NHS NOTTINGHAM AND NOTTINGHAMSHIRE CCG OVERSIGHT AND ASSURANCE BRIEFING

NOTTINGHAM HEALTH SCRUTINY COMMITTEE

NOTTINGHAM UNIVERSITY HOSPITALS

Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) has been working closely with Nottingham University Hospitals NHS Trust (NUH), CQC and NHS England and NHS Improvement (NHSEI) over the past year to oversee improvements in maternity services and more widely across the trust. This briefing will aim to summarise the work and illustrate system oversight arrangements in the relation to all services being provided at NUH.

System Approach

1.1 As the clinically led statutory NHS body responsible for the planning and commissioning of healthcare services, NHS Nottingham and Nottinghamshire CCG plays an integral role in ensuring we get the best care and outcomes for our local population. The CCG supports local improvement, working in line with the trust regulator (NHS England and Improvement) and the regulator for the quality of services (Care Quality Commission). The regulators have legal powers of intervention and the CCG monitors quality standards, instigating improvement actions where required

1.2 As we transition to the proposed new statutory arrangements (Integrated Care Systems) it is essential that there is a shared ambition for health and wellbeing of our citizens.

1.3 The Integrated Care Board (ICB) will take on the duties of the CCG in terms of local quality oversight and improvement. This will require close collaboration working with system partners (including providers, people using services, NHS England and NHS Improvement, regulators, and wider partners), shared quality improvement priorities and shared ownership of risks.

1.4 Our ICS and current CCG approach has clear governance and escalation processes for quality (including safety) in place, and actively monitors and manages system quality risks, in a way that enables continual learning and improvement.

1.5 In preparation for this transition, a system-wide Quality Assurance & Improvement Group (QAIG) has been established. This group will report into the ICB Quality Committee however in the interim reports into the ICS Board and NHS Nottingham and Nottinghamshire CCG Quality & Performance Committee.

1.6 QAIG has been established to ensure the system works collaboratively across health and care partners to support, improve, and sustain high quality care across Nottingham and Nottinghamshire:

- To ensure the fundamental standards of quality are delivered – including managing quality risks, including safety risks, and addressing inequalities and variation; and
- To continually improve the quality of services, in a way that makes a real difference to the people using them

The group takes a proactive and systemic approach to managing and improving quality drawing on evidence, best practice and quality improvement methodologies in a way that is transparent and measurable.

1.7 The CCG and the ICS act in accordance with the National Quality Board taking the responsibility for monitoring the quality and safety of health and care services as per Local Quality Requirements:

- **QUALITY PLANNING**: Work to a common definition of quality
- **QUALITY IMPROVEMENT:** Deliver quality improvement and develop a core set of quality metrics which can be used to measure quality
- **QUALITY CONTROL**: Contribute and embed quality oversight with a shared commitment to working together

2. Nottingham University Hospitals (NUH)

2.1 As part of enhanced surveillance on maternity services at NUH a Safety Oversight and Quality Assurance Group for NUH Maternity was established during January 2021. As part of information and intelligence it was evident that the concerns identified within maternity were more widespread and commissioner oversight was enhanced. Appendix A provides more detail of the maternity assurance actions.

2.2 Additionally, routine quality assurance arrangements identified a number of concerns, beyond those identified in maternity around wider organisational culture, safety, effectiveness, and experience of care.

2.3 During May 2021 the CCG formally sought assurances around the quality of care being provided across the Trust, to further understand the steps being taken to address operational demands plus recovery and restoration of services following the pandemic.

2.4 To support this the CCG worked with NUH to identify and populate a set of 'Key Issues and Risks' (KIARs) outlining the actions being taken plus the system support required to ensure the necessary improvement. In addition to identifying the impact of increased operational demands this exercise identified a number of specialist services experiencing staffing and resource challenges, making them fragile and vulnerable to disruption of provision. These included services such as Maternity, Emergency Department (ED), Urology, and more recently Oncology, specifically chemotherapy.

2.5 As a result of these challenges and associated KIARs the recommendation from QAIG (August 2021) to the ICS board (and CCG Quality and Performance Committee) that NUH to be under enhanced surveillance so that there is greater scrutiny and the formation of a system action plan to o identify opportunities to utilise the system mutual aid offers, support NUH to build a positive learning culture and work as a system to ensure the best outcomes for our citizens

2.6 A system action plan has been developed with collaboration from NUH. In the past few months system mutual aid has been used to support operational pressures in maternity and emergency care, as well as supporting improvements in NUH internal governance and oversight.

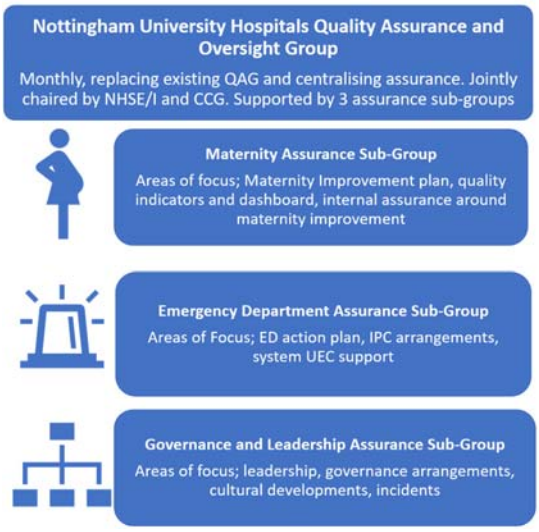
2.7 In September Trust have received an overall CQC rating of Requires Improvement following a focussed Well-Led Inspection and visits to surgery and the emergency department. The report highlighted many areas which have been identified as part of our system quality oversight, and additional concerns in relation to a culture of bullying across the organisation.

3. NUH Commissioner Actions/Involvement

3.1 Enhanced surveillance and system/regulatory support will continue, the CCG and ICS continue to work closely with Nottingham University Hospitals NHS Trust to ensure rapid improvements are made, providing capacity to support, as well as continuing to provide scrutiny and challenge.

3.2 We have Established a system oversight framework (detail in Appendix B) to monitor progress of both immediate safety plus the transformation and change programme. This includes establishing an Oversight and Quality Assurance Group (QAG) co-chaired by the CCG Accountable Officer and NHSEI Regional Chief Nurse (Midlands), with three focussed assurance subgroups which will provide oversight and support for the improvement programme. Representation includes Healthwatch, Professional Bodies, Health Education England, Care Quality Commission (CQC), and Local Authority Public Health.

3.2.1 Figure 1 High Level Oversight Arrangements



3.3 In addition, quality and safety oversight continues with increased touchpoints with NUH. This includes CCG representatives at a number of internal NUH meetings such as the Incident Review Meetings, Harm Free Groups, Corporate Quality Committee, Maternity Oversight & Operational Groups. Relationships have also been established with the new

Chief Nurse, new Director of Midwifery, and new Associate Director of Quality Governance and teams.

3.4 A programme of system supported quality insight visits are being planned, including a system Winter preparedness visit to the Emergency Department.

