Milton Keynes Hospital NHS
NHS Foundation Trust

# CARE QUALITY COMMISSION INTERVENTION INTO MATERNITY SERVICES

## 1. Background

The Healthcare Commission (HCC), now known as the Care Quality Commission (CQC), published an intervention report in December 2008 into Maternity Services at Milton Keynes Hospital NHS Foundation Trust. This report examined clinical governance systems and processes in relation to identifying and managing risk, reporting and investigating incidents and learning from such incidents. A total of twelve recommendations were made, seven of these related to improving clinical governance, and five related to general improvements in the way maternity services were delivered. Following this intervention report a Maternity Services Intervention Action Plan was developed in conjunction with the CQC and NHS Milton Keynes (PCT).

A planned follow up visit by the CQC took place in September 2009 which reviewed progress made against the recommendations within the action plan.

The CQC's report of this follow up visit was published on 19 January 2010. Attached is a covering letter from the CQC Regional Director (Annex A) and their report (Annex B).

## 2. Summary of Report Findings

Whilst the CQC noted the improvements the Trust has made to date, it highlighted areas for further work to ensure the Trust meets all the recommendations in full. In summary, four recommendations were met in full, six were mostly or partly met and two were not met.

The two recommendations that were not met (6 and 7) relate to the recruitment of permanent midwives and opening more beds permanently.

### *Availability of Midwives*

In addition to our ongoing drive to recruit more midwives, a range of additional measures to ensure the appropriate availability of midwives (recruitment, midwifery back-up, and robust escalation processes in times of surges of activity) are being actioned:

- A Lead midwives on call system
- Sharing midwives across regional units
- Reviewing community midwifery services
- Embedding a revised maternity escalation policy
- NHS Milton Keynes commissioners considering repatriating women from neighbouring Trusts areas back to those Trusts.

All the above actions are in addition to the Trusts continued recruitment drive to achieve 1:30 (midwife to mother) ratio.

***Availability of Beds***

Six beds continue to be opened flexibly, whilst we review how we can best realign staffing with clinical dependencies.

## 3. Next Steps

The Executive Team and Divisional Team have been working closely with the Strategic Health Authority, NHS Milton Keynes, Care Quality Commission and Monitor.

The Trust has drafted a detailed action plan to respond to all of the issues raised in the CQC follow-up report and is working hard to ensure that the Trust delivers on all of the recommendations and continues to embed the clinical governance improvements that have been made both within Maternity and across the Trust as a whole.

The draft action plan has been sent to CQC for approval and copied to Monitor and NHS Milton Keynes for comment.

**Tony J Halton**
**Director of Nursing**
**21 January 2010**

The Care Quality Commission's predecessor, the Healthcare Commission, made 12 recommendations for improvement in maternity services at Milton Keynes Hospital NHS Foundation Trust (MKHFT) in December 2008 following a review of maternity services.

CQC followed this up with a review in September 2009 to look at progress. This review included a detailed two-day visit by a team from CQC and two independent clinical advisers, reviewing information from the local Primary Care Trust, and reviewing documentation from the Trust setting out how they had addressed our December 2008 recommendations.

The trust has made improvements made to important aspects of the maternity service, particularly in the areas of:

- leadership;
- supervision of midwives;
- training; and
- 24 hour access to a dedicated obstetrics theatre.

However, improvements have not always happened fast enough.

CQC remains particularly concerned about capacity. CQC has been working closely with the trust, Monitor, NHS Milton Keynes and the strategic health authority to address immediate capacity concerns.

Temporary measures are now in place to ensure there are enough midwives to provide safe and effective care for mothers and babies.

The following areas are a top priority to ensure that improvements are sustainable in the longer term:

- recruitment of more permanent midwives
- opening more permanent beds
- better contingency planning for emergency situations – including work to anticipate periods of pressure, for example due to complicated births
- ensuring that staff are aware of contingency plans and these are being implemented on the wards

The report outlines further recommendations to improve services.

CQC will take all of this information into account when assessing the trust's application for registration.

