Title: Maternity update from Nottingham University Hospitals NHS Trust

Report for: Nottinghamshire County Council Health Scrutiny Committee

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1. Purpose of this report

This report provides an update of maternity performance and ongoing improvement work at Nottingham University Hospitals NHS Trust (NUH).

2. Introduction

In March 2022, the Care Quality Commission (CQC) carried out an inspection of maternity services at Nottingham City Hospital and the Queen's Medical Centre. Following this inspection, the maternity services at NUH were rated as inadequate overall.

Since then, the Trust has developed a comprehensive Maternity Improvement Programme (MIP) to address the findings identified in the CQC report. The MIP is now well established to support the delivery of sustained and continuous improvement.

3. Maternity Improvement Programme - overview and governance

The MIP is a comprehensive programme of improvement that includes actions we are taking in response to:

- Findings and recommendations from CQC inspections
- Feedback from women and families using our services, as well as staff working in maternity services
- Local learning gathered from investigations and coronial inquests
- Ongoing assessment of local needs
- Savings Babies' Lives standards (a care bundle for reducing perinatal mortality)
- Better Births (a five year forward view for maternity care)
- Recommendations and learning from maternity reviews carried out elsewhere (Morecambe Bay, Shrewsbury and Telford Hospital and East Kent)

Progress of the MIP is overseen by the Maternity Oversight Committee (MOC), which is chaired by a Non-Executive Director who is the Trust's Maternity Safety Champion.

The purpose of the MOC is to provide assurance to the Trust Board, through monthly reporting to the Quality Assurance Committee (QuAC), that the objective and aims of the MIP and the actions are being delivered and relevant recommendations from

national maternity reviews are actioned. NHS England's Director of Intensive Support and Maternity Improvement Adviser (National Maternity Safety Support Programme) are standing invitees. The Chair of the Maternity Voices Partnership attended the Committee in February 2023 and will be a member going forward.

4. Maternity Improvement Programme – progress to date

The MIP action plan is a well-established programme and has driven key changes across the service, helping to improve outcomes for women and babies. These include:

- Triage service (urgent care in pregnancy) - further to the separation of the triage service from the Day Assessment Unit in April 2022, the service has maintained an improved position against the 90% target of 'attendees seen within 15 minutes of arrival' to the triage area.
- Implementation of Birmingham Symptom Specific Triage System (BSOTS) - the service has implemented BSOTS, which ensures women are now seen in order of clinical urgency.
- Structured Handover of Care Review (SBAR approach - Situation, Background, Assessment and Recommendation) - we have implemented the SBAR approach, with October 2022 audit results showing 100% compliance across labour ward, sanctuary and maternity triage. SBAR supports clinicians to make effective escalation and efficient handover by providing a framework for communicating critical information that requires attention and action, thereby improving patient safety.
- Clinical risk assessment at booking appointment and every contact - audits demonstrate 100% compliance with risk assessments at the booking contact and continual assessment of risk throughout pregnancy.
- Investment in jaundice meters across the community – these meters test the level of bilirubin in blood to identify jaundice, which has resulted in babies being more accurately identified and treated. We have seen a reduction in serious incidents where jaundice is a theme.
- Enhanced Cardiotocography (CTG) equipment and training - improved training rates has resulted in fewer serious incidents, related to issues with CTG monitoring.
- Introduction of a maternity advice line - this provides 24 hour access to a midwife via a dedicated phone lines before or after birth
- A range of additional actions have been delivered, which include:
    - The opening of the Rainbow Clinic, to support those who have lost a baby
    - Expanded the infant feeding team
    - Improved access to clinical guidelines with the introduction of the Pocket Pal app for maternity staff and aligned Trust guidelines with national recommendations where available
    - Implemented BadgerNet, a maternity digital clinical system to support seamless care across all parts of the pregnancy pathway

- Investment in staff training for obstetric emergencies, foetal heartbeat monitoring and human factors
- Introduced foetal monitoring leads for midwifery and obstetrics, tasked with supporting the team to follow best practice
- Strengthened the senior clinical team, appointing more consultant obstetricians and providing better cover across our two hospitals
- Ongoing recruitment of midwives, including from overseas and the appointment of two heads of midwifery
- Focus on retaining midwives, offering the option to work flexibly to suit their needs
- Introduced a flow coordinator role to support the maternity service 24 hours a day, seven days a week
- Ongoing improvement of our staff feedback service and encouraging colleagues to raise any concerns through our Freedom to Speak Up Guardians and through other channels
- Improving record-keeping, including the assessment of risks and handovers between midwives and medical staff
- Developed a maternity dashboard to identify themes and trends in activity, clinical incidents and staffing to ensure better oversight of the service

5. Maternity Improvement Programme – next steps

Proposals have been developed for a new 'Accelerated Development' phase of the MIP during January-March 2023. A dedicated focus is being given to four priority areas of work, which will collectively deliver on 17 objectives within the improvement programme, by the end of March 2023. A sprint approach, is being applied to underpin the four priority areas:

1. Governance
2. Communications and engagement
3. Clinical pathways (postnatal care)
4. BadgerNet implementation (a maternity clinical digital system to record care from booking to discharge)

A recognised quality improvement approach has been adopted across the programme, using the five-step methodology of:

1. Set up and plan
2. Discovery
3. Design and trail
4. Implementation and roll out
5. Embed and sustain

The QI methodology is dovetailing with a strengthened project and programme management function and tighter reporting processes, to underpin monitoring and assurance mechanisms with greater oversight at divisional and executive level.