3.5 The CCG has also established weekly triangulation meetings incorporating Contracting, Commissioning, Quality, Recovery and Transformation leads to ensure there is a consistent and up to date view of quality.

3.6 It is recognised that quality monitoring and oversight needs to evolve to ensure that we operate in an environment which is proactive and at the forefront of improvement. Historical approaches have been responsive and reliant on key performance indicators which are not necessarily always able to provide the 'whole story' in terms of what quality looks and feels like. As a system we have agreed a set of quality principles which will underpin a single view of quality.

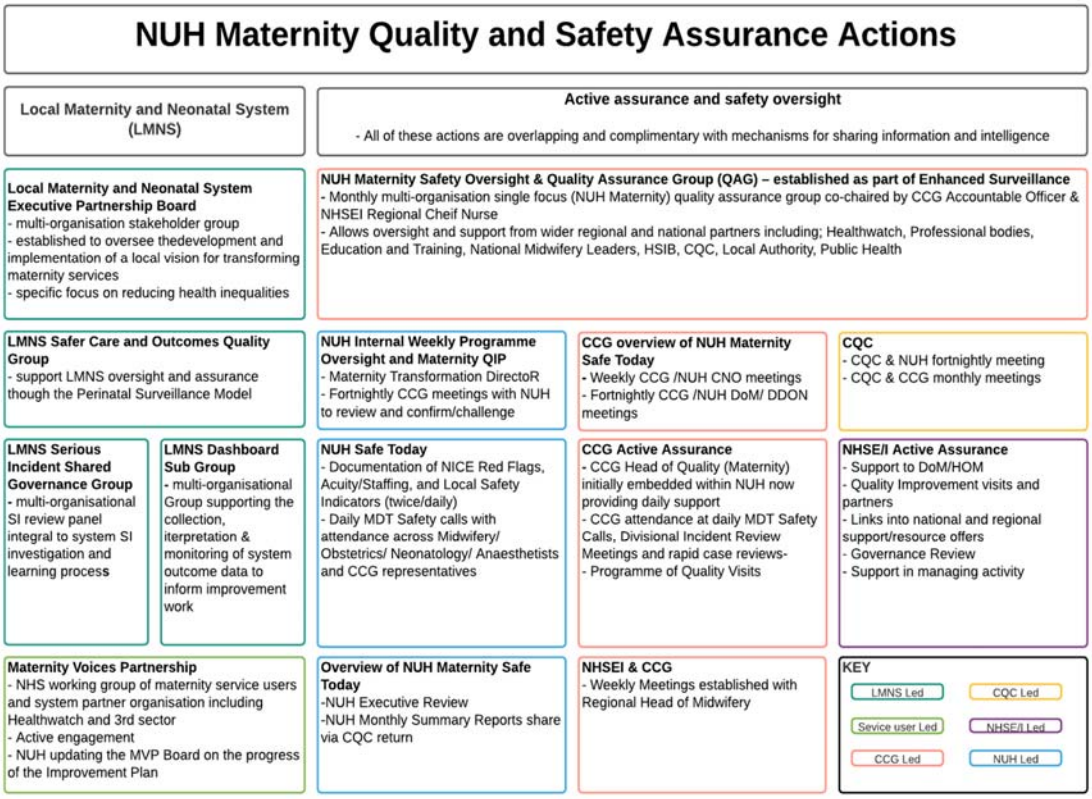
3.7 Since January 2021 there has been a Maternity focussed QAG however concerns persist in this are due to the lack of pace and assurance seen across the NUH Maternity Improvement Programme and a lack of focus on impact and outcomes. Although there has been considerable work to develop a meaningful Improvement Plan and a Provider Maternity Dashboard there is still not clear triangulation between these or the challenges the maternity service faces. Improvement progress, in maternity particularly has been hindered by the change in critical leadership roles (there have been four Directors of Midwifery and three Chief Nurses in eight months) as well as the on-going operational demands.

3.8 An Independent Review of NUH Maternity Services has been jointly commissioned by the CCG and NHSEI Midlands Regional team to drive rapid improvements to maternity services in Nottingham by focussing on issues where change is urgently needed. The Review will analyse a broad range of information from complaints, incidents, concerns, and family experiences, but will also have a clear focus on current practice to ensure that the appropriate standards of safety and quality are being delivered.

3.9 The Review will be completely independent of NUH, includes involvement from families and the findings and report will be made public when complete. We are committed to ensuring that affected families will be kept up to date and involved throughout the review. Families will shape the Terms of Reference (Appendix C), membership and engagement in the Reference Panel and a written monthly update will be provided to all families and interested parties.

3.10 Whilst the situation at NUH is far from where we want it to be, we recognise that rating of 'outstanding' for caring is testament to the staff working there. However, patients, citizens and staff should be receiving much better care and leadership. We are committed to working with system partners and the Trust to support improvement, expecting better to be delivered so we can ensure that our citizens receive the excellent care that they deserve.

Appendix A NUH Maternity Quality Assurance



Appendix B - NUH Assurance Oversight Framework

ENHANCED SURVEILLANCE: Monthly meeting jointly chaired by CCG and NHSE/I with 3 active subgroups; acting as collaborative improvement and assurance group

- **MATERNITY:** Monthly multi-organisation single focus (NUH Maternity) quality assurance group chaired by CCG Chief Nurse. Allows oversight and support from wider partners and oversight from trust engagement and review of progress against Maternity Improvement Plan
- **ED:** To Be Established. Areas of Focus: ED action plan, IPC arrangements, UEC support incl. surge plans, workforce
- **GOVERNANCE, LEADERSHIP, CULTURE:** To be Established. Areas of focus: Leadership & Workforce, Governance arrangements, Cultural Development, Incident Management

ICS/NHSEI System Review Meeting

Nottingham University Hospitals (NUH) Quality Assurance Oversight Group

ICS Executive Leadership Board

System Assurance, Support, & Oversight

ICS Quality Assurance & Improvement Group

NUH Maternity Safety & Assurance Oversight Group

NUH Emergency Department Oversight Group

NUH Governance, Leadership & Culture Oversight Group

NUH Quality & Safety Oversight Committee
Provider-wide focus on Key Issues & Risks (KIAR). CCG in attendance. KIARs with system support plan reports ICS Quality

NUH/CCG Monthly Executive Meeting
Support & Review of CQC Well Led

NHSEI Regulatory Assurance & Support
- Quality Improvement Partner
- Insight Visits
- Links into national and regional support/resource offers as part of SOF 4 package
- Monthly regulatory review meetings
- NHSEI seconded support

Care Quality Commission (CQC)
- CQC & NUH fortnightly meeting - review action plans
- CQC & CCG monthly meeting

