Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	15 July 2021
Paper number	-

Maternity Service Improvement Plan

For approval:	For discussion:	For assurance:	To note:
		X	

Responsibility	Names
Accountable Director	Paul Brennan – Chief Operating Officer
Presented by	Justine Jeffery – DoM Becky Williams – DDOps Angus Thomson - DD
Author /s	Justine Jeffery – DoM Becky Williams – DDOps Angus Thomson - DD

Alignment to the Trust's strategic objectives (x)

Best services for local people	Best experience of care and outcomes for our patients	Best use of resources	Best people
X	X	X	X

Report previously reviewed by

Committee/Group	Date	Outcome

Recommendations

Trust Board are asked to:

- Note the contents of the paper
- Approve additional resource to support the success of the maternity service improvement plan
    - Directorate Manager 8b
    - Maternity Governance manager band 7
    - Audit and Guidelines lead Band 6 (potentially covered via Ockenden funding)
    - Corporate support for improvement work streams

Meeting	Trust Board
Date of meeting	15 July 2021
Paper number	-

Executive summary

This paper provides a background to the current position of the maternity service at Worcestershire Acute Hospitals NHS Trust.

It demonstrates the implementation of the National Maternity Transformation Programme and the assurance of safety within the service.

A number of staffing challenges and changes in practice over the last 18 months have resulted in a CQC inspection and subsequent reduction in the maternity CQC rating on 'well led' from 'good' to 'requires improvement'. The challenges led to a decision to hold further advancement with the major transformational change in the service, Continuity of Carer.

The paper outlines the proposed structured service improvement programme to support staff and leaders, improve culture and ensure that safety is maintained to enable transformation to continue. The resources and risks associated with the programme are included in the report.

Risk

Which key red risks does this report address?	What BAF risk does this report address?

Assurance level	0	1	2	3	4	5	6	7	NA

Financial Risk
N/A

Action

Is there an action plan in place to deliver the desired improvement outcomes?	Are the actions identified starting to or are delivering the desired outcomes?	If no has the action plan been revised/ enhanced	Timescales to achieve next level of assurance
Y	Y	Y	January 2022
X	X		
N	N	N	
N/A	N/A	N/A	

Meeting	Trust Board
Date of meeting	15 July 2021
Paper number	-

Maternity Service Improvement Plan

Worcestershire Acute Hospitals NHS Trust

Authors:

Justine Jeffery – Director of Midwifery

Becky Williams – Director of Operations Women and Children's Division

Angus Thomson – Divisional Director Women and Children's Division

June 2021

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	15 July 2021
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1 Introduction

The maternity service at Worcestershire Acute Hospitals NHS Trust (WAHT) delivers 5000 women per annum. The service is staffed by an establishment of 218 midwives, 55 non registered midwifery support workers and 16 consultants (obs & gynae) and 35 middle grade/junior medics shared across obstetrics and gynaecology.

Maternity services explained

Worcester royal hospital

- Delivery suite
- Alongside midwifery led birth centre
- Postnatal / transitional care (33 beds)
- Infant feeding team
- Antenatal ward (14 beds)
- Triage dept
- Day assessment unit
- Midwife / obstetric
- Antenatal clinics
- Fetal medicine level 2
- Maternal medicine
- Antenatal screening

Kidderminster treatment centre

- Maternity hub
- Obstetric antenatal clinics
- Midwife antenatal clinics
- Scanning
- Parent education
- Social prescribing
- Smoking Cessation

Alexandra general hospital

- Maternity hub
- Obstetric antenatal clinics
- Midwife antenatal clinics
- Scanning
- Parent education
- Smoking Cessation

Community Teams

- Worcester
- Malvern
- Redditch
- Bromsgrove
- Evesham
- Droitwich
- Kidderminster

Home Visits

- GP surgeries
- Children's centres
- Home birth
- Parent Education
- Mixed risk caseload

Continuity of carer

- Sapphire (Pershore)
- Ruby (Worcester)
- Opal (Stourport)
- Pearl (Worcester)
- Emerald (Bromsgrove/ Redditch)
- Amythest (Droitwich)

Entire Maternity Pathway from booking - delivery – postnatal care

- Home visits
- Inpatient care
- Mixed risk caseload

Services provided are also shown in diagram 1:

Meeting	Trust Board
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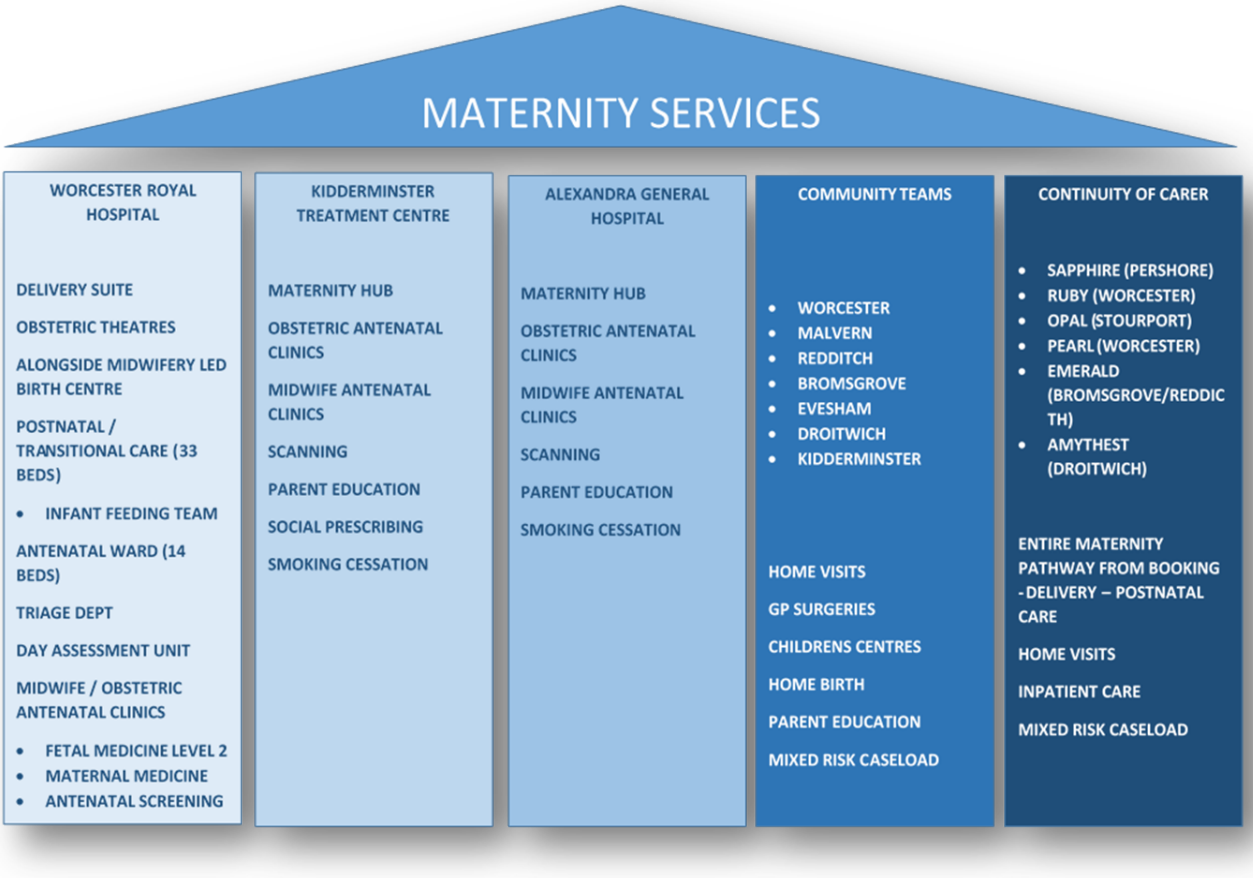


Diagram 1 Maternity services WAHT by site

The service sits within the Herefordshire and Worcestershire Local Maternity and Neonatal System (LMNS), and has worked within the system to deliver the National Maternity Transformation Programme requirements over the past 3 years.

In the past year the maternity service at WAHT has experienced decreasing staff morale, an increase in staff CQC whistleblowing / negative press and concerns raised by team members regarding the safety of the service. This has led to increasing internal and external scrutiny of the service, with the CQC undertaking an unannounced inspection in November 2020, and the downgrading of maternity from 'good' to 'requires improvement' on well led.

The position of the maternity service has been driven by midwifery staffing shortage, the impact of the COVID-19 pandemic on staffing and leadership deficits. These challenges have been overlaid with the change management process to deliver Continuity of Carer, a key requirement of the National Maternity Transformation Programme.

Due to the challenges faced by the service, a decision has been made to put on hold further roll out of the large scale transformation of the service, Continuity of Carer.

Since October 2020 the Division has undertaken some key transactional actions to remedy concerns raised by team members and the CQC. Whilst this action plan is having some impact, it is now recognised that, moving forward, a structured service improvement programme is required to ensure engagement of team members across the service, and ultimately support cultural change. It is hoped that this will then facilitate the positive restart of our transformation programme in line with national requirements.

This paper provides detail on the journey of the maternity service to date together with an outline of the proposed service improvement plan with:

- A progress update on delivery of the National Maternity Transformation Programme within the WAHT maternity service
- An outline of quality and safety measures within the service, and a provision of assurance that these measures are being followed and indicate that the service is safe
- A description of the challenges the service has faced
- An overview of the work to date on service improvement actions
- The proposed service improvement plan to address challenges going forward, key performance indicators, risks and timeline

2 Maternity transformation – the national and integrated care system (ICS) context

The national vision for maternity services is described in

- Better Births: improving outcomes of maternity services in England (DH,2016)
- NHS Long Term Plan
- The National Maternity Transformation Programme

The maternity strategy in Herefordshire and Worcestershire is aligned to the National Maternity Transformation Programme. The local strategy seeks to achieve the vision set out in Better Births by bringing together a range of organisations under the umbrella of the Herefordshire and Worcestershire Local Maternity and Neonatal System (LMNS). Over the last 3 years WAHT maternity service has been working within the LMNS to deliver the national transformation programme.

Shared goals of the workstreams for national transformation

The workstreams for national transformation are all safe, family friendly, kind, personalised and professional.