CQC continues to work closely with Monitor, the regulator of foundation trusts, to check on clinical leadership and management of risk.

Roxy Boyce
CQC Regional Director, South East Region
19 January 2010

**Intervention at Milton Keynes Hospital NHS Foundation Trust**

**Summary of Progress against Recommendations of the Intervention Report**

The intervention report, which was published by the Healthcare Commission in December 2008, looked at the systems in place to investigate and learn from incidents, in order to prevent the same thing happening again. The Healthcare Commission considered whether the underlying principles of clinical governance were understood and properly embedded within maternity services, and if the clinical governance systems and processes within maternity services (antenatal care, care during delivery, and postnatal care) were effective.

The Healthcare Commission concluded that there were a number of improvements that need to be made in maternity, as well as identifying where improvements needed to be made more widely across the trust. A total of 12 recommendations were put forward. Seven of these directly related to improving clinical governance, whereas five recommendations related more to the actual improvements that needed to be made in the way maternity services were delivered by the trust.

The Care Quality Commission carried forward the legacy actions of the Healthcare Commission which undertook to assess the trust's progress against the recommendations of the report. We have now completed our assessment of progress.

**Methodology**

The follow up of the intervention involved:

- Reviewing documentation - the trust was asked to provide a statement on how it had addressed the recommendations from our report. In addition, the trust provided a range of documents to evidence the progress the trust had made.
- Reviewing information provided by the main commissioner of the service, NHS Milton Keynes ('the PCT'), on how the trust had addressed the recommendations.
- A two day follow up visit to the trust by a review team from the Care Quality Commission and two independent clinical advisers to interview members of staff and representatives from the PCT.

**FINDINGS**

We were told that it had taken some time for the trust to get up to speed with the implementation of the action plan, but that more rapid progress had been made beginning in the summer of 2009. The review of evidence by the PCT was in August 2009, showed that the PCT assessed the Trust as providing acceptable evidence against all of the actions that were due at that time.

Our impression from our interviews was that the staff we spoke were more positive and optimistic now, as compared to a year ago. Overall staff morale within the maternity services seemed to have improved.

The findings presented below follow the order of the original recommendations published in the Healthcare Commission report.

**Recommendation 1:**

**The trust must take steps to further embed its clinical governance arrangements to ensure that they are observed in its daily operation. For example, it must ensure that all members of staff who need to attend clinical governance meetings are able to do so as part of their normal duties, and not as an addition to them.**

The trust has made some improvements against this recommendation.

We found a wide range of evidence that incidents, complaints and Serious Untoward Incidents (SUIs) are discussed at various forums within the maternity division (Division A) and that these discussions lead to improvement actions.

Feedback is provided to staff through a wide range of methods, ensuring that staff are informed about relevant learning and/or practices that need to be changed.

The Healthcare Governance Committee (HGC) receives regular information on governance from the Divisions, but we found that this committee needs to look at the way it sets its agenda as well as the information it receives through the quarterly reports. For example, greater time needs to be devoted to the presentation of quarterly clinical improvement group (CIG) reports to this committee. There also needs to be a greater level of detail in certain areas of these reports as well as more consistency between the divisions, to enable the committee to be fully assured that governance is effectively being managed within each of the Divisions.

During interviews, members of staff demonstrated a much improved understanding of healthcare governance arrangements within the trust. Attendance at governance meetings had improved through the introduction of the protected time week and following up on non-attendance; although a few pockets of low attendance remained that need to be addressed. We are concerned that there appears to be low attendance from key staff from paediatrics at the Division A – Healthcare Governance Board (HGB).

We saw evidence of the benefits of the work done within the maternity directorate spreading out and improving governance arrangements throughout the trust, although it was acknowledged that more time was needed to ensure it became fully embedded. Examples include a template for divisional governance reports and revision of terms of reference for clinical improvement groups. More work is in the process of being implemented throughout the trust in terms of reviewing the structures to ensure it is simple, fit for purpose and avoids duplication.

