FOR PUBLICATION

DERBYSHIRE COUNTY COUNCIL

IMPROVEMENT AND SCRUTINY COMMITTEE – HEALTH

16 January 2023

Report of the Integrated Care Board

Overview of Maternity Services in Derbyshire - (following the Ockenden Report)

1. Purpose

This paper provides an overview of maternity services in Derbyshire and information on the governance, assurance and safety of maternity services locally.

2. Information and Analysis

2.1. Definitions

Definitions for terms used in this paper are:

- **Maternal mortality/death –** is the death of a woman during or up to 6 weeks (42 days) after the end of a pregnancy (whether the pregnancy ended in termination, miscarriage or a birth or was an ectopic pregnancy).
- **Neonatal mortality/death** – is the death of a live born baby within the first 28 days of life.
- **Perinatal mortality/ death** – is both stillbirths and neonatal deaths.
- **Preterm birth -** babies born alive before 37 weeks of pregnancy.
- **Stillbirth –** when a baby is born dead after 24 weeks of pregnancy.

2.2. National policy

Maternity care oversight, assurance and transformation is informed by the following national reports:

- **Better Births, the report of the National Maternity Review** (2016) sets out a vision to help achieve better and safer outcomes for families. The recommendations were to make care more personalised; improve shared decision making for families and provide a supported, high performing workforce who work across boundaries. The Maternity Transformation programme addressed the Better Births recommendations

- **NHS Long Term Plan (2019)** – focuses on action to achieve a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.

- **The Saving Babies Lives Care Bundle Version 2 (2019)** – provides detailed information on how to reduce perinatal death and pre-term birth. This brings together five elements of care that are widely recognised as evidence based and/or best practice:

    - 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

- **Clinical Negligence Scheme for Trusts (CNST) / Maternity Incentive Scheme (Year 4) –** this provides financial reward to Trusts for achieving ten recommended safety actions and meeting strict criteria for monitoring and assurance. The safety actions are Perinatal Mortality Reviews, Maternity Services dataset, avoiding term admissions to the neonatal unit and transitional care, clinical workforce, midwifery workforce, Saving Babies Lives Care Bundle, Maternity Voice Partnerships, multidisciplinary training, safety champions and digital strategy.

- **The Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust** (2020) provided 7 Immediate and Essential Actions (IEAs) for Trusts to review and implement:

    - Enhanced safety

    - Listening to women and families
    - Staff training and working together
    - Managing complex pregnancy
    - Risk assessment throughout pregnancy
    - Monitoring fetal wellbeing
    - Informed Consent

- **The Final Report of the Ockenden review** (2022) – identified an additional 15 Immediate and Essential Actions (IEAs) for Trusts.

- **The Mothers and Babies: Reducing Risk through Audit and Confidential Enquiry (MBRRACE) reports** provide guidance on national indicators and causes of maternal and neonatal mortality used to identify areas for improvement locally and nationally.

- **The Reading the Signals: Maternity and Neonatal services in East Kent** report (2022) Following an investigation into 2 hospitals this report makes four key action areas:

    - Key Action Area 1: Monitoring safety performance – finding signals among noise
    - Key Action Area 2: Standards of clinical behaviour – technical care is not enough
    - Key Action Area 3: Flawed teamworking – pulling in different directions
    - Key Action Area 4: Organisational behaviour – looking good while doing badly

2.3. LMNS Governance, Oversight and Assurance

The Local Maternity and Neonatal System (LMNS) is the collective term for clinicians, managers, service users, Local Authorities, NHS providers and commissioners who come together to plan, deliver and evaluate maternity services within the Joined Up Care Derbyshire Integrated Care System (ICS) to meet the needs of pregnant people, babies and families. The LMNS was established in 2016 and is the maternity arm of the ICS. The role of the Derbyshire LMNS has developed into one of supporting transformation and having oversight and assurance of the safety of maternity services and the LMNS Board provides governance for these areas and transformation.

