Cabinet 7 February 2017	
Report of: Graham White, Acting Corporate Director Governance	**Classification:** Unrestricted
Review of Maternity Services at the Royal London Hospital, Scrutiny Review Report and Action Plan	

Lead Member	**Councillor Amy Whitelock Gibbs, Cabinet Member for Health & Adult Services**
Originating Officer(s)	Daniel Kerr, Corporate Strategy, Policy & Performance Officer
Wards affected	All
Key Decision?	No
Community Plan Theme	**A healthy and supportive community**

Executive Summary

This paper submits the report and recommendations of the Health Scrutiny sub-committee Scrutiny Review on Maternity Services, and the Action Plan for implementation.

Recommendations:

The Mayor in Cabinet is recommended to:

1. Note the scrutiny review report as agreed by the Health Scrutiny Sub-Committee on 28th June 2016 **(Appendix 1)** and agree the Action Plan in response to the review recommendations. **(Appendix 2)**.

2. Note the outcome of the latest Care Quality Commission (CQC) inspection of Maternity Services at the Royal London Hospital (RLH).

1. REASONS FOR THE DECISIONS

1.1 The Health Scrutiny Sub-Committee identified the performance of maternity services at the Royal London Hospital (RLH) as the subject for a review in its work programme for 2015-16. The Sub-Committee wanted to find out the extent to which patients' experiences have improved since the move from the old Royal London Hospital (RLH) to the new site, which opened in 2012, and to examine the improvement plans that Barts Health Trust (BHT) and the Tower Hamlets Clinical Commissioning Group (THCCG) have developed for the service.

1.2 In doing so, the Sub-Committee's main objective was to produce an informed, practical and evidence-based review, including recommendations and an Action Plan that would help the RLH and partners implement improvements to maternity care. Barts Health Trust has agreed in principle to endorse the recommendations outlined in the review and to work with the council and other stakeholders through a Maternity Partnership Board to address the issues identified.

1.3 Since the completion of this review and Action Plan, a CQC inspection of maternity services at RLH has identified a number of concerns and rated the service as 'Inadequate' (December 2016).

1.4 This report seeks the endorsement of the Mayor in Cabinet of the Sub-Committee's review and its related Action Plan. Through the implementation of the Action Plan many of the issues identified in both the scrutiny review and the CQC inspection report will be targeted and improved.

2. ALTERNATIVE OPTIONS

2.1 To take no action. This is not recommended as the scrutiny review provides an evidence base for improving maternity services in Tower Hamlets.

2.2 To agree some, but not all recommendations. All of the recommendations are achievable within existing resources as outlined in the Action Plan.

3. DETAILS OF REPORT

3.1 This report provides the Health Scrutiny Sub-Committee with the final report and recommendations from its review of maternity services at the Royal London Hospital. The review specifically addresses patient experience as feedback from patient organisations had highlighted instances of poor experiences in terms of compassion and continuity of care.

3.2 Annually 5,300 women give birth in Tower Hamlets, and the majority of them have their babies at the RLH. Clinical outcomes at the RLH are excellent, and the hospital deals with a high proportion of complex, high acuity births. However, a number of inspections and investigations that have taken place in

the last two years. Most significantly the report of the Care Quality Commission (CQC) published in May 2015 had raised concerns about aspects of the service, for example long delays in waiting areas and inadequate staffing levels, both of which can impact on patient care.

3.3 Through listening to patient feedback the review explored the extent to which women are involved in monitoring and planning services and how accessible and responsive services are for people from different social and equalities backgrounds. The Sub-Committee members were also keen to understand the reasons for the differences across the sites (RLH and Barkantine Birth Centre) and the extent to which various improvement plans were impacting on the quality of patient experience.

3.4 In summary, the aim of the review was:

- To understand the reasons for differences in patient experiences from the Barkantine Birth Centre compared to the main Royal London Hospital site;
- To assess the actual and planned impact of various initiatives and programmes that Barts Health Trust (BHT) has put in place to improve patient experience in maternity care;
- To evaluate evidence from a range of data sources in order to understand whether there are inequalities in terms of the quality of patient experience that affect particular groups or communities;
- To look at the role of local community services that are designed to support pregnant women through their pregnancies and birth and how these services can be developed further;
- To explore the extent to which local women are involved in planning and monitoring services.

