3,054)	(137,144)	(119,462)	(17,683)	(159,130)	(112,223)	(46,907)
Operating Profit/(Loss)	345	130	215	1,721	1,363	358	1,624	1,381	243
OP %	*2.2%*	*1.0%*	*1.2%*	*1.2%*	*1.1%*	*0.1%*	*1.0%*	*1.2%*	*-0.2%*
Operating Profit/Loss EKHUFT	305	120	185	1,125	595	530	990	482	508
Operating Profit/Loss Retail	40	10	30	596	768	(173)	633	899	(266)
Interest Receivable	227	246	(19)	2,585	2,792	(207)	2,812	3,037	(224)
Interest Expense	(184)	(190)	6	(2,051)	(2,113)	62	(2,235)	(2,302)	67
Net Profit/(Loss) before Tax	388	186	202	2,255	2,043	213	2,201	2,115	86
NPBT %	*2.5%*	*1.5%*	*1.0%*	*1.6%*	*1.7%*	*-0.1%*	*1.4%*	*1.9%*	*-0.5%*
Tax	(94)	(103)	9	(696)	(999)	303	(928)	(710)	(218)
Net Profit/(Loss) after Tax	294	83	211	1,559	1,043	516	1,273	1,405	(132)
NPAT %	*1.9%*	*0.7%*	*1.2%*	*1.1%*	*0.9%*	*0.3%*	*0.8%*	*1.2%*	*-0.4%*

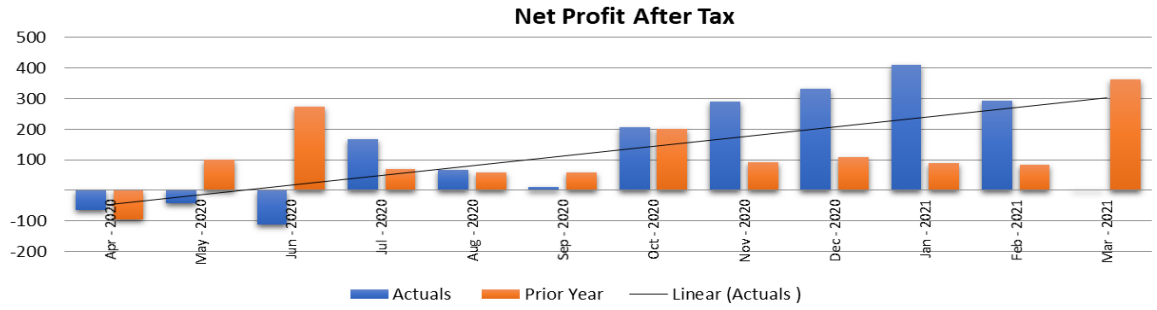
The YTD Operating Profit and Profit after Tax level is a profit of £1,721k and £1,559k respectively.

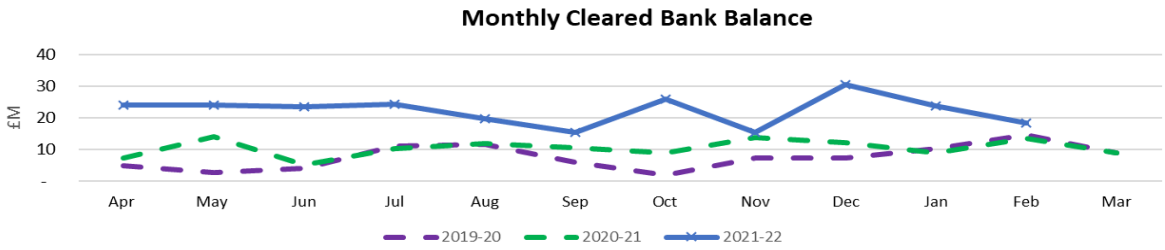
Within the profit for the month, there is a benefit of additional sales of inventory £56k. The efficiencies highlighted in October are being delivered and we remain on track to deliver £1.6m Operating Profit.

All other operating costs and overheads continue to be actively managed and in line with the year end forecast.

Operating Working Capital has increased to £19.3m. Cash is £18.4m.(we have started paying suppliers in 7 days in line with EKHUFT and NHS guidance). EKHUFT debt is £31.2m.

BALANCE SHEET £000's	**Mar-21**	**Feb-22**	**Movement**
Total non-Current Assets	**85,894**	**80,248**	**(5,646)**
Trade and other Receivables	49,708	31,896	(17,812)
Prepayments	1,608	1,486	(122)
Accrued Income	4,412	883	(3,528)
Total Debtors	**55,727**	**34,264**	**(21,463)**
Stocks	**4,481**	**4,532**	50
Creditors and other payables	(26,795)	(13,471)	**13,324**
Accruals	(20,112)	(14,968)	5,144
Deferred Revenue	(8,720)	(9,473)	(753)
Total Creditors	**(55,628)**	**(37,913)**	**17,715**
Cash	**8,804**	**18,444**	**9,640**
Operating Working Capital	**13,384**	**19,327**	**5,943**
Borrowings	**(65,771)**	**(63,968)**	**1,804**
Net Assets	**33,507**	**35,607**	**2,100**
Share Capital	30,267	30,267	
Retained Profit/(Loss) - Prior Year	3,240	4,799	1,559
Shareholders Funds	**33,507**	**35,066**	**1,559**





Cash Flow

Month 11 (February) 2021/22

Year to Date		This Month			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual		Plan	Actual	Variance	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast
67,943	**Opening Cash Balance**	5,625	10,028	4,403	67,943	28,920	33,022	30,796	32,047	34,447	22,755	12,409	16,187	17,244	10,028	12,700
	Prior Year Main Contract CCGs															
551,301	Kent & Medway CCG Contract	49,894	49,340	(553)	40,239	50,720	53,258	49,902	49,896	49,906	55,712	50,480	51,366	50,483	49,340	42,049
9,962	Prior Year Main Contract CCGs		179	179	256	2	100	11	188	77	11	74	8,793	271	179	
1,858	Other CCG block Contracts		168	168	166	166	167	166	166	166	187	168	168	168	168	
126,341	NHS England	9,790	13,331	3,541	9,967	10,286	10,044	11,335	13,228	12,052	11,210	11,877	12,514	10,498	13,331	10,098
33,970	All Other NHS Organisations	838	5,877	5,038	6,212	284	1,297	6,942	97	849	1,849	363	9,234	967	5,877	766
0	Capital Receipts															
62,903	All Other Receipts	3,715	1,736	(1,979)	7,006	581	9,972	2,786	7,359	3,913	5,931	12,169	7,076	4,374	1,736	32,296
0	Provider Sustainability Fund															
0	PDC Loans															
0	Loans Repaid															
786,335	**Total Receipts**	**64,238**	**70,632**	**6,394**	**63,846**	**62,038**	**74,837**	**71,142**	**70,934**	**66,962**	**74,900**	**75,131**	**89,151**	**66,761**	**70,632**	**85,209**
	Opening Cash Balance															
(392,680)	Monthly Payroll inc NI & Super	(34,950)	(36,422)	(1,472)	(34,532)	(34,347)	(34,667)	(34,946)	(34,743)	(36,836)	(37,725)	(35,858)	(36,313)	(36,290)	(36,422)	(36,284)
(444,498)	Creditor Payment Run	(28,395)	(31,538)	(3,144)	(68,339)	(23,588)	(42,396)	(34,945)	(33,791)	(37,418)	(47,520)	(35,495)	(51,781)	(37,687)	(31,538)	(51,374)
0	Capital Payments	(1,600)		1,600												(2,250)
(4,400)	PDC Dividend Payment									(4,400)						(4,549)
	Interest Payments															
(841,579)	**Total Payments**	**(64,945)**	**(67,960)**	**(3,015)**	**(102,870)**	**(57,936)**	**(77,063)**	**(69,891)**	**(68,534)**	**(78,655)**	**(85,245)**	**(71,353)**	**(88,095)**	**(73,977)**	**(67,960)**	**(94,457)**
(55,244)	**Total Movement In Bank Balance**	**(707)**	**2,671**	**3,378**	**(39,024)**	**4,102**	**(2,226)**	**1,251**	**2,400**	**(11,693)**	**(10,346)**	**3,779**	**1,057**	**(7,216)**	**2,671**	**(9,248)**
12,700	**Closing Bank Balance**	**4,918**	**12,700**	**7,781**	**28,920**	**33,022**	**30,796**	**32,047**	**34,447**	**22,755**	**12,409**	**16,187**	**17,244**	**10,028**	**12,700**	**3,452**
	Plan				28,930	27,537	22,345	15,272	16,067	6,941	5,649	8,766	11,575	5,625	4,918	3,208
	Variance				(10)	5,484	8,451	16,775	18,380	15,814	6,759	7,421	5,669	4,403	7,781	244

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTERS**
MEETING DATE:	**7 APRIL 2022**
BOARD SPONSOR:	**GROUP COMPANY SECRETARY**
PAPER AUTHOR:	**RISK MANAGER**
APPENDICES:	**APPENDIX 1: FULL BOARD ASSURANCE FRAMEWORK 30.03.22** **APPENDIX 2: FULL CORPORATE RISK REGISTER 30.03.22**

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	Assurance	**Discussion**
Purpose of the Report:	This report provides the BoD with updates on and changes to risks on the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) as at 30 March 2022.				
Summary of Key Issues:	• The reporting of risks to the BoD and its Committees has been streamlined and refreshed to ensure clarity in relevant risk information. • The full BAF and CRR in its new format is being presented to the BoD for the first time (attached as Appendices 1 and 2 of this report). • The key changes to the new BAF and CRR template are the addition of the following headings: Effects; Emergent risks/issues; Future opportunities; Risk appetite status; Assurance level; Projected target date; Rationale for current risk score; and Latest commentary. • Work is ongoing with the Executive Leads for each risk to populate the new BAF and CRR template. This will be complete at the end of April 2022. • There has been no movement on the BAF since the last report. • 3 new risks have been added to the CRR relating to Independent Investigation into East Kent Maternity Services (IIEKMS); Radiology and Duty of Candour (details provided on Pages 2 & 3 of this report). • It should be noted that the Risk team will be working with the Chair of IAGC to revise the report further to ensure it provides the Board and Committees with adequate assurance.				
Key Recommendation(s):	The BoD is asked to **DISCUSS** whether: • the correct risks are identified in the BAF and CRR; • any reports or assurances received in the work of the Board and its Committees impact on the assurance levels in the BAF and CRR; • controls, assurance, gaps and actions are appropriate; • any further controls may be required to mitigate the risks identified.				

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**

East Kent Hospitals University NHS Foundation Trust

Link to the Board Assurance Framework (BAF):	This paper provides an update on the BAF.	
Link to the Corporate Risk Register (CRR):	This paper provides an update on the CRR.	
Resource:	N	Resource implications are considered as part of the risks.
Legal and regulatory:	N	Legal and Regulatory implications are considered as part of the risks.
Subsidiary:	N	The Trust has a Subsidiary Shared Risk Register that is monitored at the Contract Performance Meeting
Assurance Route:		
Previously Considered by:	Executive Management Team on 30 March 2022 (in lieu of the Executive Risk Assurance Group (ERAG)).	

CORPORATE/BAF RISK REGISTERS

1. Purpose of the report

1.1. This report provides the BoD with an update on and changes to risks to on the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) as at 30 March 2022.

2. Board Assurance Framework

2.1 The BAF contains the principal risks for the Board corporately to assure itself about successful delivery of the organisation's strategic objectives.

2.2 The reporting of risks to the BoD and its Committees has been streamlined and refreshed to ensure clarity in relevant risk information. The full BAF in its new format is being presented to the BoD for the first time (attached as Appendices 1 of this report). Although the BAF will be presented at each Board and Committee meeting, the full BAF will be presented quarterly and a summary BAF presented at the other meetings.

2.3 Meetings with the Executive Leads for each risk to populate the new BAF are in progress and will be complete at the end of April 2022.

2.4 **Key changes to existing risks**: There have been no key changes to risk scores on the BAF since the last report to the BoD. Other changes to the risk have been highlighted in red font.

3. Corporate Risk Register

3.1 The CRR is the high-level risk register that captures overarching risks with a current rating of 12 and above, that may be escalated from Care Group Risk Registers and that take on a wide scope.

3.2 The reporting of risks to the BoD and its Committees has been streamlined and refreshed to ensure clarity in relevant risk information. The full CRR in its new format is being presented to the BoD for the first time (attached as Appendices 2 of this report). Although the CRR will be presented at each Board and Committee meeting, the full CRR will be presented quarterly and a summary CRR presented at the other meetings.

3.3 **Key changes to existing risks:** There have been no key changes to risk scores on the CRR since the last report to the BoD. Other changes to the risk have been highlighted in red font.

3.4 **New risks for escalation**

The following risks have been agreed for escalation to the CRR at the Executive Management Team (in lieu of ERAG) and will be presented to the Clinical Executive Management Team for approval on 13 April 2022.

3.4.1 IIEKMS – Executive Lead: Chief Nursing & Midwifery Officer

There is a risk that as a result of the outcome of the Kirkup inquiry, there will be an impact on the Trust's ability to recruit high calibre staff and an increase in the workload for existing staff. Pregnant women in east Kent may not have confidence in east Kent maternity services and the Trust may receive increased scrutiny from regulators. A working group has been established to have oversight of the pre-planning of the publication of the report.

3.4.2 Radiology – Executive Lead: Chief Medical Officer

Unreported Accident & Emergency (A&E) chest x-rays. The current backlog of unreported Emergency Department (ED) chest x-ray backlog is around 13,000 with the oldest dating back to mid-June 2021. The current demand for ED/inpatient chest x-rays has tripled in the past 2.5 years which is impacting on the current reporting turnaround time. A review of current rosters to implement a better plan to utilise the reporting capacity has been completed with the backlog expected to be cleared by end March 2022.

3.4.3 Duty of Candour – Executive Lead: Chief Medical Officer

Patients will not be informed of incidents where the Trust may have caused/contributed to harm. There is continued poor compliance with Duty of Candour; a lack of completion of Datix to confirm Duty of Candour completion; a lack of responsibility for completing the formal letters confirming the Duty of Candour conversation; a lack of awareness/ownership of immediate requirements of Duty of Candour; a lack of Duty of Candour training. The effect of this is a negative effect on culture of being open for patients and staff; missed opportunities to engage with patients and families regarding an adverse event leading to complaints and subsequent claims; breach of contractual obligations to provide to the service user and any other relevant person all necessary support and all relevant information in the event that a reportable patient safety incident occurs and potential fines for non-compliance and prosecution under regulation 20.

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BOARD ASSURANCE FRAMEWORK (BAF)
QUARTER 4 - 2021/22

Date of issue: 30 March 2022

STRATEGIC GOAL: 1) Our Quality & Safety:
Strategic Objective: Improve **patient safety** reduce harm

Executive Owner: Chief Medical Officer (CMO)
Responsible Committee: Quality and Safety Committee

Date last reviewed: December 2021
Next review scheduled: January 2022
Date risk identified: May 2021

Principal Risk – BAF 32
There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.

Effect: Poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers, reputational damage, financial impact, litigation

Risk Appetite
The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L3 x S5 = 15

A	M	J	J	A	S	O	N	D	J	F	M
NA	'N'	=	=	=	=	=	=	=	=	=	=

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 March 2025

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks
117 – Patients may be harmed through poor medicines management due to poor culture towards medicines prescription and administration at ward and department level that may result in patient harm, poor patient experience and increased length of stay (16)
77 – Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services (15)
110 – Children may receive sub-optimal quality of care and poor patient experience within our children's services (15)
36 – Patient outcome, experience and safety may be compromised as a consequence of failure to 1. Identify patients with additional vulnerabilities (adult and children) 2. Assess their needs 3. Plan appropriate care, including relevant safeguarding legislation and local safeguarding policies 4. Mitigate any risks 5. Work in line with relevant legislation (including Children Act, Care Act, Mental Capacity Act, Equalities Act, Mental Health Act) (12)
116 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs (20)
122 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate midwifery staffing levels and skill mix to meet patient's needs (20)
123 - Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs (15)

Emergent Risks/Issues
- Difficult to evidence delivery of improvement workstreams
- Change in focus of We Care objectives
- Staffing levels

Future Opportunities
- Realisation of Safer Staffing Business Case
- We Care Improvement Programme – In Year Breakthrough Objectives
- RSP exit

Risk and Scoring Commentary

Rationale for Current risk score
The current risk score is rated as a high (15) risk. The severity of the risk is scored as extreme (5), due to the number of patients affected by the risk; potential for multiple permanent injuries; non-compliance with national standards with significant risk to patients if unresolved; sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.
The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
Patient Safety Committee terms of reference to be presented to March Quality and Safety Committee for approval. CEO has produced a document to describe the model for matrix working. Currently recruiting to Site Medical Director who will pick up the work to review clinical effectiveness structures and meetings. Governance process for new NICE guidance has been implemented. Breakthrough objectives agreed for coming year; Care Groups will present to April PRMs. New action added regarding implementation. The JD for a Clinical Guidance Governance manager, band 6 has been agreed. Recruiting to a six-month funded post was unsuccessful. A permanent post has been included in the Quality Governance Division Restructure which is currently undergoing consultation. A draft policy is under review.

Actions (Planned)

Action required and date
1) Approval of Quality Strategy by Q&SC **CNO Mar 22**
2a) Building on training and experience of centre of excellence team by KPMG. **Director of Strategy Mar 22**
2b) Revised trajectory for roll out to frontline teams agreed by 'Centre of Excellence' team to complete **Director of Transformation Mar 22**
3) Implement outputs of quality and safety reporting meetings and structure review with emphasis on learning within Terms of Reference (ToR). Director of Quality Governance (**DoQG)**
4) Review of subsidiary governance and reporting structures and feed into Q&S reporting structures.
Group Company Secretary
5a) Agree model for matrix working. **COO Jan 2022**
5b) Implement agreed model. **COO TBC once pilot concluded**
6a) Review clinical effectiveness structures and meetings. **CMO**
6b) Establish effective governance of NICE guidance. **CMO**
6c) Review governance and approval for clinical guidelines. **DoQG**
7) Implementation of updated focus for We Care improvement for 22/23 **CMO**

Controls in place (Existing)

1) The Quality Strategy (2019-2022), approved at Quality & Safety Committee (Q&SC), Sep 19

2) Reduction in harm and reduction in mortality are True North objectives agreed by the Executive team and progress monitored monthly at Executive management Team meetings and reported in the Board Integrated Performance Report (IPR)

3) NHSE/I led Governance review supported restructure and revised terms of reference for the Q&SC

4) Breakthrough Objectives aligned to True North are monitored at monthly Executive management Team meetings and reported in the Board IPR

5) Monthly performance Review Meetings established to ensure Care Group accountability against the delivery of quality and safety priorities, and to escalate new concerns to driver metric status through Catchball when identified
CQC Improvement meeting established under the Chair of CNO to monitor regulatory requirements to deliver safe care

6) Care Group Governance Reports to Q&SC

Assurances

Internal
1) Approval and monitoring of the Trust Quality Strategy through SLT, Q&SC and Board of Directors (BoD).
2) Approval and monitoring of the Trust Quality Strategy, We Care objectives and Trust priority improvement projects through SLT, Q&SC and BoD

External
1) CQC reports monitored by the BoD and action plans developed and monitored by CQC and NHSE/I

Gaps in controls and assurance

1) The Quality Strategy needs realigning with the We Care improvement programme to support quality and safety priorities and the Medium-Term Improvement Plan

2) Roll out of We Care programme to frontline teams where improvements delivered were delayed by the Covid-19 pandemic

3) Revised Quality and Safety reporting structures and reporting to be established. Initial meeting of CNO, CMO and DoQG to
describe quality and safety meetings needed to deliver agenda now being implemented into structures with agreed Terms of Reference (ToR) and chairs

4) Improve oversight of health and safety governance that impacts on patient safety

5)Establish responsibility and accountability for Hospital Director teams for delivery of safe care on their respective sites

6) Improve clinical outcomes through internal review, effective use of data and implementation of recommendations from national clinical audits and outcomes, NICE recommendations and Getting it Right First Time (GIRFT)

STRATEGIC GOAL: 1) Our Quality & Safety:
Strategic Objective: Improve **patient safety** reduce harm

Executive Owner: Director of Infection Prevention and Control (DIPC)
Responsible Committee: Quality and Safety Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: May 2021

Principal Risk – BAF 31
Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements and Covid-19

Effect: Leading to harm, including death, breaches of externally set objectives, possible regulatory action, prosecution, litigation and reputational damage

Risk Appetite
The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L3 x S5 = 15

A	M	J	J	A	S	O	N	D	J	F	M
NA	'N'	=	=	=	=	=	=	=	=	=	=

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 March 2025

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks

Emergent Risks/Issues
- Ongoing Covid-19 pandemic
- Fragility of infrastructure

Future Opportunities
- Plan to increase surveillance through annual plan

Risk and Scoring Commentary

Rationale for Current risk score
The current risk score is rated as a high (15) risk. The severity of the risk is scored as extreme (5), due to the number of patients affected by the risk; potential for multiple permanent injuries; non-compliance with national standards with significant risk to patients if unresolved; sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.
The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
Annual plan to be presented to Board of Directors in April 2022. This will include IPC workplan for 2022/23. Hygiene Code action plan will be presented as part of the annual plan.

Actions (Planned)

Action required and date
1) Annual IPC plan to be presented to the Board of Directors **DIPC Apr 22**

Controls in place (Existing)

1) Surveillance and reporting of HCAI via Public Health England (PHE) Data Capture System (DCS) and national Covid-19 reporting
2) Compliance with requirements of the "hygiene code" with a plan to address any gaps
3) Collaboration and agreement with 2gether Support Solutions (2SS) on priorities for investment to address gaps in infrastructure compliance, based on clinical (infection prevention) risk and included in business planning
5) Third wave of Covid-19 business continuity planning

Assurances

Internal
1) Formally reportable data are signed off by the CEO are reported monthly to the Quality and Safety Committee and annually, publicly via DIPC Annual Report
2) Infrastructure issues reported via Director of Strategic Development and Capital Planning (reference to strategic goal 4 and statutory compliance)
3) "Hygiene Code" gap analysis report to Quality and Safety Committee, Covid third wave planning reports to Covid Gold command, twice weekly

External
1) Data are shared with CCG and are available to NHSE/I and CQC (automatically)

Gaps in controls and assurance

1) "Hygiene Code" gap analysis identified gaps in compliance and assurance

STRATEGIC GOAL: 2) Our Patients:
Strategic Objective: Improve **Patient Experience** deliver excellent clinical outcomes

Executive Owners: Director of Quality Governance (DQG) and Group Company Secretary (CoSec)
Responsible Committee: Quality and Safety Committee

Date last reviewed: December 2021
Next review scheduled: January 2022
Date risk identified: May 2021

Principal Risk – BAF 33
There is a risk of failure to adequately resource, implement and embed effective governance processes throughout the Trust.

Effect: Poor delivery and quality and safety of services; failure to meet statutory and regulatory requirements resulting in damage to reputation, regulatory action, harm patients, legal challenge.

Risk Appetite
The Trust has a **HIGH** appetite for risks to 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. We will be willing to consider all delivery options that provide acceptable levels of patient related outcomes. However, we will prefer not to take risks with compliance to external performance standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L2 x S5 = 10
Current Risk Rating: L2 x S5 = 10

A	M	J	J	A	S	O	N	D	J	F	M
NA	'N'	=	=	=	=	=	=	=	=	=	=

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 December 2022

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks
None

Emergent Risks/ Issues
- Trust-wide governance framework not in place
- Strategies/policies not consistently followed and are not embedded
- Staffing structures may not be adequate to deliver the governance agenda.
- Knowledge and skills gaps identified

Future Opportunities
- CQC Well led review recognising improvements in governance.
- Trust evidencing improvements in the Leadership and Governance domain as part of the exit criteria of the Recovery Support Programme.

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a moderate (10) risk. The severity of the risk is scored as extreme (5), due to the potential for patient experience to be unsatisfactory; breaches of statutory duty and subsequent prosecution; adverse publicity undermining public confidence in organisation; inquest/ombudsman inquiry.
The likelihood of the risk is scored as unlikely (2), due to the expectation that the risk is not expected to crystallise due to the controls in place however it is possible it may do so.

Latest Commentary
The development of an overarching Governance handbook for the Trust is in progress. The draft will be presented to the IAGC for discussion in February 2022. A review of all strategies/policies in relation to governance framework is in progress and will be complete by Jul 22. A review of the clinical and corporate governance team structure has commenced and will be complete in Jul 22. Initial review of staffing structure has resulted in the movement of Risk Management, Policy Management and Freedom of Information reporting lines to Corporate Governance. The Governance Review action plan is in train. An update of progress is being presented to the next GIG on 28 January 2022.

Actions (Planned)

Action required and date
1a) Undertake a review of all strategies/policies in relation to governance framework to streamline/simplify **DO/TI Jul 22**
1b) Once reviewed strategic/policies are in place communicate/train and embed **DO/TI Jul 22**
2) Review the structure in 6 months' time **SAc/AA Dec 22**
3) Undertake a review of the clinical and corporate governance team structure **TI/DO Jul 22**
4a) Undertake a review of the Care Group governance support and team structure and present a business case to ensure adequate resource is in place **TI Jul 22**
4b) ensure the knowledge, qualification and skills in the job descriptions are fit for purpose **DO/TI Jul 22**
5a) Governance review Action plan to be delivered **PC Apr 22**
5b) Agree how the focussed work will move to business as usual PC **Apr 22**
6) Develop specific risk management training and roll out across the Trust **DO Jul 22**
7) Develop overarching governance principles for the Trust **DO/TI Apr 22**

Controls in place (Existing)
1) Suite of governance policies in place
2) Additional Executive post created, and portfolios split to provide more capacity and expertise. Director of Quality Governance appointed and joined the Trust May 21
3) Organisational structure in place below Executive Level to support the governance agenda
4) Governance Review Action plan in place and agreed with NHSEI
5) Terms of reference for various committees and groups approved
6) Risk registers in place, BAF, CRR and Care Group level
7) Incident Management, Complaints Management and Clinical Audit process in place
8) Statutory training in place that includes elements of risk management
9) Other training including incident investigation

Assurances

Internal
1) Policies are presented to PAG and BoD (if required) for ratification. Robust sign off process for policies including via groups and PAG
2) Challenge of BAF and CRR at Board and Board Committees
3) We Care meetings to provide evidence against progress for each metric
4) Calibration and challenge of risks on Care Group, Corporate and Board Assurance Framework (BAF) risk registers at ERAG

External
1) RSM independent audit program (Risk management planned)
2) Regional oversight committees
3) Well-led governance review (NHSE/I)

Gaps in controls and assurance
1) Strategies/policies not consistently followed and are not embedded
2) The new structure/job descriptions have not been tested and it will take to assess any gaps, overlaps or challenges
3) Corporate and Care Group structure to support quality governance is not well resourced
4) Possible gaps in understanding of the breadth of both the clinical and corporate governance agenda
5) Deliver and embedding of the actions from the Governance Review action plan and agree how outcomes will be measured
6) Gaps in knowledge due to a lack of specific training in risk and governance, for all levels and roles
7) A lack of overarching governance principles for the Trust

STRATEGIC GOAL: 2) Our Patients:
Strategic Objective: Improve **Patient Experience** deliver excellent clinical outcomes

Executive Owners: Chief Operating Officer
Responsible Committee: Quality and Safety Committee

Date last reviewed: January 2022
Next review scheduled: February 2022
Date risk identified: May 2021

Principal Risk – BAF 34
There is a risk that our constitutional targets are not met

The fluctuating nature of the Covid-19 pandemic necessitates a localised approach to escalation. When the number of positive patients admitted exceeds trigger points for safe, effective cohorting there is a risk that elective care capacity is then utilised.

Effect:
Access for patients who are Covid and non-Covid Patients who present in the emergency department are subject to testing and the results of this test determine the IPC regulations that support admission
Patient harm, An increase in very long waiting patients and an exacerbation of health inequality
Patient experience
Legal action
Financial impact of exceeding agreed thresholds for contract
Remain in RSP if agreed thresholds for improvement aren't reached these include the reduction of very long waiting patients and a decrease in waiting list size

Risk Appetite
The Trust has a **HIGH** appetite for risks to 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. We will be willing to consider all delivery options that provide acceptable levels of patient related outcomes. However, we will prefer not to take risks with compliance to external performance standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S4 = 16
Current Risk Rating: L4 x S4 = 16
Movement of the current risk rating within the financial year

A	M	J	J	A	S	O	N	D	J	F	M
NA	'N'	=	=	=	=	=	=	=	↓	↑	=

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 December 2022

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks
CRR 78 – Risk of overcrowding in ED compromising patient safety and patient experience due to a lack of capacity in the system and increased local demand

Emergent Risks/ Issues
- Reintroduction of national restriction in future waves of Covid-19
- Temporarily suspended – patients in lower categories waiting longer
- Current IPC restrictions – cannot bring patients quickly in if there are last minutes cancellations
- Demand and capacity are unbalanced between hospitals

Future Opportunities
- Structure services on cold and hot site scenario – allow us to have a clearer access pathway for patients
- Independent sector and insourcing – extend resources and capacity to mitigate any delays
- Continued focus on length of stay
- Manage demand more effectively – cognisant and focused on quality issues around waiting list

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a moderate (12) risk. The severity of the risk is scored as significant (4), due to the number of patients affected by the risk; potential for increased length of hospital stay; non-compliance with national standards with significant risk to patients if unresolved; sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.
The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
Omicron variant has meant a change in trajectory to reduce the number of 104 week waits. Trajectory revised to reduce to 0 by June 2022.

Actions (Planned)

Action required and date
1) Review of outpatient clinic space, allocations and specialties **Dep COO Aug 21**
2) Tender for insourcing across four key specialties, orthopaedics, general surgery, gynaecology and ENT **Dep COO Sep 21**
3) Clinical validation of patients needing procedures to reduce cancellation on the day targeting high risk groups **MD for Recovery**
4) Weekly meeting with Care Group Directors, COO and Recovery MD for individual case management. Trajectory to reduce to 0 by March 22. **COO Mar 22**
5) Access Policy to be presented to CEMG for approval **Dep COO Feb 22**
6) Insulate priority work at the Kent and Canterbury Hospital site to preserve elective operating in the face of winter and Covid

Controls in place (Existing)
1) Kent and Medway System Elective Care Programme Board provides system wide strategic direction attended by the COO
2) 4R programme is overseen by the Clinical Director
3) Waiting list validation of prioritisation codes by clinicians is at 97%
4) Weekly monitoring at the PTL meeting is chaired by the COO
5) Live reporting via the Referral to Treatment (RTT) App is monitored by the Deputy COO for planned care
6) Use of the independent sector is managed by the Deputy COO for planned care. Capacity is maximised.
7) K&M Systemwide PTL established
8) Contracts signed with community providers
9) Trigger tool developed to move elective capacity to K&CH and ICS

Assurances

Internal
1) We Care Breakthrough Objective 'Improving theatre capacity' monitored monthly through the Integrated Performance Report presented to the BoD

External
1) Kent and Medway System Elective Care Programme Board reports the ICS Partnership Board

Gaps in controls and assurance
1) Delivery of 25% of all patient appointments and 60% of all follow ups to be conducted virtually
2) Optimisation of additional capacity via CCG
3) Number of same day cancellations reducing theatre utilisation
4) Waiting list patients exceeding 104 weeks

STRATEGIC GOAL: 3) Our People:
Strategic Objective: To deliver our People Strategy to develop a positive culture and address key risks faced in terms of retention and recruitment to become an "**employer of choice**" by **enabling staff** to maximise their potential.

Executive Owner: Director of HR and OD
Responsible Committee: People and Culture Committee

Date last reviewed: January 2022
Next review scheduled: February 2022
Date risk identified: February 2016

Principal Risk – BAF 35
Proposed new title: There is a risk of failure to recruit and retain high calibre staff

There is a risk of negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff

Effect: Negative patient outcomes, reputational damage, ability to deliver services, financial, patient harm, regulatory impact, staff wellbeing

Risk Appetite
The Trust has a **SIGNIFICANT** appetite for risks to making the Trust a great place to work. We will be innovative in taking risks in relation to workforce/staff engagement that will offer potential higher benefits to staff, patients and the organisation.
Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L3 x S5 = 15

A	M	J	J	A	S	O	N	D	J	F	M
NA	'N'	=	=	=	=	=	=	=	=		

Target Risk Rating: L2 x S5 = 10
Projected Target Date: 31 January 2023

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks
CRR 115 – Staff health and wellbeing is compromised due to the sustained level of work created by Covid-19 pandemic
CRR 118 – There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace
CRR 116 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs
CRR 122 – Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour
CRR 123 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate medical staffing levels and skill mix to meet patients' needs

Emergent Risks/ Issues
- Do not have the right establishment

Future Opportunities
-

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a high (15) risk. The severity of the risk is scored as extreme (5), due to the potential for non-delivery of key services due to lack of staff or ongoing unsafe staffing levels
The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
International nurse and midwifery recruitment pipeline well established and reported to the Executive Directors. The development of rotational and joint posts to support medical staff recruitment is progressing through the HCP Partnership Board meeting. New marketing material in place for medical and Agenda for Change (AfC) posts; early results suggest an increase in applications for hard to recruit posts. Work ongoing to build stronger working relationships with partner organisations. Workforce group meeting held in March to review recruitment to priority posts. Recruitment being undertaken under the Family First initiative with exploration undertaken to further these opportunities. A social media post has been recruited to; an increase in applicants has been seen from recruitment advertising.

Actions (Planned)

Action required and date
1a) Centralised booking team and development of collaborative bank approach across the system **Director of HR and OD Apr 23**
1b) International Nurse and midwifery recruitment pipeline utilisation with cohorts planned throughout 2022 to achieve 493 additional nurses by Mar 2023 **Deputy Director of HR Mar 23**
2a) Links with HCP and newly formed Kent and Medway Medical School (KMMS) to develop rotational and joint posts to support medical staff recruitment **Director of HR and OD Jun 22**
2b) Workforce Summit to be held at a system level to develop actions to deliver the recruitment strategy **Deputy Director of HR and OD Jul 22**
2c) Active involvement in HCP recruitment and retention strategy **Director of HR and OD ongoing, cycle of continual review**
3) Ready to Care Programme launched to address Healthcare Assistant retention **Associate Director of OD ongoing, cycle of continual review**

Controls in place (Existing)

1) A five-year People Strategy – People at the Heart 2020-2025 has been approved by Trust Board and is monitored via the People and Culture Committee (PCC).
2) Engagement of staff scores are True North measures which are reported and monitored monthly via We Care and Staff Committee
3) A Recruitment and Retention Strategy with associated plans has been signed off and is monitored via the PCC
4) A Rural and Coastal Strategy led by the Associate Medical Director has been developed and agreed at Trust Board and is monitored via the PCC
5) The Director of HR and OD attends ICP workforce groups to align plans and develop other system side opportunities and agendas
6) A Diversity and Inclusion action plan has been developed and published as part of Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and is monitored via the Equality, Diversity and Inclusion (EDI) Steering Group, Staff Committee and reported to PCC
7) Medical recruitment toolkit launched on 24 September 2021
8) Developing a positive culture strategic initiative
9) Refreshed EDI strategy
10) Launch of cultural programme
11) Revised People Strategy

Assurances

Internal
1) Approval and monitoring of the agreed HR KPIs (inc vacancy rate and engagement scores) are monitored via We Care and PRMs and reported at PCC.
2) The People Dashboard has been developed with the aim of demonstrating progress against the key objectives identified in the People Strategy. The Dashboard brings together information in an accessible and co-ordinated format that is reviewed as part of our regular People team processes each month and reported through the People and Culture Committee.
3) Workstreams and project work is monitored via the HR Senior Leads meeting, We Care and reported through PCC to BoD.

External
1) Review of EKHUFT's People Strategy via NHSE/I. Benchmarking and links with national People Team.
2) Director of HR and OD part of Future of NHS and OD national programme
3) Trust involvement in Kent and Medway Health and Wellbeing Board and Kent and Medway Recruitment and Retention Board

Gaps in controls and assurance

1) Lack of supply of professional qualified staff including AHPs is a national issue
2) Hard to recruit areas such as Nursing and Consultants have been identified
3) Highest turnover identified in Nursing and HCA workforce

STRATEGIC GOAL: 4) Our Future:
Strategic Objective: Develop a clinical strategy for the Trust that addresses key risks faced in terms of **service delivery, workforce and estate condition (backlog and statutory compliance).**

Executive Owner: Deputy Chief Executive Officer
Responsible Committee: Finance and Performance Committee

Date last reviewed: January 2022
Next review scheduled: February 2022
Date risk identified: April 2021

Principal Risk – BAF 36
Failure to implement the strategic change required to address the service delivery, workforce and estate condition identified in the Pre-Consultation Business Case (PCBC)

Effect: Result in lapses in core clinical standards and patient safety issues, and may affect adherence to estate statutory compliance, increased estate backlog risks this could result in further emergency service moves/restrictions and impact on the Trust's reputation

Risk Appetite
The Trust has a SIGNIFICANT appetite for risks to transforming the way we provide services across east Kent. We will pursue innovation and challenge current working practices. We will use new technologies as a key enabler of operational delivery and devolve authority across the Trust to enable us to offer excellent integrated services.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L4 x S5 = 20
Movement of the current risk rating within the financial year

A	M	J	J	A	S	O	N	D	J	F	M
NA	'N'	=	=	=	=	=	=	=	=	=	↑

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 31 Mar 2032

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks
CRR 127 – Failure to allocate and/or attract significant revenue and additional capital will inhibit the Trust's ability to adhere to statutory compliance, as well as the ability to rectify the identified backlog maintenance
CRR 115 – Staff health and wellbeing is compromised due to the sustained level of work created by Covid-19 pandemic
CRR 118 – There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace
CRR 116 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs
CRR 122 – Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour
CRR 123 – Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate medical staffing levels and skill mix to meet patients' needs

Emergent Risks/ Issues
- Reliance on locums
- Risks are increasing due to retirement and covid

Future Opportunities
- Recruitment strategy (BAF 35)
- New hospital programme
- Emergency capital
- Robotic strategy
- Development of medical school

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a high (15) risk. The severity of the risk is scored as catastrophic (5), due to the potential for permanent loss of core services, disruption to facility leading to significant 'knock-on' effect across local health economy and extended service closure.
The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
Statutory compliance is monitored through the Contract Performance Meeting. Due diligence and soft market testing are being undertaken.

Actions (Planned)

Action required and date
1a) Trust has put in an expression of interest to joining the new hospital improvement programme. Due to be finalised by Autumn 22. **Deputy CEO Sep 22**
1b) Continue to lobby key stakeholders to maximise success of EOI **DCEO Sep 22**
1c) Clear lines of accountability and responsibility for the sign off, of the East Kent Transformation (including the PCBC) is identified in the STP/ICS Partnership Board Strategic Priorities **CEO Sep 22**
1d) Continue lobbying NHSEI if expression of interest for new hospital improvement programme is not successful **DSD&CP Mar 23**
2a) Implement annual investment plan for statutory compliance and monitor in year improvements against the agreed trajectory for 22/23 **DCEO Mar 23**
2b) Prioritise through SIG the investments for backlog maintenance as part of the PEIC capital investment programme. This will be informed by the Six Facet Survey, the work undertaken by NHSE/I on reducing the backlog position and the ARUP report. Investment will be monitored through FPC and BoD **DSD&CP Mar 22**
3) Issued PIN for due diligence **DSD&CP Aug 22**
4) Produce business cases ready to bid for any available capital allocations **DCEO Jul 22**

Controls in place (Existing)
1) The Chairman and CEO confirm that the Sustainability and Transformation Partnership (STP)/ICS Partnership Board prioritises and signs off the East Kent Transformation for agreement with NHSE/I.
2) The Director of Strategic Development and Capital Planning ensure that the PCBC is signed off by the Trust's FPC and BoD.
3) The Director of Strategic Development and Capital Planning ensures that the implementation of the clinical strategy receives oversight from the Joint Development Board and FPC
4) The Trust's position in terms of statutory compliance is published, reported and reviewed six-monthly by CEMG and the BoD
5) The Trust's investment programme in statutory compliance is approved by CEMG, FPC and BoD
6) The Trust wide backlog maintenance plan is approved and reviewed by SIG, CEMG, FPC and BoD
7) Rural and Coastal Recruitment Strategy

Assurances

Internal
1) Approval and monitoring of the Trust framework proposals and workstreams through Strategic Investment Group (SIG), CEMG, JDB, Q&SC, FPC and BoD (Controls 2 and 3)
2) Minutes of JDB, CEMG, FPC, SIG, Q&SC and BoD (Controls 4,5 and 6)

External
1) Sign off by ICP, STP/ICE and NHSE/I (Control 1)
2) Stage 2 assurance process passed awaiting allocation of capital (Control 1)

Gaps in controls and assurance
1) Final sign off and approval of capital investment is outstanding from NHSE/I
2) Gaps and risks relating to backlog and statutory compliance have been identified
3) Unable to consult
4) Risk appetite reduced by regulators. Derogation required from regulators to maintain services
5) Procurement due diligence not yet complete
6) Interim capital required to meet the compliance of estate and equipment risks

STRATEGIC GOAL: 4) Our Future:
Strategic Objective: Develop a Trust wide strategy to deliver cultural change, innovation and improvement

Executive Owner: Chief Executive Officer
Responsible Committee: Finance and Performance Committee

Date last reviewed: February 2022
Next review scheduled: March 2022
Date risk identified: May 2020

Principal Risk – BAF 30
Failure to deliver the full benefits of the We Care Improvement system

Effect: Improvement plan will fail to deliver, sub-optimal implementation, financial impact, HR impact, reputational risk

Risk Appetite
The Trust has a SIGNIFICANT appetite for risks to transforming the way we provide services across east Kent. We will pursue innovation and challenge current working practices. We will use new technologies as a key enabler of operational delivery and devolve authority across the Trust to enable us to offer excellent integrated services.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S4 = 16
Current Risk Rating: L3 x S4 = 12
Movement of the current risk rating within the financial year

A	M	J	J	A	S	O	N	D	J	F	M
↑	=	=	=	=	=	=	=	=	=		

Target Risk Rating: L1 x S4 = 4
Projected Target Date:

Assurance Level: None/**Limited**/Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks
None

Emergent Risks/ Issues
•

Future Opportunities
•

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a moderate (12) risk. The severity of the risk is scored as significant (4), due to the potential for the Trust to face some major difficulties which are likely to undermine its ability to deliver quality services on a daily basis and / or its long-term strategy. The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
Actions completed: In line with business planning for 22 / 23, True North and Breakthrough Objectives reviewed and priorities agreed with the BoDs

On track for methodology to be established and agreed by BoDs in May 22. Plan in place to onboard new Chief Executive; bootcamp scheduled for May 22.

Actions (Planned)

Action required and date
1) Methodology to be established and agreed by SLT, sub Board Committees and BODs. **DCEO May 22**
2) Onboard new Chief Executive to We Care improvement system. **Head of Transformation Apr 22**

Controls in place (Existing)

1) We Care Improvement Strategy approved by BoDs and implemented across the Trust.
2) SLT leads monthly cycle of the OMS and reports and update progress on implementation
3) Executive led workstreams in place (strategic deployment; OMS Frontline / Management; Leadership behaviours; Transformation and Step Change; Centre of Excellence; and Communications) reporting into SLT.
4) IPR linked into We Care and reports monthly to sub Board Committees and BoDs
5) Monthly PRMs with Care Groups wired in to We Care
6) Intensive Support process agreed for implementation as and when required.
7) Establish plan in place to delay / pause all of certain elements of the programme depending on severity of 3rd wave of Covid-19

Assurances

Internal
1) Coaching and mentoring in place for Executive Team; Care Groups; and Frontline Teams.
2) Skills matrix agreed for internal Improvement Team, which links to personal objectives

External
1) System has been implemented and proven to work in international healthcare systems (USA, Canada, Iceland) and in similarly complex NHS organisations.
2) VFM review undertaken by NHSEI with positive findings reported.
3) Endorsement for the change model from the National Director for Lean Transformation

Gaps in controls and assurance

1) Methodology that links the We Care Improvement Strategy to organisational strategies (such as the Quality Strategy) to be established.
2) Year two priorities analysed and agreed
3) We Care requires stable leadership, risk to continuity of programme during transition of Chief Executives

STRATEGIC GOAL: 5) Our Sustainability:
Objective: Achieve sustainable **financial health**

Executive Owner: Director of Finance (DoF)
Responsible Committee: Finance and Performance Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: May 2021

Principal Risk – BAF 38
Failure to deliver the financial breakeven position of the Trust as requested by NHSE/I

Effect: not having adequate cash to continue adequate operations of the organisation, potentially make poor financial decisions which will result in reputational damage and non-compliance with regulators.

Risk Appetite
The Trust has a HIGH appetite for taking financial risks within a context of clear and reliable financial controls. We are prepared to invest for return and minimise the possibility of financial loss by managing risks to a tolerable level. Value and benefits will be considered, not just the cheapest price. Resources will be allocated in order to capitalise on opportunities and provide better, more effective patient care.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L3 x S5 = 15
Movement of the current risk rating within the financial year

A	M	J	J	A	S	O	N	D	J	F	M
NA	'N'	=	=	=	=	=	=	=	=	=	=

Target Risk Rating: L1 x S5 = 5
Projected Target Date: 30 April 22

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned Corporate Risks
None

Emergent Risks/ Issues
•

Future Opportunities
•

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a high (15) risk. The severity of the risk is scored as catastrophic (5), due to the financial impact being at least £5million non-recurrent or at least £10million over 3 years.
The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.

Latest Commentary
Paper presented to FPC 01 March, to be presented to BoD on 10 March. Final draft plan to NHSE/I on 24 March. Final plan to be agreed by end April 22.

Actions (Planned)

Action required and date
1) Trust to develop medium term and long-term financial plans in conjunction with NHSEI and Kent and Medway ICS **Director of Finance Apr 22**

Controls in place (Existing)

1) There is a first half year financial plan in place which will be presented at BoD on 27 May 21.
2) The Director of Finance is the lead for this risk, and it is managed through the Finance and Performance Committee, Clinical Executive Management Group, Finance and Investment Oversight Group, Performance Meetings with Care Groups and Directors
3) Individual finance reports go to Care Groups on a monthly basis. Finance is monitored through the monthly IPR plus Finance report which goes to Finance and Performance Committee and Trust Board on a monthly basis
4) Other controls in place; annual business planning process, annual cost improvement programme developed, weekly activity review group in place.
5) Approved funding regime with Kent and Medway with a shared target across the Kent and Medway system.

Assurances

Internal
1) The plan and monthly performance are monitored and minuted at monthly performance meetings with care groups, with the Finance and Performance Committee and the Trust Board

External
1) The financial performance of the Trust is monitored by NHSE/I through a monthly return. This is approved by the Director of Finance. In addition, the Trust has a monthly oversight meeting with the regional NHSE/I team to discuss financial performance (amongst other agenda items).

Gaps in controls and assurance

1) Trust doesn't have a medium term or long-term financial plan. The Trust is likely to remain in financial special measures (FSM) until a balanced longer-term plan is developed

NHS
East Kent
Hospitals University
NHS Foundation Trust

CORPORATE RISK REGISTER (CRR)
QUARTER 4 - 2021/22

Date of issue: 30 March 2022

STRATEGIC GOAL: 1) Our Quality & Safety:
Strategic Objective: Improve **patient safety** reduce harm

Executive Owner: Chief Medical Officer (CMO)
Responsible Committee: Quality and Safety Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: June 2019

Principal Risk – CRR 117
There is a risk of poor medicines management

Effect: Patient harm, increased length of stay, poor patient experience

Patients may be harmed through poor medicines management due to poor culture towards medicines prescription and administration at ward and department level that may result in patient harm, poor patient experience and increased length of stay

Risk Appetite
The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L5 x S4 = 20
Current Risk Rating: L4 x S4 = 16

A	M	J	J	A	S	O	N	D	J	F	M
=	=	=	=	=	=	=	=	=	=	=	=

Target Risk Rating: L2 x S4 = 8
Projected Target Date: 31 March 2023

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned BAF Risk
BAF 32 - There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.

Emergent Risks/Issues
- Poor culture towards medicines prescription and administration at ward and department level

Future Opportunities
-

Risk and Scoring Commentary

Rationale for Current risk score
The current risk score is rated as a high (16) risk. The severity of the risk is scored as significant (4), due to the potential for major injuries/harm to a person/people resulting in prolonged length of stay. The likelihood of the risk is scored as likely (4), the severity will probably happen or recur but is not a persisting issue.

Latest Commentary
ePMA go live slipped to Sept 22. T3 Board to agree a Go Live date for ePrescribing. Additional phase of consolidation of existing modules such as ClinDocs/ED/OrderComms to make sure system is fit for ePMA and system is utilised

Actions (Planned)

Action required and date
1) Implementation of electronic prescribing to support improved culture towards medicines prescription and administration at ward and department level **Director of Pharmacy ~~Sep 21 Oct 21 Feb 22 Dec 21~~ Jun 22**
2) Safe and effective discharge Trust Priority Improvement Project **Medical Director for Recovery Jun 22**
3) Review of terms of reference of Medicines Safety Group to include attendance as part of wider quality governance review **Medication Safety Officer Dec 21**
4a) Develop a training needs analysis for insulin safety training **Medication Safety Officer Jun 22**
4b) Implement training for insulin safety **Medication Safety Officer Jun 22**
5a) Develop a training needs analysis for medication safety training **Medication Safety Officer Jun 22**
5b) Implement training for medical gases **Medication Safety Officer Jun 22**
6) Review reporting metrics for Medication Safety to effectively monitor delivery against the plan

Controls in place (Existing)

1) Medication Safety Plan approved by Drugs and Therapeutics Committee
2) The Trust has a Controlled Drugs (CD) Accountable Officer that reviews CD usage and oversees Trust training and audits
3) Medication Safety Self-Assessment Tool triangulated with emerging incident themes reported to Medicines Safety Group
4) Medicines Policies, procedures and patient group directives available for staff on 4policies.
5) Pharmacists and technicians are working on those wards assessed as high risk, clinically checking prescriptions

Assurances

Internal
1) Medication metric approved as part of We Care metrics, reviewed on a monthly basis at ST
2) Care Group Governance Reports to Q&SC
3) CQC Improvement meeting established under the Chair of CNO to monitor regulatory requirements to deliver care
4) Medication Safety Plan reported to Patient Safety Committee
5) Audit programme in places for high risk areas
6) All medication safety errors and those Grade C and above reported through Integrated Performance Report (IPR) to Board of Directors (BoD) on a monthly basis

External
1) Quarterly report to CDLIN
2) CQC Stakeholder events annually
3) Annual benchmarking
4) Regional QA determines risk level of organisation

Gaps in controls and assurance

1) Delivery of electronic prescribing
2) Significant number of clinical incidents related to discharge and discharge medication
3) Medicines Safety Group is not currently delivering all elements of the Medication Safety Plan
4) Curriculum for medication including insulin safety training doesn't meet the needs to improve the culture around prescribing and administration of medicines
5) Curriculum for medical gases safety training doesn't meet the needs to improve the culture around prescribing and administration of medical gases
6) Sufficient assurance isn't provided across all aspects of the Medication Safety Plan

STRATEGIC GOAL: 1) Our Quality & Safety:
Strategic Objective: Improve **patient safety** reduce harm

Executive Owner: Chief Nursing Officer (CMO)
Responsible Committee: Quality and Safety Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: January 2020

Principal Risk – CRR 77
There is a risk of failure to provide adequate maternity services to women and their families

Effect: Patient harm, poor patient experience leading to increased complaints, regulatory concerns, legal challenge, reputational damage

Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services

Risk Appetite
The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L3 x S5 = 15

A	M	J	J	A	S	O	N	D	J	F	M
=	=	=	=	=	=	=	=	=	=	=	=

Target Risk Rating: L2 x S5 = 10
Projected Target Date: 31 March 2023

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned BAF Risk
BAF 32 - There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.

Risk and Scoring Commentary

Rationale for Current risk score
The current risk score is rated as a high (15) risk. The severity of the risk is scored as extreme (5), due to the potential for serious harm to be caused to a

Latest Commentary
Risks reviewed with Care Group during March. Risk to be split in to three separate risks; maternity estate; culture; Kirkup inquiry

Actions (Planned)

Action required and date
1) Recovery of CTG training **Director of Midwifery**

Emergent Risks/Issues • **Future Opportunities** •	person/people resulting in death or significant multiple injuries. The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally.	
Controls in place (Existing)	**Assurances**	**Gaps in controls and assurance**
1) Maternity Improvement Plan monitored by Maternity and Neonatal Assurance Group (MNAG) and reported to the Board of Directors. This includes mandatory training and establishment of maternity dashboard to monitor improvement against key performance indicators	**Internal** 1) Maternity Improvement Plan monitored by Maternity and Neonatal Assurance Group and reported to the Board of Directors **External** 1) Assurance received from internal auditors reported to IAGC	1) Training cancelled during pandemic. Training escalation established with Director of Midwifery (DoM)/Head of Midwifery (HoM)
2) Centralised CTG monitoring in both labour wards with facility for viewing via VPN		2) Staffing levels have been impacted by Covid-19 (Jan 2022) which is challenging the daily prevalence of the supernumerary band 7
3) Audits undertaken of consultant presence on labour ward		
4) Dissemination of HSIB reports and recommendations		

STRATEGIC GOAL: 1) Our Quality & Safety:
Strategic Objective: Improve **patient safety** reduce harm

Executive Owner: Chief Nursing Officer (CMO)
Responsible Committee: Quality and Safety Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: January 2020

Principal Risk – CRR 110 There is a risk of failure to provide adequate paediatric services to patients **Effect:** Patient harm, poor patient experience leading to increased complaints, regulatory concerns, legal challenge, reputational damage Children may receive sub-optimal quality of care and poor patient experience in our maternity services	**Risk Appetite** The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards. **Risk Appetite Status**: Within appetite	**Initial Risk Rating: L5 x S4 = 20** **Current Risk Rating: L4 x S4 = 16** **Target Risk Rating: L2 x S4 = 8** **Projected Target Date: 30 June 2022** **Assurance Level:** None/**Limited/**Adequate/Substantial

A	M	J	J	A	S	O	N	D	J	F	M
=	=	=	=	=	=	=	=	=	=	=	=

Risks & Opportunities	**Risk and Scoring Commentary**		**Actions (Planned)**
Aligned BAF Risk **BAF 32 -** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **Emergent Risks/Issues** • **Future Opportunities** •	**Rationale for Current risk score** The current risk score is rated as a high (16) risk. The severity of the risk is scored as significant (4), due to the potential for major injuries/harm to a person/people resulting in prolonged length of stay. The likelihood of the risk is scored as likely (4), the severity will probably happen or recur but is not a persisting issue.	**Latest Commentary** Meeting scheduled to review with Care Group 08 April 2022.	**Action required and date** 1) Recruitment of six additional consultants at each acute site **Operations Director, Paediatrics Jun 22** 2) Revised plans for ED to include separate triage for paediatrics **Hospital Director, Emergency Care Jun 22**
Controls in place (Existing)	**Assurances**		**Gaps in controls and assurance**
1) Deteriorating patient reviewed monthly as a quality and safety metric	**Internal** 1) PEWS / Sepsis is a We Care metric and is monitored at monthly deteriorating child group and driver meetings **External** 1) CQC inspection report for children's service		1) Paediatric consultants not consistently available out of hours
2) Established communication channels between paediatrics and ED. Teams actively work together to support care of children and assist with flow / decision making etc.			2) Physical environment in which paediatric services are delivered
3) RCPCH standards are being mitigated on both sites by locums, consultants and extended working hours and cover is present on both sites – consistently at QE and developing at WHH with locum – second reg cover is available on all shifts to mitigate and also support Paeds ED			
4) Senior nurse cover 24/7			
5) Deteriorating child group meets monthly			

STRATEGIC GOAL: 1) Our Quality & Safety:
Strategic Objective: Improve **patient safety** reduce harm

Executive Owner: Chief Nursing Officer (CMO)
Responsible Committee: Quality and Safety Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: May 2021

Principal Risk – CRR 36
There is a risk of failure to provide adequate safeguarding arrangements for adults and children

Effect: Patient harm, poor patient experience leading to increased complaints, regulatory concerns, legal challenge, reputational damage

Patient outcome, experience and safety may be compromised as a consequence of failure to:
1. Identify patient with additional vulnerabilities (adult and children)
2. Assess their needs
3. Plan appropriate care, including relevant safeguarding legislation and local safeguarding policies
4. Mitigate any risks
5. Work in line with relevant legislation (including Children Act, Care Act, Mental Capacity Act, Equalities Act, Mental Health Act)

Risk Appetite
The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S4 = 16
Current Risk Rating: L3 x S4 = 12

A	M	J	J	A	S	O	N	D	J	F	M
NA	'N'	=	=	=	=	=	=	=	=	=	=

Target Risk Rating: L2 x S4 = 8
Projected Target Date: 28 Feb 2023

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned BAF Risk
BAF 32 - There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.

Emergent Risks/Issues
•

Future Opportunities
•

Risk and Scoring Commentary

Rationale for Current risk score
The current risk score is rated as a moderate (12) risk. The severity of the risk is scored as significant (4), due to the potential for major injuries/harm to a person/people resulting in prolonged length of stay. The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally.

Latest Commentary
Director of Nursing (DoN) has contacted all Care Groups to ensure safeguarding is a standard agenda item. Meeting held in March; the IT dashboard will include safeguarding in the build at end March 2022. Restraint Policy is being presented to Drugs and Therapeutics Committee on 23 March 2022 for approval. Two sessions of Maybo training have run during March with a further two planned for June. L&D helping to determine TNA and mapping against Care Groups. Referral to Sunrise system made for implementing Think Family safeguarding assessment tool. Ward Manager Enhance Observation Audit Tool has been created and is available for use but there remain issues with being able to drill down into the data for reporting.

Actions (Planned)

Action required and date
1a) Care Group governance meetings to include safeguarding as standard item. Safeguarding team to attend quarterly or by exception **DoN Jul 21**
1b) Care Groups to invite Safeguarding team to Care Group governance meetings **DoN Feb 22**
1c) Evidence of safeguarding attendance at Care Group governance meetings **DoN Feb 22**
2) Inpatient PTL with vulnerabilities flagged on ward and departmental whiteboards **Head of Information Development Jan 22**
3) Development of a safeguarding dashboard to enable staff to view real time safeguarding data **Head of Information Development Jan 22**
4) GSM and UEC Care Groups to provide trajectory to demonstrate how they will meet training compliance gaps **DoN Dec 21**
5) Review and ratify restraint policy and roll out actions to embed **DoN Aug 21**
6a) Roll out MAYBO training (adults) **Sharon Hatfield-Tugwell**
6b) Roll out MAPA training (children) **Natalie Oliver-Hendy**
7) Roll out of awareness training for model of enhanced observation and managing people at risk **DoN Jan 22**
8) Strengthen Safeguarding Champion roles in Children's and Maternity services **Head of Safeguarding for Children Jun 22**
9) Establish Safeguarding Champion (Mirroring dementia champion) roles for adults. Create JD for roles involving Care Group triumvirates. Advertise and recruit. Establish programme of workshops and mentoring for roles **Head of Safeguarding for Adults Jun 22**
10) Implement Think Family safeguarding assessment tool on Sunrise **HoN – IT Feb 23**
11) Ward Managers Enhanced Observation Audit Tool **HoN – IT Dec 21**

Controls in place (Existing)

1) Safeguarding improvement plan, incorporating actions from cultural and NHSEI and CCG Safeguarding governance reviews and SIs
2) Comprehensive training needs analysis (TNA) and training programme for safeguarding in place
3) New model for managing people at risk developed (replacing Safe Assist)
4) Clearly documented Trust processes for safeguarding
5) Appropriately resourced adult and children safeguarding teams
6) Safeguarding Champions
7) Comprehensive registers with flags for dementia, learning disability and MARAC and children subject to child protection plans and safeguarding concerns

Assurances

Internal
1) Safeguarding Improvement Plan agreed at Safeguarding Committee and Quality and Safety Committee
2) GSM review and evidence documented
3) TNA and training compliance figures by care group quarterly
4) CQC Improvement meeting in place

External
1) Joint Safeguarding Improvement meeting (with Kent and Medway CCG) to review evidence of implementation of action plan

Gaps in controls and assurance

1) Lack of ownership of safeguarding at Care Group level
2) Lack of visibility of vulnerabilities for ward managers
3) Lack of real time safeguarding data for front line staff
4) Safeguarding Training compliance not 85% for level 3 adults
5) Restraint policy under review
6) MAYBO (adult breakaway training) and MAPA (children breakaway training) training being rolled out
7) New model of managing people at risk (vulnerable adults and children) to replace use of SafeAssist not fully rolled out
8) Need to develop Safeguarding Champion roles in Children's and Maternity services
9) Need to develop Safeguarding Champion model in adult services
10) Think Family Safeguarding assessment tool for use on admission (Sunrise development)

STRATEGIC GOAL: 1) Our Quality & Safety:
Strategic Objective: Improve **patient safety** reduce harm

Executive Owner: Chief Nursing Officer (CMO)
Responsible Committee: Quality and Safety Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: October 2021

Principal Risk – CRR 125
There is a risk of failure to meet patients' nutrition and hydration needs

Effect: Patient harm

Patient may suffer harm due to their nutrition and hydration needs not being met as a result of inadequate supervision during mealtimes

Risk Appetite
The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S3 = 12
Current Risk Rating: L4 x S3 = 12

A	M	J	J	A	S	O	N	D	J	F	M
NA	NA	NA	NA	NA	NA	'N'	=	=	=	=	=

Target Risk Rating: L3 x S3 = 9
Projected Target Date: 31 March 2022

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned BAF Risk
BAF 32 - There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.

Emergent Risks/Issues
- Inadequate supervision during mealtimes

Future Opportunities
-

Risk and Scoring Commentary

Rationale for Current risk score
The current risk score is rated as a moderate (12) risk. The severity of the risk is scored as moderate (4), due to the potential for harm to a person/people resulting in a prolonged length of stay. The likelihood of the risk is scored as likely (4), the severity will probably happen or recur but is not a persisting issue.

Latest Commentary
Meeting scheduled to review this risk 01 April 2022

Actions (Planned)

Action required and date
1) Development of a spilled hot drinks aggregate action plan **Director of Nursing Mar 22**
2) Development of a food allergy aggregate action plan **Director of Nursing Mar 22**
3) Additional training, support and audit to be provided by the Nutrition and Hydration Nursing Team **Director of Nursing Mar 22**

Controls in place (Existing)
1) Patient safety huddles in place
2) Improved communication pre-meals between nursing and catering teams.
3) Trial undertaken of behind the bed notices
4) Awareness raising undertaken amongst nursing and catering staff

Assurances
Internal
1)

External
1)

Gaps in controls and assurance

STRATEGIC GOAL: 1) Our Quality & Safety:
Strategic Objective: Improve **patient safety** reduce harm

Executive Owner: Chief Nursing Officer (CMO)
Responsible Committee: Quality and Safety Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: January 2022

Principal Risk – CRR 129
There is a risk that the Trust may not be adequately prepared for a CQC inspection

Effect:

The Trust needs to know its current position in relation to CQC rating, including the areas that require improvement, and those that are good or outstanding. Inspection ratings are indicative but many core services have not been inspected for several years and so these cannot be relied upon. In the past self-assessments were undertaken against the CQC's Key Lines of Enquiry (KLOEs), and these were last undertaken in February 2020.

Risk Appetite
The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S4 = 16
Current Risk Rating: L4 x S6 = 16

A	M	J	J	A	S	O	N	D	J	F	M
NA	NA	NA	NA	NA	NA	NA	NA	NA	N	=	=

Target Risk Rating: L3 x S4 = 12
Projected Target Date: 31 December 2022

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned BAF Risk
BAF 32 - There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care.

Emergent Risks/Issues
-

Future Opportunities
-

Risk and Scoring Commentary

Rationale for Current risk score
The current risk score is rated as a high (16) risk. The severity of the risk is scored as significant (4), as there may be external reporting of consequences required with potential national adverse publicity. The likelihood of the risk is scored as likely (4), the severity will probably happen or recur but is not a persisting issue.

Latest Commentary
Risk reviewed with CNO, additional action added. Specialist CQC manager commences in post March 2022.

Actions (Planned)

Action required and date
1) Internal CQC assurance framework approved at Board December 2021, to be implemented in Spring 2022 **Compliance and Assurance Lead Jun 22**
2) Care Groups and corporate leads to self-assess, rate themselves and identify actions to get to Good and then Outstanding **Compliance and Assurance Lead Jul 22**
3) Focussed assurance visits and reviews to be undertaken examining progress against CQC inspection action plans **Compliance and Assurance Lead Jun 22**
4) Head of CQC Compliance and Quality recruited to new position in CNO's structure **CNO Jun 22**
5) NHSI supported with funding to support CNO with specialist CQC manager for 6 months to pump prime diagnostic work with Care Groups **CNO Mar 22**
6) Explore options for an information system to manage CQC compliance and assurance **Compliance and Assurance Lead Sep 22**
7) Delivery of the Trust's ward accreditation programme **Compliance and Assurance Lead Dec 22**
8) Develop Care Group dashboards to incorporate measures relating to CQC compliance **Compliance and Assurance Lead Apr 22**

Controls in place (Existing)
1) Action plans in place for each CQC inspection that has been completed
2) CQC Improvement Steering Group meets monthly chaired by CNO

Assurances
Internal
1) Monthly reports to QSC

Gaps in controls and assurance
1) Lack of understanding across all services in relation to CQC preparation and baseline of performance against KLOEs

3) Compliance and Assurance Team support Care Groups with CQC inspections and action plans and meets monthly 4) Monthly reports to the Quality and Safety Committee 5) Regular meetings between the CQC, CNO and CMO, progress against action plans discussed.	2) CQC Action plans monitored by Care Group Governance systems reported to CQC Improvement Steering Group **External** 1) CNO and CMO have engagement meetings with CQC 2) CQC inspections	2) Insufficient capacity within CQC team

STRATEGIC GOAL: 1) Our Quality & Safety:
Strategic Objective: Improve **patient safety** reduce harm

Executive Owner: Deputy Chief Executive Officer (DCEO)
Responsible Committee: Quality and Safety Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: October 2021

Principal Risk – CRR 128
Failure to ensure adequate controls and safeguarding arrangements are in place at mortuaries

Effect: increases the risk of distress to families and exposes the Trust to legal challenge and reputational damage

Risk Appetite
The Trust has a **HIGH** appetite for risks to improving the quality of care/patient outcomes. This will be undertaken by considering all potential delivery options while ensuring compliance with clinical standards, professional practice and quality safety standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L3 x S5 = 15
Current Risk Rating: L2 x S5 = 10

A	M	J	J	A	S	O	N	D	J	F	M
NA	NA	NA	NA	NA	NA	N	=	=	=	=	=

Target Risk Rating: L1 x S5 = 10
Projected Target Date: 31 March 2022

Assurance Level: None/Limited/**Adequate**/Substantial

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned BAF Risk **BAF 32 -** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **Emergent Risks/Issues** • **Future Opportunities** •	**Rationale for Current risk score** The current risk score is rated as a moderate (10) risk. The severity of the risk is scored as extreme (5), due to the potential for serious harm to a be caused and protracted national adverse publicity. The likelihood of the risk is scored as unlikely (2), the severity is unlikely to occur.	**Latest Commentary** The mortuary security action plan is complete and the HTA inspection is scheduled for 28 March 2022.	**Action required and date** 1) Deliver mortuary security action plan **DCEO Dec 21** 2) HTA inspection in March 2022 **DCEO Mar 22**

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) Risk assessment undertaken against the formal HTA reportable incident categories. Risk confirmed as low with all controls measures in place. 2) Annual risk assessment undertaken of security in the mortuary. August 2021 assessment found that all possible control measures have been implemented.	**Internal** 1) **External** 1) Internal audit of mortuary processes undertaken in 2021 – reasonable assurance given.	

STRATEGIC GOAL: 2) Our Patients:
Strategic Objective: Improve **Patient Experience** deliver excellent clinical outcomes

Executive Owners: Chief Operating Officer / Chief Nursing Officer
Responsible Committee: Quality and Safety Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: June 2020

Principal Risk – CRR 113
There is a risk of insufficient capacity within tier 4 Children and Young Peoples Mental Health Services (CYPMHS)

Effect: Resulting in patients being inappropriately placed within the Trust impacting on staff and patients

Risk Appetite
The Trust has a **HIGH** appetite for risks to 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. We will be willing to consider all delivery options that provide acceptable levels of patient related outcomes. However, we will prefer not to take risks with compliance to external performance standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L5 x S4 = 20
Current Risk Rating: L4 x S4 = 16

A	M	J	J	A	S	O	N	D	J	F	M
=	=	=	=	=	=	↓	↑	=	=	↓	=

Target Risk Rating: L3 x S4 = 12
Projected Target Date: 31 March 2022

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned BAF Risk None **Emergent Risks/ Issues** • **Future Opportunities** •	**Rationale for current risk score** The current risk score is rated as a high (16) risk. The severity of the risk is scored as significant (4), due to the potential for major injuries/harm to a person/people resulting in prolonged length of stay. The likelihood of the risk is scored as likely (4), the severity will probably happen or recur but is not a persisting issue.	**Latest Commentary** Risk highlighted for discussion at the Clinical Executive Management Group 13 April 2022. The Chief Nursing Officer has recommended that the risk remain at an extreme (20) due to complications relating to eating disorders, further actions to mitigate this risk to be articulated.	**Action required and date** 1) Increase in Maybo training for all staff in ED **DoN Jun 22** 2) Recruitment of Band 6 CAMHS support for each acute ward enabling liaison and support for ward teams **HoN, Paediatrics Nov 21** 3) Consideration and planning for designated spaces to be developed with support from H&S and NELFT to enable a safe environment for placement of CYPMHS within the acute wards **HoN, Paediatrics Nov 21** 4) Dialogue with regional and system partners and CAMGS providers to increase access **COO Mar 2022** 5) Utilising support of RMNs trained in control and restraint working across Emergency Floor. Legal advice taken for each individual case.

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) Kent and Medway wide mental health pathway in place to address system-wide shortage of mental health beds	**Internal** 1) Mental Health Steering Committee 2) Daily Gold command meets and review any significant/high risk issues including CAMHS patients awaiting access to a specialist bed 3) Learning from incidents, serious incidents and complaints **External** 1) Regional meeting with CAMHS and the specialist tier 4 providers network case managing access and risk assessing delays 2) Daily regional system calls have CAMHS and NELFT representation and/or the closure of health beds to support a delay are discussed	1) ED staff ability to treat mental health patients
2) Regional escalation on the shortage of CAMHS beds		2) Insufficient CAMHS staff currently employed by the Trust
3) Review of patient demand data and coordinate response		3) Inadequate space for CYMPHS patients within the Trust
4) Mental health liaison team in place		4) Adequate capacity not commissioned
5) Regional system case conferences held for individual patients to support any delays in accessing CAMHS		5) Lack of trained staff in the Trust if young person required physical restraint
6) Weekly case review meetings with NELFT supported by CCG and Tier 4 network		
7) Close health acute beds around the CAMHS patient to protect the patients on the ward and the staff as well as the child awaiting Tier 4 bed		

STRATEGIC GOAL: 2) Our Patients:
Strategic Objective: Improve **Patient Experience** deliver excellent clinical outcomes

Executive Owners: Chief Operating Officer
Responsible Committee: Quality and Safety Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: January 2020

Principal Risk – CRR 78
There is a risk of overcrowding in ED due to a lack of capacity in the system and increased local demand

Effect: compromised patient safety and patient experience

Risk Appetite
The Trust has a **HIGH** appetite for risks to 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. We will be willing to consider all delivery options that provide acceptable levels of patient related outcomes. However, we will prefer not to take risks with compliance to external performance standards.

Risk Appetite Status: Within appetite

Initial Risk Rating: L5 x S4 = 20
Current Risk Rating: L4 x S4 = 16

A	M	J	J	A	S	O	N	D	J	F	M
↓	=	=	=	=	=	↑	=	=	↑	=	=

Target Risk Rating: L2 x S4 = 8
Projected Target Date: 31 May 2022

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned BAF Risk **BAF 34 -** There is a risk that our constitutional targets are not met **Emergent Risks/ Issues** • **Future Opportunities** •	**Rationale for current risk score** The current risk score is rated as a high (16) risk. The severity of the risk is scored as significant (4), due to the potential for major injuries/harm to a person/people resulting in prolonged length of stay. The likelihood of the risk is scored as likely (4), the severity will probably happen or recur but is not a persisting issue.	**Latest Commentary** Meeting scheduled to review this risk 12 April 2022	**Action required and date** 1) Introduction of criteria led discharge and continued collaboration with system partners to improve timeliness to community capacity **COO, Jun 21** 1a) Decision to admit tool is being implemented to ensure patients have access to the right care to meet their needs **COO, Dec 21** 2a) Deliver Flow Plan to reduced overcrowding in ED **COO, Mar 22** 2b) Deliver expansion of Emergency Departments at QEQM and WHH **COO, Dec 21** 3a) KCHFT and KCC with EKHUFT are reviewing ways to support recruitment of care workers. This is part of winter discussions. **COO, Nov 21** 3b) Looking at alternative to pathway 1 spot purchasing additional beds **COO, Oct 21** 3b) Regional level – K&M ICS meeting with social care providers to help facilitate an improvement with their position with staffing and support **COO, Nov 2021** 4) The Trust Winter Plan actions focus on: Simple Discharged to discharge lounge before midday 33%; 7 day working and medical model; re-siting any elective work to K&CH for January and February. Active work undertaken to improve performance on a daily basis.

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) Systemwide Accident and Emergency Delivery Board in place, attended by the Chief Executive	**Internal** 1) We Care Breakthrough Objectives monitored monthly through the Integrated Performance Report presented to the Board of Directors **External** 1)	1) Lack of capacity in the system to enable timely discharge
2) Health Economy Plan in place		2) Footprint of current ED not adequate to meet demand
3) Weekly site-based meetings in place to improve ownership of the emergency care pathway and reduce overcrowding in the emergency department		3) Insufficient care workers in the community to facilitate pathway 1 – home with support
4) Demand and capacity reviewed and monitored in all areas outlined in the Operating Framework		
5) Urgent Treatment Centres in place with Alliance model now seeing between 20 and 30% patients with an aspiration to see 50%		
6) We Care Breakthrough Objective 'Reducing patient time in ED once there has been a decision to admit'		
7) Trust Access Standards monitored as part of True North 'ED 4 Hour Compliance'		
8) Aging well fund being utilised		

STRATEGIC GOAL: 3) Our People:
Strategic Objective: To deliver our People Strategy to develop a positive culture and address key risks faced in terms of retention and recruitment to become an "**employer of choice**" by **enabling staff** to maximise their potential.

Executive Owner: Director of HR and OD
Responsible Committee: People and Culture Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: June 2019

Principal Risk – CRR 118
Proposed new title: There is a risk of failure to address poor organisational culture

Effect: Negative patient outcomes, reputational damage, ability to deliver services, financial, patient harm, regulatory impact, staff wellbeing

There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace. Specifically, there is a requirement for urgent and significant improvement in relation to staff attitudes and behaviours.

Risk Appetite
The Trust has a **SIGNIFICANT** appetite for risks to making the Trust a great place to work. We will be innovative in taking risks in relation to workforce/staff engagement that will offer potential higher benefits to staff, patients and the organisation.
Risk Appetite Status: Within appetite

Initial Risk Rating: L5 x S4 = 20
Current Risk Rating: L4 x S4 = 16

A	M	J	J	A	S	O	N	D	J	F	M
=	=	=	=	=	=	=	=	=	=	=	=

Target Risk Rating: L2 x S4 = 8
Projected Target Date: 30 June 2022

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned BAF risk - BAF 35 - There is a risk of failure to recruit and retain high calibre staff

Emergent Risks/ Issues
- Do not have the right establishment

Future Opportunities
-

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a high (16) risk. The severity of the risk is scored as significant (4), due to the potential for low staff morale affecting multiple staff. The likelihood of the risk is scored as likely (4), the severity will probably happen or recur but is not a persisting issue.

Latest Commentary
NHSEI culture and leadership programme proposal has been approved subject to funding from NHSEI and production of a supporting business case. Final EDI and culture report being presented to the BoD in April. Draft EDI Strategy presented to EDI Steering Group in March 22. Implementation date extended to deliver formal training for decision makers on the decision tree pending the outcome of the business case. Follow up workshop to identify root causes undertaken in March and final A3 being developed.

Actions (Planned)

Action required and date
1) Map roles and responsibilities to appropriate levels of the leadership framework to develop clear career pathways **Director of HR and OD Mar 22**
2) Freedom to Speak Up Champion job description being developed to expand networks **Director of HR and OD Mar 22**
3a) NHSE/I culture and leadership programme for Women's Health and Children and Young People Care Groups
3b) Peer Messenger Programme due for launch in December 2021
3c) Review of EDI and culture by external consultants which will report in December 2021
4a) Share the decision tree with Staff Committee and Executives Dec 2021
4b) Deliver formal training for decision makers **Jun 2022**
5) Workshop has taken place with key stakeholders. Workshop has identified root causes. The next step is to identify actions to put in place.

Controls in place (Existing)
1) Agreed HR KPIs (Inc. vacancy rate, turnover and engagement scores)
2) Clinical and non-clinical leadership programmes in place
3) Freedom to Speak Up policy and dedicated Freedom to Speak Up guardians
4) Guidance and toolkits for managers
5) Leadership Development Plans and targeted development plans for individuals in place
6) Leadership diagnostics
7) Staff Survey local action plans
8) Staff webinars monthly
9) Trust-wide leadership competency framework
10) Alignment of leadership framework with the behavioural framework and competencies within We Care
11) Revised Disciplinary Policy to include Just and learning culture practices

Assurances

Internal
1) Monitoring of the agreed HR KPIs via We Care, PRMs and reported at PCC
2) Freedom to Speak Up guardians meet with Director of HR monthly
3) Take up of leadership programmes
4) Annual appraisals

External
1) Annual Staff Survey
2) Quarterly Staff Survey

Gaps in controls and assurance
1) Leadership diagnostics in progress to identify gaps in controls
2) Engage with frontline staff on all sites with enhanced presence and accessibility
3) Identifying appropriate interventions to improve culture by utilising appropriate tools such as the NHSE/I culture and leadership programme and the Peer Messenger Programme
4) Developing a positive culture in employee relations interventions (Just and learning culture)
5) Reduction in bullying and harassment has been identified as a We Care Strategic Initiative

STRATEGIC GOAL: 3) Our People:
Strategic Objective: To deliver our People Strategy to develop a positive culture and address key risks faced in terms of retention and recruitment to become an "**employer of choice**" by **enabling staff** to maximise their potential.

Executive Owner: Director of HR and OD
Responsible Committee: People and Culture Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: April 2020

Principal Risk – CRR 88
Proposed new title: There is a risk of failure to manage staff health and wellbeing

Effect: Negative patient outcomes, reputational damage, ability to deliver services, financial, patient harm, regulatory impact, staff wellbeing

There is a risk that the underlying organisational culture impacts on the improvements that are necessary to patient and staff experience which will prevent the Trust moving forward at the required pace. Specifically, there is a requirement for urgent and significant improvement in relation to staff attitudes and behaviours.

Risk Appetite
The Trust has a **SIGNIFICANT** appetite for risks to making the Trust a great place to work. We will be innovative in taking risks in relation to workforce/staff engagement that will offer potential higher benefits to staff, patients and the organisation.
Risk Appetite Status: Within appetite

Initial Risk Rating: L5 x S4 = 20
Current Risk Rating: L4 x S4 = 16

A	M	J	J	A	S	O	N	D	J	F	M
=	=	=	=	=	=	=	=	=	=	=	=

Target Risk Rating: L2 x S4 = 8
Projected Target Date: 30 September 2022

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned BAF risk - BAF 35 - There is a risk of failure to recruit and retain high calibre staff **Emergent Risks/ Issues** • Sustained level of work created by Covid-19 pandemic **Future Opportunities** •	**Rationale for current risk score** The current risk score is rated as a high (16) risk. The severity of the risk is scored as significant (4), due to the potential for low staff morale affecting multiple staff. The likelihood of the risk is scored as likely (4), the severity will probably happen or recur but is not a persisting issue.	**Latest Commentary** The Kent and Medway Workplace Wellbeing Silver Award was issued in December 2021 which established wellbeing strengths and areas of good practice in this sphere. It is an excellent example of delivery against the key performance indicators and associated metrics and should provide assurance, not least because it involves interviewing unknowing external stakeholders. The Trust is now actively targeting the Kent & Medway Workplace Wellbeing Gold Award and making an additional 15 pledges against these actions. A Wellbeing Wednesday programme was launched throughout November and December 2021, with 323 staff attending across 6-week programme and reporting an exceptionally positive experience. Wellbeing Wednesday has now become a programme which is being locally adopted, with great practice for example seen at QEQM. Wellbeing Wednesday events are planned throughout 2022, beginning with a 6-week programme specifically focussed on sleep hygiene factors – something evidence tells us is one of the primary issues our staff face. It has been developed with Clinical Psychologists and will be delivered with specialist expertise. The Staff Experience Team ran an incredibly successful Nutrition and Hydration week – securing funding from our Apprenticeship Team and with materials from our Charity. The Wellbeing Team have also met with the Chair of the Charitable Funds Committee to discuss the need for continued charities support for colleagues throughout 2022.	**Action required and date** 1) Working with system to develop a system-wide response to health and wellbeing **Director of HR and OD Mar 22** 2a) Developing range of benefits and activities to encourage social interaction and physical wellbeing **Head of Staff Experience Mar 22** 2b) Extend Wellbeing Wednesday events throughout 2022 following positive response 3) Engaging with charities for additional support for staff experience **Head of Staff Experience Mar 22**
Controls in place (Existing)	**Assurances**		**Gaps in controls and assurance**
1) A five-year People Strategy – People at the Heart 2020 – 2025 has been approved by Trust Board 2) Agreed HR KPIs (Inc vacancy rate, turnover and engagement scores) 3) Health and Wellbeing Team in place 4) 4R Programme led by Clinical Director with workforce representation 5) Health and Wellbeing hub 6) TRIM practitioners across the Trust 7) Mental health toolkit available for staff 8) Take 5 rooms on each site 9) Staff Zone signposts staff to support 10) Employee Assistance Programme available 24/7 11) Kent and Medway Workplace Wellbeing Bronze and Silver award 12) Wellbeing Wednesday events held through November and December	**Internal** 1) Monitoring of People Strategy at the People and Culture Committee (PCC) 2) Monitoring of the agreed HR KPIs via We Care and PRMs and reported at PCC **External** 1) Review of EKHUFT's People Strategy via NHSE/I 2) MoU across the Kent and Medway system to include staff passporting		

STRATEGIC GOAL: 3) Our People:
Strategic Objective: To deliver our People Strategy to develop a positive culture and address key risks faced in terms of retention and recruitment to become an "**employer of choice**" by **enabling staff** to maximise their potential.

Executive Owner: Chief Nursing Officer
Responsible Committee: People and Culture Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: April 2021

Principal Risk – CRR 116	Risk Appetite	Initial Risk Rating: L5 x S4 = 20
Proposed new title: There is a risk of inadequate nursing staffing levels and skills mix to meet patient's needs **Effect:** Patient outcomes, experience and safety Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate nursing staffing levels and skill mix to meet patient's needs	The Trust has a **SIGNIFICANT** appetite for risks to making the Trust a great place to work. We will be innovative in taking risks in relation to workforce/staff engagement that will offer potential higher benefits to staff, patients and the organisation. **Risk Appetite Status:** Within appetite	**Current Risk Rating: L5 x S4 = 20** **Target Risk Rating: L2 x S4 = 8** **Projected Target Date: 30 September 2022** **Assurance Level:** None/**Limited/**Adequate/Substantial

A	M	J	J	A	S	O	N	D	J	F	M
'N'	=	=	=	=	=	=	=	=	↑	=	=

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned BAF risk - BAF 35 - There is a risk of failure to recruit and retain high calibre staff **Emergent Risks/ Issues** • **Future Opportunities** •	**Rationale for current risk score** The current risk score is rated as an extreme (20) risk. The severity of the risk is scored as significant (5), due to the potential for unsafe staffing levels for more than five days. The likelihood of the risk is scored as certain (5), the severity will undoubtedly happen/recur, possibly frequently.	**Latest Commentary** IEN pipeline increased from 30 to 40 a month from April, this is being closely monitored at a bi-monthly review meeting. Additional cohort of return to practice nurses was completed by CCCU; awaiting confirmation of numbers but expect there will be five nurses that will come and work with the Trust on course completion. The review of student placements is currently taking place and will be concluded in June when recommendations will go to the CNMO. The Safe Staffing review for ED is currently ongoing.	**Action required and date** 1a) Review and increase international recruitment pipeline **DoN Dec 22** 1b) Recruit additional cohort of return to practice nurses in conjunction with Christchurch University **DoN Apr 22** 1c) Increase student placements **DoN Sep 22** 2) Site triumvirate reviewing and taking action to mitigate risk where levels of escalation are a cause for concern **DoN Apr 22** 3) Complete Safe Staffing review for ED **DoN Jun 22** 4) The 4R programme is working with Care Groups to support the delivery of services in a pandemic. This involved planning for workforce to support low Covid prevalence and the return of an elective programme but also plans to respond to further waves or recurrence of Covid in the community or hospital environment **COO Sep 21** 5) Recruitment and retention strategy to be developed in line with HR People Plan following the SNCT outcome **DoN Jun 22**
Controls in place (Existing)	**Assurances**		**Gaps in controls and assurance**
1) Action plan in place following NHSE/I gap analysis against NQB 2016 and NHSI 2018 standards 2) Safe Care Live tool in place for internal staffing. Committed resource to oversee e-rostering. Rosters reviewed 6 weeks in advance. 3) Strong relationships with NHSP, temporary staff booked where gaps are identified 4) Weekly NHSP shift fill reports received to monitor usage and flag areas requiring targeted action 5) Enhanced NHSP rates 6) CNO daily staffing escalation meetings with Hospital Directors of Nursing at times of pressure 7) Safer staffing business case to right size establishment for 41 adult inpatient wards approved by BoD 8) Safer Staffing Policy in place to cover day to day monitoring and on-going six-month acuity reviews	**Internal** 1) Nursing Staffing Data is published on Trust website 2) Monthly safe staffing reports to Quality and Safety Committee 3) Bi-annual full Board report. Quarterly update to Board directly. **External** 1) Nurse staffing data submitted to Unify. Data and forums details which supports benchmarking. A number of workforce submissions provided as requested to NHSE/I.		1) Some gaps in compliance with NQB 2016 and NHSEI2018 Governance standards 2) Overreliance on securing agency and bank staff to maintain safe staffing levels 3) Funding is not available for the required staffing levels to deliver 4) Staffing levels have not been consistent in clinical areas due to pandemic 5) Recruitment strategy linked to Trust projected requirements

STRATEGIC GOAL: 3) Our People:
Strategic Objective: To deliver our People Strategy to develop a positive culture and address key risks faced in terms of retention and recruitment to become an "**employer of choice**" by **enabling staff** to maximise their potential.

Executive Owner: Chief Nursing Officer
Responsible Committee: People and Culture Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: September 2021

Principal Risk – CRR 122	Risk Appetite		Initial Risk Rating: L5 x S4 = 20
Proposed new title: There is a risk of inadequate midwifery staffing levels and skills to meet the needs of women and their families **Effect:** Patient outcomes, experience and safety Inadequate midwifery staffing levels may result in women receiving sub-optimal care during labour	The Trust has a **SIGNIFICANT** appetite for risks to making the Trust a great place to work. We will be innovative in taking risks in relation to workforce/staff engagement that will offer potential higher benefits to staff, patients and the organisation. **Risk Appetite Status:** Within appetite		**Current Risk Rating: L5 x S4 = 20** **Target Risk Rating: L1 x S4 = 4** **Projected Target Date: 31 Mar 2023** **Assurance Level:** None/**Limited/**Adequate/Substantial

A	M	J	J	A	S	O	N	D	J	F	M
NA	NA	NA	NA	NA	'N'	=	=	=	↑	=	=

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned BAF risk - BAF 35 - There is a risk of failure to recruit and retain high calibre staff **Emergent Risks/ Issues** • **Future Opportunities** •	**Rationale for current risk score** The current risk score is rated as an extreme (20) risk. The severity of the risk is scored as significant (5), due to the potential for unsafe staffing levels for more than five days. The likelihood of the risk is scored as certain (5), the severity will undoubtedly happen/recur, possibly frequently.	**Latest Commentary** Recruitment is ongoing. Maternity Speak up safety guardian appointed and in post. New flow coordinator posts to be appointed to have operational oversight of the maternity acute units to assist in the compliance with 1:1 care in labour and maintain helicopter safety overview of the clinical areas.	**Action required and date** 1a) Develop business case for appropriate workforce funding. This will include funding for specialist roles, a leadership structure and a retention premium for band 6 roles **Interim Director of Midwifery, Sep 2021** 1b) Establish working group to recruit to the business case once approved. Deployment of further strategies to attract staff e.g. recruitment premium, also working with region re international recruitment **Interim Director of Midwifery, Jan 2022** 2) Daily mitigation of risk **Interim Director of Midwifery, Mar 2022**
Controls in place (Existing)	**Assurances**		**Gaps in controls and assurance**
1) Daily site wide SitRep to assess safe staffing and ensure escalation policy is appropriately followed 2) Line booking of NHSP and agency, framework and off framework with applied incentive 3) Specialist midwives redeployed to fill gaps 4) Suspension of continuity of carer 5) Utilisation of managers on call and community midwives	**Internal** 1) Maternity improvement plan is now monitored through the Maternity and Neonatal Assurance Group (MNAG) and reported to Board of Director. This includes mandatory training and establishment of maternity dashboard to monitor improvement against key performance indicators. 2) People and Culture Committee 3) Internal governance re incidents/complaints/claims **External** 1) LMNS 2) CQC and HSIB regulators 3) Weekly staffing SitRep to regional team		1) Current establishment does not meet the acuity and activity in line with Birthrate Plus 2) Rise in sickness noted due to impact of Covid-19 (Jan 2022)

STRATEGIC GOAL: 3) Our People:
Strategic Objective: To deliver our People Strategy to develop a positive culture and address key risks faced in terms of retention and recruitment to become an "**employer of choice**" by **enabling staff** to maximise their potential.

Executive Owner: Chief Medical Officer
Responsible Committee: People and Culture Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: October 2021

Principal Risk – CRR 123
Proposed new title: There is a risk of inadequate medical staffing levels and skills mix to meet patients needs

Effect: Patient outcomes, experience and safety

Patient outcome, experience and safety may be compromised as a consequence of not having the appropriate medical staffing levels and skill mix to meet patients' needs.

Risk Appetite
The Trust has a **SIGNIFICANT** appetite for risks to making the Trust a great place to work. We will be innovative in taking risks in relation to workforce/staff engagement that will offer potential higher benefits to staff, patients and the organisation.
Risk Appetite Status: Within appetite

Initial Risk Rating: L5 x S3 = 15
Current Risk Rating: L5 x S3 = 15

A	M	J	J	A	S	O	N	D	J	F	M
NA	NA	NA	NA	NA	NA	'N'	=	=	=	=	=

Target Risk Rating: L3 x S3 = 9
Projected Target Date: 31 Mar 2023

Assurance Level: None/**Limited/**Adequate/Substantial

Risks & Opportunities

Aligned BAF risk - BAF 35 - There is a risk of failure to recruit and retain high calibre staff

Emergent Risks/ Issues
•

Future Opportunities
•

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a high (15) risk. The severity of the risk is scored as moderate (3), due to the potential for unsafe staffing levels. The likelihood of the risk is scored as certain (5), the severity will undoubtedly happen/recur, possibly frequently.

