Nottingham City Council

Health and Adult Social Care Scrutiny Committee

Minutes of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 17 February 2022 from 10.00 am - 12.08 pm

Membership

Present	**Absent**
Councillor Georgia Power (Chair)	Councillor Cate Woodward
Councillor Michael Edwards	
Councillor Samuel Gardiner	
Councillor Maria Joannou	
Councillor Kirsty Jones	
Councillor Angela Kandola	
Councillor Anne Peach	
Councillor Nayab Patel	

Colleagues, partners and others in attendance:

Debbie Graham	-	Clinical Lead for Midwifery, Independent Thematic Review of Maternity Services provided by Nottingham University Hospitals NHS Trust
Paul Haigh	-	Head of Adult Social Care Provision
Cathy Purt	-	Programme Director, Independent Thematic Review of Maternity Services Provided by Nottingham University Hospitals NHS Trust
Michelle Rhodes	-	Chief Nurse, Nottingham University Hospitals NHS Trust
Sara Storey	-	Director of Adult Health and Social Care
Sharon Wallis	-	Director of Midwifery, Nottingham University Hospitals NHS Trust
Councillor Adele Willams	-	Portfolio Holder for Adults and Health
Laura Wilson	-	Senior Governance Officer
Emma Powley	-	Governance Officer

58 Apologies for absence

Councillor Cate Woodward (Other Council Business)
Sarah Collis, Healthwatch Nottingham and Nottinghamshire

59 Declarations of interest

None

60 Minutes

The minutes of the meeting held on the 13 January 2022 were agreed and signed by the Chair.

61 Nottingham University Hospitals NHS Trust Maternity Services

Michelle Rhodes, Chief Nurse, and Sharon Wallis, Director of Midwifery, Nottingham University Hospitals NHS Trust (NUH) attended the meeting to provide an update on the progress made by the Trust in introducing improvements following the Care Quality Commission's rating of maternity services as 'Inadequate' in 2020. The Committee were updated on the progress that had been made since the last report to the Committee specifically on this issue in July 2021. The following information was highlighted:

a) There has been continued engagement with women and families via a number of methods including social media and last year the 'Maternity Views' email address was launched as a further means to engage with women and families to give themed feedback on services.

a) Under the Maternity Improvement Plan a number of milestones have been met including:
   - The birth reflection service is in place.
   - The jaundiced baby policy has been finalised.
   - Training of Bilirubinometers (for Community Staff) has been completed and the equipment is now in use.
   - Four new consultants are in post, with a further four consultancy posts being advertised.
   - Additional fetal monitoring is taking place.
   - Leadership development for senior midwives is being embedded, alongside the development of maternity support workers.
   - Stage two of the cultural change programme has been agreed.
   - 150 new electronic observation devices have been provided ensuring every member of staff has a dedicated eObs device, plus spares for agency or locum staff.
   - Every community midwife and support worker now has a laptop and mobile phone.
   - The Maternity Advice Line has been launched as a single point of contact for women and families looking to get advice. It is staffed 24 hours a day seven days a week by experts able to escalate problems as required. Data shows when the key times are that women call, and a triage workflow is in place to help record advice given.

b) The Committee were provided with the maternity dashboard for NUH, also providing nationally comparable maternity data for December 2021.

During discussions, and following questions from the Committee, the following points were raised:

c) At the Committee's meeting on the 14 January 2021, it was reported by NUH that it expected improvement works to take a number of months to fully address the issues identified by the CQC and embed improvements. At that time the Trust had stated that it's ambition was to see the Maternity Unit move

from an 'inadequate' to a 'good' rating within 12 months. However, despite that previous statement, the Chief Nurse and Director of Midwifery are clear that this is not achievable and a more realistic target is for the service to be rated as 'good' in 3 years time.

d) Committee members commented that, 13 months on from the original report to the Committee, there is concern about the pace of improvement, and a continued frustration with the information being provided as evidence of progress. Whilst the Maternity Improvement Dashboard had been provided, there was very little context and as such, with no narrative, the information and any progress recorded was not easily measurable and able to publicly demonstrate improvement.

