Equality, Health Inequality Impact and Risk Assessment

Birthing Services at County Hospital, Stafford and Samuel Johnson, Lichfield

NHS Staffordshire and Stoke-on-Trent ICB

Current Status
Stage 1 Approved

Review Date
19/08/2024

Person Responsible
Heather Johnstone Chief Nursing and therapies Officer (SSOT ICB)

Service
Birthing services

Service Area
Maternity

Project Lead

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Stage 1 has been Bypassed

Explanation
As part of the ongoing involvement, the ICB and system partners are continuing to review maternity services in Staffordshire and Stoke-on-Trent. As part of this, we are exploring the future of the birthing services at the freestanding midwifery birth units (FMBUs). These are units at County Hospital in Stafford and Samuel Johnson Community Hospital in Lichfield, where women with low-risk pregnancies could choose to give birth. The two FBMUs were closed for births during the COVID-19 pandemic, to ensure safe staffing at the acute units at Royal Stoke University Hospital and Queen’s Hospital, Burton. Whilst the initial closures were directly related to COVID-19, significant staffing challenges in the maternity workforce have prevented both Trusts from being able to safely reopen these units. Staffordshire &Stoke-on-Trent ICB is currently undertaking a service change programme in relation to the birthing services that are temporarily closed. The service change programme will be conducting in accordance with the NHSE guidance - Planning, assuring and delivering service change for patients (https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf) Antenatal and postnatal services continue to run from these sites. No decisions have yet been made on the future of birthing services at these sites. A detailed Stage 2 Assessment has been completed for this proposal and is attached along with supporting documentation.

Supplementary Files

SSOTTR~1.PDF (636864 bytes) - *Attached below*

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- **Document 17_SSOT maternity literature review v0.3 with added section.pdf** (451972 bytes) - *Attached below*
- **UNPUBLISHED Clinical Senate Review SSOT Maternity Services April 2024.pdf** (1655891 bytes) - *Attached below*
- **Stage 2 EHIIRA Template - Freestanding Midwifery Birth Units 05July2024.pdf** (364952 bytes) - *Attached below*

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Stage 2 Details

Equality Policies

No files uploaded

Equality Other

No files uploaded

Human Rights

No files uploaded

Additional Files

No files uploaded

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Comments

Assessment Comment

Stage 1 was overridden as a Stage 2 assessment has been produced. Granville Thelwell ICB Equality Diversity Inclusion Business Partner 19/08/2024
29/08/2024
Gill, Gina

Approval Comment

Hi Gina, Thank you for providing a comprehensive assessment along with supporting documentation. You have demonstrated sufficient due regard to the Equality Acts Public Sector Equality Duty, and I can approve and finish the assessment at this point. I have included below the estimated timelines you provided. Thank You. October 2024- NHS England assurance September/October 2024 -Update to Staffordshire County Council Health and Care Overview and Scrutiny Committee and Derbyshire County Council Improvement Scrutiny Committee - Health (status of programme and potential plans for involvement) November 2024ICB decision on whether to proceed with further involvement December 2024 - February 2025 Potential involvement activity March-May 2025Analysis of outputs from involvement activity Summer/Autumn 2025Develop decision-making business case Granville Thelwell - Equality Diversity and Inclusion Business Partner, Staffordshire, and Stoke-on-Trent Intergrated Care Board 03/09/2024
03/09/2024
Thelwell, Granville

Stage 2 Comment

No comment saved

Last Activation Comment

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Last Deactivation Comment

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Reviewing proposals for birthing services at the freestanding midwife-led birthing units

Report of Findings from Deliberative Event held 6 December 2023

Report produced January 2024

Contents

This report presents the findings from the Maternity deliberative event held on Wednesday 6 December 2023.

The purpose of the event was to:

- Give an overview of the birthing services at the freestanding midwife-led birthing units (FMBUs) and the proposal for the case for change
- Talk about how the proposal was developed and any challenges faced
- Gather feedback from participants about their own experiences, and about the recommended proposal.

A copy of the information packs shared with participants ahead of the event, and slide pack used on the day is available upon request. All proposals were discussed within the event including the advantages and disadvantages of each.

Structure of this report of findings

Background and objectives

- Methodology
- Demographic profiling
- Summary of feedback on the three questions asked
- Summary of findings
- Appendix 1 – feedback gathered after the event

Background to the workshop

Over the past few years, Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) has been working to make Staffordshire and Stoke-on-Trent the healthiest places to live and work. During this time, the maternity services have been reviewed. This report of findings will be reviewed by the Maternity Service Change Steering group to help inform proposal development and the subsequent business case that will go through to NHSE Assurance processes.

Below is a summary of the engagement that has taken place so far:

Summer 2019
Public conversation to understand what is working well and what could be improved in health and care services

Jan/Feb 2020
Focus groups to talk in more detail about maternity services

March 2020
Involvement work paused to allow partners to respond to COVID-19

Summer 2021
With COVID-19 cases reducing, now is the right time for this transformation programme to progress

Spring 2023
Previously proposed on-demand model no longer viable

July 2023
Case for change submitted to NHS England

September 2023
Technical event to review options and develop a shortlist of viable proposal options

Background and objectives

The proposal

The technical group recommended that only one proposal is viable: **to make permanent the temporary closure of the birthing service at the freestanding midwife-led birthing units (FMBUs) at County Hospital, Stafford, and Samuel Johnson Community Hospital, Lichfield**.

The proposal needs to be considered alongside the maternity clinical model:

- No change to the provision of consultant-led services
- Midwifery-led care would continue to be offered at Royal Stoke Hospital and Queen's Hospital, Burton – alongside consultant-led units
- Reintroduce and grow homebirth services
- Develop and grow a continuity of carer model for the most vulnerable in the county
- Antenatal and postnatal care will continue at the FMBUs.

Advantages and disadvantages of the proposal to make permanent the closure of birthing services at County Hospital and Samuel Johnson Hospital

Advantages	Disadvantages
• Women would **continue to receive** the majority of **antenatal and postnatal care** within the units • Staff-to-patient **ratios would be the same** across all units • **Midwives can support** the homebirth services and midwife-led units • They can also **fully utilise their skills and experience** to support other areas of maternity care where there are national recommendations – for example with women who are booked in for an induction of labour that should take place at 40 weeks plus 7 days • Patients who develop complications would **no longer need to be transferred** to a hospital unit during labour.	• There may be **travel implications** for women who are eligible to give birth at County Hospital or Samuel Johnson Community Hospital, who live close to the units and would have chosen to give birth there • Requires the **reinstatement of homebirth services** to ensure **full patient choice** is offered.

Meeting and engagement approach

- The workshop was held online, via **Microsoft Teams**
- Participants registered in advance with an **online registration form** – which included **demographic profiling questions**
- The workshop began with all participants viewing a **presentation**. Participants were then split into smaller **breakout groups** to allow detailed discussion
- Feedback and comments were collated on a '**Jamboard**' during the event. This is like a virtual 'flipchart' with sticky notes where participants can add their feedback directly to the board in real time.

Jamboard:

Online registration form:

Maternity deliberative event registration form

Our **freestanding midwifery birthing units (FMBUs)** are units at County Hospital, Stafford, and Samuel Johnson Community Hospital, Lichfield, where women with low-risk pregnancies could choose to give birth.

The two FBMUs were closed for births during the COVID-19 pandemic, to ensure safe staffing at the consultant-led and midwife-led units at Royal Stoke University Hospital and Queen's Hospital, Burton.

Both the Trusts that run the FMBUs are providing antenatal and post-natal care at

Background of registrants and attendees

Registrants

28 people registered to attend the event

- 9 patients or members of the public
- 17 representatives from NHS trusts
- 12 representatives from voluntary organisations and charities

Attendees

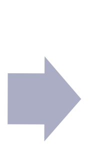
16 people participated in the event

- 3 patients or members of the public
- 7 representatives from NHS trusts
- 6 representatives from voluntary organisations and charities

Those who registered but did not attend have been contacted to arrange a one-to-one telephone interview to gather their feedback.

Structure of the event

National maternity services plan and our local maternity services model

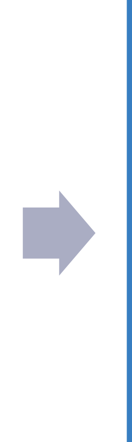


A. Our challenges, opportunities and the case for change: why we are reviewing maternity services

Included a breakout session for questions about challenges faced

B. The options appraisal process and how the ICB developed the proposals for maternity services

Included a breakout session for questions about the options appraisal process



C. The proposals for maternity service change

Included a breakout session for views on the proposal for maternity service change

Next steps

Objectives of the event

To discuss **why** the ICB is reviewing its maternity services and go through the **challenges** faced

Explain more about **how** the proposal was developed and **why** it is recommended that there is only **one viable proposal**

Getting **feedback on the proposal** for birthing services at the FMBUs

Demographic profiling

Demographic profiling

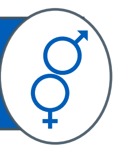
Ethnicity

- 1 (8%) from a mixed/multiple ethnic group: white and black Caribbean
- 12 (92%) white: British

Age

- 1 (8%) under 30
- 3 (23%) 30-39
- 8 (62%) 40 or over

Sex



- 10 (77%) female
- 2 (15%) male

Relationship status

- 1 (8%) live with partner
- 9 (70%) married
- 2 (15%) single

Sexual orientation

- 12 (92%) heterosexual

Carer

- None of the respondents were carers

Religion

- 7 (54%) Christian
- 4 (31%) had no religion

Pregnancy

- None of the participants were currently pregnant

Maternity

- 2 (15%) had or their partner had given birth in the last six months

Disability or long-term condition

- 1 (8%) have an invisible condition
- 11 (85%) do not have any conditions or disabilities that impact their day-to-day life

Armed forces

- None of the respondents had served in the armed forces

***Base 13**

This information is based on the 13 people who completed the registration form and attended the event. 3 of the 16 attendees did not complete the registration form.

