Title: Summary of feedback received from the Independent Maternity Review and the Care Quality Commission (CQC), and improvements made in maternity services at Nottingham University Hospitals NHS Trust because of this

Report for: Nottinghamshire County Council Health Scrutiny Committee

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1. Purpose of this report

This report provides a summary of the feedback that has been received to date by Nottingham University Hospitals (NUH) Trust from the independent Chair of the Independent Maternity Review (IMR) and an update on the work that the Trust has undertaken to respond to the feedback to improve the safety and quality of maternity services for women and families.

2. Introduction

The Independent Maternity Review of NUH was established in September 2022. It is led by Donna Ockenden as the independent Chair supported by a multidisciplinary team including clinicians and administrators. Its focus is to identify areas of concern within maternity care at NUH, providing information and recommending actions to help improve the safety, quality and equity of maternity care and the handling of concerns at NUH when they are raised by women and/or their families and staff members. The Review publication date has been extended to June 2026 following a review of the terms of reference and the inclusion of babies born outside off NUH but who were transferred in the neonatal period for specialist care.

NUH receives feedback from the independent Chair when areas of concern are identified in a number of ways. These include regular scheduled learning and improvement meetings and via direct communication and correspondence between the independent Chair and NUH Executives to alert the organisation to any concerns outside of the regular meetings if required.

The Learning and Improvement meetings are held bi-monthly and these are used to share learning from the case reviews and engagement with women and families undertaken by the IMR with NUH. The format and regularity of the meetings enables NUH to take time action on the information we are given to address the feedback raised and make immediate improvements in our maternity services.

A Maternity Improvement Programme (MIP) is in place, and in September 2023, the CQC improved maternity ratings at Queen's Medical Centre and City Hospital to Requires Improvement. Further visits were undertaken by the CQC in June/ July 2024 with subsequent request and provision of evidence from the maternity service. There were no immediate safety actions or concerns raised. A draft report was received and returned with factual accuracy amendments in December 2024 however a final report has not yet been published due to system issues in the CQC.

3. Themes of the feedback received (July 2024)

- Governance processes – Subject Access Request (SARs) and complaint response delays, poor quality response to complaints and resources to support improved communication
- Cleanliness
- Lack of kindness & civility

4. Actions taken or underway to respond to the feedback received

The initiatives in place to respond to the feedback received are detailed below:

4.1 Governance

Improving our responses to Subject Access Requests (SAR) and complaints is a priority for the Trust, in the face of unprecedented demand. We have restructured the team which deals with SARs, Freedom of Information requests and access to medical records. In July 2024, 14 new colleagues were appointed and commenced throughout August and September 2024. All posts have now been recruited to. Staff were offered overtime and additional hours to move progress forward whilst recruitment was completed.

Requests related to the review are prioritised. Additional clinical resource to support the data team to review all items included in SARs is being sourced. A monthly report is submitted by the Head of Information Security & Data Protection Officer to the IMR oversight group for updates and escalations.

Complaints are managed through a dedicated complaints team who attend weekly meetings with matrons and Head of Midwifery to support timely responses. Delays to responses are escalated to the division and reported through to trust board via the governance route. All complaints are reviewed either by the Head or Director of Midwifery before final sign off by the Chief Nurse as divisional executive lead for complaints.

The requests for birth reflections and planning has increased over the year with 313 women referred into the service. The resources for supporting the Listening Service have been increased including two Family Liaison Officers who have recently started in the service with continued reduction in the waiting time for appointments.

4.2 Cleanliness

An issue was identified by the CQC regarding dates not visible for curtain changes which was rectified immediately. Other actions to address hygiene and cleanliness included:

- Monthly cleaning meetings with Head of estates as part of the infection prevention and control agenda
- Reiteration of wider responsibilities for the clinical environment with support staff
- Audit to be undertaken of dress code standards
- Feedback to the team about observed poor Infection Prevention Control (IPC) practice
- Spot checks of sharps boxes and review of the cleanliness of curtains and curtain changes.

