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Maternity County OSC Report

March 2022

Update of progress in our Maternity Improvement Plan

Nottingham University Hospitals NHS Trust

Engagement and Inclusion
- Our birth reflections service is up and running for women and their partners

Safe Practice
- Our jaundiced baby policy has been finalised and a new pathway is now in place
- Our virtual ward continues to provide safe care for women who have Covid-19

Equipment
- Training on Bilirubinometers for community staff has been completed and the equipment is now in use

Digital
- Supplier engagement and system demonstration event across NUH and SFH

Staffing
- We are managing staffing on a daily basis as well as forward planning
- We are exploring options of different ways to manage capacity to make the best use of our resources
- All four of the new consultants we recruited in summer 2021 are now in post
- We have recruitment and retention specialist support for maternity to help boost recruitment

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Update of progress in our Maternity Improvement Plan

Training and Education
- Additional fetal monitoring training is taking place
- Our project to develop our Maternity Support Workers is progressing
- Training on Human Factors is being rolled out

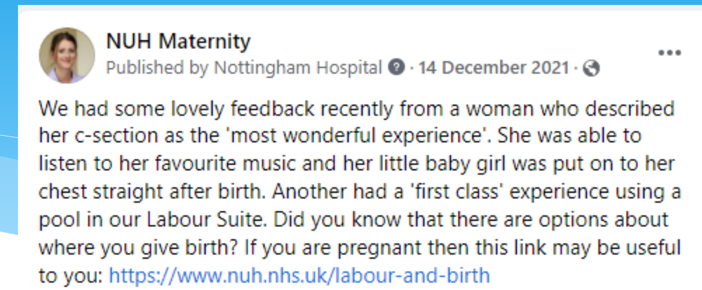
Culture and Leadership
- We've repeated the Psychological Safety Survey
- Leadership development for senior midwives
- Bespoke interventions on team working
- Cultural change programme stage two has been agreed
- Continued to increase the visibility of leaders

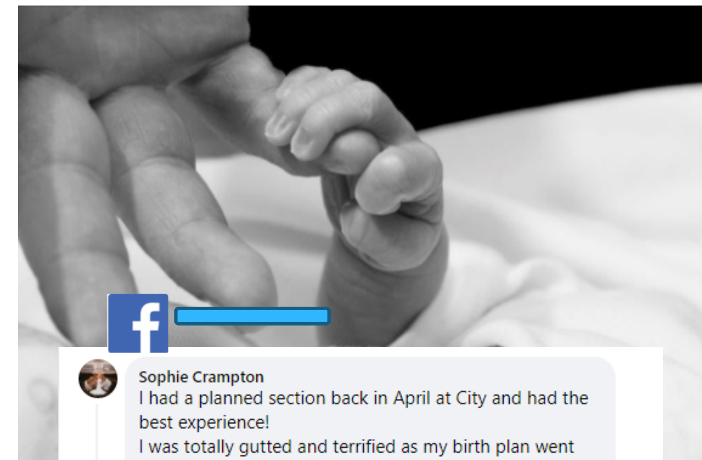
Governance
- We have a new Quality Risk and Safety structure in place
- Funding has been received for Maternity Governance Support

Listening to the voices of our families

- We continue to increase our engagement with women and families via different methods – this month we'll focus on social media.

- We now have more than 6,000 followers on Facebook. At the end of last year we launched the Maternity Views email address, and encouraged women and families to give themed feedback - in December 52 women contacted us via this method. Our Director of Midwifery also conducts filmed Q&As.





Do services feel safe today?

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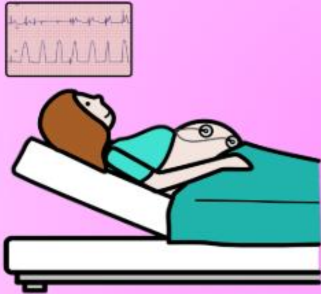


Delivered competency based **CTG Training**

Daily oversight of **Safe Staffing**

Ongoing **Recruitment** campaigns

No reduction in Harm incidents seen as yet, but **Increased Assurance** Incidents are correctly graded

