Agenda Item No: 11

Maternity Services at Cambridge University Hospital Foundation Trust (CUHFT)

To:	Adults and Health Committee
Meeting Date:	10th October 2024
From:	Roland Sinker Chief Executive, CUHFT
Electoral division(s):	Trumpington

1. Background

The Rosie is part of Cambridge University Hospitals, within the Cambridgeshire and Peterborough (C&P) Integrated Care System (ICS), supporting circa 5,500 births per annum. The Rosie serves the local community as well as being a regional tertiary centre for complex pregnancies, with a tertiary neonatal unit.

The Care Quality Commission (CQC) inspected two domains Safe and Well Led in May 2023. Safe care was rated as 'Requires Improvement', with Well Led domain receiving 'Good'. The CQC issued one must do and 13 should do actions.

The report below is structured in response to the areas of focus highlighted, and specific questions raised, by the Adults and Health Committee – and is not intended to be a comprehensive report on maternity services.

2. Main Issues

2.1 Safety

2.1.1 *Current completion rates for safeguarding children and adults training amongst Maternity Services staff*

Training compliance – Maternity services staff Position on 11th September 2024	
Safeguarding adults Level 1	96.9%
Safeguarding adults Level 2	96%
Safeguarding adults Level 3	73.3% (up from 17% and 34% for medics and midwives)
Safeguarding children Level 1	98.6%
Safeguarding children Level 2	97%
Safeguarding children Level 3	90%

Source: DOT Training database, includes all staff Obstetrics, gynaecology, and midwifery staff. Trust target is 90% for all training

Safeguarding training for Maternity staff is compliant with Trust targets in all areas with the exception of safeguarding adults' level 3.This was new training implemented in 2023 and is actively being improved. The Trust has a safeguarding team for Maternity services as well as a corporate team for support and advice. All safeguarding referrals in Maternity have been managed in line with policy.

2.1.2 *What monitoring arrangements are in place to ensure compliance with the Trust's policies on safeguarding children and adults training going forward?*

Training compliance is monitored at divisional level with oversight at monthly Executive Divisional Meetings. Safeguarding training compliance is overseen by the Trust's Joint Safeguarding Committee reporting directly to the Management Executive and Board sub committees. For all staff, mandatory training is monitored as part of their annual appraisal cycle.

2.1.3 Whether medical staffing in triage has been reviewed and improved to deliver care in safe time frames.

A full medical workforce review was undertaken following the CQC inspection. An investment was made for six additional junior Doctors and six Consultants. With the new juniors in post, medical capacity has been increased to support cover for triage during daytime hours Monday to Friday, now rostered for triage 8-5:30pm. An additional Doctor is now rostered on night shift to cover all areas including triage. A second review of medical workforce is now underway, forecasting future needs.

2.1.4 NHS England support- has Maternity been enrolled on the nation Maternity improvement programme?

A Maternity Oversight Board has been established with NHSE Regional Chief Midwife and ICS Chief Nurse in attendance. A programme of enhanced visits from both the region and ICS is in place to allow scrutiny in practice with supportive feedback to team on further improvements .CUHFT has not been required to enrol on the NHS England Maternity Safety Support Programme.

2.2 Workforce

2.2.1 *Current figures for staffing of CUHFT's Maternity Services, including vacancy levels and use of agency staff, and to ascertain whether there are enough suitably qualified competent staff to meet the needs of the service.*

Current Midwifery vacancy as of July 2024 is 7.3% against Trust target of 5% (pipeline data of new starters planned from October will result in full establishment). Bank staff are used to cover any shortfalls, no agency Midwives are used.

The Obstetric Consultant vacancy in July 2024 was 17%, (three whole time equivalent against establishment of 18 Obstetric Consultants) with further appointments due to be made. There is one substantive vacancy in the senior Doctor rota, and two vacancies in the junior Doctor rota with appointment offers made. The Foundation year one/two Doctor rota is now at full complement.

