



**Community and Wellbeing Scrutiny  
Committee**  
23 August 2021

**Report from London North West  
University Hospitals NHS Trust**

**Northwick Park Maternity Services Maternity Improvement  
Plan**

<b>Wards Affected:</b>	All
<b>Key or Non-Key Decision:</b>	Not Applicable
<b>Open or Part/Fully Exempt:</b> (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
<b>No. of Appendices:</b>	None
<b>Background Papers:</b>	<a href="#">London North West University Healthcare NHS Trust Northwick Park Hospital CQC Inspection report 25 June 2021.</a>
<b>Contact Officer(s):</b> (Name, Title, Contact Details)	Lisa Knight MBE, Chief Nurse

## 1. Purpose

The purpose of this report is to share the details of the improvement plan for maternity care with reference to information requested on behalf of the Community and Wellbeing Scrutiny Committee.

The report will explain the external reviews that provide the recommendations and inform some of the improvement actions, the governance and delivery of the improvement journey, challenges and next steps.

## 2. Recommendations

That the plan and work in progress be noted.

## 3. Detail

### 3.1. Maternity Improvement Plan

The Maternity Improvement plan (MIP) is the coordinating document for the complex streams of work being undertaken in the maternity unit. It has been drawn together following a series of concerns, reports and intelligence about the maternity service.

These sources are:

### **Independent Review of Perinatal Deaths**

In August 2020 the Trust noticed a rise in perinatal mortality over the previous months. A letter of concern was sent to the leadership of the Integrated Care System (ICS) to inform them of the issue and that the Trust board were commissioning an external review. The ICS were asked to support this and convened a panel to review the cases which reported in January 2021. All 28 recommendations from the review are included in the MIP.

### **Health Education England (HEE)**

HEE undertook a Multi-professional Learner and Educator Review of the service in May 2021 and issued recommendations on the 16th June 2021. This was a follow up review from October 2020 when multiple concerns had been raised by trainees in relation to their experience of behaviours as well as a lack of engagement of educators/ senior medical clinicians. The follow-up HEE review indicated a lack of progress in areas highlighted and did not feel that LNWUH Women's services were a conducive environment for learning.

### **Care Quality Commission (CQC)**

The Maternity Unit was rated as inadequate in 2018 and requires improvement in 2019. The recommendations from these inspections along with more recent concerns from CQC enquires were used to inform the improvement actions.

The CQC undertook an inspection on the 19th April 2021 and rated the Maternity Unit as inadequate for the safe and well led domains, and therefore inadequate as an overall rating. Trust overall ratings were unaffected. Altogether the service had 19 'Must Do' Actions required by the CQC. These actions are being managed as part of the Maternity improvement plan.

The Trust Ockenden self-assessment, recommendations from Health Service Investigation Branch(HSIB) reports and feedback detailed in the 2020 staff survey have also been incorporated into the improvement plan along with staff ideas for improvement collected from a number of engagement events, task and finish groups and suggestions.

The Maternity Improvement Plan is updated weekly and is a live document. The Trust has a Maternity web pages which include the updates from the report and the plan. The link is available here: <https://www.lnwh.nhs.uk/maternity-improvement-plan>

