Title: Progress from the 2023 CQC inspection and the Independent Maternity Review

Report for: Nottingham City Council Health and Adult Social Care Scrutiny Committee

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1. Purpose

To review the progress from the Care Quality Commission (CQC) inspection of maternity services at Queen's Medical Centre and Nottingham City Hospital on 25 and 26 April 2023 and inspection of the 'well-led' question assessing leadership, culture and governance.

To review progress and improvement to date with the Independent Maternity Review, expected timescales and oversight arrangements.

2. Progress against the Trust-wide 'must-do' to ensure that it complies with its statutory responsibilities for duty of candour

When reviewing performance against statutory duty of candour (DoC), the CQC found that the Trust was not consistently meeting the timescales of both verbal and written disclosure creating 'a risk of potential fines, patient dissatisfaction, and negative publicity.'

Since then a Trust-wide duty of candour improvement action plan has been underway with a total of nine actions to improve the quality of interactions with patient, families and carers and ensure an open, honest and transparent approach to engaging with patients, families and carers, particularly when care does not occur as planned. This is overseen at the Trust-wide Quality, Safety and Oversight Group and Quality Assurance Committee.

There has been clear progress against individual actions in the DoC action plan, however Q3 KPIs and quality audits have identified complexities and variability in Divisional support and oversight which is causing delays in the delivery of timely statutory DoC. Six of the nine actions on the plan are assessed as providing high or very high assurance and there are two actions rated as medium demonstrating that gaps in assurance remain. One remaining action has been stood down.

3. Timetable for monitoring and updates is agreed with NUH to provide assurance:

3.1 The progress made towards achieving an overall 'Good' rating for maternity services from the CQC within the next 3 years;

Progress continues to achieve the 'Good' rating in the next 3 years and sustain the improvements made in 2023 when all warning notices and conditions on the Trust's provider license were removed. Since then, the CQC undertook an unannounced inspection of maternity services on 18 June 2024 at the Queen's Medical Centre and on the 19 June 2024 at the City Hospital. Subsequent follow up visits also occurred on both sites on 3 July 2024.

The verbal feedback after inspection site assessments found there were no immediate safety concerns raised by the CQC.

A comprehensive action plan has been provided to the CQC that specified immediate actions taken and subsequent follow-up actions that need to be completed. This action plan will be monitored and overseen monthly by the new Perinatal Improvement, Assurance and Oversight Group internally, which reports to the Quality Assurance Committee.

A draft report is expected from the CQC towards the end of the calendar year.

3.2 The outcomes of the planned further improvements to patient experience within maternity services over the next 12 months

A number of projects have been underway to improve patient experience within maternity services. This includes:

- A re-launch of the Home Birth service which continues to experience good engagement - there have been 25 Homebirths and eight intrapartum transfers (NUH in 2023 supported a total of 11 births) since March 2024
- A new quality improvement project to develop a clear pathway for women leaving NUH with complex wound care
- Numerous engagement developments working with underrepresented communities through the Inclusive Maternity Work Programme
- Investment in new digital health records allowing women to access their maternity notes on a tablet phone or PC at any time
- New fetal medicine unit opened providing women and families with personalised care in a purpose-built facility

In addition to this, a deep dive review has been commissioned into community services to review current systems and processes, with a view to understand

how the service is currently operating and make recommendations of sustainable improvements led by those impacted, the clinical workforce.

3.3 The development of the current Maternity Improvement Plan into a live system of continuous improvement over the next 12 months.

The NUH Maternity Improvement Programme has been functioning under phase 2 since April 24. Phase 2 aims to improve the quality, safety and experience of maternity services by concluding the original action plan, whilst developing a culture of continuous improvement where opportunities for learning and improvement are identified and progressed. This will be provided by mechanisms which support robust service insight including the maternity dashboard, operational performance, the maternity QRS framework and national improvement priorities.

As of 30 September 2024, there are 26 ongoing projects spread across four different pathways; Service redesign and safe practice, governance, culture and engagement and workforce development. Progress against each of these projects is overseen and monitored at the MIP DLT and through the recently established Perinatal, Improvement, Assurance and Oversight Group (PIAOG). Any escalations or concerns raised would be escalated to the Trust's Quality Assurance Committee (QUAC).

4. To recommend that further support is provided to staff to ensure that they have the skills and capacity to engage effectively with patients in writing in relation to any problems or complaints, following their discharge from hospital.

Additional resource has been added to the maternity team to address complaints in a timely manner, particularly those received via the independent review.

NUH is participating in an NHS England project to pilot the Maternity and Neonatal Independent Senior Advocate role which is hosted by the Nottingham and Nottinghamshire ICB. This role helps make sure women and families' voices are listened to, heard, and acted upon by their care teams after experiencing adverse outcomes in maternity and/or neonatal care.