e) The Committee requested a progress chart where measures could be placed alongside each area of focus with a RAG status to show where, when and if specific goals were being met and questioned what milestones they expected to have met and by when.

f) The Trust acknowledged that there was a need for better project management of all the areas for improvement required, with prioritisation and focus on the improvements most needed. NUH is aware of the areas that it is behind on and the Trust assured the Committee that work is being undertaken to identify the reasons for this and ways to address them.

g) Residual staffing issues remained a concern although some progress has been made with a successful bid for 15 international midwives who are anticipated to be in place by July 2022. A rolling advert had been placed for the recruitment of Band 5 and 6 midwives, with student midwives currently studying in Nottingham guaranteed a job at the end of their studies subject to them successfully completing their degree. The shortage of midwives is not specific to Nottingham. There is a recognised national shortage of midwives, and efforts are being made to retain and recruit with offers of progression and development and flexible working arrangements.

h) Committee members raised concern about the impact that the current situation is having on women and babies; with morale being low and confidence in the service compromised, expectant parents will have concerns. It was emphasised that any Serious Incident not only has an impact on the prospective parents but the ramifications extended much further, in some instances, to the whole family unit; and wider confidence and trust in the service.

i) To maximise engagement, NUH continues to work with the Maternity Voices Partnership (MVP) and efforts are being made to involve and engage with ethnic minorities to ensure an accurate representation of service users. Web-pages of the NUH site are fully accessible and options for translated information is available in many languages with users being asked to participate in the MVP survey. This is being promoted on the NUH website and to the wider community, for those with limited internet access, by community midwives and health workers.

j) NUH stated that monthly meetings continue to be held with the trade unions and claims made by the unions that they have struggled to get timely appointments with the NUH were refuted.

In response to questions from the Portfolio Holder for Adults and Health, the following information was provided:

k) There is a commitment to reinstate home births, which were suspended for a time during the pandemic. Increasing choice for birthing women is a priority across Nottinghamshire.

l) Priority and focus will be placed on the relatively high rates of tearing (during delivery) with increased training and efforts made to identify any common themes that could lead to, or assist, the reduction in tearing.

m) Anecdotal evidence suggests that staff are now more comfortable to report risk and concerns. There has been increased reporting, with the number of incidents reported increasing but the instances of harm reducing. 'Safety Champions' have played a part in engaging with staff and they can report any concerns as part of the wider cultural change programme.

n) Referring to a recent coroner's report it was explained that a number of issues had been identified which had led to a Serious Incident being reported. Issues included staff shortages coupled with the unavailability of a registrar on duty during an exceptionally busy time. The Committee requested the written response that NUH gave to the coroner be sent to them.

o) Capacity remains an issue with more doctors needed on a rotational basis. Staff relations are improving with a midwifery forum, numerous engagement events, team talks with the involvement of a external communications company.

p) There have been a number of instances where diversions had been put in place for birthing women; diversions were, to a certain extent, unavoidable and a proactive measure to ensure the safety of mothers and babies. This was attributed to capacity within the maternity ward and staffing levels.

Cathy Purt, Programme Director of the Independent Thematic Review Team updated the Committee on the Independent Thematic Review of NUH Maternity Services that had been jointly commissioned by NHS England/ NHS Improvement and the Nottingham and Nottinghamshire Clinical Commissioning Group. She highlighted the following points:

q) Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) and NHS England and NHS Improvement (NHSEI) jointly established the independent thematic review of maternity incidents, complaints and concerns at Nottingham University Hospitals NHS Trust (NUH).

r) The aim of the Review is to drive rapid improvements to maternity services in Nottingham, by focussing on issues identified where change is urgently needed. Family engagement is embedded within the review process so that

feedback from every family with experience and opinions can be acknowledged and considered.

s) An online self-referral for Nottingham and Nottinghamshire Let's Talk Wellbeing Service is available on the website alongside signposts to other support groups that specifically relate to the loss of a child and birth trauma.

t) The relationship between the thematic review team and the NUH remains neutral and both have worked well together and engaged in meaningful dialogue.

u) Part of the review is examining data from as far back as 2006 to date, to analyse the themes and understand the context and the culture of how maternity services care had been provided, the final report not being expected to be completed until November 2022. However, the purpose of the thematic review is not to wait until the end to learn lessons, but to identify themes, learn lessons and implement improvements in a dynamic and expedient way.

v) Funding has been secured from the CCG to support a psychological review, and families and staff members had come forward to give feedback on their experiences. Staff and family interview data has been collated but is not yet in the public domain, and is anticipated to be released in March/April 2022. A number of interim reports will be produced prior to the being made available in November 2022.