Latest Commentary
Programme of work to review the medical workforce strategy and medical recruitment process has commenced with NHSEI support for joint review with HR. Medical workforce deployment group has been developed, additional actions to be identified following initial meeting. Meeting scheduled in March with medical recruitment team to audit implementation of requests to extend locums beyond two years. Meeting with Head of PMO scheduled for March 22 to discuss PMO support for the review of RMO contract. Phasing out plan timescales dependent on PMO support being agreed. Project management support for medical appraisals for doctors begins end Mar 22 with Deputy CMO interviews due to be held end Mar 22 also. Decision to be made with how the Faculty of Medical Leadership and Management can support with ensuring medical appraisers are appropriately skilled and competent. Action plan against gap analysis of GMC clinical governance standards to be presented to BoD April 2022. Specification for appraisal platform has been finalised, due to be sent to suppliers by end Mar 22.

Actions (Planned)

Action required and date
1) Review the medical workforce strategy and medical recruitment process **CMO Mar 22**
2a) Establish a task and finish group to support doctors to appropriate substantive roles including use of the new specialist contract **CMO team Dec 21**
2b) Request to extend beyond two years will be escalated to CMO team **CMO Mar 22**
2c) Policy to be developed **CMO Dec 21**
3a) Review RMO contract to improve quality assurance pending a long-term solution **CMO Apr 22**
3b) Regular audit of all pre-employment checks and local induction to be established **Head of Temporary Staffing Dec 21**
4a) Establish a medical workforce **CMO Dec 21**
4b) Development of a business case for funding to recruit a central medical staffing function **CMO Jul 22**
5) Temporary Staffing team to monitor and regularly audit the process
6a) To review capacity within CMO team to support **CMO – Feb 22**
6b) Develop action plan against gap analysis of GMC clinical governance standards **CMO – Feb 22**
6c) Develop action plan against gap analysis of GMC clinical governance standards **CMO – Feb 22**
6d) Review PReP platform to ensure it is fit for purpose Senior Business Operational Manger to the **CMO – Jul 22**

Controls in place (Existing)

1) Associate Medical Director in post to innovate in medical recruitment
2) Task and finish group established around medical recruitment including consultants
3) Medical recruitment team have process in place to check and challenge requests to extend locums beyond two years
4) Locum policy describing induction for locum doctors

Assurances

Internal
1) Report medical vacancy rate

External
1) Internal audit undertaken for Locum doctors in Women's Health

Gaps in controls and assurance

1) Inability to recruit in key specialties and to key grades specifically diabetes WHH, acute medicine QEQM, ED QEQM, ITU QEQM, HCOOP QEQM
2) Long term locums covering consultant vacancies who do not meet the requirements for substantive appointment
3) No assurance process in place to demonstrate the RMO contract is quality assured including pre-employment checks, fitness for purpose and effective local induction
4) Insufficient resource to manage the medical staffing functions
5) Locum policy inconsistently followed outside of Women's Health
6) Inconsistent delivery of high-quality medical appraisals for doctors

STRATEGIC GOAL: 4) Our Future:
Strategic Objective: To ensure the Trust is aware of the risks related to the statutory compliance and backlog of its estate and implements an agreed programme of revenue and capital investment to address the prioritised risk

Executive Owner: Deputy Chief Executive Officer
Responsible Committee: Finance and Performance Committee

Date last reviewed: January 2022
Next review scheduled: February 2022
Date risk identified: February 2016

Principal Risk – CRR 127
Proposed risk title: There is a risk of failure to adhere to statutory compliance and to rectify the identified backlog maintenance.

Effect: Result in lapses in core clinical standards and patient safety issues, increased estate backlog risks which could result in further emergency service moves/restrictions and impact on the Trust's reputation

Risk Appetite
The Trust has a SIGNIFICANT appetite for risks to transforming the way we provide services across east Kent. We will pursue innovation and challenge current working practices. We will use new technologies as a key enabler of operational delivery and devolve authority across the Trust to enable us to offer excellent integrated services.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S5 = 20
Current Risk Rating: L3 x S5 = 15
Movement of the current risk rating within the financial year

A	M	J	J	A	S	O	N	D	J	F	M
=	=	=	=	=	=	=	=	=	=	=	=

Target Risk Rating: L2 x S5 = 10
Projected Target Date: 31 Mar 2023

Assurance Level: None/Limited/**Adequate**/Substantial

Failure to allocate and/or attract significant revenue and additional capital will inhibit the Trust's ability to adhere to statutory compliance, as well as the ability to rectify the identified backlog maintenance.		

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned BAF Risks BAF 36 - Failure to implement the strategic change required to address the service delivery, workforce and estate condition identified in the Pre-Consultation Business Case (PCBC) **Emergent Risks/ Issues** • £120million backlog maintenance required • Lack of capital **Future Opportunities** •	**Rationale for current risk score** The current risk score is rated as a high (15) risk. The severity of the risk is scored as extreme (5), due to the potential for permanent loss of core services, disruption to facility leading to significant 'knock-on' effect across local health economy and extended service closure. The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.	**Latest Commentary** Statutory compliance is monitored through the Contract Performance Meeting. New date to be set for the ward decant and refurbishment programme following the pause during Covid surge.	**Action required and date** 1) Finalisation of the Site Control Plans, based on the Six Facet Survey and the ARUP Report to include a proposed ward decant and refurbishment programme **DCEO Oct 21** 2) Implement annual investment plan for statutory compliance and monitor in year improvements against the agreed trajectory for 22/23 **DCEO Mar 23**

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) Six Facet Survey undertaken 2) ARUP report 3) Annual prioritisation and investment plan to rectify backlog 4) Statutory compliance investment plan that reaches appropriate compliance by 23/24 approved by the BoD	**Internal** 1) Statutory compliance published, reported and reviewed six-monthly by CEMG and the BoDs 2) Investment programme in statutory compliance is approved by CEMG, FPC and BoDs 3) Backlog maintenance plan is approved and reviewed by SIG, CEMG, FPC and BoD 4) The Six Facet Survey identifying the backlog risk across all Trust sites has been presented to CEMG and the BoDs 5) The Trust's statutory compliance position and approved plan of investment has been approved by CEMG and the BoDs. 6) Approval and monitoring of the Trust's annual prioritisation of revenue and capital investment to address the identified risk is approved by PEIC, SIG, CEMG, SCP&PC, FPC and the BoDs. **External** 1) The Trust's subsidiary, 2gether Support Solutions, has commissioned external assurance/evidence and audit advice relating to statutory compliance and the level of backlog maintenance via the following technical service audits: Six Fact Report; ARUP Report; and Oakleaf Report 2) The CCG and NHSE/I have assured themselves of the assessed level of risk and proposed investment plan as part of the stage two approval process of the PCBC.	1) Outstanding backlog remains and it is likely this will continue without a significant investment into the Trust's estate 2) Full statutory compliance is not in place in all categories

STRATEGIC GOAL: 4) Our Future:
Strategic Objective: To develop a Trust wide strategy to deliver innovation and change through the implementation of new technology

Executive Owner: Deputy Chief Executive Officer **Responsible Committee: Finance and Performance Committee**	**Date last reviewed: January 2022** **Next review scheduled: February 2022** **Date risk identified: October 2017**

Principal Risk – CRR 60 Potential negative impact during transition from paper health records to T3 which may result in a reduction in performance, loss of patient information and reputational damage **Effect:**	**Risk Appetite** The Trust has a SIGNIFICANT appetite for risks to transforming the way we provide services across east Kent. We will pursue innovation and challenge current working practices. We will use new technologies as a key enabler of operational delivery and devolve authority across the Trust to enable us to offer excellent integrated services. **Risk Appetite Status**: Within appetite	**Initial Risk Rating: L4 x S4 = 16** **Current Risk Rating: L3 x S4 = 12** **Movement of the current risk rating within the financial year** A: = M: = J: = J: = A: = S: = O: = N: = D: = J: = F: = M: = **Target Risk Rating: L2 x S4 = 8** **Projected Target Date: 31 Mar 2023** **Assurance Level:** None/Limited/**Adequate**/Substantial

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned BAF Risks BAF 36 - Failure to implement the strategic change required to address the service delivery, workforce and estate condition identified in the Pre-Consultation Business Case (PCBC) **Emergent Risks/ Issues** • **Future Opportunities** •	**Rationale for current risk score** The current risk score is rated as a moderate (12) risk. The severity of the risk is scored as significant (4), due to the potential for patient care to be affected with major consequence. The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.	**Latest Commentary** Models of go live for ePMA in discussion	**Action required and date** 1) T3 Board to agree a Go Live date for ePrescribing **Director of IT Apr 22** 2) Additional phase of consolidation of existing modules such as ClinDocs/ED/OrderComms to make sure system is fit for ePMA and system is utilised **Director of IT Jul 22**

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) Clinical Safety Risk Management Strategy in place in line with NHS Digital Guidance	**Internal** 1) The impact is regularly reviewed at the T3 Programme Board and discussed and reported to Executive Management Team (EMT) and CEMG. 2) The Clinical Safety Risk Management Strategy is signed off at the Clinical Design Authority chaired by the Clinical Chief Information Officer. **External** 1) External Assurance Process in place for T3 including regulator reviews by the auditors	1) Outstanding backlog remains and it is likely this will continue without a significant investment into the Trust's estate 2) Full statutory compliance is not in place in all categories
2) Hazard Log published at each stage of the programme in line with Risk Management Strategy. Signed off at the Clinical Design Authority.		
3) An assessment of performance impact is performed at each stage of programme		
4) All Authority of Proceed decisions are taken by SLT who will be able to decide on whether the level of potential impact on the organisation is acceptable or not		

STRATEGIC GOAL: 5) Our Sustainability:
Objective: To ensure the Trust is aware of the risks related to the equipment replacement programme and implements an agreed programme of revenue and capital investment to address the prioritised risk

Executive Owner: Deputy Chief Executive Officer (DCEO)
Responsible Committee: Finance and Performance Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: February 2016

Principal Risk – CRR 13
Proposed risk title: There is a risk of failure to implement an adequate asset replacement programme

Effect:

Failure to allocate and/or attract significant additional capital and revenue will inhibit the Trust's ability to implement an adequate asset replacement programme for equipment and devices approaching the end of their asset life.

Risk Appetite
The Trust has a HIGH appetite for taking financial risks within a context of clear and reliable financial controls. We are prepared to invest for return and minimise the possibility of financial loss by managing risks to a tolerable level. Value and benefits will be considered, not just the cheapest price. Resources will be allocated in order to capitalise on opportunities and provide better, more effective patient care.

Risk Appetite Status: Within appetite

Initial Risk Rating: L5 x S4 = 20
Current Risk Rating: L3 x S4 = 12
Movement of the current risk rating within the financial year

A	M	J	J	A	S	O	N	D	J	F	M
=	=	=	=	=	=	=	=	=	=	=	=

Target Risk Rating: L2 x S4 = 8
Projected Target Date: 30 July 22

Assurance Level: None/Limited/**Adequate**/Substantial

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned BAF Risks BAF 36 - Failure to implement the strategic change required to address the service delivery, workforce and estate condition identified in the Pre-Consultation Business Case (PCBC)	**Rationale for current risk score** The current risk score is rated as a moderate (12) risk. The severity of the risk is scored as significant (4), due to the potential for patient care to be affected with major consequence. The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.	**Latest Commentary** Risk reviewed, additional actions added and action closed as complete for 21/22 financial year.	**Action required and date** 1) Agree capital investment for next financial year **DCEO May 22** 2) Produce business cases ready to bid for any available capital allocations **DCEO Jul 22**
Emergent Risks/ Issues • Lack of capital			
Future Opportunities •			

Controls in place (Existing)	Assurances	Gaps in controls and assurance
1) Annual prioritisation and investment plan to replace equipment and devices	**Internal** 1) The Trust's investment programme in replacement equipment and devices is approved by CEMG, FPC and BoD 2) Budget for MDG monitored through the Capital Programme weekly chaired by DCEO 3) Approval and monitoring of the Trust's annual prioritisation of revenue and capital investment to address the identified risk is approved by MDG, SIG, CEMG, FPC and the BoD 4) A strategy that prioritised and proposed a method of funding and the replacement of high cost equipment was approved by SIG, CEMG, FPC and BoDs 5) The clinical risk is presented to PSC by the Head of Medical Physics and then Q&SC **External** 1) NHSEI/CCG sign off occurs for individual business cases	1) Access to sufficient capital restricts the Trusts ability to enact a comprehensive equipment and device replacement programme
2) The Trust's Medical Devices Group ensures capital spend on medical devices is risk assessed and prioritised, based on the end of asset life. The prioritised plan is submitted and monitored via the SIG.		
3) The clinical risk is presented to PSC by the Head of Medical Physics and then to Q&SC		
4) Regular supplier monitoring meetings to minimise short term, unplanned changes		
5) Procurement monitor costs of maintaining equipment and assets		

STRATEGIC GOAL: 5) Our Sustainability:
Objective: To implement a strategy that sustains and improves health and safety standards and compliance across the Trust

Executive Owner: Deputy Chief Executive Officer (DCEO)
Responsible Committee: Finance and Performance Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: September 2016

Principal Risk – CRR 34
Failure to sustain and improve health and safety standards across the Trust will result in an increase in incidents affecting staff, patients and visitors and could lead to prosecution and fines. These standards cover the following areas: Ligature points/Slips, trips, falls/Ineffective use of storage/documentation and use of COSHH substances/fire incidents/manual handling/lone working/first aid/DSE assessments/stress management/security management/covid resilience.

Effect: The consequences of major non-compliance in Health and Safety standards may result in enforcement notices being issued by HSE and/or Kent Fire Brigade (for fire safety). This may result in potential prosecution due to non-compliance with the Health and Safety Act 1974

Risk Appetite
The Trust has a HIGH appetite for taking financial risks within a context of clear and reliable financial controls. We are prepared to invest for return and minimise the possibility of financial loss by managing risks to a tolerable level. Value and benefits will be considered, not just the cheapest price. Resources will be allocated in order to capitalise on opportunities and provide better, more effective patient care.

Risk Appetite Status: Within appetite

Initial Risk Rating: L4 x S4 = 16
Current Risk Rating: L2 x S4 = 8
Movement of the current risk rating within the financial year

A	M	J	J	A	S	O	N	D	J	F	M
=	=	=	=	=	=	=	=	=	=	=	=

Target Risk Rating: L1 x S4 = 4
Projected Target Date: 31 March 2023

Assurance Level: None/Limited/**Adequate**/Substantial

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Aligned BAF Risks None **Emergent Risks/ Issues** • **Future Opportunities** •	**Rationale for current risk score** The current risk score is rated as a moderate (8) risk. The severity of the risk is scored as significant (4), due to the potential for enforcement action or improvement notices. The likelihood of the risk is scored as unlikely (2), the severity is not expected to happen or recur with the current controls in place.	**Latest Commentary** New action identified to create bespoke HASTA audits for Care Groups. Proposal to be presented to July 22 Strategic Health and Safety Committee for sign off.	**Action required and date** 1) Planned roll out of link worker training in 2022/23. Dates in place and attendance by Care Group will be monitored. **DCEO Mar 23** 2) Work with H&S Leads for the Trust to create bespoke HASTA audits for Care Groups **DCEO Aug 22** 3) Produce a three-year Health and Safety Strategy **DCEO Oct 22**
Controls in place (Existing)	**Assurances**		**Gaps in controls and assurance**
1) The Trust's Health and Safety Leads (who are part of the Care Group governance structures) meet monthly with the Trust Intelligent Client and 2gether Support Solutions Health and Safety Leads 2) A trust-wide Health and Safety Audit (HASTA) is undertaken annually in all clinical and non-clinical areas to monitor health and safety standards in these specific areas both clinical and non-clinical 3) Health and Safety policies and Safety Statements available to staff on Staff Zone 4) Statutory Health and Safety training is in place and available for Trust staff to book. These include IOSH, Maybo training, First Aid training and Fire Safety training 5) 2gether Support Solutions Health and Safety Team support the Trust in identifying any issues within each area and will provide professional advice and guidance on improving standards and sustaining compliance in all matters of health and safety. 6) Review completed that HASTA outcomes assigned to each Care Group are accurate. The information team hold the master copy of each ward and department assigned to each Care Group	**Internal** 1) Compliance to Health and Safety Standards are monitored via the Strategic Health and Safety Committee chaired by the Trust's DCEO 2) Compliance to Health and Safety standards are also presented to CEMG and BoDs every six months **External** 1) Inspections from the CQC and HSE have specific safety elements 2) Annual inspections and further in year 'spot checks' by Kent Fire and Rescue Service are in place 3) Specific catering inspections by Environmental Health Officers take place		1) Link Worker training has been implemented and is being robustly attended by Link Workers 2) Changes to Trust policies and additional health and safety metrics not measured in the HASTAs. These have been identified and additional policies have been implemented i.e. ligature policy, violence and aggression policy 3) The Trust should have an overarching Safety Strategy that covers the next three-year period to drive the health and safety agenda.

STRATEGIC GOAL: 5) Our Sustainability:
Objective: To minimise delays in the supply chain and deliver on time and to budget the capital programme in 2022/23

Executive Owner: Deputy Chief Executive Officer (DCEO)
Responsible Committee: Finance and Performance Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: October 2021

Risks & Opportunities	Risk and Scoring Commentary		Actions (Planned)
Principal Risk – CRR 124 Proposed risk title: There is a risk of failure to manage supply chain delays **Effect:** Additional regulations have been put in place at the UK borders and as a consequence the supply chain to the Trust is facing delays in delivery of goods and materials. This may impact on the delivery of the capital programme in 2021/22	**Risk Appetite** The Trust has a HIGH appetite for taking financial risks within a context of clear and reliable financial controls. We are prepared to invest for return and minimise the possibility of financial loss by managing risks to a tolerable level. Value and benefits will be considered, not just the cheapest price. Resources will be allocated in order to capitalise on opportunities and provide better, more effective patient care. **Risk Appetite Status**: Within appetite		**Initial Risk Rating: L3 x S4 = 12** **Current Risk Rating: L3 x S4 = 12** **Movement of the current risk rating within the financial year** A: NA; M: NA; J: NA; J: NA; A: NA; S: NA; O: 'N'; N: =; D: =; J: =; F: =; M: = **Target Risk Rating: L2 x S4 = 8** **Projected Target Date: 31 March 2023** **Assurance Level:** None/**Limited/**Adequate/Substantial
Risks & Opportunities	**Risk and Scoring Commentary**		**Actions (Planned)**
Aligned BAF Risks None **Emergent Risks/ Issues** • Additional regulations put in place at the UK borders **Future Opportunities** •	**Rationale for current risk score** The current risk score is rated as a moderate (12) risk. The severity of the risk is scored as significant (4), due to the potential for the Trust to face some major difficulties which are likely to undermine to its ability to deliver quality services. The likelihood of the risk is scored as possible (3), the severity might happen or recur occasionally with the current controls in place.	**Latest Commentary** Procurement continue to source alternative products where required. It is expected that this will continue for the next financial year.	**Action required and date** 1) Where delays are significant alternative products will be sought through the Procurement department **DCEO Mar 23**
Controls in place (Existing)	**Assurances**		**Gaps in controls and assurance**
1) Procurement processes are monitoring the supply chain 2) Procurement have changed Just In Time to Just When Needed reducing the stock holding levels 3) 2gether Support Solutions hold a contingency supply of patient food for three days	**Internal** 1) Contract Performance Meeting 2) Capital forecast weekly reports. Reviewed at weekly meetings chaired by DCEO **External** 1) NHS Supply Chain		1) Delays in the supply chain for existing capital infrastructure and expenditure begin to appear. Alternative products may be more expensive. Potential cancellation of surgery if products are unavailable.

STRATEGIC GOAL: 5) Our Sustainability:
Objective: To establish an Accommodation Strategy that ensure the Trust has access to adequate residential, office and training and education facilities

Executive Owner: Director of Finance (DoF)
Responsible Committee: Finance and Performance Committee

Date last reviewed: March 2022
Next review scheduled: April 2022
Date risk identified: June 2021

Principal Risk – CRR 126
Proposed risk title: There is a risk of failure to provide adequate accommodation (residential, training and office)

Effect: Unable to recruit and retain staff

There is a risk that we are unable to recruit and retain staff due to the current capacity and / or standard of residential, office accommodation and training and education facilities.

Risk Appetite
The Trust has a HIGH appetite for taking financial risks within a context of clear and reliable financial controls. We are prepared to invest for return and minimise the possibility of financial loss by managing risks to a tolerable level. Value and benefits will be considered, not just the cheapest price. Resources will be allocated in order to capitalise on opportunities and provide better, more effective patient care.

Risk Appetite Status: Within appetite

Initial Risk Rating: L3 x S4 = 12
Current Risk Rating: L2 x S4 = 8
Movement of the current risk rating within the financial year

A	M	J	J	A	S	O	N	D	J	F	M
NA	NA	'N'	=	=	=	=	=	=	=	=	=

Target Risk Rating: L1 x S4 = 4
Projected Target Date: 31 March 2022

Assurance Level: None/Limited/**Adequate**/Substantial

Risks & Opportunities

Aligned BAF Risks
None

Emergent Risks/ Issues
•

Future Opportunities
•

Risk and Scoring Commentary

Rationale for current risk score
The current risk score is rated as a moderate (8) risk. The severity of the risk is scored as significant (4), due to the potential for the Trust to face some major difficulties which are likely to undermine to its ability to deliver quality services. The likelihood of the risk is scored as unlikely (2), the severity is not expected to happen or recur with the current controls in place.

Latest Commentary
Agile working policy approved at Staff Committee in March 22.

Actions (Planned)

Action required and date
1a) Additional investment in 2gether team to deliver Accommodation Management Plan **Intelligent Client Mar 22**
1b) Update Accommodation Policy and tenancy agreements **Intelligent Client Mar 22**
1c) Deliver additional external capacity in Canterbury and Thanet **Intelligent Client Mar 22**
2) Central management of all education and training spaces to be developed **Director of HR Mar 22**
3a) Agile working policy to be developed **Director of HR Mar 22**
3b) Space utilisation review **Intelligent Client Mar 22**

Controls in place (Existing)

1) Accommodation Strategy Steering Group established chaired by Director of Finance
2) Residential modelling completed
3) Office and training and education capacity modelling completed
4) Accommodation Management Plan (Dec 21 to Jul 23) approved

Assurances

Internal
1) Accommodation Steering Group has an agreed timeline to produce recommendations for SLT
2) Accommodation Strategy Steering Group reports progress on a monthly basis to the Joint Development Board which is chaired by the Deputy CEO
3) Trust Priority Improvement Programme Reports are provided to SLT on a monthly basis as part of We Care

External
1)

Gaps in controls and assurance

1) Requirements for residential accommodation are unknown
2) Requirements for training and education facilities are unknown
3) Requirements for office accommodation is unknown

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East Kent
Hospitals University
NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**				
REPORT TITLE:	**INFECTION PREVENTION AND CONTROL (IPC) BOARD ASSURANCE FRAMEWORK (BAF)**				
MEETING DATE:	**7 APRIL 2022**				
BOARD SPONSOR:	**CHIEF EXECUTIVE**				
PAPER AUTHOR:	**DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC)**				
APPENDICES:	**APPENDIX 1: IPC BAF** **APPENDIX 2: DRAFT IPC ANNUAL WORK PLAN 2022-2023 HIGH LEVEL SUMMARY**				
Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	Information	**Assurance**	Discussion
Purpose of the Report:	The IPC BAF is required to be updated and reviewed by the Trust Board on a monthly basis during the Covid-19 pandemic.				
Summary of Key Issues:	At the time of writing (29 March 2022) it is clear that the BA.2 sub-variant of Omicron is now dominant across the UK. With the complete lifting of societal restrictions and waning immunity, this has led to some of the highest levels of Covid-19 yet seen in the community. Although community testing is now limited, Office for National Statistics (ONS) data confirms this. This is reflected in the number of patients in our hospitals who have tested positive for Covid-19 (as well as large numbers attending Emergency Departments (EDs) and other ambulatory areas). We currently have 187 inpatients, which is more than the peak in May of 2020, though fewer than half of the peak in January 2021. In the majority this is an incidental finding and mortality, morbidity and need for critical care remain low but the operational pressure created is considerable. There is limited scope for moving to a more 'business as usual' approach to managing Covid-19 until this peak passes. Thus, any proposals to remove some of the burden of additional personal protective equipment in some patient areas have been put on hold pending national guidance and/or a reduction in prevalence. The IPC draft high-level summary 2022-2023 Work Plan is appended as Appendix 2. Changes to the BAF this month: Section 1 • Risk based decisions made regarding patient placement that balances IPC risks and other risks e.g. corridor care in ED (by IPC and operational and clinical managers). • Review of patient moves in progress, reviewing the need to maintain optimal IPC and optimal speciality-based care and treatment and minimise unnecessary moves.				

East Kent Hospitals University NHS Foundation Trust

	• Kent & Medway (K&M) agreed position on closing Covid-19 outbreaks after 10 days of no new cases (no evidence of onward transmission agreed by Gold and implemented. Section 4 • An update on national visiting guidance is awaited. Current visiting risk assessments have been reviewed and re-published for clarity. Section 10 • Change in national guidance that removes distinction between vaccinated and unvaccinated staff when deemed a contact – implemented, updated K&M risk assessment now implemented.
Key Recommendation(s):	The BoD is asked to discuss and **NOTE** the contents of the IPC BAF report and **NOTE** the IPC draft high-level summary Work Plan for 2022-2023.

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	**Our people**	Our future	Our sustainability	**Our quality and safety**

Link to the Board Assurance Framework (BAF):	BAF 31 – Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements and Covid-19, leading to harm.	
Link to the Corporate Risk Register (CRR):	N/A	
Resource:	Y/N	N
Legal and regulatory:	Y/N	N
Subsidiary:	Y/N	N
Assurance Route:		
Previously Considered by:	N/A	

Infection Prevention and Control (IPC) board assurance framework (BAF)

The IPC BAF is required to be updated and reviewed by the Trust Board on a monthly basis during the Covid-19 pandemic.

This version of the BAF is a completely revised update, based on the version published by NHS England/NHS Improvement (NHSE/I) on 26 December 2021. The previous iteration presented to the Trust Board in November 2021 has been archived and will be available as a record of the iterations to that date.

Note: guidance changes related to the NHS approach to 'living with Covid-19 are expected but may be delayed by the current UK wide surge of Omicron BA.2.

Changes to the BAF this month in red in the body of the BAF

Section 1

- Risk based decisions made regarding patient placement that balances IPC risks and other risks e.g. corridor care in Emergency Department (ED) (by IPC and operational and clinical managers).
- Review of patient moves in progress, reviewing the need to maintain optimal IPC and optimal speciality-based care and treatment and minimise unnecessary moves.
- Kent & Medway (K&M) agreed position on closing Covid-19 outbreaks after 10 days of no new cases (no evidence of onward transmission agreed by Gold and implemented.

Section 4

- An update on national visiting guidance is awaited. Current visiting risk assessments have been reviewed and re-published for clarity.

Section 10

- Change in national guidance that removes distinction between vaccinated and unvaccinated staff when deemed a contact – implemented, updated K&M risk assessment now implemented.

Infection prevention and control board assurance framework

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • a respiratory season/winter plan is in place: ○ that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services ○ to enable appropriate segregation of cases depending on the pathogen. ○ plan for and manage increasing case numbers where they occur. ○ a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	The Trust Covid-19 response escalation plans include the need to test for other respiratory viruses, including POCT for influenza and Respiratory Syncytial Virus (RSV). Cases of confirmed Covid-19 are managed in Covid-19 areas (Blue) and confirmed cases of other seasonal respiratory viruses are managed in single rooms according to specialty/clinical need. Risk based decisions made regarding patient placement that balances IPC risks and other risks e.g. corridor care in ED (by IPC and operational and clinical managers		
• health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone. • Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: ○ based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. ○ applied in order and include elimination; substitution, engineering, administration and Personal Protective Equipment (PPE)/Respiratory Protective Equipment (RPE). ○ communicated to staff. • safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been	The Trust has maintained all workplace requirements as instituted previously, including, but not limited to, social distancing, appropriate PPE, hand hygiene, enhanced cleaning and alterations to work patterns (including work from home requirements and staggered breaks). Existing risk assessments for individual staff are all in the process of being updated. Risk assessments for staff as contacts of Covid-19 cases are		

approved through local governance procedures, for example Integrated Care Systems.	agreed on a Kent and Medway-wide basis. Other risk assessments have been approved within the organisation.		

• if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	The Trust has maintained compliance with current iteration of the national guidance and has not derogated any matters.		
• risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents. • if an unacceptable risk of transmission remains following the risk assessment, the extended use of RPE for patient care in specific situations should be considered. • ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	Environmental risk assessments done in response to previous surges of Covid-19 are being reviewed in light of changing epidemiology of the Omicron variant. RPE has been made available to all staff in any area, not limited to 'Blue' areas and if specified in individual risk assessments. Review of patient moves in progress, reviewing the need to maintain optimal IPC and optimal speciality-based care and treatment and minimise unnecessary moves IPC are monitoring and reviewing patient movements and any impact on transmission.	Not all areas have had an environmental risk assessment based on previous Covid-19 epidemiology	Data on previous risk assessment completeness being reviewed to inform further work
• the Trust Chief Executive Officer (CEO), the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratoryinfections, and hospital onset cases	CEO or Executive sign off for data submissions, DIPC signs off IIMARCH forms for outbreaks, Daily Sitrep analysis shared with senior staff		
• there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	Gemba and other senior leader engagement activities continue. Execs and senior leaders frequently in clinical and non-clinical areas.		
• resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency	All necessary resources are in place		

and external contractors).
• the application of IPC practices within this guidance is monitored, e.g.:
  • hand hygiene.
  • PPE donning and doffing training.
  • cleaning and decontamination.
	IPC audits are conducted in all clinical areas and the results are monitored by the IPC Committee and the IPC Team. Additional audits are conducted by the IPC Team when indicated (e.g. outbreak situations)		

• the IPC BAF is reviewed, and evidence ofassessments are made available and discussed at Trust Board.	IPC BAF is reviewed at every Board meeting		
• the Trust Board has oversight of ongoing outbreaks and action plans.	The DIPC reports to the Quality and Safety Committee and The Trust Board and provides updates on outbreaks and, where relevant, trust-wide actions. Kent & Medway agreed position on closing Covid-19 outbreaks after 10 days of no new cases (no evidence of onward transmission agreed by Gold and implemented		
• the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	The trust has access to a range of FFP3 with sufficient stocks, monitored at Gold.		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of i infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and processes are in place to ensure that:
• the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.
• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms
• cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.
• increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.
• Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.
• if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.
• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.
• a minimum of twice daily cleaning of:
  ○ patient isolation rooms.
  ○ cohort areas.
  ○ Donning & doffing areas
  ○ 'Frequently touched' surfaces e.g., door/toilet handles, patient call bells, over bed tables and bed rails.
  ○ where there may be higher environmental contamination rates, including:
  • toilets/commodes particularly if patients have diarrhoea.
	The Trust Board has approved the business case for implementation of 2021 National Standards of Healthcare Cleanliness and 2gether Support solutions have developed an implementation plan to achieve full compliance by the October 2022 deadline for Trusts. This will include mechanisms to identify and communicated changes in functionality of rooms/areas
	Cleaning issues are escalated through existing processes and to the IPC Team if required. Cleaning escalations are discussed at the IPC Committee
	
	Cleaning schedules and methods for isolation areas are as per policy. EKHUFT uses Tristel Fuse™ which is a Chlorine Dioxide based environmental disinfectant approved by the IPCT.
	
	Products are used as per protocol (incorporating manufacturers' instructions).
	
	In addition enhanced technologies (UV and Hydrogen Peroxide Vapour) are deployed as per IPC protocol.
	
	Cleaning frequencies, protocols and procedures meet these requirements		

• A terminal/deep clean of inpatient rooms is carried out: ○ following resolutions of symptoms and removal of precautions. ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); ○ following an Aerosol Generating Procedures (AGP) **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room). • reusable non-invasive care equipment is decontaminated: ○ between each use**.** ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment. • Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment. • As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. • In patient Care Health Building Note 04-01: Adult in-patient facilities. • the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer. • a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways • where possible air is diluted by natural ventilation by opening windows and doors where appropriate • where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	Terminal cleans (including enhanced technologies deployed where appropriate) are done, as described across, according to Trust IPC policy as described in the 'What Clean do You Need' posters. This is business as usual and included in the decontamination policy Cleaning is monitored by 2gether and as part of IPC audits and reported to the IPC Committee Much of the EKHUFT clinical estate is older property without mechanical ventilation (other than specialist systems as described in HTM 03-01, specialist ventilation for healthcare building). As described above, previous assessments of ventilation have focussed on areas for known or suspected Covid-19 cases (Blue). The Omicron variant has significantly different epidemiology with cases in any clinical setting. Alternative technologies under consideration but experience from other organisations is that there is no	Described above	Described above

• when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	advantage to their deployment. IPC and estates/facilities discuss all physical changes to estate, incorporating impact on air flow where relevant.		

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and process are in place to ensure that: • arrangements for antimicrobial stewardship are maintained • previous antimicrobial history is considered • the use of antimicrobials is managed and monitored: ○ to reduce inappropriate prescribing. ○ to ensure patients with infections are treated promptly with correct antibiotic. • mandatory reporting requirements are adhered to, and boards continue to maintain oversight. • risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	The Antimicrobial Stewardship Group (ASG) meets monthly and monitors and implements the ASG work plan.	The Antimicrobial Stewardship resource is small and fragile (person dependent) Further work is needed to increase the scope and cover of the ASG programme	A Consultant Pharmacist (AMS) is being recruited A proposal for further work under the auspices of the We Care programme will form part of the work plan for 2022/2023

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • national guidance on visiting patients in a care setting is implemented. • restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment. • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing. • if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an Fluid Repellent Surgical Mask (FRSM).	Trust visiting policy reflects this guidance as described across (all bullet points in this section) - agreed by Gold command An update on national visiting guidance has been published and the trust visiting guidance updated accordingly Front of house 'meet and greet' processes are being reviewed by the Chief Operating Officer (COO) team and site leadership teams to establish a sustainable approach.		

• visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible. • visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian. • Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Relevant aspects of the toolkit implemented as part of the communications approach and approved by Gold Command	Not all elements in the toolkit in use	Further review of toolkit by IPC to establish if any elements will add further value

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival. • infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred. • staff are aware of agreed template for screening questions to ask. • screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment. • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance. • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible. • there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	Signage in place at entry points to hospital sites, using national toolkit graphics and information Included in transfer protocols, including those patients deemed medically fit for discharge Standard screening questions in place for admission/triage/transfer across all protocols – on Trust intranet Covid-19 pages and IPC policies (for other respiratory viruses) In place as per existing protocols (as above) as per national guidance. See above Routine testing protocol compliance constantly monitored via the Patient Tracking List (PTL).		

• patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated. • patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result. • patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing. • patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.	All patients are currently supplied with and encouraged to wear a surgical face mask as described (not limited to these criteria) As per existing IPC policies and Covid-19 specific protocols already in place This is business as usual and supported by existing IPC policies and management Patients who were previously classified as Clinically Extremely		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that:			
• appropriate infection prevention education is provided for staff, patients, and visitors.	Education for staff is described in mandatory training requirements. Patients and visitors have patient information and communications materials as required.		
• training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	FFP3 training as part of fit testing protocols. IPC measures as part of mandatory training, ad-hoc supplemented by IPC (e.g. outbreaks, on request)		
• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	As above		
• adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	Included in regular IPC audits, monitored by the IPC Committee		
• gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with Standard Infection Control Precautions (SICP's) and Transmission Based Precautions (TBP's).	This is business as usual supported by existing policies, protocols and training.		
• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.	Hot air dryers not in use in clinical areas. Paper towels as per guidance.		
• staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	No derogation from 2 metre distancing where possible (as described above)		
• staff understand the requirements for uniform laundering where this is not provided for onsite.	Scrubs are worn on all Covid wards and several other wards and clinical areas by clinical and facilities staff. Scrubs are laundered by the Trust and staff are advised not to take		

• all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance. • to monitor compliance and reporting for asymptomatic staff testing • there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals). • positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	them off-site Staff launder their own uniforms. Guidance has been published through the Covid intranet page. All staff advised to travel to and from work in their own clothes and change on site Staff changing and shower facilities provided on all acute sites Full information and support available on Covid intranet pages, Kent and Medway wide risk assessment in place and supported by Occupational Health and approved by Gold Epidemiology and modelling reported to Gold on at least a weekly basis for information and action as advised by DIPC Managed as per national protocols and reported to the national system and local partners (Clinical Commissioning Group (CCG)/Integrated Care System (ICS) and Health Protection Team)		

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and processes are in place to ensure:			
• that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	Clear advice in place and regularly reinforced by leaders at site huddles and by IPC team		
• separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	Remains in place as previously established for Covid-19 surges, includes other seasonal respiratory viruses		
• patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	Covid-19 patients have specific 'Blue' pathways, well established. Other respiratory viruses managed using existing IPC policies all available on intranet		
• patients are appropriately placed ie, infectious patients in isolation or cohorts.	As per protocols, business as usual and Covid-19 specific		
• ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	Dealt with as part of business as usual and with IPC input on request or in light of issues/incidents		
• standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	Business as usual supported by existing IPC policies and protocols		
• the principles of SICPs and TBPs continued to be applied when caring for the deceased	Business as usual supported by specific IPC policy		
8. Secure adequate access to laboratory support as appropriate			

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals. • patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance; • staff testing protocols are in place	Testing undertaken by registered biomedical scientists with documented competencies Methods validated prior to diagnostic testing National testing protocols remain in place as previously described including for non-Covid seasonal viruses in symptomatic patients Staff testing protocols in place supervised and supported by Occupational Health		

• there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data). • screening for other potential infections takes place. • that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission. • that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise. • that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission. • that sites with high nosocomial rates should consider testing COVID-19 negative patients daily. • that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. • those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance • there is a assessment of the need for a negative PCR and 3 days self	Testing turnaround times reported to Gold weekly Constantly monitored via the PTL system As per protocol and part of business as usual All ED patients and other emergency patients are POCT or LFT (SDEC) tested Part of clinical protocols Monitored by the PTL system with testing prompts on electronic whiteboards and PTL Enhanced testing used when advised by IPC Team As per national protocol – in place As per national protocol – in place		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that • the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must	IPC audits in all care groups, reported to IPC Committee monthly		
include all care areas and all staff (permanent, agency and external contractors). • staff are supported in adhering to all IPC policies, including those for other alert organisms. • safe spaces for staff break areas/changing facilities are provided.	IPC team and microbiology/virology support staff in managing all alert organisms. Policies/Standard Operating Procedures (SOPs) in place for all organisms specified in the "hygiene code"		
• robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	Outbreak policy updated in 2021 and followed – Covid-19 outbreaks recorded on national database using IIMARCH format		
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance.	Treated as infected linen as per protocol		
• PPE stock is appropriately stored and accessible to staff who require it.	Managed locally and supported by IPC		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy. • bank, agency, and locum staff follow the same deployment advice as permanent staff. • staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance) • staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE. • a fit testing programme is in place for those who may need to wear respiratory protection. • where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: ○ lead on the implementation of systems to monitor for illness and absence.	Occupational Health service available to all staff and staff reminded and encouraged to seek support Agreed Kent and Medway wide approach implemented and on Covid intranet pages Change in national guidance that removes distinction between vaccinated and unvaccinated staff when deemed a contact – implemented, updated K&M risk assessment now implemented Covered in previous section Fit testing programme in place and widely advertised and information on intranet Occupational Health team review all staff cases of Covid-19 and advise if deemed work related and support staff as required		

○ facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce ○ lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 ○ encourage staff vaccine uptake. • staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control	See above and supported by microbiology/virology Staff illness and absence (Covid related and total) as well as vaccine uptake monitored and reported to Gold at least weekly Included in business as usual and Covid-19 specific requirements		

precautions, including PPE, as outlined in national guidance. • a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. • A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; • that advice is available to all health and social care staff, including specific advice to those at risk from complications. • Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff . • A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff. • vaccination and testing policies are in place as advised by occupational health/public health.	Individual risk assessments for all staff, taking into account all of the criteria described are in place and being updated with booster vaccination status As part of the above Risk Assessment (RA) process As above with Occupational Health (OH) support where needed OH policies and processes in place Covered in above (repeated point)		
• staff required to wear FFP3 reusable respirators undergo training that is compliant with Health and Safety Executive (HSE) guidance and a record of this training is maintained andheld centrally/Electronic Staff Record (ESR) records. • staff who carry out fit test training are trained and competent to do so. • all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used. • all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation. • those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	Policies in place and approved by Gold or existing policy Training contracted to an accredited training organisation and conducted to HSE standards As above (accredited trainers) As per policy and above Not fully implemented as staff previously tested only tested on 1 type of mask and supply of those masks is stable Records exist and alternative respirators and hoods area available	Records are held locally not centrally (although reported by contractor back to the trust) Not all staff tested on more than one mask Records are held locally not centrally (as above)	Revising arrangements for managing fit testing contract/service to include recording Included in review described above Included in review described above
• that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	For failed fit testing, alternative is use of PAPR hoods Managed locally and supported by		

East Kent Hospitals University NHS Foundation Trust

Infection Prevention and Control (IPC) Work Plan 2022-2023 DRAFT

High Level Summary

IPC Leadership Team

Version 1 DRAFT, March 2022

We care

Principles

- 'Inch wide – mile deep'
  - Business as usual activities to continue
  - Drivers – improvement activities using A3 approach (see notes)
  - Progress reported to Quality and Safety Committee on a quarterly basis and monitored by Infection Prevention and Control Committee (IPCC) monthly

Priorities – The 'Big Stones'

NHS
East Kent Hospitals University
NHS Foundation Trust

Governance and assurance

Team and service development

Infection reduction priorities

Antimicrobial Stewardship

Education and Link Practitioners

'Must do'

Surveillance, Audit and Epidemiology

Governance and Assurance

Lead(s)	Neil Wigglesworth (DIPC) & Lisa White (Deputy DIPC)
Scope	Terms of reference, reporting, structure for: • Infection Prevention and Control Committee • Decontamination Committee • Water Safety Group • Ventilation Safety Group (new requirement, not yet established) • IPC Business Continuity Plans and succession planning
Process	Review of each committee and group and overall IPC governance and assurance processes
Output & Outcomes	• Fully revised Terms of Reference (TOR) and processes, clear lines of reporting, escalation and accountability, clinical and other stakeholder engagement • Clear evidence of a 'Well Led' IPC infrastructure

Infection Reduction Priorities

Lead(s)	IPC Leadership Team
Watch Metrics (Business as Usual (BAU))	• *Clostridioides difficile* • MRSA • *E coli* • Seasonal infections (e.g. Covid-19, Influenza, Norovirus)
Driver Metrics	• *Klebsiella species* • *Pseudomonas aeruginosa* • *Meticillin-Sensitive Staphylococcus Aureus (MSSA)*
Processes	For each Driver Metric an A3 to be developed by end of April 2022 Each A3 to detail root causes and counter measures and to include delivery timetable and agreed improvement objectives

Team and Service Development

Leads	Neil Wigglesworth & Lisa White
Team development	• 'Brilliant Teams' event – May 2022 • Agreement and development of IPC Site Leads' trust wide portfolios • Deputy DIPC to take on decontamination/built environment lead role • All team members to do Kent Fundamentals training as minimum to contribute to A3s and improvement activities • At least one peer-reviewed poster/publication
Service development	• Ensuring IPC coverage across working day/working week • Increase to permanent seven day IPC service • Development of epidemiological/analysis support (subject to funding) • Contribution to Kent & Medway (K&M) System IPC Leadership

IPC Education and Link Practice

Lead(s)	IPC Site Lead (portfolio responsibility) TBC
Scope	• IPC education provision for all staff groups • Link Practitioner programme

Process	• Review of all IPC education trust wide
	• Review of role and responsibilities of IPC Link Practitioners including:
	  • Preparation/education/network
	  • Expectations of link practitioner
	  • Expectation of ward/department/line manager (e.g. protected time for role)

Output & Outcomes	• Revised IPC education provision (mandatory/non-mandatory) • Refreshed IPC Link Practitioner programme

Surveillance, Audit and Epidemiology

East Kent Hospitals University NHS Foundation Trust

Lead(s)	IPC Site Lead (portfolio responsibility) TBC & Neil Wigglesworth
Scope	• IPC Audit programme • A scoping exercise will be the initial activity for the surveillance of Healthcare Associated Infection (HCAI) (this is a longer term piece of work and this will only be the first stage, possibly Surgical Site Infection Surveillance, TBC) • Increased epidemiology/analytical capacity (scope subject to funding) • Exploration of possibilities of automated/semi-automated surveillance (AI/machine learning/big data)
Process	• Review of IPC Audit programme • Scoping exercise for surveillance • Initial exploration of automated surveillance etc. (as above)
Output & Outcomes	• Revised IPC Audit programme • Pilot of HCAI surveillance • Possible proposal for a Trust Priority Improvement Project to establish surveillance, which will have to be assessed against the We Care Strategic Filter

‘Must Do’

Lead(s)	Neil Wigglesworth
Scope	• Code of practice on the prevention and control of infections 2015 (Health and Social Care Act 2008) • Currently under review, revised code expected 2022
Process	• Complete outstanding compliance requirements under existing code • Gap analysis and action plan against revised code once published • Strengthening of evidence of compliance across all domains
Output & Outcomes	• Robust evidence of full compliance (and beyond) in support of EKHUFT working towards being ‘good’ and ‘outstanding’

Antimicrobial Stewardship

Lead(s)	Dr Steve Glass, Amy Dalton/Doreen Flower, Neil Wigglesworth (+ Consultant Antimicrobial Pharmacist when appointed)
Scope	• Improvement activity beyond the BAU of the antimicrobial stewardship team and committee – scope to be agreed
Process	• An A3 will be developed that identifies and sets out an approach to the biggest currently unaddressed contributor(s) to improving antimicrobial stewardship at EKHUFT
Output & Outcomes	• The A3 process is likely to result in a proposal for a Trust Priority Improvement Project (TPIP) which will need to be assessed against the We Care Strategic Filter process

Notes

1. Business as usual IPC activity will continue and be reported as currently to IPCC and Quality and Safety Committee (as well as the expected revised post-Covid-19 Board Assurance Framework to the Board, periodically to be agreed).
2. Each element that is being 'driven' will be developed using A3 methodology, unless a simple 'must do' or existing approach (e.g. review of TOR)
3. Each element will have a detailed action plan with timelines and outcomes, gateways and responsibilities assigned
4. Progress will be reported via the IPCC monthly and to Quality and Safety Committee, with a RAG rating, on a (suggested) quarterly basis
5. Some elements will be dependent on resource availability
6. The antimicrobial stewardship activity will reflect the contribution of the Consultant Antimicrobial Pharmacist when one is appointed (recruitment in progress at time of writing).

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) MATERNITY INCENTIVE SCHEME YEAR 4 – QUARTERLY REPORT** **SAFETY ACTION 3: TRANSITIONAL CARE (TC) SERVICES TO MINIMISE SEPARATION OF MOTHERS AND THEIR BABIES AND TO SUPPORT THE RECOMMENDATIONS MADE IN THE AVOIDING TERM ADMISSIONS INTO NEONATAL UNITS (ATAIN) PROGRAMME**
MEETING DATE:	**7 APRIL 2022**
BOARD SPONSOR:	**CHIEF NURSING & MIDWIFERY OFFICER (CNMO): MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**
PAPER AUTHOR:	**INTERIM DIRECTOR OF MIDWIFERY**
APPENDICES:	**APPENDIX 1: TC AND ATAIN ACTION PLAN**

Executive Summary:					
Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion
Purpose of the Report:	• The purpose of this report is to update the Maternity and Neonatal Assurance Group (MNAG) and BoD on East Kent Hospitals Maternity's progress in implementing Safety Action 3 and provide a quarterly update on the audits required against the standards. • Raise awareness of risks in achieving Safety Action 3 and assure the Board there is an action plan in place to mitigate (see Appendix 1: ATAIN and Transitional Care Action Plan). • Highlight recommendations for future service development that would support the principles of Avoiding Term Admissions to Neonatal Unit and keep mothers and babies together in a fully functioning Transitional Care Environment.				
Summary of Key Issues:	a) Weekly ATAIN review meetings and Monthly Transitional Care audits continue and have now been included in the formal Trust Audit programme to support visibility of themes and learning through reviews. b) A request has been made to include a joint signatory from the maternity/neonatal clinical leads for ATAIN and Transitional Care in compliance of this standard. c) Estates action plan includes future development of a dedicated Transitional Care area that is staffed by Maternity and Neonatal staff and able to provide a fully functional service to maximise opportunities to keep Mums and Babies together.				

East Kent Hospitals University NHS Foundation Trust

	d) To support a fully functioning Transitional Care area, training and competency of staff would be required in areas including: ➢ Recognition of the unwell infant; ➢ Intravenous (IV) Line care; ➢ Competencies to use Nasogastric (NG) tubes; ➢ Enhanced Monitoring and Support (Including Neonatal Abstinence Syndrome (NAS)); ➢ Facilities for Saturation Monitoring. e) Require formal agreement that the Transitional Care and ATAIN reviews and action plan findings will also be shared with the Local Maternity and Neonatal System (LMNS) and Integrated Care System (ICS) quality surveillance meeting.
Key Recommendation(s):	The BoD is invited to: 1. **NOTE** and **DISCUSS** the report; 2. Receive **ASSURANCE** that there is an effective process established of ongoing assessment and that the evidence provided is sufficiently robust; 3. To **NOTE** the receipt and content of this CNST Safety Action 3 Quarterly update report; 4. To **NOTE** the review of the Transitional Care and ATAIN action plan; and 5. **SUPPORT** the broader considerations and the development of further improvements as defined within the appended action plan.

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	**Our people**	**Our future**	Our sustainability	**Our quality and safety**

Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff.	
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.	
Resource:	Y	Staffing and training resource required to develop Transitional Care into a fully functioning service.
Legal and regulatory:	Y	CNST, British Association of Perinatal Medicine (BAPM) standards.
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	N/A	

CNST Maternity Incentive Scheme Year 4

Safety action 3: Transitional care services to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme

Quarterly Report

1. Purpose of the report

1.1 The purpose of this report is to update the Board of Directors on East Kent Hospitals Maternity's progress in implementing Safety Action 3 and provide a quarterly update on the audits required against the standards.

1.2 Raise awareness of risks in achieving Safety Action 3 and provide assurance there is an action plan in place to mitigate (see Appendix 1: ATAIN and Transitional Care Action Plan).

1.3 Highlight recommendations for future service development that would support the principles of Avoiding Term Admissions to Neonatal Unit and keep mothers and babies together in a fully functioning Transitional Care Environment.

2 Background

2.1 It is recognised that Nationally, over 20% of admissions of full-term babies to neonatal units could be avoided. By providing services and staffing models that keep mother and baby together, the harm caused by separation can be reduced.

2.2 The Avoiding Term Admissions (ATAIN) campaign encourages maternity and neonatal services to work together to identify babies whose admission to a neonatal unit could be avoided and to promote understanding of the importance of keeping mother and baby together when safe to do so.

2.3 There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child.

2.4 This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

2.5 ATAIN focuses on four areas of significant potential harm to babies. It is believed that these areas are where there can be the greatest impact:

- respiratory conditions;
- hypoglycaemia;
- jaundice;
- asphyxia (perinatal hypoxia-ischaemia).

2.6 Weekly cross site, Multiprofessional ATAIN meeting take place at East Kent where all applicable baby admissions are reviewed to identify any learning around missed risks or care management that could potentially have avoided admission to the Neonatal Unit and opportunities to inform future care delivery through shared learning of cases.

2.7 Learning theme posters are developed and shared with the wider Team around impact of care management on Neonatal Admissions of babies i.e. delayed feeding

support impacting on hypoglycaemia and not giving antibiotics, where indicated, to a mother in labour resulting in baby needing IV antibiotics.

2.8 Transitional Care was developed in partnership with BAPM to enable the safe management of babies with medical conditions, whilst allowing baby to remain with mother.

2.9 Babies suitable for management on a fully equipped TC unit;

- At Least 34weeks gestation and at least 1600g birth weight who do not fur fill criteria for High Dependency Care (HDC)/Neonatal Intensive Care Unit (NICU) admission;
- Well babies with Suspected Sepsis requiring IV Antibiotics;
- Congenital Anomalies requiring NG assisted feeding;
- Jaundiced babies requiring phototherapy (Single or Enhanced);
- Babies requiring feeding support with NG assisted feeding;
- Babies under observation or treatment for Neonatal Abstinence Syndrome;
- Babies who require assistance with thermoregulation.

2.10 Transitional Care services were launched on each acute site at East Kent in 2018.

2.11 The service is provided on the postnatal wards, led by Midwifery staff but with care involvement by the Neonatal team.

2.12 The following sections provide East Kent's current position against each of the CNST Safety Action 3 Standards a to g**.**

3 Standard a)

Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

3.1 The Neonatal Transitional Care (NTC) Guideline was developed in 2018, updated in September 2021 and is based on the principles of BAPM transitional care.

3.2 The policy was developed jointly by maternity/neonatal clinical leads and includes auditable standards that inform the quarterly audits that are in progress.

3.3 A request has been made to include a joint signatory from the maternity/neonatal clinical leads for ATAIN and Transitional Care in compliance of this standard.

3.4 There is evidence of neonatal involvement in care planning through discussions that take place at board rounds, ward rounds and documentation in care records and discharge summaries.

3.5 Admission criteria is defined within the 'Bobble Hat' risk assessment proforma that is completed on all babies and identifies the appropriate care setting based on need. Neonatal Transitional Care (NTC) admission criteria meets a minimum of at least one element of HRG XA04

3.6 There is an explicit staffing model with maternity staff identified on the e-Roster system as NTC on each shift. Midwives lead on the care of NTC mothers and babies but there is an allocated Neonatal Nurse also allocated as point of contact.

3.7 To develop the service into a fully functioning NTC, Neonatal and Midwifery staffing, training, equipment and estates resource investment is required. The estates requirements are captured within the maternity estates workstream.

4 Standard b)

The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion,

Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.

4.1 Audit data is captured on all babies who have care within NTC to monitor compliance against the guideline and auditable standards (see table below)

4.2 Audit findings are shared with the Neonatal Safety Champion monthly and will from Quarter 3 be shared with the Board Safety Champion through the Maternity and Neonatal Assurance Group.

4.3 Barriers to achieving full implementation of the policy will be captured on an action plan and will be shared with the neonatal safety champion and be appended to the quarterly reports.

4.4 A process for sharing with the LMNS, Commissioners and integrated care system is under review.

Auditable Standards		October 2021		November 2021		December 2021	
		QE	WHH	QE	WHH	QE	WHH
Number of Mothers and Babies cared for in Transitional Care Setting		14	33	17	29	18	26
Admitted from: e.g. Labour ward, Postnatal Ward, SCBU etc	Ward	9	21	8	23	11	13
	Theatre	1	5	6	4	1	3
	Labour Ward	4	7		1	4	5
	SCBU			3		2	
	Other Trust				1		
	Unknown						5
Criteria for TC: (IVABX / Weight <2kg /<10th centile/ 34-35+6wks /significant SGA/ Phototherapy / NAS) Meets minimum of HRG XA04 as defined in Red section of Bobble Hat criteria?	Infection suspected/confirmed requiring IV antibiotics	7	15	2	11	11	11
	Small for Gestational Age (SGA)	2		1			
	Prematurity	2	3	2	1	1	
	Jaundice requiring phototherapy	1	5	3	11	5	6
	• Infection suspected/confirmed requiring IV antibiotics • Jaundice		2	2	3		2
	Respiratory disease			1			
	• Infection suspected/confirmed requiring IV antibiotics • Prematurity		1	1		1	
	• Infection (suspected sepsis) IV ABX • NAS Observation		1				

	• Small for Dates (SGA/IUGR) • Poor weight gain (postnatal) • Jaundice		1				
	• Jaundice • Prematurity		2				
	• Infection (suspected sepsis) IV ABX • Hypoglycaemia		2				
	• Jaundice • NG Tube feeding • Infection (suspected sepsis) IV ABX		1				
	• "Infection (suspected sepsis) IV ABX • Jaundice • Small for Dates (SGA/IUGR) • Hypoglycaemia-Nasogastric tube feeding				1		1
	• Infection (suspected sepsis) IV ABX • Jaundice • Prematurity				1		1
	• Prematurity • SGA				1		
	Not recorded	2		5			5

5 Standard c)

A data recording process for capturing existing transitional care activity, (regardless of place which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0- and 36+6-weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.

5.1 Data on Transitional Care activity is captured on the Maternity Dashboard and is shown on the table below both by bed days and number of babies

Transitional Care Activity						
	October		November		December	
Key Performance Indicator (KPI)	**WHH**	**QEQM**	**WHH**	**QEQM**	**WHH**	**QEQM**
Transitional Care Location/Care Days	**71**	**38**	**59**	**35**	**55**	**40**
Transitional Care Location/ Care Babies	**24**	**13**	**17**	**15**	**20**	**14**

5.2 Secondary Data Recording Process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting.

5.3 The following table shows Babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered

5.4 There is no target measure set against this secondary data recording but it does provide information on late preterm babies who are currently cared for in the Neonatal Unit, who could be cared for in a fully functioning TC setting, to inform future capacity planning/management.

Secondary Data Recording to inform future capacity management for late preterm babies who could be cared for in a TC setting.						
	October		**November**		**December**	
KPI	**WHH**	**QEQM**	**WHH**	**QEQM**	**WHH**	**QEQM**
Babies 34-36+6 Weeks, Special Care and normal care days w/o O2 total	**77**	**32**	**45**	**18**	**36**	**27**
Babies 34-36+6 Weeks, Special Care and normal care days w/o O2 cared for on Neonatal Unit	**49**	**17**	**12**	**4**	**22**	**19**

6 Standard d)

Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), Local Maternity and Neonatal System (LMNS) and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.

6.1 The Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 is captured and recorded locally on the Badgernet Neonatal Information System and may be used for the purposes of direct care, clinical audit, Reference Costs, and other local uses.

6.2 There is not a requirement for the Trust to regularly submit this data but the fact that it is possible to download it from Badgernet, if requested, means the CNST criteria are met.

6.3 The following table shows the Quarterly ATAIN summary reports that are provided by the Neonatal Operational Delivery Network (ODN).

6.4 The National Target set for ATAIN is under 5%, both QEQM and WHH have consistently remained well below this level.

ATAIN Unit Summary

Network	Unit	Live births (all)	Term admissions n	Term admissions % live births
Kent Surrey Sussex	Conquest Hospital	2205	99	4.5%
	Darent Valley Hospital	3697	146	3.9%
	Princess Royal Hospital	1754	70	4.0%
	Queen Elizabeth the Queen Mother Hospital	1876	56	
	Royal Surrey County Hospital	2288	64	2.8%
	Worthing Hospital	1729	47	2.7%
	East Surrey Hospital	3664	182	5.0%
	Frimley Park Hospital	4171	123	2.9%
	Tunbridge Wells Hospital	4578	173	3.8%
	Medway Maritime Hospital	3607	176	4.9%
	Royal Sussex County Hospital	2064	87	4.2%
	St Peter's Hospital	2587	93	3.6%
		2760	91	
	KSS Network Total	**36980**	**1407**	**3.8%**

SCU	LNU	NICU

Unit	Live births (all)	Term admissions n	Term admissions % live births	Respiratory n	Respiratory % term ads	Respiratory per 1000 births	Infection n	Infection % term ads	Infection per 1000 births	Hypoglycaemia n	Hypoglycaemia % term ads	Hypoglycaemia per 1000 births
Queen Elizabeth the Queen Mother Hospital	1876	56	3.0%	22	39%	11.7	9	16%	4.8	4	7%	2.1
William Harvey Hospital	2760	91	3.3%	45	49%	16.3	2	2%	0.7	7	8%	2.5

Unit	Live births (all)	Term admissions n	Term admissions % live births	Monitoring n	Monitoring % term ads	Monitoring per 1000 births	Suspected HIE n	Suspected HIE % term ads	Suspected HIE per 1000 births	HRG 3-5 only NNU 1 Day	HRG 3-5 only % term ads	HRG 3-5 only NNU>1 Day	HRG 3-5 only % term ads
Queen Elizabeth the Queen Mother Hospital	1876	56	3.0%	2	4%	1.1	1	2%	0.5	7	13%	30	54%
William Harvey Hospital	2760	91	3.3%	5	5%	1.8	0	0%	0.0	6	7%	27	30%

7 Standard e)

Reviews of term admissions to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion.
The reviews should report on the number of admissions to the neonatal unit that would have met current TC admissions criteria but were admitted to the neonatal unit due to capacity or staffing issues.
The review should also record the number of babies that were admitted to or remained on Neonatal Units because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there.
Findings of the review have been shared with the maternity neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.

8.1. Weekly cross site Multidisciplinary Maternity and Neonatal Review meetings take place to discuss in detail all term admissions into the Neonatal Unit and critically assess whether the admission could possibly have been avoided if risk had been identified and/or care had been provided differently.

8.2. Learning theme posters are generated to communicate opportunities to improve with the wider team.

8.3. An audit tool template has been formalised and ATAIN is now registered on the Trust Audit programme to support improved capture of themes and tracking of learning from cases.

8.4. The ATAIN and TC Action Plan (Appendix 1) shows areas of focused improvement.

8.5. The following Table shows Quarter 3 Term Admissions to Special Care Baby Unit (SCBU)/Neonatal Unit (NNU).

Quarter 3 Term Admissions to SCBU/NNU							
Site	**Threshold**	**October**		**November**		**December**	
QEQM	4.2%	1.8%	4	3.4%	7	5.4%	10
WHH	4.2%	2.5%	8	3.3%	10	2.4%	7
Total	4.2%	2.2%	12	3.3%	17	3.7%	25

8.6. The following table shows the themes of term admissions

Site Themes of Term Admissions						
Theme	October		November		December	
	QEQM	WHH	QEQM	WHH	QEQM	WHH
Infection	2		2		2	1
Congenital Abnormality Suspected	1				1	
Respiratory	1	4	2	5	4	3
NAS Suspected/ confirmed		1	1			
Metabolic Disease			1			
HIE			1			
Jaundice				1	1	1
Investigation					1	
Monitoring					1	
Hypoglycaemia		2		1		
Surgery		1				
Neurological Disease				1		
Cardiovascular Disease				1		
Gastrointestinal Disease				1		
Birth Trauma						2

8.7. The following table shows babies that could have been cared for in the existing Transitional Care (TC) and those that could have been cared for if there was a fully functioning TC:

	Could Care have been	Could care have been provided in fully

	provided in existing TC	functioning TC (i.e. babies that were admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there)
October	No	1 Baby requiring NAS observations 2 Babies needing tube/feeding support
November	No	1 Baby with Respiratory Distress could have been cared for in a fully functioning TC environment 1 enhanced Jaundice
December	No	2 enhanced Jaundice

8.8. A review of TC capacity and staffing issues did not identify any impact on admission to Neonatal Unit.

8.9. **Opportunities to keep Mothers and Babies together through Future Development.**

8.9.1. If Nasogastric (NG) assisted feeds were to be delivered on a Transitional Care Uni in line with BAPM Guidance, 2 babies could have avoided admission and separation from their mother.

8.9.2. Infants requiring enhanced Phototherapy can also be managed on a TC unit, if they can maintain adequate hydration by mouth or by NGT. This equates to 3 babies in Quarter 3.

8.9.3. Training and competency of staff to provide care in TC setting would be required in areas including:

- Recognition of the unwell infant;
- IV Line care;
- Competencies to use NG tubes;
- Enhanced Monitoring and Support (Including NAS);
- Facilities for Saturation Monitoring.

8.10. Findings of the reviews have been shared quarterly with the maternity and neonatal safety champions and Board level champion.

8.11. The findings will also be shared with the LMNS and ICS quality surveillance meeting, via the Maternity and Neonatal Assurance Group, ongoing reporting structure.

9. Standard f)

An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point e) has been agreed with the maternity and neonatal safety champions and Board level champion.

9.1. The Transitional Care and ATAIN action plans have been developed and approved by the Clinical and Midwifery Leads and Neonatal Safety Champion and are shared with the Maternity and Board Safety Champions through the Bi-Monthly meetings and moving forward MNAG and Board reporting arrangements.

9.2. Evidence that progress with the action plan has been shared with the neonatal, maternity safety champion, and Board level champion, LMNS and ICS quality surveillance meeting each quarter is through the agreed Trust Board reporting structure, including MNAG.

9.3. See Appendix 1 for the Transitional Care and ATAIN action plan.

10. Standard g)

Progress with the revised ATAIN action plan has been shared with the maternity neonatal and Board level safety champions LMNS and ICS quality surveillance meeting.

10.1. An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from the pathway audit (point b) and the ATAIN reviews (point e).

10.2. Presentations have been provided by leads at Care Group Audit Days, an audit tool has been developed with support from the Trust Audit Team to formalise the process and reporting structures have been agreed with Trust Board within the 'Foreword Planner, reporting timetable'.

10.3. CNST Year 4 reporting was paused in December 2021 and Trusts are waiting for new guidance to be published. The Trust Has continued with weekly ATAIN review meetings and Transitional Care auditing to maximise opportunities for lessons to be learnt and shared.

10.4. Evidence that progress with the action plan has been shared with the neonatal, maternity safety champion, and Board level champion, each quarter is through the agreed Trust Board reporting structure, which includes MNAG. A plan for reporting into the LMNS and ICS quality surveillance meeting is in progress.

10.5. See Appendix 1 for the Transitional Care and ATAIN action plan.

11. Next steps

11.1. To agree and formalise the joint signatory from the maternity/neonatal clinical leads in compliance of this standard.

11.2. To continue the development of the Estates action plan, which includes future development of a dedicated Transitional Care area that is staffed by Maternity and Neonatal staff and able to provide a fully functional service to maximise opportunities to keep Mums and Babies together.

11.3. To develop an action plan that supports the Training and competency of staff to provide care in TC setting would be required in areas including:

- Recognition of the unwell infant;
- IV Line care;
- Competencies to use NG tubes;
- Enhanced Monitoring and Support (Including NAS);
- Facilities for Saturation Monitoring.

11.4. To formally agree that the Transitional Care and ATAIN reviews and action plan findings will also be shared with the LMNS and ICS quality surveillance meeting.

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Appendix 1: TRANSITIONAL Care and ATAIN Action Plan

Item No	Link to ATAIN admission criteria (i.e. Respiratory, Jaundice, Hypoglycaemia, HIE, Observation, Poor feeding)	Recommendation identified following case review	Action plan to achieve compliance with recommendation (SMART)	Lead Responsible	Date for completion	RAG rating	Progress/comments	Date completed
1.	Respiratory	Reduce the number of babies admitted with respiratory issues there needs to be a reduction in the number of elective Caesarean Section (CS) performed under 39 weeks unless there is a clear contraindication	• Not arranging elective Lower Segment Caesarean Section (LSCS) before 39 weeks unless clinically indicated. • If needed, ensuring mother is given antenatal steroids as per Royal College of Obstetricians and Gynaecologists (RCOG) guideline	Consultant Neonatologist Midwifery Sister and Kingsgate Ward Manager Midwife	Sept-22	In Progress within time line	Weekly review meeting and feedback of any cases and learning. Understand route cause against individual cases	Ongoing
2.	Hypoglycaemia	Reduce admission of babies at risk of hypoglycaemia	Educate and share awareness of importance of feeding within 60 minutes of delivery and feeding support during postnatal period. Audit compliance within auditable standards of Transitional Care Guideline and ongoing audit	Consultant Neonatologist Midwifery Sister and Kingsgate Ward Manager Midwife	Sept-22	In Progress within time line	Audit template agreed for Transitional Care. Monthly audits in progress.	Ongoing
3.	ATAIN review process	To ensure that all admissions to the Neonatal Unit are reviewed using an agreed audit template to identify areas of improvement	To agree NEW Audit Review Template and begin using within review meeting/as part of monthly audits	Consultant Neonatologist Midwifery Sister and Kingsgate Ward Manager Midwife	Sept-22	In Progress within time line	Audit template has been developed that aligns to weekly case review template but will generate data trend information to support learning	Ongoing
4.	Reduction in repeat themes and improved learning	Identifying themes/trends in term admissions on action plan template	• completion of electronic audit tool and Action plan for ATAIN and Transitional Care admissions and report findings. • Reviewing how data is presented in clinical areas and as part of monthly reporting to align with the quarterly reporting coming from the Operational Delivery Network (ODN) based on Badgernet data. • Neonatal and Maternity leads to attend weekly review meeting to review antenatal and intrapartum care elements and support shared learning that comes out of the meetings.	Consultant Neonatologist Midwifery Sister and Kingsgate Ward Manager Midwife	Sept-22	In Progress within time line	Monthly local data collection via Badgernet and Maternity Dashboard data reporting to Care Group Governance, Maternity and Neonatal Assurance Group and into Trust Board. Action plan reviewed in the weekly meetings, the Safety Champion/MNAG meetings and quarterly LMS meetings.	Ongoing
5.	To monitor opportunities for future development of Transitional Care service to reduce Neonatal Admissions and keep mums and babies together	• Monitor babies that could have been looked after in Transitional Care if Nasogastric tube feeding was offered	• Recruitment of staff to comply with Neonatal workforce staffing template to ensure appropriate cover and skill mix to support Transitional Care service development	Consultant Neonatologist Midwifery Sister and Kingsgate	October-21	In Progress within time line	Data is recorded on the Maternity Dashboard and included within Quarterly reporting TC working party group is established and currently focussed on achieving CNST Year 4 standards. Next steps will be to include Safety	

		• Explore estate development opportunities for a dedicated TC location • Staff training needs assessments for provision of Transitional Care including Nasogastric tube feeding • Secondary Data Recording Process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. • Babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number	• TC working party group to develop proposal for future service needs • Further development of outreach service to increase cot capacity and early discharge • Babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of normal care days and special care days is now recorded on the Maternity Dashboard	Ward Manager Midwife			Champions in exploring options for future service needs. The estates development/options for space is captured through the aligned workstream.	

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**BRIEFING NOTE: FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS FROM THE INDEPENDENT REVIEW OF MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (SATH)**
MEETING DATE:	**7 APRIL 2022**
BOARD SPONSOR:	**CHIEF NURSING & MIDWIFERY OFFICER (CNMO): MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**
PAPER AUTHOR:	**INTERIM DIRECTOR OF MIDWIFERY** **CNMO: MATERNITY AND NEONATAL BOARD SAFETY CHAMPION**
APPENDICES:	**APPENDIX 1: OCKENDEN REPORT FINAL** **APPENDIX 2: NHS ENGLAND & NHS IMPROVEMENT LETTER**
Executive Summary:	

Action Required: (Highlight **one** only)	Decision	Approval	**Information**	Assurance	Discussion

Purpose of the Report:	The purpose of this report is to provide a high level summary of the findings following the release of the final report by Donna Ockenden into the findings from the independent review of maternity services at SATH.
Summary of Key Issues:	The final report by Donna Ockenden was published on the 30 March 2022 and followed on from the initial report published in December 2020. A copy of the full report is attached in Appendix I. In response to the publication a letter was sent to all Trusts, received on 2 April from NHS England and NHS Improvement advising that all Boards have a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening at their organisation / within the local system. The letter is attached in Appendix 2. The request within the letter was that the Ockenden report should be taken to the next public Board meeting and for the report to be shared with all relevant staff and strongly recommends that everyone reads it, regardless of their role. After reviewing the report, Trusts are asked to take action to mitigate any risks identified and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars: 1. Safe staffing levels; 2. A well-trained workforce; 3. Learning from incidents; 4. Listening to families. The first report outlined a number of Local Actions for Learning (LAfL) and Immediate and Essential Actions (IEAs) to be implemented at Trust and across all maternity services nationally. The final report indicates that concerns remain that NHS Maternity services and Trust Boards, are failing to adequately address and learn lessons from serious maternity events, and also to recognise the workforce challenges. NHS England and NHS Improvement are working with the Department of Health and Social Care to implement the 15 Immediate & Essential

	Actions (IEAs) and every trust, Integrated Care System (ICS) and Local Maternity System (LMS)/Local Maternity and Neonatal System (LMNS) Board must consider and then act on the report's findings. The final report has identified thematic patterns in the quality of care and investigation procedures carried out by SATH, leading to a failure to identify where there were opportunities for learning and improving quality of care. The report also highlights the failing to follow national clinical guidelines, delays in escalation and poor working relationships. The key findings against the four pillars are themed as follows: **Clinical Governance** The report highlights concern around the quality of incident investigations and the inclusion of the families, as well as poor processes for how complaints were handled, resulting in lack of learning from incidents and leading to persistent failings; inappropriate downgrading of Serious Incidents, failure to use Root Cause Analysis (RCA) methodology, poor timelines for completing investigations and failing to close the actions resulting from findings. One of the contributing factors was seen as the lack of senior oversight within the Care Group to provide appropriate monitoring and holding people to account. **Clinical Leadership** Analysis of the workforce highlighted the inadequacy of the obstetric medical staffing levels and the ability to achieve timely senior clinical reviews, which had created an environment where it was the accepted norm to wait for a senior review/opinion. Recommendations are made around how midwifery frontline numbers should be assessed and also the role of the matron, labour coordinator and consultant midwife are highlighted. The report identifies the impact that the lack of team working, civility, lack of leadership, accountability and situational awareness had on the overall safety of the unit. **Antenatal Care** Investigations into incidents had lacked a professional concern for women from vulnerable backgrounds. The report identifies a number of areas across various complex antenatal pathways where early signs, through lack of antenatal risk assessment were not recognised, leading to poor outcomes. **Labour Care** Key areas focused around escalation of concerns and deterioration of the clinical picture, the lack of senior obstetric involvement and poor documentation by the band 7 co-ordinator, especially when escalating concerns. Staff reported that where labour care took place outside of the obstetric labour ward, there was a fear of reproach when contacting the labour ward coordinator for advice and to escalate clinical concerns. This is also linked to the role of the midwifery led unit and the operational risk that was

	allowed to evolve as women were cared on the unit that did not meet the criteria for low risk births.
	
	The report highlights the reliance on medical locums at middle grade and raised concerns around the level of supervision and governance for this group of staff.
	
	Postnatal Care
	The report identifies how postnatal care is the Cinderella of the service, with staffing levels on the ward being inadequate and lack of appropriate medical input for women with complex clinical need.
	
	Findings highlight the lack of compassion and kindness reported by women.
	
	Postnatal readmissions are flagged as an area where clear pathways of care are required with appropriate and timely review by the medical team.
	
	Anaesthetics
	The report highlights the role of the anaesthetic team in the care of women, including those who are critically ill, the importance of being involved in the Multi-Disciplinary Team (MDT) planning and stipulates the minimum requirements for an obstetric service in terms of consultant sessions. The importance of anaesthetic involvement in maternity governance is highlighted.
	
	Neonatal care
	The findings highlight the need for clear pathways of care for the provision of neonatal care and endorses the recommendations from the Neonatal Critical Care review (December 2019) to expand neonatal critical care, increase neonatal cots, develop the workforce and enhance the experience of families.
	
	Bereavement
	There was a strong recommendation to improve the end to end pathway of care for bereaved families to ensure they receive the appropriate bereavement care services.
	
	The recommendations are then further divided across 15 categories
	• Workforce Planning;
	• Safe Staffing:
	  • Escalation and accountability;
	  • Clinical Governance and Leadership;
	  • Clinical Governance - incident investigation and complaints;
	  • Learning from Maternal deaths;
	  • Multidisciplinary training;
	  • Complex Antenatal care;
	  • Preterm births;
	  • Labour care and birth;
	  • Obstetric anaesthetics;
	  • Postnatal Care;
	  • Bereavement pathways;
	  • Neonatal services;
	  • Supporting families.

	An initial review of the report, themes and recommendations indicates that the EKHUFT maternity improvement plan is aligned and has already identified many of the key areas and effectively mitigated risk. There are however some specific areas that warrant a more in-depth analysis in relation to the professional behaviours and culture. There are a number of recommendations associated with specific training and development requirements for groups of staff, which EKHUFT need to include within leadership programmes, with the priority being those staff working at William Harvey Hospital (WHH). A further review of workforce is also recommended to ensure any gaps are addressed to meet the clinical leadership roles especially in relation to the consultant midwife numbers, as well as a further review of senior obstetric workforce. Through the Maternity and Neonatal Assurance Group, discussions have already commenced around the need to review the neonatal strategy, with meetings already in the diary with clinical leads. The recommendations contained within the final Ockenden report will guide this work moving forwards, and will also steer the review of the obstetric anaesthetic model at EKHUFT. A working group has already been established to undertake the gap analysis and develop robust plans against areas where services will need to make changes, led by the Clinical Director and Interim Director of Midwifery. This work will be completed by the end of April and presented to MNAG, with a detailed report being submitted to the Trust Board for discussion and consideration in May 2022.
Key Recommendation(s):	The Board of Directors are invited to: 1. **NOTE** the content of this report and the failings identified; 2. **NOTE** that a full gap analysis of the final report findings and recommendations will be completed against the Maternity Improvement Plan to ensure EKHUFT takes forward the identified learning and where necessary robust plans will be developed as part of the existing plan.

Implications:				
Links to 'We Care' Strategic Objectives:				
Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**

Link to the Board Assurance Framework (BAF):	**BAF 32:** There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **BAF 35:** Negative patient outcomes and impact on the Trust's reputation due to a failure to recruit and retain high calibre staff	
Link to the Corporate Risk Register (CRR):	**CRR 77**: Women and babies may receive sub-optimal quality of care and poor patient experience in our maternity services. **CRR 122**: There is a risk that midwifery staffing levels are inadequate.	
Resource:	Y	Potential but needs to be scoped in line with the review of the recommendations.

Legal and regulatory:	Y	Care Quality Commission (CQC) requirements; NHS Resolution (NHSR)
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	N/A	

OCKENDEN REPORT - FINAL

FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS **FROM THE INDEPENDENT REVIEW OF MATERNITY SERVICES** at The Shrewsbury and Telford Hospital NHS Trust

Our Final Report

30 March 2022

Return to an Address of the
Honourable the House of Commons
dated 30 March 2022 for

FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS **FROM THE INDEPENDENT REVIEW OF MATERNITY SERVICES** at The Shrewsbury and Telford Hospital NHS Trust

Our Final Report

HC 1219

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Letter to the Secretary of State for Health and Social Care from Donna Ockenden

30 March 2022

Dear Secretary of State

I publish the final report of the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust, at a time when the NHS continues to face significant challenges arising from the Covid-19 pandemic. In the 2 years of this pandemic since early 2020 the NHS and its staff have had to be ever more innovative in the ways services are delivered to ensure the provision of high quality care to patients.

NHS staff, including maternity teams who have worked throughout this pandemic, are exhausted. We have seen so many frontline NHS staff go above and beyond the call of duty to support and care for their patients in these truly extraordinary times. Our NHS is rightly held in high regard by so many for the lives it saves and the care it provides.

However, this final report of the Independent Maternity Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust is about an NHS maternity service that failed. It failed to investigate, failed to learn and failed to improve and therefore often failed to safeguard mothers and their babies at one of the most important times in their lives.

This review owes its origins to Kate Stanton Davies, and her parents Rhiannon Davies and Richard Stanton; and to Pippa Griffiths, and her parents Kayleigh and Colin Griffiths. Kate's and Pippa's parents have shown an unrelenting commitment to ensuring their daughters' short lives make a difference to the safety of maternity care. It was through their efforts that your predecessor, the former Secretary of State for Health Jeremy Hunt requested this independent review. When it commenced this review was of 23 families' cases, but it grew to include reviews of nearly 1,500 families, whose experiences occurred predominantly between 2000 and 2019.

This final report follows on from our first report which was published in December 2020. In the first report we outlined the Local Actions for Learning, (LAfL) and Immediate and Essential Actions, (IEAs) to be implemented at the Trust and across the wider maternity system in England. This second report builds upon the first report in that all the LAfL and IEAs within that report remain important and must be progressed. For this second report my independent maternity review team have identified a number of new themes which we believe must now be shared across all maternity services in England as a matter of urgency to bring about positive and essential change. Our Local Actions for Learning for the Trust and Immediate and Essential Actions, must be implemented by The Shrewsbury and Telford Hospital NHS Trust with the IEAs considered by all Trusts across England in a timely manner.

Since the publication of our first report, the Government has introduced a range of measures[1] and invested very significantly in supporting maternity services across the country. This focus and funding is a significant stride in the right direction. Much of this funding is for workforce expansion. NHS Providers[2], as cited in the recent Select Committee report[3] has estimated the cost of full expansion of the maternity services workforce to be £200m - £350m. We endorse and support this view.

In the last year since our first report was published we have seen significant pressures in maternity services in the recruitment and retention of midwives and obstetricians. Workforce planning, reducing

1 https://www.gov.uk/government/publications/safety-of-maternity-services-in-england-government-response/the-governments-response-to-the-health-and-social-care-committee-report-safety-of-maternity-services-in-england

2 https://nhsproviders.org/media/690887/2021-02-04-letter-from-nhs-providers-to-hscc.pdf

3 https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm

attrition of maternity staff and providing the required funding for a sustainable and safe maternity workforce is essential. Continuing progress on funding the maternity multi-professional workforce requirements now and into the future will mean that we can continue to ensure the safety of mothers and their babies and meet the Government's key commitment to halve the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries in babies occurring soon or after birth by 2025[4].

In our first report we wanted to ensure that families' voices were central, as for far too long women and families who accessed maternity care at the Trust were denied the opportunity to voice their concerns about the quality of care they had received. Many hundreds of families who received maternity care at the Trust have told us of experiencing life-changing tragedies which have caused untold pain and distress. In order to ensure families' voices are heard, listened to and acted upon within maternity services the NHS will need to continue progress on the role of the independent senior advocate role within maternity services that was an Immediate and Essential Action in our first report.

Secretary of State, through our work to date we have recognised a critical need for timely and independent reviews of serious maternity incidents to ensure lessons are learned and changes implemented effectively. We note and endorse the creation of a Special Health Authority[5] to oversee maternity investigations, taking over the work of HSIB. We fully support your view that the provision of 'independent, standardised and family focussed investigations of maternity cases that provide families with answers' is essential. We further urge that there must be a timeliness to this work since delay in introducing change and learning leads to the risk of repeated incidents, as we saw at The Shrewsbury and Telford Hospital NHS Trust. We would expect that learning and service change from maternity incidents be introduced into clinical practice within six months of the incident occurring and that all investigations are independently chaired.

Finally and importantly Secretary of State we state that DHSC and NHSE&I must now commission a working group independent of the Maternity Transformation Programme that has joint RCM and RCOG leadership to make plans to guide the Maternity Transformation Programme around implementation of these IEAs and the recommendations of other reports currently being prepared.

Thank you Secretary of State for your ongoing support,

Yours sincerely,

Donna Ockenden

Chair of the Independent Maternity Review

4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

5 https://questions-statements.parliament.uk/written-statements/detail/2022-01-26/hcws560

Acknowledgements

The work contained in this final report and the first report of the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, came about from the exceptional efforts of parents Rhiannon Davies, Richard Stanton, and Kayleigh and Colin Griffiths, who daughters died as a result of the care they received at the Trust.

The deaths of Rhiannon and Richard's daughter Kate in 2009, and Kayleigh and Colin's daughter Pippa in 2016 were both avoidable. Owing to their unshakeable commitment to ensure the precious lives of their babies were not lost in vain, this review has implementation of meaningful change, not only in maternity services at The Shrewsbury and Telford Hospital NHS Trust – but also across England. As we publish this final report, we want to acknowledge and pay tribute to Rhiannon, Richard, Kayleigh and Colin.

Very importantly, and as Chair of this review, I want to extend my heartfelt thanks to all of the families who have come forward to share their experiences. So many families have explained to me that for more than two decades they have tried to raise concerns but were brushed aside, ignored and not listened to. My review team and I have listened to families and heard their concerns and distress. This final report has come about following the careful consideration by my review team of 1,592 clinical incidents involving mothers and babies resulting from the maternity care of 1,486 families. Their contribution to this review and report has, in my view, been central to a review of maternity services which I hope and believe will now save lives and reduce harm in maternity services across England.

Thanks to the bravery and determination of all the families in sharing their experiences we have produced this report, which my review team colleagues and I believe will continue to shape the learning which will profoundly change maternity care now and in the years to come. Never again should families be left to grieve or suffer in isolation, with the additional pain of feeling their legitimate concerns are being ignored. Our intention is that this report will underpin the future journey of maternity services in England, so that maternity services will be safer, will hear families better and will be more accountable.

Why this Report is Important

The impact of death or serious health complications suffered as a result of maternity care cannot be underestimated. The impact on the lives of families and loved ones is profound and permanent.

The families who have bravely contributed to this review know all too well the devastation which follows such events, and have explained to my review team and me that they want this review to answer their questions. Families have also clearly explained that they want what happened to them to matter and to ensure that in future voices, such as their own, are listened to and heard and that meaningful and sustained changes will be made to try to ensure that what happened to them will not happen to others in future.

The accounts of families involved in events at maternity services at The Shrewsbury and Telford Hospital NHS Trust has not only put a spotlight on this service but also on other maternity services across England, as can be seen by recent reports of concerns in a number of other trusts. That is why this report aims to not only address specific concerns about The Shrewsbury and Telford Hospital NHS Trust but to provide Immediate and Essential Actions for all maternity services across England. Sometimes that spotlight can feel harsh to staff on the front line doing their very best in what are often extremely challenging circumstances. As a multi-professional clinical review team, largely made up of midwives and doctors currently working on a daily basis in NHS maternity services across England, we understand that.

Even now, early in 2022 there remains concern that NHS maternity services and their trust boards are still failing to adequately address and learn lessons from serious maternity events occurring now. We recognise that maternity services have very significant workforce challenges and this must change. Clearly, workforce challenges that have existed for more than a decade cannot be put right overnight. However, it is our belief that if the 'whole system' underpinning maternity services commits to implementation of all the Immediate and Essential Actions within this report with the necessary funding provided then this review could be said to have led to far reaching improvements for all families and all NHS staff working within maternity services.

The size and scale of this review is unprecedented in NHS history. After reviewing the experiences of so many families and listening carefully to both those families and to the past and present staff who came forward, we have been given a once in a generation opportunity to improve the safety and quality of maternity service provision for families across England, now and in the future.

Donna Ockenden

Chair

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Explanation of Terminology

In this report the review team has used words or medical terms which some readers may not be familiar with. While we have tried to keep the use of such words and terminology to a minimum, at times it is unavoidable. This is so we can accurately address specific clinical issues we found within our review as well as make recommendations to improve maternity care now and in the future at the Trust and across the NHS in England.

To try to aid readers' understanding where we think language has become technical, where the terms are used for the first time, we direct readers to a glossary (found at the end of the report) which will give further explanation of their meaning.

Executive summary

This Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust ("the Trust") commenced in the summer of 2017. It was originally requested by the Rt Hon Jeremy Hunt, MP, when he was Secretary of State for Health and Social Care and commissioned by NHS Improvement (NHSI), to examine 23 cases of concern collated by the tireless efforts of the parents of Kate Stanton-Davies and Pippa Griffiths, who both died after birth at the Trust in 2009 and 2016 respectively.

Since the review was commissioned it has grown considerably. Our independent and multi-professional team of midwives and doctors reviewed the maternity care of 1,486 families, the majority of which were patients at the Trust between the years 2000 and 2019. It has previously been reported that this review was considering 1,862 family cases. However after removing duplication of recording, and excluding cases where there were missing hospital records or consent for participation in the review could not be obtained, the final number of families included in this review is 1,486. Some families had multiple clinical incidents therefore a total of 1,592 clinical incidents involving mothers and babies have been reviewed with the earliest case from 1973 and the latest from 2020.

In line with the terms of reference, the review examined the Trust's internal investigations where they occurred. In addition, the review team has considered external reports into the Trust's maternity services over these years (national regulatory reports and locally commissioned reports) and examined local clinical governance processes, policies and procedures, as well as ombudsman and coroner's reports.

Throughout this process our priority has been to ensure that the families impacted by the maternity services at the Trust are heard. They wanted to understand what had happened to them, as well as ensure that finally lessons are learned so that no further families experience the same harm and distress that they did. Families were offered a variety of methods to engage with the review team and share accounts of their care and treatment. Throughout this report we have included vignettes of the care received by families either through our review of their maternity care considering the documentation that was received from the Trust, or by quoting family members directly from their communication with the chair of the review or team members.

As well as listening to families, the review team wanted to ensure that staff had an opportunity to be heard as well. In 2021 the review team interviewed 60 present and former members of staff about their opinions on the maternity services they worked within. We also offered staff the opportunity to complete a questionnaire for the review, which 84 staff did. We have included vignettes of these interviews and questionnaires throughout this report in order to ensure that staff voices are clearly heard. In the final weeks leading up to publication of the report, a number of staff withdrew their cooperation from the report and therefore their content (or "voice") was lost from the report. The main reason for withdrawing from the report as cited by staff was fear of being identified. This was despite our reassurance that staff would only ever be identified as 'a staff member told the review team...'

Within this report we have included a timeline of events which led up to the commissioning of this independent review (see chapter 1). This highlights a number of cases that became known of, many in the public domain between 2001 and 2016, as well as a number of external reviews from the various commissioning and regulatory bodies which took place during the period under review. It would be expected that the number of incidents featured in this timeline would have warranted closer scrutiny of maternity services at an earlier point than we are at now. However, in our opinion due to concerns around other clinical areas within the Trust and also due to the significant turnover at Executive and Board level, issues within maternity services remained largely unseen. This was to the detriment of the families receiving care.

Patterns of repeated poor care

Through the review of 1,486 family cases, the review team has been able to identify thematic patterns in the quality of care and investigation procedures carried out by the Trust, and identify where opportunities for learning and improving quality of care have been missed.

For example, in the nine months preceding the avoidable death of Kate Stanton-Davies in March 2009, the review team has identified two further incidents of baby deaths which occurred under similar circumstances.

In May 2008 Baby Joshua was born in poor condition at Ludlow midwifery-led unit, and was transferred by air ambulance to the Royal Shrewsbury Hospital Neonatal Unit. Joshua's mother was considered to have a low risk pregnancy, and even after she reported episodes of severe uterine tenderness and tightening at 31 weeks this risk profile was not changed. She reported reduced baby movements the day before her labour at 37+5 weeks gestation, but on her admission the baby's heart rate was not monitored appropriately. Joshua was delivered with no signs of life and died at six days old, when care was withdrawn.

In January 2009 Baby Thomas was born following his mother's long, slow labour stretching over more than a day. His mother, who had given birth to a large baby during a previous pregnancy, had been treated as a low risk case throughout this pregnancy, and no check for gestational diabetes was conducted. She had been due to give birth in a midwifery-led unit, but was admitted to the antenatal ward in the consultant-led unit. The review team found that despite abnormal heart rate readings, a high dose of oxytocin infusion was used, and his mother was infrequently monitored. In the hour before birth, examinations showed signs of obstructed labour and uterine rupture, as well as difficulties establishing the baby's heart rate, but despite this a ventouse delivery was attempted before an emergency caesarean was conducted. Thomas briefly had a heartbeat but at 34 minutes of age resuscitation was stopped.

