Maternity services at ESNEFT: update for Essex Health Overview Policy and Scrutiny Committee
2 September 2021

1. Introduction

1.1 Between 30 March and 7 April 2021 the Care Quality Commission (CQC) undertook unannounced inspections of East Suffolk and North Essex NHS Foundation Trust' (ESNEFT) maternity services at the two main units. Feedback included that there were no urgent concerns about the safety of women or their babies.

1.2 The full reports can be seen at:

Colchester Hospital https://api.cqc.org.uk/public/v1/reports/c12a4b80-6263-42f2-8c5d-336db4a3348d?20210621104708 (this has also been appended to this report)

1.3 The Trust's CQC rating for maternity services has changed from 'Good' to 'Requires Improvement'. There have been no restrictions placed on ESNEFT's CQC registration.

1.4 This report provides the Health Overview Policy and Scrutiny Committee with an outline of ESNEFT's approach to improving leadership and governance in maternity services and its response to the CQC report and the outcomes of the first meeting of the Programme Board.

2. Background and timeline to the CQC review

2.1 In January 2021, the ESNFT Trust Board approved an investment of £1.4 million in maternity staffing to bring the service into line with 'Birth Rate Plus' staffing ratios, as recommended by the NHSE/I national team. This was part of ongoing work to address existing challenges within Maternity with respect to leadership, culture and the consistent delivery of safe staffing. The Trust's lead CQC inspector had been routinely kept informed of this action by the Trust's Chief Nurse.

2.2 In February 2021, the East of England Regional Chief Midwife and Director of Nursing undertook a Quality Assurance visit. Their visit highlighted a number of issues and some key clinical pathways which required review. No safety concerns for women or their children were noted.

2.3 Also during February 2021, an independent review was commissioned by the Chief Nurse into the introduction of Continuity of Carer – a scheme that supports women to have continuity of the person looking after them throughout their pregnancy – and the associated staff consultation that was conducted to bring the scheme in at ESNEFT. The review had a specific focus on leadership, culture and staffing. The review was carried out by two independent reviewers, both experienced NHS managers who have both held head of midwifery posts. Following the review, the Chief Nurse recommended that the planned implementation should be placed on hold until assurance could be given that the workforce model was safe to support the transition.

2.4 Between the 30 March and 7 April 2021 the Care Quality Commission (CQC) undertook unannounced inspections of ESNEFT maternity services at the two main units. Feedback included there were no urgent concerns about the safety of people or their babies.

2.5 On 27 July 2021, the first monthly meeting of the ESNEFT Every Birth, Every Day programme board took place.

3. Addressing issues in Maternity

3.1 Maternity Safety Support Programme (MSSP)

3.1.1 The Trust has accepted the invitation to be on the Maternity Safety Support Programme by the Chief Midwifery Officer for England. The MSSP is led locally by a dedicated Maternity Improvement Advisor who works alongside the senior clinical team identifying additional support and drive the overall programme. As part of this, ESNEFT will also receive the support of a maternity obstetric improvement advisor.

3.1.2 The MSSP has a six-staged approach:

i. introduction
ii. implementation
iii. diagnostics
iv. improvement
v. sustainability
vi. exit from the programme.

3.1.3 The initial supportive site visit will take place at the beginning of September.

3.2 ‘Every Birth Every Day’ improvement programme

3.2.1 A improvement programme to support the delivery of priorities has begun, titled ‘Every Birth Every Day’. The programme will be chaired by the Chief Executive, supported by the Chief Nurse in his capacity as Maternity Board Level Safety Champion. Four workstreams will address organisational development, safety culture, governance, and staffing and workforce.

3.2.2 These workstreams will feed into the Programme Board on a monthly basis. The ICS Director of Nursing, Regional Chief Midwife, NHSE/I Maternity Improvement Advisor, representatives from Maternity Voices Partnership and the Trust non-executive lead for safety are invited to attend to provide assurance oversight.

3.2.3 An action from the first meeting was that the membership be extended to local council members. Currently, Councillor Julie Young has accepted membership on behalf of Colchester Borough Council and an Essex County Council representative is pending. There are also ongoing discussions with relevant Healthwatch teams.

3.2.4 The Programme Board had been formed to address continuous improvement in maternity services rather than a programme to answer the particular actions as set out in external visits and inspections. It was noted it would be a place for accountability and not blame, an approach welcomed by external advisors in attendance.

3.2.5 There will be communication and engagement with staff, and with the pregnant people we work with to provide assurance that actions are undertaken and sustained. The actions relating to the CQC ‘must do’ actions will be shared with them in line with regulatory requirements, along with routine updates on the wider programme.

3.2.6 This includes an eight-point plan relating to workforce which will be circulated to all staff imminently. Some minor issues have already been resolved following the monthly feedback sessions with staff.

3.2.7 Oversight of this work will be through our Quality & Patient Safety Assurance Committee, which is a sub-committee of the Board, and through the Trust Board itself.

4. Conclusion

4.1 The Trust was aware of the challenges within maternity services prior to the CQC inspection and was taking steps to improve the leadership and governance structures to support them.

4.2 On 31 August a new Director of Midwifery joined ESNEFT to provide expert clinical leadership, and the Trust is in the process of recruiting 30 additional midwives to support our services. Maternity services across the country are facing similar staffing issues and we are not an outlier.

4.3 The Trust Board takes these matters very seriously and welcomes the support and guidance our national and local colleagues and stakeholders to carry out the improvement plan.

ENDS