ADULT SOCIAL CARE AND PUBLIC HEALTH COMMITTEE

23rd JANUARY 2024

REPORT TITLE:	**MATERNITY AND NEONATAL QUARTERLY REPORT**
REPORT OF:	**DIVISIONAL DIRECTOR OF NURSING & MIDWIFERY, WOMEN'S AND CHILDREN'S DIVISION, WIRRAL UNIVERSITY TEACHING HOSPITALS NHS FOUNDATION TRUST**

REPORT SUMMARY

The report provides an update and oversight of the quality and safety of maternity services at Wirral University Teaching Hospital NHS Foundation Trust (WUTH).

This paper provides a specific update regarding Year 5 of the Maternity Incentive Scheme (MIS). There is also an update on progress on the Saving Babies Lives Care Bundle, which is one of the ten safety actions included in the MIS and on the Three-Year Delivery Plan and Maternity Continuity of Carer (MCoC). The paper also highlights the outcome of the recent Care Quality Commission (CQC) inspection of the maternity services provided by WUTH.

This is not a key decision.

RECOMMENDATION

The Committee is asked to note the updates within the report and progress by Wirral University Teaching Hospital NHS Foundation Trust (WUTH) on the delivery of safe maternity services.

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1.1 The Adult Social Care and Public Health Committee requested a report on the quality and safety of maternity services in Wirral. These services are commissioned by NHS Cheshire and Merseyside and provided by Wirral University Teaching Hospitals NHS Foundation Trust (WUTH). This report sets out progress being made by WUTH in delivering the requirements set by NHS Cheshire and Merseyside commissioning and regulatory organisations for safe and high-quality maternity services. The Committee is therefore asked to note the updates within the report and progress by WUTH on the delivery of safe maternity services.

2.0 OTHER OPTIONS CONSIDERED

2.1 No other options have been considered.

3.0 BACKGROUND INFORMATION

3.1 Maternity Incentive Scheme (MIS), Year 5

3.1.1 The Clinical Negligence Scheme for Trusts (CNST) handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1st April 1995 (or when the body joined the scheme if that is later). It is administered by NHS Resolution, which is an "arm's length" body of the Department of Health and Social Care (DHSC). Of the clinical negligence claims notified to NHS Resolution in 2021/22, obstetrics claims represented 12 per cent of clinical claims by number but accounted for 62 per cent of the total value of new claims; almost £6 billion.

3.1.2 The Maternity Incentive Scheme (MIS), introduced by NHS Resolution, supports the delivery of safer maternity care through an incentive element to trust contributions to the CNST. The MIS has been established as part of a wider Maternity Safety Strategy, as set out in *Safer maternity care: progress and next steps,* first published by the DHSC in November 2017. The MIS has been developed in partnership with the National Maternity Safety Champion, Dr Matthew Jolly, and rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services.

3.1.3 The 10 safety actions that trusts providing maternity and neonatal services, such as WUTH, are required to address are:

- Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
- Action 2: Are you submitting data to the Maternity Services Data Set to the required standard?
- Action 3: Can you demonstrate that you have transitional care services to support Avoiding Term Admissions into Neonatal Units programme?
- Action 4: Can you demonstrate that you have an effective system of medical workforce planning to the required standard?

- Action 5: Can you demonstrate that you have an effective system of midwifery workforce planning to the required standard?
- Action 6: Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?
- Action 7: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you act regularly on feedback?
- Action 8: Can you evidence that 90% of each maternity staff group have attended an "in house" multi-professional maternity emergencies training session within the last training year?
- Action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?
- Action 10: Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification Scheme?

3.1.4 WUTH has reported to NHS Resolution that they remain on track to meet the requirements of each safety action.

3.2 Saving Babies Lives

3.2.1 The Saving Babies' Lives Care Bundle (SBLCB) Version 3 was launched by NHS England in July 2023. It provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality.

3.2.2 The NHS has worked hard towards the national maternity safety ambition, which was to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020. Office for National Statistics (ONS) data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there was more to do to achieve the ambition in 2025. Version 3 of SBLCB was redeveloped to include a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes Audit (NPDA).

3.2.3 The Three-Year Delivery Plan for Maternity and Neonatal Services also sets out that providers should fully implement Version 3 of the SBLCB by March 2024. An implementation tool was developed nationally to support its implementation. Maternity services at WUTH have met the required compliance achieving 84% compliance as 4th December 2023. The requirement is to exceed 70% compliance with a robust action plan to achieve 100% compliance by 31 March 2023.

3.3 Ockenden Review of Maternity Services

The Independent Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust, the Ockenden Review, was published on 30th March 2022. There were 15 immediate and essential actions that every trust was asked to act upon following this review. The maternity services at WUTH are and have maintained compliance against the 15 immediate and essential actions.

