Title | Homerton Maternity Review
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The Board is asked to:

- **Note** the findings of the review
- **Comment** on the implications for the inspections of acute trust inspections going forward

### 1. Summary

1.1 The Homerton University NHS Foundation Trust underwent a comprehensive inspection in February 2014. The trust was rated overall as good and its maternity services were rated as good for all key questions.

1.2 In response to a cluster of maternal deaths and concerns expressed by the CCG a responsive inspection of the maternity services was undertaken in March 2015. This rated the maternity services as requires improvement overall, but inadequate for safety.

1.3 To understand why there was a difference between the two inspections findings a small group from the Hospitals Directorate and from Strategy and Intelligence reviewed the evidence in the two reports and discussed the findings with the chairmen and heads of hospital inspection for the two inspections. The National Professional Advisor for maternity services, who was involved in both inspections, was also interviewed.

1.4 The report of the review is attached for information.

### 2. Discussion and Implications

2.1 The review did identify real differences in the quality of clinical care observed by inspectors at the two inspections, but the developments in inspection methodology between the two inspections and the differences between announced comprehensive inspections and unannounced responsive inspections may have also played a part in the contrasting findings of the two inspections.
2.2 As a result of the focused inspection of March 2015 the trust was issued with three warning notices under section 29 of the Health and Social Care Act 2008.

2.3 A further unannounced focused inspection of the maternity services at the trust was undertaken on 28th October 2015 and 4th November 2015. It was found that improvements had been made to the safety of the service, although further improvements were necessary.

2.4 Cleanliness was much improved and there had been improvement made in the leadership and governance of the service.

2.5 Further improvements were required in the observational checks on babies and in embedding the improved governance systems. A requirement notice was issued.

2.6 The maternity service was rated as requires improvement for safety and requires improvement overall.

3. Conclusion and Next Steps

3.1 The differences in findings between the 2014 and 2015 inspections of the Homerton maternity service have highlighted important issues. The review has shown that there were differences in the quality of care found at the two inspections. There was also evidence that our improved methodology had increased the rigor of the inspection process.

3.2 As we are developing our plans for the hospitals inspection process going forward we have incorporated the learning from this review. Our plans are for a more risk based and flexible inspection methodology. While we will continue in a few cases to use the announced comprehensive model, there will be more focused inspections of clinical services when concerns are raised or where our monitoring indicates a significant risk. Inspections will be predominantly unannounced.

3.3 Maternity services at the Homerton University NHS Foundation Trust have improved as a result of our intervention. We will continue to monitor the quality of care there closely and will undertake further inspections in due course.

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Date: 15 March 2016
Homerton maternity review

Introduction

This review was undertaken following the focused inspection of maternity services at the Homerton University Hospital NHS Foundation Trust between 17th and 24th March 2015. This inspection drew significantly worse conclusions about care quality in the maternity service compared to the comprehensive inspection of the whole trust, which took place between 6th and 15th February 2014.

The purpose of the review is to establish the extent to which the different findings of the two inspections are explained by developments of our inspection methodology and to what extent by real changes in the quality of the maternity service.

Background

The maternity service at the Homerton is moderately large. Approximately 5,500 babies are born there every year. The hospital service consists of co-located midwifery led and obstetric led units. The trust also provides a community based midwifery led service.

The local population is more ethnically diverse and more deprived than average. Life expectancy is significantly worse than the England average. It serves a higher proportion of older mothers, has a higher proportion of women presenting late in pregnancy and has a higher proportion of multiple deliveries than average. The perinatal mortality (stillbirth and deaths aged less than 7 days) rate in Hackney is 7.6 (England average 7.5).¹

There have been concerns about the quality of the maternity services at the Homerton Hospital for several years. In 2012 a whistle-blower reported to the CQC that there was bullying in the maternity service. This was followed up with the trust and no cause for concern found. Further contact was made by a whistle-blower early in 2013, using the name “angry midwives”. The allegation was that there was still an issue and it was affecting clinical outcomes for infants. An inspection under the old system was undertaken in February 2013. Staff and patients gave excellent feedback about the care received and no evidence of bullying or the concealment of poor outcomes was found.

¹ NHS London Health programmes 2012
A comprehensive inspection of the whole trust using the new methodology was undertaken in February 2014. This was a “wave 2” inspection. The trust was selected because intelligence monitoring identified it as high risk (band 1). The trust was rated as “good” for each of the key questions and “good” overall. Maternity services were rated as “good” for all five key questions. Accident and emergency services were rated as “outstanding” and all other core services were rated as “good”.