3.5 The most recent CQC inspection of the RLH took place in June 2016 and was published on 15th December 2016. The inspection identified a number of concerns with the maternity ward and rated the service as ‘Inadequate’. The inspection based this assessment on the following findings: A shortage of midwives meant that maternity wards were at times inadequately covered. Only 92% of women had one-to-one care in labour, far short of national guidelines. There was also a low level of maternity Consultant cover. Women had inconsistent experiences, some very poor, of maternity services, and some women and partners reported a lack of respect from midwives. The maternity service did not demonstrate care for its own staff, rosters were late, approval of annual leave was slow, midwives felt their concerns were not listened to and morale was low. Moreover issues were identified around security on the maternity ward. Baby security was not robust, with poor compliance to the wearing of baby name bands, and the infant abduction policy had not been disseminated to staff - the policy assumed the use of an electronic baby tagging system which was not in use in the hospital.

3.6 The most recent CQC report throws additional light on some of the underlying factors that might contribute to the issues identified in the Health Scrutiny Sub-Committee Review. Many of the issues identified in the CQC inspection

report are also identified in the scrutiny report and addressed in its recommendations.

3.7 The report with recommendations is attached at Appendix 1. The review made 17 recommendations, which are detailed below:

Recommendation 1: That Barts Health Trust explores how it can further implement good practice on offering compassionate care, particularly for women who have had traumatic births and those who do not speak English as their first language.

Recommendation 2: That Barts Health Trust reviews its midwife recruitment strategy to ensure that it strengthens its approach to increasing the diversity of staff to reflect the characteristics of the local population.

Recommendation 3: That Barts Health Trust carries out a 6-12 months in depth study focused on patient experience following the opening of the new co-located unit in August 2016 to provide deeper insight and assurance around improvement plans that are being implemented.

Recommendation 4: That Barts Health Trust develops options to ensure that there is sufficient time dedicated for a range of staff to provide information to patients, particularly for women who do not speak English as a first language.

Recommendation 5: That Barts Health Trust ensures that it incorporates the findings and recommendations from the National Maternity Review in terms of how it tailors support to women who do not read and speak English.

Recommendation 6: That subject to the findings of an evaluation of the Maternity Mates service; Tower Hamlets Clinical Commissioning Group and Barts Health Trust work to further develop and strengthen the Maternity Mates service to expand its role working with midwives and local women in hospital settings and the wider community. This should include working with a diverse range of local women both as service users and Maternity Mates with a particular focus on minority groups such as the Somali community.

Recommendation 7: That Barts Health Trust regularly reviews the process for conducting handovers between shifts to ensure that this process is as seamless as possible for staff and patients.

Recommendation 8: That Barts Health Trust reviews the information provided as part of antenatal and postnatal care and works with patient groups (Maternity Services Liaison Committee, Healthwatch Tower Hamlets, National Childbirth Trust) and local residents to ensure information is accessible, appropriate and meets local needs.

Recommendation 9: That the Tower Hamlets Clinical Commissioning Group continues to fund, support and strengthen the Maternity Services Liaison Committee as a key mechanism for involving local women in shaping the future of maternity services in the borough.

Recommendation 10: That Barts Health Trust strengthens its discharge planning with patients and ensures that adequate time is taken for patients to understand the information provided and that it reflects their needs and choices. This is particularly the case for women who do not speak English as a first language.

Recommendation 11: That Barts Health Trust reviews its resource allocation systems to enable staff to have more time to spend with patients.

Recommendation 12: That Barts Health Trust builds on its work to engage staff groups and patient organisations in plans for designing wards and waiting areas.

Recommendation 13: That Barts Health Trust develops a 'listening in action' programme so that midwives and ward staff can share practice with managers and learning is cascaded 'up' the management chain.

