Statement by Dr P E Stevens, Consultant Nephrologist and Medical Director, East Kent Hospitals University NHS Foundation Trust

The expectation of the Richford family in November 2017 was that they would receive a healthy newborn baby boy (Harry Richford) following Mrs Sarah Richford's confinement. East Kent Hospitals failed to deliver that expectation. I cannot apologise enough for that failure and will never forget the agonies that the family have experienced as a result.

I became aware of this incident when I read a draft root cause analysis (RCA) report in March 2018 and immediately contacted Mr and Mrs Richford to offer to meet them both. In that and subsequent meetings I became aware of the family's deep conviction to ensure that the outcome from their own experiences is to continuously improve the experience of others for the future.

It is no secret that the Trust has been challenged in recent years and at the time I was appointed to the role of Medical Director the Trust was placed in special measures by the Care Quality Commission following a full inspection of all the Trust's services in March 2014. At the time of that inspection maternity services were rated as 'Requires Improvement' overall. Key findings were a lack of leadership, equipment shortages and a culture of bullying and harassment. During that first visit the unit at Margate, although rated 'Good' for caring, was rated 'Inadequate' for safety. Between that visit and the subsequent CQC inspection in July 2015, although some improvement had occurred, the rating of 'Requires Improvement' remained with similar themes to before. A month prior to that inspection the Medical Director and acting Chief Nurse had already recommended to the Trust Board that an independent review of maternity services be commissioned from the standards department of the Royal College of Obstetricians and Gynaecologists (RCOG). That review took place at the end of November 2015.

The terms of reference for the RCOG review included a review of the provision of care in relation to national standards; review of the workforce in relation to the level of clinical activity; review of the education and supervision of obstetric middle grades and trainees including consultant accessibility and presence on the delivery suite; and a review of the culture and relationships of the different health professionals involved in the safe delivery of maternity services.

The RCOG review report was published to the Trust in February 2016. Although recognising that perinatal outcomes compared favourably, in keeping with the CQC reports there were key deficiencies noted and a number of recommendations were made for improvement. In particular the report made note of deficiency in consultant accessibility and presence on the delivery suite. The actual number of hours per week of timetabled consultant presence (70 hours/week at Ashford and 60 hours/week at Margate) was consistent with RCOG guidance, but the impression the review team gained from talking to staff was that this was not consistently complied with. They also made note of the competing priorities between obstetrics and gynaecological emergencies out of hours.

Following receipt of the RCOG report the findings and an action plan against the recommendations from the report were presented by the then clinical lead and Head of Midwifery to the April 2016 Women's Health Business and Governance Meeting. An audit of consultant attendance at the 0800/1300/1800 labour ward handover and board/ward round meetings for both weekdays and weekends was subsequently undertaken with positive results on the Ashford site (98% physical attendance) but less positive results in Margate (68% physical attendance) indicating a definite need for improvement. The job plans of the QEQMH consultants were revised to bring them in line with the WHH and deliver 70 hours/week of timetabled consultant presence. Since that time there have

been disciplinary investigations resulting in a formal warning and subsequent consultant resignation and a further consultant has been under investigation. The obstetric leadership team has been completely refreshed on both sites and a new Head of Midwifery came into post in February 2018. Since 2018 all Trusts have also had the benefit of independent review of clinical incidents in maternity services from the Healthcare Safety Investigation Branch (HSIB) who meet with the Trust on a quarterly basis to review findings and recommendations.

The analysis of the root cause of Harry Richford's death led to actions similar to some of those in the RCOG review, CQC reports of 2014-2016 and the HSIB recommendations, indicating a failure to sufficiently embed learning. However, I believe that a number of key improvements have been made and are embedded, whilst there are still further improvements that must be made. The physical presence of consultants on the labour ward for the 0800/1300/2000 labour ward handover and board/ward round meetings at QEQMH has continued to be routinely monitored and in the last 6 months has ranged from 97-100%.