3.4 Three-Year Delivery Plan (East Kent)

3.4.1 The Three-Year Delivery Plan has been prepared considering the independent report into maternity services at East Kent Hospitals University NHS Foundation Trust. Over the next three years the following four themes will be focused on:

- Listening to and working with women and families, with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning, and support; and
- Standards and structures that underpin safer, more personalised, and more equitable care.

3.4.2 Delivering this plan will continue to be a collaboration with maternity and neonatal services to support women and families and improve care. Progress is monitored via a local Maternity and Neonatal Quality Assurance Board and WUTH continues to implement within the timescales.

3.5 CQC Maternity Inspection

3.5.1 The maternity services provided by WUTH were recently inspected by the Care Quality Commission (CQC). This included services on the Arrowe Park site and at the Seacombe Birth Centre in Wallasey. The inspection took place on 24th and 25th April 2023. The inspection was part of the national review into maternity safety currently underway by the CQC. The CQC rated the services provided by WUTH as 'Good' for safe care and 'Good' for well-led services, with areas of outstanding practice being reported in the Trust's joint work with Wirral Maternity and Neonatal Voices Partnership.

3.5.2 Among the many positive findings in the report, the CQC noted that:

- Staff are competent and feel valued and supported.
- There is clear and visible leadership, including Maternity Champions at Board level.
- The service has a positive culture, with openness, honesty, and strong commitment to safety.
- The Leadership Team has the skills and abilities to manage the service well.
- There is a positive culture within the service where people, their families and staff felt they could raise concerns.
- Staff are committed to improving services to ensure people receive a high standard of care. Engagement and involvement with women, families, and birthing people was strong – especially the partnership working with Wirral Maternity and Neonatal Voices Partnership, which was rated as outstanding.
- Care is individualised, compassionate and personalised.
- The team had a commitment to training and research.
- The service is committed to improvement, innovation and continued learning.
- The Trust was the only service within the local maternity services network to offer 4 birth choices to woman and birthing people.

3.6 Implementation of Maternity Continuity of Carer

3.6.1 The Maternity Service continues to deliver care via two models of maternity care – one that is traditional in its approach, and the other a Continuity of Carer (CoC) Model of Care. Women being cared for by a team of midwives under the CoC model

appreciate the benefits of improved outcomes and experience compared to those cared for by a traditional model.

3.6.2 As a provider WUTH has six maternity continuity of carer teams and in line with upskilling programs and safe staffing levels, further teams are anticipated in 2024.

4.0 FINANCIAL IMPLICATIONS

4.1 There are no financial implications arising from this report.

5.0 LEGAL IMPLICATIONS

5.1 There are no legal implications arising from this report.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 There are no resource implications arising from this report.

7.0 RELEVANT RISKS

7.1 All relevant risks pertaining to maternity provision in Wirral are managed and mitigated by WUTH, as provider of these services, in conjunction with NHS Cheshire and Merseyside as the commissioner of this provision.

8.0 ENGAGEMENT/CONSULTATION

8.1 The maternity services provided by WUTH work closely with the Wirral Maternity and Neonatal Voices Partnership. This engagement has been recognised by the CQC as outstanding.

9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council and NHS organisations have a legal requirement to make sure their policies, and the way they carry out their work, do not discriminate against anyone. No Equality Impact Assessment (EIA) is required for this report.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 There are no environment or climate implications arising from this report.

11.0 COMMUNITY WEALTH IMPLICATIONS

11.1 There are no community wealth implications arising from this report.

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APPENDICES

There are no appendices to this paper.

BACKGROUND PAPERS

NHS England » Maternity and Neonatal Safety Improvement Programme

Maternity incentive scheme - NHS Resolution

Ockenden review: summary of findings, conclusions and essential actions - GOV.UK (www.gov.uk)

Maternity and neonatal services in East Kent: 'Reading the signals' report - GOV.UK (www.gov.uk)

Wirral University Teaching Hospital NHS Foundation Trust - Care Quality Commission (cqc.org.uk)

TERMS OF REFERENCE

This report is being considered by the Adult Social Care and Public Health Committee in accordance with Section 2.2 (g)(iv) of its Terms of Reference,

“(iv) to consult, be consulted on and respond to substantial changes to local health service provision, including assessing the impact on the local community and health service users”

and Section 2.3 (b)(ii)

“b) Overview and Scrutiny – The Committee holds responsibility: (ii) for the overview and scrutiny of external organisations whose services or activities affect the Borough of Wirral or any of its inhabitants where this does not fall within the role or remit of another service Committee or where it relates to cross cutting issues;”

SUBJECT HISTORY (last 3 years)

Council Meeting	Date