East Suffolk and North Essex NHS Foundation Trust

Board of Directors

8 July 2021.

Report Title:	Every Birth Every Day Improvement Programme (Maternity Services)
Executive/NED Lead:	Giles Thorpe, Chief Nurse
Report author(s):	Giles Thorpe, Chief Nurse
Previously considered by:	Executive Management Team 17 June 2021.

☐ **Approval** ☐ **Discussion** ☑ **Information** ☑ **Assurance**

Executive summary

The Trust Board has been aware of and kept informed of local concerns relating to maternity services via the Executive Team. This report provides a high-level summary of the national context for maternity services, local reviews to support local improvement work and a section on the outcome of the recent Care Quality Commission inspections of the services.

The report introduces the 'Every Birth Every Day' Maternity Improvement Programme which will draw together the recommendation and actions both in relation to nationally driven programmes and those specific to ESNEFT in to one oversight ensuring a positive working environment for our staff.

Action Required of the Board

To note the findings from the CQC reports, the associated regulatory improvement actions that have been taken, and to endorse the response of the Trust to continue to improve maternity services in all sites, through the development of the 'Every Birth Every Day' maternity improvement programme.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Keep people in control of their health	☑
SO2	Lead the integration of care	☐
SO3	Develop our centres of excellence	☑
SO4	Support and develop our staff	☑
SO4	Drive technology enabled care	☐

Risk Implications for the Trust *(including any clinical and financial consequences)*	A failure to ensure that Maternity Services are not compliant with all Fundamental Standards of Care as outlined in the Health and Social Care Act 2008 Regulated Activities (Regulations) 2015 may lead to increased scrutiny of services, and associated regulatory and reputational risk to the Trust overall.
Trust Risk Appetite	The Board has a cautious risk appetite when it comes to compliance and regulatory issues. Where the laws, regulations and standards are about the delivery of safe, high quality care, it will make every effort to meet regulator expectations and comply with them and will only challenge them if there is strong evidence or argument to do so.
Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc)*	A failure to evidence improvements against the Must and Should Dos as outlined in the CQC report, in addition to the findings of Trust commissioned external reviews may lead to

	further sanctions being placed upon the Trust's registration.
Financial Implications	Consideration of the Trust as being an organisation that can expand and deliver increased services, through bids for capital and increased revenue, may be affected if the Trust cannot evidence the delivery of safe and effective care across all its services.
Equality and Diversity	Due to the nature of maternity services it is recognised that any gaps in service provision will negatively affect pregnant people and their families, and any detriments to their healthcare must be addressed as an urgent priority.

Every Birth Every Day – Maternity Improvement Programme

1. Background

1.1 There are a series of nationally-led improvement programmes and recommendations from inquiries focusing on maternity services which include, but are not limited to:

- The Kirkup Report (March 2015) – the independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at University Hospitals Bay NHS Foundation Trust from 2003 to 2013;
- The Ockenden Report – emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust;
- Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme – the scheme supports the delivery of safer maternity care through the implementation of ten maternity safety actions;
- Continuity of Carer (Implementing Better Births) - sets out a vision for maternity services in England which are safe and personalised; that put the needs of the women, her baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving. At the heart of this vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth

2. Local context

2.1 The Trust, through the use of Divisional Accountability, have been aware of and taking action to address challenges that our maternity services faced in terms of leadership, culture and the delivery of safe staffing consistently.

2.2 Throughout this period the Trust's lead inspector was routinely kept inform of actions being taken through relationship meetings with the Chief Nurse. With the following supportive actions being noted:

- January 2021, the Board approved an investment of £1.4 million investment for maternity staffing to bring the service into line with Birth Rate plus© staffing ratios, as recommended by NHSE/I national team.
- February 2021, the East of England Regional Chief Midwife and Director of Nursing undertook a Quality Assurance visit. The findings of their visit highlighted the issues relating to leadership and culture, and some key clinical pathways which required review. No safety concerns for women or their children were noted.
- March 2021, a review into the proposed implementation of Continuity of Carer with a specific focus on leadership and culture (commissioned by the Chief Executive). The findings of this review were shared with the Executive Management Team and Board of Directors following completion in March 2021. Following the findings of the review, the Chief Nurse recommended that the planned implementation of Continuity of Carer should cease, until such time assurance could be provided that the workforce model was safe to support the transition of working practice into a continuity model. (The term 'continuity of carer' describes consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour and the postnatal period).

