NHS
Nottingham
University Hospitals
NHS Trust

Please ask for the Medical Director's Personal Assistant

Our Ref: [redacted]

4th December 2020

Medical Director's Office
3rd Floor, Trust Headquarters
City Hospital Campus
Hucknall Road
Nottingham
NG5 1PB

Tel: [redacted]
Email: [redacted]
www.nuh.nhs.uk

STRICTLY CONFIDENTIAL

Miss Laurinda Bower
HM Assistant Coroner for Nottingham City and Nottinghamshire
HM Coroner's Court
The Council House
Market Square
Nottingham NG1 2DT

Dear Miss Bower

Inquest: Wynter Andrews and Prevention of Future Death Notification

Please find attached a commentary that I have prepared in response to the Preventing Future Deaths Report issued to Nottingham University Hospitals following the inquest into the death of Wynter Andrews.

I was not present at the inquest but note that there are two broad matters of concern identified in the PFD notification.

My response to each of the concerns identified in the PFD have been informed following work undertaken by colleagues involved in the Midwifery Service and Family Health Division and other individuals and teams in the organisation including the Chief Nurse, the newly appointed Senior Responsible Officer for our Maternity Transformation programme, the Associate Director of Quality Governance and the Head of Patient Safety.

The actions either taken or planned in response to the learning from the inquest are summarised below. The oversight of the delivery of these actions will be through a newly formed Maternity Programme Oversight Committee chaired by the Chief Executive Officer and the Quality and Safety work stream of this, which I Chair. The Quality Assurance Committee of the Board will be receiving reports on progress and the full Board will be kept informed.

I hope that this commentary provides assurance that we are committed to learning from this, and other incidents to significantly enhance the care of mothers and their babies at Nottingham University Hospitals NHS Trust.

Yours sincerely

Dr [redacted]
Medical Director
GMC Number [redacted]

cc: [redacted], Chief Nurse, [redacted], Inspector and CQC Freedom to Speak up Ambassador, [redacted], Head of Quality, NHS Nottingham and Nottinghamshire Clinical Commissioning Group.

Response to concerns identified through the PFD

(1) Lack of robust initial critical analysis of deaths

NUH Response

Coroner Referral and Scrutiny of Deaths

The Trust has a well-established Medical Examiner service, comprising eight Medical Examiners, who provide independent scrutiny of all adult deaths.

At the time of WA's death, all deaths of children were reported to the Senior Coroner for Nottinghamshire. Scrutiny of child and neonatal deaths by the Medical Examiners did not commence until after the 1st October 2019, in accordance with guidance issued by the Chief Coroner. Since that date, all neonatal and child deaths at Nottingham University Hospitals have been reported to the Medical Examiner service including all babies born showing signs of life at any gestation. The well-established Child Death Review Process (CDRP) continues to run in parallel but the Medical Examiner scrutiny takes precedence (within the first 24 – 48 hours) in order that this independent review is completed as quickly as possible. This includes ensuring that, where there is a clear reason for notifying the Senior Coroner, this is achieved at the earliest opportunity. The work of the ME Service now provides independent scrutiny of all neonatal and child deaths in a way that was not in place at the time of the death of baby WA.

Having considered the matters of concern in the Preventing Future Deaths report it is now determined that the processes in support of early review/scrutiny by the Medical Examiners can be further strengthened through a number of planned improvements, outlined below. Unless otherwise stated all actions will be complete by 1st February 2021:

- Broadening understanding of the Medical Examiner process through more widely engaging maternity and paediatric staff through training and awareness seminars. There will be sharing of expectations of information needed by the Medical Examiner for early and robust collection of relevant details from Neonatologists, Paediatricians, Midwives, Obstetricians and parents/carers/family.
- Community midwives are moving from System 1 (a GP community system) to Maternity Medway (the NUH digital record software) which will increase digitalisation of the antenatal pathway and increased visibility of the care record. This is a substantial change and will be complete by 4th January 2021.
- The initial Child Death Review (CDR) / Medical Examiner (ME) referral form will be changed to include space for all professionals involved in a child's antenatal and postnatal care to be clearly identified. This will support the Medical Examiner team to contact relevant clinical teams and gain information in person and from records.
- The Medical Examiner Service will make contact with all bereaved families in order to independently ascertain the details of any concerns. The child bereavement booklets given to parents will be modified to include Child Bereavement *and* Medical Examiner team contacts. Wherever possible, the Medical Examiner will talk to families the next working day after a child's death.
- An early multidisciplinary review meeting will, wherever possible, take place within five working days of the child's death to gather the team involved in the antenatal and post-natal care of the mother and child. This meeting will invite the CDR/ME professionals, allowing further collection of detailed information and review of any concerns of care, including representation of the parents' views of care.