4.3 Lack of civility and kindness

Women and families using our services have a right to always expect kindness and civility. The Director of Midwifery addressed the expectations that all staff at NUH are expected to always communicate in a professional and courteous way. The Chief Nurse and Medical Director reminded colleagues that unacceptable communication of any kind must be dealt with as a professional standards matter.

Inappropriate language in emails is unacceptable and where identified is dealt with through HR processes and via the relevant professional standards route by either the Chief Nurse or Medical Director. The Chief Executive Officer wrote to all staff in the Trust to remind them of their obligation to communicate in a professional and courteous way.

There is continued work within the service as part of the culture and engagement workstream with various leadership programmes and support for staff in giving effective feedback for example. Creating psychologically safe working environments through handover processes and escalations is one project underway as is the implementation of labour ward coordinator framework.

As a Trust we are aligning ourselves to the Patient Safety Incident Response Framework (PSIRF) established by NHS England, PSIRF focusses on systems and processes, rather than individual fault. PSIRF emphasises a just and restorative culture framework used for responses to incidents (including HR related matters). Colleagues within the culture and engagement workstream are considering how we enact the approach within the service.

We have had feedback from Donna Ockenden that our services are not as inclusive as they should be. Our Inclusive Maternity Work Group has been established to lead on tackling these issues, and we are absolutely committed to improving in this area. The team has prioritised a number of key initiatives, including specialist clinics in community settings, improving translation, stronger links to charities and community groups and better cultural awareness through training and development.

Feedback on patient experience is received on a monthly bass and triangulated with other feedback mechanisms such as the CQC national maternity survey and from Maternity &

Neonatal Voices Partnership (MNVP) colleagues. NUH performed well in the last national maternity survey with statistically better scores thank other trusts on five questions.

No.	Question	Picker average	NUH Score	Comparison
Antenatal Care				
B3	Offered a choice of where to have baby	**84%**	**97%**	
B20	Felt that concerns were taken seriously by the midwife or doctor during the last triage	**93%**	**97%**	
Labour and Birth				
C9	Partner / companion involved (during labour and birth)	**94%**	**98%**	
Care after Birth				
D6	Found partner was able to stay with them as long as they wanted (in hospital after birth)	**67%**	**95%**	
Postnatal care				
F15	If needed it, received support or advice about feeding their baby during evenings, nights or weekends	**70%**	**82%**	

There was one question that scored worse than other trusts.

No.	Question	Picker average	NUH Score	Comparison
Care after Birth				
F4	Saw the midwife as much as they wanted (postnatal)	**59%**	**50%**	

Actions are underway to improve community midwifery services including self-referral into the service and reintroduction of post-natal clinics.

Communication with fathers and birth partners especially when the pregnancy is not straightforward has been identified. The following actions have been implemented:

- Strengthened our approach to this through training and education programmes. One example is the training provided through Practical Obstetric Multi-Professional Training (PROMPT). There is a designated person to look after the partner and keep them informed of what is going on during emergencies. They escort the partner to theatre, for example, when they need to get changed.
- We encourage partners to attend postnatal debriefs and birth reflection appointments.
- Questions from partners are encouraged during any investigation as we recognise the impact that birth trauma can have on them.
- Access to counselling and psychological support includes partners

- Birth partner stories to be included in culture and inclusivity training day staring from April
- Maternity and Neonatal Voices Partnership (MNVP) session established within the PROMPT training.

More broadly, as part of the People First Strategy, a new set of Trust values has been launched. The new values are:

- Kind – We are compassionate and caring to everyone
- Inclusive - Everyone is welcome
- Ambitious – We continuously improve
- One team – We achieve more if we do it together

The values link with the Workforce Inclusion Strategy approved by the Trust Board on 11 January 2024. This Strategy is accompanied by a comprehensive implementation plan.