NUH Maternity Improvement Programme

System Support / Working Groups

ICS Planned Care Board

Cancer Programme Board

Diagnostics

Elective & Outpatients Transformation

LMNS Executive Partnership Board

ICS Capacity & Planning

ICS Infection Control Assurance Group

ICS A&E Delivery Board

ICS Patient Safety Specialist Group

ICS People & Culture Board

NUH Oversight & Operational MIP Meetings
NUH Maternity Transformation Programme Director / support from NHSEI Improvement Partners
Fortnightly Meetings with CCG in attendance to support assurance, provide confirm/challenge

NUH Maternity SafeToday
Daily MDT Safety calls with attendance across Midwifery/ Obstetrics/ Neonatology/ Anaesthetists and CCG representative

LMNS Perinatal Surveillance Group
focus on quality and safety outcomes; areas for improvement

LMNS SI Shared Governance
Multi-agency panel in place to focus on maternity serious incidents and learning; reps include subject matter experts from across the system and network, provider reps, CCG

CCG / NUH Contracting Interface

CCG Assurance, Support, & Oversight

- NUH/CCG Contract Executive Board
- Activity & Finance Ops Group
- Tomorrows NUH Long COVID/Post COVID & Neutralising Monoclonal Antibodies

CCG Information Sharing

EXAMPLES OF REFRESHED WORKING ARRANGEMENTS
- Review of programme of quality insight visits
- Weekly triangulation meetings (contracting/ commissioning/ quality/ recovery & transformation)
- Increased touchpoints with both Executive Teams and Quality Teams
- System/CCG support and improvement plans - Key Issues & Risks (KIARs)
- Mutual aid
- CCG Head of Quality (Maternity) providing daily support (Maternity SafeToday)
- CCG attendance internal NUH meetings e.g. Divisional/Corporate Incident Review Meetings, Maternity Rapid Case Reviews, Quality & Safety Oversight Committee, Harm Free Care
- Involvement in review of ED 12 hour breaches and lessons learned
- IPC support and focus on IPC BAF / cleanliness / estate / and social distancing

NUH Led
CCG Led
System
Regulatory
New Oversight Groups

Appendix C - Independent Maternity Review Terms of Reference

TERMS OF REFERENCE

Independently led thematic review of incidents relating to maternity care at the Nottingham University Hospitals NHS Trust (the Review)

Introduction

1. In response to concerns regarding the quality of maternity services at Nottingham University Hospitals NHS Trust (the Trust), enhanced oversight and surveillance processes were put in place by NHS England and NHS Improvement (NHSE/I) and the NHS Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) during Autumn 2020.

2. A system oversight framework was established, monitoring progress of both immediate safety concerns and the Transformation & Change Programme; this aims to provide oversight and support for the NUH Maternity Improvement Programme. Partners from the Nottingham and Nottinghamshire Local Maternity & Neonatal System (LMNS) put increased scrutiny processes in place of untoward events and serious incidents at the Trust, whilst also working with the Trust to retrospectively review a number of maternity incidents.

3. This enhanced oversight identified a failure to learn from incidents and investigations, and also the potential for a number of incidents, complaints and concerns in relation to maternity care that may not have been appropriately identified, reviewed or escalated.

4. NHSE/I and the CCG recognise that the maternity care provided by the Trust has not been of the quality required, and that issues remain ongoing. NHSE/I and the CCG are committed to improving the quality and safety of the services that women, people who require medical terminations, people who give birth and their families receive from the Trust.

5. NHSE/I and the CCG will therefore commission an independently led review of maternity services at the Trust. The review will be known as the *'Independent thematic review of incidents relating to maternity care at the Nottingham University Hospitals'* ('the Review') and will be undertaken by an independent Review Team ('the Review Team').

6. NHSE/I and the CCG recognise that significant work has already been undertaken nationally in relation to commissioned maternity reviews. This includes the learning and recommendations made most recently in the form of immediate and essential actions arising from the Ockenden Review of maternity services at the Shrewsbury and Telford NHS Hospital Trust (2020)[1] . It was acknowledged in those findings '*that there must be an end to investigations, reviews and reports that do not lead to lasting meaningful change'.*

7. NHSE/I and the CCG will therefore seek to trial a new approach to maternity review, that captures local themes, trends and learning in order to inform specific and measurable actions for rapid improvement. This Review will examine both current and

[1] https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

recent concerns with maternity services at the Trust, in order to explore correlating trends, causation and connections, recognising that concerns may have previously been seen as isolated or individual events.

8. While the Review will consider the significant body of evidence already available, it will also identify additional evidence required from the Trust, NHSE/I, the CCG and wider system, in order to gain insights into current and recent maternity practice, culture and processes. The Review will also work with women, people who give birth and families to ensure the Review learning and recommendations reflect people's lived experience.

9. Throughout the period of the Review, NHSE/I and the CCG will continue to work closely with the Trust to ensure rapid improvements are made, providing capacity to support, as well as continuing to provide scrutiny and challenge to the Trust's maternity improvement plans. The Review will ensure key areas of learning are fed into that process and that this informs the NUH Maternity Improvement Programme.

10. This Review does not replace the statutory processes that exist around the response to individual cases, the duty of candour, notification of incidents, concerns relating to individual practitioners or other obligations relating to the provision of care by the Trust, either retrospectively or prospectively.

11. **In order to deliver a thematic Review, the Review Team will consider the detail of individual cases. However, it is recognised that the Review Team may identify individual cases which require further action or investigation; such as retrospective significant events, complaints or concerns, and/or where professional referrals are required.**

12. **An Independent Investigation Team (IIT) will therefore be established in order to undertake these investigations. This Independent Investigation Team will only complete individual investigations identified as being required by the Review Team, and this will be completed in line with national guidance, policy and best practice.**

13. **The IIT process will ensure that individual, retrospective case investigations are not tied to the Review timescales. The process will ensure that specific answers or outcomes are provided where possible to women, people who require medical terminations, people who give birth and families affected. While the IIT process will run separately to the Review, it will be overseen by the Review's independent Programme Director to ensure that actions from these investigations are reported back to inform maternity improvement at LMNS and Trust level.**

14. **Terms of Reference for the IIT will be devised by the Programme Director and independent Clinical Leads upon commencement of the Review.**

15. In the future, serious incidents, significant events, cases, complaints, concerns or professional referrals will be subject to a strengthened process, overseen by the LMNS, as recommended by the Ockenden Report. To facilitate this, the Nottingham and Nottinghamshire LMNS Perinatal Surveillance Quality Group have established a Serious Incident Shared Governance Group, which includes external clinical specialist opinion from outside the Trust.

16. It is recognised that ongoing support will be required for families affected by their experience of maternity services at the Trust. While separate to the Review, the CCG

and NHSE/I (as joint commissioners of the Review) will work with the Trust to ensure that there are appropriate and robust support services in place.

Purpose of the Review

17. The Review will provide an independently led assessment of what has happened with the Trust's maternity services and identify lessons and conclusions, including but not limited to the following:

    a. Determining if the systems and processes adopted by the Trust to identify and report serious incidents and harm are in line with national guidance, fit-for-purpose and effective;
    b. Identify any areas to support future recognition of concerns to allow earlier intervention;
    c. Identifying any service related themes/wider issues or links that are apparent from this Review;
    d. Evaluating the Trust's approach to risk management and implementing lessons learnt from HSIB and other internal investigations;
    e. Assessing the Trust's governance arrangements and making recommendations to address any identified gaps from Board to ward;
    f. Reviewing all identified themes against the Trust's current quality improvement work.