2.3 30 March and 7 April 2021 the Care Quality Commission undertook unannounced inspections of ESNEFT maternity services at the two main units, with the findings

provided in section 3 of this report. Immediate feedback post-inspection and subsequently within the report, no urgent concerns were raised about the safety of women or their babies.

3. Care Quality Commission Inspection

3.1 The Care Quality Commission undertook unannounced inspection of ESNEFT maternity services in March / April 2021 and have taken regulatory action and issued ESNEFT with requirement notices in respect of:

- Regulation 12 – Safe care and treatment
- Regulation 17 – Good governance
- Regulation 18 – Staffing

3.2 These are described as 'actions we must do' to comply with our legal obligations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Further to this the report describes 'action we should do' which are associated with minor breaches that do not justify regulatory actions, with the services being rated from 'Good' in January 2020 to being 'Requires Improvement' in the latest inspections.

There have been no restrictions placed on ESNEFT CQC registration.

3.3 The inspectors reported the following on Colchester Hospital maternity service:

- Sustained periods of reduced staffing and issues with the management of the maternity triage system and the process for induction of labour impacted on staff wellbeing and their confidence in keeping themselves and women and babies safe.
- Staff were not always compliant with important training, for example, sepsis and safeguarding training to protect women from harm or abuse. Medicines were not always stored correctly and there were gaps in emergency equipment checks.
- The was a lack of oversight from the trust board and the senior leadership team, with delays in managing and implementing timely actions despite the known ongoing concerns relating to many of the issues highlighted above.
- The service did not control infection risk well; we found issues in relation to furniture and clinical waste and there were gaps in emergency equipment checks.
- Leaders did not always run services well. Staff did not have access to a clear strategy with aligned governance processes. Staff were not all familiar with the service's vision and values, and how to apply them in their work. Staff did not always feel respected, supported and valued by the trust and the leadership teams. Staff were not clear about their roles and responsibilities.
- There had been significant changes in senior leadership which had led to an instability in the team with a gap in accountability and ownership. Leaders were not making a demonstrable impact on the quality or sustainability of services. Governance structures, processes and systems of accountability were unclear to staff. Levels of governance and management did not function effectively.
- Staff recorded safety incidents; however, some incidents were graded as no harm thereby potentially missing the opportunity to review the incidents in greater detail and improve practice.

However:

- Staff provided pain relief when needed. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

3.4 The inspectors reported the following on Ipswich Hospital maternity service:

- Staff did not always feel respected, supported and valued by the leadership teams. Staff were not clear about their roles and responsibilities. Staff we spoke with told us morale was low and there was a disconnect between unit staff and the leadership team.
- Leaders and teams did not always use systems to manage performance effectively. There was insufficient oversight and management of risks. The risk register was not up to date and leaders were unaware that mitigating actions were not being carried out. Some incidents were graded as no harm thereby potentially missing the opportunity to review the incidents in greater detail and improve practice.
- The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. The number of midwives and maternity care assistants on duty did not match the planned numbers.
- Not all staff had completed mandatory training or specialist training in line with trust requirements. Compliance rates for medical staff were low. Managers could not be assured that medical staff were competent in key aspects of their role due to failure to complete this training.

However:

- Staff we spoke with told us they felt supported by their peers and they worked well as a team. They were focused on the needs of women receiving care and providing the best care possible.
- Managers and staff carried out a comprehensive programme of audits and quality improvement work to improve maternity care. The trust was trialling autistic support plans developed using experiences of caring for women with autism and were designed to enhance maternity care for women with autism or those who had learning disabilities.

