NHS
East Kent Hospitals University
NHS Foundation Trust

Strategy for Excellence in Maternity Care

We care

Foreword

The foundations for good health and well-being start with pregnancy, birth and the early days of childhood. This strategy sets out our vision for achieving high quality maternity services in East Kent and its alignment with 'Better Births', the national review into maternity services.

Our strategy is one of continuous improvement, creating the right environment for our staff to be able to implement best practice and to have the confidence to raise concerns when standards are not being met. Our objective is to provide high quality maternity care, which is safe, effective and centred on the women and babies that need it, and the people that work in it.

We have listened to women and families – to those who have received excellent care, and also those we have failed by not providing the right standard of care. To these women and families we are profoundly sorry.

We have also listened to the views of our own multi-professional staff on what values and skills they need to be equipped with, in order to deliver a safe high quality service.

We have taken onboard what's been said and we have produced a vision for our future which responds to the issues that really matter to our staff and our women. Our framework for excellence sets focused and measurable objectives that put people at the centre of decisions, so that all women, babies and their families receive the highest quality of care.

Person-centred, safe and high quality care for mothers and babies throughout pregnancy, during birth and following birth can have a positive impact on the health and life chances of women and babies, as well as on the healthy development of children throughout their life. This can help to reduce the impact of inequalities which can have longer-term health consequences for families, securing the best possible outcomes for mothers, babies and communities.

Our strategy builds on our existing maternity service improvement programme (Birthing Excellence: Success Through Teamwork (BESTT) to deliver the ambitions of 'Better Births' and the National Maternity Transformation Programme. The Trust is now embarking on a new trust wide programme that draws on continuous improvement methodology 'We Care'. Maternity joined this as part of phase one in October 2020.

Our road map to deliver 'Better Births' locally also incorporates recommendations from independent investigations, findings and feedback into maternity care at East Kent Hospitals to ensure the recommendations and lessons learned from these are fully embedded and to lay the foundations for our Maternity Strategy. This includes the NHS England maternity support programme; NHS Improvement; the Care Quality Committee (CQC); Kent and Medway Clinical Commissioning Group; Kent and Medway Local Maternity Systems; the Maternity Voices Partnership (MVP); and Healthwatch Kent.

An associated integrated action plan will ensure that the services we deliver are patient- centred and safe, and that our staff are supported to deliver excellent care. The plan will report into the Maternity Improvement Committee so that progress can be robustly monitored and assurance provided.

Focusing our resources to improve maternity services is essential to the long-term health and well-being of women now and for future generations. It is key to improving long term health outcomes, thereby reducing health inequality in East Kent.

We live and work among the people who use our services and we want to be their hospital of choice, providing safe services in a compassionate way.

> "We are determined to provide an excellent standard of care to every mother and child who uses our maternity service"

Our multi-professional maternity family
Signed by all staff

Director of Midwifery

Clinical Director

Operational Director

Maternity Voices Partnership

Interim Chief Nurse

Chief Medical Officer

Chief Executive Officer

Background

Our Maternity Strategy is aligned with:

- **Better Births: Improving outcomes of Maternity Services in England (2016)**
- **NHS Long Term Plan (2019)**
- **The National Maternity Transformation Programme**

Better Births: Improving outcomes of maternity services in England

Better Births presents a vision for Maternity Services across England to become safer, more personalised, kinder, professional and more family friendly. Women and families will have access to information which enables them to make decisions about their care and support centred around their individual needs.

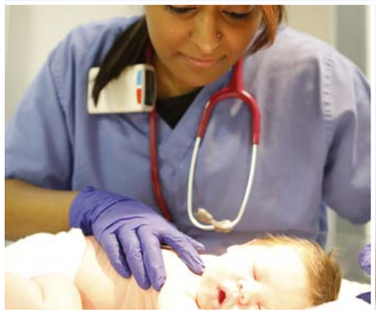
Better Births identifies the need to ensure that staff are supported to deliver care which is person-centred, working in high performing teams, in organisations which are well led and in cultures that promote innovation, continuous learning and break down organisational and professional boundaries.

NHS Long Term Plan

In 2019, the NHS published its 10-year Long Term Plan. It aims to ensure the NHS is fit for the future and will get the most value for patients out of every pound that's invested.

In relation to maternity care, the plan presents the following ambitions:

- 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.
- Roll out the Saving Babies Lives Care Bundle (SBLCB) across every maternity unit.
- Targeted continuity of carer model for the most vulnerable mothers and babies (75% by 2024).
- A focus on preventing pre-term birth by minimising unnecessary intervention and define a more holistic approach to risk assessment during labour, alongside further improvements to cardiotocography monitoring, and reductions in smoking during pregnancy.
- Offer all women who smoke during their pregnancy, specialist smoking cessation support to help them quit.
- Expand the roll-out of maternity digital care records with the aim of all women being able to access their maternity notes and information through their smart phones or other devices by 2023/24.
- Improve the quality of perinatal mental health care for mothers, their partners and children and how this can be accessed.
- Improve access to postnatal physiotherapy to support women who need it to recover from birth.
- Achieving Baby Friendly Initiative.
- To continue to improve, learn from mistakes and minimise the chances of them happening again.
- Redesign and expand neonatal critical care services.



