Written evidence submitted by East & North Herts NHS Trust (MSE0070)

Introduction

Herts and West Essex Local Maternity and Neonatal System (LMNS) is based on the geographical footprint of the Herts and West Essex Sustainability and Transformation Partnership (STP). It consists of CCGs in Hertfordshire and West Essex, and local NHS Maternity providers i.e. East and North Hertfordshire NHS Trust, West Hertfordshire NHS Trust and The Princes Alexandra Hospital NHS Trust.

The Herts and West Essex LMNS is on the London Commuter belt. The west part of the STP footprint is Hertfordshire, served by West Hertfordshire NHS Trust and East & North Hertfordshire NHS Trust. The east of the footprint is West Essex, served by Princess Alexandra Hospital in Harlow.

Although the majority of women in our STP footprint choose to access maternity care within Herts and West Essex, there are many who choose to access services in neighboring STP footprints. In addition women in neighboring areas access maternity services within our STP footprint. Therefore Herts and West Essex LMNS reviews the maternity pathways and transformation plans across the boundaries with a view to ensure women and their families are accessing high quality, consistent and equitable maternity services wherever they choose to access them.

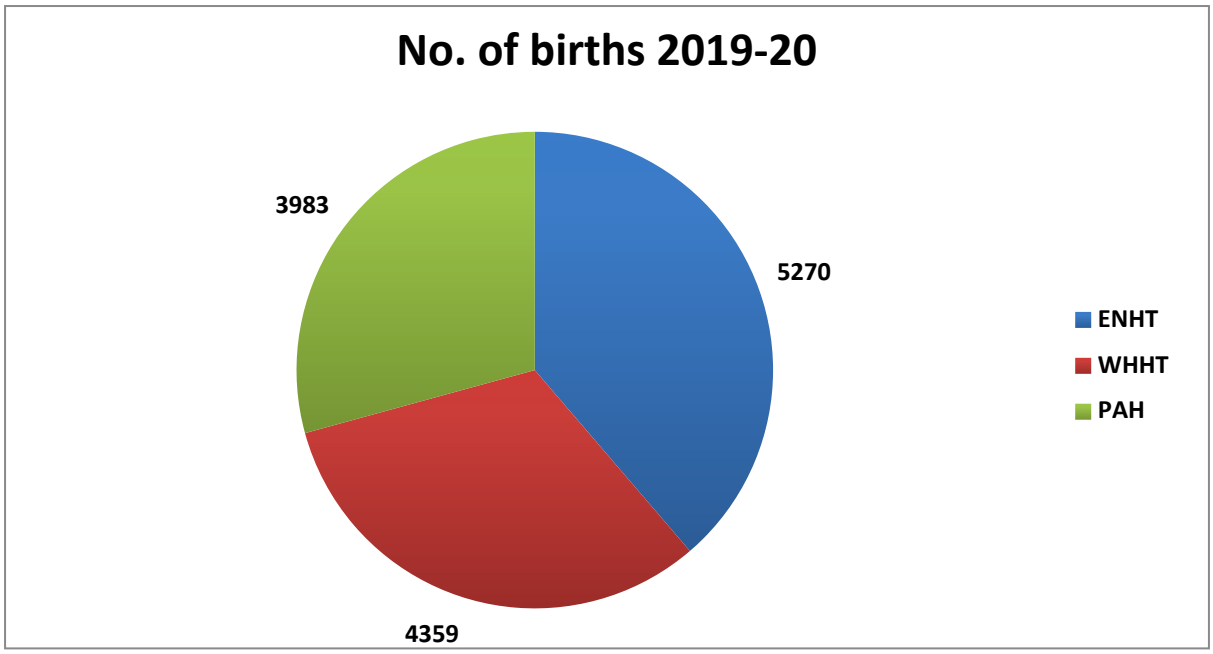
Population Split by CCG

East and North Herts CCG	559,100
Herts Valleys CCG	588,200
West Essex CCG	300,200
Total	1,447,500