Then on 1 March 2009 Rhiannon Davies gave birth to Kate Stanton-Davies at the Ludlow midwifery-led unit, despite reporting a reduction in her baby's movements in the two weeks before the birth. There was a lack of appropriate heart rate monitoring during labour and missed opportunities to manage Kate's health as she was born severely anaemic. Kate suffered a cardiopulmonary collapse at 90 minutes of life and was transferred by air ambulance to a tertiary neonatal unit, where she died shortly after arrival at six hours of age.

The review team found evidence of poor investigation into all three of these cases which took place within less than a year of each other, as well as a lack of transparency and dialogue with families. This resulted in missed opportunities for learning, and a lost opportunity to prevent further baby deaths from occurring at the Trust.

Unfortunately these three cases were not isolated incidents and throughout this review we have found repeated errors in care, which led to injury to either mothers or their babies. During our work we have considered all aspects of clinical care in maternity services including antenatal, intrapartum, postnatal, obstetric anaesthesia and neonatal care.

In total 12 cases of maternal death were considered by the review team. They concluded that none of the mothers had received care in line with best practice at the time and in three-quarters of cases the care could have been significantly improved. Only one maternal death investigation was conducted by external clinicians, and the internal reviews were rated as poor by our review team. These internal investigations frequently did not, recognise system and service-wide failings to follow appropriate procedures and guidance. As a result significant omissions in care were not identified and in some incidents women themselves were also held responsible for the outcomes.

As part of the review 498 cases of stillbirth were reviewed and graded. One in four cases were found to have significant or major concerns in maternity care which if managed appropriately might, or would have, resulted in a different outcome. Hypoxic ischaemic encephalopathy (HIE) is a newborn brain injury caused by oxygen deprivation to the brain. There were significant and major concerns in the care provided to the mother in two thirds (65.9 per cent) of all HIE cases. After the baby had been born, most of the neonatal care provided was considered appropriate or included minor concerns, however these were unlikely to influence the outcome observed.

Most of the neonatal deaths occurred in the first 7 days of life. Nearly a third of all incidents reviewed (27.9 per cent) were identified to have significant or major concerns in the maternity care provided which might or would have resulted in a different outcome.

The review team found that throughout the review period staff were overly-confident in their ability to manage complex pregnancies and babies diagnosed with fetal abnormalities during pregnancy. There was sometimes a reluctance to refer to a tertiary unit to involve specialists such as paediatric surgeons and geneticists in care. For

example, the neonatal unit at Royal Shrewsbury Hospital continued to work as a neonatal intensive care unit for many years after it had been re-designated as a local neonatal unit. Although the review team noted that care provided by staff in the unit was generally good, it was operating beyond its designated scope. Staff suggested this was due to a lack of capacity within the surrounding services, but this view has been rejected by the neonatal network.

Internally, within maternity services at the Trust women were frequently not referred to or discussed with colleagues from the wider multidisciplinary team. It has been observed that there were repeated failures to escalate concerns in both antenatal and postnatal environments. There are also multiple examples within this report, where there were delays in women being admitted to the labour ward during induction of labour, being assessed for emergency intervention during labour or reviewed by consultants in the postnatal environment. On occasion this resulted in families being discharged from hospital but later readmitted for emergency procedures due to becoming extremely unwell through the lack of earlier appropriate review of care. Other examples of a lack of appropriate escalation are of obstetric anaesthetists involved at the last minute, not enabling them to assess women appropriately for urgent obstetric interventions.

Failure in governance and leadership

Throughout the various stages of care the review team has identified a failing to follow national clinical guidelines whether it be for the monitoring of fetal heart rate, maternal blood pressure, management of gestational diabetes or resuscitation. This, combined with delays in escalation and failure to work collaboratively across disciplines, resulted in the many poor outcomes experienced by mothers or their babies, such as sepsis, hypoxic ischaemic encephalopathy and unfortunately death.

Some of the causes of these delays were due to the culture amongst the Trust's workforce. The review team has seen evidence within the cases reviewed that there was a lack of action from senior clinicians following escalation. The review team has also heard directly from staff that there was a culture of 'them and us' between the midwifery and obstetric staff, which engendered fear amongst midwives to escalate concerns to consultants. This demonstrates a lack of psychological safety in the workplace, and limited the ability of the service to make positive changes.

Unfortunately these poor working relationships were also witnessed by families, and in some cases mothers have described the additional stress these interactions had on them at one of the most vulnerable moments in their lives. In addition, repeatedly throughout this review we have heard from parents about a lack of compassion expressed by staff either while they were still receiving care or in follow-up appointments and during complaints processes. Examples include clinicians being unprepared for follow-up briefings with families, and response letters to complaints including inaccurate information, justifying actions or omissions in care and in some cases even including explanations which laid blame on the family themselves for the particular outcome.

As summarised earlier, there were often delays in escalation of care to appropriate clinicians, in part these delays in care could be attributed to staffing and training gaps at the Trust. The review team found there were significant staffing and training gaps within both the midwifery and medical workforce, which negatively affected the operational running of the service. The review team identified how it was widely accepted that the labour ward coordinator did not have supernumerary status, often having their own clinical caseload, preventing them from being readily accessible to junior staff and the wider midwifery team for clinical advice, care planning and support.

Similarly, the medical staff rotas have been overstretched throughout the time period covered by the review. Inadequate support from consultant obstetric and anaesthetic services caused a consistent lack of clinical expertise to be available. Where locum doctors filled in rota gaps, there is evidence of them being unsupported and on occasions unsafe clinical practice was not addressed or challenged. Staff also cited suboptimal staffing levels and unsafe inpatient to staffing ratios to the review team, and said they often felt fearful and stressed at work due to poor staffing levels.

The review has found the Trust leadership team up to Board level to be in a constant state of churn and change. Therefore it failed to foster a positive environment to support and encourage service improvement at all levels. In addition the Trust Board did not have oversight, or a full understanding of issues and concerns within the maternity

service, resulting in a lack of strategic direction and effective change, nor the development of accountable implementation plans.

Our consideration of clinical governance processes and documents at the Trust has shown that investigatory processes were not followed to a standard that would have been expected for the particular time the incident occurred. The reviews were often cursory, not multidisciplinary and did not identify the underlying systemic failings and some significant cases of concern were not investigated at all. In fact, the maternity governance team inappropriately downgraded serious incidents to a local investigation methodology in order to avoid external scrutiny, so that the true scale of serious incidents at the Trust went unknown until this review was undertaken.

Where investigations took place there was a lack of oversight by the Trust Board, unfortunately the review believes this has persisted in some incident investigations as late as 2018/2019 considered as part of this review.

This meant that consistently throughout the review period lessons were not learned, mistakes in care were repeated and the safety of mothers and babies was unnecessarily compromised as a result.

There were a number of external reviews carried out by external bodies including local Clinical Commissioning Groups and the Care Quality Commission during the last decade. The review team is concerned that some of the findings from these reviews gave false reassurance about maternity services at the Trust, despite repeated concerns being raised by families. It is the review team's view that opportunities were lost to have improved maternity services at the Trust sooner.

Local Actions for Learning and Immediate and Essential Actions

This review has considered all aspects of maternity care at Shrewsbury and Telford Hospital NHS Trust and as a result has made a significant number of recommendations for improvement of care across each of the maternity disciplines.

In total more than 60 Local Actions for Learning have been identified specifically for the Trust in light of the care received by the 1,486 families featured in the review. The review team are encouraged by staff reports that following our first report in December 2020 there does seem to have been a recent improvement in maternity services at the Trust with increased numbers of senior clinicians employed.

It is recognised that many of the issues highlighted in this report are not unique to Shrewsbury and Telford Hospitals NHS Trust and have been highlighted in other local and national reports into maternity services in recent years. This is why the review team has also identified 15 areas as Immediate and Essential Actions which should be considered by all trusts in England providing maternity services. Some of these include: the need for significant investment in the maternity workforce and multi-professional training; suspension of the Midwifery Continuity of Carer model until, and unless, safe staffing is shown to be present; strengthened accountability for improvements in care amongst senior maternity staff, with timely implementation of changes in practice and improved investigations involving families.

It is absolutely clear that there is an urgent need for a robust and funded maternity-wide workforce plan, starting right now, without delay and continuing over multiple years. This has already been highlighted on a number of occasions but is essential to address the present and future requirements for midwives, obstetricians, anaesthetists, neonatal teams and associated staff working in and around maternity services. Without this maternity services cannot provide safe and effective care for women and babies. In addition, this workforce plan must also focus on significantly reducing the attrition of midwives and doctors since increases in workforce numbers are of limited use if those already within the maternity workforce continue to leave. Only with a robustly funded, well-staffed and trained workforce will we be able to ensure delivery of safe, and compassionate, maternity care locally and across England.

OCKENDEN REPORT - FINAL

Section 1

History, methodology and families

- Introduction
- Chapter 1. Concerns that led to this review - a timeline
- A case study highlighting failure to investigate, inform and listen
- Chapter 2. How we approached our review
- Chapter 3. Supporting the families during our review

Introduction

Our first report, *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust*, was published in December 2020[1]. The report, which was outside the terms of reference for this review, was prepared at the request of the then Minister of State for Patient Safety, Suicide Prevention and Mental Health Nadine Dorries MP. It observed important emerging themes which required urgent action following review of the maternity care experienced by 250 families. The aim was to focus on immediate improvements for the Trust through **Local Actions for Learning** (LAfL) and the wider maternity system across England with **Immediate and Essential Actions** (IEAs).

This second publication reports on the care of all families included in this review of maternity services at Shrewsbury and Telford Hospital NHS Trust. It explores internal and external factors that may have contributed to the failings in care we have found. Of importance, and in accordance with the Terms of Reference, this report is particularly focussed on the Trust's failings in governance processes which directly led to the harm that families experienced.

From its start, in the summer of 2017, we have seen the number of families included in this Secretary of State Independent Maternity Review increase substantially from the original 23 families. It is now recognised that this review is likely to include the largest ever number of clinical reviews conducted as part of an inquiry relating to a single service in the history of the NHS.

We reported in July 2020 that 1,862 individual families were included in this review. After further analysis and validation of data with the Trust, the total number of families included in this review is now established to be 1,486 resulting in 1,592 clinical reviews of care. The majority of cases are from the years 2000 to 2019. However, a number of families came forward in the early period of the review whose care preceded these years and it was agreed by NHS England that, where possible, their care would also be reviewed.

All care and treatment provided to families, the quality of any Trust-led incident investigations, Trust-led reviews, external reviews and the resultant recommendations, actions and learning have been considered with reference to the relevant guidance and standards of the day, by clinicians who were in clinical practice at the time.

Every clinical review undertaken has been led by expert clinicians and each case has been carefully considered using a consistent standardised methodology. The multidisciplinary review team has been expanded during the process to reflect the growing number of families. The majority of reviewers currently work in clinical posts at trusts across England, with the number of team members who have been a part of the review since its start exceeding 90.

Over the course of the review, the team has faced many challenges and these are explained in more detail within the report. These have been mainly related to systems and processes required in order to undertake a review of this size, as it became evident that the required protocols, procedures and structures were not immediately available to support it. The COVID-19 pandemic at times impeded progress as our clinicians quite rightly prioritised their NHS commitments.

We have always emphasised that the voices of the families are central to this review. Throughout, we have ensured that families have been updated on the review's progress and we have worked closely with support agencies to ensure that listening, counselling and psychological help is and has been available for those in need.

The voices of staff at the Trust have also been important to assist with our understanding of events. We launched our Staff Voices engagement strategy to reach out to both former and current staff at the Trust. They were offered the opportunity to engage with us through an initial questionnaire survey and further conversations to share their experiences of working at the Trust. Despite reaching out through social media and the local press including radio, TV and a local newspaper and joint messaging with the Trust, fewer staff and ex-staff contacted us than we had anticipated or hoped for.

1 Ockenden, D. Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (2020) https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

At the time of publication only just over 100 current and former staff had contributed to the review with a further number of staff withdrawing from the review in the weeks before publication. This led to a number of last minute changes to the report as we were unable to use staff contributions without their consent. Those staff withdrawing were apologetic but most were concerned about being identified in the report. Despite our assurances, they maintained that they did not want to be quoted in the final report and we respected their decision.

Since our first report, we are encouraged to hear of progress at the Trust through its improvement programme in response to both our **Local Actions for Learning and Immediate and Essential Actions**. Indeed, we heard through staff of the willingness of their colleagues and themselves to learn from the review, in order to continue to improve and work towards building and maintaining a safer local maternity service.

The review team was particularly encouraged by the overwhelming positive response to our first report from maternity colleagues across England and the wider NHS. We were equally encouraged to see that our call for action to ensure investigations, reviews and reports that lead to meaningful change was heard.

We acknowledge that the proposed funding of £95million towards workforce and training provided by NHS England and Improvement is a major stride in the right direction. However, we are equally conscious that this is only the start of the journey and state that what is required in order to continually improve safety in maternity services is a multi-year funding increase for workforce expansion and training, in forthcoming years.

Our **Immediate and Essential Actions** from this report, based on our findings from the clinical reviews and listening to the voices of both families and staff, identify that the wider system must invest further in staffing across the whole maternity team to ensure that there are sufficient numbers, and that the workforce is equipped with the right skills and is able to deliver care in the right place at the right time.

Until proposed staffing levels are improved to recognise the increasing complexities of maternity care in the 21st century, NHS maternity services must not, and cannot, focus on the implementation of midwifery continuity of carer. Before continuity of carer is recommenced in any form there must be a thorough review of the evidence that underpins continuity of carer to assess if it is a model fit for the future. Further investment in enhancing staff numbers across the multidisciplinary team will go a long way to improve overall safety in maternity services.

Whilst the review has been heartened by the Trust's progress over the last year, NHS England and Improvement must continue to provide appropriate support and ongoing oversight of its continued progress. Regulators such as the Care Quality Commission together with the Royal Colleges, including those of Midwives, Obstetricians and Gynaecologists, Anaesthetists, and Paediatrics and Child Health must continue to strengthen their collective efforts of collaborative working to hasten the implementation of these further **Local Actions for Learning** and **Immediate and Essential Actions** outlined in this final report.

We are aware that since the inception of this review, there are now at least two other independent maternity service reviews in progress. This may be indicative of some wider systemic issues. At this very moment there may be other maternity services across England which are facing challenges that impact on their ability to provide a safe service as a result of insufficient staffing levels, substandard governance processes, and structures which impede learning.

Over and over, families have expressed their two key wishes for this review. They want answers so that they can understand what happened during the care they received and why. We hope that this report will go some way in identifying and explaining the factors that contributed to the systemic failures which led to the harm they experienced. Secondly, they want the system to learn. We note that as a result of our findings in our first report, through our **Local Actions for Learning** and **Immediate and Essential Actions** the Trust and the wider NHS are beginning to learn and improve. We anticipate that through this report the learning will be sustained. No more families should have to live with the consequences of poor governance systems and structures within the NHS.

We must ensure that for all the families who contributed to this review there continues to be visible, measurable and sustainable change at the Trust and across the wider maternity system in England. That change through the implementation of our **Local Actions for Learning** and **Immediate and Essential Actions** will be the legacy of these families and the terrible loss and harm they have experienced.

Chapter 1

Concerns that led to this review

1.1 The Ockenden Review into the Shrewsbury and Telford Hospital NHS Trust maternity services spans the period from 2000 to 2019 and was commissioned by the then Secretary of State for Health Jeremy Hunt MP at the end of 2016. Donna Ockenden was asked to lead the review, then comprising of 23 families, in the summer of 2017. The following is a chronology of reports and reviews into the Trust's maternity services over this time.

1.2 This timeline shows the failure of the Trust's maternity services to listen to families and to learn from critical incidents spanning the entire period of the review. In 2001, a woman gave birth to a baby in very poor condition who subsequently died at 21 minutes of age. The cause was due to failure to recognise abnormalities in the fetal heart monitoring. The family felt that there was no attempt to be honest with them in subsequent correspondence from the Trust and they claimed that as well as clinical mistakes, there was obfuscation, and a cover-up. The family subsequently took legal action against the Trust in order to get answers that they had been unable to get from the Trust before litigation commenced.

1.3 In 2002 a baby girl named Olivia died following a traumatic ventouse and forceps delivery. The subsequent independent medical report prepared for this family found severe failings in obstetric care. The mother described how at that time she felt like a *'lone voice in the wind'* trying to raise concerns about the Trust's maternity unit. Olivia's mother made multiple attempts to publicise what had happened to her daughter including appearing on national television on the 'This Morning' programme in 2006.

1.4 Olivia's mother told the review chair in late 2018: *'I hope that by speaking out other women who've suffered in childbirth will come forward …to expose the cover-ups that clearly happen…at the time, because I ended up on This Morning as well, talking about this, and the amount of women that day that phoned in, who'd gone through similar things, and it gave me a kind of peace because I knew that they were getting help in the right direction…'*

2007 Healthcare Commission

1.5 In 2004, two babies were born in poor condition which resulted in cerebral palsy. These cases were reported in the local press at the time and the solicitor who represented both families wrote to the then regulator of NHS trusts, the Healthcare Commission (HCC), and the Shropshire and Staffordshire Strategic Health Authority calling for an inquiry. The review team has not seen any evidence that an inquiry took place.

1.6 Three years after the experience of these families in April 2007 the Healthcare Commission wrote to the then CEO of the Royal Shrewsbury Hospital[2] regarding its concerns about the maternity service. The HCC said they had received concerns in March 2006 with regards to poor care resulting in birth injuries. The allegations raised with the HCC were that staff failed to recognise and act upon abnormal cardiotocograph[3] (CTG) tracings, that there was non-adherence to the National Institute of Health and Clinical Excellence (NICE) guidelines and there was a lack of, and inappropriate, staff training.

1.7 The HCC visited the maternity service and said it was satisfied that CTG training for staff and audit had been introduced and that the Trust then used NICE guidance. The HCC considered that the concerns raised with it did not meet its criteria for an investigation and therefore did not undertake one, but suggested areas for improvement with a plan to monitor the implementation of the recommendations until it was satisfied that sufficient progress had been made. The HCC noted the Trust's low caesarean section rate of 14 per cent in 2005 compared to the UK national average of 23.2 per cent. The HCC did not examine unplanned

2 Healthcare Commission Letter to the Trust's Chief Executive Officer 18 April 2007 https://www.sath.nhs.uk/wp-content/uploads/2017/05/Doc-1-Letter-from-Healthcare-Commission-to-Trust-April-2007.pdf

3 See glossary

admissions to the Neonatal Intensive Care Unit (NICU), rates of hypoxic ischaemic encephalopathy (HIE) or relevant other near misses. This was a significant lost opportunity for learning at an already troubled Trust.

1.8 In the letter from the HCC to the Trust dated April 2007, the following recommendations were made:

RECOMMENDATIONS	
CTG	The Trust should send a copy of the latest CTG audit to the Commission and ensure that staff are aware of it for their learning. Trends, learning and improvements should be identified and acted upon.
Lack of/inappropriate staff training	Skills drills training programmes should be evaluated and revised where necessary.
Risk Management Systems (including incident reporting, root cause analysis, actions plans, follow-up and learning from incidents)	The Trust needs to improve the quality of the action plans resulting from clinical incident cases and high risk case reviews, i.e. the actions need to be clearly measurable, the accountable person named and they should have timescales.
How policies and procedures are rolled out to staff and embedded in practice	Policies and procedures should be reviewed in a timely manner, in line with national guidance, and staff should be clear of any revisions.
Clinical Governance	The Trust should share its revised Clinical Governance structure with the Commission.
Clinical Risk Adviser	The Trust should consider the need for permanent additional resource for the Clinical Risk Adviser for the Children and Maternity Service.

2008 Baby Joshua, and baby Kate Stanton-Davies in 2009

1.9 In March 2009 baby Kate Stanton-Davies died following her birth at Ludlow birth centre. Richard Stanton and Rhiannon Davies, Kate's parents have up to the present day voiced their concerns about the circumstances surrounding Kate's death and about the safety of maternity services at the Trust. The Ockenden review team notes that another baby was born the year before, in May 2008, also at Ludlow Birth Centre. Baby Joshua died a few days after birth after also being born in a very poor condition. A review of this case by the review team has noted that there were significant concerns in the care provided to Joshua's mother and that there was not an appropriate investigation. The coroner did not hold an inquest, following receiving information provided by the Trust, but the family explained to the review chair that they were not involved in these discussions between the Trust and the coroner.

1.10 In summary, the births of baby Joshua and Kate Stanton-Davies have similar features. Both mothers presented with antenatal clinical concerns and reduced fetal movements, there were concerns during the labours, there were resuscitation concerns for both babies and both babies required air ambulance transfer. Both families were dissatisfied with the internal investigations and failure to obtain answers to their questions.

1.11 A paediatric death review (an internal investigation by the Trust) occurred in September 2008 following the death of baby Joshua in May 2008. The minutes of the meeting state that all midwives were up to date with neonatal resuscitation and *'advised all midwives to call 999 at the first sign of mother or baby being compromised'.* This was also stated in the action plan which said: *'an ambulance should be called as soon as there are indications that transfer of mother or baby may be required due to the time lag in the ambulance arriving.'* When Kate Stanton-Davies was born 10 months after baby Joshua in the same birth centre an ambulance was not called for 90 minutes, despite signs that Kate was seriously unwell from birth.

1.12 One overarching theme from this review is that over the years there has been a failure within maternity services at the Trust to investigate and learn from serious clinical incidents. It is apparent that baby Joshua's death in 2008 did not result in any actions or learning. It is also noted that when the subsequent death of Kate Stanton-Davies was investigated[4] by Debbie Graham Ms Graham could not locate any definitive guidance for the operating of Ludlow MLU for 2009[5]. This was despite the fact that after the earlier death of baby Joshua these issues were raised as being of importance to ensure the safety of mothers and babies, yet no action appears to have been taken.

1.13 Joshua's parents were scathing of the Trust and their lack of transparency and openness and their failure to learn. In a meeting with the review chair in early 2022 Joshua's mother told of *'phoning and phoning the [Royal] Shrewsbury Hospital for over a year, waiting and waiting for answers, they were always on leave, always in surgery, always not available. No one spoke to me..'* Joshua's father described the Trust as *'ducking and diving, avoiding telling the truth, they've been dodging and weaving all these years..*' Joshua's parents eventually commenced litigation in order to get the answers they wanted from the Trust.

1.14 The Ockenden review team has also searched within the vast amount of information provided by the Trust for relevant guidelines. The SaTH guideline *Resuscitation of the Neonate at a Midwife-Led Unit or a Home Birth by a Midwife and When to Summon Assistance* was first implemented in June 2010. It took just over 2 years after the death of baby Joshua and 15 months after the death of Kate Stanton-Davies to ensure this critically important clinical guideline was introduced.

1.15 In 2015 a woman had a delayed transfer from the midwifery-led unit and fetal monitoring was not undertaken during the transfer period. The baby was delivered in very poor condition and subsequently died. The family were critical of the ensuing investigation, and of correspondence with the Trust, and said during a meeting with the Ockenden review team that they had been *"put off, fobbed off and had obstacles put in our way".*

2013 Clinical Commissioning Groups' (CCGs) review

1.16 In 2013, there was a review into the maternity services at the Trust by the two Clinical Commissioning Groups[6]. This review was commissioned following concerns over an increased incidence of serious clinical adverse events and the safety of the clinical model of maternity care in Shropshire.

1.17 The CCGs' review of risk management focussed on reported serious incidents and near misses in the period April 1, 2012 to March 31, 2013[7]. The review team has found evidence of significant underreporting and cases that should have been investigated not being investigated, so it is our view that the CCGs' review would have underestimated the scale and volume of the incidents at the time. The CCG review also looked at policies, clinical governance systems, care pathways, and training, and concluded that *'there was an openness and transparency in reporting and investigation culture, which has led to a higher*

4 Graham, D. Independent Review of the case of Kate Seren Stanton-Davies at the Shrewsbury and Telford Hospital NHS Trust (2015) https://www.sath.nhs.uk/wp-content/uploads/2016/12/IndependentReview.pdf

5 Ibid n3 p25

6 Telford and Wrekin Clinical Commissioning Group, Shropshire Clinical Commissioning Group. Maternity Services Review The Shrewsbury and Telford Hospital NHS Trust (2013) https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MTU5OTY%3D

7 Ibid n5 p5

reporting of serious incidents than would have been reported elsewhere'. The review stated further *'there is a robust approach to risk management, clinical governance, and learning from incidents'.* The higher reported rate of unexpected admissions to the NICU compared to other local units was attributed in part to *'diligent reporting*[8]' and a thematic analysis was recommended to understand the reasons for this higher NICU admission rate.

1.18 Of note in this CCGs' report is a recommendation for neonatal services that *'measures to implement standards for 'Local Neonatal Units' are actioned immediately so that babies less than 27 weeks gestation receive initial stabilisation and intensive care in Shropshire before being transferred to an appropriate unit for ongoing intensive care'.* There is evidence within this second Ockenden report that this recommendation was not implemented, (see more in neonatal chapter 12). Furthermore a recommendation concerning serious incidents said that the Trust must *'ensure serious incident reporting is congruent with the National Patient Safety Agency (2010) and NHS England (2013) Serious Incident Framework'.* There is no evidence in the documentation provided to the review team by the Trust that this recommendation was actioned, (see more in clinical governance chapter 4). There is also no evidence that the CCG held the Trust to account for meeting these very important recommendations.

1.19 The 2013 CCG review also included comments from 47 women across 13 maternity service user focus groups[9]. It should be noted that this survey took place when the labour ward was at the much older Royal Shrewsbury Hospital prior to a move in 2014 to a new purpose-built maternity unit at the Princess Royal Hospital, Telford, so any negative comments on the condition of the estate could be reasonably disregarded.

1.20 Within the 2013 report there were some very positive comments from women:

All of the staff involved in my care both during my pregnancy and in labour were excellent. The midwife who dealt with my labour was first rate.

The care we had was excellent - the midwives acted swiftly to save my daughter's life, as did the neonatal ward in Shrewsbury.

However, there were also some very concerning negative comments:

I had a terrible experience and ended up being treated for post-traumatic stress following this birth, ahead of my second child. I felt frightened and not listened to during the birth and was 'cared' for by a rude uncaring doctor.

The whole experience of labour and the birth was horrific. The midwife was horrible, the on-call consultant was bad tempered.

I felt the midwives were unprofessional and rude. I had no help with feeding and consequently felt really alone. I thought midwives would be kind and they weren't a bit, they just kept telling me how busy they were. I don't want to have another baby at Shrewsbury.

I had an awful experience giving birth, the midwife was horrible to me, I felt I got no support. Afterwards in the ward I got no help with breastfeeding.

I felt that my concerns during labour were not addressed, that I was made to have a natural birth when an emergency c section was more appropriate just so they didn't dent their precious natural birth rate target. I felt like I was on a butcher's slab.

1.21 Although, as commented by the authors of the CCG report, 90 per cent of the patient feedback was favourable the 10 per cent negative feedback contains some very concerning family stories indicating poor maternity care. The sample size of 47 women was also very small. The report thanks *'the young mums*

8 Ibid n5 p7

9 Ibid n5 p19

who provided valuable feedback[10]*'* It is of note that the families' concerns, which do not appear to have been followed up by the CCG, are very similar to many of those heard by the Ockenden review team.

1.22 The overall assessment from this CCG review was that this was a safe and good quality service. The report states: *'it is clear that Shropshire has a maternity service to be proud of and that the model of service provision is safe and robust…'* The Trust Board reviewed this report[11] and in the minutes it noted '[*some]* *concern about some families' experiences but this was in the context of generally good services.'*

NHS Litigation Authority

1.23 In March 2014 the Trust was assessed by the NHS Litigation Authority[12]. This assessed the maternity service for organisation, clinical care, high risk conditions, communication, and postnatal and newborn care. The Trust was awarded the Level 3 standard, this was the highest standard available to be awarded. It should be noted that the Clinical Negligence Scheme for Trusts (CNST) standards at the time were assessed almost entirely from self-reporting of guidelines and procedures.

1.24 In 2014 there was a Deanery (medical training) review[13] into the training received by obstetrics and gynaecology staff. Under areas for improvement and with reference to clinical governance it said:

1.25 *'The Trust must integrate Clinical Governance into learning outcomes for trainees and ensure that there are clear and robust mechanisms in place to learn from Clinical Incidents and that any learning points are clearly disseminated to trainees appropriately.'* There is no evidence that has been seen by the review team that this was actioned by the Trust.

2015 Care Quality Commission

1.26 In 2015 there was a Care Quality Commission Quality Report on SaTH[14] which followed on from a visit to the Trust in 2014. The overall rating for maternity services was "good". It is noticeable that in this CQC report other Trust services such as medical care, surgery and urgent and emergency services were rated as 'requires improvement'. The CQC did comment that staffing levels should be improved on the labour ward and also commented that: *'the Trust must ensure that all staff are consistently reporting incidents, and that staff receive feedback on all incidents raised, so that service development and learning can take place'.* However, this comment was a Trust-wide action and not specific to the maternity service.

2015 Debbie Graham independent review

1.27 In 2015 there was an independent review by Debbie Graham[15] which reviewed the high profile case of Kate Stanton-Davies and made some criticisms of the Trust's response to the family.

1.28 The independent review by Graham found that although clinical governance processes were in place in 2009, at the time of Kate's birth there was a disconnect between policy, and the systemic mechanisms in place, which prevented effective clinical governance activity from being embedded into the culture of the organisation. This lack of a safety culture within maternity services at the Trust prevented Kate's death being raised as a Serious Incident (SI). Instead of an SI investigation the death was investigated as a High Risk Case Review (HRCR), and secondly as an unconnected midwifery supervisory investigation, therefore no learning started to occur from Kate's death until the findings of the coroner's inquest in 2015, 6 years after Kate died.

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10 Ibid n5 p3

11 2014 Trust Board papers supplied to the review team

12 NHS Litigation Authority Clinical Negligence Scheme for Trusts. Maternity Clinical Risk Management Standards 2013-14. The Shrewsbury and Telford Hospital NHS Trust. Level 3. (2014)

13 NHS Health Education West Midlands. PMET Review Findings Report Summary (2014)

14 Care Quality Commission. Shrewsbury and Telford Hospital NHS Trust Quality Report (2015) https://api.cqc.org.uk/public/v1/reports/0826982d-e4d9-48da-bc92-a78c8fc9b933?20210518113404

15 Ibid n3

1.29 In its conclusions the Graham report stated that *'…the learning from these events, in conjunction with the appointment of key personnel, have led to considerable improvements in the provision of maternity services…In particular the development of advocate roles within the Trust that will work to strengthen the voices of patients and their families so they may be heard in the future'.*

2016 Baby Pippa Griffiths

1.30 Kayleigh Griffiths gave birth to her daughter Pippa Griffiths at home in April 2016. Pippa died the day after her birth due to neonatal meningitis from Group B streptococcus infection. Kayleigh Griffiths had phoned midwifery staff about Pippa's feeding, breathing and other symptoms a number of times overnight after her birth and before she died, but had been reassured. It was established at the coroner's inquest that Pippa would have survived had post-delivery literature been given to Pippa's parents, and had a complete systematic enquiry into her neonatal health taken place.

1.31 Kate's and Pippa's parents (Rhiannon Davies, Richard Stanton, Kayleigh and Colin Griffiths) wrote a joint letter to the Trust Board in April 2017 expressing concern about maternity services at the Trust, discussing their own losses and other cases and saying that nothing had been learned and nothing had changed with regards to maternity services since Kate's death in 2009. At interview with the chair of this review in December 2017 Colin Griffiths, Pippa's father, described the behaviour of the Trust at the time of her death and afterwards as feeling *'like it was a sweep under the carpet, that's what it felt like'.*

1.32 Kayleigh, Pippa's mother, described to the Chair of the review in November 2017 the significant effort the family made to try to get the Trust to investigate her death in April 2016. She said: *'so…I left it until late May, and then it went into June and we'd heard nothing at all from them so I phoned...and said what's happening, surely there's an investigation taking place? And [X[16]] said to me "oh, it's just an internal thing, we're looking into it, but if you've got any questions just send them to me and I'll ask them to look at them…"* 'Kayleigh continued: *'I…said "it's not right, you don't just have a sudden, unexplained death and then say there's no investigation and the family's not going to be involved". So I went online straight away and got some NHS England guidance up about involving families and sent it…emailed it…And said there's got to be more to it, and I sent…some questions… And, from there, I contacted…I was just thinking something's not right and I'd seen a lot about Richard and Rhiannon Davies and I made contact with them…I contacted the Chief Exec at SaTH and said, you know, this has got to be investigated…'*

2017 Ovington Review (internal)

1.33 In 2017 the Quality and Safety Committee of SaTH commissioned an internal review into the maternity services following on from concerns raised by bereaved parents and the increased perinatal mortality rate, which had resulted in public attention. This report, Review of Maternity Services 2007-2017[17] was authored by Colin Ovington, then working within the Trust, and published in 2017.

1.34 The Ovington report made recommendations that the maternity service should ensure that governance arrangements are more transparent and open, and should improve the learning from incidents and investigations. It recommended engaging peers from other trusts to assist in the investigation and learning from incidents, and that the Trust should use a standardised process for investigating stillbirths and neonatal deaths. It is unclear whether these recommendations were ever acted upon since the review team has not been provided with or seen any connected action plan or any evidence of completion of the actions following that report.

16 X – identifier removed by review team

17 Ovington, C. Report Review of Maternity Services 2007-2017 Shrewsbury and Telford Hospital NHS Trust (2017) https://www.sath.nhs.uk/wp-content/uploads/2019/12/170629-06-Safety-of-Maternity-Services-2007-17-final-version-June-17.pdf

2017 Royal College of Obstetricians and Gynaecologists Invited Review

1.35 In 2017 there was a Royal College of Obstetricians and Gynaecologists Invited Review and subsequent report into the maternity services based on a visit to maternity services at the Trust carried out from 12-14 July 2017[18]. This report noted the following:

- There were workforce issues, with insufficient numbers of consultants providing obstetric cover. It also noted that middle grade rotas were not always filled by the deanery meaning that the maternity service relied on overseas trainees and locums.
- Risk management and governance systems were inadequate with a lack of resources.
- Incident reporting was inadequate with little evidence of widespread learning from incidents.
- The assessors viewed the allocation of the workforce across the sites as a patient safety issue.
- Current morale among the midwifery workforce was very low.
- The midwifery manager on-call rota required managers to deal with clinical areas they had no experience with.
- The perinatal mortality rates had remained above average compared with rates in similar trusts. The assessors did not see evidence of action plans and resulting changes in practice to act on this concern.

The RCOG report was not presented to the Trust Board until July 2018, and when presented it was prefaced by a report addendum dated 27 April 2018 which reported on interim progress on the recommendations from the original report.

2020 NHS Improvement response

1.36 Concerns were raised by families as to the time taken for this report to be presented to the Trust Board. On 29 November 2019 a letter of complaint was sent to the National Medical Director by two families. The letter alleged that the RCOG report was withheld from the Trust Board for 12 months. Furthermore, it alleged that Trust management sought to 'water down' the RCOG report by requesting a further document (the addendum) to be produced by the RCOG acknowledging improvements that had apparently been made. This addendum document was then added to the original report before being presented to the Trust Board in July 2018.

1.37 In response to this letter, NHS Improvement's Investigation Team conducted a review into these allegations and published the document *Review of the handling of a report produced by the Royal College of Obstetricians and Gynaecologists on maternity services at Shrewsbury and Telford NHS Trust* in July 2020[19].

1.38 This NHSI review noted that twelve months elapsed between the RCOG's site visit and the report being presented to the Trust's Board. It noted that when the draft report was received three months after RCOG's site visit, a number of Trust staff were unhappy with the findings feeling it was not an accurate representation of the service. The CEO, in part guided by maternity staff feedback, initially did not accept the RCOG draft report.

1.39 Following further discussions with RCOG, the Trust did then accept the report in early January 2018 but remained concerned about its tone and content, particularly in relation to the executive summary. The Trust made representations to RCOG to address this, and also proposed a follow-up exercise to evidence improvements the Trust felt it had made. The RCOG declined to make any further changes to the report,

18 Royal College of Obstetricians and Gynaecologists. Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust (2017)

19 NHS Improvement. Review of the handling of a report produced by the Royal College of Obstetricians and Gynaecologists on maternity services at Shrewsbury and Telford NHS Trust (2020) https://www.england.nhs.uk/midlands/publications/review-of-the-handling-of-a-report-produced-by-the-royal-college-of-obstetricians-and-gynaecologists-on-maternity-services-at-shrewsbury-and-telford-nhs-trust/

but did agree to this follow-up exercise, to be conducted as a 'progress review meeting' at the RCOG's premises in London. The RCOG did not visit the Trust to assess the 'improvements' for themselves.

1.40 When the report was finally presented to the Trust Board the covering paper was overwhelmingly positive in tone, with its twelve-point summary reflecting only the most complimentary aspects of the addendum itself. The overall result was a document that gave the impression that issues in the maternity service had been largely resolved, when in fact there was still significant further work to do.

1.41 The NHS Improvement report further found that governance arrangements at the maternity service and care group level were not operating effectively in relation to the report and associated action plan. Although a lot of work was initially done to implement actions and keep the action plan updated, there had been very limited ongoing scrutiny of the plan by local or corporate governance forums. This was concerning given the severity of some of the issues identified in the 2017 RCOG report.

1.42 The NHS Improvement report noted that the Trust was not obligated to commission the RCOG Invited Review but chose to do so and committed from the start to publish the results, knowing that this would open it up to further scrutiny. However, when the outcome was less favourable than hoped for, the primary focus of maternity services and the Trust seemed to shift towards the perceived public reaction to the report, rather than getting the right internal assurance and scrutiny to ensure the necessary improvement of patient services.

1.43 Following the publication of the RCOG report there was significant criticism in the media and from families that the body had not alerted the regulator (the CQC) with regard to its findings. Instead the RCOG had only released the report to the Trust. At the time[20] the RCOG sent reports arising from Invited Reviews to the service/Trust that had been reviewed, without always notifying regulators[21]. The 2015 policy was clear that the RCOG would *'encourage dialogue…with regulatory agencies and authorities'* and *'encourages the sharing of the report with the CQC...'* (RCOG 2015, p3).The RCOG policy was subsequently strengthened in 2020 with the policy stating that *'the RCOG will send a copy of the final report to the organisation's healthcare regulatory bodies'.*[22]

2018 Care Quality Commission

1.44 In 2018 there was a CQC report[23] which rated the maternity service inadequate under the safety domain. Of note there were concerns about cardiotocograph training and mandatory training. The report also commented: *'We found areas of concern that were raised in our last inspection December 2016, for example service wide sharing of learning from serious incidents was not evident, not all staff could give an example of learning'*.

1.45 The review team has been contacted by and interviewed a number of staff who have worked at the Trust over the period of this review. A number of Trust staff at Board level have also been contacted by the review team and interviewed, these have included some current and former Chief Executive Officers, Chairs of the Trust, Chief Nurses and Medical Directors.

1.46 A number of themes have come from these interviews and broadly this feedback forms a consistent picture of the culture in the Trust during the period of this review, with the documentary evidence also considered by the review team.

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20 Royal College of Obstetricians and Gynaecologists Invited Reviews a guide (2015) https://www.rcog.org.uk/globalassets/documents/about-us/invited-reviews/rcog-invited-reviews---a-guide-oct-2015.pdf

21 Royal College of Obstetricians and Gynaecologists. Statement regarding an Invited Review by Royal College of Obstetricians and Gynaecologists (RCOG) into maternity services at Shrewsbury and Telford Hospital NHS Trust (2020) https://www.rcog.org.uk/en/news/statement-regarding-an-invited-review-by-royal-college-of-obstetricians-and-gynaecologists-rcog-into-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust/

22 Royal College of Obstetricians and Gynaecologists. Invited Review Service: https://www.rcog.org.uk/en/about-us/invited-review-policy/

23 Care Quality Commission 2018 report Shrewsbury and Telford NHS Trusts https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-report-shrewsbury-telford-hospital-nhs-trust

1.47 It was clear from a number of staff interviews that this was a Trust which had a number of problems. A Board member told the review team that: *'there seemed to be a number of political issues making reform of services difficult'* and there were comments that the populations of Shrewsbury and Telford differed and that *'everybody in Telford wanted all the services in Telford and everybody in Shrewsbury wanted all the services in Shrewsbury'.*

1.48 One staff member said to the review team *'people just didn't do anything… and there just wasn't a culture of accountability for completion..'* and another commented: that *'this wasn't just a maternity unit in chaos and under pressure, this was a whole organisation where it was difficult to find an area which was not under pressure'*. The review team has noted that for many years there have been concerns with regard to safety and performance across the whole of the Trust, including the emergency department.

1.49 One interviewee described the maternity service as the *'Republic of Maternity, where, often, the maternity service seemed to consume its own smoke, and didn't like having oversight by the corporate team'."*The same interviewee commented that *'there was a disconnect both ways actually, I believe, from the corporate team to maternity and maternity to the corporate team'.*

1.50 Over a prolonged period, the Trust Board and executive team were dealing with a situation where the general standard of the whole organisation was poor and according to a staff member *'women's and children's was largely trusted to take responsibility for their own affairs and, to some extent, there was less scrutiny of them by virtue of the fact that they were perceived as being satisfactory to good'.* The impression given from multiple staff interviews with the review team was that the maternity department preferred to manage its service without Trust oversight.

1.51 The Trust had an executive team and Board that had continual change and churn over the period of this review, with documentation provided to the review team by the Trust[24] showing 10 Board Chairs from 2000, with 10 Chief Executive Officers (CEO) from 2000 to early 2020, of which 8 were in post between 2010 and the current day. This lack of continuity at Board and CEO level resulted in a loss of organisational memory and contributed to this "self-management" and lack of oversight of a maternity service that had clearly been in trouble for many years. The overwhelming impression of the staff interviews is that despite significant evidence to the contrary, the maternity unit up until about 2017 was actually not considered to be a trust risk.

1.52 One staff member interviewed stated that following serious incident reports there would have been recommendations made and that often these reports and recommendations were good but what was missing was the follow-up of the actions from the recommendations. It was said that *'there just wasn't a culture of accountability for completion'.*

Concerns from local external bodies

1.53 In late 2021 the review team also spoke to some senior staff of the Clinical Commissioning Groups (CCG) in post between the years 2013 to 2020. We were told that the CCGs did have concerns about maternity services at the time and were aware of the local press reports and family concerns. The CCGs had concerns about the length of time that SIs took to be reported and we were told by a contributor that *'reviews of serious incidents seemed to take a long, long, time to happen and there was an impression of evasiveness around how the learning from those reviews was shared'.* The same contributor told the review team that the CCG did have meetings with the maternity service representatives from the Trust but were assured that *'things were improving',* and were told that the CCGs were in any event *'limited in their power to change things for the better'.* It should be recognised that the CCGs were also concerned about SI investigations and learning from other services across the whole Trust and not just maternity.

24 Who's Who at the Trust – internal document received by the review team on 9 September 2020

Missed opportunities

1.54 In summary this was a Trust which had a number of problems, but the perception was that until 2017 the maternity service was not a major risk. The consistent message coming from both senior maternity staff and from Trust Board members was that external reports into the maternity service were generally favourable and that there were more pressing problems in other services at the Trust. The management of the maternity service was perceived to be competent and able and governance concerns seem to have been managed within the service and not escalated.

1.55 The review team believes that the Trust Board and the CCGs were 'reassured' rather than 'assured' with regards to governance and safety within the maternity service. Although independent and external reports consistently indicated that the maternity service should improve its governance and investigatory procedures this message was lost in a wider healthcare system which was struggling with other significant concerns.

Case Study

Thematic review of three cases at the Trust sharing similar themes within a nine month period (2008-2009)

1a.1 Here we examine the case of Kate Stanton Davies and deaths of two other babies which occurred within a short time period at the Trust. Throughout this report we highlight repeated incidents where maternity services at the Trust failed to investigate, learn and make impactful changes to improve patient safety.

1a.2 Within nine months, between May 2008 and March 2009, there were three neonatal deaths of babies that should have led to a systematic review of governance processes, strong actions and learning as well as a coronial inquiry into safety at the Trust. In all three cases there are significant failings in the care and treatment provided, omissions in the subsequent investigation into care, and failure to learn and establish processes for safe delivery in the midwifery-led unit (MLU) and consultant unit.

1a.3 Most concerning is a lack of transparency and honesty in communication with the families concerned despite internal recognition at the Trust that the investigations were not robust.

Baby Joshua 2008:

1a.4 The maternity review team has found evidence of a case that occurred nine months earlier than that of Kate Stanton Davies. In May 2008 a baby boy called Joshua was born at Ludlow midwifery led unit (MLU) in poor condition. Joshua was transferred by air ambulance to the Royal Shrewsbury Hospital (RSH) Neonatal Unit and died there on day 6 after his care was withdrawn.

1a.5 Joshua's mother was considered low risk with a previous pregnancy and birth and it seems an assumption was made that she would deliver in the freestanding MLU at Ludlow. There was no analysis of risk to ensure normality and whether or not it was appropriate or not to deliver in Ludlow. However, from 31 weeks of pregnancy the maternal risk changed. Joshua's mother reported three episodes of severe uterine tenderness and tightening. One occasion led to an ambulance admission to RSH and this review team believes that concealed abruption should have been considered by clinicians at the time.

1a.6 Joshua's mother reported decreased fetal movements the day prior to labour at 37+5 weeks gestation. No admission CTG was performed; she progressed quickly in labour, and an amniotomy[25] performed at 9cm revealed significant meconium. Seventeen minutes later her baby was delivered with no sign of life. No ambulance had been called in preparation for delivery and no attempt was made to perform a CTG once the meconium was identified.

1a.7 Two midwives at the unit attempted to resuscitate the baby but did not follow UK resuscitation guidance. A paediatrician doing a peripheral clinic took over the resuscitation. An ambulance road crew arrived to help. Joshua was transferred unsecured on a stretcher and ventilated by valve and mask in the air ambulance to RSH where he was ventilated, and remained comatose until treatment was withdrawn on day 6, after a head scan revealed severe widespread damage to Joshua's brain.

1a.8 The review team observes that timely intermittent auscultation was not performed in labour, and what monitoring did occur was not described in an accepted manner. The review team is concerned by alterations added to the notes in a different pen that appear to change the fetal heart rate recordings documented during labour.

1a.9 Placental histology confirmed a significant abruption with an attached and organised blood clot. The pathologist concluded that the abruption was silent and established. Despite this, the explanation given

25 See glossary

to the parents at the bereavement consultation was that the abruption must have been acute in the final 15 minutes of labour, perhaps secondary to a tight umbilical cord causing an unpredicted, acute placental detachment. This is despite no evidence of fresh blood loss at birth or post-partum haemorrhage. The bereavement letter stated: *'nothing could have been done or predicted'* and lacked any apology or reassurance that lessons would be learned.

1a.10 The review team do not accept this opinion of the likely pathology. In addition, we observe from the maternity records supplied by the Trust that the meconium revealed prior to birth was thick and established, indicating that the release was likely to have been some time before, perhaps in the days leading to labour when decreased fetal movements were reported. The review team consider that concealed abruption most likely occurred in the third trimester, contrary to the opinion offered to the parents at the bereavement appointment.

1a.11 There are a number of documents provided to the review team by the Trust which show discrepancies between the factual events and what was actually discussed with the parents. There are also extracts that contain additional information which was not disclosed to the family. This information is found in incident reports filed by members of staff and communications between professionals, provided to the review team by the Trust.

1a.12 The review team conclude that the risk management review of this incident by the Trust failed to follow appropriate local investigation processes to identify the root cause. The Trust also failed to decide on appropriate actions in order to prevent similar harm in the future. It is of concern that a decision to refer to the coroner was reversed by a small number of individuals within the Trust who decided to manage this incident internally.

1a.13 The review team has been aware of internal reports of concern around the lack of vital resuscitation equipment being available at Ludlow. As well as a lack of familiarity with equipment and poor standards of resuscitation, including the failure of midwives to achieve respiratory resuscitation. In addition the lack of ability to monitor oxygen saturation and to monitor the baby during resuscitation, and the lack of facility to thermoregulate and monitor the baby in the air ambulance.

1a.14 Documents shared with the review team by the Trust show that the lack of a portable resuscitaire in Ludlow MLU had been on the maternity risk register since 2005. The Trust did not support this concern and excused the lack of equipment on the basis that it would only be used by a neonatologist. There was an assessment of the resuscitation equipment at the unit but no details were given of the outcome. The review team is concerned by the response to this risk as it demonstrates poor evidence of learning. The additional information around the maternity risk register and the fact that this was a known risk regarding Ludlow MLU was never detailed to the parents during their meeting with the obstetrician or to any other professionals outside the organisation.

1a.15 A few weak action points from this case were circulated via a memorandum suggesting that change in practice was not mandatory and it was optional whether to use CTG monitoring if a woman presented with reduced fetal movements at the MLU. It also suggested it was optional to summon an ambulance when amniotomy was performed with evidence of meconium.

1a.16 A clinician who cared for the baby initially, stated in a letter to the Clinical Director in July 2008 that they had serious concerns regarding the quality of the case review. They pointed out a number of inaccuracies in the findings of the review and wrote: *'I really do wonder whether they have actually read these notes and wonder [about] the quality of the case review'*, and *'I am concerned that there is evidence the parents have not received an accurate explanation of the events leading up to the birth, during the birth and the resuscitation'.*

Baby Thomas 2009

1a.17 In January 2009, after the birth and death of Joshua but before Kate Stanton-Davies was born, a multiparous mother delivered in the consultant unit. Uterine rupture was diagnosed at caesarean section after a failed ventouse and prolonged labour with injudicious oxytocin use. The baby, named Thomas died at 34 minutes of age and was classified as an early neonatal death. The coroner agreed to the stated cause of death as: 1. Multiple organ failure; 2. Severe HIE; 3. Ruptured uterus and placental abruption. No post mortem was performed.

1a.18 The mother was booked for an MLU delivery despite having had a very long previous labour with a macrosomic[26] baby. No gestational diabetes testing was performed in this second pregnancy. Numerous attendances in a long latent phase of labour were apparent and all clinical midwifery reviews highlighted a large for dates baby with poor engagement of the fetal head.

1a.19 The mother was admitted to the consultant-led antenatal ward, contracting at 4cm dilatation. 19 hours later she was taken to the labour ward for amniotomy at 5cm. During the 11 hours following amniotomy there were repeated periods of abnormal CTG and high dose oxytocin infusion was administered for long periods of time leading to and after full dilatation. The contraction frequency was 5 in 10 minutes for long periods and poor medical input was noted. Vaginal examinations revealed classic signs of obstructed labour of a baby in the deflexed occipito-posterior position[27]. An hour prior to eventual birth by caesarean section there were classic signs of uterine rupture including haematuria[28], breakthrough pain, hypotension, and diminished uterine activity, failure to establish between a clear fetal or maternal heart rate. The midwife sought assistance for possible uterine rupture[29]. A ventouse delivery was initiated 35 minutes later and failed after 3 pulls. A caesarean was conducted 10 minutes later and uterine rupture with placental abruption[30] was found. The baby briefly had a heartbeat, but at 34 minutes of age resuscitation was discontinued.

1a.20 A DATIX[31] submission was generated following this event and the outcome of uterine rupture, early neonatal death and major obstetric haemorrhage (4.8 litres) was classified as low harm. It was stated that the case would be discussed in a case review meeting that same month but to date the review team has received no documents from the Trust pertaining to a risk review or outcomes.

1a.21 The review team has graded this incident as Grade 3 (the highest grade of harm) and has major concerns with the management of the incident and the apparent lack of scrutiny.

1a.22 In a bereavement letter, the Trust inaccurately informed the parents that the demise was acute and no one could be certain when the rupture occurred. No reference is made in the letter to the reasons why the mother's uterus was ruptured, or to the chronic hypoxia revealed by the cord ph. There is no reference in the letter to lessons being learned or actions that could prevent such tragedy in the future.

The Stanton Davies family and baby Kate 2009:

1a.23 Two months after the birth and death of baby Thomas and 9 months after the birth and death of baby Joshua, baby Kate died avoidably on 1 March 2009 after her birth at Ludlow MLU. Kate died at 6 hours of age following cardiopulmonary collapse at 90 minutes of life. She was severely anaemic and paediatric help should have been sought earlier.

1a.24 The case has been reviewed extensively: with a highly criticised supervisory investigation, multiple external opinion reports and finally in 2012 a coroner's inquest with jury, all of these occurring after constant pressure from Kate's grieving parents. The inquest concluded that Kate should not have been born at Ludlow. The 2 weeks of reduced fetal movements prior to labour was a factor in Kate being born anaemic, as she had likely suffered repeated episodes of feto-maternal haemorrhage[32]. The MLU staff failed to provide Kate and

26 See glossary
27 See glossary
28 See glossary
29 See glossary
30 See glossary
31 See glossary
32 See glossary

her mother Rhiannon with midwifery expertise. Intermittent auscultation in labour was not adequate and opportunities to manage a baby in difficulty during the first hours of life were missed. Kate died shortly after arrival by air ambulance at a tertiary neonatal unit.

1a.25 There have been numerous specialist opinions on this case over a long period of time. It is clear that the Trust failed to fulfil its responsibility to establish the facts and establish accountability. In particular, the Trust failed to investigate Kate's death appropriately, failed to hold staff to account and failed to address her parent's concerns, and particularly those pertaining to the inadequacy of the supervisory investigation. Further external opinions revealed that midwives did not consider her mother Rhiannon's antenatal care as a whole and did not consider the bigger picture, which would have indicated that Kate should not have been delivered in an MLU. The Trust's investigation into midwifery practice is described as ineffective and half-hearted and the consultant feedback is criticised as being badly considered.

1a.26 Consideration of these three cases of term babies, Joshua, Thomas and Kate who were born and died within 10 months of each other show that by early 2009 there was already a systematic failure within the Trust to investigate its maternity services. Following on from their failure to investigate the deaths of Joshua, Thomas and Kate the Shrewsbury and Telford Hospital NHS Trust completely failed to identify appropriate actions for learning from the deaths of these babies.

1a.27 The review team is particularly concerned by the lack of transparency internally within the Trust and the lack of honesty and transparency with families. This is all the more concerning, when it is clear that major issues in safety were apparent in both MLU and consultant settings during the period leading up to the birth and death of Kate Stanton-Davies, and before her the birth and death of baby Joshua and then baby Thomas.

Chapter 2

How we approached this review

2.1 This Independent Review into Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (SaTH or similar abbreviation) was commissioned in May 2017 by NHS Improvement (NHSI) at the request of the Right Honourable Jeremy Hunt MP, then Secretary of State for Health and Social Care. This was in response to concerns raised with Mr Hunt by Rhiannon and Richard Stanton Davies and Kayleigh and Colin Griffiths about the deaths of their daughters in 2009 and 2016 respectively and about 21 further families which experienced adverse outcomes at SaTH. These concerns were with regards to the maternity care received at the Trust and with the failure of the Trust to provide satisfactory answers to questions asked about the care it provided.

2.2 The first terms of reference in 2018 were written for the planned review of 23 families, but were amended in November 2019 to encompass a much larger number of families. Both the first and the current terms of reference are found in appendices 5 and 6.

2.3 This is the second report published by the Ockenden review team. The original plan was to publish one complete report when the reviews of all the cases had been completed. However in July 2020, following an increase in the number of families included in the review, the then Minister of State for Mental Health, Suicide Prevention and Patient Safety, Nadine Dorries MP, requested a first report focussing on important early actions and learning to improve local and national maternity services. That first report, based on the first 250 clinical reviews, *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Hospital Trust*[33] was published on 10 December 2020.

2.4 For this second report we have reviewed all reported cases of maternal and neonatal harm in the period 2000-2019. As stated in the terms of reference, these comprise cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other complications in mothers and newborn babies. A number of cases were reviewed outside of these years and the earliest case reviewed was in 1973 and the latest in 2020. In total this review has examined the maternity care of 1,486 families resulting in 1,592 clinical incidents involving mothers and babies.

The start of the review in 2017

2.5 When this review began in late 2017 a small team of six obstetricians, midwives, neonatologists and administrative staff were recruited by Donna Ockenden (chair of the review) to begin work as agreed with NHSI. During summer 2017 and early 2018 some original hospital records were transported securely from the Trust to the review's office in Chichester, West Sussex and reviews were undertaken by the clinical team using these records.

2.6 Although this review commenced with 23 families many more came into the review through a number of different channels up until July 2020. This was in response to Trust-led action, word of mouth, social media and press reports. As a consequence the review continued to change and grow throughout the period, as we describe below.

2.7 The period under review has been largely determined by the data the Trust provided to the review team and the terms of reference (TOR) formulated by the review team and NHSI. The year 2000 was identified as a starting point because the first case within the original 23 Secretary of State cohort occurred in 2000.

33 Ockenden, D. Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (2020) https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

2.8 The terms of reference for the review were revised in November 2019 to take account of many further families' cases coming to the review's attention. Many of these additional clinical cases came from the Trust directly reporting families to the review. For instance, a large number of additional cases were reported to the review team by the Trust following a data collection exercise referred to as the 'Open Book', in which the Trust (supported by NHSI) undertook an internal investigation to identify cases of stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3) and maternal deaths. This started as an electronic review in autumn 2018 but further cases were added later in July 2020 (Extended Open Book) after analysis of paper records held by the Trust. The Open Book and Extended Open Book exercises resulted in more than 700 cases of poor outcomes across the four categories within the period 2000-2018 being referred to the review.

2.9 As requested by NHS Improvement, (NHSI) the Ockenden review team drafted an interim report based on early findings and progress which was sent to NHSI in January 2019. Prior to this in autumn 2018 NHSI had formed an oversight committee to scrutinise the work of the Ockenden review team, comprising NHSI, RCOG, RCM and CQC, to which it circulated the interim report. This committee was subsequently withdrawn after concerns were raised by families and in the media.

2.10 The interim report was leaked to the media by an unknown source in November 2019. In response, the number of families contacting the review rose rapidly. Over the course of the review further media coverage resulting from debates in Parliament and from police enquiries resulted in large numbers of families contacting the review.

2.11 In addition, further families were referred to the review by local solicitors representing families and there were additions to the review following contact with the local coroner.

The families within the review have been assigned to a number of different cohorts as shown in Table 1.

Table 1: Family cohorts and timing on entering the review

COHORT	DESCRIPTION	YEAR
Secretary of State (SOS)	The original 23 families at the foundation of the review	2017
Original Direct Contact	Families contacted the Chair having learnt of the review through contact with other families or via social media	2018-2019
Legacy (the Trust named this the 'Legacy' cohort)	Trust-led investigation of further cases identified by the review team following scrutiny of documents pertaining to the Secretary of State cohort of 23	2018
Original post-media coverage	In response to growing media interest	2018-2019
Open Book (Trust-named)	NHSI-led data gathering at the Trust (electronic records only)	May 2019
Post-November 2019 media coverage	In response to the interim status update to NHSI which was leaked to the media	November 2019
Post-parliamentary adjournment	In response to a parliamentary adjournment debate on the review	January 2020
Solicitor	Families approached a law firm in response to media coverage which then referred them to the review team	April 2020
Extended Open Book	Trust-led data gathering (to include all paper copies of medical records)	July 2020
Post-West Mercia Police announcement	In response to West Mercia Police statement regarding the launch of an investigation	July 2020
Coroner	Coronial referrals to the review	July 2020
Saves and Learning (Trust-named)	The Trust identified a number of cases to demonstrate learning within maternity services – a selection of these cases were then passed to the review team	October 2020

Changes to the organisation of the review

2.12 By the time of the first COVID-related national lockdown in March 2020 the review had received only a small number of medical records and associated governance documents from the Trust. There were significant delays in receiving medical records from the Trust throughout 2018 and 2019 with NHS Improvement needing to intervene to try to secure the release of records on an ongoing basis.

2.13 In consequence of the growth in the size of the review's investigation NHSE&I commissioned a company to provide the review with an Electronic Document Records Management System (EDRMS) so that the team could access securely Trust medical records which were scanned and uploaded remotely. This was expedited because owing to lockdown the review team's progress was temporarily halted as the team were unable to travel to the review office. The team commenced accessing the medical records via this secure platform from July 2020. All medical records that had been received from the Trust were securely returned to the Trust once the EDRMS system was up and running.

2.14 The review's internal governance structures were adjusted in response to the high volume of enquiries from families who contacted through emails, social media and telephone calls. All of the initial family contacts were recorded, with follow-up arranged, then an assessment and full clinical reviews were conducted where required. In April 2020 a press statement was released advising the public that the review would close to new families in July 2020.

2.15 The first Ockenden report published on 10 December 2020 was outside the original terms of reference but was requested by the Minister to ensure early learning was disseminated to the Trust and the wider NHS. That first report has occasioned some delay to the publication of the final report.

Closure to new families and progression to final report

2.16 When the review closed to new families in July 2020 it confirmed that 1,862 families came within the review. This was widely reported in the media.

2.17 It should be noted that well over this number of families contacted the review; however the events experienced by some of those families fell outside the review's terms of reference and the review team advised them of the alternative routes they could explore, including approaching the Trust through the email address it had set up for families if they had any concerns.

2.18 Once the screening process had been completed there were 1,815 families for whom the review requested medical records in order to conduct full medical reviews. The reduction of 47 cases arose from a number of duplicate cases, (where for example the Trust and the review team had two different names for a woman following marriage).

2.19 After excluding cases where there were missing hospital records or where consent for participation in the review was not given or could not be obtained the final number of families included was 1,486. Some mothers had more than one incident reviewed over the period of this review and in total 1,592 clinical incidents have been reviewed.

Clinical incident categories and data validation

2.20 Families have been assigned to clinical incident categories. The four clinical incident categories described above (maternal deaths, stillbirths, neonatal deaths, and HIE) were defined by NHSI and the Trust when undertaking the Open Book data collection exercise. The remaining categories (maternal morbidity, cerebral palsy, and the combined category) were defined by the review team to encompass other clinical incidents and issues the families experienced.

Table 2: Clinical incident categories

CLINICAL INCIDENT CATEGORIES
Maternal deaths
Stillbirths
Neonatal deaths
Hypoxic ischaemic encephalopathy
Maternal morbidity
Cerebral palsy
Combined category*

**Combined category: comprises medical termination of pregnancy, missed fetal abnormality, intraventricular haemorrhage, infant death, child death*

2.21 All of the families assigned to the maternal morbidity category self-referred to the review and were largely motivated to do this following reports about the review in the media, or through speaking to other families already within the review. The Trust was aware of a few of these cases, where the family had initially raised concerns through the Trust's complaints process. However, the majority did not have any form of governance investigation, whether initiated through the Trust's clinical incident investigation process at the time of the incident or through the complaints process. The overall conclusion by the review team is that the Trust appeared not to be aware of these families' concerns.

2.22 The majority of the families in the cerebral palsy category also self-referred. Similarly, the majority of these families did not have a Trust investigation at the time of their maternity episode. Many of the families reported being concerned about their baby from the time immediately following their birth and spent a number of years trying to find out from health professionals, or through commencing litigation, why their child had been damaged.Whilst the review spans the years 2000 to 2019 it should be recognised that the review team were contacted by many families whose maternity episode at the Trust occurred before 2000 and the earliest case reviewed was in 1973.

2.23 A total of 170 families from before 2000 and 15 families from after 2019 are included in this review by agreement with NHSE&I as a variation to the original terms of reference. Reviews of these cases have been largely determined by the availability of medical records, with the team being unable to review family cases where there were no medical records. For all the cases under review the standards of care that would have been considered acceptable at the time the incident or concern occurred, and the policies and normal practice at that time, have been used as the benchmark.

2.24 Families included within the review after December 2018 are those who self-referred and a small cohort named by the Trust as 'Saves and Learning'. The families within the Saves and Learning cohort were offered to the review team by the Trust as it wished to demonstrate learning and positive service change in its approach to categorising and investigating serious incidents. Some of these cases had been investigated by the Healthcare Safety Investigation Branch (HSIB). The review team felt that as these cases were offered as examples of change and progression, the governance processes for them should also be reviewed. More detailed commentary on this cohort is included within the clinical governance chapter.

2.25 Families who contacted the review with more recent concerns about their maternity experience were referred back to the Trust to be addressed through the Trust's formal complaints process and timeline. The small number of families from 2019 who self-referred and who remained with the review were those who continued to be dissatisfied with the Trust's response to their concerns. The review includes 15 families

from 2019-2020. Some families from 2021 and 2022 also came forward wishing to share HSIB reports and their experience. The review team advised these families to contact the Trust as we were unable to consider their case due to the review being closed.

2.26 The review received some enquiries and heard accounts from a small number of families with poor maternity experiences at other NHS Trusts across England. Following discussion with NHSE&I the review team advised those families to contact the trusts concerned.

Clinical review methodology

2.27 The core review team comprised obstetricians, midwives, obstetric anaesthetists and neonatologists, with professionals from other disciplines joining the team as and when their specialist expertise was required. Over the course of the review the number of clinical reviewers recruited increased to reflect the growing number of families to be considered. The majority of reviewers retained clinical posts at NHS trusts across England, from Leeds to Plymouth, and all review team members remain on their relevant professional registers.

2.28 As the family numbers grew, the methodology for the clinical reviews underwent several iterations, with the process more efficiently managed once the bespoke electronic platform had been built. Each of the family cases has been reviewed, discussed and graded in accordance with the methodology agreed. The clinical care has been graded using a long-established grading of care[34] scoring system developed by the University of Leicester which was also used in the *Report of the Morecambe Bay Investigation*[35] (2015) by Dr Bill Kirkup.

Governance documentation

2.29 Much of this review centres on the quality of the governance processes in place within the Trust, the quality of clinical incident investigations and any subsequent learning following clinical incident investigations. In our first report, we mentioned that we had received a large volume of governance documentation from the Trust which we had yet to consider. We also reported that in the 250 cases considered to date there was evidence that some serious incidents were not investigated. Subsequently we have found that a number of these cases were investigated, but the governance documentation had not been sent to the review team.

2.30 In the summer of 2021 we were advised by the Trust that it had located many boxes of documents potentially relating to former patients and staff, which had been stored in an unused accommodation block. Subsequently it was confirmed that 171 of those boxes contained information relating to maternity cases. Initially the Trust advised the review team that the maternity governance records found were copies of information already sent to us. This was not correct.

2.31 The review had forecast completion of most of the clinical reviews by mid-August 2021 in order to commence writing the report, which was then planned for publication in December 2021. The Trust provided the review team with information relevant to the families we were aware of, undertaking the screening and sorting of this information themselves, the review team were not involved. Having received this new governance documentation concerning so many families in July 2021, concerns were escalated to NHSE&I as this meant that the reviews already undertaken would need to be reconsidered in light of the new information. Our ability to deliver a second report in December was now severely compromised. The Trust continued to send governance documentation until the end of September 2021, which we agreed as a cut-off date. At this late stage, we had received documentation concerning more than 500 families within the review meaning that each case needed to be reopened and the new documents needed to be reviewed in order to determine whether they changed the reviewer's findings and conclusions following the clinical review which had already been completed.

34 https://pubmed.ncbi.nlm.nih.gov/12390986/

35 Kirkup, B. The Report of the Morecambe Bay Investigation. (2015) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

Family voices

2.32 Many families have been offered the opportunity to meet with the chair of the review. From December 2017 until the beginning of 2020 these meetings were through one-to-one meetings in Shrewsbury. These were supported by telephone and email conversations with senior midwives working as part of the review team. Following severe flooding in the Shrewsbury area, and as the COVID pandemic ensued, video-conferencing platforms were used. Conversations were recorded and transcribed, the families were offered copies of the transcript so that they could review and add to their conversation, and the recordings were deleted.

2.33 The review has contacted the families regularly with an all families update on the review's progress. As the review grew in size and the pandemic lengthened, making travel very difficult, it was clear that the review chair would not be able to offer all families a face-to-face meeting. Instead families were invited to submit their accounts and questions via email, phone call or in writing to the review team.

2.34 Families have been offered support through a collaboration with SANDS, Bereavement Training International, and Child Bereavement UK. There is also a psychological support service provided by Midlands Partnership NHS Foundation Trust which will be discussed in detail later on in this report.

Staff Voices

2.35 The Staff Voices engagement strategy, which will be discussed in detail later in the report, was also significantly delayed. This was firstly and understandably at the request of the Trust due to the enormous pressures that it was facing due to the impact of the COVID pandemic. The Trust then delayed the launch of the Staff Voices process which was scheduled for February 2021, until April and then 11th May 2021. There were several hurdles which the review team had to overcome owing to the way that the Trust launched the process within its organisation. This, alongside the late delivery of significant amounts of governance documentation contributed to further concerns about the ability to publish this report by December 2021.

Data platform

2.36 The review team spent many hours screening telephone conversations and emails in order to ensure that the families included within the review met the terms of reference. From November 2019 it became increasingly evident that maintaining records on a system originally intended for 23 families was no longer viable.

2.37 NHSE&I were unable to either provide us access to a fit for purpose secure electronic platform or suggest any other review or public enquiry which could help with recommending a platform for holding the review data, as a review of this volume appeared to be unprecedented. In August 2020 the review commenced conversations with an external provider and were able to secure a contract for development of a bespoke data platform which could be accessed remotely. This data platform was able to securely hold family details and it enabled the review team to write up their clinical findings directly onto the platform.

2.38 The review team started using the platform in April 2021 and transferred over all data from previously completed reports, including the 250 cases reported on in the first report. This enabled the review team to work more responsively and flexibly as the majority of clinical reviewers were now working remotely.

Limitations with regard to data comparisons

2.39 There are limitations that should be acknowledged when interpreting the data presented in this review. For instance, we are unable to be certain whether all cases which meet the terms of reference between 2000 and 2019 have been identified and shared with the review. We anticipate that, using the approaches described above, most of the cases have been identified. However it remains the case, (especially with so much governance material found stored at the Trust in an inappropriate setting and provided to the review team so late in the review process) that there may have been cases that have not been provided to us.

2.40 Finally, we are also cognisant that the Trust has not provided us with information regarding families who experienced adverse outcomes more recently than December 2018, which is the cut-off date it applied in the Open Book and Extended Open Book exercises.

Working with the Shrewsbury and Telford NHS Hospital Trust

2.41 Throughout, the review has been keen to maintain good working relationships with the Trust. There have been several attempts to establish consistency and good communication by ensuring that the review team have a key point of contact at the Trust to assist with swift responses to requests. These contacts changed over time as staff joined and left the Trust.

2.42 The review team also received a very small number of emails from families who have received good care at the Trust. These were acknowledged and shared with the Trust.

Reporting progress to NHSE&I

2.43 The review team has been conscious of the time this review has taken. Following on from the publication of the first report in December 2020 the review team and NHSE&I both wished to follow this up with the final report in December 2021. As outlined earlier the delay in publication to March 2022 has been due to several factors: introducing new electronic data systems, delays in receiving information from the Trust and delays in engaging Trust staff for their views, the complexities of managing a review of this size, and the fact that most of the reviewers in the team held full-time NHS positions.

2.44 During the national COVID restrictions in January 2021, we became increasingly worried regarding the reduced availability of our clinical team owing to the pandemic pressures and the need for them to quite rightly prioritise their NHS commitments. We raised this concern with NHSE&I and with their assistance, and that of the Royal Colleges, we were able to welcome additional colleagues to the team between March and May 2021. This was essential as our projected plan between January and July 2021 was to complete in excess of 1,200 clinical reviews.

Request to delay publication

2.45 In August 2021, recognising that the December publication date was now compromised owing to the late delivery of the large amount of governance documentation from the Trust and the delay with the staff voices engagement strategy, the review team wrote to the Secretary of State for Health and Social Care raising concerns and suggesting an alternative publication date of March 2022. Following discussions this extension of time was agreed by the Parliamentary Under Secretary of State, Minister for Primary Care and Patient Safety, Maria Caulfield MP.

Family feedback

2.46 It is not possible or appropriate to publish clinical reviews of all individual families' experiences in the report. However it has always been intended that the review team would feedback to families in a way that will help them to understand what happened during their maternity care. In August 2021, the review team wrote to NHSE&I outlining the reasons why giving individualised feedback to families about what had happened in their care was so important and why the feedback should be given by the review team. This process of feedback has been agreed and will take place throughout April, May and June 2022.

Closedown of the review

2.47 The review team has used an independent legal team for advice throughout the review. In particular we have received advice on data protection aspects of the review, and will be closing down the review and archiving its records in accordance with all legislative requirements.

Cost of the review

2.48 From its inception, the review has always been mindful that it has been financed through public funding. The review chair has held senior positions within the NHS and is well aware that large budgets have to be managed accordingly with demonstrable accountability for expenditure. All costs have been clearly accounted for each month and ranged from day to day office costs, to the management of the various secure platforms.

2.49 Since 2017, it is publicly reported that the Trust (via NHS Resolution) has paid out at least £50million to families as compensation for babies who have suffered brain damage or have died. In 2018/19, across England, there were 188 successful maternity claims averaging £9.9million each, amounting to £1.86billion in total (NHS Resolution 2019)[36].

2.50 The additional hidden costs for patients of failures in clinical care include relationship breakdowns, mental health issues and ongoing family suffering, which invariably lead to an increase in demand for resources across health and social care. All of these consequences have been acknowledged, recognised and witnessed through the review team's meetings with families in the course of the review.

2.51 Whilst the review team recognises that the costs for conducting this review are significant, they are a fraction of the cost of one successful cerebral palsy claim. It is intended that our **Local Actions for Learning** and the **Immediate and Essential Actions** are deemed strong enough to continue their positive influence of enhancing the safety culture within maternity services across England, in addition to clearly stating the essential sustainable improvements required within the maternity service at the Trust. They are intended to help with the ongoing repair and restoration of public confidence and trust in maternity services both locally in Shropshire and more widely across England.

36 https://resolution.nhs.uk/2020/07/16/nhs-resolutions-annual-report-and-accounts-2019-20/

Chapter 3

Supporting the families during our review

Three tiers of dedicated family support

The Listening Ear service (Tiers 1 and 2)

3.1 The Listening Ear service, comprising three partner organisations: Bereavement Training International, Child Bereavement UK, and SANDS, was commissioned directly by the review team to be available for all families involved in this review. We recognised that the experience of families coming forward and their case being discussed and revisited with them would reignite difficult and painful feelings.

3.2 Key objectives of the Listening Ear service were as follows:

- To offer a support service, not a counselling service, providing in most cases a one-off listening ear session to families.
- To act as a second tier sign-posting service, providing details of national and regional support services for ongoing or specialist support.
- To provide onward referral to a dedicated team of psychologists offering specialist psychological support (Tier 3) where appropriate, or if requested by the family.

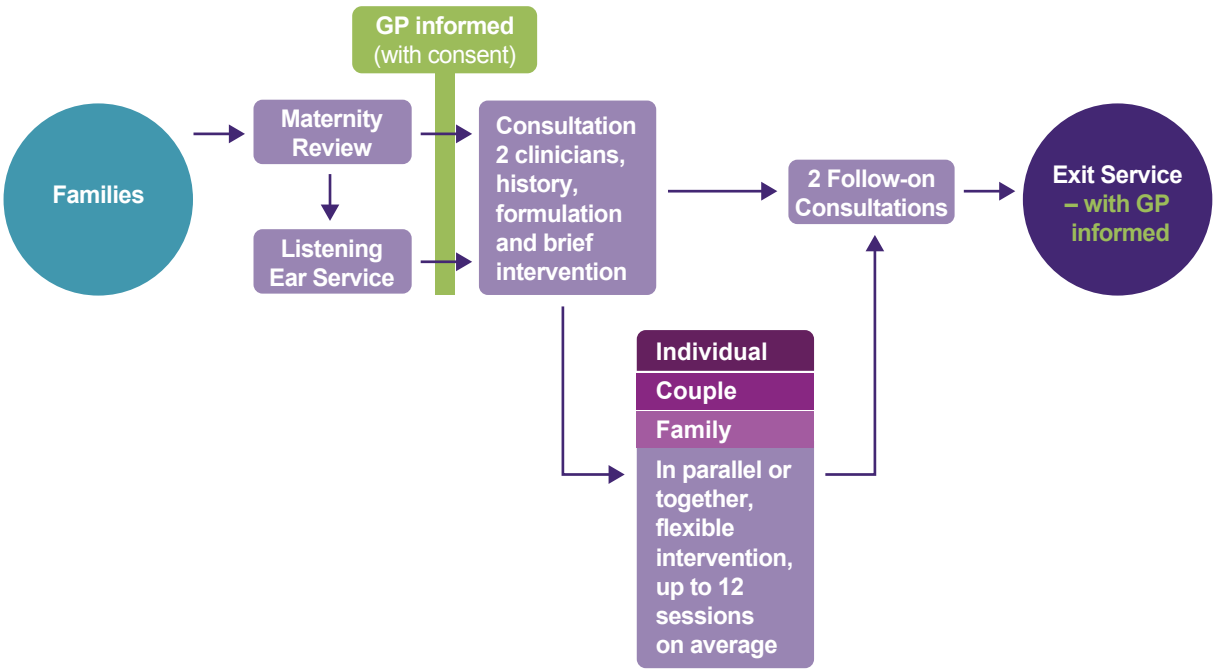
Specialist psychology service (Tier 3)

3.3 As the review team began meeting with families to review their adverse maternity experiences the Chair of the review identified that further support was needed for some families. There was recognition of a gap in service provision for those with complex grief, trauma and emotional distress. This service was beyond the scope of primary care services, but in most cases would not reach the criteria for secondary mental health services. Working in collaboration with the local clinical network and other system-wide stakeholders a specialist psychology service, hosted by Midlands Partnership NHS Foundation Trust (MPFT) and commissioned by NHS England and Improvement (NHSE&I) was established. This dedicated service was designed for families to benefit from an experienced clinician "front-loaded" model, differing from existing services which deliver a stepped model of care.

3.4 A consultant psychologist-led team was recruited to work on a flexible, and at points due to the COVID-19 pandemic remote, basis which also enabled access for those families now living out of the area. Face-to-face provision was also available to any families requesting this, where possible. The duration of support was planned for an 18 month to two year period, with key stakeholders and related care pathways across the local system involved in active, regular review of the emerging clinical data, in order to develop clear plans for transition into relevant care-pathways at the conclusion of this time-limited provision. Extension of the service beyond this timeframe for a period of 3-6 months, to the end of 2022 has recently been requested, in anticipation of the increase in demand following publication of the final report and as families begin to process its findings.

3.5 Access to the specialist psychology service has been via the maternity review team and the Listening Ear service. All families referred were offered a minimum of two consultations (an initial appointment, with the offer of 1-2 subsequent sessions as required) with two psychologists, providing them with an opportunity to feel that their experiences had been listened to and heard. Through embedding this model it was

anticipated that many families would be able to receive support and sufficient intervention at the point of consultation: promoting a positive, strengths-based model, acknowledging the resources families had drawn upon, often over many years, in their own lives to cope with what they had been through. The option of further intervention sessions with two clinicians provided the versatility of either two clinicians working with the whole family, or different parts of a family working in parallel with a different clinician. This model was designed specifically with the importance of continuity of care in mind, in order that families would not have to repeat their story. The diagram below provides an overview of the offer:



3.6 Where initial consultations indicated the need for further psychological interventions, families have been offered a range of NICE recommended treatments based on the individual formulation of their experiences. Treatments have included trauma-focussed Cognitive Behavioural Therapy[37] or CBT, Eye Movement Desensitization and Reprocessing or EMDR[38], couples therapy, and family or systemic interventions. The quality and effectiveness of these interventions has been routinely measured with the use of validated outcome measures, and bespoke client experience measures.

3.7 From the outset the specialist psychology service was developed with a clear exit strategy, remaining responsive to the needs of families, but with the flexibility to adapt the delivery and type of interventions as appropriate, given the time available. Communication with the families has been transparent to explain the scope, access and duration of the service, and with stakeholders preparing for the transition to relevant care pathways both within the NHS and wider local system at the close of this specialist provision.

3.8 Family feedback to the service has highlighted the importance to them of having a dedicated team of specialists with specific knowledge and expertise in the psychological impact of adverse maternity experiences. In particular families have valued the ease of access to the service, with an absence of waiting lists or restrictive referral criteria. Families have also reported how important to them it has been to have the experience of being listened to, understood, and believed, offering the opportunity for a restorative experience of compassionate care.

37 See glossary

38 See glossary

In conclusion

3.9 The provision of a comprehensive package of emotional and specialist psychological support available to all families involved in the review process has been central to helping them navigate the profoundly significant and potentially very painful process of their adverse maternity experiences being reviewed. Many families will have found their maternity experiences to have been life-changing, involving many layers of distress and trauma, with the ripple effects felt by whole families, the wider community, and across generations. The availability of dedicated expert support has meant that families have not had to manage this latest process alone, and have been empowered to have the opportunity to reflect on and understand what they have been through, with professionals committed to facilitating this with care and compassion.

3.10 It is strongly recommended that should any review or investigation be required in the future, this model of family support should be used to inform good practice, drawing on what has been learnt with regards to procedures, protocols and pathways. Above all, there must be recognition that any review of this nature will inevitably impact on those involved, and that the provision of emotional and psychological support should be integral to how the system responds to this need.

LOCAL ACTIONS FOR LEARNING: SUPPORTING FAMILIES AFTER OUR REVIEW IS PUBLISHED

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

3.11 Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families.

3.12 There must be dialogue with NHS England and Improvement and commissioners and the mental health trust and wider system locally, aiming to secure resources which reflect the ongoing consequences of such large scale adverse maternity experiences. Specifically this must ensure multi-year investment in the provision of specialist support for the mental health and wellbeing of women and their families in the local area.

OCKENDEN REPORT - FINAL

Section 2

Internal oversight and external scrutiny

- Background information about the Trust
- Chapter 4. Clinical governance
- Chapter 5. Clinical leadership
- Chapter 6. Our findings following review of family cases

Background information about the Trust

Service overview

3a.1 The maternity service at the Trust is provided as a 'hub and spoke' model with a consultant-led maternity unit surrounded by various midwifery-led units within the Shropshire region.

3a.2 The consultant maternity unit was originally based at the Royal Shrewsbury Hospital site (RSH) until 2014 when consultant-led services were transferred to the Princess Royal Hospital (PRH) site at Telford. Throughout the years there have been a number of midwifery-led units, however some of these are temporarily or permanently closed for intrapartum care due to operational reasons. The current five midwifery-led units are based at Royal Shrewsbury Hospital, the Princess Royal Hospital Telford (the Wrekin unit), Bridgnorth, Oswestry and Ludlow. At the time of publication of this report, the only midwifery-led unit providing intrapartum care is the Wrekin unit co-located (or alongside unit) at the PRH in Telford. There are additional community bases at Whitchurch and Market Drayton.

Geographical area

3a.3 The geographical area covered by the service is approximately 2,500 square miles (including the local authority areas of Shropshire, Telford and Wrekin and parts of mid-Wales). A significant amount of the catchment area is rural; this is likely to be a contributing factor to the number of midwifery-led units within the region and the Trust's ongoing community midwifery service provision.

Birth rate

3a.4 The birth rate figures below have been extracted from the Trust's maternity dashboard and are based on financial years (April - March). The birth rate is gradually decreasing; whilst a proportion of this change is recognised as being in line with the national birth rate, some staff also shared concerns with the review team that women are choosing to give birth elsewhere within the region, rather than at the Trust. One staff member told the review:

'We have a lot of women who come under the Trust's locality but they are choosing to birth elsewhere because they do not want to go there.'

Table 1. Annual birth rate at the Trust 2008 – 2020

												YEAR
WARD	**08/09**	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**	**19/20**
Shrewsbury MLU	503	478	550	478	421	367	235	207	140	120	69	15
Wrekin MLU	477	488	436	435	401	362	336	359	338	351	285	224
Bridgnorth MLU	86	59	98	69	68	75	68	82	75	26	4	0
Ludlow MLU	100	77	81	86	71	62	49	51	37	12	4	0
Oswestry MLU	90	82	83	87	72	74	69	83	46	15	4	0
MLU Totals	1256	1184	1248	1155	1033	940	757	782	636	524	366	239
Home Births	92	90	96	86	91	86	82	63	63	68	75	56
BBA Other	15	11	19	18	21	8	19	14	25	3	8	41
MLU Totals plus Home Births	1348	1274	1344	1241	1124	1026	839	845	699	592	441	295
All Non CU Births (MLU+Home+BBA)	1363	1285	1363	1259	1145	1034	858	859	724	595	449	336
Shrewsbury/Telford CU	3871	3965	3856	3983	4009	3978	3796	4001	4204	4060	4062	4086
TOTAL BIRTHS	**5234**	**5250**	**5219**	**5240**	**5154**	**5012**	**4654**	**4859**	**4928**	**4655**	**4511**	**4422**

Reference: Shrewsbury and Telford Hospital NHS Trust Maternity Dashboard

Demographic

3a.5 The term demographic refers to the structure of a population including (but not limited to) factors such as age, ethnicity, employment and education status. Data was available from a variety of sources including local data from the Trust, as well as large-scale reports such as the Indices of Deprivation[39]. Now more than ever, it is recognised that women from black and ethnic minority backgrounds, and women living in areas with higher rates of social deprivation, are at increased risk of maternal and neonatal morbidity and mortality[40]. Therefore, the continual monitoring of the local demographic is vital in terms of ongoing planning and provision of maternity services[41].

3a.5 The use of electronic maternity information systems (MIS) is now standard in most maternity units in England. However it is important to acknowledge that MIS data is at times incomplete, sometimes because of incomplete data capture as well as individual user input error. Missing data can also be attributed to the constraints and designs of data capture systems, however this is likely to improve with the ongoing development of electronic maternity information systems. It has been recommended that quality improvement indicators should incorporate metrics on data completeness[42].

Ethnicity

3a.6 The majority of women receiving maternity care at the Trust were reported to identify as white British[43]; whilst approximately 10 per cent of the maternity population identified as originating from a Black, Asian or Minority Ethnic background, (BAME) in comparison to a national average of 19-22 per cent[44].

3a.7 Unfortunately, there were 9,276 missing ethnic background details within the data provided by the Trust, which accounts for approximately 9 per cent of the overall data throughout the timescale of the review. It is also evident that the trend of incomplete data on ethnic background is increasing in recent years (Figure 1). The incomplete datasets are also recognised within the Trust's annual perinatal mortality reports between 2013 and 2018[45].

3a.8 Consequently, there are limitations with regard to the correlation of any trends or themes directly linked to ethnicity. However, due to the evidential links of poor maternal and neonatal outcomes of women from ethnic minority backgrounds, as previously stated, it is suggested that all trusts should aim to improve the accuracy of their datasets as part of quality and safety monitoring. Research suggests this is achievable with the use of self-declaration within maternity booking systems[46].

39 Ministry of Housing, Communities and Local Government (2019) 2019 Indices of Deprivation – Telford and Wrekin. https://www.telford.gov.uk/download/dowidnloads//15603/index_of_multiple_deprivation_2019_-_telford_and_wrekin.pdf

40 Knight, M., Bunch, T., Tuffnell, D., Patel, R., Shakespeare, J., Kotnis, R., Kenyon, S. Kurinczuk, JJ. (Eds.) on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19*. (2021) Oxford: National Perinatal Epidemiology Unit, University of Oxford.

41 NHS England and NHS Improvement. *Equity and equality. Guidance for local maternity systems*. (2021) https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf

42 *National Maternity and Perinatal Audit Clinical Report 2017* https://maternityaudit.org.uk/downloads/RCOG%20NMPA%20Clinical%20Report(web).pdf

43 Shrewsbury and Telford Hospitals NHS Trust (2020). Deliveries by Ethnic category and age – 2000-2020.

44 MBRRACE-UK. *Perinatal mortality surveillance report for births* (2013-2018)

45 Ibid n7

46 Jardine, JE., Fremeaux, A., Coe, M., Urganci, IG., Pasupathy, D. and Walker, K. *Validation of ethnicity in administrative hospital data in women giving birth in England: cohort study* (2021) British Medical Journal Open, 11(8). doi: https://doi.org/10.1136/bmjopen-2021-051977

Figure 1. Number of records with incomplete ethnicity data at the Trust 2000 – 2020

Reference: Shrewsbury and Telford Hospital NHS Trust[47]

Age

3a.9 The lower and upper ranges of maternal reproductive age are recognised as a risk factor for adverse outcomes in pregnancy. Although research is limited, evidence suggests younger mothers are at increased risk of various complications including preterm birth and are more likely to have a baby with a low birth weight[48]. Mothers of advanced maternal age are recognised to be at greater risk of complications including pre-eclampsia, preterm birth, stillbirth and neonatal morbidity and mortality[49].

3a.10 Upon analysis of national data for younger mothers, it was observed that the age parameters for 'teenage pregnancy' vary. Whilst the Office for National Statistics (ONS) collates data on conception rates of women aged 15 to 17 years old, national reports into perinatal morbidity and mortality categorise 'teenage' pregnancies as mothers under 20 years old[50]. It is therefore not possible to correlate national teenage pregnancies with perinatal morbidity and mortality.

3a.11 Data from the Trust was compared with data from the ONS to identify whether there was a greater incidence of teenage pregnancies, and pregnancies to women of advanced age, within this review than the national average.

3a.12 The review team noted the Trust predominantly covers two local authority areas, Shropshire as well as Telford and Wrekin. Although the local rates of conceptions to younger mothers have fallen in line with the national average, within Telford and Wrekin teenage conception rates were consistently higher than the national average throughout the timescale of the review (Figures 2 and 3). These findings are also recognised within the Trust's annual perinatal mortality reports[51].

