Royal College of Obstetricians and Gynaecologists – Written evidence (PRT0072)

Supporting the maternity workforce

1. **Both the prevention of preterm birth, and ensuring the best outcomes for babies born preterm, requires an adequately staffed and well-supported workforce. Underpinning all recommendations set out in this response is the need to address significant existing pressures on the maternity workforce.**
2. Several reviews into the safety and quality of maternity services in England have shone a spotlight on the need to increase staffing numbers. Although trainee attrition from obstetrics and gynaecology (O&G) has decreased significantly in recent years, rota gaps persist in many units, and the GMC's National Training Survey shows that O&G doctors are one of the specialties most at risk of burnout.[1]
3. Inadequate staff numbers directly impact patient care and safety, morale, training opportunities, job satisfaction and culture within services, and so it is vital that we have an evidence-based understanding of staffing needs now and in the future.
4. As part of a research and workforce planning exercise, the Department of Health and Social Care (DHSC) commissioned the Royal College of Obstetricians and Gynaecologists (RCOG) to more accurately quantify the number of obstetricians required in maternity units in England. A prototype tool which enables Trusts to compare their obstetric and anaesthetic staffing levels with national averages, local context, complexity of caseload and quality indicators, was developed and provided to the DHSC in 2023, with a final report providing an estimate of the required number of obstetric staff in England.[2] However, continuation of this work is

[1] GMC, National Training Survey: 2023 results (2023)

dependent on the DHSC confirming plans for the next phase of the project. **Information is not available at this point on when this confirmation may be expected – we urge the DHSC to progress this work.**

5. The RCOG cautiously welcomed the recent UK Government commitment to the provision of £35 million over the next three years to improve maternity safety in England, with a focus on staff training and recruitment. **However, it is imperative that the UK Government takes further action towards retaining the skilled workforce (including obstetricians, midwives, anaesthetists, neonatologists and supporting healthcare professionals) already trained and working in the NHS.** This includes exploring ways to build more supportive and learning cultures, encouraging multi-disciplinary training, and increasing flexible working.
6. The NHS England Long-term workforce plan outlined a commitment to boost medical school places, which is welcome. **There now needs to be a commitment and plan for a commensurate increase in the number of specialty training programme places to accommodate these new doctors.** Otherwise the UK Government risks creating a bottleneck in the training pathway.
7. The Government must significantly build upon the present maternity services workforce and infrastructure by **implementing fully-funded policies and programmes to ensure all women and people giving birth receive high-quality, personalised and safe maternity care**, which supports their physical and mental health during and after pregnancy. This is a key requirement in reducing the incidence and consequences of preterm labour and birth.

[2] RCOG, The Workforce Planning Tool for Obstetrics and Anaesthesia

8. Greater support for neonatal services is also required. Ideally, all babies should be delivered in a unit appropriate to their needs, rather than having to be transferred after birth. However, staff shortages, cot shortages, and an overstretched neonatal ambulance service means that this is often not possible, and trying to overcome these barriers to successfully transfer women takes up clinical time, often when there is a limited time window for transfer before birth.
9. **In addition, the supporting infrastructure, including administrative support with adequate modern computerised records and processes is essential.** There is a clear need for staff to be supported by stronger IT systems which are fit for purpose and can provide joined-up information from secondary and primary care across a woman's life course.

Implementation of the Saving Babies Lives Care Bundle

10. NHS England's Saving Babies Lives Care Bundle (SBLCB) sets out evidence-based best practice guidance for providers and commissioners for the reduction of stillbirth and neonatal death.[3] SBLCB was published and recommended for implementation in English maternity units in 2016. Audit and evaluation produced by researchers at the University of Manchester in 2018 found that stillbirths fell by a fifth in maternity units where SBLCB had been implemented.[4]
11. However, uptake and implementation have been slow and under-resourced in some areas. Services need the capacity and resource to deliver what we know works. **Services must be supported to fully implement and sustain SBLCB version 3 (SBLCBv3),**

[3] NHS England, Saving babies' lives: version 3 (2023)
[4] University of Manchester, Action plan can prevent over 600 stillbirths a year (2018)

including through financial resource, safe staffing levels and protected training time.