Key Better Births recommendations include:

Personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.

Continuity of carer, to ensure safer care based on a relationship of mutual trust and respect in line with the woman's decisions.

Safer care, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.

Better postnatal and perinatal mental health care, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.

Multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.

Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.

A payment system that fairly and more precisely compensates providers for delivering different types of care to all women, while supporting commissioners to commission for personalisation, safety and choice.

Background *continued*

The National Maternity Transformation Programme

The Maternity Transformation Programme seeks to achieve the vision set out in Better Births by bringing together a wide range of organisations to lead and deliver across 10 work streams.

Local transformation supported by national enabling action is key to realising the Better Births vision. Providers and commissioners of maternity services have formed Local Maternity Systems, which will plan the design and delivery of services of populations of 500,000 – 1,500,000 people. Our Kent and Medway Local Maternity System (LMS) is supporting.

Local drivers for change

Workstream 1 *Supporting local transformation:* Transform local maternity services in line with recommendations from Better Births, The NHS Long Term Plan and Postnatal Improvement Plan including Continuity of Carer.

Workstream 3 *Increasing choice and personalisation:* Improve the offer of choice in maternity services; deepen and widen the choices available to women accessing and using maternity services. All women can expect to be offered a personalised care and support plan by 2021.

Ten National Maternity Transformation Programme work streams are supporting the implementation of Better Births locally:

Service improvement

Workstream 2 *Promoting good practice for safer care:* Adoption of best practice through targeted support to embed a safety, learning and improvement culture throughout NHS maternity services. This includes a commitment to achieve the 'halve it' ambition for maternal deaths, neonatal deaths, still birth and brain injury. The Saving Babies' Lives Care Bundle Version Two has been launched to include action on avoiding preterm birth. We are also working to address the variation in outcomes for certain BAME groups and women living in the most deprived areas.

Workstream 4 *Improving access to perinatal mental health services:* This is a joint work stream between the Maternity Transformation Programme and the Mental Health Programme. It aims to improve access for women to high-quality specialist mental health care, closer to home, when they need it during the perinatal period.

Workstream 9 *Improving prevention:* Led by Public Health England, work is aimed at preventing poor outcomes through actions to improve women's health – before, during and after pregnancy to ensure that families get off to the best start possible.

Workstream 10 *Transforming neonatal critical care:* To improve neonatal outcomes by aligning capacity and demand, developing the neonatal workforce and improving parental support in line with the Neonatal Critical Care Review (NCCR) Action Plan.

System enablers

Workstream 5 *Transforming the workforce:* Ensure we have the right workforce with the right skills to implement the vision set out in Better Births.

Workstream 6 *Sharing data and information:* Improve data and information collection, quality and sharing to drive maternity service improvement at local, regional and national levels.

Workstream 7 *Harnessing digital technology:* Ensure that all records in England can be accessed digitally by professionals and women. Provide women access to unbiased information that enables them to have choice.

Workstream 8 *Reforming the payment system:* Ensure the payment system appropriately reimburses providers for delivering efficient, safe and high-quality maternity care.

Introduction

Pregnancy and childbirth are life changing events for approximately 6,500 women and their families that deliver in our trust every year.

Birth rates are highest in the most deprived areas of East Kent and there is strong evidence that those women and babies from more deprived backgrounds have a higher risk of poor pregnancy outcomes. Deprivation shows a wide range of variation with some of the electoral wards of Thanet being amongst the most deprived in England.

Socio-economic status is also strongly associated with maternal deprivation, and these deprived areas have a higher prevalence of smoking, alcohol intake, drug use, obesity, and malnourishment. This in turn can adversely impact on lifelong health. Across East Kent we have a growing number of people living with long-term conditions like diabetes, lung disease and heart disease and 1 in 4 east Kent residents are affected by a mental health problem.

The percentage of teenage mothers is higher in east Kent than the rest of Kent, particularly in Thanet and South Coast Kent CCGs. There are also higher rates of smoking during pregnancy and almost one in five mothers is a smoker when their babies are born. We have lower rates of breast feeding in these areas and Thanet has the fifth highest incidence of alcohol-related disease in the country.

Across East Kent, we provide antenatal, intrapartum and postnatal care across East Kent through a mix of consultant-led and midwife-led antenatal clinics and antenatal day units at all five hospital sites delivering a 24/7 service on both the Queen Elizabeth the Queen Mother Hospital at Margate and William Harvey Hospital Ashford.

