Department of Health & Social Care

From Nadine Dorries MP
Minister of State for Patient Safety,
Suicide Prevention and Mental Health

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7 June 2021

Dear Professor Dame Jane Dacre,

On behalf of my officials at the Department of Health and Social Care and NHS England and NHS Improvement, I would like to thank you for the helpful meeting on 29 April in relation to your evaluation of the Government's progress in delivering its maternity commitments.

During the meeting, my officials agreed to send you additional data and information to assist with your evaluation.

The committee clerk has since written, and kindly set out the information you require as follows:

1) Documents relating to the bespoke definition of brain injury developed in 2017, including the BMA paper cited.

2) Information in relation to funding and methodology of the new obstetric workforce tool (equivalent of BirthRate Plus).

3) Attrition rates relating to midwifery and obstetric staff.

4) A summary of disaggregated data relating to commitments 1, 2 and 4; and disaggregated data relating to 2018/2019 brain injuries from Imperial College London.

5) A breakdown of funding/spending arrangements relating to all four of the commitments, and for clarification regarding the sources of funding, and whether the funding was a reallocation of existing budgets or new money.

This information has been provided below. Please accept my apologies for the delay.

Please do not hesitate to contact me if you have any further questions or would like some additional information to support your evaluation.

NADINE DORRIES

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

Provide two documents relating to the bespoke definition of brain injury developed in 2017, including the BMA paper cited

1. Links to the documents relating to the bespoke definition of brain injury are below.

    a. Imperial College London. Brain injury occurring during or soon after birth: a report for the national maternity ambition commissioned by the Department of Health, 2017. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662974/Report_on_brain_injury_occurring_during_or_soon_after_birth.pdf

    b. Gale C, et al. Arch Dis Child Fetal Neonatal Ed 2017;0:F1–F6. doi:10.1136/archdischild-2017-313707: Neonatal brain injuries in England: population-based incidence derived from routinely recorded clinical data held in the National Neonatal Research Database (bmj.com)

2. As mentioned in our first submission, a correction to the brain injury data published in 2017 was published earlier this year. Those publications can be found via the links below:

    a. Imperial College London. Brain injury occurring during or soon after birth: annual incidence and rates of brain injuries to monitor progress against the national maternity ambition 2018 and 2019 national data commissioned by the Department of Health and Social Care. Microsoft Word - 2018 2019 Brain injury occurring during or soon after birth NATIONAL DATA 280121.docx (imperial.ac.uk)

    b. Correction: Neonatal brain injuries in England: population-based incidence derived from routinely recorded clinical data held in the National Neonatal Research Database Archives of Disease in Childhood - Fetal and Neonatal Edition 2021;106:e1-e4. Correction: Neonatal brain injuries in England: population-based incidence derived from routinely recorded clinical data held in the National Neonatal Research Database | ADC Fetal & Neonatal Edition (bmj.com)

Funding and methodology of the new obstetric workforce tool (equivalent of BirthRate Plus).

3. Several high-profile enquiries, most recently the Ockenden Report, highlighted the need to gain a deeper understanding of what constitutes safe staffing in maternity care. Whilst Birthrate Plus exists as a framework to calculate safe midwifery staffing levels, no such tool exists for medical staffing.

4. The Royal College of Obstetricians and Gynaecologists (RCOG) worked in partnership with Health Education England (HEE) to develop a proposal to create a tool which will determine the number of obstetricians required in units across England and Wales. Ministers have agreed to fund this work, which is expected to begin soon.

5. The RCOG intend to make this tool available to the NHS free-of-charge.

6. The primary aim of the proposal is to calculate the number of obstetricians at all grades required nationally to provide a safe, woman-centred maternity service within the context of the wider workforce. Additional objectives of the proposal include:

a. Identifying innovative ways of working to better utilise our current workforce;

b. Developing a safe maternity staffing tool to guide numbers of obstetricians and the skill set required within individual units; and

c. Gaining a better understanding of the factors which promote safety and positive culture within maternity units and how these can be embedded nationally.

7. A mixed methods approach will be used to gather qualitative and quantitative data on current staffing models within each unit in the country alongside determinants of quality and acuity of their service and patient population. The gathering of data will include:

    d. Interviews with Obstetric and Gynaecology (O&G) clinical directors from across the country.

    e. Focus groups with the wider O&G workforce and women and families.

    f. Evaluation of the efficiency of current junior doctor rotas and consultant job plans.

    g. Work to understand which interventions are most effective at improving outcomes.

    h. In-depth study of innovative multidisciplinary working to deliver cost- effective patient care.