A. Our challenges, opportunities and the case for change Responses from breakout session on questions about challenges faced

Participants received a presentation on the national strategy and process, the current situation and the recommended proposal for maternity service change. These are their questions (on the left) and some responses from the NHS team (on the right).

"999 transfers to hospital are not reliable - this is a potential risk factor."

"There are regional challenges around the safety of maternity services – the system needs to ensure there are options for low-risk births."

"Is there a plan Nationally to look at how to reduce the complexity of patients and reduce the high-risk cases?"

"I'd be interested to know data of how many women are choosing to freebirth* and any adverse outcomes if their first choice for place of birth isn't available."

"Increasing clinical complexity is a national trend. The three-year delivery plan looks at this to a certain extent, but a public health response is required and a long-term plan that addresses poverty, access to healthy food, smoking cessation service."

"Alongside units offer this for low-risk births and home birthing would address this. But there needs to be a model of care where the service can be sustained "

"Freebirthing* is so rare that it is not recorded on our electronic system – births are classed as 'born before arrival'. At UHDB these numbers equate to one or two per year."

**Freebirth: choosing to birth your baby without medical or midwifery assistance.*

B. The options appraisal process and how the ICB developed the proposals for maternity services Responses from breakout session for questions about the options appraisal process

Participants received a presentation on the options appraisal process and how the ICB developed the proposals for maternity services. These are their questions (on the left) and some responses from the NHS team (on the right).

"What will the appraisal process be? How is continuity of care affected and how can this be looked at ?"

"What concerns have been raised in CQC reports about safety ratings?"

"Why are we seeing FBUs closing down?"

"Plans were made to implement continuity of care at UHNM but had to be paused after the Ockenden review. We are still working to get a full staffing complement in place to reach the required level of birthing standards, but resources currently don't permit this.
UHDB have this in place for the most vulnerable patients and are aiming to expand the cohort this is rolled out to."

"There are low numbers of people using FMBUs; this may be because the model is opt-in and not opt-out. 17% of pregnancies could go to a FMBU but we didn't see these kind of numbers coming through the doors, despite our promotion of the units.. "

***FBU: Freestanding Birthing Units - another name for FMBU.*

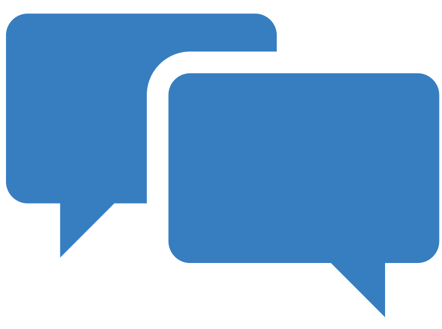
C. The proposals for maternity service change

Responses from breakout session for views on the proposal for maternity service change

Feedback on maternity service change – recorded on the Jamboard

Participants were then asked the following questions for their views on the proposal for maternity service change:

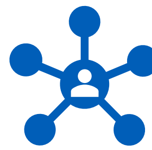
1. **To what extent do you think this proposal is a good solution?**
2. **Are there any groups that you think may be disadvantaged by this proposal?**
3. **Do you think there are any alternative proposals we should consider?**



1. To what extent do you think this proposal is a good solution?

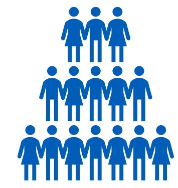
Key themes

Maintaining the competency and skill set of midwives is important



Care offered should be personalised regardless of setting

Increased staffing should be a priority



Workforce challenges are a concern

Assurance that units are safe will be women's top priority

1. To what extent do you think this proposal is a good solution?

Feedback recorded on the Jamboard from the patients and public breakout room

Feedback from patients and public

Positive
- Midwifery units are where patients feel safest
- Assurance that units are safe is the top priority and conversations are now focused on safety.

Negative
- Workforce challenges are a concern as is the shortage of midwives
- Worry about expertise and competence of midwives.

General
- Increased staffing should be a priority
- Homebirths should be reinstated
- FMBUs should be reinstated
- Why reinstate homebirths and not the FMBU?
- Reinstate both FMBUs and home births
- Keep Samuel Johnson Hospital running alongside
- Reason for closure unknown (for example: financial?)

Key themes are highlighted in **blue**

1. To what extent do you think this proposal is a good solution?

Feedback recorded on the Jamboard from the trusts and voluntary organisations breakout room

Feedback from trusts and voluntary organisations

Positive
- No concerns about the alongside units
- Midwifery units are where patients feel safest
- If the service is not being used, then it makes sense to close it
- It could work
- Increased staffing in one location would improve outcomes for patients and staff.

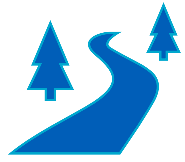
Negative
- FMBUs are worrying as a stand-alone site
- Information about changes needs to be clearer
- Estates and facilities need improving in Burton
- Workforce challenges are a concern.

General
- Increased staffing should be a priority
- Homebirths should be reinstated
- FMBUs should be reinstated
- Maintaining the competency and skill set of midwives is important
- Distance between home and the birthing units needs to be considered
- Care offered should be personalised regardless of setting
- How can they provide midwifery-led care without FMBUs?
- Assurance that units are safe will be women's top priority
- Replicate Royal Derby at Burton for good practice.

Key themes are highlighted in **blue**

2. Are there any groups that you think may be disadvantaged by this proposal?

Key themes



Those who have a long distance to travel

Disadvantaged groups (for example: low-income families, migrants and new arrivals to the UK)

2. Are there any groups that you think may be disadvantaged by this proposal?

Feedback recorded on the Jamboards from public and patients and trusts and voluntary organisations

Feedback from patients and the public

Positive

- Antenatal care is important for **everyone.**

Negative

- Those who have a long distance to travel/no access to car
- Disadvantaged groups (for example: low-income families, migrants and new arrivals to the UK).

General

- More research needed on how this will affect disadvantaged groups
- More awareness raising of all the wrap around services available
- Those who need emergency services (for example: 999) need reliable services close by or on site.

Feedback from trusts and voluntary organisations

Negative

- Those who are not kept informed of decision making
- Those who have a long distance to travel
- Women with mental health complexities

- Some Burton midwives would find it preferable and more suitable to support the on-demand service due to certain changes in service delivery in the new proposal.

Key themes are highlighted in **blue**

3. Do you think there are any alternative proposals we should consider?

Key theme

3. Do you think there are any alternative proposals we should consider?

Feedback recorded on the Jamboards from public and patients and trusts and voluntary organisations

NB: no alternative proposals were put forward but feedback from the session was recorded as per below:

Feedback from patients and the public

- **Maternity services in a continuity of care model**
- Look at what services are provided outside of the ICS and ensure that they are fit for purpose
- Improve continuity of care with new model
- Continuation of antenatal and postnatal care
- Look at maternity services as a whole
- Concerns over neonatal rates locally compared to nationally
- Support for minority ethnic groups to improve outcomes
- How can the proposals be monitored.

Feedback from trusts and voluntary organisations

- An on-demand service is necessary
- More emphasis on supporting women from ethnic minority groups where the risks are higher in pregnancy and childbirth.

Key themes are highlighted in **blue**

Summary of findings

Summary of findings

Feedback on the proposal

- Maintaining the competency and skill set of midwives is important
- Workforce challenges are a concern
- Increased staffing should be a priority
- Assurance that units are safe will be the top priority.

Who would be disadvantaged

- Disadvantaged groups (for example: low-income families, migrants and new arrivals to the UK)
- Those who have a long distance to travel
- Those who need emergency services (for example: 999) need reliable services
- Midwives currently working in Burton
- Women with mental health complexities*.

Alternative proposals

There were no alternative proposals to the service model identified, but participants wanted to ensure:

- Maternity services in a continuity of care model
- Look at what services are provided outside of the ICS and ensure that they are fit for purpose.

*Notes: *Women with mental health complexities would not be suitable to give birth in FMBUs*

Appendix 1

We conducted interviews with women who were unable to attend the deliberative event to gather their feedback. We sent them the information pack to read in advance.

We interviewed three women. Both had given birth in the last three years and are local to the area.

We asked them the same questions that were asked in the deliberative event. Their feedback is summarised in this appendix.

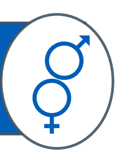
Demographic profiling

Ethnicity

- 3(100%) white: British

Age

- 1 (33.3%) 25-29
- 1 (33.3%) 30-34
- 1 (33.3%) 35-39

Sex 

- 3 (100%) female

Relationship status

- 2 (66.6%) live with partner
- 1 (33.3%) married

Sexual orientation

- 2(66.6%) heterosexual
- 1 (33.3%) bisexual

Carer

- None of the participants were carers

Religion

- 1 (33.3%) Christian
- 2(66.6%) had no religion

Pregnancy

- None of the participants were currently pregnant

Maternity

- 0 (0%) had or their partner had given birth in the last six months

Disability or long-term condition

- 3 (100%) do not have any conditions or disabilities that impact their day-to-day life

Armed forces

- 1 (33.3%) of the participants had served in the armed forces

***Base 3**

This information is based on the 3 people who completed the profiling questions.

