Staffordshire and Stoke-on-Trent Integrated Care Board

# Health and Care Overview and Scrutiny Committee – 29th July 2024

## Maternity and Neonatal Services Update

### Recommendation(s)

I recommend that:

a. Overview and Scrutiny Committee (OSC) receives and takes note of the content of the report – recognising progress towards improving maternity and neonatal services whilst also acknowledging the challenges maternity services are currently facing.

b. OSC receives a further update in March 2025 on the:

- Update and progress towards improving maternity and neonatal services
- Home Birth service

c. A further update be implemented based on the recommendations that will arise from the review of maternity services currently being undertaken in Nottingham and any further reviews or recommendations that are made during that period.

**Report of the Staffordshire and Stoke-on-Trent (SSoT) Integrated Care Board (ICB) – Jenny Brown, LMNS Lead Midwife**

### Summary


This paper provides a briefing to Staffordshire OSC on specific areas as requested:
a. Post Ockenden update
b. The strategy of maternity service delivery
c. Recruitment of maternity & neonatal staff
d. Stillbirths and Neonatal Mortality
e. Home Birth Services

This paper is also an opportunity to provide an update on maternity and neonatal service provision to the residents of Staffordshire and Stoke-on-Trent (SSoT) and includes areas of particular focus, responses to regulatory reports (CQC (Care Quality Commission)) and areas to be commended as well as areas that need further support.

All those working in maternity and neonatal services continue to address the challenges of workforce gaps whilst also remaining responsive to recommendations that arise from inquiries where delivery has fallen well below what should have been expected.

**Report**

**Background**
Maternity services in Staffordshire and Stoke-on-Trent in recent years have been provided from a number of locations;

a. Royal Stoke University Hospital and Queens Hospital, Burton, offering Consultant and midwife led services.
b. Freestanding Midwifery Birthing Units (FMBUs) at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield
c. Home Birth services provided by both UHNM and UHDB

It is important to note that Derby and Derbyshire ICB are the lead commissioners for the services provided by University Hospitals Derby and Burton NHS Trust. This includes Samuel Johnson Community Hospital.

Women are also able to access maternity services from neighbouring providers organisations outside of Staffordshire and Stoke-on-Trent, e.g. Royal Wolverhampton NHS Trust (RWT), Good Hope Hospital, Walsall Manor Hospital.

## 1.0 Post Ockenden update

The Second Ockenden Insight visit to University Hospitals North Midlands (UHNM) NHS Trust maternity services was completed on the 7th of September 2023. This was led by the LMNS and Staffordshire and Stoke-on-Trent Integrated Care Board (ICB), in partnership with regional support. The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working, to ensure that the actions taken to meet the Ockenden recommendations were embedded in practice. The team were delighted with the progress made over the past year. It was acknowledged that UHNM is on an improvement journey, the morale of every staff member that was interviewed, was one of positivity and strength.

A further combined Regional and ICB led Insight visit will take place in September 2024. This visit will include oversight and assurance in line with the NHS Oversight Framework which would include a face-to-face visit, meetings, and discussions with key individuals across the service and service users. It will also include a walk around to determine that policies and procedures are up to date, robust and reflected in practice.

A visit from the Chief Midwifery Officer (CMO) for England, took place on the 5th of December 2023, with the aim of getting to know the area better. The visit was seen as a success through assurance received from the Trust and increasing knowledge about maternity services delivered in the Midlands. The national CMO was able to see University Hospitals of North Midlands (UHNM) Maternity Assessment Unit Triage area and the difference it has made to the experiences of mothers and families since it opened on the 18th of September 2023.

A joint Regional NHSE team and Integrated Care Board (ICB) clinical site visit took place on the 15th of March 2024. The team demonstrated great leadership and motivation to drive improvements. It was clear the staff were proud to work in the organisation and there was a perceptible energy throughout the visit. We were pleased to note that the UHNM Improving Together methodology was present through the development and implementation of the improvement plan and across the unit.

The Local Maternity & Neonatal System has benchmarked against the early findings from NUH Ockenden, and actions are being taken forward through the LMNS Equity and Equality Plan for 2024/2025. Key areas of focus are to develop further information in different languages for birthing people & families. The Maternity and Neonatal Voice Partnership (MNVP) continue to focus their work on seldom heard groups and further work is in progress for the MNVP Champions to reflect the ethnic diversity of the local population. To strengthen and lead the Equity and equality agenda, the LMNS have funded an EDI Lead Midwife, to be hosted by our main provider, UHNM. Interviews are due to take place on the 7th of August 2024.