18. The Review will draw conclusions as to the adequacy of the actions taken at the time by the Trust and organisations surrounding the Trust, including the CQC, NHSE/I and the CCG. Taking account of improvements and changes made, the Review will aim to provide lessons helpful to the Trust in ensuring appropriate actions are taken to improve maternity services.

19. NHSE/I, the CCG and the Trust will act upon the findings of the Review and ensure the learning and recommendations are incorporated into the maternity improvement programme. The Trust will be expected to implement the recommendations from the Review.

Scope of the Review

20. The Review will consist of four component areas:

    A. **Data & Analytics:** a review of data, trends and management information at the Trust since its inception in 2006, in order to assess patterns of incidents over time, correlating themes or trends, and potential causal factors.
    B. **Detailed Review & Key Lines of Enquiry:** examining current and recent concerns with maternity services at the Trust and investigating specific themes and trends, in order to gain insights into practice, culture and processes.
    C. **Listening to Women, People Who Require Medical Terminations, People Who Give Birth and Families:** ensuring that the Review incorporates the learning and experience of those with lived experience of maternity services at the Trust
    D. **Review of the Governance & Oversight of Maternity Services at the Trust:** looking at the levels of assurance to ensure the safety and quality of service provision

A. Data & Analytics

21. The Review will examine data, trends and management information at the Trust since its inception in 2006, in order to assess patterns of incidents over time, correlating themes or trends, and potential causal factors. This will support the identification of any strategic issues or events within the Trust that may have had a bearing on the way that maternity services were run.

22. It is acknowledged that themes and trends may pre-date 2006. However, as 2006 represents the inception of the Trust, it is not possible to obtain or extract data and information prior to this date.

23. The Review will examine a number of information and data sources to support the identification of themes and trends. These will not be considered in isolation and, where possible, will be correlated in order to identify any interconnecting themes, issues or trends. Information and data sources will include (but not be limited to) the reporting of:

    a. Serious incidents (including, but not limited to fetal medicine, intrapartum stillbirths, neonatal deaths, maternal deaths and babies with severe injuries) – numbers, themes and trends
    b. Healthcare Safety Investigation Branch (HSIB) referrals and recommendations made
    c. Incidents which have been internally recorded by the Trust (including incidents recorded as low or no harm) – numbers, themes and trends
    d. Near misses - numbers, themes and trends
    e. All coronial cases held and, where relevant, resultant Prevent Future Death reports
    f. Number and types of litigation proceedings issued in relation to maternity care
    g. Concerns and/or complaints that have been lodged to or from any source about maternity care at the Trust – numbers, themes and trends
    h. Cases of maternal admission to ITU following delivery
    i. Maternity cases resulting in a referral to the General Medical Council (GMC) / Nursing and Midwifery Council (NMC) / Health and Care Professions Council (HCPC)
    j. Professionals referred to the General Medical Council (GMC) / Nursing and Midwifery Council (NMC) / Health and Care Professions Council (HCPC)
    k. Staffing vacancies, turnover and professional supervision within maternity and the wider trust
    l. Findings of staff surveys in relation to the Trust's culture, in particular the prevalence and effectiveness of the patient safety culture
    m. Staff complaints, whistleblowing and Freedom to Speak Up (FTSU) concerns– numbers, themes and trends
    n. Staff training and compliance
    o. Data and information collated within the Trust for the purposes of assurance and monitoring.
    p. Data shared with the Trust's regulators and commissioners in relation to quality, activity, assurance and monitoring

B. Detailed Review & Key Lines of Enquiry

24. The Review will examine current and recent concerns with maternity services at the Trust and investigating specific themes and trends, in order to gain insights into practice, culture and processes. The Review will expedite and examine themes and

Key Lines of Enquiry (KLOEs) identified using a clear methodology, as well as learning from the review of data and management information.

25. This detailed element of the Review will consider a number of Key Lines of Enquiry and use the appropriate evidence to do so. While a number of KLOEs will emerge as the Review progresses, the following areas may be included:

    a. Improvement & Improvement Culture: Where internal reviews or regulatory / externally commissioned reviews into the Trust's maternity services have taken place in the past:
        i. Has the learning been implemented?
        ii. Have all required changes to practice been sustainably embedded in the Trust?
        iii. How were the recommendations and actions assured?
        iv. Were the actions specific, measurable and/or adequate?
        v. Are staff able to articulate the actions that were implemented, or the impact of actions implemented?

    b. How, in the individual cases which were referred to the coroner and to HSIB, did the Trust respond and seek to learn lessons? Did the Trust provide appropriate support and compassionate care to families after these referrals?

    c. Communication:
        i. How far are women, people who require medical terminations, people who give birth and their families listened to, and communicated with, in an open, honest and transparent way?
        ii. How far do women, people who require medical terminations, people who give birth and their families feel informed about their health and care, or the health and care of their child?
        iii. How far do women, people who require medical terminations, people who give birth and their families feel engaged in decision-making?

    d. How robustly do the Trust share information with families following an early termination, neonatal death, maternal injury or other high-harm event?

    e. Does the Trust provide compassionate, respectful and culturally-sensitive care?
        i. Is sensitive care provided to families affected by early termination, neonatal death, maternal deaths and babies with severe injuries?

    f. Following early termination, neonatal death, maternal injury or other high-harm event, does the Trust have robust, practical arrangements in place to support women, people who require medical terminations, people who give birth and their families?
        i. Are there processes and procedures in place that are followed?

    g. Is there documented evidence of a timely verbal and written apology to women or people who give birth, as a part of the duty of candour process?
        i. Does the Trust do this now?
        ii. Are staff trained in, and confident around, the duty of candour process?
        iii. The Review will quantify both the volume and themes of incidents, complaints, concerns and Freedom to Speak Up (FTSU) concerns in relation to maternity care within the Trust and will include an examination of Trust policies and procedures directly applicable to the Review.

h. How robust are the Trust's maternity triage processes?

i. How robust are the Trust's systems in relation to post-mortem and pathology following neonatal or maternal incident?

j. What infrastructure, training and resources are in place to ensure that Trust effectively supports pregnant women and pregnant people who have pre-existing mental health needs?
    i. What infrastructure, training and resources are in place to ensure that the Trust effectively supports women and people who give birth who develop post-natal mental health conditions?

k. How robust are the Trust's current processes around record-keeping and information sharing?
    i. What processes are in place to ensure that accurate, timely medical information is shared between maternity units?
    ii. Does the Trust have a robust process in place for securely sharing medical notes with women, people who give birth and their families?
    iii. Are these processes routinely followed?

l. Did the Trust's Quality Assurance Framework ensure the effective reporting, investigation and monitoring of serious incidents in line with the NHS Serious Incident Framework and Trust policies?

m. Where individual cases have been identified through any source, were these recognised appropriately? Are there any gaps in the identification and investigation of individual cases?

n. How did the Trust respond to complaints and concerns raised with them by women, people who require medical terminations, people who give birth and their families in relation to the maternity services?
    i. How did the Trust seek to engage and learn from these?

o. How did the Trust respond to whistleblowing or Freedom to Speak Up (FTSU) concerns raised by staff in relation to the maternity services?
    i. How did they seek to engage and learn from these?

p. For maternity staff departing the Trust, have exit interviews been completed? How has the feedback informed service improvement, staff experience and workforce development?

q. Does the Trust have a maternity service that is culturally-competent? How far do services provide differential care to women, people who require medical terminations, people who give birth and their families from underrepresented groups?

r. How far does the maternity workforce represent the demographics of the people it cares for?

s. How does the Trust assure itself that it is following national guidelines and appropriately updating internal policies in line with this, across all aspects of fetal medicine, maternity care and neonatal care?