The LMNS is required to support the Trusts to achieve full compliance with national report recommendations and gain assurance of progress with full reporting to the local LMNS Board. This supports the expectation within the national Perinatal Quality Surveillance Model that LMNS's have both an

assurance role and supportive role to each trust. Onward exception reporting by system and to region will be undertaken through the monthly NHS Midlands Regional Perinatal Quality Group (RPQG) meeting, which forms the regional layer of governance.

Derbyshire LMNS has a monthly Perinatal Quality and Safety Group (PQSG) where Trusts provide an update on their current position against national recommendations and guidance. An update on current perinatal mortality rates and any patient safety incidents is provided to monitor against national indicators. If required deep dives are requested along with completed audits to provide evidence of safe care. The Perinatal Safety Forum (a subgroup of the PQSG) provides an opportunity to discuss progress and action plans and escalate areas of concern to PQSG.

The development of reporting templates to align with the Trusts reporting is in progress to provide a clear, consistent picture of maternity services across Derbyshire.

2.4. Derbyshire Maternity Service Provision

Maternity services within Derbyshire consist of two acute Trusts, Chesterfield Royal Hospital Foundation Trust (CRH) and University Hospitals of Derby and Burton Foundation Trust (UHDB). UHDB has two sites providing maternity care: Royal Derby Hospital (RDH) and Queens Hospital Burton (QHB). Prior to COVID a standalone birth unit was available at Samuel Johnson Hospital for residents in the south of the county, however this closed due to staffing pressures and has remained closed since, pending review. All sites have Neonatal Units, Consultant Led Care and Midwifery Led Care Units providing care for approximately 11,500 people per year and families.

CRH has approximately 3500 births per year and covers North Derbyshire and Chesterfield primarily. RDH has approximately 6000 births per year and covers South Derbyshire and Derby City. Both hospitals provide care to residents of the High Peak. QHB covers South Derbyshire and Burton and therefore extends into Staffordshire. Derbyshire County residents have a choice of place of birth, including home and may access services at the hospitals discussed or may attend Nottinghamshire, Staffordshire or Greater Manchester Trusts. This is reciprocated where residents of the counties listed may choose maternity care within Derbyshire.

2.5. Stillbirth and neonatal death rates

The current stillbirth and neonatal deaths rates for CRH and UHDB compared to the national ONS (2021), and MBRRACE (2022 rate based on 2020 data) rates are given in Table 1.

Table 1: Stillbirth and neonatal death rates for Derbyshire Trusts compared to national data

	Derbyshire		National	
	CRH (Nov 22)	**UHDB (Nov 22)**	**Office of National Statistics (ONS) (2021)**	**MBRRACE (2022 based on 2020 data)**
Stillbirth rate / 1000 total births	2.79*	3.92*	4.2	3.33
Neonatal death rates / 1000 live births	0.35*	2.14*	2.7	1.53

* 12 month rolling average

For both Trusts the stillbirth rates and neonatal death rates are below the national average ONS rates in 2021 than the MBRRACE report which is based on 2020 data.

There have been two external visits to UHDB recently. The first by NHS England in early December. No immediate safety concerns were identified, and a report is due early in 2023. In addition, the Healthcare Safety Investigation Branch (HSIB) which conducts independent investigations is undertaking an external review of 7 cases of poor maternal and fetal outcomes. This is currently on-going, and the outcome is expected early in 2023. The LMNS will have oversight of both reports when published.

2.6. Ockenden Recommendations – current position

Following the publication of the Ockenden report in 2020, work has been ongoing to meet the 7 IEAs. The impact of COVID on the workforce and the complexity of the workload, has had a significant impact on the review of the gaps in service to meet the recommendations. All hospital Trusts in the country have completed a gap analysis against the recommendations.

There was a national ask that the Regional Perinatal Teams visit all maternity services by the end of September 2022 to gain assurance for progress in completing the initial 7 IEAs. All 21 Trusts in the Midlands region were assessed by the regional team as having reduced compliance from their self-assessed position of March 2022. There were no Trusts that achieved full compliance.

