NHS NOTTINGHAM AND NOTTINGHAMSHIRE CCG

MATERNITY IMPROVEMENT BRIEFING – COUNTY 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).

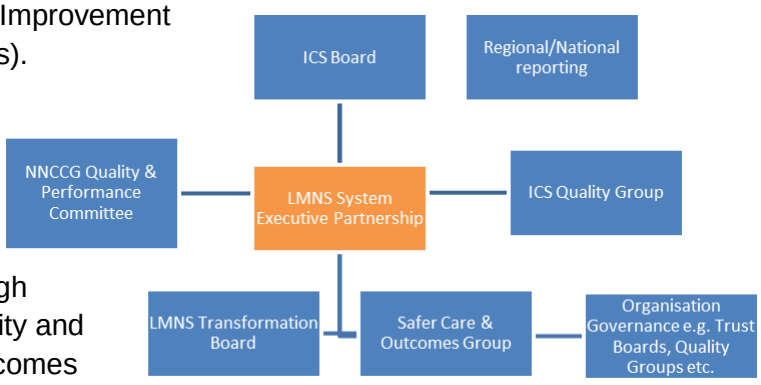
This briefing will aim to summarise the work and illustrate maternity improvement system oversight arrangements in addition the progress specifically in relation to Nottingham University Hospitals Maternity Services.

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