C. Family Group

26. The Review Team will work independently with women, people who require medical terminations, people who give birth and their families to establish a Family Group. The purpose of the Family Group is to ensure that women, people who require medical terminations, people who give birth and their families can share their experiences of the Trust's maternity services with the Review Team, in order to inform learning, themes and recommendations.

27. The Family Group will be led by an independent Chair or representative from the Group (the "Chair"). The Chair will support the work of the Review Team and act as an independent advocate, to ensure that the voice of those with lived experience is effectively captured. In supporting the Review Team, the Chair will not have access to any patient-identifiable information.

28. The Family Group will be publicised using a variety of communication methods, in order to be as open and accessible as possible. Families can join the Family Group at any stage throughout the Review process.

29. The Review Team will ensure that members of the Family Group receive regular progress updates on Review activity. The Review Team will ensure that updates and communications are accessible and are shared via a range of methods.

30. The Review Team and Chair of the Family Group will seek to ensure that the Family Group is representative of the population served by the Trust's Maternity Services. This will ensure that the Family Group has appropriate representation from: Black, Asian and minority ethnic (BAME) families; lesbian, gay, bisexual, transgender and queer (LGBTQ+) communities; Gypsy, Roma and Traveller (GRT) communities; and other underrepresented groups.

D. Review of the Governance & Oversight of Maternity Services at the Trust

31. The Review Team will consider whether the Trust has had, and continues to have, governance and oversight arrangements in place to ensure appropriate identification and actions related to themes emerging from incidents, complaints and concerns at all levels.

Review Timescales

32. The Review will update NHSE/I, the CCG, the Trust, the LMNS Board and the Trust's Quality Assurance Framework Group at regular intervals throughout the Review to ensure that learning can support the active maternity improvement journey underway within the Trust.

33. The Review set-up, including the recruitment of staff and ratification of the Terms of Reference, will take place in October 2021. Clinical Reviews will commence from November 2021.

34. The Review will aim to complete and share the final report with NHSE/I, the CCG Governing Body (or other relevant statutory body), the Trust Board, the LNMS and Quality Assurance Groups within 12 calendar months of commencement.

35. The findings of the Review will be made publically available through public facing LMNS Board and Integrated Care Board papers.

Protocol

The final protocol and methodology will be jointly agreed by the Review Lead, NHSE/I and the CCG in line with the principles outlined here.

Principles Underpinning the Review

- Women, people who require medical terminations, people who give birth and families involved in the Review will be treated with compassion and kindness, and appropriate support will be provided for all those who are engaged in the Review
- Women, people who require medical terminations, people who give birth and families who share their story as part of the Review will be provided with appropriate and robust support services, should they require ongoing support
- The Review will accept the experiences and stories of women, people who require medical terminations, people who give birth and families as truth
- The Review will be led by an independent Programme Director, supported by a strong project management office (PMO) structure to support timely delivery against objectives and adopting an evidence-based approach
- The Review Lead, expert clinical panels, investigators and specialist advisors will be independently appointed and have no association or connection to the Trust
- In order to remunerate members of the Review Team, CCG business mechanisms may need to be used. In doing so, this will not mean that members of the Review Team are “employees” of the CCG
- There will be a clear Scheme of Delegation and Review Programme Plan in place, to ensure that the Review remains independent and cannot be curtained by NHSE/I or the CCG
- The Trust will cooperate with the Review, including supplying documentation, as and when requested
- The Review Team will develop an independent Communication and Engagement Strategy, to ensure that all families and stakeholders who wish to receive updates and communications do so
- There will be a clear, consistent methodology used to undertake the review which will be determined by the Review Lead, NHSE/I and the CCG
- All personal and special category data accessed for the Review will be accessed and stored in accordance with the Data Protection Act (2018), the UK General Data Protection Regulation (GDPR), CCG and NHSE/I policies
- At no point in the Review will cases, incidents, concerns or complaints be considered “historic”, in recognition that harm and loss is not historic for the families affected
- This Review does not replace the statutory processes that exist around the response to individual cases, the duty of candour, notification of incidents or other obligations relating to the provision of care by the Trust either retrospectively or prospectively
- The Review will look in detail only at those individual cases for which consent is granted to access the records pertaining to the case
- The Review conclusions will be shared with the wider system via the Trust's Maternity Quality Oversight Group and other ICSs and NHSE/I quality oversight and assurance routes

NHS NOTTINGHAM AND NOTTINGHAMSHIRE CCG

MATERNITY IMPROVEMENT DETAILED BRIEFING

HEALTH SCRUTINY COMMITTEE

The Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) has been working closely with Local Maternity & Neonatal System (LMNS) partners over the past year to oversee improvements in maternity services and implement Urgent Clinical Priorities following the publication of the interim Ockenden Report (December 2020).

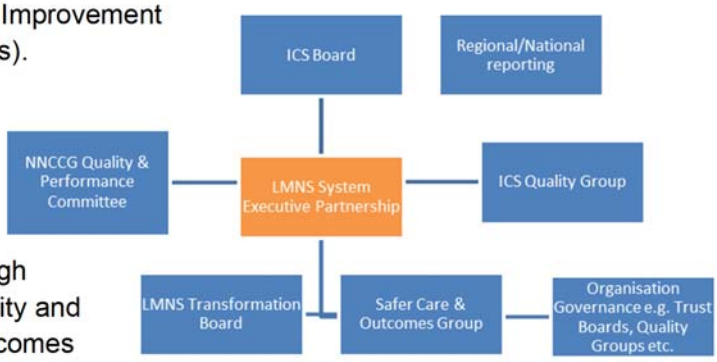
This briefing will aim to summarise the work and illustrate maternity improvement system oversight arrangements in addition the progress specifically in relation to Nottingham University Hospitals Maternity Services.

1. System Approach to Maternity Assurance & Quality

1.1 As the clinically led statutory NHS body responsible for the planning and commissioning of healthcare services NHS Nottingham and Nottinghamshire CCG plays an integral role to ensure we get the best maternity care and outcomes for our local families.