Locum Doctor shifts are all filled internally by existing staff. There are two long-term agency locums which have been in the Trust for over a year. There are no short-term locums in the department.

2.2.2 Whether wait times for medical reviews have been reduced. The CQC found that lack of adequate staffing levels sometimes meant that service users had to wait for medical reviews

Timely assessment of women attending Triage is essential to ensure safe care.

A significant and sustained improvement was seen in the percentage of women receiving initial triage (midwife review in 15 minutes) within a month of the CQC Inspection in May 2023 (see Appendix 1). This figure increased from 55% in April 2023 to consistently above 70%. The latest data in July 2024 reports a rise to 90%.

Medical cover for triage was increased in the Doctor rota from August 2024 and the impact is currently being measured. Service users triaged by Midwives as most urgent (red category) are seen immediately and treated by an appropriate Doctor.

2.2.3 What steps have been taken to address the CQC's finding that Maternity staff felt respected, but did not always feel supported and valued?

The service leadership (Perinatal Quadrumvirate) are participating in the Perinatal Culture and Leadership Programme. This involves diagnostic analysis around the culture within the Rosie which will result in an organisational development plan to address themes and issues. The Trust has commissioned external expertise to support this. Monthly all staff listening events are held, in addition to regular senior leadership and Board Safety Champion walkarounds speaking to staff to understand their lived experiences of working in the teams.

There is enhanced support for junior Doctors, including monthly Chief Resident Meetings with visits from the Speak up Guardians and Psychology staff. Feedback is discussed at the weekly Consultant Meetings for shared learning and action. Joint culture and leadership multi professional sessions were delivered by the Midwifery and Medical regulatory bodies.

2.3 Service Users' Feedback

2.3.1 Steps taken to actively encourage service users and families to feedback on their experiences.

The Maternity and Neonatal Voices Partnership (MNVP) runs rolling surveys to gather feedback from service users about their experiences of maternity, neonatal and bereavement care. These run alongside targeted surveys on topics such as diabetes and mental health. The Trust shares data from the Friends and Family Test and CQC surveys with the MNVP to support triangulation of service user feedback and identifies opportunities for improvement.

The MNVP holds regular outreach events as well as community-specific engagement events. Alongside this the MNVP visits parent and baby provision such as the Young Parents' Group at Romsey Mill, Children's Centre parent and baby groups and community events. The MNVP runs a 121-listening service for parents wanting to feedback about their care. It also runs quarterly 15 Steps ward walks where service users are encouraged to give a 'fresh eyes' view of the environment.

2.3.2 Processes in place for service user feedback to inform and influence improvement

The embedding of service user feedback within the trust plans was noted as an area of outstanding practice in the CQC report. Feedback from surveys and outreach events is compiled into reports for the Trust, along with action plans (15 Steps reports) and key points for consideration. This feedback is combined with other service data and quality metrics and integrated into the Maternity Improvement Plan and workstream action plans.

Senior staff and the Non-Executive Director (NED) attend quarterly MNVP meetings to discuss how the feedback can be further addressed and acted upon.

Trust guidelines and patient information leaflets are shared with the MNVP for feedback. The lead representative provides input on behalf of the group, while more detailed feedback on guidelines and patient information leaflets is gathered from a panel of service user representatives. Ongoing co-production projects include a redesign of the bereavement suite, delivery unit lighting, communications guide, induction of labour information and consent and choice policy and information.

2.3.3 Current service user satisfaction rates in 2023 (post CQC inspection) compared to 2024

NHS Friends and Family test (see Appendix 2) show consistent scores above 80% since CQC visit, with no significant change. The complaints received for Maternity services reduced between 2022/23 and 2023/24 (see table below).

Complaints data

	2022/23	2023/24
Division E (Women & Children)	187	166
Maternity	91 (plus 1 maternal medicine)	68 (plus 1 maternal medicine)

2.4 Partnership working:

2.4.1 Whether learning is being taken from other system partners. We understand NWAFT Maternity services were also inspected in April 2023 as part of the CQC's national Maternity services inspection programme and received an upgraded rating of Good.

