NHS
East Suffolk and North Essex
NHS Foundation Trust

Board of Directors

Thursday, 09 September 2021

Report Title:	Every Birth Every Day Improvement Programme (Maternity Services) – programme update
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Previously considered by:	Executive Management Team 17 June 2021.

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

Executive summary

The 'Every Birth Every Day' Maternity Improvement Programme forms the governance framework through which the Trust has oversight of all improvement work relating to maternity services.

The paper provides an overview of the actions being taken to support the Trust's response to external reports and the CQC recommendations following the inspection carried out in March and April 2021.

Action Required of the Board

To note the outputs of the 'Every Birth Every Day' maternity improvement programme, gaining assurance that the Trust has robust oversight of the key work streams which focus on the delivery of improvements across maternity services in the Trust.

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 Update

1. Background

1.1. 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**).

1.2. The Programme Board is chaired by the Chief Executive, supported by the Maternity Board Level Safety Champion (Chief Nurse).

1.3. The key work streams that form the key focus areas of the EBED programme board are:

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

1.4. The work streams feed into the **EBED** Programme Board on a bi-monthly basis (Staffing and Organisational Development one month, Governance and Safety Culture second month). The Integrated Care System Director of Nursing, NHSEI Regional Chief Midwife, NHSEI Maternity Improvement Advisor, Care Quality Commission Relationship Manager and the Trust Non-Executive Director Safety, which includes maternity services, attends to provide assurance oversight.

1.5. In addition, to ensure that the voices of pregnant people and their families are heard, the Maternity Voices Partnerships for North East Essex and Ipswich and East Suffolk are represented at the programme board.

2. Meeting Outputs

2.1. EBED has met twice at the time of writing.

2.2. The first meeting outlined the purpose of the programme board, welcoming commentary from external stakeholders to ensure that the Terms of Reference and work plan were robust and would focus on providing oversight of the key improvement activities being undertaken across maternity services at ESNEFT.

2.3. An update was provided by the EBED Programme Manager outlining the engagement work undertaken with the maternity workforce, and outlining how the development of the key work streams had been determined.

2.4. During the first meeting the Regional Chief Midwife highlighted the escalation of the challenges facing maternity services at a national level and informed the programme board that an eight point plan would be released by the national team and that this would include actions to be taken at a national, regional and local level. It was confirmed that the plan would be reviewed by the maternity and neonatal safety champions during their September meeting to ensure that a robust gap analysis was completed that could be fed into one of the EBED work streams.

2.5. The second meeting received update reports from the Workforce and Organisational Staffing work streams.

2.6. The workforce work stream shared the current plan supporting ongoing recruitment and retention plans which included:

- Placement of all student midwives into ESNEFT

- Ongoing international recruitment as a pilot site (planned for 30 midwives to join ESNEFT over the following six months)
- Ongoing recruitment campaign locally and nationally to attract experienced midwives.
- Senior leadership roles shortlisted for interview to strengthen leadership across services
- New Director of Midwifery commencing in post 31 August 2021
- Professional Midwifery Advocate role (full time) out to advert to support
- Support role review to commence to ensure consistency and development opportunities for staff

2.7. The organisational development work stream shared the plan to support the workforce and generate stronger team working, which included:

- Weekly MDT meetings in place to discuss OD objectives to create a structured plan outlining interventions to support clinical teams
- Increased visibility of senior clinicians (midwifery and obstetrics) via the DMT walkabout
- Career development pathways being developed to evidence opportunities within the service to inspire future careers and support retention
- ‘A Day in the Life’ programme developed to highlight positive experiences of working cross-site
- Robust engagement and communication plan in place to ensure the workforce are fully updated on the plans for ongoing OD work and team development activities

2.8. An update was provided regarding the Trust’s progress against the CQC ‘must do’ actions with many of those being completed, and awaiting sustained evidence of compliance in order to share with CQC for closure. This was noted positively by the programme Board. An update against the ‘should dos’ would be shared with the programme board during the next cycle.

2.9. An update was also provided regarding implementation against Continuity of Carer, with further information being provided against appropriate funding to support CoC teams.

3. Future Planning

3.1. The Governance and Safety Culture work streams will be presenting their update reports to the programme board during the next cycle.

3.2. External stakeholder feedback will include an initial session with the Trust’s Maternity Improvement Advisor as part of the Maternity Safety Support Programme (MSSP).

4. Recommendation

4.1. To note the outputs of the ‘Every Birth Every Day’ maternity improvement programme, gaining assurance that the Trust has robust oversight of the key work streams which focus on the delivery of improvement across maternity services in the Trust.