Reviewing pathways of care to make improvements to **Quality and Safety**

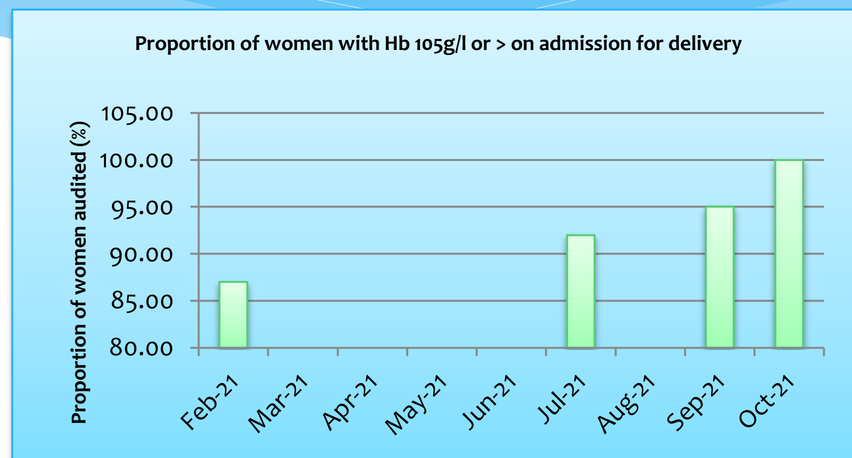
Safe Practice – A Case Study

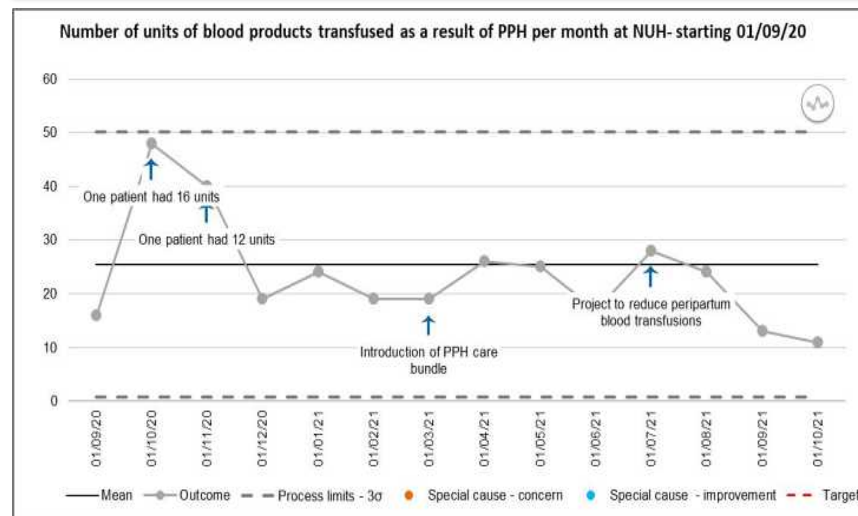
Women and their babies are protected from avoidable harm

Nottingham University Hospitals NHS Trust

Postpartum Haemorrhage (PPH)

Date	Work done
Jan and Feb 21	Understanding the problem (baseline audit and thematic review of our major PPHs)
Mar 21	4 stage PPH care bundle introduced, including a standardised risk assessment
July 21	Project to optimise antenatal Hb levels
July 21	Project to reduce peripartum blood transfusions
August 21	Project to improve maternal experience. Dissemination of maternal experience survey results with key learning points
September - October	Work to improve uptake of PPH risk assessments and the use of the bundle in women having an ELLSCS





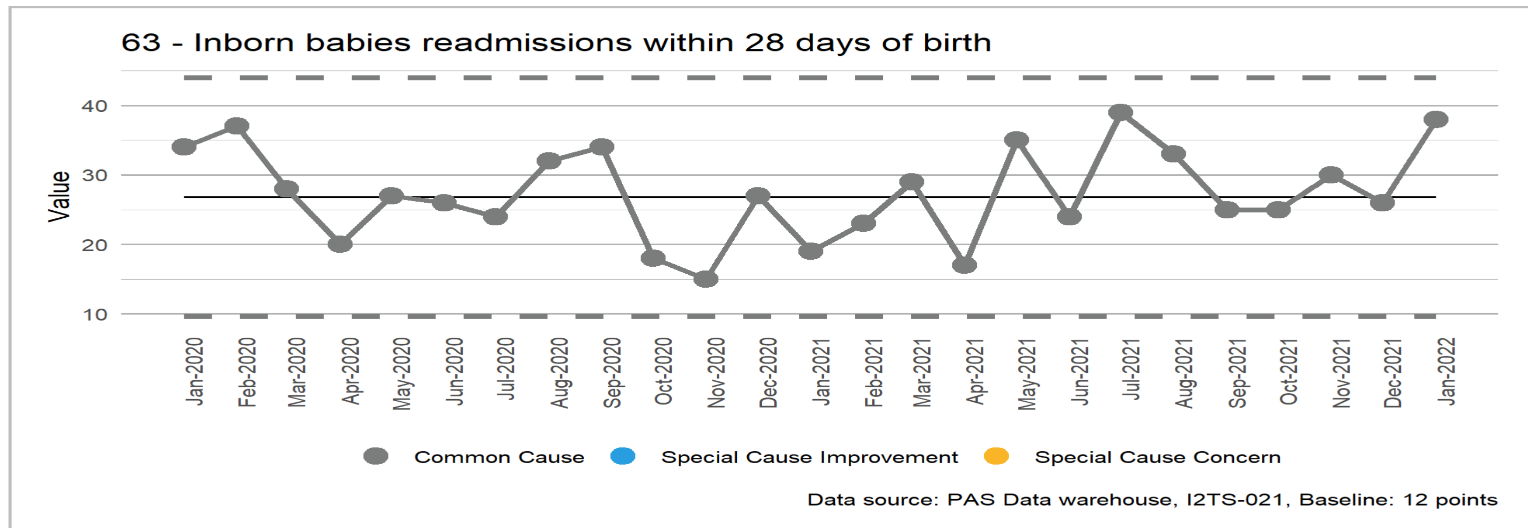
Results:

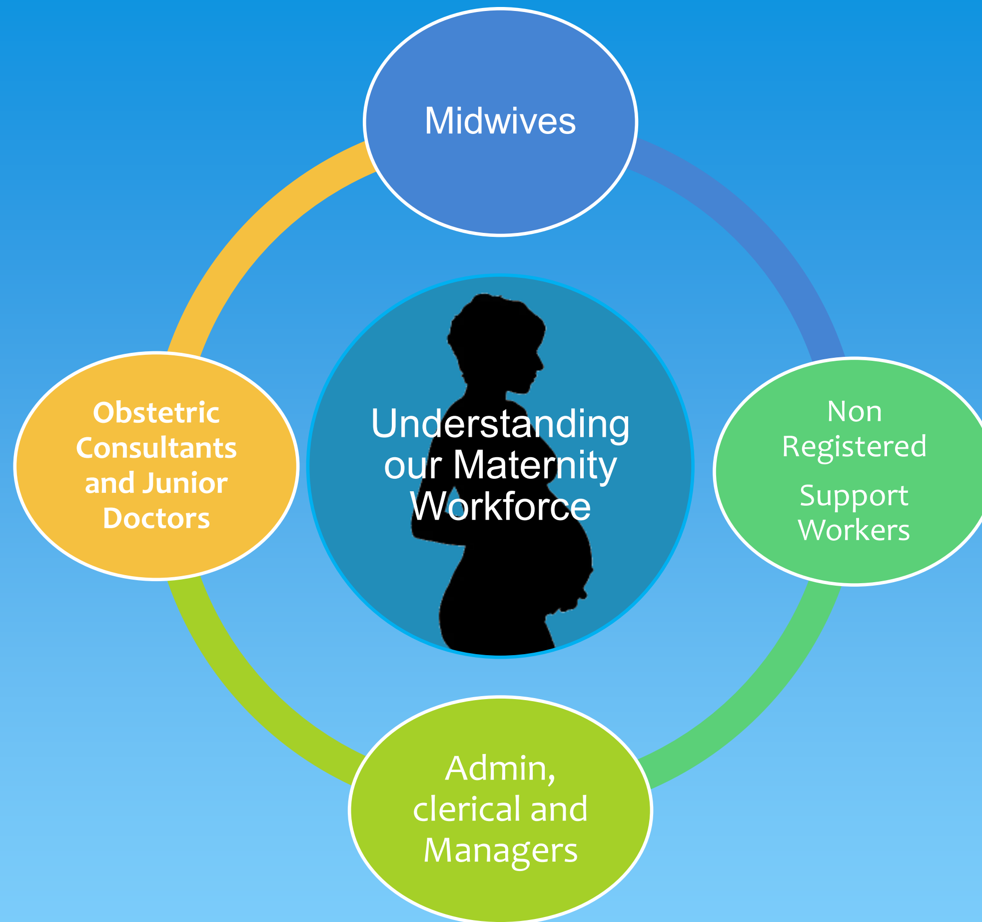
- Better use of ferrinject antenatally and peripartum has allowed us to improve the proportion of women with a normal Hb on admission for delivery and has reduced our rate of peripartum blood transfusions

Safe Practice: Women and their babies are protected from avoidable harm

New born babies receive care and treatment which is in line with national guidance. There will be a reduction in the number of avoidable admissions to the neonatal unit.
We will see an improvement in our ATAIN metrics and they will be aligned to the national average.