3.5 The CQC highlighted the following ‘must do actions’:

- Ensure that staff complete mandatory and safeguarding training and ensure compliance with the trust target.
- Implement an effective governance system and ensure systems to manage risk and quality performance are effective.
- Ensure robust review of incidents to ensure they are appropriately graded and managed to keep women and babies safe and ensure appropriate follow up care is provided.
- Ensure a robust strategy and vision to set out clear objectives and direction for the service and staff.
- Ensure all steps are taken to appropriately manage and maintain safe staffing in the maternity unit.
- Carry out and record regular baby abduction drills and evacuation drills.

- Ensure leaders have sufficient oversight of the risk register, and that risks are managed, and mitigations are in place.
- Ensure that women's records are completed in line with trust policy. Ensure the delivery suite coordinator is always supernumerary.

3.6 The CQC also highlight the following 'should do actions':

- Ensure that safety champion roles and responsibilities are clear to maternity staff and they are involved in the process.
- Ensure cross site working and consistency to improve relationships and share good governance including policies and procedures.
- Ensure they are infection prevention control compliant.
- Ensure multidisciplinary team working is improved.

3.7 Under regulation 17(3) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014, we were required to send a written report to the CQC of the action the Trust is going to take.

4 Maternity Safety Support Programme (MSSP)

4.1 As the Trust's CQC rating for maternity services has changed from Good overall to Requires Improvement, the Trust has been invited onto the Maternity Safety Support Programme by the Chief Midwifery Officer.

4.2 The MSSP will be led locally by a dedicated Maternity Improvement Advisor who will work alongside the senior clinical team to support, facilitate and provide practical advice, identifying where the service may benefit from additional support, as well as drive the overall programme.

4.3 The programme approach is built on previous successful work in improving outcomes at maternity units across England and will employ a six staged approach:

- Initiation of entry to the programme
- Implementation stage
- Diagnostic phase
- Improvement phase
- Sustainability phase
- Formal exit from the programme

4.4 The Trust's allocated Maternity Improvement Advisor will arrange a meeting with the Chief Executive, Chief Nurse and members of the team. The National Specialist Advisor, Consultant Obstetrician Professor Donald Peebles, may be asked to undertake a joint visit with our allocated advisor. A response from the Trust will be sent back to the CMO's office, upon which a date will be expected to be confirmed for the initial supportive visit.

5. Maternity Services Improvement Programme

5.1 In line with the Trust's philosophy that 'Time Matters', and with the restart of the Time Matters Board, a transformation programme has been set, which will support the delivery of national, regional and local priorities for improvement. The programme has been titled '**Every Birth Every Day**' (**EBED**).

5.2 The Programme Board will be chaired by the Chief Executive, supported by the Maternity Board Level Safety Champion (Chief Nurse).

5.3 Key work streams are:

- Organisational Development,
- Safety Culture,
- Governance, and
- Staffing/Workforce.

5.4 The work streams will feed into the **EBED** Programme Board on a monthly basis. It is expected that the Integrated Care System Director of Nursing, Regional Chief Midwife, NHSEI Maternity Improvement Advisor and the Trust Non-Executive Director lead for (Safety), which includes maternity services, will attend to provide assurance oversight.

5.5 Alongside the **EBED** programme there will be a robust communication and engagement plan with our staff, and with the pregnant people we work with, in order to assure them that the actions identified are undertaken and sustained. Such a large-scale transformative programme of work must involve all stakeholders as partners in order for this to be successful.

5.6 The programme actions directly relating to the CQC must do actions will be shared with the Care Quality Commission in line with regulatory requirements, along with routine updates on the wider programme.

5.7 Oversight will be through to the Time Matters Board, and onwards to the Quality & Patient Safety Assurance Committee, and the Trust Board.