East Suffolk and North Essex NHS Foundation Trust

Trust Board

4 May 2023

Report Title:	Three Year Delivery Plan for Maternity and Neonatal Services
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Report author(s):	Giles Thorpe, Chief Nurse
Previously considered by:	Every Birth Every Day Quality and Patient Safety Committee

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

Executive summary

On 30th March 2023 NHS England published the Three-Year Delivery Plan for Maternity and Neonatal Services.

The delivery plan is directed at frontline staff and leadership, describing the building blocks needed to ensure the needs of women, babies and families are at the heart of services. It summarises responsibilities for each part of the NHS including Trusts, Integrated Care Boards and Systems including Local Maternity and Neonatal Systems and Operational Delivery Networks, and NHS England.

This plan aims to deliver change rather than set out new policy. It seeks to help each part of the NHS to plan and prioritise their actions by bringing together learning and action from a range of national reports and plans into one document. Listening to what you had to tell us has informed what we need to do and therefore the four themes of our plan:

1. **Listening to, and working with, women and families with compassion.**

Care should be personalised and service users have an informed choice. Voices of all women including those from diverse backgrounds must be heard, and services should work closely with all service users to collaboratively plan, design and improve care.

All women will be offered personalised care and support plans. By 2024, every area in England will have specialist care including pelvic health services and bereavement care when needed; and, by 2025, improved neonatal cot capacity.

2. **Growing, retaining, and supporting our workforce with the resources and teams they need to excel.**

There must be sufficient highly-skilled staff across the whole maternity and neonatal team whilst combatting workforce inequalities. Staff should feel valued, with plentiful opportunity for skills and career development to facilitate a lifelong career in the NHS.

Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24.

During 2023/24, Trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.

From 2023, NHS England, ICBs, and Trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability

3. **Developing and sustaining a culture of safety, learning, and support.**

There should be a positive safety culture in every maternity and neonatal service, where everyone takes responsibility for safer care and learning, and leaders understand and act based on how it feels for their teams to work at their organisation.

Throughout 2023, all Trusts must effectively implement the NHS-wide "PSIRF" approach to support learning and a compassionate response to families following any incidents.

NHS England, ICBs, and Trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.

4. **Standards and structures that underpin safer, more personalised, and more equitable care.**

Best practice should be consistently implemented across the country, with timely, accurate data available to support learning and early identification of emerging safety issues. Women can access their records, and interact with their plans and information to support informed decision-making.

Trusts will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new "MEWS" and "NEWTT-2" tools by 2025.

By 2024, services will progress work to enable women to access their records and interact with their digital plans

Further detail pertaining to the requirements of the Single Delivery Plan are provided within the body of the report

Action requested

The Board is invited to:

a. Note the expectations of the Three Year Delivery Plan
b. Note that the Every Birth Every Day programme board will include a standing agenda item that will link with all expectations outlined within the Plan
c. Note that the Quality and Patient Safety Committee will receive a regular update regarding the Plan's actions for assurance as part of the standing Maternity Transformation Agenda item
d. Note that the Board of Directors will receive updates regarding the Three Year Delivery Plan as part of the CKI process from QPSC and also information will be shared via the Trust's Integrated Performance Report.

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	☑
SO5	Drive technology enabled care	☑

Risk Implications for the Trust *(including any clinical and financial consequences)*	If the Trust is unable to meet the expectations of the Maternity and Neonatal Single Delivery Plan then there is the potential that pregnant people and their babies will be placed at increased risk of complications and mortality, poor experience and an associated impact on staff morale and retention within the Trust..
Trust Risk Appetite	Compliance/Regulatory: The Board has a minimal risk appetite when it comes to compliance with regulatory issues. It will meet laws, regulations and standards unless there is strong evidence or argument to challenge them.
Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc)*	If ESNEFT is unable to meet the requirements of the Single Delivery Plan then there is an increased risk of breaches to the Fundamental Standards and associated Regulations as outlined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015.
Financial Implications	If ESNEFT does not have effective process in place for regulatory requirements then it may not make best use of its resources; failure to deliver improvements in maternity and neonatal services may lead to an increased exposure to potential litigation costs and regulatory sanctions.
Equality and Diversity	The report recognises that there are particular protected characteristics which are at a greater risk of maternal and neonatal complications as outlined in the Core20PLUS5 guidelines, specifically: Populations we would expect to see identified are: • ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, known as inclusion health groups coastal communities (where there may be small areas of high deprivation hidden amongst relative affluence). Inclusion health groups include: • people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups. It is recognised that one of the 5 clinical areas which required accelerated improvement is within maternity services. The specific action noted is as follows: • Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care

	requires appropriate staffing levels to be implemented safely.