## **3.2. Governance and Delivery of the Improvement Journey**

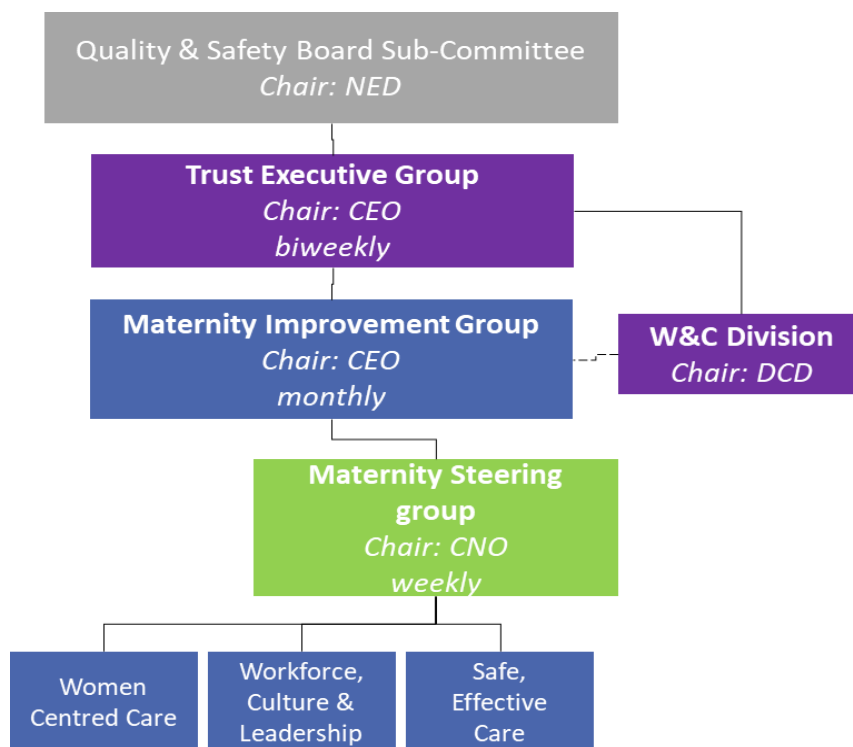
The Trust has undertaken a themed review of all of its external reports and internal intelligence grouping actions into themes to make the maternity improvement plan more user friendly. These themes are:

- Workforce Culture and Leadership,
- Woman- Centred Individualised Care
- Safe and Effective care

The maternity improvement plan is reviewed at the following meetings:

- Weekly internal Maternity steering group (Chair Chief Nurse)
- 2 weekly ICS deep dive assurance meeting (CQC)
- 2 weekly Trust Executive Group (Chair CEO)
- Monthly Maternity Improvement Group (Chair CEO also attended by NED maternity champion)
- Monthly ICS led System Oversight meeting (CQC and NHSEI attend)
- Board Quality and Safety sub-committee and Trust Board

The governance structure for managing the MIP is below:



### 3.3. External Support

The Trust has been working closely with the Local Maternity and Neonatal System (LMNS) to convene a programme of support for the unit. This includes reviewing the opportunity for on-site presence of a multi-disciplinary team to assist in delivering substantive change. Colleagues from leadership teams at Sector maternity units have already visited the Unit to support.

As a consequence of the CQC inadequate rating the unit has triggered the criteria for the National Maternity Safety programme. The Trust exited the programme in January 2020 following the previous inadequate rating. There has been a collaborative meeting between the national programme leaders, the LMNS and the Trust to coordinate an approach that sees the delivery of one support programme so that the Trust can

manage the operational complexity of the visits and also so that the staff only see one team of people that they get to know. It has been agreed that the LMNS will coordinate this approach.

### **3.4. Organisational Development Programme**

The main theme of all of the reports is the team working and culture that is pervading the unit. This is primarily general lack of civility to each other, and claims that staff are scared to speak out. The Trust has also noticed that some members of the consultant body are disengaged.

The Trust has commissioned the Organisational Development Company STEPS to deliver a multi professional programme of training and support to the clinical leaders of the service. This programme has just commenced and due to run over a 6 month period in the first instance.

### **3.5. Working with Women**

There has been a substantive history of collaborative working with our Maternity Voices Partnership (MVP) which continued weekly through the pandemic. During this process the chair has been regularly updated and is a full member of the Maternity Improvement Group. We are very aware that the recent publicity may have made women worried about having their babies at Northwick Park. We see a number of women through the antenatal and postnatal periods of their pregnancy, with a smaller number of deliveries as a result of a proportion of women choosing to deliver their babies at neighbouring units.