Vision – Birthing Excellence: Success through teamwork (BESTT)

Shared purpose "We will provide women and families with safe, personalised and positive experiences through equipping our multi-professional team to develop the right skills, values and behaviours supported by transformative leaders, innovation and a culture of continuous learning."

We offer five choices of place of birth: home, alongside birth centre and consultant-led obstetric unit in The Queen Elizabeth the Queen Mother Hospital Margate and William Harvey Hospital at Ashford.

Our multi-professional maternity team play an essential role in this momentous journey and have the opportunity to support a woman and her family by ensuring safe, effective and personalised care are provided. In order to ensure women's long-term wellbeing and that our population in East Kent have the best start in life, we need to develop sustainable services that are responsive to their social, emotional and physical health needs. Caring for our staff and each other will be fundamental to achieving this.

This Vision has been developed and informed by women and their families facilitated by our maternity voices' partnership, our multi-professional team and external service improvement experts.

How will we achieve our vision?

BESTT – Birthing Excellence: Success Through Teamwork/We Care

BESTT is our vision and current improvement programme which blends two improvement methodologies – IHI and transformational practice development because of their focus on improving workplace culture. Aligned with the National patient safety strategy it is all about Continuous and sustainable improvement, with everyone habitually learning from insights to provide safer care. Building on the multi-professional staff who have already undertaken the Maternity and Neonatal Safety Improvement Programme (MNSIP, previously the Maternity and Neonatal Health Safety Collaborative), BESTT will continue to offer the tools to understand variation, study systems, build learning and capability internally necessary to deliver our strategy.

This will be supported and integrated into the trust wide approach to continuous improvement methodology – 'We Care', supported by KPMG, which launched October 2020.

Having heard the voice of women, families, staff and our external partners, five strategic themes supported by five enablers were identified. These enablers are the 'Golden Threads' weaving through everything that we do and the entire strategy is underpinned by our trust values and behaviours. Each strategic theme supports delivery of

- Better Births: Improving outcomes of Maternity Services in England (2016)
- The National Maternity Transformation Programme
- NHS Long Term Plan (2019)

Introduction *continued*

Our Five Service strategic themes:

1. **Women and families**
2. **Our Quality and Safety**
3. **Our People**
4. **Our Future**
5. **Our Sustainability**

Each strategic theme has its own individual framework connecting back to achieving our True North and supported by the five key enablers which act as golden threads weaving through each theme. These are described further below.

Our Golden Thread enablers

Leadership A transformative and transparent leadership culture which is collaborative and compassionate. Those in formal leadership positions are visible to staff, live and role model our shared purpose and trust values. They enable and empower everyone to play a leadership role and support them to develop and reach their full potential whilst cultivating a just culture that is open and fair, which rewards when things go well and learns when they do not, making staff feel safe to speak up.

Teamwork Our EKHUFT maternity team is both participative and inclusive. Our team will cultivate an open learning culture where everyone plays a role in improvement and leadership. Founded on the principles of trust within and between different professional groups; learning together to work better together and working with women and families as part of our team.

Improvement capability A culture focussed continuous improvement. It supports staff to develop Quality Improvement (QI) skills to actively seek out, measure and use the right data which helps identify and embed small changes that make a big difference. People's experience – staff and women, is actively sought out to ensure their improvement ideas/feedback are heard and acted on.

Learning Leadership training including QI skills, safety training and multi-professional staff training. Learning with women and staff to generate improvement. Learning is prioritised by the service as an enabler of safety. An empowering approach to teaching/learning enables everyone to develop themselves through utilising the workplace as the main source of learning to generate a culture of continuous improvement.

Integration Maternity remains a Trust Board priority providing sufficient time for maternity service to share concerns, innovative ideas and service changes of the necessary breadth and depth to deliver the service strategy. We have governance in place to ensure all aspects of our service remain integrated; across the organisation, regionally through the Kent and Medway Local Maternity Service; and through national programmes.

Values and behaviours

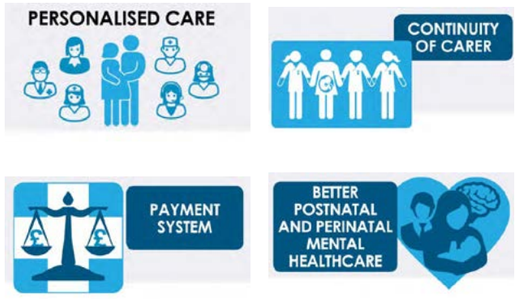
Our approach has to be supported by strong foundations.Everything is underpinned by our Trust values.

Women and Families

Our Vision

"Women and families will receive personalised care by a multi-professional team, planned in partnership with them and reflecting their choices and health needs."