Preterm birth clinics and lead teams

12. SBLCBv3 recommends that women at risk of preterm birth receive care in a preterm birth prevention clinic. However, there is no reliable data on workforce numbers in preterm birth clinics, and RCOG members have flagged significant regional variation between Trusts, from Whole Time Equivalent roles offering good continuity of care, to limited or no dedicated staff.
13. **Providers must ensure that all women and people at known risk of preterm birth can access high quality and timely specialist care,** through ring-fenced, funded and appropriately staffed preterm birth prevention clinics or access to regional centres, and support for clinicians to participate in preterm birth, maternal and fetal medicine and neonatal networks.
14. SBLCBv3 also recommends that each provider has a Preterm Birth Lead Team. Facilitating shared leadership amongst teams is an important element of making staff feel listened to and valued. **There is an opportunity to develop cross specialty leadership training across O&G, neonatal and anaesthetics. As with all improvement initiatives this training requires investment, and staff need the support of their employer to attend training to build a supportive and learning culture.**

Preventing preterm birth

Screening

15. At present, screening for preterm birth is limited to clinical history taking for risk factors for preterm birth, cervical length

measurements, and the use of fetal fibronectin. Our members raised specific areas where improvement is needed:

a. A national shortage of fetal fibronectin, used in decision aids such as QUiPP to target optimisation interventions at the right group of women, is hampering identification of those at risk.

b. Greater consistency of clinical history taking at the booking visit is needed to ensure appropriate risk stratification, such as accurate recording of different types of procedures to remove cells from the cervix.

c. Electronic patient and digital records, which vary by area or region and are often not accessible between organisations, can act as a barrier to delivering appropriate screening. These records also vary in quality.

16. The UK National Screening Committee does not currently recommend screening for low risk asymptomatic women for their risk of preterm birth. The last screening reviews took place in 2015 and 2020, with the next review estimated to be completed in 2023/24.

17. Most women and people who give birth preterm have no identifiable pre-existing risk factors, and many risk factors for preterm birth are dependent on what has happened in a previous pregnancy. **More research is needed into options for population screening, why women and people in their first pregnancy have preterm birth, and what the best predictive tests and treatments are for them. We support greater funding in this area.**

<u>Technology and the work of the Tommy's National Centre for Maternity Improvement</u>

18. Technology can have an important role in supporting maternity staff to provide personalised care and more effectively and efficiently

identify and treat women who would go on to experience a premature birth. Examples include the QUiPP App and Tommy's Pathway clinical decision support tool.[5]

19. The Tommy's National Centre for Maternity Improvement provides context-specific information for both the woman and the clinician providing her care. The Centre is an alliance of the RCOG, the Royal College of Midwives and Tommy's, and aims specifically to reduce the number of babies born prematurely or stillborn each year in the UK.

20. Phase three of the Tommy's Pathway project is currently commencing and the Tommy's team is focusing on the implementation of the device at scale prior to a national roll out.

Postnatal care

21. The Royal College of Pathologists recommends that placental histology is sent for all women giving birth at less than 32+0 weeks' gestation, which may help provide an explanation of the cause of the preterm birth and inform management of future pregnancy.[6] However, the critical shortage of perinatal pathologists means that in practice there are real limitations in offering this service and even when it is offered, the lack of specialist postnatal clinics means that the results are often not followed up. **We urge the UK Government to support and develop the perinatal pathologist workforce.**

22. **Improving access to specialist postnatal follow-up for women and people who have given birth preterm should be a priority for the UK Government and the NHS** – allowing them to discuss the reasons they gave birth prematurely, any mental health

[5] BAPM, QUiPP App Toolkit; RCOG, Tommy's Pathway
[6] RCPath, Tissue pathway for histopathological examination of the placenta (2022)

impacts, and to make a plan for their next pregnancy if relevant, to reduce the chance of recurrence.

23. There is also unmet need for postnatal psychological support for women who give birth prematurely, and antenatal psychological support for women identified as high risk of preterm birth. **We urge the UK Government to consider what additional support is needed for services to provide this.**

24. As a member of the Maternal Mental Health Alliance the RCOG is calling for new and expectant mothers' mental health to be valued as much as their physical health. This means **supporting services so that they are equipped to ensure mental health is sensitively discussed at every contact pregnant women have with a health professional**.[7]

Supporting good health across women's life course

25. Spontaneous preterm birth and late fetal loss is an outcome related to many risk factors, and in many cases happens for unknown reasons.[8]

26. It is widely recognised that maternity outcomes are influenced by factors that start well before pregnancy, and sit far beyond the remit of the health system. Women who are in good health have a better chance of becoming pregnant, having a safe and healthy pregnancy and giving birth to a healthy baby.[9] Supporting good health across the population, women's health across their life course, and good health in an individual's preconception period, are all dependent on and relevant to, reducing the overall incidence of preterm birth.

[7] MMHA, Maternal Mental Health in the UK (2024)
[8] Tommy's, Causes of premature birth
[9] PHE, Making the Case for Preconception Care: Planning and preparation for pregnancy to improve maternal and child health outcomes (2018)

Reversing public health cuts

27. Ensuring women can maintain good health and take decisions about their preconception and pregnancy health requires UK governments to ensure that public health services are adequately funded and accessible.

