University Hospitals Sussex
NHS Foundation Trust

Health Overview Scrutiny Committee
Maternity update

November 2024

Background

- In September 2021, our maternity services were inspected by the CQC:
  - St Richard's, Princess Royal and Worthing – **Requires Improvement**
  - Royal Sussex County – **Inadequate**

- Maternity Safety Support Programme (MSSP) support commenced in February 2022
- Informal CQC visit April 2022 showed improvements being made
- No further formal inspection of maternity since September 2021

- All CQC actions completed:
  - Training compliance
  - Governance improvements and equipment checking
  - Datix improvements
  - Workforce funding improvements
  - Estate work to improve triage facilities at PRH – funded and planned for September

Maternity Safety Support Programme (MSSP)

- Entered programme February 2022.
- Maternity Improvement Plan monitored under bi-monthly executive led Maternity. Improvement Group attended by Trust, system and regulatory stakeholders.
- Review and Reset meeting by MSSP and regional and national stakeholders on 30th May - **"demonstrable improvements from ward to board noted by all stakeholders".**
- Trajectory to move to Sustainability phase by November 2024 with a view to programme exit early next year.

Exit Criteria and CNST

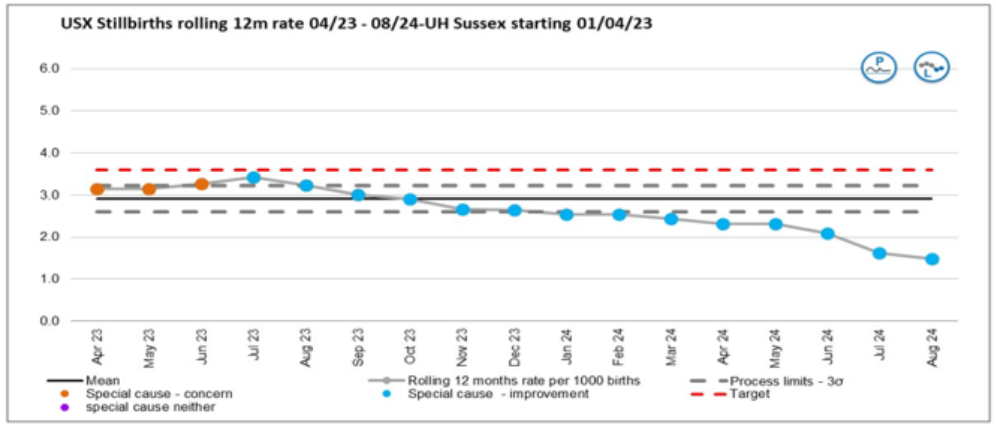
Criteria	Actions required	Estimated completion
Permanent midwifery leadership structure	Clinical Operating Model (COM) finalisation then recruitment	Q4 2024/25
Developed Perinatal leadership structure	Clinical Operating Model (COM) finalisation then recruitment	Q3-4 2024/25
Consultant job planning re leadership and governance	Clinical Operating Model (COM) finalisation then recruitment	Q3 2024/25
Maternity Governance Framework	Finalisation and ratification	Q3 2024/25
Access to separate theatre for elective caesareans on Brighton site with a view to relocation on other sites.	Successful pilot completed – negotiations with surgery underway	Q4 2024/25
Developed maternity strategy	Discussion with Chief Strategy Officer	Q4 2024/25
Cross site maternity audit plan and guideline group	Central guideline group in place, audit plan in development	Q3 2024/25