The Derbyshire visits were supported by the LMNS and involved review of the evidence, walkarounds and focus groups with clinical staff, Trust Executives

and with Derbyshire Maternity and Neonatal Voices (DMNV). DMNV represents service users and works with local Trusts to coproduce services to meet their needs. Following the visit each Trust had a requirement to report to their Trust Board with an updated compliance level; produce an action plan with trajectories for full compliance for the initial 7 IEA Ockenden actions and regularly report their progress towards full compliance through quarterly meetings to the LMNS.

The assessed compliance for both Derbyshire Trusts was 39% which demonstrates amber rating across all 7 IEAs. It was identified that those Trusts that were not compliant with Saving Babies Lives Care Bundle v2 (see 2.6) were less compliant with the Ockenden IEAs due to the overlap of recommendations. No safety concerns were identified. Moving forwards, there is a need to undertake audits to assess compliance and this will be initiated in 2023 reporting back to the NHS England Regional Perinatal Team in April 2023.

The final Ockenden report was released in March 2022 has given 15 new recommendations, building on the initial 7. National guidance is awaited in early 2023, to progress with compliance and assurance. The LMNS will work with the Trusts to establish robust reporting mechanisms to provide the required level of assurance for the Integrated Care System and the service users.

2.7. Saving Babies Lives Care Bundle (v2) (SBLCB) – current position

For CRH the reported compliance in October 2022 was 56% which had increased from 17% in February 2022. The Midlands Regional Perinatal Team is supporting CRH to achieve full compliance of SBLCB through bimonthly assessments of available evidence. Significant improvements have been made in supporting women who smoke in pregnancy which is a major contributing factor for perinatal mortality.

UHDB are completing the regional assessment and will receive feedback on compliance in February 2023.

Saving Babies Lives Version 3 is also expected in 2023 and will build on the Version 2 currently being implemented.

2.8. Clinical Negligence Scheme for Trusts (CNST) / Maternity Incentive Scheme (Year 4) – current position

The submission date for Trusts to demonstrate that they meet the criteria is February 2023. Both Trusts will report partial compliance due in part to the impact of COVID on staff attendance on multidisciplinary training. Full training

plans are now resumed, however the shortfall over the past twelve months can't be achieved in the timeframe. Saving Babies Lives Care Bundle compliance is also a requirement and as neither Trust has full compliance with all elements, they will not meet that safety standard. The LMNS will be sighted on the action plans to achieve compliance.

2.9. Quality Improvement in Maternity Services – current position

In Derbyshire the following changes have taken place as part of the Maternity Transformation programme addressing the Better Births recommendations:

- a maternal mental health service to support women who do not meet the criteria for the perinatal mental health team.
- the practice of personalised care through the use of and embedding of personalised care and support plans.
- Midwifery Continuity of Carer to support women throughout their pregnancy journey to improve outcomes for the most disadvantaged.
- an NHS Tobacco Dependency pathway for pregnant smokers to improve outcomes for babies.
- the development of the workforce across maternity and neonatal services.
- the implementation of multidisciplinary training to improve skills and patient safety.
- the development of a meeting structure to allow shared learning across teams and organisations within the LMNS.

The following areas of clinical care that have been reviewed and changes made following LMNS scrutiny are:

- **Third and fourth degree perineal tears** (which can occur following a vaginal birth). For CRH numbers were higher than the national average. Through working with the Trust, and the introduction of quality improvement measures this has now reduced, and the Trust is no longer an outlier. UHDB are also using the same care pathway and have remained within the national average.

- **Postpartum haemorrhage (PPH)** (which is excessive bleeding following a birth). A national quality improvement measure has been recommended to improve outcomes for mothers. At UHDB, the pathway was introduced to ensure PPH is managed with correct escalation, expertise, and monitoring to provide timely and appropriate treatment. UHDB are currently reviewing their data and CRH will be taking part in a pilot of a similar pathway in 2023.

