NHS England

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 discussion

Organisation Objective:

NHS Mandate from Government	☐	Statutory item	☐
NHS Long Term Plan	☒	Governance	☐
NHS People Plan	☐		

Executive summary:

This paper provides an overview of the report following the independent investigation into Maternity and Neonatal Services at East Kent University Hospital's Foundation Trust, covering the key actions and next steps.

Action required by the Board:

i. To note the progress made by maternity and neonatal services.

ii. To note the collaboration required across NHSE in order to implement learning from the report on East Kent University Hospital's Foundation Trust.

iii. That a focussed discussion is held with the Board in the coming months on the findings and the implications of the reports on East Kent and Shrewsbury and Telford, ahead of the Board's consideration of this and the wider refreshed delivery plan for maternity and neonatal care in early 2023.

Background

1. Our aim is safer, more personalised, and more equitable maternity and neonatal care, improving outcomes and experience for babies, mothers and families. This includes our ambition to halve the rates of stillbirth, neonatal death, and brain injury between 2010 and 2025 with an interim target of a 20% reduction by 2020, which was surpassed.[1]

2. Additional funding in recent years has enabled us to increase our aggregate staffing establishment by 1,682 midwives, 311 obstetricians, 387 maternity support workers and over 550 neonatal nurses.

[1] 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.

3. Good progress has been made with our NHS Long Term Plan objectives, including:
   - The establishment of 14 Maternal Medicine Networks to provide specialist management for women with pre-existing medical conditions.
   - Perinatal Pelvic Health Services which are on track for full roll-out by March 2024.
   - Capital investment in neonatal services over the next three years which is enabling an increase and realignment of cot capacity to meet local needs.

Current challenges in maternity and neonatal services

4. Despite the progress detailed above, there are significant challenges facing maternity and neonatal services, particularly around quality, workforce and the effect of the Covid-19 pandemic.

5. The 2021 NHS Staff Survey demonstrated that midwives have the lowest scores of all staff groups on work-related pressure and morale, and while the £21m recurrent investment in the maternity workforce and £12.7m recurrent investment in the neonatal workforce has started to address staffing gaps, there are current establishment gaps of around 800 obstetricians, 250 neonatologists and at least 1100 midwives and 100 obstetric anaesthetists.

6. The most recent data on perinatal outcomes has revealed the direct and indirect impact of the Covid-19 pandemic, although research indicates that outcomes are good for the majority of babies born to women with a Covid-19 infection. Higher Covid-19 infection rates and higher mortality rates in pregnant women with Covid-19 have contributed to the increase in stillbirth rate from 3.8 per 1000 births in 2020 to 4.1 per 1000 births in 2021. While neonatal mortality rates continued to reduce, from 1.4 per 1,000 live births in 2019 to 1.3 per 1,000 live births in 2020, some evidence of an increase in neonatal mortality rate in 2021-22 has recently emerged. In response we are looking at where neonatal mortality has reduced and ensuring interventions used in those areas are introduced more widely. Data to be published by ONS in early 2023 will quantify the actual change in neonatal mortality rate from 2020 to 2021.

7. Maternal mortality rates have also been directly and indirectly impacted by the pandemic. The maternal mortality rate during pregnancy and the 6 weeks after birth increased from 8.8 per 100,000 maternities in the triennia from 2017-19 to 10.9 per 100,000 maternities in 2018-20. Excluding maternal deaths due to Covid-19, the maternal mortality rate was 10.5 per 100,000 maternities in 2018-20, just 1.6% lower than the 2009-11 national ambition baseline. There was also an increase in the rate of maternal suicide occurring within a year after the end of pregnancy.

Reports into Maternity Services

8. Maternity and Neonatal services have received two significant reports this year which highlight examples of failings in care. At the May Board meeting we provided an update on our actions to respond to the Ockenden report, including our commissioning, with DHSC, of an Independent Maternity Working Group.

This is now established and is meeting on a monthly basis, chaired by the Royal Colleges.

9. 'Reading the Signals', Bill Kirkup's report on maternity and neonatal services at East Kent University Hospital's Foundation Trust, was published on 19 October. The recommendations from this report are much more wide-ranging and extend beyond the scope of maternity and neonatal services.

10. A letter was sent to Trust and ICB CEOs and Chairs to ensure that this report was discussed at their next public board meeting, and for Boards to be clear on the action they will take to tackle the themes within the report.