A programme management office (PMO) is in place to provide project and programme support, alongside dedicated leadership from transformation midwives and organisational development specialists. We also have some 'enabling work streams', such as staffing and culture and leadership, which continue to progress key aspects of the programme.

The remaining actions have been reviewed to form a matrix based on risk to enable prioritisation for the next quarter's actions. Actions have been reviewed to provide an overview of timescales for completion, resource required and outcome measures with an aim to complete by March 2024.

6. **Maternity Improvement Programme - accelerated development phase**

Governance: A sustainable, robust maternity governance system and process

- Robust framework for maternity QRS Governance Processes
- Serious Incident Reporting and Learning
- Risk Management Process
- Up-to-date Maternity Clinical Guidelines, SOPs and Pathways

The focus of this workstream will be to ensure robust governance processes and structures are in place to deliver safe services, including increased accountability at all levels. This focus will underpin the whole of the MIP and enable more effective and measurable progress across all of the work streams. The workstream will also oversee the delivery of our ongoing recovery work to eliminate any over-due serious incident (SI) investigations, open incidents and guidelines.

We monitor the total number of open SI's on the Strategic Executive Information System (StEIS) each week, with our ICB partners. The aim is to eliminate all outstanding SI investigations (for those which occurred pre 14 September 2022) by the end of March 2023. As of 6 February 2023, the backlog of open serious incidents is 29 (down from 61).

A trajectory for completion has been developed and is reviewed weekly, so any required mitigations can be identified. This is monitored via a weekly Incident Management Cell Structure, to give additional oversight to the recovery work.

Additional support to complete the investigations has been provided by a range of internal and external sources. Families have been contacted where there have been delays. The Local Maternity and Neonatal System (LMNS) which is part of the ICB, review and sign off the SI reports as part of the process. They have commented on the improved quality of the investigations and action plans. Additional processes for senior sign off have been implemented and will continue.

The Quality, Risk & Safety (QRS) team are led by a new Head of Midwifery and have recently undertaken a process-mapping exercise to strengthen and embed lessons learned from incidents, including measuring outcomes. The QRS team will lead on family liaison and engagement throughout the enhanced investigation process, with the support of a matron for engagement role, which is out to advert currently.

Communication: More effective communications and engagement

We have committed to:

- Improving communication with colleagues in maternity, including gaining feedback, through a baseline 'temperature check' to understand how we can better communicate and engage colleagues on the work of the MIP
- Using data and insight to inform our communications and engagement activity to ensure that our audiences receive the information most useful for them in a format that is suitable and accessible.
- Engaging proactively and openly with women, families and our communities, including through local media and stakeholders, and provide updates on the work of the Maternity Improvement Plan, including where we have more work to do.

In addition:

- The Director of Midwifery leads monthly engagement sessions with staff - the entire Maternity workforce is invited to each session, to communicate updates on progress within the Maternity Improvement plan and contribute to the ongoing improvement work
- Over the last year, the service has worked hard to improve the response rate to the Friends and Family Test (FFT), to ensure feedback from our families is received and acted upon. In December the service received 243 responses to the FFT, 93% of all responses were positive.
- The service has responded to the feedback from the national maternity survey, much of the postnatal pathway work combines pre-exiting actions as part of the MIP, as well as additional actions that are in response to the survey feedback.
- In January 2023, the service held a system wide event called 'Who's Shoes', to plan the future of the homebirth service.
- In March 2023, the Chief Executive and Maternity Safety Champion (Non-Executive Director) will hold a series of staff focus groups to listen and engage with colleagues in maternity

Postnatal Pathway: Clinical Pathway improvement focusing on the postnatal pathway

This workstream will focus on streamlining the postnatal pathway, with a view to the discharge process, and flow and efficiency. This is a key area of service user and staff feedback, and links to existing medicines management actions. Followed by continued improvements to the induction of labour and elective Caesarean section pathways already underway.

The planned benefits of this work will reduce the incidents associated with capacity and flow, such as diverts and the temporary closure of the service. The outcome of this priority will promote timely discharge for women, reduce waiting to be seen, and where appropriate women will experience midwifery led discharge. We hope to see a reduction in complaints and negative feedback on surveys in relation to elements of the postnatal pathway.

