Independent Thematic Review of Maternity Services at NHS Nottingham University Hospitals (NUH)

Thematic review of incidents relating to maternity care at NUH: Interim report summary

Independent Review Team (IRT)

April 2022

Introduction

Addendum to the interim report: *As of 26 May 2022, further to an announcement from Sir David Sloman, the Independent Thematic Review of Maternity Services at Nottingham University Hospitals has concluded and therefore there will be no further reports.*

- This report describes the progress made so far in the independent thematic review of maternity services provided by Nottingham University Hospitals NHS Trust ("the Trust") between 1 April 2006 and October 2021
- The Terms of Reference for the review were agreed by NHS England and NHS Improvement (NHSE/I) Midlands and NHS Nottingham & Nottinghamshire Clinical Commissioning Group (CCG), following involvement of a number of families, and given to the review team at the start of the review
- The team has looked at the findings and recommendations from the reviews of maternity services at Morecambe Bay and Shrewsbury & Telford, and is in contact with other ongoing reviews in East Kent and Cwm Taf
- The review focusses on families who have highlighted concerns with their experiences of maternity services at the Trust. It aims to understand why, despite previous reviews and complaints, some families' concerns remain unresolved, recommendations have not been implemented and services remain inadequate
- The review team thanks all families for their openness and honesty in sharing their experiences

Background

- The review was set up by NHSE/I Midlands and the CCG in November 2021 following maternity incidents, complaints and concerns at the Trust
- The Care Quality Commission (CQC) report in October 2020 rated maternity services as inadequate and found a number of concerns around the safety of women and babies
- The independent review team is made up of a team of experts who have no connection with the Trust
- It is led by Cathy Purt, an experienced NHS senior manager, who works closely with three senior clinical leads:
    - Dr Teresa Kelly, Consultant Obstetrician at Manchester University NHS Foundation Trust
    - Debbie Graham, Independent Maternity Services Advisor and Registered Midwife
    - Dr Alison Bedford Russell, Neonatal co-Clinical Director at the Liverpool Neonatal Partnership

Other members of the team have vast experience in senior NHS management, nursing, data analysis and family liaison.

What is a thematic review and how different is it to a public inquiry?

- The aim of a thematic review is to identify the key themes that are affecting maternity services at NUH and look into these in detail
- The review team will then make recommendations on how the Trust can make immediate and lasting changes to improve the care they provide. This will be achieved through a detailed review and comparison of the following:
    - Listening to the individual experiences of women and families
    - Listening to the individual experiences of staff working in maternity and neonatal services
    - Interviews with those in leadership roles
    - Analysing data from the Trust
    - Reviewing all relevant documentation
- A thematic review is different to a public inquiry as it does not have a legal basis, and therefore cannot hold individuals to account
- While public inquiries often take several years to progress, a thematic review can make recommendations for improvements more quickly which then allows improvements to be made more quickly
- If the review team finds that there has been a possible breach in the duty of care by a member of staff, they would be referred to the relevant professional body.

Access to information and documents

- As with any review, the review team has to be able to have secure access to data and documents from the Trust
- The legal consent needs to be in place to be able to access patient case notes, where appropriate
- This process has taken much longer than expected and has therefore limited the progress of the review

Recommendations

- In all future independent reviews of maternity or other clinical services, whether a thematic review or a public inquiry, sufficient time should be allowed to set up all relevant systems and processes
- This includes IT systems, Data Sharing Agreements, rules around consent, financial budget, approval processes and the recruitment of a team

What the data tells us

- The review team is looking at maternity information from the Trust and how it compares to 5 Trusts with a similar profile relating to: deprivation, ethnicity, age, complexity, and size
- So far they have analysed data from the period shortly before, during, and immediately after giving birth (known as ‘Peripartum Period’) and has found the following:
    - The number of babies being delivered and the number of caesarean deliveries each year at NUH from 2017/18 to 2020/21 is similar to the other Trusts
    - From 2017 to 2021, 15-18% of mothers did not have their ethnicity recorded. This is lower than the other 5 Trusts (the best performing Trusts recorded 3-4%)
    - During this period, 12% of women stayed at NUH for more than 5 days after giving birth. This is higher than the other 5 Trusts (they had an average of 2.4%)
- The team will continue to analyse this further

Recommendations

- Further investigation is carried out to understand why the Trust reports that a significantly higher number of women stay at NUH for more than 21 days compared to the other 5 Trusts
- The Trust improves its recording of ethnicity
- An improvement plan is put in place to reduce the number of ‘not known’ records to equal or be better than 3-4% (in line with the best performing Trusts)
- The Trust ensures that the mother’s postcode is recorded accurately.