Population Split by Local Authorities

Essex	1,443,000
Hertfordshire	1,035,000

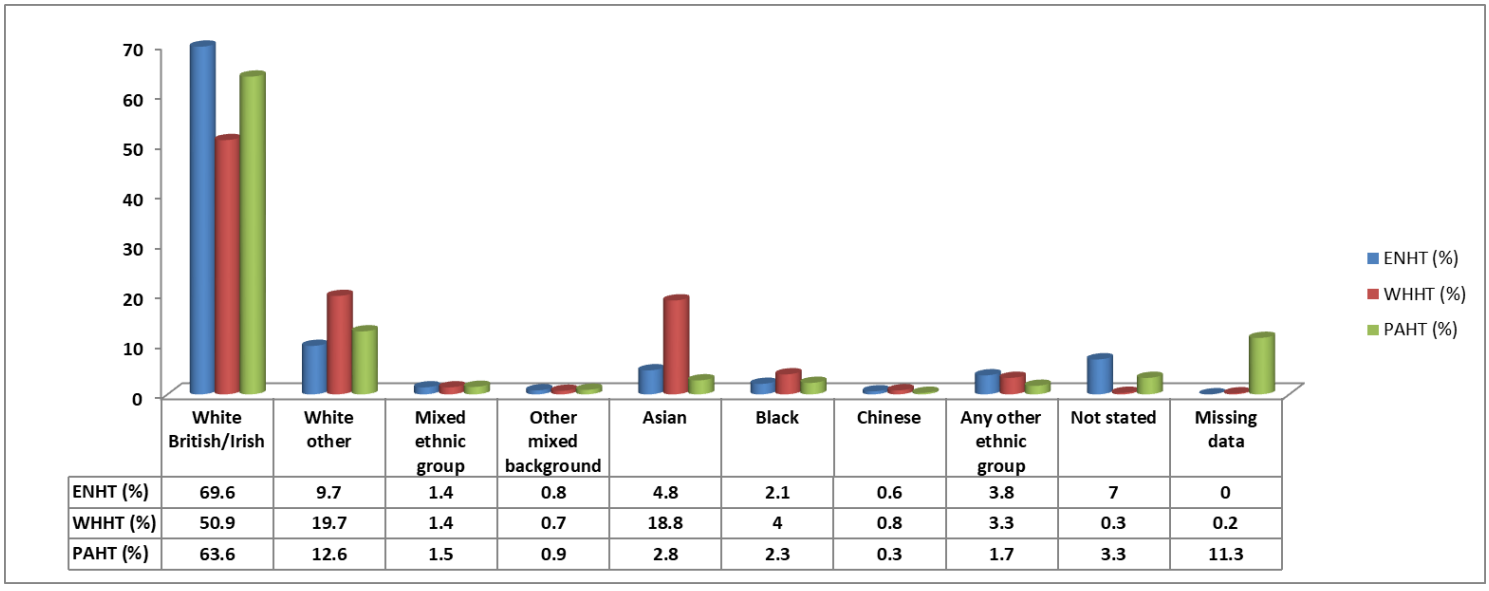
Number of births in financial year 2019-20



West Essex has slightly more older people and fewer 15-34 year olds than the national average and is less ethnically diverse than that of the England average. The average life expectancy for West Essex is above the England average. Despite an upward trend in life expectancy, there are inequalities with significant pockets of poorer health related to deprivation, lifestyle choices and poor engagement with statutory agencies. Males have a lower life expectancy than females. The most common conditions - as reported by disease register size - are hypertension, obesity, asthma, diabetes, and depression. Smoking is still the largest contributing risk factor for morbidity and mortality. About two thirds of adults in West Essex are overweight or obese; even though not statistically significantly different than the national average this is still a concerning figure.

Hertfordshire - Over half a million people live in the NHS Herts Valleys Clinical Commissioning Group (HVCCG) area and this figure is expected to rise by just under a quarter (23%) between 2010 and 2035 (Population Projections Unit, ONS, March 2012). In 2011 the resident population in the five districts in the HVCCG area was 563,000. Approximately 20% of residents were aged under 16, 64% were of working age (16 to 64) and 15% were aged 65 and over. Compared to regional and national population breakdowns there is a slightly higher proportion of children and adults of a working age living in HVCCG. Approximately 200 different languages are spoken by pupils living in the county of Hertfordshire.

