NHS
Nottingham and Nottinghamshire

Nottingham University Hospitals NHS Trust (NUH)
Maternity Services: Assurance & Oversight

Nottingham City Health Scrutiny Committee

1. Background

1.1. Nottingham University Hospitals NHS Trust (NUH) maternity services have been subject to enhanced surveillance since Autumn 2020 in response to quality concerns, with increased scrutiny and support provided by the NHS Nottingham and Nottinghamshire Integrated Care Board (ICB)[1], Care Quality Commission (CQC), NHS England and NHS Improvement (NHSEI) and the Local Maternity and Neonatal System (LMNS) in agreeing, monitoring, and delivering a Maternity Improvement Plan. A CQC inspection of NUH in 2021 resulted in 'Requires Improvement' overall, with 'Inadequate' for maternity services. In March 2022 an unannounced CQC inspection of NUH maternity services resulted in additional concerns raised, specifically about the timeliness of initial reviews on arrival to maternity triage and the execution of maternal observations on the postnatal ward. There are concerns about the pace and scale of progress against the NUH Maternity Improvement Plan, further evidenced at both the Nottinghamshire County Health & Social Care Scrutiny Committee in January 2022, and Nottingham City Health & Adult Social Care Scrutiny Committee in February and March 2022.

1.2. Although improvements are being made, it is widely acknowledged that the pace is not where we want it to be for our women and their families. The scale of improvement required will take time and has been further compounded by operational demands and response to the pandemic. This however has not prevented the efforts of our teams to maintain the focus. The offers of support to NUH Maternity Services from system partners and regulators have been broad and longstanding.

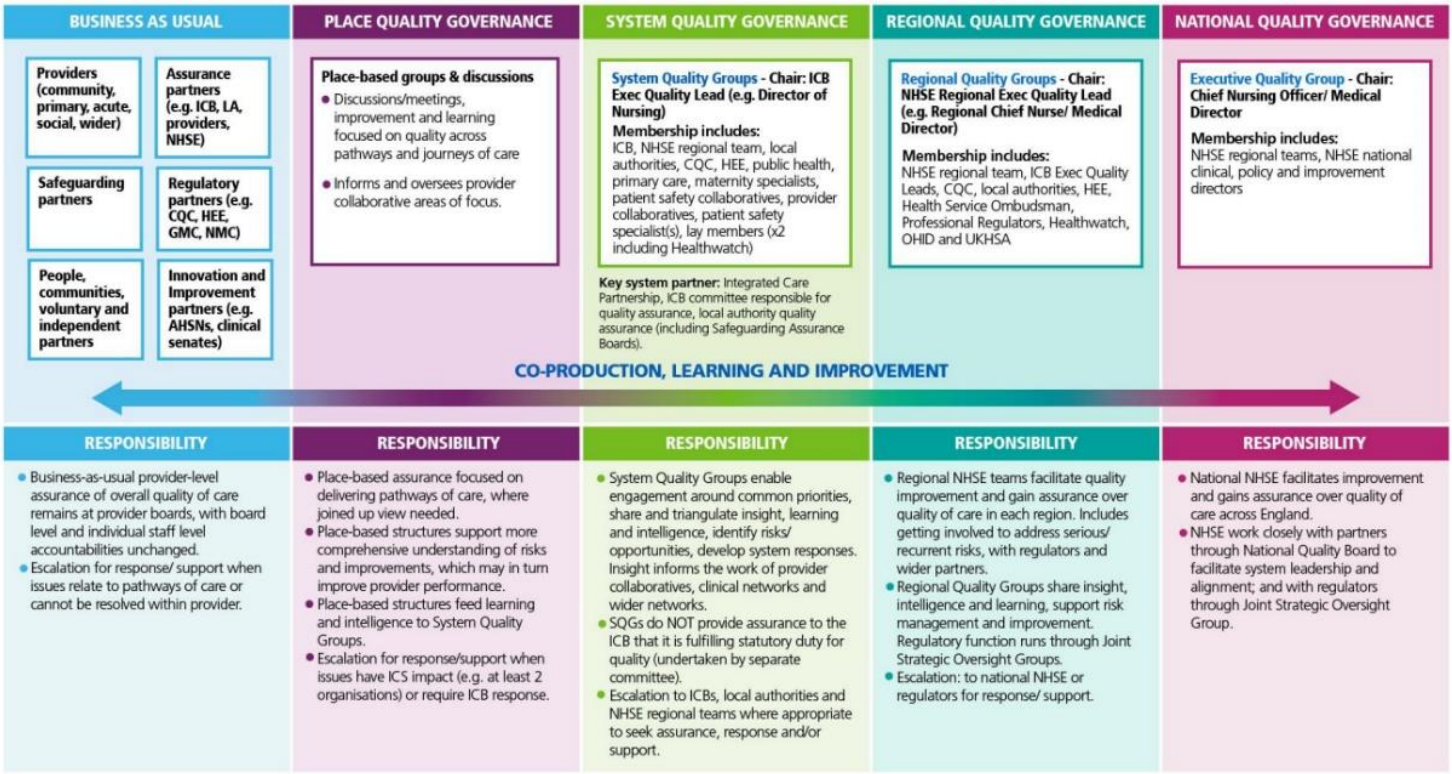
2. System & Regulator Oversight Arrangements

