Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
26th September 2013

TITLE	**Paediatric and Maternity Service Invited Review**
EXECUTIVE SUMMARY	Earlier in the year the Trust Board authorised an invitation to the Royal College of Paediatrics and Child Health (RCPCH) to conduct a review of maternity services and paediatric services provided by the Trust in order to provide assurance on quality and safety. The attached slide set gives an overview of both the approach and the recommendations. The Review concluded that there were no areas of major concern of practice but did give recommendations for areas of quality and service that can be improved. A detailed action plan has been articulated by the Division in collaboration with the clinicians and shared with NW Surrey Clinical Commissioners.
ASSURANCE (Risk) / IMPLICATIONS	This report gives the RCPCH assurance provided by the Review and further assurance that key areas for improvement are being addressed and progress monitored.
LINK TO STRATEGIC OBJECTIVE	**SO1**: To achieve the highest possible quality of care and treatment for our patients in terms of outcome, safety and experience.
STAKEHOLDER / PATIENT IMPACT AND VIEWS / STAFF VIEWS	All key stakeholders (staff and patients), internal and external have been involved in developing the Terms of Reference for the Review, collating evidence for the review, participated in the review and are now involved in the actions for improvement going forward.
EQUALITY AND DIVERSITY ISSUES	All of our services give consideration to equality of access taking into consideration disability and age. All matters are dealt with in a fair and equitable way regardless of ethnicity or religion of patients.
LEGAL ISSUES	Poor quality for patients can lead to potential litigation. Poor quality care can lead to non-compliance with essential standards of quality and safety. Compliance with these standards is a legal requirement of the Health and Social Care Act 2012 and failure to do so could affect the Trust's registration and Monitor licence.
The Trust Board is asked to:	Review the paper and discuss the contents seeking additional assurance as necessary.
Submitted by:	Suzanne Rankin, Chief Nurse, Paul Crawshaw, Divisional Director Women's Health and Paediatrics.
Date:	19th September 2013
Decision:	For Assurance

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

RCPCH Invited Service Review
2013

Paul Crawshaw

Divisional Director Women's Health, Paediatrics & GUM

Executive Sponsor, Suzanne Rankin, Chief Nurse
Supported by Jacqui Rees, Clinical Governance Manager

Context of the Review

Why a review of paediatric and maternity services?

To assure the Board and external stakeholders, such as the Clinical Commissioning Group, with regards to:

- our perinatal mortality rate
- child safeguarding
- our caesarean section rate
- culture and governance
- our approach to pathway development
- seek advice on specific areas for improvement

Perinatal mortality rate = stillbirth rate plus neonatal deaths in 1st week of life

Why an external review?

- objectivity
- credibility
- capacity
- expertise

The Invited Review Process

Provided by RCPCH Royal College of Paediatrics and Child Health Leading the way in Children's Health

"***Service reviews*** – provide an independent perspective or 'healthcheck' and can be initiated either to explore specific concerns around safety, quality or sustainability, or to examine pathways of care and 'benchmark' a functioning service against models elsewhere. Service reviews deliver a swift and expert view and, in some cases, proposals for changes to improve a service"

Invited Review Process

- RCPCH gathered documentary evidence before site visit
  - multi-professional team with lay member
- 2 day site visit 24th/25th April 2013
- large number of staff and some users ***interviewed*** in private and in confidence by Invited Review Team
- Clinical Commissioning Group Children's Clinical Lead also interviewed
- extensive use of existing standards documents against which to assess our services

Overview from RCPCH

"The College was pleased to be invited to assist the clinical management of Ashford and St Peter's NHSFT to review the current status of its services for children and their progress against ambitious development plans.

The College found that overall the service was managed extremely positively and was clearly benefitting from confident leadership that recognised the importance of investment in children's services across the Trust. As in most reviews conducted by RCPCH the team identified some areas for improvement, including particularly the arrangements for High Dependency Care and SSPAU development but ***unlike most reviews there were no areas of major concern of practice*** *that the team identified and the recommendations were lengthy primarily because the Trust was extremely keen to excel in improving its approach to children and young people's care."*

Findings of the Review

Perinatal mortality and stillbirth

"Trust data relating to perinatal mortality were taken from the maternity statistics and the dashboard and compared with national rates (ONS 2011). These data appear to include all perinatal deaths, including women who were originally booked to deliver in other hospitals, but were transferred in because of the neonatal facilities."