1.2 The CCG is key partner of the Nottingham and Nottinghamshire Local Maternity & Neonatal System (LMNS). The LMNS Executive Partnership Board is currently chaired by the Chief Nursing Officer of Nottingham and Nottinghamshire Integrated Care System (ICS) and CCG.

1.3 LMNS representatives include Executive Leads from both of the maternity providers (Sherwood Forest Hospitals and Nottingham University Hospitals), Nottingham and Nottinghamshire Maternity Voices Partnership (MVP), CCG, Local Authority Public Health, and NHS England and NHS Improvement Head of Maternity Network (Midlands).



1.4 The LMNS has a specific role in overseeing delivery of the national priorities to tackle health and care inequalities focusing on the transformation and delivery of high quality, safe and sustainable maternity and neonatal services and improved outcomes and experience for woman and their families. As collaborative partners the LMNS Executive Partnership Board drives the LMNS Programme to deliver sustained improvements in safety, equity, quality and outcomes.

Appendix A describes system partnership roles across the LMNS.

1.5 The Ockenden Report recommends that increased authority and accountability is given to LMNS' to ensure the safety and quality in the maternity services they represent. During

June 2021 Terms of Reference and LMNS work programmes were reviewed to ensure that the LMNS purpose specifically included key Ockenden deliverables:

LMNS Ockenden Deliverables 2021/2022	Nottingham and Nottinghamshire Position
Oversight of quality in line with implementing a revised perinatal quality surveillance model	Perinatal Quality Surveillance oversight through the LMNS Perinatal Quality Surveillance Group (previously Safer Care & Outcomes Group) reporting into the LMNS Partnership Executive Board and ICS Quality Committee. The Group will lead on the production of a local quality dashboard which brings together a range of sources of intelligence relevant to both maternity and neonatal services from provider trusts within the LMNS. The Group will take timely and proportionate action to address any concerns identified and building this into local transformation plans. The onus should be on trusts to share responsibility for making improvements, making use of strengths in individual neighbouring trusts within the LMNS to ensure that learning and data gathered through perinatal improvement work is shared across the ICS to inform wider delivery improvement.
To share information and learning in a structured and systematic way, working with partners to turn learning into service improvement.	An LMNS Dashboard Sub Group (DSG) is now in place (August 2021) reporting into the LMNS Perinatal Quality Surveillance Group aim to create a perinatal surveillance system dashboard to support the collection, interpretation & monitoring of system outcome data for both perinatal surveillance and improvement purposes. The DSG is chaired by the CCG Head of Quality (Maternity) with representatives from across maternity and neonatal services, system analytics and public health. An external analytics company has been commissioned to support the development of a dashboard. There is a two to three year time lag in publishing national maternity and perinatal mortality data and we need to do more to oversee and understand local outcomes. NHS Digital released a major update to the Maternity Services Data Set (MSDS) in April 2019 which enables clinical data to be collected for great insight. Improved data quality is absolute focus for the LMNS.
To oversee local trust actions to implement the immediate and essential actions from the Ockenden report	Trusts are required to submit quarterly reports to NHS England and NHS Improvement (NHSEI) regarding compliance with the 7 Immediate and Essential Actions described in the Ockenden report. A process is in place for the LMNS to review provider submissions with a focus on quality assurance and action plans. See Appendix B for further detail.
To ensure action is taken to improve the culture of maternity and neonatal services as a building block for safe, personal and more equitable care	The national Perinatal Equity Strategy will be reviewed by the LMNS Board once available. Early work to address health inequalities has commenced e.g. the perinatal mental health work stream is currently developing a health inequalities action plan informed by local data and information about access and engagement with local perinatal mental health services. This plan will drive forwards actions that are aimed at improving access to services across the perinatal mental health care pathway. Currently, every woman is provided with a paper Personalised Care and Support Plan (PCSP). Whilst the plan is reviewed throughout the pregnancy, work over the next year will focus on the quality of the plans and embedding their use with both women and

	professionals during the maternity journey. This will include training of the workforce in shared decision making and the principles of choice and personalisation. Plans to digitise PCSP's on Patient Knows Best public facing digital app will support with the embedding of quality PCSP. Both NUH and SFH are developing plans to ensure that they have the building blocks of continuity of carer in place to support women to have personalised care delivered by a consistent person.
To co-design and implement a vision for local maternity and neonatal services with local women through Maternity Voices Partnerships (MVP)	Currently in Nottingham and Nottinghamshire there is a MVP which is an independent, multi-disciplinary advisory body, made up of local parents, representatives and professionals who evolved from the Maternity Service Liaison Committee. Our committee currently includes representatives from NUH and SFH with both midwifery and obstetric representatives attending; CCG; Nottingham City and County Local Authorities; HealthWatch; Small Steps Big Changes (SSBC), and doulas. At each meeting there are several service users who have used Nottinghamshire maternity services and have volunteered to be active members of our MVP. MVP volunteers with the support of HealthWatch have undertaken several engagement activities including 'walking the patch', '15 Steps' and themed surveys.
To implement shared solutions wherever possible through shared clinical and operational governance	A LMNS Serious Incident (SI) Shared Governance Group has been established (April 2021) reporting into the LMNS Perinatal Quality Surveillance Group. This is a multi-organisation collaborative group of system and regional subject matter experts (representatives include leads for midwifery, obstetrics, and neonatology both NUH and SFH; NHSE/I; Maternity Neonatal System Improvement Partners (MatNeoSiP) Clinical Leads; and ICS Patient Safety Specialists). The principal duties of the group are to lead on the scrutiny, oversight and transparency of all maternity-related incidents which meet the following criteria identified as serious incidents with a focus on shared learning and the development of recommendations which will support providers to initiate impactful quality improvement work. The Group is responsible for identifying common causal factors and themes to support oversight and improvement.

2. Nottingham University Hospitals NHS Trust Maternity Services - Commissioner Actions/Involvement

2.1 In response to concerns regarding the quality of maternity services at Nottingham University Hospitals (NUH) enhanced surveillance was initiated during Autumn 2020. Actions included:

- Temporary release of midwifery subject matter expertise to establish and support SafeToday (December 2020 – April 2021)
- Establishing regular information sharing meetings and touch-points at both Executive and Operational levels
- Support with serious incident management and assessment of harm-related incidents. This includes CCG active involvement as part of internal rapid reviews and Trust incident review meetings, in addition to establishing an independent system panel to review incidents through the LMNS

- Support with emergency planning and seeking mutual aid
- Establishing a system oversight framework (see Appendix C) to monitor progress of both immediate safety plus the transformation and change programme. This includes establishing the NUH Maternity Safety Oversight and Quality Assurance Group (QAG) co-chaired by the CCG Accountable Officer and NHSEI Regional Chief Nurse (Midlands). The group aims to provide oversight and support for the NUH Maternity Improvement Programme. Representation includes Healthwatch, Professional Bodies, Health Education England, Regional Chief Midwife, Care Quality Commission (CQC), and Local Authority Public Health.