47 Ibid n6

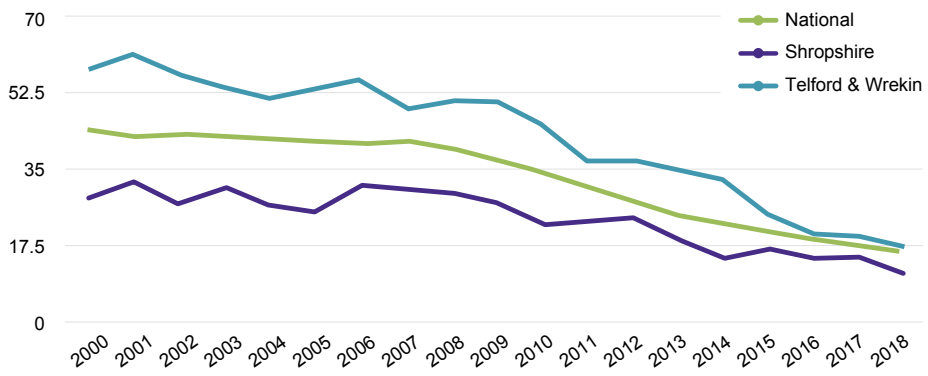
48 World Health Organisation. *Adolescent pregnancy.* (2020) https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

49 Royal College of Obstetricians and Gynaecologists. *Induction of Labour at Term in Older Mothers.* (2013) https://www.rcog.org.uk/globalassets/documents/guidelines/scientific-impact-papers/sip_34.pdfe

50 Ibid n3

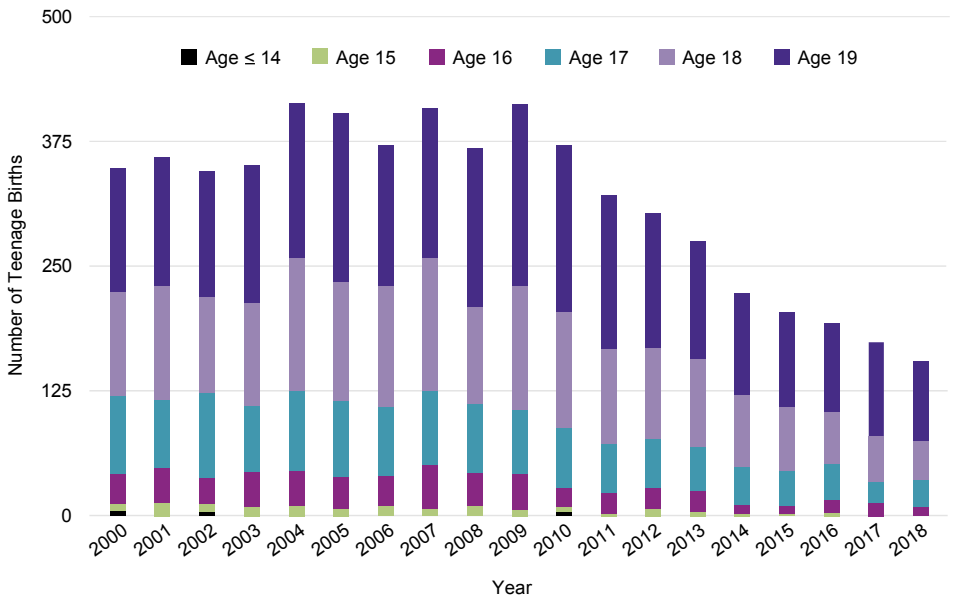
51 Ibid n7

Figure 2: Aged 15 – 17 years of age conception rates per 1000 women



Reference: ONS[52]

Figure 3: Number of teenage births (mothers under 20) at the Trust



**Data from 2019 and 2020 are not reported due to the observed discordance of the annual birth rate reported within the maternity dashboard and birth rate stratified by maternal age provided by the Trust*

Reference: Shrewsbury and Telford Hospital NHS Trust[53]

3a.13 Despite there being a higher proportion of teenage pregnancies at the Trust than the national average, teenage pregnancy cases within the review population (i.e. with adverse outcomes) comprise only 6.4 per cent of cases, which is comparable to the overall proportion of teenage pregnancies at the Trust during the timescale of the review. Consequently, the review team concluded that the increased rate of adverse outcomes observed in the Trust against the national average is unlikely to be due to teenage pregnancies.

3a.14 The incidence of women with advanced maternal age was found to be less than or similar to the national average during the timescale of the review[54]. The lower parameter of advanced maternal age is 35 years old, above which there is a statistically significant increase in the risk of stillbirth and other adverse outcomes

52 Office for National Statistics. *Conceptions in England and Wales:* 2018. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2018#conceptions-by-area-of-usual-residence

53 Ibid n6

54 Ibid n7

listed above. The proportion of women with advanced maternal age at the start of the review was 15 per cent in 2000 and gradually increased to 20 per cent in 2007, after which the proportion did not increase further. This was noted to be in line with national rates of maternities for women aged 35 years and over[55]; therefore, it should not disproportionately affect morbidity and mortality rates at the Trust.

Deprivation

3a.15 Similarly to ethnicity, social deprivation is recognised to be a significant risk factor for morbidity and mortality. MBRRACE-UK reports that women living in the most socially deprived areas[56] are three times more likely to die during or within the year that follows pregnancy than those living in the least deprived areas. Deprivation rates are monitored throughout the country by the assessment of factors such as income, employment, education, living environment, crime, health and barriers to housing.

3a.16 Throughout the time period of the review, a proportion of the geographical area covered by the Trust was regularly ranked within the top 10 per cent of the most deprived areas within the country[57]. Despite this, due to other areas within the region being classified as the 'least deprived', annual perinatal mortality reports consistently highlight the levels of deprivation as similar to the national average[58], therefore morbidity and mortality rates should not be disproportionately affected.

3a.17 The overall conclusion of the review team was that the ethnicity data (though incomplete), the deprivation rates, and the maternal age distribution for the Trust should not have caused any disproportionate effect on morbidity and mortality rates at the Trust when compared with the national average.

55 Office for National Statistics. *Birth characteristics in England and Wales:* 2019. (2020) https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthcharacteristicsinenglandandwales/2019#age-of-parents

56 Ibid n3

57 Ibid n2

58 Ibid n7

Chapter 4

Clinical governance

Introduction

4.1 In line with the terms of reference of the review, this chapter aims to explore whether the local governance within maternity services at the Trust met the standards that would be reasonably expected of it between 2000 and 2019. In doing this, the review team examined a broad range of governance documents supplied by the Trust including, but not limited to, risk management documentation, minutes of meetings, job descriptions, incident notifications, investigation reports, policies, guidelines, audits and complaint responses.

4.2 Whilst acknowledging that the review covers a considerable time frame, and taking account of the fact that governance requirements changed over time, the review team found that the working practices and prevailing attitudes within the maternity service and the maternity governance team at the Trust did not pay sufficient attention to the safety of mothers and babies.

4.3 The key themes identified requiring improvement within maternity services at the Trust were:

- The poor quality of incident investigations
- Poor complaints handling
- Local concerns with statutory supervision of midwifery investigations
- Concerns with clinical guidelines and clinical audit

1. Quality of incident investigation

Background and historical context of incident investigation.

4.4 The definitions and processes for reporting and investigating incidents have changed throughout the time period of the review and therefore the review team has been careful to examine how the Trust reported and investigated incidents in relation to the expected standards at the time.

4.5 A patient safety incident is any unintended or unexpected event which can, or does, lead to harm for one or more patients receiving healthcare[59]. In 2003 the National Reporting and Learning System **(NRLS)**, which is a central database where trusts report incidents, was created and thereafter the culture of reporting incidents to improve safety in healthcare improved nationally. Serious Incidents **(SI)** are acts or omissions in care that results in unexpected or avoidable death or serious harm: 'where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified'[60] to prevent it from occurring again. However it was not until 2010 that a nationally consistent definition of what constituted a SI was published and the use of a specific methodology, Root Cause Analysis[61] **(RCA)**, was recommended for conducting these investigations[62].

59 NHS England, *Report a patient safety incident* https://www.england.nhs.uk/patient-safety/report-patient-safety-incident/

60 NHS England, *Serious Incident Framework*, (2015) https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf

61 See glossary

62 National Patient Safety Agency *National framework for reporting and learning from serious incidents requiring investigation.* (2010) https://www.afpp.org.uk/filegrab/NPSAconsultationdocument.pdf?ref=1064

4.6 In our first report, we identified some of the key issues from the 250 cases we reviewed, which included inconsistent multidisciplinary input to SI investigations which were often cursory and did not identify underlying systemic failings, and failed to learn lessons. In fact we found that some significant cases of concern were not investigated at all.

4.7 Having now considered the care of all families included in the review, in addition to the aforementioned cases for our first report, the review team has identified the following concerns regarding governance in maternity services at the Trust:

a) Incidents that should have triggered a Serious Incident investigation were inappropriately downgraded to a local investigation methodology known as a High Risk Case Review **(HRCR)**, apparently to avoid external scrutiny.

b) When serious incident investigations were conducted many were of poor quality.

c) There was a lack of learning and missed opportunities to improve safety.

d) There was a lack of oversight of serious incidents by the Trust's commissioners.

e) There were repeated persistent failings in some incident investigations as late as 2018-2019.

a. Incidents that should have triggered a serious incident investigation were inappropriately downgraded to a local investigation methodology known as a High Risk Case Review (HRCR), apparently to avoid external scrutiny

4.8 The review team has found a concerning and repeated culture at the Trust of not declaring adverse outcomes as an SI in line with the national framework. Instead, they were inappropriately downgraded and investigated by what the Trust termed a High Risk Case Review (HRCR). This method of investigating incidents, created by the Trust, was less robust, varied considerably in quality and lacked the rigour and transparency of an SI investigation. Notably, HRCRs were not reported to NHS England, the Clinical Commissioning Groups **(CCGs)** or the Trust Board, and therefore avoided external scrutiny.

4.9 In October 2021 during the 'staff voices' 'interviews the review team asked a member of staff for the circumstances in which the HRCR process started appearing within the Trust's local investigation process they responded:

4.10 *One year we were criticised for over-reporting too many Serious Incident investigations. This raised a red flag with the CCG, or the PCT or whatever it was at the time, and they said you've got an awful lot of SIs. We looked back at them and when they were reviewed again, it was decided was that some of them shouldn't have been reported as SIs, we were over-reporting. In our mind these are cases that needed significant review, so we designated them as a High-Risk Case Review, where we will spend quite considerable time looking at them and examining them and trying to learn from them because they are important, but they didn't hit the SI criteria.'*

4.11 The review team saw that frequently an early assessment was made by the maternity service that there was no act or omission in care, which meant that the investigation was downgraded to a HRCR. This meant that the true scale of serious incidents within maternity services at the Trust went unknown over a long period of time.

4.12 The earliest version of the maternity service's Risk Management Strategy available to the review team, version 5, June 2010, correctly defines a Serious Incident (or what was then termed a Serious Untoward Incident) in line with the national guidance[63] and, within section 8.7, includes a clear list of maternity-specific categories that must be investigated as an SI. This list included but was not limited to:

- Maternal death (booked at The Trust and who died up to 1 year following delivery)
- Intrauterine death: over 37 weeks gestation and during an inpatient admission
- Intrapartum death: specifically those that die during labour or during an inpatient admission

63 Ibid n4

- Unexpected neonatal death: from 37 weeks gestation to 28 days post delivery
- Maternal unplanned admission to ITU
- Unexpected admission to NICU: where APGARS[64] are below 4 at 10 minutes and/or the baby has already required intubation.

4.13 Section 8.7.1 said: 'Arrangements for ensuring that all Serious Untoward Incidents undergo a root cause analysis', explains that within the maternity governance meeting 'a decision is made to whether a high risk case review is needed'. Within the document, there is no definition of what an HRCR is. In Version 6.1 from March 2014, section 9.2.9 states that an HRCR will be conducted for those cases 'where there is a poor outcome, patient experience or near miss not fitting the Serious Incident criteria. This additional scrutiny will be an opportunity for transparency, learning and service enhancement'.

4.14 The review team however, found many examples of families who met the criteria to have a full SI investigation, but had an internal HRCR conducted instead. For example, between 2011 and 2019 there were a number of maternal deaths, stillbirths, neonatal deaths and babies born with HIE where an HRCR was conducted. Where these cases correctly underwent a SI investigation, rather than an HRCR, the subsequent investigations were often found by the review team to be of poor quality. Examples of this are found throughout this chapter and other clinical chapters in this report.

4.15 This practice of conducting an internal HRCR when an SI was required is illustrated by a family in **2015**. This involved a baby born by instrumental delivery, which clearly fell outside national guidelines (this delivery occurring with 10 pulls of three sequential instruments). This baby suffered significant skull fractures, brain injury and has ongoing long-term disabilities as a result. Despite this meeting national SI criteria as an act or omission in care which resulted in serious harm[65], the decision was made to conduct an HRCR instead. The HRCR did follow an RCA approach but the quality of the investigation was poor. It did not involve the family, did not identify the root causes but instead concentrated on the incidental findings and the mitigations. Seemingly, the action plan did not offer any learning to the Trust so that similar incidents were prevented from happening again in the future.

4.16 In a typed transcript provided to the review team by the Trust, of a recording of the meeting at which the decision was made to undertake an HRCR instead of an SI for the case of this family, it is stated that an HRCR approach was utilised because *'A high risk case review has a very similar process, but it doesn't get reported to our non-executive, Health England and Tom, Dick and Harry… an SI gets reported all over the patch as far as I can see...'* This approach was taken despite the fact that following its 2014 visit the CQC highlighted its concern to the Trust about an under-reporting of SIs in maternity. There is also evidence from the same meeting that some individual members of staff present were not happy with how the investigation process was being run, with one attendee, (a staff member) insisting that the meeting was recorded. They said: *'My experience of the way that some of the investigations have been run have led me to believe that I should record this'.*

4.17 From the documentation supplied to us by the Trust the review team has been unable to identify when the Trust started using HRCRs or why they were implemented but the 2014 Maternity and Risk Management Strategy, version 6.1 stated that their aim was to *'establish a clear and complete chronology of what happened on the date of the incident and any preceding events that could have impacted on the outcome for the family'.* This is too narrowly focused and so, in many cases, an HRCR failed to identify why the incident occurred, meaning that many learning opportunities were missed. Confusingly, the HRCR investigations often used phrases such as 'Root Cause Outcome', 'RCA meeting' and 'RCA discussion', when in fact a root cause analysis was often not performed. Failing to do this properly meant that families were not given the answers they sought and deserved, the Trust did not identify the underlying issues that led to the incident occurring, and lessons were not learnt, so increasing the risk of further harm to families under the care of the Trust.

64 See glossary
65 Ibid n2

b. When Serious Incident Investigations were conducted many were of poor quality

4.18 When an SI was declared and a full RCA was conducted the quality of the reports was better than for the HRCRs, however many were still not of the standard that would have been expected. The review team has described the specific omissions with regards to serious incident investigation within the chapter on maternal deaths, however the review also found similar themes when assessing other serious adverse outcomes.

4.19 The Royal College of Obstetricians and Gynaecologists **(RCOG)** undertook an Invited Review of maternity services at Shrewsbury and Telford Hospital NHS Trust on 12–14 July 2017. This identified that the Trust's process of investigating SIs was complex and failed to adhere to recommended timescales; in one case reviewed by the RCOG team some 8 months after a stillbirth the report was still incomplete. The RCOG team also identified that the Trust's internal team conducting the investigations was not appropriately resourced or trained in RCA methodology. It also identified that there was no culture of shared learning, that the RCAs often focused on the wrong issues, lacked system wide actions and focused instead on non-specific actions such as 'share report widely' and 'learn from events'. There was no documentation that action plans were completed and recommendations often focused on individuals, rather than recommendations for system changes.

4.20 The Ockenden review team has found similar failings to those identified by the RCOG team in 2017 including long waits for families to be given answers, investigations that focused on describing what happened rather than why, a focus on individual errors rather than systemic issues, and actions that were unlikely to prevent recurrence.

4.21 *A young mother in **2013** had what the RCA described as a 'prolonged pregnancy with intrauterine death' but failed to examine why this occurred and missed causative factors identified by the review team such as lack of fetal monitoring for 15 hours during the induction of labour process. The review team also identified terminology in the Trust report which could be seen as imparting blame on the mother, suggesting that 'patients liked to be left to sleep', putting the emphasis on the mother for not reporting fetal movement concerns, rather than assessing why there was a lack of fetal monitoring. The RCA recommended that fetal viability should be assessed at least once per shift and the Maternity Governance meeting (06.08.13) 'Confirmed with the… manager, [this recommendation was] now embedded in practice and agreed that manager to undertake audit'. The review team however has found no evidence that an audit was undertaken and even within the Trust's 2017 v5.5 Induction of Labour guideline, there is no evidence this practice has been embedded. (2013)*

4.22 *In **2015**, a family did not receive an apology from the Trust, were not involved in the investigation, were not asked to submit questions and waited over 12 months to find out why they suffered an intrapartum stillbirth. The subsequent report focused on individual errors, for example "educational need for midwife – sticker regarding fetal movements absent" and missed the systemic issues contributing to the incident. (2015)*

4.23 *In **2015**, a family waited more than 9 months for an SI to be declared after they suffered an early neonatal death, despite the Trust's 2014 Maternity Service's Risk Management Strategy Version 6.1 stating an SI should have been conducted from the outset. The RCA described the cause of death as a 'sub-acute cord compression leading to acute cord obstruction', but failed to identify why this happened. There was no mention of concerns identified by this review team such as a failure to upgrade intrapartum care to a high risk pathway, and staffing issues and shortages meaning that 1:1 care could not be provided. There was also a failure to monitor the fetal heart rate adequately. This lack of attention to the root cause of the incident meant the systemic issues related to why the incident occurred were not identified and the recommendations that were made did not address the systemic issues within the Trust's maternity services at the time. (2015)*

4.24 In later years there is evidence of improvement in the quality of some SI investigations. In **2017**, a family suffered a similar incident to earlier cases, namely an intrauterine death whilst awaiting an induction of

labour in hospital. The RCA identified multiple systemic and organisational issues resulting in a delay in transferring the mother to the labour ward. The recommendations focused on addressing the issues that created the delay, for example the closure of triage at 8pm putting additional pressure on the labour ward, and how these could be addressed. The report also highlighted that there was *'a culture of normalising long waits for women undergoing induction of labour, who are ready to be transferred to the delivery suite [labour ward] when the delivery suite is busy'*. It should be acknowledged that this was highlighted and multiple recommendations were focused on making improvements. However the review team is of the opinion that the poor investigation of the earlier incident from 2013 represents a missed opportunity to improve and to potentially prevent future incidents, such as this incident in 2017.

c. Lack of learning and missed opportunities to improve safety

4.25 Once investigations were conducted the review team still found there were multiple missed opportunities for the Trust's maternity service to learn, improve and prevent future harm occurring to other women and babies.

4.26 There have been some attempts to improve the safety culture and learn from incidents. In June 2017 the Trust conducted an internal review[66] of maternity services. It considered the history of maternity services between 2007 and 2017, focussed on issues of patient safety, learning, and engagement with bereaved parents. The report further stated that the service must 'create a coordinated approach to the maternity safety improvement plan' and that 'safety in maternity is protected by the efforts of the staff and supported by leaders'. The review concluded that 'all patient safety actions should be in one plan against a framework that makes sense to the staff that run the service'. As of January 2022, the review team has not been provided with this action plan or seen any evidence of its existence in the information provided by the Trust and therefore we cannot comment on the efforts made and any impact of this plan in improving learning and safety at the Trust.

4.27 *In **2010** a woman developed chorioamnionitis[67] and the baby was born in a poor condition, requiring cardiac massage, and subsequently developed brain damage. At the time there was no incident report completed, no review of the care provided, no investigation performed and therefore no learning. In 2018, the Trust asked external experts to review the care provided to the family and they found that the CTG heart monitoring was abnormal for most of the duration of the labour and that there was a lack of obstetric reviews despite midwifery concerns. Oxytocin was started and increased inappropriately when the CTG was abnormal and was also increased despite hyperstimulation in the second stage. They also found that there was a long period of fetal bradycardia not acted upon, and despite performing an instrumental delivery with meconium present the neonatal team were not called to be present at the delivery. This was not one failing in care, but multiple failings. What is clear from the intrapartum section of this report is that issues with the inappropriate use of oxytocin, amongst other failings identified in this case, did continue after 2010.*

4.28 *The lack of investigation in **2010** for a family resulted in a missed opportunity to learn and, due to this it is likely to have resulted in similar situations occurring to other women. Also concerning is that the family were seen a week after the birth of their baby by an obstetric consultant who explained that 'You made good progress in labour and had a very straightforward ventouse delivery for delay in the second stage of labour. Your baby's condition was much unexpected… what is very confusing is that the continuous heart rate monitoring that was performed during labour did not show any signs of your baby becoming distressed and this is unusual'. This was either an unintentional misunderstanding of the clinical situation or a purposeful lack of transparency and honesty. Either way, this follow-up and review was not fit for purpose. The poor governance processes at the time meant that this family waited 8 years to find out there had been significant failings in care that led to their child suffering brain damage. (2010)*

66 Review of Maternity Services 2007 – 2017 by Colin Ovington, on behalf of the Quality and Safety Committee, dated 27th June 2017, provided to the review team by the Trust

67 See glossary

4.29 The review team also found evidence, over many years, of how a failure to investigate harm appropriately at the time meant learning opportunities were missed and subsequently led to other women suffering similar harm. The following three examples over a 12-year period demonstrate exactly this:

4.30 *Firstly, in **2006** a child was born with brain damage (HIE) after the mother developed an infection (chorioamnionitis) due, in part, to multiple inappropriate vaginal examinations after her waters had broken before she was in labour. No investigation was done, no learning identified and therefore no actions were taken to prevent a recurrence. (2006)*

4.31 *Secondly, in **2011** a child developed multiple long term disabilities secondary to inappropriate care in a similar situation (waters breaking before labour). Despite the baby spending 23 days on the neonatal unit there was no investigation performed and again, a missed opportunity for learning. The Trust acknowledged at the time that the 2004 guideline followed at the time was inappropriate and 'very out of date'. Nevertheless, it was still not updated for another three years until 2014. (2011)*

4.32 *Thirdly, in **2015** a very similar incident occurred, with repeated unnecessary vaginal examinations despite the woman's waters having been broken for more than 48 hours before labour and this subsequently led to an infection (chorioamnionitis) and a poor outcome for the baby This poor outcome could potentially have been prevented had investigations been conducted in previous years following competent and appropriate multi-professional governance processes by a team with a willingness to learn. (2015)*

4.33 *In **2016**, the Trust had a second opportunity to review the care provided to a family but this opportunity was again missed. The mother initially made a complaint but after receiving an inadequate response from the Trust, contacted the Parliamentary and Health Service Ombudsman (PHSO[68]), who conducted a review in 2018 and identified failings in care. It was only at this point, three years after this third incident, that the Trust created an action plan to reduce the likelihood of recurrence in the future. The review team however has been unable to find any clear evidence from the information supplied to us by the Trust that the change following the PHSO report has been implemented. (2016)*

4.34 Sadly, the review team encountered many further examples of repeated missed opportunities to learn:

*In **2009** a baby born at the Trust was admitted to the neonatal unit with severe hypoxia and suspected HIE. The baby subsequently died within 12 months of birth due to complications from severe cerebral palsy. There was no investigation performed after the baby was admitted to the neonatal unit with HIE and a missed opportunity for improvement. After the birth the parents met with two consultants who could not identify what went wrong and decided against asking for an external investigation. (2009)*

4.35 *In **2010**, the Trust had a further opportunity to review this case after receiving a complaint letter from the family. However the family have explained to the review team that this response lacked sympathy and compassion and again did not identify any failings in care. The issue of a lack of learning is multi-professional and the neonatal team did not review the care they provided either. Subsequently a letter to the GP from the consultant obstetrician explained that the labour care was 'appropriate' and nothing could have been done differently.*

4.36 *It was only after a second complaint response in **2017**, with a new Chief Executive at the Trust that an external investigation was conducted. In 2018, 9 years after the initial incident occurred, an investigation*

68 See references – various documents on PHSO consulted for this chapter inc:

1. Parliamentary and Health Service Ombudsman (PHSO). Learning from mistakes. 2016.
2. Parliamentary and Health Service Ombudsman (PHSO). A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged. 2015.
3. House of Commons Public Administration and Constitutional Affairs Committee. Will the
4. NHS never learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England. 2017.

identified multiple failings, substandard care and that the delivery should have been sooner. Despite the long delay and the multiple failings, the review team could not find any evidence that this report was shared with the family.

4.37 *In **2011** a woman was inappropriately discharged home with severe pre-eclampsia and subsequently had an eclamptic seizure within 24 hours. No incident form was completed, no investigation occurred (2011)*

4.38 *A mother at 36 weeks gestation with diabetes whose antenatal CTG was persistently abnormal for 3 days whilst in hospital, which should have prompted delivery, was discharged home without a plan in place and subsequently her baby died (2011)*

4.39 In the second case above the review team found the care provided to the mother to be significantly suboptimal, however only a cursory internal review was conducted, (notably the CTGs had disappeared) and no clear recommendations for improvement were made.

4.40 The review team also identified that many governance documents between 2009 and 2019 included the following inappropriate images. These images were found on multiple SI reviews, HRCR reviews, minutes of maternity governance meetings, quarterly maternity safety reports, patient safety events, feedback of learning documents and an external letter to the ambulance service. The review team felt that having such images on governance documents was insensitive and demonstrated a lack of professionalism.

d. Lack of oversight of Serious Incidents by the Trust's commissioners

4.41 When an SI investigation is completed locally, it is reviewed by the local Clinical Commissioning Group (CCG) for approval and closure if the investigation and action plan are deemed appropriate. Previous national reports have highlighted concerns that despite closure of incidents, once external scrutiny is applied to the original investigations they are often found to be of poor quality, thereby questioning the oversight of commissioners in this process[69]. The review team also identified extensive and repeated concerns with the quality of SIs undertaken by the Trust, which may indicate a lack of external scrutiny.

4.42 The Telford and Wrekin, and Shropshire, CCGs undertook a review of the Trust's maternity services which was published in 2013 and found the Trust was *'a safe and good quality service, which is delivered in a learning organisation'*[70]. The commissioners' review of risk management focused on reported SIs and near misses in the period 1 April 2012 to 31 March 2013, which was likely to have underestimated the scale and volume of incidents. It also looked at policies, clinical governance systems, care pathways, and training, and concluded that: *'There was an openness and transparency in reporting and investigation culture,*

69 *Magro M, Learning from five years of cerebral palsy litigation claims.* (2017) NHS Resolution https://resolution.nhs.uk/wp-content/uploads/2017/09/Five-years-of-cerebral-palsy-claims_A-thematic-review-of-NHS-Resolution-data.pdf

70 Telford and Wrekin Clinical Commissioning Group, Shropshire Clinical Commissioning Group, *Maternity Services Review: The Shrewsbury and Telford Hospital NHS Trust* (2013) https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MTU5OTY%3D

which has led to a higher reporting of serious incidents than would have been reported elsewhere'. The review stated further *'There is a robust approach to risk management, clinical governance, and learning from incidents'.* The review team has identified failings in a lack of incident reporting, low levels of SIs being declared, poor quality RCAs and investigations where lessons are not learnt and further harm is caused at the same time. These failings beg the question as to whether the CCG review process was fit for purpose.

e. Persistent failings in incident investigations as late as 2018-2019

4.43 The Trust shared with the review team a selection of self-selected maternity incident investigations from 2019 which the Trust entitled 'Saves and Learning.' These maternity cases were submitted to the review team with the aim of demonstrating improvements in maternity investigation methodology during the latter years and as examples of good practice. There were 12 cases in total. The total number of maternity incidents occurring in the Trust during 2019 are unknown. Improvements in investigation processes have been developed since 2018 and there is now more focus on learning and feedback in different forums, however what is not clear from the evidence seen by the review team is whether these forums are open to all staff groups and whether staff are enabled and encouraged to attend. Extracts from the Maternity and Neonatal Collaboration Survey in 2018[71] demonstrate that staff felt that feedback from incidents was still not disseminated as well as it could have been *'Ensure feedback from any incidents is clearly communicated to staff to ensure continued staff learning and development'.*

4.44 The 'Saves and Learning' investigations demonstrated improvements in asking families to contribute to investigations, they were asked to forward their concerns and recollections or attend a meeting if preferred. There was also improved oversight of the recommendations and actions at governance meetings and when actions were delayed, the review team saw evidence that there was timely follow up with action leads. However, the review team identified from the small sample provided by the Trust that the local processes needed to be further improved, in particular:

- There was a lack of consistency in the seniority and staff groups that attended the rapid review meetings and the panels did not comprise of staff members senior enough to decide on the level of investigation.
- There was no oversight or accountability from the Director of Midwifery nor the Clinical Director for obstetrics or the consultant lead for risk.
- There was still a reluctance to declare an SI and in most cases a HRCR was still conducted, when an SI would be the appropriate investigation.
- Actions did not always correlate with the findings of the investigation.
- Action plans were monitored by the quality improvement midwife however there was no evidence in the cases reviewed that they were overseen by the senior leadership team. During the staff voices meetings in late 2021 a member from the senior Trust team raised concerns to the review on the suitability of staff who were responsible for quality improvement and safety. They explained that staff were promoted to roles without previous substantive clinical experience and without any means of formal support.
- Significant delays in completing all of the 12 Saves and Learning cases from 2019 that were shared with the review team by the Trust.
- Despite families being asked to contribute to the investigation they were not actively involved or empowered to do so. This is in stark contrast to the recommendations from NHS Resolution[72] that

71 Maternity and Neonatal Collaboration survey 2018, provided by the Trust

72 Ibid n11

women and their families should be actively involved in investigations. Best practice from HSIB[73] shows that with a dedicated focus on actively encouraging families to be involved, 86% of families within maternity investigations will engage with investigations.

- In discussing the safety of the unit and the robustness of governance processes, during the time they worked there, some staff showed a willingness to bring in changes to improve safety in an unsupportive system. When asked if the unit was safe they responded: *'I don't … I don't even know if I can answer that. I felt it was safe on a day-to-day business basis, based on day-to-day firefighting and operational exhaustion from people trying to do the right thing'.*

4.45 Despite the improvements the Trust believes it has made, anonymised extracts from the Maternity and Neonatal Collaboration Survey in 2018 demonstrate concerns by their own staff regarding an unsupportive culture and one of blame following SI investigations. One extract included *'I am concerned that midwives who have made errors are treated badly, one midwife was on the verge of suicide due to the way she was treated in her involvement in a SI. More support and care, counselling and help needed in these situations so that the practitioner is not pushed to breaking point or self-harm from intense pressure.'* Another contributor to the same 2018 survey said: *'senior management in care group or above not understanding real issues. Not learning from mistakes'.*

4.46 These findings by the review team differ from the publicly presented findings of two external reviews; firstly, the addendum to the RCOG Review of Maternity Services on 27 April 2018[74]. The original report, which was more critical, had been completed in 2017, but was not presented to the Trust's Board until an addendum had been prepared which highlighted a much more positive situation with risk management than actually existed. This is discussed in more detail elsewhere in this report. The 2018 addendum to the 2017 RCOG report stated that: *'The Care Group has strengthened its risk management structure, risk management meetings are held regularly and rapid review meetings following incidents are executive led' and that 'RCA investigations follow the NHS Improvement SI Framework'.* Secondly, the 2019 CQC[75] report of maternity services at Princess Royal which felt that *'the service mostly managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service'.*

4.47 Patient safety relies on maternity services receiving appropriate and timely feedback from regulating bodies to ensure improvements can be made and in these examples above the external systems for review and monitoring of the Trust seem to have failed.

2. Poor complaints handling

4.48 Effective local complaints handling is a part of good clinical governance, enshrined in the NHS Constitution[76]. Done well and in a timely manner, a complaint response can provide patients and families with the answers they deserve, allows areas of concern to be identified and can be used to analyse trends to improve services. In Wales[77] the NHS has published extensively on the benefits of complaints to a service. The review team identified that the Trust performed poorly in all of these areas and identified the following concerns:

a) Lack of senior oversight and input into complaints handling and patient experience

b) Lack of openness and transparency.

73 Healthcare Safety Investigation Branch *Annual Review 2020/21* (2021) https://hsib-kqcco125-media.s3.amazonaws.com/assets/documents/HSIB_Annual_Review_Brochure_2020-21_FINAL.pdf

74 Shrewsbury and Telford Hospitals NHS Trust Board Report (2018) outlining the Royal College of Obstetricians and Gynaecologists review of maternity services. https://www.sath.nhs.uk/wp-content/uploads/2018/07/12-RCOG-Report.pdf

75 CQC report provided by the Trust to the review team, site visits were November 2019 and the report published in January 2020

76 NHS Constitution; NHS Complaints Guide, (updated January 2021). https://www.gov.uk/government/publications/the-nhs-constitution-for-england/how-do-i-give-feedback-or-make-a-complaint-about-an-nhs-service [Accessed on 28 October 2021]

77 NHS Wales Using the gift of complaints (2014) http://www.wales.nhs.uk/usingthegiftofcomplaints

a. Lack of senior oversight and input into complaints handling and patient experience

4.49 The review team identified that there was a lack of input from senior members of the leadership team in the writing, review, approval, quality control and trend analysis of complaints. There is no evidence available that the Head of Midwifery, Director of Midwifery and Clinical Director were ever advisory on complaint responses before they were sent to the Trust's Patient Experience Team for the then CEO's signoff. Neither is there any evidence, that complaint themes and trends were analysed and used proactively to improve the service. Even in the latter years of the review period it was unclear what structure was in place for answering complaints and where the accountability lies.

4.50 The review team identified that in 2009, the Trust created a Patient Experience Midwife post. This role was created to provide an effective and timely complaints and claims procedure framework. One of the main objectives of the role was to develop a patient involvement strategy to contribute to the clinical governance agenda and to maternity service development. This role and scope was innovative for the time, however there is no evidence shared with the review team that the objectives of the role were actually ever met. Despite the creation of this role many years earlier there has been no documentation provided of a patient experience strategy or any evidence seen that the Maternity Services Liaison Committee **(MSLC)** or (from 2017) that Maternity Voices Partnership **(MVP)** meetings were included within the terms of reference for clinical governance meetings.

4.51 Whilst the review team acknowledges that the role and job description was forward thinking, the patient experience midwife post lacked the required experience and authority to lead on patient experience, complaints and claims. This meant that from its introduction the post was undervalued. Additionally, it devolved responsibility and oversight from the divisional senior leadership team to members of staff who had no real influence in changing practice.

4.52 Between 2007 and 2013 it appears from information provided by the Trust that complaints were managed between two members of staff who worked part time, one of them a retired member of staff who returned to work one day a week.

4.53 One staff member described the process of responding to a complaint to the maternity review team as: *'[the second midwife] would look up some of the notes or [they] would get information, [they] would start to put a response together and then I would look at it, tidy it up or ask for more information when I came in. The actual complaint came in and we started to look at the notes, look at all the things that had been written down and then talked to the people that were involved in that case. Then from their comments and from what was written and from the patient's letter, we started to investigate what had happened and understand what had happened and then try to put a response together for the patient. Those all had to go, of course, to the Chief Executive office because they all go out in [their] name, not ours'.* There was no evidence that other members of the maternity department contributed, or that responses were reviewed before being sent to the CEO for approval.

4.54 With regards to trend analysis, the review team has seen evidence that complaint trends were identified at maternity governance meetings but there was no evidence that actions were taken to prevent similar incidents occurring. In 2009, the Clinical Director informed the members at the maternity governance meeting about the existence of a separate monthly meeting where complaint themes were discussed and that monitoring of actions would occur at the maternity governance meeting. The review team however has seen no evidence that this forum was ever formed and no evidence of action plans being presented to the governance meeting.

b. Lack of openness and transparency

4.55 There is evidence that complaint responses lacked transparency and honesty, especially with regards to clinical care. The review team has identified families where care was sub-optimal, where different management would likely have made a difference to the outcome, however the complaint responses

justified actions, delays and omissions in care. In addition, they often lacked compassion and in a number of responses it was implied that the woman herself was to blame.

4.56 There are examples of families whose complaint letters were dismissed, only for external investigations, sometimes many years later, to identify failings which should have been evident at the time, had a thorough complaints investigation been conducted.

4.57 *In one example from **2013** a baby was born in a midwifery-led unit and diagnosed with Hypoxic Ischemic Encephalopathy (HIE) secondary, due to a failure to monitor the fetal heart rate (FHR) appropriately in labour. The complaint response from the CEO stated that the fetal heart rate was normal, and that it was recorded at specified intervals of every 30 minutes in labour. The multi-professional review team did not agree that the heart rate was normal and thinks the response to the family is incorrect. (2013)*

4.58 On a number of occasions parents wrote to the Trust find out whether their case had been investigated, often in situations where an investigation should have been conducted and the family involved from the outset; cases range from intrapartum deaths to severe physical and developmental disabilities.

4.59 *After complaining in **2009** a mother reported to the review team that: 'The response to my complaint made me so angry. It didn't address any of my concerns…and was misspelt.' (2009)*

4.60 *In **2009** another family wrote to the Trust pleading for them to open an investigation into the death of their baby, requesting to be involved in the investigation and asked whether if things were done differently the outcome would have been different. In the response received the Trust said: 'The protocols for dealing with CTGs are clear and laid down for all staff. All staff, both midwives and doctors receive updates on the interpretation of CTG traces every 6 months. The loss of X was unexpected therefore difficult to prevent as [the] CTG trace was not indicative of an at-risk fetus that needed immediately delivery. If every dubious or worrying CTG resulted in an emergency caesarean section then ⅓ of all women would be delivered surgically'.*

4.61 The Trust continued: *'Patients cannot demand a caesarean section. They can request one and discuss the issues with the consultant but if the attending medic does not agree that a caesarean is necessary they will not undertake one'.* (2009)

4.62 This is a tragic case of a neonatal death where an independent investigation undertaken in 2018 identified significant failings in care and also a failure of the Trust at the time to learn lessons and recognise that earlier delivery could have altered the outcome for this family.

4.63 *In **2018** an investigation was started without the woman being told an investigation was ongoing or being asked to contribute. This is despite Duty of Candour[78] being well embedded nationally and being a legal requirement. The family received a written complaint response that outlined actions the Trust had put in place and completed but at a subsequent complaint meeting the parents questioned the honesty and transparency of the written response as the actions had not started at the time of the meeting. The family said: 'It's the fact that, when all this first happened, we went through an awful lot…and to be told that you had spoken to Dr X. Dr X had completed some key learns and due to that, you thought nothing was wrong, so you closed the investigation…but since then, obviously, we've found out that none of that actually took place'. (2018)*

3. Local concerns with statutory supervision of midwifery investigations

4.64 The overarching responsibility of the Local Supervisory Authority (LSA) and Midwifery Supervision was to protect the public by monitoring midwives' fitness to practice and instigate remedial actions where necessary.

78 General Medical Council, The professional duty of candour https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong/the-professional-duty-of-candour

4.65 From 2001, the Nursing and Midwifery Council **(NMC)** gave powers to the midwifery body, composed of trained Supervisors of Midwives **(SoMs)**, in the form of statutory supervision in accordance with the NMC's rules and standards to regulate midwives. Supervision was subsequently removed from statute in 2017 and replaced by a new model which was based on midwifery education and quality improvement. The review team has considered the role of midwifery supervision in-line with what was current practice from 2000 to 2017.

4.66 As a consequence of family complaints there were a number of independent reviews commissioned into the quality of supervisory investigations undertaken by SoMs at the Trust. From the governance documents the review team has received from the Trust there is minimal evidence that investigations were taking place, however there are some SoM updates within the maternity governance reports which indicate that investigations were taking place. We have received a small number of investigation reports which were of poor quality and which, from their dates, appear to have been conducted many years after the incident.

4.67 A significant number of SoM investigations provided by the Trust to the review team were all dated during one week in December 2016 and written by a single SoM. Some of these investigations related to incidents that occurred over 10 years prior. The review team were informed that this was due to a member of staff recognising that the original investigations lacked objectivity, with gaps in their quality.

4.68 This appears to be a conscious attempt to identify any significant practice issues, however it is unclear whether the midwives involved in the older clinical incidents received feedback - although this would have been out of date given the length of time since many of the incidents took place.

Findings from an RCA review and supervisory records:

4.69 A family experienced an unexpected admission of a term baby to the neonatal unit in **2015**, with the baby subsequently dying aged 5 months. A rapid response meeting was held to review the care and identify any immediate learning. At this meeting there were no identified SoMs present.

4.70 This initial review recommended that, due to the potential for long term harm, the RCA level should be undertaken as a serious incident. The supervision, (SoM) team was notified 2 weeks after the incident and a supervisory investigation was undertaken a month later. The investigation went ahead, however there was no chronology to benchmark the midwifery care against the standards of care at the time. From the initial 72 hour review there appeared to be a primary fixation on the lack of differentiation between the maternal and fetal heart rate, contributing to the difficulty in interpreting the fetal heart rate.

4.71 At this first meeting, it is unclear whether the maternity team considered the overall picture of this mother's labour. A further rapid review meeting was held 3 weeks later. The discussion at this stage still failed to demonstrate a detailed understanding of the 66 minute period when the fetal head was on the perineum, at a time when the umbilical cord will have been compressed. (2015)

How staff members described the SoM team:

4.72 Staff members described to the review team that the culture of the SoM team between 2010 and 2016 was discriminatory and non-inclusive. The review team heard from a midwife, in October 2021 who stated that they '*never felt [they} could fit in with the culture of the unit and were made to feel like an outsider by [their] colleagues'.* Though initially supported upon qualification to undertake the SoM Preparation Course [X] was not appointed into a SoM role because 'the existing SoM team did not want [X] appointed'.

4.73 Another member of staff raised concerns that SoM investigations were not transparent or fair and lacked rigour: *'I started to see gaps and I started to point them out and say, "Well actually, look, we've got the same people. The same people are involved in these reviews. The same people did the supervisory investigations, the same people marked them, the same people in the LSA marked them, we've got these patterns".'* It is evident that staff raised concerns about the quality of the investigations at the time, and

some conscious attempts were made to establish some objectivity, the same staff member added: *'There were reviews from a supervisory perspective and we still just about had supervision then [2016] so we did do that and we did some deep dives into…so we did reviews, but if you like, we were still marking our own homework.'*

External reviews of the SoM function at the Trust

4.74 Information provided to the review team indicates that there have been two external independent reviews of a midwifery supervisory investigation previously undertaken by the Trust's SoMs. The Local Supervising Authority Midwifery Officer (LSAMO) – the senior person who was responsible for upholding the standards of midwifery supervision at a regional level - Annual Report April 2014 – March 2015 stated that a complaint was received regarding the LSA function during the 2014-2015 supervisory year. The complaint related to a family who requested a review of a supervisory investigation in relation to the birth of their daughter in 2009. The family were gravely concerned at the lack of quality and accuracy of the initial investigation.

4.75 The external review concluded that the quality of the supervisory investigation was poor. There were a number of inaccuracies in the timeline and events, the facts of the incident were not established and the principles of the midwifery supervisory investigation were not adhered to. In the period between the initial investigation and the external report in 2015, there was no local learning or safeguarding of the public during a 6 year hiatus. Following the external review, the investigating SoM was found to be unsuitable for the role and they were removed from their supervisory duties by the LSAMO.

4.76 The second independent review was of a case of maternal death and intrauterine death. It was commissioned by the regional Chief Nurse in 2016. From information provided to the review team we found that the original investigation is incomplete, and has focused on the methodology of the investigation rather than the actual investigation of the incident.

4.77 The external investigation identified that two of the nine midwives who cared for the family would benefit from more support and development and the remaining seven should reflect on the care they provided. The original Trust investigation had only reviewed the care of one midwife and found no further learning was required. It had concluded that there were not any serious concerns in relation to midwifery practice.

4.78 The review team considered the language used at times in the reports seem to be inappropriate for the tragic outcomes and impact on the whole family. When discussing a meeting with family members as part of the investigation, they used terms such as the family being 'brave'. The external reviewers thanked the family member for involvement in the second review and described their 'graciousness' for taking part in the investigation.

4.79 The review team's opinion is that the external (or second) investigation also failed to identify that with improved care the outcome for the woman could have been significantly different. The first investigation failed to identify any systemic issues around CTG interpretation and sepsis management, which were relevant, factors. It was also felt by the review team that the few recommendations for improvements made would not have prevented a similar situation occurring in the future. The second investigation relied on the presumed cause of death (amniotic fluid embolism) as 'unavoidable' and therefore did not address salient issues particularly around the identification and management of the critically ill mother, sound escalation plans and multidisciplinary team working.

4.80 Two years after the mother's tragic death, the external assessors acknowledged that some of the recommendations for improved care were still *'in progress'.* It is the review team's opinion that despite being a second investigation the LSA (external) investigation still missed significant points for learning, and improvement, specifically that had the sepsis been treated more promptly earlier, that the outcome might have been significantly different.

Causes of supervisory failings and failure to learn:

4.81 The review team identified the causes of supervisory failings as:

- The supervision function was not independent from the management team, therefore the same people scrutinised clinical incidents regardless of whether this was a supervisory review or not.
- The short staffing levels did not appear to provide supervisors with protected time to carry out supervisory activities.
- A lack of involvement of supervisors in risk management and incident reviews which prevented them from identifying the incidents that warranted supervisory review.
- A lack of integration between supervision and clinical governance.
- A lack of leadership within the maternity governance structure.

4. Concerns relating to clinical guidelines and audits

4.82 The writing, review and use of clinical guidelines to inform best practice and the conducting of clinical audits to monitor compliance with these guidelines is an integral part of ensuring a service is safe. The review team has identified the following concerns:

a) A lack of multidisciplinary input into guideline management and audits

b) A lack of a change in practice and monitoring of compliance in response to clinical incidents

c) The repayment of an NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Incentive scheme payment.

a. A lack of multidisciplinary input into guideline management and audits

4.83 Before 2010, and following review of the guidelines supplied to the review team by the Trust, the approach to guideline and protocol management lacked a multidisciplinary approach at the Trust. Guidelines appeared to have been drafted by midwifery staff, with no input or oversight by the obstetric consultants.

4.84 From 2012 onwards the review team identified a named guidelines midwife in post, and identified that subsequent to this, there was a more consistent approach to how guidelines were written, reviewed and then referenced. The review team were unable to find evidence of a named obstetric lead, and obstetric input was not well defined, which meant that there was a lack of multidisciplinary input into guideline management. A member of staff stated '*practice wasn't evidence-based but there was nobody qualified, competent or capable to update guidelines or to even write guidelines. They didn't have very many and what they had weren't evidence-based...I know full well that their guidelines were woefully out of date'.*

4.85 With regard to audits, there is evidence supplied by the Trust of formal registration of women's and children's audits throughout the review period, forming part of the yearly corporate audit plan. This is in line with general practice in maternity units and the majority were conducted by an audit midwife with only a small number, in comparison, having obstetrician involvement. Anaesthetists were involved in audits in earlier years, then no longer featured at the audit meetings and their involvement in maternity audits was not seen in recent years.

4.86 Experience from the multidisciplinary members of the review team is that good practice for most maternity units would be for audit meetings to be multidisciplinary, where all clinicians learn together. The review team noted that the attendance record at audit meetings, especially prior to 2012, demonstrated that, in general, very few midwifery and nursing staff attended, with no midwives present at some. The meetings were often obstetrician-led, attended by the obstetric team and had obstetricians conducting the audits. This shows a culture of exclusion and disparity between the staff groups. After 2012 there was clearly a shift, as most audits were midwife-led, usually by the audit midwife with little involvement by other staff groups. Actions to try to improve obstetric attendance were noted at meetings as late as July 2017.

4.87 For example, in September 2018 the operative vaginal delivery audit was conducted by a midwife and demonstrated that no analgesia was used for ventouse deliveries. The review team felt this was unlikely to be correct, as it would be surprising if none of the women who had a ventouse had an epidural, which is known to increase the risk of instrumental delivery. However, a suggestion was made at audit meetings for this to be investigated and for consultants to supervise future audits with the aim that their presence would promote evidence-based practice and influence a change in practice. The lack of obstetric involvement in the initial audit would have made it difficult for the auditor to develop a robust plan to effect change as it is based on the individual's limited knowledge and experience on the subject.

4.88 Audits were also presented within the maternity governance meetings which to 2012 were mostly attended by midwifery staff. After this time, the review team has noted good attendance by consultant obstetricians and midwives but attendance by junior medical staff was often lacking. The updating of guidelines and leaflets was a regular item on the agenda, however this item was often cancelled when there were more pressing matters being discussed, at the expense of guideline updates.

4.89 Maternity audit action plans were also agreed at these meetings, but discussion when it occurred commonly appeared as perfunctory which was inappropriate as the forum did not have full representation and authority to make decisions. Many action plans merely stated the means of dissemination of findings, rather than addressing the discrepancies identified. Often there was no action plan to improve compliance and then to re-audit. The review team found therefore that management of maternity audits were a significant lost opportunity to improve the quality of maternity care at the Trust throughout the entire period of the maternity review.

b. A lack of a change in practice and monitoring of compliance in response to clinical incidents.

4.90 The review team has identified cases where similar and continuing errors in practice have occurred over the years, which suggests a failure to learn lessons and implement change in maternity practice. When an incident has been investigated and an action plan created, it is vital that these actions are implemented to prevent future harm occurring. The review team has found repeated instances where this has not been the case in maternity services at the Trust.

4.91 *In **2015** a woman with a previous baby on the 5.5th centile was not offered an obstetric review or growth scans. She subsequently suffered a stillbirth at 37 weeks. The baby had a birth weight less than the 3rd centile. The subsequent investigation into this stillbirth recommended that: 'Any previous birth weight between 5.0 and 5.5 centile will be rounded down to 5th centile for the purposes of ascertaining which patients will be offered routine scans at 32 and 36 weeks'. This recommendation however was not written into the Assessment (Antenatal) Guideline Version 11 (2015) nor any versions afterwards. Despite the 2013 RCOG Green Top Guideline[79] recommending use of the 10th centile to determine when ultrasound scans are required, this was not followed at the Trust until 2018. (2015)*

4.92 *In **2016** a woman, for whom English was not her first language, telephoned maternity triage with abdominal pain and was advised to remain at home and sadly attended with a concealed placental abruption and had a neonatal death. The recommendation from the investigation was to update the maternity triage operating procedures to include that women for whom English is not their first language should be invited in for assessment to avoid issues with communication. There is no evidence this occurred. (2016)*

4.93 *In **2018** a woman in early labour telephoned the maternity triage as she believed her 'waters had broken' but she was not invited in for assessment, and the outcome in this case was an early neonatal death. The Latent Phase of Labour and Intrapartum Care on an MLU guideline was updated following this incident and a compliance audit was recorded as being completed, however no evidence of this compliance audit has been supplied to the review team by the Trust. (2018)*

4.94 There is evidence of sharing audit findings at audit meetings. However, there is lack of consistent evidence

79 Royal College of Obstetrics and Gynaecology *Investigation and Management of the Small-For-Gestational-Age Fetus Green-Top Guideline number 31* (2013) https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf

that practice changed as a result of audits. Of particular note is that the majority of audits did not make reference to previous audit findings, hence the opportunity for comparison and therefore learning to improve the quality of maternity care was lost.

4.95 One example is that an electronic training package used by staff for CTG training was discussed at the maternity governance meeting held in February 2016 and it was said to be in routine use. However, in the July 2017 governance meeting, it is reported that staff were unfamiliar with the aforementioned training package. This is inconsistent with the assurances given at prior maternity governance meetings and to external bodies such as the Commission for Health Improvement as far back as 2007. Poor CTG interpretation leading to poor outcomes for babies was a recurring theme among many cases over the period of time considered by the review team.

c. The repayment of an NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Incentive scheme payment.

4.96 The Clinical Negligence Scheme for Trusts, better known as CNST, is an insurance scheme administered by NHS Resolution (previously known as the NHS Litigation Authority), whereby individual NHS organisations pay an annual premium to mitigate against the cost of clinical negligence. In the earlier years the CNST standards were met by auditing practice against prescribed standards and identifying evidence of improvement in practice informed by those audits. Successful achievement of Level 1, 2 or 3 resulted in a percentage reduction of trust payments to the NHSLA for indemnity insurance.

4.97 The review team saw evidence that guidelines were amended and updated based on the CNST assessment reviewer's comments and the maternity unit was successful at gaining Level 1. A member of staff stated in a meeting with the review team that as early as 2009 there were significant concerns amongst individuals about standards of maternity care and governance at the Trust.

4.98 In discussing CNST, a staff member told the review team *'…in 2009, there were signs then that governance was not as it should be and I fought a battle even then just with regard to CNST and I was told we're going to get CNST Level 2, and I said, "We're not", and I was told, "We are", and I said, "We're not", and that was the first time that I experienced having a battle with the…leadership at the time, and the Board…but you know what's right and you can't get beyond that barrier. So I considered that I won that battle, in that we did the right thing…we weren't going to get Level 2 unless we fudged it, so those are my words…but it was met with absolute disdain and I remember…being dragged into [X's] office and told, "Sit there with your laptop, we're going to do this action plan for CNST together..." .'*

4.99 This was also confirmed by another member of staff stating: *'I don't think that anybody on the Board expected me to be finding us non-compliant, because obviously that had gone through the Board, so that was a really difficult time as well. …It was a really difficult time, because we were then saying to the Board that information that they'd signed off six months previously, they didn't have the evidence for it, and then obviously we had to look at year one and then we owed a significant amount of money. I think that, you know, that's an example of where they didn't know how much information they should have.'*

4.100 The Trust subsequently gained level 2 in 2012. The review team saw some of the best conducted audits in 2013–2014, with the Transfer of Women Audit being noted as an example of good practice in its structure and findings.

4.101 During 2013/14 the Trust was preparing for Level 3 assessment. The Trust scored a remarkable 48/50 of the required criteria. NHS Resolution **(NHSR)** stated[80] *'the audit reports were in general of a high quality, with readily identifiable measurable standards'* and *'Particularly impressive was the spread of actions that had been implemented as a result of the audit findings…It was clear to the assessors that each deficit identified had been carefully considered and time and effort had been put into drilling down to the root causes and applying meaningful measures to rectify the issues'.* However, there is a distinct disparity

80 NHS Resolution, NHS Litigation Authority. *NHS Litigation Authority Clinical Negligence Scheme for Trusts: Maternity Clinical Risk Management Standards 2013-14, The Shrewsbury and Telford Hospital NHS Trust,* Level 3, p23 (March 2014)

between those observations of NHSR and the findings of the review team as in subsequent years the audit reports did not lead to sustainable safety improvements in maternity services at the Trust.

4.102 In 2017 NHS Resolution changed the CNST assessment to become an incentive towards improving safety. Maternity services provided self-assessments which were signed off at Board level on 10 safety actions which it was thought, if achieved, would demonstrate that a Trust was providing safer maternity care[81]. By achieving all 10 safety actions Trusts would recover the elements of their contribution to the CNST maternity incentive fund and also receive a share of any unallocated funds.

4.103 The Trust received its rebate in 2018, but after a CQC inspection report in November 2018 rated the maternity services as inadequate[82] the Trust was obliged to return the money it had received. The review team has heard from a member of staff that it was obvious the Trust would not achieve the CNST standard. This is evidenced by the fact that although the Trust declared in 2019 a 90% or more compliance with the multidisciplinary training target in 2018 and 2019 the maternity clinical governance meeting minutes on 25 February 2019 records that there was discussion of the risk that the Trust would not achieve this target.

4.104 In August 2019 the Training Figures document states that the *'maternity incentive scheme training requirements were achieved'*. However the review team has heard evidence from a member of staff that actions were signed off as *'actions met'* without appropriate evidence being either shared with, or requested by, the executive team and Board.

4.105 A member of staff said to the review team: *'...I have thought a great deal since my interview and how things will not change unless we are prepared to push aside feelings of dismay, anxiety and fear and unless we are prepared to act by the very principles we are expecting from others.'* The staff member stated to the review team that *'X advised me when I was undertaking a review of CNST year 2 submission to "be careful what you find" as it will cause "reputational damage" to the Trust'.*

4.106 The review team has identified multiple and repeated failings in maternity governance throughout the timeframe of this review, spanning poor quality incident investigations, poor complaints handling, concerns with how the Trust implemented statutory supervision of midwifery supervisors and concerns with implementation of the systems for guideline development and clinical audit. The review team feel that these serious failings led to unnecessary harm occurring to mothers and babies over a prolonged time period.

LOCAL ACTIONS FOR LEARNING: IMPROVING MANAGEMENT OF PATIENT SAFETY INCIDENTS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.107 Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework.

4.108 The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists and anaesthetists to undertake incident investigations.

4.109 All investigations must be undertaken by a multi-professional team of investigators and never by one individual or a single profession.

4.110 The use of HRCRs to investigate incidents must be abolished and correct processes, procedures and terminology must be used in line with the relevant Serious Incident Framework.

81 NHS Resolution. The maternity incentive scheme year 2 results. Published 13th February 2020. https://resolution.nhs.uk/2020/02/13/the-maternity-incentive-scheme-year-two-results/#:~:text=The%20maternity%20incentive%20scheme%20was%20launched%20by%20NHS,but%20also%20a%20share%20of%20any%20unallocated%20monies.

82 Care Quality Commission, Shrewsbury and Telford Hospital NHS Trusts Inspection report (2018)https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-report-shrewsbury-telford-hospital-nhs-trust

4.111 Individuals clinically involved in an incident should input into the evidence gathering stage, but never form part of the team that investigates the incident.

4.112 All SIs must be completed within the timeframe set out in the SI framework. Any SIs not meeting this timeline should be escalated to the Trust Board.

4.113 All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy. These training courses must commence within the next 12 months

4.114 The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms as in HSIB investigation reports.

4.115 Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.

LOCAL ACTIONS FOR LEARNING: PATIENT AND FAMILY INVOLVEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.116 The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process.

4.117 All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings.

4.118 The maternity governance team must work with their Maternity Voices Partnership (MVP) to improve how families are contacted, invited and encouraged to be involved in incident investigations.

LOCAL ACTIONS FOR LEARNING: SUPPORT FOR STAFF

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.119 There must be a robust process in place to ensure that all safety concerns raised by staff are investigated, with feedback given to the person raising the concern.

4.120 The Trust must ensure that all staff are supported during incident investigations and consideration should be given to employing a clinical psychologist to support the maternity department going forwards.

LOCAL ACTIONS FOR LEARNING: IMPROVING COMPLAINTS HANDLING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.121 Complaint responses should be empathetic and kind in their nature. The local MVP must be involved in helping design and implement a complaints response template which is relevant and appropriate for maternity services.

4.122 Complaints themes and trends should be monitored at the maternity governance meeting, with actions to follow and shared with the MVP.

4.123 All staff involved in preparing complaint responses must receive training in complaints handling.

LOCAL ACTIONS FOR LEARNING: IMPROVING AUDIT PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.124 There must be midwifery and obstetric co-leads for audits.

4.125 Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored.

4.126 Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred.

4.127 Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team.

4.128 Matters arising from clinical incidents must contribute to the annual audit plan.

LOCAL ACTIONS FOR LEARNING: IMPROVING GUIDELINES PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.129 There must be midwifery and obstetric co-leads for developing guidelines.

4.130 A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use.

LOCAL ACTIONS FOR LEARNING: LEADERSHIP AND OVERSIGHT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.131 The Trust Board must review the progress of the maternity improvement and transformation plan every month.

4.132 The maternity services senior leadership team must use appreciative inquiry to complete the National Maternity Self-Assessment[83] Tool published in July 2021, to benchmark their services and governance structures against national standards and best practice guidance. They must provide a comprehensive report of their self-assessment, including any remedial plans which must be shared with the Trust Board.

4.133 The Director of Midwifery must have direct oversight of all complaints and the final sign off of responsibility before submission to the Patient Experience team and the Chief Executive.

83 NHS England. Maternity self-assessment tool (2021) https://www.england.nhs.uk/publication/maternity-self-assessment-tool/

The NHS Patient Safety Incident Response Framework (PSIRF)

4.134 As has been clearly explained within this chapter, there have been many failings in how maternity incidents were investigated in-line with the national frameworks at the time, namely the 2010 National Framework for reporting and learning from serious incidents requiring investigation[84] and the 2013 and 2015 Serious Incident Frameworks[85]. It is also widely accepted that prior to this review, multiple reports, including maternity specific reports, have already highlighted significant shortcomings in the way patient safety incidents are investigated and learned from[86].

4.135 To improve this situation, NHS England published the 2019 NHS Patient Safety Strategy[87] and will be implementing the Patient Safety Incident Response Framework (PSIRF)[88] which is due for gradual implementation across all organisations from spring 2022. Taking into account that at the time of publishing this report there will be more than 20 organisations working within the PSIRF framework[89] who will continue their work after this report is published, the review team has discussed the PSIRF methodology with NHS England. These discussions have helped ensure that the approaches and principles within the PSIRF are aligned with those of this maternity review.

4.136 The PSIRF differs from the current SI framework, which it will replace, in a number of ways and the review team support the fact that it will have a broader scope, moving away from 'hard-to-define thresholds for serious incident investigations' and that it is committed to engaging and supporting patients, families, carers and staff in accordance with a just culture. The PSIRF Introductory framework , published in March 2020, identifies the process currently being used by early adopter sites and has been published 'so that all parts of the NHS, patients, families and other stakeholders can engage with the proposals and help [NHSE] learn how we best ensure our aim is met'.

4.137 The review team has engaged in dialogue with NHS England based on the findings of this review to receive assurances that the PSIRF works effectively for maternity services. The following issues are of key importance:

PSIRF- Resources and expertise:

4.138 The review team discussed with NHS England that the National Maternity Assessment Tool recommends the following minimum staffing levels for governance teams:

- Maternity governance lead (who is a midwife registered with the NMC)
- Consultant obstetrician governance lead (Minimum 2 PAs[90])
- Maternity safety manager (who is a midwife registered with the NMC or relevant transferable skills).
- Maternity clinical incident leads
- Audit midwife - a lead midwife for audit and effectiveness

84 Ibid n4

85 Ibid n2

86 Royal College of Obstetrics and Gynaecologists. Each Baby Counts: key messages from 2015 (2016) https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/rcog-each-baby-counts-report.pdf

Parliamentary and Health Service Ombudsman. Learning from mistakes. (2016) https://www.ombudsman.org.uk/publications/learning-mistakes-0

Parliamentary and Health Service Ombudsman. A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged. (2015) https://www.ombudsman.org.uk/publications/review-quality-nhs-complaints-investigations-where-serious-or-avoidable-harm-has

House of Commons Public Administration and Constitutional Affairs Committee. *Will the NHS never learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England*. (2017) https://publications.parliament.uk/pa/cm201617/cmselect/cmpubadm/743/743.pdf

87 NHS England website. NHS Patient Safety Strategy 2019. https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

88 NHS England. NHS Patient Safety Strategy 2019. https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

89 NHS England. Introductory Patient Safety Incident Response Framework. (2020) https://www.england.nhs.uk/wp-content/uploads/2020/08/200312_Introductory_version_of_Patient_Safety_Incident_Response_Framework_FINAL.pdf

90 A PA or 'programmed activity' is the unit of currency in a consultant contract, each PA broadly equalling 4 hours – see https://www.nhsemployers.org/sites/default/files/2021-06/consultant-contract-faqs_0.pdf

- Practice development midwife
- Clinical educators, to include leading preceptorship programme
- Appropriate governance facilitator and administrative support within the maternity department.

4.139 The review team is assured that these are key team members who will need to understand PSIRF principles and should be involved in planning preparations locally for implementation of PSIRF.

PSIRF and Training:

4.140 The review team is assured that appropriate training in patient safety incident investigations, and safety science more widely, will be a core feature of the PSIRF and that NHSE&I will set minimum levels of training required for investigation leads.

4.141 The review team strongly supports the notion that training must be available prior to PSIRF implementation and are assured that this will be set out within an investigation training framework which will include a straightforward mechanism for providers to commission the training that their staff need.

4.142 The review team is assured that all relevant tools and templates will be available prior to rollout and should further investigation skills training become necessary over time, the minimum training standards requirement will be adapted as appropriate.

PSIRF- What to investigate and ensuring effective oversight

4.143 Maternity and neonatal incidents which meet the Each Baby Counts and maternal deaths criteria will be referred to HSIB for a HSIB-led PSII (or new statutory body). Organisations will also be required to continue to report to NHSR Early Notification Scheme, RCOG EBC project and MBRRACE-UK as well as the PMRT being used for all stillbirths and neonatal deaths. The review team supports this approach of maintaining set criteria for what must be investigated externally.

4.144 The review team also supports the move away from subjective and hard to define thresholds for SI investigations and towards a proactive approach to safety and learning investigations, which can be based on findings from more than one similar completed incident investigation.

4.145 The review team raised concerns that the PSIRF focuses on trusts determining locally what to investigate and although well intentioned to promote a culture of learning, felt this could lead to similar problems as found at Shrewsbury and Telford Hospital NHS Trust, where incidents were downgraded and not appropriately investigated. The review team has been assured that there will be appropriate oversight built into the PSIRF framework with organisations expected to conduct a gap analysis to assess this, whilst also being assured that a training specification for oversight training will be in place before roll out begins. It is the expectation of NHSE&I that the relevant individuals in oversight roles will have received the appropriate training prior to organisations transitioning to PSIRF.

PSIRF and linking complaints to investigations to aid learning

4.146 The review team has been informed that although this is not part of the PSIRF, providers will be encouraged to bring patient safety and complaints teams together as part of the PSIRF implementation and encourage a collaborative and coordinated process. As stated in the IEAs underpinning this final report all trusts must ensure the maternity complaints process is incorporated within the maternity governance team structure responsible for incident investigations to ensure that complaints are not completed and responded to in isolation. The review team states that **NHSE&I must undertake work to provide those dealing with complaints appropriate training in effective complaints handling**.

PSIRF and reducing variation in investigations

4.147 The review team support the notion of a standardised investigation template and are assured that the patient safety incident investigation (PSII) template has been built on the principles developed by HSIB and that the template will be available prior to PSIRF implementation.

Patient and family involvement in investigations

4.148 The review team has been assured that the active involvement of women and families in investigations is fundamental to the PSIRF and that NHSE&I are currently working with HSIB and a group of independent stakeholders (including academics, patients and patient advocates) to develop an involvement guide that will ensure these requirements are covered in detail.

Chapter 5

Clinical leadership

Introduction

5.1 Safe, high-quality maternity care across England is not an ambitious or unrealistic goal and should be the minimum expectation for all women, their families and their babies. Effective clinical engagement and leadership is critical to improving quality, safety and patient outcomes within the NHS[91]. Frontline teams do not operate[92] in a vacuum; leadership is the key determinant of the organisational culture in which frontline teams operate. 'When things go well, it is down to good leadership and when they don't, who takes responsibility? Does it rest with the 'senior' midwife, the trust's chief executive, the board or the midwife delivering the care?'[93]

5.2 Historically, strategic and operational leadership roles within maternity services were held by the obstetric clinical lead, the clinical director and the director of midwifery[94]. These roles have overarching responsibility for the daily operational delivery and strategic management of maternity services locally and are accountable to the trust board for quality, performance, governance and professional leadership. This responsibility includes making positive changes in the workplace where necessary to shape a fair and positive environment, and encouraging a culture which supports improved clinical outcomes for women and their families. The review team has identified that these responsibilities were not always met within maternity services at Shrewsbury and Telford Hospital (SaTH) NHS Trust.

5.3 During a 'Staff Voices' interview with the review team in late 2021 a member of staff reported how the Trust's board did not have oversight of the concerns relating to patient safety, quality and performance or poor clinical outcomes within maternity services.

5.4 The staff member told the review team: *'I don't think that actually the Board knew what was needed in maternity services. I was giving them information that they'd never had before'.*

5.5 The primary influence of clinical leadership is through the expression of clinical expertise, with direct involvement in patient care. A recent RCOG publication[95] (2021) reiterated how the role of the consultant obstetrician is that of the clinical expert, one who influences both clinical decision-making and standards of clinical practice thereby reducing variation in patient care and optimising clinical outcomes in maternity settings by being physically present and visible[96]. The absence of such clinical leadership has been identified by the review team as a contributory factor in the failure of maternity services at the Trust to provide high quality and safe maternity care to women and their families, and is an overarching theme in this report. This has been widely reported in many national maternity reports over many years[97]. These national maternity reports include those by the Department of Health, Royal Colleges and CEMACH.

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91 Joseph & Huber 2015, https://pubmed.ncbi.nlm.nih.gov/29355179/ 2015

92 NHS England: *National Maternity Review: Better Births: Improving Outcomes of maternity services in England* (2016) p72: https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

93 Royal College of Midwives (RCM) (2012). Leadership - what's that got to do with me? Midwives Magazine Issue 2 2012 [online]. Available at: https://www.rcm.org.uk/news-views/rcm-opinion/leadership-what-s-that-got-to-do-with-me/ [Accessed 24th November 2021].

94 Royal College of Obstetricians and Gynaecologists (2007) *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.* Available at: https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf [Accessed 01 December 2021].

95 Royal College of Obstetricians and Gynaecologists (2021) *Workplace Behaviour Toolkit.* Available at: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/workplace-behaviour/toolkit/ [Accessed 01 December 2021].

96 Ibid n4 RCOG (2007 and 2021)

97 Department of Health *Why Mothers Die. Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1994–1996.* (1998). RCOG, 2004, CEMACH, 2007, Kirkup, B. (2015) *The Report of the Morecambe Bay Investigation.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf [Accessed 01 December 2021]. Knight et al, 2016 and NHS, 2019.

Review of independent reports

5.6 It is acknowledged that the assessment of maternity services has continually evolved over the 20-year span of this independent review, and that different standards and priorities have been expected of maternity services at different times. Key national reports continued to highlight poor leadership as the reason that maternity services were failing women and hampering continued development of the professions[98]. In assessing the quality of leadership within maternity services at the Trust, the review team has considered the most recent external reports reviewing maternity services at the Trust and whether the leadership team were responsive in making effective changes following the recommendations made in those reports.

5.7 A review of maternity services at the Trust was undertaken by the two local clinical commissioning groups[99] (CCG's) in 2013. This was in response to concerns regarding the increased number of serious incidents (SIs) at the Trust, and the safety of the 'hub and spoke' model[100] of maternity care. The findings from the CCG's were favourable, with the overall assessment noting that maternity services provision at SaTH was a safe and good quality service. The Trust board reviewed this report noting: *'There had been concern about some families' experiences but this was in the context of generally good services'.*[101]

5.8 In March 2014, the Trust was reviewed by the NHS Litigation Authority and awarded Level 3, the highest standard under the Clinical Negligence Scheme for Trusts (CNST). The Trust was benchmarked against the requirement to demonstrate good leadership, with an open and supportive culture, providing a service that can fulfil the needs and expectations of women and their families. A maximum score of 10 out of 10 was awarded in 2014, suggesting there were no concerns regarding leadership and management at that time.

5.9 Following the successful submission of CNST data, a staff member explained to the review team that they had voiced concerns regarding the accuracy of the data submitted, suggesting there was no evidence to support that the service was ever compliant in meeting the criteria. The staff member told the review team:

5.10 *'We were then saying to the Board that information that they'd signed off six months previously, they didn't have the evidence for it.'*

5.11 In 2014, a Deanery review of medical training was undertaken. Clinical governance was identified as an area for improvement. The Deanery report stated:

5.12 *'The Trust must integrate clinical governance into learning outcomes for trainees and ensure that there are clear and robust mechanisms in place to learn from clinical incidents and that any learning points are clearly disseminated to trainees appropriately.'*

5.13 An independent review in 2015 by Debbie Graham which considered the case of a family who had suffered the death of their baby daughter criticised the Trust's response to the family. However the report concluded *'…the learning from these events, in conjunction with the appointment of key personnel, have led to considerable improvements in the provision of maternity services and the strengthening of the Trust's clinical governance and complaints processes. In particular the development of advocate roles within the Trust that will work to strengthen the voices of patients and their families so they may be heard in the future'.* Graham (2015) does not state the basis upon which this conclusion was reached. When considering a number of cases after 2015 and through until 2019 the review team has not seen evidence that this belief came to fruition.

5.14 For instance, in 2018 a family in conversation with the review's Chair described the approach of the Trust at listening to families following critical incidents as *'tinkering at the edges'*. In reviewing the SI report into the

98 RCM 2012

99 See glossary

100 See glossary

101 2014 Trust Board papers supplied to the review team

death of their baby the family (who had significant professional experience in risk management and root cause analysis) said of the Trust's SI report: *'It's not getting down [to the detail]…it says here root cause analysis, they're fine words but the words don't mean anything because they don't understand…and, again with all due respect to them, as I say, from my world I live, eat, sleep and breathe root cause analysis…'*.

5.15 The 2017 Ovington report compiled internally within the Trust stated how *'safety in maternity is protected by the efforts of the staff and supported by leaders'.* It concluded that governance arrangements should be more transparent and open. It also highlighted how learning from incidents and investigations should be improved. No action plan to meet these recommendations in Ovington (2017) has been provided to the review team at the time of writing this report in spring 2022.

5.16 In 2017, there was an invited review of the maternity services by the RCOG. This review found that while there was evidence of strong leadership and good working relationships between the various staff groups, concerns relating to workforce numbers and insufficient numbers of consultants providing obstetric cover were identified. There was evidence of middle grade rotas not always filled by the Deanery, resulting in maternity services relying on overseas trainees and locums. In accordance with other previous reviews, the RCOG report identified a lack of resources and inadequate incident reporting, risk management and governance systems. This report was subsequently not presented to the Trust Board until May 2018. The Trust's 2018 Care Quality Commission report concluded within the 'Well Led' domain that leadership required improvement and also raised governance concerns stating:

5.17 '*Staff were overwhelmingly positive regarding the local management of the service in the hospital. They told us that the senior team were visible and they were approachable and able to raise issues and concerns. However, they were not certain that these issues were then heard at board level. We were not assured that the executive team had engaged well with staff to develop the vision for the service.'*

5.18 *'We found areas of concern that were raised in our last inspection in December 2016, for example service-wide sharing of learning from serious incidents was not evident, not all staff could give an example of learning.'*

Obstetric services, workforce and clinical leadership

5.19 It is clear from the evidence provided by the Trust to the review team that prior to 2012 the obstetric medical staffing at both consultant and junior doctor level at the Trust was inadequate for the size of the unit at around 5,000 births per year. The number of consultants, and the number of women that they were responsible for meant that timely reviews of women on the labour ward, or in other inpatient areas would have been very difficult, if not impossible, to provide at times. Therefore, midwives wishing to escalate clinical concerns would have been regularly working in an environment in which it would have been difficult to obtain a timely senior obstetric review.

5.20 The poor provision of medical staffing resulted or certainly contributed to delays in the instigation of appropriate medical management. This created an environment in which it was accepted within maternity services at the Trust that it was normal practice to wait for an obstetric review, thus leading to clinical risks, which ultimately contributed to poor maternity outcomes. The review team has heard from one member of the medical staff who confirmed that for many years the registrar had to cover both gynaecology and obstetrics clinical areas.

5.21 This staff contributor told the review team:

'One of the problems...in this sort of context that I've been describing, was a very, very overburdened and thinly stretched middle tier in the obstetric team. I was, frankly, flabbergasted at what I was being told, you know, doctors were being asked to cover services that, it was manifestly clear, you couldn't possibly do that on your own.'

5.22 There is evidence within business plans to the Board (provided by the Trust to the review team) that the Trust was working to increase the number of doctors at both middle grade and consultant level. The number of hours of consultant presence on the labour ward subsequently increased from 40 hours in 2011 to 76 hours in 2013. These plans included evidence that solutions were being sought to support this, including better provision of elective caesarean section lists, for example. In spite of these efforts, in 2016 the Trust had difficulty in being able to appoint the required number of middle grade doctors, resulting in the staffing levels being below the recommended standard for both consultant and middle grade staff. At the time of writing this report in early 2022 there has been further consultant expansion at the Trust supporting an increase in resident consultant hours on the labour ward.

Neonatal services, workforce and leadership

5.23 It is clear from the majority of medical records reviewed that involvement of the consultant neonatologists in clinical decision-making, in the provision of neonatal care and in communication with parents and other family members was of a high quality. The medical records suggest that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents. They often wrote discharge summaries themselves and were also usually involved in the long-term follow-up of their patients, providing continuity of care for their parents. For some of the clinical cases reviewed, the consultant providing cover for the neonatal unit was also covering the general paediatrics service. This may compromise the availability of skilled care, and, given the size of the neonatal service at the Trust, it would be important to have separate consultant cover for the neonatal and general paediatrics services. This has now been achieved.

5.24 Advanced neonatal nurse practitioners (ANNPs) played an important role in the management of sick infants on the NNU and of babies on the postnatal ward. As far as can be judged it appeared that their practice was appropriate and likely to have made an important contribution to neonatal practice within the Trust. For some of the cases reviewed it was clear that, out-of-hours, middle-grade neonatal medical staff were covering the paediatric unit as well as the neonatal unit. This can compromise the availability of skilled care in both units. The employment of ANNPs has undoubtedly provided some mitigation of this but it was not clear whether the service was adequately covered to this level at all times.

5.25 The review found some evidence of senior neonatal leadership within maternity and perinatal governance processes, and on occasions in raising concerns about individual cases in the perinatal service. We heard evidence of attendance by a neonatologist at Perinatal Mortality and Morbidity (M&M) meetings. In interviews with the review team, we were told of neonatologists attending joint mortality meetings from the early 2000's. Neonatologists contributed data to the national neonatal audit project, which collects important neonatal outcomes. Neonatologists and obstetricians told the review team that they usually met bereaved parents independently, but the review team found some evidence of correspondence between them, including selected cases where a neonatologist wrote to the consultant obstetrician requesting a case review after an adverse outcome.

5.26 Some of the neonatologists told the review team that they raised concerns in the early 2000s about a perceived higher than expected incidence of hypoxic ischaemic encephalopathy (HIE). They also raised concerns about lack of recognition of IUGR and of trauma secondary to instrumental delivery. At interview members of the neonatal team told the review team that these concerns were raised with clinical colleagues and the divisional management team, however the outcome remains unclear.

5.27 A staff member told the review team: *'We have been always very closely involved because we have regular monthly perinatal mortality reviews, meetings every third Wednesday, third Friday of every month and we would actually attend all the late fetal losses, stillbirths, everything, it's not just neonates…so we would robustly challenge them…and those were very well attended meetings, including midwives, obstetric, neonatal teams, perinatal pathologist and geneticist etc.'*

5.29 They continued:

'I think the consistent feature from the neonatal side for us for many stillbirths etc. was the lack of recognition for fetal growth restriction and I think that's another part we repeatedly brought out. I think that led to the introduction of the customised growth centiles as well as the GROW programme.'

Midwifery roles, workforce and leadership

5.30 Frontline midwifery leadership incorporates a myriad of midwifery roles across maternity services including midwives[102], matrons, senior midwifery managers, labour ward coordinators, community clinical leads and specialist midwives. It is notable that, in spite of the RCOG safety recommendations from 2007 on standardising an approach to clinical leadership roles, the Trust did not have any consultant midwife posts for all of the time period considered for this review. The Trust has informed the review team that their first consultant midwife is due to take up employment in early 2022. The national recommendation remains that midwifery-led units (MLU) have one full-time consultant midwife post and obstetric-led units have one additional full-time consultant midwife post to every 900 births, based on 60 per cent low risk women receiving midwifery-led care[103].

5.31 The review found no evidence that there was a consideration of developing the role of the consultant midwife, during the time period under consideration. In conjunction with the consultant obstetrician, the consultant midwife could have provided the balance of professional and effective clinical leadership to ensure the improvement of both quality and safety across maternity services.

The labour ward co-ordinator

5.32 The role of the labour ward coordinator is multi-faceted and central to ensuring the safety of pregnant and labouring women and babies. It encompasses the role of midwifery clinical expert; to inform and challenge practice, and to escalate clinical concerns whilst prioritising and managing the complex demands of contemporary midwifery and maternity care in the high-risk clinical setting of the labour ward.

5.33 Maintaining oversight and knowledge of the management of all clinical cases, the coordinator acts as a source of clinical support for junior midwifery and obstetric staff and a professional conduit across multidisciplinary teams thereby ensuring appropriate use of resources to enable the effective and safe provision of care. While there were some examples of good midwifery leadership seen, staff within maternity services at the Trust shared with the review team their own lived experiences of when this was not always the case.

5.34 A staff member told the review team:

'I was, I think, three months into my labour ward rotation and I kept pressing the call bell saying she's bleeding a lot quicker than I'd like, you know, I think we're up to 500mls now, and the coordinator kept coming in saying I'm on [the] ward round, it'll have to wait…I felt like I'd let that woman down because my skills weren't good enough, that's how I was made to feel when, actually, that was a situation I should have had help in…if she was bleeding that much I should have had help.'

5.35 Each labour ward must have a team of experienced senior midwives rostered as labour ward coordinators, who have supernumerary status; this is defined as having no caseload of their own during a shift and is fundamental to the effective running of the labour ward, which is a high risk clinical area. This is also a recognised requirement in the CNST safety standards[104].

102 Ibid n4 RCOG (2007) & Kings Fund, 2008https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/safe-births-everybodys-business-onora-oneill-february-2008.pdf

103 Ibid n4 RCOG (2007) RCM, RCA, RCPCH, 2007 and Kings Fund, 2008

104 NHSR, 2020

5.36 The review team found that the Trust allocated one band 7 labour ward coordinator per shift who had overall responsibility for coordinating the care throughout a clinical shift, and for the allocation of staff (Labour Ward Staffing v2, 2015). Out-of-hours in the absence of the management team, the coordinator was also responsible for overseeing the clinical activity across the whole of maternity services, including the distant MLUs, and community activity across Shropshire, with escalation to the on-call manager at home, according to the Future Model of Care, 2016 document, shared with the review team by the Trust.

5.37 Reports by the CCG in 2013 and the RCOG in 2018 found that due to midwifery staffing shortfalls, the coordinator was supernumerary for only 50% of the time (RCOG, 2018). This mirrored the findings of the review team who identified that, in many instances, the coordinator had their own women for whom they were responsible for providing clinical care and were therefore not able to fulfil their required role, in particular the provision of support for junior midwives and doctors. Nor were they able in these circumstances to achieve and maintain the necessary 'birds eye' view of the labour ward.

5.38 A staff member told the review team:

5.39 *'The shift leader was constantly having a patient and from the time that I was working on their labour ward, ...you sometimes couldn't get hold of the shift leader because she was in looking after a woman.'*

5.40 Another staff member told us:

5.41 *'I was frightened about putting in…being put into an area that I just, just wasn't my area of expertise and not having support. But it wasn't just lack of support, it was actually, I was just frightened of going past a labour ward; I didn't want to do it, it wasn't my area of expertise and at the time if you voiced those concerns that was probably going to mean you were going to go there full time…'*

Midwifery matron

5.42 The role of the midwifery matron is deemed to be the cornerstone for improving the quality of clinical care through visible, compassionate and inclusive leadership and management. The role has evolved considerably since the publication of The Matron's 10 Key Responsibilities in 2003, and the Matron's Charter in 2004. However, the fundamental aspects remain the same: this includes promoting professionalism in the workplace, ensuring good patient safety and service-user experience, control of infection responsibilities, and monitoring the cleanliness of the clinical environment. It is widely acknowledged that midwifery matron roles also encompass workforce management, budgetary responsibilities and effective resourcing of equipment and maintenance of estates. The recommended minimum requirement for presence is one full-time equivalent, with additional on call and out-of-hours cover, ensuring 24-hour managerial cover[105].

5.43 The review has identified that as late as 2015 the Trust did not meet these recommendations, as the labour ward manager was found to be a hybrid of roles consisting of two shifts working as a labour ward coordinator and three shifts as a matron according to Labour Ward Staffing v2, 2015. In addition, the lead midwife/clinical risk co-ordinator role for consultant inpatient service also had responsibility for leading midwifery care and management on the labour ward. This combination of roles would have resulted in a workload that was not manageable and would have led to key issues being overlooked.

Statutory supervision of midwifery

5.44 Prior to its removal as a statutory function in March 2017, the West Midlands Local Supervisory Authority (WMLSA) had overarching responsibility for statutory supervision of midwifery at the Trust. While there were many professional principles for midwifery supervision, in terms of clinical leadership its purpose was to maintain and improve quality, and to protect women and babies by actively promoting a safe standard of

105 bid n4 RCOG (2007) and RCM, RCA, RCPCH, 2007

midwifery practice, which contributed to the protection of the public. The role of a supervisor of midwives (SoM), who was appointed by the WMLSA was intended to play an important part in providing expert, professional leadership for midwifery at both local and regional level[106].

5.45 A SoM timeline produced by the review team consisting of information extracted from documentation provided to the review including WMLSA audit reports, identified a high level of confidence in the supervisors of midwives at both Trust executive and clinical levels. The supervisors were said to be 'cohesive', had a 'very good team dynamic', and were said to be actively involved in staff training, which included participating and leading in obstetric emergency drills.

5.46 In 2012, a WMLSA visit reviewed the Trust's SoMs' investigation process, which concluded that the team would benefit from further support and guidance around report writing. This training was said to be provided in a supplementary visit to the Trust, however there is no evidence in the documentation provided to the review team that the WMLSA ever returned to the Trust to ensure improvement had occurred.

5.47 Until 2017, the caseload numbers of SoMs at the Trust were repeatedly identified as being above the then recommended ratio of one SoM to 15 midwives. To address these concerns, four of the current supervisors held a double caseload (i.e. 30 midwives) and received double financial remuneration and 15 hours of time in which to manage the additional workload. Similarly, appropriately qualified staff who had retired or previously left the Trust were recruited on a bank basis to provide further support to the supervisory team. There is also evidence which suggests the SoMs were supporting the CNST team; while the context of this is unclear, this may have given rise to a perceived conflict of interest as documented in the Midwifery Regulation in the United Kingdom report (Kings Fund 2015).[107]

5.48 In response to a complaint from a family, an external review was commissioned by the Trust to review an original investigation, which had been conducted by the Trust and signed off by the Local Supervisory Authority Midwifery Officer (or LSAMO) in 2009. The external review concluded that the quality of the supervisory investigation was poor, noting that the principles of root cause analysis were not applied, resulting in key events not being investigated. A repeat investigation by two midwives independent of the Trust made a number of recommendations relating to midwives involved in the clinical care; these included consideration of supervised practice, development support and referral to the Nursing and Midwifery Council (NMC). Furthermore, a significant number of systems issues were identified, that had not been identified in the original investigation including the escalation of staffing issues during times of increased activity/emergency. The absence of a systematic root cause analysis and the lack of support available to the investigating SoM, in particular when interviewing midwives, was also highlighted.

5.49 An independent review was instigated of WMLSA governance and assurance arrangements to determine whether the management and oversight of midwifery supervision was adequate. The review, which was carried out by NICHE patient safety[108] identified a lack of rigour around oversight of the investigative process, best practice was not followed and the quality of reports was not sufficient to prevent reoccurrences. With the purpose of statutory supervision of midwifery being to maintain and improve quality, and to protect women and babies by promoting a safe standard of midwifery practice, these were lost opportunities to achieve these objectives over a long period of time.

5.50 In late 2016, the WMLSA instructed the Trust to review a number of its cases internally. These appear to be some of the cases of the original 23 families, from 2000 onwards which make up the cohort that was highlighted to the Secretary of State and began the process of this review. This task appears to have been undertaken by one SoM at the Trust. The Trust found that none of the nine case investigations, which have been made available to the review required further investigation, thereby missing valuable opportunities for wider organisational learning and further improvement to processes. None of the families were contacted to be involved. Despite the complexity of some of the cases, this was a single professional review, failing

106 NMC, 2015

107 https://www.kingsfund.org.uk/projects/midwifery-regulation-united-kingdom

108 NICHE 2016 Independent Review of West Midlands local Supervising authority (LSA) Supervisory Investigations Governance arrangements dated 31st August 2016, ref 2031-16, supplied by the Trust

to involve other key colleagues who could have potentially provided significant assistance; for example obstetric, neonatal or anaesthesia colleagues. The review team believes that the WMLSA's instruction to undertake a further internal supervisory review of the investigations is questionable as we have not been able to evidence that assurance had been sought arising from the LSA's initial concerns regarding the quality of supervisory investigations, originally identified several years before.

Concerns regarding governance and concerns from families

5.51 Independent reports into maternity services at the Trust, including Graham (2015), identified governance issues, concerns from families and failure to learn from incidents and investigations. There is often a clear disconnect between the issues raised by the families and the findings in the subsequent investigations report. It is also clear that the maternity department, the Trust and the CCG were aware of these issues raised by families. The governance chapter of this report reviews this in more detail, but the evidence available and seen by the review team is that whilst the various reports made recommendations these did not translate into consistent improvements. As indicated in the first Ockenden Report (page 15) there were examples in 2016 and 2017 of families' dissatisfaction with investigation reports. Further examples were found in multiple interviews with families by the review chair throughout 2018 and 2019.

5.52 The RCOG undertook an invited review of maternity services at the Trust during July 2017, which was commissioned by the Trust's Medical Director to evaluate the culture within the service and to assess the safety and effectiveness of maternity and neonatal services.

5.53 The review team was provided with documentation updating on the progress of actions against the recommendations of the RCOG review; including an addendum to the report received during June 2018. This addendum had been prepared following a visit to the RCOG in London by a Trust team. The RCOG had not returned to the Trust to assess the accuracy of the evidence submitted. Quotes from the 'addendum' include the following: *'Review had been undertaken of the manager on-call rota and the rota is now "working better". The escalation policy is firmly in place and was referred to on many occasions, particularly during times when an MLU is closed and services are diverted to another unit.'*

Team working, culture and civility

5.54 The complexities and challenges of team working are not exclusive to healthcare settings, however unlike in some specialities, the effect of poor relationships and collaboration can have catastrophic long-term consequences for individuals, teams and organisations[109].

5.55 National reports into failing maternity services over a number of years have highlighted conflicting agendas and poor teamwork as significant contributory factors towards adverse maternal and neonatal outcomes[110]. Whilst there was some evidence of multidisciplinary team working at the Trust, there was often a notable lack of leadership, accountability and situational awareness.

5.56 *'In **2015** a woman in labour with a twin pregnancy at 36 weeks gestation did not receive an obstetric review on arrival to the labour ward. The neonatal unit were not informed of the admission. No progress in cervical dilatation was escalated to the labour ward coordinator, however there was no change to the management plan or escalation for obstetric review.'*

5.57 *'At full dilatation, an obstetrician attempted to perform a ventouse delivery of twin two. The ventouse cup came off after four pulls. Keilland's forceps were subsequently applied and five pulls were attempted. Neville Barnes forceps were then applied and the baby was delivered in poor condition with one further pull (ten with an instrument in total). The baby had moderate to severe hypoxic ischaemic encephalopathy.' (2015)*

109 Fatolitis, P. and Masalonis, A. 'Human Factors in Aviation and Healthcare: Best Practices, Safety Culture and the Way Ahead for Patient Safety', Journal of Ergonomics vol 11 issue 5. (2021) Available at: https://www.longdom.org/open-access/human-factors-in-aviation-and-healthcare-best-practices-safety-culture-and-the-way-ahead-for-patient-safety.pdf [Accessed 01 December 2021].

110 Kirkup, B. (2015) The Report of the Morecambe Bay Investigation. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf [Accessed 01 December 2021].

5.58 Due to the requirement for 24/7 cover of a significant proportion of service provision, teams within maternity units increasingly involve various practitioners of different clinical expertise[111]. Teams are also rarely constant, resulting in a number of individuals practising their specific roles within interchangeable groups. As such, training should enable maternity practitioners to function effectively in whichever team or environment they find themselves working in.

5.59 Furthermore, the labour ward can be a particularly challenging environment for even the most cohesive teams or groups due to its acute, unpredictable and specialist nature.

5.60 A staff contributor told the review team in late 2021:

'The fear was being pulled to somewhere else in the middle of a nightshift or being on-call for homebirths or midwife-led units. Being on-call perhaps having worked the day before, working the next day and then being called in to the labour ward to work a whole night shift because it was lacking in staff and that was very fearful…'

5.61 *'Yes, I certainly wasn't equipped because I was a community midwife…those were my areas of expertise, and I was expected to go in and act as a manager on labour ward and I was terrified. I was terrified and much stressed, and very emotional all the time about it.'*

5.62 Throughout the years, there have been multiple reports and research detailing the intricacies of team working and its direct relationship with safety outcomes and patient experience[112]. Additionally, there have been recommendations from leading organisations over a long period of time with the aim to improve safety through the standardisation of minimum multidisciplinary staffing requirements[113]. Despite this, the overall team working at the Trust remained suboptimal, which contributed towards many preventable incidents and adverse outcomes.

5.63 A staff contributor told the review team in autumn 2021:

'Culture is a big thing because I feel there's a reluctance to change there. Yes, they do need to change because this has resulted in lots of families having a terrible event happen in their lives that shouldn't have happened and I'm a midwife, and I know that things don't always go to plan. I don't believe that anybody has set out to go to work to cause harm or anything like that, but I think that probably some processes, some attitudes have definitely been a reason as to why things have not gone to plan.'

5.64 Another staff member said the following to the review team in early 2022:

'If I could say anything to the families it would be that there were people who tried to make changes, we tried to escalate our concerns and be heard but every process we used was set up not to acknowledge our voices or the problems we were highlighting. We were ignored and made out to be the problem but ultimately we failed to make ourselves heard....'