Introduction and Background

On 30th March 2023 NHS England launched the Three Year Maternity Delivery Plan, which sets out how the NHS will make maternity and neonatal care safer, more personalised and more equitable for women, babies, and families. Whilst it is recognised that most women have a positive experience of such services, and outcomes have improved there are times when the care provided is not as good as anyone would want it to be.

Recent independent reports by Donna Ockenden on maternity services in Shrewsbury and Telford and by Dr Bill Kirkup on maternity and neonatal services in East Kent, and previously Morecambe Bay, set out many examples of poor care over years. It is also well known that families from some groups, especially ethnic minorities, have had particularly poor experiences. The plan set out how this can be changed.

Furthermore, while most people using maternity and perinatal services are women, the CQC Maternity Survey (2022) found that 0.65% of respondents stated that their gender was not the same as their sex registered at birth. Intersex, transgender, and non-binary people experiencing pregnancy and birth can experience particular health inequalities including poorer access and a lack of information and support in relation to their specific clinical and care needs within maternity services. The information in the plan also applied to these people.

It is everyone's responsibility to provide or support high quality maternity and neonatal care. That includes a responsibility at each level of the NHS to understand the quality of care and identify, address, and escalate concerns. NHS England have sought to improve their approach to quality surveillance at Trust, ICS, regional, and national level.

This involves bringing together all relevant partners at each level to facilitate robust understanding and action, informed by shared and accurate information. Some Trusts need additional support to improve – this is provided through the Maternity Safety Support Programme (MSSP) (which ESNEFT is included in following a CQC inspection in 2021), which aligns with the overall NHS Oversight Framework and tiered support, so that support for maternity and neonatal care forms part of a wider response where needed.

For the next three years, NHS England are asking services to concentrate on four high level themes. The plan is aimed at frontline staff and leaders and asks them to take some time to consider these themes, what they mean to them and to the women and babies they care for. The overarching aim of the plan is based on working together, so that all healthcare professionals involved in neonatal and maternity services can make a real difference.

The plan is constructed into four themes:

Theme 1: Listening to and working with women and families with compassion

Listening and responding to all women and families is an essential part of safe and high-quality care. It improves the safety and experience of those using maternity and neonatal services and helps address health inequalities..

Objective 1: Care that is personalised

Personalised care gives people choice and control over how their care is planned and delivered. It is based on evidence, what matters to them, and their individual risk factors and needs. This information can be included in each personalised care and support plan to help ensure that service users do not have to repeat their story.

It is the responsibility of trusts to:

- Empower maternity and neonatal staff to deliver personalised care by providing the time, training, tools, and information, to deliver the ambitions above.
- Monitor the delivery of personalised care by undertaking regular audits, seeking feedback from women and parents, and acting on the findings.
- Consider the roll out of midwifery continuity of carer in line with the principles around safe staffing that NHS England set out in September 2022.
- Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027.

Objective 2: Improve equity for mothers and babies

Significant health inequalities exist in maternity and neonatal care in England. For example, outcomes for women and babies from minority ethnic groups are worse than for white women, and outcomes for those living in the most deprived areas are worse than for those in the least deprived (MBRRACE-UK, 2022).

The NHS approach to improving equity (Core20PLUS5) involves implementing midwifery continuity of carer (MCoC), particularly for women from minority ethnic communities and from the most deprived areas.

It is the responsibility of Trusts to:

- Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings.

- Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds. This data should be used to make changes to services and pathways to address any inequity or inequalities identified, to improve care.

Objective 3: Work with service users to improve care

Acting on the insights of women and families improves services. Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it. This is done through maternity and neonatal voices partnerships (MNVPs) and by working with other organisations representing service users.

It is the responsibility of Trusts to:

- Involve service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services.