Do you have any comments about the national or local issues we are facing?

"From my experience, I was aware there was a shortage of midwives, throughout my pregnancy I saw a different midwife at every appointment I went to."

"I had a negative birth experience and time in hospital – I was on the ward for four days and it was clear that (Royal Stoke) staff were busy and things were getting missed."

"The shortages of qualified staff is impacting birthing experiences for so many and this was only exacerbated by the changes made since COVID, we still don't have home births as an option now."

"It does put me off having another child because of my negative experience and knowing that I can only birth at Stoke and I have no choice in that."

"This staff shortage has been a problem for a while now and it's not being managed in time to prevent the current situation getting worse."

"I understand there is shortage of midwives and I think that it's frustrating as an end user that after all this time the Government isn't doing enough to help."

"Home birth wasn't an option for me, but a family member wanted a home birth and she wasn't able to do that because of the shortages of staff. Not being able to follow her wishes for her birth impacted her in a big way."

"I understand the challenges the maternity sector faces and that everything is stretched – it's a difficult time."

Do you have any questions or comments on the process we have undertaken?

"I would have appreciated the opportunity to engage in the deliberative event – I think there could have been more dates made available, rather than just one.
I think everything else has been done very thoroughly."

"I live 40 minutes away from Stoke hospital in a more rural setting and for people who live that far away the proposal is quite a disadvantage especially when you're in labour and are concerned about getting to hospital."

"I was surprised that the figures for women using the FMBU were so low as I know a lot of people who used it."

"I understand the proposal and the options – but services have been like this since 2020 so people are used to now."

"No – a lot of things have been explored before the proposal was made so I understand how you arrived at this proposal."

1. To what extent do you think this proposal is a good solution?

Feedback recorded from interviews conducted outside the deliberative event

Feedback from patients

Positive
- The homebirth option should definitely be made available for people who want that choice
- It's a good proposal on the basis that there is a community option to receive that care pre- and post-birth
- Options that are not feasible are being removed for safety and economic reasons - I agree with that.

Negative
- It's not ideal for everyone because of travel - either no access to car / unable to get near enough to public transport / can't afford
- If patients have had a negative hospital experience, they then face the problem that they have no other option than to go back to that hospital again for their next birth
- The proposal takes choices away from people, but I understand that the shortage of staff and lack of specialist trained staff across locations – we can't spread it more thinly across more facilities for safety reasons
- If you're not able to deliver a community option to receive care pre- and post-birth – then I wouldn't support the closure of the units, even though I appreciate that they are underused.

2. Are there any groups that you think may be disadvantaged by this proposal?

Feedback from patients

Negative

- Residents from rural areas living far away from the hospital but still falling into the catchment area of those hospitals
- Not everyone has access to a car – those people will struggle
- People who don't want to choose a clinical setting to give birth
- Treatment and care closer to home is always better in these situations and it was something I worried about during my pregnancy. It gave me some anxiety thinking about the long journey to Stoke hospital and the fact that parking has always been an issue – this would affect all women who are giving birth and anxious about the run up to birthing.

General

- It would be interesting to understand if rural communities would still be disadvantaged when it came to birth if the community model of wrap-around care was adopted?

3. Do you think there are any alternative proposals we should consider?

Feedback from patients

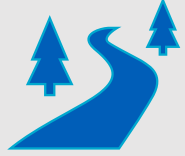
- "I think we hoped that FMBUs would be that middle ground and the data suggests not."
- "Stoke has a good reputation but I worry that it's over-used."
- "My views are that we are becoming over-medicalised but our system isn't set up to support the other end of the system. I think the home birth option is essential."
- "I don't know – it's difficult because there just doesn't seem to be any other alternative that would work in this area."
- Promoting the option for the home births for low-risk births is important – make it clear that this is an option and give people the choice rather than say they have to go to hospital if they don't like that environment or the clinical side to it.
- "Due to the shortage of emergency transport, the ambulance arrangement that we had previously is now gone – so you can't rely on an ambulance if you needed more specialist treatment."
- "Other convenient birthing locations are going to be further away from the consultancy led units so that's not going to work either."
- "I don't think there is another option apart from Burton and Stoke – I asked to give birth in Burton, I was told no as it was under a different Trust."
- "Because my home catchment area is under Stoke – even though the two hospitals are equidistant from my home – my only option was to give birth at Stoke. I would have liked the option to choose to be made available to the patient and not controlled by the Trust."

Key themes

Q1) To what extent do you think this proposal is a good solution?

Choice, including home birth option

Q2) Are there any groups that you think may be disadvantaged by this proposal?



Rurality and those that need to travel

Q3) Do you think there are any alternative proposals we should consider?

No alternative proposals were put forward, but women want to see full range of choice offered

Presentation report compiled by:
Insight, Engagement and Consultation team

NHS Midlands and Lancashire
Commissioning Support Unit

Review of Maternity documents to inform service transformation

February 2024

1 Introduction

The purpose of this review is to provide key information about findings on maternity and neonatal care to inform service transformation.

The feedback has been collated from five documents with information about maternity and neonatal care from the national guidance to local engagement feedback (see table below).

1.1 References

Document owner	Document title	Year	Published	Link (if available)
Staffordshire and Stoke-on-Trent Integrated Care Board (SSOT ICB) (ML and AGEM CSUs)	Joint Forward Plan engagement report of findings	2023	No	Joint Forward Planning RoF.pdf
SSOT ICB (ML and AGEM CSUs)	ICP Clinical Strategy engagement survey findings	2022	No	ICP Strategy Engagement Survey
Healthwatch Derby	Black, Asian, and Minority Ethnic (BAME) Women's Maternity Experiences During COVID-19	2021	Yes	BAME-women-maternity-experiences-during-Covid-19.pdf (healthwatchderby.co.uk)
SSOT ICB (ML and AGEM CSUs)	Giving everyone the best start in life: Maternity involvement	2021	Yes	https://staffsstoke.icb.nhs.uk/your-nhs-integrated-care-board/our-publications/findings/maternity-summary-report-of-findings-february-2022/?layout=default
SSOT ICB (ML and AGEM CSUs)	Together We're Better Listening Exercise Report of Findings	2019	Yes	https://staffsstoke.icb.nhs.uk/~documents/publications/2019-listening-exercise/together-were-better-report-of-findings-full
SSOT ICB (ML and AGEM CSUs)	Maternity Engagement: Report of Findings. Together We're Better – April 2020	2020	No	Maternity%20report%20v3.docx

2 Joint Forward Plan engagement report of findings | 2023

2.1.1 Introduction

The purpose of this engagement was to gather the views of the public on healthcare services across Staffordshire and Stoke-on-Trent. The feedback will support delivery of the Integrated Care System's (ICS) first Joint Forward Plan and the development for the future.

The engagement survey ran between Wednesday 21 June and Sunday 27 August 2023. It received 54 responses. Of these, three respondents provided feedback on maternity services.

In this literature review we have reviewed section 5.11 (page 76 and 77) which focuses on maternity and neonatal care.

2.1.2 Findings

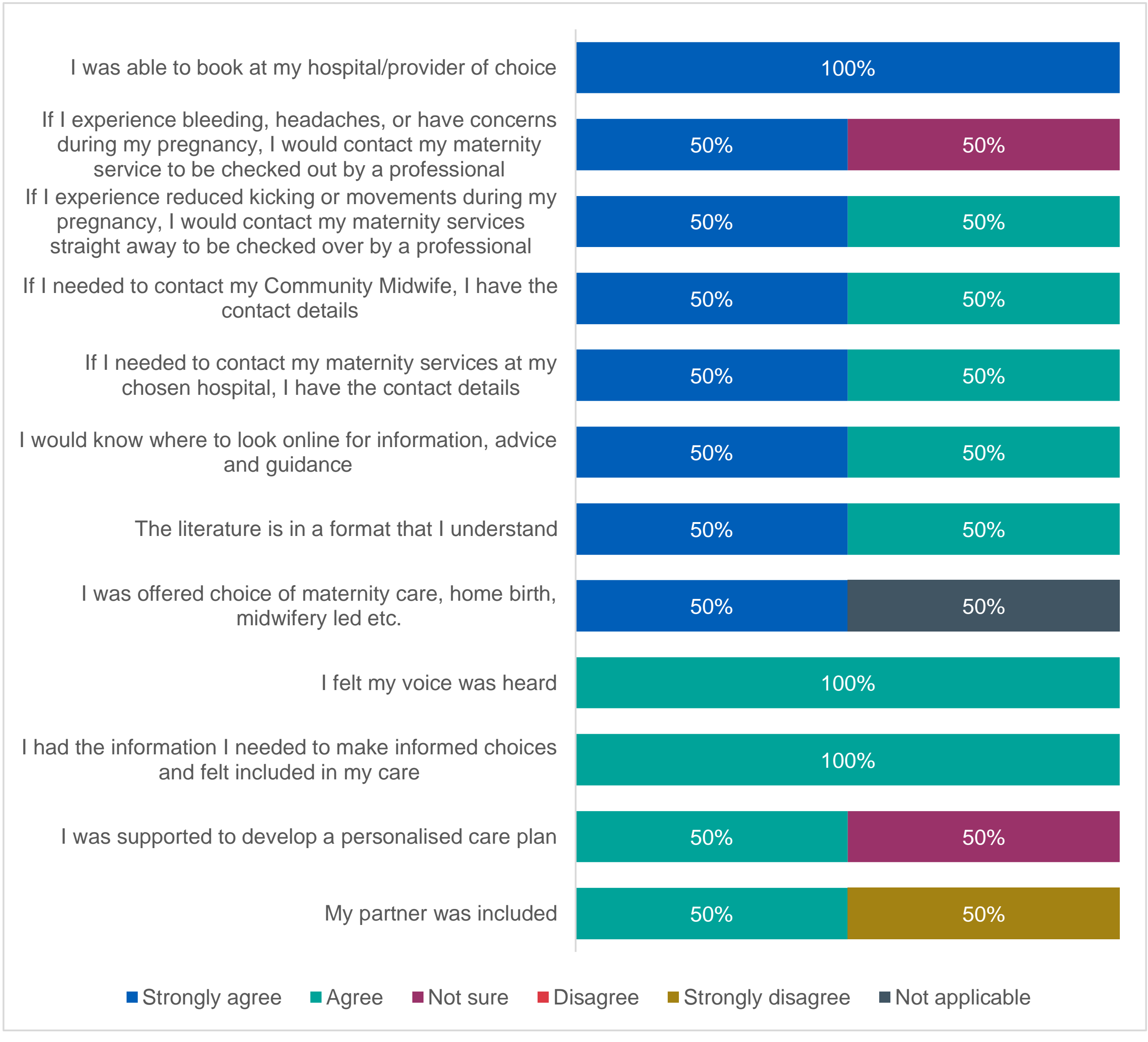
Respondents were asked how the ICS could improve people's use and experience of maternity or neonatal care. A summary of the key findings is presented below.