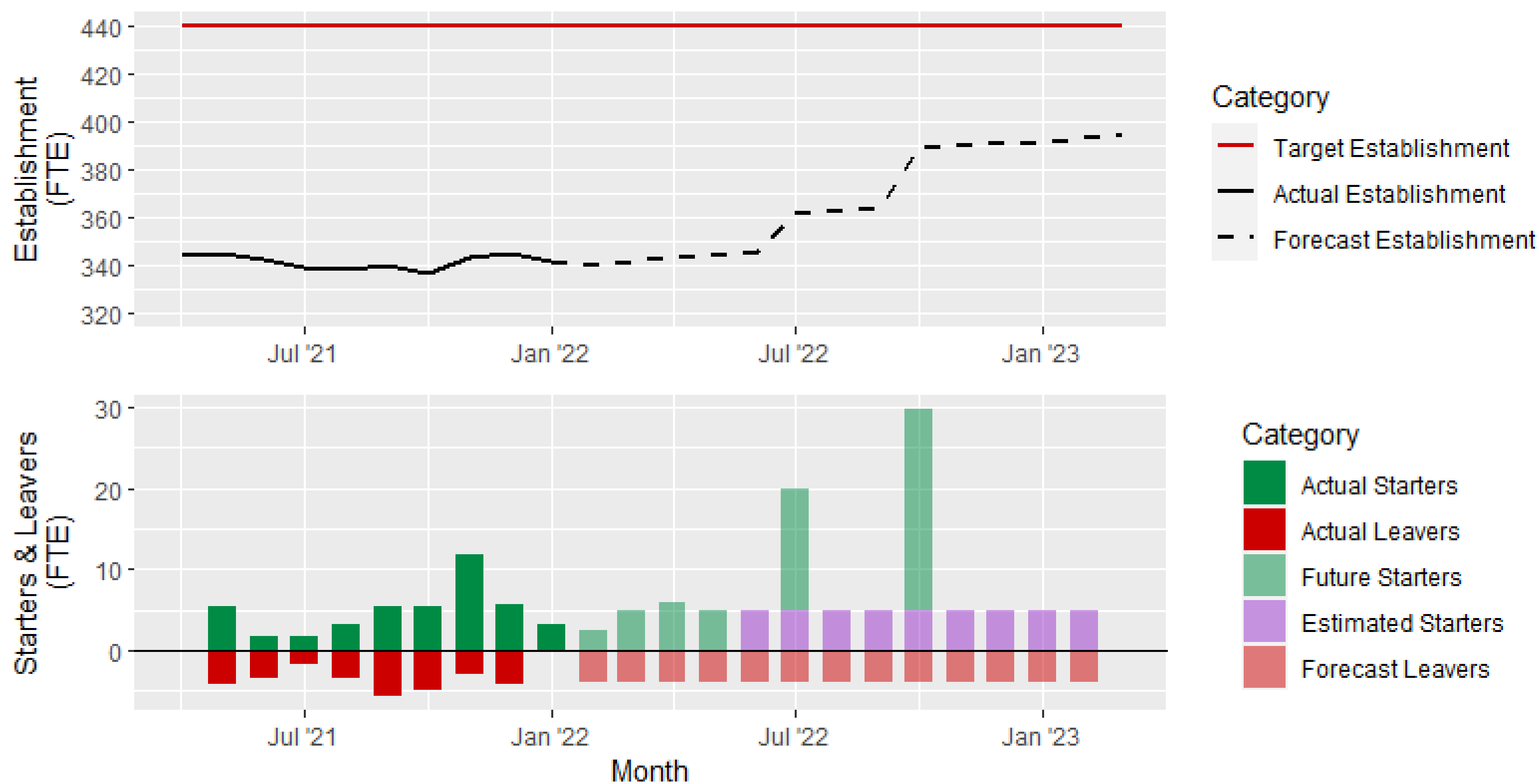
- Jaundiced baby pathway reviewed and updated now in line with best practice. Pathway implemented and working well.
- Staff trained in use of Bilirubinometers
- Education on the care of the newborn baby through posters, Facebook messages, workshops
- Monitoring the impact of improvements to the care new born babies received.





Understanding our workforce is key for us to be able to provide safe, effective, compassionate, and responsive care to our women and babies.

