1. Introduction

This briefing has been prepared by Calderdale and Huddersfield NHS Foundation Trust (CHFT) and Mid Yorkshire Hospitals Trust (MYHT) in partnership to update Kirklees Health & Adult Social Care Scrutiny Panel on progress with:

- Recommendations and local improvement and action plans following publication of the Ockenden reports.
- Maternity workforce and the impact of these on childbirth choices for childbearing people in Kirklees, with reference to freestanding midwife led birth centres in the area.
- Risk assessment of midwifery-led birth units against published European birth centre standards.

2. Ockenden Update

On the 30 March 2022 the Secretary of State for Health and Social Care published Dame Donna Ockenden's final report from the independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust. This second report builds upon the first report in that all the Immediate and Essential Actions within that report remain important and must be progressed. The second report goes on to identify new themes from which additional immediate and essential actions for Trusts have been developed.

FINAL_INDEPENDENT
_MATERNITY_REVIEW_

The investigation team heard evidence from 1486 families who wanted to understand what had happened during their care and wanted the system to learn. The investigation team identified thematic patterns in the quality of care, Trust investigation procedures, and identified where opportunities for learning and improving the quality of care have been missed. The review team found failures in governance and leadership, failure to follow national guidelines, failure to escalate and work collaboratively across disciplines.

In terms of clinical governance, investigatory processes were not followed and of a poor standard. Reviews were not multidisciplinary, and the trust board did not have oversight or a full understanding of the issues and concerns within the maternity service, and there was a lack of oversight by the trust board when investigations took place maternity governance teams downgraded serious incidents to local investigations.

The first report made explicit recommendations around 7 Immediate Essential Actions (IEAs) with an expectation that all providers provide assurance against, and the final report includes a further 15 IEA recommendations with 75 actions, again with an expectation that all Trusts will ensure compliance.

Regional maternity teams were commissioned to undertake Ockenden Assurance Visits in each Trust in England to examine evidence of compliance with the first 7 IEAs.

CHFT and MYHT had assurance visits in June 2022. The visit team comprised the Regional Chief Midwife and Deputy Chief Midwife, Regional Chief Obstetrician, representatives from

NHS England and Maternity Voices Partnerships (MVPs). The visit schedule included one to one meetings and focus groups with service users and staff as well as review of documentary evidence (including policies and guidelines, serious incident reports and action plans) and site visits. Initial feedback was provided to Trust Executives at the end of the visit. A full report will be published by NHS England in August/ September 2022.

Feedback for both Trusts was extremely positive.

On day feedback for CHFT:

- Staff in all areas are really welcoming and willing to speak to the visiting team
- Clear governance processes, with patient safety a priority and is valued
- Open and responsive culture
- The 'weekly view newsletter' is received by all and provides feedback and learning to all staff. Staff value this.
- Evidence of staff involvement of developing new processes and risk assessments (Avoiding Term Admissions into Neonatal units) ATAIN risk assessment)
- The MVP chair feels very valued and listened to. The MVP is well funded
- Comprehensive training packages with good compliance and trajectories, which is responsive to learning from incidents, complaints & relevant national policy
- The value of an end-to-end maternity system is threaded throughout, ensuring personalisation of care and ability to audit quickly and accurately
- Clear evidence of commitment to addressing inequality
- Audit is being embedded as an everyday occurrence with everyone responsible for it
- Good MDT working

On day feedback for MYHT:

- The evidence submitted prior to the visit was exemplary – well done!
- Open & honest staff, however the medics were difficult to locate
- Clear reporting structure
- 'BOSH' prompts on ward to enhance safety ('BOSH' is an approach to assessing staff wellbeing in shift)
- Governance processes are good, with good examples of testing learning
- Sharing of learning via different sources to capture staff in all areas and levels
- Good visibility of senior leaders on labour ward especially in times of high acuity, providing support
- Supportive preceptorship midwife
- Now has a functioning MVP and huge improvements made in the past 12months
- On the whole, the team are receptive to improvement and innovation
- Clear about their challenges, which includes recruitment/staffing, culture, and morale
- Peer support mechanisms across the service
- Good psychological support for staff – which is staff-led

Both Trusts reviewed the second Ockenden report and recommendations and undertook a RAG rating exercise.

