Nottingham City Council

Health Scrutiny Committee

Minutes of the meeting held in the Dining Room - The Council House, Old Market Square, Nottingham, NG1 2DT on 15 July 2021 from 10.00 am - 12.21 pm

Membership	**Absent**
Present	Councillor Kirsty Jones
Councillor Georgia Power (Chair)	Councillor Phil Jackson
Councillor Cate Woodward (Vice Chair)	
Councillor Michael Edwards	
Councillor Samuel Gardiner	
Councillor Maria Joannou	
Councillor Angela Kandola	
Councillor Anne Peach	

Colleagues, partners and others in attendance:

Michelle Rhodes,	Chief Nurse, Nottingham University Hospital (NUH)
Sharon Wallis,	Director Midwifery, Nottingham University Hospital (NUH)
Lucy Dadge,	Chief Commissioning Officer, Nottingham and Nottinghamshire CCG
Lewis Etoria	Head of Insights and Engagement, Nottingham and Nottinghamshire CCG
Ajanta Biswas	Nottingham and Nottinghamshire Healthwatch
Jane Garrard	Senior Governance Officer (NCC)
Emma Powley	Interim Governance Officer (NCC)

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17 Apologies for absence

Councillor Kirsty Jones (unwell)
Councillor Phil Jackson (personal)

18 Declarations of interest

None

19 Minutes

The Committee agreed the minutes of the meeting held on 17 June 2021 as an accurate record and they were signed by the Chair.

20 Nottingham University Hospitals NHS Trust Maternity Services

Michelle Rhodes, Chief Nurse, and Sharon Wallis, Director of Midwifery, NUH, attended the meeting to present and update on the progress made by Nottingham University Hospitals NHS Trust in introducing improvements following the Care

Quality Commission's rating of maternity services as 'Inadequate'. The following information was highlighted:

a) Following the publication of the Care Quality Commission (CQC) report in December 2020 which re-rated Nottingham University Hospitals NHS Trust (NUH) maternity services from 'Requires Improvement' to 'Inadequate' along with a warning notice, representatives of NUH attended the 14 January 2021 meeting of the Health Scrutiny Committee.

b) Since then, there had been a fundamental commitment to improving the maternity service and to offer women an improved experience and to learn from previous mistakes.

c) The improvements will not be immediate and will require additional staff training, which is already being implemented. This includes improving staff training on the use of the cardiotocography (CTG) machines which had been identified as an area of concern as they had not been used correctly. This has had catastrophic consequences for birthing women and children within the care of NUH.

d) There have been some difficulties in delivering training due to the pandemic as there had been limited staff and face to face training had been restricted due to the need for socially distancing. A 'fresh-eyes' approach had been implemented as part of the review into antenatal and postnatal care.

e) Staff, specifically community midwifes, had reported issues with the technical systems being used and their accessibility, reporting that the digitalisation had impeded their efficiency. This was being looked into to speed up the system and to make it more accessible.

f) A Patient Liaison Service has been established and allows women affected by past experiences of poor care to access the service to voice their concerns and to identify shortcomings in the care they received. Women are being encouraged to come forward and speak up about their experiences and there has been a recent shift in care to empower women in birth/labour. Women who have suffered from trauma as a result of the service had been written to and face to face meetings had been offered to them.

g) There have been mistakes made in maternal care at a nationally and this was attributed in part, to Covid. However, NUH maternity services has also suffered from staff shortages and difficulties in recruiting midwifes. It was suggested that there was a reluctance for newly trained midwives to join a service that had been rated as 'inadequate' following the publication of the CQC report.

Ajanta Biswas, Healthwatch Nottingham and Nottinghamshire, spoke to the Committee about the work that Healthwatch had been undertaking, including with bereaved parents, to gather insight into past and current provision of maternity services by NUH.

The Chair noted that a written statement from the Chair of the Nottingham and Nottinghamshire Maternity Voices Partnership was included in the papers; and, prior to this meeting, the Committee had met informally with a parent whose child had died whilst in the care of NUH's maternity services to hear their perspective.

In response to questions from the Committee and in the subsequent discussion the following points were made:

h) The number of midwifes leaving the NUH Trust far outweighs the number of students qualifying. This is challenge for the Trust and different incentives are being explored. In addition, neighbouring hospitals with over-recruitment are being contacted with the rotation of students between hospitals being considered.

i) A buddy-up programme has been implemented with University of Coventry and Warwickshire Trust and there has been an increase in the number of 'Speak up Guardians' encouraging more engagement and communication on (potential) issues and concerns.

j) A complaints process is in place but the Trust recognise that improvements are needed. Maternity related complaints are collected and processes are in place to help expedite responses to complaints. There have always been processes in place to enable patients to raise concerns and complaints but the Service is now much more proactive in ensuring patients and families know about ways to raise concerns. A thematic review of complaints is currently being carried out.