System Quality Governance

2.1. As the clinically led statutory NHS body responsible for the planning and commissioning of healthcare services, the **Nottingham and Nottinghamshire ICB** plays an integral role in ensuring the delivery of high quality and safe local health and care services. In accordance with the National Quality Board (NQB) guidance (Figure 1), the ICB and Integrated Care System (ICS) are responsible for monitoring the quality and safety of health and care services; this includes quality planning, quality improvement and quality control across the Nottingham and Nottinghamshire ICS footprint.

[1] Integrated care boards (ICBs) replaced clinical commissioning groups (CCGs) in the NHS in England from 1 July 2022.

Figure 1: National Quality Board guidance



2.2. These national responsibilities have been embedded in our local governance arrangements as the ICB has been established and *Figure 2* provides an overview of the new system quality oversight arrangements in place for the Nottingham and Nottinghamshire ICS and ICB.

2.3. The **ICS System Quality Group** (SQG) provides a strategic forum for partners from across health, social care, public health and wider within the ICS to have a clear line of sight on quality performance, good practice, concerns, and risks. The SQG has a focus on building an improvement culture, rather than focusing on performance management, and will allow for a collaborative and proactive response to supporting quality improvement across the system.

STRATEGIC Oversight & Quality Planning Alignment of system plans, narratives and responses

SYSTEM Oversight – Quality Assurance & Quality Improvement Identifying and managing system /PLACE / population risks and issues

COLLABORATIVEASSURANCE & DELIVERY– Quality Planning, Quality Assurance & Quality Improvement

Figure 2: ICS/ICB Quality Governance and Reporting Structure

ICB BOARD

Chair: ICB Designate Chair	Monthly

ICS SYSTEM OVERSIGHT MEETING (SOG)

Chairs: tbc	Monthly

NUH IMPROVEMENT OVERSIGHT & ASSURANCE GROUP (IOAG)

Chairs: Regional Medical Director (NHSEI Midlands) and ICS Executive Lead/ICB Accountable Officer	Monthly

NHSE REGIONAL QUALITY GROUP

SYSTEM SAFEGUARDING PARTNERSHIPS / BOARDS

ICB QUALITY & PEOPLE COMMITTEE

Chairs: ICB NED	Monthly

ICS SYSTEM QUALITY GROUP

Chairs: ICB Chief Nurse / ICB Medical Director	Quarterly

ICS CLINICAL EXECUTIVE GROUP & PROFESSIONAL CABINETS

ICS PEOPLE & CULTURE

SQG PROVIDER / PLACE HIGHLIGHT REPORTS

BAU Quality Oversight & Assurance

- ICB
- Acute, Community, Mental Health, and Independent Sector Provider
- PLACE Quality Lead
- Provider Collaborative
- NHSEI Specialised Commissioning