2.2 The CCG continues to work closely with Nottingham University Hospitals NHS Trust to ensure rapid improvements are made, providing capacity to support, as well as continuing to provide scrutiny and challenge to the Trust's maternity improvement plans.

2.3 Working with LMNS partners the CCG has put in place a robust assurance process to track progress against required actions, increased scrutiny of untoward events and serious incidents at the Trust, and worked with the Trust to retrospectively review a number of maternity incidents

2.4 The CCG has worked with LMNS partners and NUH to respond to the findings and recommendations of the Ockenden report and taken steps to ensure the implementation of rapid safety changes within the Trust.

2.5 Working with the Maternity Voices Partnership and NUH the CCG has worked to make rapid improvement to maternity care and ensure the voice of the women and families is reflected in the Trusts' improvement plan. We know that listening to the stories of women and their families is an essential step in improving maternity services and we are committed to ensuring that happens.

2.6 A revised service specification is currently being drafted with an expected completion date of October 2021

2.7 A programme of Quality and Safety Insights visits was established in May 2021 where CCG and system partners including NHSE/I attended the Maternity service at NUH (across all areas). The purpose of these visits was to gain assurance about the quality and safety of services commissioned across Nottingham and Nottinghamshire. Though positive approaches to care was observed by the visiting team, and women and families reported kind and compassionate care, a number of areas of concern were identified. These included Infection Prevention and Control (IPC) practices, Medicines Management, availability of equipment (both essential and emergency), staffing and skill mix, communication and involvement, and a lack of learning culture. A number of immediate actions were identified.

2.8 Oversight and support was further strengthened through the creation of a CCG Head of Quality (Maternity) and Quality Manager (Maternity) posts.

2.9 The CCG has also worked with the LMNS and system partners to ensure oversight of the operational demands whilst responding to the COVID pandemic and roll out of both the

maternity COVID vaccination programme and COVID virtual wards. The LMNS PMO has coordinated a system approach to increasing uptake of the Covid vaccination for pregnant women, including a particular focus on clinically vulnerable pregnant women, on behalf of the vaccination cell. This multi-partner approach, including Maternity Voices Partnership, has resulted in agreed system communications as part of the every contact counts approach, vaccination clinics collocated with antenatal clinics, online webinars for women and families to access factual, clinically-led information and the development of a staff training package to support midwifery staff to have conversations with women who are vaccine hesitant.

2.10 This is not an exhaustive list however provides some insight into the numerous actions taken by the CCG to oversee and support the necessary improvements so babies, women and their families get the safe, effective and personalised care that they deserve.

3. Nottingham University Hospitals NHS Trust – Maternity Improvement Progress

3.1 Since January 2021 NUH have provided monthly progress updates to the QAG however concerns persist due to the lack of pace and assurance seen across the NUH Maternity Improvement Programme and a lack of focus on impact and outcomes.

3.2 Although considerable work to develop a meaningful Improvement Plan and a Provider Maternity Dashboard there is still not clear triangulation between these or the challenges the service faces.

3.3 Progress has been hindered by the change in critical leadership roles such as 4 Director of Midwife's and 3 Chief Nurse's in 8 months as well as the on-going operational demands.

4. NUH Maternity Improvement – CCG/ICS Upcoming Actions

4.1 Enhanced surveillance and system/regulatory support continues to be in place at Nottingham University Hospitals as part of Maternity Safety Oversight and Quality Assurance.

4.2 In addition to the established quality and safety oversight framework daily active assurance continues with CCG representatives present at daily Maternity MDT Safety Call, Maternity Divisional Case Review Meetings, Daily Rapid Reviews Meetings and Trust Incident Review Meetings.

4.3 A system-wide response and support offer is in place to address the on-going challenges at NUH with maternity governance, systems and procedures

4.4 Another Quality & Safety Insight Visit is scheduled for 28 and 29 September 2021 and key lines of enquiry have been developed based upon the initial visits, the maternity improvement plan and available system intelligence (including serious incidents).

4.5 NUH received £2,716,293 in NHSEI BirthRate+® funding (Sherwood Forest Hospitals (SFH) received £171,677). Plans to address the current NUH midwifery gap of 73WTE and 12 consultants are ongoing and will be reviewed through the NUH Maternity Safety Oversight and Quality Assurance Group and ICS workforce forums.

4.6 Continue support across the system due to recent operational demand & challenges:

- Progress Mutual Aid offers including access to the Improving Access to Psychological Therapies (IAPT) services, Let's Talk –Wellbeing with new processes in place to provide rapid access for families affected by NUH maternity services
- Support the review of planned/elective activity
- LMNS support to maximise vaccination uptake; vaccination hesitancy remains a local and national challenge
- Support with Quality Impact Assessment of Home Birth Services
- Regional input from NHSEI and Neonatal Network

Independent Review of NUH Maternity Services

4.7 On 10 September 2021 an update was shared with partners to inform of an *Independent Review of NUH Maternity Services* jointly commissioned by the CCG and NHSEI Midlands Regional team

4.8 The aim of this Review, which is due to commence October 2021, is to drive rapid improvements to maternity services in Nottingham by focussing on issues where change is urgently needed. The Review will analyse a broad range of information from complaints, incidents, concerns and family experiences, but will also have a clear focus on current practice to ensure that the appropriate standards of safety and quality are being delivered.

4.9 Initial thinking is that the review will need to draw on a large body of existing evidence: serious incidents, Healthcare Safety Investigation Bureau (HSIB) referrals, incidents internally recorded by the Trust, all coronial cases and relevant Preventing Future Death reports, number and types of litigations raised, complaints and concerns, cases of maternity admission to intensive care, maternity cases resulting in a referral to the GMC/NMC, workforce (vacancies and turnover), findings of cultural and staff surveys, data and information, and committee papers.

4.10 Critically, we want to make sure that we listen to and acknowledge areas of concern, and that these are put right, so that services are safe and provide high quality care for future families.

4.11 The Review will be completely independent of NUH, includes involvement from families and the findings and report will be made public when complete.

Involvement of Families

4.12 The Review will engage with families and is actively seeking membership of the proposed Reference Panel to support the work of the Review as it commences and throughout. It

is intended to share the draft Terms of Reference with families (as outlined below) shortly. We are committed to ensuring that affected families will be kept up to date and involved (in whatever way they wish) throughout the review. This will include membership and engagement in the Reference Panel and a written monthly update to all families and interested parties.

4.13 In addition to this, we will ensure that any concern raised through the Review by families is given full attention and unless already completed that these are thoroughly investigated through an Independent Investigation processes.

4.14 We have met with the legal representative of a considerable number of families and have further meetings arranged with several families and local and regional Maternity Voices Partnership Chairs to shape the Terms of Reference. Additionally, families who have contacted us but do not want to meet are providing written feedback on these ToR.

Key Personnel

4.15 A Programme Director has been appointed to support the independent Review team, who has the appropriate skills, experience and qualifications to undertake the work required and demonstrates clear independence from NUH.