These workstreams are highlight the need for:

- Supporting local transformation

- Increasing choice and personalisation
- Transforming the workforce
- Sharing data and information
- Harnessing digital technology
- Reforming the payment system
- Promoting good practice for safer care
- Improving prevention
- Improving access to perinatal mental health services

Work streams for national transformation are shown the diagram below:

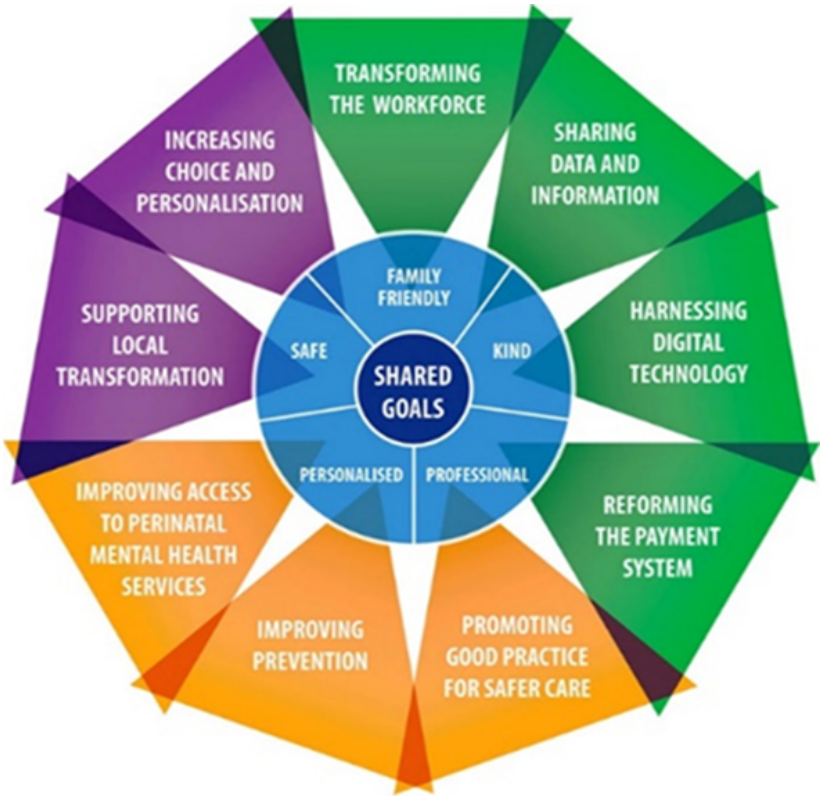


Diagram 2 National Maternity Transformation Work streams (NHS England/RCM, 2020)

3 Progress with maternity transformation at WAHT

Working within, and enabled by, the Herefordshire and Worcestershire LMNS the Maternity team at WAHT have made progress on a number of key areas of the local system transformation programme. These are:

3.1 Supporting transformation

a. Delivery of Continuity of Carer to 28% (target 35% by March 2021)

- The roll out of continuity across Worcestershire has been successful to date, with demonstrable improved outcomes for mothers and babies on a continuity pathway. The challenges of introducing & maintaining the model will be discussed later in the paper.

3.2 Harnessing digital technology

- The Badgernet maternity system was introduced in 2020, including the roll out of patient held digital maternity records.
- Virtual safety huddles are taking place between Wye Valley Trust and Worcester Acute

3.3 Transforming the workforce

- The midwifery leadership team have been working with Health Education England to transform the midwifery support worker workforce.
- The nationally recommended tool, Birth Rate Plus, has been utilised to ensure the midwifery establishment is right sized
- A Continuity of Carer coach has been employed to support the workforce to develop autonomy as self-managing practitioners.

3.4 Perinatal Mental Health (PMH)

3.4.1 Maternal mental health services (MMHS)

- MMHSs are a key part of NHS England and NHS Improvement's (NHSE/I) programme to transform specialist perinatal mental health services across England, as outlined in the NHS Long Term Plan

- In 2020 the LMNS submitted a successful proposal to NHSE/I and received funding to take part in the development and testing of Maternal Mental Health Services. The work that sites will do in 2020/21 and 2021/22 will be vital to ensure that MMHSs are available across the country from 2023/24. This will combine maternity, reproductive health and psychological therapy for women experiencing moderate-severe/complex mental health difficulties directly arising

from, or related to, the maternity experience. he service is currently on track to commence in Autumn 2021.

3.5 Personalisation

3.5.1 Introduction of Maternity 'hubs' - at Kidderminster and Alexandra hospitals

- The hubs have brought together services to support women in the antenatal and postnatal period; thus, improving personalisation and choice and prevention, for example, smoking cessation initiatives.

3.5.2 Consultant Midwife

- In 2018 the Trust employed a Consultant Midwife who is the strategic lead for the implementation of Continuity of Carer across Worcestershire. This full-time post is shared equally with the University of Worcester.

- In the recent Ockenden report it is recommended that each Trust considers the maternity leadership requirements set out by the Royal College of Midwives in 'Strengthening midwifery leadership: a manifesto for better maternity care' which recommends an increase of Consultant Midwives to provide enhanced midwifery leadership.

3.6 Prevention

- The maternity team have worked with Public Health England partners to implement smoking cessation and now pelvic floor services within the acute setting.
- Funding has been provided for 1.8WTE public health midwives in Worcestershire for 2 years to focus on smoking, obesity and lifestyle.

4 Assurance of quality, good practice and safer care

The assurance of quality and safety within our maternity service is achieved in a number of ways: Regulatory assessment via CQC, submission of quality and safety

measures under the Clinical Negligence Scheme for Trusts (CNST) together with evaluation against service reviews such as Ockenden. This is underpinned via submission of the maternity minimum data set which is a set of key quality performance indicators for the service.