8. The RCOG aims to provide workforce calculations for the number of obstetricians required within six months of funding being granted. Subsidiary objectives will be delivered within 12 months.

Provide attrition rates relating to midwifery and obstetric staff.

<u>Staff Attrition Rates</u>

9. According to data provided by NHS Digital, in the year to January 2021, 2,238 (8.0%) of midwives left the midwives staff group. Over the last 10 years, the number of leavers and leaver rate for midwives has not significantly changed.

10. Data from NHS Digital also suggests that in the year to January 2021, 178 (6.0%) doctors in the specialty Obstetrics & Gynaecology left the HCHS doctors staff group. Over the last 10 years, the number of leavers and the leaver rate for doctors with a specialty of Obstetrics & Gynaecology has not significantly changed.

11. It is important to note that turnover data is based on headcount and shows people leaving or returning to active service. Staff going on maternity leave are not counted as leavers in these figures. This differs from NHS Digital published turnover statistics. The figures quoted are leavers from the specified staff group and so will include more than just those who left the NHS. Due to the different ways in which leavers can be classified and counted, these figures may be different to previous analysis.

12. Attrition figures for midwives and obstetrics & gynaecology staff each year since 2010 are set out below:

headcount

	Obstetrics & Gynaecology HCHS Doctors		Midwives	
	Leavers	Leaver rate	Leavers	Leaver rate
January 2010 to January 2011	179	7.6%	2,059	8.3%
January 2011 to January 2012	181	7.6%	1,962	7.7%
January 2012 to January 2013	186	7.6%	2,062	8.0%
January 2013 to January 2014	189	7.6%	2,172	8.3%
January 2014 to January 2015	183	7.2%	2,308	8.7%
January 2015 to January 2016	180	6.9%	2,473	9.2%
January 2016 to January 2017	170	6.3%	2,552	9.5%
January 2017 to January 2018	203	7.4%	2,357	8.7%
January 2018 to January 2019	203	7.2%	2,441	8.9%
January 2019 to January 2020	179	6.2%	2,406	8.7%
January 2020 to January 2021	178	6.0%	2,238	8.0%

Source: NHS Digital NHS Hospital & Community Health Service (HCHS) workforce statistics.

Trainee Attrition Rates

13. HEE has provided the data below on attrition rates relating to midwifery and obstetric trainees.

Course Name	Year	Starters	Attrition (%)
Midwifery	2019/20	3,068	8.63%
	2020/21	3,610	1.22%

Source: Student Data Collection[1] 2019/20 - 2020/21

[1] **Student Data Collection**
- The 'Starters' field shows how many students joined the course on the course start date
- The current year may not be complete for subjects that have Spring starters
- Year is defined as academic year, with each year covering the period from September to August
- Uses subject mapping created by HEE to standardise course names.
- Attrition: this is provisional data and subject to change.
- Further caveats on the Student Data Collection can be found via the link below:
https://healtheducationengland.sharepoint.com/providerprofiles/Lists/Student Data Collection Data Quality Issues/AllItems.aspx

Specialty Group	Year		Still in training	Successfully completed training	Left programme	Removed from programme
Obstetrics & Gynaecology	2019/20	No.	1,998	149	55	3
		%	90.65%	6.76%	2.50%	0.14%

Specialty	StartYear (Calendar)	Starters
Obstetrics & Gynaecology	2021	37
	2020	238
	2019	272
	2018	313
	2017	238
	2016	234
	2015	214
	2014	226
	2013	206
	2012	242
	2011	286
	2010	311

14. As Student Data Collection does not include historical data, HEE has provided the following attrition rates for midwifery from HESA Student Records[2].

Subject group	Year	Attrition
Midwifery	2009-2010	3.8%
	2010-2011	3.7%
	2011-2012	4.0%
	2012-2013	4.1%
	2013-2014	3.2%
	2014-2015	3.3%
	2015-2016	2.7%
	2016-2017	2.6%
	2017-2018	2.7%
	2018-2019	2.8%

15. The Royal College of Obstetricians and Gynaecologists published an O&G Workforce Report in 2017[3] and 2018[4].

NHSEI to provide a summary of disaggregated data relating to commitments 1, 2 and 4; and DHSC to provide disaggregated data relating to 2018/2019 brain injuries from ICL.

Commitment 1 – The National Maternity Safety Ambition

16. A breakdown by ethnicity and area of deprivation has been provided for stillbirths, neonatal deaths and maternal deaths at Annex A.