4.16 Programme Director: Catherine Purt. Extensive NHS experience in commissioning, acute hospitals and primary care as well as private sector roles. Majority of experience in the North West of England but also across the South West and West, currently Non-Executive Director, Shropshire Community Health NHS Trust.

4.17 Over the coming week the appointment of two clinical leaders for the Review team will also be finalised and we will share their details.

Terms of Reference

4.18 A draft set of Terms of Reference (ToR) has now been drawn up and during September shared with affected families for their comments and input. A final version of this ToR is therefore anticipated to be produced at the start of October and will be published shortly afterwards. The ToR will describe the overall approach of the Review, its operating model, the areas of focus, how the families will be involved, its timescale and how the findings will be published. This ToR will be provided to the committee as soon as available.

4.19 The Review itself will commence its work at the beginning of October.

APPENDIX A - KEY SYSTEM ROLES & FUNCTION

Local Maternity & Neonatal System (LMNS): The LMNS is a partnership collaborative established to oversee the development and implementation of a local vision for transforming maternity services based on the principles of Better Births, the NHS Long Term Plan, the National Neonatal Review (Better Newborn Care), and the interim Ockenden Report.

The LMNS was established in 2017 following the publication of Better Births (2016) which set out the vision that through transformation, all maternity services across England will become safer, more personalised, kinder, professional, and more family friendly. A refreshed local Maternity Transformation Plan developed by the LMNS outlines the shared vision to ensure that women and their babies have access to consistently high-quality and safe services. This includes a commitment to move from operating within a traditional service-specific approach to outcome-focused commissioning.

On behalf of the Nottingham & Nottinghamshire Integrated Care System **LMNS Programme Management Office (PMO)** hosted by the CCG oversees the development and progress of evolving delivery plans to take forward priorities and ambitions.

The **LMNS Executive Partnership Board** seeks to obtain assurance that plans are progressing at a local level ensuring that transformation remains person centred to address the national priorities and trajectories for:

- Personalised Care
- Continuity of Care
- Safer Care
- Better Postnatal and Perinatal
- Mental Health
- Multi-Professional Working
- Working across Boundaries
- Payment System

Clinical Commissioning Group (CCG): As the clinically led statutory NHS body responsible for the planning and commissioning of healthcare services, the CCG plays an integral role to ensure we get the best maternity care and outcomes for our local families. The CCG is a key partner of the LMNS and the CCG/ICS Chief Nurse is the Senior Responsible Officer (SRO) for Maternity Transformation.

The **Maternity Voices Partnership (MVP)** is an NHS working group of maternity service users and system partner organisation including Healthwatch and 3rd sector.

LMNS Partner Organisations involved in developing and delivering maternity improvement and transformation:

Representing service users	Healthwatch Nottingham City and Healthwatch Nottinghamshire
	Nottinghamshire Maternity Voices Partnership
	Small Steps Big Changes (led by Nottingham CityCare Partnership)
Maternity and neonatal service providers	Nottingham University Hospitals NHS Trust
	Sherwood Forest Hospitals NHS Foundation Trust
Public Health and early years providers	Child Health Information Service (CHIS), Nottinghamshire Healthcare NHS Trust (county) and Nottingham CityCare Partnership (city)
	Children's centres: Nottinghamshire Childrenn and Families Partnership (county) and Nottingham City Council (city)
	Public health nursing: Healthy Families Programme, Nottinghamshire Healthcare NHS Foundation Trust (county)
	Small Steps Big Changes (led by Nottingham CityCare Partnership and funded by Big Lotto)
	Weight management: ChangePoint, Everyone Health
	Smoking cessation: Smokefree Lives Nottinghamshire, Solutions for Health (county), New Leaf, Nottingham CityCare Partnership (city)
Mental health providers	Insight Healthcare (psychology therapy)
	Nottinghamshire Healthcare NHSFT (mother and baby unit, perinatal psychiatry service, psychological therapy, child & adolescent)
	Trent PTS (psychology therapy)
	Turning Point (psychology therapy)
Other key providers	East Midlands Ambulance Service
	General Practice
	NHS 111 Service
	Social care (adult and children)
Commisssioners	Nottingham and Nottinghamshire CCGs
	Nottinghamshire Children's Integrated Commissioning Hub
	Nottinghamshire County Council
	Pubic Health England

APPENDIX B - NOTTINGHAM AND NOTTINGHAMSHIRE LMNS OCKENDEN: UPDATE

Immediate and Essential Action

Better Births
Nottingham and Nottinghamshire
NHS

In December 2020, a review into maternity services was published by Senior Midwife Donna Ockenden and a team of leading health care professionals. The report had seven immediate and essential actions that NHS Trusts needed to follow. Here are some of the ways we are working together to provide the best maternity care possible for women and their families across Nottingham and Nottinghamshire.

1 Enhanced Safety

What we need to do:

Neighbouring Trusts must work together to make sure that investigations into serious maternity incidents (SIs) are looked into by local and regional maternity teams.

Our plan:

- We have set up a system working group to review and learn from serious incidents.
- Our Local Maternity and Neonatal System (LMNS) Board will have oversight of safety and learning from serious incidents will be shared across our local NHS organisations to make services safer.

2 Listening to Women and Families

What we need to do:

Maternity services must make sure that women and their families are listened to with their voices heard.

Our plan:

- We are working closely with our Maternity Voices Partnership (MVP) to involve women and families in planning and decisions about their care.
- We are working with local partners to make sure services involve fathers and partners in discussions about appointments and care.

3 Staff Training and Working Together

What we need to do:

Staff who work together must train together

Our plan:

- We will make sure staff have the right skills needed to safely care for women and thier families.

4 Managing Complex Pregnancy

What we need to do:

Make sure there are processes in place to help manage and support women with complex pregnancies

Our plan:

- Trusts have developed ways to help support women with complex pregnancies and will continue to review this.
- We are working with neonatal services to make sure women are able to give birth in the setting that is safest for them and their babies.

5 Risk Assessment Throughout Pregnancy

What we need to do:

Staff must make sure women have a risk assessment at each contact throughout their pregnancy.

Our plan:

- Midwives will continue to support women to make the right choice for them about where they want to have their baby.
- We are working together with women and their families to plan their care based on their needs.

6 Monitoring Fetal Wellbeing

What we need to do:

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with expertise to focus and show best practice in fetal monitoring.

Our plan:

- Trusts will have Midwife and Consultant Fetal Monitoring leads to improve practice, share learning and support staff with fetal wellbeing monitoring.

7 Informed Consent

What we need to do:

All Trusts must make sure women have access to accurate information so they can make choices about where they want to give birth and the mode of birth, including maternal choice for caesareans.

Our plan:

- Trusts will continue to update their websites to provide women and families with information about places of birth and how they will receive care, with printed and translated information also available.
- Trusts will work with the MVP and other partners make sure information is easy to find and suitable.

APPENDIX C - NUH MATERNITY QUALITY & SAFETY ASSURANCE ACTIONS