Department of Health & Social Care

From Nadine Dorries MP
Minister of State for Patient Safety,
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18 June 2021

Dear Professor Dame Jane Dacre,

Thank you for your letter dated 17 May in relation to your evaluation of the Government's progress in delivering its maternity commitments.

I am glad that you have found the information provided thus far useful. Maternity Policy colleagues at the Department of Health and Social Care and NHS England and NHS Improvement have set out answers to the questions you listed in your recent correspondence below.

My officials look forward to meeting with you in due course to discuss the preliminary findings of your evaluation. In the meantime, please do not hesitate to contact me if you have any further questions.

NADINE DORRIES

MINISTER OF STATE FOR PATIENT SAFETY, SUICIDE PREVENTION AND MENTAL HEALTH

Q1: Are health interventions in the pre-conception period within the scope of the maternal deaths target included in commitment 1[1]?

The Department and its Arm's Length Bodies (ALBs) are undertaking a range of work in relation to public health to help women, including those in the pre-conception period, to be as healthy as possible. This includes work on smoking cessation, promoting a healthy lifestyle and healthy eating.

We would therefore include health interventions in the pre-conception period within the scope of commitment 1, but as part of a larger piece of work being undertaken across the Department and it's ALBs.

Q2: How long after birth are women expected to be on the Continuity of Carer pathway, given high rates of maternal suicide post birth referenced in Better Births?

Women are expected to be on a continuity of carer pathway for as long as they are under midwifery/obstetric care. This can be up to 28 days postpartum according to midwives' statutory duties, but is normally around 10 days postpartum, when most women are discharged from maternity services and transferred to the care of the health visitor.

Midwives are also responsible for ensuring the correct referrals are made to the appropriate healthcare professionals depending on the needs of women and should liaise with health visitors who provide place-based care to help support this.

Q3: Clarify expectations and standards of good practice for Personal Care and Support Plans (PCSPs), including how they are expected to contribute to service planning and delivery.

Expectations and standards of good practice for personalised care and support plans:

Personalised care and support planning comprises a series of facilitated conversations in which the woman/birthing person actively participates, to explore the management of their health and wellbeing within the context of their life and family situation, so that all considerations that may impact on safe care, are accounted for.

Personalised care and support planning involves a holistic assessment of the woman's health needs; the clinician provides the best available evidence for a range of options which includes the risks and benefits of each option; the care options take into account the woman's values, preferences and risk tolerances; and the woman is supported to make an informed decision which is documented, shared and implemented with other health professionals.

It is expected that these conversations take place at every encounter with the midwife or obstetrician, from booking to postnatal and that key points from the antenatal PSCP will be pulled through to her intrapartum records (ideally electronic) to inform her care.

Women with additional health and social needs may require personalised care and support planning with a variety of wider healthcare professionals as indicated by clinical requirements.

Published guidance on PCSPs state that five technical criteria which have been agreed for Personalised Care and Support planning across the NHS should be met:

[1] Commitment 1: By 2025, halve the rate of Stillbirths; neonatal deaths; maternal deaths; brain injuries that occur during or soon after birth. Achieve a 20% reduction in these rates by 2020. To reduce the pre-term birth rate from 8% to 6% by 2025.

Five Technical criteria:

A. People are central in developing and agreeing their PCSP including deciding who is involved in the process
B. People have proactive personalised conversations which focus on what matters to them, paying attention to their needs and wider health and wellbeing
C. People agree the health and wellbeing outcomes they want to achieve in partnerships with the relevant professionals
D. Each person has a sharable PCSP which records what matters to them, their outcomes and how they will be achieved
E. People are able to formally and informally review their PCSP

The guidance sets out that in maternity services this means:

- Listening to women and birthing people
- Recording their informed choices
- Continuous risk assessment, acting on any new information
- The care plan is owned by the woman but shared with services

A tool for auditing the Personalised Care planning and Support Process is appended to the guidance.

<u>How they contribute to service planning and delivery:</u>

Personalised care and support planning acknowledges that each woman and her pregnancy is unique and that the woman is best placed to make an informed decision about her care plan.