Registered Midwives Establishment



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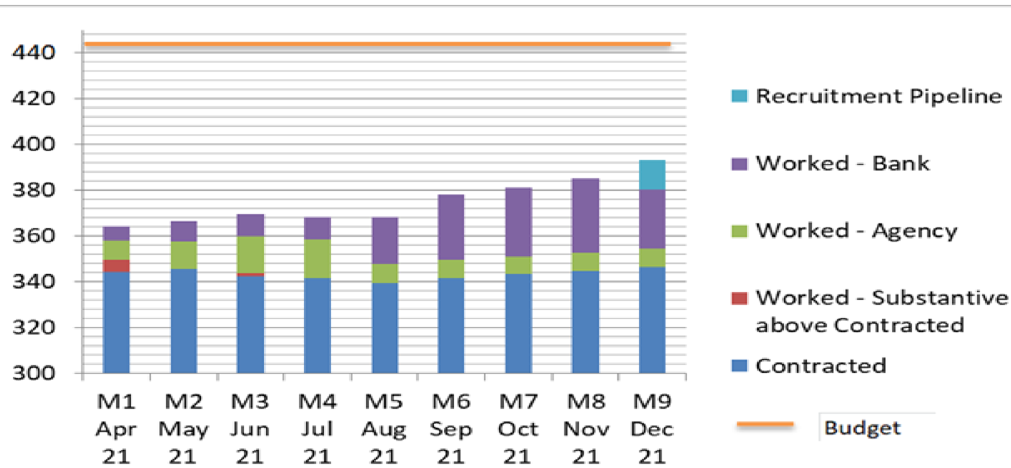
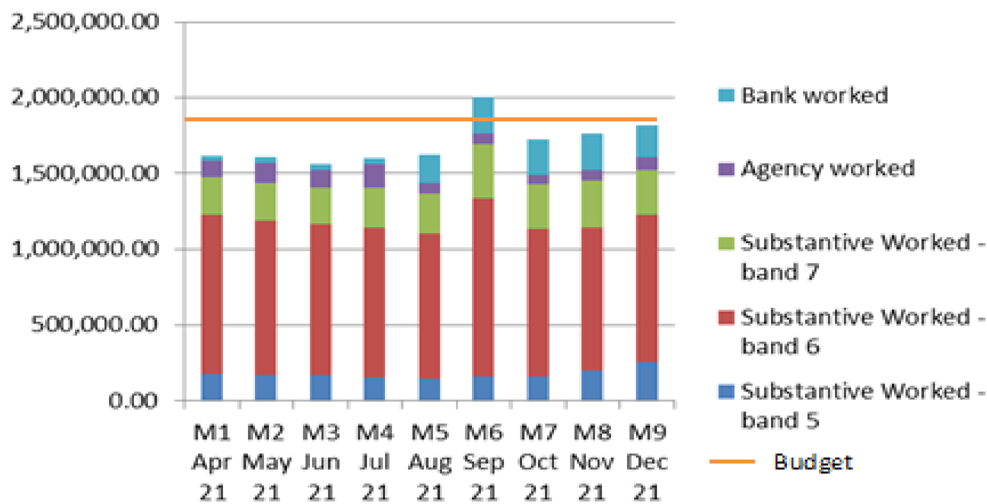


Worked WTE by month broken down by substantive midwives, bank, agency and those in the recruitment pipeline (i.e. offered but not yet started)



Monthly spend analysis for clinical midwifery establishment 21/22 showing bands 5/6/7 and agency and bank utilisation against a budgeted £1,837,941 monthly spend.

Digital Transformation

Devices:

- 150 new electronic observation devices. Ensuring every member of staff has a dedicated eObs device, plus spares for agency or locum staff
- Every community midwife and support worker now has a laptop and mobile phone

Access:

- We launched the Maternity Advice Line as a single point of contact for women and families looking to get advice. Staffed 24/7 by experts able to escalate problems as required. Data shows us when the key times are that women call, and a triage workflow is in place to help record advice given.

Serious Incidents

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HSIB top Themes from Final Reports	
2020 analysis	**2021 analysis**
Fetal Monitoring	Practice issues
Escalation	Risk assessment
Triage/ management of telephone calls	Escalation
Diagnosis of labour	Systems and Processes
Documentation and ICT systems	Impacts of COVID19
Safe Discharge	Staffing/ Acuity
	Fetal Monitoring

The Healthcare Safety Investigation Branch (HSIB) Maternity investigation programme is part of a national action plan to make maternity care safer. They undertake approximately 1,000 independent maternity safety investigations a year to identify common themes and influence systemic change.