We have strengthened the established governance arrangements with neighbouring ICS's. From 2024, UHNM attend the Staffordshire and Stoke-on-Trent LMNS Quality and Safety Oversight Forum (QSOF) and ICB Midwives now attend meetings with Black Country LMNS and Derby and Derbyshire LMNS along with their respective LMNS Board meetings. This has supported the ICB to have access to a broader range of intelligence and discussions, rather than relying on the Trust to bring headlines to our QSOF and taking up valuable midwifery time to attend more meetings.

Following an immediate and essential action from the Investigation into maternity Services at the Shrewsbury and Telford NHS Trust, SSOT have appointed a Maternity and Neonatal Independent Senior Advocate (MNISA) as part of a pilot project supported by NHS England. The MNISA is now operational and working with families who either live in Staffordshire and Stoke-on-Trent or have used the maternity or neonatal services within the ICB footprint. The MNISA has received specialist training to be able to support women and families trying to navigate complex investigation processes following on from an adverse outcome (significant health

complication and/or bereavement). The MNISA role supports families to ensure that their voice is heard, and their feedback used to support transformation of maternity and neonatal services both at a local and national level.

## 2.0 Maternity Strategy - Aligning ICB governance processes to NHSE Guidance

In March 23, NHSE published the Three Year Maternity and Neonatal Delivery Plan which focuses on 4 key themes:
**Theme 1:** Listening to and working with women and families with compassion.
**Theme 2:** Growing, retaining, and supporting our workforce.
**Theme 3:** Developing and sustaining a culture of safety, learning and support.
**Theme 4:** Standards and structures that underpin safer, more personalised, and more equitable care

A full version of the Delivery Plan can be found at https://www.england.nhs.uk/wp-content/uploads/2023/03/B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf . This plan incorporates the earlier actions identified through The Emerging Findings and Recommendations from the Independent Review of maternity Services at the Shrewsbury and Telford Hospitals NHS Trust (2020); The Final Report of the Ockenden review (2022) and Reading the Signals: Maternity and Neonatal services in East Kent report (2022).

LMNS continues oversight of Year 2 implementation of the Three-year delivery plan for maternity and neonatal services across the system. Progress against the three-year delivery plan continues, a different theme each month is reviewed and monitored through QSOF which focusses on service and quality improvement. This is reported to the Local Maternity and Neonatal System Partnership Board on a monthly basis.

## 3.0 Monitoring and regulation:

The CQC inspection of UHNM maternity services in March 2023 with the final report being published in June 2023 reported a rating of 'Inadequate' for Safe, and 'Requires improvement' for Well led. Both elements had deteriorated from previous inspections. The overall CQC rating of 'Requires Improvement' for this service was also a reduction in rating. The concerns raised in the 'safe' element resulted in the CQC serving notice to the Trust under Section 29A of the Health and Social Care Act 2008.

A System Maternity Oversight and Assurance Group (SMOAG) was developed led by the SSoT ICB Chief Nurse and the Regional Chief Nurse in August 2023 and the group were accountable for gaining assurance for the delivery of the overall integrated quality improvement plan, and particularly progress against the actions being taken to address the CQC Section 29a conditions and the CQC actions which the Trust have been advised they must or should take to improve their maternity services.

The SMOAG was stepped down following the UHNM Rapid Quality Review meeting that was held with the national team, regional team, ICB, CQC, GMC, NMC, Maternity Safety Support Programme and UHNM on the 5th of April 2024. The Trust presented their progress against the CQC Action Plan, Maternity Incentive Scheme actions and any ongoing concerns or issues. The Trust was commended for all the work they have achieved over the last year and the focus now should be on sustainability. The ICB was also praised for the pragmatic way in which it worked and supported UHNM. The ICB will continue with oversight locally through the LMNS QSOF and the data will be reviewed monthly through a Perinatal Quality Oversight pack that has been developed.

The latest recommendation from the National Institute for Health and Care Excellence (NICE) (2021)) (NG 207), states that mothers should be offered an Induction of Labour (IOL) at 7 days past their due date, i.e., 40+7. Women commence the IOL pathway based on specific guidelines according to their risk. Because of the unpredictable nature of labour and the workforce challenges, there will be times when IOLs must be delayed, resulting in a breach against specific guidelines according to risk. UHNM had challenges last year regarding the induction of labour pathway, the Blossom Induction of Labour Suite was extended from a 4 to 8 bed unit in December 2023. Improvements have been made this year and current performance remains above the 95% trajectory at 97% and has been maintained over a 6-month period. IOLs breaches are monitored daily through the regional sitrep report and reviewed monthly through QSOF which provides oversight of implementation and informs future quality improvement work across the IOL pathway.

The MNVP are planning a Listening Event with birthing people and families in September 2024 regarding induction of labour pathway to inform future service development.