[2] **HESA student records**
- HESA data covers both undergraduate and postgraduate courses. Only pre-registration courses have been selected for this query.
- Attrition: Non-completing leavers / Number of students * 100. Non-completing leavers include students whose reason for leaving is recorded as 'Academic failure/left in bad standing/not permitted to progress', 'Health reasons', 'Death'. 'Financial reasons', 'Other personal reasons & dropped out', 'Written off after lapse of time', 'Exclusion', 'Gone into employment', and 'Other', and excludes 'Successful completion of course', 'Transferred to another provider', 'Transferred out as part of collaborative supervision arrangements', 'Completion of course - result unknown', and 'Unknown'. NB: 'Unknown' covers those who are still on their course therefore the majority, if not all, of these are not non-completing leavers. The exclusion of unknowns for this reason therefore means some genuine drop-outs will be excluded as their reason for leaving has not been recorded. It is best to treat the resulting attrition figures as a minimum as a result of this.
- Includes courses delivered by English HEIs only.
- Uses subject mapping created by HEE to map course codes to subjects. HEE has revised the subject mapping to match course data as specified by each Higher Education Institution. Some of the historical figures may therefore have changed in the process.
- Excludes courses that cannot lead to appropriate professional registration in Britain or UK.
- HESA student record data may not reconcile with other sources of student numbers. Data quality is variable, particularly prior to 16/17.

[3] https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/rcog-og-workforce-report-2017.pdf
[4] https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/rcog-og-workforce-report-2018.pdf

17. Please note that a different definition of 'area of deprivation' has been used for 2018 for stillbirths and neonatal deaths. This means that data from 2018 can not be fully compared with previous years. This has been reflected on the tables by the insertion of a black line and footnote.

18. A breakdown of data by these categories is currently not available for brain injuries and pre-term births.

Commitment 2 – Continuity of Carer

19. There is the ambition to measure both rates of continuity of carer placement and receipt routinely using data submitted by maternity services to the Maternity Services Dataset. These measures have been defined in technical guidance, and data is being published on placement on a monthly basis, including by ethnicity and deprivation. The latest data is available via https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics/january-2021. However, the majority of trusts continue to work to reach the data quality required to demonstrate placement. Demonstrating receipt is a further challenge, requiring sustained data quality over the whole maternity pathway. For this reason, the current measure is still considered experimental and cannot be relied upon for reporting purposes.

20. While work continues to improve data quality, NHS England and NHS Improvement is assessing services' capacity to provide Continuity of Carer through surveys monitoring the number and capacity of Continuity of Carer teams. Data from the next survey will be available in June.

21. The panel has therefore already been provided with the most reliable, granular data currently available on continuity of carer:

> *"a recent baseline survey of 108 trusts indicated that in October 2020, services had sufficient continuity of carer teams in place to offer continuity to 15.9% of women. That represents 347 teams, made up of 2,322 midwives offering CoC to an estimated 94,000 women. Of these teams, over 60% (214) were reported as being placed in areas of deprivation, and around half (165) in areas with high proportions of black, Asian and mixed ethnicity women.*

22. Since then, a number of providers have continued to launch continuity of carer teams, and a follow-up survey of providers is expected to show an improved position as of 31 March 2021. This information will be available for the panel in the Summer.

Commitment 4 – Personalised Care and Support Plans

23. The latest data from the Maternity Services Dataset (January 2021) shows that 113 of 125 providers now have Personalised Care and Support Plans in place during at least one part of the maternity pathway for a total of 53,135 women. More useful data on the proportions of women with personalised care and support plans in place during the whole maternity pathway and split by ethnicity and deprivation is not currently available but will be from April 2021 data onwards (published in July 2021). However, this will be classed as experimental whilst data quality is reviewed.

24. Further work would be needed in order to analyse both continuity of carer data and personalised care and support planning data by physical disability. The Maternity Services Dataset does not currently report data on mental health disabilities (but could potentially be achieved through technical linkage to the Mental Health Services Dataset) or LGBTQ status.

Data relating to 2018/2019 brain injuries from ICL

25. The Department has commissioned this information from Imperial College London and is expected to be provided in one or two months. We will share this with you once received.

DHSC to provide a detailed breakdown of funding/spending arrangements relating to all four of the commitments and clarify the sources of the funding and whether the funding is a reallocation of existing budgets or new money.

26. We have provided a breakdown of the funding arrangements listed in our initial response below.

27. Some of the funding listed relates to either more than one commitment, or funding which relates to one of the commitments as part of a wider package of funding. We have therefore broken down funding arrangements into five key categories.

28. It is important to note that the funding arrangements listed below are separate from each other and are not reallocations of money.