Although staff seemed to be aware of how the system for managing risk was supposed to work within the maternity division, more efforts are needed to ensure that the system that has been identified for managing risks works effectively. There was a lack of evidence that risks are sufficiently discussed at board level.

**Recommendation 2:**

**The trust should ensure that its maternity guidelines are updated regularly, using a multidisciplinary approach across midwives, junior and middle grade doctors, and consultants, to help gain multidisciplinary ownership of them.**

This recommendation has been met.

We found that the maternity division has a system in place that ensures maternity

guidelines are updated when required, using a multidisciplinary approach.

There is joint working between nursing staff, including midwives, and doctors in guidelines development and the process described has improved and is appropriate. Guidelines are discussed at meetings that have multidisciplinary attendance, before being cascaded down. More staff members are now involved in the process.

Doctors, most Band 7s and relevant specialties receive new / revised guidelines per email and are provided with an opportunity to comment, before they are approved at first at the relevant clinical improvement group and subsequently (within the maternity division) at the Healthcare Governance Board. There are different ways used to ensure that information on updated guidelines is cascaded down to staff.

Reviewed and agreed guidelines are put on the intranet for Trust-wide access. A sample of recent guidelines and policies was reviewed, which showed that guidelines are referenced to the appropriate national standard or guidelines.

**Recommendation 3:**

**The trust should put in place a more formalised audit programme, covering all its divisions including maternity. This should be multidisciplinary in approach, and focused on adherence to recognised standards.**

This recommendation has been partly met

Overall, the Trust has the documents, committees and reporting structure needed to meet the requirements for this recommendation. There is more evidence now of multidisciplinary working in audits, although most audits are still predominantly done by doctors. There is further room for improving the involvement of midwives, as well as others who have a particular interest in the area being audited.

Attendance at Obstetrics and Gynaecology Audit Half Days consists mainly of (junior) doctors, but the trust told us that more midwives will be given an opportunity to attend as part of the protected training week.

We saw evidence of an improved systematic approach in developing the trust's audit programmes, which are now informed by external factors (such as NICE regulations) as well as internal factors, such as SUIs and risks. However, we saw no evidence that any of the audits included were a result of incidents or complaints. Staff we spoke to saw audits as an important tool to improve quality by promoting adherence to standards, where previously audits were only seen as an educational tool that might improve practice.

**Recommendation 4:**

**The trust should continue to work with the PCT to help develop its system of monitoring of serious untoward incidents and ensure that they are appropriately reported, investigated and audited, and that lessons are learnt.**

Further significant work is still required to be undertaken against this recommendation.

We found that there has been an improvement in the quality and timeliness of SUI reports within the maternity division. There is evidence from minutes, reports and interviews, that SUIs from the maternity division are highlighted and traced all the way up from ward level, through the divisional structure, to the Healthcare Governance Committee. Feedback is

provided to staff on lessons learned through a wide variety of means, and we have seen evidence of learning having taken place from SUIs.

The trust needs to review the information on SUIs being submitted to the Healthcare Governance Committee and ensure that the responsibility for monitoring the timely implementation of action plans is clearly mentioned in the Terms of Reference of the Division A – Healthcare Governance Board. It also needs to ensure that there is a clear understanding which committee is responsible for ensuring actions are implemented within agreed timescales, and deciding if an action plan has been implemented enabling a SUI to be closed. Furthermore, Root Cause Analysis training for key staff involved in risk management needs to be prioritised.

We are concerned that a serious untoward incident involving the death of a newborn baby occurred in May 2009, which was referred to the coroner and which follows a previous serious untoward incident which occurred in June 2007, also referred to the coroner. The first case led to our original involvement with the trust.

While the circumstances of both cases were different, the trust still needs to urgently examine and identify potential incidents and formulate detailed contingency plans to anticipate and plan for their occurrence. It also needs to ensure that it has the necessary systems and safeguards in place to anticipate potential emergencies and periods of high pressure on its maternity and labour ward facilities and high pressure on members of staff. There needs to be a process of early recognition of potential and actual complex or problematic cases, early involvement of and speedy, secure, and effective access to consultants, supervisors of midwives and back up midwives when necessary. The trust needs to review its systems to ensure that no single event can be the cause of unwarranted failure.