Ethnic group measured by mothers at Birth across LMNS using ONS categories for financial year 2019-2020



	White British/Irish	White other	Mixed ethnic group	Other mixed background	Asian	Black	Chinese	Any other ethnic group	Not stated	Missing data
ENHT (%)	69.6	9.7	1.4	0.8	4.8	2.1	0.6	3.8	7	0
WHHT (%)	50.9	19.7	1.4	0.7	18.8	4	0.8	3.3	0.3	0.2
PAHT (%)	63.6	12.6	1.5	0.9	2.8	2.3	0.3	1.7	3.3	11.3

The East & North Herts NHS Trust is part of a wider LMNS system as detailed above with West Herts Hospitals and Princess Alexandra Hospital Harlow. Ideally, a response would have been submitted from an LMNS perspective, however, due to the limited time available for submission of the

response, the information given following the Parliamentary call is based on evidence submitted by the East & North Herts NHS Trust only.

What the impact has been of the work which has already taken place aimed at improving maternity safety, and the extent to which the recommendations of past work on maternity safety by Trusts, Government and its arm's-length bodies, and reviews of previous maternity safety incidents, are being consistently and rigorously implemented across the country;

- Within the Trust most recently safety improvement projects aligned with the Maternity and Neonatal Safety Collaborative and the Local Learning Systems (LLS) have improved outcomes in care of women with diabetes with uptake of the group class for women with Gestational Diabetes from 63% to 100% within 14 days. With regard to the diagnosis and management of maternal sepsis we noted a significant improvement in the use of the Sepsis trust screening tool from 17% to over 80% over 6 month period which has been sustained The prevention and management of massive obstetric haemorrhage (MOH), has been enhanced with the development and implementation of a specifically designed tool for risk assessment in labour.
- Use of the Perinatal Mortality Review Tool (PMRT) has enabled the service to recognise and act upon factors implicated in intrauterine deaths (IUD) and neonatal deaths (NND) including; the management of pregnancies affected by reduced fetal movements and the detection and management of small for gestational age (SGA) and growth restricted babies (FGR). External scrutiny within the meetings ensures that there is transparency, openness and honesty to the proceedings. This has been further enhanced by the implementation of a new Consultant led pathway for the increased surveillance and support of families affected by pregnancy loss, to reduce the potential for adverse outcomes in any future pregnancies they undergo. The East of England data has demonstrated a decline in still birth rates at East and North Herts from 2015. The Stillbirth rate ranged from 1.14 - 2.4 per 1000 from 2017-2019 which is below the national average.
- The Each Baby Counts project enables the Trust to review incidents with the formulation of actions plans to develop staff and promote learning.
- Given the government ambition of the reduction of cases of hypoxic ischemic encephalopathy (HIE), the Trust reviewed how cardiotocograph (CTG) traces were analysed and categorised. A master class was undertaken by all staff within the maternity services as the evidence suggested that signs of fetal distress could be better identified when the whole clinical picture was reviewed from a physiological perspective. This includes a 'fresh eyes' approach to minimise clinical bias; the Trust has been successful in a bid to employ a specialist fetal monitoring midwife. Her role encompasses all areas of fetal heart rate monitoring including those babies monitored in the low risk environment using intermittent auscultation. The Trust has established developed its own fetal monitoring faculty to deliver inhouse training to staff and deliver training across the LMNS
- The ATAIN programme has enabled the service to recognise and respond to factors influencing term admissions to the neonatal unit (NNU) for example, respiratory distress syndrome (RDS), hypoglycaemia and hypothermia.
- Thematic reviews of serious incidents (Sis) and root cause analysis (RCAs) have provided evidence to inform projects for improvement, for example, the emphasis on fluid management and fluid balance in labour to prevent hyponatraemia. Further interrogation of the reports has been undertaken by clinicians external to the Trust to provide a greater level of objectivity to the review and findings.