Many women from Staffordshire give birth at Queens Hospital in Burton on Trent. Following the latest CQC Inspection in August 2023 with the full report being published in November 2023, Queens Hospital Burton (QHB) was overall rated requires improvement and a CQC Section 29a notice was issued across UHDB. UHDB continue support from NHSE through the Maternity Safety Support Programme (MSSP) and the CQC section 29a

remain in place. Further support has been offered from the NHS Midlands Perinatal team to ensure the Trust have support in addressing their key areas of concern. Derby and Derbyshire ICB are responsible for gaining assurance about Maternity and Neonatal services at UHDB and therefore are an ICB that we work very closely with.

The CQC identified some immediate areas for improvement and required rapid changes to some elements of practice to meet regulatory requirements. This included post-partum haemorrhage / major obstetric haemorrhage management; fetal heart monitoring in labour and training compliance; triage; leadership and governance. Progress has been made, with all actions either completed or on track however further evidence of embedding the actions is required before a regulation exit plan can be developed for the Trust.

On 9 January 2024, the All-Party Parliamentary Group (APPG) on Birth Trauma established the first national inquiry in the UK Parliament to investigate the reasons for birth trauma and to develop policy recommendations to reduce the rate of birth trauma. We welcome the practical recommendations in the paper include integrating principles of trauma informed care across maternity settings and ensuring that women's rights are respected before, during and after birth. As a system, we look forward to putting the recommendations within the report, into action, as an enabler, to improve the birth experience of women and their families, helping ensure that birth is a safe and positive experience for all. A current benchmarking exercise is taking place with all key stakeholders, in collaboration, to identify gaps within the current service provision, with an improvement plan and this will be presented to the Local Maternity and Neonatal System Partnership Board in the coming months.

## 4.0 Recruitment of Maternity and Neonatal staff

Operational pressures continue within all maternity and neonatal services providing care in Staffordshire. UHNM, UHDB and RWT report positive recruitment programmes and are taking proactive action to attract midwives into their services. All Trusts continue to work towards their Birthrate Plus establishment. RWT are fully established to Birthrate plus and UHNM report they will be up to full Midwifery establishment by November 2024. UHDB have reported Midwifery gaps of around 40 whole time equivalents (10-12%) have been evident for the past 2-3 years. This has now been addressed with recruitment of 46 newly qualified and

internationally recruited midwives. Supervision will however be required during the preceptorship period of 12 months, to ensure that they are not counted in the numbers on shift until established in their role, to ensure they have opportunity to develop their skills.

There has been positive progress with appointing to Obstetric & Neonatal Consultants and the medical workforce at UHNM, however vacancies remain. UHNM report the medical workforce should be fully established by November 2024. A maternity safety case to improve workforce was agreed by Trust Board at UHDB in 2020/2021 with a phased investment into Maternity, Neonates and Anaesthetics over 4 years totalling £3.6m by year 4. In 2023/24 this investment was reviewed and a further investment of £4m was supported providing a combined investment of £7.6m. Vacancies remain for medical staffing with mitigations in place and the Trust is working closely with the East Midlands Healthcare Workforce Deanery and the Royal College of Obstetricians and Gynaecologists.

**5.0 Stillbirths and Neonatal Mortality.**

Recently published Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE –UK) Perinatal Mortality Data –1st January 2022 to 31st December 2022 (published March 2024) highlighted that nine of the eleven ICBs (Integrated Care Board) across the Midlands had neonatal mortality rates (stabilised and adjusted) that were over 5% higher than the UK average of 1.69 per 1,000 live births. Staffordshire and Stoke-on-Trent (SSoT)ICB had the third highest rate of Neonatal Mortality at 2.11 per 1,000 births across the Midlands. UHNM had a rate above the national average of 2.68 per 1,000 births and UHDB had a rate below the national average at 1.45 per 1,000 births.

Stillbirth rates remain below the national average across SSoT ICB at 3.6 per 1,000 births. UHNM remain above the national average at 3.59 per 1,000 births and UHDB below the national average as outlined in Table 1 below.

Table 1:

| | **Staffordshire & Stoke-on-Trent SSoT ICB** | **National Average** |
|---|---|---|

| | UHNM (MBRRACE2022) | UHDB (MBRRACE 2022) | SSoT (MBRRACE 2022) | UK average MBRRACE (2022) |
|---|---|---|---|---|
| Stillbirth rate / 1000 total births | 3.59 | 3.26 | 3.26 | 3.35 |
| Neonatal death rates / 1000 live births | 2.68 | 1.45 | 2.11 | 1.69 |

Neonatal Mortality is now reviewed at QSOF monthly to identify any areas for learning and improvement. UHNM have reviewed all the MBRRACE Mortality cases to identify any themes or learning. An action plan has been developed on the MBRRACE Perinatal Mortality data which is currently being signed off through Trust governance and will be shared in August 2024. The QSOF agenda also includes quality assurance on the neonatal services which includes progress against Saving Babies Lives v3, the Neonatal Critical Care Review Action Plan and Neonatal and Neonatology staffing.

