

8 October 2020		ITEM: 5
Thurrock Health and Wellbeing Board		
Basildon University Hospital Maternity Services		
Wards and communities affected: All	Key Decision: Not applicable.	
Report of: Diane Sarkar, Chief Nursing Officer, Mid and South Essex NHS Foundation Trust.		
Accountable Head of Service: Not applicable – report produced by Council Partner		
Accountable Director: Not applicable – report produced by Council Partner		
This report is Public		

Executive Summary

The Care Quality Commission (CQC) carried out an inspection of maternity services at Basildon University Hospital on Friday 12 June 2020. Following this inspection, and a review of Trust incident reports, the CQC published its report on Wednesday 19 August 2020. This rated the service as Inadequate.

The Trust is extremely disappointed, but fully accepts the findings of the report and has taken urgent and significant action to improve the service. Mothers should feel safe when giving birth, and it is vital that staff are able to provide the best care to women and babies. The Basildon Maternity Unit remains safe, but did not keep pace with the increasingly complex demands being placed upon the service.

A number of changes have already been implemented and the CQC highlights this in its report. These include investing £1.8million in recruiting 29 more midwives and two additional consultants, improved security and a restructuring of ward facilities, plus we have increased bed capacity on the Delivery Suite and Cedar Ward. We have learned from these incidents, with immediate leadership changes. The changes already made will be embedded, putting in place enhanced robust processes so that our Maternity Unit can deliver at the very highest standards.

1. Recommendation

1.1 For the Health and Wellbeing Board to note and comment on this report.

2. Introduction and Background

2.1 The CQC inspected maternity services at Basildon University Hospital on Friday 12 June 2020. The inspection was unannounced and focused on maternity services. It was carried out in response to concerns raised by a whistleblower about safety in the department. Alongside this, a review of incident reports provided by the Trust showed that in March and April 2020, there were six serious incidents where babies were born in a poor condition and transferred for cooling therapy.

2.2 There is a safe maternity service at Basildon University Hospital, with lower-than-average neo-natal deaths and stillbirths. However, the service did not keep pace with the increasingly complex demands being placed upon it, with more higher-risk women using the service and a greater prevalence of obesity and diabetes, leading to increased risks of complications for these women.

3. Issues, Options and Analysis of Options

3.1 The report was published on 19 August 2020. It found the following issues:

- Poor multi-disciplinary working
- Training was not always up to date
- Staff shortages
- Safety concerns were not always identified and escalated
- Junior medical staff were not supported sufficiently
- High-risk women were giving birth in a low-risk area
- Incidents were not always graded correctly
- Lessons learnt were not always implemented
- Care records were not always securely stored.

3.2 The report found the following areas of good practice:

- Recognised issues are being addressed, but not yet embedded
- Good control of infection risk
- Staff managed medicines well
- Women protected from abuse
- Staffing levels and skill mix reviewed and adjusted
- Bank and agency staff given full inductions.

3.3 The Trust has already made the following improvements:

- New leadership team in place
- Mandatory training back on track following COVID-19
- Consultants given bleeps to respond to emergencies
- New processes and procedures in place

- £1.8million invested to recruit 29 additional midwives and two consultants
- Foetal Surveillance Lead Midwife and Better Births Lead Midwife recruited
- Three more delivery beds opened for high-risk women and four more post-natal beds
- Creation of a 24-hour triage service
- Two Continuity of Care Teams launched
- Bereavement room restructured and refurbished to provide a self-contained suite
- Birthing pool to be provided in delivery suite
- Dedicated drugs rooms built on all three ward areas
- Improved security for women and their babies: controlled entrance and exit to all ward areas
- Safe staffing and escalation policy updated and implemented
- Central monitoring for CTG
- All staff have had CTG refresher training
- Educational update for instrumental deliveries
- Strengthened delivery suite handover and huddles.

Learning will be shared across all of our hospitals.

3.4 This has already led to positive results:

- Number of perinatal deaths is below expected levels
- Number of still-births is below expected levels
- Number of complaints down on previous years and in line with national average

4. Reasons for Recommendation

4.1 This report provides an overview of the changes made and planned to the maternity services at Basildon University Hospital.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Consultation has taken place with Health and Care system partners. There have been extensive opportunity for local stakeholders to engage with management at the Trust to discuss these issues.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The recommendations of the report as set out in 1.1 have implications for users of the maternity services Basildon University Hospital. There are also implications for stakeholders including the NHS.

7. Implications

7.1 Financial

Implications verified by: **Not Applicable**

Not applicable – externally produced report

7.2 Legal

Implications verified by: **Not Applicable**

Not applicable – externally produced report

7.3 Diversity and Equality

Implications verified by: **Not Applicable**

Not applicable – externally produced report

7.4 Other implications (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- Inspection [Report](#) of the CQC: Basildon University Hospital, Wednesday 19th August 2020.

9. Appendices to the report

- None.

Report Author:

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