BOARD/COMMITTEE REPORT

Meeting	**HEALTH & SOCIAL CARE SCRUTINY COMMITTEE**		**Date: 14th September 2017**
Report Title	**WALSALL MATERNITY SERVICES**		**Agenda Item: Enclosure No.:**
Lead Director to Present Report	Richard Kirby, Chief Executive		
Report Author(s)	Richard Kirby, Chief Executive		
Executive Summary	• The Trust's maternity service was rated "inadequate" by the CQC in February 2016 following their inspection in September 2015. • In response the Trust delivered a set of actions including reducing the number of births in Walsall, recruiting additional midwives, changing the leadership of the service and launching a "normality" strategy as the focus for our model of care. • The CQC re-inspected the service in June 2017 and reported that *"there have been some improvements across many areas within this service since our inspection in September 2015, however there are significant problems outstanding".* Their concerns concentrate on staffing levels and the culture in the maternity team. • The Trust has accepted these concerns and agreed a Maternity Improvement Plan with stakeholders including the CQC, CCG and NHS Improvement to respond quickly and effectively. • The plan includes action to improve staffing levels in the short-term whilst developing a more sustainable solution in the longer-term, further action to improve leadership and culture and a focus on key areas of practice and process where we have problems. • These actions are set in the context of a longer-term strategy for maternity services in Walsall for 2020 which is consistent with the wider Black Country Sustainability & Transformation Plan.		
Purpose	**Approval** ☐	**Decision** ☐	**Discussion** ☒	**Note for Information** ☐
Recommendation	1. CONSIDER the report and NOTE the Trust's continued action to improve maternity services in response to the CQC's concerns.			

<table>
<tr><td rowspan="5"><u>Trust Objectives Supported by this Report</u></td><td>Provide Safe High Quality Care Across all of Our Services</td><td>Embed the quality, performace and patient experience improvements that we have begun in 2016/17</td></tr>
<tr><td>Care for Patients at Home Whenever we can</td><td>Embed continual service improvement as the way we do things linked to our Improvement plan</td></tr>
<tr><td>Work Closely with Partners in Walsall and Surrounding Areas</td><td>Deliver a sustainability review of all our services to set plans for next 5 years</td></tr>
<tr><td>Value our Colleagues so they recommend us as a place to work</td><td>Embed an engaged, enpowered and clinically led organisational culture</td></tr>
<tr><td>Use resources well to ensure we are Sustainable</td><td>Ensure our hospital estate is future proof and fit for purpose</td></tr>
<tr><td><u>Care Quality Commission Key Lines of Enquiry Supported by this Report</u></td><td colspan="2">The report supports the following Key Lines of Enquiry:
<table><tr><td><u>Safe</u></td><td>☒</td><td><u>Effective</u></td><td>☒</td></tr><tr><td><u>Caring</u></td><td>☒</td><td><u>Responsive</u></td><td>☒</td></tr><tr><td><u>Well-Led</u></td><td>☒</td><td></td><td></td></tr></table></td></tr>
<tr><td><u>Board Assurance Framework/ Corporate Risk Register Links</u></td><td colspan="2">Risks to the successful delivery of improvements in maternity services are identified in both our Board Assurance Framework and our Corporate Risk Register.</td></tr>
<tr><td><u>Resource Implications</u></td><td colspan="2">Our financial plan in 2016/17 committed additional resources to maternity staffing. Our capital plans for 2017/18 include c. £6m for our phase 1 estate development. The short-term action we have taken to release midwives in response adds a financial pressure of at least c. £0.5m in 2017/18.</td></tr>
<tr><td><u>Other Regulatory /Legal Implications</u></td><td colspan="2">The Trust remains in special measures following our September 2015 CQC inspection and is in Segment 4 in NHS Improvement’s oversight framework. We are waiting for our draft report from the June 2017 inspection.</td></tr>
<tr><td><u>Report History</u></td><td colspan="2">No previous consideration</td></tr>
<tr><td><u>Next Steps</u></td><td colspan="2">No direct next steps</td></tr>
<tr><td><u>Freedom of Information Status</u></td><td colspan="2">The report is subject to the Freedom of Information Act. Whilst it is intended that it may be released into the public domain at a future date, it may not be copied or distributed further without the written permission of the Chair of the Trust Board/ Chair of the Committee</td></tr>
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Walsall Healthcare NHS
NHS Trust