This section presents the feedback from the following questions:

- Have you, or a partner, had experience of maternity or neonatal care in the last two years?
- Please indicate how strongly you agree with the following statements:

Of the three respondents, two (67%) stated that they, or their partner, have had experience of maternity or neonatal care in the last two years. These respondents were from the Cannock and South Staffordshire areas. These two respondents were asked to rate a series of statements relating to maternity and neonatal care. Figure 55 in the report (page 77) shows there was a high level of agreement across all statements.

Figure 1. Please indicate how strongly you agree with the following statements: Base: 2.



3 ICP Clinical Strategy engagement survey findings | 2022

3.1.1 Introduction

This report was generated on 24 November 2023. There were 39 responses to the questionnaire. Key themes identified from a review of the open question responses on maternity and neonatal care are presented here.

3.1.2 Findings

In response to the question asking respondents to share their experience on public or community services:

- One respondent highlighted, due to recent changes to digital technology, maternity services having online referrals and digital notes.

4 Black, Asian, and Minority Ethnic (BAME) Women's Maternity Experiences During COVID-19 | 2021

4.1.1 Introduction

In 2021, NHS England and NHS Improvement wrote to every local maternity and neonatal system (LMNS) in England and asked them to look at perinatal support for black, Asian and minority ethnic (BAME) women during the COVID-19 pandemic.

They wanted local maternity systems to take four specific actions. They were asked to:

- increase support for at-risk pregnant women
- reach out and reassure pregnant black, Asian and minority ethnic women
- minimise the risk of Vitamin D insufficiency
- make sure the correct data was being gathered.

Derbyshire LMNS worked with hospital trusts to achieve these key aims by putting a number of new initiatives in place. Maternity trusts developed risk assessments to identify those women who were most at risk and ensure that support was available.

A survey was designed in partnership with the Maternity Transformation team and Healthwatch. The survey was open from 26 April 2021 to 22 May 2021.

19 women completed the survey:

- 13 women who had given birth
- six women who were pregnant (between 17 weeks and 37 weeks pregnant).

4.1.2 Findings

Prenatal care:

- Mixed reviews around care and treatment and communication with patients/between services
- Negative comments were around a lack of consistency in care and information shared
- Positive comments mentioned how staff had listened to concerns and supported appropriately.

Inpatient hospital care:

Positive:

- Overall service and care – supported, personalised, comfortable and safe
- Communication – felt listened to, understood and received good information
- Staff – calming and supportive.

Negative:

- Communication/lack of empathy – did not feel listened to or felt talked down to
- Lack of support
- Care – long wait for pain relief, no pain relief to take home, minimal care, long wait for food/drinks, issues at point of discharge
- COVID-19 restrictions – lonely / understaffed – no support to have a shower or to pick up baby.

One lady very sadly lost her baby, and her feedback was given as a case study. The key points are below:

- Much more support is needed following the loss of a baby
- There was a lack of empathy and lack of a personalised/patient-centred approach.

Postnatal care:

Positive feedback was around overall service and care and good communication.

Negative feedback was about a lack of support from visiting staff and a lack of respect for home boundaries and some COVID-19 restrictions during visits – for example, not taking off shoes, using the toilet.

Staffordshire and Stoke-on-Trent Integrated Care System

What could be improved?

- Care and treatment
- Staffing and training
- Attitudes
- Communication.

Women commented that they wanted to see more of the following:

- Digital technology
- Increased support and access to professionals
- Improvement in attitudes and reduction in assumptions
- An increase in BAME maternity staffing
- Increased communication.

Healthwatch received responses from Chesterfield Royal Hospital, University Hospitals of Derby and Burton, and Derbyshire Community Health Services NHS Foundation Trust, all acknowledging the feedback. Each trust provided an action plan that addressed any concerns and detailed how the trusts would respond to the feedback and improve services.

5 Giving everyone the best start in life | 2021

5.1.1 Introduction

Between 16 July 2021 and 15 August 2021, the Together We're Better health and care partnership for Staffordshire and Stoke-on-Trent ran a survey and held two workshops about local maternity services.

The survey questions asked about:

- people's experiences of using maternity services before and during COVID-19
- whether women and their partners would choose a homebirth, and why
- people's view on two proposed models of maternity care.

240 people responded to the survey on their experience of local maternity services and 28 people took part in the two online events held.

- 90% were patients or members of the public
- 9% were NHS employees

- 75% had used maternity services in the last three years
- 28% were currently expecting a baby (or their partner was)
- 22% had recently given birth.

5.1.2 Findings

Before COVID-19 – what went well

Respondents' experience before COVID-19:

- 58% said that maternity staff were professional and supportive
- 43% said that quality of care was good
- 20% said that communication between staff and service users was good (e.g. were informed).

Respondents answering about experiences before COVID-19 said the following improvements were needed:

- Better support for birth planning
- Getting the right information to promote good choices at each stage of the journey
- Being listened to and treated with respect
- Receiving more help with breastfeeding
- Consistent advice and seeing the same midwife.

Respondents answering about experiences before COVID-19 expressed these ideas about improvements and changes needed:

- 27% said that communication required improvement
- 22% said that the quality of care needed to improve
- 16% said there was a need for more staff and a better attitude of staff towards patients.

During COVID-19

Respondents' experience during COVID-19:

- 50% said that staff were professional and supportive
- 32% said that quality of care was good.

Respondents answering about experiences during COVID-19 said the following improvements were needed:

- Allow partners to be there at appointments, scans and at birth

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- Reopen midwife-led units
- Consistent advice and seeing the same midwife
- Staffing levels, and kindness and empathy of staff
- Breastfeeding support
- Well-organised services and good communication between professionals.

Respondents answering about experiences during COVID-19 expressed these ideas about improvements and changes needed:

- 39% said that partners and close family members with negative COVID-19 tests should be allowed to attend to support before and after birth
- 18% said that there was a need for adequate staffing
- 17% said that staff should consider improving communication with service users.

Respondents answering about considerations when planning where to give birth raised the following:

- Access: Location of hospital / birth unit is important (e.g. close to home, distance) (68 / 34%)
- Estates and facilities: Available facilities are important (e.g. birth pool, private room, hypnobirthing, doula support) (33 / 17%)
- General: There were no options (e.g. high-risk pregnancy, COVID restrictions) (30 / 15%).

Respondents answering about if they would consider a home birth:

- 39% would consider a homebirth – the key themes being that the pregnancy was low risk and that access to emergency care would be available, if required
- 49% would not consider a homebirth – further feedback showed that 48% of those who said they wouldn't choose a homebirth believed that hospital was a safer place to give birth.

Respondents answering about travelling distances when preparing to give birth:

67% would be willing to travel 10 or more miles to give birth – the majority stated that a travel time of up to 40 minutes was acceptable. Of those who said they would travel that far, 76% were pregnant at the time of the questionnaire.

Responses regarding the two proposed models:

Continuity of carer model:

67% of respondents agreed with the continuity of carer model, the main themes being that it would help to improve quality of care (e.g. meet patient needs, holistic care, safety of care) and would improve women's confidence (e.g. less anxiety, build trust).

10% disagreed with the model.

On-demand service:

61% said they agreed with the on-demand service with key themes being that the proposal made provisions for adequate staffing and offered more options for where to give birth.

15% of respondents disagreed with this proposal, stating that more details about the service were required around access for high risk-pregnancy, integration with specialists and emergency care.

6 Together We're Better Listening Exercise Report of Findings | 2019

6.1.1 Introduction

Between 3 June 2019 and 25 August 2019, the Together We're Better Sustainability and Transformation Partnership for Staffordshire and Stoke-on-Trent undertook a county-wide involvement exercise.

Numbers of people who took part in the engagement.

- 367 responses to the main involvement survey
- 746 responses to the postcard survey
- 108 listening events, roadshows, and workshop events, with a total attendance of 2,975
- 354 participant workbooks completed
- 113 facilitator resource packs
- 69 note taking templates
- 11 pieces of correspondence received.