"The stillbirth rate for the Trust (year to date) is below the national rate"

Rates per 1000	National	ASP	ASP data
Stillbirths	5.2	4.9	19/3854
PNMR	7.5	8.3	32/3854
Neonatal	2.9	3.4	13/3835

Findings - Safeguarding

- “The hospital serves large areas of deprivation and sees a higher number of children with safeguarding concerns than other hospitals in Surrey”
- staff felt that though there were a lot of resources embedded in child protection, the service would benefit from improved joint working
- medical safeguarding links with other local providers and commissioners and the designated doctor would benefit from strengthening
- safeguarding practice in maternity was reported as excellent
- the Named Doctor needs additional time and a clearer job plan and outline of responsibilities

Safeguarding

- there was a suggestion that some Consultants needed to better understand their role in safeguarding
- the Surrey Local Safeguarding system would benefit from a more coherent approach to engaging with local professionals
- Health Visitor liaison is provided by a partner organisation 2 days per week since Sept 2012 – a reduction on previous support

Findings – Caesarean Section Rate

- total CS rate (year to date) on the maternity dashboard is 25.8% compared with a 2011 England rate of 24.8%
- planned CS rate 11.8% compared with 10.1% England
- emergency CS rate 13.9% compared with 14.8% England
- elective CS rate for first time Mums is 9.0%. ... the figure is above the national average
- increasing the uptake of vaginal birth after C-section would be likely to result in a reduction in the elective CS rate and in the overall rate

Findings - Culture & Governance

- overall impression was that staff are committed to delivering high quality patient care, based on current evidence
- a ‘can do’ approach from senior management
- full engagement from ‘ward to board’ is not yet in place with some reluctance by frontline staff to engage fully in clinical governance processes
- staff across the service described often working to their limits in the delivery of patient care which they describe limits their capacity to attend to other commitments
- governance meetings within the Division need to be prioritised and attendance needs to be broader
- all clinical teams need to embrace challenge as a way of working

Other Findings

- the Paediatric Emergency Department is under great pressure and undersized
- a perception by some that leadership within the Trust was overly focused on targets and finance
- the paediatric service is not integrated with the community paediatric service . . . which is a disappointment to staff
- recruitment to nursing posts was reported as difficult
- High Dependency Service requires specialist commissioning. The Trust is not funded . . . to provide this care but in practice there is insufficient capacity in other hospitals to transfer very sick children away. This is a significant concern and needs to be addressed by working with the Commissioners
- review of antenatal care in those deliveries with a poor outcome should be strengthened to be more forensic

Positive findings

- staff are committed to delivering high quality patient care, based on current evidence
- . . . discussion with parents indicated a good level of satisfaction with the service
- the members of the senior nursing team interviewed in each of the areas came across as dedicated and skilled
- medical staff are described as ‘high calibre’
- there is a ‘can do’ approach from senior management which has made tangible changes to the profile of Children’s Services in the Trust
- there is good support from the Chief Nurse & Executive Team

RCPCH Invited Review Recommendations

- Priority areas and immediate actions/response:
  - management of children requiring High Dependency Care
    - existing provision reviewed and clear management guidance in place (children requiring close observation)
    - work underway to gather activity data to support on-going discussions with NW Surrey Commissioners
  - review nurse staffing and skill mix against RCN standards
    - benchmarking of NICU staffing completed, review of establishments underway Sept 2013 for presentation to Trust Board Oct 2013
  - implement a clearly understood cascade process, including multi-disciplinary meetings for divisional governance and operational priorities
    - additional clinical governance resource and expertise to be embed within division Oct 2013

RCPCH Invited Review Recommendations

- review the medical leadership of safeguarding
  - additional PA investment made – more time allocated to Named Doctor
- Review the Paediatric Emergency Department (size and staffing) so that the service can meet demand
  - short term solution to increase the size of the department to be in place October 2013
  - longer term demand and capacity planning being used to inform future estate requirements
  - 2 new Consultants joining the team October 2013
- The Short Stay Paediatric Admission Unit should be properly commissioned, located and staffed to meet intercollegiate and RCN standards
  - service specification developed by Commissioner and with clinical team for review

Other national standards to be met

- Speech and Language Team - lack of provision on the neonatal ward is a breach of the BAPM standards
  - therapist appointed to meet standard
- NICU - in order to provide sufficient consultant presence on the ward and provide a Tier 3 service in line with BAPM standards it was suggested that two more consultants may be required
  - review against specialist commissioning standards to be undertaken alongside a risk analysis and demand and capacity assessment

How have we responded to the Review?

- positive multidisciplinary team approach to improvement and action planning
  - risk rated action plan monitored in 2 weekly meetings
- additional support to clinical governance teams within Divisions allocated
- scoping further work to review antenatal care pathway
- assurance meetings with CCG and health economy partners on 19th September and 27th September
- agreed a shared approach to action planning and monitoring with CCG
- CCG Chief Nurse to attend Trust Child Safeguarding Steering Group