Criteria are:
All term babies (at least 37 completed weeks of gestation) born following labour, who have one of the below outcomes.

- Intrapartum stillbirth (where the baby was thought to be alive at the start of labour but was born with no signs of life)
- Early neonatal death (when the baby died within the first week of life (0-6 days) of any cause).
- Potential severe brain injury
- Maternal deaths

Serious Incidents reported January – December 2021

Nottingham University Hospitals NHS Trust

Month	Number of Serious Incidents reported	Number reported to HSIB
January 2021	4	3
February 2021	6	1
March 2021	1	0
April 2021	7*	1
May 2021	11**	0
June 2021	5***	2
July 2021	4****	2
August 2021	2	0
September 2021	3	1
October 2021	3	1
November 2021	3	0
December 2021	3	0

*3 incidents relate to retrospective review
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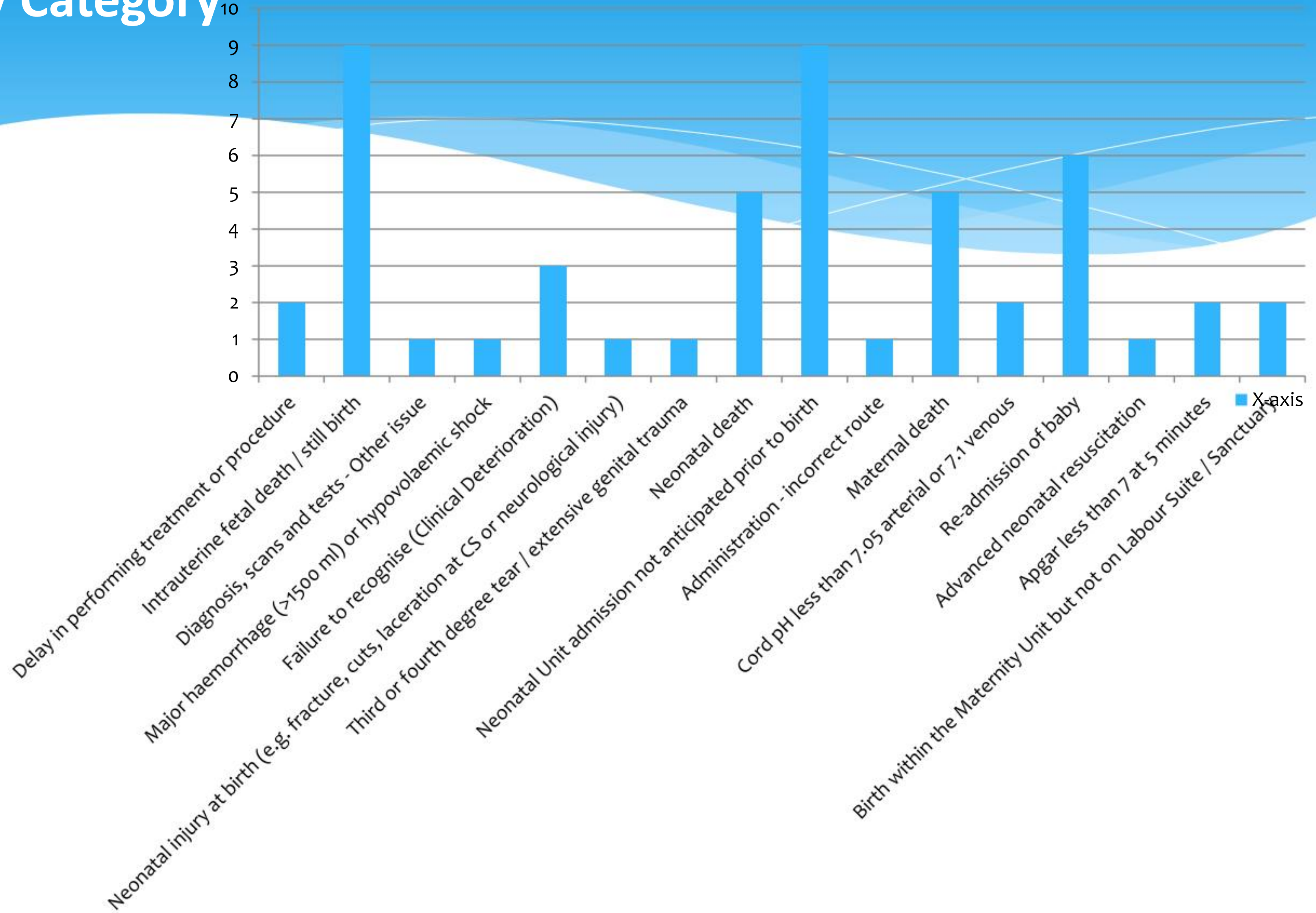
Incidents by Sub category

