NHS England Board meeting

Paper Title: Maternity and Neonatal Services - Update

Agenda item: 5 (Public session)

Report by: Ruth May, Chief Nursing Officer

Paper type: For information

Key area: Strategy ☐ Performance ☐ Policy ☒

Link to strategic objective(s):

Please choose as appropriate:

- Supporting integration of care and enable change ☒
- Recovery of the health service ☐
- Continued COVID-19 response ☐
- Achieving long term financial sustainability ☐
- Workforce and investment in our people ☒
- Transformation of services ☒
- Digital and data ☐
- Statutory item ☐
- Governance ☐
- Other: please state below ☐

Executive summary:

This paper provides an update on progress on maternity and neonatal care since the May Board, and on independent reviews into maternity services at East Kent and Nottingham.

Previously considered by:

We have provided a similar update to Audit and Risk Assurance Committee.

Risk

Whilst maternity and neonatal services have made good progress on outcomes they are under significant strain. We must take further action to address this and apply learning from independent reviews of maternity services.

High ☐ Medium ☒ Low ☐

Action required by the Board:

To note the progress on improving maternity and neonatal care, and to note the delay to the East Kent report and the delivery plan.

Background

1. The vision for maternity and neonatal services is to deliver safer and more personalised care across England. We updated the Board in May on progress

towards this, and action being taken to implement learning from Donna Ockenden's review of maternity services at Shrewsbury and Telford NHS Trust. We are expecting a report on maternity services at East Kent Hospitals University NHS Foundation Trust later this year.[1]

2. In light of concerns raised by families who were part of the initial, regionally led review, Donna Ockenden has been appointed Chair of the independent review into maternity and neonatal services at Nottingham University Hospitals. The terms of reference along with a formal governance and oversight structure have been agreed. The review, expected to take 18 months, was formally launched on 1 September. It will consider cases from April 2012 up until 3 months before publication of the final report, and cases since 2006 by exception. The Trust will identify cases that meet the criteria set out in the terms of reference; communications have been sent from the review team asking for people who may have been affected to get in touch. Regular contact between NHSE and the review team will ensure any areas of concern identified that impact current patient safety will be shared at the earliest opportunity so they can be immediately addressed.

3. At the May Board we confirmed that 2020 ambitions to reduce neonatal mortality and stillbirth rates by 20% compared to 2010 were surpassed.[2] The neonatal mortality rate for babies born at 24 weeks gestation or over fell by 36% to 1.3 per 1000 live births and the stillbirth rate fell by 25% to 3.8 per 1000 births.

4. We now have more evidence of the impact of the pandemic on our safety ambitions. Recently published statistics indicate an increase in the stillbirth rate to 4.1 per 1000 births (19.3% lower than in 2010).[3] While research indicates that outcomes are good for the majority of babies born to women with a COVID-19 infection, higher COVID infection rates and higher mortality rates in pregnant women with COVID have contributed to the increase in stillbirth rate in 2021.[4]

5. Poor maternity and neonatal care can have a tragic impact on families. It also results in significant clinical negligence costs to the NHS. In 2021/22, NHS Resolution paid out £900m in relation to past obstetric negligence cases, compared to NHS spend of around £3bn on maternity services. NHS England has a comprehensive programme to improve maternity and neonatal care, and we have updated on progress below. This is complemented by NHS Resolution's work to address clinical negligence and encourage early resolution when things go wrong. Their Early Notification Scheme is providing contemporaneous feedback for the NHS so that lessons can be

[1] Changes to the Parliamentary Timetable as a result of the Queen's funeral have led to the East Kent report being postponed from September, with a consequent impact on the timing of the NHS England delivery plan for maternity and neonatal care.

[2] ONS 2020 Mortality Statistics

[3] ONS 2021 Births Statistics

[4] Report on the Management and implications of severe COVID-19 in pregnancy in the UK, based on data collected in the UK Obstetric Surveillance System (UKOSS) COVID-19 in Pregnancy Study found that severe COVID-19 in pregnancy increases the risk of adverse outcomes including: 13.9% of 4436 pregnant women hospitalised with symptomatic COVID had severe infection; approximately 3% of births to women admitted to hospital with severe COVID was a stillbirth compared to approximately 1% in those with mild / moderate COVID; and approximately 2 in 3 babies born to a mother admitted with severe COVID was admitted to a neonatal unit. This compares to approximately 1 in 7 of all babies requiring neonatal care in 2019 according to the National Neonatal Audit Programme Report 2020.

learnt at the earliest opportunity. Their Maternity Incentive Scheme continues to drive improvements in safety; it is developed in partnership and reviewed each year with the national maternity safety champions – Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent OBE.

Progress on improving maternity and neonatal care

6. Since we updated the Board in May, we have made further progress on actions to improve care and implement learning from the Ockenden report – set out below. This is supported by an additional £127m announced earlier this year.

    a. Maternal Medicine Networks are now commissioned, and all are expected to be operational by the end of 2022. They will provide timely access to specialist care for all women with pre-existing medical conditions and those that arise during pregnancy.

    b. A £45m capital investment is underway to support regions and networks in the reconfiguration of capacity (cots) required to meet the ambitions and recommendation of the Neonatal Critical Care Review.

    c. 2021/22 funding for neonatal care to fund the most urgent nurse staffing gaps has enabled an establishment increase of 123 WTE nurses compared to December 2020. Figures on recruitment against 22/23 additional Long Term Plan funding will be available shortly.