28. However, the Health Foundation has estimated that reductions in spend on a real-terms per person basis for the English public health grant include a 39% reduction for sexual health services, 34% reduction for public health advice, 31% reduction for drug and alcohol services for young people, and 12% in stop smoking services.[10] **The UK Government should commit to increasing the public health grant in England to ensure that these vital services are accessible to everyone who needs them.**

29. Access to good preconception health information and advice is important. This may include education about sexual and reproductive health, as well as provision of information for women planning a pregnancy, and regionally specific communication campaigns where appropriate. This requires services to be adequately supported to provide these services.

30. Behaviours which affect health, such as smoking, alcohol consumption, diet and exercise, relate to access to public health services, and also the wider contexts in which people live. They are also drivers of health inequalities in the UK.[11] We urge the committee to consider the role of population level interventions to improve health and tackle inequalities more widely. **Supporting people to live healthily requires government policy which recognises and addresses the role played by the wider**

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[10] Health Foundation, Investing in the public health grant (2024)
[11] The King's Fund, A vision for population health: Towards a healthier future (2018); Health Foundation, Addressing the leading risk factors for ill health (2022)

environment and the private sector in influencing individual behaviour and shaping health.[12] This includes action to tackle the advertising, promotion, relative expense and availability of healthy and unhealthy food, alcohol, and tobacco.[13]

31. Other Government actions to reduce rates and tackle inequalities in preterm birth include:

32. **Cervical screening** - Some treatments for abnormal cervical cells are linked to an increased risk of preterm birth.[14] Some groups are much less likely to access screening – **the UK Government should focus on understanding and addressing the barriers to cervical screening amongst currently underserved groups, and to boosting uptake and addressing regional disparities in uptake of the HPV vaccination**. Earlier screening and detection leads to less invasive treatment that is less likely to increase the risk of preterm birth.

33. **Smoking -** Smoking in pregnancy is one of the biggest modifiable risk factors for poor birth outcomes, including preterm birth.[15] Element 1 of SBLCBv3 aims to reduce smoking in pregnancy, through carbon monoxide (CO) testing offered to all pregnant women at antenatal booking, and an opt-out referral to an in-house treatment pathway for all women who smoke. This pathway is currently being rolled out, with promising results so far. **To fully realise the benefits of this pathway Trusts and ICBs must sustain these services long-term, beyond the transformation period.**

34. We are also supportive of the ongoing rollout of the national financial incentive scheme. Currently, committed funding will only support women signing up by March 2025. **We would like to see**

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[12] The Health Foundation, Addressing the leading risk factors for ill health (2022)
[13] The Health Foundation, Addressing the leading risk factors for ill health (2022)
[14] Castanon A et al, Risk of preterm birth after treatment for cervical intraepithelial neoplasia among women attending colposcopy in England: retrospective-prospective cohort study *BMJ* (2012)
[15] RCOG, Creating a smokefree generation (2023)

the national financial incentive scheme become an established part of the support package for pregnant women, supported by long-term funding, as the current situation risks creating uncertainty for services offering incentives.

35. We are **fully supportive of the UK Government's plans for a Smokefree Generation, including raising the age of sale for tobacco products,** which will play a pivotal role in creating a smokefree generation and delivering a smokefree start for every child.[16]

36. **Access to care for women with complex social factors -** Targeted interventions are required to ensure women with complex social factors access appropriate maternity care. For example, women with unofficial migration status, and women in prisons.

Tackling ethnic and socioeconomic inequalities in preterm birth

37. Higher rates of preterm birth at any gestation are associated with increased socioeconomic deprivation. Rates can also vary by ethnicity, with preterm birth rates among babies from Black and Asian ethnic groups consistently higher than their white counterparts.[17] This mirrors persistent socioeconomic and ethnic disparities found in rates of maternal and perinatal mortality and morbidity, as documented by MBRRACE-UK.

38. Sustainably and effectively tackling the increased risk faced by some groups requires action at multiple levels – including within healthcare services, primary prevention and health promotion across the population, and addressing the root causes of these inequalities.[18] This is a vital part of improving women's health and

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[16] RCOG, Creating a smokefree generation (2023)
[17] ONS, Birth characteristics in England and Wales: 2021 (2023); NMPA, Ethnic and Socio-economic Inequalities in NHS Maternity and Perinatal Care for Women and their Babies (2021)
[18] Jardine J et al, Adverse pregnancy outcomes attributable to socioeconomic and ethnic inequalities in England: a national cohort study *Lancet* (2021)

addressing persistent inequalities in maternal and perinatal outcomes.

