	**Community and Wellbeing Scrutiny Committee** 18 April 2023
	Report from London Northwest University NHS Trust

Northwick Park Maternity Services Progress Update

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	0
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Lisa Knight Chief Nurse, London Northwest University Hospitals NHS Trust Lisa.knight17@nhs.net

1.0 Purpose of the Report

1.1 The purpose of this report is to update the committee on the delivery against our Trust Maternity Improvement plan and our Maternity Strategy and update the committee on our regulatory compliance.

2.0 Recommendation(s)

2.1 The Committee is requested to note the updates in the report

3.0 Detail

3.1 Present Position

In October 2021 the Trust received an unannounced CQC inspection of its maternity services with a resultant rating of 'Inadequate'. The outcome and associated plan were discussed at the Brent Council Community and Wellbeing Scrutiny Committee in August 2021.

The Trust received a subsequent unannounced inspection in October 2021 with an improved outcome of 'Requires Improvement'. Please follow link for full report - https://api.cqc.org.uk/public/v1/reports/ee6cdff3-390c-4966-a8df-c4e454127adb?20221128141412

The report remarked on the many improvements in the unit particularly – staff morale, leadership and multidisciplinary team working. It also highlighted that there were ongoing challenges with staffing, mandatory training and equipment management.

In previous discussion with the committee, The Trust highlighted the cyclical nature of the quality of care in the unit over the past 20 years and the desire for a different approach to ensure that changes were sustainable and embedded.

3.2 External Assurance

As a result of the 'inadequate' rating the Trust was placed on the National Maternity Safety Programme. This consists of onsite support from a senior midwife and access to the national support team. Our advisor has supported us with delivering our compliance actions, reviewing meeting and governance structures, and helping the redesign of clinical pathways such as the triage service. The advisor produces monthly reports on progress, which are reviewed both internally and by the national team. The national medical team are supporting us with consultant engagement.

In March 2022 Donna Ockenden released The Independent Report into Maternity Care at Shrewsbury and Telford NHS Trust. As a result, all trusts were asked to undertake a self-assessment of the 10 immediate actions and a series of external peer visits were announced to benchmark those self-assessments.

In August 2022, 14 assessors visited Northwick Park Hospital Maternity Unit to undertake the external assessment. The findings against the 8 benchmarks are detailed below:

Action 1: Enhanced Safety	8/8 compliance
Action 2: Listening to Women and families	6/6 compliance
Action 3: Staff training and working together	5/7 compliance

- The trust did not have in place twice daily consultant ward rounds. The ward rounds commenced in November 2022, and we would now be complaint with this action

Action 4: Managing complex pregnancy	6/6 compliance
Action 5: Risk Assessment during pregnancy	4/4 compliance
Action 6: Monitoring Foetal wellbeing	5/5 compliance
Action 7: Informed consent	4/6 compliance

- The assessors suggested improvements to our website and required us to co-produce an engagement plan with our Maternity Voices Partnership (MVP) both of which have been completed.

  Workforce planning and guidelines: 4/5 compliance

- The assessors expressed concerns about the volume of midwifery vacancies that the unit continues to carry

3.3 Update on the Maternity Improvement Plan

The Trust developed a maternity improvement plan to map our development journey and track delivery against our actions.
This action plan has developed into our Maternity Strategy, which was approved by The Trust Board in October 2022. The Strategy builds on the 3 pillars of our improvement plan, whilst also setting the strategic direction for the service. The strategy was developed with input from multiple staff and patient groups. The 3 pillars of the maternity strategy are: Leadership Culture and Workforce, Safe Effective Care and Person-Centred Care

- Leadership Culture and Workforce

The vacancy rate for Band 6 midwives remains over 35% and continues to be our highest rated risk. The turnover rate for the unit has reduced to 10.3% which is presently lower than the general trust turnover rate.

The Trust has increased the number of midwifery students with the local universities and is looking to recruit them once they qualify. The unit is recently in receipt of The Capital Midwife Kite Mark for Preceptorship, a quality mark for the content of our programme for supporting newly qualified midwives and is reflective of the improvement of our preceptorship offer.

The Trust is recruiting overseas midwives and has a solid pipeline of individuals appointed, who will join us over the upcoming year. Even with these actions the shortage of midwives remains a national issue.

Our recruitment and retention working group is piloting self-rostering for all the midwives, to provide ultimate flexibility in shift patterns, and the cultural safety work group is prioritising the implementation of the civility and anti-racism toolkit.

The unit has appointed 3 consultants with specialist interests in urogynae, labour ward and fetal medicine. There are presently no consultant vacancies. Considerable work has been undertaken reviewing how we train and look after our junior doctors. Health Education England have noted significant improvements in how we do this and have removed any conditions around our junior doctors.

The Maternity unit has employed its own health and wellbeing advisor who provides positive wellbeing events, refreshments, listening and reflecting events. The feedback from the staff is that this is a highly valued role.

- Safe Effective Care
  In August 2023 the Trust will go live with our electronic patient record including taking all maternity documentation from paper to digital other than the handheld patient notes. We are taking this opportunity to integrate all our electronic systems with the new record which will provide a safety net on patient information.

  The key other areas we are focussing on are Triage and have just introduced Birmingham Symptom Specific Obstetric Triage System (BSOTS).
  BSOTS enables an initial standardised assessment of each woman, identifying her presenting condition, key clinical symptoms and vital signs. This information is then used to define the level of clinical need using a four-category scale: green (non-urgent), yellow (requires further assessment), orange (priority) and red (emergency).