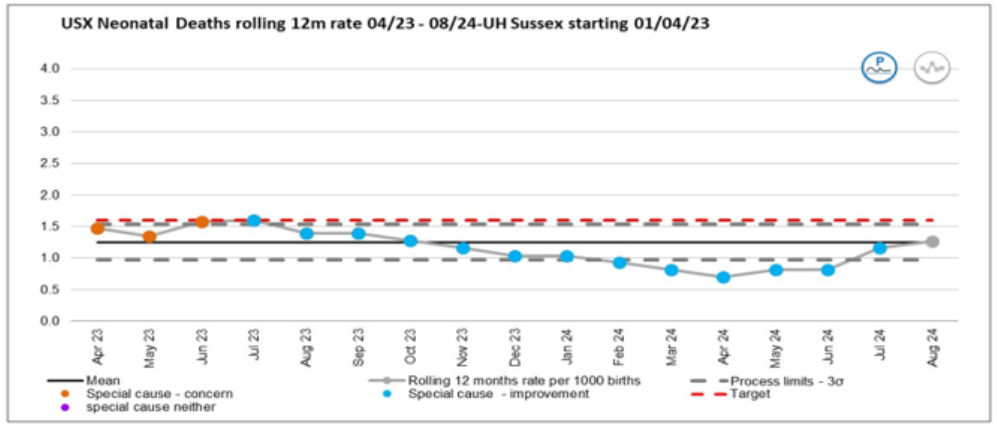
NHS Resolution

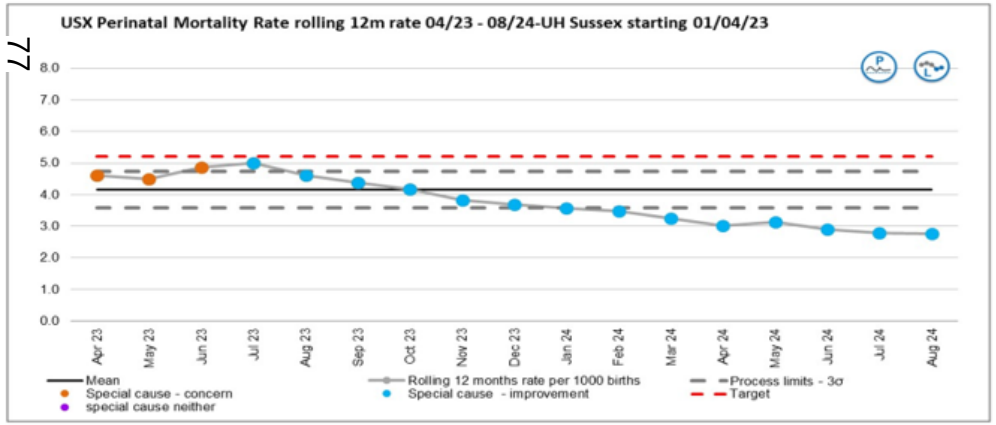
University Hospitals Sussex maternity service met the full requirements of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme year 5 (2023/24) and is on track to be fully compliant with the year 6 requirements (submission due Feb 2025).

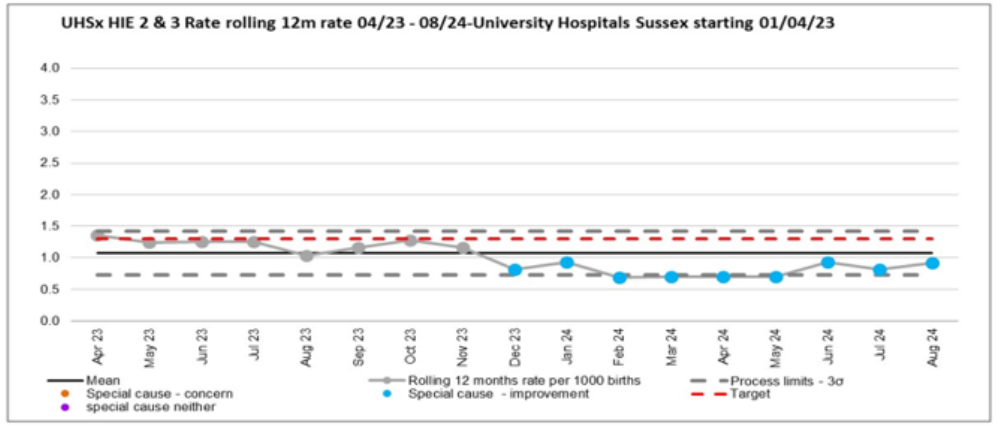
What our data is showing us - outcomes

University Hospitals Sussex NHS Foundation Trust









Any loss during pregnancy is a tragedy for the family.
Sadly, pregnancy loss will never be completely preventable, however, we are determined to continue to reduce cases involving avoidable harm.
The Trust is proposing a programme of Restorative Justice work with bereaved families.

- These charts demonstrate a statistically significant reduction in both perinatal mortality rates (stillbirths and neonatal deaths combined) and Hypoxic Ischemic Encephalopathy (brain injury) rates.
- Both measures are well below national benchmark rates for equivalent service configurations.
- Quality improvements within the Saving Babies Lives care bundle v3 have contributed to this. The service achieved 100% implementation of the bundle requirements in June 2024.
- Maternal death rates are also below national rates (national - 0.28/ 1000 – UHSx 0.12/1000).

Outcomes - Brighton

These charts demonstrate statistically significant special cause improvement in all measures. Orange markers demonstrate special cause concern in stillbirth rates earlier this year, triggering a review of cases where no themes were identified.