- The Multidisciplinary Team (MDT) Case Review Meeting in maternity (held every Monday) will be reviewed and strengthened by promoting inclusivity, the voice of the clinical midwives and the views of the parents. The review will form part of the Trusts recently convened (November 2020) Maternity Transformation Governance Group.

Revisions to the Trust incident escalation report (formerly referred to as the 72 hour report)

At the current time, when an incident has occurred that might meet the threshold for an investigation within the Serious Incident Framework, an initial "72-hour report" is completed and presented at a weekly Trust multi-disciplinary Incident Review Meeting. The initial "72-hour report" has been modified to now contain prompts to ensure that wider review of potential information is considered in the context of an individual case (for example complaints/concerns, claims, known risks on risk register, Structured Judgement Case Review learning, consideration of previous similar events and contextual incidents/events).

It is expected that this change will result in a broader review of the context in which an incident occurs, in addition to the specific adverse event itself. Care quality ratings [from excellent to very poor] across the patient's pathway have been included to strengthen the review. The escalation report has been updated to provide guidance on the definitions of a Serious Incident [with links to the national Serious Incident framework].

To further support the identification of cases (maternity or otherwise) which may meet the criteria for a Serious Incident Investigation, a digital application has been built that pulls data from multiple sources to help identify possible high risk cases. This would include, for example, where there may be a concurrent incident, complaint and claim. The application consolidates internal data in relation to patient deaths, formal complaints, family concerns, patient safety incidents, coroner's inquests, clinical negligence claims and maternity early notifications.

In addition, in support of the Multidisciplinary Team (MDT) Case Review Meeting in maternity, the Perinatal Mortality Review Tool (PRMT) will be used to inform the case review discussions. The PMRT is a national standardised tool designed to support high quality, systematic, mulitprofessional reviews of stillbirths and neonatal deaths that take into account the views of the parents. The output of the reviews is the production of a report for parents that includes a plain English explanation of why their baby died and whether the care was appropriate. Full completion of the PMRT requires input from the parents, placental histology and post-mortem reports which can take several months to be returned. The use of a live version including all available information to date, to inform the case review meeting, is being piloted.

Classification of Serious Incidents [Maternity]

The national Serious Incident Framework (2015) does not provide an explicit list of triggers/categories that would indicate a case should be declared and investigated as a Serious Incident (SI). In response to the national focus on reducing stillbirths and following the delay to declaring the WA case a Serious Incident, the Trust has decided to declare unexpected early [term] neonatal deaths [HSIB define this as days 0-6] and intrapartum term stillbirths as Serious Incidents. This process will exclude babies on an identified care pathway with life-limiting conditions including congenital abnormalities, except where there has been a deviation from the pathway that requires further investigation.

This decision takes the Nottingham University Hospitals' approach beyond that required by the national Serious Incident framework but provides assurance that a full investigation of all such cases is being undertaken. We will keep this decision under review in light of any future changes to the Serious Incident Framework.

(2) The unsafe culture prevailing within Midwifery Services

(a) Failure to listen to and respond to staff safety concerns

NUH Response

Safe culture work:

- In December 2019, a Birthrate Plus (BR+) staffing review on maternity services was undertaken. The NUH report by the national body undertaking this work was published in June 2020. This highlighted that, when considering the acuity of care required in the maternity services, there was a shortfall in the midwifery staffing establishment of 73 Whole Time Equivalent (WTE). We have been recruiting to resolve this issue and fifteen newly qualified midwives commenced in September, 23.84 WTE new starters were recruited in late October (26 individuals) and will start in January 2021. A further recruitment campaign is underway. Agency staff and overtime have been offered to bridge the gap in the interim. Staffing levels and acuity are being monitored daily, and activity diverted or reduced, or staff redeployed, as necessary to maintain safe staffing levels.
- The visibility of the work of the Freedom to Speak Up Guardian has been increased within maternity including posters in clinical and non-patient facing areas. A number of "maternity we are listening" events have been held during November and December where staff can book one to one meetings with the guardian.
- The midwife in charge of each clinical area completes a safe staffing application for each clinical shift. In addition the labour suite coordinator completes a midwifery acuity tool every three hours. If a clinical area is declared unsafe for staffing, the Maternity Escalation Guideline describes subsequent decision making and escalation actions. The local manager's decision around safe staffing is supported and not changed. Escalation actions involve redeployment of staff to support safe care, delay in elective work, diversion of services to the other campus or closure of both Maternity Units and possible redirection to other units.
- A medical obstetric handover checklist is being piloted and will include a question for the outgoing medical team regarding whether they have been able to take breaks. This will be used, along with the midwifery acuity, to assess the safe staffing of the unit for the preceding 12 hour period.
- A weekly review of incidents reported on Datix is being undertaken by the maternity governance team. This includes a review of themes and actions. Feedback of learning to staff commenced on 1st November 2020.