REPORT TO THE SCRUTINY COMMITTEE
14TH SEPTEMBER 2017

WALSALL MATERNITY SERVICES

INTRODUCTION

Maternity Services in Walsall have faced a series of challenges over recent years. Having been rated "inadequate" in Walsall Healthcare's Care Quality Commission (CQC) inspection report published in February 2016, the Trust has worked hard to deliver improvements. Feedback from the most recent June 2017 CQC inspection recognised progress but raised continued serious concerns mainly regarding staffing and culture. This was discussed initially at the Scrutiny Committee in July 2017 and this report sets out in more detail the original action taken by the Trust and our response to the most recent CQC feedback. In doing so it seeks to place our short-term improvement work in the context of our longer-term strategy for maternity services in Walsall.

BACKGROUND

The Trust was originally inspected by the Care Quality Commission in September 2015. Maternity was one of the services included within the Section 29A Warning Notice that the Trust received following the inspection in October 2015. In their report published in February 2016 the maternity service was rated "inadequate" with the following ratings across the CQC's five domains.

Service	CQC Domain					Overall
	Safe	Effective	Caring	Responsive	Well-Led	
Maternity Services	Inadequate	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate

The CQC's concerns related to activity and staffing levels, leadership, quality of care and culture within the service.

The Trust's Patient Care Improvement Plan launched in response to the inspection as part of our five year improvement journey to 2020 included a set of actions to address the issues in maternity services. The Scrutiny Committee has been briefed on these actions and progress with delivery during 2016 and 2017. These actions included:

- limiting activity to 4,200 births a year through agreement with Royal Wolverhampton NHS Trust to ensure safe activity levels for the available staffing and estate. This limit transferred c. 600 births a year from the Manor

to New Cross Hospital. Although there have been fluctuations between months, overall activity was within this limit in 2016/17 and is forecast to remain within it for 2017/18. Decision have yet to be taken in discussion with Wolverhampton about activity levels for 2018/19;

- recruitment of additional midwives to reduce the birth to midwife ratio from 1:37 to the national average of 1:28. This supports the consistent delivery of one to one care in labour. We also introduced a 4 hourly intrapartum acuity tool to assess staffing levels against demand in real time from March 2017. Our latest reported ratio (July 2017) is on track at 1:28;
- changes to the leadership of the service with the appointment of new medical and midwifery leaders;
- establishment of a Transitional Care Unit to improve the interface between postnatal wards and the neonatal unit;
- development and approval of a c. £6m business case for a second dedicated maternity theatre and an extended neonatal unit with 18 cots. The contracts for this work are due to signed in the next few weeks.
- launch of a strategy to promote "normality" as our standard approach to birth with the aim of promoting an approach that only uses medical interventions (e.g. c-sections) when needed. This includes new equipment, new clinics and work with staff to redesign pathways. Our latest c-section rate (July 2017) was 26% showing a reduction on previous rates of c. 30%.

We presented an assessment of the action we had taken and impact it was having to Scrutiny Committee in February 2017 as part of a wider Trust Improvement Plan update.

These changes enabled the Trust to make improvements in the service during 2016 and 2017. It was, however, necessary to make the changes to activity, staffing and leadership in order to deliver the longer-term cultural change necessary in the service. We were aware that more remained to be done in maternity and the service continued to face some significant risks and had reported on this to stakeholders through the Special Measures Oversight Group during the spring of 2017.

CQC INSPECTION 2017

The Trust undertook a self-assessment as part of the preparation for our re-inspection in June 2017. Recognising that progress had been made with staffing, activity and leadership, we self-assessed maternity services as "requires improvement". This assessment was based on our review of the service against the CQC's guidance and included:

- our Friends & Family Test results for maternity which at c. 95% are within national averages for the experience of birth
- a reduction in reported clinical incidents in 2016/17 compared to 2015/16 including a 27% drop in staffing-related incidents;
- a 20% reduction in complaints in maternity from 2015/16 to 2016/17.