Document 17 – SSOT Maternity literature review

Staffordshire and Stoke-on-Trent Integrated Care System

6.1.2 Findings

Themes from the main involvement survey feedback in relation to respondents' experience

- Respondents tended to have positive experiences of maternity care services, with 26 (76%) respondents rating their experience as excellent or good, compared to six (18%) who rated their experience as poor or very poor
- Respondents rating maternity care services as excellent or good highlighted the care and treatment by staff, while those rating neutral, poor, or very poor highlighted staff numbers, workload and working conditions
- Key areas identified for improvement were staff numbers, workload and working conditions; maternity services in general; communication by staff and access, such as distance to hospital; the waiting list and appointments process and administration and information from healthcare providers.

Themes from the main involvement survey feedback

The top three themes for respondents rating maternity services as excellent or good were: General positive:

- Positive comment / all good / improved
- Staff: care and treatment
- Services: maternity services in general.

The top three themes for respondents rating maternity services as poor or very poor or having no opinion were:

- General negative: negative comment / experience
- Services: maternity services in general
- Staff: staff numbers / workload / working conditions.

The most frequently mentioned themes by respondent type for those rating maternity services as excellent or good were:

- Public: general positive: positive comment / all good / improved
- Staff: general positive: positive comment / all good / improved and staff: care and treatment.

The most frequently mentioned themes by respondent type for those rating maternity services as poor or very poor or having no opinion were:

- Public: general negative: negative comment / experience
- Staff: general negative: negative comment / experience.

7 Maternity engagement: Report of Findings. Together We're Better – April 2020

7.1.1 Introduction

This report summarises the feedback from a series of roadshow events and focus groups held across Staffordshire and Stoke-on-Trent in October 2019 and January and February 2020 as part of the Together We're Better Maternity Transformation Programme.

There were six focus groups that hosted 25 participants, and a group session was also held during the Maternity Voices Partnership relaunch on 6 February 2020. Four roadshows were held where feedback was gathered from short postcard surveys – to which there were 40 responses.

These focus groups were held with new mothers, expectant mothers, people thinking about having a baby and relevant maternity staff.

The purpose of the events was to listen to participants' views and experiences of local maternity services. This engagement built on the feedback captured from the listening exercise in summer 2019 and formed part of the Together We're Better Maternity Transformation Programme. The aim of gathering the feedback was to help to inform and improve maternity services in Staffordshire and Stoke-on-Trent.

7.1.2 Findings

Experiences of maternity services – focus group feedback

Participants largely had positive experiences with healthcare staff – highlighting the good quality of care from community midwives, healthcare assistants, health visitors and paramedics.

From the focus groups, 21 (88%) of those attending were currently using or had used maternity services in the last 12 months. All attendees but one said they were White British.

A number of areas were highlighted for improvement, specifically:

- **Continuity of carer:** The need for improved continuity of carer to enable them to develop rapport with staff and avoid getting conflicting advice
- **Communication:** The need for improved communication between services, as well as clearer explanations of processes and tests to avoid stress and anxiety
- **Access to support services:** The need for improved access to breastfeeding support, mental health services and support for partners
- **Medical records:** Issues with staff unable to access notes, information missing from notes and problems logging onto systems
- **Access to services close to home:** The need to reduce travel and have services available locally, including access to home visits.

Clinical model and considering where to give birth

Participants identified the following key factors in deciding where to give birth:

- Safety
- Recommendations from friends and medical professionals
- Health needs and requirements
- Partners being able to be present throughout the birth
- Wanting to give birth in a calm, less clinical environment
- Space, privacy and dignity.

Many participants wouldn't consider a **homebirth** due to feeling unsafe and practical reasons, such as not having enough space and having to clean afterwards. Some participants felt they weren't informed about the option of a homebirth and that greater information and awareness would make them more likely to consider this option in the future.

Most participants would consider a **community birth** as they could be closer to home, have familiar staff, give birth in a less clinical environmental with more person-centred care. Other positive factors were easier car parking and opportunities for partners to be more involved.

What is important to you

Participants highlighted the need for:

- Improved continuity of carer
- Greater access to breastfeeding and mental health support
- The model to be implemented effectively.

Experiences of maternity services – postcard survey feedback

40 people responded to the postcard survey. Of those completing the survey 31 (80%) were pregnant at the time of completing the survey and 4 (11%) had recently given birth.

31 (82%) of respondents identified as White British with 4 (12%) of respondents identifying as mixed ethnicity. 34 (95%) of respondents were heterosexual.

What's working well – top three themes

	No.	%
Care provided by staff (e.g. friendly staff)	14	42%
Efficient and timely appointments (e.g. waiting times)	11	33%
Information and advice provided	5	15%
Base	33	-

What could be improved – top three themes

	No.	%
Clearer explanations and information (e.g. regarding test results)	6	20%
Nothing requires improvement	6	20%
The appointment booking process	4	13%
Base	30	-

What one thing would you change now? – top three themes

	No.	%
Nothing	9	39%

Car parking (e.g. prices, spaces)	3	13%
Clearer communication and explanation from staff	3	13%
Base	22	-

Summary of all feedback

- Most participants had positive experiences with **healthcare staff**, highlighting the good quality of care from community midwives, healthcare assistants, health visitors and paramedics. Postcard survey respondents also praised the efficiency of appointments.

- The need for **continuity of carer** throughout pregnancy and the birth was highlighted. Those who experienced continuity of carer said this allowed them to develop a rapport and ask questions, while those who didn't received conflicting advice from different professionals and found they had to repeat themselves.

- The need for **greater information** was highlighted. Processes and tests need to be clearly explained to avoid stress and anxiety, and there should be greater awareness of the different birthing options available.

- The need for improved communication and integrated, joined-up working between services was highlighted.

- The need for person-centred and individualised care was highlighted.

- Access to support services, such as mental health and breastfeeding support, was highlighted as an area that require improvement.

- The need for greater **support for birthing partners** was also highlighted, as well as partners being able to be present throughout the birth.

- The need for **access to services closer to home** was highlighted, including home visits. Being close to home was listed as an important consideration in deciding where to give birth.

Review of the Staffordshire and Stoke-on-Trent Intrapartum Maternity Services

Report of the Independent Clinical Senate Review Panel (26th April 2024)

June 2024

england.wmcs@nhs.net

Glossary of abbreviations

BSol	Birmingham and Solihull
CCG	Clinical Commissioning Group
CLU	Consultant Led Unit
DMS	Document Management System
EIA	Equality Impact Assessment
FMBU	Freestanding Midwifery Led Birthing Unit
GP	General Practitioner
HOSC	Health Overview and Scrutiny Committee
ICB	Integrated Care Board
ICS	Integrated Care System
LMNS	Local Maternity and Neonatal System
MDT	Multi-disciplinary Team
MLU	Midwifery Led Unit
ONS	Office for National Statistics
SSOT	Staffordshire and Stoke-on-Trent
UHDB	University Hospitals of Derby and Burton
UHNM	University Hospitals of North Midlands
WTE	Whole Time Equivalent

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1. Foreword by Dr Will Taylor, Clinical Review Panel Chair

Clinical Senates have been established as a source of independent and objective clinical advice and guidance to local health and care systems, to assist them to make the best decisions about healthcare for the populations they represent.

Clinical Senates are built on the voluntary engagement and goodwill of local clinicians and other health and care professionals to ensure that the wider NHS can benefit from this expertise and experience.

We would like to thank Staffordshire and Stoke-on-Trent Integrated Care Board (SSOT ICB) on behalf of the Integrated Care System (ICS) for engaging in the Senate's processes. The Senate would also like to particularly thank staff at University Hospitals of North Midlands NHS Trust (UHNM) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) for hosting a subset of the Senate panel in a pre-visit to the two acute providers. Senate members were shown the pathway/unit at each site which included the assessment area, low risk room, ward, proximity to the neonatal unit and theatres. This was an essential part of the Senate's review process and staff at both sites were extremely accommodating and clearly passionate about the services they are working in.

Additionally, the full Senate panel on the review day itself had an opportunity to meet with the respective teams who made the time to answer the panel's broad and extensive questions throughout the day. The transparent and honest approach to the day by all in attendance was greatly appreciated. This enabled the panel to understand the service spanning the different organisations and to be able to provide clear and coherent independent advice, which will hopefully help the system to move forward with a clear action plan for their intrapartum maternity services.

It is also with thanks to our wide-ranging clinical review panel for their participation and commitment and whose expertise was drawn from both the West Midlands and East Midlands Clinical Senates memberships to ensure that the full potential of independent clinical advice could be maximised.

The panel recognised that the system had already undertaken a significant amount of work to understand the needs of the population, as well as successful recruitment and retention work demonstrated by both acute providers. The Senate panel welcomed the work undertaken to date across the breadth of partners to support this service change proposal.

Dr Will Taylor
Panel Chair
West Midlands Clinical Senate Vice Chair

2. Clinical Senate Review Panel executive summary and recommendations

In undertaking this review, the panel received in both written and verbal form, evidence to support the conclusions and advice, and in addition, a subset of the clinical review team undertook two site visits before the full review day itself. On the review day a further site visit was carried out to the FMBU at County Hospital in Stafford.