The Directors of Midwifery (DoMs) from CUH and NWAFT are members of the Local Maternity and Neonatal System Board, where learning is shared. Additionally, both DoMs also sit as members of both Trusts Improvement Boards. CUHFT DoM also chairs the Shelford Group Maternity Community of Practice meeting where members of the 10 largest teaching hospitals come together to share best practice.

2.4.2 Is CUHFT's learning being actively shared with system partners?

There are regular system and regional meetings attended by members of the Midwifery Leadership Team, where learning is shared amongst peers from other units. There are monthly Head of Midwifery/Director of Midwifery meetings with input from the NHS England regional team. The Director of Midwifery joined an enhanced visit at the North West Anglia Foundation Trust (NWAFT) to observe practice and share learning. CUHFT have shared learnings on best postpartum haemorrhage practice with the regional Clinical Reference Group in March 2024.

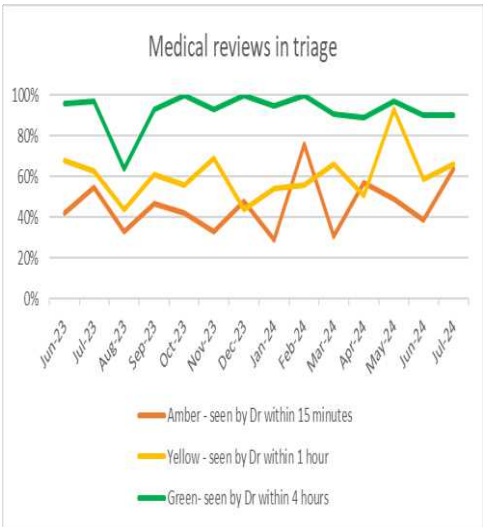
2.4.3 Provide anonymised case studies illustrating changes to practice in response to the CQC's findings.

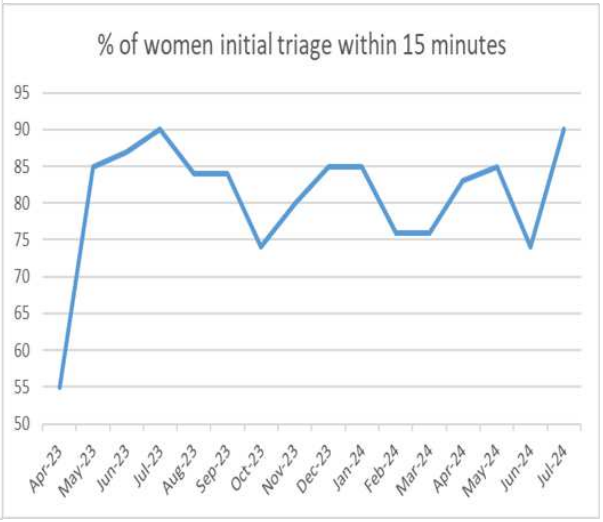
Examples of changes in process include design of a framework (ROBUST) to guide clinicians on managing postpartum haemorrhage and the implementation of escalation and communication around induction of labour, meaning service users consistently know what to expect and when.

3. Accessibility

3.1 The information contain in this report is available in ana accessible format on request. Please contact democraticservices365@cambridgeshire.gov.uk

Appendix 1





Appendix 2

FFT result for Maternity (4 touch points combined)	Good Score	Poor Score
January 2023	97.3%	1.4%
February 2023	93.3%	3.00%
March 2023	95.5%	2.2%
June 2023	97.0%	0.0%
July 2023	99.20%	0.80%
August 2023	93.00%	3.00%
September 2023	90%	5.50%
October 2023	89.50%	3.20%
November 2023	85.40%	6.70%
January 2024	82.80%	10.20%
February 2024	92.60%	3%
March 2024	87.50%	8%
April 2024	90.70%	5%
May 2024	87.50%	9%
June 2024	90.0%	6.7%
July 2024	86%	7.50%