- MBBRACE highlighted the need for joint clinics for women with epilepsy, perinatal mental health services and pathways. This allowed the maternity service to successfully argue the need for a midwife specialising in mental health. The importance of the implementation of robust venous thrombosis embolism (VTE) assessments and pathways. The report has consistently highlighted that the BAME community are disadvantaged in terms of health care with much poorer outcomes than their white counterparts and this has been further exemplified with COVID. There is an ongoing project to address these deficiencies within the Trust which includes ethnic group as part of morbidity reviews.
- Working with the neonatal network on the right place of birth programme to ensure that neonatal care is delivered by Trusts with the right facilities to provide the appropriate level of care. In the year 2018-2019, there were 23 pre-term deliveries, 12 of these were transferred to Trusts with the ability to provide level 1 care to these babies.
- Engagement with the national quality improvement programme for PReCePt supported the Trust to make changes which highlighted the administration of magnesium sulphate (MgsO4) to reduce the incidence of cerebral palsy in pre-term infants. This has been successful in increasing the administration from 44% to over 90%.
- The Trust has been instrumental in disseminating Human Factors training to other providers within the Local Maternity System (LMS) in order to support a just no blame culture and learning for all staff following adverse incidents. A SBAR system has been introduced to increase safety following transfer of care and carers and safety huddles have been introduced in all clinical areas
- The local maternity dashboards are disseminated amongst the LMS in order to promote and share good practice with good outcomes for CS 3rd degree tears. Our detection rate for SGA babies has twice been above the GAP user average from 35-42% detection rate.
- All of the above demonstrate work undertaken and benchmarked against a safer maternity care action plan. This focuses specifically on training, staffing, early identification and treatment of women suffering from perinatal mental health supported by strong visible leadership at every level of maternity services.

the contribution of clinical negligence and litigation processes to maternity safety, and what changes could be made to clinical negligence and litigation processes to improve the safety of maternity services;

The Early Notification scheme progress report (Sep 2019) made a number of recommendations;

- In cases where there has been an adverse outcome, these families should receive an apology in accordance with the statutory duty of candour. Whilst this does happen, further training is needed for staff to understand the background, specific requirements and psychology behind these conversations and communications.
- The Trust has met the ten safety steps for NHSR on two occasions.
- The Trust continues to work with the LMS in implementation of Saving Babies Lives Care Bundle – the introduction of carbon monoxide monitoring to identify and offer appropriate referral for smoking cessation advice. The Trust was recently successful in a bid to employ a health and wellbeing midwife in order to address some of the inequalities of women within the footprint of the LMS.

- Support for staff to address their mental health and wellbeing particularly following adverse incidents. Although there is an employee support agency, this is not well used, staff need to be further encouraged to seek support from this and other resources for example the professional midwifery advocates (PMAs). Staff often report not feeling supported following incidents and the reasons for this need to be investigated so that the correct individualised support need can be considered which will increase retention of staff within the service and thereby the quality and safety of the services delivered. This also promotes the culture of the unit which encourages staff support
- The evidence supports that a standardised approach to fetal monitoring in England is required. A physiological approach is being embedded across the LMNS, however the progress of the other local hospitals in adopting this physiological approach is varied. This is a risk for all staff when they leave to join another Trust where CTG analysis may be different.
- Detection of maternal deterioration in labour – see above regarding the Maternal and Neonatal collaborative. The Trust spent a significant period on time on the design and embedding of a maternity specific MEOWS charts. As well as fluid balance charts following several occasions where it was recognised that this had not been managed well for women and babies during labour.
- Increase awareness of high quality neonatal resuscitation; none of the local HSIB reports so far has highlighted neonatal resuscitation and it was not a theme prior to HSIB. It does however warrant a mention in training as there needs to be a more of an MDT approach .
- Within the LMNS we have noticed a Trend amongst all families whose cases have been reviewed by HSIB. They have all chosen to follow litigation. our concern is that this maybe the consequence of the report.
- There is a robust process in place for any member of staff wishing to raise a safety concern within the Trust and an algorithm to identify how this concern will be escalated and managed up to Trust Board level.

Advice, guidance and practice on the choices available to pregnant women about natural births, home births and interventions such as C-sections, and the extent to which medical advice and decision-making is affected by a fear of the "blame culture";

- Birth planning clinics ensure that women are supported to make fully informed choices for care which may be outside of that recommended by local and national guidance. All national guidance recommends that women are encouraged to participate in this decision making which goes towards alleviating the clinicians fear of "blame" in the event of adverse outcomes.
- We support maternal choice for caesarean section as per national guidance. We have an excellent reputation within the LMNS for supporting women in vaginal breech birth with excellent outcomes.
- It is always going to be difficult to balance the advice that needs to be given in order for women to make an informed choice particularly in relation to the Montgomery Ruling. This can often be viewed by women as scaremongering, particularly in relation to potential big babies and the fear of shoulder dystocia. In the absence of any national policy in place to support these women for example – early induction of labour they face the stark choice of a caesarean section or potential for a damaged baby.
- The principle of continuity of care will further support women to make choices appropriate to them and their situations. It is recognised however, that during times of high acuity within the delivery suite, the acute services will take priority over staffing to the detriment of the home birth service thus restricting the choice that women are able to make about

their planned place of birth. It is envisaged that when the continuity of care model is fully functional this will reduce the inequity between the needs of the acute service and that of community midwifery services as more midwives will be deployed accordingly.