11. As part of the national response to the recommendations, we have now launched our Culture and Leadership programme to support positive behaviours, compassionate leadership and teamworking across perinatal services. As part of this, the Board Safety Champion programme will focus on understanding data, data oversight, interpretation and assurance implications. It will provide participants with the confidence and capability to interrogate and understand data to inform discussion and action on perinatal safety, and the capability to lead discussions and assure Boards about maternity and neonatal safety culture.

12. While the Chief Nursing Officer is the SRO for maternity services in England and individual Trust Boards are responsible for their maternity services, given the breadth of the East Kent action areas, other senior NHS leaders will also own the implementation and assurance of work in these areas, which will help to ensure a culture of compassionate care and positive team working across the NHS.

Planned actions for delivery in the next 3-6 months

13. We understand the need to respond to the first recommendation of the East Kent report at pace and are therefore establishing a working group to assess and address the current gaps in maternity and neonatal intelligence and data. As well as membership from NHSE, we will be seeking expertise from stakeholders including DHSC and Royal Colleges.

14. Moving forward we have identified four key areas where maternity and neonatal services need to improve:

    - **Listening to women**: The reports from Shrewsbury and Telford and East Kent both detailed the experiences of women and families not being listened to enough during their care. We know that, as well as being distressing, this can have a negative impact on outcomes. We recognise the importance of personalised care and informed choice and are working to ensure that this is provided to all women, with enhanced levels of care for the women who are most vulnerable. We have recently allocated funding to pilot Independent Senior Advocates to support listening and advocacy for women, particularly where there has been an adverse outcome. The establishment of Maternity Voices Partnerships and the commitment to service user voice representation

at every level of the maternity and neonatal programme has enabled the voices of women and families to be heard in forums where decisions about services are made and has facilitated co-production. We are committed to continuing and further developing this.

- **Workforce**: As detailed above, recent investment has enabled an increase in staffing establishment but the pandemic has contributed to an unprecedented number of midwifery leavers compounded by recent retirements. This has resulted in a reduction in the number of midwives in post. There are several initiatives in place to increase the midwifery workforce, including an increase in undergraduate training places of 3,650 over four years from 2018/19, international recruitment and interventions to support retention.

- **Culture and Leadership**: In recognition of the importance of a positive culture and compassionate leadership, the maternity and neonatal team have recently launched their Culture and Leadership programme. The Kirkup report in particular highlighted the negative impact that a poor culture can have on the safety and effectiveness of services, as well as on staff morale. The Culture and Leadership programme will work with the quadrumvirate leadership of maternity and neonatal services at all trusts by March 2024, as well as supporting Board Safety Champions and aspiring midwifery leaders.

- **Standards and Infrastructure**: These are essential to underpin and support high quality services. Maternity services have led the way with system working with the formation of Local Maternity and Neonatal Systems (LMNS) and this is now reflected more widely in Integrated Care Systems. LMNS and the seven regional teams provide support and guidance to providers, facilitating cross-boundary, collaborative working. We will continue to support and develop the roles of these teams including ensuring sustainable funding. The Core Competency Framework and Saving Babies Lives Care Bundle have set standards for trusts to promote best practice. We are committed to ensuring these are updated and renewed as necessary to reflect the most recent evidence. Data enables identification of areas for improvement, so we are supporting trusts to submit high quality data to the maternity services data set, and will continue to commission audits to enable us to analyse outcomes and women's experiences of care. Digitalisation of maternity and neonatal records will help to facilitate better data collection as well as improving women's access to their records, a commitment from Better Births. Through the Maternity Safety Support Programme we are getting upstream to provide support to Trusts that need it, and have recently enabled four Trusts to meet the standards for exiting the programme.

15. Focusing on these fundamentals, and bringing together the recommendations from the reports, along with existing commitments from the Long Term Plan and Maternity Transformation Programme, the maternity and neonatal team are creating a refreshed delivery plan which will be published in 2023. As set out in the 19 May Board paper, we are committed to engaging with people who use, work in, oversee and/or are stakeholders for maternity and neonatal services. Since August, we have held or attended over 30 events with service users, members of the workforce, LMNSs, ICB/ICSs and our stakeholders, reaching

over 500 people. To further support our engagement, we have launched a survey which has so far received over 1,000 responses. We will be collating the feedback to help inform how the single delivery plan is brought together to set priorities which will drive further improvement and support safer, more personalised, and more equitable care.