**Recommendation 5:**

**The trust's board should assure itself that it is receiving adequate information on clinical incidents and serious untoward incidents, so that it can take any appropriate action to protect the safety of patients at the trust.**

This recommendation has been partly met.

We found that the trust board has increased the amount it spends on discussing issues related to quality of care, such as information from reviews and the patient safety indicator reports.

However, at present, insufficient information is being provided to the board on SUIs and there was a lack of evidence that these incidents are discussed at board level.

The trust has recognised that more detailed information on SUIs need to be reported to the trust board, which will enable it to be sufficiently assured that SUIs are efficiently and effectively dealt with within the trust. The trust has also recognised that more regular (quarterly) written reports need to be submitted by the HGC to the board.

**Recommendation 6:**

**While recognising the trust's previous efforts to increase its number of midwives in post, the trust needs to take immediate further steps to remedy these shortages.**

Despite acknowledging the efforts made by the trust to recruit additional midwives, this

recommendation has not been met.

The trust has employed a range of strategies in order to increase the number of midwives in post. Although this has not as yet resulted in achieving the required additional number of midwives, all staff we spoke to during our visit felt that staffing levels had improved on the wards. This, according to staff, had resulted in reduced pressure on staff, midwives having a lower caseload, and staff being able to spend more time with patients.

Despite having had some success in recruiting additional midwives, staffing issues were still regularly featuring as incidents in 2009 (accounting for 25 % of reported incidents); community midwives are still regularly drafted in to assist in the maternity unit. Midwives to birth ratio's are still too high at 1 substantive midwife to 42 births (as of September 2009) compared to the national recommended ratio of 1 to 28 for hospital births (Royal College of Midwives). Therefore, more work is required to reduce the immediate vacancy gap between midwives in post and funded establishment, as well as the mid to long term projected increase needed in staffing levels to 150+ by 2013/14. The trust needs to continue its efforts to recruit additional midwives, and work with its commissioners to control the workload until the vacancy gap for midwives has been addressed and the midwife to woman ratio has been lowered to meet nationally recommended levels.

The necessary increase in resource as identified in the original intervention report remains inadequately addressed. Adequate staffing is essential in the prevention of serious incidents at times of high pressure.

**Recommendation 7:**

**It is recognised that the trust is committed to developing a capital building project within the next five years to increase the capacity of the maternity unit. However, in the short term, the trust needs to urgently review and reassess the number of beds likely to be required to run the service and ease the current pressure on beds, and also to take into account the predictions of future growth in the birth rate until the capital building project is completed.**

The trust has not made sufficient improvement against this recommendation.

The trust addressed the need to increase its immediate capacity by opening 6 additional beds on Ward 10 an intermittent basis if and when required. This, according to staff, had already resulted in a decrease in bed pressure and none of the staff we interviewed expressed any concerns anymore that mothers and babies were being discharged too early.

The trust decided that it needed to rethink the idea of a wrap around project by exploring alternatives that would use the existing physical space of the hospital. It planned to increase its bed capacity within maternity on a permanent basis from October 2009, when 12 additional beds were to be created on Ward 10, thereby increasing its bed capacity to 42, far earlier than originally planned.

However, due to delays in recruiting the required number of additional midwives needed to open this ward on a permanent basis, beds on ward 10 are still only open if and when required. This means that on a permanent basis the trust still only has 30 beds, albeit the capacity to increase to 42.

According to the trust, 42 beds will be enough capacity for the next 3-4 years. It will however still be short of the 47 beds identified in the 2003 'birth rate plus' assessment. We

were told that discussions are ongoing with commissioners with regards to the longer term plans of establishing a midwifery-led unit.

The trust needs to review its progress against this recommendation and continue to work with its commissioners to develop and agree middle and long-term capacity plans for the maternity service to ensure it can keep up with the projected increase in childbirths in Milton Keynes.