Summary of RAG rating:

CHFT	MYHT
10 Red actions: All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent. **New MVP Chair in post who we are working with to share themes, trends, and responses** Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.- **The trust has two named consultants leads and we are progressing work to provide a specific clinic with dedicated ultra-sonographer** There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit. **All deliveries <27weeks are currently reported to the LMS with a case summary. CHFT level 2 NNU criteria gestation >27 weeks. The neonatal team are progressing the continuous audit.** Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required. **The Neonatal team are progressing solutions to meet this requirement** Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point	7 Red actions: Education and training of Labour Ward Co-ordintors – **awaiting publication of national programme** Supernumerary clinical skills coordinators in all areas – **in process of recruiting suitably qualified staff** Every Trust must have a patient safety specialist – **in progress** Maternal medicine specialist – **post recruited to and waiting for pre employment checks** There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit **– in progress with neonatal team**. Midwifery units must complete annual risk assessment – **completed** Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday – **currently provide specialist care Monday to Friday – workforce review in progress.** 25 Amber actions – key areas: Training – **actions progressing but compliance not yet at ambition target due to clinical demands and pressures.**

more clearly in the NLS **algorithm Local Guidance under review** Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications **Action plan completed and mitigations due to current non-compliance. Non-compliant due to not having 2 Registrars across paediatrics and neonates at night. Mitigation night registrar supported by on-call consultant and twilight registrar until midnight** There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate. **Review being undertaken of current pathway** Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences. **Review being undertaken of current provision** Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care. **Review being undertaken of current provision and workforce, including training needs analysis** All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals. **Developing a policy, but currently have human factors and civility included in mandatory multidisciplinary training day**	

A multidisciplinary action plan has been devised that incorporates all the recommendations/actions, with regular updates provided to both Divisional and Trust Boards within CHFT and MYHT.

Whilst local improvement work continues, the brief from the national maternity team has been that once the East Kent Inquiry report is published, a national maternity improvement plan will be developed which will supersede local plans.

3. Midwifery Workforce

Over the last year CHFT and MYHT have experienced unprecedented midwifery staffing shortfalls against planned workforce levels across all areas due to vacancy, sickness, and maternity leave. To ensure the safety of women and babies, and in accordance with guidance from NHSEI, both Trusts have had to prioritise provision of 1:1 care for women in established labour, this has contributed to decisions to temporarily suspend Huddersfield Birth Centre and Bronte Birth Centre.

Staffing levels in Huddersfield and Bronte Birth Centres has been critical, with 76.2% of Bronte Birth Centre staff being unavailable for work for at least three months due to sickness and maternity leave. At CHFT the current overall midwifery staff unavailability in July including vacancy, sickness and maternity was 32%.

Despite these challenges women continue to be offered three choices of place of birth by both Trusts in line with the aspirations of Better Births: home birth, midwife led alongside birth centre and consultant led unit in Halifax and Wakefield.

Both Trusts have a recruitment and retention strategy which is informed by the national maternity recruitment and retention campaign. Both Trusts have dedicated recruitment and retention lead midwives who are responsible for delivering the national campaign. MYHT also participate in the NHS Flex for the Future Project.

Local exit interviews suggest the main reasons midwives leave are retirement, relocation, moving to a smaller Trust where it is perceived the workload is less, leaving the profession (either to become self-employed or to take some time out), promotion and to work for an Agency (Flexibility, no requirement to work on call or in a continuity of carer team (mainly community midwives)).

All Trusts in the Local Maternity System (LMS) are part of the LMS Band 5 Midwife (newly qualified midwife) recruitment scheme. For the first time in many years CHFT and MYHT forecast an ongoing deficit of midwives once the cohort of newly qualified midwives start work in October/ November 2022. This is in part due to the small number of student midwives completing their studies at Huddersfield University this year. LTHT and Bradford forecast similar situations, LTHT to a lesser degree. The longer-term impact of this is a forecast deficit against Birthrate Plus recommended staffing levels throughout 2022-2023 and into 2023-2024. Birthrate Plus is currently the only midwifery-specific, national tool that gives intelligence and insights needed to be able to model midwifery staffing numbers.