5. Staffing

Midwifery staffing continues to be positive in relation to recruitment and retention. The highlights for noting are:

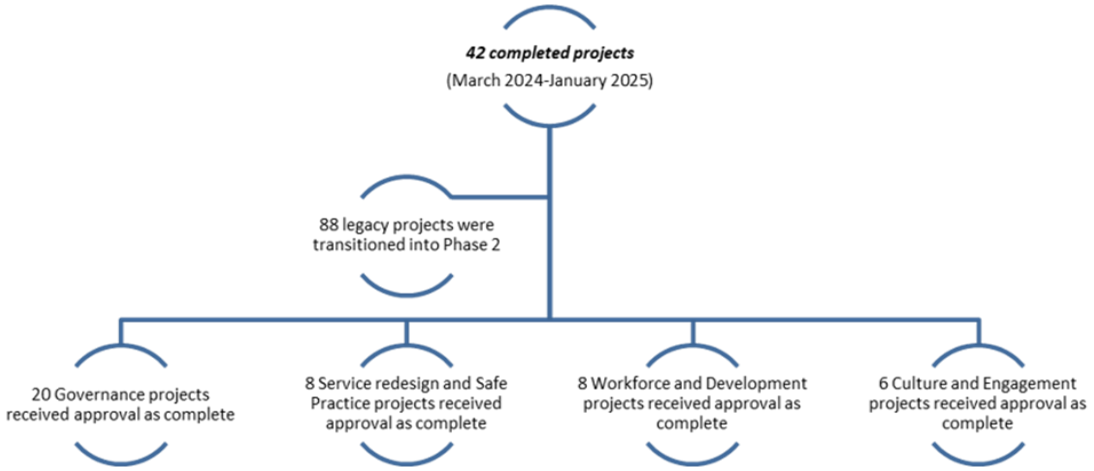
- Board support above BirthRate+ (workforce tool) recommendations (30WTE)
- 60+ midwives joined since April 2024, including recruitment of B6 midwives
- Total vacancies projected by 31 March 2025 – 16.12wte despite uplift in midwifery budget by 11.81WTE due to MNR expansion December 2024
- Leavers within the registered workforce are the lowest since 2019-2022
- Turnover continues to reduce overall and was 6.89% in December 2024
- Agency use stopped, 27 January 2025
- NHSP rates alignment from 1st April
- Positive feedback from Newly Qualified Midwives on the preceptorship programme and the support they receive
- Band 2-3 transition completed with Band 3 completing a refresher and update training week.
- Pregnancy mentor band 4 now in substantive posts in community to provide family support

Medical staffing is challenged at times however recruitment continues with suitable applicants interested in working at NUH. Additional posts within the middle grade resident doctor group have been agreed. Other points are;

- Recruitment into additional consultant posts leaving 2.5 Consultant rota gaps
- Further reduction in rota gap (down to 1.5) following commencement of newly recruited Consultant
- Reduced Consultant workforce risk
- Additional leadership roles developed to support the service and the MIP – Head of Service for Culture, Workforce and Safe Practice
- Additional funding agreed for two Resident Doctor posts to reduce rota gaps
- Plans to reduce the resident doctor rota from 1:14 to 1:9
- Development of Safe Staffing Levels for Obstetrics Standard Operating Procedure as part of the escalation process as agreed locally with consultants.

6. Maternity Improvement Programme

The NUH Maternity Improvement Programme is now functioning under Phase 2. Phase 2 aims to improve the quality, safety and experience of Maternity Services at NUH by concluding the original Maternity Improvement 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. This is a dynamic process as actions are completed or added to the MIP. It will continue indefinitely to reflect changes in national and local drivers. Below is the progress of projects in Phase 2.



7. Conclusion

The Trust recognises that there is more work needed to continue to improve the safety, quality and equity of maternity services and address the concerns that have and are being raised with us by the Chair of the Independent Review. We have improvement programmes underway to address the feedback we have received and will continue to ensure that these are responsive to and reflective of the areas being raised with us.

We welcome and are grateful for the timely feedback being provided and the opportunity this gives us to improve services for our women and families rather than waiting for the publication of the review to act.