Supports delivery of Better Births recommendations:



Supports delivery of National maternity programme workstreams:

1 Supporting local transformation

3 Increasing choice and personalisation

4 Improving access to perinatal mental health services

9 Improving prevention

We commit to…

- Providing excellent experience for women, babies and families through care that is centred on them and is clinically effective every time they encounter our services.
- Supporting and empowering women to make informed choices about their care that's personalised through providing women with the right care, from the right person, at the right time, and in the right place including place of birth and birth choices.
- Being empathetic, open and transparent with women and families when things do not go as planned. Ensuring we learn from their experiences and embed sustainable system change.
- Improving equity of access and reducing inequalities in experiences, quality and outcomes of care for those women at highest risk of poor outcome including those women under 20 years, vulnerable groups, mobile population (Gypsy and Traveller women and those who are recent migrants to the UK), socioeconomic deprivation, mental health, BAME, domestic abuse.
- Embracing digital technology solutions to ensure women receive timely, personalised and evidence-based information that puts them and their baby at the centre of shared decision making.
- Ensuring decisions related to service planning and delivery are co-produced with women and their families to ensure we meet their individual needs.
- Providing choice in place of birth through appropriately staffed and resourced community midwifery teams, alongside midwifery units and obstetric units across East Kent. Women will be given information about local birth outcomes relevant to their individual circumstances to support them to make decisions about place of birth.
- Putting in place actions to improve women's health – before, during and after pregnancy to ensure that families get off to the best start possible including promoting breastfeeding.
- Undertaking a prompt investigation and multi-professional review of the care provided. When necessary we will use the MBRRACE national perinatal mortality review tool. We will ensure that the mother and her family are listened to, supported and have an active role in any review if they wish to do so. During this period a named point of contact will be allocated.
- Seeking out feedback from women and demonstrate changes have been sustained. This includes working closely with our Maternity Voices Partnership (MVP) so that service users are involved in service development, recruitment and business planning in partnership with our service leaders.

You'll know we are successful because we will…

- Achieve UNICEF Baby Friendly Breastfeeding initiative level 2 by Q3 20/21 including that at least 70% of babies are breastfed within an hour of delivery, where the woman chooses to breast feed.
- Enable at least 90% of mothers who are low risk for complications in labour are enabled to consider giving birth in any setting.
- Ensure that plans are in place for at least 35% of women to be placed onto a continuity of carer pathway by March 2021. 35% of this proportion will be women from a BAME background in areas of 10% lowest deprived. Teams will be mixed risk, geographically based and prioritise the most socially deprived areas of the Trust first. Each team will be made up of 6-8 midwives with named lead obstetricians.
- Ensure 100% of women who feel they require support after birth will have access to a formal debrief.
- Inform the parents of babies who were born and died in the Trust that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby will be sought. This includes any home births where care was provided by our Trust staff and the baby died (target 95% as defined by CNST year 3).
- Complete a diagnostic review of the discharge process when transferring care from hospital to community by Quarter two 2021/22.
- Ensure 100% of safety huddles will be attended by the supernumerary midwife, consultant, registrar, anaesthetist and other relevant professional groups. If this is not possible because of clinical demands the reason for not attending will be documented.
- Ensure our Maternity App, MOMA, is available in our top four non-English-speaking languages by 2022.
- Ensure 100% of women have access to our Maternity App MOMA (and therefore their digital health records and education material) by Quarter two 2021/22.
- Monitor the number of women who have download the Maternity App by 2021 and continuously measure how many women use it (target 60%).
- Ensure all (100%) women can expect to be offered a personalised care and support plan during 2021.
- Ensure all (100%) of women are supported to write their birth preference plan.
- Ensure all women in active labour will receive one-to-one midwifery care and a real time review process will be in place to support escalation and mitigation if compromised.
- Ensure that 90% of relevant maternity care staff will receive training in relation to perinatal mental health.
- Ensure that 100% of women are screened for past and current mental health problems at booking.
- Ensure that 100% women are asked about their mental wellbeing at each routine point of contact during the antenatal period.
- Ensure that 100% of women identified as having mental health problems during the perinatal period will be offered an appropriate plan of care to support their mental health needs.
- Offer bereavement lead midwives support to 100% of women where there has been a pregnancy loss.
- Develop and implement a localised patient experience survey that gives us more frequent access to information, to be used alongside The Friends and Family Test, Maternity Survey and inpatient survey by 2022.

> "Women and families will receive personalised care by a multi-professional team, planned in partnership with them and reflecting their choices and health needs."

Our Quality and Safety

Our Vision

"We have systems in place which provide continuous assurance that our care is safe and effective. Underpinned by a culture of continuous learning it aims to reduce unnecessary variation and improve the quality of the experience for women and staff."