5.65 Many different factors affect the dynamics of team working which are well illustrated within various national programmes including Each Baby Counts. The following feature as contributory factors in adverse incidents:

- Individual human factors (present within 58 per cent of cases)
- Team communication issues (present within 53 per cent of cases)
- Lack of team leadership (present within 24 per cent of cases)
- Poor intra- or inter-professional communication (present within 43 per cent of cases).[114]

111 Flin, R., O'Connor, P. and Crichton, M. Safety At The Sharp End. (2008) CRC Press; Florida.

112 Ibid n20 and Liberati, E., Tarrant, C., Willars, J., Draycott, T., Winter, C., Chew, S. and Dixon-Woods, M. (2019) *How to be a very safe maternity unit: An ethnographic study*. Available at: https://www.thisinstitute.cam.ac.uk/research-articles/safe-maternity-unit-ethnographic-study/ (Accessed 01 December 2021).

113 National Institute for Health and Care Excellence Safe *midwifery staffing for maternity settings*. (2015) Available at: https://www.nice.org.uk/guidance/ng4 [Accessed 01 December 2021] and Ibid n4

114 Royal College of Obstetricians and Gynaecologists (2020) Each Baby Counts. 2020 Final Progress Report.

5.66 Similarly, Civility Saves Lives (2017)[115] articulates how negative behaviour such as rudeness or bullying results in a significant decrease in a clinician's performance and/or cognitive ability. Furthermore, incivility is recognised to not only affect an individual recipient, but also bystanders, patients/relatives and the wider team within healthcare settings[116].

5.67 A staff member told the review team that:

'There is culture of bullying on labour ward 24. Staff don't always feel supported by the shift co-ordinators. As I have said previously even though I am experienced I still felt I needed support and didn't always get it. I was told that I was a band 6 midwife so I should have no problems. I also got told by one shift co-ordinator that I was qualified longer than her and why was I asking her to support me with what was a difficult delivery?'

5.68 Whilst the identification of human factors will always remain integral to patient safety, there is more recent emphasis on addressing and preventing such issues from occurring in the first instance. Consequently, there is an increasing recognition of the importance and value of workplace culture and civility.

5.69 Workplace culture can be defined as 'shared ways of thinking, feeling and behaving within an organisation'[117]. The Trust consistently demonstrated negative behaviours and practices, resulting in many staff learning to accept poor standards as it became the cultural norm; this constitutes organisational abuse, similar to that found in the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013).

5.70 It is imperative to ensure the 'culture' within all healthcare settings is one that promotes openness, transparency and the psychological safety to escalate concerns. Yet the review team found evidence of disempowerment, with staff encouraged not to complain or raise awareness of poor practice within both personal and professional capacities.

5.71 A staff contributor told the review team that:

'You feel like you're penalised constantly in this organisation. I'm keeping my head down now. I have raised it before, I went to HR and it was almost as though I was causing trouble.'

5.72 Another staff member told the review team:

'Whilst reviewing the governance and assurance processes, I was approached by a consultant [obstetrician] who said be careful what you find.'

5.73 Reflecting on the harm caused to families a current staff member told the review team in early 2022:

'I am sorry and I know that sorry is not enough but by engaging with this review we hope that our voices will finally be acknowledged and that change will happen so that there are robust and independent places for clinicians to speak out that acknowledge what we are saying, what needs changing and act on this without fearing reprisals..'

5.74 Positive behaviour strategies have been designed to address negative cultures within healthcare, to improve the working environment for staff and so promote the delivery of safe and compassionate care for patients. Some of these strategies include the implementation of a Workplace Behaviour Toolkit (RCOG, 2021), Civility Toolkit (HEE, 2021) and the creation of national patient safety movements such as Civility Saves Lives (2017) and Learning from Excellence (2014).

5.75 Whilst it is of equal importance for all staff within maternity settings to demonstrate positive behaviours in their everyday practice, it is vital that leaders, such as the labour ward coordinator and senior obstetricians,

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Available at: https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/each-baby-counts/ebc-2020-final-progress-report.pdf [Accessed 01 December 2021].

115 Civility Saves Lives (2017) Civility Saves Lives. Available at: https://www.civilitysaveslives.com/ [Accessed 01 December 2021].

116 Youngson, G. and Flin, R. Patient safety in surgery: non-technical aspects of safe surgical performance (2010). doi: 10.1186/1754-9493-4-4.

117 Mannion, R. and Davies, H. Understanding organisational culture for healthcare quality improvement, British Medical Journal (2018) doi: 10.1136/bmj.k4907.

are acutely aware of their own behaviour and how this influences other members of the wider team. Where negative workplace practices or behaviours are identified, leaders should ensure they take proactive steps to support individuals, address concerns and prevent the creation of a systemic negative culture similar to that described by staff at the Trust.

5.76 During the staff voices interviews some staff stated to the review team that there was a culture of bullying within the leadership team, and that this was not confined to the senior maternity management team but went across the Trust management structure.

5.77 A staff member told the review team:

'At a study day in 2016/2017, following the Kirkup report, a senior manager made the comment "we (SaTH) are not a Morecambe Bay". I made the comment that we absolutely were a Morecambe Bay - a trust full of unhappy staff with ineffective poor leadership, looking to hide or ignore poor care and poor management. I have worked for [another NHS Trust] which learned from its mistakes and supported its staff for the past [number of] years'.

5.78 *'I didn't realise how bad things were in SaTH until I left. The bullying culture from top down breeds bullying. I used to be proud to work there, but that changed from 2006.'*

5.79 Another member of staff told the review team of events within maternity services in 2019:

5.80 *'SaTH was managed with a big…stick from behind, there was no forward thinking leadership. We had changes in policy imposed on us, we did not contribute to changes. We were bullied, everything was done under the guise of 'clinical need' or 'your contract says.' We had issues with pay being withheld, managers not happy to reconcile hours/wages. The on-call rotas and change lists were both used as bullying tools. [An] entire team of five experienced midwives left the Trust in less than 18 months…I tried to raise a concern and instead of being listened to I was referred straight to occupational health. It seemed that as I dared raise a concern I must obviously be mentally unwell (this was in 2019)…this whole conversation was held in public unbeknown to me. Other midwives sitting in the office were listening to the way the manager spoke to me. I was and am still absolutely appalled by that action. I resigned…There are a lot of, I would say, home grown midwives, there are cliques there and, you know, they are Band 6s, Band 7s, Band 8s and they are a little gang, and, yes, they will make your life hell'.*

5.81 They continued: *'It's very hard to speak up because despite what anybody will tell you, there are consequences to speaking up and the consequences are your life gets made very difficult or you get subtle … you can't really pinpoint it as bullying, it's like subtle, made to feel uncomfortable when you go to work…'*

5.82 The staff interviews with the review team also highlighted that there was a lack of respect and role appreciation between the consultant unit staff and the community teams.

5.83 A staff member told the review team that *'There was a…bit of a feeling that because they were the consultant unit, they knew better than you, but actually, we're in the outlying units because we're experienced and we know what we're doing, but…we didn't feel like that respect was always there. Often our decisions were questioned as to, "Well, try this, try that", "Well no, actually, I'm sending her... [the mother in]" '.*

5.84 They continued:

5.85 *'Actually, they need to know our role; they need to know what it's like half an hour, 45 minutes. ...Nearly an hour away from the consultant unit, and they forget that you have to think that far ahead because of what might happen. We don't have an emergency buzzer to have the whole team in, so we have to think ahead and I think they forget that.'*

Conclusion

5.86 External reviews of the maternity services at the Trust between 2013 and 2017 gave the overall message that this was a safe maternity service. This review is concerned that some of those messages gave false reassurance and as a consequence opportunities were lost to have improved maternity services at the Trust sooner. For example, there were a number of concerns arising from these reports regarding governance issues and concerns raised by families, however these issues did not appear to have been prioritised.

5.87 The workforce is a cause for concern, and there were missed opportunities to address the shortfalls in staffing. It is clear that there were insufficient numbers of consultant obstetricians and junior obstetric staff and that there was inadequate anaesthetic support to the maternity unit. It is clear that the midwifery staffing across the service was poor and resulted in the service constantly working in escalation. This impacted on staff confidence and morale, creating a culture of fear and anxiety. There is also evidence of a lack of role appreciation across the service, particularly with those providing maternity services in the community.

5.88 The review team found evidence from documents provided by the Trust (2013-2016) that the local leadership had identified and escalated workforce issues and business plans had been drawn up to increase consultant and middle grade staffing. In recent times there has been a significant expansion in consultant obstetrician staffing.

5.89 Overall, there is a picture of external, independent and internal reports not being critical of clinical leadership at the Trust. However, the review team is concerned that even where recommendations were made, there is no evidence of who was accountable for their implementation or who, within the context of leadership, was responsible for maintaining oversight of these. Because of this, there was no effective strategy for meaningful change within maternity services at the Trust which further perpetuated the cycle of harm to women and families accessing maternity services at the Trust over an extended period of time. Staff who are currently employed in maternity services at the Trust and who engaged with the maternity review team as recently as early 2022 told us of a fear of speaking out in maternity services that persist to the current time. This is of very significant concern to the review team and has been shared with the Trust in advance of publication of this report.

Chapter 6

Our findings following the review of family cases

6.1 A total of 1,862 cases were either reported by the Trust or self-referred to the review. After the closure date for referrals the database was reviewed and 47 duplications were identified and removed leaving 1,815 cases.

6.2 The review was intended to span the years 2000-2019. However, as discussed in previous chapters, some earlier and later cases were reviewed in line with the updated terms of reference. The earliest case reviewed occurred in 1973 and the latest in 2020.

6.3 After excluding cases for which hospital records were missing, or where consent for participation in the review was not given or could not be obtained, the **final number of families whose cases were reviewed was 1,486**. It is important to note that some families had more than one clinical incident reviewed, as some mothers had more than one pregnancy during the review period. **In total 1,592 clinical incidents were reviewed.** Table 1 outlines the number of families and clinical incidents throughout the review period.

Table 1: Time period of family cases included in this review

YEARS	FAMILIES	CLINICAL INCIDENTS
Pre-2000	170	181
2000-2019	1,305	1,393
Post-2019	15	18
Totals	**1,486***	**1,592**

** Four families had clinical incidents that fell both within the 2000-2019 years and outside these years. Therefore there are 1,486 unique families in total.*

6.4 In line with the terms of reference underpinning this review we reviewed all 1,592 clinical incidents and analysed two aspects. Firstly, we graded the care provided by the Trust as set out overleaf. Secondly, we reviewed all the maternity governance documentation provided to the review team and graded the quality and appropriateness of the incident investigation in line with national frameworks at the time.

Grading of care

6.5 All the clinical incidents were reviewed by members of the review team which comprised obstetricians, midwives, neonatologists, and other specialists where appropriate. The clinical care was graded using an established grading of care scoring system (Table 2) developed by the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI), which was similarly used in the Morecambe Bay investigation report by Dr Bill Kirkup, OBE. Further details on the findings and the Immediate and Essential Actions recommended by this review are described in the accompanying chapters.

Table 2: Grading of maternal and newborn care provided

GRADE	SUMMARY DESCRIPTION OF CARE	DETAILED DESCRIPTION OF CARE
0	Appropriate	Appropriate care in line with best practice at the time
1	Minor concerns	Care could have been improved, but different management would have made no difference to the outcome
2	Significant concerns	Suboptimal care in which different management might have made a difference to the outcome
3	Major concerns	Suboptimal care in which different management would reasonably be expected to have made a difference to the outcome

6.6 Table 3 shows the grading of care for the major incident categories. For the incident categories HIE, neonatal death and cerebral palsy / brain damage the investigation into mother and baby is considered as one family. **It is important to note that a mother or baby can be in more than one category and this includes the maternal morbidity category and the combined category.**

Table 3: Clinical review findings for each of the major incident categories

INCIDENT CATEGORY	REVIEW TYPE	NUMBER OF REVIEWS*	GRADING OF CARE SCORE				PERCENTAGE OF CARE AT GRADE 2 AND 3
			0	1	2	3	
Maternal Death		12	0	3	6	3	75.0%
Stillbirth		498	193	174	93	38	26.3%
Hypoxic Ischaemic Encephalopathy	Mother**	44	10	5	16	13	65.9%
	Baby***	41	26	13	2	0	4.9%
Neonatal Death	Mother**	251	107	74	38	32	27.9%
	Baby***	237	182	38	13	4	7.2%
Cerebral Palsy/ Brain Damage	Mother**	147	35	47	45	20	44.2%
	Baby***	139	99	30	8	2	7.2%

**Some mothers had more than one pregnancy where a clinical incident occurred during the period of the review (for example a stillbirth in one pregnancy followed by another incident in a subsequent category).*

***Review of the care provided to the mother*

****Review of the neonatal care provided to the baby after birth*

Maternal deaths

6.7 There were 12 maternal deaths reviewed and in nine of the 12 cases (75 per cent) the review team identified significant or major concerns in the care received. Maternal deaths are further discussed in chapter 10.

Stillbirth

6.8 498 cases of stillbirth were reviewed and graded. One in four cases were found to have significant or major concerns in care which if managed appropriately might, or would have, resulted in a different outcome.

Hypoxic Ischaemic Encephalopathy (HIE)

6.9 HIE is a newborn brain injury caused by oxygen deprivation to the brain. There were significant and major concerns in the care provided to the mother in two thirds (65.9 per cent) of all cases. After the baby had been born, most of the neonatal care provided was considered appropriate or included minor concerns however these were unlikely to influence the outcome observed.

Neonatal death

6.10 Most of the neonatal deaths occurred in the first 7 days of life. Nearly a third of all incidents reviewed (27.9 per cent) were identified to have significant or major concerns in the maternity care which might or would have resulted in a different outcome.

Cerebral palsy

6.11 All of the families in this group self-reported to the review. The diagnosis of cerebral palsy was often made some years following their maternity episode. On reviewing the medical records, where it was found that the neonatologists at the Trust had recorded a diagnosis of HIE in the early neonatal period, a small proportion of families were subsequently transferred to the HIE incident category. From the remaining cases of cerebral palsy, more than 40 per cent were identified to have significant or major concerns in maternity care which might have resulted in a different outcome. The grading of neonatal care in most of the cases was either appropriate or with only minor concerns.

Maternal morbidity

6.12 Within this group were families who did not meet the incident categories identified in the NHS England and Improvement (NHSE&I) and Trust-led Open Book exercise conducted in the autumn of 2018 (maternal death, stillbirth, neonatal death and HIE). There were 614 women in this group, and they included women who experienced morbidity such as admission to intensive care, women who had had a caesarean hysterectomy, women who had severe sepsis or major haemorrhage or reported having experienced rare adverse outcomes such as eclampsia, amniotic fluid embolus or a cardiac arrest. Our reviewers identified significant and major concerns in the care provided to one in four women in this group. The care provided to the baby was considered appropriate in more than 90 per cent of records reviewed.

Combined category

6.13 This group included families who were outside the other categories. Some of these families self-reported. This category included medical termination of pregnancy, missed fetal abnormality, neonatal intraventricular haemorrhage, infant death and child death. There were 58 cases reviewed in this group. Most of these cases were graded as receiving appropriate care or care with only minor concerns.

Quality of investigation

6.14 We graded the quality and appropriateness of clinical incident investigations undertaken at the Trust throughout the time period of the review. Nationally, investigative processes have improved over time and this is described further in Chapter 4. Table 4 outlines the grading system used for the clinical incidents from 2011 onwards.

Table 4: Grading of investigations from 2011 onwards

GRADE	INVESTIGATION	FAMILY INVOLVEMENT
Appropriate	Incident investigated by team of clinicians Appropriate collection of evidence (statements, notes, policies etc.) Appropriate care and service delivery problems identified Strong recommendations for improvement with clear plan for implementation.	Families involved in investigation by compassionate communication with family at time of incident. Feedback to family once investigation concluded.
Poor	Any of the above missing (state which).	Very little family involvement, or feedback to family lacking after investigation.
None	Incident not investigated.	No family involvement.

6.15 The tables below show the results for stillbirths and neonatal deaths for the period 2011-2019. The maternal death investigations are discussed more fully in Chapter 10. Where there was no Trust investigation this is shown. In some cases the review team reported "unable to grade" which was usually due to incomplete documentation. Only where there was sufficient documentation for a review was a grading of appropriate or poor given.

Table 5: Stillbirths (2011-2019)

Total number of cases	GRADING OF INVESTIGATION				GRADING OF FAMILY INVOLVEMENT IN INVESTIGATION			
	Total number of cases where an investigation took place	Appropriate	Poor	Unable to grade	Total number of cases where an investigation took place (with enough data)	Appropriate	Poor	Unable to grade
168	100	36%	49%	15%	85	32.9%	40.0%	27.1%

6.16 In the period 2011-2019, 68 (40 per cent) of the 168 stillbirths reviewed did not have an investigation. Of those where an investigation occurred 36 per cent were found to be appropriate. Family involvement was graded as appropriate in 33 per cent of cases.

Table 6 Neonatal Deaths (2011 – 2019)

Total number of cases	GRADING OF INVESTIGATION				GRADING OF FAMILY INVOLVEMENT IN INVESTIGATION			
	Total number of cases where an investigation took place	Appropriate	Poor	Unable to grade	Total number of cases where an investigation took place (with enough data)	Appropriate	Poor	Unable to grade
77	44	54.5%	34.1%	11.4%	41	41.5%	31.7%	26.8%

6.17 In the period 2011-2019, 33 (43 per cent) of the 77 neonatal deaths reviewed did not have an investigation. Of those where an investigation occurred 55 per cent were considered to have been appropriately investigated. Family involvement was graded as appropriate in 42 per cent of cases.

6.18 In the hypoxic ischaemic encephalopathy group there were 12 cases reviewed for the period 2011-2019 and of these eight were investigated by the Trust. This group was considered too small to draw conclusions on the quality of the investigation.

OCKENDEN REPORT - FINAL

Section 3

Our findings of what happened to the families

- Chapter 7. Antenatal care
- Chapter 8. Intrapartum care
- Chapter 9. Postnatal care
- Chapter 10. Maternal deaths
- Chapter 11. Obstetric anaesthesia
- Chapter 12. Neonatal care

Chapter 7

Antenatal care

7.1 Safe and individualised antenatal care must be the foundation underpinning a woman's pregnancy and birth journey. From the point at which a woman notifies her pregnancy, often to her GP, and then attends a booking appointment with a midwife, a detailed and thorough risk assessment must be undertaken. Comprehensive, individual and woman and family-focussed questioning permits an accurate risk assessment so that care can be personalised and women can be signposted to the most appropriate antenatal care pathway.

7.2 For many women antenatal care is provided by a wide group of professionals including midwives, doctors and sonographers, as well as individuals from external agencies such as social care. This relies upon the sharing of accurate information between primary care and hospital maternity services and on occasion other medical specialities. Throughout antenatal care provision there is a necessity for close interdisciplinary working between these groups to ensure optimal and safe antenatal care is delivered. This chapter focuses on aspects of antenatal care that were not previously addressed in the first report and aims to highlight areas within the maternity service provided by the Trust which the review team felt warranted further attention.

Good practice in antenatal care and missed opportunities for learning

7.3 Throughout the time period of the review our multi-professional review team found a number of examples of good practice, of compassionate and safe antenatal care. However, also throughout the entire period of the review our team found poor standards of antenatal care, showing a lack of consistency and significant opportunity for improvement. Unfortunately there were significant numbers of poor standards of investigation when things went wrong or investigations that should have taken place which did not. Overall, the Trust continued to miss significant opportunities for significant learning throughout the entire time period of the review.

Care of vulnerable women

7.4 Pregnancy is a well-documented catalyst that may increase maternal vulnerability and inequalities already present in the lives of some women[118]. Vulnerability can be seen in women that have previously or are currently experiencing poverty, homelessness, domestic abuse, learning difficulties, seeking asylum, substance misuse, poor mental health, complex co-morbidities and teenage pregnancy. It is widely recognised that pregnancy carries a great deal of uncertainty. Women who are vulnerable in pregnancy are more likely to be exposed to additional harm, stress and anxiety.

7.5 The review team found evidence of missed opportunities to further investigate women from vulnerable groups. There was a lack of professional concern and in some cases a lack of appropriate referral in cases where further exploration was warranted. It is recognised that vulnerable women who receive appropriate support and intervention have improved outcomes[119].

7.6 *In **2009** a young woman in her first pregnancy was booked for consultant-led care due to her age and was diagnosed as having a baby with fetal gastroschisis[120]. She was not referred for additional support from the teenage pregnancy midwives but instead was seen by multiple midwives. As a result there were missed opportunities to explore her possible complex social needs as her care continued to be focused largely on the fetal gastroschisis (2009).*

118 NHS England. Better Births (2016) https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

119 Centre for Maternal and Child Enquires. Perinatal Mortality 2008 (2010) https://www.publichealth.hscni.net/sites/default/files/Perinatal%20Mortality%202008.pdf

120 See glossary

7.7 *A very young woman was booked for her first pregnancy in **2013**. There was no referral to the teenage pregnancy service nor any further exploration relating to her social circumstances, particularly as her partner was significantly older than her. She was not offered appropriate additional support and care. (2013)*

7.8 *In **2013**, a young teenage woman presented with a history of three previous pregnancies, all of these ending in miscarriage. Whilst she was appropriately referred to the teenage pregnancy midwife there was a lack of professional exploration or questioning around her social background, support networks and mental health. Appropriate signposting and referrals were not made in the pregnancy, and she did not receive the necessary additional offers of care and support. (2013)*

7.9 National guidance for women with complex social factors was updated in 2010[121] and emphasised the need to improve support for women with additional needs. The Trust has guidance available with care pathways and referral processes for specialist practitioners such as the safeguarding team and teenage pregnancy midwife. The review team considered many cases where guidance was followed and referrals had been appropriately made

7.10 *In **2018**, the review team had concerns around a lack of appropriate safeguarding and domestic violence screening- not completed at the booking visit. There were a number of missed opportunities to follow up the questions about domestic violence. It is appreciated there is always a possibility that an individual may not disclose any concerns. Following what was thought to be a domestic violence incident there was significant maternal morbidity and stillbirth. The review team subsequently saw evidence of learning from the Trust and changes to practice following this case. (2018)*

Good practice

7.11 *In **2008** a young teenage woman in her first pregnancy received appropriate input and referrals from the teenage pregnancy midwives and additional input and investigation from the fetal medicine consultant. Bilateral talipes[122] were identified on an ultrasound scan. The baby was born at term and had an extended stay on the neonatal unit for nearly 1 month due to its inability to feed and the need for nasogastric feeding. There were extensive investigations for a possible neuro-muscular disorder and the family were counselled and supported by a geneticist about this. (2008)*

7.12 *A young woman in her first pregnancy in **2016** was appropriately referred to the teenage pregnancy team. The review team observed use of interpreters and the offer of a comprehensive assessment which would have resulted in an holistic consideration of the family strengths and needs. This was declined by the mother and the family (2016).*

7.13 Whilst highlighting these examples of good practice, the review team found that overall there was a lack of consistency, potentially exposing women and their babies to increased risk and potentially unnecessary harm.

Fetal growth assessment and management

7.14 Monitoring fetal growth is an integral component of safe and effective antenatal care. Over the last 20 years there has been increasing evidence that fetal growth restriction (FGR) is associated with stillbirth, neonatal death and increased perinatal morbidity. The Perinatal MBBRACE report in 2015[123] on term antepartum stillbirths found that 'about one in three term, normally formed, antepartum stillbirths are related to abnormalities of fetal growth'.

121 National Institute for Health and Care Excellence. Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (2010) https://www.nice.org.uk/guidance/cg110

122 See glossary

123 MBRRACE-UK. Perinatal Confidential Enquiry. *Term, singleton, normally-formed, antepartum stillbirth* (2015) https://www.hqip.org.uk/wp-content/uploads/2018/02/perinatal-confidential-enquiry-term-singleton-normally-formed-antepartum-stillbirth-report-2015.pdf

7.15 In November 2015, the Department of Health[124] announced a new ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2030. The National Maternity Review, Better Births[125] (2016) highlighted a range of measures which can enhance the safety of care for women and babies, and identified a 'care bundle' as good practice in reducing stillbirths.

7.16 NICE (2003, 2008)[126] and RCOG (2013)[127] guidance advocates the use of symphysis fundal height (SFH) measurement and plotting these on a growth chart in the maternity handheld notes as essential to the care of low risk women. A referral for an ultrasound growth assessment is indicated where thresholds are reached or for women who are deemed to be high risk.

7.17 In 2016 NHS England produced the Saving Babies Lives Care Bundle Toolkit for maternity units to reduce the risk of stillbirth. The 'toolkit' was a range of measures that could be deployed to improve safety for mothers and their babies. One element of this has been the detection and surveillance of fetal growth restriction (FGR); (version 2 published 2019)[128]. However, it must be acknowledged that historically, national guidance for monitoring of fetal growth has been conflicting and this has been a contentious issue across the UK over the last 20 years. There remains extensive regional variation in the adoption of guidance and practice.

7.18 In 2007-2008 the Trust introduced customised growth charts as part of the national Growth Assessment Protocol (GAP)[129] and Gestation Related Optimal weight (GROW)[130] programme with the West Midlands being one of the first regions to introduce the programme. Prior to this time the non-customised SFH and ultrasound growth charts were in use within the Trust's handheld antenatal notes.

7.19 The review team found many instances where fetal growth restriction occurred but was not identified. Whilst it is recognised that despite following guidance it is not always possible to detect FGR (given the limitations of available methods including ultrasound) there were definite themes that emerged from review of these cases:

- The SFH measurement was not always completed and documented at each antenatal visit from 24 weeks.
- The SFH measurements taken were both inconsistently and inaccurately plotted onto the growth chart.
- A lack of appropriate referral when SFH measurements would have triggered an ultrasound scan.
- Failure to monitor growth by ultrasound in babies at high risk of FGR (e.g. women with underlying hypertension).
- Lack of recognition, action and wider learning by the Trust when babies were born growth restricted, including those who died.

7.20 *In 2017 a nulliparous[131] women was assessed at her an antenatal visit at 27 weeks and it was noted that the symphysis fundal height (SFH) plotted above 90th centile when plotted on the customised growth chart. Following this fetal growth appeared to be reducing in trajectory. According to local guidance a fetal growth scan should have taken place .This did not occur. At 35 weeks gestation a stillbirth occurred of a grossly fetal growth restricted baby (birthweight at delivery on the 1st centile). The Trust recognised that*

124 https://www.england.nhs.uk/mat-transformation/saving-babies/

125 Ibid n1

126 National Institute for Health and Care Excellence. Antenatal Care Clinical Guidance 6 (2003) https://www.nice.org.uk/guidance/cg6 and Antenatal Care for uncomplicated pregnancies Clinical Guidance 62 (2008) https://www.nice.org.uk/guidance/cg62

127 Royal College of Obstetrics and Gynaecologists *Investigation and Management of the Small-For-Gestational-Age Fetus Green-Top Guideline number 31* (2013) https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf

128 NHS England. Saving Babies' Lives Version 2: a care bundle for perinatal mortality (2019) https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

129 Clifford, S., Giddings, S., Southam, M., Williams, M., Gardosi, J., *The Growth Assessment Protocol: a national programme to improve patient safety in maternity care.* (2013) https://www.perinatal.org.uk/wwwroot/pdf/nz/GAP_article_MIDIRS_Dec_2013.pdf

130 Gestation Network. Growth Charts GROW https://www.gestation.net/growthcharts.htm

131 See glossary

there were missed opportunities to detect IUGR and refer appropriately. There was confusion from staff about guidance and when a woman should be referred for a scan. Had this severe IUGR been detected earlier delivery may have been expedited prior to stillbirth occurring. (2017)

Staff voices on fetal growth:

7.21 A staff contributor told the review that that they had encountered problems with women being referred for growth scans and had found that some clinical colleagues were uncertain of SFH measurement technique:

'When I was doing some of the clinics, I would be seeing antenatal women who should have had a scan… and in one clinic session, there were three women who should really have been referred for a growth scan and obviously, I did refer them, but I mean even the one partner had plotted the growth on the chart because they said the midwife hadn't plotted it…'

7.22 *The staff member continued: 'I was even asked the one time, "How do you measure fundal height?" by a midwife? I don't know, having a joke or something, I says, "How do you mean?" and [midwife] said, "Well…" literally [they] described how they measure the fundal height, I said, "Well, it's clear on the growth chart how to measure it you know, this is how you do it; it's on the growth chart itself how to measure it," and [they] says: "I do it the opposite way", which wouldn't give you the correct measurement'.*

7.23 Incorrect assessment of fetal growth was repeatedly observed by the review team. Some examples of this include:

*In **2011** a woman had continuity of care with the same midwife during her antenatal care, however the SFH measurements were incorrectly documented at some visits (not written in centimetres), and were incorrectly plotted in their position and mark used on the growth chart. The plots, if correct should have alerted referral for an ultrasound scan to assess growth. The pregnancy ended in a stillbirth of a baby with growth restriction. (2011)*

7.24 The Trust's initial investigation in June 2011 did not recognise that there had been missed growth restriction. The governance documentation reviewed was poorly completed and there was no indication that any of the actions had been achieved. Following a complaint from the family in October 2011 a further investigation took place and it was acknowledged that the growth measurement and plotting did not identify growth restriction. An action plan was made and evidence subsequently supplied to the family that the actions had been completed. However the learning only took place after a family complaint and not before. Families consistently told the review team of investigation only commencing after receipt of a complaint or commencement of litigation. The review team has seen this was a regular feature during the whole time period of this review. (2011)

7.25 *At 36 weeks' gestation in **2013** a woman experienced an intrauterine death. Following birth it was found the baby was significantly growth restricted. On case review it was established the SFH was not plotted on the GROW chart. The SFH was persistently measured as >90th centile (when retrospectively plotted) but the baby was profoundly growth restricted, and weighed 1.53kg at birth (1st centile). This case highlights poor SFH measurement techniques by several different antenatal care providers. (2013)*

7.26 Governance documents supplied by the Trust to the review team for the above case recognised that growth was not plotted appropriately and there had been missed FGR. Actions stated by the Trust were to ensure GROW training was being accessed by all, including GPs. GAP training was due to start in 2014. A further meeting in 2015 found that the CCGs had not progressed these actions and the GPs had not accessed the GAP training. Following this meeting the action was for the patient safety manager to highlight the need for the GAP training with the CCGs in conjunction with the recent MBRRACE report. The target date was February 2016, 3 years after the case. The review team has not been provided with evidence by the Trust to demonstrate this actually happened despite the significant passage of time.

7.27 *In **2015**, a woman became pregnant who had previously had a small baby with a birth weight just above the threshold in the local guideline to merit referral for an ultrasound scan. She was a current smoker and in this current pregnancy missed antenatal appointments due to issues with scheduling and non-attendance. Despite these risk factors, in the pregnancy in 2015 the complete clinical picture was not considered and she was not appropriately referred for an obstetric review or serial growth scans. (2015)*

7.28 *Her baby was stillborn at 37 weeks, with a birth weight less than the 3rd centile. The investigation by the Trust recommended a change to guidelines, to clarify exactly which centiles must be included in the risk assessment guidance for referral for scans in a subsequent pregnancy. The following two versions of the guidance did not change and the antenatal risk assessment was not updated until **2018**, a gap of 3 years following the incident.*

7.29 *A woman who was known to have large uterine fibroids had midwifery-led care throughout her pregnancy in **2016**. There were errors in the interpretation of the baby's growth, fetal and growth restriction was not detected and an obstetric opinion on the ultrasound scan was not obtained. The baby was born at 31 weeks and was severely growth restricted with a birthweight less than the 1st centile. The baby died the same day from a severe hypoxic birth injury. Local investigation recognised there was a missed opportunity for earlier specialist ultrasound scanning. (2016)*

7.30 Staff interviews undertaken during late 2021, as part of the Staff Voices initiative, supported the view that the Trust remained slow in implementing recommended changes. A staff member told the review team: *'so we're going to put that into our protocols and policies and before it was just 'mañana', we'll do it tomorrow. Tomorrow never comes. There's no urgency to address or change or do anything. They'll do that and if it works for them, we'll do it. No, we have to do it. We're answerable, we're accountable'.*

Specialist antenatal care

7.31 Some aspects of antenatal care require the input of specialised services. The review team identified the following areas of concern with specialist services that were being delivered at the Trust.

Fetal medicine care

7.32 A number of cases were considered where fetal medicine care was provided at the Trust. The review team identified incidences where a baby was born with an abnormality which was not detected until after birth or where a fetal abnormality was detected during the pregnancy and the review team had concerns about the care provided. From review of clinical records, in most cases the quality of fetal medicine care at the Trust appears to have been appropriate or good for the year that the pregnancy occurred. Some fetal abnormalities would not necessarily have been expected to be diagnosed antenatally and for those diagnosed it was evident that appropriate, kind and compassionate care had been provided both during the pregnancy and following a pregnancy loss.

Good care

7.33 *In **2007** a woman had a pregnancy complicated by multiple abnormalities found on the anomaly scan. She was seen by the fetal medicine consultant at the Trust and counselled regarding the increased chance of a chromosomal abnormality and she had an amniocentesis. The baby was confirmed to have a chromosomal abnormality and a referral to the genetics team was made. The parents decided to terminate the pregnancy. There was documented evidence of good communication with the parents and GP antenatally and postnatally and evidence of compassionate antenatal and bereavement care. (2007)*

7.34 *In **2012**, a baby was diagnosed with a significant brain abnormality at the anomaly scan. There was referral to the tertiary centre and the parents were counselled by the geneticists and paediatric neurologists at the tertiary centre and the neonatal and fetal medicine team at the Trust. The woman had regular scans and thorough investigations during the pregnancy with good multidisciplinary antenatal care and*

communication noted. The baby was delivered at 37 weeks and the baby died at a few hours of age. There was appropriate follow-up with the neonatal and genetic teams. (2012)

7.35 *A woman had a pregnancy in **2016** complicated by multiple fetal abnormalities identified at the anomaly scan at 19 weeks. She was seen by a fetal medicine consultant and offered an amniocentesis (invasive testing) and possible termination of pregnancy which she declined and had a stillbirth at 36 weeks. She was seen regularly by the midwives and obstetricians throughout the pregnancy and offered bereavement support. (2016)*

7.36 These cases demonstrate that there was often appropriate multidisciplinary care, support, counselling and bereavement care for the parents, including care at the tertiary centre where appropriate, following the diagnosis of a significant fetal abnormality.

Poor care

7.37 However, the review team found a number of cases where care was substandard. For fetal abnormalities such as cardiac abnormalities, babies that require surgery immediately post birth, babies with multiple abnormalities suggestive of a genetic syndrome or babies with severe early onset FGR, then referral to a tertiary fetal medicine centre during the antenatal period is the appropriate care pathway expected. This would ensure multidisciplinary counselling and expert care and for many babies birth in a unit with a Level 3 neonatal unit would be appropriate. There appeared to be a reluctance by some clinicians to refer some women for tertiary centre fetal medicine care for advice and counselling, or to transfer care to a Level 3 centre as a more appropriate place for birth. In cases where a fetal abnormality was detected postnatally or a baby died with abnormalities there was often no Trust investigation of the screening process or care. Thus opportunities for learning were lost.

7.38 When interviewed by the review team a member of staff at the Trust agreed that there was sometimes a reluctance to refer fetal medicine cases for an external review.

7.39 The contributor told the review: *'I think I'd probably, in retrospect, agree…to some extent. I think there was a degree of fetal medicine clinical overconfidence…but there are other things that you thought perhaps ought to have been referred elsewhere earlier on, yes'.*

7.39 *A woman booked in her third pregnancy in **2015**; although the 20/40 week anomaly scan was normal, significant fetal abnormalities were diagnosed at a later scan, which were likely to be associated with a poor outcome for the baby. She was counselled by a Trust fetal medicine consultant; although documentation of the discussion and possible outcomes were poor. The plan was made for the baby to be delivered at the Trust and for the neonatal team to be at the birth. The baby was delivered at 36 weeks and died within the first 24 hours of life. (2015)*

7.40 This case highlights the importance of appropriate antenatal communication and consideration for best place for birth. Although in cases, such as this, where the outcome is likely to be poor and the pregnancy is continuing, the outcome may be unchanged by referral to a tertiary centre, appropriate practice would be offering referral to a tertiary fetal medicine unit to ensure the provision of detailed counselling regarding the prognosis, including counselling from the wider multidisciplinary specialists. The specialist team would comprise geneticists, neonatal surgeons and speciality paediatricians to plan appropriate antenatal surveillance and postnatal care and ensure informed decision making by the parents.

7.41 Ongoing antenatal care following referral can be shared between the local and tertiary centre but at least one visit to the tertiary centre will ensure that key expertise is sought. Consideration must also be given to birth in the tertiary centre in complex cases, where the abnormality is likely to require early surgery and where level 3 neonatal care may be required to ensure optimisation of care at birth. With all of this information provided to the woman and her family they are then able to make an informed choice.

7.42 *In **2008** a women in her sixth pregnancy was identified as having a baby with a significant congenital abnormality at the anomaly scan. She was counselled by a Trust obstetric consultant, the neonatal team and neonatal surgeons at the tertiary centre. She decided to continue her pregnancy and delivered her baby at the Trust. The baby was transferred to the tertiary centre postnatally and died aged four days. Following review of this case it was agreed that referral to tertiary fetal medicine service should have been made and consideration given to the appropriate place of birth. (2008)*

7.43 *In **2019**, a woman had a pregnancy affected by severe early onset fetal growth restriction. There was no referral to a tertiary centre for specialist review, counselling or advice, particularly when the woman was reluctant to consider local advice regarding birth. The review team found there was limited evidence, pointing to inadequate counselling, and fetal medicine management was not in keeping with best practice. (2019)*

7.44 In the chapter focussing on neonatal care the review team discuss the change in designation of the neonatal unit in 2006 from level 3, (neonatal intensive care unit or NICU) to level 2, or a 'local' neonatal unit. Staff interviews supported the culture of reluctance to transfer women in utero or neonates to a Level 3 tertiary unit following the Royal Shrewsbury Hospital being designated a Level 2 or local neonatal unit, (LNU) in 2006. Staff described a gap of circa 8 years before the changes introduced in 2006 were actually implemented, but some were reluctant to be quoted within the report. Some staff members from the Trust stated that there was a lack of capacity at the designated level 3 units in the surrounding area, leading to the Royal Shrewsbury Hospital continuing to care for babies outside its designation. However this was disputed by the neonatal network.

7.45 One staff contributor told the review: *'Part of the sense of futility is that we have raised concerns, you know, sometimes we've actually had quite heated debates about…if on the obstetric side they feel that they don't want to send to Stoke or Birmingham, and…want...to keep the patient, and you're made to feel that you're letting the side down by not agreeing to proceed…I think for some of them there is a reluctance, and I don't know if that is a cultural thing because I think for a long time, particularly while based at RSH, there was a feeling that it was a very standalone unit and it did its own thing. So I think culturally there's been that feeling…'.*

Multiple pregnancies

7.46 About 1 in 60 pregnancies is a twin or triplet pregnancy (NICE 2015). A unit with approximately 5,000 births a year such as the Trust would expect on average 65-75 pregnancies resulting in multiple births a year. Multiple pregnancies are known to be at greater risk of adverse obstetric outcomes and so additional antenatal care is required.

7.47 NICE guidelines on twins and triplet pregnancy were first published in 2011 and have since been updated in 2019[132]. Guidance has emphasised the importance of detailed antenatal counselling for women with twins or triplets especially with regards to intrapartum management. This is best facilitated through a specialist clinic. The review found multiple cases where limited or no counselling was evident with regards to management of twin pregnancies.

7.48 *In **2013**, a multiparous[133] woman booked with a DCDA[134], twin pregnancy. At 31 weeks she was seen by a registrar and requested birth by caesarean section. She was told this was not necessary but there was no documented discussion regarding the risks associated with vaginal birth for the second twin. Twin 2 experienced a complicated birth and suffered HIE Grade 3. The child is now profoundly disabled and the mother suffered post-traumatic stress disorder. (2013)*

132 National Institute for Health and Care Excellence. Twin and triplet pregnancy NICE Guideline NG137 (2019) https://www.nice.org.uk/guidance/ng137

133 See glossary

134 See glossary

7.49 *In **2014**, a 41-year-old first time mother who conceived through assisted conception was advised an induction of labour at 36+ weeks as her twins were small. There was no evidence of any antenatal counselling. Labour was induced and she required an assisted vaginal birth for both twins in theatre. The second twin had a very complicated birth and as a consequence suffered HIE. (2014)*

7.50 *In **2017**, a primiparous[135] woman was induced at 37 weeks and 5 days as she had a DCDA[136] twin pregnancy, this was in accordance with local guidance. There was inadequate documented antenatal discussion with regards to the process of induction of labour, consideration of epidural analgesia and the potential risk of caesarean section for twin 2. Furthermore, at the time of induction prostaglandin (medication given to start the labour) was given without an obstetric review or an ultrasound scan to confirm presentation of the twins. An emergency caesarean section was undertaken for a fetal heart rate abnormality. There was a postpartum haemorrhage of 2500mls which was appropriately managed. (2017)*

7.51 Further cases of concern regarding the management of multiple pregnancies were seen by the review team. In conclusion, the review team found that multiple pregnancy management at the Trust gave cause for concern across the entire review period.

Diabetic Care

7.52 The care of women with diabetes encompasses women with both pre-existing diabetes and women who develop diabetes during pregnancy, known as gestational diabetes mellitus (GDM). UK rates of GDM have steadily increased over the last decade with Diabetes UK estimating that about 1 in 16 women will develop GDM. Women with pre-existing diabetes make up a smaller proportion of the women requiring diabetes care, but pregnancy complications are greater in this group.

7.53 UK guidance for the management of diabetes in pregnancy was first published by NICE in 2008 (revised in 2015 and updated 2020)[137]. Prior to NICE guidance CEMACH[138] published a landmark report in 2007 that highlighted women with pre-existing diabetes had a fivefold increased risk of stillbirth and a threefold increased risk of perinatal mortality. All these reports emphasise the importance of multidisciplinary care for women with diabetes and that women must have ready access to specialists with expertise in the care of diabetes in pregnancy.

7.54 Diabetes care at the Trust must be led by a named consultant obstetrician who acts as a lead for the service. This lead consultant must have sufficient time in their job plan to lead the diabetes service effectively. This can be benchmarked against other similar sized trusts. The lead consultant must work in conjunction with a consultant diabetologist, specialist nurses, midwives and also a diabetes dietician. It is imperative that these individuals work together in a collaborative manner. The diabetes service at the Trust was created in 1999 and has increased in size over the last 20 years. The number of women presenting with diabetes has been increasing significantly.

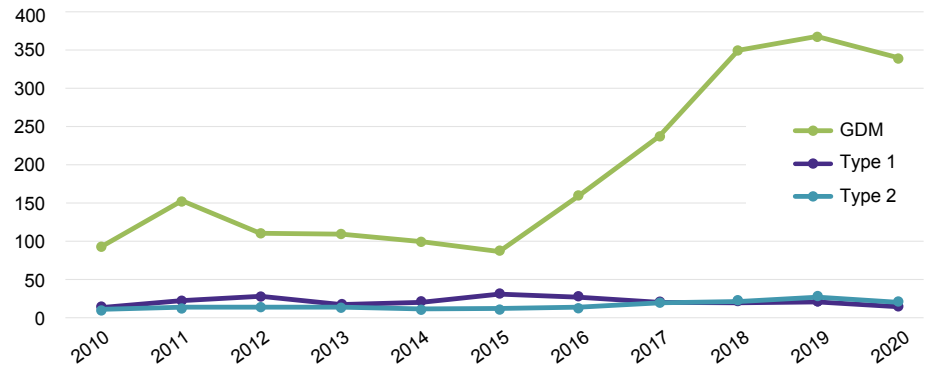
135 See glossary

136 See glossary

137 National Institute for Health and Care Excellence. *Diabetes in pregnancy: management from preconception to the postnatal period NICE guideline NG3* (2020) https://www.nice.org.uk/guidance/ng3

138 Confidential Enquiry into Maternal and Child Health. Diabetes in pregnancy: are we providing the best care? (2007) https://www.publichealth.hscni.net/publications/diabetes-pregnancy-are-we-providing-best-care

Diabetes yearly breakdown



Source: Shrewsbury and Telford Hospital NHS Trust

7.55 *In **2016**, a woman had appropriate multidisciplinary team antenatal care that involved senior obstetric, diabetic specialists and midwifery input. However there was failure not to act or further investigate increasing ketonuria[139] and fetal macrosomia[140] in a diabetic smoker all of which are individual risk factors for intrauterine fetal death. An antepartum stillbirth occurred at 34 weeks and 6 days. There was no evidence provided to the review team that this case was discussed at a governance meeting or that any learning was identified. (2016)*

7.56 *In **2016** a women with Type 1 diabetes who had poor control prior to pregnancy, suffered a stillbirth at 34 weeks' gestation. There were multiple missed opportunities to improve diabetic control and care sometimes seemed fragmented. The risks of the pregnancy were not shared with the patient. The patient had a pregnancy the following year where the care was much improved with evidence of better multidisciplinary team working. (2016)*

Staffing of the maternity diabetic service at the Trust

7.57 The Trust has advised the review team that the present diabetic service consists of two consultant obstetricians, and two endocrinologists. There is one Band 7 midwife and two band 6 midwives who both provide less than 0.5 full time equivalent cover. The service also has access to diabetes nurse specialists. The review noted current problems with staffing and capacity within the diabetic service, especially given the increasing workload. Firstly, there is no current provision for consultant cover during periods of annual leave, study leave and other absences, meaning women have limited access to the correct specialist during their antenatal care.

7.57 Furthermore, from the documentation provided to the review team there appears to be only one fortnightly clinic run for women with GDM. This is inadequate for the number of women managed with GDM in the service, which is on average 29 women a week (based on the Trust's data for the last 3 years). Having such limited appointments available for complex pregnancies means that an appropriately detailed assessment is unlikely to be made, which increases the likelihood that omissions will occur and errors will be made.

Good practice

7.59 Whist the review had concerns regarding the maternity department's ability to support the diabetes service it saw good practice, in that the department had invested to develop a midwifery non-medical prescriber. This model of care means a specialist midwife has a greater depth and understanding of diabetes and also continues to manage women with gestational diabetes when medical therapy is required.

139 See glossary

140 See glossary

Preconception care and diabetes

7.60 An important facet of diabetes management is access to preconception care for women with pre-existing diabetes. Women with very poor diabetic control must be advised against becoming pregnant until better diabetic control is established and must have access to appropriate advice on contraception and medications to avoid when embarking upon pregnancy. The review found evidence of numerous cases of women with pre-existing diabetes who had not had access to preconception care. This includes the case below, which is relatively recent.

7.61 *In **2019** a woman with underlying type 2 diabetes and an elevated BMI booked with an average blood glucose level of 117 prior to pregnancy (desired upper level for pregnancy is 48). Whilst she was first seen prior to 10 weeks of gestation, she unfortunately suffered an intrauterine death at 16 weeks, which may have been related to her pre-pregnancy diabetic control. (2019)*

7.62 Cases such as this evidence the disconnect between diabetes care, general practice and maternity services and the need for greater emphasis on preconception care. With better access to preconception care and provision of appropriate contraception services, this will help reduce or minimise cases of pregnancy loss associated with a woman's diabetic status.

7.63 As pregnancies in women with underlying diabetes are at elevated risk of poor fetal outcome it is imperative that women undergo thorough clinical and risk assessment at all antenatal visits. This includes assessment of blood pressure, urine and measuring and plotting the SFH.

7.64 A further important component of antenatal care for women with diabetes is that of birth planning. Women with diabetes are far more likely to require induction of labour or birth by planned caesarean section, particularly in the presence of fetal macrosomia or fetal growth restriction. There was evidence that this failed to occur in several cases leading to poor fetal outcome at the Trust.

7.65 *In **2014** a woman with type 1 diabetes was seen at 35 weeks and a plan was made for induction of labour at 38 weeks. There was no assessment of fetal growth beyond 35 weeks, but it was noted the abdominal circumference plotted above the 95th centile. At the time of induction, it was noted that the SFH measured 46cm and yet this was not acted upon. The patient underwent induction of labour which culminated in a vaginal birth complicated by a shoulder dystocia and abnormal fetal blood gases. Unfortunately, an early neonatal death occurred which was related to fetal hypoxemia at birth. (2014)*

7.66 When planning the place and mode of birth, maternity team members must provide women with evidence-based advice and recommendations. This will enable women to make an informed choice about their pregnancy and birth. This discussion must be fully documented in the maternity notes.

Good practice

7.67 There is evidence within the diabetes service that the Trust has made efforts to enhance antenatal care for diabetic women. The Trust has invested in the use of smartphone technology to allow remote reviews and telephone consultations for women with gestational diabetes. Additionally, NHS England recently mandated funding for all women with type 1 diabetes to have access to continuous glucose monitoring (CGM) in pregnancy. This funding stream has commenced after the period of the review but it is nevertheless important that the Trust ensures women have equity of access to CGM early in pregnancy.

Hypertension management

7.68 Gestational hypertension (also referred to as pregnancy induced hypertension) is a common disorder and may affect up to 1 in 10 pregnancies. It describes new onset hypertension in pregnancy occurring after 20 weeks gestation where maternal blood pressure is greater than 140/90 on two separate readings more than 4 hours apart. Hypertension identified prior to this point is known as chronic hypertension and affects about 1-2% of women. Gestational hypertension as well as chronic hypertension are known to be

risk factors for the development of complications in pregnancy and so women must undergo assessment of blood pressure at every antenatal visit. Furthermore, women who develop hypertension may require antihypertensive treatment during pregnancy to reduce the risk of developing severe hypertension.

7.69 National guidance for hypertension management was first published by NICE 2010 with collaboration from the RCOG and the RCM. It has since undergone revision in 2019[141]. Prior to 2010, the UK confidential enquiry in maternal deaths (CEMACH)[142] emphasised the importance of treating severe hypertension which may have contributed to cases of maternal death. Given how common hypertension is, all healthcare professionals working in maternity services must be aware of the need for monitoring and onward referral of woman with hypertension for obstetric review.

7.70 The Trust shared with the review team its first guidance for hypertension in pregnancy. This appears to have been created in 2006. The document is entitled Hypertension Severe (it has no implementation date but was due for review in 2008). It is noteworthy that the guidance stated that the initiation of antihypertensive medication for high blood pressure was only required if the systolic was 170 or greater, and they acknowledge that the Confidential Enquiry recommendation (published 2007) stated a lower blood pressure of 160 systolic required treatment. This potentially indicates a reluctance within the Trust's maternity service to treat severe hypertension according to national guidance. It must be noted these thresholds are much higher than the current guidance set out from NICE where blood pressure requires treatment when it is 150/100 or greater.

7.71 This review covers an extended period over 20 years and underpinning the review is a methodology acknowledging that assessment of cases must utilise the national guidance in use at the time. When reviewing the management of hypertension, the review team has focused on cases from 2009 onwards so that maximum learning could be established for the Trust as regards current service provision from the cases reviewed. Nevertheless, it must be acknowledged that there were many significant cases that were encountered where there was suboptimal management of hypertension prior to 2009. One example is:

7.72 *In **2001**, a woman developed severe hypertension with a blood pressure 165/100 and proteinuria at 36 weeks' gestation. A 24 hour urine collection was raised at 0.5g/l. No treatment was started, instead her elevated blood pressure was attributed to anxiety, despite clinical signs of severe hypertension. Over a week later induction of labour was finally decided upon when she developed epigastric pain and felt very unwell. There was no long term harm to mother or baby in this case. (2001)*

7.73 Following publication of the 2010 NICE guidance the review team found continued deviation from NICE guidance in the treatment of women with hypertension at the Trust.

7.74 *In **2011** a woman developed hypertension at 38 weeks' gestation in her first pregnancy, despite multiple elevated blood pressure readings that would have justified treatment, no treatment was started. She suffered an intrapartum stillbirth during the induction of labour, (IOL) process. The review team felt this was a high risk case, and a scan should have been carried out prior to IOL. In addition, assessment should have been made by an experienced midwife, not a student. If the CTG had been normal at the beginning of induction, then it is more likely than not that with adequate and ongoing observation and assessment, the outcome would have been different. (2011)*

7.75 *A woman developed hypertension and proteinuria at 33 weeks gestation in **2011**. She was admitted to the antenatal ward and started on treatment and given intramuscular steroids in anticipation of early birth. She had persistent vomiting and an ongoing headache. A consultant review occurred and it was decided she could have outpatient management. The woman was discharged but had an eclamptic seizure at home and was transferred and delivered by emergency caesarean at another hospital. The review team have not been provided with any documentation by the Trust that indicated any investigation or subsequent learning occurred as a result of this case. (2011)*

141 National Institute for Health and Care Excellence. Hypertension in pregnancy: *diagnosis and management NICE guideline NG133* (2019) https://www.nice.org.uk/guidance/ng133

142 Confidential Enquiry into Maternal and Child Health. *Saving Mothers' Lives 2003-2005* (2007) https://www.publichealth.hscni.net/publications/saving-mothers-lives-2003-2005

7.76 *In a **2013** pregnancy a woman with type 1 diabetes was reviewed as an inpatient at 37 weeks as she had developed hypertension and proteinuria. Her blood pressure was elevated at 162/98mmhg. Her case was escalated to a consultant who despite clinical signs of hypertension and proteinurea indicated that no treatment was required. The review team found had concerns that such a high risk case had induction of labour started on the antenatal ward. There was poor management of her pre-eclampsia; earlier medication/treatment for pre-eclampsia would be recommended in this case. The review team notes with concern the management of a high risk IOL on the antenatal ward. Due to the complexity of this case, IOL should have been managed on the labour ward. There were also concerns regarding the management of this woman's diabetes with a delay in starting an insulin 'sliding scale'. (2013)*

Chronic hypertension

7.77 Another key element to managing hypertension in pregnancy is the recognition of women who have chronic hypertension. This cohort of women are at greater risk of developing severe hypertension in pregnancy as well as pre-eclampsia, having a preterm birth or a baby born small for gestational age. Women identified with chronic hypertension must be cared for throughout their antenatal period on a consultant-led care pathway. Current evidence suggests women should be advised to take aspirin from 12 weeks' gestation[143]. Additionally, women may require additional fetal growth scans to assess for growth restriction, which is more common in this cohort of women.

7.78 *A 42-year-old woman with a history of previous pregnancy affected by pre-eclampsia had a booking blood pressure of 140/80 with dipstick proteinuria in **2015**. She was appropriately referred to see a consultant at 11 weeks. However, there was no consideration that this might be chronic hypertension with an underlying renal disease. Unfortunately, the woman developed superimposed pre-eclampsia and experienced a stillbirth at 27 weeks' gestation. (2015)*

Inpatient antenatal care

7.79 It is estimated that about 12 per cent of all pregnant women are admitted to the antenatal ward during their pregnancy[144]. Women admitted for hospital care antenatally are more likely to need extra surveillance for an existing or new condition during their pregnancy. As a review team we acknowledge that there is an absence of national guidance that sets thresholds for when a woman must be admitted. Nevertheless, when women are admitted to the antenatal ward a clear consultant obstetrician-led plan of care is required as a standard.

Obstetric ward rounds

7.80 The Trust's Maternity Clinical Operation Policy (2015) describes the cover and support for the wards (wards described as labour ward; antenatal ward; postnatal ward and other pregnant women in hospital such as ITU) with a consultant on site from 08.30 to 20.30 from Monday to Friday and 08.00 to 16.00 on weekends and bank holidays. However, there is no clear description of what this 'support' entails. There is no mention of dedicated ward rounds on the antenatal ward. The RCOG Roles and Responsibility of a Consultant[145] (published 2009 and updated 2021) has identified that obstetric ward rounds enable staff to monitor, anticipate and respond in a timely way to emerging problems. They permit women to voice their concerns and enable them to ask questions and receive answers with regard to their care.

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143 Ibid n25

144 Tracy, K. et al. *Caseload midwifery care versus standard maternity care for women of any risk: M@NGO*, A randomised controlled trial. (2013) Lancet. Vol 382, Issue 9906 p1,723-32

145 Royal College of Obstetrics and Gynaecologists. Roles and Responsibilities of a Consultant – Workforce Report (2021) https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

7.81 Handovers must also include high risk women in the antenatal ward, enabling the out of hours team to be aware of concerns and possible reviews needed during their shifts (RCOG 2010[146], NHS1 2019[147]).

7.82 The review team found many incidents of high-risk women admitted to hospital not being reviewed by consultants. There was a lack of consultant presence on the antenatal ward and no evidence seen of a structured antenatal ward round. Medical assessments of antenatal inpatient women seemed to happen when a midwife asked for a clinical review rather than being part of the daily routine in maternity services.

7.83 When a plan for treatment or intervention was decided, documentation of detailed discussions with the women and their partners was rarely found within the records supplied to the review by the Trust.

7.84 *In **2005**, a woman with a complex pregnancy had an amniotic fluid drainage (removal of excess amniotic fluid around the baby) on the ward. There was no mention of a discussion of the procedure with the woman or any record of the procedure itself. The only documentation in the medical records provided to the review team by the Trust is the amniotic fluid biochemistry. (2005)*

7.85 During the staff voices interviews in autumn 2021, staff were asked about inpatient care and if registrars couldn't get hold of consultants to see high-risk antenatal patients, whether they would make it known that it was a concern. A staff member replied: *'No, they wouldn't, they would just act on whatever... they would just do whatever they can'.*

7.86 *In **2017** a woman was booked in for low risk midwifery care, but placed on aspirin as there was a family history of pre-eclampsia. The woman presented as large for her dates, had oedema and reduced fetal movements on presentation at 39 weeks and 6 days gestation. She was booked for an induction of labour. Following Propess[148] times 1 and Prostin[149] times 3, when ready for artificial rupture of membranes (ARM) the labour ward was too busy to accept her transfer, so the mother remained on the antenatal ward. Approximately 12 hours later, she was transferred to the labour ward. However, on attempting to auscultate the fetal heart, intrauterine death was identified and confirmed on ultrasound scan. (2017)*

7.87 Additionally, the review team encountered multiple instances where women who were admitted for induction of labour did not have a clinical review at all prior to commencing the induction process.

7.88 *A woman was admitted for induction of labour at 40+1 weeks in **2013**. Through the documentation provided by the Trust to the review team the indication for induction was not clear. Prostaglandins were given as the cervix was unfavourable. No obstetric review is documented in the notes until 48 hours after admission. Baby was born delivered by emergency caesarean section. Parents report their experience around induction, labour and the immediate postnatal experience being 'horrific.' (2013)*

Escalation of concerns

7.89 The RCOG Each Baby Counts (2020)[150] documented that 'failure to escalate/act upon risk/transfer appropriately' occurred in 36 per cent of reviewed reports. Factors affecting escalation nationally included site-based or professional team alliances, and skill gaps within specialisms and wider teams.

7.90 The review team identified many cases where midwifery staff appeared reluctant to escalate their concerns regarding care and treatment to obstetric and neonatal colleagues. High risk and complex cases were not escalated to the right person in a timely manner. Sometimes, there was recognition by the midwifery team of the need to escalate but as the junior doctor was often busy, they just waited despite their concerns.

146 Royal College of Obstetrics and Gynaecologists. Improving patient handover: Good practice no. 12 (2010) https://www.rcog.org.uk/en/guidelines-research-services/guidelines/good-practice-12/

147 NHS Improvement. Implementing huddles and handovers 0- a framework for practice in maternity units (2019) https://www.pslhub.org/learn/patient-safety-in-health-and-care/transitions-of-care/handover/nhs-improvement-implementing-huddles-and-handovers-%E2%80%94-a-framework-for-practice-in-maternity-units-25-march-2019-r136/

148 https://www.medicines.org.uk/emc/files/pil.135.pdf

149 https://bnf.nice.org.uk/drug/dinoprostone.html

150 Royal College of Obstetrics and Gynaecologists. *Each Baby Counts: 2019 progress report* (2020) https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/reports-updates/2019-progress-report/

In other cases, they did not recognise a sick or deteriorating women and failed to escalate. The cases below are examples from across the timespan of the review. In addition, frequently women with confirmed preterm pre-labour ruptured membranes were not given antibiotics in keeping with national guidelines.

7.91 *In **2002** a woman was admitted with repeated episodes of antenatal bleeding. Her waters then broke at 25 weeks' gestation. She reported tightenings but was asked to go for a walk and given some analgesia. It was eventually realised that the so called tightenings were labour and she experienced a vaginal breech birth just 75 minutes later. (2002)*

7.92 *A woman with a history of ruptured membranes for 3 days in **2011** was admitted feeling unwell and had a raised pulse. Despite raised inflammatory markers on her admission bloods, there was a delay in recognising how unwell the woman was and she was transferred to labour ward with overwhelming sepsis 14 hours later. (2011)*

7.93 *In **2016**, a woman with preterm pre-labour ruptured membranes was admitted at 35 weeks' gestation. Antibiotics were not given. She was seen by several different doctors and advised to try for a vaginal birth if her labour started spontaneously even though the baby was breech. She experienced an intrapartum stillbirth with evidence of E.coli sepsis. (2016)*

7.94 The review team also saw multiple cases where women who were considered high risk were admitted to the antenatal ward to commence an induction of labour when induction should have occurred (or it should at least have been considered) on the labour ward. Lack of senior review or awareness meant that care provision happened in the wrong place and often without full consideration of the clinical risks involved in the care provided.

7.95 *In **2010** a woman was transferred from the midwife-led unit, (MLU) by ambulance to the consultant-led unit. There was high clinical activity at the time and yet there was no escalation to the labour ward consultant. The registrar was unable to make a full assessment because they were conducting a twin delivery with another patient at the time. This case sadly resulted in the baby needing to be cooled and developing HIE. (2010)*

7.96 *In **2012**, a 25-year-old mother with a history of previous caesarean section for breech decided to attempt vaginal birth after her membranes ruptured at 36 weeks. Prostaglandin was given on the antenatal ward. There was no documentation in the records provided by the Trust with regard to information given on the increased risk to the mother or her baby. The mother suffered a uterine rupture and the baby was born in poor condition. The baby died at 7 days of age. (2012)*

7.97 *In **2014**, a woman with preterm pre-labour ruptured membranes was admitted at 35 weeks' gestation however antibiotics were not given. She was seen by several different doctors and advised to try for a vaginal birth if her labour started spontaneously, even though the baby was breech. Her baby was born showing no signs of life. Resuscitation was initiated, but neonatal death was confirmed at 27 minutes of age. (2014)*

7.98 *A woman who was 25 weeks' gestation in **2016**, was admitted to the antenatal ward with preterm pre-labour ruptured membranes, she developed a MEOWS score of 7 indicating that she was severely unwell. The midwife contacted the registrar who was busy, but there was no escalation to another clinician until almost an hour later. At this point the women was severely unwell and a decision was then made for an emergency caesarean section. (2016)*

7.99 *In **2019**, a 35-year-old woman in her third pregnancy was induced as her baby was severely growth restricted, with absent end diastolic flow[151]. She also had gestational hypertension. A decision was made to commence the induction on the antenatal ward. The CTG was deemed suspicious on admission and she was transferred to the labour ward. The consultant review was at first to prescribe prostaglandin, but*

151 See glossary

fetal monitoring remained suspicious and a category 2 caesarean section was performed. The review team is of the view that induction should have been started on the labour ward in the first instance due to consideration of the mother's known hypertension and a severely growth restricted fetus (placental pathology). This baby therefore needed frequent monitoring. (2019)

Delay in transfer of women to the labour ward

7.100 The review team found many incidences where there was a delay in transfer of women in established labour to the labour ward. Women were frequently not monitored appropriately despite being identified as high risk. There were also several cases of women experiencing induction of labour where following delays in transferring to labour ward an intrauterine death occurred. In other cases, the delay subsequently led to a category 1 caesarean section.

7.101 *In **2003**, a 28–year-old woman was admitted to the antenatal ward at 29 weeks with abdominal pain. On the ward she collapsed with a tender abdomen. It took nearly 50 minutes to transfer her to the labour ward and conduct an emergency caesarean where a placental abruption was confirmed along with the death of her baby. (2003)*

7.102 *In **2013**, a woman undergoing induction of labour on the antenatal ward was delayed in transfer to the labour ward. When the family requested for the fetal heart to be monitored as it had not been for an hour, the fetal heart could not be located. The midwife asked the woman to go for a walk and have a drink as it was handover. An intrauterine death was diagnosed on her return an hour later. (2013)*

7.103 *A type 1 diabetic mother had a high risk pregnancy in **2013** and was admitted having evidence of pre-eclampsia. There was delay in planning induction of labour (IOL). When IOL commenced it was conducted on the antenatal ward and transfer to labour ward was not arranged until the mother had reached 4cm cervical dilatation. The baby was born by emergency caesarean section and initially responded well to resuscitation, but required transfer to the neonatal unit at seven hours of age. The baby remained an inpatient for three weeks, and is now doing well. However, as well as a delay in transfer to the labour ward the review team also has concerns regarding the care provided in labour once transfer occurred. (2013)*

7.104 *In **2015** a woman who experienced an antepartum haemorrhage in late pregnancy was inappropriately advised by the consultant obstetrician that her plans to birth in a midwifery led unit (MLU) did not need to be reconsidered or changed. When problems were identified in labour there was a delay in transfer to the labour ward, and fetal wellbeing was not adequately monitored during the transfer period. The baby was delivered in very poor condition and hypoxic ischaemic encephalopathy (HIE) was later confirmed. The baby subsequently died. The family were critical of the ensuing investigation and correspondence with the Trust. (2015)*

7.105 *In **2017**, a woman whose transfer to labour ward was delayed during the induction process as the unit was very busy experienced an antepartum stillbirth whilst on the antenatal ward. During their investigation into what happened, the Trust through their Root Cause Analysis (RCA) recognised there were delays in transfer primarily due to maternity unit activity. In the RCA analysis section of the report the causes were identified as a lack of capacity on the labour ward, increased activity and emergency caesarean sections being undertaken. It also found that there was a 'culture of normalising long waits for women undergoing induction of labour when labour ward is busy'. (2017)*

7.106 Various versions of the Trust's Escalation of Maternity Services policy have been provided to the review team by the Trust since version 1 from June 2010 to version 5 in 2018. The policy repeatedly states that if the labour ward is busy, this must be escalated to the highest level and if women are waiting more than eight hours to be transferred to continue induction of labour then a senior obstetric review must occur. The review team found numerous cases where the trust did not follow its own escalation policy.

Misinterpretation of the antenatal cardiotocograph (CTG)

7.107 Fetal well-being assessments are a significant component of antenatal inpatient care and this will frequently be through CTG monitoring. Typically, women admitted to the antenatal ward may need enhanced fetal monitoring so it is imperative that CTG monitoring is undertaken appropriately and interpreted correctly. Delaying action or misinterpreting an antenatal CTG may lead to a poor fetal outcome. This is especially true in high risk women, such as those with pre-eclampsia, diabetes or severe fetal growth restriction.

7.108 The RCOG 'Green Top' guidelines Reduced Fetal Movements[152] advises that all women have an antenatal CTG from 28 weeks (pre-computerised CTG) if they are not in labour. CTG monitoring for at least 20 minutes provides an easy and accessible means of detecting fetal compromise. The presence of a normal fetal heart indicates a healthy fetus with a functioning autonomic nervous system. Interpretation of the CTG must be according to the NICE classification of fetal heart patterns.

7.109 The review team found there were many cases where an antenatal CTG was incorrectly classified, or there was a delay in acting upon a clearly abnormal CTG leading to poor fetal outcome.

7.110 *In **2003**, at 37+4 weeks gestation, a woman reported to the maternity triage unit with reduced fetal movements. The CTG was reported as having a baseline rate of 90 beats per minute (grossly abnormal) but there was no escalation made to an obstetrician, an intrauterine death was confirmed 30 minutes later. (2003)*

7.111 *In **2011**, a woman at 34 weeks' gestation attended the day assessment unit with reduced fetal movements and symptoms of pre-eclampsia. She was sent home and informed to return at a later time. When she was eventually seen by a locum registrar four hours later the CTG was interpreted as being abnormal but was not correctly classified and immediate escalation did not occur. Even when the case was reviewed by the consultant there was a delay in expediting birth to a category one caesarean section, instead, opting to perform an obstetric ultrasound scan. The baby was born requiring admission to the neonatal unit and was later diagnosed with hypoxic ischaemic encephalopathy grade 3. (2011)*

7.112 *In **2010**, a woman with a complex social history was admitted to the antenatal ward with preterm pre-labour ruptured membranes, (PPROM) at 29 weeks gestation. The review team found a failure to obtain adequate CTG's and a failure to perform additional fetal wellbeing tests such as a fetal biophysical profile whilst the woman was an inpatient. The review team also found no use of prophylactic use of antibiotics once there was confirmed PPROM, which may have reduced the risk of maternal infection and its complications. There was a lack of communication to the woman and her family and a lack of a clear obstetric plan. An intrauterine fetal death occurred 4 days after ruptured membranes occurred. Examination of the placenta showed there was histological evidence of acute chorioamnionitis[153] and funisitis[154]. There was a complaint made by the family regarding treatment and plans were made with lessons to be learned but there is no evidence from the documentation shared with the review team by the Trust of these actions having been put in place. (2010)*

152 Royal College of Obstetrics and Gynaecologists. Reduced fetal movements: Green top guideline 57 (2011) https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg57/

153 See glossary

154 See glossary

LOCAL ACTIONS FOR LEARNING: CARE OF VULNERABLE AND HIGH RISK WOMEN

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.113 The Trust must adopt a consistent and systematic approach to risk assessment at booking and throughout pregnancy to ensure women are supported effectively and referred to specialist services where required.

LOCAL ACTIONS FOR LEARNING: FETAL GROWTH ASSESSMENT AND MANAGEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.114 The Trust must have robust local guidance in place for the assessment of fetal growth. There must be training in symphysis fundal height (SFH) measurements and audit of the documentation of it, at least annually.

7.115 Audits must be undertaken of babies born with fetal growth restriction to ensure guidance has been followed. These recommendations are part of the Saving Babies Lives Toolkit (2015 and 2019).

LOCAL ACTIONS FOR LEARNING: FETAL MEDICINE CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.116 The Trust must ensure parents receive appropriate information in all cases of fetal abnormality, including involvement of the wider multidisciplinary team at the tertiary unit. Consideration must be given for birth in the tertiary centre as the best option in complex cases.

7.117 Parents must be provided with all the relevant information, including the opportunity for a consultation at a tertiary unit in order to facilitate an informed choice. All discussions must be fully documented in the maternity records.

LOCAL ACTIONS FOR LEARNING: DIABETES CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.118 The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.

LOCAL ACTIONS FOR LEARNING: HYPERTENSION

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.119 Staff working in maternity care at the Trust must be vigilant with regard to management of gestational hypertension in pregnancy. Hospital guidance must be updated to reflect national guidelines in a timely manner particularly when changes occur. Where there is deviation in local guidance from national guidance a comprehensive local risk assessment must be undertaken with the reasons for the deviation documented clearly in the guidance.

LOCAL ACTIONS FOR LEARNING: CONSULTANT OBSTETRIC WARD AND CLINICAL REVIEW

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.120 All patients with unplanned acute admissions to the antenatal ward, excluding women in early labour, must have a consultant review within 14 hours of admission (Seven Day Clinical Services NHSE 2017). These consultant reviews must occur with a clearly documented plan recorded in the maternity records.

7.121 All women admitted for induction of labour, apart from those that are for post-dates, require a full clinical review prior to commencing the induction as recommended by the NICE Guidance Induction of Labour 2021.

7.122 The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR to enable all staff to escalate and communicate their concerns.

LOCAL ACTIONS FOR LEARNING: ESCALATION OF CONCERNS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.123 The Trust's escalation policy must be adhered to and highlighted on training days to all maternity staff.

7.124 The maternity service at the Trust must have a framework for categorising the level of risk for women awaiting transfer to the labour ward. Fetal monitoring must be performed depending on risk and at least once in every shift whilst the woman is on the ward.

7.125 The use of standardised computerised CTGs for antenatal care is recommended, and has been highlighted by national documents such as Each Baby Counts and Saving Babies Lives. The Trust has used computerised CTGs since 2015 with local guidance to support its use. Processes must be in place to be able to escalate cases of concern quickly for obstetric review and likewise this must be reflected in appropriate decision making. Local mandatory electronic fetal monitoring training must include sharing local incidences for learning across the multi-professional team.

Chapter 8

Intrapartum care

Multidisciplinary working

Failure to escalate and lack of senior obstetric input

8.1 Effective communication between healthcare professionals and women is an integral component of safe maternity care, this is absolutely vital during intrapartum care. Maternity services should foster a team approach based on mutual respect, a shared philosophy of care and a clear organisational structure for both midwives and medical staff, with explicit and transparent lines of communication[155].

8.2 In our first report[156], which was a review of 250 cases across the timespan of the review, evidence was provided that concerns were not appropriately escalated, leading to direct impact on the safety and quality of care provided to women. In this second report the review team has selected vignettes from more recent years to highlight both a failure to learn and a lack of progression at the Trust in terms of governance and learning.

8.3 All midwives and medical staff have a duty to call for help if they consider that a clinical situation requires the direct input of a consultant. The consultant should be responsive and attend in person in complex situations such as the cases outlined in the vignettes below[157].

8.4 *In **2014**, a pathological CTG in the second stage of labour failed to attract the attention of the obstetric team for too long. The trainee was busy but even during the daytime, there was no apparent attempt to call the consultant obstetrician despite a complicated operative delivery of a baby in the operating theatre. This baby now suffers cerebral palsy and no governance review was conducted. (2014)*

8.5 *In **2016** a woman was taken to the operating theatre for an attempted forceps delivery. The baby's head was in the posterior position and the delivery was undertaken by a junior registrar. No attempt was made to rotate the baby's head to the correct position and during the forceps delivery the woman sustained a 4th degree tear. There was no evidence of duty of candour being performed and the issue does not appear to have been raised with the junior doctor as a training issue. (2016)*

Consultant presence on labour ward

8.6 The requirement for consultant obstetricians to be directly involved and lead in the management of all complex pregnancies, labour and delivery, with planned twice daily consultant-led ward rounds was identified as a local action for learning for the Trust within our first report. As the review team has continued to review all of the cases for this report we have found little evidence of planned consultant level reviews throughout the time period of this review. There were many cases which demonstrated that the supervision of trainee doctors during day and night time did not meet the required standards. Many high risk women received minimal obstetric care during the induction of labour and intrapartum period, until a point of midwifery request for review.

155 Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. *Safer Childbirth Minimum Standards for the organization and delivery of care in labour (2007)* https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf

National Institute for Health and Care Excellence Safe midwifery staffing for maternity settings (2015) https://www.nice.org.uk/guidance/ng4

156 Ockenden, D. *Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust.* (2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

157 Royal College of Obstetricians and Gynaecologists Safe Staffing (2021) https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/safe-staffing/

8.7 *In **2007**, in the death of a woman who was a practicing Jehovah's Witness and who laboured and gave birth to twins, no middle grade or more senior review was received until the final stages of her second stage of labour. Consultant input into her care was only sought when an extensive perineal haematoma was discovered many hours after the birth. (2007)*

8.8 *In **2012** a woman who did not initially want a vaginal birth after a previous caesarean section birth was advised to undergo an induction of labour after pre-labour preterm rupture of membranes with signs of infection. The registrar advised oxytocin to be administered after 2 hours of pushing and the woman pushed in the second stage of labour as the oxytocin continued to be increased for over 4 hours until she suffered a uterine rupture and her baby died. No consultant input was evident within this birth or during the immediate postpartum period. Oxytocin was prescribed by the registrar during advanced labour when there were signs of obstructed labour without first performing a medical review. No apology was given for the mismanagement of this case and the conclusions of the subsequent Trust risk review were not appropriate or relevant to the real issues at the time. (2012)*

8.9 One midwife spoke to the review team in autumn 2021, describing that in a previous trust they had been familiar with a system in which a senior trainee, anaesthetist and obstetric consultant would lead a ward round after handover twice a day. The midwife was concerned that there were no ward rounds at the Trust however when questioning this, the response they received was: *'No, no, no, you are the Band 7 coordinator, you should know when the doctor needs to see the patient'.* The midwife described to the review team how she was laughed at and ridiculed for suggesting that multi professional ward rounds were necessary.

8.10 Evidence was found by the review team that when care was escalated at the Trust there was a failure of the senior clinical team to respond appropriately:

*In **2016**, a woman was admitted to the labour ward with evidence of excessive uterine contractions with a reassuring CTG and severe hypertension. This was escalated to the registrar who decided upon no further intervention. The midwife's written statement indicated unhappiness with this response however these concerns were not escalated further. The CTG was pathological for one hour before delivery of a large for dates baby with significant shoulder dystocia and postpartum haemorrhage (PPH). The baby was later diagnosed with grade 3 hypoxic ischemic encephalopathy (HIE). Escalation and obstetric involvement in this case was poor throughout. (2016)*

8.11 *In **2016**, a woman spent approximately 8 hours on the labour ward, where she received minimal medical input despite midwifery requests for a medical review of her raised blood pressure (BP). At numerous times during the late first and second stages of labour the woman's BP was recorded as 160/105 mmHg or higher which is a medical emergency. Repeated attempts to have the woman reviewed due to her high BP were unsuccessful and when the consultant was informed, nothing was written in the notes and the consultant did not review the woman, instead prescribing an anti-hypertensive which had little effect. During a subsequent major postpartum haemorrhage this same consultant attended, advised on drug use and again documented nothing. The governance review failed to address these issues of lack of consultant review and action. (2016)*

Midwifery leadership and culture on the labour ward

8.12 A lack of documentation regarding decision-making by the labour ward coordinator was often evident when the labour ward coordinator was asked to attend a room for review of a case. Although the role of the coordinator is challenging, with contemporaneous documentation sometimes difficult when dealing with emergency situations, many cases reviewed have failed to demonstrate even any good quality retrospective documentation. The verbal and written communication between the coordinator and obstetrician is paramount and there is evidence that it failed in numerous cases.

8.13 *In **2015**, a woman with a raised BP had her labour augmented with oxytocin for 12 hours without an obstetric review. The labour ward was so busy that the labour ward coordinator was caring for another*

labouring woman and did not perform a 'fresh eyes' assessment on a CTG when asked. The midwife had previously attempted to escalate clinical findings of raised maternal BP, significant proteinuria and an abnormal CTG with no documented evidence that she was supported by senior obstetric or midwifery staff even when the emergency buzzer was pulled due to fetal bradycardia. Eventually a decision was made to expedite the delivery using forceps and the baby required admission to the neonatal unit for suspected infection. (2015)

8.14 It is not ideal for the coordinator to be caring for a woman in labour, although the review team appreciates this can happen occasionally in an emergency situation. This role must be supernumerary so that the labour ward remains safe and there is senior presence available to assist midwives and to facilitate escalation to the obstetric team[158]. Midwives also have a duty to escalate care and challenge decisions when there is a concern about safety[159].

8.15 *In **2016**, a woman who laboured at the birth centre was not adequately monitored as 'the unit was busy'. When problems were eventually identified in labour there was a delay in transferring the mother to the labour ward, where her baby was delivered in a very poor condition having suffered a brain injury. The baby subsequently died. (2016)*

8.16 There is evidence that over a long period of time midwives may have been reluctant to ask for help when working on the Trust's labour ward. One midwife explained to the review team in late 2021 how *'you just tried to keep your head down...asking for help was seen as a bad thing. People were derided for asking for help. Even something simple like a junior midwife asking for support suturing, they were like … [ridiculed]...'.*

8.17 Midwives providing intrapartum care outside the labour ward described facing reproach from labour ward colleagues when they telephoned regarding a possible need to transfer the woman to labour ward. One midwife outlined the challenges midwives faced when transferring women into labour ward or planning ahead when the clinical picture of the woman they were caring for started to change stating that there was *'a bullying culture'* on the labour ward.

8.18 The same midwife explained to the review team how the general culture on the labour ward was to joke that the transferring midwife did not know how to look after a woman in labour, for example, *'Do you not know how to look after a woman in labour? So that was the culture. It started off as being a little bit more of a jokey sort of thing, then it became really quite insidious so that I used to dread it, I would dread ringing. In the end I would say…this is the situation I am bringing the lady up, expect me in an ambulance in forty five minutes, and then I would always get, well if you bring her up, you would have to look after her yourself'.*

8.19 Another midwife told the review team in autumn 2021 of a culture of bullying on labour ward. *'Staff don't always feel supported by the shift co-ordinators. As I have said previously even though I am experienced I still felt I needed support and didn't always get it.'*

8.20 A further example was provided by a midwife who described being belittled when asking for support on the midwifery-led unit due to an excessive and complex workload. *'I said: "I can't accept somebody in labour because there are nine women, nine babies, a midwife who's not familiar that needs my support as well and I don't feel it's safe…" [A manager] came storming down and said, "You've got no authority to close this MLU", and I was like, "I'm not closing the MLU, I'm saying that we need further support to be able to safely do this." [The manager] belittled me in front of a group of staff there and told me, "You're taking this woman".'*

8.21 The same midwife also commented on how midwives were belittled when transferring women to the labour ward: *'You'll hand over care to somebody on the consultant-led unit and the comments that they make*

158 Ibid n1 and Royal College of Midwives. *RCM guidance on implementing the NICE safe staffing guideline on midwifery staffing in maternity settings* (2016) https://www.rcm.org.uk/publications/publications/rcm-guidance-on-implementing-the-nice-safe-staffing-guideline-on-midwifery-staffing-in-maternity-settings/

159 Nursing Midwifery Council. *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.* (2015, updated 2018) https://www.nmc.org.uk/standards/code/

in front of the woman, can be very belittling and degrading to your face in front of a family and that's not cohesive. That's not putting the woman first'.

8.22 It is evident from considering numerous reviews and hearing staff voices throughout the autumn and winter of 2021 that there continues to be some major issues relating to the culture of intrapartum care at the Trust. Influencing factors include human factors, leadership from senior clinicians, lack of escalation, locum doctors working for many years with little supervision, lack of robust governance processes and a lack of multi-professional working.

8.23 The culture of intrapartum care at the Trust may have resulted in harm to mothers and babies due to failure in escalation to the most appropriate professional in a timely manner. This starts with the allocated midwife not escalating to the labour ward coordinator. The coordinator in turn fails to escalate to the consultant, when the trainee is either busy or is performing practice against guidance (for example unsafe operative delivery and, in particular, a number of inappropriate breech deliveries). These examples continue throughout the period of the review to the very end. Examples of these are detailed throughout this report.

8.24 The direct links between incivility and patient safety have been well documented. Civility Saves Lives[160] sets out the detrimental impact uncivil behaviours have on team functioning, decision-making, performance and safety. The consultant obstetrician and labour ward coordinators have an integral role to play in role-modelling the professional behaviours and personal values that are consistent with positive team working, including the demonstration of respect for colleagues and women[161].

Use of medical locums at obstetric middle grade

8.25 The review team found that there appeared to be a high reliance on the locum medical workforce working at middle grade at the Trust without evidence of documented supervision and governance.

8.26 *During the birth of twins in **2015**, a family told the review team the doctor was 'so aggressive, he was shouting. The midwives didn't like him; that was obvious'. The doctor conducted a poorly managed twin delivery and walked out of the room (not to return) during a postpartum haemorrhage and episode of extreme hypotension. The Trust has not shared any evidence of learning or the development of actions following this case with the review team. (2015)*

8.27 *In **2016** a locum doctor failed to recognise or intervene during a 40 minute terminal bradycardia resulting from acute intrapartum hypoxia. After alienating both the midwife and woman, he was told to leave the room and did so without any further delivery of care. The baby was born with HIE and severely acidotic cord blood results. The Trust risk review process was not robust and there was no evidence of internal reflection. The RCA report failed to investigate and recognise that this incident occurred due to gross lack of team working, failure in escalation, failure to monitor the actions of locum staff, failure to recognise acute bradycardia in labour and failure to document to an expected standard. The report concluded that, 'it is difficult to understand the team dynamics'. (2016)*

8.28 The review team found several examples where locum doctors acted unsupervised, leading to poor outcomes for mothers and babies. Equally it appears that there were not clear escalation plans to the consultant or midwife in charge. In cases of adverse outcomes there is evidence that these were not investigated in line with the incident framework utilised at the time and individuals were not held to account.

8.29 Consultants must be visible, approachable and demonstrate effective leadership skills, enabling other team members to speak up when something is wrong, ensuring good information flow and clinical prioritisation[162].

8.30 The widespread shortage of suitably qualified obstetricians who can safely undertake the role of senior resident doctor out-of-hours with indirect supervision from a consultant who is non-resident has been well documented. The RCOG has highlighted the need for adequate support and supervision of locums

160 Civility Saves Lives. Civility Saves Lives (2017) https://www.civilitysaveslives.com

161 Ibid n3

162 Ibid n3

who enter the workplace and has recently released guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland and Wales[163].

8.31 Locum doctors are employed to cover staffing shortfalls and trusts should have appropriately robust recruitment processes in place including assessment of their skills and knowledge, with structured feedback and support before they are released to work independently.

LOCAL ACTIONS FOR LEARNING: MULTIDISCIPLINARY WORKING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

8.32 The labour ward coordinator must be the first point of referral and be proactive in role modelling the professional behaviours and personal values that are consistent with positive team working and providing timely support for midwives when asked or when abnormality in labour presents.

8.33 The labour ward coordinator at the Trust must be supernumerary from labour care provision and provide the professional and operational link between midwifery and the most appropriately trained obstetrician.

8.34 There must be a clear line of communication from the duty obstetrician and coordinating midwife to the supervising consultant at all times. Consultant support and on call availability are essential 24 hours per day, 7 days a week.

8.35 Senior clinicians such as consultant obstetricians and band 7 coordinators must receive training in civility, human factors and leadership.

8.36 All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out and feel able to speak out when they have concerns about safe care.

Fetal Assessment and Monitoring

8.37 National intrapartum guidelines[164] recommend intermittent auscultation (IA) of the fetal heart rate (FHR) in low-risk pregnancies and continuous FHR monitoring if there are abnormalities such as tachycardia or decelerations, meconium, bleeding, or interventions such as epidural analgesia or oxytocin administration.

8.38 Intrapartum monitoring of the baseline FHR, presence of decelerations, and visually determined FHR variability are used to assess the risk of fetal acidaemia[165] via a set of clinical guidelines. However, FHR abnormalities during labour rarely correlate with fetal compromise because the FHR is highly sensitive to hypoxaemia/hypoxia (both common during labour), but lacks specificity for fetal acidosis, the end point of intrapartum hypoxia.

8.39 On the one hand this mismatch results in increased operative delivery of non-acidotic babies; whilst clinicians on the other hand may miss fetal compromise because current guidelines remain silent on the adverse role played by intrapartum factors, which impair fetal adaptation to the challenges of labour such as fever, chorioamnionitis, meconium, abnormal fetal behavioural states, and excessive head moulding. National perinatal audits and quality improvement programmes such as the Confidential Enquiries into

163 Royal College of Obstetricians and Gynaecologists *Guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland and Wales*. (2021) https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/safe-staffing/rcog-guidance-on-the-engagement-of-long-term-locums-in-maternity-care.pdf

164 National Institute for Health and Care Excellence *Intrapartum care for healthy women and babies* (2017) https://www.nice.org.uk/guidance/cg190

165 See glossary

Stillbirths and Deaths in Infancy (CESDI) and Each Baby Counts (EBC) have highlighted the significant contributions of these conditions to adverse perinatal outcomes.

8.40 In our first report we found significant problems with the conduct of intermittent auscultation and the interpretation of CTG traces. The review team found problems with intermittent auscultation of labour throughout the entirety of the review period right up to the very end of the review timeline. Vignettes from the cases considered by the review team are presented below which continue to illustrate significant knowledge gaps and examples where the care of complex cases was left in the hands of inexperienced staff.

Failure to recognise and/or escalate the abnormal CTG in early labour

8.41 *In **2012**, a woman presented to the MLU in labour. A CTG was performed on admission, which was reassuring, and early labour was diagnosed. The woman described her pain as constant, but the midwife did not perform an abdominal examination. Intermittent auscultation (IA) showed a significant drop in the baseline fetal heart rate (FHR) although remaining within normal parameters. The FHR was not auscultated for 1 full minute following a contraction. The FHR was auscultated prior to the lady entering the pool and found to be 90bpm. There was a delay in escalation. The baby was born in very poor condition and was later diagnosed with cerebral palsy. The family had concerns that the FHR was not listened to enough. The Chief Executive's letter to the family incorrectly stated that the FHR would be auscultated every 30 minutes during labour. (2012)*

8.42 Fetal bradycardia should be reviewed urgently by an experienced obstetrician to exclude irreversible obstetric emergencies (abruption, cord prolapse and uterine rupture) and to correct reversible causes such as supine or epidural hypotension and uterine hyperstimulation due to excessive oxytocin use. Urgent delivery should be undertaken where indicated if the bradycardia does not improve.

8.43 *In **2012**, a multiparous woman with an uneventful pregnancy had a membrane sweep at 41^{+2} and at 41^{+4} weeks and later admitted to the MLU contracting regularly. The woman presented with a temperature of 37.7^{0}C, maternal heart rate (MHR) 120bpm, and cervix 3cm dilated. Following concerns the woman was transferred and arrived on the labour ward 2 hours later. A female baby was delivered in poor condition by ventouse with an Apgar score of 1[166] at 1 minute and 1 at 5 minutes. Despite intensive resuscitation the baby died after 40 minutes. Post-mortem findings were consistent with infection as a cause of the death. (2012)*

8.44 Clinicians should always consider factors which can influence the fetus. Antenatal factors such as placental insufficiency, intrauterine infection, meconium aspiration, hypoglycaemia, recreational substance abuse or fetal brain injury can all influence fetal heart rate patterns. Where suspected, these cases should all be escalated urgently to make an appropriate plan for delivery.

8.45 *In **2018**, a woman in labour had meconium stained liquor and fetal tachycardia. The family were given the option to 'carry on' with the labour or opt for immediate caesarean. There is no evidence of discussion with the consultant regarding an appropriate plan of care. The CTG was not considered pathological by the maternity review team and therefore to give the woman 'an option' to have a category 1 caesarean is not the standard practice. There is also no evidence that a further vaginal examination was performed prior to the caesarean to exclude or confirm full dilatation, in which case an emergency caesarean may not have been necessary. (2018)*

8.46 Fetal heart rate tachycardia associated with meconium staining of the amniotic fluid raises the likelihood of fetal infection significantly. The team should involve a consultant in the management as soon as possible to set out a plan of care, and the family should be involved in a Montgomery[167] compliant manner.

166 See glossary

167 https://www.rcog.org.uk/globalassets/documents/members/membership-news/og-magazine/december-2016/montgomery.pdf

Augmentation

8.47 Augmentation of labour is the process of increasing the frequency, length and strength of uterine contractions after the onset of labour. This can be achieved either by intravenous oxytocin infusion and/or artificial rupture of membranes.

Use of oxytocin

8.48 Oxytocin can be used to increase uterine contractions when they are reduced, particularly during prolonged labour and to facilitate cervical dilatation and vaginal birth.

8.49 Many examples of the injudicious use of oxytocin were highlighted in our first report. The review team has found further examples of inappropriate oxytocin use which impacted upon fetal wellbeing and neonatal outcomes suggesting that sufficient learning from previous cases had not occurred. A common theme identified by the review team was the inappropriate commencement and continuation of oxytocin despite evidence of deterioration of the baby's condition.