There had been two maternal deaths in the seven months leading up to the February 2014 inspection. Three further maternal deaths have taken place since the February 2014 inspection. We were notified of the third of these in January 2015. In response to this a focused, unannounced inspection of the maternity service was undertaken in March 2015.

**Comprehensive inspection of February 2014**

The inspection was led by an experienced Head of Inspection and an experienced chair. In view of the pre-existing concerns about maternity services, care was taken to ensure that the maternity inspection team was well resourced. It included a consultant obstetrician and the CQC national professional advisor for maternity services. The inspection team as a whole reported positively on the trust leadership, with strong and effective governance. The trust provider level report is relatively brief, but comments positively on the trust leadership, culture and values. The trust appeared to be well prepared for the inspection.

There was further contact from a whistle-blower representing a group of “unhappy midwives” shortly before the inspection. They raised concerns about culture and leadership of the trust and about the recent maternal and neonatal deaths. The inspection team were aware that NHS England had already completed an investigation into the maternal deaths and had found no cause for concern. The whistle-blower raised concerns about the quality of this investigation and alleged that the trust was attempting to hide concerns during the CQC inspection.

The Head of Hospital Inspection contacted the whistle-blower and offered a meeting with them to include CQC national professional advisor for maternity. The whistle-blower refused to meet the CQC as by that stage the on-site inspection had already taken place and they regarded the meeting as “not worthwhile”.

The data pack for the inspection highlighted that the emergency caesarean section and puerperal sepsis rates were high and had triggered recent outlier
alerts. The high rate of puerperal sepsis was an elevated risk on intelligent monitoring. Perinatal mortality, elective caesarean sections and neonatal readmissions were within the expected range.

Maternity services were visited during both the announced and the unannounced parts of the inspection. The inspection team took evidence from a wide range of staff and 30 women who were using the service during the inspection.

The important findings by key question were:

Safety (good)

- There was a higher than average emergency elective caesarean section rate. The trust had taken steps to reduce it (down to 18% compared to national average of 14%) and was monitoring it closely.
- There was good practice in the investigation of serious incidents and disseminating the learning to staff. This included the investigation of a recent maternal death.
- There was good practice with infection control, use of early warning scores and medicine management.
- There was a good midwifery staffing level (1 midwife to 28 births), although midwives were busy.
- Consultant cover on the labour ward was 80 hours per week. The trust planned to increase this to 98 hours per week by October 2014.

Effectiveness (good)

- There had been an outlier alert related to puerperal sepsis in October 2013. The trust had undertaken audits and updated clinical guidelines.
- Outcomes were detailed based upon number of serious incidents reported and audits of the use of the early warning scores.
- No concerns noted with training, staff or facilities.

Caring (good)

- CQC survey of maternity care (December 2013) rated the trust as worse than average in several areas.
- Women interviewed during the inspection gave good feedback.
- Friends and family scores were good.
Responsiveness (good)

- There was good support for different languages from the local population.
- Other specific groups of women had good support tailored to their needs.
- The service very rarely closed to admissions.
- Good discharge arrangements were in place.
- Complaints were managed corporately, but there were changes to services based on learning from complaints.

Well-led (good)

- There was a clear trust vision and a good understanding of risk.
- The governance arrangements were clear and effective.
- The culture was good. Staff were happy to report concerns with no fear of blame.
- There was no evidence found to support concerns raised by the whistle-blower alleging racism and poor leadership of maternity services and the trust as a whole.

The reports from this inspection are typical of wave 2 reports. The provider level report is briefer than more recent reports and it does not provide much additional information about trust level leadership. The hospital level report is much shorter than recent reports and has much less detailed evidence set out in the text.

Focused inspection of maternity services March 2015

The incidence of maternal deaths is higher in London than England as a whole. It occurs in about 1 in 5,000 pregnancies. The Homerton, with 5,500 births would be expected to have about one a year on average. There were two maternal deaths in 2013 and two in 2014. This does not make it a statistical outlier. Nevertheless NHS England commissioned an external review into these four deaths, which was undertaken by the London Clinical Senate. Confidential enquiries into maternal deaths typically find elements of sub-standard care in about half of cases. This report found avoidable factors in two of the four deaths. It also identified areas of good practice in these cases. The report makes 16 recommendations for improvement. The CQC received a copy of this report in February 2015.