Supports delivery of Better Births recommendations:

Supports delivery of National maternity programme workstreams:

1 Supporting local transformation

2 Promoting good practice for safer care

We commit to…

- Continuously provide a high quality and safe standard of care, considering the individual woman's needs and delivered in line with best practice and the best available evidence.
- Ensuring our governance system is transparent and trusted by women, families and staff. One which identifies themes, trends and causation efficiently and manages them effectively. It continually promotes a just learning culture through ensuring that they all have a role to play, and are aware of this role.
- Building a safety culture, underpinned by civility and psychologically safe teams, who are alert to the need for learning and sharing safety learning that's about maximising the things that go right and minimising the things that go wrong for people accessing our services and care.
- Continuing to share safety intelligence amongst midwifery, neonatal, obstetric staff, governance teams, and board safety champion and also through the LMS and Local Learning System (LLS) so that trust-level safety improvement priorities are quickly identified and acted upon.
- Ensure maximum safety at all times by reducing avoidable harm through delivery of the actions required in the CNST maternity incentive scheme (including Saving Babies Lives 2 care bundle) and by improving the prevention, early recognition and management of deteriorating mother or baby. Minimise unnecessary intervention and define a holistic approach to risk assessments during labour alongside further improvements to fetal monitoring, and reductions in smoking during pregnancy.
- Reducing unwarranted variation by moving further towards a culture of continuously reviewing and acting upon quantitative and qualitative data integrated into our monitoring systems and processes.
- Standardising the process of review and shared learning from maternal and perinatal morbidity and mortality incidents, near misses and complaints.
- Developing a just culture charter (based on the NHS just culture guide) to ensure all staff understand their role in keeping patients safe and empowering them to raise concerns which are acted upon. This also includes providing staff with the time and resources to capture and generate rapid learning after serious incidents, setting expectations for writing statements and support for attending investigations and legal proceedings.
- Ensuring all job plans for senior medical staff, midwives, senior midwife and above have protected time to actively contribute to/lead on educational, risk governance and quality improvement projects and work streams.
- Developing a proactive safety culture which supports practice development and continuous quality improvement linked to patient safety improvement methodology and enabled by human factors overseen by a Trust Non-Executive Safety Board Champion who would provide support to ensure this culture is delivered and sustained.

You'll know we are successful because we will…

- Write and fully implement a new governance framework, linking to the corporate governance strategy once developed. This will provide job planned time for everyone to be involved in the investigation process, to attend reviews and meetings where necessary. It will identify areas where rapid system changes can be made.
- Implement all 10 CNST maternity incentive scheme safety actions as set annually.
- Complete a review using the Perinatal Mortality Review Tool (PMRT) of all deaths of babies, suitable for review using the PMRT, within four months of each death. This includes deaths after home births where care was provided by our trust staff and the baby died. (As per CNST year 3).
- Ensure that deaths of babies (suitable for review using the PMRT) who were born and died in the trust, including home births, are reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated, within four months of each death. (As per CNST year 3).
- Submit quarterly reports to the Trust Board of all perinatal deaths and including reviews and action plans. The quarterly reports will be discussed with the trust maternity safety champion.
- Ensure 100% of Quality Standards are in date with systems and processes in place and identify gaps and review on a 3-yearly basis unless earlier review is required.
- Complete the surgical safety checklist in 100% of cases.
- Triage all women telephoning and attending using RAG rating so that women are seen within the right time, by the right person, in the right place, according to risk.
- Ensure all audits integrate into wider quality improvement projects using a defined QI methodology and align with evidencing delivery of our strategy.
- Ensure 100% of national patient safety alerts concerning maternity/neonatal are reviewed and changes made where required.
- Increase Sepsis screening rates according to trust guideline
- Reduce the rates of women smoking at the time of delivery in line with targets set against the Saving Babies Lives Care Bundle V2 Element one.
- Implement all elements of the Saving Babies Lives Care Bundle.

"We have systems in place which provide continuous assurance that our care is safe and effective. Underpinned by a culture of continuous learning it aims to reduce unnecessary variation and improve the quality of the experience for women and staff"

Our People

Our Vision

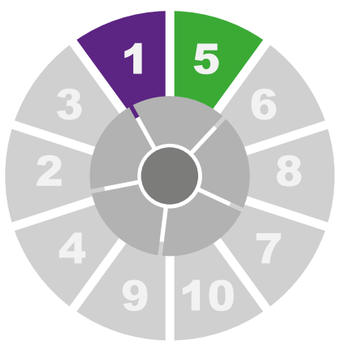
"To create a positive learning environment where staff development is encouraged and fostered to build a team with the values, skills, and experience to embed a safety culture based on continuous quality improvement. We will be a staff wellbeing focussed employer who people chose to join, want to stay with and where they can develop their careers."