Co-creation of Quality & Risk Profiles per provider

Quality Intelligence & Insights Group	**Safeguarding, LAC, SEND Assurance Group**	**Mental Health Transformation**
Infection Prevention Control Assurance Group	**Patient Safety Specialist Steering Group**	**Health Inequalities Programme**
Primary Care Assurance Group	**Care Sector Strategic Partnership**	**Learning Disabilities & Autism (Ageing Well)**
Health Protection & Vaccinations	**Personalisation Board (including CHC)**	**Perinatal Quality Surveillance Group (LMNS)**

SYSTEM INTERDEPENDENCIES

- Strategic Commissioning Committee
- System Delivery / Operational Groups
  - Digital
  - Finance
  - Performance
  - Planning / Strategy
- System Transformation Programmes
  - Children & Young People
  - Community Services Transformation
  - Estate
  - Planned Care & Cancer
  - Urgent & Emergency Care / Proactive Care
  - Ageing Well

NUH Improvement Oversight & Assurance Group (IOAG)

2.4. The ICB has been working closely with system partners and NUH to oversee improvements in the services, providing capacity to support, as well as continuing to provide scrutiny and challenge to the improvement plans.

2.5. From January 2021 to March 2022, NUH provided monthly progress updates to a system wide NUH Maternity Safety & Oversight (QAG) subgroup, co-chaired by the ICS Chief Nurse and NHSEI Regional Chief Midwife (Midlands).

2.6. However, following the CQC inspection of maternity services in March 2022 and subsequent changes to system governance, arrangements have been refreshed and streamlined. An **NUH Improvement Oversight and Assurance Group** (IOAG) has been established. This group combines partners from across the ICS and is co-chaired between the ICB and Regional NHSE, overseeing the Trust's response to all the quality and governance concerns currently present at NUH. The IOAG and relationship with wider system quality governance arrangements is illustrated in *Figure 2* above. The IOAG meets monthly with membership from: CQC, Health Education England (HEE), Healthwatch Nottingham and Nottinghamshire, General Medical Council (GMC), Nursing and Midwifery Council (NMC), as well as calling on key members of the Trust's leadership team to provide updates and information.

2.7. The group has significant focus on maternity services, whilst ensuring that trust-wide interdependent improvement work, such as culture and inclusion, has complete read across in terms of aims and objectives. The IOAG's aim is to:

- provide support and challenge to drive continued improvement in quality and safety
- provide collective oversight and assurance of progress
- ensure sustained progression of improvement actions

2.8. Work is underway to ensure that the IOAG provides assurance to stakeholders, illustrating how associated clinical and quality risks are appropriately assessed and addressed. It is also imperative that support requirements are clear whilst providing opportunity for stakeholders to provide constructive challenge where appropriate.

2.9. Regular briefings summarising the IOAG discussion are circulated and are available on request.

Perinatal Quality & Local Maternity and Neonatal System (LMNS)

2.10. 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 more recently the Ockenden recommendations.

2.11. Over the past year, significant work has taken place to evolve the LMNS perinatal governance structure and associated meetings. The overarching aim has been to

strengthen effectiveness and support timely identification and escalation of safety and quality concerns in line with the Perinatal Quality Surveillance Model.

2.12. Quality and safety of maternity services now has system visibility, led by the LMNS. Whilst NUH have the IOAG in place, it is essential that the system sustains the level of rigour and support, not just for services delivered at NUH but beyond.

2.13. The LMNS Perinatal Surveillance Quality Group (PSQG) is intrinsic to system oversight. Key highlights are shared with the LMNS Executive Partnership Board and into the ICS System Quality Group. The LMNS has established a Serious Incident (SI) Shared Governance Group which meets alternate weeks, having oversight of all Maternity Serious Incidents. This group is chaired by the ICB, attended by all system partners, representatives from NHSE, and the Lincolnshire LMNS, offering a sphere of clinical practice and independence.