4.1 CQC

In 2018 the maternity service at WAHT was rated 'good' by the CQC. In 2020, prompted by a number of whistle blows focussing in the impact of midwifery staffing levels and continuity of carer on the safety of the service, the CQC made an unannounced visit to the maternity service. The outcome of this visit was a reduction in the 'well led' key line of enquiry to 'requires improvement'. This then reduced the overall rating of the service to 'requires improvement'.

No concerns regarding service safety were raised, acknowledging the escalation policy in place to ensure safe staffing. 'Must dos' were related to staffing, recording of escalation and leadership.

As a result of the reduction in the CQC rating on well led the maternity team has been supported by the NHSE/I maternity service improvement team who are helping to identify specific interventions to improve the service.

4.2 Mortality and Morbidity

4.2.1 MBRRACE

MBRRACE – UK publishes a number of reports to monitor national perinatal mortality and morbidity and also maternal deaths. The three sets of published reports are:

Confidential Enquiry into Maternal Death and Morbidity (latest publication January 2021 reporting on deaths that occurred in 2016-18)

Perinatal Mortality Surveillance Report (latest publication 10th December 2020 reporting on deaths that occurred in 2018)

Perinatal Mortality and Morbidity Confidential Enquiries. (latest publication 28th November 2017)

The Perinatal Mortality Surveillance report provides trust specific data and this is presented in *Table 1.* The figures below provide a comparison to the average still birth and neonatal death rates for similar Trusts in the UK.

Table 1. Comparison to the average for similar Trust

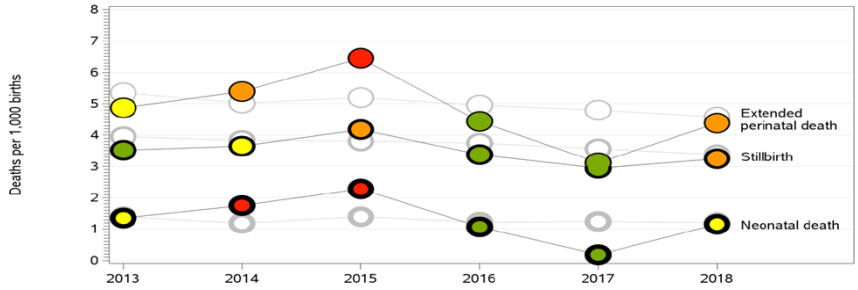
Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)	Comparison to the average for similar trusts & health Boards
Stillbirth	17	3.24	3.40 (2.76 to 4.16)	Up to 5% higher or up to 5% lower
Neonatal	6	1.14	1.14 (0.72 to 1.79)	More than 5% and up to 15% lower
Extended perinatal	23	4.53	4.53 (3.81 to 5.64)	Up to 5% higher or up to 5% lower

In summary the Trust reported fewer neonatal deaths in this period and slightly higher numbers of still births (up to 5% higher). This is due to a slightly higher than national intrapartum stillbirth rate as the Trust reported 3 deaths in 2018 when the national average rate was 1.5 cases. It is recognised that these rates are subject to random variation, especially when the number of deaths is small.

The stabilised & adjusted mortality rates are presented in chart 1 which provide more reliable estimates of the underlying (long-term) mortality rates for the Trust.

Chart/Table 1 Crude mortality rates for the Trust

Year	Extended perinatal death deaths per 1000 births	Stillbirth deaths per 1000 births	Neonatal deaths per 1000 births
2013	4.8	3.5	1.4
2014	5.4	3.6	2.8
2015	6.4	4.2	2.3
2016	4.4	3.3	1.1
2017	3.1	2.9	0.2
2018	4.4	3.2	1.2



4.2.2 Healthcare Safety Investigation Branch (HSIB)

HSIB conduct independent investigations of patient safety concerns in NHS-funded care across England. WAHT have made referrals to HSIB since 2018 following agreed criteria which includes:

a. Babies

- Eligible babies include all term babies (at least 37+0 completed weeks of gestation) born following labour, who have one of the below outcomes.
- Intrapartum stillbirth - Where the baby was thought to be alive at the start of labour but was born with no signs of life.
- Early neonatal death - When the baby died within the first week of life (0-6 days) of any cause.
- Potential severe brain injury - Potential severe brain injury diagnosed in the first seven days of life, when the baby:
  - Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE).
  - Was therapeutically cooled (active cooling only).
  - Had decreased central tone and was comatose and had seizures of any kind.

b. Maternal Deaths

- Investigate direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy.

Following the receipt of each report an action plan is prepared which is monitored via the Maternity Governance Meeting and the Trust Serious Incident Review Group.

HSIB provide regular quarterly feedback to the Trust; this feedback is a summary of the reports completed. To date the following themes have been identified:

- Guidance
- Escalation
- Fetal monitoring
- Clinical oversight
- Triage

1 report had no safety recommendations

4.3 CNST maternity incentive scheme

CNST supports the delivery of safer maternity care through an incentive element to Trust contributions to the CNST. In order to meet the incentive, scheme the Trust must achieve 10 safety actions. Including

- Achievement of Saving babies lives care bundle version 2
- Evidence of perinatal mortality reviews
- Trust maternity safety champions
- Coproduction with MVP
- Safe staffing levels

In 2021/22 the Trust will be submitting compliance with all 10 safety actions.