**Recommendation 8:**

**The trust should take steps to increase the number of Supervisors of Midwives to reach the recommended national ratio of Supervisors of Midwives to midwives, and to ensure that their value to the trust is suitably recognised and rewarded.**

This recommendation has been met.

The Supervisors of Midwives (SoMs) to midwives ratio has been reduced to 1.15, which is the ratio recommended by the Nursing and Midwifery Council. All SOMs receive a full annual remuneration payment of £2000, plus their on-call payments. In addition, SoMs are supported with two working days per month protected time for their SoM work. SOMs are fully involved within the governance arrangements within the Division, including membership on SUI panels, and all SOMs we spoke to felt valued and recognised by the trust.

**Recommendation 9:**

**The trust should ensure that it takes the necessary steps to fill all vacant posts that have a significant impact on the operational and clinical governance effectiveness of the maternity division and wider trust.**

This recommendation has been met.

The vacancies which previously existed for a Risk Midwife, Trust Risk Manager, and Director of Nursing, which we identified as essential, have all been recruited to and all of them are now in post. In addition, funding has been agreed with the PCT to recruit a Consultant Midwife, with the post expected to be advertised during December 2009.

The trust has a schedule of contingency plans in place for short and longer term absence for key posts in the Trust and all of its directorates, which will assist in preventing a similar situation from reoccurring in the future.

**Recommendation 10:**

**The trust should undertake a review of its training provision, including the provision of protected time for doctors, midwives and maternity care assistants to attend normal birth workshops and multi-professional mandatory and developmental training, including training as outlined in the service specification for maternity services 2008/09.**

This recommendation has been mostly met.

The trust has undertaken a review of its training provision, and introduced a system of protected time for doctors and maternity care assistants, and a protected time week for midwives, during which staff attend their required multi-professional mandatory and

developmental training. Training attendance is monitored and reported to the Directorate Governance Meetings.
However, despite a range of initiatives to promote normal births, including trainings and workshops with midwives, students and doctors, the reduction of caesarean rates / promoting normal birth is still an area that needs to be addressed. It is hoped that the appointment of the consultant midwife will provide the real push needed towards normalising births.

**Recommendation 11:**

**The trust should review its anaesthetic rota and theatre arrangements, to ensure that it complies with the requirement to have a 24-hour dedicated obstetric theatre, and 24-hour immediate availability to an anaesthetist.**

This recommendation has been met.

The trust has 24-hour/7-days per week dedicated obstetric theatre with 24-hour/7-days per week immediate availability of an anaesthetist.

**Recommendation 12:**

**We recommend that the acute trust and PCT increase their collaboration in order to enable the recommendations of the two previous reviews into maternity services at Milton Keynes and the requirements of the service specification for maternity services 2008/09 to be successfully completed.**

The trust has made improvements against this recommendation.

The trust and the PCT conducted a gap analysis of the action plans and recommendations of previous maternity service reviews. This analysis identified that some actions / recommendations had already been implemented. For those areas where gaps had been identified, actions were agreed on to address these. The trust has been working closely and collaboratively with the PCT, through the Maternity Matters Implementation Group, which is responsible for monitoring and reviewing progress with regards to the implementation of the remaining actions.

**Conclusion**

The Care Quality Commission has noted the actions taken in order to implement the recommendations identified in the Healthcare Commission Intervention report. As such, we concluded that the trust has made some improvements. However we have identified a number of areas where sufficient progress has not been made. Without detracting from progress needed on other recommendations, we note in particular that the trust needs to make significant improvements against Recommendations 1, 4, 5, 6 and 7. It is of particular concern that two key areas of clinical governance, robust discussion of clinical improvement at the Healthcare Governance Committee (HCG) and discussion of SUIs at Board level were still not in place at the time of our follow up visit, some 9 months after the original recommendations.

We recommend that CQC in conjunction with the trust, Strategic Health Authority, Monitor and Milton Keynes PCT determine the most appropriate and effective way of ensuring that these necessary improvements are accelerated and achieved within a short and stated timeframe.