8.50 Oxytocin should only be used when there is a valid indication and potential benefit for its use and appropriate guidelines and equipment available to support its safe administration. One-to-one midwifery care must be provided and the FHR rate and maternal contractions must be closely monitored. The identification and escalation of any concerning features relating to CTG changes should occur promptly and oxytocin reduced or discontinued in the presence of excessive uterine contractions or fetal heart rate concerns.

8.51 Appropriate risk assessment should be carried out before oxytocin use in the first stage of labour, and again before use in the second stage of labour. Decision-making regarding the plan of care and mode of birth should consider any additional risk or intrapartum factors which impair fetal adaptation to the challenges of labour and the stage of labour that has been reached.

8.52 *In **2012** a woman presented in spontaneous labour at 30 weeks' gestation. After an hour of pushing in the second stage, the fetus remained high in the pelvis with a pathological CTG. An oxytocin infusion was commenced. After a further hour of pushing, the woman consented to a trial of instrumental delivery in theatre. A manual rotation was undertaken followed by the application of Wrigley's forceps with a presenting part level with the ischial spines. No descent was noted after one pull. An emergency caesarean section was undertaken, and the infant was delivered in poor condition. The infant was resuscitated, but later died due to complications of severe hypoxic ischaemic injury and massive hypoxic damage to multiple organs. (2012)*

8.53 *In **2014**, a woman who had a previous caesarean section was in active labour. Despite FHR abnormalities, oxytocin was commenced and was continued despite evidence of deterioration of the baby's condition. The baby was born in poor condition and died a few months later. A case review was undertaken by the Trust but it failed to identity or address the errors in the management of the mother's labour thus leading to a complete failure to learn lessons or change future clinical practice. (2014)*

LOCAL ACTIONS FOR LEARNING: FETAL ASSESSMENT AND MONITORING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

8.54 Obstetricians must not assess fetal wellbeing with fetal blood sampling (FBS) in the presence of suspected fetal infection.

8.55 The Trust must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work.

8.56 Midwives and obstetricians must undertake annual training on CTG interpretation taking into account the physiological basis for FHR changes and the impact of pre-existing antenatal and additional intrapartum risk factors

Midwifery-led units

8.57 There are five Midwifery-led-units (MLUs) that have provided antenatal, intrapartum and postnatal care in addition to the consultant maternity unit at the Trust, during most of the time period of this review. The Royal Shrewsbury Hospital, (RSH) in Shrewsbury, provided consultant-led care until 2014. Consultant obstetric services were relocated to the Princess Royal Hospital (PRH) in Telford in 2014. An overview of births by each MLU is provided in table 1 below. The review team is advised that Wrekin MLU has recently moved to a new location adjacent to the Shropshire Women and Children's Centre at the PRH.

Table 1: Births by MLU Overview (Source: SaTH Clinical Dashboards)

MLU	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bridgnorth	69	68	75	68	82	77	26	4	0
Oswestry	87	72	74	69	83	52	15	4	0
Ludlow	86	71	62	49	51	36	12	4	0
Shrewsbury	478	421	367	235	207	142	120	69	15
Wrekin	435	401	362	336	359	337	351	285	224

8.58 Issues relating to MLU closures and staffing availability have been highlighted within the local press and Telford and Wrekin CCG's Quality and Safety Report in 2013. Staff shortages within maternity are also raised as an issue within the Trust's 2021 CQC report[168] and remain an urgent wider issue for maternity care on a national basis.

8.59 Evidence from staff who have contacted the review team suggest that there was an expectation for midwives working on the MLU to manage with reduced staffing. A midwife who had worked at the Trust until 2021 commented that: *'historically, whilst working in the MLU, there was an expectation to stretch the boundaries of what was considered normal…MLU staff are seen as less important, less valuable, and less skilled. There can be poor conversations between teams frequently but teams working together stick together and support one another. This remains to this day. There is a very toxic culture within the place and it seems impossible to break despite some individuals trying to raise as an issue - myself included and part of the reason I have now left'.*

8.60 Another long term community midwife reflected on the impact this had on safe care provision on the MLU where there were *'...incidents where we are caring for a woman and the second midwife has been told to leave the unit to move to another area. This is unsafe practice as there should be two midwives on the unit when a woman is birthing at all times'.*

168 Care Quality Commission Inspection (2021) https://www.cqc.org.uk/provider/RXW?referer=widget3

LOCAL ACTIONS FOR LEARNING: SPECIFIC TO MIDWIFERY-LED UNITS AND OUT-OF-HOSPITAL BIRTHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

8.61 Midwifery-led units must complete yearly operational risk assessments.

8.62 Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.

8.63 It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust.

Delay in escalation and taking appropriate action

8.64 The review team found evidence of failure to appropriately document the FHR and undertake continuous electronic fetal monitoring (CEFM) using a CTG when abnormal FHR changes were detected on the MLU. Evidence of this has also been presented above. Information gained from any investigations performed after a birth were not always shared with women and families, and evidence of appropriate governance and shared learning from such incidents is frequently unavailable.

8.65 *In **2006**, a multiparous woman was noted to have an abnormal FHR whilst in labour on the MLU. This was not acted upon, a CTG was not performed nor was the case escalated. The woman suffered a stillbirth. In the bereavement follow-up appointment the consultant gave incorrect information and initially withheld information from the parents about the possible cause for their baby's death. (2006)*

8.66 *In **2010**, a primiparous[169] woman attended the MLU in labour. Intermittent auscultation (IA) was started, however there was a delay in starting CEFM when this became abnormal. Eventually the CTG was started and a further examination was undertaken which revealed a cord prolapse. Emergency transfer was arranged and delivery by caesarean section. The baby was born in poor condition and required cooling. There were missed opportunities for earlier transfer. (2010)*

8.67 *In **2010** there was a failure to appropriately document intermittent auscultation (IA) of the fetal heart and commence CTG monitoring for a woman labouring in the pool with meconium. There was a significant delay from the time of decision to transfer to the Royal Shrewsbury Hospital (RSH) to calling the ambulance for transfer. The midwife failed to ascertain the fetal wellbeing during transfer. Following admission to labour ward a CTG was commenced and was abnormal. The midwife escalated her concerns to the registrar and prepared the woman for an emergency caesarean section. Due to the workload of the labour ward the registrar was called away to attend a twin birth and there should have been escalation to the on-call consultant, who should have attended. The baby was born in poor condition, intubated and received cardiac compressions before receiving hypothermic cooling. (2010)*

8.68 A number of the MLU cases reviewed by our team reflected some of the wider issues found on the labour ward relating to failures in appropriate escalation and consultant obstetric review once transfer to the consultant-unit was achieved. In a number of cases there was inappropriate risk assessment and management of labour when women presented with a history of reduced fetal movements. The wider clinical picture was not always appropriately assessed and acted upon. Evidence of poor teamwork and communication during transfer has also been presented elsewhere in this and other chapters of this report.

169 See glossary

8.69 *In **2010** a mother self-referred to Wrekin MLU with absent fetal movements and abdominal pain. There was a failure of the two midwives working there to recognise the evident clinical signs of placental abruption: an obstetric emergency. There was no attempt to cannulate the mother and it took 80 minutes to assess her and order a "blue light" ambulance transfer from Telford to Shrewsbury. No paramedic crew were requested. Arrival time at the consultant-unit from initial admission was 1 hours 45 minutes. Following arrival there was appropriate assessment and whilst the baby's death appeared unpreventable there are many care delivery issues that suggest that learning from this event was required. Postnatal care was not appropriate and there was no obstetric documentation in the notes until 09.45 the next day. There is no evidence of a governance review or learning from this case by the Trust. (2010)*

8.70 *In **2013** a woman with a history of multiple miscarriages attended the MLU for a post-term membrane sweep at 40+5 weeks gestation. A fetal bradycardia was noted prior to the procedure and the woman walked over to the consultant-unit and was in theatre within 20 minutes for a category 1 caesarean section. There followed a delay of 17 minutes after the consultant arrived in theatre where he discussed the possibility of not performing a caesarean section. The parents opted to proceed and the baby was born in poor condition and developed severe cerebral palsy. Neonatal care at all points within this case was excellent. The SI investigating team was solely made up of midwifery staff with no evidence of inclusion of an obstetrician, neonatologist or Trust executive all of whom would be expected to have involvement in this level of investigation. (2013)*

8.71 *In **2016** a primigravid[170] woman called Wrekin MLU at 09:18 stating that she did not think things were right as her baby was not moving as much and the pattern of movements had changed. She was advised to lie on her side, have a cold drink, and focus on the baby's movements over the next two hours. The woman responded that she had done all of that already and still had reduced fetal movements. The MLU staff member responded that they had a lot on that morning so to wait until lunchtime before coming in. On arrival there was difficulty ascertaining the FHR, an ultrasound scan (USS) performed and urgent transfer to the consultant-unit was arranged where a category 1 caesarean section was performed. The baby was born in poor condition and died the following day. The parent's comments suggest that they were put off attending the MLU earlier that day when they phoned with concerns because the unit was busy. The parents expressed many concerns about the bereavement care, the lack of information and their belief that the emphasis was on damage limitation for the hospital. (2016)*

8.72 A midwife employed at SaTH for many years who left in recent years[171] told the review team that: *'The MLU's practice needed to be standardised and updated as practice was not evidence-based. There was nobody competent to update guidelines, what guidelines they had were not evidence-based'.* In relation to learning from incidents the midwife emphasised that there was a reluctance to rotate staff to different clinical areas for updating for fear of upsetting people and *'When an incident happened, once the cause had been identified and the actions agreed it took too long to implement change'.* The review team notes that many guidelines have since been reviewed and updated.

8.73 Recent findings from national perinatal surveillance data which focussed on intrapartum stillbirths and intrapartum-related neonatal deaths in planned births at freestanding MLUs and those alongside consultant-led units found that in 75 per cent of deaths improvements in care were identified that might have made a difference to the outcome for the baby[172]. The authors conclude that these findings do not address the overall safety of midwifery-led settings for healthy women with straightforward pregnancies, but suggest areas where the safety of care can be improved. Issues with care were identified around risk assessment and decisions about planning place of birth, intermittent auscultation, transfer during labour, resuscitation and neonatal transfer, follow-up and local review.

170 See glossary

171 Date of leaving provided to review team but not stated to maintain confidentiality of staff member

172 Rowe, R, Draper, ES, Kenyon, S, Bevan, C, Dickens, J, Forrester, M, Scanlan, R, Tuffnell, D, Kurinczuk, JJ. I*ntrapartum-related perinatal deaths in births planned in midwifery-led settings in Great Britain: findings and recommendations from the ESMiE confidential enquiry*. (2020) BJOG 127

8.74 Findings published from a national cross-sectional survey of all 122 UK maternity services found that 92 per cent of local admission guidelines varied from national guidance[173]. These findings suggest that variation in admission criteria for MLUs exists nationally which presents a potentially confusing and inequitable basis for women making choices about planned place of birth. An earlier study also found that local guidance for transfer of women from MLUs to consultant units were of poor quality[174].

8.75 *In **2018** a woman made numerous contacts with Wrekin MLU triage throughout her pregnancy and early labour due to concerns about reduced fetal movements, bleeding and spontaneous rupture of membranes (SROM). Based upon national guidance it would have been appropriate for the woman to have been transferred to the consultant unit. Local Trust guidance did not align with national guidance. The baby was born in poor condition on the MLU and despite extensive resuscitation and neonatal support a decision was made to withdraw care and the baby subsequently died. (2018)*

8.76 National guidance recommends that when there are maternal concerns about fetal movements, the woman and the baby should be assessed (NICE, 2021). It is important that this assessment takes into consideration the full clinical picture and previous history of reduced fetal movements.

8.77 The importance of ensuring that women undergo a risk assessment at each contact throughout the pregnancy pathway was presented as an essential action in report 1. The review team continued to find evidence that this did not always happen. All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made.

Vaginal breech birth

8.78 Further evidence of poor escalation, failure to involve the consultant obstetrician and to respect women's wishes in relation to mode of birth were evident within the vaginal breech cases reviewed across the timespan of the review. Women reported to the review team that they were persuaded to have a vaginal breech birth without the associated risks being explained or there was a failure to make decisions regarding mode of birth in a timely way. There is a lack of evidence that governance processes were fully implemented which may have provided the Trust the opportunity to refine its decision-making processes, define the personnel needed for a safe breech vaginal delivery and refine the escalation pathways on the labour ward.

8.79 *Request for consultant advice or attendance was never made for the vaginal breech birth of a woman at 36/40 weeks gestation in **2003**. There was a lack of formal documentation regarding the mother's birth wishes and advantages and disadvantages of mode of birth. The middle grade doctor was asked by the midwife to examine for footling breech but declined to do so. It was inappropriate for the most inexperienced member of the medical team (SHO) to be conducting a footling breech delivery alone in the labour room without registrar or consultant attendance. During the birth an emergency caesarean section was arranged. There is no documentation of involving the consultant in any way and when the consultant attends in theatre [they] appear surprised in [their] notes at the impending situation. The baby was born with no signs of life and after extensive resuscitation died at approximately 3 hours of age. (2003)*

8.80 *There was a failure to appropriately plan and escalate care for a woman at 31 weeks' gestation in labour with prolonged premature rupture of membranes in **2011**. On the day of delivery, there was a failure to escalate for consultant decision-making, failure to make definitive decisions regarding the mode of delivery, failure to have adequate and highly trained individuals at the delivery, and failure to understand that a footling breech delivery at 31/40 weeks is relatively contraindicated by local and national guidelines. There was also no internal investigation of this case and so no evidence of lessons learned. (2011)*

173 Glenister C, Burns E, Rowe R. *Local guidelines for admission to UK midwifery units compared with national guidance: A national survey using the UK Midwifery Study System (UKMidSS)*. (2020) PLoS One. Oct 20;15(10):e0239311. doi: 10.1371/journal.pone.0239311. PMID: 33079940; PMCID: PMC7575094.

174 Rowe RE. *Local guidelines for the transfer of women from midwifery unit to obstetric unit during labour in England: a systematic appraisal of their quality.* (2010) Quality and Safety in Health Care19 (2):90-4.

Management of twin pregnancies and births

8.81 Some of the issues within this section reflect the findings presented previously in this chapter, namely unsafe operative delivery, inappropriate use of oxytocin and a failure to escalate care with the added complication of a twin delivery to consider. The review team found significant concerns with the management of twin labour and births throughout the whole of the review period right to the very end of the review.

8.82 *In **2013**, a primiparous woman with an IVF conceived twin pregnancy was induced at 36+5 weeks gestation as the second twin was found to be small. After one hour of pushing a decision was made for trial of instrumental delivery in theatre under spinal anaesthetic by a consultant and registrar. The first twin was born in good condition following a Keilland's forceps rotation. The second twin was born 37 minutes later by Neville Barnes forceps, after a total of 9 attempts at delivery by ventouse and Keilland's forceps. The baby was born in very poor condition and required resuscitation and transfer to the NNU where he underwent cooling and had multiple blood transfusions. He was subsequently diagnosed with moderate to severe HIE, subgaleal and subdural haemorrhage with depressed bilateral skull fractures. The administration of second stage oxytocin did not follow any guideline or regime. There was no concluded Trust investigation provided to the review team. (2013)*

8.83 *Inappropriate use of oxytocin and poor CTG management was noted with no escalation during the labour of a woman with a twin pregnancy at 35+4 weeks gestation in **2013**. The second twin's birth was not expedited when it should have been and the baby was diagnosed with HIE 2. There was no obstetrician or neonatologist in the room for the birth of twin 1 despite twin 2 being breech, they were called to assist with twin 2 following a placental abruption and the baby required a vaginal breech extraction. (2013)*

8.84 *A woman was admitted to hospital in **2014** at 34+6/40 weeks gestation with a suspected urinary infection with uterine tightenings. It was found that that both twins had died in utero. Placental abruption was noted at birth, with partial dehiscence of the uterine scar. Brown liquor was also noted which was mildly offensive. (2014)*

8.85 *The antenatal care was complex as the woman had numerous admissions to hospital for abdominal pain and tightenings, urinary symptoms and back ache. It was noted that the CTGs during admissions often had loss of contact or poor quality interpretation that was not escalated. The woman's voice was not heard as it was documented that there were reduced fetal movements but no action was taken. The woman met with the Trust who made promises around improving bereavement support, but the mother told this review that it felt that this was not actioned. (2014 until 2020)*

8.86 *In **2016** a woman who had a twin pregnancy, complicated by twin to twin transfusion syndrome, developed pre-eclampsia and was allowed to go home despite signs of evolving pre-eclampsia. Subsequently one twin died and the governance review documentation leans towards blaming the woman for the outcome, as she decided to go home rather than accept the 'offer' to remain in the unit as an inpatient. (2016)*

Management of high-risk and complex mothers

8.87 In a significant number of cases the review team found evidence that the poor outcomes in mothers and babies were caused mainly because clinicians failed to recognise women at high risk of medical complications. They failed to respond adequately to problems arising during labour, failed to make appropriate clinical decisions and failed to respond in a timely manner to signs of impending serious complications such as severe hypertension and significant antepartum haemorrhage. There were many instances of poor communication between doctors and midwives which led to inappropriate and delayed clinical decision-making.

8.88 *A woman presented on multiple occasions around term with hypertension and proteinuria in **2009**. There were missed opportunities to manage hypertension appropriately with the woman returning at least four times for assessment of blood pressure, when there could have been consideration for delivery. During this time she saw a relatively junior member of medical staff and there was a failure to consider the worsening*

picture of pre-eclampsia and no involvement of the labour ward coordinator. There appeared to be no urgency to treat the severe hypertension and there was little thought as to whether to give magnesium when this was appropriate. The baby was born in poor condition with Apgar scores 1 at 1 minute and 6 at 5 minutes. (2009)

8.89 *In **2017** a primigravid woman in spontaneous labour developed mild intrapartum hypertension. She required emergency caesarean delivery and received ergometrine intraoperatively. Subsequently, she developed significant postnatal hypertension and required treatment. Her medical records and subsequent correspondence indicate significant friction between the midwives and the registrar over the administration of ergometrine and its subsequent effect. The parents' concerns and communication about investigation of the drug error were poorly handled, leading to a formal complaint. (2017)*

Psychological birth trauma

8.90 The degree of life-long psychological trauma revealed by families in this report is harrowing and profound. Women and families have given graphic written and verbal accounts describing their recollection of events that have led to long-term depression, anxiety, distressing memories and post-traumatic stress disorder (PTSD). Some have sought psychological treatment, whilst others have remained silent until now.

8.91 Descriptions of physical trauma, pain, lack of attention, vulnerability, unkind words, swearing, sarcasm and bullying towards women as well as unkind treatment of colleagues, amongst midwives and obstetricians have been found to be widespread throughout the review period.

8.92 *A woman who gave birth in **2009** told the review team: 'I was lying on the table and was prepared for surgery but they couldn't find the anaesthetist. The senior midwife said to the assistant who was there "If this baby dies it's on his head". I reminded her I was still awake and she said "sorry no it will all be fine...". After the anaesthetist was found I was put under. My husband who was waiting outside was told 'go and walk round the car park for 45 minutes. But I have to prepare you don't hold out much hope for the baby' I had counselling after the experience but still felt I needed to complain as I knew how lucky we had been that our daughter was not only alive but well. I wrote my concerns down and the response I had just made me so angry. It didn't address any of my concerns…it was so bad that to be honest I gave up and just tried not to think about it.' (2009)*

8.93 There were many cases reviewed in which the care provided aligns with national standards and where there is evidence of the maternity team at the Trust going above and beyond the usual expectations in an attempt to support women. It is evident that for many women, any deviation from the expected progress of events, such as passage of meconium, bleeding of any degree or suspicious features on CTG is recalled by them years later as a failure of appropriate care.

8.94 Sometimes, despite documented good quality care and reassurances, the woman's recollection is terror, guilt, suspicion and feelings of Trust cover up. In addition, many women perceived any deviation from normality to be an indicator that a caesarean section was needed and that this was subsequently denied to them by the Trust. Despite this, the review team has seen many cases of meconium stained liquor, marginal placental abruption and mild infection that were managed appropriately with a trial of labour and outcomes that have been satisfactory.

8.95 *In **2017**, a woman whose baby presented in the occipito-posterior position laboured for 15 hours having experienced a small antepartum haemorrhage. The woman received very good care during labour with ongoing and appropriate efforts to address her anxiety and analgesia requirements. A caesarean section was performed within a standard timeframe and both mother and baby were well following this. Despite good care, the woman's recollection of labour has developed into ongoing treatment for PTSD. (2017)*

8.96 Formal diagnosis of PTSD is a common finding in the review and despite the evidence of some good care as detailed above, there were also many cases reviewed that demonstrate poor management in labour that resulted in ongoing physical and psychological harm for women as detailed in the following vignettes.

8.97 *In **2011**, a woman suffered psychological harm after being accused of 'being lazy in labour'. Also, as an employee of the Trust, she was advised against making a complaint. (2011)*

8.98 The review team has heard recollections from women relating to feelings of loss of control and power, **(2016)**, excessive and painful vaginal examinations **(2003)**, not being listened to **(2002; 2004; 2015; and 2016)** which resulted in psychological trauma for themselves and on occasion their birth partners.

8.99 *In the case of a forceps delivery and a missed recto vaginal fistula in **2009**, a woman told the review team: 'Following my daughter's birth by forceps, I was passing wind through my vagina. My wound was never checked whilst I was a patient in the hospital. It was only when I got home that a midwife asked me how I was and I said I felt something wasn't right. She did then check me at home but found no problem. A couple of weeks later I went to see my GP about it and I was referred back to the hospital.*

8.100 *I saw a consultant obstetrician. After examining me the doctor informed me that I'd had a large baby and that had caused in her words "a baggy fanny". To say I was upset is an understatement and despite telling her that I could tell the wind was coming from my back passage and passing through to the front, she said no further investigation was required. My issues got worse and the anxiety of going outside and embarrassing myself by having no control of passing wind meant I became nervous, anxious and depressed which seemed to exacerbate the situation. All of which resulted in upset stomachs and loose stools which resulted in my passing faeces through my vagina. Feeling that I should have pushed this matter further in the hospital made me feel inadequate as a mother. With the fistula causing personal care issues for me, the depression got worse. It wasn't diagnosed for quite some time. The emotional effects of all this still affect me 10 years on.' (2009 -2019)*

8.101 *A consultant said to a woman with physical disabilities in* **2008***: 'How do people like me get pregnant, who would do that [have sexual intercourse] to me, and did I know what I was doing?'. (*2008*)*

8.102 *Many women describe how they moved to different units for subsequent births or even to other countries. One woman in **2013** described to the review team how she could never contemplate giving birth in the UK again and found her experiences in the USA far more acceptable. (2013)*

8.103 *After not feeling listened to in **2016** another woman described: 'not having the courage to stand up and advocate for herself'. (2016)*

8.104 The few cases of maternal ICU admission for life-threatening illness are strongly associated with ongoing psychological morbidity and PTSD and women have expressed their strong desire for professional psychology services to be available to them.

8.105 *In a case of chorioamnionitis and failure to act on a pathological CTG in **2012** a woman told the review team: 'They spent half an hour trying to resuscitate my daughter in the corner of the room, didn't say anything to us until it was: "I'm sorry, but we couldn't save her". [I said] "But you were telling us everything was fine". On top of that, the aftercare was absolutely appalling as well. They left us in the [delivery] room for I don't know how long and then they put me in a wheelchair, gave my daughter to me, put us in a room and left us there basically. What was even worse, they put us on the maternity ward so we could hear babies crying. We could hear people being congratulated'. (2012)*

8.106 *Following a cardiac arrest in **2014**, a woman still finds it difficult to come to terms with her condition and feelings she could still die. She described to the review team unhelpful comments from an unknown doctor saying, ' "Hi, I was the guy that restarted your heart". I couldn't cope with that. I was really struggling with the gratitude I felt for the people that had saved my life but also needed some counselling.' (2014)*

8.107 *There were failings within the MDT in **2014** to manage a woman's history and experience of childhood sexual violence. There was evidence of a disconnect between the midwifery notes and the woman's recollection of events. Following her birth experience, the mother contacted the review team to help her to determine if her PTSD, and a birth injury which took years to heal, and left her unable to work is 'normal and acceptable'. The woman explained to the review team that she had been unable to leave the house between 2014 and 2018.*

8.108 Evidence that staff at the Trust often try to settle fears and anxieties is present in many case reviews yet long term psychological harm has still occurred. Postnatal discussion meetings have routinely been offered to women at the Trust over many years but a debrief with a midwife is often not enough for women who have harboured deep seated anxieties and memories and have complex clinical questions that require answers. Most midwives in the UK are not trained to provide professional counselling and may not have the clinical knowledge to adequately explain clinical scenarios that require the input of an obstetrician, neonatologist or anaesthetist.

8.109 It would seem that women receiving their maternity care at the Trust may require the opportunity to review their birth experience more often and in a different way than is currently provided, even if the care was perceived as good. In cases where clinical care was below optimal or complications occurred, ongoing psychological support for women is necessary.

8.110 The NHS Long Term Plan[175] renewed the commitment for the NHS to improve specialist perinatal mental health services. The Perinatal Mental Health Programme and the Maternity Transformation Programme are working together to fulfil this ambition to enable maternal mental health services to be improved by establishing nationwide Maternity Outreach Clinics by 2023/24. This service will help provide support for women with moderate to severe complex mental health problems resulting from their maternity experience and is expected to address issues such as PTSD, perinatal loss and tocophobia (fear of childbirth).

8.111 In July 2020, NHS England and NHS Improvement invited proposals for pilot areas for the testing and development of a maternal mental health service. Shropshire Telford and Wrekin were selected as an early implementer and have revised and updated their Maternity Mental Health guidance. There is evidence that the Trust is working towards improving access to perinatal mental health services.

Conclusion

8.112 This second report builds upon our first report[176] published in December 2020. In that first report, evidence was provided that concerns were not appropriately escalated, leading to a direct impact on the safety and quality of care provided to women and their babies. In this second report which concludes our review of family cases the review team has highlighted both a failure to learn and a lack of progression at the Trust in terms of governance and learning across the timespan of the review.

8.113 In this chapter the review team has highlighted the essential need for effective communication between all healthcare professionals providing maternity care and the women they provide that care for. We have highlighted numerous examples where communication was not at the standard expected or required. As with other chapters in the report there is an ongoing concern from maternity staff at the Trust feeling unable to speak out and raise concerns about care at the Trust. This is an issue that requires urgent action and resolution at the time of publishing this report.

175 NHS England. *The NHS Long Term Plan* (2019) https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

176 Ockenden, D. *Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust*. (2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

Chapter 9

Postnatal care

9.1 There is a need for continuing midwifery and multi-professional observation of the mother and her baby during the postnatal period since serious events or deterioration of already known conditions can occur in this time. The time after the birth of a baby is often when new mothers report they feel most vulnerable, with vulnerability increased where a woman already experiences social disadvantage or pre-existing medical co-morbidities. It is essential, therefore that postnatal care is safe, supportive and compassionate.

9.2 The importance of senior (consultant) involvement in acute care, including postnatal care, was emphasised by the RCOG 2021[177] when it noted that 'consultants must ensure that they fulfil the standard that all women should be reviewed within 14 hours of admission' and that 'this standard also applies to postnatal admissions'. This is not new advice, and reiterates Keogh[178] standard 2 first published in 2015 and emphasised by MBRRACE UK 2019[179]. MBRRACE advised a 'review of guidance [was] needed to ensure that deviation from the usual clinical pathway, with unexpected, or unexplained, symptoms [then] triggers a consultant review'. MBRRACE also noted 'These enquiries have emphasised repeatedly the importance of senior review in relation to abnormal postnatal symptoms'.

9.3 Overall improvements in postnatal care across the wider maternity system require significant investment in both workforce, and technology, especially the improved availability of information technology on postnatal wards and across the community too. Midwifery and support staffing on postnatal wards is often poor, and across England maternity teams will recognise that staff are moved from postnatal wards and the community when there are staff shortages in those areas considered to be more acute, such as the labour ward. Across postnatal care the staff at the Trust have described to the review team how they are stretched beyond capacity. This can then lead to poor physical, social and emotional care provision for mothers and their babies.

9.4 Early postnatal discharge from hospital to home is not always appropriate, despite pressure (which can be from families or the maternity service) for women to leave hospital soon after birth. It must therefore only occur if clinically appropriate, and there must be appropriate support in the community after discharge. Across England, improved midwifery and support staffing levels in postnatal care will improve the safety of that care and lead to an increase in family satisfaction. Consultant job planning must also be considered to ensure that postnatal reviews are a timetabled activity.

Lack of consultant involvement in the management of complex postnatal cases at the Trust

9.5 The review team noted many cases where there was no consultant review, or inadequate consultant involvement, in the management of complex postnatal problems in maternity services at the Trust. For example:

9.6 *In **2002** a woman spent 17 postnatal days in critical care, and sadly died. During that time she was only reviewed on four occasions by an obstetric consultant. There should have been greater consultant obstetrician input into her ongoing care. (2002)*

9.7 *In **2006** a woman with known cardiac problems was discharged home soon after birth without consultant review, despite having been fluid overloaded in labour requiring treatment with diuretics and oxygen. She was admitted some three weeks later in significant heart failure and died. (2006)*

177 Royal College of Obstetricians and Gynaecologists, Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology (2021) https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/roles-and-responsibilities-of-the-consultant-workforce-report-june-2021.pdf

178 Keogh B, *Seven Days a Week*, NHS England (2015) https://www.england.nhs.uk/seven-day-hospital-services/the-clinical-case/

179 Knight M, Bunch K, Tuffnell D, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17.* Oxford: National Perinatal Epidemiology Unit, University of Oxford (2019). https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf

9.8 *In **2007** there was no postnatal consultant review after a difficult caesarean section, even though the registrar who performed the surgery informed a consultant that they were concerned that there might have been bladder damage during the operation. The consultant simply advised an indwelling catheter for 14 days, however, after the woman was discharged home on day five she was readmitted on day 12 but was not reviewed by a consultant until day 15 when she was finally diagnosed with a ureteric injury which occurred during her caesarean section. (2007)*

9.9 *In **2011** a woman with known pregnancy induced hypertension, who required a prolonged postnatal stay in hospital because of labile blood pressure, had no postnatal consultant review. Earlier consultant review could have identified seriously deteriorating HELLP[180], from which the mother subsequently died. (2011)*

9.10 *In **2018** a woman who underwent a caesarean hysterectomy because of a placenta accreta[181] had her surgery performed by a consultant, who also reviewed her the day after surgery, but there was no further consultant involvement in her care after this. (2018)*

Complex postnatal care requiring readmissions

9.11 Postnatal readmissions, for maternal complications, are uncommon, and are by definition complex. Management should therefore include review by a consultant. However, there were several cases where timely consultant review did not occur:

9.12 *In **2006** a woman was admitted with postnatal faecal incontinence, but was not seen by a consultant until 4 days after admission. (2006)*

9.13 *In **2009** a woman remained on the postnatal ward for 15 days after a caesarean hysterectomy for placenta accreta. In the first week she had regular obstetric review, including consultant reviews on days 1, 3 and 8. In the second week recording of maternal observations was very ad hoc and all the reviews were by very junior doctors. This woman was discharged home on day 15 by a junior doctor but was readmitted later the same day with severe sepsis, requiring ITU admission. Adequate observations, and thorough review before discharge, should have alerted clinicians to the developing sepsis, and would have allowed more timely management, possibly avoiding the need for ITU care. (2009)*

9.14 *In **2018** a woman was admitted with postnatal endometritis[182], but did not have any consultant reviews. In this case the management was not timely, as it was not recognised that she had retained placental tissue requiring removal under anaesthetic until 3 days after admission. (2018)*

Observations and appropriate responses

9.15 Observation of vital signs, and appropriate response if they are not normal, underpins the provision of safe maternity care. This should occur at all stages of pregnancy, including the postnatal period. The review has noted many cases where this did not occur across the timespan of the review.

9.16 *In **2000** there were very limited postnatal observations recorded of a woman who had experienced a stillbirth, with abruption, and a 3 litre blood loss, which required a blood transfusion. (2000)*

9.17 *In **2008** there had been abnormal observations recorded but the midwife simply discontinued observations without explanation. This resulted in a delay arranging the blood transfusion this woman required. (2008)*

9.18 The review team has also noted a number of cases where women with known pregnancy-induced hypertension either had few postnatal observations recorded, or had hypertension recorded but there was no response to the abnormal readings (both on the postnatal ward and in the community). These cases include examples seen in **2008** and in **2011**.

180 See Glossary

181 See Glossary

182 See glossary

9.19 *In **2008** when a woman reported severe rectal pain after a forceps delivery there was little consideration that she may have a serious complication. She was given analgesia, but very few observations of her vital signs were made, even when it was noted that she had only passed small volumes of concentrated urine. It was eventually realised, when it was noted that her heart rate was 140–160 bpm that an internal haemorrhage was likely, and her management was discussed with the on-call consultant who advised examination under anaesthetic (EUA) in theatre. Initially no plans were made for the consultant to attend theatre, but as the woman had still not gone to theatre 90 minutes after the decision for EUA, the consultant did attend. The woman went on to have a laparotomy[183], and drainage of a large retropubic haematoma[184]. She also required a 6 unit blood transfusion. Earlier recognition of her blood loss should have led to more timely management. (2008)*

9.20 Shock in the postnatal period should be recognised by all members of the multidisciplinary maternity team. The team must be aware that as most pregnant women are fit and healthy they can compensate for blood loss, and therefore may not show all the classic signs of hypovolaemia[185], which are an increasing heart rate with a fall in blood pressure, usually secondary to blood loss. The review team noted a number of cases where there was a significant delay in either recognising postnatal shock, or a slow response to the situation by clinicians. These are discussed below:

9.21 *In **2006** a woman was admitted with a significant secondary postpartum haemorrhage (PPH). Fluid resuscitation was slow, as was the decision for an examination under anaesthetic (EUA) during which the mother required a hysterectomy. (2006)*

9.22 *In **2006** the midwife noted excessive blood in the drains after an emergency caesarean section with an associated tachycardia and fall in oxygen saturation. The midwife did inform both the registrar and consultant of her concerns. A litre of colloid fluid did not improve the mother's tachycardia, and her oxygen saturation deteriorated, but the obstetric team did not appear concerned as the blood pressure remained normal. It was not until approximately 2.5 hours after leaving theatre that a bedside blood test was performed which revealed a life threateningly low haemoglobin level of 3.3g/dL. She was then rapidly transfused and returned to theatre where she underwent repair of a bleeding left uterine artery. (2006)*

9.23 *In **2008** a woman with known severe pre-eclampsia developed pulmonary oedema some 36 hours after an emergency caesarean section. This is a recognised potential complication, which is why her postnatal care should have been multidisciplinary (obstetrics and anaesthetics) and should have included a clearly documented postnatal MDT[186] management plan of fluid restriction, careful monitoring of fluid balance and regular MDT clinical review including chest auscultation[187]. In this case the care was not multidisciplinary, and did not involve appropriate fluid management. Had this occurred she would certainly have been better managed, and the pulmonary oedema possibly avoided, or managed earlier, so that admission to the medical HDU where her pulmonary oedema was well managed might have been avoided. (2008)*

9.24 *In **2016** a consultant obstetrician ignored clinical signs suggesting an ongoing problem. After a normal birth a woman had a high uterus and ongoing bleeding, this was managed with an oxytocin infusion but the heavy trickle of blood continued. She developed symptoms of light headedness, as well as a fast heart rate, and low blood pressure. Her blood loss was recognised, and managed with one unit blood transfusion. As her bleeding was still ongoing 7 hours after birth the registrar planned for her to have an examination under anaesthetic (EUA) to check for any retained placental tissues, or unrecognised tears. When she was reviewed by a consultant, some 9 hours after the birth, the consultant decided that EUA was not needed. The woman was transferred to the postnatal ward, where she had a further 3 unit blood transfusion the*

183 See glossary
184 See glossary
185 See glossary
186 See glossary
187 See glossary

next day, and was discharged home on day 3. She was readmitted 20 days later with heavy bleeding, and when she did undergo the EUA a large (9 x 5 x 3cm) piece of placental tissue was removed. Clearly the initial management controlled the immediate symptoms, but did not treat the underlying cause of retained placental tissue. Had the EUA occurred 7–8 hours after the birth, as planned by the registrar, then this woman would not have been exposed to the increased risk of infection and secondary haemorrhage. (2016)

Escalation

9.25 The review team has noted many cases where abnormal findings by midwives have then not been escalated to the midwife in charge of the ward/unit or to appropriately senior medical staff.

9.26 *In **2008** a postnatal woman, with known pre-eclampsia, had her blood pressure taken 5 times over a 20 minute period with all readings showing significant hypertension with no further escalation. A junior doctor came to review, but on attending found the woman asleep so the review did not occur until she woke up very confused, and with a headache about 2.5 hours after the hypertension was first noted. She was subsequently managed with a magnesium infusion and antihypertensive medication. (2008)*

9.27 In some cases midwives appropriately escalated concerns to medical staff, but the response to the escalation was poor.

9.28 *In **2019** a midwife escalated concerns about a woman's one-sided weakness the day after a manual removal of placenta was performed under spinal anaesthetic. The midwife's concerns were raised after the woman had been reviewed by an anaesthetist on a routine ward round, when no issues had been identified. The anaesthetist had not documented their clinical review in the medical records. The midwife's concerns led to a further review by an anaesthetic registrar who concluded that the woman's weakness could be explained as "prolonged effects from spinal". This was incorrect as spinal anaesthetic does not cause one-sided weakness. The midwife again raised her concerns, and the woman was then reviewed by a consultant anaesthetist who arranged a head CT scan which diagnosed a subarachnoid haemorrhage. In this case there was a delayed diagnosis of a serious condition. (2019)*

What Trust staff have told the review team

9.29 In late 2021 a number of maternity staff from the Trust, including current and past employees, spoke to the review team:

9.30 One contributor told the review team that '*There wasn't really much working together at all, it was very much we're midwives, they're obstetricians…if you knew certain obstetricians were on [duty] you would be fearful of calling them…because of their way with women…not very nice to the women'.* Another contributor, also noted *'A midwife couldn't ring the consultant on-call…afraid to ring with any concerns'.* A further staff member told the review team: *'It seems to be [with] processes, protocols, guidelines, some are using it, and some are not…policies and guidelines are all there…but not being followed'.*

9.31 A staff member described *'a very, very overburdened and thinly stretched middle tier in the obstetric team… doctors were being asked to cover services that you couldn't possibly do on your own'.*

9.32 Another staff contributor described: *'There were one or two, or even three, consultants that would intimidate the midwives and junior doctors, and make sure they were not approachable…many registrars have been intimidated not to contact the consultant during the night, and if they contact they get told off'.* The same contributor also commented on the relationship between consultants and midwives: *'They don't get on well…there is a barrier'.* Another contributor, commented on the relationship between consultants and midwives and said: *'Some you were seriously on your guard with… [would] bite your head off…I wouldn't have phoned a consultant lightly… [They] weren't particularly approachable'.*

9.33 Some staff also shared with the review team the lack of a supportive culture for junior or inexperienced staff that they had experienced very recently but declined to have their words used directly. It was explained to the review team that asking for help was seen as a bad thing and that junior staff at the start of their careers were often too frightened to ask for support when needed.

9.34 Overall staff feedback to the review team in late 2021 describes poor team working, failure to follow guidelines and an overstretched middle tier of obstetricians. This undoubtedly influenced the ability of postnatal ward midwives and junior doctors to be able to escalate potential clinical complications appropriately. These issues with lack of escalation were found within our first report and feedback directly to the review team from current maternity staff supports the findings in report 1.

9.35 There were however some encouraging reports from staff that the culture has started to change within maternity services at the Trust over recent years. A member of staff, interviewed in October 2021, who had only been with the Trust for a short period reported: *'Overall I think the culture is good…on the postnatal ward'.* The same contributor reported: *'Two new consultants [are]…trying to update the MEWS (modified early warning system) charts'* in reference to escalation from the postnatal ward, a recommendation from our first report.

9.36 Another staff contributor, referring to previously poor escalation at night commented *'Doesn't happen now…consultant now covering labour ward at night'.* The same contributor also commented that the relationship between doctors and midwives was *'improved now'*. Another member of staff, commented on the appointment of an individual consultant in 2018 who changed the culture *'in terms of consultant engagement…is engaged, approachable, woman-centred…and was the start of potentially the tide turning with what was quite an old and staid consultant body…it's much better now…24/7 consultant cover on labour ward'.* The same contributor said *'that is a good thing to come out of all this scrutiny'.*

Clinical follow-up in the postnatal period:

9.37 Clinical follow-up is comprised of two main aspects: firstly, follow up of results of investigations with potential amendments to already existing plans of care. Secondly, follow-up discussion and debriefing of care especially for families who have experienced perinatal loss, or a serious adverse event. This is essential to help women and their families understand, and begin to come to terms with, what has happened to them.

9.38 Follow-up discussions should address ongoing care needs, and discussion about any implications that events within the current/most recent pregnancy may have for care in a future pregnancy. In some cases it may be appropriate for this discussion/debrief to occur before discharge from the postnatal ward, but in others a formal follow-up appointment is required.

9.39 Such discussions require effective and timely communication with both the mother and her GP. It is therefore vital that the appointment occurs in an appropriate setting, within a reasonable timescale and is accurately documented and that the appointment is with a senior doctor who gives the family time for adequate discussion. The doctor also needs to listen to the family, who may hope that any investigation of their case could lead to learning and changes that might avoid another family experiencing a similar event. When a stillbirth occurs MBRACE-UK 2017[188] advised that *'All parents should be offered a follow-up appointment, in an appropriate setting, with a consultant obstetrician to discuss events leading to their baby's stillbirth, the actual or potential cause, chances of recurrence and plans for any future pregnancy'.* The same report also advised that *'A summary of their follow-up appointment, written in plain English, should be sent to the parents, and their GP'.* The review team found many examples where this did not happen:

9.40 *Failure to address the mother's ongoing care needs were noted by the review team when in* ***2007*** *a woman was discharged from maternity care still on antihypertensive medication, which had been started during the pregnancy, but with no instructions to either the GP or the woman, about ongoing blood pressure management. (2007)*

188 MBRACE-UK Perinatal Mortality Surveillance Report: *UK Perinatal Deaths for Births from January to December 2015* (2017) https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK-PMS-Report-2015%20FINAL%20FULL%20REPORT.pdf

9.41 *In **2014** a mother's membranes ruptured well before 24 weeks, and she went on to have a very pre-term birth and neonatal death after a few hours. In her pregnancy she had been informed of a positive test result, and advised to collect a prescription for treatment, which she did not do. This test result was noted when she was admitted, and appropriate treatment prescribed, but it was never given. This information was not relayed to the GP, nor was it addressed when the mother saw the consultant for follow-up. (2014)*

9.42 Similarly there are cases of women who experienced serious physical trauma at birth with potential implications for future births, where they and their GP do not appear to have been advised about these implications. One example is the following:

9.43 *There was a lack of information given to a mother in **2018** when a woman had an 'inverted T incision' on the uterus at caesarean section for the birth of the second very pre-term twin (25 weeks gestation). Sadly both twins died in the neonatal period. In the records provided by the Trust there was no evidence that the parents were made aware of the unusual incision on the uterus which does have implications for a future pregnancy: if this woman were to labour in the future there is a high risk of uterine rupture, which can be catastrophic for both mother and baby. The discharge summary to the GP did not include any information about the 'inverted T' incision. (2018)*

9.44 The review noted many perinatal loss cases where there was no evidence in the medical notes that the family had been offered a follow-up appointment; this was noted across the years of the review (2000–2019). For most of the last 20 years the majority of maternity units have arranged that these follow-up appointments take place away from any clinic associated with maternity care, but the Trust was still seeing these families in the gynaecology clinic as late as 2014.

9.45 These appointments are often distressing for the families, and must therefore be conducted sensitively. The written summary of the discussion must also be both sensitive, accurate and easily understood by the family. This was often not the case for the families considered by the review team.

9.46 *A family told the review that they felt that the consultant was 'unprofessional' during their post-stillbirth appointment in **2006**, as he was ill-prepared, had not read the post-mortem report, and sent a letter with multiple factual errors after the appointment. The family explained to the review team that the consultant exacerbated their distress in an already extremely difficult situation, and they then had to write back to the consultant to get the factual errors in the letter corrected. (2006)*

9.47 *A family described their post-stillbirth consultant appointment in **2011** as 'very brief in and out in less than five minutes, and 'did not give [them] any answers'. The consultant was described to the review team as 'inattentive' and he is said to have 'sat on the table swinging his legs'. (2011)*

9.48 *A family who suffered a neonatal death in **2013**, after a traumatic birth, reported that at the follow-up appointment the consultant 'showed no compassion or understanding of the trauma experienced'. (2013)*

9.49 In some cases the letter sent to the family after the follow-up appointment did not offer condolences, or was written using a lot of unfamiliar medical terminology. The review team has seen examples of this in both **2016 and 2018**. In other cases the letter used inaccurate wording that the family found upsetting for example in **2018** the consultant's letter after a stillbirth noted that the mother had *'gone through labour and delivered a very healthy girl'* which is inappropriate given that the baby was stillborn. (2018)

9.50 It is expected that families are given complete and honest information both before discharge from the hospital and at the follow-up appointment. The review team found a number of instances where the information given was either incomplete, or misleading:

9.51 *In **2002** after an intrapartum stillbirth, the consultant's postnatal letter stated 'all the findings would probably suggest there was a little bit of growth restriction at the end, and that labour on top of a compromised baby caused the ultimate demise'. However, the letter failed to mention that the CTG was grossly abnormal for nearly 90 minutes before the stillbirth, that there was thick meconium, and that earlier birth by caesarean section would probably have resulted in a live birth. (2002)*

9.52 *In **2005** after a stillbirth there was appropriate discussion of the family's concerns, but no discussion about the growth restriction noted at post-mortem (not detected in the antenatal period) as a cause of the stillbirth, as well as an infection after probable pre-labour rupture of membranes. (2005)*

9.53 *In **2006** a family whose baby died at 3 days of age with severe HIE[189] and bleeding into an arachnoid cyst, noted that at post-mortem they were given the impression that 'haemorrhage into the cyst had caused the HIE' rather than hypoxia during labour. The multi-professional review team concluded there was clear evidence of a pathological CTG prior to birth and that the resulting features of HIE would be consistent with an intrapartum hypoxic insult which was likely to be due to cord compression worsened by injudicious use of oxytocin. (2006)*

9.54 *In* **2008** *a woman who experienced an abdominal wound dehiscence 5 days after caesarean section was told that 'the suture had snapped, and this was an equipment failure, not a medical issue'. (2008)*

9.55 *In **2013** after an intrauterine death that occurred in hospital during induction of labour, the family and GP were told that the cause of death was that the labour ward was too busy for her to be transferred for artificial rupture of the membranes (ARM). The Trust RCA did not consider that failure to monitor the fetal heart for 15 hours, (which contravened Trust policy), was the true cause. (2013)*

9.56 *In **2014** following IUD of 28 week twins, the consultant told the family that the scan a week before fetal demise showed that 'Doppler assessments of flow in the cord and brain were normal'. However, there was no evidence in the medical records that they measured Doppler flow in the brain when performing this scan. (2014)*

9.57 *In **2015** after a traumatic operative vaginal birth of the second twin, using 3 sequential instruments, a consultant discussed issues around the birth with the mother, on the postnatal ward, and explained that the baby was 'short of oxygen' during the birth, but did not mention the skull fractures that the baby had sustained. (2015)*

9.58 *Similarly in **2018** a family were told that there was no evidence of pre-eclampsia before a mother was admitted with an abruption and intrauterine death. However the review team noted that in the 2 weeks prior to the abruption the mother was being managed as an outpatient with proteinuria (measured by urinary PCR) and blood pressure that was increased from that recorded at booking. This does indicate that this mother did have known pre-eclampsia, which was a risk factor for abruption. Abruption cannot be predicted, or prevented, but if this woman had been managed as an inpatient, then urgent delivery as soon as the abruption was recognised might have achieved a different outcome. (2018)*

9.59 In a number of cases families felt that the Trust was reluctant to undertake investigations, or to change practice.

9.60 *After experiencing a neonatal death in **2005** a family told the review team: 'We just wanted to understand and maybe work with the hospital to try to change practice to avoid any parents having to go through the same painful ordeal. However, this certainly wasn't an option. It was like the door had been slammed in my face'. (2005)*

9.61 *In **2012** a family were told that there was a Trust investigation after the mother had to return to theatre because of intra-abdominal bleeding after an elective caesarean section, and that nothing different could have been done. However, the Trust has not given the review team any evidence of an internal investigation. The review team is critical of the care this woman received after her elective surgery. (2012)*

9.62 *In **2014** a meeting with the family to discuss the findings of the Trust investigation did not occur until more than 2 years after the birth, and the baby's neonatal admission, from an MLU with severe sepsis. After this meeting the Medical Director did send the family a letter outlining the results of the investigation, but also indicated that the letter had been composed from the Head of Midwifery's notes and transcription (it was obviously 'cut and pasted'). The letter concludes that there were still questions to be answered and confirmation was still required as to whether actions from the investigation had been undertaken.*

189 See glossary

This was 2 years after the case occurred. The review concluded that this letter was unprofessional and reinforced the apathy shown towards the case. The review team considers there appeared to have been little involvement with or support shown to the family. (2014)

Compassion and kindness

9.63 Many families reported to the review team a lack of compassion and kindness shown to them by Trust staff.

9.64 *In **2002** a woman with pre-eclampsia discharged herself 36 hours after delivering 25 week stillborn twins as she felt her care 'was appalling'. (2002)*

9.65 *In **2008** a woman reported her distress about the care she received on the postnatal ward after undergoing a postnatal laparotomy for a retropubic haematoma. She felt that on the ward 'There was no communication at all. I was shouted at, ordered about and forgotten…I was made to feel like an inadequate mother and made to feel like I was making up how poorly I was and I like I shouldn't have rung the bell or asked for help'. (2008)*

9.66 *In **2011** two families commented that 'midwives didn't care', 'showed no kindness [and] support' and 'there was no caring involved'. One mother told the review that she felt unsupported after suffering a cardiac arrest and was not offered any psychological support. She told the review that she was made to feel 'I was in the way and they wanted rid of me, they were in no way subtle about it once they decided that I had spent enough time in the unit'. (2011)*

9.67 *Another woman in **2015** told the review that she felt she had received poor care that also lacked empathy. (2015)*

9.68 The review team heard from families who felt unsupported and uncared for when their babies were unwell:

*In **2010** a baby was readmitted with significant jaundice. The family felt that their baby was 'starving to death' and complained about lack of feeding support. A review of the medical records indicated that inconsistent advice had been given to the parents. (2010)*

9.69 *In **2012** a mother felt ridiculed for having followed another staff member's advice on how to put on her daughter's nappy. (2012)*

9.70 *In **2014** a mother reported , whose baby was on the neonatal unit, that she was 'told off' for 'worrying about her pain too much'. The woman reported to the review team that she was told by staff 'what we tend to find is that those women who have babies next to them have more important things to think about. People like you who do not, are only concerned with themselves'. (2014)*

9.71 *In **2015** two families described the postnatal care as being 'truly awful' and that they 'felt like a burden' and 'not listened to'. One of these families also described a midwife calling the mother 'a princess' for asking for formulafeed for her baby. (2015)*

9.72 *In **2016** a mother reported being left alone in the birth room, with the call bell out of reach, just 40 minutes after giving birth. (2016)*

9.73 Concerning attitude issues towards families were also reported by some staff. One contributor to the staff voices process, reported to the review team that *'some staff [on the wards] ignored buzzers unless it was "their buzzers".'* This meant that some women asking for help could not access any support if their own midwife was busy, off the ward, or on a break. This contributed to some families feeling that *'midwives didn't care'.* The same contributor also commented that postnatal ward staff were probably quite unhappy and described *'not much understanding between labour ward and the postnatal ward'.* The same member of staff also stated: *'I wouldn't have wanted to go there as a patient'.*

9.74 Staff members told the review team that asking for help was seen negatively but were unwilling to be quoted directly as having said this, despite assurances of anonymity. This was not an attitude likely to foster a good working environment for staff, nor likely to lead to good care for families. Another member

of staff, stated that the Trust was *'a dreadful place to work…practice wasn't evidence based …guidelines woefully out of date…I tried to raise concerns unsuccessfully'.*

9.75 Whilst the review team noted that the Trust had a perineal follow-up clinic for women who had experienced 3rd and 4th degree tears, or other perineal problems, they also noted issues with some staff communication in this clinic.

9.76 *In **2009** a woman was referred to this clinic because of persistent perineal symptoms, despite no known history of significant perineal trauma at birth. In the clinic the consultant who saw her dismissed her symptoms, and said that no further investigation was required, without even examining the woman. This woman was subsequently seen in another hospital where a rectovaginal fistula was diagnosed, which must have occurred because of significant trauma at birth, probably a missed 3rd or 4th degree tear. (2009)*

9.77 *In **2014** when a woman was reviewed in this clinic after a 3rd degree tear the doctor wrote in the notes: 'Well, but fat and very anxious. Can try for a vaginal birth – risk of re-occurrence low'. (2014)*

Receiving postnatal care in the correct location

9.78 Care in the postnatal period for mother and babies must take place in an appropriate setting, according to clinical need.

9.79 *In **2012** there was inappropriate transfer to midwifery-led care in the postnatal period which led to poor management. The transfer of care, to a distant MLU, occurred 3 days after birth despite a complex caesarean section, massive obstetric haemorrhage, anaemia, postpartum pyrexia, persistent tachycardia and persistent pain. The mother was eventually transferred back, very unwell, to the consultant-led unit (inappropriately by car) on day 8 with severe sepsis, with both a pelvic abscess and a lung empyema[190]. (2012)*

9.80 *In **2017** a woman with known pre-eclampsia was transferred to a distant MLU for ongoing postnatal care on day 3, despite her blood pressure remaining elevated. (2017)*

9.81 *In **2017** a mother and baby who had been transferred to a standalone midwifery-led unit (MLU) for postnatal care after birth was advised by a midwife: 'Don't tell them the baby is 'grunty' or they will send you back to the consultant unit'. A family member subsequently highlighted their concerns and the mother and baby were transferred back to the consultant-led unit (2017)*

9.82 *In **2018** a mother and baby were discharged home 4 hours after vaginal birth but the baby's temperature was 36.1°C with no evidence of repeat measurement, the review team felt this was inappropriate. (2018)*

9.83 Follow-up appointments by community midwives after postnatal discharge from hospital should aim to both support the mother, and to detect and appropriately refer any maternal, or baby problems identified. In some cases this did not occur.

9.84 *In **2011** when a woman reported 'very little bowel control' on day 10, the midwife advised her to report this to her GP, rather than referring her to the obstetric team for review and management, or continuing to* review the situation herself. (2011)

9.85 In other cases women who had experienced pregnancy loss were advised to see their GP to get a prescription for therapeutic lactation suppression. It is normal practice to offer women lactation suppression after perinatal loss. The review noted evidence that lactation suppression was discussed with parents, but from the records of a **2016** early neonatal death it appears that Cabergoline was not stocked on the labour ward. This suggests that the management for families experiencing loss was not holistic.

190 See glossary

Staffing

9.86 Poor staffing levels, both midwifery and obstetric, will affect both the quality of patient postnatal care, and staff morale. It would appear that staffing levels and staff morale were an issue for some time at the Trust.

9.87 When contributing to the Staff Voices initiative in late 2021 one contributor graphically described the stress staff felt because of poor staffing levels, with postnatal ward midwives regularly being *'pulled to labour ward'* and described the way this affected care as: *'you … try and just do the work as quickly as possible, and there wouldn't be any quality of care'.* The same contributor also described that this prioritisation of the labour ward, leaving the postnatal ward understaffed *'really increased our stress levels because obviously, it's upsetting when you can't give the care that you want to give…especially on a postnatal ward where it led to healthcare assistants or the women's services assistants doing most of the clinical care with midwives just running in with some painkillers or IV antibiotics, or doing a quick check'.*

9.88 The response from the staff member, when asked about escalation of concerns regarding staffing levels on the postnatal ward, was *'you know, you can escalate, but you know if there's nowhere to pull, there's nowhere to pull. You're just left and you just have to get on with it'.* The contributor also reported pressure for early discharge *'they [postnatal women] can't even stay in for breastfeeding support'.*

9.89 Many staff contributors also reported significant staffing issues. They described: [a] '*shortage of midwives… needing to pull in staff (from wards and community)…robbing Peter to pay Paul,'* and *'[being] concerned about safety and staffing'.*

Bereavement

9.90 It is sadly inevitable that many of the families included in this review have experienced the loss of a baby, which can have a huge impact on their long-term wellbeing. As noted by SANDS (2021) *'Good care cannot remove the pain and devastation that bereaved parents experience, but poor or insensitive care makes things worse, both immediately and in the months and years that follow'.*

9.91 Compassionate bereavement care must begin when a family are told that their baby has died (or before death if the baby is known to have an abnormality incompatible with survival), it is therefore vital that all staff communicate compassionately with families at this very difficult time. Below are some cases from across the timespan of the review identified by the review team where families felt this did not happen:

9.92 *In **2002** a family complained about the way that a midwife sonographer informed them that one of the twins had died when the mother presented with ruptured membranes at 37 weeks gestation. (2002)*

9.93 *Similarly in **2009** a family complained about the manner of the doctor who diagnosed the absence of fetal heart activity, which they felt was insensitive. (2009)*

9.94 *In **2018** the review team noted that a family wished to continue a pregnancy with known abnormalities incompatible with survival and they were seen by the bereavement midwife and consultant neonatologist together during the pregnancy to plan care at the time of birth. After these meetings a letter outlining the plans for care was sent to the family. However, this information was inadequately conveyed to the labour ward staff, who were unaware of the agreed plans. This led to the inappropriate repeated discussion of the issues when the mother was in labour, and after the baby was born. It was also noted that some of the agreed plans were not followed, such as the family spending as much time with the baby as possible before discharge from the hospital. It is clear from the documentation that at the time of birth there was little, or no, discussion with the family with regards to meeting their individual requirements, nor to fulfil their required cultural and religious practices despite these having been agreed at the pre-birth meetings. (2018)*

9.95 In most maternity units it is routine practice to suggest that women go home after being given oral mifepristone following the diagnosis of an intrauterine death, to return after 36-48hrs for further management to induce labour. It is however very important that staff ensure that parents are given the option of staying in the hospital if they prefer, or that they are clearly informed that they can return to the hospital at any time if they wish.

9.96 *A mother described how she felt in **2010** 'When I left the hospital on the day I found out that my baby had died [at a scan]. I was told that they wouldn't expect me to return for 48 hours, from when the tablet was taken'. This family reported that they felt unsupported. (2010)*

9.97 *Similarly a mother raised concerns regarding staff attitudes after the very early neonatal death of a very premature baby in **2014**, who was born at 21+ week's gestation. She explained that she had to 'wait for the corridors to be empty before carrying her son back to the birth suite'. In her notes there was minimal documentation regarding postnatal bereavement care. (2014)*

9.98 Women who experience perinatal loss need to be cared for in a clinically appropriate area, so that both their physical and emotional needs can be addressed.

9.99 *In **2012** a family reported that their care after an intrapartum stillbirth was upsetting. Firstly the family were 'left in the room for I don't know how long…then put me in a wheelchair, gave baby to me (to hold), put us in a room and left us there'. This family also reported 'what was worse they put us in the maternity ward so we could hear babies crying'. Families have clearly explained to the review team how both compassion and an appropriate place of care can help make the unbearable more bearable. (2012)*

Consent to post-mortem examination

9.100 Post-mortem is the most useful investigation in supporting the determination of cause of death and its value is frequently underestimated by health professionals[191]. Deciding on whether to have a post-mortem investigation conducted can be one of the most difficult decisions bereaved parents face in the period immediately after their baby dies. It is essential that this is dealt with in a sensitive way by a professional trained to take post-mortem consent. The review team noted cases where discussion with families about having a post-mortem examination was insensitive or unhelpful. Below are two examples:

9.101 *A family in **2009** told the review team that: 'The doctor who went through the consent process for the post-mortem examination was observed by the midwife who documented "Noted that he went through documents very quickly and with little empathy. Family distressed by this and told me they were not happy with this when he left. Apologies given".' (2009)*

9.102 *Also in **2009**, a family reported that following the stillbirth of their daughter 'there wasn't time or space to make the important and difficult decision about consenting to, or declining, a post-mortem examination'. In this case the post-mortem consent was discussed only 6 hours after an unexpected stillbirth, and the family felt that the consultant obstetrician counselled them against having a post-mortem, and this was their 'largest concern about the care' the family received. (2009)*

Ongoing care after bereavement

9.103 Not surprisingly parents are very fragile at this difficult time, something all maternity staff should be aware of. Some families reported experiencing a lack of sensitivity to the review team. A family told the review team that in **2009** they found a consultant's attitude to be *'rude and completely dismissive of [their] concerns'.* (2009)

9.104 A family in **2011** felt deeply about *'the lack of compassion and empathy exhibited by the midwife'*. Also from **2011** the review team noted poor bereavement care and support and that there was evidence of a breach of confidentiality as there had been disclosure of the death of the baby to the woman's father without her consent. This had caused a strain in their relationship ever since. (2011)

9.105 It is reasonable to expect that maternity staff are careful to obtain accurate information when caring for bereaved families, or those with sick babies on the neonatal unit.

9.106 *A mother complained about the postnatal care she received in **2009** following a bereavement saying that the staff appeared unaware of the issues and she had to keep explaining distressing details at every shift change. (2009)*

191 https://www.sands.org.uk/professionals/sands-post-mortem-consent-package

9.107 *In another instance in **2014** a bereaved family reported seeing a different community midwife at each postnatal visit. (2014)*

Specialist bereavement care

9.108 Families who have experienced baby loss must have ongoing support, either from their own community midwife, or from a bereavement midwife. The review team noted a lack of support for bereaved families in many cases, over a long period of time.

9.109 *From a case in **2003** the review team noted that one woman said she was happy with the antenatal and intrapartum care she received but when she needed support following her term stillbirth this was 'sadly lacking'. In this case there was no information in the medical records about bereavement care apart from a checklist and mention of counselling in the bereavement follow-up letter. It is unclear whether this was ever arranged. (2003)*

9.110 *Following the loss of her baby in **2010** the clinical records indicated that the mother was discharged from maternity care on day 8 and advised to 'call if further support needed'. (2010)*

9.111 *In **2011** the review team noted an apparent lack of bereavement support after a stillbirth. The only evidence of involvement from the Trust was a single telephone call some four weeks after the birth. The notes from this call, provided by the Trust, indicate that the mother was advised to contact other healthcare professionals for support if she wished. (2011)*

9.112 *In **2012** one family reported that the bereavement care they received was 'appalling' and another family felt that the bereavement support was 'very tick box' and that they found the maternity bereavement service 'of no help'. (2012)*

9.113 *In **2016** the review team heard from parents of a lack of care and compassion in bereavement care following the neonatal death of their baby shortly after birth. (2016)*

9.114 Another important aspect of care at this difficult time is ensuring that parents receive all the information they require, or request, and that all appropriate services are informed of the bereavement.

9.115 *A family reported that in **2010** when they requested that the community midwife follow up the missing photographs of their stillborn baby that this did not occur. As the photographs had still not been sent to her months later the woman had to phone the ward herself to obtain them. (2010)*

9.116 *A family reported that in **2011** there was a delay in them being told that their baby had been returned following the post-mortem, which led to a significant delay in arranging the funeral. (2011)*

9.117 *In **2016** a health visitor was unaware of the neonatal death and provided congratulations and Bounty literature continued to be sent to the family, which they found distressing. (2016)*

Good bereavement care

9.118 In some cases, there was evidence of kind and compassionate support given to families after bereavement. The following are examples of that kind and compassionate care.

9.119 *In **2006** the community midwife was praised by the family for her care and compassion and they specifically asked for her in subsequent pregnancies. (2006)*

9.120 *In one case in **2011** the obstetric registrar offered condolences and gave a detailed discussion about post-mortem and the parents opted for a limited one with the knowledge that there was a limit to the information they would receive. (2011)*

9.121 *There was evidence in some cases that the maternity staff tried to help families with stillbirth registration. In **2014** a couple with English as a second language were escorted to the registry office to register their stillborn twins. It was also arranged for an interpreter to be present when the couple came to see their consultant for a follow-up appointment. (2014)*

9.122 *In **2012** the family reported that through bereavement support it was ensured that the family's concerns and questions were addressed in the Trust investigation.*

9.123 *In **2017** the parents reported effective information sharing, good levels of care including continuity of care after bereavement. (2017)*

Good postnatal care

9.124 Whilst the review has identified poor postnatal care it should be acknowledged that in the cases the maternity review team considered we also found examples of women receiving good, safe and supportive postnatal care.

9.125 *In **2011** there was evidence of effective team work with appropriate referral and involvement of social services, GP and health visitors. (2011)*

9.126 *In **2014** the review team also noted that 'the immediate midwifery care provided during the postnatal period was of good standard and aligned with local and national guidelines'. (2014)*

9.127 *In **2014** evidence was noted of extra postnatal community visits to provide more emotional support to a new mother. (2014)*

Good record keeping and good care planning

9.128 Good record keeping is fundamental to safe and high quality maternity care, and remains so in the postnatal period. Whilst the review has criticised poor record keeping, examples demonstrating appropriate and good quality postnatal record keeping were identified in **2010** and **2013**. The review team also identified sensitive documentation in the care of a family in **2008** and in another case involving a family in 2016 documentation was described as having a *'detailed midwifery record'* by the review team.

9.129 The review team also identified examples where problems likely to lead to a difficult outcome were identified during the pregnancy with evidence of good care planning in 2008. In cases from **2011** and **2015** the review team also noted evidence of family involvement in the planning of care.

9.130 Some cases of good clinical care were also noted. In **2011** timely multidisciplinary management was noted when a woman was readmitted with a severe wound infection after a caesarean section. The infection was promptly recognised as the severe life threatening condition of necrotising fasciitis, which was managed well.

9.131 In **2013** when a woman informed her community midwife that she felt 'unwell' at a routine visit, the community midwife recognised the severity of her condition and arranged prompt referral directly to the labour ward. When this woman arrived on the labour ward the midwives ensured that she was seen promptly by the obstetric registrar, who rapidly diagnosed sepsis and appropriately administered intravenous fluids and antibiotics within 30 minutes of her arrival in the maternity unit. She then went on to have good multidisciplinary management, including a short spell in ITU, and made an excellent, and fairly rapid, recovery. (2013)

LOCAL ACTIONS FOR LEARNING: POSTNATAL CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

9.132 The Trust must ensure that a woman's GP is given complete, accurate and timely, information when a woman experiences a perinatal loss, or any other serious adverse event during pregnancy, birth or postnatal continuum.

9.133 The Trust must ensure complete and accurate information is given to families after poor obstetric outcome. The Trust must give families the option of receiving the governance reports, which must also be explained to them. Written summaries of any debrief meetings must also be sent to both the family and the GP.

Chapter 10

Maternal deaths

The impact on families when a mother dies

10.1 Families have explained to the review team that the impact of a maternal death and thus losing a mother, wife, daughter, sister, or grandchild is far reaching across a whole extended family and the effect of this remains with them forever. Here are some of the ways families who have spoken to the review team about maternal death have described this to us:

10.2 'It never goes away…you just kind of…and it's a natural thing, you just kind of withdraw within yourself a little bit. Usually, for me, that's like a month, six weeks, two months.' (**2002**)

10.3 'It's just sad, I ache for her every day, every day.' (**2007**)

10.4 'I think her Mum and Dad, they're still grieving now…Even now like, I mean you go round the house and there's always a candle lit, you know, they've got our wedding photos still up, you know, it's just a constant reminder when you go round to their house.' (Husband talking about his wife who died in **2011**)

10.5 '…she was having some problems and eventually she said to her step mum that she felt bad that her Mummy had died because she'd wanted to have a brother or sister.' This example is from a bereaved husband, talking about his first-born daughter whose mother died during a later pregnancy. His daughter believed that her wanting a sibling was the reason her mother had died in **2016**.

10.6 The review team noted that several families felt their questions surrounding the maternal death had not been addressed by the Trust. Bereavement support after the event was also described by families as inconsistent:

10.7 When asked as to whether an investigation into the death had been performed a husband whose wife had died in **2002** responded: *'There was no…it was just the…it was pulmonary oedema and obviously pre-eclampsia was like mentioned, or part of it. Yes, fluid on the lungs. No, they never gave an explanation for that, for why'.*

10.8 Another family member said to the review chair: *'It's what makes me angry, because I feel like the Trust got off lightly at the time with me, because I feel that they recognised, in that meeting, how desperately distraught I was and they just decided…like everything was done, you know…We can't find any reason for, but if you want to take a complaint elsewhere that's up to you…but as far as we're concerned there's no case to answer…is what they basically said. And I came out flabbergasted because I think I'd expected them to offer me a big apology, you know, and say oh yes, we've made loads of failings here, and all this, that and the other...And of course they didn't and when they didn't do it I just thought I can't do any more, like I haven't got the energy to do any more. So I think they got off lightly really, and it makes me feel bad that I didn't have the energy to do it, but it would have been too much for me to go through…because I want to go through this process [the Ockenden review] to get some answers for my own peace of mind as to what happened, because I laid a lot of blame on myself afterwards…'*

10.9 The family member further recalled: *'one doctor that wasn't so pleasant or helpful…when I rang him to ask some of the questions, his exact words to me were "if you keep digging into this you'll just find things you don't want to find". That's what he said to me, and then he put the phone down'.* (This feedback is from the partner of a mother who died in **2002**)

10.10 A partner of a woman who died in **2014** told the review chair: *'I was actually told that I would get to see [the investigations], they did an independent review on their midwives and then they did another one, I saw another lot…so the ones above them also went back on her case and went through all that, I was also told I would get them...[investigation reports] and we've never had them'.*

Number of maternal deaths reviewed

10.11 At the time of concluding this review, in total 19 maternal deaths were noted by the review team. Three of these occurred prior to the core review period (before 2000) and one death in **2015** occurred after the mother was transferred in labour to another trust. This woman's pregnancy care was reviewed by the team as the majority of the pregnancy care occurred at the Shrewsbury and Telford Trust's maternity services, but her death was not.

10.12 Of the 16 cases that occurred within the core review period, there were eight direct[192], and seven indirect maternal deaths[193], plus one accidental death resulting from a road accident, which was not investigated further by the review team.

10.13 One death which occurred at the Trust during pregnancy in **2019** was comprehensively investigated by the regional Healthcare Safety Investigation Branch[194] (HSIB) as per NHS policy. This case was not reviewed further by our team.

10.14 One mother who delivered at the Trust died in another hospital in **2019** and the family declined the HSIB review. It was not possible to obtain permission from the family regarding inclusion into our review. In cases such as this, there is ultimately learning for the whole maternity system and trusts involved must learn together through digital or remote means if necessary. The review team is not aware of any such joint learning in this case.

10.15 Clinical notes were unavailable for one woman who died in **2001**, despite recommendations that all maternity records should remain available for 25 years after the birth of the last child[195]. An external governance review was arranged after the family complained to the Trust and provided to the review team by the Trust. The review team was therefore able to review the quality of the Trust's internal investigation after the death, but not the clinical care.

Analysis of the maternal deaths

10.16 The remaining 12 maternal deaths were each reviewed by a multi-professional team of midwives, consultant obstetricians, a consultant obstetric physician and a consultant anaesthetist, with special interest in obstetric and cardiothoracic anaesthesia. Further experts (including experts in intensive care, cardiology, neurology and others) joined the team to give expert opinion or answer specific clinical questions where required.

10.17 As with all other reviews, for each maternal death review the team adopted a holistic and multi-professional approach, including access to all available governance documentation provided by the Trust and communication with the family of the deceased mother.

10.18 Although statistical analysis of the maternal deaths is limited due to the small numbers, the review team noted the relatively high number of direct maternal deaths at the Trust. This is in contrast to the overall national trend, where direct deaths have been declining since 2004[196]. This may be an indication that the care for pregnancy related conditions such as pre-eclampsia (PET), sepsis and major obstetric haemorrhage needs to be further improved locally.

10.19 The review team noted that all but one woman who died were of white ethnicity, a patient group which usually has a lower risk for mortality in pregnancy. Seven of the women who died were classified as obese at booking for maternity care (BMI> 30 kg/m2) and therefore were of higher risk for pregnancy related complications.

192 See glossary

193 See glossary

194 See glossary

195 Department of Health, Records Management: NHS Code of Practice: Parts 1 and 2: 2006, revised 2009 and 2016, include reference to HSC 1998/217: Preservation, Retention and Destruction of GP General Medical Services Records Relating to Patients (Replacement for FHSL (94) (30))

196 MBRRACE-UK, Saving Lives, Improving Mother's Care (2020)

10.20 Two maternal deaths did not have a coroner's inquest. In three cases where there was a coroner's inquest the review team commented further on the cause of death as stated by the coroner:

*In **2002** a woman with pre-existing lung disease developed pre-eclampsia and had inappropriate fluid management with significant fluid overload, over many days. She later died from acute respiratory distress syndrome (ARDS). The pathologist at the inquest speculated that very high oxygen levels during ventilation on the intensive care unit led to the ARDS. The underlying respiratory condition and inappropriate fluid management were not identified at the inquest. The review team is of the opinion that this was a missed opportunity for learning from the death of this woman.*

10.21 *In **2014** a woman with poorly managed sepsis and prolonged resuscitation efforts was found to have squamous epithelial cells in the pulmonary vessels at the post-mortem investigation and the cause of death was determined as amniotic fluid embolism (AFE). The review ream is of the opinion that fetal squamous cells in the systemic or pulmonary circulation of the deceased is not necessarily proof that she died of AFE and that sepsis was a significant contributing factor. The review team is also of the opinion that this was a missed opportunity for learning from the death of this woman.*

10.22 *The post-mortem investigation in a woman who died of major obstetric haemorrhage in **2017** found evidence for an undiagnosed cardiac condition, which was classified as contributory to the death The review team is of the opinion that there is no evidence that the woman was affected by the cardiac condition in any way and that this did not contribute to her death.*

10.23 The clinical care and quality of the subsequent investigation were rated by agreement between the review team members as per below:

GRADING OF CARE	DEFINITION
0 Appropriate	Appropriate care in line with best practice at the time.
1 Minor Concerns	Care could have been improved, but different management would have made no difference to the outcome.
2 Significant Concerns	Sub-optimal care in which different management might have made a difference to the outcome.
3 Major Concerns	Sub-optimal care in which different management would reasonably be expected to have made a difference to the outcome.

10.24 The quality of the incident investigation root cause analysis or RCA at the Trust was rated differently depending on the year the incident occurred, to reflect the national developments in incident reporting and investigation.

For cases up to and including 2010:

	INVESTIGATION	FAMILY INVOLVEMENT
Appropriate	Incident investigated by team of clinicians. Evidence of recommendations for improvement.	Compassionate communication with family at time of incident.
Poor	Any of the above missing.	Very little or non-compassionate communication with family.
None	Incident not investigated.	No family involvement.

For cases from 2011:

	INVESTIGATION	FAMILY INVOLVEMENT
Appropriate	Incident investigated by team of clinicians. Appropriate collection of evidence (statements, notes, policies etc.) Appropriate care and service delivery problems identified. Strong recommendations for improvement with clear plan for implementation.	Families involved in investigation by compassionate communication with them at the time of incident. Feedback to the family once investigation concluded.
Poor	Any of the above missing.	Very little family involvement or feedback after the investigation.
None	Incident not investigated.	No family involvement.

Grading of care

10.25 The review team reviewed the maternal death cases individually prior to agreeing the grading at multidisciplinary team discussions. With hindsight, one will often judge a past decision by its outcome instead of based on the quality of the decision at the time it was made, given what was known at that time. The review team is conscious of the fact that there is a danger of judging past care decisions by the outcome, instead of based on the quality of the decision made at the time, which can lead to outcome bias when applying any grading of care. It is important to note that all cases were reviewed in accordance with best clinical practice and guidelines available at the time of the incident, to avoid outcome bias as much as possible.

10.26 The reviewers found none of the maternal death cases had received care in line with best practice at the time (grade 0). Three cases were found as requiring improvement in care, however, the eventual outcome would not have changed (grade 1). In six cases the care was rated as 2, meaning the reviewers found suboptimal care of the women and different management might have changed the eventual outcome. Three cases were graded as 3, where the eventual outcome could have reasonably been expected to be avoidable, had the care been different.

Grading and analysis of internal investigations

10.27 In line with the Terms of Reference of the review, all available governance documentation and family communication were reviewed in the context of best practice at the relevant time. A total of 11 incident investigations were considered. However, in some cases no comprehensive serious incident (SI) report was available (as would have been the expectation), but rather an abbreviated High Risk Case Review (HRCR), in the form of a spreadsheet. This appears to have been an internal Trust review process that has not been seen outside the Trust by review team members. It was not always clear to the review team whether, and if so how, these were shared with the families of the deceased women.

10.28 One maternal death in **2017** was investigated by an external provider. The review team agreed that the standard of the investigation was appropriate.

10.29 A maternal death that occurred in **2002** was not investigated by the Trust as the care was rated by them as appropriate, a finding with which the review team fundamentally disagree. The Trust maternity governance team noted *'This case was reported as a serious untoward incident and also a full report sent to CEMD (Confidential Enquiry into Maternal Death). It was also discussed at the mortality meeting, but it was felt*

that there were no lessons to be learned. This was a high risk pregnancy and Mrs X was aware of the potential effect this could have on her future. The staff were extremely saddened by her death'.

10.30 The review team acknowledges that the pregnancy in this case from **2002** was high risk, however there were multiple missed opportunities and a lack of understanding in regard to the mother's underlying condition and poor management of developing complications. The family in conversation with the chair of the review has explained how they felt the Trust 'blamed' the mother and her husband for her death, because had the mother not got pregnant she would not have died.

10.31 In another case in **2001** the family made three requests via the NHS complaints procedure for an external review into the death of the mother. It was finally arranged by the Trust's lay chairman and complaints convenor two years after the death in 2003 and identified significant issues in the care. In their letter to the family it is stated *'The lay chairman and I agree that there has been a long period of local resolution, including a meeting with the consultant in charge…and several letters from the chief executive. In fact, this is the third request for an independent review. The independent clinical advice supports your view that there are still significant issues which need to be addressed concerning the standard of care provided…'* From the available documentation the review team can conclude that the initial investigation into the death by the Trust was poor.

10.32 The review team rated all available Trust investigations into these maternal deaths as poor. We found repeatedly that significant omissions in care were not identified by the Trust investigators, leading to missed opportunities for learning that could affect the outcome for other women and babies in the future.

Findings

10.33 Many RCAs did not involve a multidisciplinary team, even if there were multiple professions involved in the care of the woman (for example there was usually an absence of specialities such as obstetric anaesthesia, intensive care, infectious diseases, cardiology and/or haematology). Frequently only a few internal maternity staff performed the investigations and even at mortality and morbidity review meetings a truly multidisciplinary discussion did not happen.

10.34 It appears that all these cases of maternal deaths were investigated purely internally, with no external expert opinion sought, except in the one case mentioned above.

10.35 If and when post-mortem results became available during the investigation that seemingly pointed to a direction of an 'inevitable outcome', the direction of the investigation changed in such a way that detailed scrutiny and holistic review of the entire care did not happen.

10.36 Issues in care that were identified were frequently treated as individual failings and actioned by 'internal reflection' of involved staff. The investigations did not follow the appropriate systems-based approach as outlined in the relevant NHS incident frameworks and significant learning opportunities for the Trust and the wider maternity teams were lost. These frameworks are discussed further in the report chapter focussing on clinical governance.

10.37 The review team noted that frequently the women themselves were blamed or held responsible for the adverse outcomes, without identifying underlying and obvious failings in care. A husband recalled how in **2011** his deceased wife was blamed when he was told: *'[it was] difficult for the midwives to listen to baby's heart beat due to her size'.* This was also recorded in the maternity records. Trust documentation pertaining to a maternal death in **2002** stated *'…she knew of the risks [related to pregnancy] and accepted these'.* In another case in 2002 the following was said *'...she must have been responsible for some of that because she clearly did not complain very much and tended to ignore many of her symptoms…'.*

10.38 In one case in 2014 there was a significant discordance between what was discussed with the relevant clinicians involved in the incident by email and the stated outcome of the internal incident investigation. The Trust investigation concluded *'no deviation in care and management identified relating to root cause'.* However, in emails that were sent by one of the lead investigators to individual staff involved in the care

of the mother, it is clear that significant omissions in care were identified: '*…none felt that discharge to the antenatal ward at that point was the correct action'.* This case highlights significant cultural problems in the Trust at the time. There appeared to be a lack of ability to come together and examine why this happened. There was no insight into the problem resulting in a poor investigation, which later informed the coroner's inquest. This affirms the overall findings of the review team that significant contributory factors and/or the root causes for poor outcomes were not identified, or to the extent they were identified, were not addressed with a robust action plan; demonstrating a lack of rigour and transparency in the RCA investigations.

10.39 There is also evidence from the available governance documentation and conversations with families that in some cases failings in care were not communicated in an open and transparent way, once the investigations were completed.

10.40 *In **2006** a woman with an underlying cardiac condition, developed significant tachycardia and low blood pressure after the delivery. In a meeting with the family after the investigation they were told that 'The ECG of a pregnant woman can be misleading to a junior doctor with general medical experience; as it can appear to suggest the heart is not coping; which is incorrect and a normal rhythm in pregnancy.' At no point was it discussed with the family as to whether this complication should have been escalated to a more senior doctor or cardiologist. There was also a missed opportunity to manage and treat the underlying causes of the tachycardia.*

10.41 *In **2014** another family who questioned the appropriateness of treatment for maternal sepsis were told in a debriefing meeting that 'she did not have signs of profound infection' which is not corroborated by the clinical notes. The internal discussion at the Trust regarding the serious incident found that the sepsis treatment had been not well coordinated, but this was not disclosed to the family.*

Learning from maternal deaths

Local Actions for Learning and Immediate and Essential Actions from report 1:

10.42 The review team re-emphasises the importance of the previous Local Actions for Learning for the Trust and Immediate and Essential Actions for the wider maternity system from their first report regarding the learning from the maternal deaths at the Trust. They can be found in Appendix 2 and form a vital part of the ongoing learning for the Trust and wider maternity system. In particular continued focus must be around timely escalation to an appropriately senior level and multidisciplinary team working. MDT training involving maternity teams working with ITU, anaesthetic and other colleagues in management of the deteriorating pregnant woman is needed. This will ensure the right team are always available with the skills to manage complexity.

LOCAL ACTIONS FOR LEARNING: MATERNAL DEATHS
The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

10.43 In view of the relatively high number of direct maternal deaths, the Trust's current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the LMS.

Chapter 11

Obstetric anaesthesia

11.1 Expert advice was sought from anaesthetist colleagues within the Maternity Review Team for a number of cases. Criteria for anaesthetic review for this report were the presence of severe pre-eclampsia or HELLP; eclampsia; postpartum haemorrhage of 3000ml or more; significant pre-existing maternal medical disease; and concerns regarding the management of obstetric anaesthesia. As a consequence, 68 cases were referred to anaesthetists within the Review Team. This is a small percentage of the overall number of cases reviewed in this report and an even smaller proportion of the overall number of maternities taking place at the Trust during the past two decades. Consequently, there is a limit as to how representative of anaesthetic provision at the Trust these cases can be considered to be. However, there were a number of recurring themes that are worthy of comment to facilitate further learning.

Anaesthetists and the multidisciplinary team

11.2 The role of the anaesthetist on duty for obstetric anaesthesia is much broader than being merely a technician for provision of pain relief and anaesthesia. They must also work as part of the multidisciplinary team in the management of women experiencing pregnancies or childbirth, complicated by certain obstetric issues or pre-existing medical disease. As described in the first report, the review team again found evidence that anaesthetic input on the labour ward was often task-focussed and lacking consideration of the wider clinical picture of the women in their care.

11.3 *In **2012**, ten days after emergency caesarean a woman was displaying florid signs of sepsis and a decision was made to reopen her wound. The specialty doctor anaesthetist gave appropriate intraoperative care at laparotomy which revealed pus in the caesarean wound and pus within the peritoneum[197]. However, there was no evidence of discussion regarding where the patient would be best managed postoperatively and no postoperative instructions were documented by the anaesthetist. She was discharged back to the labour ward overnight and stepped down to the postnatal ward the following day despite the patient's concerns about her breathing. A respiratory examination was not undertaken until the second postoperative day when the patient was experiencing chest pain and had a significant oxygen requirement. She was later found to have a loculated empyema[198] for which she was admitted to the high dependency unit and later transferred to another hospital for surgical management. There was no anaesthetic input into the subsequent high risk case review. (2012)*

11.4 *In **2019**, a woman developed severe intraoperative hypertension under spinal anaesthesia. Early the following morning the midwife noted unilateral arm and leg weakness and requested an assessment by the anaesthetist who suggested that this was a residual effect of the spinal anaesthetic, but did not document their review. Later in the day, after no improvement, a further review was requested and documented and the anaesthetist escalated their concerns to the consultant anaesthetist and medical team. A CT scan ten hours after initial concerns were raised revealed a subarachnoid haemorrhage[199] an internal Trust review of the case by a consultant anaesthetist found no problems with the anaesthetic care. (2019)*

11.5 As well as occasions where anaesthetists failed to involve themselves in the care of critically ill women, there were cases where the obstetric and midwifery teams failed to involve or inform the anaesthetist on duty about women with significant morbidity. Often the anaesthetist was only called to review a patient once a decision had been made to take them to theatre, sometimes for very urgent surgery, thus denying the anaesthetist the opportunity to make a considered assessment of the patient and to take steps to optimise the patient's condition prior to anaesthesia.

197 See glossary
198 See glossary
199 See glossary

11.6 *In **2004**, at 0520h, 50 minutes after a vaginal delivery, a woman had bled in excess of 1000ml. The midwife did not escalate this to the obstetric team until 0550h who, in turn, did not alert the anaesthetist until 0730h, just prior to transferring the patient to theatre for an examination under anaesthetic. Local guidelines regarding key personnel to be notified in the event of post-partum haemorrhage were therefore not followed. The woman raised concerns about her care when she subsequently attended an obstetric outpatient appointment. There is no evidence that her case was reviewed by the maternity governance team even though the consultant obstetrician stated in his letter from that appointment that it should be. The consultant mentioned that she would have a midwifery debrief appointment in order to address 'her various anxieties'. (2004)*

11.7 *In **2006**, ten days after an emergency caesarean section a woman was readmitted with collapse and blood loss in excess of a litre. Despite a decision within 20 minutes of admission by the consultant obstetrician that the patient would need an examination under anaesthesia, there is no evidence that the anaesthetist was notified for more than 4 hours (contrary to the Trust's postpartum haemorrhage guidance at the time). The anaesthetist assessed the patient 9 minutes before she was transferred to theatre. She was so unstable that she required a general anaesthetic, hysterectomy, and a blood transfusion of 11 units. An incident report was submitted but a consultant obstetrician decided that a high risk case review was not required. The consultant wrote to the obstetrician who performed the caesarean section stating that 'care throughout [the readmission with postpartum haemorrhage] seems to have been appropriate and decision making made at the appropriate level' but queried the possibility of injury to the uterus at caesarean section. (2006)*

11.8 *In **2008**, a multiparous woman was admitted with raised inflammatory markers[200] after premature rupture of membranes at 33 weeks of pregnancy. A scan the day after admission showed the baby was in a footling breech position. Despite a recognised high probability of the need for early delivery, the anaesthetist was not called to review the patient until a decision was made for a category 1 caesarean section when the patient had reached 7cm cervical dilatation 6 days later. There is no evidence of learning arising from this case. (2008)*

11.9 *In **2018**, despite repeated previous admissions with antepartum haemorrhage in a woman with known low anterior placenta accreta[201], the duty anaesthetist was not alerted to the presence of the woman in the hospital until the decision was made that she required a category 2 caesarean section, almost 36 hours after her admission with a further antepartum haemorrhage. Escalation by the duty anaesthetist to senior anaesthetic staff and involvement of additional theatre staff was then swift and her overall anaesthetic care good and safe. There is no governance documentation relating to this case. (2018)*

11.10 Failure of anaesthetic and obstetric resident on-call teams to escalate promptly to senior staff during times of high workload or when managing deteriorating or very ill women was noted in this review's first report and seen again in further cases reviewed for this current report. In response to a Local Action for Learning point from the first report, the Trust now has a specific guideline advising when the on-call consultant anaesthetist must be contacted by the resident anaesthetist. However, as with all guidelines advising on escalation to specific personnel (including the ones that were not followed in the vignettes below), this will only result in service improvement if its advice is adhered to, and if the consultant on-call is free to attend. Anaesthetic staffing at the Trust remains a concern which is discussed later in this chapter.

11.11 *In **2004**, the resident anaesthetist was called at 0530h to see a woman in labour following an intrauterine death thought to be due to placental abruption. He was unable to attend for an hour and a half due to workload, by which time the patient had bled 1400ml and was tachycardic[202].There is no evidence that this incident was reported or that any investigation or learning occurred.(2004)*

11.12 *In **2013**, a woman had labour induced due to pre-eclampsia. She had significant oedema, headache and visual disturbance. Her blood pressure was 166/115mmHg and she was struggling to cope with the impact*

200 See glossary

201 See glossary

202 See glossary

of an oxytocin infusion on her labour pains. 2h 25min elapsed between the duty anaesthetist being called and their attendance to site the epidural as they were busy in theatre. During this time the oxytocin infusion had to be switched off due to the woman's distress. Once the epidural was sited, the anaesthetist left the midwife to administer the initial doses, contrary to Trust guidance, as they were called for a category 1 caesarean section for another patient. There is no evidence that efforts were made to contact another resident anaesthetist or the consultant on-call to assist with the workload. An incident report was submitted about an unrelated aspect of her peripartum care, but no action plan or investigation was documented or made available to the review team. (2013)

Anaesthetic services, workforce and leadership

11.13 The first report raised concerns about anaesthetic staffing at the Trust, in particular at consultant level. The 2017 RCOG report[203] commented that anaesthetic consultant staffing was non-compliant with the 2013 Obstetric Anaesthetists' Association/Association of Anaesthetists of Great Britain & Ireland (OAA/AAGBI) Guidelines for Obstetric Anaesthesia Services[204] which recommended 12 consultant anaesthetist sessions per week to cover just the emergency work of the labour ward, with additional sessions required for management of clinics and elective caesarean list workload.

11.14 The Trust has a document reflecting its anaesthetic staffing and plans: Strategy for Staffing Levels – Obstetric Anaesthetists and Assistants. Its first iteration was in 2010 and it has been amended over the years in response to service changes, audits, and a Clinical Negligence Scheme for Trusts (CNST) report, with a full review and update in 2015. At that point, the Trust self-evaluated that it required 14 sessions of anaesthetic consultant cover in order to comply with the OAA/AAGBI guidance but that it had a shortfall of three consultant sessions. Prospective cover for leave involved cover by another consultant or a specialty doctor.

11.15 By 2018 the self-evaluated number of sessions that required cover had risen to 16 but actual staffing remained static at coverage of 11 sessions only, a deficit of 5 sessions. Since the publication of the first report, the Trust has advised the review team that elective lists and clinics are almost always staffed by a consultant grade anaesthetist but that the labour ward only has dedicated consultant cover 50% of normal daytime hours. This falls short of current guidance from the Royal College of Anaesthetists (RCoA) as detailed in the Guidelines for the Provision of Anaesthetic Services (GPAS)[205].