Supports delivery of Better Births recommendations:

Supports delivery of National maternity programme workstreams:

1 Supporting local transformation

5 Transforming the workforce



We commit to…

- Staff having the time, skills and training to listen to women and care for her and her baby.
- Developing a sustainable workforce through attracting, developing and retaining people with the skills, competencies and values to deliver our service strategy.
- Developing effective transformative leaders and support them to develop the skills necessary to drive continuous improvement.
- Ensuring leaders are visible and role model safety and effectiveness in all that they do. Advocating and Educating for Quality Improvement (A-EQUIP) and the associated role of the Professional Midwifery Advocate (PMA) supports a continuous improvement process that aims to build personal and professional resilience of midwives, enhance quality of care for women and babies and support preparedness for appraisal and professional revalidation.
- Developing an open and transparent culture by continually improving ourselves and others through multi-professional learning and team-working.
- Identifying and developing quality improvement leads to support delivery of a continuous learning culture who will work with women and the multi-professional team supported by national quality improvement resources to deliver the national maternity safety and improvement ambitions within our local setting and resources.
- Ensuring our maternity staff training is aligned with national policy, recommendations, reports such as CNST and Saving Babies Lives V2, and local risk governance including audit, complaints and investigations. Our workplace based learning will embed learning from when events haven't gone as planned and evidencing lessons have been learned.
- Designing a workforce plan which ensures effective and safe recruitment and ongoing working practices of permanent and temporary staff (medical and non-medical). Appraisal and workforce patterns will ensure delivery of this strategy including the Continuity of Carer model for most women.
- Building a supportive and effective workplace through developing a culture of compassionate leadership, which provides staff with positive feedback through mentorship, appraisal and their day to day work e.g. Encouraging Praise in Colleagues (EPIC).
- Creating a positive learning environment where staff development is encouraged and fostered and the principles of patient safety are embedded within relevant education, training and staff development.
- Provide excellent training and development opportunities for staff and students.

You'll know we are successful because we will…

- All staff at band 7 or above and consultant level will complete formal training/qualification in clinical leadership and management by 2025.
- All staff at band 7 or above and consultant level will complete quality/service improvement training course by 2025.
- All staff complete the National patient safety curriculum as applied locally by 2023.
- At least 90% of clinical (medical and midwifery) staff will attend multi-professional training each year, including: fetal monitoring training, emergency skills, human factors and simulation training.
- At least 85% of staff complete corporate mandatory training compliance annually.
- At least 80% of staff survey responses say "my organisation values my work" by 2022.
- All staff who are required to give or are involved in legal proceedings receive relevant supportive training.
- All of those holding formal leadership positions will have undertaken formal training/qualifications in clinical leadership and management by end of 2022.
- At least 80% of staff have undertaken a quality/service improvement course 2024.
- All staff who are in mentorship roles are required to undertaken mentorship training by 2022.
- 85% of staff will have had an annual appraisal and at least 80% of staff will have felt that their appraisal was effective.
- That we actively encourage staff to complete the staff survey and Staff Friends and Family Test and for women to complete Friends and Family Test, CQC and Inpatient Surveys.
- All appraisers have job planned/identified time to undertake appraisal by end of 2021.
- All newly appointed consultants and senior midwives will be allocated a mentor.
- All staff involved in clinical incidents are offered access to Trauma Risk Management (TRiM) session.
- All midwifery staff will have an allocated Professional Midwifery Advocate (PMA) who will support and encourage reflective restorative supervision.

> "To create a positive learning environment where staff development is encouraged and fostered to build a team with the values, skills, and experience to embed a safety culture based on continuous quality improvement. We will be a staff wellbeing focussed employer who people chose to join, want to stay with and where they can develop their careers."

Our Future

Our Vision

"Our Maternity Service will be actively involved in research, development, innovation and improvement to enhance the safety, effectiveness and quality of experience for women, their families and our staff."

Supports delivery of Better Births recommendations:

Supports delivery of National maternity programme workstreams:

1 Supporting local transformation

7 Harnessing digital technology

9 Improving prevention

We commit to…

- Using digital and technological solutions wherever possible to support staff to do their job efficiently and effectively to enable safe care and improve the experience of women and families using our service.
- Building estates and facilities which support the delivery of safe care and improved experience for women and families whilst ensuring the environment for staff enables learning and wellness.
- Having more agile data collection systems in place which improve our measurement of safety and quality. Multi-sourced systems which continuously identify where we need to improve, where there is best practice learning to be shared and feeding this back to staff in line with our just culture charter.
- Building partnerships with academic, research, third sector and community institutions which will benefit women, families and staff.
- Using quality improvement methods to make sense of qualitative and quantitative data, use it in safety, learning, feedback and all that we do to improve the safety and effectiveness of care.
- Ensuring we have the systems, processes and infrastructure to deliver on the Digital Transformation vision for East Kent, aligned to the National vision including interoperability and personalisation for mothers and babies.
- Ensuring that all data collection within the service is useful, easily accessible, purposeful and provides insight to generating learning and improvement, supports a regular service review to ensure it remains effective and provides feedback to women and staff. Data collection will align with our service strategy and national programmes of work i.e. CNST, Saving Babies Lives V2 care bundle, diabetes. This will support us to review and identify areas for development based on the DHSC Safer maternity care plan and the NHS patient safety strategy.
- Ensuring that women, our MVP and staff play an active role in continuing to develop our information for women. We are committed to digitalisation of information and services to reduce our carbon footprint; improve the quality and accuracy of the information thereby supporting women to make unbiased informed choices for them and their baby.
- Ensuring that our estates are optimised as learning and research environments – reducing non-clinical space wherever possible and utilising technology enhanced solutions to support a culture of continuous multi-professional team training and learning within the workplace.
- Ensuring that we have systems and processes in place which seek out the best available research evidence and/or best practice and where appropriate implement this within our service.