Digital Development: Continued development of the Badgernet information system

This workstream will work to ensure the delivery of the system into business as usual, addressing emerging data quality issues as part of the ongoing rollout. The launch of electronic capture of time stamps for the triage service and electronic assessment will form a part of this, supporting the improvement of key metrics aligned to practice improvements.

Successful implementation of Badgernet took place in November 2022. In the first month, 424 babies were born and added to Badgernet, with 681 bookings completed on Badgernet in Community. A full benefits evaluation exercise is being completed and the initial estimate indicates a positive return on investment. One of the key safety element of Badgernet is the 'break-glass' function. This was used 66 times in the first month alone, meaning clinical staff were able to access 66 electronic patient records that have been referred from out of area, that otherwise wouldn't be accessible.

7. National CQC Maternity Picker Survey Results (2022)

The National CQC Maternity Picker Survey 2022, was published on 11 January 2023. Picker is commissioned by 65 Trusts to undertake this survey, and results show our benchmarking position in relation to these trusts.

For this survey, the data for NUH was collected from all eligible maternity service users aged 16 and over, at the time of delivery, who had a live birth in February 2022. Our response rate to the survey was 41%, which is lower than the Picker Average of 48%. (Our response rate for the 2021 National Maternity survey was 58%).

In comparison with the National Picker Average (65 Trusts), the service has done significantly better in five questions (choice of where to have a baby, given help by antenatal midwives, involved in decisions during labour, personalised care after birth and feeding help and advice), about the same in 45 questions and significantly worse in three questions (able to get help when needed after the birth, partner able to stay in hospital and midwives input with feeding).

8. Workforce and staffing

Our most important asset is our people. Within a national context of workforce challenges in both midwifery and medical staffing, it is vital that NUH invests in people to reduce attrition and become an employer of choice. The following actions support this aim.

- Birthrate plus is a national workforce tool for midwifery staffing, reflecting the complexity and care needs of women, versus safe staffing levels and additional roles such as specialist midwives and managers. The Birthrate plus workforce report was received in December 2022 and a separate report has been produced to outline the findings. Based on current midwives in post, the gap is 32 whole time equivalents (WTE), which consists of 23 WTE clinical midwives across acute, and community midwifery services and nine WTE specialist roles. The NUH Trust Board has supported an over-establishment to provide an enhanced skill mix, above Birthrate plus recommendations. The business case for this is being developed for approval in March 2023.
- A recruitment and retention strategy and action plan for 2023 is currently out for consultation. In addition, a Local Maternity and Neonatal System (LMNS) workforce strategy was approved in December 2022 and will be presented to the System People and Culture Group.
- Maternity services are progressing a longer term workforce strategy for the next 3-5 years, aligning to LMNS strategy to include a review of models of care, innovative roles and skill mix reviews.
- A designated recruitment and retention matron is currently being advertised to provide additional capacity.
- Midwifery leadership capacity has been increased, with the recruitment of two heads of midwifery.
- Three new substantive Obstetric Consultants commenced in post in January 2023
- The proactive use of agency and bank colleagues to mitigate staffing gaps continues.
- Recruitment of international midwives, in consortium with other East Midlands Trusts also continues, with one midwife commenced in post and three joining in January 2023. A trip to South Africa took place in January 2023 to recruit international midwives, 18 posts offered for a summer 2023 start date.
- Following successful recruitment activity, in January we welcomed three international midwives plus ten newly qualified midwives, with offers to another twenty six people.
- An external company, supported by NHS England, has reviewed adverts for midwives at bands 5 and 6. The Trust is also liaising with regional peers to benchmark people metrics (vacancy, sickness and turnover).
- Enhanced rates in place for NUH contracted staff and competitive rates of pay for NHS Professionals (bank) staff.
- Recruitment incentives for newly qualified midwives in place since July 2021 and remain in place until December 2023 following recent review by the Executive and Divisional Leadership Team.

- A bespoke shortened ‘Nurse to Midwife’ course (MSc) commenced at Derby University in January, with all 10 places filled.
- Recruitment open day took place on 4 February 2023 for midwifery vacancies (band 5 and band 6) with further dates planned in March, May, July and November 2023.

9. Continued engagement with the Independent Review of Maternity Services (Ockenden Review)

We are committed to making the necessary and sustainable improvements to our maternity services and continue to engage fully and openly with Donna Ockenden and her team on their independent review.

On Thursday 2 February, NUH and NHS England colleagues met with Donna Ockenden and her team to receive early feedback. Donna provided feedback about where communication with women and families, written and spoken, should have been better.

Women and families can be assured that the feedback and learning that Donna shared us at the meeting, and throughout the review, will be used to make improvements to our maternity services immediately.

We are not waiting for the review to conclude before making changes and our staff have been working hard to make the necessary improvements now. Crucial to these improvements is ensuring that family voices are heard and we are encouraging people who have significant or serious concerns about their maternity care to contact the review team. We are also encouraging current and former staff who work directly in or closely with our maternity services, to come forward and engage with the review.