Nottingham University Hospitals NHS Trust

Report for Nottingham County Health Overview & Scrutiny Committee, March 2021

1.0 Introduction

In July 2020, the Trust became aware of a number of issues within its maternity services and in response to these concerns established a transformation programme to deliver improvements in the quality of care.

Subsequently in September 2020, the inquest into the death of baby Wynter Andrews resulted in the issuing of a Prevention of Future Deaths Report requiring the Trust to take action to ensure services are safe.

Following this inquest the Care Quality Commission (CQC) undertook a focussed inspection of our maternity services in October 2020 and in December 2020 published their report re-rating our maternity services from 'Requires Improvement' to 'Inadequate' along with issuing regulatory notices requiring the Trust to make immediate action to make service safe for mothers and babies .

Following the initial feedback from the CQC on 15 October we made some immediate changes in order to maintain the safety of the service and have continued to make further changes.

As a result of the above, the Trust took the decision to move from a transformation to improvement programme and strengthened oversight.

In addition in December 2020 the first report of the independent review into maternity services at the Shrewsbury and Telford Hospital NHS Trust was published requiring all Trusts to implement 12 urgent clinical priorities that were to be implemented and to undertake an assessment of their own maternity services against the reviews immediate and essential actions. The trust has completed this assessment and incorporated further actions in to our overall Improvement Programme.

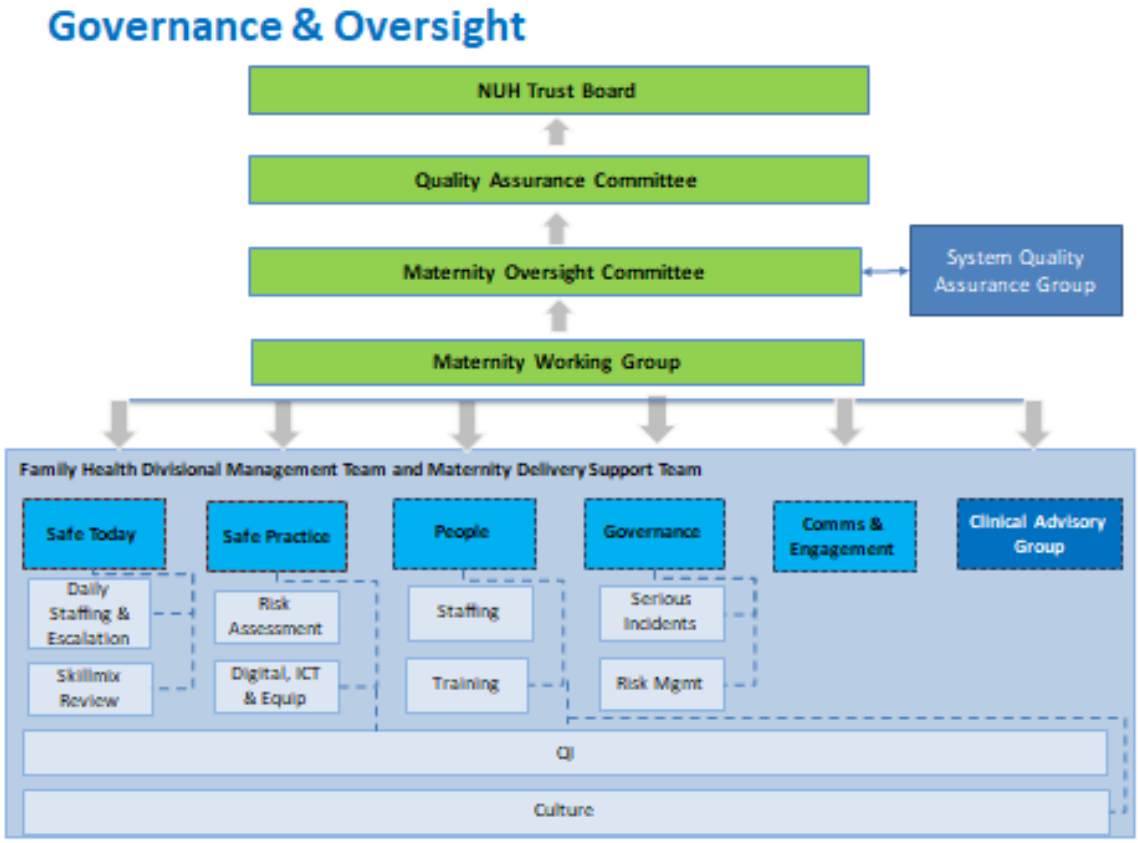
This report provides the Overview and Scrutiny Committee with details of the actions taken in response to the above to ensure our maternity services are safe for mothers and babies.