You'll know we are successful because we will…

- Identify an area on the main sites to support workplace training and learning by 2025.
- Implement the use of an intrapartum acuity tool to monitor and track activity on Labour Suite.
- Achieve 100% supernumerary status of the Labour Suite Coordinator, minimise NICE Staffing Red Flags, and closely monitor Labour Suite Acuity levels with immediate effect.
- Ensure all women are able to access their end to end Maternity notes and information through their smart phones or other devices by 2023/24.
- Ensure all staff have connectivity to access systems necessary to deliver personalised care by 2023/24.
- Engage with the Prevention of Cerebral Palsy in the Preterm Infant (PReCePT) and other national measured programmes as they are launched.
- Achieve 50% reduction in still births, neonatal deaths and brain injury by 2025.
- Achieve Good or Outstanding CQC results by 2022.
- Appoint a lead for research and building third sector relationships by 2022.
- Review and where necessary implement outstanding 'Listening into action' identified areas for improvement.
- Establish a continual audit of second stage trial of instrumental deliveries in theatre and Caesarean Section data to ensure that we are compliant with our guideline/ national guidelines.
- Conduct a research and innovation needs analysis including research and innovation goals (partnerships across the integrated care system - including academic, research, third sector, primary, community etc. by 2022.
- Develop a reporting tool to review all admissions of term babies to Neonatal unit in line with the national Avoidable Term Admission into Neonatal Unit (ATAIN) programme with immediate effect.
- Ensure that the rate of ATAIN is less than 5% of all births.
- Eliminate Red Flags from the GMC Doctor in Training Survey by 2022 and improve feedback from all trainees and student surveys.

"Our Maternity Service will be actively involved in research, development, innovation and improvement to enhance the safety, effectiveness and quality of experience for women, their families and our staff."

Our sustainability

Our Vision

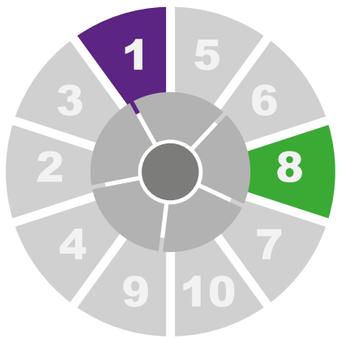
"Maternity Staff, our leadership team and the Trust will live the vision, it's values and behaviours and pledge to spend resources for providing best value for the use of public money to sustain and deliver our strategy."

Supports delivery of Better Births recommendations:

Supports delivery of National maternity programme workstreams:

1 Supporting local transformation

8 Reforming the Maternity Payment



We commit to…

- Ensuring long-term financial sustainability, within the care group, that can deliver against our strategy. We will have tools for monitoring capacity and demand which allow us to plan services accordingly.
- Streamlining our core business processes including efficient planning and utilisation of services, development of safe and highly reliable systems, processes and pathways of care maximising the skills of staff and ensuring stability and protecting our future including workforce succession planning.
- Implementing measures to reduce our carbon footprint including paper lite, opportunities to review travel and use of consumables.
- Learning from lived experiences and innovations that stemmed from service modifications during the COVID-19 Pandemic such as virtual clinics, outpatient Induction of Labour and Blood Pressure Monitoring from home.
- Ensuring a fair system of payment (as in "Better Births") which fairly compensates providers for high-quality provision of care, working with the LMS and national teams to utilise nationally developed tools.
- Providing best-value whilst improving patient care aligning to the belief that high-quality care costs less. To grow revenue streams.
- Embedding the structures to learn from experience and invest in staff so that they feel valued and supported. Use our resources effectively to maintain and enhance our provision of learning including workplace, clinical skills, mandatory and systems learning.
- Build services and processes with service users and external partners involvement. Review and identify areas for development based on the Department of Health Safer Maternity Care Plan and NHS Patient Safety Strategy.
- Creating a performance-focused culture by building well-led, high-performing teams of confident, competent and enabled staff and grow the critical mass of staff who can lead on improvement change.
- Ensuring the maternity governance structures, policies and processes are effective and consistently comply with regulators' standards.