What our data is showing us - incidents

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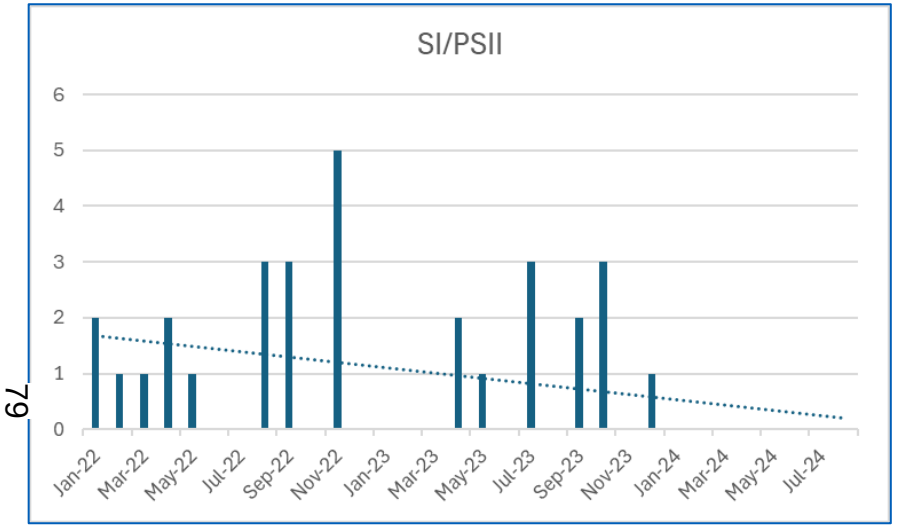
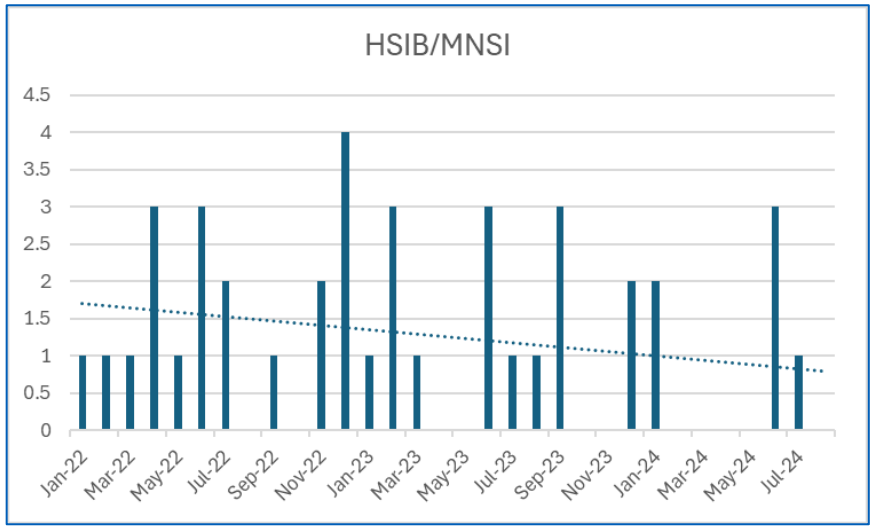
Trust Wide





- Numbers of serious incidents (SI) now known as Patient Safety Incident Investigations (PSII) have reduced.
- The governance process for the assessment of grading of incidents and therefore, the type of investigation required is more robust supported by the central Patient Safety team.
- Referrals to the Maternity and Neonatal Safety Investigations (MNSI) team (previously HSIB), have also reduced.
- MNSI referrals have very specific triggers.
- Robust process of learning from incidents and complaints in place.
- Collaborative system sharing and learning processes in place.

Brighton only

There have been no PSII's in Brighton this calendar year to date.
There has been one case which has met criteria for referral to the MNSI team.

The Trust is exploring the provision of a restorative programme led by expert facilitators with lived experience of baby loss. This will be offered to families locally.

What our service users say

Service user feedback themes are triangulated quarterly, and quality improvements actioned