Serious Incidents By Category



Maternal Deaths

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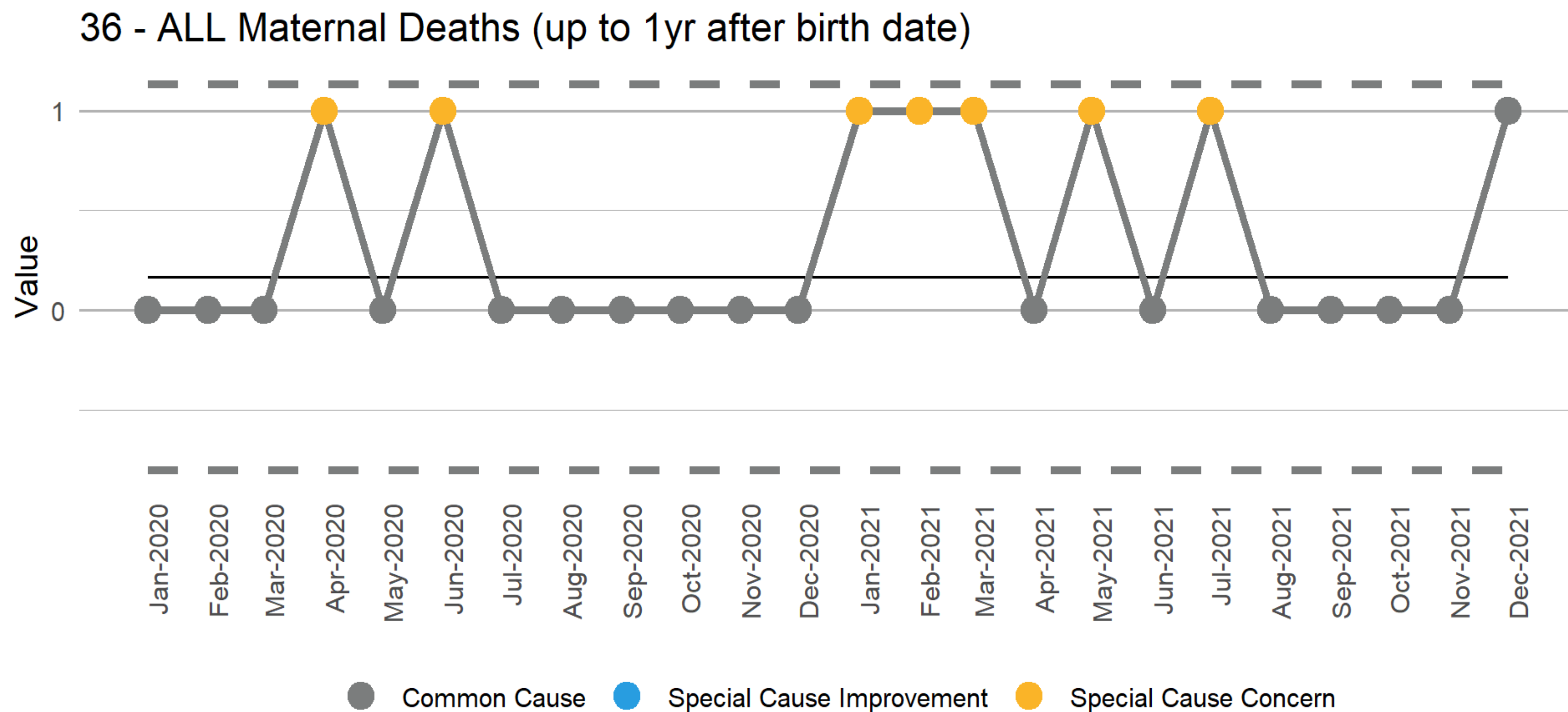
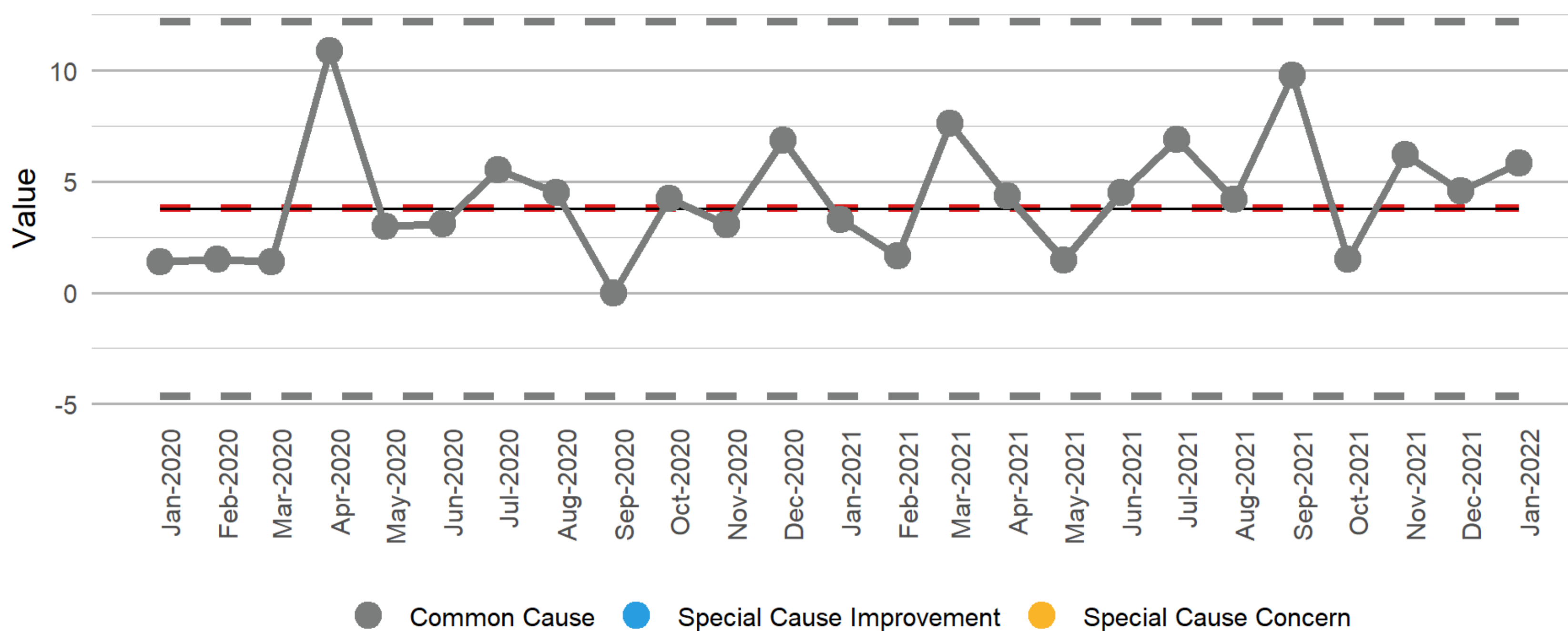