### **3.6. Leadership and Managerial Capacity**

The Chief Nurse is the senior responsible officer for Maternity and therefore the Maternity Improvement Programme. The Division responsible for the maternity service (the Women's and Children's Division) has a substantive Clinical Director, long-term interim Divisional General Manager until March 2022, and a new interim Director of Midwifery. The substantive appointment of the Director of Midwifery has been postponed due to applicants withdrawing from the process. It will be re-advertised in September.

Additional divisional support is being provided in governance, human resources, operations, a transformation fellow, an improvement manager as well as a senior maternity improvement manager.

Even with this additional support the leadership environment is very challenging. The need for many levels of internal and external assurance is complex and stressful for the team.

### **3.7. Recruitment and Staffing**

The unit continues to experience high levels of absence in both medical and midwifery staffing, due to vacancies which continues to be exacerbated by high levels of turnover.

Whilst there are recruitment plans in place it should be noted that competition for midwives will increase due to funding streams from national maternity investment, resulting in a general increase in midwifery posts. We have been fortunate to receive this funding but our priority is to fill the already existing vacancies. This workforce gap will further increase stressors on our staff but also make participation in our improvement work more challenging.

### **3.8. Requested detail**

*The overall plan and timeline for the Trust's improvement of maternity services, plus governance and oversight of the plan and delivery. Dates of any CQC (or other inspection regime) review.*

The improvement plan is regularly updated, the latest version is available on this [link](#). The Governance and oversight is described above section 3.2. CQC Inspections are unannounced .

*Does the new leadership team of the maternity service at Northwick Park Hospital have a proper governance structure in place - is the Trust able to provide assurance that they have the skills and abilities to run the service, or to implement meaningful changes to improve the safety of the service?*

Described above section 3.2/3.6

*How are leaders made aware of the challenges to the service? How were they aware of the challenges prior to inspection?*

The Trust was aware of many of the challenges prior to the inspection. It was the Trust's escalation to the ICS on the issues that was one of the reasons a CQC inspection was triggered, as the Trust had sent them the report along with all of the

other reports discussed in the paper. Prior to the CQC inspection the Trust was already in the process of developing the Maternity Improvement Plan (MIP).

The current improvement journey is managed and monitored at all levels within the organisation, with a lot of improvement actions being developed and delivered by staff caring for our women. There is enthusiasm for change and the divisional leadership are supporting this inclusive approach.

*How are leaders made aware of what is on the risk register, including longstanding issues within the service that are yet to be addressed.*

At the time of the inspection the risk register did require a more robust review. This has been completed and updated. The risk register is reviewed at the division's monthly governance meeting and high rated risks reviewed at the Trust's Risk and Compliance Meeting. The Trust has a BAF risk on maternity, which is reviewed at Trust Board.

*How are leaders visible and clearly engaged in addressing issues on time?*

Leaders are visible at morning and evening handovers.

The Trust has been running bi-weekly staff engagement and briefing events co-ordinated by the team. There is constant leadership present on the shop floor rounds especially since the arrival of the new director of midwifery. There are twice weekly executive walk rounds shared amongst the members of the executive heads.

*The trust reported 13 serious incidents between March 2020 and March 2021, which included eight perinatal (baby) deaths over a five-week period, during July and August last year, which is a very high number over such a short period. The trust escalated this to the North West London Integrated Care System (ICS) for an external review and the Trust had an improvement plan in place to address issues identified in the ICS report. What was the outcome of the review, what were the underlying reasons for this and what is the current rate of serious incidents reported?*

All 28 recommendations from the external review are part of the MIP. The summary of the findings and the actions to address the recommendations are available on the Trust's internet for patients, families and the general public to access. This will be updated at regular intervals.

Serious incidents are managed within the service in line with the National process. The Trust have not seen a cluster of incidents for the service.

*How do doctors, nurses and other healthcare professionals work well together as a team to support each other to provide good care*

The service recently introduced twice-daily multidisciplinary ward rounds and is in the process of making them work as effectively as possible, in part to ensure good patient flow between the different units in maternity.