Maternity services must have an excellent understanding of their patient demographic and ensure there is adequate supply of appropriate services to enable the implementation of support plans. This includes but is not limited to, ensuring appropriate access to mental health services such as the Improving Access to Psychological Therapies (IAPT), specialist perinatal mental health community teams and in-patient Mother and Baby Units (MBUs), sufficient midwifery support for vulnerable and bereaved women (continuity of carer or specialist midwives and nurses), a networked approach to maternal medicine available to women with medical complexities and sufficient community midwifery services to support births in low-risk settings.

All healthcare professionals working in maternity services will require training on personalised support and care planning. This is currently being developed by NHSEI. Senior midwives and the Local Maternity Systems are expected to provide additional oversight and support in the implementation of personalised care and support planning. Additionally, Maternity Voices Partnerships (MVPs) should be involved in the development of services that meet the needs of the local population and provide feedback on the progress of personalised care and support planning locally.

PCSPs will be key to service delivery as they set out the care plan agreed with the woman, based on a holistic risk assessment and evidence based information sharing, supporting informed consent throughout the pathway and being regularly reviewed to take account of new information. Personalised care is also integral to continuity of carer as Personalised Care and Support Planning is most effective when there is a trusting relationship developed between women and their midwife/midwives and Obstetrician, where appropriate.

Q4: To what extent has the reduction in stillbirths led to an increase in brain-injured babies and what evidence is there for this?

Since 2010, the stillbirth rate has fallen from 5.1 stillbirths per 1,000 births to 3.8 stillbirths per 1,000 births in 2019.This represents a 25% reduction in the stillbirth rate and is ahead of target to meet the 2020 ambition and on track to meet the 2025 ambition. The number of stillbirths is more than 750 fewer than if the rate had stayed the same as in 2010, meaning that hundreds of babies' lives have been saved each year.

The findings from the most recent report published in January 2021 depicting progress shows that the brain injury rate has fallen to 4.2 per 1,000 live births in 2019, since rising from 4.2 to 4.7 per 1,000 live births between 2012 and 2014.

There are a number of factors and initiatives in place which may potentially impact the brain injury rate and the stillbirth rate. With the data currently available to us, it would be difficult to conclude whether the reduction in stillbirths has led to an increase in brain injured babies.

Q5: How many stillbirths were recorded in the England and Wales in 2020?

Preliminary data on stillbirths is first published in Births in England and Wales: summary tables - Office for National Statistics (ons.gov.uk).

We expect preliminary data for 2020 to be published in July or August 2021, with a final figure expected to be published in Spring 2022.

Q6: In paragraph 11 of the Department's written response, the Department outlines a new definition of neonatal deaths that excludes babies born <24 weeks gestation. Has the population of babies excluded by the new definition been included in the reported stillbirth rates? If not, where are these deaths accounted for?

The definition of a neonatal death has not changed.[2]

As set out in paragraph 12[3] of the Department's written response, it is the measure of progress against the National Maternity Ambition which was changed to take into account the impact of changes in clinical practice since 2010[4].

As 'stillbirth' is defined as babies born after 24 or more weeks completed gestation which did not, at any time, breathe or show signs of life, babies born before 24 weeks gestation not showing signs of life are not included in the stillbirth rate. Instead, the are considered to be 'miscarriages' or 'late fetal losses' depending on the gestational age.

The Office of National Statistics publishes the overarching neonatal death rate, which includes babies born showing signs of life for all gestational ages who subsequently died.

Q7: In relation to paragraph 19 of the Department's written response, have there been changes in the diagnostic criteria relating to HIE (hypoxic ischaemic encephalopathy) that would impact the number of recorded infants with HIE between 2014 and 2019?

The figures supporting paragraph 19 have been calculated using a consistent definition of HIE throughout the time period. However, use of therapeutic hypothermia (one of the criteria used in

[2] Neonatal deaths are defined as the death of a baby born at any time during a pregnancy who lives, even briefly, but then dies with 28 days of being born.

[3] Paragraph 12 - Due to the impact of changes in clinical practice since 2010, we consider it important to measure progress against the National Ambition consistently.

Therefore, from now on we will measure progress against the neonatal ambition using mortality rates in babies born at or greater than 24+0 weeks gestation.