4.4 Review of Maternity Services across England

Following the National Maternity Review in 2016 the publication of 'Better Births' provided a number of recommendations to improve safety for women and their babies. This informed the national maternity transformation plan and was implemented locally via the LMNS.

Since the publication of 'Better Births' two formal inquiries have been undertaken in England and significant safety issues have been identified at both Shrewsbury & Telford NHS Trust (Ockenden inquiry) and East Kent Hospitals University NHS Foundation Trust. Nottingham University Hospitals NHS Trust has recently been highlighted as having significant safety issues and it is unknown at this time whether another national inquiry will be requested.

Due to the repeated, reported safety concerns in some of England's maternity services a change in local and national surveillance has been developed to monitor and provide assurance that progress against inquiry recommendations is delivered.

4.4.1 Ockenden Review

The recommendations of the Ockenden inquiry were published in December 2020 and each Trust was required to submit initial evidence against eight immediate and essential actions. Initial submissions suggested a positive position with no immediate actions to be undertaken and where gaps were identified progress has been made e.g. recruitment of a fetal wellbeing midwife and development of a process to review serious incidents at Trust Board before submission to the LMNS.

A further submission of evidence (approximately 200 documents) to NHSEI was completed on 30th June 2021. The outcome of this submission will be reported to the Trust and further opportunities for improvement will be highlighted at that time.

4.4.2 Perinatal Surveillance Model

Published in December 2020 the revised quality oversight model has the following four principles;

Principle 1 – Strengthening trust-level oversight for quality (local)

Principle 2 – Strengthening LMS and ICS role in quality oversight (system)

Principle 3 – Regional oversight for perinatal clinical quality (region)

Principle 4 – National oversight for perinatal clinical quality (national)

To date the maternity service at WAHT has succeeded in implementing principle one and is currently working with the LMNS to develop a standard operating procedure to ensure that principle 2 is embedded

4.4.3 Expected future quality and safety reviews / measures

Further inquiry recommendations are expected in autumn 2021 as the Ockenden inquiry continues and the East Kent inquiry will be concluded.

5 Challenges to the maintenance of safety and future transformation

To date the safety of our maternity service has been maintained, as demonstrated by our KPIs and submissions to CNST and the CQC inspection. However, the maintenance of safety has been demanding in the face of leadership deficit (vacancy and skill set) and staffing shortage overlaid with transformation change in the service. This is reflected in the reduction in our CQC rating on well led, and has a causal link to:

- Low morale in the midwifery team
- Increased whistle blowing, outside normal Trust escalation routes, by maternity team members concerned over the safety of the service which resulted in negative stories in the media
- Concerns from the multidisciplinary maternity team regarding inequalities in care related to continuity of carer

The above concerns have led to a decision to hold further advancement with the major transformational change in the service, Continuity of Carer. The narrative below describes in greater detail the challenges which have contributed to the current position.

5.1 COVID-19 pandemic

The workload within maternity services is all Priority 1 and 2 work that cannot be deferred. Consequently, the maternity workload throughout the COVID pandemic continued with more complex delivery pathways due to Covid, whilst the staff available to deliver the service were depleted due to sickness, shielding and isolation.

During COVID-19 waves 1&2 the focus of leaders in the maternity service was to enact required national guidance, managing pathways and day to day command and control within the service to maintain safety.

Leadership visibility at levels of the service was reduced. Normal meeting arrangements at all levels of the Division ceased in line with Trust guidance; reducing normal routes of communication and support and lessening the ability to cascade/escalate through normal governance routes such as team and Directorate meetings.

The unintended consequence of this was a reduction in communication from ward to board and back, and a reduced access to leaders at all levels to listen to and raise non-COVID-19 related concerns.

5.2 Change management

In the past 2 years the midwifery team at WAHT have seen 2 significant changes which affect working practices and patterns.

5.2.1 Increasing unpaid breaks in a 12-hour long shift

In 2016 the Trust moved the majority of nursing teams to an hour unpaid break in a 12-hour shift; this ensured that team members were taking their requisite rest period. In Women's and Children's, only the gynaecology nursing team moved to the new working pattern. Maternity and Children's services were undergoing centralisation of inpatient services to WRH, and therefore a decision was made to not progress with the change at that time. It was identified in 2019 that this change needed to be enacted to provide equity across the Trust, support rest periods and provide efficiencies where paid breaks were being taken. In 2020 the Division undertook a formal management of change process across nursing and midwifery teams to move them in line with the rest of the Trust. This process closely followed the change management policy and staff side were involved.

Following the change, the impact of staffing shortage and high acuity/activity in Q3 of 2020 meant that the midwifery team were having difficulty in taking their hour breaks. They also felt aggrieved that not all services in the Trust had moved from ½ hour to an hour unpaid break; including ED.

5.2.2 Continuity of Carer

Part of the national transformation programme, Continuity of Carer presents a very different way of working than the traditional community / inpatient model that the

maternity team at WAHT have worked within. It also requires midwives to increase flexibility and autonomy at work. The Division took the decision to initially roll out the current 6 continuity teams via 'willing volunteers' and newly appointed midwives, with a gradual increase in the number of pregnant women cared for under a continuity pathway.

The impact of this gradual change on the remainder of the team was underestimated by the Directorate and Division. The maternity team raised concerns regarding the impact on staffing and pathways within inpatient and traditional community service as well as individual work/life balance and working arrangements. These concerns grew over time, and events to communicate how the new model worked did not touch enough of the maternity team and did not change hearts and minds.