We have not yet received the report on our inspection from the CQC but we reported on their initial feedback when we attended Scrutiny Committee in July 2017.

Overall, the CQC's initial feedback concluded that

> *"since our last inspection in September 2015 we had seen improvements to many of the acute and community services [including] a positive change in staff attitude and behaviour since the last CQC, improvements to the overall governance structure [and] staff were kind, caring and compassionate across acute and community services".*

With regard to maternity services the initial feedback concluded

> *"This service caused the greatest concern. We acknowledge there have been some improvements across many areas within this service since our inspection in September 2015, however there are significant problems outstanding."*

These concerns centred on staffing levels, a culture of bullying in some parts of the service and inconsistent delivery of some key clinical processes.

The CQC informed us that they were considering enforcement action under section 31 of the Health & Social Care Act as a result of these concerns. In response the Trust has provided an action plan which has been accepted by the CQC, Walsall Clinical Commissioning Group, NHS England and NHS Improvement at our Oversight meeting on 29th August 2017. The CQC have therefore confirmed that they will not be taking enforcement action under section 31 but, at the time of writing, we are expecting their concerns about maternity to be formalised in a section 29A warning notice although this has not yet been received.

IMPROVEMENT PLAN AND PROGRESS

We have taken seriously the continued concerns raised by the CQC and are fully committed to responding to them quickly and effectively to ensure that we provide a safe and effective maternity service in Walsall.

This section of the report sets out the action we have taken and the progress that we have made in response to the inspection feedback.

Governance

Following the original inspection we put in place a Maternity Taskforce to lead our improvement work. We have strengthened our oversight of our work in maternity. This includes:

- establishing a weekly operation group led by the Divisional Operations Director for Women's & Children to ensure delivery of the Improvement Plan;
- nominating a second non-executive director to join our Maternity and Neonatal Taskforce which meets monthly and is chaired by the Chief Executive.
- extending the membership of the Taskforce to include all of the consultants and the senior midwifery leadership;
- monthly reporting from the Taskforce to the public trust board through the Quality & Safety Committee.

Safe Staffing
At the time of the original inspection in September 2015 the midwife to birth ratio was 1:37 compared to a national standard set through Birthrate Plus of 1:28. As a result of the action we took in 2016 it dropped to as low as 1:22 in February 2017. It has risen since then and on track at 1:28 in June and July 2017.

Staffing levels are tracked in two ways:

- compliance with our staffing standards – aiming for a minimum of 9 midwives on each shift and up to 11 where possible;
- completion of an intrapartum acuity tool every 4 hours that provides an assessment of the number of midwives needed in light of the numbers and acuity of the women in delivery suite. The results of this tool are reviewed through our Safety Huddles three times every day.

Since June 2017 we have taken four main actions to further improve staffing levels in Delivery Suite:

- continued to recruit to vacant midwifery posts with newly appointed staff commencing in September;
- temporarily relocated Midwifery Led Unit activity and staffing to the Manor Hospital Delivery Suite;
- used agency theatre nursing staff to release midwives from maternity theatre scrub roles;
- used agency nurses on to provide care on the post-natal wards where this is clinically appropriate (e.g. to provide post-operative care for women following c-section).

For the longer-term we are working with staff to set revised core staffing levels of the unit in the light of the outputs of our 4 hourly acuity tool. We are also looking at options for staffing theatres that do not depend on agency staff. We will review the outcome of this work and the future of the Midwifery Led Unit activity by the end of September to establish a sustainable plan for the service.

Leadership & Culture
Following the original inspection we took action to change the leadership of the maternity service as the first step in establishing an improved culture in the team. The full new senior midwifery team is now in place led by Nicola Wenlock as Divisional Director of Midwifery, Gynaecology & Sexual Health and including new leadership for our “normality” work and for delivery suite. A development programme has also already commenced for our Band 7 midwives. The role of Clinical Director for the service is currently vacant but we have recently appointed Mr James Davis as Deputy Clinical Director supported by an experienced obstetrician and former medical director from outside the Trust.