- All maternal deaths are reported to MBRRACE
- All maternal deaths are investigated by HSiB

Stillbirths



- Please also see data on perinatal deaths in the MBBRACE report (Maternal, Newborn and Infant Clinical Outcome Review Programme).

Claim Data

Nottingham University Hospitals NHS Trust

Member Name		CNST Damages	CNST NHS Legal Costs	CNST Claimant Costs	CNST Total Paid
University College London Hospitals NHS Foundation Trust		18,369,685	288,905	811,870	19,470,460
Liverpool Women's NHS Foundation Trust		15,516,119	594,961	1,574,499	17,685,579
Lewisham Healthcare NHS Trust		19,198,546	578,889	1,975,156	21,752,590
Chelsea and Westminster Hospital NHS Foundation Trust		16,388,669	469,556	1,834,515	18,692,740
Leeds Teaching Hospitals NHS Trust		19,197,704	614,186	1,577,805	21,389,695
Guy's and St Thomas' NHS Foundation Trust		16,044,233	490,319	1,258,777	17,793,328
University Hospitals of Leicester NHS Trust		16,549,608	708,976	964,310	18,222,894
Nottingham University Hospitals NHS Trust		14,616,500	479,602	1,759,099	16,855,201

Comparator data taken from NHS Resolution for claims 2019/20 for Trusts with similar size services including tertiary services.

Maternity Dashboard

* The service uses a dashboard of outcome measures and indicators to monitor the quality of care delivered to women and babies.
* The graph below is an example of the dashboard data. The trust uses Statistical Process Control in the dashboard which is best practice. We have a number of measures relating to clinical outcomes for women, babies, service delivery, quality risk and safety.