k) A maternity care dashboard has been produced to map where improvements are necessary from a clinical perspective and identify areas for improvements. This will be reviewed over a 3 month period in order for the data to identify trends, and this will then feed into an action plan for improvement.

l) In order to retain staff and improve overall morale the following steps are being taken:

    i) Weekly meetings by the Chief Nurse and Director of Midwifery with staff and ward matrons

    ii) Recruitment of 6 consultants; 3 permanent and 3 locums

    iii) Incentive schemes to be offered to attract more staff – yet to be signed off but continued progress being made

    iv) Offering flexible hours and encouraging retired midwifes to re-join.

m) Choices of birthing options will continue including home births, although unfortunately this has to be suspended if there is insufficient staffing levels and that is determined by clinical rationale.

n) The Trust does not consider that the issues identified in relation to maternity services are systemic across the organisation. However, there are

opportunities for the organisation to learn from the improvement activity taking place in relation to maternity services, for example the rapid review process for assessing risk, identifying harm and taking immediate action and learning.

o) The Trust recognises that improvements to translation services are needed to ensure all women can communicate adequately. Studies are being undertaken to address the potential for antenatal and postnatal care to be transferred to community hubs which could improve communication with BAME women.

p) The CCG commissioned Healthwatch to support the Maternity Voices Partnership (MVP) work. Their focus for the current 6 months was on improving maternity services for ethnic minority service users by setting up a new review group that will include both maternity professionals and service users from an ethnic minority background.

q) Since March 2021, there has been an increased frequency of meetings between NUH maternity services and MVP service user representatives (MVP chair and MVP project officer at Healthwatch) and currently there are bi-weekly catch-up meetings. NUH engagement and communication staff are participating in and supporting these meetings.

r) Three NUH maternity staff members with an ethnic minority background have stepped forward to participate in the upcoming Healthwatch/MVP working groups and are committed to improving maternity services for ethnic minority service users.

s) A Committee member highlighted the benefits of co-designing services and involving women in decisions about the service and their own care. It was suggested that there has been a medicalisation of child birth, with women's control being removed at a time when they were at their most vulnerable which needed to be addressed and reformed.

t) At its meeting on 14 January 2021, the Trust had indicated to the Committee that it expected the improvement work to take a number of months to fully address and embed the issues identified by the CQC, with an ambition to see the Maternity Service move from an 'inadequate' to 'good' CQC rating within 12 months. However, having not been working for the Trust at that time, the Chief Nurse and Director of Midwifery both now consider this to be unrealistic and set out that, given the nature and scale of improvements required, it will be 2-3 years before the service will achieve sufficient sustained improvement in all areas.

u) The Improvement Plan initially developed in response to the CQC report has been reviewed to ensure all actions are meaningful. It has a dashboard of key performance indicators and measurable outcomes. Once the Improvement Plan has been through the NUH governance processes it can be shared with the Committee. The Committee highlighted the importance of openness and transparency in discussions at Board level and raised concern that some previous Board papers are not publicly available.

v) The Maternity Oversight Committee, chaired by a Non-Executive Director, meets monthly to oversee the action plan and hold the Service to account for delivery of the action plan. The Committee also reviews Serious Incidents and immediate learning arising from them. There are also weekly maternity improvement meetings to identify any barriers to improvement and to help implement improvement actions.

w) The Trust currently has fortnightly meetings with NHSE and there is a monthly quality assurance meeting involving a range of stakeholders including the Clinical Commissioning Group, NHSE/I, NHSE Education and Healthwatch.

x) Whilst clarifying there will always be instances of Serious Incidents (Sis) in maternity services, the representatives of NUH concurred with the Committee's view that the Trust needs to ensure that there is always an open and transparent reporting process and when such incidents are reported, it is paramount that learning takes place as a result and that learning results in real sustainable change. Thematic reviews of SIs do take place and have identified commons issues such as staffing and training. The Health and Safety Investigation Bureau also produce reviews of lessons learnt from SIs nationally.

y) The representatives of the Trust acknowledged that the Service hadn't always got it right in the past in relation the identification and investigation of Serious Incidents in maternity services. Processes are being put in place to ensure that all Serious Incidents are appropriately identified. Staff should not be deterred from reporting a potential SI and if, upon investigation, it is subsequently found not be a Serious Incident the categorisation will be changed, but staff are told that it is preferable to report it initially so that be investigated appropriately. Decisions in relation to Serious Incidents are not decided by an individual and are made collectively by the Service itself.

The Trust offered the opportunity for the Committee to visit sites where maternity services are delivered, once the situation in relation to Covid permits.

The Chair of the Committee thanked the NUH representatives for their attendance.