[4] See also pages 18-19 in Safer Maternity Care Progress Report 2021 [Insert title of report] (england.nhs.uk)

the calculations) has increased in recent years, particularly to treat babies with milder HIE (Changing clinical characteristics of infants treated for hypoxic-ischaemic encephalopathy in England, Wales and Scotland: a population-based study using the National Neonatal Research Database, *Hage, Jayekumaran et al*: BMJ ADC fetal and neonatal edition(2021); available at https://fn.bmj.com/content/early/2021/02/03/archdischild-2020-319685)

Q8: When was the roll-out of Continuity of Carer model commissioned, when did this roll-out begin, and in how many Trusts?

In December 2016, seven Early Adopter sites were selected and funded to implement Local Maternity System objectives faster. Of these, six developed and tested models of continuity of carer.

In March 2017, *Implementing Better Births: A Resource Pack for Local Maternity Systems* first set out the ask for all Local Maternity Systems to ensure that most women receive continuity of carer by March 2021. More detailed guidance on implementing continuity of carer was published in December 2017.

NHS Planning Guidance for 2018/19 set out the first interim universal deliverable, for Local Maternity Systems to place 20% of women in a continuity of carer pathway by March 2019.

Q9: Is identifying and/or addressing problems with workplace culture and practice within the scope of commitment 3?

The commitment on safe staffing relates to ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals to deliver quality care and keep patients safe from avoidable harm.

Whilst workplace culture and practice are not within the scope of the safe staffing commitment, there are a number of initiatives in place to address this issue, which are set out below.

Maternity Leadership Training Fund

In January, the Government launched a new £500,000 fund for Maternity Leadership Training for NHS maternity and neonatal leaders. The training aims to equip leaders with a range of skills and knowledge to address poor workplace culture and facilitate collaborative working between nurses, doctors, midwives and obstetricians.

The leadership programme is now being rolled out to train maternity and neonatal leaders across 125 Trusts and 44 local maternity systems.

This addresses issues raised in the Ockenden review recommendations of disconnect between “ward and Board” in maternity services and the importance of multi-disciplinary training, escalating concerns to senior leaders, and applying lessons learned from serious incidents. It will equip maternity leaders with the skills and knowledge to improve workplace culture and facilitate greater collaborative working between nurses, doctors, midwives and obstetricians.

Maternity Safety Champions

Strong leadership has been established across the system with the appointment of named regional and local Maternity Safety Champions led by two national Maternity Safety Champions (Matthew Jolly and Jacqueline Dunkley-Bent). In every Trust, frontline Maternity Safety Champions (one obstetrician, one midwife and one neonatologist) work closely with a Board Maternity Safety Champion to promote unfettered ‘floor-to-board’ communication.

Q10: In relation to paragraph 102 of the Department's written submission, please provide a breakdown of obstetric versus gynaecology consultants within the total FTE 2,487 estimate.

The estimate of 2,487 FTE O&G consultants was provided by NHS Digital. NHS Digital have confirmed that O&G consultants are categorised as one speciality and are therefore unable to be divided into sub-specialties.

Q11: Paragraph 100 of the Department's written response refers to a gap of 1088 FTE midwives between funded establishment and Birthrate Plus recommended establishment. Please provide the calculation on which this claim is based.

Health Education England (HEE) undertook work to evaluate data produced by Trusts via a national midwifery workforce survey undertaken by NHSEI in January – February 2021.

The survey took into account that midwife-to-birth ratios varied from Trust to Trust based on local requirements including birth rates and acuity, as recommended by Birthrate Plus. The survey received responses from all NHS Trusts where maternity services are provided.

To determine the gap between staff in post, the funded establishment and the Birthrate Plus assessed requirement, HEE triangulated the survey data with Electronic Staff Record (ESR) and NHS Digital numbers.[5] HEE's default is to use all employed full-time equivalent (FTE) on the ESR for 'Staff in Post'.

HEE' s analysis of the data identified that there are **23,664** FTE midwives employed and in post, **24,508** FTE funded establishment midwife posts for 2020/21, and **25,596** FTE recommended establishment midwife posts for 2020/21, based on Birthrate Plus or the most recent board review of safe midwifery staffing as stated in the NHSEI national midwifery workforce survey of January - February 2021.This gives a gap of **844 FTE (3.5%)** midwives between employed FTE staff in post and funded establishment, and a gap of **1,088 FTE (4.4%)** midwives between funded establishment and Birthrate Plus recommended establishment. Following the national midwifery workforce survey and as a result of the Ockenden report NHSEI have committed significant funding to meet the midwifery workforce gaps by funding an increase in establishment across England of 1200 midwives in 2021/22. Our expectation is that every maternity service will meet their Birthrate Plus recommendations by the end of 2021/22, using both national funding and by investing in their workforce locally.