The next steps of our work to create a clinically-led, engaged and empowered culture in maternity services include:

- a full review by the Royal College of Obstetricians & Gynaecologists (RCOG) of practice and behaviours in the service that will be undertaken in October;

- continuing to recruit to an external experienced Clinical Director for the service (we are being supported by NHS Improvement in this);
- commissioning external support for a programme of clinical team building;
- using our staff engagement approach, Listening into Action and our Freedom to Speak Up Guardians to gather feedback from staff in the team to inform further action;
- using formal HR processes in a small number of individual cases where that is the appropriate response to persistent poor behaviour.

Establishing a stable senior leadership team to drive the culture change needed in maternity has been difficult but the new team along with the external support that is in place provides a basis for this change going forward.

A renewed focus on working with women and their families to understand what they want from the local service and how they experience services currently will also be part of this work in future. Healthwatch Walsall has very helpfully agreed to support us in this work.

Clinical Practice & Processes

In addition to the main issues of concern about staffing and culture the CQC raised concerns about some specific elements of our practice and processes that we have also responded to in our Improvement Plan.

These include:

- CTG monitoring – all staff have been reminded of the importance of CTG monitoring and especially the “fresh eyes” check from another colleague. A process of daily checking and weekly auditing of a sample of cases is driving rapid improvement in compliance in this area;
- Safeguarding Training – we have plans to ensure Safeguarding training is fully up to date for medical staff by end September and for – the much larger number of – midwifery staff by December.
- High Dependency Unit (HDU) Care – we have 10 midwives fully compliant with the standards for providing HDU care, a further 6 due to complete their training in September and plans to train 20 more during this year. Our rotas ensure that there is always an HDU-trained midwife on duty and this is managed through the daily Safety Huddles and monitored weekly.
- Pain Relief – effective administration of pain relief is overseen through our daily Safety Huddles and in the last two weeks we have had no reported incidents of delays in pain relief.
- C-Section Delays to Theatre – by the end of July 100% of our category 1 (the most clinically urgent) c-sections were in line with the 30 minute standard (decision to delivery of baby); 88% of category 2 sections were in theatre within the 75 minute standard.
- Readmissions – having reviewed our data, our readmission rate is 3.2% compared to a national average of 2.4% and the clinical team are working to reduce this further.

LONGER-TERM SERVICE DEVELOPMENT

The Trust's 2020 service strategy includes a maternity service at Walsall Manor delivering c. 4,500 – 5,000 births a year supported by a Level 2 Neonatal Unit and delivering care in line with the national "Better Births" strategy. The Trust's maternity service is an active part of the Black Country Local Maternity System (LMS) that has been established as part of the wider Black Country Sustainability & Transformation Plan (STP).

To deliver this strategy successfully there are a number of important issues that will need to be addressed with our community over the next 6 – 12 months including:

- successful delivery of our "normality" strategy and the Better Births model of care based on greater choice and personalisation of care;
- sustainable models for future staffing based on predicated activity levels;
- the future of midwifery-led care either continued in a stand-alone unit or in a purpose-built facility alongside delivery suite at the Manor Hospital;
- potential Phase 2 estate development to address Delivery Suite and Postnatal ward capacity plus any changes to the MLU;
- stronger network arrangements with other local providers through the Black Country LMS including Black Country work on the service capacity, catchments and choice. This work will be important in making decisions about how we can begin to remove the restrictions on choice of delivery at the Manor for mothers registered with some GP practices in the west of Walsall.

As the service addresses the immediate issues raised by the inspection, therefore, we are seeking to do so in the context of a longer-term strategy for the maternity service in Walsall.

CONCLUSION AND RECOMMENDATIONS

This report has set out the action that the Trust has been taking to address concerns about maternity services in Walsall especially relating to staffing levels and the culture in the team. This work commenced following our original CQC inspection. Although the CQC recognised progress when they re-inspected in June 2017, they continue to have serious concerns about the service. We have responded to these through a further set of actions designed to ensure that we accelerate short-term improvement while building a longer-term sustainable future for maternity services in Walsall.

The Scrutiny Committee is recommended to:

1. CONSIDER the report and NOTE the Trust's continued action to improve maternity services in response to the CQC's concerns.

4th September 2017