Alongside this work, the Children and Young People (CYP) Programme Board had commissioned an Infant Mortality review which showed that the majority of deaths occurred in the first 28 days, i.e., within the neonatal period. An Infant Mortality Steering System Group has been established which is led by Stoke-on-Trent Public Health Authority with ICB Midwives in attendance.

The Local Maternity and Neonatal System (LMNS) to continue to support the Trusts with implementation of the Saving Babies Lives Care Bundle (SBLCB) v3. A national reporting template was published in June 2023 to review implementation across the six elements:

- Element 1: Smoking in Pregnancy
- Element 2: Fetal Growth Restriction
- Element 3: Reduced fetal movements
- Element 4: Effective fetal monitoring in labour
- Element 5: Preterm Birth
- Element 6: Diabetes in pregnancy

Both UHNM and UHDB continue to progress implementation across all six elements.

The LMNS will continue to work with the Trusts to ensure the data informs actions for improvements. The continued oversight and involvement in Perinatal Mortality Review Tool group and oversight of the mortality data

and Clinical Negligence Scheme for Trusts (CNST)/Maternity Incentive Scheme (MIS) Year 6 submission which is due on the 3rd of March 2025.

The LMNS will also continue to ensure implementation of the LMNS Equity and Equality Plan in 2024/2025 to improve equity for mothers and babies from Black, Asian, and Mixed ethnic groups and those living in the most deprived areas.

**6.0 Home Birth service**

The Home birthing services at UHNM and UHDB were both reinstated for bookings in April 2024. Each Trust will be monitoring uptake and outcomes and feedback through the LMNS quality and safety oversight forum.

**7.0 Points for concern**

Vacancies remain across Midwifery, Obstetric and Neonatal Consultants, however the successful recruitment campaigns have significantly reduced the vacancy rate. With each Trust on track to be fully established by Autumn 2024

Neonatal Mortality remains above the national average, and it must be acknowledged the clear link between perinatal mortality and the multidimensional effects of poverty, age, and ethnicity. Therefore, a multi-agency system working targeted approach is required to have a positive impact.

**8.0 Points for celebration**

UHNM was stepped down from regional support following the UHNM Rapid Quality Review meeting that was held with the national team, regional team, ICB, CQC, GMC, NMC, Maternity Safety Support Programme and UHNM on the 5th of April 2024 and commended for the progress they have made.

The ICS has successfully introduced and is working to achieve the aims of the Three-Year Maternity and Neonatal Delivery Plan.

The Maternity and Neonatal Independent Senior Advocate (MNISA) is now operational and working with families who either live in Staffordshire and Stoke-on-Trent or have used the maternity or neonatal services within the ICB footprint.

**Link to Strategic Plan**
The Staffordshire and Stoke-on-Trent Integrated Care System (ICS) has an agreed vision: Working with you to make Staffordshire and Stoke-on-Trent the healthiest places to live and work.

***Our purpose***

- If you live in Staffordshire and Stoke-on-Trent your children will have the best possible start in life and will start school ready to learn.
- Through local services we will help you to live independently and stay well or longer.
- When you need help, you will receive joined up, timely and accessible care, which will be the best that we can provide.

This report supports the ICS priority 'Delivering improvements in Children and Young Peoples services and Maternity care'.

**List of Background Documents/Appendices:**

Three Year Delivery Plan for Maternity and Neonatal Services NHS England » Three year delivery plan for maternity and neonatal services

Saving Babies Lives version 3: a care bundle for reducing perinatal mortality NHS England » Saving babies' lives version three: a care bundle for reducing perinatal mortality

Clinical Negligence Scheme for Trusts (CNST) / Maternity Incentive Scheme (Year 6) Maternity incentive scheme - NHS Resolution

The Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust (2020) Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust - GOV.UK (www.gov.uk)

The Final Report of the Ockenden review (2022) - OCKENDEN REPORT - FINAL (ockendenmaternityreview.org.uk)

The Mothers and Babies: Reducing Risk through Audit and Confidential Enquiry (MBRRACE) reports - MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | MBRRACE-UK | NPEU (ox.ac.uk)

Better Births, the report of the National Maternity Review (2016) - NHS England » Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care

Reading the Signals: Maternity and Neonatal services in East Kent report (2022) - Maternity and neonatal services in East Kent: 'Reading the signals' report - GOV.UK (www.gov.uk)

Maternity and Neonatal Independent Senior Advocate pilot – Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk)

**Appendices -** as above

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