Theme 2: Growing, retaining, and supporting our workforce

The ambition of safer, more personalised, and more equitable maternity and neonatal services in this plan can only be delivered by skilled teams with sufficient capacity and capability. However, despite significant investment leading to increases in the midwifery, obstetric, and neonatal establishment, NHS maternity and neonatal services do not currently have the number of

midwives, neonatal nurses, doctors, and other healthcare professionals they need. This means existing staff are often under significant pressure to provide the standard of care that they want to.

Objective 4: Grow our workforce

The maternity and neonatal workforce encompasses a wide range of professions, including midwives, maternity support workers, obstetricians, anaesthetists, neonatologists, neonatal nurses, sonographers, allied health professionals, and psychologists. Growing our workforce requires the tailoring of interventions to professional groups, career stage, and local requirements.

It is the responsibility of Trusts to:

- Undertake regular local workforce planning, following the principles outlined in NHS England's workforce planning guidance. Where trusts do not yet meet the staffing establishment levels set by Birthrate Plus or equivalent tools endorsed by NICE or NQB, to do so and achieve fill rates by 2027/28.
- Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and clinicians who wish to return to practice.
- Provide administrative support to free up pressured clinical time.

Objective 5: Value and retain our workforce

Our maternity and neonatal staff perform critical, life-changing work every day. We must ensure they are valued and have a fulfilling and sustainable career within the NHS. A growing number of staff who leave are aged under 55 and do so for reasons other than retirement. Some staff groups, including ethnic minority staff, are more likely to report negative experiences of working in NHS maternity and neonatal services.

It is the responsibility of trusts to:

- Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan.
- Implement equity and equality plan actions to reduce workforce inequalities.
- Create an anti-racist workplace, including for example, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates resource.
- Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey.
- Offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time. Newly appointed Band 7 and 8 midwives should be supported by a mentor.
- Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce.

Objective 6: Invest in skills

Staff feel valued when they are supported to develop. Effective training of frontline clinicians in technical and non-technical skills has been shown to improve outcomes, yet unwarranted variation in training and competency assessment currently exists, especially for temporary staff.

It is the responsibility of Trusts to:

- Undertake an annual training needs analysis and make training available to all staff in line with the core competency framework.

- Ensure junior, speciality and associate specialist obstetricians, and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively.
- Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums.

Theme 3: Developing and sustaining a culture of safety, learning, and support

An organisation's culture is shaped by the behaviour of everyone in it. In maternity and neonatal services, a safety culture improves the experience of care and outcomes for women and babies and supports staff to thrive. Everyone should experience the positive culture that exists in many services – poor cultures need to be challenged and addressed. The failures in care identified in the Kirkup report stemmed from weaknesses in culture throughout the organisation, including a lack of team-working, professionalism, compassion, listening, and learning.

Objective 7: Develop a positive safety culture

Culture is everyone's responsibility and key to enabling cultural change is compassionate, diverse, and inclusive leadership in maternity and neonatal services and beyond.

It is the responsibility of Trusts to:

- Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. This includes time to engage stakeholders, including MNVP leads.
- Support all their senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes by April 2024, identifying and sharing examples of best practice.
- At board level, regularly review progress and support implementation of a focused plan to improve and sustain culture, including alignment with their FTSU strategy.
- Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit.
- Ensure all staff have access to FTSU training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways.

Objective 8: Learning and improving

Staff working in maternity and neonatal services have an appreciation and understanding of 'what good looks like.' To promote safer care for all, everyone must actively learn from when things go well and when they do not. To do this, there needs to be a continuous learning and improvement approach, from teams to ICBs.

It is the responsibility of Trusts to:

- Establish and maintain effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. These should include the principles of duty of candour and a single point of contact for ongoing dialogue with the trust.
- Understand 'what good looks like' to meet the needs of their local populations and learn from when things go well and when they do not.
- Respond effectively and openly to patient safety incidents using PSIRF.
- Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well.
- Ensure there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale.

- Consider culture, ethnicity and language when responding to incidents (NHS England, 2021).

Objective 9: Support and oversight

While some Trusts and ICSs do effectively support their maternity and neonatal services to improve and change; others do not. Good oversight is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise.