Commitment 4

Q12: How many women with PCSPs received the care or mode of birth or place of birth they specified in their plan, and how does this relate to women without PCSPs?

This information is not collected centrally.

Q12b: How many women have had a PCSP for the entire pregnancy pathway?

Collection of this information began in April 2021 but is not currently available.

Q13: Are there any anticipated barriers relating to integrating PCSP within existing midwifery workloads? If so, how are these barriers being addressed?

[5] Data taken from the ESR Data Warehouse by HEE includes all staff employed in post by default. NHS Digital data by contrast includes only those in receipt of payment, and so would exclude staff on maternity leave (i.e., not in receipt of payment) to assess the gap.

The anticipated barriers are as follows:

- Education and training in personalised support and care planning – NHSEI to release the national training programme alongside the maternity specific training package.
- Training in personalised support and care delivery – midwives and obstetricians may require additional training in delivering personalised care. NHSEI has commissioned an e-learning package from the Personalised Care Institute which has just been launched. This forms part of the Core Competencies for staff. They also provide links to other resources to support informed decision making and risk communication such as NHS Personalised Care site and Winton Centre for Risk communication, Resources for Health Professionals.
- Improving Access to Psychological Therapies (IAPT) services – The Long Term Plan sets ambitious targets for year-on-year increases in access to IAPT services and growth in workforce to support this. Additional funding to support with COVID recovery has been allocated to IAPT services, however there will inevitably be a time lag between funding and implementation of additionally trained IAPT practitioners.
- Continuity of carer - Personalised care is facilitated in a continuity of carer model where midwives / obstetricians are seeing many women they are familiar with. NHSEI continues the roll-out of the continuity of carer programme and Trusts must ensure they have sufficient services to support vulnerable women through continuity and continue to provide sufficient support for routine services.
- Specialist midwives and nurses continue to play an important role in the care pathways for vulnerable and bereaved women. However, the provision of, role of, and training required to be a specialist is not defined.
- Maternal medicine networks – NHSEI continues to support the roll-out of maternal medicine networks. Further work regarding the monitoring access to the networks in relation to personalised care and support planning is required.
- Governance – the monitoring of personalised care and support planning is difficult as it is nuanced. Auditing the documentation of personalised care plans through the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme's Safety Action 3 and feedback from MVPs will provide the best assessment of implementation.
- Digital – electronic patient records that can be shared between the woman and clinicians will facilitate personalised care and support planning. Some maternity information systems can already provide this, and we are moving towards all services being able to offer Maternity Digital Care Records as soon as possible. A workplan is currently being developed with NHSX for a framework of minimum standards that maternity information system suppliers must meet. This will be supported with some match funding available to enable trusts to procure the right solutions.

Q14: What is being done to improve real-time data collection for information relating to all four commitments?

Improving data collection was identified as a key enabler from the outset of the Maternity Transformation Programme. In response, a significant upgrade to the Maternity Services Data Set (MSDS) was developed and went live in April 2019. The time interval from data submission by a Trust to data publication by NHS Digital is three months. Despite very significant improvements in data quality, it is still not of a suitable standard to enable use of reliable measures in some areas we would like. There is a continued focus on improving data quality with new initiatives to improve the digital maturity of Trusts.

A particular barrier to Trusts achieving the required digital maturity is the capability of the maternity information systems used in maternity services to collect and submit all the required data items to NHS Digital for inclusion in the MSDS. Information Standards Notices have been published which set out the requirements and a workplan is currently being developed with NHSX for a national commercial framework which will mean trusts will only be able to procure systems which comply with these minimum standards.

The development of interoperable electronic personal care records will enable real time data transfer from the maternity service to women. However, real time data transfer to the MSDS for analytical purposes is a very significant technical challenge which will take several more years to achieve. Given the length of the maternity pathway and the data processing which needs to take place, a time lag in generating metrics from the data is inevitable and the availability of real time metrics is an unrealistic aim. Some metrics are also based on rare events, which means that a timely assessment at a granular organisation level is not meaningful. For example, maternal mortality is measured on the basis of a UK-wide three year rolling average.

Q15: How was funding allocation for each of the four commitments assessed and determined?