- Women Centred Care.
  The Trust has now refurbished the Delivery Suite, antenatal and administration areas, the inpatient ward and is presently redecorating the birthing suite and creating an additional 14 bed unit for early pregnancy and gynaecology. Our final task is to extend the waiting areas to create a light and modern space with additional seating, for which we have received a charitable donation.

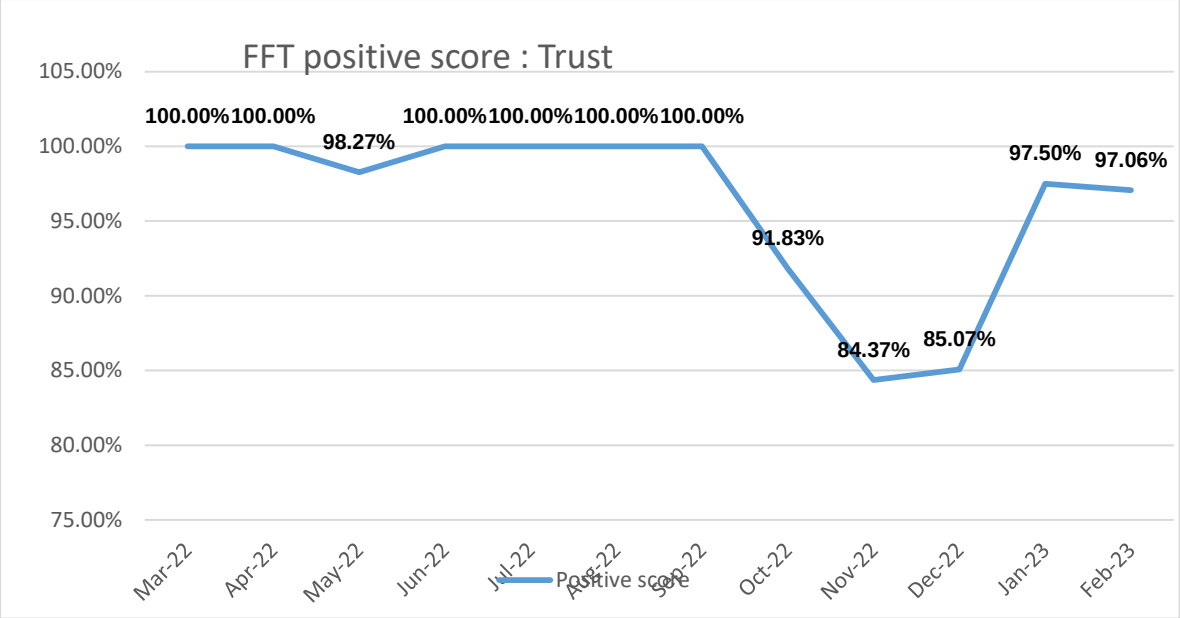
  We continue to have weekly Maternity Voices Partnership meetings and this group has been assisting with the designs for the building works and in the design of our new clinical pathways.

  The community teams are undertaking a piece of work on prioritising 1st day visits for mothers in the community.

3.4 Patient Feedback

We continue to actively search for and monitor feedback from families who use our service.

The Trust collects and friends and family recommender score data every month which is charted below. The Trust implemented a new electronic system in October and had some data validation issues in the following months. Since this has been resolved the average recommender rate is averaging around 97%. Families also give us experiential feedback - a couple of examples are listed below.



"Amazing delivery suite with professional people who really care We spent 5 days there on New years day with people away from their families to give us their best. The reviews on google are not what you meet there People have big expectations without to look on themselves first. Congratulations to NHS and the good work they do. Thank you for everything"

'" Second pregnancy with twins, truly amazing consultant; Dr Sanaroye, he has a wealth of knowledge and an asset to the trust and NHS. Another member who stands out to me is Teresa at reception, so patient, calm, and positive regardless of the angry patients from the lobby waiting. My 2 midwives Sam and Sarah are fantastic too, very helpful and happy. Occasionally the waiting times can be long and as observer, it seems like the agency isn't fell by the staff. I have waited as long as 1.5h in the first time after appointment but since being allocated to medicine it has been a very smooth, efficient journey."

" We were discharged too quickly in 14 hours after having c section and was told we can come back anytime within the 6 weeks. When we visited the maternity triage due to some concerns the next day, the staff was very rude and told us that I should go to GP and not come to maternity triage."

3.5 Ongoing Risks and Issues

As previously highlighted the vacancy rate in midwifery remains our highest rated risk. It creates day to day staffing issues for service delivery and increases the risk of staff stress and burnout, continuing the cycle. It has other consequences such as an inability to release staff for training, or to attend meetings or events. As previously highlighted our recruitment and retention group continues to monitor and act to reduce this risk.

4.0 Financial Implications

4.1 Not Applicable.

5.0 Legal Implications

5.1 Not Applicable.

6.0 Equality Implications

6.1 The Trust is actively working to address the known national statistics around mortality and morbidity associated with women of colour in childbirth. An example of this is the work undertaken to improve access to interpretation services.

7.0 Consultation with Ward Members and Stakeholders

7.1 Not applicable.

Report sign-off:
Lisa Knight
Chief Nurse, London Northwest University Hospitals NHS Trust