    d. A £6m investment is being made to create additional leadership capacity for obstetric consultants, enhance the recruitment and retention of maternity services support workers and increase bereavement care through additional training plus targeted funding for providers with limited bereavement care provision. Expressions of interest have been received from almost all providers and we are in the process of evaluating the responses.

    e. Latest figures show that the smoking rate for pregnant women at the time of birth fell to 9.1% in 2021-22, the lowest annual rate on record, and down from 10.6% prior to the Long Term Plan in 2019.

    f. We extended our offer to all Trusts to support the international recruitment of midwives and we are providing further support to those wanting to expand their existing ambitions.

    g. We have invited expressions of interest to pilot a new Independent Senior Advocate role to help ensure that women and their families are listened to.

    h. By mid-October, Regional Chief Midwives will have completed assurance visits with all Trusts to support detailed implementation of the first Ockenden report.

    i. With DHSC, we have commissioned an independent working group to guide the implementation of actions and recommendations from the reports into Shrewsbury and Telford and East Kent.

7. Midwifery Continuity of Carer (MCoC) is a commitment of the Long Term Plan and is highlighted as an effective intervention in Core20PLUS5. At the heart of the MCoC model is the vision that women should have consistent, safe and personalised maternity care, before, during and after the birth. It is a model of care provision that that is evidence-based. It can improve the outcomes for most women and babies and especially women of Black, Asian and mixed ethnicity and those living in the most deprived neighbourhoods.

8. This model of care requires appropriate staffing levels to be implemented safely. In light of the continued workforce challenges that maternity services face, following the publication of the final Ockenden report we wrote to Trusts to clarify the action to pause on MCoC rollout where safe staffing is not in place. This built on the guidance we had already issued in October 2021. We have again written to services clarifying that Trusts are not expected to deliver against a target level of MCoC, and this will remain in place until maternity services in England can demonstrate sufficient staffing levels to do so.

9. We will continue to support the pilot of 62 enhanced MCoC teams beginning this year to specifically support those living in the most deprived 10% of neighbourhoods. We are investing £1.3m in 2022/23 and are considering further investment for upcoming years.

10. NHS England remains committed to ensuring that digital maternity records are available for women and clinicians to appropriately access. Due to varying levels of digital maturity and change capacity across maternity services, we expect that under current timeframes (March 2024), complete delivery of the Long Term Plan commitment will be a challenge. In addition, our approach to technology adoption has changed – moving away from numerous specialised systems to a more pragmatic and sustainable approach of implementing comprehensive electronic patient records with all functionality built into the core system. This may require a revision to the previous commitment. In 21/22, we invested £40.8m across 128 units and Trusts to put in place the digital foundations that services require, and it is still a priority for NHS England.

Workforce

11. To continue to improve care it is essential we have safe staffing with a skilled multi-disciplinary maternity team. We are, however, faced with significant workforce challenges.

12. The number of Midwives substantively has decreased nationally, at c.22,809 FTE, this is 693 FTE less than the same period last year. Maternity services have worked tirelessly through the pandemic, and results from the NHS Staff Survey show we need to support the morale of the maternity workforce. At the same time, providers have told us that: the number of support workers in post within maternity services has increased to 6,454 FTE as at July 2022, up 127 FTE since July 2021, and the number of obstetrician consultants in post increased to 1,487 FTE as at July 2022, an increase of 216 FTE since July 2021.

13. We are taking action to invest in establishment, recruitment, and retention and to provide additional support to the maternity workforce. To realise our

ambitions to provide safe and more personalised care, and to implement learning from Ockenden and East Kent, we will need to go further to retain and recruit maternity staff.

14. A national investment of £95m was announced in March 2021 to increase establishment in midwifery by 1,200 full time equivalent (FTE) and obstetric roles by 100 FTE. The latest data shows this has been built on by Trusts to further increase establishments to +1,682 FTE for midwifery and +311 FTE for obstetric roles. At the same time, the establishment of support workers in maternity services has increased by 387 FTE. A further investment of £51m is being made between 22/23 to 23/24 in the maternity and neonatal workforce in England. This will support Trusts to expand supernumerary midwifery capacity, enhance the retention and development of support workers, increase bereavement provision, and increase obstetric leadership capacity. In the Neonatal workforce, there will be an expansion in Allied Health Professionals and medical staff.

15. On supply, our primary route for midwifery is through domestic supply. There is an existing commitment to expand midwifery training places by 3,650 from 2018/19 with an increase of 650 in 2019/20 and 1,000 per year over subsequent years until 2022/23. The target to date has been overachieved by 166 places and Health Education England (HEE) remains confident of achieving the additional 1,000 this year.

16. While the domestic undergraduate programme is the primary source of newly qualified midwives, early in 2022 HEE secured additional national funding to support 300 places per year for nurses to train as midwives via the postgraduate midwifery programme. There is significant demand for this shortened route to the register, which takes 20 months on average, and some HEE regions have been able to fund places in addition to the 300 nationally funded places.

17. We have the highest ever number of students on undergraduate courses and expect this to be the first year where the impact of increased numbers of newly qualified midwives enter the system.

Next steps

18. We will update the Board following publication of the East Kent report. In early 2023, we will publish a refreshed delivery plan for maternity and neonatal care. The plan will set priorities to drive further improvement and support safer, more personalised and more equitable care. To help those leading or providing care to support that improvement, it will bring together action they need to take following the reports on East Kent and Shrewsbury and Telford with our existing deliverables from the NHS Long Term Plan and Maternity Transformation Programme.