The Committee noted the progress that has been made and plans to continue the improvement journey and also noted the external context such as the national shortage of midwives and the impact of Covid on driving improvement, such as the challenges in delivering training. It was acknowledged that it will take time for sustainable change to be made, but the Committee noted that the issues and concerns about care have already been known for some years. The Committee remained concerned about a number of areas including how women are listened to and involved in decisions about their care and when things go wrong; the Service's processes for hearing about when things don't go well, such as complaints from patients, and confidence by staff to speak up about concerns, and the extent to which learning takes place as a result; care for women from ethnic minority groups, particularly those who require translation services, as an inability to communicate with the professionals providing care can affect a woman's engagement in decisions about her care and her ability to raise issues or concerns.

The Chair also stated that the Committee would not accept the term 'historical' by the Trust in relation to the concerns about maternity services as, for example, there continue to be a significant number of Serious Incidents reported. Incidents have been severe and prolonged, and the term 'historical' diminishes this and distances the Trust from the reported issues and trauma that women have experienced that resulted in infant deaths, brain damage and the delivery of stillborn babies.

Resolved to

(1) request that Nottingham University Hospitals NHS Trust review its publication of Trust Board papers on its website to ensure that all appropriate Board papers are open and easily available to view to provide transparency in the work and decision making of the Board;

(2) request that Nottingham University Hospitals NHS Trust provide the Committee with a copy of its agreed Improvement Plan for Maternity Services;

(3) welcome the prospect of an independent review of maternity services provided by Nottingham University Hospitals NHS Trust, to be commissioned the Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) and NHS England/Improvement (NHSE/I);

(4) to speak to the CCG in relation to the scoping of the review of maternity services to seek assurance regarding the Terms of Reference and process for, and publication of the review. Based on the outcomes of these discussions, the Committee will decide how it wishes to proceed in terms of further scrutiny on this issue.

21 Tomorrow's NUH

Lucy Dadge, Chief Commissioning Officer, Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) and Lewis Etoria, Head of Insights and Engagement, Nottingham and Nottinghamshire CCG and Integrated Care System addressed the Committee with details of engagement that has taken place so far in relation to the Tomorrow's NUH Programme and plans for further stakeholder, patient and public consultation and engagement. They highlighted the following key information:

a) In their previous updates to the Committee, work that had been done to date had been described and was summarised in the report, which included an update on the work that had been done since January 2021.

b) Nottingham and Nottinghamshire Clinical Commissioning Group has a statutory duty to involve the public in proposals for changes to services. They also have a statutory duty to consult the Local Authority on any proposals for substantial variation to services and it is anticipated that the proposals coming forward as part of the Tomorrow's NUH programme will involve substantial changes to a range of services.

c) The CCG will develop a Pre Consultation Business Case that describes the proposed service changes in detail and the business case will be approved by its Governing Body and NHS England/Improvement (NHSE/I).

d) It will be supported by a Consultation Document, which will set out the proposals to the public and seek their feedback. It is anticipated that the consultation will be launched in 2022.

e) The Consultation Document will be specifically designed to target populations most likely to be impacted by changes. Mixed methodology had been used to compile the document and it will also proactively be made available in different languages, specific to Nottingham, rather than waiting for requests for copies in a specific language. There will also be promotion of the document on various social platforms and the media.

f) A core reference document was the pre consultation business case; there was a statutory requirement for this to be shared with the CCG and the Local Health Scrutiny Committee.

g) It is anticipated that the decision making business model will be in place by 2022.

h) Staff are also being consulted as it is considered essential to engage with them in order to build a sustainable workforce delivering the care to its patients. It was paramount that there was engagement with front line staff and their views listened to in order for the service to be a success.

i) Whilst there was an under-representation of young people responding to engagement so far, it is important that they were engaged with as students will be the future professional health care workers, in addition to being current and future service users.
Overall the Committee welcomed the CCG's commitment to engagement and consultation on proposals. The Committee suggested that there would be benefit in the CCG utilising existing community groups and networks to engage with different population groups as part of the consultation. The CCG agreed to provide a list of stakeholders already identified and confirmed that it would welcome additional suggestions from members of the Committee.

The Chair thanked both representatives for attending the meeting and delivering their updated information, and the Committee agreed to schedule further consideration of the Programme as it develops

22 Work Programme

The Committee noted its current work programme and plans for the work programme 2021/22.

The Chair reminded the Committee that there would be not be a meeting in August 2021, but the work outlined on the plan for the 16 September 2021 was as follows;

a) **Assessment, Referrals and Waiting Lists for Psychological Support**::
To consider the Nottinghamshire Healthcare NHS Foundation Trust's plans for managing access to psychological support, particularly in relation to step 4 psychotherapy and psychological therapies.

b) **Reconfiguration of Acute Stroke Services**:
To consider proposals for making changes to the configuration of acute stroke services permanent. Changes were made on a temporary basis to support the response to the Covid pandemic. If it is proposed to make the changes permanent, then this is likely to be a substantial variation to services and the Committee will need to carry out its statutory role as a consultee

c) **Covid 19 Local Vaccination Programme:**
To assess progress with local delivery of the vaccination against national targets (at 23/03/21 the whole population should have had at least one dose by the end of July 2021)