This programme of transformation work is being led by Staffordshire and Stoke-on-Trent Integrated Care Board (SSOT ICB) on behalf of the Integrated Care System (ICS) including University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and University Hospitals of North Midlands NHS Trust (UHNM). The review focused on the intrapartum element of the maternity pathway and specifically, the proposal to make permanent the temporary closure of the birthing/intrapartum service at the two Freestanding Midwifery Led Birthing Units (FMBUs) at Samuel Johnson in Lichfield and County Hospital in Stafford. The birthing element at both FMBUs had been temporarily closed since the onset of the Covid-19 pandemic. The home birthing service was also included within this review as it was also paused during the Covid-19 pandemic and had not been able to restart fully since. This service also has a direct impact on how the system offers choice to birthing mothers.

There had clearly been a great deal of work undertaken by the sponsoring organisation historically and more recently leading up to requesting the Senate review. The review panel appreciated the depth and breadth of the information supplied and the discussions held throughout the full process.

The clinical review panel were encouraged by what they heard from both the ICB's and the provider Trusts' senior representatives and all the staff working within the services. Having the opportunity to engage with staff working in the midwifery led birthing units was felt to be essential to ensure the panel were able to make a full assessment and gain a real understanding of all the relevant issues and opportunities facing the different sites and the system as a whole.

The panel would again like to thank all those involved for their commitment throughout the process.

The ICB has undertaken a considerable amount of work to understand its population and their needs, and by undertaking a series of listening and engagement events over several years and in multiple different geographical locations using varied methods of information gathering, as well as sharing feedback with both the public and staff on the progress made.

One clear area of challenge for the service that has again been the subject of some in depth and wide-reaching work is that of recruitment. In 2022 the service had a shortfall of 70 whole time equivalent staff at University Hospitals North Midlands, and through intense recruitment and retention work will be at full establishment in October 2024. This is an incredible achievement and a very positive story for the team.

During the review, the panel were asked to assess the proposal against four key questions and the clinical review team provided high-level feedback to the sponsoring organisation both verbally on the day and subsequently through section 6 within this report.

One key question was whether the panel supported the closure of the freestanding midwifery led birthing units at County Hospital in Stafford and Samuel Johnson in Lichfield. The panel unanimously concluded that they supported the proposal to make permanent the temporary closure of the birthing/intrapartum service at these two freestanding midwifery led birthing units. Given the intensity of resource needed, coupled with the relatively low numbers of births taking place prior to Covid-19 (in some cases only 8 births per month), it was not considered to be a sustainable use of clinical staffing.

The panel have drawn together five recommendations based on the feedback and evidence received and these are also set out in section 7 of the report.

- The panel supports the ICB's proposal to make permanent the temporary closure of birthing/intrapartum service at the two FMBUs for intrapartum maternity care and reinstate the home birthing service.

- The panel recommend that consideration is given to the different standards of birthing environment in place across the acute sites to ensure patients have a comparable high standard environment regardless of the birthing location.

- The panel recommend that engagement with neighbouring ICBs at an LMNS level is widened to ensure that mothers receive equitable care during birthing and consider putting in place systems to ensure that all clinical notes are made accessible to those that need them in a timely manner.

- The panel recommend that the ICB works with the provider Trusts to fully develop and implement the home birthing service to ensure it is fully planned and understood to ensure safe delivery of babies at home. The panel was supportive of the workforce and operational/clinical model being led and developed by the staff in the services with oversight from senior midwives.

- The panel suggest the ICB and provider Trusts give due consideration to the naming of the FMBUs to ensure the public are clear on what services will be available going forwards.

3. Background and advice request[1]

The Clinical Senate were proactively approached by the sponsoring organisation in February 2024. This programme of work is being led by Staffordshire and Stoke-on-Trent Integrated Care Board (SSOT ICB) on behalf of the Integrated Care System (ICS) including University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and University Hospitals of North Midlands NHS Trust (UHNM).

3.1 Description of current position

The Integrated Care Board (ICB) in Staffordshire and Stoke-on-Trent is responsible for the health and care of 1.1 million people across a geographical area of 1,048 square miles. The ICB is aligned with two upper-tier local authorities, Staffordshire County Council and Stoke-on-Trent City Council. The population is diverse with complex health and care needs, comprising both rural and urban areas, extremes of affluence and deprivation, as well as significant health inequalities. For this programme of work, the ICB is working closely with its provider partners the University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and the University Hospitals of North Midlands NHS Trust (UHNM).

UHDB run the services that are offered in Samuel Johnson Community Hospital Lichfield and UHNM run the services that are offered at County Hospital Stafford. Derby and Derbyshire ICB are the organisation who hold the contract for UHDB.

Intrapartum services in Staffordshire and Stoke-on-Trent in recent years have been provided from a number of locations as listed below and identified on the map.

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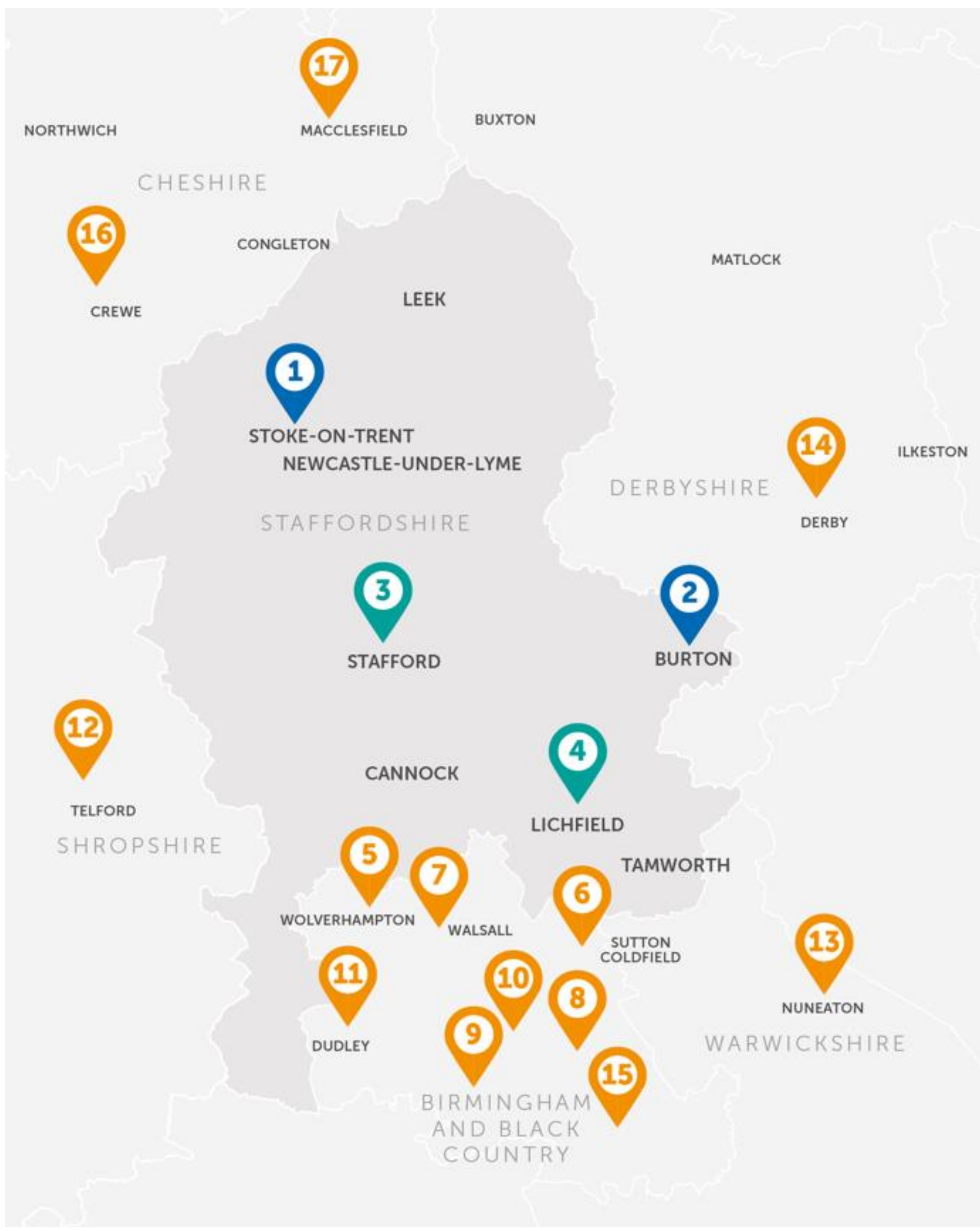
[1] Details within this section are taken from the sponsoring organisation's evidence submission to the Clinical Senate. Terminology/definitions are lifted directly from this evidence for consistency.



- Consultant led units in Royal Stoke University Hospital (1) and Queen's Hospital Burton (2)
- Alongside midwife led units/services in Royal Stoke University Hospital (1) and Queen's Hospital Burton (2)

- Freestanding Midwifery birth units at County Hospital, Stafford (3) and Samuel Johnson Community Hospital, Lichfield (4)
- Homebirth services

Freestanding Midwifery Birth Units (FMBUs) are midwifery-led units, separate from a hospital site, where some pregnant people (considered low-risk) can choose to give birth. They do not have immediate obstetric, neonatal, or anaesthetic care, so people may need to be transferred to an acute hospital if there are complications during or after birth.

In 2020, at the beginning of the Covid-19 pandemic and in line with national guidance, birthing services at both FMBUs were temporarily suspended to consolidate the workforce at the main acute sites.