Recommendation 14: That Tower Hamlets Clinical Commissioning Group and Barts Health Trust review the demand modelling process to ensure they can better understand future demand and enable Barts Health Trust to ensure sufficient resources can be allocated more swiftly to meet peaks in demand.

Recommendation 15: That Barts Health Trust improves the way that data on patient experience is collated and finds a way of bringing together data from various sources that can be analysed at a sufficient level of granularity, for example ethnicity, age group and site specific.

Recommendation 16: That Barts Health Trust strengthens how it is using patient feedback (good and bad) and to demonstrate to patient representative groups how this feeds into improvement plans.

Recommendation 17: That Barts Health Trust works with patient representative groups and forums to develop easily accessible, timely and intuitive ways to give feedback. Linked to this that Public Health review how the new birth visit (and 6-8 weeks check) could provide an opportunity to better capture patient experience feedback and to develop a process to feed this information back to Barts Health Trust.

3.8 The Action Plan attached in **Appendix 2** outlines the response from the Council and relevant partners, including Barts Health Trust. A Maternity Partnership Board has been set up to track the progress of the Action Plan and ensure the recommendations are implemented. The Maternity Partnership Board includes members from Barts Health NHS Trust, Tower Hamlets CCG, Tower Hamlets Public Health, and the Chair of the Health Scrutiny Sub-Committee.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 This is a nothing report and there are no direct financial implications on the Council as a result of the recommendations within this report. However, the 17 recommendations above aimed at improving maternity services at the Royal London Hospital, could have financial implications on both Barts Health Trust and Tower Hamlets CCG. These will need to be considered by the relevant bodies.

5. LEGAL COMMENTS

5.1 The Council is required by section 9F of the Local Government Act 2000 to have an Overview and Scrutiny Committee to discharge the functions conferred by sections 9F to 9FI of the Local Government Act 2000; or any functions which may be conferred on it by virtue of regulations under section 244(2ZE) of the National Health Service Act 2006 (local authority scrutiny of health matters). The scrutiny of health matters is undertaken by this Sub-Committee. Both the Committee and the Sub-Committee may also make reports and recommendations to the Full Council or the Executive in connection with the discharge of any functions.

5.2 This report provides details of a Health Scrutiny Sub-Committee review looking at Maternity Services at Royal London Hospital. A review report has been prepared and which makes 17 recommendations all of which appear to be capable of being carried out within the Council's powers.

5.3 When considering its approach to scrutiny of health matters, the Council must have due regard to the need to eliminate unlawful conduct under the Equality Act 2010; the need to advance equality of opportunity; and the need to foster good relations between persons who share a protected characteristic and those who do not.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 The scrutiny report makes a number of recommendations to improve maternity services at the Royal London Hospital. A key focus is on ensuring the service explores how they can further implement good practice on offering compassionate care, particularly in cases where women have had traumatic births and do not speak English as a first language. This will help to ensure all communities have access to the appropriate level of support.

7. BEST VALUE (BV) IMPLICATIONS

7.1 There are no direct best value implications arising from this report or its Action Plan.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 There are no direct environmental implications arising from the report or recommendations.

9. RISK MANAGEMENT IMPLICATIONS

9.1 There are no direct risk management implications arising from the report or recommendations.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 There are no direct crime and disorder implications arising from the report or recommendations.

11. SAFEGUARDING IMPLICATIONS

11.1 The report relates to services that have frequent contact with vulnerable mothers and children. Although no safeguarding issues were specifically identified in the report or Action Plan, it is noted that practitioners must remain mindful of potential safeguarding issues during the implementation of the recommendations. The concerns identified in the CQC inspection report about security on the maternity ward do have potentially serious safeguarding implications.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- **Appendix 1 - Review of Maternity Services at the Royal London Hospital 'Report'**
- **Appendix 2 – Review of Maternity Services at the Royal London Hospital 'Action Plan'**

Background Documents – Local Authorities (Executive Arrangements)(Access to Information)(England) Regulations 2012

- NONE

Officer contact details for documents:
N/A