Health and Adult Social Care Scrutiny Committee
17 February 2021

Nottingham University Hospitals NHS Trust Maternity Services

Report of the Head of Legal and Governance

1 Purpose

1.1 To review action to improve maternity services provided by Nottingham University Hospitals NHS Trust following a Care Quality Commission rating of 'Inadequate' in December 2020.

2 Action required

2.1 The Committee is asked to review progress in improvement of maternity services provided by Nottingham University Hospitals NHS Trust and whether:

a) it wishes to make any comments or recommendations; and

b) the focus and timescales for further scrutiny.

3 Background information

3.1 In December 2020, the Care Quality Commission (CQC) published a report which re-rated Nottingham University Hospitals NHS Trust (NUH) maternity services from 'Requires Improvement' to 'Inadequate, along with a warning notice.

3.2 Representatives of NUH attended the Committee's meetings in January and July 2021 to discuss the CQC findings and actions being taken and planned to address the identified failings. At the July meeting the Committee also considered evidence from the Nottingham and Nottinghamshire Maternity Voices Partnership and Healthwatch Nottingham and Nottinghamshire. In addition, the Committee met informally with a parent whose child had died whilst in the care of NUH's maternity services to hear their perspective. The Committee noted the progress that had been made to that point and plans to continue the improvement journey. It acknowledged that it will take time for sustainable change to be made but noted that the issues and concerns about care had already been known about for some years. The Committee also 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 Committee was also concerned about the number of Serious Incidents still being reported.

3.3 In September 2021, the CQC published a report of an inspection it carried out into how well NUH is lead and some specific service areas in July. Following this inspection, the Trust was issued with a Section 29a warning notice under the Health and Social Care Act 2008 and rated as Requires Improvement, with an inadequate rating in relation to whether services are well-led. Some of the failings identified by the CQC in relation to maternity services were also reflected in the findings of how well the Trust as a whole is led. The Acting Chief Executive and Chief Nurse, along with other colleagues, attended meetings of the Committee in November 2021 and January 2022 to discuss action being taken to address identified failings. The CCG has provided information to the Committee in relation to its role in supporting and holding NUH to account for improvement and the Chair has spoken to the NHS England Regional Medical Director for the Midlands about NHS England's role in supporting improvement. The Committee has also held informal evidence gathering sessions with representatives of trade unions representing workers employed by NUH.

3.3 For this meeting, the Trust has submitted a written briefing, which is attached. Michelle Rhodes, Chief Nurse, and Sharon Wallis, Director of Midwifery at NUH will be attending the meeting to discuss the Trust's progress in implementing improvements since the last meeting and ongoing plans to tackle outstanding actions required to improve the quality and standards of maternity services.

3.4 Healthwatch Nottingham and Nottinghamshire will be attending the meeting to provide an update on their latest evidence and engagement with NUH on this issue and also on the work of the Maternity Voices Partnership.

3.5 An independent thematic review of NUH maternity services has now been commissioned jointly by NHS England/ NHS Improvement and Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) with the aim of driving rapid improvements to maternity services. The Committee has welcomed an independent review and, prior to its commencement, sought reassurance from its commissioners regarding the terms of reference, process for carrying out the review and publication of the review. The Chair also held an informal meeting with the Accountable Officer of the CCG about the review.

3.6 An update on the thematic review is attached and the Programme Director and Clinical Lead for Midwifery will be attending the meeting on behalf of the review team to answer questions from the Committee.

4 List of attached information

4.1 Written briefing from Nottingham University Hospitals NHS Trust

4.2 Update on the Independent Thematic Review of Nottingham University Hospitals Maternity Services

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6 Published documents referred to in compiling this report

6.1 Care Quality Commission Nottingham City Hospital Published 02/12/2020

6.2 Care Quality Commission Queens Medical Centre Published 02/12/2020

6.2 Care Quality Commission Nottingham University Hospitals NHS Trust Inspection Report Published 15/09/2021

6.3 Reports to, and minutes of the Health Scrutiny Committee meetings held on 14 January 2021, 15 July 2021, 11 November 2021 and 13 January 2022.

6.2 Independent Thematic Review into Nottingham University Hospitals Maternity Services Terms of Reference and Published Updates available at https://nottsccg.nhs.uk/get-involved/independent-review-of-nuh-maternity-services/

7 Wards affected

7.1 All

8 Contact information

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