Home birth services were also temporarily suspended at the start of the pandemic and neither Trust have been able to sustainably reinstate these services due to the ongoing midwifery staffing workforce shortage. The Trusts are looking to reinstate the booking of women into the home birthing service from April 2024 (these would not be women who are due to give birth imminently i.e. in their last trimester, but the Trusts would be looking at providing this service for those booking in with a midwife in the first trimester).

Whilst the initial FMBU closures were directly related to the Covid-19 pandemic, significant staffing challenges in the maternity workforce have prevented both Trusts from being able to safely reopen these units to intrapartum services.

Both Trusts continue to provide antenatal and post-natal care at their FMBUs and offer the choice of a consultant-led or midwifery-led birth at Royal Stoke University Hospital and Queen's Hospital Burton.

At the time of the temporary closure, the transformation of maternity services had already begun and the ICB had completed various involvement activities to understand people's experiences of using maternity services. During 2019 and 2020, a range of activities were undertaken to listen to people and understand what worked

well and what could be improved in health and care services as well as seeking views on emerging models of care and criteria for evaluating proposals. In 2021, post pandemic feedback was sought, together with views on the homebirth services and new models of care proposed at that time.

More recently, the ICB have been working with colleagues from UHNM, UHDB and Derby and Derbyshire ICB to outline the current position in relation to the FMBUs and consider proposals for the future, as each Trust is using their workforce in a different way to deliver safe services.

At a technical event held in September 2023, clinicians reviewed seven potential proposals to develop a shortlist of viable proposals. These were assessed against six essential criteria. During the event it was recommended that only one proposal is viable at this stage - which is to make permanent the temporary closure of intrapartum birthing services at County hospital and Samuel Johnson hospital.

3.2 Case for change

The ICB's viable proposal describes the current service provision with women receiving antenatal and post-natal care at their FMBUs if this is their preference, with the choice of a consultant led or midwifery led birth at Royal Stoke University Hospital or Queen's Hospital Burton. Women also have the choice of alternative providers outside of Staffordshire and Stoke-on-Trent. It is anticipated that home birth services will be reinstated in Spring 2024 to ensure women are offered the choice of place of birth recommended by the National Perinatal Epidemiology Unit (NPEU) Birthplace Study, Better Births and the National Institute of Clinical Excellence (NICE).

Although feedback on the birthing units was positive prior to their closure, it is clear partners need to consider the viability of re-opening these units for a number of factors. The changing complexity of the maternal population leading to earlier and increasing levels of intervention and thus a smaller number of women who would meet the criteria for birth in an FMBU. Birthrate Plus™ assessment completed at both Trusts showed that the levels of complexity have continued to rise over the years and

even fewer women may now be suitable for low-risk care across Staffordshire and Stoke-on-Trent.

The low demand for births at the units before the pandemic, with virtually no complaints about their unavailability for births post-pandemic, indicated less appetite for a birth in a freestanding unit amongst those whose pregnancy is considered low risk.

A previous Trust Special Administrator (TSA) review of maternity services at County Hospital recommended that the unit manage a minimum of 350 births per year to be clinically and financially viable. There were not enough births in the FMBUs to ensure this and the increasing complexity within the population, alongside the reduced demand for these units despite repeated promotional campaigns, make it unlikely the number of births in the FMBUs would rise if they were to re-open.

Skill mix and sustained competency of midwives is also a key safety factor to consider when birthing numbers are so low. Staffing shortages in midwifery are a challenge across the NHS with a shortage of just under 2500 midwives across England (Royal College of Midwives, 5 April 2023) and consideration must be given to the need to grow, retain and support the maternity and neonatal workforce and ensure their skills and experience are fully utilised.

3.3 Scope and limitations of review

The West Midlands Clinical Senate were proactively approached by SSOT ICB in February 2024 to undertake this clinical review as part of their decision-making process, which will propose to make the temporary service changes made during the Covid-19 pandemic permanent.

The sponsoring organisation consider their preferred option to be a viable proposal as the current service provision, meaning women will receive antenatal and post-natal care at their FMBUs if this is their preference – and with the choice of a consultant-led or midwifery-led birth at Royal Stoke University Hospital or Queen’s Hospital Burton. Women also have the choice of alternative providers outside

of Staffordshire and Stoke-on-Trent. The Trusts have reinstated the booking of women into the home birthing service from April 2024. This will ensure women are offered the choice of place of birth recommended by the National Perinatal Epidemiology Unit (NPEU) Birthplace Study, Better Births and the National Institute of Clinical Excellence (NICE).

The Clinical Senate team was asked to review the information provided by Staffordshire and Stoke-on-Trent ICB, University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and University Hospitals of North Midlands NHS Trust (UHNM) and to consider the proposal presented.

The proposal was considered alongside the maternity clinical model, which is:

- No change to the provision of consultant-led services.
- Midwifery-led care would continue to be offered at Royal Stoke Hospital and Queen's Hospital Burton, alongside consultant-led units.
- The reintroduction of and growing the homebirth services.
- To develop and grow a continuity of carer model for the most vulnerable in the county.
- That antenatal and postnatal care will continue at the FMBUs.

The panel were specifically asked to consider:

1. If they support the proposal to make permanent the temporary closure of the birthing/intrapartum service at the Freestanding Midwifery birth units at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield.
2. Does the clinical model consider the wider interdependencies of the maternity/birthing pathway, specifically around safe care during unexpected complications?
3. Does the proposed model align with national and local strategy to make maternity care safer, more personalised and equitable for all?
4. If there are factors that the panel thinks need further consideration, which have not been covered. This should include a review of any potential unintended risks/consequences, patient experience and patient outcomes and with consideration given to addressing health inequalities.

4. Methodology and governance

4.1 Details of the approach taken

Staffordshire and Stoke-on-Trent Integrated Care Board (SSOT ICB) on behalf of the Integrated Care System (ICS) including University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and University Hospitals of North Midlands NHS Trust (UHNM) formally engaged with the Clinical Senate on 2nd February 2024 and subsequently a Clinical Senate review was scheduled for 26th April 2024. The SSOT ICB (Helen Slater, Associate Director of Transformation, Gina Gill Transformation Programme Lead and Kathryn Whitfield, Programme Manager) and the Clinical Senate (Emma Orrock, Head of Clinical Senates) had been holding regular monthly meetings in the lead up to the formal engagement of the Clinical Senate.

Once the review date was scheduled, these meetings were opened up to additional representatives from the ICB as required and their frequency was increased to regular planned (weekly) meetings. This was to ensure all background information was made available for the Clinical Senate review and that the review day itself and the pre-visit could be appropriately planned for. Supporting documents were provided to the panel for their consideration; a full list of which is provided in Appendix B.

Panel members and patient representatives were identified from the West Midlands Clinical Senate Council and Assembly memberships, as well as a small number of direct approaches were made within systems to ensure appropriate representation across all key clinical roles.

As the maternity services being reviewed are spread across a large geography, it was agreed that opportunities for all sufficient site visits on the day would be logistically quite challenging. Thus, it was agreed that it would be more suitable for pre-arranged visits to be undertaken by a small number of Clinical Senate panel members ahead of the full review day on 26th April 2024. The review would take place at Entrust in Staffordshire and on this day, a visit to County Hospital Stafford would be undertaken as part of the afternoon's session.

It was agreed that on 18th April 2024, four members of the review panel supported by the Head of Clinical Senates would visit Royal Stoke Hospital in the morning to meet with staff working in the service and to explore the unit/estate. The afternoon was a visit to Queen's Hospital Burton, and which replicated the morning visit. This ensured equity in the Senate's review process by visiting both acute providers. The subset of the clinical review team would then feedback their observations to the full clinical review panel on the day of the review.

A draft report was sent to panel members and then the sponsoring organisation to check for matters of accuracy on 17th May 2024. The final report was submitted to the Senate Council (and ratified on 31st May 2024).

This report was then submitted to the sponsoring organisation, Staffordshire and Stoke-on-Trent Integrated Care Board (SSOT ICB) on behalf of the Integrated Care System (ICS), on 10th June 2024. The slight delay in the overall timeline was due to annual leave (although it was agreed in advance).

The West Midlands Clinical Senate will publish this report on its website once agreed with Staffordshire and Stoke-on-Trent ICB. The anticipated publication date is 31st July 2024.

4.2 Original documents used

The full list of documents provided by the sponsoring organisation for the clinical review can be found in Appendix B. The main submission occurred on 27th March 2024 with further documents received on 9th April 2024. A final set of documents was submitted on 19th April 2024. All documents were shared with Clinical Senate panel members on the day they were received via its document management system (DMS).

5. Key findings from the clinical review

Prior to the commencement of the presentation in the morning session by the sponsoring organisation, the panel received feedback from the group of four clinical review team members who had undertaken the pre-visit to Royal Stoke Hospital and Queen's Hospital Burton on 18th April 2024. During that visit, photographs had been taken and were shared with the full review panel to show the different units, their environments and access points. The pre-visits had also provided an opportunity to meet with staff in their normal working environments. The visual presentation of the pathway/units was invaluable, as it provided all panel members with insight into the physical environments to take forward through the day. The panel wish to formally express its thanks to the staff in these units for accommodating these visits and spending time showing the team the environment and describing their services with such enthusiasm and passion.

The Clinical Senate panel Chair opened the review with thanks to the sponsoring organisation for hosting the Senate. The Chair extended thanks to the review panel for dedicating their time to attend and sincere appreciation to the sponsoring organisation for the significant amount of work that was evident to the panel in the breadth and volume of evidence submitted.