Best Practice Clinical Care

29. **Brain Injury Reduction Programme -** £9.4m was awarded in the 2020 Spending Review to improve maternity safety, including a national brain injury reduction programme that aims to reduce incidences of brain injury but also to improve the quality and safety of services across the country. The programme will also address some of the issues identified in the Ockenden Review.

30. **Maternity safety innovation fund –** a £250,000 maternity safety innovation fund to support local maternity services to create and pilot new ideas.

31. **National Bereavement Care Pathway -** Funding to Sands, the Stillbirth and Neonatal Death charity to work with other baby loss charities and Royal Colleges to produce and support the roll-out of a National Bereavement Care Pathway to reduce the variation in the quality of bereavement care provided by the NHS. (£50,000 in 2016/17, £106,000 in 2018/19, and £106,000 in 2019/20).

32. **Funding for Local Maternity Systems (LMS) -** £90.05m was provided across three years (18/19: £18.16m; 19/20: £38.99m and 20/21: 32.9m) for local maternity systems development, for the fulfilment of the Maternity Transformation Programme. As part of this, funding was provided to support the Saving Babies' Lives Care Bundle, Continuity of Carer, and the establishment of Maternal Medicine Networks across England.

33. It is important to note that funding provided to LMS's is given with a set of objectives but is not ringfenced to deliver certain initiatives. Funding is allocated in this way to allow LMS's to meet the needs of their local areas.

Training

34. **Saving Babies' Lives Care Bundle Training -** HEE allocated £420,000 funds in 2019/2020 to directly support maternity safety training via implementation of the SBLCBv2, this included £400,000 to support the delivery of the national training offer across LMS's and a further £20,000 to support the creation of e-Learning resources.

35. **Implementation of Continuity of Carer -** In 2018/19 HEE distributed £745,000 to support the implementation of Continuity of Carer models in maternity care. In 2020/21 HEE has also been delivering a national training package to support Continuity of Carer at an expected cost of c.£300,000.

36. **Maternity Safety Training Fund -** £8.1m. 30,945 training places delivered in team communication, human factors, situational awareness, cardiotocography (CTG), and emergency skills and drills.

37. **Maternity Leadership Training Fund -** £500,00 for NHS maternity and neonatal leaders to address some of the issues raised in the Ockenden review. This includes key issues such as the disconnect between "ward and board" in maternity services and the importance of multi-disciplinary training, escalating concerns to senior leaders, applying lessons learned from serious incidents and listening to women and families.

Quality Improvement

38. **Maternity and Neonatal Safety Improvement Programme -** £3.75m to support development of Quality Improvement capacity and capability in all maternity units.

Case Reviews and Investigations

39. **Each Baby Counts (EBC) programme -** £431,000 between 2014 - 2021 for the RCOG EBC programme. Having established the successful EBC programme, DHSC agreed to provide additional funding of £1.7 million over three years to provide support for the RCOG and Royal College of Midwives (RCM) to launch the 'Each Baby Counts Learn and Support', a programme that is working with a number of local maternity units to support multi-professional learning and clinical leadership, improve joint working and drive innovation from within the NHS.

40. **Perinatal Mortality Review Tool (PMRT) -** £500,000 for the development of a standardised PMRT which was launched in 2018 and is used by all trusts to support objective, robust and standardised reviews to provide answers for bereaved parents about why their baby died. The PMRT also supports local and national learning to improve care and ultimately prevent future deaths

41. **MBRRACE-UK confidential enquiries** and surveillance reports provides learning about the underpinning causes of avoidable mortality and brain injuries that are informing improvements in care.

42. **NHS Resolution Early Notification (EN) scheme -** enables proactive action to reduce legal costs and improve the experience for the family and affected staff, share learning rapidly with the individual trust and wider system, and improve the process for obtaining compensation for families, meeting needs in real time where possible.

43. **Healthcare Safety Investigation Branch Maternity Investigations - including** £10,272,000 in 2018-19, £16m in 2019-20 and £16m in 2020-21. HSIB investigates all cases of intrapartum stillbirth, neonatal death, maternal death and intrapartum brain injury to identify common themes and changes to improve safety. To date, HSIB have completed 1,426 maternity reports.

System (Including Safe Staffing)

44. **HEE transformation fund -** £1m for LMS's to map their existing maternity support workforce.

45. **NHSE/I Maternity Investment -** £95.6m to target the three overarching themes identified in the Ockenden Report: workforce numbers, training and development programmes to support culture and leadership, and strengthening board assurance and surveillance to identify issues earlier, thereby enabling rapid intervention.

Incentives

46. **Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme -** incentivises the delivery of safer maternity care through the achievement of ten safety actions agreed by the national maternity champions and system partners