Midwifery staffing shortages in the inpatient area were attributed by the inpatient team to the roll out of continuity, exacerbated by the stepped reduction in numbers on inpatient rotas in line with the roll out of each team, and a lack of communication to the team regarding the true drivers for staffing shortage. This in turn led to poor behaviours demonstrated between different parts of the service.

The gradual roll out also meant that there were 2 models of care running alongside each other. The obstetric consultant team raised concerns that, at times of high induction /suboptimal midwifery staffing numbers, women on a continuity pathway were able to jump the induction queue because they were being cared for by a non-unit midwife, raising the possibility of delay in higher risk inductions of women on a traditional pathway.

5.3 Staffing

The midwifery establishment at WAHT (218 WTE) is in line with the 2018 findings of the Trust Birth Rate Plus (BRP) audit; this was based on 5500 deliveries (the rate in 2017/18). The Trust now delivers circa 5000 women per annum, and subsequent high level 'desk top' evaluations of the service suggest that the establishment could be reduced. The Division is awaiting a date its next formal BRP audit, at which point the establishment will be formally reviewed in line with findings.

In Q2 / 3 of 2020/21 the midwifery workforce, and the staffing levels required in the inpatient areas, were impacted significantly by:

- sickness (8-14%),
- COVID-19 related absence, including high shielding /CEV level
- Small vacancy rate
- flexible working arrangements in the inpatient areas
- a change in the induction policy outside of national guidance which increased induction numbers and acuity (45% induction rate)

This led to suboptimal midwifery staffing levels in the inpatient areas, which were particularly marked during high activity in September & October 2020. Safety in the

service was maintained by enacting the maternity escalation policy, but this required the movement of midwives from their normal working areas on the inpatient wards or community / continuity service. Some midwifery team members did not feel comfortable working outside of their usual working environments, and again this led to a feeling of being unsupported.

HR data has historically been aggregated to Directorate / Divisional level for reporting, therefore the sickness challenges in the midwifery team, were being masked by good performance in other areas of the Division. Sickness hotspots in the service have now been identified as pre-dating COVID-19.

5.4 Staff wellbeing

The maternity team have been well supported in the last 2 years with psychological input and debrief following specific incidents such as maternal death.

COVID-19 presented a new challenge to the support of staff wellbeing. With the leadership team initially very focussed on the operational delivery of new COVID 19 guidance in the service, and managers pulled to cover staffing shortage, support for staff wellbeing was not at the level that it could have been. The Trust wellbeing offer is extensive but may not have been accessed by team members without signposting.

5.5 Leadership

For a period of time during 2019/20 there were significant vacancy gaps in the maternity leadership team, clinically and operationally. It has also now been recognised that there were also some skills deficits in the existing clinical leaders within the service.

This, together with the pandemic, resulted in reduced accessibility and visibility of leaders at all levels of the service. This was highlighted in the Divisional staff engagement sessions in Oct/November 2020 and led to the team feeling unsupported and unable to escalate concerns appropriately.

6 Service improvement plan

6.1 The journey so far

In order to address the challenges described in section 5, the Women and Children's Division developed an action plan. This transactional plan was designed to move towards 'getting the basics right' in the management of the maternity service and combined action from staff feedback sessions with the Divisional and Executive team together with CQC must and should do's.

There are 100 actions within the combined plan and it is recognised that there is some repetition. However, of the 100 actions 76 have now been completed. The action plan is being led by managers within the maternity service.

6.2 Managing future service improvement

In order that the Maternity Service at WAHT can move forward with future transformational change in line with the national programme, it is recognised by the Division that further work needs to be undertaken on service improvement, with increased co-production, engagement and communication with staff within the service.

The service improvement plan, with 3 key areas of focus.

Area 1: Maternity Strategy & Transformation Plan

- National maternity transformation programme
- Local maternity and neonatal system (LMNS) strategy
- Herefordshire and Worcestershire integrated care system
- Local maternity strategy
- Worcestershire acute hospitals NHS trust

Area 2: System / Place Reporting Structure

- LMNS board
- Trust board
- Time
- Women and children's divisional board
- Maternity steering group

Area 3: Workstreams for Service Improvement

Staff Health & Wellbeing

- Psychological support
- Trust wellbeing offer
- Civility and respect
- 4 ward advocates
- Equality, diversity & inclusion
- Clinical pathways

Clinical pathways

- Capacity & flow
- Escalation
- Induction of labour
- Continuity of Carer

Leadership & workforce

- Recruitment and retention
- Organisational development
- Role development
- Information development
- Education and training

All feeding into engagement and communication with the maternity team and improving professional accountability and culture.

Diagram 3 below outlines the service improvement plan, with 3 key areas of focus.