From the CQC inspection and Coroners inquests, the Trust accepts that there is evidence of long standing concerns around maternity at NUH. Although actions have been taken previously and assurance gained from national data showing still birth and neonatal deaths were both significantly better than the national median there was more action that needed to be undertaken to improve the service for women and babies. The Trust is completely committed from the staff who directly care for women through to the Board to now fully rectify this situation and has set itself an ambition to move out of inadequate to 'good' within 12 months of the previous CQC visit.

2.0 Maternity Oversight

The principle governance committee for oversight of maternity improvement is the Maternity Oversight Committee chaired by a Non-Executive Director, who is our Maternity Safety Champion; this Committee is supported by work streams led by Executive Directors. This includes groups for safe practice, learning from experience and quality improvement, people (leadership, teamwork, culture and innovation), governance (including incident and risk management), Safe Today and a Clinical Advisory Group, chaired by the Divisional Director for Family Health.

The diagram overleaf illustrates the governance structure for maternity improvement



Linked to the Maternity Oversight Committee is an external panel which will include experts in maternity and obstetrics from other NHS Trusts who are rated 'Good' or 'Outstanding' by the CQC, maternity leads from NHS England/ Improvement and service users. During 2021 we will be working closely with the Maternity Voices Partnership to ensure we embed the voice of women and families into our improvement work. These groups/ committees meet monthly and work through the CQC action plan and making improvements to the service.

Improvement actions are monitored internally by the Maternity Oversight Committee and assurance provided to the Board Quality Assurance Committee and Trust Board. External oversight is undertaken by the System Quality Assurance Group, chaired by the Accountable Office for the Clinical Commissioning Group and the Regional Chief Nurse for NHS England and Improvement.

3.0 Actions and Improvement

Our action plan is a large and complex document that takes account of the feedback from the CQC, recent inquests, feedback from HSIB, recommendations from the Ockenden Report, feedback from staff and service users.

The action plan contains a number of 'themes' and the table overleaf summarises some of the actions already completed. The table overleaf details some key actions completed to date against the areas for improvement.

Key Actions completed

Area for Improvement	Progress to date
Maternity Leadership	• Interim Director of Midwifery in post • Development for senior leaders
People and Culture	• Birthrate plus assessment undertaken • Recruitment to additional midwifery staffing numbers • Freedom to Speak Up Guardian activity to encourage staff to raise concerns • Recruitment plans for additional Obstetricians
Safe Today	• Process for the identification and escalation of concerns in place • Improved triage of mothers
Safe Practice	• Improved partnership working between team members • Deep dive of incidents to identify actions and learning • Improvement in training for key areas e.g. cardiotocography (CTG) • Developed competency training
Governance	• Review and implementation of a revised Serious Incident process
Communications & Engagement	• New and regular communications (weekly newsletter, leader walkabouts, MS Team feedback sessions) • Improving our links with the Maternity Voices Partnership with regular monthly meetings

The Trust is confident that the actions that are being taken will result in improvement that with the new governance and reporting arrangements that will be in place will ensure this is sustained in the future.

Dr Keith Girling, Medical Director

Sarah Moppett, Interim Chief Nurse