Receipt of the report and a further maternal death in January 2015 prompted a responsive focused inspection of the maternity services. This was initially
unannounced. The inspection team included a senior obstetrician, a Head of Midwifery, the CQC’s national professional advisor for maternity services (who was the only member of the team who was on both inspections) and two CQC inspectors. It was led by an experienced Head of Inspection and inspection manager.

The pre-inspection data pack showed similar findings to the 2014 inspection. There had been a never event (retained vaginal swab) in December 2014. The midwifery staffing appeared to have slightly deteriorated (1 midwife to 30 births). The rates of emergency caesarean section, neonatal readmission and puerperal sepsis were all within the expected range, although the emergency caesarean section rate had not fallen since the 2014 inspection and was still 21%. The trust was now a low risk on intelligent monitoring (band 5), with no risks related to maternity services.

The important findings by key question were:

Safety (inadequate)

- Incident reporting was generally good, with high numbers of incidents being logged. However, some types of incident such as deliveries outside the labour ward were not being recorded.
- Incidents were not being investigated in a timely manner.
- Information on venous thromboembolism (VTE) assessments and catheter-associated infections was being collected but not displayed. VTE assessment rates were low (82%). Catheter associated urinary tract infection rates were satisfactory.
- The maternity unit was dirty. The cleaning schedules were unsatisfactory. Hand hygiene was poor. Some staff wore jewellery.
- All necessary equipment was available, but several individual items had not been tested recently.
- Fridge temperatures were unsuitable for milk storage.
- The resuscitation trolleys had not been checked.
- The massive obstetric haemorrhage trolley had not been checked.
- There had been several serious drug errors.
- Storage of drugs was poor and some drugs were out of date.
- The safeguarding policy was out of date.
- Examination of some records showed that early warning scores (MEOWS) were not always being used and escalated appropriately despite audits showing a persistent problem. However, junior doctors reported that the early warning scores were used effectively.
- The midwifery staffing was 1 midwife for 30 births, acuity assessment indicated that 1 to 26 was required.
• Frequently more than half of the midwives on the labour ward were agency staff.
• Consultant cover for the labour ward had increased in February 2015 to 98 hours per week.

Effective (requires improvement)
• There were good, up to date clinical guidelines.
• There was an active audit programme, but actions and follow up were not clear and the audit plan was not comprehensive.
• There was good pain relief and management of nutrition and hydration.
• The emergency caesarean section rate was still elevated.
• One to one care in labour could not be assessed because the standard practice of 2 hourly assessments was not undertaken.
• The rates of post-partum haemorrhage and perineal tears were high.
• There were concerns about training of midwives and supervision of junior staff.
• Multidisciplinary working was good.
• Training about the Mental Capacity Act and DoLs was inadequate and staff understanding was poor.

Caring (good)
• The response rate for friends and family test was low, but positive responses were high.
• The maternity survey 2013 was unchanged from that reported in the 2014 inspection.
• Direct feedback from patients was positive.

Responsive (good)
• There had been no closures of the maternity service in the past year, but escalation plans at times of high demand were unclear.
• A range of care pathways were available for women with co-morbidities.
• There was variable support for different languages of the local population. There was good availability of different interpreters, but unclear guidance. There was some reliance on families to interpret against national guidance.
• The local Orthodox Jewish community was well served and initiatives to support the local Muslim community also being developed.
• Online booking was available to local women.
• Complaints were not being dealt with within 25 days.
Well-led (requires improvement)

- The vision and strategy for maternity services was not documented, but senior staff did describe a vision and presented a list of objectives linked to trust’s objectives.
- Staff were positive and said they were supported by management.
- There was good feedback from staff in 2014 Maternity staff survey.
- The trust board had put maternity under a great deal of scrutiny and was reviewing maternal deaths.
- Risk governance arrangements were well established, but did not effectively manage all the recognised risks.
- There was a poor risk register, not related to maternal deaths or other outcome concerns.
- There was no clear evidence of effective management of the puerperal sepsis outlier issues.
- There was some evidence of isolated dysfunctional senior behaviour that had not emerged before.

Principal differences in findings

For two of the key questions, caring and responsive, the two reports present essentially the same evidence and the ratings are the same.

For the remaining three key questions there is a significant difference in the evidence presented, which appears to reflect a real change in quality of the service, but may also partly derive from a more detailed analysis of the available evidence.