2.14. Also reporting into the PSQG is the LMNS Quality Outcomes Dashboard Sub-group (DSG), the purpose of which is to ensure that the LMNS dashboard data is regularly scrutinised for key themes that require either escalation or general sharing. The LMNS Quality and Outcomes Dashboard provides an overview of the Local Maternity and Neonatal System performance against a defined set of indicators across a broad range of maternity, neonatal and associated services and was developed over 2021/2022.

3. Future Planning and Support

3.1. In addition to achieving full compliance of both the Ockenden recommendations and SBLCB, insight visits have identified additional areas to strengthen as part of the improvement programme of work:

- Whilst it is improving, more collaboration is required with the Maternity Voices Partnership (MVP)
- To continue to address timeliness of investigations and reporting of Serious Incidents. During insight visits staff were able to provide examples of learning cascade, however there is insufficient evidence to make a full assessment on the learning culture. This is further impacted on the backlog of incidents requiring investigation (both local and HSIB reportable)
- To review time allocated in the new consultant job plans for specialist roles to create realistic capacity for mandatory training
- To actively manage the staff training compliance across all areas
- To improve involvement of all staff as part of responding to the Ockenden recommendations

3.2. Following the announcement of Donna Ockenden to chair a new review, Donna has visited families in Nottingham on 11 July 2022[2]. The review into maternity services at NUH commenced on 1 September 2022[3] with an early indicative timeline of eighteen

[2] https://twitter.com/DOckendenLtd/status/1546383988247461889
[3] https://twitter.com/OckReview/status/1546509262599462918

months; subject to the Terms of Reference for the Ockenden NUH Review which are yet to be confirmed (as of 01 September 2022).

3.3. The ICB welcomes the Review of NUH maternity services chaired by Donna Ockenden, which will give further opportunity to support the families involved in maternity services at NUH have their voices heard, and provide valuable learning to support the rapid improvement in quality in these services to benefit our citizens.

3.4. We are fully committed to both supporting this review and implementing the findings at pace.

4. NHS England Support

4.1. The Trust entered the NHS England (NHSE) Recovery Support Programme (RSP) in September 2021. An embedded Improvement Director and Deputy Improvement Director have been allocated to the Trust and a comprehensive support package has been agreed. The package includes funding and access to subject matter expertise across NHSE to address issues identified through the initial RSP assessment. The RSP support package funding is £1.536M over two years and includes Board and Leadership development, cultural transformation, governance and maternity as well as ongoing support from the national Intensive Support Team.

4.2. The Trust has also been part of the NHSE Maternity Safety Support Programme since January 2021. This programme has been recently refreshed as part of the national Intensive Support Programme and the Trust is supported by two Maternity Improvement Advisors (Obstetric and Midwifery).

4.3. The Regional NHSE team has also provided considerable support to the Trust over the last 18 months, including;

- Regional maternity team general support and specific support with governance, digital and Serious Incidents
- Regional digital team support with procurement of new IT system and other digital issues affecting maternity
- Regional workforce team support with recruitment and HR
- Regional (and national) EDI team support with EDI strategy implementation
- Regional comms support, including temporary acting Director of Comms backfill
- Support to Trust to bid for national programme funding totalling £4.34M for transformation, digital and workforce

5. Summary and Upcoming Actions

5.1. This briefing is not exhaustive however it provides some evidence into the changes and actions being taken by the ICB, Trust and system partners to oversee and support the necessary improvements so babies, women and their families get the safe, effective, and personalised care that they deserve.

5.2. Enhanced surveillance and system/regulatory support continues to be in place, and we are committed to playing an active role with NUH to ensure the momentum is not lost and the radical changes to service delivery are implemented

5.3. The ICB will provide all information requested by Donna Ockenden's team and is available to feed in other relevant information and data as required.

5.4. Improving the quality of care delivered at NUH's maternity services is one of the top priorities for the ICB.