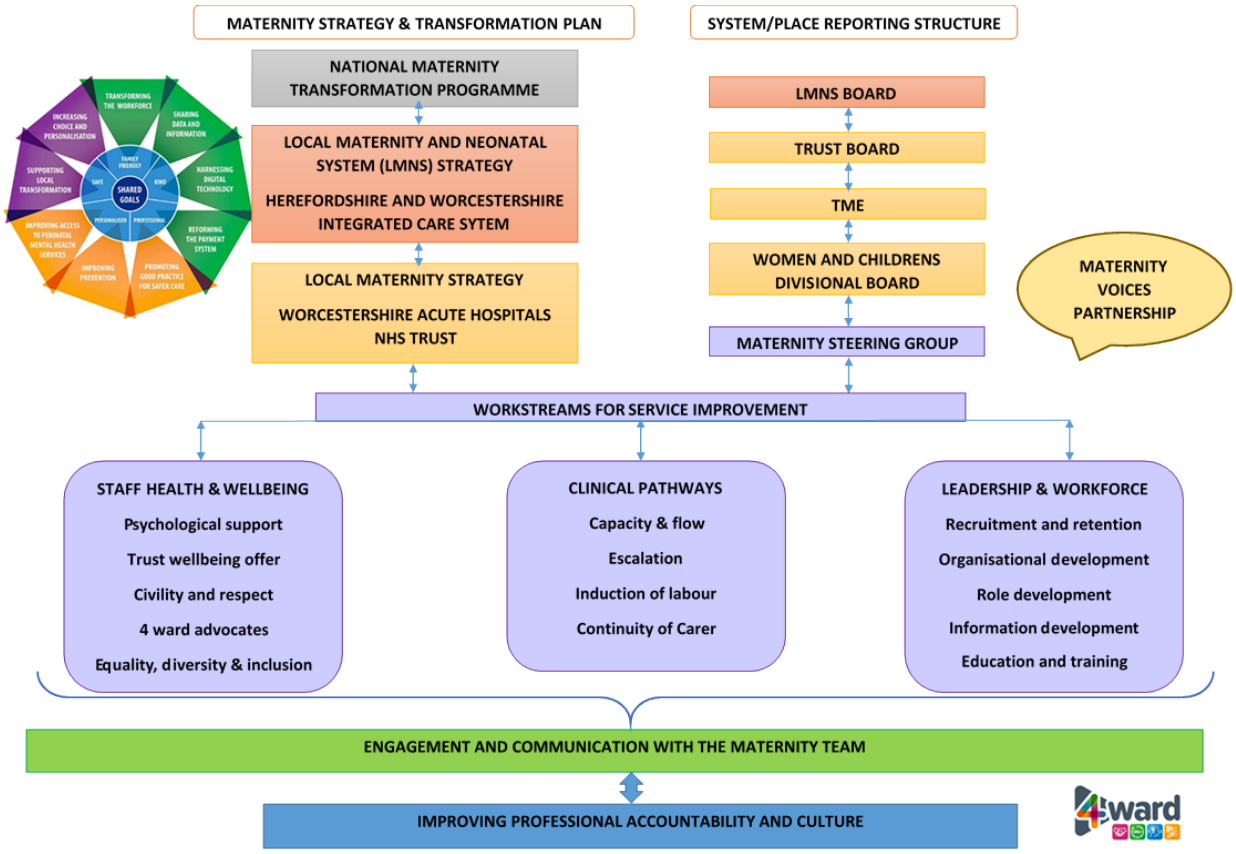


Diagram 3 WAHT Maternity Service Improvement plan

6.2.1The work streams

As described in diagram 3, the workstreams cover our main areas of challenge; health and wellbeing, clinical pathways and leadership & workforce.

Each work stream will have a lead from the maternity service, and team members from across all areas of the service will be asked to join to shape the outcomes.

Engagement will be sought from service users via the Maternity Voices Partnership.

6.3 Communication and engagement

The improvement plan will be underpinned by a communication and engagement strategy to ensure team members are fully informed of progress and changes within the service.

This will also be supported by existing routes of communication that are now back in place following the pandemic; ward huddles, team meetings, Directorate and Divisional meetings.

Current leadership visibility routes will be assessed and discussed with the wider team to ensure maternity colleagues feel that leaders at all levels are accessible and visible and that escalation and communication from ward to board is effective.

6.4 Culture

The current culture within the maternity team has contributed, and to some extent been driven by, the challenges the service has faced. There is a level of disempowerment amongst team members, and a lack of civility between individuals, teams within the service and professions.

It is recognised that a positive team culture supports the delivery of a safe service, and is therefore key to maintaining our safety position. The aim of the 3 work streams in the plan is to create a culture where:

- Team members feel positive about coming to work, and attitudes are positive
- Team members / teams are empowered to create their own solutions
- Colleagues at all levels and in all disciplines are treated with civility and respect
- Colleagues feel included and listened to
- Poor behaviours are not accepted
- The Trust 4ward behaviours are demonstrated in all that we do
- All areas of the service feel welcoming to enter
- ‘Leaders’ at all levels promote honesty and demonstrate empathy

The Division recognise that culture takes time to change, but it is hoped that the improvements made will facilitate positive change in the service.

7 Resource requirements to support service improvement

7.1 Operational support

The Directorate structure in the Women and Children's Division has a single Directorate manager covering both the Women's (Maternity and Gynaecology) and Children's (Paediatrics and Neonates) Directorates. The Division recognise that the operational & business support provided by this structure to the maternity service is very limited.

In order to increase the operational support to the maternity service, the Division need to move in line with other clinical Divisions with an 8b Directorate manager for each directorate. This would strengthen the directorate structure, supporting the clinical director and matrons in Women's services and improve engagement and visibility of the Directorate management team within the maternity service.

The Division need agreement/support to the funding of an additional 8b Directorate Manager.