Under safety there are different findings in the two reports. Some of these are undoubtedly real differences. The environmental problems, cleaning, equipment checking, fridge temperatures are all substantial findings. The assessment of the quality of incident investigation is different in the two reports. The criticisms in the 2015 report are significant, particularly in the context of the recent maternal deaths. The difference is probably due to a more forensic analysis in the recent inspection, reflecting development of our inspection methodology.

For the effective key question our inspection methodology has certainly changed between the two reports. For example, the clinical audit programme is much more thoroughly analysed in the second report and found to have significant weaknesses. Outcomes are tested against benchmarks more explicitly in 2015 and the explanation that the population served is higher risk is not so readily accepted. In some cases the 2014 report recognised that adverse outcomes were being addressed, while by 2015 it was clear that no
improvements had been observed between the two inspections and the actions being taken were seen to be ineffective.

The difference in the well-led rating reflects our how our approach to assessing leadership has developed in the intervening period. The well-led key question is now more focused on local leadership and less on trust wide leadership in the core service reports. This is why, the trust vision is cited as a positive in 2014, while the lack of a written maternity specific vision is seen as a negative in 2015. There is more focus on effective local risk management and use of performance data. The failure to sustain the improvements in outcomes noted in 2014 is an important and substantial difference in the evidence between the two reports.

Possible causes of differences

There are four underlying reasons for the differences in the two reports.

1. Real differences in the quality of the service

   The chair of the 2014 inspection reported that the trust was well prepared and appeared confident about its quality of care, with good governance systems. The chair of the 2015 inspection found the maternity service and the wider trust leadership nervous and defensive about service quality. The run of maternal deaths and the scrutiny the trust had been under had clearly affected the staff confidence in the quality of care they provided. One SPA was on both inspections and described a real difference in atmosphere between the two inspections. In 2014 staff appeared confident, in 2015 they appeared “punch drunk”, with the external scrutiny they had been experiencing. There does appear to be real evidence of a loss of morale in the service and a failure of maternity and trust leadership to adequately address this. As noted above, this is reflected in different findings in the two reports.

2. Development of the inspection methodology

   There has been considerable development of our inspection methodology since the wave 2 inspections. The first draft of the inspection framework of KLOEs was published in February 2014 only just before the 2014 Homerton inspection. At that stage it was a new and untried approach. Since then the core service frameworks have been extensively developed with further input from external clinical experts. These developments have added core service prompts and have been the subject of a programme of core service training for inspection teams. The much more detailed analysis of evidence
in areas such as root cause analysis, clinical audit, clinical outcomes and risk management in the 2015 report are evidence of the effectiveness of this programme.

The report template has developed considerably between the two reports. This has enabled inspectors to present evidence in a much more structured way closely aligned to the KLOEs. Judgments about poor care can now be made with more clarity and greater confidence.

3. Different hypothesis of a responsive inspection

While it was known that there were concerns about the maternity service prior to the 2014 inspection, these had already been assessed at a previous inspection in 2013 when the service was judged to be satisfactory. The two maternal deaths leading up to the 2014 inspection had been reviewed by NHS England and no cause for concern found. The trust as a whole was judged to be well-led and providing good quality care.

The 2015 inspection was responsive to concerns from several sources about the maternity service. The recent Clinical Senate review of maternal deaths had identified issues that required action. The incidence of maternal deaths was regarded as significantly high, even though it was not statistically an outlier. The hypothesis may well have been that there was a problem and the inspection was needed to find out what the underlying causes were.

4. Unannounced versus announced inspection

The trust prepared well for the 2014 comprehensive inspection. Issues such as cleanliness, equipment checking and staff preparedness were all clearly much better than for the 2015 unannounced inspection, where the trust was caught off-guard. This may have been a factor.

Conclusions

There are undoubtedly differences in the quality of care we observed on the two inspections. Full judgement about how significant the changes have been is difficult in the face of our improved methodology and the different context of the two inspections.

The difference in findings between the 2014 and 2015 inspections of the Homerton maternity service have important lessons. Our inspection methodology has improved and this gives us increasing confidence in
identifying poor quality care. However, there are considerations about how we approach responsive versus programmed inspections, unannounced versus announced inspections and focused versus comprehensive inspections to ensure that our judgements are consistent in all cases.

The focus going forward must be to make the right judgements about the service in the current circumstances and ensure we use this as an opportunity to learn how we can make our judgements about services going forward more rigorous and more consistent.

Ted Baker
16 August 2015