It is the responsibility of Trusts to:

- Maintain an ethos of open and honest reporting and sharing of information on the safety, quality, and experience of their services.
- Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the PQSM and informed by the national maternity dashboard.
- Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions.
- Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.
- At board level, listen to and act on feedback from staff, including Freedom to Speak Up data, concerns raised, and suggested innovations in line with the FTSU guide and improvement tool

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

To deliver the ambition set out in this plan, maternity and neonatal teams need to be supported by clear standards and structures. This includes being enabled to implement best clinical practice for all families, having high quality data to inform the decisions of clinicians and leaders, and having digital tools that enable information to flow. In many areas this is already in place; this plan does not seek to introduce new standards, extra reporting, or change structures, but to ensure that these enablers are consistently implemented to support care.

Objective 10: Standards to ensure best practice

Advances in clinical practice have been crucial in the improvement in maternity and neonatal outcomes over the last decade. However, the Ockenden report found that many women cared for at the trust were not offered care in line with best clinical practice. Better Births also identified that variation in protocols, policies, and standards between services creates additional burden and hinders the ability to work together to provide effective care. Additionally, the Kirkup report highlighted the detrimental effect that sub-optimal estates have on the provision and experience of care.

It is the responsibility of Trusts to:

- Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025.
- Regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services.

- Ensure staff are enabled to deliver care in line with evidence-based guidelines, with due regard to NICE guidance.
- Complete the national maternity self-assessment tool if not already done, and use the findings to inform maternity and neonatal safety improvement plans.

Objective 11: Data to inform learning

The Kirkup report highlighted the need for accurate, up to date data to highlight safety issues promptly. Such data enables providers to learn and act. Work is underway to review what data is needed for monitoring, and in the meantime, the NHS should continue to use the data it already collects.

It is the responsibility of Trusts to:

- Review available data to draw out themes and trends and identify and promptly address areas of concern including consideration of the impact of inequalities.
- Ensure high-quality submissions to the maternity services data set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and national perinatal epidemiology unit.

Objective 12: Make better use of digital technology in maternity and neonatal services

Digital technology will make it easier for women to access the information they need and for services to offer safe and personalised care. There is currently significant variation in the use of digital technology. While some maternity services remain almost entirely paper-based, others support personalised care with apps and benefit from an integrated electronic patient record (EPR). Most neonatal units use the same electronic product, which is designed for neonatal data capture, though some Trusts and neonatal units are considering how to improve neonatal alignment with maternity and paediatrics as part of their EPR roll out.

It is the responsibility of Trusts to:

- Have and be implementing a digital maternity strategy and digital roadmap in line with the NHS England 'what good looks like' framework.
- Procure an EPR system – where that is not already being managed by the ICB – that complies with national specifications and standards, including the digital maternity record standard and the maternity services data set and can be updated to meet maternity and neonatal module specifications as they develop.
- Aim to ensure that any neonatal module specifications include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set.

Assessment

Many of the requirements raised within the body of the Three Year delivery plan for maternity and neonatal services are already identified within ESNEFT's improvement plan for maternity services, as outlined and discussed at the Every Birth Every Day Programme Board. However, the plan now gives a clarity of focus for delivery against clear metrics that can be quantified in terms of process delivery.

It is key, however, that an aligned set of outcome metrics is also considered alongside process metrics to ensure that the actions being taken are having a positive outcome for pregnant people, babies, and their families across all protected characteristics, underpinned by a commitment to reducing health inequalities within the communities we serve.

Further work is required to understand the totality of involvement of both clinical and corporate services across the Trust in order to effect the work required in terms of delivery against the expected standards, and to ensure that appropriate informatics capacity is underpinning a triangulation of the impact of activity and redesign of services.

Recommendations

The Committee is invited to:

- Note the expectations of the Three Year Delivery Plan
- Note that the Every Birth Every Day programme board will include a standing agenda item that will link with all expectations outlined within the Plan
- Note that the Quality and Patient Safety Committee will receive a regular update regarding the Plan's actions for assurance as part of the standing Maternity Transformation Agenda item
- Note that the Board of Directors will receive updates regarding the Three Year Delivery Plan as part of the CKI process from QPSC and also outcome and process delivery information that will be shared via the Trust's Integrated Performance Report.