- The blame culture will continue because maternity services litigation process is based on admission of liability fundamentally. The parents have to prove breach of duty of care and the professionals become defensive in their practice because they are worried that their advice will be questioned and undermined in the event of a poor outcome. This requires a national review in collaboration with the professional and legal framework

How effective the training and support offered to maternity staff is, and what improvements could be made to them to improve the safety of maternity services;

- Multidisciplinary training already takes place within PROMPT, however, it is recognised that the needs of the ambulance service are not considered. There are plans at Trust level to ensure that training is cascaded to this cohort of clinicians in order to ensure that women / babies transferred into the service are already undergoing early and appropriate treatment. It is felt that this training should also be extended to include the health visitors and GP's where appropriate.
- Human factors training is paramount to reducing incidents to embed themes of communication, teamwork, leadership and escalation. Attempting to integrate this into all aspects of training for sustainable effects on delivering good outcomes remains a challenge. Introduction of case scenarios may be more beneficial than an entire day of training.
- The introduction of full day Fetal monitoring training and establishment of a fetal monitoring faculty has helped to embed the physiological approach translated into a reduction in severe HIE. Annual updates are paramount along with case reviews. Virtual sessions may limit the impact of such reviews.
- There are some concerns that the training needs of the Student Midwives are not being met. It is widely acknowledged that women under the care of the maternity services now suffer greater morbidity than they have done previously. They are more likely for example to be overweight with the associated health problems, have cardiac issues and IVF pregnancies with the exponential rise in multiple births. A review of student midwifery training will be required to ensure that we produce midwives fit for the future of the midwifery services. Furthermore, the withdrawal of the bursary has had a detrimental impact on the selection, recruitment and retention of student midwives.
- The use of webinars and podcasts will enhance training and will be necessary whilst social distancing is in place during the Covid climate
- Live drills are carried out frequently and in varied scenarios as the evidence suggests that these are much more beneficial than classroom teaching.
- Investigators for RCAs or SIs using a human factors approach facilitate the production of robust reports, sound recommendations, widespread learning and an improved safety culture. These reports are shared amongst the LMS in order to promote and share good practice.
- IT support is required to include not only Trusts at a local level but from a national perspective – this will ensure that care delivered on a local level is safe as it will include elements of care delivered in other Trusts / areas of the health service.

The role and work of the Healthcare Safety Investigation Branch in improving the safety of maternity services, and the adequacy and appropriateness of the collection and analysis of data on maternity safety;

- National reports are welcomed as an independent review and scrutiny of adverse incidents. They are a useful way of informing on areas for improvement and collection of national data to confirm thematic trends. There is a need however, to align this work with the Each Baby Counts project in order to avoid replication of work for maternity services.
- Although HSIB seeks to adopt the human factors principles to investigations this is not always evident.
- The sudden unexpected neonatal collapse after delivery report acknowledges that staff are often trying to carry out a number of task simultaneously and that this may contribute to a lack of ability to observe the mother and baby's condition effectively, but does not make any recommendations about staffing levels to help address this. There are numerous examples of fatigue being an implication in incidents, but never any national recommendation or remedy for e.g. fatigue as a result of shift patterns and lack of breaks – it is frustrating that recommendations are made in the absence of any resources in which the Trust would be supported to be able to accomplish this.
- HSIB Safety recommendations are made within the reports if they are considered to be on the causal pathway. The consequence of this is that the Trusts are left to extrapolate from the reports any other areas where omissions or transgression from guidance has potentially caused harm. The scrutiny within the report is of such detail that it may be viewed as a missed opportunity to not highlight areas where improvements in practice may be beneficial. Inclusion of additional recommendations not on the causal pathway would further enhance the detailed thematic analysis if the similar consistent approach was applied.
- The reports can sometimes take a significant period of time to produce which causes frustration for the families, as well as anxiety and distress for all those involved.

15 September 2020