11.16 The review team has been advised by the Trust that, out-of-hours, the anaesthetic consultant on-call at The Princess Royal Hospital, Telford, has responsibility for general theatres, intensive care, paediatrics, and the head and neck surgical service as well as obstetrics. This results in situations where, understandably, they are unable to be in more than one place at a time. The review team has been advised by staff that attempts to recruit new consultant anaesthetists in order to provide a separate rota to cover intensive care have so far been unsuccessful. The required training and skillset of the obstetric anaesthetists and also that required for the non-obstetric anaesthetists who cover the maternity service out-of-hours is not specified in RCoA's guidelines. The Trust's Strategy for Staffing Levels – Obstetric Anaesthetists and Assistants document states that *'Staff are made aware of the availability and access to all guidelines, protocols and policies during their induction'* but does not give any more detail on any measures taken to assure staff training and updates. A list of consultants who provide input to the on-call service has been provided by the Trust and it is notable that a significant proportion are locums. There is a nominated lead obstetric anaesthetist who has an active role in leading and managing the service, and this is reflected in their job plan.

11.17 A team of specialty doctors provide the out-of-hours and much of the within hours resident cover to the maternity service. They are described by the lead obstetric anaesthetist as a 'senior stable workforce'.

203 The RCOG report -Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust July 2017

204 OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, June 2013, London

205 Guidelines for Provision of Anaesthesia Services (Chapter 9 Guidelines for Provision of Anaesthesia Services for an Obstetric Population 2020). RCoA. (https://rcoa.ac.uk/gpas/chapter-9)

Doctors in training spend daytime hours on obstetrics but have not contributed to out-of-hours provision since 2011. The Trust has provided no detail to describe the training and ongoing development of the specialty doctor group of anaesthetists upon which the service relies so very heavily. Access to learning and development opportunities can be limited for staff grade, associate specialist and specialty doctors (SAS) generally within the NHS, specifically in comparison to consultant colleagues or doctors in formal training programmes. This may be due to the role of SAS doctors in managing service pressures and their lower supporting professional activity (SPA) allowance compared to consultant staff.

11.18 A member of staff talking to the review team in the autumn of 2021 told us; *'We're just about functioning but we are having to use locums and every week you look at the system and it's just a mess of extra people doing different lists, slotting in. So we're getting by, you know, week to week. It's quite a challenge…you raise your concerns and everybody says yes, yes, this is a big concern but nothing really happens'.*

Management of common obstetric conditions

11.19 In a surprisingly large proportion of the cases reviewed for this report, common obstetric conditions were not recognised or not managed in line with established guidelines. There is evidence of women receiving excessive volumes of intravenous fluid prescribed by both anaesthetists and obstetricians. This took place in the presence of severe pre-eclampsia, contrary to local and national guidance regarding fluid restriction in such circumstances, and also after post-partum haemorrhage. In some cases, the women were displaying clear signs and symptoms of fluid overload over a protracted period before it was noted by medical staff.

11.20 *In **2004**, after discharge to recovery following examination under anaesthesia for post-partum haemorrhage, the patient continued with 100-150ml intravenous fluids per hour despite plentiful oral intake. Some 3.5 hours later she was noted to be desaturating and an hour after that she complained that her hands felt 'tight' and they were documented as oedematous. Her urine output overnight peaked at 320ml/h. An obstetric SHO prescribed a further two units of blood as there was a decrease in the woman's haemoglobin. The following morning, with oxygen saturations of 88% on air, she was finally diagnosed as being fluid overloaded. She passed 1600ml of urine in the hour after she was given intravenous furosemide[206] and shortly afterwards was able to stop oxygen therapy. (2004)*

11.21 *A woman who had symptoms and signs of severe pre-eclampsia in **2008** had her baby delivered by caesarean section after failed induction of labour. She was diagnosed with left ventricular failure[207] and pulmonary oedema[208] in the postoperative period when she had a positive fluid balance in excess of 2000mls. Fluid administration was consistently in excess of the nationally advised limit of 80ml/h with 1500ml being given in theatre alone. A handwritten note in the patient's hospital records stated that her case had been discussed at a governance meeting, but no documents reflecting this were supplied to the review team by the Trust. (2008)*

11.22 Obstetric haemorrhage is a common condition that all staff involved in the care of obstetric patients must be confident in recognising and managing. However, there were a number of instances where the obstetric and anaesthetic teams seemed slow to diagnose bleeding as the underlying cause of a woman's deterioration. For example:

11.23 *In the early hours of the morning after an elective caesarean section in **2012**, a woman became progressively tachycardic and hypotensive[209] feeling hot, clammy and dizzy, with a sense of ringing in her ears, vomiting, and loss of consciousness with a brief seizure. Despite a 30g/l drop in haemoglobin on blood gas sample analysis, raised lactate, and uterine tenderness, the staff grade anaesthetist who was called to see her (and the obstetric on-call team) did not recognise that the patient was bleeding as there was 'no excessive*

206 See glossary
207 See glossary
208 See glossary
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blood loss seen'. The medical registrar was called to comment on the seizure and suggested bleeding as an underlying cause. She was finally diagnosed as such once the obstetric consultant was contacted. An incident report was submitted, but there are no other documents available related to the case. (2012)

11.24 *Following a vaginal delivery in **2016** a woman suffered a postpartum haemorrhage which resulted in tachycardia, hypotension, and the administration of 3.5 litres of crystalloid[210] by the obstetric team. The haemoglobin pre-delivery was 123g/l and at its lowest was 60g/l. The obstetric registrar estimated blood loss as 1000ml and wanted to take the patient to theatre for an examination under anaesthetic. The consultant anaesthetist estimated blood loss as 2000-3000ml. The consultant obstetrician estimated blood loss as 1200ml and overruled the plan for examination under anaesthesia. After a unit of blood that day and three the following day, the haemoglobin improved to 89g/l. A blood loss of just 800ml was later documented on the woman's discharge summary. When the woman was readmitted a month later she had a large remnant of placenta removed under anaesthesia and required a further blood transfusion. There was no incident reporting concerning these events. (2016)*

11.25 Local Actions for Learning from our first report highlighted the need for development of evidence-based guidelines and multidisciplinary training for developing and maintaining staff skills in the diagnosis and management of obstetric conditions. The Trust's anaesthetists have worked to create a full range of obstetric anaesthesia guidelines in response to the first report, and now acknowledge the challenge in embedding them into clinical practice and monitoring adherence to them. It is reassuring to hear from staff interviews that obstetric skills and drills are now undertaken regularly on the labour ward and involve the multidisciplinary team, including the anaesthetists.

Postnatal follow-up

11.26 In the process of undertaking reviews of clinical records for the purposes of this report, it is apparent that many women who experienced complications did not have the opportunity to have a proper discussion with clinicians about their peripartum care. On occasion there has been poor practice and care on the part of the Trust that has not been adequately discussed, and on other occasions women have had a complicated and difficult childbirth. From the communications between women, their families and the review team it is clear that a sense of not being listened to, as well as a lack of understanding about peripartum events, has persisted for some women and families for many years, impacting negatively on their psychological state, even now.

11.27 With the power of retrospection, it is clear that many women would benefit from postnatal discussion with clinicians who can actually give individualised answers about their care. Such discussion can occur at the time of events taking place but must be reinforced after discharge, when women are more able to gather their thoughts and questions in advance of a meeting, be supported by the presence of a friend, relative or advocate if they so choose, and take notes of answers.

11.28 Outpatient postnatal follow-up by an anaesthetist must be offered for women for whom significant issues have occurred, especially where they may impact on anaesthesia management or anxiety during future childbirth. Such issues include inherent anaesthetic complications such as intraoperative pain, including where conversion to general anaesthesia became necessary, suboptimal epidural pain control with significant consequent distress, and postdural puncture headache. More serious complications such as awareness under general anaesthetic and neurological complications related to anaesthesia must also be followed-up in an outpatient setting. Clinicians must also recognise situations where women would benefit from a conversation and explanations regarding their anaesthetic care even when nothing has actually gone wrong. Provision of such appointments must be seen as part of a culture of openness and willingness to maximise improvement of patient care, rather than as an admission of failure on the part of the Trust.

210 See glossary

11.29 *A woman made contact with the Review Team regarding her 'horrendous' experience of pain during caesarean section under epidural top-up with intraoperative conversion to general anaesthesia in **1999**. Despite the passage of time, the experience still causes the woman distress to this day. On review of the medical records it is clear that the epidural never offered adequate pain relief in labour and there is no evidence that the top-up for surgery was checked for adequacy. Twenty minutes after arriving in theatre the patient was given a general anaesthetic with a note documenting 'switch to GA after initial incision for surgical reasons'. After a midwifery debrief, the patient's notes were passed to a consultant anaesthetist who wrote a note saying that 'bar reassurance, probably there is no specific reason to see her'. Although this case occurred before the main period of the review, it is included here as a reminder to all clinicians involved in maternity care how psychological injuries may persist for years afterwards. Efforts must be made to minimise such occurrences and to provide adequate help to manage the consequences of such events when they do occur.*

11.30 *Two days after an emergency caesarean in **2017**, a woman was admitted to HDU with acute lung injury. A confusing and conflicting range of underlying diagnoses were reflected in the notes and discussed with the patient by the obstetric, anaesthetic and respiratory teams. At discharge, the patient asked about the possibility of a debrief with an obstetrician. She later had a debrief with a midwife only, where no further insights on the woman's underlying medical diagnoses were discussed and she remained unclear as to what had caused her significant illness. Over a year later she was still requiring psychological support. In this case a multi-professional meeting with clinicians who had been involved in her care would have been more appropriate than a midwife-only debrief. (2017)*

Documentation

11.31 On performing reviews of medical records for this report, midwifery documentation has tended to offer the most consistent evidence for understanding the development and timing of events. Brief reviews by both obstetric and anaesthetic doctors are often not documented by the doctors themselves despite being of clinical significance, and anaesthetic documentation is commonly restricted to an anaesthetic chart only. Documentation on the anaesthetic charts was frequently patchy, lacking detail of block adequacy achieved before surgery, or medication administered.

11.32 *Despite attending a patient with massive antepartum haemorrhage, the duty anaesthetist in **2004** did not document their actions or plan. The patient was reviewed a number of times over the course of the subsequent day by a consultant anaesthetist who again did not document anything. Their reviews, actions and advice were documented by the midwife only. (2004)*

11.33 *Following a category 1 caesarean section for antepartum haemorrhage complicated by massive obstetric haemorrhage in **2015** the patient remained cardiovascularly compromised for a time period in recovery, as evidenced by low blood pressure and high heart rate on her observation chart. The healthcare worker who completed the observation chart also documented the presence of the consultant anaesthetist for the full 45 minutes of that instability, although the anaesthetist made no entry in the notes. (2015)*

Learning from adverse outcomes

11.34 An important part of the purpose of reporting adverse events is in order to inform staff about the possibility of risks, to learn from the adverse outcomes of the practice of others, as well as oneself, and to take steps, where possible, to minimise similar occurrences in future. Failure to learn from such occurrences and share reflections with colleagues, risks a failure of 'institutional memory' and may result in repeated and needless patient harm. Staff of all grades and specialties benefit from continual peer and self-review of their practice in the form of morbidity and mortality meetings. Just 39 incident reports concerning obstetric anaesthesia were submitted in the Trust during the time period 2008-2021. The Trust must consider whether such a low reporting rate indicates staff acceptance of poor practice and complications, or a lack of faith that reporting can effect change.

11.35 *A spinal anaesthetic was sited for a forceps delivery in **2010**. Documentation on the anaesthetic chart stated 'no pain on insertion/injection'. The woman developed foot and leg pain the following day but the anaesthetist declined to review the patient as they 'thought it unlikely to be related to spinal anaesthesia'. An MRI requested by the orthopaedic team showed oedema[211] of a low-lying and tethered conus[212]. Documentation of subsequent discussion between the anaesthetist and the woman reflects that she had actually experienced 'electric shock' pains on initial spinal insertion but the anaesthetist wrote that they had withdrawn the spinal needle when this had occurred. There was no explanation as to why there was a discrepancy between the documentation on the anaesthetic chart and the subsequent conversation. The patient needed ongoing management for neuropathic pain and foot drop after discharge. The chief executive's response to a complaint letter included the statement: 'Training is not an issue as [the anaesthetist's] main activity is undertaking epidural and spinal anaesthetics in the maternity department'. (2010)*

11.36 *In **2012**, a woman experienced non-postural headache and focal neurological symptoms after an epidural for labour by a staff grade anaesthetist (which took a number of attempts to insert, worked sub-optimally, and was sited more than five hours after it was requested due to labour ward workload). It was only on her fourth readmission with symptoms that brain imaging was undertaken and bilateral subdural haemorrhage diagnosed. In the Trust's response to her complaint letter, it stated that the anaesthetist had said that the subdural haemorrhage could not have related to an accidental dural puncture as none was noted at the time of epidural insertion, thus failing to acknowledge that unrecognised dural puncture may take place. Possible causes suggested in the letter were high blood pressure in labour, the stress of her baby being admitted to the neonatal unit, and a pre-existing neurological susceptibility. (2012)*

11.37 *In **2018**, a root cause analysis into the management of a woman with what was considered to be an atypical presentation of pre-eclampsia (drowsiness, reduced level of consciousness in conjunction with elevated blood pressure, headache, vomiting and epigastric pain) looked at statements from three midwives and an obstetric middle grade. It did not involve the consultant anaesthetist or consultant obstetrician involved in the patient's care at the time culminating in her emergency caesarean section and seizure. Nor did it address the failure of the obstetric and midwifery teams to check on blood results taken in triage the night before, when the woman was assessed and discharged home, which would have shown her to be severely hypercalcaemic[213]. Nor did it investigate how an incorrect (elevated) value of INR[214] was verbally reported to the team caring for her, resulting in unnecessary administration of blood products, a decision not to perform a planned lumbar puncture, and a decision not to manage a fibroid at the time of caesarean section. (2018)*

11.38 Anaesthetists should be included in and engage fully with the multidisciplinary team, both clinically, and in maternity governance activity. The Trust's Women's and Children's Root Cause Analysis planning proforma in use in 2018 has a list of job roles with the option of indicating who should be present. None of the 17 job roles listed is that of consultant anaesthetist.

11.39 Involvement of the anaesthetic team in governance activity requires a change in culture and attitude but also requires time and planning. Departmental leads and the executive team must address the resource requirements necessary for anaesthetists to take an active role in obstetric governance and ensure time away from clinical commitments is allowed for this purpose in anaesthetic staff job plans. This will necessarily have cost and recruitment implications. Conflicts of demands on the time of consultant anaesthetists must be addressed at executive level and not left solely to individual anaesthetists to resolve.

11.40 The terms of reference for the Trust's maternity governance meetings from January 2018 state that an anaesthetist is required to attend every three months – minutes of attendance suggest that even this low benchmark is not being achieved. It is important that, even in times of high clinical workload, anaesthetic presence at governance meetings must be maintained to ensure the safety and the integrity of the service in the longer term. This is certainly challenging if, as Trust staff advised the review team, there are still considerable issues with consultant anaesthetic staffing.

211 See glossary
212 See glossary
213 See glossary
214 See glossary

Local Actions for Learning

11.41 The review team re-emphasises the importance of the Local Actions for Learning and Immediate and Essential Actions for obstetric anaesthesia services from the first report. These can be found in Appendices 5 and 6 and form a vital part of the ongoing learning for both the Trust and maternity services nationally.

11.42 The following Local Actions for Learning are based on themes recognised whilst undertaking the current review and must be addressed by the Trust as a priority. The RCoA 'Guidelines for Provision of Anaesthetic Services' (GPAS) document stipulates the key requirements in the provision of obstetric anaesthesia services and these Local Actions for Learning address requirements where the Trust currently falls short. We place a responsibility on the Trust's executive team to support the anaesthetic department in achieving compliance. They are also applicable to hospitals experiencing similar issues and should therefore be used to inform wider improvements in obstetric anaesthesia care.

LOCAL ACTIONS FOR LEARNING: OBSTETRIC ANAESTHESIA

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

11.43 The Trust's executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with GPAS at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave.

11.44 The Trust's executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all of the Trust's services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service.

11.45 The Trust's executive team must support the anaesthetic department to ensure that job planning facilitates the engagement of consultant anaesthetists in maternity governance activity, and all anaesthetists who cover obstetric anaesthesia in multidisciplinary maternity education and training as recommended by GPAS in 2020.

11.46 The Trust's anaesthetists have responded to the first report with the development of a wide range of new and updated obstetric anaesthesia guidelines. Audit of compliance with these guidelines must now be undertaken to ensure evidence-based care is being embedded in day-to-day practice.

11.47 The Trust's department of anaesthesia must reflect on how it will ensure learning and development based on incident reporting. After discussion within the department, written guidance must be provided to staff regarding events that require reporting.

Chapter 12

Neonatal care

Introduction

12.1 In this chapter we focus primarily on the clinical care provided by the neonatal team to babies delivered at the Trust. The majority of the care reviewed took place on the neonatal unit (NNU), but the neonatal team were involved in resuscitation of babies on the labour ward as well as managing some babies on the postnatal wards.

12.2 It is important to emphasise that in line with the terms of reference the cases reviewed only represent less than two per cent of the total births at the Trust and a small minority of neonatal admissions over the review period. Cases were ascertained due to either parental concerns about the quality of maternity care or due to poor outcomes - specifically neonatal death or brain injury. In addition, some cases came to light in the Open Book exercise arranged by the Trust which considered HIE and neonatal death as factors for referral to the review.

12.3 As well as identifying areas for improvement and learning, the review team also noted many examples of good neonatal practice and often excellent communication. The number of complaints by families about the care they received in the neonatal unit was quite low.

Organisation of neonatal services in the UK (2000-2019)

12.4 In 2001 the British Association of Perinatal Medicine (BAPM) updated its 1996 standards for hospitals providing neonatal intensive care. There was a recommendation that hospitals work together in networks and care of the smallest and sickest infants be centralised into larger centres, neonatal intensive care units (or NICU), known as level 3 units. This led to the development of managed neonatal networks and was incorporated into the Maternity Services National Service Framework in 2004. It was also recognised that clinical skills needed to be maintained in the local neonatal units (LNU), known as level 2 units, to provide short term intensive care (usually up to 48 hrs) for more mature babies in close liaison with their designated level 3 NICU.

12.5 In 2009 a Department of Health taskforce of neonatal professionals and parent representatives published a Toolkit for High Quality Neonatal Services[215] with service specifications to standardise special care, high dependency care and intensive care. In 2010 the National Institute for Health and Care Excellence (NICE)[216] published quality standards for neonatal specialist care. In most trusts compliance with these standards is reviewed through clinical governance processes.

12.6 NHS England commissions all levels of neonatal critical care. The commissioning of care is usually agreed with the neonatal network but ultimately is a formal agreement between the commissioners and the provider unit trusts.

Neonatal transport

12.7 Babies should ideally be delivered in the most appropriate setting for their predicted care needs. In utero (before delivery) transfer is preferable to postnatal transfer and has been shown to improve outcomes. However babies do sometimes need to be transferred after birth for escalation of care, or to access

215 Department of Health. Toolkit for High-Quality Neonatal Services (2009) https://webarchive.nationalarchives.gov.uk/20130123200735/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107845

216 National Institute for Health and Care Excellence. Neonatal specialist care Quality Standard (QS4) (2010)

specialist care (e.g. for neonatal surgery). Over the period of this review, neonatal transport services, which were traditionally provided and staffed by the larger NICUs, were centralised in all networks so that a dedicated transport team is responsible for moving babies between units, and since 2015 most services have had a centralised telephone triage system. In the West Midlands, a centralised team has provided transport services 24/7 since 2008. Teleconferenced triage has become available in very recent years.

Organisation of neonatal services at the Trust (2000-2019)

12.8 Following the establishment of neonatal networks in England in 2004, the Trust's neonatal services initially formed part of the Staffordshire, Shropshire and Black Country Neonatal Network (SSBCNN) becoming an operational delivery network in 2013 (SSBCODN). The NNU and the obstetric services at the Trust are located within the Shropshire Women and Children's Centre, based at the Princess Royal Hospital (PRH) in Telford, having moved there from the Royal Shrewsbury Hospital (RSH) in late 2014.

12.9 Prior to 2006 the neonatal service at the Trust provided intensive care. Since 2006, when unit categories were first defined, it has been designated as a Local Neonatal Unit (LNU) of level 2. This means that it is commissioned to provide special care and high dependency care for newborn babies, as well as intensive care for periods of up to about 48 hours. Babies requiring longer-term intensive care and singletons born at less than 27 weeks gestation, if not transferred in utero, should be discussed with and transferred to a level 3 unit (NICU).

12.10 The neonatal unit at the PRH in Telford has 22 cots and is busy compared to other LNUs with above average numbers of preterm babies admitted. In 2018-19 it provided 7,425 care episodes, which was in the top quartile of critical care activity for neonatal units providing critical care in England.

12.11 The review team heard that the neonatal service at the Trust disputed its revised designation and did not work in line with the new scope of its responsibilities. There is debate why this was. Some at the Trust felt that due to the unit's size, expertise and geographical location (including receiving babies from Wales) it should have been designated as a level 3 unit. Others at the Trust have stated that there were insufficient cots and expertise elsewhere throughout the region, although this is disputed by the neonatal network[217]. The West Midlands Neonatal Operational Delivery Network confirmed in correspondence with the Chair of this review that *'capacity in both University Hospital North Midlands (which is the care pathway for SaTH and Royal Wolverhampton Hospital NHS Trust) has rarely been so that they would not take a baby that required NICU care'.* Despite this, the review team found evidence of non-compliance by the Trust with its 2006 level 2 designation until at least 2015.

12.12 The review team noted that for a period of nine years after the designation to a level 2 unit, transfer of babies from the Trust that required intensive care did not consistently occur in line with the national and network guidelines. According to the neonatal network capacity issues were not causative. The review team is of the clear opinion that NICU care relies on a properly resourced multidisciplinary team and that the designation as a level 2 unit after 2006 should have been respected and adhered to.

12.13 Following the contested designation as a level 2 unit in 2006, the review team has been advised that network leadership and the commissioners met with the Trust on several occasions, especially after the publication of a network care pathway document in 2011 to try to ensure that neonatal care within the Trust followed the guidance.

12.14 The Royal College of Paediatrics and Child Health (RCPCH)[218] carried out an invited review in 2013. They noted that *'given the availability of experienced and dedicated neonatologists, at the time of the visit the unit cared for a number of babies under 27 weeks and provided an enhanced range of intensive care services'.* They noted that this intensive care activity was not supported by the neonatal network and that the unit would in future work as a standard level 2 local neonatal unit. The Trust continued to deliver some aspects of intensive care outside the agreed care pathway until the unit moved to the Telford site in 2014.

217 Letter to Donna Ockenden from West Midlands Neonatal ODN dated 3rd September 2021

218 Report provided to the review team by the Trust

Cases considered by the review team also demonstrated that this progressive change in neonatal care took many years to be embedded into clinical practice:

12.15 *In **2011** a baby was delivered at 26 weeks gestation after threatened preterm delivery from 23 weeks with no record of consideration of in utero transfer Senior staff were closely involved in care at the Trust with a good relationship with the family and evidence of compassionate care was seen after the poor outcome. (2011)*

12.16 In the next revision of the network care pathway in 2015, it was made more explicit that advanced therapies should not be delivered at the Trust, unless in exceptional circumstances and after discussion with a neonatologist at the Royal Stoke Hospital (now University Hospitals of North Midlands) NICU. Sometime after the move to the new unit in Telford the neonatal unit started operating at the designated level 2.

Perinatal and neonatal mortality

12.17 The perinatal mortality rate (PMR) and the neonatal mortality rate (NMR) are measures which are used as benchmarks of the quality of obstetric and neonatal care, although other factors such as socioeconomic circumstances and maternal age also have an important influence on these measures.

12.18 The MBRRACE-UK perinatal surveillance annual reports have been available since 2013, and they have provided PMR and NMR data, 'adjusted and stabilised' with regard to key contributory factors, for individual trusts from 2014[219]. The neonatal mortality rate (NMR) for the Trust was above the average for similar providers (similar numbers of births LNUs) for the years 2014–2016, but in 2017 it dropped to below the average. In 2018 and 2019 it was 'red' (more than 5 per cent above the group average). It should be noted that in all these years the NMR and PMR were comparable to many similar units and were not statistical outliers. Mortality rates for preterm babies born between 2015 -2018 were also high for babies born within the SSBCODN network and for two of its neighbouring networks.

12.19 In 2009 the neonatal service at the Trust described itself in the National Neonatal Audit Programme (NNAP) report as a NICU, despite having been designated as a level 2 NNU in 2006. This review has also been provided with documentation of a presentation to the CCG in 2018 where a Trust representative outlined that one of the reasons that the Trust felt its neonatal unit had higher perinatal mortality than its peers was because it was being compared with level 2 units (LNUs) when it had in fact been operating as a level 3 unit (and therefore accepting and continuing to care for more complex cases) until 2016. In this presentation the Trust representative made the case that therefore the figures were not representative. They stated the reason for operating at level 3 was due to capacity issues elsewhere in the network. There has been no evidence seen by the review team that capacity in other units was an issue and this has been confirmed by the neonatal network. The review team note that the data is difficult to interpret as the Trust had consistently not worked at the level it had been allocated and that it should not have taken in excess of eight years for the Trust to have worked at the level it had been designated.

National Neonatal Audit Programme

12.20 The National Neonatal Audit Programme (NNAP) has measured the quality of care delivered by neonatal units since 2006. NNAP reports available online (2014-2019) indicate that, for the limited number of quality indicators, the NNU at the Trust was performing at above the average for LNUs in the UK. In particular, the Trust NNU achieved one of the best scores compared with other LNUs for communication (the proportion of parents who meet with a senior member of the neonatal staff within the first 24 hours of admission). Temperature control of babies was also above average and eye-screening was excellent for this period.

12.21 The length of stay on the NNU at the Trust for late preterm babies and more mature babies was reported to be longer than in other NNUs - this may reflect a need to improve transitional care facilities at the Trust. In 2018 and 2019 the proportion of neonatal nurses working in the NNU at PRH who had a specific

219 MBRRACE Perinatal mortality surveillance reports 2013-2016 https://www.npeu.ox.ac.uk/mbrrace-uk/reports/perinatal-mortality-surveillance
MBRRACE Perinatal mortality surveillance report 2017 https://www.npeu.ox.ac.uk/mbrrace-uk/reports

qualification in the care of sick newborn infants was lower than the average for LNUs in the UK and appears to be falling.

Review of neonatal clinical care at the Trust

12.22 During our reviews we identified a number of cases where individual errors were made or there was poor practice. However, these were very much the exception and we have found no evidence of systemic poor neonatal practice or lack of care or compassion in the neonatal service. The review found evidence that identified failings in care were addressed by the Trust with the development of appropriate guidelines, but the review team does not know if the development of these guidelines then led to improvements in care. However, some incidents occurred with sufficient frequency, or were sufficiently important, that we feel there is scope for wider learning on a national level.

12.23 It appears from the majority of the medical records reviewed that involvement of the consultant neonatologists in the provision of neonatal care and in communication with parents was of a very high quality. The medical records invariably record that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents. There were frequent examples of the consultants being called to assist with resuscitations of newborn babies on the labour ward and in many cases their interventions led to an improvement in the short-term outcome.

12.24 Review of the medical records shows that the Trust was an early adopter of the Advanced Neonatal Nurse Practitioner (ANNP) model and that ANNPs played an important role in the management of sick or premature infants at delivery, on the neonatal unit and on the postnatal ward. We noted their practice to be appropriate and that the ANNPs formed an important part of the neonatal staffing model. The quality of their entries in the medical records was generally noted to be of a very high standard. During the reviews we did not identify any systematic concerns about nursing care.

Transfers, referrals and escalation of care

12.25 Neonatal care is most effective when delivered in close partnership with other services as discussed above. When reviewing individual cases we found evidence of effective joint working:

12.26 *In **2005**, after an uncomplicated term delivery a baby became progressively seriously ill with breathing and neurological problems. On the first day of illness the problem had been recognised as a very severe metabolic disorder and advice on care was obtained from regional and national specialist services. Despite transport to the national centre being arranged sadly it was not possible for the baby to survive. Successful genetic diagnosis allowed counselling about future risk to be provided to the family. (2005)*

12.27 *In **2010** antenatal scans had suggested the possibility that a baby might have problems and a plan was in place for assessment and care at birth After delivery it became clear that the baby could not manage to breathe strongly enough on their own and needed support from a ventilator. Specialist reviews were arranged in Shrewsbury and the required investigations quickly carried out with close involvement of regional and national services. A definitive diagnosis of a neuromuscular disorder was very quickly established and palliative care agreed with the family. We found good evidence of highly effective and compassionate care with input from multiple specialists. (2010)*

12.28 We found evidence of appropriate communication with tertiary specialists when babies required escalation for specialist care, including surgical or cardiac care and good liaison with Alder Hey and Birmingham specialists regarding MRI scans and post-mortem reports. However, in some other cases we found planned deliveries being arranged at the Trust which had not had the involvement of specialist services as would have been expected.

12.29 *In **2008**, a baby was diagnosed with significant spina bifida[220] (lumbar myelomeningocoele) with severe hydrocephalus in the antenatal period. There was no evidence of tertiary fetal medicine or neurosurgical*

220 See glossary

discussion regarding appropriate tertiary referral. The baby delivered at the Trust. There were challenges delivering respiratory support in head box oxygen[221] and baby needed support with a ventilator when the transport team arrived at 30 hours of age, before they could be moved to Birmingham Children's Hospital, (BCH). Despite continuing intensive care in the regional unit the baby developed worsening respiratory distress at BCH as well as a coagulopathy[222] and remained too ill for surgery and died. (2008)

12.30 During the period when the neonatal service continued to operate as a NICU, despite its designation as a neonatal unit, some babies were delivered with major congenital anomalies requiring high level intensive care.

12.31 *In **2008**, there was an antenatal diagnosis of diaphragmatic hernia[223]. The parents were seen by a neonatologist and plans for delivery in Shrewsbury were discussed. An antenatal appointment was offered at Alder Hey. Parents declined this as they felt they had too many appointments to attend. The surgical service were aware of the plan to deliver locally and to transfer the baby after stabilisation. No major difficulties were encountered with the baby's initial care at Shrewsbury and baby was transferred but at the tertiary unit the baby progressively deteriorated and did not survive. (2008)*

12.32 In the same year another baby with the same major anomaly was delivered in Shrewsbury:

*The baby was diagnosed in the antenatal period in **2008** with a diaphragmatic hernia. The neonatologist wrote a letter to the parents and another to the paediatric surgeons in the local surgical centre at Birmingham Children's Hospital (BCH). This states 'baby has diaphragmatic hernia, booked to deliver at RSH and as a unit that is able to perform all levels of intensive care we feel that we are in a position to offer neonatal resuscitation and stabilisation pre-surgery at Shrewsbury. One of the neonatologists will personally be on call for the lady's delivery'. (2008)*

12.33 *The regional surgical service were aware of the planned delivery with no evidence seen by the review team that that they suggested any alternative plan. The baby died after three hours after challenges in delivering aspects of intensive care. Whilst the outcome might not have been different it was not clear that the parents had been offered the opportunity to discuss options with the specialist surgeons in Birmingham prior to delivery.*

12.34 Babies found to have diaphragmatic hernia during antenatal scans are now transferred for delivery in Birmingham Women's Hospital or Liverpool Women's Hospital. In our review of the medical records it was not always apparent that early consultation with a tertiary centre, to consider planning of transfer of care where appropriate, had taken place. It is possible that such consultations did take place but were not documented in the medical records to which we had access.

12.35 *In **2011** a woman presented at 25 weeks, with a twin pregnancy complicated by twin to twin transfusion syndrome[224]. There was antenatal discussion with Birmingham but the babies were born at RSH. The first twin needed prolonged resuscitation at birth. Later in the first week he required exceptionally extensive intensive care after a large brain bleed. There was no recorded discussion with a NICU and missed opportunities to transfer out in the first 2 days before baby became critically unstable. Sadly, the baby died. The other twin died at 5 months of age in a specialist centre, with airway problems. (2011)*

Management of babies with Hypoxic-Ischaemic Encephalopathy

12.36 Hypoxic-Ischaemic Encephalopathy (HIE) is due to impaired delivery of oxygen to the brain. Until around 2010 treatment was largely supportive, although clinical trials of brain or body hypothermia were undertaken in the early 2000s and published in 2005-2009 and cooling therapy was initially offered in a limited number

221 See glossary
222 See glossary
223 See glossary
224 See glossary

of centres participating in these trials. By 2009 it was established that therapeutic hypothermia significantly reduced the incidence of death or disability from HIE and the BAPM issued a position statement on its use. At this time therapeutic hypothermia (cooling) was normally delivered in NICUs although some larger LNUs in the UK still undertook this therapy on a transitional arrangement if agreed by the network.

12.37 To be most effective, cooling should be commenced (either passively or actively) by 6 hours of age. It is important that cooling therapy follows evidence-based pathways wherever possible. We found some examples of cooling outside this pathway.

12.38 *In **2010,** a baby born after cord prolapse with an umbilical cord pH 6.8 was cooled quickly and effectively, required full intensive care including inotropes to support blood pressure and mechanical ventilation to support breathing. The baby was not discussed with or transferred to a NICU. (2010)*

12.39 The review found that the clinical management of HIE in many cases was of a good quality but found that the cooling therapy delivered at the Trust was outside the agreed network pathway for this provider which stated: *'Newly born infants who require cooling for treatment of perinatal asphyxia will have active cooling initiated at RSH prior to being transferred with continued active cooling to UHNS or New Cross Hospital the Network Lead Centres or an appropriate neonatal intensive care unit'.*

12.40 *In **2011** a baby was cooled because of HIE. The seizures were very difficult to control despite anticonvulsants and so there was a documented discussion with a NICU outside the network but with a strong research reputation for cooling, who suggested it could be extended by 24 hours. The cooling in fact continued for a total of 6 days. Whilst there was no evidence of direct harm from this, it was unusual practice and outside the advised practice. The child continued to have epilepsy through early childhood. (2011)*

12.41 We did however find evidence of good practice in that the Trust diligently reported babies receiving therapeutic hypothermia for HIE to the 'cooling registry' which gathered data after the TOBY[225] study on hypothermia was published.

Resuscitation and stabilisation at birth

12.42 The review found a number of cases where the Newborn Life Support algorithm was not followed in the correct order. In particular, where cardiac compressions were started before lung inflation had been achieved. It is vital that an airway is established and effective lung inflation achieved before moving on to cardiac compressions as they otherwise will not be effective.

12.43 Intubation of small babies is a difficult skill, and one that is increasingly hard to gain competence in as intubation opportunities have become less frequent with greater use of non-invasive ventilation. We found in general that babies were intubated on the labour ward appropriately. The Trust appeared to be relatively late adopters of CO_2 detectors (which can help confirm the endotracheal tube is correctly placed). In some cases babies had multiple extubations and intubations in the first minutes of life, either due to uncertainty about their position or due to accidental extubation.

12.44 *In **2007**, an extremely preterm baby weighing just over 500g was in poor condition at birth, and had five intubation attempts including the use of a bougie. When successfully inserted, the ET tube was inserted too far. (2007)*

12.45 *In **2008** a baby at 23 weeks born in the Trust had two accidental extubations within the first hours of life, so required three intubations in four hours. The baby deteriorated on day 10 for which they were given a third dose of surfactant (unusually late). Deterioration was found to be secondary to intestinal perforation and they were then transferred to a surgical NICU. (2008)*

225 TOBY study group. Whole body hypothermia for the treatment of perinatal asphyxial encephalopathy: A randomised controlled trial (2008) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2409316/

Communication during neonatal resuscitation

12.46 In the cases considered by this review we sometimes found that a structured approach to communication to a senior doctor in a crisis situation did not always happen. Our view is that there should be a shift in expectations such that, when it is known that senior help cannot attend immediately, a formal two-way telephone dialogue, based on the SBAR (Situation, Background, Assessment, and Recommendation) structure, should take place at the time of calling for the senior help. This two way conversation directly with the resuscitation team should involve a review of the interventions which have been tried and advice from the senior help concerning the actions to be taken pending their arrival. This situation is not unique to this Trust.

Management of hypoglycaemia (low sugar levels)

12.47 The review identified a number of cases where there was prolonged hypoglycaemia without effective or timely intervention. In some instances this was due to the need to transfer from the midwife-led unit (MLU) to the neonatal unit.

12.48 *In **2018**, a term baby was born at the MLU in Princess Royal Hospital, Telford, at 03:44 with a very slow heart rate. After the neonatal team arrived and baby was intubated the heart rate improved. On arrival at the NNU at 04:55 the baby was hypotensive, hypothermic (planned) and had an apparently unrecordable blood glucose at 05:26 and 05:43. There is no evidence of it having been measured prior to this. An emergency blood transfusion was given for low haemoglobin, but the glucose was not addressed (even having been measured) until a bolus and infusion of dextrose were given at 07:05. This is 3 hours and 20 minutes after a major resuscitation (known to deplete glucose stores) and 1.5 hours after the glucose was first noted to be unrecordable. This may have contributed to the failure of the heart to respond to inotropes, fluids and other resuscitation measures. The first dose of antibiotics was not administered until 3 hours after admission to NNU and 2 hours after it was prescribed, despite IV access being in place. This is an unacceptable delay. Sadly, the baby died. (2018)*

12.49 *In **2007**, a growth restricted term baby had very low cord pH at birth (but the baby quickly recovered with Apgar[226] scores of 8 and 10), and required only facial oxygen. A paediatrician appropriately requested to keep baby warm and establish feeds. On review at 30 minutes, they noted profound hypoglycaemia. The paediatrician instructed "commence feeds as soon as mum ready and if concerned to inform NNU". A doctor was called to review the baby when it was noted to be dusky aged 1 hour. The requested senior review said baby did not need admission. No further glucose levels documented until admitted at 13 hours, when they were normal. This baby was later diagnosed with HIE. (2007)*

Management of sepsis

12.50 In general the management of babies with suspected sepsis was in line with national recommendations and common practice. However, in the majority of cases reviewed where infection or suspected infection were part of the clinical picture, it did not seem that the use of infection markers such as C-reactive protein[227] (CRP) for 'tracking' of the progress of the infection was standard practice. This was an active decision on the part of the neonatal consultants. We have not been able to identify a situation where the absence of these measurements was likely to have had a significant influence on the clinical outcome. However, infection markers can be useful in both the identification of infection and in guiding treatment and are widely used in neonatal practice. In more recent years the Trust has adopted the use of CRP.

226 See glossary

227 See glossary

Communication with families and documentation

12.51 Case reviews almost invariably showed evidence of good communication with the parents, especially by the ANNPs and consultants. There was evidence of compassionate care for the babies and their families, especially at the end of life or when considering reorientation of care towards comfort-orientated care.

12.52 *In **2002** a baby was born at full term and unexpectedly found to have severe respiratory problems from birth. The baby was diagnosed on the neonatal unit at Shrewsbury with severe pulmonary hypoplasia, (under-development of the lungs) and sadly this was untreatable and the baby died on the first day of life. There was extensive consultant involvement in the baby's short life, including the involvement of a second consultant in reviewing an unexpectedly serious case, a consultant doing the summary letter and, most importantly, sometime after the sad death, when all results were back, the consultant visited the family at home to go through the results of the baby's post-mortem examination and other specialised tests. The review observed this as an example of exceptionally good practice. (2002)*

12.53 We also found evidence that some parents had confidence in the quality of the consultant-led neonatal follow up:

*In **2001**, a baby was delivered by forceps after an eight hour 2nd stage of labour and developed HIE. The baby was discharged home well on day 9. The parents moved to Leicestershire but declined transfer of care to a local consultant and chose to come back to Shrewsbury for each neonatal follow-up visit to maintain continuity of care. (2001)*

12.54 We found some examples where neonatologists requested that obstetricians at the Trust review a baby's care when they perceived there were unexpectedly poor outcomes.

12.55 *In **2009**, a baby was born at 42 weeks, 50 hours after rupture of membranes with the cord tightly round its neck and thick meconium, and with a low cord pH of 6.5. Fortuitously the baby had a normal MRI brain scan and was said to be developing normally at 2 years of age. After seeing the family at an outpatient appointment the neonatologist wrote first to the risk manager in August suggesting the case was reviewed. The neonatologist also wrote to the obstetrician requesting a parental meeting and wrote again in November chasing this up as the family had still not heard anything. The long term outcome of this case is not known. (2009)*

12.56 In another case the neonatologist had concerns about the care of a baby after transfer between other NICUs:

12.57 *In **2008**, a baby was born at 23+1 weeks in RSH after in utero transfer and received 11 days intensive care before being transferred to a surgical NICU due to intestinal perforation. Having received surgery the baby was repatriated to a third neonatal unit and apparently arrived in a 'shocked' condition, hypotensive and hypothermic and died 1 week later. The neonatal consultant at RSH wrote to the neonatologist at the receiving hospital suggesting they raise this with the referring surgical centre as this was 'unacceptable'. This represents evidence of concern for governance and ensuring quality of care. These examples were infrequent, but evidence a desire to ensure good quality of care for patients and their families. (2008)*

Combined medical and nursing notes

12.58 The clinical records that were reviewed had separate medical and nursing entries. This has the potential for important information not being accessed by key members of staff involved in the care of individual babies. The standard of medical and ANNP note-keeping was generally good and the admission clerking in particular was generally very comprehensive. However, there was no obvious systematic approach for daily ward round reviews, which meant that continuity of potentially important information was sometimes lacking.

12.59 Although by no means universal, prior to the introduction of electronic clinical records many NNUs had moved to having combined medical and nursing notes. The Trust now uses joint neonatal and medical notes and are moving to an electronic patient record.

Middle grade or Trust Tier 2 neonatal staffing

12.60 For some of the cases reviewed it was clear that, out of hours, middle-grade neonatal medical staff were covering the paediatric unit as well as the neonatal unit. This can compromise the availability of skilled care to both units. It is for this reason that it is a service specification for level 3 NICUs that there is separate middle-grade cover for neonatal and paediatric units and why level 2 LNUs should not undertake prolonged intensive care.

12.61 The review found evidence that in some cases this led to a delay in middle-grade attendance at deliveries and in reviewing sick babies on the neonatal unit. As already discussed the Trust were early adopters of the ANNP model and this undoubtedly provided some mitigation but it was not clear whether the neonatal unit was adequately covered at middle-grade level at all times.

Consultant neonatologist staffing

12.62 It is clear from the majority of case notes reviewed that involvement of the consultant neonatologists in clinical decision making, in the provision of neonatal care and in communication with parents and other family members was of a very high quality. The case notes usually record that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents. They were usually involved in the long-term clinic follow-up of their individual patients, providing continuity of care. Information sharing was aided by the neonatal discharge summaries often being written by a consultant. Having met with staff it is apparent to the review team that this high level of direct consultant input may have been at some personal cost and may have been offered in part due to a desire to continue as a NICU after designation as a LNU in 2006.

12.63 For some of the cases reviewed the consultant providing cover for the neonatal unit was also covering the general paediatrics service. This can also compromise the availability of skilled care. Given the size of the maternity and neonatal service at the Trust, if it was aiming to provide ongoing neonatal intensive care at the time, it would be essential to have designated neonatal consultants on call 24/7. This was highlighted by the RCPCH invited review in 2013:

12.64 *'The neonatal rota is not compliant with BAPM staffing arrangements given the level of intensity of services provided at the RSH site. There is an enthusiastic staff team keen to develop their skills and care for babies locally, and a consultant group that provides prospective cover out-of-hours, coming in to support juniors and general paediatric consultants even when not on call. This is not sustainable and must be addressed when the service moves. The current enhanced status is not supported by the network following a CCG-commissioned review of maternity services and will in future operate as a standard level 2.'*

12.65 It is the review team's understanding that separation of the neonatal and paediatric consultant on call rotas has now been achieved, and we found evidence that the neonatal service has, since the move to Telford and publication of the updated care pathway by the neonatal network in 2015, largely been operating appropriately as a level 2 Local Neonatal Unit.

LOCAL ACTIONS FOR LEARNING: NEONATAL CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

12.66 The Trust must ensure that there is a clearly documented, early consultation with a tertiary NICU for babies who require, or are anticipated to require, continuing intensive care. This must be the subject of regular audit.

12.67 As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners (ANNPs), the Trust must have a strategy for continuing recruitment, retention and training of ANNPs.

12.68 The Trust must ensure that sufficient resources are available to provide safe neonatal medical or ANNP cover at all times commensurate with a unit of this size and designation, such that short term intensive care can be safely delivered, in consultation with a NICU.

12.69 The number of neonatal nurses at the Trust who are 'qualified-in-specialty' must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review.

OCKENDEN REPORT - FINAL

Section 4

Our call for essential action following completion of this review

- Chapter 13. What happened in maternity services after our first report
- Chapter 14. Local Actions for Learning (LAfL) - the Trust
- Chapter 15. Immediate and Essential Actions to improve care and safety in maternity services (IEA) across England

Chapter 13

What happened in maternity services across England after our first report

13.1 Our first report Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust was based on a review of 250 family cases and was published on 10 December 2020. The report outlined seven Immediate and Essential Actions, (IEAs) for maternity systems across England and 27 Local Actions for Learning, (LAfL) for the Trust.

13.2 Since the publication of the first report, trusts and maternity services across England have shared their plans to ensure full implementation of the seven IEAs takes place. The NHS has been working with regions, systems and Royal Colleges to implement the IEAs. Significant funding has been provided by the NHS, although we all recognise that much more is needed. The NHS has also reviewed the Maternity Transformation Programme to ensure future plans are in line with the seven IEAs.

13.3 All trusts have now assessed their position against the IEAs and submitted evidence to demonstrate compliance which has been independently quality assured. The commitment to system-wide improvement in maternity services has also seen all NHS standard contracts include conditions whereby any provider delivering maternity services must provide and implement an action plan, approved by its governing body, describing, with timescales, how it will implement the immediate and essential actions set out in the Ockenden Review.

Additional funding for maternity services

13.4 Our first report highlighted that the amount of improvement required must be backed by real investment in maternity services.

13.5 In March 2021[228] the Government made available £95.6million of investment for maternity services across England for:

- 1,200 additional midwifery roles
- 100 whole-time equivalent consultant obstetricians
- Backfill to allow for multidisciplinary team training
- An additional midwife in every unit to support newly qualified midwives as they begin their careers.

13.6 Alongside this, in July 2021 the Government announced £2.45m[229] to be invested into maternity services. These funds were allocated to the Royal College of Obstetricians and Gynaecologists (RCOG) to find the best ways of spotting early warning signs of infants in distress.

13.7 For 2021/22, more than £80m of additional funding has been allocated to be distributed as targeted System Development Funding (SDF)[230]. This funding will be focused on areas where it will have the biggest impact on delivering the immediate and essential actions and ensuring the safety of women, babies and their families.

228 NHS England and NHS Improvement Board Meeting November 2021. Agenda Item 6: Maternity and Neonatal Services Update https://www.england.nhs.uk/wp-content/uploads/2021/11/board-item-6-251121-maternity-and-neonatal-update.pdf

229 Gov.uk press release. Government pledges £2.45million to improve childbirth care (2021) https://www.gov.uk/government/news/government-pledges-245-million-to-improve-childbirth-care

230 NHS England. Guidance on finance and contracting arrangements for H1 2021/22 (2021) https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-h1-21-22-guidance-on-finance-and-contracts-arrangements.pdf

13.8 With a shortage of midwives, and concerns around continuing attrition of midwives and obstetricians, actions have been taken to increase the workforce by recruiting midwives internationally and £4.5m funding for 2021/22 has been allocated. Additional investment has also been made in Professional Midwifery Advocates, who provide educational and psychological support for midwives, increasing the number to 800 in England. To support retention of midwives, NHSE&I has also funded a pastoral care midwife[231] role in every maternity unit during 2021/22.

13.9 With midwifery and obstetric staffing numbers continuing to cause significant concern and attrition from the midwifery profession, midwives and doctors remaining on the frontline are working tirelessly to support mothers and their babies in achieving a safe outcome.

Our call to action

Funding

13.10 Whilst the funding announcements we have seen have already made significant strides in the right direction in improving maternity services for all, much more still needs to be done. The Health and Social Care Committee report[232] on maternity safety in England, published in June 2021, stated that NHS maternity units in England needed an investment of £200-£350m to prevent women and babies dying or sustaining avoidable harm. This view was supported by the NHS Confederation[233] and we state this level of investment must be forthcoming.

Continuity of carer (CoC)

13.11 We recognise the original aim of CoC which seeks to ensure a mother receives safe and personalised care from the same midwifery team with a named midwife who coordinates the care and takes responsibility for ensuring that the needs of the woman and her baby are met through all stages of maternity care. The CoC model was introduced with little recognition of its potential impact on an already pressured maternity system across England.

13.12 Recent guidance[234] has aimed to address the concerns expressed that CoC will lead to unsafe and inconsistent staffing and provides guidance for local planning and implementation of CoC. At a time of unprecedented stress on NHS resources we continue to hear concerns relating to attempts to support this model, which can lead to inequities in care provision. The CoC model must be reviewed and suspended until all Trusts demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that CoC models of care place on maternity services already under significant strain. The reinstatement of CoC should be withheld until robust evidence is available to support its reintroduction

13.13 As a multi-professional clinical review team comprising midwives, obstetricians, neonatologists and other specialist colleagues who work within (and closely with) maternity services in trusts across England, we strive to ensure that all women receive high-quality, safe care throughout their pregnancy pathway which is tailored to their individual needs. We all recognise the challenges faced by maternity services across England as they work to ensure that the maternity care provided leads to the best possible outcomes for mothers and their babies.

13.14 In our interactions with families, we have seen clearly that the Shrewsbury and Telford Hospital NHS Trust failed to learn, failed to improve and failed to safeguard families over a prolonged period of time. This is a Trust that was also failed by the wider maternity system which did not act, and this must not happen again.

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231 Ibid n1

232 Ibid n2

233 NHS Providers letter to Rt. Hon Jeremy Hunt MP Chair, Health and Social Care Select Committee (2021) https://committees.parliament.uk/publications/6290/documents/69337/default/

234 NHS England/ I (2021) *Delivering Midwifery Continuity of Carer at full scale Guidance on planning, implementation and monitoring 2021/22* Available: https://www.england.nhs.uk/wp-content/uploads/2021/10/B0961_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf

13.15 We urge maternity services across England to continue their work in implementing the IEAs from our first report. We have seen so much excellent practice and a real desire to improve. Now, the NHS across England and the Shrewsbury and Telford Hospital NHS Trust must make ambitious plans to ensure timely implementation of the additional Local Actions for Learning, (LAfL) and Immediate and Essential Actions, (IEA) from our final report.

13.16 As difficult decisions loom about NHS funding post the COVID-pandemic, maternity services in England **must not slip down the priority list.** The scale of this review is unprecedented in NHS history and after listening to so many families, we have been given an unrivalled opportunity to change and improve maternity service provision for all parents and their families now and in the future. Together the changes we have outlined, and the demand for better funding will ensure safer outcomes for more women and families, reducing the risk of unnecessary loss of life, injury and resultant heartbreak.

Chapter 14

Local Actions for Learning (LAfL) - the Trust

Clinical governance

LOCAL ACTIONS FOR LEARNING: IMPROVING MANAGEMENT OF PATIENT SAFETY INCIDENTS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.1 Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework.

14.2 The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists and anaesthetists to undertake incident investigations.

14.3 All investigations must be undertaken by a multi-professional team of investigators and never by one individual or a single profession.

14.4 The use of HRCRs to investigate incidents must be abolished and correct processes, procedures and terminology must be used in line with the relevant Serious Incident Framework.

14.5 Individuals clinically involved in an incident should input into the evidence gathering stage, but never form part of the team that investigates the incident.

14.6 All SIs must be completed within the timeframe set out in the SI framework. Any SIs not meeting this timeline should be escalated to the Trust Board.

14.7 All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy. These training courses must commence within the next 12 months

14.8 The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms as in HSIB investigation reports.

14.9 Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.

LOCAL ACTIONS FOR LEARNING: PATIENT AND FAMILY INVOLVEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.10 The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process.

14.11 All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings.

14.12 The maternity governance team must work with their Maternity Voices Partnership (MVP) to improve how families are contacted, invited and encouraged to be involved in incident investigations.

LOCAL ACTIONS FOR LEARNING: SUPPORT FOR STAFF

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.13 There must be a robust process in place to ensure that all safety concerns raised by staff are investigated, with feedback given to the person raising the concern.

14.14 The Trust must ensure that all staff are supported during incident investigations and consideration should be given to employing a clinical psychologist to support the maternity department going forwards.

LOCAL ACTIONS FOR LEARNING: IMPROVING COMPLAINTS HANDLING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.15 Complaint responses should be empathetic and kind in their nature. The local MVP must be involved in helping design and implement a complaints response template which is relevant and appropriate for maternity services.

14.16 Complaints themes and trends should be monitored at the maternity governance meeting, with actions to follow and shared with the MVP.

14.17 All staff involved in preparing complaint responses must receive training in complaints handling.

LOCAL ACTIONS FOR LEARNING: IMPROVING AUDIT PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.18 There must be midwifery and obstetric co-leads for audits.

14.19 Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored.

14.20 Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred.

14.21 Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team.

14.21 Matters arising from clinical incidents must contribute to the annual audit plan.

LOCAL ACTIONS FOR LEARNING: IMPROVING GUIDELINES PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.22 There must be midwifery and obstetric co-leads for developing guidelines.

14.23 A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use.

LOCAL ACTIONS FOR LEARNING: LEADERSHIP AND OVERSIGHT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.24 The Trust Board must review the progress of the maternity improvement and transformation plan every month.

14.25 The maternity services senior leadership team must use appreciative inquiry to complete the National Maternity Self-Assessment[235] Tool published in July 2021, to benchmark their services and governance structures against national standards and best practice guidance. They must provide a comprehensive report of their self-assessment, including any remedial plans which must be shared with the Trust Board.

14.26 The Director of Midwifery must have direct oversight of all complaints and the final sign off of responsibility before submission to the Patient Experience team and the Chief Executive.

235 NHS England. *Maternity self-assessment tool* (2021) https://www.england.nhs.uk/publication/maternity-self-assessment-tool/

Antenatal care

LOCAL ACTIONS FOR LEARNING: CARE OF VULNERABLE AND HIGH RISK WOMEN

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.27 The Trust must adopt a consistent and systematic approach to risk assessment at booking and throughout pregnancy to ensure women are supported effectively and referred to specialist services where required.

LOCAL ACTIONS FOR LEARNING: FETAL GROWTH ASSESSMENT AND MANAGEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.28 The Trust must have robust local guidance in place for the assessment of fetal growth. There must be training in symphysis fundal height (SFH) measurements and audit of the documentation of it, at least annually.

14.29 Audits must be undertaken of babies born with fetal growth restriction to ensure guidance has been followed. These recommendations are part of the Saving Babies Lives Toolkit (2015 and 2019)[236].

LOCAL ACTIONS FOR LEARNING: FETAL MEDICINE CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.30 The Trust must ensure parents receive appropriate information in all cases of fetal abnormality, including involvement of the wider multidisciplinary team at the tertiary unit. Consideration must be given for birth in the tertiary centre as the best option in complex cases.

14.31 Parents must be provided with all the relevant information, including the opportunity for a consultation at a tertiary unit in order to facilitate an informed choice. All discussions must be fully documented in the maternity records.

LOCAL ACTIONS FOR LEARNING: DIABETES CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.32 The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.

236 Ibid n11

LOCAL ACTIONS FOR LEARNING: HYPERTENSION

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.33 Staff working in maternity care at the Trust must be vigilant with regard to management of gestational hypertension in pregnancy. Hospital guidance must be updated to reflect national guidelines in a timely manner particularly when changes occur. Where there is deviation in local guidance from national guidance a comprehensive local risk assessment must be undertaken with the reasons for the deviation documented clearly in the guidance.

LOCAL ACTIONS FOR LEARNING: CONSULTANT OBSTETRIC WARD ROUNDS AND CLINICALREVIEW

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.34 All patients with unplanned acute admissions to the antenatal ward, excluding women in early labour, must have a consultant review within 14 hours of admission (Seven Day Clinical Services NHSE 2017[237]). These consultant reviews must occur with a clearly documented plan recorded in the maternity records.

14.35 All women admitted for induction of labour, apart from those that are for post-dates, require a full clinical review prior to commencing the induction as recommended by the NICE Guidance Induction of Labour 2021[238].

14.36 The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR[239] to enable all staff to escalate and communicate their concerns.

LOCAL ACTIONS FOR LEARNING: ESCALATION OF CONCERNS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.37 The Trust's escalation policy must be adhered to and highlighted on training days to all maternity staff.

14.38 The maternity service at the Trust must have a framework for categorising the level of risk for women awaiting transfer to the labour ward. Fetal monitoring must be performed depending on risk and at least once in every shift whilst the woman is on the ward.

237 NHS England. *Seven day services clinical standards* (2017) https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf

238 National Institute for Health and Care Excellence. Inducing labour NICE Guideline 207 (2021) https://www.nice.org.uk/guidance/ng207

239 See glossary

14.39 The use of standardised computerised CTGs for antenatal care is recommended, and has been highlighted by national documents such as Each Baby Counts[240] and Saving Babies Lives[241]. The Trust has used computerised CTGs since 2015 with local guidance to support its use. Processes must be in place to be able to escalate cases of concern quickly for obstetric review and likewise this must be reflected in appropriate decision making. Local mandatory electronic fetal monitoring training must include sharing local incidences for learning across the multi-professional team.

Intrapartum care

LOCAL ACTIONS FOR LEARNING: MULTIDISCIPLINARY WORKING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.40 The labour ward coordinator must be the first point of referral and be proactive in role modelling the professional behaviours and personal values that are consistent with positive team working and providing timely support for midwives when asked or when abnormality in labour presents.

14.41 The labour ward coordinator at the Trust must be supernumerary from labour care provision and provide the professional and operational link between midwifery and the most appropriately trained obstetrician.

14.42 There must be a clear line of communication from the duty obstetrician and coordinating midwife to the supervising consultant at all times. Consultant support and on call availability are essential 24 hours per day, 7 days a week.

14.43 Senior clinicians such as consultant obstetricians and band 7 coordinators must receive training in civility, human factors and leadership.

14.44 All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out when they have concerns about safe care.

LOCAL ACTIONS FOR LEARNING: FETAL ASSESSMENT AND MONITORING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.45 Obstetricians must not assess fetal wellbeing with fetal blood sampling (FBS) in the presence of suspected fetal infection.

14.46 The Trust must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work.

14.46 Midwives and obstetricians must undertake annual training on CTG interpretation taking into account the physiological basis for FHR changes and the impact of pre-existing antenatal and additional intrapartum risk factors.

240 Ibid n32

241 Ibid n11

LOCAL ACTIONS FOR LEARNING: SPECIFIC TO MIDWIFERY-LED UNITS AND OUT-OF-HOSPITAL BIRTHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.47 Midwifery-led units must complete yearly operational risk assessments.

14.48 Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.

14.49 It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust.

LOCAL ACTIONS FOR LEARNING: MATERNAL DEATHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.50 In view of the relatively high number of direct maternal deaths, the Trust's current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the LMS.

LOCAL ACTIONS FOR LEARNING: OBSTETRIC ANAESTHESIA

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

The review team re-emphasises the importance of the Local Actions for Learning and Immediate and Essential Actions for obstetric anaesthesia services from the first report. These can be found in Appendices 5 and 6 and form a vital part of the ongoing learning for both the Trust and maternity services nationally.

The following Local Actions for Learning are based on themes recognised whilst undertaking the current review and must be addressed by the Trust as a priority. The RCoA 'Guidelines for Provision of Anaesthetic Services' (GPAS) document stipulates the key requirements in the provision of obstetric anaesthesia services and these Local Actions for Learning address requirements where the Trust currently falls short. We place a responsibility on the Trust's executive team to support the anaesthetic department in achieving compliance. They are also applicable to hospitals experiencing similar issues and should therefore be used to inform wider improvements in obstetric anaesthesia care.

14.51 The Trust's executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with GPAS at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave.

14.52 The Trust's executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all of the Trust's services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service.

14.53 The Trust's executive team must support the anaesthetic department to ensure that job planning facilitates the engagement of consultant anaesthetists in maternity governance activity, and all anaesthetists who cover obstetric anaesthesia in multidisciplinary maternity education and training as recommended by RCoA in 2020.

14.54 The Trust's anaesthetists have responded to the first report with the development of a wide range of new and updated obstetric anaesthesia guidelines. Audit of compliance with these guidelines must now be undertaken to ensure evidence-based care is being embedded in day-to-day practice[242].

14.55 The Trust's department of anaesthesia must reflect on how it will ensure learning and development based on incident reporting. After discussion within the department, written guidance must be provided to staff regarding events that require reporting.

LOCAL ACTIONS FOR LEARNING: NEONATAL

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.56 The Trust must ensure that there is a clearly documented, early consultation with a tertiary NICU for babies who require, or are anticipated to require, continuing intensive care. This must be the subject of regular audit.

14.57 As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners (ANNPs), the Trust must have a strategy for continuing recruitment, retention and training of ANNPs.

14.58 The Trust must ensure that sufficient resources are available to provide safe neonatal medical or ANNP cover at all times commensurate with a unit of this size and designation, such that short term intensive care can be safely delivered, in consultation with a NICU.

14.59 The number of neonatal nurses at the Trust who are "qualified-in-specialty" must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review.

LOCAL ACTIONS FOR LEARNING: POSTNATAL

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.60 The Trust must ensure that a woman's GP is given complete, accurate and timely, information when a woman experiences a perinatal loss, or any other serious adverse event during pregnancy, birth or postnatal continuum.

242 RCoA Raising the Standards: RCoA Quality Improvement Compendium. Chapter 7 Obstetric Practice. 4th Edition September 2020

14.61 The Trust must ensure complete and accurate information is given to families after any poor obstetric outcome. The Trust must give families the option of receiving the governance reports, which must also be explained to them. Written summaries of any debrief meetings must also be sent to both the family and the GP.

LOCAL ACTIONS FOR LEARNING: STAFF VOICES

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.62 The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service as illustrated by the results of the 2018 MatNeo culture survey.

LOCAL ACTIONS FOR LEARNING: SUPPORTING FAMILIES AFTER THIS REVIEW IS PUBLISHED

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.63 Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families.

14.64 There must be dialogue with NHS England and Improvement and commissioners and the mental health trust and wider system locally, aiming to secure resources which reflect the ongoing consequences of such large scale adverse maternity experiences. Specifically this must ensure multi-year investment in the provision of specialist support for the mental health and wellbeing of women and their families in the local area.

Chapter 15

Immediate and Essential Actions to improve care and safety in maternity services (IEA) across England

15.1 We include these **Immediate and Essential Actions, (IEAs)** to improve safety in maternity services across England. These IEAs complement and expand upon the **Immediate and Essential Actions** issued in our first report. We note that NHS England and Improvement (NHSE&I) has supported the implementation of these actions in trusts across England since our first report was published.

15.2 These further **Immediate and Essential Actions** arise from findings from this large review into maternity services at Shrewsbury and Telford Hospitals NHS Trust. However, we are aware that similar problems may occur in other trusts across England and therefore these actions must be implemented widely in all maternity services.

15.3 This review is supporting and endorsing the latest Health and Social Care Committee Report "The Safety of Maternity Services in England"[243]. We agree with the select committee that the budget for maternity services be increased by £200-350million per annum with immediate effect. This funding increase should be kept under close review as more precise modelling is carried out on the obstetric workforce and as trusts continue to undertake regular safe staffing reviews of midwifery workforce levels.

15.4 We further agree that the Department of Health and Social care (DHSC) must work with the Royal College of Obstetricians and Gynaecologists, (RCOG) and Health Education England to consider how to deliver an adequate and sustainable level of obstetric training posts, to enable trusts to deliver safe obstetric staffing over the years to come. This work must also consider the anaesthetic and neonatal workforce and be advised by the Royal College of Anaesthetists (RCOA), Obstetric Anaesthetists' Association (OAA), Royal College of Paediatrics and Child Health (RCPCH) and British Association of Perinatal Medicine (BAPM). In this regard, the review team is also aware of and endorses the initiatives on workforce planning by the RCOA and the current national review of the obstetric anaesthesia workforce by the OAA in response to the first report.

15.5 We endorse the Health Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit. We also agree that NHS trusts must report this in public through their annual Financial and Quality Accounts.

15.6 We endorse the Health Select Committee recommendation that the Maternity Transformation Programme Board should establish what proportion of maternity budgets should be ring-fenced for training but it must be sufficient to cover not only the provision of training, but the provision of back-fill to ensure that staff are able to both provide and attend training.

15.7 We endorse the recommendation that a single set of maternity training targets agreed in all maternity services in England should be established by the Maternity Transformation Programme board, working in conjunction with and advised by the main Royal Colleges and the Care Quality Commission (CQC).

15.8 We endorse the recommendation that training targets should be enforced by NHSE&I's Maternity Transformation Programme, the Royal College of Midwives (RCM), the RCOG and the CQC through a regular collaborative inspection programme.

15.9 Along with staffing and training the Health Select Committee clearly articulated the need to learn from patient safety incidents. This issue has taken up a large part of both this second report and our first report and we endorse the committee's findings that families must be involved in the investigative process and that lessons must be learned and implemented in a timely way to prevent further tragedies.

243 Health and Social Care Committee. *The Safety of Maternity Services in England* (2021) https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm

15.10 We also note the committee recognised that maternity units appear to have been penalised for high caesarean section rates and recommended that there should be an end to the use of total caesarean section percentages as a metric for maternity services. We note the progress on this with the recent advice from NHS England and NHS Improvement to Trusts[244] to stop monitoring caesarean section rates. The recognition that Shrewsbury and Telford Hospital NHS Trust had a lower than average caesarean section rate (and was often praised for this) was identified in our first report. We noted that some mothers and babies had been harmed by this approach and we welcome the committee's findings and the progress on this.

15.11 This review also supports the NHS Maternity Digital Programme. We recognise this as a key enabler to improve quality and safety. The use of maternity digital notes will empower women by providing them with their own digital maternity care plan and record, discussed and agreed with them and their midwife. Enhancing and improving the digital programme will improve communication, and ultimately contribute to making maternity care safer.

15.12 The Parliamentary Health and Social Care Committee Report recommendations on staffing, training and learning from patient safety incidents echoes much of the work of our first and now this final report. We believe there is still so much more to do in order to make the maternity service in England the safest it can be. It is our intention that implementation of these further Immediate and Essential Actions will make a significant contribution to the delivery of safe maternity care.

15.13 Importantly: We state that DHSC and NHSE&I must now commission a working group independent of the Maternity Transformation Programme that has joint RCM and RCOG leadership to make plans to guide the Maternity Transformation Programme around implementation of these IEAs and the recommendations of other reports currently being prepared.

244 Letter dated 15th February 2022- Ref PAR 1393

1: WORKFORCE PLANNING AND SUSTAINABILITY	
Essential action – financing a safe maternity workforce The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	• The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England. • Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements. • Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave. • The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.
Essential action – training We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.	• All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this. • All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.

1. WORKFORCE PLANNING AND SUSTAINABILITY (CONTINUED)	
	• All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce. • All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development. • All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7. • All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience. • The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.

2: SAFE STAFFING

Essential action

All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.

- When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.
- In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.
- All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.
- All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.
- The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction
- The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.
- All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.
- Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.

2: SAFE STAFFING (CONTINUED)	
	• All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication. • All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.

3: ESCALATION AND ACCOUNTABILITY	
Essential action Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	• All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals. • When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role. • Trusts should aim to increase resident consultant obstetrician presence where this is achievable. • There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit. • There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.

4: CLINICAL GOVERNANCE-LEADERSHIP	
Essential action Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	• Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans. • All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board. • Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services. • All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities. • All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement. • All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research. • All maternity services must ensure they have midwifery and obstetric co-leads for audits.

5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS

Essential action

Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.

- All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.
- Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.
- Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.
- Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.
- All trusts must ensure that complaints which meet SI threshold must be investigated as such.
- All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.
- Complaints themes and trends must be monitored by the maternity governance team.

6: LEARNING FROM MATERNAL DEATHS

Essential action

Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.

In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.

- NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.
- This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.
- Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.

7: MULTIDISCIPLINARY TRAINING

Essential action

Staff who work together must train together

Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.

Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training

- All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.
- Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.
- All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.
- There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.
- There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.
- Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.
- Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.

8: COMPLEX ANTENATAL CARE

Essential action

Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.

Trusts must provide services for women with multiple pregnancy in line with national guidance

Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy

- Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.
- Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.
- NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.
- When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.
- Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).

9: PRETERM BIRTH

Essential action	
The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	• Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability. • Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered. • Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability. • There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.

10: LABOUR AND BIRTH

Essential action	
Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	• All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made • Midwifery-led units must complete yearly operational risk assessments. • Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan. • It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust. • Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing. • Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.

11: OBSTETRIC ANAESTHESIA

Essential action

In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.

Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.

Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.

- Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.
- Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.
- All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC
- Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.

Obstetric anaesthesia staffing guidance to include:

- The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.
- The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.
- The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.
- Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.

12: POSTNATAL CARE

Essential action	
Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times	• All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward. • Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum. • Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary. • Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.

13. BEREAVEMENT CARE

Essential action	
Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	• Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday. • All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations. • All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome. • Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.

14: NEONATAL CARE

Essential action

There must be clear pathways of care for provision of neonatal care.

This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.

- Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.
- Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.
- Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.
- Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.
- Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.
- Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.

14: NEONATAL CARE (CONTINUED)	
	• Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm. • Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.

15: SUPPORTING FAMILIES	
Essential action Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	• There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate. • Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences. • Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.

OCKENDEN REPORT - FINAL

Appendices

- Appendix 1: Hearing the voices of staff
- Appendix 2: Immediate and Essential Actions (IEAs) from our first report
- Appendix 3: Glossary of terms
- Appendix 4: References
- Appendix 5: Terms of reference (TOR) - May 2018
- Appendix 6: Revised terms of reference (TOR) - Nov 2019
- Appendix 7: Review team members and who we worked with

Appendix 1: Hearing the voices of staff

Staff voices engagement strategy

1.1 In engaging with and listening to current and former staff at the Trust, we intended to highlight where they saw and see scope for improvement, but also to report on good practice in maternity services over the years. Staff were offered the opportunity to share any information with us that they felt would support them in having their views and voices heard. The culture within the Trust and specifically maternity services and whether it has changed over time is an important factor in order to understand the potential cause of any systemic problems.

1.2 Prior to conducting the staff survey for this review we reviewed the results from annual NHS staff surveys at the Trust over the previous 10 years. Staff across NHS organisations are encouraged to complete this survey each year and data are used to improve staff experiences locally and throughout the NHS, ultimately benefitting patient care. We also reviewed the Trust results from the Maternity and Neonatal Health Safety Collaborative (MatNeo) Culture Survey in 2018, which was part of the national Maternity and Neonatal Improvement Programme.

1.3 The NHS annual staff survey has undergone several iterations over the years and the Trust has restructured its service centres/ clinical divisions on a number of occasions. It therefore proved difficult to attribute the available data specifically to staff who worked directly within maternity services. The MatNeo Survey[245], although identifying themes particular to the service, had limits in covering historical aspects of the culture at the Trust.

1.4 The review team worked directly with the Trust to ensure that past and present staff were offered the opportunity to contribute to this review. Reassurances were given with regards to anonymity and confidentiality and that responses would not be shared with the Trust. We developed a staff voices engagement strategy - known as 'Staff Voices', using a bespoke questionnaire survey followed by conversations with staff. The chair of the review also conveyed messaging regarding the Staff Voices strategy through local radio stations and via social media with the aim to reach out to as many former and current staff as possible.

1.5 Despite the assurances around confidentiality and not sharing findings with the Trust there is evidence from multiple conversations and contacts from staff themselves that they remained reluctant to participate. There appeared to be two main concerns from the staff who contacted the review who were uncertain about whether to participate or not - firstly they described being dissuaded from participating by their managers at the Trust. Secondly they expressed concerns about the ongoing police investigation at the Trust, Operation Lincoln, and whether the review team intended to pass information from staff to the police as a matter of routine. Whilst this was not the intention of the review team, the police have requested that we retain any relevant material and we may be required to disclose information to the police in due course.

1.6 In total only 109 staff came forward and participated in the review, some completed the survey only, some both completed the survey and spoke to us and some only spoke to us, declining to fill in the survey. We are sorry that so few staff members felt able to participate. In the last few weeks immediately prior to publication, 11 of the 109 staff who had come forward either fully or partially withdrew their cooperation or did not respond to multiple requests to use their content. This means that overall we have been able to use the staff voices of only 98 current or former staff at the Trust.

245 Provided to the review team by the Trust

The launch of Staff Voices

1.7 The staff voices survey was conducted from 12 May until 30 June 2021, with follow up conversations with staff occurring until January 2022.

1.8 Some staff employed by the Trust contacted the review team directly using the designated staff voices email address and asking for the link to the survey rather than accessing the link provided through the Trust. Many of these messages sought reassurance that the Trust would not know they had completed the survey. Some staff messaged the review chair directly, seeking assurance of confidentiality.

'...[I am] working for the trust and would like to take part in this survey but only if 100% confidential'. (Staff member, email to the review team)

'[working]...within SaTH [the Trust] as long as my name won't be mentioned and whatever I say is kept confidential I'm willing to take part in the survey'. (Staff member, email to the review team)

'Some staff were told be careful about how they answered this survey and were told to remember any comments made could be considered as part of the police investigation. This is the kind of passive aggressive approach of threat that NHS organisations use to deter staff from speaking up. It is so historically ingrained in the culture and possibly will have put staff off participating in the survey'. (Staff member, email to the review team)

1.9 These concerns were further confirmed during conversations held with current staff. One member of staff said: :

'…….and I know a lot of my colleagues didn't want to get involved because they were frightened, they were intimidated by the process'.

1.10 Another member of staff told the review team:

'I said, "Have you written out your questionnaire yet?" "No, we have been told not to"……...but people won't because they have to put their name against the allegations and that sort of thing, and these people they've, as I have said before, they've got their friends and they just will not speak up, they daren't, they daren't speak up, you know.'

'So I know multiple people that have not approached you to speak because of fear, because of how it was put in that briefing [from the Trust to staff] …….. there were people that had every intention of completing their survey and then after that, no way. I was like but this is your chance to speak. How can you make any changes? How can you do anything about it when we're given this opportunity but they're still working there? I think they were perhaps fearful of their jobs, I don't know'.

Another member of staff describing how fearful they felt about speaking up in the maternity service in early 2022 told the review:

'We used freedom to speak up and because of the reporting process they have to follow those concerns ended up going back to those we had concerns about...'

1.11 Overall, when taking into consideration the number of staff who are currently employed within the service and the number of former staff employed throughout the twenty years of the review's timeframe, we are disappointed that just 84 staff completed the survey. By comparison, in 2018, 192 (58%) staff who were working within the maternity and neonatal services at the Trust completed the MatNeo culture survey. Therefore we appreciate that our findings and conclusions are of limited value. However, having put considerable effort into hearing the voices of staff and having been told by the staff who participated how important it was to them to be heard, we believe this content is important despite the low number of participants.

Staff Conversations

1.12 Staff were asked within the questionnaire survey whether they agreed to a confidential face-to-face video interview with members of the review team and 76% of those completing the survey responded with 'yes'. Some staff contacted the review team via email requesting to speak with us, but did not want to complete the questionnaire survey.

1.13 The review team was also keen to speak with staff who held leadership positions within the Trust, maternity services and Clinical Commissioning Groups (CCG) to gain insight into the culture and changes over the years. The Trust and CCG contacted those staff who were of potential interest to the review to advise them of the request and to gain their consent for sharing their contact details. Other Trust and CCG staff were also able to contact us directly if they wished.

1.14 All interviews were conducted via a videoconferencing platform. Participants were advised they would receive a copy of the transcript of the conversation which they could annotate as they wished and that they could send additional information to the review team.

Staff Voices Results

1.15 In total, we received 84 staff survey questionnaires and conducted 60 staff interviews. Each staff member was allocated a confidential staff number. Of the survey respondents, 49% had been employed by the Trust for less than 10 years, 39% for between 10 and 20 years and 12% for more than 20 years. The majority of staff who engaged with the review were still employed by the Trust. The majority of staff were either employed or had been employed in clinical roles.

	Question	Yes	Sometimes	No	Total	Percentage 'Yes'
Professional and / or clinical concerns	Have you ever raised any professional or clinical concerns?	48	-	36	84	57.1%
	Have you ever been concerned about patient safety?	52	-	32	84	61.9%
Bullying	Have you personally witnessed or experienced bullying in the workplace at SaTH?	55	-	29	84	65.5%
Mandatory training	Do / did you have managerial support to attend mandatory training days?	55	20	9	84	65.5%
Teamwork	Did / do you think your multidisciplinary team works well together?	37	36	11	84	44.0%
Staffing Levels	Have you ever escalated concerns about staffing levels during your shift?	51	-	22	84	60.7%
Improvements	Did / do you feel there were / are any barriers to attempts to make improvements to the maternity service?	42	21	21	84	50.0%
Family and Friends Test	Would you recommend SaTH to family and friends for maternity care?	38	27	19	84	45.2%

Category	Question	Never	Rarely	Sometimes	Often	Always	Total
Culture	Whilst at SaTH did / do you enjoy coming to work?	2	16	34	27	5	84
	How often did / do you take part in multidisciplinary traning) (e.g. obstetricians, midwives, neonatologists, support staff training together)	15	16	30	12	11	84

1.16 Many staff who spoke to us appeared very committed to the Trust, spoke of pride in the service and demonstrated loyalty and support towards their colleagues. Staff members told us: *'…So I wanted to make clear that was what I'd seen. These people I've worked with have been trying really hard'*…Another member of staff said: *'I do actually enjoy it and the team that I work with are a fantastic team…'*

1.17 From the questionnaires and interviews we identified key themes that had an impact on staff working in the Trust over the years and can give (albeit limited due to the small numbers) some insight into the culture throughout the years.

Merger of two trusts to form one trust

1.18 Staff described the difficulties they felt they experienced caused by the merging of the two sites to form one Trust and subsequently the move of consultant maternity services to Telford in 2014. One staff member said:

'…I think it's really tough for the management board. I think there was a disconnect in previous Trust boards, I think it was really hard. We did have quite an aggressive management structure when it was all about reconfiguration. It clearly felt like a new Chief Exec had come, Department of Health driving through, reconfiguration and relocating to Telford. We felt pretty coerced into agreeing to relocate to Telford, which clearly is wrong, and now, there's talk about it was the wrong decision, the services are in the wrong place, but the majority of us thought that in the first place'.

1.19 Another staff member said:

'As far as I could tell, you know, the Trust had been stuck, basically, for about twenty years, unable to make any progress, the two local authorities, the two populations at daggers drawn, you know, resisting every single change. …..trying to find a way through that log jam and come out the other side of it with a set of proposals that would make services less unsustainable.'

1.20 Another staff member told the review:

'…..we hadn't merged yet, …. and one of the great things that made me take the job in Telford was because the management team were based in Telford, because it was just one hospital, and they were incredibly responsive. You would bump into the Chief Exec on the corridor, the Medical Director, you could raise a concern or make a suggestion,…. oh, I wonder if this could actually improve patient care or this would be a good thing for safety, and it was really easy to get things …..changed because there was that responsiveness. With the merger…..the management structure was almost entirely based at RSH. They don't come over, they're not based at Telford, so you get none of the corridor conversations, which shouldn't really be the way we communicate but actually is often the way communication happens, so we don't have that access.'

Trust leadership

1.21 In our first report we discussed the high turnover of Chief Executives (CEOs), executives, non executives and other leadership roles at the Trust. Such a high turnover will inevitably impact on the performance of an organisation. One staff member told the review team:

'…..I think that's part of the problem…. they haven't got a consistent leadership…..and it was a mess, you know, you can't describe it any other way, there'd been no leadership whatsoever'.

1.22 Another staff member said:

'One of the historical factors for the Trust is that there have been several management restructures, many different chief execs, and a real churn at the Trust board level as well…… I went through three management restructures, reappointed each time to a slightly different role…… Each of those management restructures sometimes took up to about eighteen months from the first letter of people being put at risk to people being

in place…… each time you lose good people, because there's only so many management restructures……. So, no sooner had you made a working relationship with an executive, than the next one was on their way. And also, with each of those structures came, obviously, slightly new ways of doing things, new policies, new training, some of the previous ways were not required, and there was a new focus'.

1.23 Another staff member said:

'….I guess that takes time, developing that trust in leadership does take time, and certainly one of the things that SaTH has not benefited from is longevity of leadership.'

1.24 Three other staff members told the review:

'So, there's been little in the way of corporate memory and additionally, the new incumbents would have to establish their relationships with the existing management structure'.

'We'd just had another Chief Executive who wanted to do yet another reorganisation and we were all supposed to apply for our posts and do maths tests and English and chemistry and I just thought, "I can't…..'".

'…it's really bizarre, we've had … we're on our third Medical Director since I've been in this role and we're on our third Director of Nursing. The current establishment, it seems to have much more traction and we seem to see much more evidence of things happening. The previous people that were in post, similarly, were saying all of the right things but it just wasn't translating it, the action wasn't happening. It was like there was a disconnect. The executives knew of the problem, they didn't understand the core cause of the problem'.

Culture

1.25 A priority when reaching out to staff at the Trust was to understand the culture within the maternity service and possibly the wider Trust. Through the survey, staff were asked 'Have you personally witnessed or experienced bullying in the workplace at the Trust? 65% of respondents replied with 'yes'. Of those 65%, 38% felt able to report it and of these, 33% felt it was adequately dealt with.

1.26 One staff member told the review team:

'Culture is a big thing because I feel there's a reluctance to change there.'

1.27 Another staff member told us:

'I feel that there are historical organisational/cultural issues that are very complex in how this situation has developed. I really believe that there are wider system errors that have let down women and their families but also staff. There are some really good people who care immensely about what they do but operating in a system that is in crisis management continually, can have significant impact on the ability to maintain passion and compassion.'

1.28 A further contributor stated: *'…. the fear of speaking out is all-pervasive in SaTH and it's a very difficult thing to get rid of if that has been the culture for not just ten years, but twenty years, thirty years, it's inbred within the culture at SaTH that if you speak out, something is going to happen to you……you'll be bullied or you'll be moved or you'll be … you know, something will happen, something will be … make it difficult for you.'*

1.29 One staff member described their own experience: *'X .was so strident that you tended not to argue with her, she was a bully, 100%'.*

1.30 Another contributor said: '

….when I joined. We just had the conversation about the need to change the culture, in terms of safety culture, that was very clear, and the organisation went with that process, including Listening into Action, which was another initiative that was brought in…… which is important, because I think staff hadn't felt previously that they'd got a voice to be heard. So, I think that Listening into Action was very important at that stage in terms of changing that culture within the organisation'.

1.31 Three different staff members told the review team:

'….previously, these groups have been split up in clinical areas but they go elsewhere and still behave in the same way. They are…big voices, they're dominating, they're intimidating…'

And: *'There are cliques there and, you know…… they are a little gang, and, yes, they will make your life hell…… I am speaking to colleagues now and they won't speak out… you couldn't speak to senior management, if you tried you got shot down'.*

And: *'And the safety huddles that we used to go to, I mean some of them were…. would speak to some of the managers like absolute … it was just you'd stand back and think, "This is bullying".'*

1.32 Other staff members described a 'clique' on the labour ward at the Trust with a culture of undermining and bullying. Some staff members described that this had negatively and seriously affected their mental health. Other staff members described that the behaviour experienced on the labour ward was so bad that they had difficulty finishing their shifts and cried secretly whilst in work. These staff declined for their direct quotes to be used, because they were fearful of being identified.

1.33 Many staff members told the review team of the fear of speaking out within maternity services. This included those who are currently working in maternity services at the Trust.

1.34 One staff member said: *'….it's very hard to speak up because despite what anybody will tell you, there are consequences to speaking up and the consequences are your life gets made very difficult or you get subtle … you can't really pinpoint it as bullying, it's like subtle, made to feel uncomfortable when you go to work, not sure how people are going to be with you, not being invited out onto nights out. Simple things like that, not being included in coffee mornings, and things like that….. it's very difficult to speak out, I've been there myself and I ended up going off ill with it'.*

1.35 A current staff member in maternity services at the Trust spoke to the review team in early 2022 but described themselves as fearful to do so. The staff member said *'I really had to think very carefully about approaching the staff voices….when we were told not to speak out, but I will do it and take the consequences because it is the right thing to do…I am clear that there is no support for those that speak up...'.*

1.36 Periodic rotation through the clinical areas within a maternity service is a system evident in most maternity services. Its aim is to ensure that staff remain competent to deliver care in the main clinical environments and gain wider experience, and it also enhances professional development. It is also believed to improve communication as there is an understanding and awareness of what happens in other clinical areas. Some staff commented on the process within maternity services at the Trust, with some saying that poor behaviours still remain at the Trust.

'…they would have almost three or four months of these rumours going around, "There's going to be a change list; there's going to be a change list", and then finally, when the change list came out, there was a lot of anxiety from quite a few midwives.'

'The communication of the change list over the years has been very poor and has caused a massive amount of stress for all of us because you just find out that you're on the change list and off you go.'

'There was a lot of cliques there, a lot of managers were cliquey, there was the change list that was used as a… you had the impression that if you were a pain you would get moved, you know and nobody wanted that and, you know, it still goes on today….. I think that the managers, I think they are aware of the clique and I think they have tried to separate them but they're so deeply ingrained into the system… the management's almost scared to get rid of them because they almost form the core of the delivery suite expertise.'

'…they just didn't want students at all, they were not happy to have students…'

Governance

1.37 We routinely questioned staff regarding the governance systems across the wider Trust. Two staff contributors said:

'……one of my concerns at the time was really that…, I don't think the Trust had a robust governance framework, to be honest.' '….and we ended up having to just work within our department, because when we asked within the Trust there just wasn't that resource... the Trust wasn't as advanced as that, they just didn't understand what we needed, so we ended up doing that'.

'certainly my experience is it's not about the people on the floor doing the work, it's the whole system behind it that isn't always as helpful as it could be and that affects those people that are trying their best …'

1.38 Another contributor told the review: *'……yes, it did feel as though we weren't perhaps hearing all that we should have been hearing…….. We struggled consistently to get information from SaTH in those meetings from 2009 -2012. Reviews of serious incidents seemed to take a long, long, long time to happen and there was an impression of evasiveness around how the learning from those reviews was shared. Reading the last Ockenden Report it was clear to me that whatever learning was taken from the incidents that are described wasn't actually shared and taken forward, so the same things were happening over and over and over again, and in the context of an organisation who may describe themselves as a learning organisation I never felt that it really was'.*

1.39 A number of other staff members told the review team of their experiences:

'It was a system wide failure to be able to escalate these priority pieces of work and to push it through, there didn't seem to be the guidance, there didn't seem to be the governance, there didn't seem to be the process of challenge…'

1.40 Another staff contributor said:

'This has just started recently, by recently I would say in the past four or five years, but before then we didn't have this system, you see. We didn't have clinical governance, it was just on the go, word of mouth, that if there was an issue you would get it discussed between you and the consultant, for example, or whoever was involved, but we didn't have this learning procedure or learning process as is currently being done.'

1.41 Another staff member said

'….things started to become visible when the CQC went in and we were given [an] inadequate rating……. but prior to that, it would be that things were kind of filtered down really by word. To be honest, there was a lack of process, a real lack of processes.'

Staff voices on statutory supervision of midwifery

1.42 Commenting on the ineffective nature of the process of statutory supervision of midwifery at the Trust one contributor said: *'My recommendation was that there was a supervisory investigation. At the time it was dismissed because it was such a tight, tight group of supervisors, it was impenetrable and if you're in, you're in, and X was in. So, they were not keen to conduct that….. If they decided that this particular practitioner did not need a supervisory investigation then it was up to them. So, if your face fits, then you were okay.'*

1.43 Other contributors told the review team that the same people were involved in supervision investigations as in internal maternity governance investigations and that statutory supervision was only a process of internally 'marking their own homework'.

Improvements in maternity governance from the perspective of staff

1.44 Some staff reported that in more recent years, the governance processes within maternity services at the Trust have improved.

'It has improved, there is no doubt that it has improved in comparison to the past, whether this is enough I don't know now. Obviously time will tell, but definitely there is now clinical governance, there are high-risk case discussions, meetings, and these issues that we've never had in the first ten, twelve years of my work here in this hospital.'

'…..there were lots and lots of changes that were really, really for the better, and the MDT really came together. I think also there was organisational developments as well, because the anaesthetist started doing some scenario-based training that we would all be invited to.'

'….there is a much better process now of incidences being shared. Certainly in the last five years, maybe even less than that……. Some line managers are very good at sharing all memos and other managers not so'.

1.45 Other staff cautioned that the improvements seen within maternity services at the Trust remain very fragile and that the Trust needs further observation, scrutiny and support as of spring 2022. A staff member said: *'Ladies are being cancelled, rebooked and cancelled due to staffing issues and I have considered leaving as I worry about the impact this is having…'. The staff member added: 'I have been really worried…it is important people are aware of the situation...'.*

Oversight of safety and performance within maternity services

1.46 A number of contributors reported to us that, for a long time, executives and board members viewed the maternity service as performing well and as a result did not apply a high level of scrutiny to the service. Equally external scrutiny did not raise sufficient concerns at board level. The following remarks illustrate this:

'….whilst they were confident and very strong individuals, very clear about their ability to manage their teams and manage the business, I didn't have any reason to question that they would come to me if they had concerns'.

Another contributor added: *'…at no stage did me, and this is my fault, but at no stage did I pick up that there was such a deep-seated problem in that service…'*

1.47 Other staff members told the review team:

'…….we got best performing and we got CNST Level 3, you know, so these are independent organisations coming in, looking at it. Therefore……. you should have some confidence in what these bodies are telling you…'

'……when scrutinised by quality and safety, when scrutinised by the Trust Board to give a reasonable account of their abilities to maintain their service. We did develop "deep dive" reviews at various stages and there was a sense that compared with some other areas of difficulty within the Trust, Maternity was not on the radar at that stage. That, of course, was triangulated with other perspectives, so views from the CQC, and you'll be aware that in the early phases, the CQC reports were positive ones. They were rated as good.'

'….it was published and it obviously came to our Board meeting, we discussed it in the Board. I think, I mean the overall message from that report was that…. they said safe and good quality services in a learning organisation.'

'It was presented to us, I think, by SaTH as being more positive than it actually was. It was a kind of oh well, the RCOG think we're okay.'

'They were one of the ones I trusted and, given all the external results we were getting that actually confirmed how good the service was they ran'.

'…..we were working within a Trust that had considerable financial challenges, some challenged services, and that was the focus of the Trust, really. So, maternity and women's and children's was referred to as the flagship of the organisation, and trying to get additional resources into the care group was really difficult.'

'….we'd achieved CNST level three gold standards, and that was … I don't know, not a badge of honour, but there was a lot of interest within the Trust that we should be awarded that….gave evidence with others at a parliamentary review into maternity care, and we were asked to go as one of those services that was considered to be providing good care, and we gave our evidence there. So, I think from that time, 2004 onwards there was this perception that we had a really good service, and we were regularly reviewed and visited.'

'As a maternity service, we were considered to be very good, which is why it's been a bit of a shock, all this happening. We were considered to be very good….'

Staffing

1.48 It appears from our survey and interviews, albeit with limited staff numbers engaging, that many staff had raised concerns about safe staffing levels over a protracted period of time. Within the survey 61% of respondents said that they escalated staffing concerns but just 33% of these received an adequate response. The following six vignettes highlight some of the concerns expressed about staffing:

'…it was really clear just how difficult it was to sustain a safe level of cover…'

'I don't remember them actually saying that they needed more funding for midwifery staff, but certainly they raised staffing as an issue repeatedly.'