A specific question has been asked with respect to referral to the Coroner. The specifics will have been addressed with Dr Mun but I met with the senior coroner at the end of August 2018 and discussed this. Her view was that, notwithstanding the diagnosis of hypoxic ischaemic encephalopathy, failure to refer may constitute obstructing the coroner. I then met formally with Dr Mun to warn him accordingly and he has reflected on this in his annual appraisal.

A second specific question has been asked about the recruitment and assessment of the locum registrar prior to him being on call without onsite consultant supervision. Although the stated policy at that time was that locums should be recruited from an approved agency and that the curriculum vitae and references should be approved by a consultant with a subsequent daytime check of core skills and competencies that was clearly not followed. One of the actions from the RCA was to considerably strengthen this with documented sign off (see below).

A further specific question concerns the past and present position vis-a-vis cardiotocographic (CTG) interpretation. CTG is a technical means of recording the foetal heartbeat and the uterine contractions during pregnancy and I understand from HSIB that its monitoring and interpretation is a national problem. Part of the reason for this is that CTG monitoring and interpretation antenatally differs significantly from the intrapartum situation. This is not my area of expertise but my understanding is that the changes our maternity services have already made to this and the further changes to be shortly introduced are held up as exemplars.

A number of changes to maternity services have been made to date and these include:

- Job planning all consultants to be present for at least 70 hours/week on labour ward
- Leadership changes referred to above
- The Birthing Excellence Success Through Teamwork (BESTT) programme launched in November 2017 with 10 safety actions in 5 separate workstreams
- Considerably strengthened locum appointment and assessment process driven by the RCA findings with the introduction of a specific checklist requiring sign off before any on call duties follow
- Increase in midwife to birth ratio from 1:32 to 1:28
- New clinical skills facilitator appointment and labour ward leads for obstetric anaesthesia and neonatology
- Introduction of the My Moma app for mothers
- Full implementation of the 7day labour ward safety huddles including a 22:00 multidisciplinary teleconference

- Rota review to ensure a supernumerary Band 7 labour ward coordinator on every shift
- Revised clinical standards for obstetric care on the labour ward
- Introduction of physiology–based cardiotocographic (CTG) interpretation and improved focus on Intermittent Auscultation monitoring (St Georges' Model)
- Introduction of a centralised station showing all CTG monitoring viewable on line by consultants when at home (going live in January 2020)
- Multidisciplinary teaching at simulated obstetric emergencies (SIM) based around electronic simulation models with mandatory yearly attendance and human factors training with a focus on communication, MDT working, recognition of the deteriorating patient and escalation skills
- Foetal monitoring competency assessment in place as part of the annual mandatory study day
- Two new Foetal Wellbeing midwives appointed
- Message of the Week is circulated to all staff and discussed at handover
- Risky Business newsletter for discussion and sharing with staff includes Serious Incidents, themes and learning (refreshed 2019)
- Weekly labour ward risk meetings to which all staff invited, rotated by site with presentation and discussion of recent Datix cases (introduced 2018)
- HSIB reports available on each labour ward in hard copy placed and available electronically (introduced as reports became available)

Consultant and middle grade staffing rotas and numbers are being reviewed together with an assessment of birthing numbers and complexity. We have just recruited a new consultant who was a former national medical director clinical fellow. He has a special interest in the care of high risk pregnant women with complex medical needs and his passion lies with understanding the impact of bullying and undermining on patient safety and the quality of medical education.

At the last CQC inspection in August 2018 the My Moma app was cited as an outstanding innovation and it was acknowledged that the maternity department had made great strides to drive learning, improve outcomes and improve innovation through a collaborative and multidisciplinary approach. Despite this the continued concerns from the HSIB report themes indicate that there is still considerable improvement work to be done.

This statement and its contents are true and correct to the best of my knowledge.

P E Stevens
17 December 2019