The Chair noted that, prior to the meeting, an informal evidence gathering session had been held with the Royal College of Midwives.

The Committee concluded that it was not satisfied with the progress being made, and decided to review all the evidence available to it prior to agreeing its next steps. recommendation.

Resolved to:

1) **request that Nottingham University Hospitals NHS Trust provide the following information:**
   i. **the project plan for improvement work, including timescales and progress to date a**
   ii. **the results from the joint survey with Maternity Voices Partnership on proposed improvements for ethic minority patients**
   iii. **a report on harm including the reporting thresholds, including why the overall level hasn't reduced and what work is being done to reduce it**
   iv. **responses from the Friends and Family Test relating to maternity services**
   v. **the response to the coroner, when it is available, in relation to the most recent coroner's inquest**

2) **review all the evidence gathered by the Committee in relation to the provision of maternity services by Nottingham University Hospitals NHS Trust to inform a decision about the Committee's next steps.**

62 Provision of services for adults with learning disabilities

Sara Storey, Director for Adult Health and Social Care, and Paul Haigh, Head of Adult Social Care Provision, provided the Committee with an update on the developments in provision of community services for adults with learning disabilities, specifically on changes for those who previously attended Summerwood Day Centre. The following points were highlighted:

a) Following the end of a consultation in May 2021, a decision was taken to close Summerwood Day Centre. 17 citizens that attended Summerwood Day Centre were transferred to Spring Meadows Day Centre in September 2021.

b) The transition from Summerwood to Spring Meadow Day Centre has enabled service users to access the same level of service that they had received when attending Summerwood.

c) Citizens and carers of those that have moved to Spring Meadow have all reported that they are happy with the new service and have transferred to their new centres successfully and have adjusted well. The Assessment Team received excellent feedback in regards to the 17 citizens who moved to Spring Meadow.

d) As a result of Covid, adult social care service provision across Nottingham has shifted significantly, with day centres being unable to open in line with government guidance. Covid related guidance for day centres has not been recently updated, however many external day centres have resumed their operations, although with reduced capacity.

e) Day centres and day services are not required to be registered with the Care Quality Commission (CQC) or Ofsted and there were no mandatory inspections. Although not inspected, they are still required to be accredited which is carried out by the Council and internal audits are undertaken for regulated services which were then inspected by CQC.

In response to questions asked by the Committee the following information was provided:

f) Prior to the closure of Summerwood Day Centre, some of the service users had been very concerned and anxious about the prospect of transferring to a new centre. However, the transfer went extremely well and citizens are enjoying a number of interactive activities at Spring Meadows. Staff, service users and the families of those using the services all played an integral part in the success of the transfer, which would be kept under review.

g) With regards to staffing, recruitment across the whole care sector is problematic, both locally and nationally. Recruitment and retention in the whole care market has been challenging for some time with a turnover rate of approximately 30% of workers leaving the market on an annual basis. The

issues for staffing have been worsened considerably, particularly during the latter part of 2021.

h) To attract more staff a range of payments and incentives has been introduced and there has been a slight increase in the number of people recruited.

The Committee thanked all of those involved in the transition from the Summerwood Centre to Spring Meadows, and acknowledged the hard work and commitment of those working in the care sector.

The Committee noted the report.

63 Work Programme

It was agreed that the 'GP Strategy - To review proposals for the draft GP Strategy' scheduled for the 17 March 2022 be moved to the June 2022 Committee.

The Committee noted its current work programme for the remainder of the year.