'I asked for a Birthrate Plus review…… which - surprise, surprise - really showed everything that we'd felt…… deficit 30 whole time [posts]…. Were your co-coordinators supernumerary? Not always, usually because of the staffing levels.'

'…the midwives, they were obviously short-staffed….. The shift leader was constantly having a patient…. When you're working on the labour ward, you sometimes couldn't get hold of the shift leader because she was in looking after a woman….. Was not supernumerary and it was really difficult.'

'….but a lot of the shifts there were like by the grace of God that one could have been me… it was scary…. it was a system issue, as in this lady needs to go and we can't get her, she can't go, there aren't enough midwives, you know. They were the issues.'

'I feel like there isn't enough of everyone to kind of go round to make sure that everybody's getting the care that they need.'

In 2018, 46% of respondents to the MatNeo survey reported concerns about poor levels of staffing.

Patient Safety

1.49 Within the staff voices survey, 62% of respondents reported they had been concerned about patient safety, with many feeling their concerns were not adequately addressed.

'T*he patient safety issues I would say they were probably more when I worked on the wards, and that was mainly again just staffing. I spent a lot of time on the antenatal ward, and the amount of times, you know, you needed to get a lady to labour ward and "no staff, no staff, I can't take her, I can't take her" or "Yes, you can bring her, but you will have to come with her", you know, leaving just one other member of staff, you know, that, that, they were the main things really, was trying to get ladies to labour ward in a timely manner. I think they would be the biggest, biggest issues I had seen really.'*

'..Nobody went out at any time wanting to harm anybody, it's just we didn't have the training and we didn't have the staff and that's how it was, unfortunately, and we didn't know any different.'

'We're not giving them the right tools here, we're not supporting them, and we're not giving them the right staffing levels.'

Caesarean section

1.50 Staff commented on the low caesarean section rate at the Trust, which was discussed in our first report. There was disagreement from the staff who contributed to the review as to whether there was a reluctance to offer caesarean section when requested. One staff member said:

'There was always a perception that we were reluctant to offer maternal request caesarean section, which wasn't true but we had a policy to arrange appointments with senior clinicians in order to fully understand the request and provide advice.'

1.51 However, a number of other staff interviewed had differing recollections on the same topic, with examples from four staff shared below:

'….and they would definitely try to avoid a caesarean section…… they were always trying to, how can you put it, try for a normal birth all the time…… it was a couple of times, I pulled the emergency bell because I had a bradycardia going on. They came in and I was actually told off for pulling the emergency bell. I thought to myself, "What's going on here?" I absolutely did not understand it. It's like, you know, they would just let things run purely because they didn't want the doctors to come in, and sometimes you could see some of the shift leaders not wanting to call the registrar in or any of the doctors in …..'

'They were always very proud of their low caesarean rates…….I personally found all the failed/attempted instrumental deliveries very difficult to deal with. I had never seen so many injuries/HIE/resuscitations from this. Nothing to be proud of.'

'I was worried with this escalation thing especially with the patients who are going with the emergency caesarean section….. when we are worried about, for example, a CTG, and they will try and try and try at the end until the baby is really poorly…..because they told me they want to keep the caesarean section really low.'

'I couldn't believe that that was still, the culture was the same – it was almost we have to do everything to get a vaginal delivery and we've got to keep the section rate low, we've got to keep the epidural rate low…….. In 2014 it was the same guys that I'd seen in early 90s', very much the same culture.'

Midwifery led units

1.52 A number of staff discussed the safety of working in the Midwifery Led Units (MLUs) and the challenges they faced. Examples from three staff are shared below:

'….that to run five midwifery-led units out of our establishment, I questioned whether our model was fit for modern-day purpose…….. but Shropshire, you know, its accolade was, "We've got five midwifery-led units". … one of the consultants described it as, you know, the MLU as being the sacred cow, and that's how it felt, that it was okay to have five midwifery-led units if we were staffing the whole organisation in the way that it needed to be done, but we weren't, and it just felt as if you'd got two completely opposite ends of the care that was being given.'

'So, I was put in this really difficult situation of knowing what to do with this woman who's booked at the consultant unit and they could have transferred her earlier. I mean, by the time I went into the room, right, I mean this woman was delivering anyway, but it was… you could say it's a near-miss really, that it was a near miss.'

'The one thing I was really struggling with was whenever the consultant unit was short-staffed, they would take MLU staff, but they wouldn't close the MLUs at that time. So some MLUs were left with one midwife available and no on-call midwife and hope that a woman didn't come in in labour because there wouldn't be a second MLU midwife to back her up and that troubled me no end. It was not a safe situation and it was a disaster waiting to happen.'

Escalating concerns

1.53 Within the survey, when asked whether they had ever raised any professional or clinical concerns, 57% responded with 'yes'. Of these, 52% said there was a clear pathway to follow to escalate professional or clinical concerns. Examples from staff are shared below:

'The culture at SaTH is that if you have done something wrong, keep it in-house and we punish you for that, you know, whether that's you're investigated or whether that's you're moved on a change list or we make your life very difficult or you end up handing your notice in because you have been almost hounded in a way to the point where you have left because of your mental health, you become more and more reluctant to speak out and that's the danger, isn't it?'

'….has actually told us off for putting in Datix, or raising critical incidents about concerns we have, because this is, [they] would describe it as whistleblowing and it's wrong….. to have significant individuals in the organisation telling you that isn't what you should do is very harmful.'

'….So I went along and was basically, yes, told that everything was, I shouldn't be raising concerns and, you know, that I didn't understand the system and that everything was fine and, you know, again just not to raise concerns. I was in tears because I was basically a rotten person and I shouldn't be upsetting the apple cart and, you know, it was irresponsible to go raising these concerns. Afterwards I was completely shocked, I actually couldn't face going in for a few days.'

'It is difficult to know where to take concerns when you have escalated through relatively senior channels and there is no improvement. A clear pathway or process would, I believe, support staff in expressing these frustrations - everyone is under immense pressure and everything is a priority however there needs to be a means of acknowledging concerns and identifying how to implement an improvement strategy irrespective of if this needs to be over a long period of time.'

'So I think we've been proportionate when we've raised concerns but most of the time people say yes, we understand, that's a valid concern, but there's no practical solution to it.'

Multidisciplinary team (MDT) working and training

1.54 Some staff were keen to share with the review team that they had positive working relationships across the multidisciplinary teams, that the Trust was a good place to work and they were focussed on giving high standards of care. When asked within the survey whether they felt the MDT works well together 87% responded with 'yes' or 'sometimes'. 37% of respondents replied that they 'rarely' or 'never' took part in MDT training, 36% said 'sometimes' and 27% 'often' and 'always'.

1.55 Some staff described fractious relationships amongst the teams that may have presented as barriers to effective communication.

'……but there were fallings out between the Band 7s and the consultants, I remember there being arguments, maybe clashes in personality….. some of the Band 7s…., maybe weren't as much good communicators.'

'…was so arrogant and rude, you'd be afraid to ring [X} with any concerns. [X] was intimidating….. was very derogatory about midwives,… the midwives found [X] very rude and arrogant and intimidating and would prefer not to deal with [X]...'

'We would find that the doctors would walk in and just come and look at what was going on because there wouldn't be that communication from the coordinator to the doctors. You just felt like there was very much an "us and them".'

'I think bullying was rife on the maternity unit and this is part of it, that these consultants, there were one or two or even three that would intimidate the midwives and junior doctors, and make sure that they are not approachable'.

'…this collaboration of training together, it really wasn't happening'.

Improvements

1.56 Within the survey, staff were asked whether they felt there were any barriers to attempts to make improvements to the maternity service. 50% of respondents replied 'yes' and a further 25% replied 'sometimes'.

'So we're going to put that into our protocols and policies and before it was just "mañana", we'll do it tomorrow. Tomorrow never comes. There's no urgency to address or change or do anything. They'll do that and if it works for them, we'll do it. No, we have to do it. We're answerable, we're accountable'.

'I think we have always wanted to improve the services because things never, you know, they must obviously change in order to improve, you just can't carry on the same way as you are. So, as far as I was concerned, yes, there was a thirst for improvement, for learning, you know, and how we can actually change things as well'.

'I wholeheartedly believe, and I know my colleagues believe senior management ….. have been a barrier for change'.

1.57 Other staff, however, reported that continuous improvements within maternity had been made over the years and the unit had engaged with national initiatives such as customised growth charts, the maternity early warning score and 'Saving Babies Lives'. A staff member told the review team:

'Since my appointment to consultant I have been involved in, instigated and led a number of improvement projects within the maternity department. All of the projects became multidisciplinary from an early stage.'

Impact of the review on staff

1.58 Staff reported being deeply affected by the ongoing review. Some staff explained that they would decline to meet with the review team for this very reason. One of the criticisms levied at the review team was there were misconceptions regarding the culture at the Trust.

'I feel that the culture in the unit now is different, I think there's a lot of people who have struggled, and personally my health's not been good as a result of this. ..there's been a lot of people who have really struggled from a mental health point of view, physical health point of view, because of this….. there's a resolve in the unit that we will improve and get better but there's also a sadness in the unit that we've ended up where we've ended up, and I think it is quite hard for the staff who've been there a long time.'

1.59 Other members of staff told the review team:

'…there's a number of colleagues who will never recover from this…'

'From the media perspective, it feels like people like me or my colleagues are portrayed as some sort of perpetrators, villains, but actually, I do feel we should all be on the same side here, but it doesn't feel like it.'

Response to the Independent Maternity Review

1.60 Staff who spoke to the review team were generally positive about the changes they had witnessed following the publication of our first report and the maternity services improvement programme:

'I think that the lessons from this inquiry are going to be transferable to the whole NHS'. The same staff member continued: *'….so the really great thing to come out of the external review has actually been the funding to expand … and I'm really grateful for that, really, really grateful'.*

1.61 Another staff member told the review team:

'No, I really hope that things change. I hope it changes for the…..good….. It's not all bad, and for the families, first and foremost really, because it's heart-breaking to see some things on Facebook where [The] Shropshire Star have put something up and if you read the comments from public members it's horrible to see people questioning whether they're going to be safe or not, when I know that there are so many staff there, I would quite happily let them look after me and have done.'

1.62 Further staff comments included their distress at not being listened to when they had tried to raise concerns at an earlier time *'… we were all just shell-shocked. Whenever a report comes in, you read it and there are bits you identify with and I couldn't even talk. I broke down ……I remember breaking down and they were proper angry sobs, it's not just, "I'm upset because families have gone through this, clinicians have gone through this", I am angry and I am hurt and I'm angry because nobody has listened and I don't believe the change has happened quick enough and I tried to explain that.'*

'I do feel very sorry about what's happened and I've reflected a lot on what I could have done differently…'

There were a number of positive comments about the first report from a range of staff including:

'I was impressed by the report identifying the need for nationwide improvements, learning from this experience. I think there's a story there that has been identified and it will be lovely to see that being implemented more effectively, more widely.'

'I mean maybe actually we didn't know necessarily the right questions to ask, so knowing some of the right questions to ask would have been helpful. For instance, I had no idea that they didn't have an adequate anaesthetic service, so that, if you haven't got adequate anaesthetic cover for your sections, obviously you're not going to do one if you can get away with it, or think you can get away with it, and that was something I had never thought of asking. So maybe it's about actually having a national sense of exactly what we should be checking on, as commissioners, so that we're not falsely reassured.'

'….it was shocking and very upsetting to see that those things hadn't come to light during the time that I thought that we were doing as good a job as we could at understanding what was going on in the services that we commissioned.'

Conclusions

1.63 This engagement strategy reached out to staff through liaising directly with the Trust and through social media platforms and local media reporting. We are extremely grateful to the staff who have been willing to share their experiences as we appreciate how difficult it has been to make that decision. Some expressed feelings of guilt at speaking with us and many were tearful as they recalled individual experiences and what they had observed in dealing with other colleagues and within their service over many years.

1.64 The members of staff who engaged with us really matter and their voices must be heard. They speak about the culture and raising concerns but not being heard. They speak about trying to do things to the best of their ability without the necessary frameworks in place that would enable them to learn from any errors made. What they say is supported by what we have seen throughout this review- that maternity services within the Trust had poor governance systems for a long time, which allowed it as an individual service to develop its own systems in isolation without effective internal and external surveillance.

1.65 We cannot underestimate the toll on staff of being under constant intense scrutiny. We met staff who were deeply affected by what had happened in their service. However, many of the staff who engaged with us stated that they were adamant to learn and do all they could to ensure their maternity services were safe for the families in Shropshire.

LOCAL ACTIONS FOR LEARNING: HEARING THE VOICES OF STAFF

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

1.66 The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service as illustrated by the results of the 2018 MatNeo culture survey and the recent feedback from current staff.

Appendix 2: Immediate and Essential Actions from our first report

Immediate and Essential Actions to improve care and safety in maternity services as outlined in our first report

1: ENHANCED SAFETY	
Essential Action Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	• Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. • External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. • LMS must be given greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them. • An LMS cannot function as one maternity service only. • The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda. • All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.

2: LISTENING TO WOMEN AND FAMILIES

Essential Action

Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.
- CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.

3: STAFF TRAINING AND WORKING TOGETHER

Essential Action

Staff who work together must train together.

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

4: MANAGING COMPLEX PREGNANCY

Essential Action	
There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	• Women with complex pregnancies must have a named consultant lead. • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team. • The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians. • This must also include regional integration of maternal mental health services..

5: RISK ASSESSMENT THROUGHOUT PREGNANCY

Essential Action	
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	• All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional. • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

6: MONITORING FETAL WELLBEING

Essential Action

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

- The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on:
  - Improving the practice of monitoring fetal wellbeing
  - Consolidating existing knowledge of monitoring fetal wellbeing
  - Keeping abreast of developments in the field
  - Raising the profile of fetal wellbeing monitoring
  - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported
  - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on he review of cases of adverse outcome involving poor FHR interpretation and practice.
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

7: INFORMED CONSENT	
Essential Action All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	• All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care • Women must be enabled to participate equally in all decision making processes and to make informed choices about their care. • Women's choices following a shared and informed decision making process must be respected.

Appendix 3: Glossary of terms

Definitions and medical and midwifery terms used throughout our report

Abruption	Is the early separation of a placenta (afterbirth) from the lining of the uterus before completion of the second stage of labour. It is one of the causes of bleeding during the second half of pregnancy.
Abscess	Collection of pus
Absent End-Diastolic Flow	Is a useful feature which indicates underlying fetal vascular stress if detected in mid or late pregnancy
Acidaemia	A condition of raised blood acidity
Acute respiratory distress syndrome (ARDS)	A life-threatening lung injury that allows fluid to leak into the lungs. Breathing becomes difficult and oxygen cannot get into the body
Advanced neonatal nurse practitioners (ANNP)	Introduced to undertake the Tier 1 duties on the neonatal rota, jointly shared with ST1 - 3s. The post holders practice at a senior practitioner level to provide autonomous clinical care
Anomalous Left Coronary Artery to Pulmonary Artery (ALCAPA)	A very rare form of congenital heart disease
Amniocentesis	A medical procedure to obtain a small amount of amniotic fluid that is used to further investigate suspected fetal chromosomal abnormalities
Amnio-infusion	Refers to the instillation of fluid into the amniotic cavity
Amniotic Fluid Embolism	A rare condition where the amniotic fluid – which surrounds and protects a baby inside the womb – can leak into the mother's blood vessels during labour, causing a blockage. This can lead to breathing problems, a drop in blood pressure and loss of consciousness. A small number of women survive amniotic fluid embolism with risks of long-term complications including neurological problems because of a lack of oxygen to the brain, however most women do not survive
Amniotomy	Artificial rupture of the membranes (ARM)
Anaemic	Lack of enough red blood cells to carry adequate oxygen to the body's tissues
Antepartum	The period of pregnancy that includes the 24th week of pregnancy until birth

Antihypertensive medication	Drugs used to control high blood pressure
Apgar score	This is an accepted method of assessing how a newborn baby has adapted to extrauterine life, immediately following birth
Augmentation of labour	Is the process of increasing the frequency, length and strength of uterine contractions after the onset of labour either by intravenous oxytocin infusion and/ or artificial rupture of membranes. It can be used to increase uterine contractions when they are reduced, particularly during prolonged labour and facilitate cervical dilatation and vaginal birth
Auscultation	A method of periodically listening to the fetal heart with a stethoscope
Arachnoid cyst	Benign cyst in the brain
BCH	Birmingham Children's Hospital
Birthing centre	A birth centre staffed by midwives, they may be "stand alone", (some distance from a consultant-led unit) or alongside, often in the same building/ on the same floor as a consultant-led unit.
Birthrate Plus® (BRP)	Is a method for assessing the needs of women for midwifery care throughout pregnancy, labour and the postnatal period in both hospital and community settings. From the data collated, the methodology calculates the number of midwives required to meet the defined standards and models of care whilst informing local workforce requirements, holiday and travel allowances etc
BLISS	A charity for babies born premature or sick
Born Before Arrival (BBA)	Refers to a birth which takes place before arrival to a maternity unit, or a homebirth before the arrival of a midwife
Bougie	A small wire over which a breathing tube can be passed in difficult airways
British Association of Perinatal Medicine (BAPM)	Is a professional association and registered charity. They aim to improve standards of perinatal care by supporting all those involved in perinatal care to optimise their skills and knowledge, deliver and share high quality safe and innovative practice, undertake research, and promote the needs of babies and their families
Cabergoline	A drug used to suppress lactation (milk production).
Caesarean hysterectomy	Hysterectomy (surgical removal of the womb) at the time of, or soon after, delivery by caesarean section

CAF	Common Assessment Framework is a tool designed to help practitioners working with children, young people and families to assess children and young people's additional needs and strengths for earlier, and more effective services, and develop a common understanding of those needs and how to work together to meet them
Cardiopulmonary	Relating to the heart and lungs
Cardiotocograph (CTG)	A technical means of recording the fetal heart rate and the uterine contractions during pregnancy and labour
Care Quality Commission (CQC)	An executive non-departmental public body of the Department of Health and Social Care of the United Kingdom. It was established in 2009 to regulate and inspect health and social care services in England
Category 1 caesarean section	Is when there is immediate threat to the life of the woman or fetus and delivery is recommended within 30 minutes
Category 2 caesarean section	Is when there is maternal or fetal compromise which is not immediately life-threatening and delivery is recommended within 75 minutes.
Catheter	Tube (usually to drain the bladder)
CBT	Cognitive Behavioural Therapy
CDH	Congenital diaphragmatic hernia, a serious congenital anomaly where some of the bowel lies within the chest and causes breathing difficulties
CEMACH	Confidential Enquiry into Maternal and Child Health
Cerebral Palsy	Is caused by a problem within the brain that develops before, during or soon after birth. Cerebral Palsy affects movement and coordination
Clinical Commissioning Groups (CCG)	Were established as part of the Health and Social Care Act in 2012, and consist of groups of general practices (GPs) which come together in each area to commission the best services for their patients and population
Clinical Negligence Scheme for Trusts (CNST)	An insurance scheme administered by NHS Resolution (NHSR) in which individual NHS organisations pay an annual premium to mitigate against the cost of clinical negligence claims. Trusts which achieve standards set by the scheme receive a reduction in premiums
Chorioamnionitis	A serious condition in pregnant women in which the membranes that surround the fetus and the amniotic fluid are infected by bacteria. It can also cause serious complications in the newborn baby. This includes infection (such as pneumonia or meningitis), brain damage, or death

Coagulopathy	Coagulopathy is often broadly defined as any derangement of haemostasis resulting in either excessive bleeding or clotting, although most typically it is defined as impaired clot formation
Colloid fluid	Non-crystal fluid used as a temporary substitute for blood
Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI)	Was created to improve the understanding of the causes of death in late fetal life (from 20 weeks post-conception) to infancy (one year after birth). CESDI created a standardised grading system to categorise mortality reviews and identify cases of suboptimal care
Consultant-led Unit (CU)	Refers to a maternity unit which has the support of obstetricians and midwives to facilitate high-risk care during the antenatal, intrapartum or postnatal period. Consultant-led units also require the support of the wider multi-disciplinary team including (but not limited to) anaesthetists, theatres and a neonatal team
Consultant obstetric unit	A place to give birth staffed by obstetricians, midwives and anaesthetists. They have a neonatal unit staffed by neonatologists and nurses
Continuous Positive Airway Pressure (CPAP)	It is a type of non-invasive ventilation (NIV) or breathing support
Cooling	Therapeutic hypothermia is an effective way to treat newborn babies who have experienced a lack of oxygen and/or blood flow to the brain and other organs before or during labour and delivery. Reducing a baby's body temperature to 33.5oC to protect the brain
Cord prolapse	Happens when the umbilical cord slips down in front of the baby after the waters have broken. The cord can then come through the open cervix (entrance of the womb)
Counselling	Professional guidance and discussion to support complex choices with families that ensures sharing of evidenced-based information to enable informed decision and personalised care
CPR	Cardio pulmonary resuscitation (chest compressions and breaths)
Critical care unit	Intensive care or high dependency care unit
CRP	C-reactive protein. A marker of infection or inflammation
Crystalloid	A solution of water and salts for intravenous administration
Culture	Organisational culture represents the shared ways of thinking, feeling, and behaving in healthcare organisations

Diaphragmatic Hernia	Diaphragmatic hernia is a birth defect where there is a hole in the diaphragm
DATIX	An incident reporting form
Dichorionic, diamniotic (DCDA) twins	Each has their own separate placenta with its own separate inner membrane (amnion) and outer membrane (chorion)
Direct Maternal Deaths	Are defined as those related to obstetric complications during pregnancy, labour or puerperium (six weeks) or resulting from any treatment received.
Deflexed occipito-posterior position	Poor position of the fetal head
Diuretics	Drugs used to increase urine production
Doppler assessment	Assessment of the blood flow in various fetal blood vessels, commonly the umbilical vessels or the middle cerebral artery (MCA)
Dual instruments	There are two main instruments used in operative deliveries – the ventouse and the forceps. In general, the first instrument used is the most likely to succeed. Dual instrumentation describes both types of instruments being used to perform an operative vaginal delivery
Duty of candour	Legislation to ensure that providers are open and transparent with people who use services. It sets out some specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
Each Baby Counts	A national quality improvement programme set by Royal College of Obstetricians and Gynaecologists (RCOG) to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. This improvement programme is now closed
Eclamptic fit	A fit occurring as a consequence of severe pre-eclampsia
E. Coli	A bacterium that can cause infection
EMDR	Eye Movement Desensitisation and Reprocessing
Empyema	Pus in a body cavity
Endometritis	Infection within the uterus (womb)
Escalate	To become more important or serious, or to make something or someone do this.
Executive Director	A member of a board of directors who also has managerial responsibilities
Extended perinatal death	A stillbirth or neonatal death

External Cephalic Version (ECV)	Is a process by which a breech baby can sometimes be turned from buttocks or foot first to head first. It is a manual procedure that is recommended by national guidelines for breech presentation of a pregnancy with a single baby, in order to enable vaginal delivery
Extradural haematoma	A sub-periosteal haematoma located on the inside of the skull, between the inner table of the skull and parietal layer of the dura mater (which is the periosteum)
Extubation	Removal of an artificial breathing tube from a baby's airway
EUA	Examination under anaesthetic
Faecal incontinence	Lack of bowel control
Fetal blood sampling (FBS)	Is a procedure to take a small amount of blood from an unborn baby (fetus) during pregnancy. FBS should be advised in the presence of a pathological fetal heart rate (FHR) trace unless there is clear evidence of acute compromise (i.e. immediate delivery is thought necessary)
Fetal bradycardia	Fetal heart rate of less than 120 beats per minute
Fetomaternal haemorrhage	The entry of fetal blood into the maternal circulation before or during delivery
Fibroids	A benign tumour of muscular and fibrous tissue which develops in the wall of the uterus
Footling breech	Is when one or both of the baby's feet are born first
Forceps	An instrument shaped like a pair of large spoons which are applied to the baby's head in order to guide the baby out of the birth canal
Fresh eyes assessment	Refers to a "buddy system" of CTG review to improve interpretation and documentation
Funisitis	Inflammation of the connective tissue of the umbilical cord that occurs with chorioamnionitis
Furosemide	A drug that promotes removal of fluid from the body by production of urine, a diuretic
GAP	The Growth Assessment Protocol: a national programme to improve patient safety in maternity care
Gastroschisis	A defect of the abdominal wall where intestines are found outside of the baby's body, exiting through a hole alongside the umbilicus (belly button)
General Medical Council (GMC)	A statutory body with the purpose to protect, promote and maintain the health and safety of the public by working to protect patient safety and support medical education and practice across the UK. The GMC works with doctors, employers, educators, patients and other key stakeholders in the UK's healthcare systems

Governance	The way that organisations are managed at the highest level, and the systems for doing this. Clinical governance can be defined as a framework through which the National Health Service (NHS) organisations and their staff are accountable for continuously improving the quality of patient care. NHS staff need to ensure that the appropriate systems and processes are in place to monitor clinical practice and safeguard high quality of care
GROW Chart	Customised antenatal charts for plotting fundal height and estimated fetal weight
Growth retardation	Growth significantly less than expected
Grunting/grunty	An abnormal noise made by a newborn baby with breathing issues
Guedel airway	A device placed in the mouth to keep the airway open
Haematoma	Blood clot (not in a blood vessel)
Haematologist	A doctor specialising in disorders of the blood
Haematuria	Blood in the urine
Haemodynamic	Relating to the flow of blood
Haemoperitoneum	Blood in the abdominal cavity
Hb	Haemoglobin level i.e. assessment of anaemia
HDU	High Dependency Unit
Healthcare Commission (HCC)	The Commission for Healthcare Audit and Inspection, also known as the Healthcare Commission was created in 2004. It was responsible for assessing standards of care provided by the NHS. Its responsibilities were taken over by the Care Quality Commission in 2009
Headbox oxygen	An oxygen hood or head box is used for babies who can breathe on their own but still need extra oxygen. A hood is a plastic dome or box with warm, moist oxygen inside. The hood is placed over the baby's head
HELLP	Haemolysis (of red blood cells): Elevated Liver (enzymes): Low Platelets. HELLP is a syndrome that occurs with serious pre-eclampsia, and indicates severely deteriorating organ function
High frequency oscillatory ventilation (HFOV)	An advanced form of respiratory support
Hypoxic ischemic encephalopathy (HIE)	Refers to the damage caused in a baby's brain when the baby does not receive enough oxygen and / or blood flow around the time of birth, or during pregnancy. Graded into HIE grades 1-3 depending on severity
High Risk Case Review (HRCR)	An internal process used in Shrewsbury and Telford Hospitals NHS Trust over the period of this review created to investigate incidents which were said to not meet the threshold for being a Serious Incident

The Healthcare Safety Investigation Branch (HSIB)	They investigate incidents that meet the Each Baby Counts criteria and their defined criteria for maternal deaths *www.hsib.org.uk/maternity/what-we-investigate/*
Higher Specialist Trainee (HST)	Middle grade, or Tier 2 doctor, registrar
'Hub and Spoke' Model	Refers to a specific type of service model design consisting of a main base supported by additional bases or branches. In maternity services, the hub is the consultant-led unit and the spokes are midwiferyled units or community bases
Human factors	Refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety
Humerus	The long bone in the arm
Hydronephrosis	Swelling of the system that collects urine from the kidney, usually because of obstruction lower down the renal tract
Hypercalcaemic	High calcium levels in the blood
Hyperinsulinism	Excessive secretion of insulin, leading to low blood sugar
Hypertension	High blood pressure
Hypotension	Low blood pressure
Hypotensive	Abnormally low blood pressure
Hypothermic cooling	Involves cooling the baby down to a temperature below homeostasis to allow the brain to recover from a hypoxic-ischemic injury
Hypovolaemia	Low blood volume, usually secondary to blood loss
Hypoxia/Hypoxic	Is a state in which oxygen is not available in sufficient amounts at the tissue level to maintain adequate homeostasis; this can result from inadequate oxygen delivery to the tissues either due to low blood supply or low oxygen content in the blood (hypoxemia)
Indirect Maternal Deaths	Are those associated with a disorder, the effect of which is exacerbated by pregnancy
Indices of Deprivation	Are datasets used to classify levels of deprivation within small areas. Deprivation rates are measured by the assessment of various factors including income, employment rates, education, housing and crime
Inflammatory markers	Substances that can be measured in blood tests that, when elevated, indicate that there is inflammation occurring within the body
Infused	Given intravenous fluid (not blood)
Inotropes	Intravenous medication to treat very low blood pressure

International Normalised Ratio (INR)	A blood test/ calculation which assesses the time taken for blood to clot
Intermittent auscultation (IA)	The technique of listening to and counting the fetal heart rate (FHR) for short periods during active labour
Instrumental delivery	An assisted birth (also known as an instrumental delivery) is when forceps or a ventouse suction cup are used to help deliver the baby
Intrapartum	During labour
Intrauterine death (IUD)	Also called stillbirth: An unborn baby dies inside the womb before birth. This is described as 'late' when it happens in a woman who is 24 weeks pregnant or more, and is estimated to occur in 1% of all pregnancies
Intraventricular Haemorrhage (IVH)	Bleeding inside or around the ventricles within the brain
ITU	Intensive therapy (care) unit
Intubation	Placing a breathing tube in a baby's airway to assist ventilation
Intraventricular haemorrhage (IVH)	Bleeding into the fluid cavities within the brain, usually in preterm babies
Ketonuria	Occurs when high levels of ketone bodies which occur when cells are broken down for energy are present in the urine
KIDS-NTS	Children's and Neonatal Transport team for the West Midlands
Labour ward coordinator	Senior midwives who coordinate the clinical workload and activity on the labour ward
Laparotomy	Surgical opening of the abdomen
Laryngeal mask	A device placed in the airway instead of intubation
Liquor	The water surrounding the baby in the womb
Left ventricular failure	When the left side of the heart is unable to pump blood to the body effectively such that it is insufficient for the body's needs
Level 3 neonatal unit	Neonatal units are graded 1-3, 3 being equipped to care for the most pre-term and unwell infants requiring the highest levels of investigation and treatment
LMNS	Local Maternity and Neonatal System
LNU	Local Neonatal Unit (formerly known as level 2 neonatal unit)
Local Authority	Refers to an organisation within local government which is responsible for public services and facilities.

Local Maternity System (LMS)	The Local Maternity Systems are the mechanism through which it is expected that a Sustainability and Transformation Partnership (STP) will collaboratively transform maternity services with a focus on delivering high quality, safe and sustainable maternity services and improved outcomes for women and their families. The LMS's are overseen by the Maternity Transformation Board
Local Supervising Authority Midwifery Officer (LSAMO)	A senior officer who was responsible for upholding the standards of statutory midwifery supervision at a regional level. Statutory supervision was abolished in 2017
Local Supervisory Authority (LSA)	This organisation was responsible for the function of statutory supervision of midwives. The LSA was accountable to the Nursing and Midwifery Council (NMC) which set rules and standards for midwifery. This authority was disbanded when Supervision of Midwifery was abolished
Loculated empyema	Pockets of pus that have collected inside a body cavity
LSCS	Lower segment caesarean section
Lower specialist trainee (LST)	Tier 1 doctor or Senior House Officer
Macrosomic	A newborn baby that is much larger than expected
Magnesium infusion	Drip used to decrease the risk of an eclamptic fit
Malpositioned baby	Usually the fetal head engages in the occipito-anterior position (more often left occipito-anterior (LOA) rather than right) and then undergoes a short rotation to be directly occipito-anterior in the mid-cavity. Malpositions are abnormal positions of the vertex of the fetal head relative to the maternal pelvis
Maternal death	Defined as the death of a woman while pregnant or within 42 days of termination of pregnancy
Maternity Dashboard	Is a tool which can be used within clinical governance to benchmark activity, and to monitor quality and performance indicators such as birth complications and mode of delivery
Maternity and Neonatal Collaboration	The maternity and neonatal safety collaborative is a programme to support improvement in the quality and safety of maternity and neonatal units across England
Maternity Transformation Programme	The purpose of the Maternity Workforce Transformation Strategy is to support NHS maternity services to deliver more personalised and safer care and improve outcomes for women by ensuring that there is the capacity in the workforce nationally

Maternity Voices Partnerships (MVP)	A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care
Mat Neo collaborative	The maternity and neonatal safety collaborative is a programme to support improvement in the quality and safety of maternity and neonatal units across England
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. A national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths
MDT	Multi-disciplinary Team
Meconium	Baby's bowel contents in the liquor (water) which sometimes suggests fetal distress (thick meconium is more likely to suggest this)
MEWS or MEOWS	An early warning score or guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs. The MEOWS is a Modified Early Obstetric Warning System
Midwife-led units (MLU)	Are another name for birth centres that are run by midwives and have a home-like environment. They are most suitable for women without complications and can be next to a hospital maternity unit ('alongside') or situated in the community ('freestanding')
Midwifery Continuity of Carer (MCoC)	Midwifery continuity of care is a model of care, which aims to limit the number of different healthcare professionals a woman sees throughout her pregnancy. Its aim is that the pregnant woman will receive intrapartum care from a midwife she has met previously during her current pregnancy, thereby providing greater continuity
Mifepristone	A drug used to prepare the uterus (womb) for early contractions usually induced by another drug given approximately 36 hours later
Monochorionic twins	Twins sharing the same blood supply from the placenta. This can lead to unequal sharing of the blood supply which can lead to the death of one or both twins
Moulding	The bones of the fetal head can move closer together or overlap to help the head fit through the pelvis.
MRI scan	Magnetic Resonance Imaging –detailed scan, often of the brain
Multiparous	A woman who has given birth once or more

Multidisciplinary team	Is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended care. In maternity this tends to be midwives, obstetricians, anaesthetists and neonatologists
Myelomeningocele	A form of spina bifida where the spinal cord is exposed at birth. This is when a sac of fluid comes through an opening in the baby's back. Part of the spinal cord/ nerves can be in the sac and are damaged
Neonatal Data Analysis Unit (NDAU)	Analyses neonatal data nationally
National Reporting and Learning System (NRLS)	Is a central database of patient safety incident reports
Neonate	Refers to an infant in the first 28 days after birth
Neonatal death	An infant who dies in the first 28 days of life • Early neonatal death - a live born baby who died before 7 completed days after birth • Late neonatal death - a live born baby who died after 7 completed days but before 28 completed days after birth
Neonatal Networks	A network of neonatal units working together to provide neonatal care to a geographical area. Also knows as 'managed clinical networks' or 'operational delivery networks'
NHS England and NHS Improvement (NHSE&I)	The body that leads the NHS in England
NHS Litigation Authority (NHSLA)	The NHS Litigation Authority (NHSLA), now known as NHS Resolution (NHSR), manages negligence and other claims against the NHS in England on behalf of its member organisations. Its aim is to help resolve disputes fairly; share learning about risks and standards in the NHS and help to improve safety for patients and staff
NHS Resolution	A body of the Department of Health and Social Care. It provides expertise to the NHS on resolving concerns and disputes fairly, sharing learning for improvement and preserving resources for patient care
National Institute for Health and Care Excellence (NICE)	Provides national guidance and advice to improve health and social care
NICHE	An independent consultancy service available to all healthcare providers (including mental health, acute, specialist, ambulance, primary and community), social care partners, commissioners, local authorities and regulatory organisations
NICU	Neonatal intensive care unit
NLS	Newborn Life Support Course (national training course)

NMR	Neonatal mortality rate (deaths within 28 days of life)
National Neonatal Audit Project (NNAP)	National audit of neonatal outcomes
NNU	Neonatal unit
Non-Executive Director (NED)	A board member without responsibilities for daily management or operations of the organisation
NQM	Newly qualified midwife of less than one year since becoming a professional registrant.
Nulliparous	Describes a mother who has not given birth before
Nursing and Midwifery Council (NMC)	The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
Occipito posterior position	Common malpresentation in labour, which can be associated with a prolonged labour
Oedema	Accumulation of fluid in bodily tissues
Office of National Statistics (ONS)	Is responsible for collating and publishing statistics relating to health, economy, population and society at local, regional and national levels
Open Book	The cases identified by the Open Book arose from the Shrewsbury and Telford Hospital NHS Trust (supported by NHSI) undergoing its own investigation of cases of stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3) and maternal deaths. These were then reported to the review team
Operative delivery	Refers to a delivery in which the operator uses forceps, a vacuum, or other devices to extract the fetus from the vagina, with or without the assistance of maternal pushing
Operative vaginal delivery	Vaginal birth assisted with forceps or ventouse
Organisational structure	The way in which a large company or organisation is organised, for example, the types of relationships that exist between managers and employees
Oscillator	A form of high frequency ventilatory support that keeps the lungs open with a constant positive end-expiratory pressure
Oxygen saturation	Concentration of oxygen carried in the blood
Oxytocin	A hormone commonly used in obstetric practice to increase uterine activity
Paediatric	Branch of medicine that is dealing with infants, children and adolescents
Parliamentary and Health Service Ombudsman (PHSO)	An organisation which works with individuals and groups in an organisation to explore and assist them in determining options to help resolve conflicts, problematic issues or concerns, and to bring systemic concerns to the attention of the organisation for resolution

PCT	Primary Care Trust
Perinatal	The period of time that includes the entirety of pregnancy up until and including the first complete year following birth
Perinatal death	A stillbirth or early neonatal death
Perineal tear	A tear occurring during childbirth. 1st and 2nd degree tears are common, and not serious. A 3rd degree tear involves the anal sphincters as well as skin, vagina and muscle. A 4th degree tear extends into the rectum
Perineal follow-up clinic	A clinic to follow-up women who have experienced 3rd and 4th degree tears
Perinatal loss	Loss of a baby during pregnancy or soon after birth. Includes stillbirths and neonatal deaths
Peritoneum	The membrane which lines part of the abdominal cavity and covers the organs that lie within it
Placental	Reference to the 'afterbirth'
Placental abruption	When the placenta separates from the uterine wall either before or during labour
Placenta accreta	Abnormally deep attachment of the placenta into the muscle of the uterus (womb)
Perinatal mortality rate (PMR)	Stillbirths and deaths within 7 days of life
Post-partum haemorrhage (PPH)	Significant bleed after giving birth
Post-partum	After the birth
Pre-eclampsia (PET)	A condition that affects some pregnant women, usually during the second half of pregnancy (from 20 weeks) or soon after their baby is delivered. Early signs of pre-eclampsia include having high blood pressure (hypertension) and protein in the urine (proteinuria). The condition can be very serious for mother and baby
Pre-labour preterm rupture of membranes (P-PROM)	Is the rupture of membranes prior to the onset of labour, in a patient who is at less than 37 weeks of gestation
PRH	Princess Royal Hospital- Telford- current location of neonatal service
Primary Care Trust (PCT)	Were part of the National Health Service in England from 2001 to 2013. PCTs were responsible for commissioning primary, community and secondary health services from providers. Primary care trusts were abolished on 31 March 2013 as part of the Health and Social Care Act 2012, with their work taken over by Clinical Commissioning Groups (CCGs)
Primiparous or Primigravid	A woman who is pregnant for the first time

Professional Midwifery Advocates (PMAs)	Support midwives to ensure that women and babies receive good quality, safe care
Prophylactic	Intended to prevent something occurring by being given early – for example a medication
Prostaglandin	A synthetic hormone that is used in obstetrics to encourage uterine contractions and cervical ripening (Shortening and dilatation)
Proteinuria	Protein detected in a urine sample
Pulmonary	Relating to the lungs
Pulmonary oedema	An excess of watery fluid in the lungs
Pyelonephritis	Severe kidney infection
Pyrexia	High temperature
Qualified in Speciality (QIS)	Postgraduate specialist training for neonatal nurses
Royal College of Midwives (RCM)	A professional organisation and trade union committed to serving midwifery and its workforce
Royal College of Obstetricians & Gynaecologists (RCOG)	Professional body of obstetricians to improve healthcare for women everywhere, by setting standards for clinical practice, providing doctors with training and lifelong learning, and advocating for women's healthcare worldwide
RCPCH	Royal College of Paediatrics and Child Health
Respiratory Distress Syndrome (RDS)	Breathing difficulty, usually in preterm babies due to immature lungs
Retained products	Pieces of placenta and/or membrane left in the uterus (womb) after delivery of the placenta (afterbirth)
Retropubic haematoma	Blood clot formed behind the pubic bone
Rectovaginal fistula	An abnormal channel that has developed between the rectum and vagina usually as a consequence of childbirth
Rectus sheath haematoma	Blood clot caused by bleeding from the rectus abdominus muscle (i.e. abdominal wall muscle)
Risk Management Strategy	The systematic identification, assessment and evaluation of risk. Used properly in healthcare, it can not only be a process to report incidents, but also minimise the harm that clinical or resourcing errors can cause to patients and staff
Root Cause Analysis (RCA)	Is the process of examining what happened in order to establish, how and fundamentally why an adverse event occurred. It should result in preventative measures to minimise future risk of reoccurrence.
RSH	Royal Shrewsbury Hospital – former location of neonatal service
SANDS	Stillbirth and neonatal death support charity

SaTH	Shrewsbury and Telford Hospital or NHS Trust or the Trust
Situation, Background, Assessment and Recommendation (SBAR)	An easy to use, structured form of communication that enables information to be transferred accurately between individuals
SBR	Serum bilirubin – to determine the level of jaundice in a baby
Serious Incidents (SI)	Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in unexpected or avoidable death, serious harm or injury. Serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Previously known as Serious Untoward Incidents (SUI)
Sepsis	Severe infection
Septicaemia	Blood poisoning
Shock	Fall in blood perfusing organs, usually recognised because of a fall in blood pressure and a rise in heart rate. Shock has a number of possible causes, blood loss being the most common in maternity patients
Shoulder dystocia	Shoulder dystocia is when a baby's head has been born but one of the shoulders becomes stuck behind the mother's pubic bone, delaying the birth of the baby's body
Situational awareness	Can be defined simply as 'knowing what is going on around us', or – more technically – as 'the perception of the elements in the environment within a volume of time and space, the comprehension of their meaning and the projection of their status in the near future'
Spina Bifida	A condition that affects the spine and is usually apparent at birth. It is a type of neural tube defect (NTD)
Squamous epithelial cells in the pulmonary vessels	Cells from the baby found in the lung vessels of the mother
SSCBCN	Staffordshire, Shropshire and Black Country Neonatal Network
SSCBCODN	Staffordshire, Shropshire and Black Country Operational Delivery Network
Stillbirth	A stillbirth is the death of a baby occurring before or during birth once a pregnancy has reached 24 weeks. An antenatal stillbirth occurs at or prior to the onset of labour. An intrapartum stillbirth occurs after the onset of labour

Subarachnoid haemorrhage	Bleeding in the space between the brain and the skull
Surfactant	A medicine given directly into the lungs of premature babies
Symphysis fundal height	A measurement from the Symphysis Pubis to the top of the fundus (womb) that monitors fetal growth
'T' incision	When the cut made on the uterus is both horizontal and vertical. The subsequent scar is weak, and therefore there is a greater risk of uterine rupture in a future pregnancy
Tachycardia	Fast heart rate
Talipes	A condition affecting one or both feet that is caused by a shortened Achilles tendon or as a result of fetal lie within the womb. Usually self-resolving with exercise or physiotherapy, but in some cases requires further intervention
Tethered Conus	Neurological condition where the end of the spinal cord is fixed by tissue attachments at the bottom of the spinal canal rather than moving freely
Therapeutic lactation suppression	Use of drugs to suppress milk production
Thermoregulate	Whereby the body maintains its core temperature
Third or fourth degree perineal tear	A perineal tear which involves damage to the fourchette, perineal skin, vaginal mucosa, muscles, and anal sphincter
Thrombosis	Blood clot in a blood vessel, usually in a vein
TOBY registry	A national register of babies that received cooling for HIE
Tocophobia	Is a pathological fear of pregnancy and can lead to avoidance of childbirth
Transfused	Given a blood transfusion
Transport team	A specialist service for safely transferring babies between care providers
Trial of instrumental birth	A term used when a difficult instrumental birth is anticipated, usually performed in an operating theatre with quick and easy recourse to caesarean section
Twin to twin transfusion syndrome (TTTS)	Is a rare condition that occurs during a twin pregnancy when blood moves from one twin (the 'donor twin') to the other (the 'recipient twin') while in the womb
UHNM	University Hospitals of North Midlands (Royal Stoke University Hospital)
Ureter	Tube down which urine passes from the kidney to the bladder
Ureteric obstruction	Blockage of the ureter

Urologist	A doctor specialising in disorders of the urinary tract
Uterine artery	Main artery (but not only artery) supplying blood to the uterus (womb)
Uterine rupture	When the uterine wall bursts, this usually occurs during labour, but can occur during pregnancy. Uterine rupture generally occurs when the uterus has a previous scar. Some types of scar, increase the risk of rupture in future pregnancies
Urinary PCR	Protein/creatinine ratio in the urine to measure the level of protein more accurately than a dipstick assessment
Ventouse delivery	A suction cap is applied to the baby's head in order to deliver the baby through the birth canal
WMNODN	West Midlands Neonatal Operational Delivery Network

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Hearing the voices of staff

Provided to the review team by the Trust

Appendix 5: Terms of reference (TOR)

Original terms of reference as of May 2018

An independent review of the quality of investigations and implementation of their recommendations relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at Shrewsbury and Telford Hospitals (the Trust).

The review will be led by NHS Improvement and will cover incidents raised with the Secretary of State in a letter dated 6 December 2016 requesting an independent inquiry (subject to receiving consent from the families).

Background

This review follows a number of serious clinical incidents, beginning with a new born baby who sadly died in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. In subsequent years from 2009 until 2014 a number of further investigations and reviews (internal and external) were also undertaken to confirm whether:

- Appropriate investigations were conducted and
- The assurance processes relating to investigations in the maternity service were adequate.

In response to these previous reviews a comprehensive maternity service improvement action plan was put in place by the Trust. The progress of the implementation of the recommendations from these previous reviews has been monitored on a continual basis by the Trust Board. The action plan was devised with input from the parents of the baby who died in 2009. The parents have received ongoing communication in regard to the progress and implementation of actions identified within the plan.

Scope and purpose of this latest independent review

The independent review will be undertaken by a multidisciplinary **REVIEW TEAM** of independent external reviewers who will submit their findings to an **INDEPENDENT REVIEW PANEL**.

The **REVIEW TEAM** will comprise:

- Two midwives
- Two obstetricians
- Two neonatologists

The multidisciplinary **REVIEW TEAM** will undertake to:

- Review only those cases for which consent is granted to access the records pertaining to the case;
- Review the quality of the investigations and subsequent reports into the identified cohort of incidents;
- Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;
- Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;
- Consider how the parents, patients and families of patients were engaged with during these investigations;
- Reserve the right to undertake a second-stage review of primary cases should the considerations

above justify such action following agreement with the Executive Medical Director NHS Improvement and

- Present their findings of the review of each case to the REVIEW PANEL for challenge and quality assurance monitoring.

The **INDEPENDENT REVIEW PANEL** will undertake to:

Receive and quality assure the **REVIEW TEAM's** findings in each case reviewed;

- Under the leadership of the chair, develop the report of the findings of the review and
- Actively engage and communicate with families relevant to the specified cases, where they have expressed a preference for such engagement, in particular around the review's findings and recommendations.

In addition the **INDEPENDENT REVIEW TEAM** will assess the extent to which the Trust had appropriate arrangements in place for the oversight and governance of the incidents and the reporting mechanisms to the Trust Board.

The review process will comprise:

- A review of all the investigations in the cohort including but not limited to root cause analysis (RCAs), preliminary fact finding reviews, supervisory investigations and associated action plans from each incident investigation. All will be reviewed in relation to the then contemporaneous Trust policy and National Guidance;
- A review of the relevant / associated improvement plan and pace of improvement against the timelines identified in the plan and
- Contact with parents or relatives to establish their understanding of their involvement in previous investigations.

The **REVIEW TEAM** and **REVIEW PANEL** will be provided with direction in relation to the conduct of the review to ensure that there is consistency in the approach to reviewing each case. The **REVIEW TEAM** and **REVIEW PANEL** will give due consideration to the application of relevant policies and procedures that were in place both nationally and locally at the time of the incident, as well as during the subsequent investigation process.

If the **REVIEW TEAM** or **REVIEW PANEL** identifies any material concerns that need further immediate investigation or review, the NHS Improvement Executive Medical Director must be notified immediately.

The **REVIEW PANEL** will provide a report and recommendations of any actions required to Dr Kathy McLean, Executive Medical Director, NHS Improvement.

The Review Panel

The **REVIEW PANEL** will be chaired by an independent chair, appointed by NHS Improvement and supported by a panel of experienced clinicians and stakeholders with expertise in maternity services or governance and assurance processes.

The **REVIEW PANEL** will comprise:

- An NHS Improvement-appointed independent chair
- An NHS Improvement-appointed Director of Midwifery from outside the region
- A Senior Quality Manger from NHS Improvement
- An external independent midwife
- An external consultant obstetrician
- An external consultant paediatrician/ neonatologist
- NHS England midwifery representative from outside the region.

Key Principles

The review will be expected to:

- Engage widely, openly and transparently with all relevant parties participating in the review process;
- Be respectful when dealing with individuals who have been impacted by the incidents being investigated;
- Adopt an evidence-based approach;
- Acknowledge the importance of inter-professional cooperation in achieving good outcomes for women and children;
- Consider links to the time relevant national policy and best practice in relation to midwifery and investigation management and
- Consider the implementation challenges of proposals including the workforce.

Timeframe

The final review report and proposals should ideally be available within one month of the review being completed.

Directions to the REVIEW TEAM and REVIEW PANEL in relation to the conduct of the review:

1. Did the Trust have in place at the time of each incident mechanisms for the governance and oversight of maternity incidents? Does the Trust have this now?
2. Were incidents and investigations reported and conducted in line with the time relevant national and Trust policies?
3. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?
4. Were families involved in the investigation in an appropriate and sympathetic way?

Appendix 6: Revised terms of Reference (TOR)

Revised Terms of Reference - November 2019

1. This document sets out the revised Terms of Reference for the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, which was commissioned in 2017 by the Secretary of State for Health. These updated Terms of Reference reflect changes to the scope of the review.
2. The original Terms of Reference set out an 'independent review of the quality of investigations and implementation of their recommendations, relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at Shrewsbury and Telford Hospital (the Trust). The review will be led by NHS Improvement and will cover incidents raised with the Secretary of State in a letter dated 6 December 2016 requesting an independent inquiry.' Terms of Reference, May 2017.
3. Following the original launch of the review, more families have come forward with concerns about the care they received at the Trust. NHS Improvement commissioned an Open Book review of Trust records which also identified additional cases for review. These two factors have led to an extension to the scope of the original independent review as outlined in the original Terms of Reference.

Background

4. The Independent Review was established following a number of serious clinical incidents, beginning with the death of a new born baby in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. From 2009 to 2014 a number of further investigations and reviews (internal and external) were undertaken to confirm whether:

   a. appropriate investigations were conducted; and

   b. the assurance processes relating to investigations in the maternity service were adequate.

Governance

5. The review was commissioned by the Secretary of State for Health.
6. The NHS Senior Responsible Officer for the review is the National Medical Director of NHS Improvement and NHS England who will periodically update the Department of Health and Social Care on progress.
7. The review will continue to be led by independent Chair, Donna Ockenden and the final report will be presented to the Department of Health and Social Care.
8. The Chair will be supported by the Review Team, a multidisciplinary clinical team of independent external reviewers.

Revised scope

9. The review will now include all cases which have been identified since the original review was established. Cases where families have contacted various bodies with concerns regarding their own experiences since the commencement of the original review will also have oversight from the clinical review team undertaking the Secretary of State commissioned review. This is in addition to cases identified in the 'Open Book' review. Any reports from previously commissioned reviews will also be submitted to the Chair of the review to ensure consistency and record any recommendations and lessons learnt for sharing more widely. The processes applied to the Trust case review and the associated governance process will also be review

Review approach

10. The multidisciplinary Review Team will:
    a. Review the quality of the investigations and subsequent reports into the identified cohort of incidents;
    b. Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;
    c. Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;
    d. Consider how the parents, patients and families of patients were engaged with during these investigations;
    e. Reserve the right to undertake a second-stage review of primary cases should the considerations above justify such action following agreement with the National Medical Director of NHS Improvement and NHS England; and
    f. The review team will present cases internally, and on an as required basis seek further external advice
11. If the Review Team identifies any material concerns that need further immediate investigation or review, the National Medical Director of NHS Improvement and NHS England must be notified immediately.
12. All relevant case notes and other information will be passed by the Trust to the Chair and the Review Team and will be treated confidentially by them. Every effort will be made to contact families to let them know whether their case forms part of the review and to ask how they wish to be engaged, if at all. In the interests of conducting a comprehensive review and maximising the clinical learning, it is necessary for the Chair and Review Team to consider all cases within the scope of the review but no patient or family member will be identified by name in the final published report unless they have consented to this.
13. Directions to the Review Team:
    a. Did the Trust have in place, at the time of each incident, mechanisms for the governance and oversight of maternity incidents? Does the Trust have this now?
    b. Were incidents and investigations reported and conducted in line with national and Trust policies, that were relevant at the time?
    c. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?
    d. Were families involved in the investigation in an appropriate and sympathetic way?

Appendix 7: Review team members

Ms Donna Ockenden – Director, Donna Ockenden Limited, Chair of the review.

Donna Ockenden was assisted and supported by the following team members (In alphabetical order from their first name):

Obstetricians

Mr Alexander Taylor – from June 2020

Dr Anthony Falconer – from November 2018 until September 2020

Dr Antoinette Johnson – from March 2021

Dr Austin Ugwumadu – from July 2020

Dr Bode Williams – from April 2021

Dr Bronwyn Middleton – from November 2020

Dr Clare Tower – from March 2021

Professor Dharmintra Pasupathy – from October 2019

Dr Elisabeth Peregrine – from February 2021

Dr Heather Brown – from November 2018 until June 2020

Dr Joanne Page – from November 2020

Dr Jonathan Frappell – from December 2019 until March 2021

Dr Louise M Page – from November 2018 until October 2020

Dr Karin Leslie – from August 2020 until March 2021

Dr Marwan Salloum – from August 2020

Dr Matthew Cauldwell – from January 2021

Dr Michael Magro – from March 2021

Dr Nikki Jackson – from October 2020

Dr Paula Galea – from September 2020

Dr Penny Law – from November 2018 until June 2021

Dr Rachel Marshall-Roberts – from September 2020 until November 2021

Mr Richard Howard – from November 2018

Dr Sandra Newbold – from January 2020

Dr Umber Agarwal – from April 2021

Midwives

Amanda Mansfield – from November 2018 until June 2020 and from March 2021

Amanda Davey – from May 2017

Angela Frankland – from May 2021

Angie West – from May 2017

Bronwen Grigg – from January 2021

Caroline Clarke – from May 2017

Carolyn Romer – from November 2018 until August 2021

Ceri Staples – from September 2020

Charlotte James – from July 2019 until January 2022

Helen Harling – from December 2020 until May 2021

Helen Smith – from March 2020

Jacqueline Oliver – from May 2019

Jane Patten – from May 2017

Jessica Scoble – from September 2019 until September 2020

John Bell – from July 2019

Julie Jones – from November 2018

Dr Kate Nash – from April 2020

Kerry Madgwick – from January 2021

Kerry Thompson – from June 2020

Konstantina Stavrakelli – from September 2020

Lauren Graham – from September 2020

Merida Sculthorpe – from November 2020

Natalie Adams – from September 2020

Nicola Rose-Stone – from November 2019 until November 2020

Teresa Manders – from October 2019

Tina Spiers – from October 2020

Neonatologists

Dr Alison Jobling – from April 2020 until October 2021

Dr Chris Day – from March 2021

Dr Charlotte Groves – from November 2018 until June 2020

Dr Eilean Crosbie – from March 2021

Dr Huw Jones – from November 2018 until March 2021

Dr Lawrence Miall – from March 2021

Dr Michelle Parr – from March 2021

Dr Michael Hall – from March 2019

Professor Minesh Khashu – from June 2021

Dr Ngozi Edi-Osagie – from March 2021

Dr Paul Crawshaw – from February 2019

Dr Ranganna Ranganath – from April 2021 until October 2021

Dr Ryan Watkins – from December 2018 until March 2021

Dr Sarah Davidson – from July 2021

Dr Sunita Seal – from April 2021

Dr Tosin Otunla – from February 2020

Dr Vimal Vasu – from February 2019 until September 2020

Paediatricians

Dr David Gibson – from August 2021

Professor Ian Maconochie – from November 2018 until June 2021

Dr Julian Sandell – from March 2019 until April 2021

Obstetric Physician

Dr Anita Banerjee – from November 2018

Anaesthetist

Dr Andrew Combeer – from February 2021

Dr Elizabeth Combeer – from February 2021

Dr Renate Wendler – from November 2018

Neurologist

Dr Sean J Slaght – from December 2019

Cardiologist

Dr Richard Jones – from May 2020

Intensivist

Dr Phil Young – from July 2020 until March 2021

Dr Frank Schroeder – from May 2021 until December 2021

Family Support and Psychology Provision for Families

Maternity Review Psychology Service, hosted by Midlands Partnership NHS Foundation Trust

Dr Katie Bohane – Lead for Psychology Service from January 2021

Dr Katie Woodward – Clinical Psychologist from April 2021

Eloise Lea – Clinical Psychologist from April 2021

Emma Campbell – Assistant Psychologist from October 2021

Dr Kirsty Langley – Clinical Psychologist from July 2021

Dr Rachel Lucas – Trust Recovery Lead and Director of Psychological Services from June 2020

Dr Ursula Bacon – Clinical Psychologist from September 2021

Dr Victoria Caines – Clinical Psychologist from November 2021

SANDS – Stillbirth and neonatal death charity

Dr Clea Harmer – Chief Executive of Sands from January 2021

Jen Coates – Director of Bereavement Support and Volunteering from June 2020

Maria Huant – Bereavement Support Services Manager from June 2020

Bereavement Training International

Paula Abramson - Bereavement Training International and lead for the Listening Ear Service from June 2020

CBUK – Child Bereavement UK

Ann Chalmers – CEO, Child Bereavement UK from June 2020

Karen Smith – PA to the Chief Executive & Executive Manager from June 2020

Sarah Harris – Director of Bereavement Support and Education from November 2021

Administrative support provided by:

Aimee Humphrey - Administration for the Maternity Review from May 2021

Barbara Watkinson – Administration for the Maternity Review from April 2019 until July 2020

Charlotte Lidster – Administration for the Maternity Review from January 2020 until December 2020

Michelle Wright – First Rate PA, Administration for the Maternity Review from April 2018

Monika Niziol – Administration Assistant to Donna Ockenden the Chair of the Maternity Review from July 2020

Rebecca Jones – Administration Assistant for the Maternity Review from October 2020 until December 2021

Sara Kempton-Hayes – Administration for the Maternity Review from February 2019 until July 2020

Zoe Bolt – Administration for the Maternity Review until September 2018

HR and Employment Law specialist:

Dianne Lambdin, Director Sussex HR Hub Ltd

Communications and media support provided by:

Kristianah Fasunloye – Astraea PR

Shaline Manhertz – Exceeding your potential

Kim Inam – Editing and proofreading

Kirsa Wilkenschildt - Graphic design

Pam Rene – Events support and logistics

Ben Cloud – Millstream Productions, film and video production

Louis Dady – Millstream Productions, film and video production

Legal advice was provided by Gowling WLG:

Nicholas Cunningham

Patrick Arben

Sarah Grey

Claire Van Ristell

Finance support

Jane Blaber – Liberty Bookkeeping

Carol Warmington – Specialist Payroll Services

Hilary Julian – Maximus Accountancy Services Limited

IT support

VENOM IT – IT services provider

Samuel Thompson – Samuel Thompson Corporate Ltd – Website design

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To:

- NHS Trust and Foundation Trust:
  - Chief Executives
  - Chairs
  - Chief Nurses
  - Chief Midwives
  - Medical Directors
- ICS leads and Chairs
- LMNS/LMS leads
- CCG Accountable Officers

CC:

- Regional chief nurses
- Regional chief midwives
- Regional medical directors
- Regional obstetricians

Skipton House
80 London Road
London
SE1 6LH

1 April 2022

Dear colleagues

OCKENDEN – Final report

The Ockenden – Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March.

Donna Ockenden and her team have set out the terrible failings suffered by families at what should have been the most special time of their lives. We are deeply sorry for the loss and the heartbreak they have had to endure.

This report must act as an immediate call to action for all commissioners and providers of maternity and neonatal services who need to ensure lessons are rapidly learned and service improvements for women, babies, and their families are driven forward as quickly as possible.

NHS England and NHS Improvement are working with the Department of Health and Social Care to implement the 15 Immediate & Essential Actions (IEAs) and every trust, ICS and LMS/LMNS Board must consider and then act on the report's findings.

We have announced significant investment to kick-start transformation of maternity services with investment of £127 million over the next two years, on top of the £95 million annual increase that was started last year. This will fund further workforce expansion, leadership development, capital to increase neonatal cot capacity, additional support to LMS/LMNS and retention support. We will set out further information in the coming weeks.

Your Board has a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening at your organisation / within your local system. The Ockenden report should be taken to your next public Board meeting and be shared

with all relevant staff – we strongly recommend everyone reads it, regardless of their role. After reviewing the report, you should take action to mitigate any risks identified and develop robust plans against areas where your services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up. We expect every trust board to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events. A dedicated maternity listening event should take place in the coming months. We will soon publish a revised national policy and guidance on speaking up.

Staff in maternity services may need additional health and wellbeing support. Please signpost colleagues to local support services or national support for our people.

The report highlights the importance of listening to women and their families. Action needs to be taken locally to ensure women have the necessary information and support to make informed, personalised and safe decisions about their care.

It includes a specific action on continuity of carer: *'All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.' (*IEA 2, Safe Staffing page 164)

In line with the maternity transformation programme, trusts have already been asked to submit their MCoC plans by 15 June 2022. In doing so, they must take into account this IEA in ensuring that safe midwifery staffing plans are in place. Trusts should therefore immediately assess their staffing position and make one of the following decisions for their maternity service:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.
2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Boards must also assure themselves that any recent reviews of maternity and neonatal services have been fully considered, actions taken, and necessary assurance of implementation is in place.

We expect there will be further recommendations for maternity and neonatal services to consider later this year given other reviews underway. We are committed to consolidating actions to ensure a coherent national delivery plan.

However, there can be no delay in implementing local action that can save lives and improve the care women and their families are receiving now.

In the 25 January 2022 letter we asked you to set out at a Public Board your organisation's progress against the seven IEAs in the interim Ockenden report before the end of March 2022. Your position should be discussed with your LMS and ICS and reported to regional teams by 15 April 2022. We will be publishing a detailed breakdown of these returns and compliance by Trust with the first Ockenden IEAs at NHSE/I public Board in May. Your trust also needs to provide reliable data to the regular provider workforce return, with executive level oversight.

For organisations without maternity and neonatal services, this report must still be considered, and the valuable lessons digested.

We know you will be as determined as we are to ensure the NHS now makes the changes that will prevent other families suffering such devastating pain and loss.

Yours sincerely

Amanda Pritchard	**Ruth May**	**Professor Stephen Powis**
NHS Chief Executive	Chief Nursing Officer	National Medical Director

NHS
East Kent
Hospitals University
NHS Foundation Trust

BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
People & Culture Committee (P&CC)	28 March 2022	Stewart Baird, Non-Executive Director	Corporate Governance & Risk Consultant	**Yes**	~~**No**~~
Appendices:	None				
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
Assurances received at the Committee meeting:					
Accommodation Strategy (Escalated from the Finance & Performance Committee on 1 March 2022)	• The Committee requested an update report on the Accommodation strategy (Trust Priority Improvement Project) to be brought to its next meeting for discussion to enable the Committee to gain an understanding of the issues in relation to supply and demand.				
February 2022 Integrated Performance Report (IPR) – We Care True North Objectives	• The Committee received and discussed the IPR report and noted the following: ○ Turnover: 12-month rolling average of the total staff turnover (12.6%) remained above the 10% threshold for the 11th month in succession. ○ In-month data currently sits at 11.27%. This shows improvement for four of the last five months and are reflected in premature and Healthcare Assistants (HCA). Turnover hotspots have been identified with individual action plans in place to address them. ○ The Committee received re-assurance of the active interventions to reduce turnover including exit interviews. ○ Data from exit interviews is accumulating, with 50 responses from 228 invites. The top two reasons for leaving are work life balance and relocation. ○ The Committee received re-assurance on the interventions in place to recruit into hard to fill roles including the family first initiative which is showing some success; improved marketing; and building new partnerships with schools. ○ The Committee noted that the issue raised at the last meeting around delay to the international recruitment pipeline due to national shortage of the nursing and midwifery Objective Structures Clinical Examination (OSCE) had now been resolved; and received re-assurance that the Trust was in a good position going forward. ○ Staff engagement: The Committee noted that the staff survey headlines and link to the results will be circulated to staff following the release of the National Staff Survey embargo on 30 March at 09.30a.m.). ○ Sickness absence: Increased above the alerting threshold of 5% to 6.0% in January 2022. A slight decrease to approximately 5.5% was reported in February 2022.				

	○ The Committee noted the recent increase in staff absences due to covid-19 and that it is anticipated that this increase will be reflected in overall absence figures. ○ Appraisal compliance has shown an upward trend during 2021 and increased slightly to 78% in February (5% above the alerting threshold of 73%). ○ The Committee challenged the low appraisal rates for the Non-clinical Care Groups and received re-assurance that targeted intervention is being put in place to ensure compliance. ○ Statutory training compliance has increased over the last four months. Overall compliance is 91.09% (0.09% above the alerting threshold of 91%).
Board Assurance Framework (BAF) & Corporate Risk Register (CRR)	• The Committee noted there was no movement on the BAF and the CRR in relation to 'Our People' during this reporting period. • The Committee also noted the BAF and CRR risks were being re-articulated and that it will receive the full BAF and CRR reports at its next meeting.
Referrals to other Board Committees	• There were no referrals to other Board Committees at this meeting.
Referrals from other Board Committees	• There were no referrals from other Committees at this meeting.
Other items of business	None

Items to come back to the Committee outside its routine business cycle:		
There was no specific item over those planned within its cycle that it asked to return.		
Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
None	N/A	N/A

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) PUBLIC					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Finance & Performance Committee (FPC)	29 March 2022	Stewart Baird, Non-Executive Director (NED)	Corporate Governance & Risk Consultant	**Yes**	~~**No**~~
Appendices:	None				
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
Assurances received at the Committee meeting:					
Month 11 Finance Report	• The Trust delivered a £1.4m surplus position in February 2022, resulting in a £1m favourable/positive variance against plan year to date (YTD). • The Trust's cash position at the end of February 2022 was £12.7m which was £7.8m above the plan, but a significant drop from the March 2020/21 year-end closing balance of £68m. • The total capital expenditure year to date spend to the end of February was £39.1m which was £4m above the internal Trust plan. Forecasting it is expected the Trust will achieve the planned expenditure of £57m at year end. This figure includes target investment funding of £5m, including circa £3m for system capital (GP order comms). • The Committee received re-assurance that the Trust's forecast continues to demonstrate a break-even position at year end. • Additional costs of £2.7m was identified in Febuary 2022 due to Covid bringing the YTD total to £20.6m. In-envelope spend being £0.6m and £2.5m greater than plan in month and H2 YTD. • In view of the change in H2 of the Elective Recovery Funding (ERF) methodology based on monthly Referral to Treat (RTT) completed pathway submissions instead of elective activity levels. £6.7m was included for H2 performance which was below planned levels of activity. • Planning guidance for 2022/23 was received in January 2022 and the Trust has agreed a draft financial plan with Commissioners which has been submitted to the national team. • With a planned deficit position for 2022/23 and a challenging efficiency target, the Committee noted that financial controls will be tightened to ensure there is sufficient working capital. • The Committee discussed the possibility of a commercial function and felt this was something to explore as part of the Trust Board's Group structure conversation in 2022/23.				

Month 11 Savings and Efficiencies Update	• The following were the key highlights of the report to the Committee:
	  • The H2 efficiencies plan contained Covid spend reductions of £5m, a reduction in Vanguard theatre rentals £0.3m, 2gether Support Solutions (2gether) efficiencies of £0.8m, with £2.2m still to be identified at that time.
	  • The savings achieved in February were £1.7m, below the planned figure of £2.4m.
	  • The Month 11 shortfall relates to unidentified schemes as all care groups struggled to find savings due to operational pressures.				

	• The Committee was assured that the full year outturn is looking favourable. • The Committee received re-assurance that a pipeline of ideas is being developed as the basis for delivery of the 2022/23 efficiency programme. • The Committee felt this was a tough year and that a balance needed to be struck with keeping a motivated workforce in alignment with the quality agenda.

We Care Integrated Performance Report (IPR)	• The following were the key highlights of the report to the Committee:
	  • Reducing falls. 147 falls were recorded in February against a target of 100.
	  • Reducing deaths from sepsis. The latest reportable figure of November 2021 shows an improvement in the sepsis/ respiratory Hospital Standardised Mortality Ratio (HSMR) figures of 94.2 this is below our target of 117.
	  • Reducing patient time in Emergency Department (ED) once there has been a decision to admit. Total aggregated delays of 907 hours in our ED remains a significant focus and is higher than our 95-hour target.
	  • Improving theatre capacity. The lost theatre opportunities in month was 60 which is worse than the 45 target.
	  • The Committee agreed to focus on breakthrough objectives at the next meeting.

Financial Recovery Plan (FRP)	• The Committee received assurance on the progress of the FRP to date and agreed the following next steps:
	  • Finalise key components of FRP i.e. financial bridges; opportunity analysis; medium term efficiencies plans; key interdependencies etc.
	  • Continue work with NHS England/NHS Improvement (NHSE/I), Financial Improvement Director (FID), Kent & Medway (K&M) system leads and Medway NHS Foundation Trust to develop and refine our financial model and FRP.
	  • Finalise medium term financial model including scenario modelling ensuring alignment to the final 2022/23 financial operating plan.
	  • Finalise the 2022/23 operating plan including minimising financial cost pressures and identifying the full £30m of efficiencies target
	  • Present a draft FRP virtually to FPC members for comments ahead of the May FPC.
	  • Present the final FRP and summary financial model to the May FPC and Trust Board.

Board Assurance Framework (BAF) and Principal Mitigated Risks	• The Committee noted there was no movement on the BAF and the Corporate Risk Register (CRR) in relation to 'Our Future' and 'Our Sustainability' during this reporting period. • The Committee also noted the BAF and CRR risks were being re-articulated and that it will receive the full BAF and CRR reports at its next meeting.

Update on Recovery, Reset, Restore and Recovery Programme (4Rs)	• The Committee received assurance of the activity across the Elective and Emergency workstreams supported by the 4R programme and the monitoring arrangements in place to support the programme.
	• The following were the key highlights of the report to the Committee:
	  • Recent 4R meetings have not taken place due to Opel 4 status.
	  • The Committee noted the key actions being taken to improve the Trust performance against the constitutional standards.

	• 52 week waits: The Committee received re-assurance that the number of patients waiting over 52 weeks is decreasing and this is due to chronological booking and transferring patients to our West Kent Independent Sector (IS) providers. • 104 week waits: The Committee received re-assurance of the measures in place to eliminate the longest waiting patients (except when it is the patient's choice). • Referral to Treatment (RTT) pathways remain elongated due to delays within diagnostics but work is underway to review diagnostic capacity and any opportunities for improved utilisation. Changes in RTT guidance are being awaited. • An Endoscopy Improvement Plan is in place and improvements are being evidenced. • The work being completed as part of the detailed business and activity planning for 2022/23 and the related NHSE/I targets outlined to support the NHS elective recovery. • The increasing and anticipated rise in Covid admissions and short-term staff absence due to Covid. • Cancer performance has been impacted as a result of access to diagnostic capacity. • The Committee received re-assurance that although the performance has deteriorated, Kent and Medway Cancer Alliance continued to record the lowest back log of all cancer Alliances of which EKHUFT is the largest contributor. • The impact of insufficient external capacity to discharge patients from wards and the resulting impact on patient flow. • The impact of Infection Prevention and Control (IPC) requirements on patient flow to safely manage contact, Covid and non Covid patients and the resulting risk of patient delay in ED. • The impact of IPC requirements in driving and meeting Trust wide elective efficiency targets. • There are still a number of patient cancellations due to Covid infections which impacts on utilisation. • The Committee received assurance of the Emergency Care Risk Summit initiated by the Executive Management Team on 23 March. • The challenges / solutions discussed at the Risk Summit included Staffing (Nursing and Medical); redirection of pathways across emergency care to a more appropriate space; Medical rotas and structure of the delivery of on-call; Challenges in social and community care and its exposure of the fragility of medical bed base. • The Committee noted that the final 4Rs update will be presented to the Committee at its next meeting.
Operational Planning Update 2022/23	• The Committee received the 2022/23 draft plan noting the draft plan was submitted to NHSE/I on 17 March 2022 with a final plan due for submission at the end of April 2022. • The Committee noted the key risks to the plan included failure to deliver efficiencies; delivery of ERF; removal of covid-19 spend; and higher than expected inflation and business cases. • The Committee agreed the draft plan and recommended it to the Board of Directors for approval.
Business Cases	• The Committee **approved** the following Business cases and were assured they had been through the appropriate approval process:

	• Picture and Archiving Communication System (PACS) Business Case - the procurement of a new PACS solution to replace the existing GE PACS (including migrating the Soliton Radiology Information System (RIS) to the new contract) and provide a technically better solution for the next 10 years. • Bank Rate Enhancements for Nursing September 2021 to March 2022 Post Project – Extended until end April 2022 and a plan brought back to the Committee at the next full meeting. • Contract Award for renewal of multifunctional devices.
5-year Capital Programme – Annual Report	• The Committee received the draft 5-year capital programme for 2022/23 submitted to NHSE/I by the Trust on 17 March 2022 noting the de minimus paper was used to prioritise the allocation. • The Committee noted that following national guidance, the capital programme is being managed at a Kent & Medway system level and the Trust is working well with other providers and the system to collectively manage risk and prioritise investment.

Strategic Capital Planning and Performance Committee (SCP&PC) Report	• The Committee received the bi-monthly report on the activities of the SCP&PC in January and March 2022 noting:
	  • NHSE/I gave formal permission to the Trust to commence the Due Diligence and Soft Market Testing exercise on 17 February 2022.
	  • The process has commenced and is expected to take approximately 4 months.

Update of Temporary Staffing Spend – 2021/22 Months 1 - 11	• The Committee noted the Trust wide temporary staffing costs have risen by 2% in months 1 – 11 of 2021/22 compared to the same period in the previous year. • While COVID attributed costs have decreased from 30% of overall spend to 14% in the same period, the overall costs have increased. • The Committee received re-assurance of the measures underway to address spend.
Other items of business	• Horizon scanning (For information). • Strategic Investment Group (SIG) Chair's report and minutes (For information). • Financial Improvement Oversight Group (FIOG) Chair's report and minutes (For information). • Committee Work Plan 2022 (For information).
Referrals to other Board Committees	• There were no referrals to other Board Committees at this meeting.
Referrals from other Board Committees	• There were no referrals from other Board Committees at this meeting.

Items to come back to the Committee outside its routine business cycle:		
None		
Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
1. Operational Planning Update 2022/23: The Committee agreed the draft plan and recommended it to the Board of Directors for approval (On Closed Board agenda as a stand-alone item). 2. Business cases: • Picture and Archiving Communication System (PACS) Business Case	Approval	7 April 2022

• Bank Rate Enhancements for Nursing September 2021 to March 2022 Post Project • Contract Award for renewal of multifunctional devices.		

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BOARD COMMITTEE ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Paper Author**	**Quorate**	
Quality and Safety Committee (Q&SC)	29 March 2022	Sarah Dunnett, Non-Executive Director (NED)	Corporate Governance & Risk Consultant	**Yes**	~~**No**~~
Appendices:	None				
Declarations of Interest made:					
No declaration of interest was made outside the current Board Register of Interest.					
Assurances received at the Committee meeting:					
Integrated Performance Report (IPR) – We Care Breakthrough Objectives & Watch Metrics	• The following were the key highlights of the report to the Committee: • Reducing deaths from sepsis. This breakthrough has reached its target. Following review of improvement priorities for 2022/23 the breakthrough objective will be closed and focus moved to fracture Neck of Femur pathway to improve outcomes for this group of patients. A Trust Priority Improvement Project (TPIP) will be launched for 2022/23 to support driving this at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) sites. • The total number of harms has increased which is driven by the rise in Covid-19 Healthcare Associated Infections (HCAI) in February 2022. • 147 falls were recorded in February 2022 against a target of 100. The 'Falls Yellow Kits' are in use in the Urgent Emergency Care (UEC) Group on the WHH site and starting at QEQM. • Improving theatre capacity continues to be a focus as we reduce cancellations, late starts, and early finishes. Increasing the number of theatre sessions is a priority. • We continue to see significant delays in the Emergency Department (ED). Long waits across the ED remains a challenge. The Committee received re-assurance of the interventions in place and noted pressures were being seen regionally and nationally. The Committee received assurance that an Emergency Care Risk Summit was convened on 23 March and discussed staffing; emergency care pathways; medical rotas and capacity. • Cancer 62 days performance has been impacted due to increase in cancer referrals and access to diagnostic capacity.				
Infection Prevention & Control (IPC) Monthly report	• The Committee received assurance and discussed the IPC monthly report noting the following: • Of the nationally reportable infections, one has breached the external threshold; P. aeruginosa. • The Committee received assurance that the position with regard to Klebsiella species has further improved and remains on trajectory; and there are no concerns related to 'C diff' and E. coli. • At the time of writing, the Trust has been managing the surge in cases caused by the Omicron BA.2 sub-variant of the Covid-19 pandemic. The impact of this has been very challenging for the Trust. • The Trust has 191 current Covid-19 inpatients which is a new peak for Omicron/BA.2.				

	• There has been increasing staff absence due to Covid-19. • The IPC draft annual work plan high level summary for 2022/23 will commence after the current Covid surge.
Care Group Governance Reports	The Committee discussed and noted the following matters of escalation: **Urgent & Emergency Care:** • Ongoing staffing gaps due to sickness in nursing and medical workforce, mitigated by cross site support and consultants mitigating middle grade gaps. • Length of stay for mental health patients remain high, mitigated by escalation to Hospital Director daily and case conferences being held with partners. • Continue to manage red and blue streams in ED dependant on need day to day. ED escalation processes have been refreshed and will be embedded. • Every effort continues to be made to reduce ambulance offload times. • Corridor care Standard Operating Procedure (SOP) in use and adhered to and policy shared with all staff members in ED. **General & Specialist Medicine:** • Nursing staffing gaps and high levels of staff sickness mitigated by use of NHS Professionals (NHSP) and agency, matrons oversight and re-distribution of staff as appropriate via daily huddles. • IPC practices re-iterated to reduce risk of transmission. Hand hygiene training on ward. **Surgery & Anaesthetics:** • There has been a reduction in patients waiting 52 weeks. The Committee received re-assurance on the actions in place to reduce long waiting lists including escalation of long waiters and patients over 100 weeks. • Reduction in number of falls in February – Measures in place including Gemba walks to visit wards with the highest fallers to understand contributing factors. • Staffing challenges due to the impact of sickness and Covid mitigated by ongoing recruitment and development of international nurses. • A business case for theatre staffing will be presented to Executive Management Team (EMT) on 30 March. **Surgery – Head and Neck, Breast and Dermatology:** • Referral to Treatment (RTT) 52 week breaches reduced to 865 in February. Patients reviewed and some activity outsourced to the Independent Sector. • There is work ongoing to eliminate 104 week breaches by 1 July 2022. Trajectory in place for ENT, with the main risk being Otology. • In Ophthalmology high risk waiters have reduced from 5232 in September to 4881 in February. Weekend clinics for glaucoma is in place, training to reduce Did Not Attend (DNAs) and cancellations to commence. • To increase theatre utilisation training of middle grades to cover theatre sessions. • The Committee received re-assurance of compliance with Level 3 safeguarding training noting the measures in place to mitigate this.

	• The Committee requested that the Care Group provide assurance at the next meeting on the classification of patients on the waiting list and how harm is prevented. **Clinical Support Services (CSS):** • Radiology action plan – 8 patients continue to be tracked no harm identified to date. • Current Laboratory Information Management System (LIMS) no longer meets the demands and requirements of the pathology service including responsiveness by provider to problems due to age and complexity of system which can lead to prolonged disruption. Measures in place to manage the risk. • Accident & Emergency (A&E) chest X-rays reporting is being escalated to the Corporate Risk Register. A review of current rosters to implement a better plan to utilise the reporting capacity has been completed with the backlog expected to be cleared by end March 2022. • A report on the outcome of a routine Human Tissue Authority inspection will be brought to a future Committee meeting. **Women's Health:** • Staffing has been impacted by sickness and absences. Covid-19 increasingly impacting on band 7 ability to be supernumerary on labour ward. • Fetal Medicine Unit – new model of service, pathways and guidelines being developed. • The recalculation of Expected Date of Discharge causing a potential risk to plans of care. • Cancer 28 days - Histopathology delays being mitigated by work including increasing the speed of letters. • Theatre utilisation. Plans are in place to mitigate short notice cancellations and availability. • Serious Incidents (SIs) - The Committee received assurance of the introduction of a formalised rapid review process for SIs where harm may have been caused. • A working group is being established to plan the roll out of the National Institute for Health and Care Excellence (NICE) guidance on induction of labour to reduce still-birth. • The Committee received assurance of the various forums by which learning is fed back to the 'shop floor' including Healthcare Safety Investigation Branch (HSIB) reports; message of the week at daily hurdles; training in CTG interpretation and escalation; and meetings. **Child Health:** • NHSP/ rotation of staff being used to maintain safety; senior nurse on call; ongoing international and local recruitment. • Additional staff required to mitigate risk of 18% of clinical audits not being completed. **Cancer, Haematology & Haemophilia:** • Focussed work is in place to improve Venous Thromboembolism (VTE) assessment compliance. Cancer achieving 100%. • The Trust, regional colleagues and the Cancer Alliance are working together to improve access to Cancer services and improve of 104, 62 and 28 days compliance.

	• We are working with local and regional colleagues to reduce delays to radiology investigations, in particular diagnostic imaging. • There are ongoing gaps in the Haematology/Haemophilia Medical Cover middle grade rota, mitigated by reviewing the recruitment strategy and exploring new ways of working.

Duty of Candour (DoC) Reporting	• The Committee received and discussed the DoC report noting the following:
	  • The Trust has a low level of compliance, this is being mitigated by updating the DoC policy, training for staff and a project to ensure improvement in compliance.
	  • The Committee noted further discussion was taking place with the Clinical Executive Management Group (CEMG) and escalation of the DoC risk to the Executive Risk Assurance Group and CEMG for addition to the Corporate Risk Register.
	  • The Committee recognised this is a significant risk to the Trust and requested a progress report to be brought back to a future meeting of the Committee.

Corporate Principal Mitigated Quality Risks	• The Committee noted the increase of the current risk score (moderate to a high) of Board Assurance Framework (BAF) BAF 34 in relation to delivery of operational constitutional standards due to the fluctuating nature of Covid-19 and the implications of infection control measures to manage this within the hospitals. • The Committee noted there was no movement on the Corporate Risk Register (CRR) in relation to 'Our Future' and 'Our Sustainability' during this reporting period. • The Committee also noted the BAF and CRR risks were being re-articulated and that it will receive the full BAF and CRR reports at its next meeting.

Care Quality Commission (CQC) Update	• The Committee received a progress report of the CQC activity/correspondence noting the following:
	  • Action plans from previous inspections continue to show slow progress.
	  • The CQC Insight report indicates overall performance for the Trust has not changed.
	  • Queries from the CQC have shown a slight increase this month and an engagement visit has been planned for 28 April.
	  • Workshops have been held to progress the strategic initiative to improve the Trust's CQC rating.

Medical Examiner update	• The Committee received and noted the report on the impact of the Medical Examiner (ME) service on referrals to the Coroner Service. • The Committee received re-assurance that the recommendations made as part of the report will improve referrals and requested for an update report to be brought back at a later date.
Safeguarding Children & Vulnerable Adults Progress Update Report	• The Committee received and noted the progress report on the externally led Safeguarding review and the planned actions over the next 3 months to address the issues cited within the review. • The Committee requested that it receives a regular report on progress of the action plan.
Safe Staffing	• The Committee received assurance and discussed the Safe Staffing update report.
Clinical Audit and Effectiveness	• The Committee received assurance and noted the update on recent activity of the CAEC including:

Committee (CAEC) Report	• Review of 22 pieces of NICE guidance that were issued in February 2022. • The Committee noted the framework was in place for ensuring compliance with relevant NICE guidance and requested an update to a future meeting on the Trust's plan to achieve compliance. • Clinical audit programme. Overall for all audits in the Trust 84% are on trajectory, the same as the previous month.

Maternity and Neonatal Assurance Group (MNAG) Report	• The Committee received assurance and noted the update on recent activity of the MNAG including:
	  • Maternity Improvement Plan - Robust programme management has been established. Progress against the actions continues and a quality assurance process within the care group has been established to ensure the validity of the evidence before actions are recorded as closed.
	  • The CQC observed the March meeting and gave positive feedback.
	• The Committee approved to change the focus of 1 of the 7 improvement Key Performance Indicators (KPIs) (i.e. replacing ''failure to escalate concerns" with "appropriate escalation being undertaken aligned to the Maternity Early Obstetric Warning (MEOWs) score").

Other items of business	• Quality & Safety Work Programme (For information). • Patient Safety Committee Chair's Report (For information and the revised Terms of Reference were approved). • Fundamentals of Care Committee Chair's Assurance Report (For information).
Referrals to other Board Committees	• There were no referrals to other Board Committees at this meeting.
Referrals from other Board Committees	• There were no referrals from other Board Committees at this meeting.

Items to come back to the Committee outside its routine business cycle:		
There was no specific item over those planned within its cycle that it asked to return.		
Items referred to the BoD or another Committee for approval, decision or action:		
Item	**Purpose**	**Date**
None	N/A	N/A

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
REPORT TITLE:	**PROPOSAL FOR GOVERNORS ATTENDANCE AT BOARD COMMITTEE MEETINGS**
MEETING DATE:	**7 APRIL 2022**
BOARD SPONSOR:	**TRUST CHAIRMAN**
PAPER AUTHOR:	**CORPORATE GOVERNANCE & RISK CONSULTANT**
APPENDICES:	**APPENDIX 1: PROPOSED GUIDELINES FOR GOVERNORS OBSERVING THE BUSINESS OF BOARD COMMITTEES IN 2022/23**

Executive Summary:

Action Required: (Highlight **one** only)	Decision	**Approval**	Information	Assurance	Discussion

Purpose of the Report:	This report presents a proposal for a pilot for Governors attendance as observers at Board Committees during 2022/23. The proposed guidelines to clarify the arrangements is attached as Appendix 1.
Summary of Key Issues:	• The Council of Governors is keen to be able to observe Board Committee meetings to see Non-Executive Directors (NEDs) in action as they seek assurance on the Trust's performance and hold Executive Directors to account. • The introduction of this as a pilot at EKHUFT would be designed to foster a relationship of trust and transparency between the Board and the Council. • In the survey carried out with the BoD on "How the Board Works" in July 2021, 6 Directors supported Governors observing Committees, 8 did not. • The proposal is to run a pilot for nominated Governors to attend 3 Board Committee meetings during 2022/23 (People and Culture Committee (P&CC); Charitable Funds Committee (CFC); and Integrated Audit and Governance Committee (IAGC). The Chairs of these Committees have all agreed the proposal in principle. • Each nominated Governor would attend 2 meetings of the respective Committee as an observer.
Key Recommendation(s):	The BoD is asked to discuss and **APPROVE:** • the proposal to run a pilot for Governor attendance as observers at 3 Board Committees during 2022/23; and • the proposed guidelines attached as Appendix 1.

Implications:

Links to 'We Care' Strategic Objectives:

Our patients	**Our people**	**Our future**	**Our sustainability**	**Our quality and safety**

Link to the Board Assurance Framework (BAF):	None
Link to the Corporate Risk Register (CRR):	None

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Resource:	N	
Legal and regulatory:	N	
Subsidiary:	N	
Assurance Route:		
Previously Considered by:	None	

East Kent Hospitals University NHS Foundation Trust

PROPOSAL FOR GOVERNORS ATTENDANCE AT BOARD COMMITTEE MEETINGS

1. Purpose of the report

1.1 This report presents a proposal for a pilot for Governors attendance at Board Committees as observers during 2022/23. The proposed guidelines to clarify the arrangements is attached as Appendix 1.

2. Background

2.1 The CoG is keen to be able to observe Board Committee meetings to see NEDs in action as they seek assurance on the Trust's performance and hold Executive Directors to account. There are various schools of thought on this. Some view this as blurring the governance lines, others including the Trust Chairman disagree.

2.2 NHS Providers argue that Board Committees should not be open to Governors. However, NHS Providers makes clear this is a matter for individual trusts.

2.3 Some Foundation Trusts do enable Governors to observe Committees' and others do not.

2.4 In the survey carried out with the BoD on "How the Board Works" in July 2021, 6 Directors supported Governors observing Committees, 8 did not.

2.5 The introduction of this as a pilot at EKHUFT would be designed to foster a relationship of trust and transparency between the Board and the Council.

3. The Proposal

3.1 The proposal is to run a pilot for Governor attendance at three Board Committees during 2022/23. These Committees are People and Culture Committee (P&CC); Charitable Funds Committee (CFC); and Integrated Audit and Governance Committee (IAGC). The Chairs of these Committees have all agreed the proposal in principle.

3.2 The BoD will extend an invite to the CoG to nominate a Governor to observe the business of two meetings of the respective Committees.

3.3 It should provide an opportunity for Governors to gain assurance about effectiveness of the governance arrangements by receiving the papers for the meetings and observing the interactions of those present at the meetings. It should also build trust between the Board and the Council and emphasise the Board's commitment to transparency. This would be an informal arrangement and not part of the Constitution.

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Proposed Guidelines for Governors observing the business of Board Committees in 2022/23

In order to strengthen the links between the Council of Governors (CoG) and the Board of Directors (BoD), the BoD of EKHUFT have agreed to extend an invite to the CoG to nominate a Governor to observe the business of the following Board Committees **as a pilot** at two meetings during 2022/23:

- People and Culture Committee (P&CC) - Chair, Stewart Baird;
- Charitable Funds Committee (CFC) - Chair, Jane Ollis;
- Integrated Audit and Governance Committee (IAGC) - Chair, Olu Olasode;

This would be an informal arrangement and not part of the Constitution. It should provide an opportunity for Governors to gain assurance about effectiveness of the governance arrangements by receiving the papers for the meetings and observing the interactions of those present at the meetings. It should also build trust between the Board and the Council and emphasise the Board's commitment to transparency. These guidelines are provided to clarify the arrangements.

1. A Governor is nominated by the CoG to observe the P&CC, CFC and IAGC at two meetings during the pilot.
2. Board Committee meetings are private and confidential.
3. The nominated Governor for each Committee is requested to keep brief notes on the business considered and provide these to the Governor and Membership Lead for circulation to the Chair of the Board Committee and CoG, in confidence.
4. Governors attending Board Committee meetings are present as observers not participants.
5. The nominated Governor will receive the agenda and papers for the meeting. These should not be copied or passed to anyone else.

Dorothy Otite, Group Company Secretary (Interim)
December 2021