39. Socioeconomic deprivation is linked to several risk factors for preterm birth, including increased rates of smoking, obesity, stress, and pollution exposure.[19] Deprivation may also act as a barrier to healthcare access, for example due to insecure work, the cost of travelling to appointments, or difficulties paying for childcare. Relevant to this inquiry, there is a strong link between deprivation and delayed access to, and low engagement with, antenatal care, which is important for a healthy pregnancy.[20]

40. As one of over 200 members of the Inequalities in Health Alliance, we are calling **for the UK Government to introduce a cross-government strategy to reduce health inequalities, underpinned by the necessary funding settlement, with clear measurable goals that considers the role of every department and every available policy lever.[21]**

41. The racial and ethnic inequalities seen in preterm birth rates are found across maternity and perinatal outcomes. **The UK Government must commit to a time-limited target to end the higher risk of maternal mortality among Black, Asian and ethnic minority women, and for women living in more deprived areas. To drive urgent cross-departmental innovation, improvement and investment, it is vital that this commitment is accompanied by ring-fenced funding.** Such an approach would reduce rates of maternal and perinatal mortality and preterm birth, as well as other health outcomes unrelated to pregnancy.

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[19] Ibid; Taylor-Robinson D et al, Quantifying the Impact of Deprivation on Preterm Births: A Retrospective Cohort Study *PLOS ONE* (2011)
[20] Jones G L et al, Understanding the relationship between social determinants of health and maternal mortality *BJOG* (2022); Tomson K et al, Socioeconomic inequalities and adverse pregnancy outcomes in the UK and Republic of Ireland: a systematic review and meta-analysis *BMJ Open* (2021)
[21] RCP, RCP view on health inequalities: a call to action for a cross-government strategy (2023)

42. MBRRACE-UK has recently delivered two confidential enquiries comparing the care of Black, Asian and white women, to investigate the role of ethnicity in increased rates of stillbirth and neonatal death for Asian and Black populations in the UK.[22] Recommendations to NHS England include planning and personalising maternity care around each woman's specific needs by improving the accurate recording of self-reported ethnicity, national support to improve access to interpretation services at all stages of perinatal care, and ensuring staff have protected time to participate in local multidisciplinary review panels.

43. **Access to high quality interpretation services is a vital part of the provision of safe, consensual and personalised care for all women who have difficulty reading or speaking English**. Healthcare professionals rely on the provision of these services to ensure women are able to make informed choices about their care and can give informed consent to treatment and procedures. Alongside services improving access to interpreters, **services must be safely staffed so that they can offer additional or longer appointments, as recommended by NICE**.[23]

Research, data collection and targets

Funding for research

44. As mentioned above**, we strongly encourage increased research funding for studies into the prevention and causes of preterm birth**. The causes and prevention of preterm birth are still poorly understood and there remains a real need for financial support for preterm birth research. This could be hugely beneficial

[22] NPEU, MBRRACE-UK collaboration sets out key recommendations for reducing inequities and improving care for babies born to Asian and Black mothers (2023)
[23] RCOG, Equitable access to maternity care for refugee, asylum seeking and undocumented migrant women (2022)

in the long term, both to families, and through financial savings to the NHS.

Areas of particular focus may include:

- Twin and multiple pregnancy, including interventions that can help prevent preterm birth
- Research into mechanisms to help target interventions appropriately
- Targeted individualised risk prediction
- Development of new predictive tests
- Long term studies into outcomes for babies born preterm
- Novel therapies for secondary prevention

Data collection

45. **Digital systems must be developed and improved to be used across the country to support data collection, with appropriate administrative and technical support to facilitate this.** For example, there is currently no comprehensive national database of outcomes and demographics, as the variation in digital systems across the country means that this is currently difficult to gather at a clinical network level.
46. In addition to collecting data on spontaneous and iatrogenic preterm birth, there should be consideration to the collection and reporting of data on spontaneous late pregnancy loss, as this is often part of the same spectrum of disease as spontaneous preterm birth.

Government targets

47. The UK Government ambition to reduce the rate of preterm birth to 6% by 2025 is a reasonable goal, but the timescale is likely now to

be unrealistic. **All future targets must be ambitious, and backed up by real resource put into the system to aim to achieve them.** We also urge the adoption of a target to drive a reduction in socioeconomic and ethnic inequalities in maternity care, outlined above.

48. It is recognised that there is a difference between spontaneous preterm birth, and iatrogenic preterm birth, which is planned and is frequently life saving for women and their babies. However, reducing the incidence of many of the causes of iatrogenic preterm birth is also positive, so on the whole, a focus on preterm birth is acceptable. Other targets that could be considered in future include the reduction of morbidity associated with preterm birth.

5 April 2024