MDT working is also being addressed as part of the external support the service is receiving and Organisational Development programme described above.

Training undertaken regularly to continually update all multi-disciplinary groups is delivered as a multi-disciplinary team approach, as recommended nationally.

*Are there any concerns about staffing levels and the high use of agency staff?*

See section above section 3.7.

*Can the Trust provide assurance that it has effective systems in place to ensure that medical and midwifery staff have the competence, skills and experience to safely care for, and meet the needs of, women and babies using the service?*

Mandatory training and learning updates are provided weekly to staff, and records of attendance are in place and reviewed weekly within the Division. Any non-compliance is targeted on an individual basis.

*Is mandatory training meeting the Trust's target? Is safeguarding training compliance meeting the Trust targets?*

The mandatory training compliance is 1% below the Trust target for this service with a plan to ensure compliance.

The safeguarding compliance meets Trust targets.

*Are domestic violence assessments always documented? Are systems in place to ensure compliance with this?*

Domestic violence assessments (time alone with women) is recorded as part of a continuous risk assessment at each appointment. Audits of handheld records and the

electronic maternity patient record are undertaken to check compliance as well as spot checks.

*Do staff routinely and always complete and update risk assessments for each patient?*

The Trust has always had a risk assessment process, which required updating. A new booking and continuous risk assessment tool was introduced in April 2021 in line with recommendations from the Ockenden report. Compliance with this tool has been audited with ongoing spot checks on a random sample [including community women] audited weekly. The Maternity Education Team will continue to train staff where required.

*Does the maternity service manage patient safety incidents well? How is this assessed and managed to ensure that any incidents are reported in a timely way or lessons learned shared amongst the wider service?*

We can confirm that in the large majority of cases, incidents are reported rapidly following their occurrence. The maternity risk team “walks the floor” each day. They identify any incidents of note each morning and ensure that they are discussed during the morning handover and are reported promptly.

Our maternity team review all reported incidents locally on our Datix system. These incidents are also reviewed by our corporate patient safety team as a second line check and challenge mechanism. Any incidents which meet the criteria are subject to a 72 hour report, which are completed by the maternity multidisciplinary risk team. We share learning locally through both service level and divisional governance forums and in the maternity newsletter. Weekly focused meetings designed for sharing any recommendations from incident reporting also provides any necessary additional training in use in the reporting system and has been well received. In this context, we also encourage people to report incidents when they occur.

*Are there any concerns regarding delays in the induction of labour for women? How long are women waiting to be induced?*

On 23 April 2021, we audited 21 cases of women who presented between March 2020 and February 2021. The audit confirmed that induction of labour occurs within 48 hours in almost half of the cases but identified delays in the remaining cases. This is largely attributable to the capacity in both our antenatal and labour ward areas at peak times, and is clearly an issue that we take extremely seriously. Following the audit, the

scheduling of women requiring Induction of Labour was changed, and a review of this change demonstrated improvement.

The induction of labour pathway is one of the areas that the ICS support team are helping with.

### **3.9. Conclusion and Next Steps**

It is important to note that many improvements and changes have occurred in the unit over the last few months, particularly addressing the urgent elements of the MIP and CQC requirements, creating a leadership structure and focussing on staff engagement, however there remains an extensive amount of work to undertake.

This includes:

- Recruit to a substantive Director of Midwifery
- Deliver the organisational development plan and cultural improvements
- Coordinate the LMS support team and the National Maternity Safety team
- Continue to work with learners to improve the educational experience
- Recruit to key posts and reduce the leaver's rate particularly in midwifery.
- Continue to deliver the Maternity Improvement Plan

### **4.0 Financial Implications**

NA

### **5.0 Legal Implications**

NA

### **6.0 Equality Implications**

NA

**Report sign off:**

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Hospitals NHS Trust