West Yorkshire and Harrogate
Health and Care Partnership
Local Maternity and Neonatal System

West Yorkshire Joint Health and Overview Scrutiny Committee

11th October 2024

Summary report			
Report title:	**Progress against ambition 7: We will reduce stillbirths, neonatal deaths, brain injuries and maternal mortality - West Yorkshire & Harrogate Local Maternity & Neonatal System Update**		
Report author:	Debi Gibson, Director of Midwifery, West Yorkshire & Harrogate Local Maternity & Neonatal System, West Yorkshire ICB		
Presenter:	Debi Gibson, Director of Midwifery, West Yorkshire & Harrogate Local Maternity & Neonatal System, West Yorkshire ICB		
Purpose of the report: (why is this being brought to the Committee?)			
Decision		Comment	✓
Assurance	✓		
Executive summary			

This report provides the committee with an update of the West Yorkshire & Harrogate Local Maternity and Neonatal System (LMNS) including:

- LMNS Overview
- Progress against ambition 7: We will reduce stillbirths, neonatal deaths, brain injuries and maternal mortality
- Risks and challenges

Local Maternity & Neonatal System Overview

The West Yorkshire and Harrogate (WY&H) Local Maternity System was established in 2019 in response to The National Maternity Review: Better Births published in 2016 as part of the Maternity Transformation Programme. In 2022 the system expanded to include neonatal services and became a Local Maternity & Neonatal System (LMNS).

Independent inquires including The Interim Ockenden Report 2020, The Final Ockenden Report 2022 and Reading the Signals 2022 highlighted persistent failings in maternity services in the provision of safe care that is personalised for women, birthing people and their families. The role of the LMNS has expanded from being focused on transformation to quality surveillance and assurance.

The revised Perinatal Quality Surveillance Model (NHSE 2020) outlines the role of the LMNS in support of quality surveillance, which is further defined in relation to the role of the ICB in NHS Oversight Framework (NHSE July 2022).

The Three Year Delivery Plan for Maternity and Neonatal Services, (NHSE March 2023) sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. It defines how NHS England, Integrated care Boards (ICBs), and Trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed to develop and sustain a culture of safety to benefit everyone.
This plan builds on the National Maternity Review: Better Births 2016, Safer Maternity Care 2016 and The Long Term Plan for the NHS (2019).

In November 2015 the national maternity ambition was launched, setting out the aim to reduce the rates of stillbirths, neonatal and maternal deaths and brain injuries that occur during or soon after birth in England by 50% by 2025.
The LMNS has a pivotal role in supporting the transformation of local maternity services to reach these ambitions, including oversight and assurance of implementation of key policies including

- The Maternity Incentive Scheme
- Saving Babies Lives Care Bundle version 3
- The Core Competency Framework
- Equity and Equality Plans

Hearing the voices of those with lived experiences of maternity and neonatal services is integral to service transformation. The LMNS works closely with local Maternity and Neonatal Voices Partnerships (MNVP's) to ensure services listen to and act on feedback. An LMNS MNVP strategic lead has been appointed to further strengthen this voice, due to commence in post in December 2024. The LMNS has supported increased hours for MNVP leads at place to ensure they are able to be integrated into the governance and quality improvements in trusts. The LMNS is part of the NHSE pilot of the Maternity & Neonatal Independent Senior Advocate role (MNISA). The role was recommended by the interim Ockenden Report (2020) and provides bespoke support to families who have experienced an adverse outcome. Our MNISA has been in post since October 2023 and has been actively working with families since February, currently 7 families are engaging actively with the service and new areas for improvement have been identified including provision of information to families whose care is being investigated, engagement in the investigation process and consistency in provision of debriefing services. The MNISA has begun leading improvements in these areas, alongside families and provider services.

Progress against ambition 7: We will reduce stillbirths, neonatal deaths, brain injuries and maternal mortality

MBRRACE-UK perinatal mortality surveillance state of the nation report published July 2024, data of UK perinatal deaths of babies born in 2022. MBRRACE data has a significant time lag in its publication but represents a comprehensive dataset with numerous advantages over other sources:

- Ability to view **Trust level** neonatal death rates excluding congenital abnormalities.
- Statistical standardisation based on population case-mix.
- National and peer benchmarking.

MBRRACE 2022 Stillbirths

Between 2021 and 2022 West Yorkshire stillbirth rate decreased from 4.7 to 3.9 stillbirths per 1,000 births. This remains above the England average for that period (3.4) but significantly closes the gap that was seen in 2021. Local data collections throughout 2023 indicate that the stillbirth rate continued to decrease across West Yorkshire that we expect to be reflected in MBRRACE 2023 next year.

MBRRACE 2022 Neonatal deaths

In this same period West Yorkshire's neonatal death rate increased from 2.0 to 3.0 neonatal deaths per 1,000 births (MBRRACE-UK) which means WY had a rate higher than average. Trust level breakdowns of neonatal deaths indicate that ~45% of deaths in WY are due to congenital anomalies (abnormality of structure during a baby's development) which is much higher than the England average previously reported by MBRRACE (34% in 2022). Total neonatal deaths in West Yorkshire hospitals saw an increase in numbers from 53 to 77 in 2022, much of this increase is due to deaths from congenital anomalies.