Table 1: Vacancy levels end July 2022

	Births	Planned WTE (MW and RN)	Actual WTE	Vacancy WTE	Planned Leavers (to end Oct)	Midwives and RN in recruitment pipeline
CHFT	4712	198	157.98	40.02	8.52	13.56
MYHT	5800	255	227.32	27.68	4.83	23.44

Table 2: Staff Unavailability end July 2022

		Annual Leave (Target 15%)	Maternity Leave (1%)	Sickness (4%)	Total (Uplift 23%)
CHFT	RM	12.29%	3.76%	6.89%	27.91%
	MSW	11.84%	2.1%	7.3%	27.82%
MYHT	RM	13.6%	4.3%	10.3%	33.3%
	RN	19.6%	0%	24.1%	45%
	MSW	11.6%	4.3%	20.8%	42.7%

4. Birth Centre Risk Assessment

CHFT and MYHT have worked together to risk assess the structure, function, governance, and standards of both birth centres against European guidelines for birth centres, and to explore opportunities for the future.

NICE Clinical guideline [CG190] Intrapartum care for healthy women and babies (NICE 2017) recommends that low-risk multiparous women are advised that giving birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Low-risk nulliparous (no previous children) women should be advised that planning to give birth in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.

Maternity and neonatal risk status can change throughout pregnancy, during labour and following birth. Currently approximately 9% of women resident in North Kirklees booked to birth at MYHT are on the intensive maternity care pathway, 50% of women are on the intermediate maternity care pathway and 41% of women are on the standard maternity care pathway. Approximately 9% of women resident in Greater Huddersfield / South Kirklees booked to birth at CHFT are on the intensive maternity care pathway, 43% of women are on the intermediate maternity care pathway and 49% of women are on the standard maternity care pathway.

To support decision making about place of birth, up to date data about ambulance response times and journey times is provided. Many women at low risk of obstetric complication during pregnancy choose to birth on the site where obstetric, neonatal, and emergency maternity theatre support is available if required.

Over the last five years there has been a year-on-year reduction in the number of women birthing in Bronte Birth Centre with 149 women birthing there in 2021. In a similar period (2019), 238 women birthed at Huddersfield Birth Centre.

Findings of the risk assessment were similar for both Trusts with robust evidence of:

- Strong governance arrangements.
- Clear leadership.
- Robust training provision for staff working in the birth centres.
- Assuming full staffing, no safety or care quality concerns related to care pathways or multidisciplinary working were identified for either birth centre.

Areas for opportunity included:

- Recommendations to develop a multi-agency, multidisciplinary birth centre advisory group – the first meeting of the CHFT/ MYHT Group will take place at the end of September, with representation from North Kirklees and Huddersfield Maternity Voices Partnerships Group as well as local partners including public health.
- Develop the birth centre as a midwifery hub.

Within the standards, reference is made to developing more integrated service models with groups of midwives working in communities, supporting homebirth and birth centre birth rather than solely working in the birth centre. This opportunity is being considered by both Trusts.

5. Conclusion

Both Trusts continue to have an ambition to re-establish a freestanding midwife led birth centre in Kirklees. Recruitment campaigns have been reviewed and an additional campaign is being developed to try to attract new staff to the birth centres.

CHFT and MYHT are working in partnership to explore a safe and sustainable model of standalone maternity services. This will be managed through the joint CEO led Partnership Board between the two organisations. Whilst committed to an offer for the population of Kirklees – a one size fits all model may not work due to the different pressures we are both facing as organisations.

6. Recommendations

(Overview and Scrutiny Committee) are recommended to note:

- Update in relation to CHFT and MYHT response to Ockenden
- Unprecedented staffing gaps in both birth centres and maternity services. These are consistent with most Trusts in the region.
- Ongoing recruitment challenges in both organisations and the impact of these on service delivery and women's choices.
- Findings of the evaluation and risk assessment against European standards for Birth centres and partnership working in the Advisory Group.
- The continued ambition of both Trusts to re-establish a free standing, midwife led birth centre in Kirklees