You'll know we are successful because we will…

- Deliver a balanced budget annually.
- Implement the improvement recommendations from Each Baby Counts audits, MBBRACE and HSIB and NHS Resolution.
- Complete the annual audit programme on time.
- Maximise utilisations of theatre lists.
- Ensure capacity matches demand for clinics.
- Achieve the required number of women on Continuity of Carer Pathways.

"Our Maternity Service will be actively involved in research, development, innovation and improvement to enhance the safety, effectiveness and quality of experience for women, their families and our staff."

Governance and Delivery

To enable our Maternity Strategy to be delivered the Trust is continuing to invest in a Maternity Transformation Programme.

The purpose of the Maternity Transformation Programme is to develop and maintain an understanding of the current and future requirements of Maternity Services at East Kent Hospitals University NHS Foundation Trust, ensuring the vision in Better Births is delivered locally.

The programme governance supports the development and delivery of this strategy ensuring it aligns to the national and local policies.

An associated overarching action plan will ensure that the services we deliver are patient centred and safe and that staff are supported to deliver this, as described throughout our strategy.

The plan will report into the Maternity Improvement Committee so that progress against the desired outcomes can be monitored. The Maternity Improvement Committee will report directly into Quality Committee, thus having a reporting route into Trust Board. The Maternity Improvement Committee will be chaired by a non-executive director.

References:
Best practice reports and recommendations

National

NHS England (Feb 2016) National Maternity Review: Better Births **https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf**

NHS Resolution Maternity Incentive Scheme (2019/20) **https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/**

NHS England Maternity transformation programme (July 2016) **https://www.england.nhs.uk/mat-transformation/**

Maternity services systems learning – Maternity self-assessment tool **https://improvement.nhs.uk/resources/maternity-safety-champions/#maternity-self-assessment-tool**

The Royal College of Obstetrician and Gynaecologists Each Baby Counts-Update Report **https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/each-baby-counts/each-baby-counts-2019-progress-report.pdf**

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the Uk (MBRRACE) report **https://www.npeu.ox.ac.uk/mbrrace-uk**

NHS England (2016) Spotlight on maternity: safer maternity care https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/11/spotlight-on-maternity-guide.pdf

Department of Health (November 2017) Safer maternity care. The national ambition **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560491/Safer_Maternity_Care_action_plan.pdf**

Organisations Maternity and Neonatal Culture Score Survey **https://improvement.nhs.uk/documents/5039/Measuring_safety_culture_in_matneo_services_qi_1apr.pdf**

NHS Long term plan (January 2019) **https://www.longtermplan.nhs.uk/**

NHS staff survey (2018) **https://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2019/**

National Maternity Perinatal Audit (NMPA) report **https://www.hqip.org.uk/resource/national-maternity-and-perinatal-audit-nmpa-clinical-report-2019/#.XslKEDh7nIV**

The Royal College of Midwives Birth-rate plus tools **https://www.rcm.org.uk/media/2375/working-with-birthrate-plus.pdf**

NHS Improvement: The NHS Patient Safety Strategy (2019) **https://improvement.nhs.uk/documents/5472/190708_Patient_Safety_Strategy_for_website_v4.pdf**

Royal College of Midwives (2018) State of maternity services **https://www.rcm.org.uk/media/2373/state-of-maternity-services-report-2018-england.pdf**

NHS England Saving Babies Lives Care Bundle Version Two **https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf**

Report of the investigations into Morecambe Bay (March 2015) **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf**

Royal College of Obstetricians and Gynaecologists (2016) Maternity Standards (2016) **https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/maternitystandards.pdf**

Organisations Monthly Maternity Dashboard **https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard**

NHS England: Implementing the Recommendations of the Neonatal Critical Care Transformation Review (December 2019) **https://www.england.nhs.uk/wp-content/uploads/2019/12/Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf**

NHS England: Implementing Better Births: A resource pack for Local Maternity Systems **https://www.england.nhs.uk/wp-content/uploads/2017/03/nhs-guidance-maternity-services-v1-print.pdf**

Better Births Health Briefing 11. Addressing ethnic inequalities in maternity service experiences and outcomes: responding to women's needs and preferences Kuldip K. Bharj and Sarah M. Salway A Race Equality Foundation Briefing Paper October 2008 **https://raceequalityfoundation.org.uk/wp-content/uploads/2018/03/health-brief11.pdf**

Local

- EKHUFT strategy 2020
- Coroner's recommendations 2020
- NHSE maternity support programme 2020
- CQC report 2020
- RCOG report 2015
- BESTT review co-production event January 2020
- Local Maternity Transformation Programme
- Co-development of a Safety Improvement and Implementation Framework March 2020
- Mapping/theming exercise of reports and recommendations against Strategic objectives

Find out more
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