7.2 Governance support

With the increasing workload associated with delivering recommendations of national inquiries it has been identified that an additional governance support is required by the Division. The current team (8a,7, 6 and band 4) cover all specialties within the Division, but current demands mean that governance work is by necessity being added to the workload of other Divisional and Directorate team members.

The Division need an additional band 6 audit & guidelines support and a band 7 governance manager to support the requirements around maternity safety and reporting, and ensure that governance is supported in all Directorates. The band 6 is expected to be covered from Ockenden funding.

7.3 Midwifery roles

The Division await a date for the next Birth Rate Plus audit. Following the outcome of the audit a review of the midwifery establishment will be undertaken to ensure that the service is supported with the requisite number of midwives delivering directly clinical care. and also the requirements of national transformation / inquiry outcomes. This work will be presented once it is available to provide assurance of staffing to national recommendations.

7.4 Corporate support

Support will be required from finance, HR, business intelligence and the project management team.

8 Risks

- If leadership and management skills are not developed in the maternity service there is a risk of non-delivery of the national plan leading to risk of increased turnover, poor reputation, and safety issues
- Non-delivery of national plan leading to a deficit in skills, risk of increased turnover, poor reputation, and safety issues
- Continued low staff morale and poor culture – potential to lead to safety issues, inability to recruit perpetuating staffing shortage resulting in increased escalation and a reduction in leadership capacity
- Loss of income due to poor reputation - if national programme is not delivered / staff morale does not improve then women may choose to birth elsewhere
- Risk of poor reputation leading to lower number of women choosing to book at the Trust and a loss of income

These risks link to BAF risks on clinical strategy, organisational culture, workforce and reputation.

9 Key performance indicators

To monitor service improvement, the following metrics have been agreed to demonstrate success:

9.1 Workforce

Key Performance Indicator	Trust target	Current position
Sickness absence	<4%	Total 7.9%
Turnover	<10%	9.22%
Midwifery Vacancy	<2.5%	5% (vacancies filled awaiting start)
PDR compliance	>90%	67%
Mandatory Training Compliance	>90%	80%
Role specific Training	>90%	75.4%

Table 2 Midwifery workforce data

Main staffing concerns and challenges have focussed on midwifery. Staffing KPIs for the medical team and other professions within the service will continue to be monitored via Directorate and Divisional meetings.

9.2 Quality & Clinical Indicators of Safety

Key Performance Indicator	Trust target	Current position
Induction of labour Rate	< 38%	43%
Elective Caesarean Section Rate*	No national target	13.8%
Emergency Caesarean Section Rate*	No national target	15.6%
Delay in IOL (transfer to DS)	<4hours	TBC
Home births	4%	4.2%
Complaint trend	No target	Trend to be reported

Table 2 Quality and Safety KPIs - whole service

* CQC no longer recognise caesarean section rate as an indicator of safety

9.3 Continuity of Carer

Key Performance Indicators	National Average	Trust Target	Current performance*
No of Births per month	-	108	TBC
Spontaneous vaginal births	55%	<55%	59.4%
Instrumental Births	12%	<12%	10.5%
Elective c/s	13.1%	<13.1%	13.2%
Emergency c/s	16.9%	<16.9%	16.7%
Total c/s	30.1%	<30.1%	29.9%
Home births	2.0%	>2.0%	1.4%
Water birth (of SVB)	-	-	11.1%
% of women receiving I/P care from a CoC midwife	70%	70%	TBC

Table 3 Continuity of carer KPIs

10 Timescales

The work on the improvement action plan continues, with the intention to fully launch the service improvement programme in *September 2021*; at this point all vacancies should be filled to required levels allowing the release of staff who wish to engage directly in the work streams.

Work streams will develop individual project plans, with the aim of seeing benefits within 1 year. The Division acknowledges that service/quality improvement is an iterative process and there will be continuing quality improvement beyond this date.

The programme will be tied in with the Trust single improvement methodology, when launched, to support ongoing cultural change and staff involvement.

11 Conclusion

The Maternity service at WAHT has had some significant challenges over the last year which have resulted in poor staff morale and the cessation of the roll out of the transformational Continuity of Carer model.

In order to move forward the service needs a structured service improvement programme to support staff and leaders, improve culture and ensure that safety is maintained.

The service improvement plan will aim to deliver:

- Improvements against KPIs within 1 year
- Maintenance of maternity safety
- A re-evaluation and restart of the roll out of continuity of carer
- Continued roll out of other aspects of the national maternity transformation programme
- Improved escalation and reporting from ward to board and back, facilitated by better communication channels and leadership visibility
- Improved morale as demonstrated by direct feedback to leaders and local staff surveys
- Improved staffing levels – driven by improving sickness, turnover and vacancy
- Improvements in behaviours and team dynamics
- Leaders who are equipped with the skills, tools and time to undertake their roles effectively

The Divisions assurance level has been rated as 4. This is based on our current position on midwifery staffing together with the hold on further roll out of Continuity of Carer. The assurance level will be raised to 7 when the service improvement plan delivers the above points and is this reflected in the KPIs.

12 Recommendation

Trust Board are asked to:

- Note the contents of the paper
- Approve additional resource to support the success of the maternity service improvement plan
    - Directorate Manager 8b
    - Maternity Governance manager band 7

- Audit and Guidelines lead Band 6 (potentially covered via Ockenden funding)
- Corporate support for improvement work streams