The maternity service is also expanding the listening service for birth planning and birth reflections with the introduction of a Family Liaison Officer to address any issues or complaints locally, reducing escalation to formal complaint processes.

5. **To recommend that the learning and improvement within maternity services in terms of the duty of candour, addressing complaints, workplace culture, and equality, diversity and inclusion are applied effectively to all other services provided by NUH, as appropriate.**

   A quarterly review of the Trust's claims scorecard alongside incident and complaint data is undertaken and discussed with the maternity service. Analysis of 2023-24 scorecard and quarter 1 data has highlighted key themes, learning and a high level summary of actions against key learning. Further review and discussion is also discussed via the Safety Champions meeting to identify improvement needs and support prioritisation.

   Learning and improvement projects for maternity is covered within the duty of candour Trust-wide action plan. Projects to improve workplace culture and equality diversity and inclusion are central to the Inclusive Maternity Work Programme.

6. **To recommend that the effectiveness of standard operating processes (such as regular equipment testing and the proper storage of expressed breast milk and medication) should not be overlooked as part of the wider improvement journey.**

   Regular equipment testing has been strengthened by regular spot checks to ensure compliance is monitored and there is oversight by the daily co-ordinator and Matron following the 2024 CQC inspection. Further improvements are planned by building in more routine critical safety checks via quality reviews, quality visits and audits involving a range of multi-disciplinary colleagues to ensure there is a wide breadth of learning and improvement.

   In May 2023, digilocks were placed on all milk storage fridges to ensure formula and breast milk is safety stored. In addition to this, a fridge temperature instruction standard operating procedure (SOP) has been developed alongside spot checking sheets used by staff. Oversight of the checks are reported through the directorate performance report into the Infection, Protection Control Committee (IPCC) to ensure any escalations are made and support is provided if needed.

7. **To recommend that the cultural improvements achieved in engaging internally with staff must also be replicated in the engagement with patients, to ensure that they feel safe and able to speak out if needed.**

   The Inclusive Maternity Work Programme promotes inclusivity within maternity services, by recognising and respecting the diverse needs and experiences of women/birthing people, staff and the communities to be able to reduce Health Inequalities and make maternity services inclusive by 2025. The Culture and Engagement work pathway aims to create opportunities for the voices of women,

families and staff from all backgrounds to be heard and their ideas to be shared. The projects underway in this pathway promote inclusivity and a sense of belonging, physical and psychological safety and mutual respect and kindness in a service that commits to listen, and to collectively own and respond to issues and feedback raised.

A one hour introduction into cultural awareness has been delivered on existing mandatory IMPACT training day for Midwifery and Maternity Support Workers. Positive feedback evaluation of the one hour session along with multiple requests to extend the training has allowed the approval of a one full day Cultural Awareness training day. Representatives from Maternity Neonatal Voices Partnership (MNVP) and community engagement from women will also help to shape the content.

8. To review progress and improvement to date with the Independent Maternity Review, expected timescales and oversight arrangements.

The Independent Maternity Review (IMR) was established in September 2022 following preparatory work, including the development of Terms of Reference (ToR) and early engagement with families and NUH from June 2022. It is led by Donna Ockenden as the independent Chair supported by a multidisciplinary team, including clinicians and administrators. The final report is expected to be published in September 2025 with cases being accepted into the review up to the end of May 2025.

Systems and processes within NUH were established to collate and transfer patient and corporate data to the external IMR team. This commenced in February 2023 and continues with regular refreshes to the cases identified via the 'open book' process and requests for supplementary information from the clinical review team.

As at 16 October 2024 the NUH IMR team have processed and transferred to the external IMR team:

- 1,964 clinical records and associated governance information for 1,964 women (and associated babies)
- 469 supplementary requests
- 110 requests for action, intervention or information from the Chair of the IMR

The work within the NUH IMR team has evolved over time and resulted in an increased number of requests for information or intervention from the Chair of the IMR on behalf of a range of families. There has also been a rise in the volume and complexity of supplementary requests from the clinical reviewers.

An internal NUH IMR Oversight Group, (IMROG) ensures delivery of the requirements of the IMR and meets monthly. This is chaired by the Chief Nurse

and is accountable to the Quality Assurance Committee (QuAC). Progress updates are also overseen and assured through the NUH Improvement, Oversight and Assurance Group co-chaired by NHSE and the ICB.

A bi-monthly Learning and Improvement meeting is held with Donna Ockenden to receive feedback, raise areas of concern and share learning from the case reviews and engagement with women and families so the Trust can take immediate actions and shape improvements. For example, after listening to feedback at the Annual Public Meeting and other forums, a new family liaison service is to be launched to develop a single point of access, contact and support after a distressing experience or bereavement during their maternity and/or neonatal care.