**Nottingham University Hospitals NHS Trust Maternity Service**

**Briefing for Nottingham City Health Scrutiny Committee, January 2021**

On Wednesday 2 December 2020 the Care Quality Commission (CQC) published their report following an unannounced inspection of our maternity services in October 2020 (14th/ 15th). This was as a result of being alerted to some concerns by HM Coroner. The Assistant Coroner implemented a Prevention of Future Deaths order, as well as a Neglect Rider on the narrative verdict on 7 October 2020 after the inquest of Wynter Andrews.

The report makes for difficult reading and includes a re-rating of our maternity service from 'Requires Improvement' to 'Inadequate' along with two Warning Notices 29a/31 which were issued immediately after the visit.

Following the initial feedback from the CQC on 15 October we made some immediate changes in order to maintain the safety of the service and will continue to make further changes.

Earlier in the year we had identified some issues in the service and had begun a piece of transformation work; the findings of the coroner and CQC concerns added to our own concerns and brought some immediacy to our actions.

The Chief Executive established a Maternity Oversight Committee, which is chaired by one of our Non-Executive Directors and supported by five work streams which are led by some of our Executive Directors. They cover safe practice, learning from experience and quality improvement, people (leadership, teamwork, culture and innovation), governance (including data and information), Safe Today and a Clinical Advisory Group, chaired by the Divisional Director for Family Health. Linked to the Maternity Oversight Committee is an external panel which will include experts in maternity and obstetrics from other NHS Trusts who are rated 'Good' or 'Outstanding' by the CQC, maternity leads from NHS England/ Improvement and service users. During 2021 we will be working closely with the Maternity Voices Partnership to ensure we embed the voice of women and families into our improvement work. These groups/ committees meet monthly and work through the CQC action plan and making improvements to the service.

Since we produced the CQC action plan we have extended it to include more areas of focus from the recently published Ockenden Report, feedback from inquests and incidents, Healthcare Safety Investigation Branch (HSIB) reports and staff feedback. This action plan is shared with the CQC on the 30th of each month, and we expect them to visit us again at some point this year.

Internally, the action plan is monitored closely by the Oversight Committee and its work streams with updates reported formally through our Quality Assurance Committee, and then our Trust Board.

**Staffing**: Last summer we were in a position where we had recruited to almost all of our midwifery vacancies, based on a tool that looks at number of births. However we wanted to take advantage of a tool called Birthrate Plus, and so during the summer as part of the transformation work we took that opportunity.

Birthrate Plus is a workforce planning tool. It helps identify how many midwives are needed to care for women based on a minimum standard of providing one-to-one midwifery care throughout established labour, taking into account total activity not just the number of births per unit. This work identified that we need more midwives to provide that care for the increasingly complex pregnancies that we are seeing. The shortfall is now 73 midwives. We are committed to recruiting more midwives and that work is ongoing, but will take time.

**Ockenden Report:** On Thursday 11 December 2020, the first report of the independent review into maternity services at the Shrewsbury and Telford Hospital NHS Trust was published. The report outlines the local actions for learning for the Trust and immediate and essential actions for the Trust and wider system that are required to be implemented now to improve safety in maternity services

for the Trust and across England. The full report can be read here: https://www.ockendenmaternityreview.org.uk/first-report/

The report is a critical reminder of the importance of safeguarding clinical quality and safety. The report includes some 'immediate and essential actions' at the request of the Minister of State for Mental Health, Suicide Prevention and Patient Safety with the aim that these will help to improve safety in maternity services across England. These actions are themed under seven areas:

1. Enhanced safety
2. Listening to women and families
3. Staff training and working together
4. Managing complex pregnancy
5. Risk assessment throughout pregnancy
6. Monitoring fetal wellbeing
7. Informed consent

On 14 December NHS England/ Improvement issued a letter to all NHS maternity providers which listed 12 urgent clinical priorities that were to be implemented and a request that all Trust Boards review an assessment of their own maternity services against the reviews immediate and essential actions. Our Trust Board will do this at a meeting arranged for Wednesday 13 January 2021.

The immediate, essential and urgent clinical priority actions from the Ockenden Review were reviewed on publication and reflect some of the areas for improvement that we have already identified and are a current area of significant action and focus for the Trust. As such these 12 urgent clinical priorities are being prioritised and actively delivered, but not all at this stage can be classed as fully implemented. Our current position is that three urgent clinical priorities were fully implemented by 21 December 2020, two will be fully implemented this month (January 2021) and seven have actions and timescales to achieve implementation clearly identified and being monitored via our maternity improvement plan.

**MP's**: We regularly brief local MP's and have updated them on the current work around improving our services. Three MPs have asked for separate more detailed briefings, two due to their connections with the Hawkins and Andrews' families. We have done this and offered them the opportunity to visit our units; two MPs have taken up this offer and will visit in January and February.

**Key achievements in the last month:**

- We have appointed an Interim Director of Midwifery who started on 4 January 2021;
- The business case to support an establishment uplift in line with Birthrate Plus has been approved to progress to Trust Board for final sign off in January 2021;
- We continued to close the gap of midwives identified by the Birthrate Plus work and in December we recruited seven WTE (whole time equivalent) midwives, bringing the total to 18.19 WTE midwives recruited recently (this means that we have more midwives against our original establishment);
- Additional consultants are in post to support triage and the Day Assessment Unit, providing an additional 4.5 sessions per week per site;
- A project group to lead the implementation of the Birmingham Obstetric Symptom Triage Model (BSOTS) and the separation of triage and day assessment activity has been established and a detailed project plan put in place to deliver a BSOTS triage model by end of March 2021;
- The migration of community midwives from Systemone to Medway Maternity (IT systems) went live on Monday 4 January 2021;
- 90% of midwives have received Dawes-Redman training in line with the planned trajectory;
- The service has developed a CTG competency assessment based on NICE Guidance and includes escalation and interpretation. It has been tested on a group of doctors and sent to the Regional Fetal Monitoring Group for comment. The training package and competency assessment are live on ESR (Electronic Staff Record);

- A lead midwife for fetal monitoring has been appointed and started in post on Monday 4 January 2021;
- A comprehensive local audit plan has been developed and is in progress;
- Weekly meetings with provider, Clinical Commissioning Groups and Regional Midwife are in place to provide support and assurance.

Finally, we recognise that the CQC findings will raise some concerns about our maternity service with local women and families and the Trust Board and Executive Team remains committed to working with the Divisional team and midwifery service to make improvements, ensuring it provides safe care every time, for every family.