Funding is not allocated on a commitment-by-commitment basis.

This means that whilst some funding covers one or more of the commitments, other funding allocations are as part of a wider package of maternity transformation programme funding.

Funding provided to Local Maternity Systems is given with a set of objectives but is not ringfenced to deliver certain initiatives. Funding is allocated in this way to allow Local Maternity Systems to meet the needs of their local areas

As such, it is not possible to set out how all funding arrangements were assessed and determined before being allocated for each commitment individually.

Q16: Set out the Department's rationale for phased rather than universal implementation of maternity initiatives including Continuity of Carer and Saving Babies Lives Care Bundle.

Continuity of carer

Since March 2017, all Local Maternity Systems have been asked to meet the same deliverables and milestones in relation to Continuity of Carer.

The level of implementation has been phased to allow Local Maternity Systems flexibility to develop models – in line with national standards and principles of best practice – that meet local opportunities, needs and challenges.

Continuity of carer requires a significant reorganisation of midwifery staffing. It has also been known that some midwives are apprehensive about working in this way. Phased implementation has given maternity services opportunity to test continuity of carer on a smaller scale and assess benefits to clinical outcomes, experience for women, and staff experience. It has also provided an important opportunity for midwives to familiarise themselves with continuity of carer teams operating in their trusts.

Saving Babies Lives Care Bundle

NHSEI asked all maternity service providers aim to fully implement the Saving Babies' Care Bundle Version 2 by April 2020. This is also supported by the Standard Contract, the NHS Long Term Plan and the CNST Maternity Incentive Scheme. However, there are still some gaps in implementation in some trusts, which we are supporting them to overcome. NHSEI undertake a quarterly implementation tracker survey across England which shows that 100% of maternity provider units are implementing some aspect of all of the 5 elements of the care bundle. Year two of NHS Resolution's Maternity Incentive Scheme showed that 128 of 131 Trusts declared that they complied with the scheme's requirement's related to Saving Babies' Care Bundle Version 1.

The care bundle was originally designed to not only help implement evidence-based care but also to describe best practice where the evidence base was incomplete. Implementation required achieving a widespread clinical consensus. The focus of the care bundle is on quality improvement. An independent evaluation of the two years to April 2017 of version one of the Saving Babies' Lives Care Bundle showed that stillbirths fell by 20% at the maternity units where implementation of the Care Bundle was evaluated.

The evaluation helped inform the approach of continuous improvement enabling a second iteration of the care bundle to be published In April 2019. Version 2 includes a new element focussed on reducing pre-term births to support the national ambition to reduce these from 8% to 6% by 2025. It also contains specific guidance on fetal growth surveillance and the introduction of carbon monoxide monitoring. It is accessible via the NHS website: https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-covid-19-information/

In 2020 additional guidance was provided in response to the impact of the Covid-19 pandemic, which included modified fetal growth surveillance pathways when scanning capacity was limited and a temporary pause to CO monitoring, an intervention which has since been reinstated.

A further evaluation will be commissioned in 2021. In the meantime, NHSEI continues to support Trusts to use the metrics within the care bundle to track implementation and inform quality improvement work to further minimise perinatal mortality.

Q17: Paragraph 21 (brain injury) of the Department's written response refers to funding awarded in 2020 to support targets. Why was there a five-year delay between the announcement of commitment 1 in 2015 and it being addressed in the 2020 spending review?

The overarching policy is for all women to have safe personalised care with safe outcomes for mothers and babies. The maternity safety ambition focuses on the most serious adverse outcomes – mortality (i.e. stillbirth and neonatal and maternal death) and birth-related brain injuries in babies. Many of the funded safety initiatives introduced to date impact on several or all of these outcomes. Additional funding sought in the 2020 Spending Review supports a programme of work to: (1) develop clinical consensus on best practice in fetal monitoring and the identification, escalation and action on fetal deterioration and (2) to model and pilot the implementation of agreed practices in 10 -12 maternity services in 2022 with a view to seeking additional funding for national implementation in the 2021 Spending Review. The evidence demonstrating links between failures in fetal monitoring/management of fetal deterioration and birth-related brain injuries comes from reviews of brain injury cases undertaken through the Each Baby Counts Programme (Oct 2017, Nov 2018) and NHS Resolution's Early Notification Scheme (Sep 2019) and makes a case for the standardisation of these processes.