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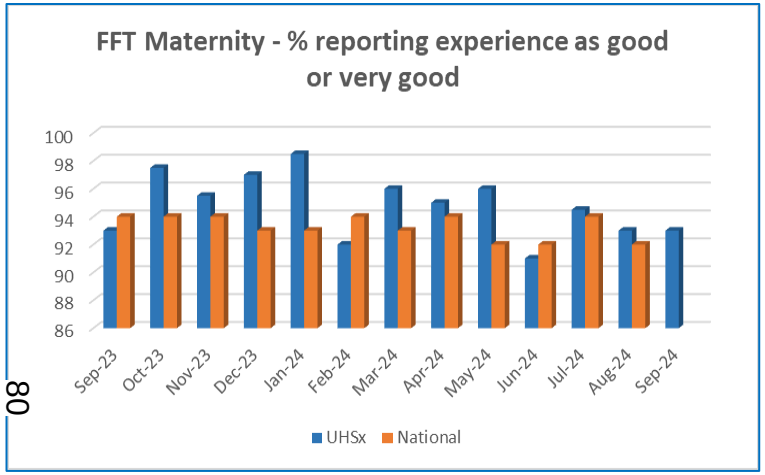
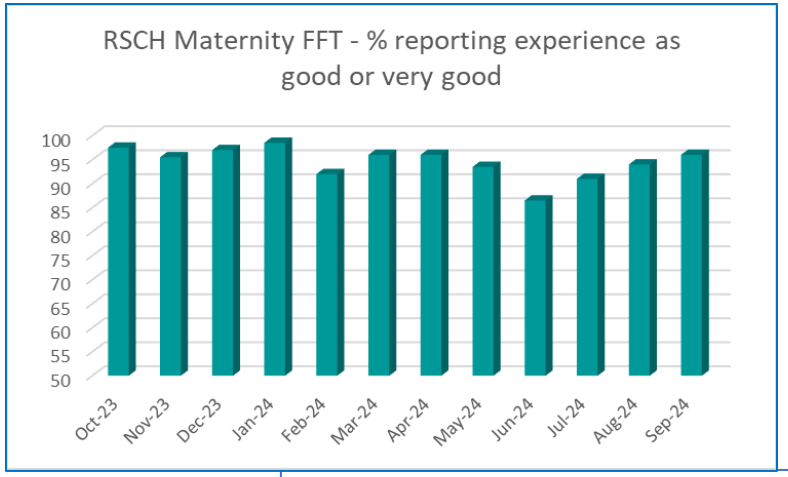
Friends and Family Test

Trust wide vs national



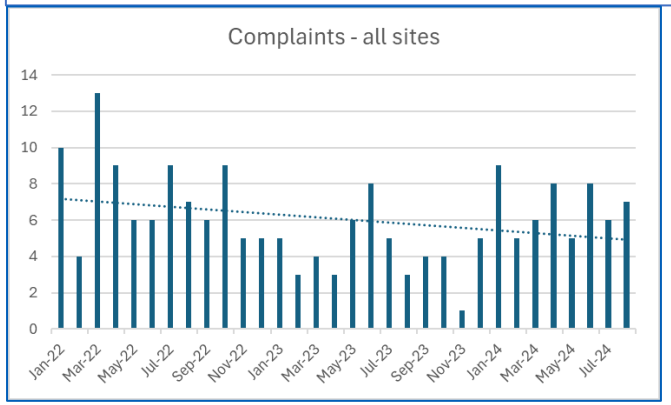
Brighton only

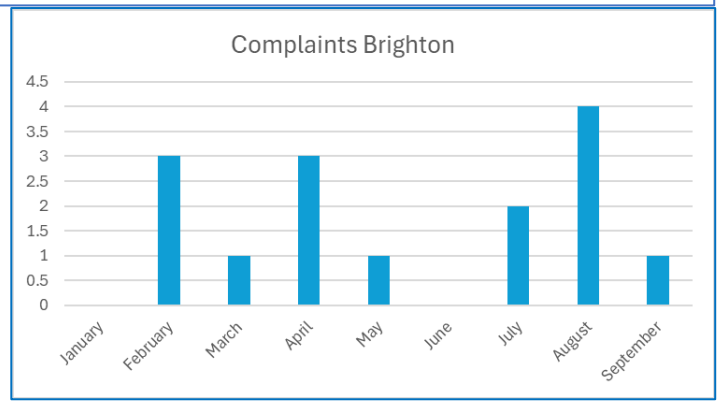


FFT summary – the Trust maternity service 'good' or 'very good' ratings exceed national rates the majority of the time. Workforce issues over the summer have been mentioned in narrative feedback via FFT.

We have an excellent working relationship with the Maternity and Neonatal Voices Partnership service user group.
Significant amounts of 'above and beyond' feedback for named staff members is received from service users via their survey and other contacts.
We have a robust process or communication with service leads to address any concerns raised directly to the MNVP.

Our formal complaint numbers have reduced since 2022, although we are reviewing and monitoring a recent increase, possibly impacted by workforce issues and media attention. We have a process of immediate contact by a senior midwife when a complaint is received to ensure support of the family and discussion of concerns.





Supporting our teams

- Monthly maternity safety forum chaired by Board Maternity safety Champion
- Monthly listening events by director of midwifery
- Monthly site-specific listening events with heads of midwifery
- Bespoke listening events as needed
- Monthly update video messages
- Divisional and maternity newsletters and improved communications
- Dedicated Microsoft Teams communication channel
- Staff social media communication groups
- Perinatal Culture Event held in June (85 attendees from MDT) – feedback positive, further improvement actions planned
- ImproveWell app implemented in June – 15% uptake so far (aim 35% at 6 months) with 41 improvement ideas submitted

Vacancy in some of our teams continues to be one of our greatest issues and has been a priority to find a permanent and sustainable solution. Various issues impact our vacancy, such as national shortages and cost of living locally, however, the vacancy has reduced from 22% in March 2022 to <5% by January 2025.