Nottingham University Hospitals NHS Trust Maternity Service

Briefing for Nottingham Health Scrutiny Committee, July 2021

The Maternity Oversight and Improvement work has moved forward and through this report we will update you on recent progress.

Key areas of progress:

1. Recruitment of additional midwives including a new substantive Director of Midwifery started at the end of June. We have now offered 57 midwifery posts (since September 2020)
2. Daily escalation meetings to ensure staffing safe for the women needing care
3. Training on fetal heart rate monitoring has progressed with all available staff now trained
4. We are auditing the care we provide, for example, our fetal monitoring. Our audits show we have more to do to ensure improvements are consistent
5. We have provided additional equipment such as CTG machines, and are working on a digital improvement programme.

Governance processes:

We have reviewed our action plan this month, refreshed and revived it to ensure that it was prioritised to the areas which made the biggest difference – this will improve the safety of the service we provide.

We have also spent time reviewing our assurance process and have created a maternity dashboard which uses recognised maternity metrics. We have built on the standard metrics to incorporate others that will measure the impact of our improvement work. We are moving from a traditional RAG (red, amber, green) rated approach to one where measures have a “variation” and “assurance.” We have introduced adverse variance reporting to improve the way we monitor our performance and the safety of the care we are delivering to women and babies.

The Care Quality Commission told us we were now compliant with the Warning Notice they had issued (in September 2020), however we still have conditions on our registration in place. As a result we continue to report monthly to CQC on our progress towards meeting those conditions. Although we have made changes, we don’t have assurance that all improvements have been embedded within the service. We still have variation and we know we have a lot more to do.

There are internal and external assurance processes in place to ensure delivery of our action plan. Internal assurance takes place via the Maternity Oversight Committee, which is chaired by one of our Non-Executive Directors. Each of the five work streams, led by Executive Directors, reports monthly to the Maternity Oversight Committee on achievement against the action plan. The Maternity Oversight Committee reports regularly into our Trust Board.

The external assurance is with the CQC and a Quality Assurance Group led by the Clinical Commissioning Group and including representatives from NHS England/ Improvement, GMC, NMS, Health Education England, Healthwatch and Public Health amongst others.

Action plan progress

Our action plan has been reviewed to ensure it is fit for purpose. It addresses the areas of concern raised by CQC but has been extended to include more areas of focus from the Ockenden Report, feedback from inquests and incidents, Healthcare Safety Investigation Branch (HSIB) reports and staff feedback. The table below identifies some of the recent areas of progress.

Theme	Actions	Summary of progress as of 30 June 2021
Safe Today	• The Trust must have an effective system in place to ensure staffing is actively assessed, reviewed and escalated appropriately to maintain safe staffing in the maternity unit in line with national guidance	• Recruitment of additional maternity staff continues • Interviews for 6 new obstetric consultants planned for early July • Requested additional support to increase leadership capacity from neighbouring trusts • Plan in place to address staffing concerns over July and August • Daily/weekly oversight of staffing in place so we can be proactive and mitigate risks.
Safe Practice	• Fetal heart rate monitoring (training): Ensure there is effective, consistent and established monitoring of Fetal Wellbeing at all stages of pregnancy • Fetal Heart Rate Monitoring (CTG Machine Replacement Programme): Ensure there is effective, consistent and established monitoring of Fetal Wellbeing at all stages of pregnancy • Antenatal Assessment: Women undergo risk assessment throughout pregnancy that is clearly documented within Medway Maternity and actioned appropriately. For women requiring Consultant Led Care, they are assigned a named consultant. • Post-partum haemorrhage: To reduce the proportion of women experiencing a post-partum haemorrhage and the morbidity associated with this to at or below national average/ peer comparator • Induction of Labour: Address any unwarranted variation in rates and reasons for induction of labour. Where induction is clinically indicated, ensure an effective process is in place to induce women in a timely manner • Community Postnatal Pathway: Ensure provision of safe postnatal community pathways which minimises avoidable readmissions of babies. • Digital Support: Ensure information technology systems are used effectively to monitor and improve the quality of care provided to women and babies	• Digital programme progressing. Progress being made to address connectivity issues within the community • Progressed with CTG competencies for all available staff • Rolled out new CTG machines and additional IT equipment • Antenatal risk assessments compliance audit shows improvements, but further work to ensure consistent practice • Weekly audits of fetal heart monitoring underway which show improvements, but still further to work to ensure consistent practice • Post-partum haemorrhage training sessions have taken place • Reviewed and made changes to our jaundice baby pathway to ensure we are working in line with national guidance.

Theme	Actions	Summary of progress as of 30 June 2021
Governance	• Risk Management: The Trust will implement an effective governance system • Serious Incidents: Ensure the Trust has a robust and effective process in place to identify, investigate and learn from Serious Incidents. Including working collaboratively with neighbouring trusts to ensure investigations have regional and LMS oversight. Ensure the Trust is using the National Perinatal Mortality Review Tool to the required standard.	• Implemented a new process for the immediate identification and learning from serious incidents • Addressing our backlog of incident investigations • Provided additional leadership capacity into our maternity governance team • Developed our maternity dashboard so that it helps us identify variance in our performance.
People	• Staffing: Plan and deliver to Birthrate Plus standard. Deliver on having consultant led labour ward rounds twice daily and 7 days per week • Training: The Trust must implement an effective system to ensure that medical and midwifery staff are suitably qualified, skilled and competent to care for and meet the needs of women and babies within all areas of the Maternity Service.	• We have offered 57 midwifery roles this year • We are progressing work to address cultural issues across the service • Undertook a pilot with the Antenatal Clinic team who have had a series of workshops to develop their Team Charter – a set of commitments that the team have signed up to that will build better team working. The intention is for a programme of Team Charter workshops to be rolled out across maternity, including with the DLT • Delivered leadership training/coaching to our ward managers • Advertised for an additional 6 consultant obstetricians • Offered support to our staff following the media stories to ensure staff feel able to speak up and share their feelings.

Summary

As you will be aware, there has been significant media attention over the past two weeks. We recognise that this has been distressing for everyone.

We understand that families may have found the information about the maternity service they are using or the news reports distressing, particularly if they are about to have a baby, so we have been reassuring those families when we come into contact with them. The majority of women and families who use our service tell us that overall they are happy with their care, however we are taking the need to improve very seriously so that every family has the experience they want and every member of our maternity team feels proud of the care they deliver.

Listening to women and families is a key way for us to learn and make improvements to our service based on what they tell us about their experiences. Whether they have received excellent care or where care has fallen short we will continue to hear what they have to share and empower our maternity team to make improvements.

We have written to the families involved in the recent media report and offering them the opportunity to meet with our new Chief Nurse and share their experiences with her first-hand.

We acknowledge that we still have a great deal of progress to make to ensure our maternity service is providing the best possible care for women and their babies. We are wholeheartedly committed to making and sustaining improvements and are strengthening the robustness of our plan to provide a greater level of assurance that we are delivering sustained improvements.