Review of clinical guidance and reports

- A clinical review of 88 clinical guidelines for maternity and obstetrics found that they vary in quality
- Some guidelines are too long (for example running to more than 70 pages) making them difficult for staff to access
- Many do not follow the format suggested by the Trust's 'Development of Guidelines'
- Several have previous versions that have been mislabelled. Some are not clear when the implementation date was or if they are overdue review. The review team is continuing with its clinical review of neonatal guidelines
- There are some excellent guidelines, including some where the Trust has led regionally (e.g. the 'abnormally invasive placenta' guideline)
- Some guidelines which would be expected are not listed, e.g. guidance on how to manage diabetes in pregnancy
- Not all qualified staff working in maternity services are up to date with training around fetal monitoring

Recommendations

- Having clinical guidelines across all areas of maternity should be a priority as part of the maternity quality improvement plan
- Trust should make sure that all HSIB recommendations are quickly addressed
- Trust to provide evidence to its commissioners that they follow the national Saving Babies Lives 2 guidance
- There is a review of the Maternity Guideline Group to make sure its approval process for maternity clinical guidelines is correct
- All staff working in maternity services, including agency staff, are trained in intrapartum fetal monitoring and have passed an annual assessment
- Trust to consider setting up a dedicated 24/7 triage phone service across both sites.

Engagement with families

- 66 families initially contacted the review team. Their experiences of maternity care at the Trust required further review in order to identify key issues and factors for detailed analysis
- The review team arranged for the CCG to provide specialist psychological support for families who have contacted the review. This has been available from March 2022
- Once this support was in place, the team reached out through social media for women and families to come forward to share their experience of maternity services at the Trust
- The social media led to more than 400 additional families coming forward. To manage the additional numbers, additional listeners were recruited to be able to speed up the listening sessions
- As of 25 April 2022, 501 families had contacted the review, with 56 listening sessions completed and a further 113 either booked in for a listening session or sending in a written account of their experience
- In addition, the team has reached out to women and families from underrepresented groups to take part in listening sessions, including women who hold refugee or asylum status and Urdu speaking women. 19 of these sessions have taken place so far with more scheduled to take place shortly.

Engagement with staff

- Listening sessions have been held with staff who work across maternity services to find out more about the culture and behaviour at NUH and identify any issues or themes
- This includes staff who have recently started and those who have worked at the Trust since it was formed
- As of 25 April 2022, 71 members of staff had contacted the review with 54 listening sessions or written accounts completed and a further 17 to be booked in or rearranged
- The review team has also:
    - Met with Consultant Obstetricians, Junior Doctors and Senior Midwives
    - Held discussions with Chair, Chief Executive and senior leads at the Trust
    - Visited City and QMC hospitals to talk with staff and give out flyers

Emerging issues and themes

- Through listening to families and staff, the review team has started to look at what has happened and understand what it's like to work in maternity services at the Trust
- The team will continue to analyse this feedback and compare it with documents and data from the Trust until we are confident that all issues have been identified
- Relevant documents and data will be reviewed to find out *why* the issues and factors identified happened and what actions still need to be taken
- A number of areas of concern have been identified that need to be addressed immediately by the Trust
- A small number of staff across all staff groups appear to show a lack of respect for colleagues and service users
- There is some evidence of bullying behaviour
- The vast majority of staff are committed to a caring and compassionate culture where excellent care can be delivered.

Recommendations

- The unacceptable behaviours and attitudes of some staff must be addressed by the Trust
- Senior management at the Trust should urgently address this
- The Trust should make clear what behaviours are expected of all staff and make sure that there are measures in place to hold staff to account

Next steps

Further to the announcement on 26 May 2022 by Sir David Sloman, Chief Operating Officer at NHS England and NHS Improvement, the independent thematic review team has now concluded. Therefore, there will be no further reports compiled.

All new enquiries should be sent to england.nuhtindrev@nhs.net