- **Induction of labour –** (this may be indicated if there are concerns over fetal or maternal wellbeing or in a pregnancy which is more than 40 weeks gestation to reduce the risk of morbidity or mortality). Nationally, numbers are rising due to the increasing complexity of pregnancies. Regionally, a pathway is in development to assist Trusts in correctly assessing the need for an induction of labour and to ensure that there is consistency in the offer of care across the Midlands. The impact of this will be monitored through the LMNS.

3. Alternative Options Considered

3.1 Alternative options are not applicable for this paper

4. Implications

4.1. The implementation of recommendations to improve safety is important, however other measures are also used to provide assurance on maternal and neonatal clinical care safety. Local data is compared to national averages to ensure Derbyshire are not outliers for any clinical measures.

4.2. A national response is awaited following the publication of Reading the Signals: Maternity and Neonatal services in East Kent in October 2022, along with the recommendations for the Final Ockenden 15 IEA's, to determine the implication for the LMNS.

4.3. NHSE has provided specific funding to implement the Ockenden recommendations and investment has been made into staffing and Perinatal Mortality Review Tool investigations. Midwifery Continuity of Carer was a significant factor in meeting some of the requirements and helping to reduce health inequalities, however staffing has affected recruitment and progression with this model of care delivery. CRH has one team in place and plan to develop more teams in 2023.

4.4. Workforce pressures have been significant since 2020. CRH had an increase in complexity of pregnant people in July 2022 and a gap in workforce due to absence, which led to a pause in activity relating to Quality Improvement to maintain the safety of the service users. The LMNS were fully aware of the situation and liaised closely with the senior management team at CRH until the situation had resolved. A workforce plan is in place and recruitment is on a rolling basis.

4.5. Data collection, audit and evidence are significant factors in providing assurance both within the LMNS and for external reporting. The IT system used requires updating to keep up with the extensive data

required. A maternity digital strategy has been developed through the Trust to allow investment and improve data collection and reporting. The LMNS has oversight of the CRH dashboard monthly which allows scrutiny, shared learning and comparison with UHDB and national data, to establish outlier status. This information is also available through the Maternity Services Dataset which is a national reporting requirement.

5. Consultation

5.1 Derbyshire Maternity and Neonatal Voices are invited to the LMNS Board meetings and the Perinatal Quality and Safety Forum to ensure that there is an open and honest approach from maternity services. Service user feedback is presented and discussed to highlight areas for coproduction. Both Trusts have participated in a "15 steps" review of maternity services. UHDB have received their report, following the visit in July 2022, with improvements recommended around four separate themes: welcoming and informative; safe and clean; friendly and personal and organised and calm to improve the patient and family user experience of the maternity service. CRH completed their review in November 2022 and the paper is being compiled.

6. Background Papers

The NHS Long Term Plan (2019) - NHS Long Term Plan » The NHS Long Term Plan
The Saving Babies Lives Care Bundle Version 2 (2019) - NHS England » Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality
Clinical Negligence Scheme for Trusts (CNST) / Maternity Incentive Scheme (Year 4) 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
National Perinatal Quality Surveillance Model - NHS England » Implementing a revised perinatal quality surveillance model

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)

15 Steps for Maternity Royal Derby Hospital and Queens Hospital Burton, July 2022

15 Steps for Maternity visit to UHD

7. Appendices

7.1 Appendix 1 – Implications.

This is not appropriate for this report.

8. Recommendation

8.1 That the Committee:

a) Reviews the contents of the report and notes the actions taken to provide governance and assurance against the national maternity service recommendations and reports ensuring that Derbyshire maternity services are safe.

9. Reasons for Recommendation(s)

9.1 Not applicable.

Appendix 1

Implications

Financial

1.1 N/A

Legal

2.1 N/A

Human Resources

3.1 N/A

Information Technology

4.1 N/A

Equalities Impact

5.1N/A

Corporate objectives and priorities for change

6.1N/A

Other (for example, Health and Safety, Environmental Sustainability, Property and Asset Management, Risk Management and Safeguarding)