All West Yorkshire (WY) units have considered this information and have again reviewed all neonatal deaths. The Trust with the most neonatal deaths and highest neonatal death rate in WY is Leeds Teaching Hospitals Trust (LTHT) which is expected because of LTHT's status as the largest hospital in WY and the regions most specialised level 3 Neonatal Intensive care Units (NICU) & neonatal surgery. This means that preterm and very unwell babies from outside of WY ICB will be transferred to LTHT.

LTHT have completed extensive reviews of data themselves and the University of Hospitals of Leicester Trust has carried out an external peer review where no concerns were raised with the care provided, clinical practices, review processes in place or the reporting and learning processes.

In addition, WY&H LMNS neonatal consultant leads are reviewing available information that considers both the published MBRRACE data and further analysis provided by LTHT.

Neonatal Brain Injury

The ambition for halving the numbers of brain injuries that occur during or soon after birth in term infants is not currently quantifiable ICB level, this is the case for all ICB's. All cases of term brain injury are investigated by Maternity & Newborn Safety Investigations (MNSI), following family consent. Themed learning from all MNSI investigations is presented to trusts quarterly. MNSI provide annual reports on learning from safety investigations and the learning identified within WY&H trusts is in line with the national picture.

Maternal Mortality

The maternal mortality rate in England during 2020-22 (MBRRACE-UK) was 13.4 per 100,000. The data also reports that maternal death is four times more likely for Black women, twice as likely for Asian women and twice as likely for women living in the most deprived geographies. West Yorkshire data indicates similar overrepresentation of maternal deaths in these groups.

All maternal deaths during pregnancy or within the first 42 days following birth are investigated by MNSI. Collation of findings from these investigations has been requested, due to the small numbers this is less effective at ICB level. The NHSE Regional Maternity have been asked to undertake a review of maternal deaths across the region. They have confirmed they will be undertaking a review which will provide a more comprehensive analysis than a system only review. The start and finish date for this review has not yet been confirmed.

WY&H LMNS Oversight

All stillbirths and neonatal deaths are subject to a multidisciplinary review utilising the national Perinatal Mortality Review Tool, including an external peer reviewer whenever possible.

Maternity & Newborn Safety Investigations (MNSI) provide independent investigation of all term babies (after 37 weeks gestation) where stillbirth occurs, where there is suspected neonatal brain injury, or where early (less than 7 days) neonatal deaths occurs. They also investigate maternal deaths occurring during pregnancy or within 42 days of birth.

The LMNS is notified of all MNSI reportable cases; Patient Safety Incident Investigations (PSII), Neonatal death (all gestations), any significant incident with learning identified and all Maternal death's via the WY&H LMNS Safety & Learning Group for sharing of any learning and peer review.

A letter has been sent to MBRRACE-UK requesting additional breakdown of data at ICB/Commissioning level to exclude congenital anomalies. This will enable a clearer view of data at system level. They are considering their response to this.

Actions to reduces stillbirths, neonatal deaths and serious brain injury:

1) Implementation of the Saving Babies Lives Care Bundle Version 3 (SBLCBV3) – focusing on 6 elements:
   - Element 1: Reducing smoking in pregnancy
   - Element 2: Fetal Growth: Risk assessment, surveillance, and management
   - Element 3: Raising awareness of reduced fetal movement
   - Element 4: Effective fetal monitoring during labour
   - Element 5: Reducing preterm births and optimising perinatal care.
   - Element 6: Management of Pre-existing Diabetes in Pregnancy

All trusts are progressing well with implementation. Ongoing monitoring of compliance occurs quarterly.

2) Established LMNS preterm birth steering group driving forward improvements. WY&H LMNS preterm birth guideline. Collaboration with maternity clinical network and neonatal operational delivery network (ODN) to identify areas for improvement.

3) Review of local small for gestational age / fetal growth restriction guidelines across the system and supporting updates as appropriate is in progress.

4) Progressing health inequalities work – early booking campaign; individual trust innovation to reach seldom heard voices to identify areas for improvement and coproduce service provision; additional support to the most vulnerable; appointment of Health Inequalities Programme Manager to drive forward the agenda.

5) All cases of stillbirth and neonatal death are subject to a review using the perinatal mortality review tool (PMRT) to identify any areas for improvement. This is a multidisciplinary team review and a peer reviewer from outside the trusts attends whenever possible.

6) Patient safety incidents and Maternity & Newborn Safety Investigations (MNSI) reportable cases are reported to the LMNS, for peer review, discussions and theming.

7) Implementation of the Three Year Delivery Plan for Maternity & Neonatal services, including

- Focus on personalised care
- Ensuring coproduction with our MNVP's
- Continued development of data and practice
- Maintain and develop ethnicity and deprivation lens on data
- Working with public health partners to ensure a strong preventative approach
- Ensure learning is embedded and shared across the system
- Supporting the development of a competent workforce
- Insight into the implementation of PSIRF (Patient Safety Incident Response Framework) across the system

Risks and challenges

Progress towards the national maternity ambitions is on the LMNS and ICB risk register and priorities have been agreed with senior leaders across the LMNS.

The level of deprivation within the WY&H LMNS footprint is one of the highest in the country, in order to accelerate the Health Inequalities agenda the LMNS has recruited to a Health Inequalities Programme Manager, who will lead the delivery of the LMNS Equity & Equality Strategy and work with system partners to improve outcomes for those in greatest need.

Recommendations and next steps

The West Yorkshire Joint Health and Overview Scrutiny Committee are asked to receive the report for information, acknowledge the complexities of the unique landscape providers are operating within and be assured on the actions taken at LMNS to progress toward the national maternity ambitions.