Safe Today Process:

A member of the Senior Leadership Team, reporting directly to the Director of Midwifery and Divisional Director, visits both sites (QMC and City) twice daily to assess staffing and acuity. They do this by:

- Working with the midwife in charge to complete a board round which includes all in-patient areas to establish acuity and activity, planned vs actual staffing and identification of NICE Red Flags (available online at: https://www.nice.org.uk/guidance/ng4)
- Ensuring that the triage area is staffed and that telephone triage is prioritised, the telephone is answered promptly and women are advised to attend immediately. The appointment system for maternity triage has been discontinued.

A Safe Today template is completed twice daily following the visits and includes any escalation plans that may be necessary. The Safe Today visits provide twice-daily assessments of safety and that women and babies are being cared for appropriately. The template records whether women are

receiving 1 to 1 care in labour, whether the buddying system for CTGs is in place and operational and whether any patient safety incidents have occurred.

The Safe Today process informs twice daily safety briefings sent to the Chief Executive Officer and Chief Nurse which respond to four key questions:

- What assurance has been sought?
- Which senior leadership is on site today?
- Any issues and mitigation?
- How are staff feeling?

(b) Failure to promote and facilitate professional challenge

NUH Response

- We have developed a multidisciplinary maternity transformation team who are working with the human factors experts from the Trent Simulation Centre to incorporate knowledge of human factors science throughout the maternity improvement plan.
- We have developed a training session for staff based around CTG interpretation, which includes the use of SBAR handover, and tools for escalation and professional challenge. This training package is currently being piloted with the intention of launching online training by mid December 2020. An associated competency assessment will test the application of these concepts.
- We will embed these concepts into staff multi-professional emergency training and in situ skills drills.
- The NUH Maternity Communication guideline will be updated to include the above concepts, with a draft to be reviewed in January 2021.
- In December we have commenced a series of communication events allowing staff to meet directly with the leadership team, in which staff have been encouraged to raise professional challenge.
- A project plan is now being created to implement Safety Huddles within the labour wards. This is based on NHS Improvement best practice and we are expecting these to be established in the next 6-8 weeks.

(c) Failure to reach decisions based on individualised patient risk

NUH Response

We recognise that our current mixed digital and paper records may act as a barrier to staff accessing the medical record for the full pregnancy pathway. Actions are being taken to resolve this include:

- Review of IT hardware to ensure mobile computers are available for ward rounds in all areas.
- Community midwives to enter information onto Maternity Medway IT system so that information about the whole care pathway is available to both community midwives and hospital staff.
- Observational audit to include an assessment of whether the digital records are accessed and feedback to be provided.
- Procurement of a new maternity system to reduce switching and duplication between paper and digital records.
- NUH is purchasing the Perinatal Institute intrapartum notes. The notes include specific sections on maternal preferences and documentation of the risks and benefits of any proposed procedure or

intervention. This will act as a discussion prompt for staff providing intrapartum care and support improved documentation.

Guidance has been changed to prevent staff providing strong opiate medication in the latent phase of labour without a face-to-face review of the woman by an obstetrician. Midwives are unable to administer strong opiates during the latent phase of labour without a medical prescription. Compliance with this has been audited and this will be repeated in January 2021.

The intrapartum risk assessment document has been updated and has been launched with accompanying staff education. The document is to be completed each time a woman presents in the latent phase or established labour. To evidence this, the maternity record keeping audit tool that is in development includes a question to assess compliance with this requirement.

A checklist has been developed for the obstetric shift handover in conjunction with the patient safety and acute rescue team fellow at NUH. This includes attendance of the band 7 midwife and the anaesthetist as well as the obstetric team. The discussion involves an SBAR (structured) handover of all women on the main labour suite, Sanctuary (Alongside Midwifery-Led Unit) and an overview of triage and the inpatient wards. The handover checklist was launched on 16th November.

The obstetric team will review all women on the main labour suite who require obstetric input with the midwife co-ordinator and anaesthetist. Following this, the midwife co-ordinator will review the records (paper and digital) of other women on the labour suite and the Sanctuary with the woman's midwife.

Summary:

The actions set out above are intended to address the matters of concern identified in the Preventing Future Deaths report in relation to: 1. Lack of robust initial critical analysis of deaths and 2. The unsafe culture prevailing within Midwifery services. Some of these have already been implemented and dates have been provided for completion of the remainder. As Medical Director, I will be chairing the Safety and Quality workstream of the Maternity Programme Oversight Committee, where these actions will be monitored.