The panel were joined by a range of representatives from the four key organisations as outlined in the table below:

Staffordshire and Stoke-on-Trent Integrated Care Board
Heather Johnstone, Chief Nursing and Therapies Officer
Lynn Tolley, Director of Nursing – Maternity and Safeguarding
Ali Budd, Lead midwife for the Local Maternity and Neonatal System
Adele Edmondson, Head of Communications and Engagement
Helen Slater, Associate Director of Transformation
Gina Gill, Transformation Programme Lead
University Hospitals of Derby and Burton NHS Foundation Trust
Sarah Noble, Director of Midwifery
Donna Bird, Director of Nursing
University Hospitals of North Midlands NHS Trust
Sarah Jamieson, Director of Midwifery

Helen Ashley, Director of Strategy and Transformation/Deputy Chief Executive Officer
Derby and Derbyshire Integrated Care Board
Letitia Harris, Assistant Director of Nursing and Quality

The presentation began with the panel hearing from Heather Johnstone from the ICB who set out the current position of the maternity services across the large geography of Staffordshire, Stoke-on-Trent and Derbyshire and how temporary changes made during the Covid-19 pandemic had not been reinstated. These changes are suspension of the birthing element at the midwifery led units at Samuel Johnson Community Hospital in Lichfield and County Hospital in Stafford and pausing the home birthing service.

The table below outlines what is currently in place across the area:

Our current birthing services

Service	Current location	Suitable for high-risk pregnancy?	Other benefits
Consultant-led births	• Royal Stoke University Hospital • Queen's Hospital, Burton	**Yes**	• Doctors and specialists on hand • An epidural (pain-relief injection) can be given
Midwife-led births	• Royal Stoke University Hospital • Queen's Hospital, Burton	**No**	• Non-clinical environment • Low-risk births only • Less likely to need intervention • Close to consultant-led unit for ease of transfer
FMBUs **(temporarily suspended)**	• County Hospital, Stafford • Samuel Johnson Community Hospital, Lichfield	**No**	• Non-clinical environment • Low-risk births only • Less likely to need intervention
Homebirths **(temporarily suspended)**	• In patients' homes throughout Staffordshire and Stoke-on-Trent	**No**	• Familiar environment with family around you • Less likely to need intervention, especially if not first birth

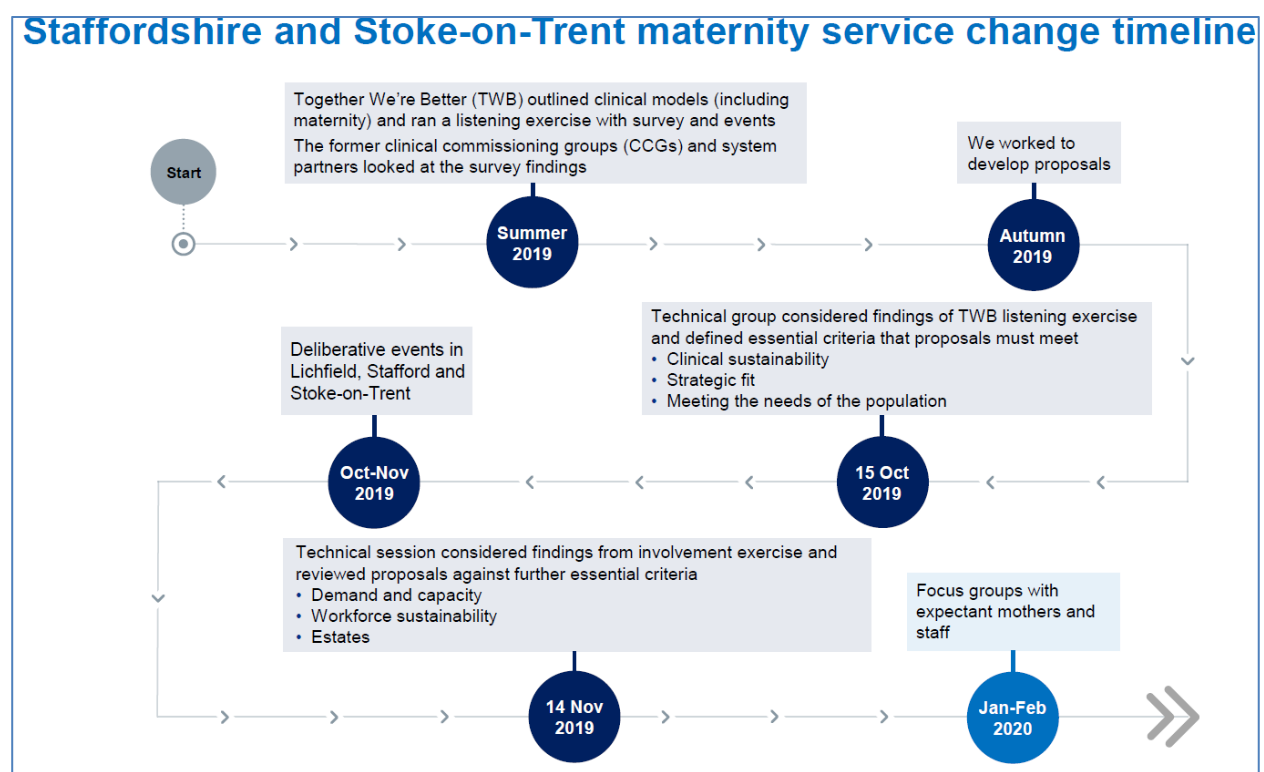
The panel received further information explaining some of the reasons for these not restarting such as significant staffing challenges in the maternity workforce which have prevented the two provider Trusts from being able to safely reopen these units, and the need for providing safe staffing levels at the consultant led units. However, continuous discussions have been taking place between Staffordshire and Stoke-on-Trent ICB, with colleagues from Derby and Derbyshire ICB, working with the two providers to outline the current position in relation to the FMBUs and the homebirth services.

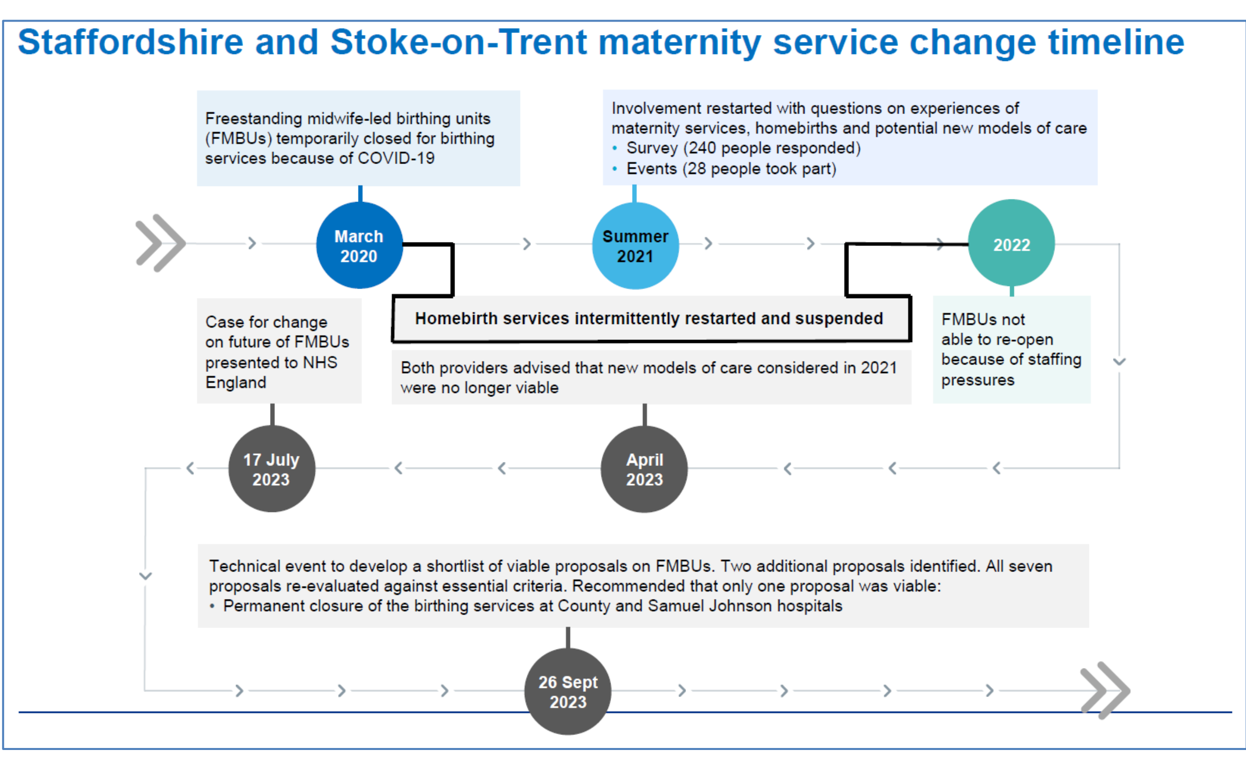
The panel heard how, since 2020, the homebirth services for both Trusts have had both fixed-term and intermittent (in line with escalation) periods of suspension and are also currently closed. As staffing has increased, attempts have been made to reinstate the homebirth services. Unfortunately, this has not been sustainable as yet and all parties recognise that the ongoing closure under the temporary service change arrangements cannot continue hence the request for both Trusts to explore all possible proposals for future service provision. Both services have however now started to take bookings for home births, as of April 2024, and these bookings are undertaken by the midwife at 8-10 weeks' gestation thus creating a pipeline of potential home births for the future.

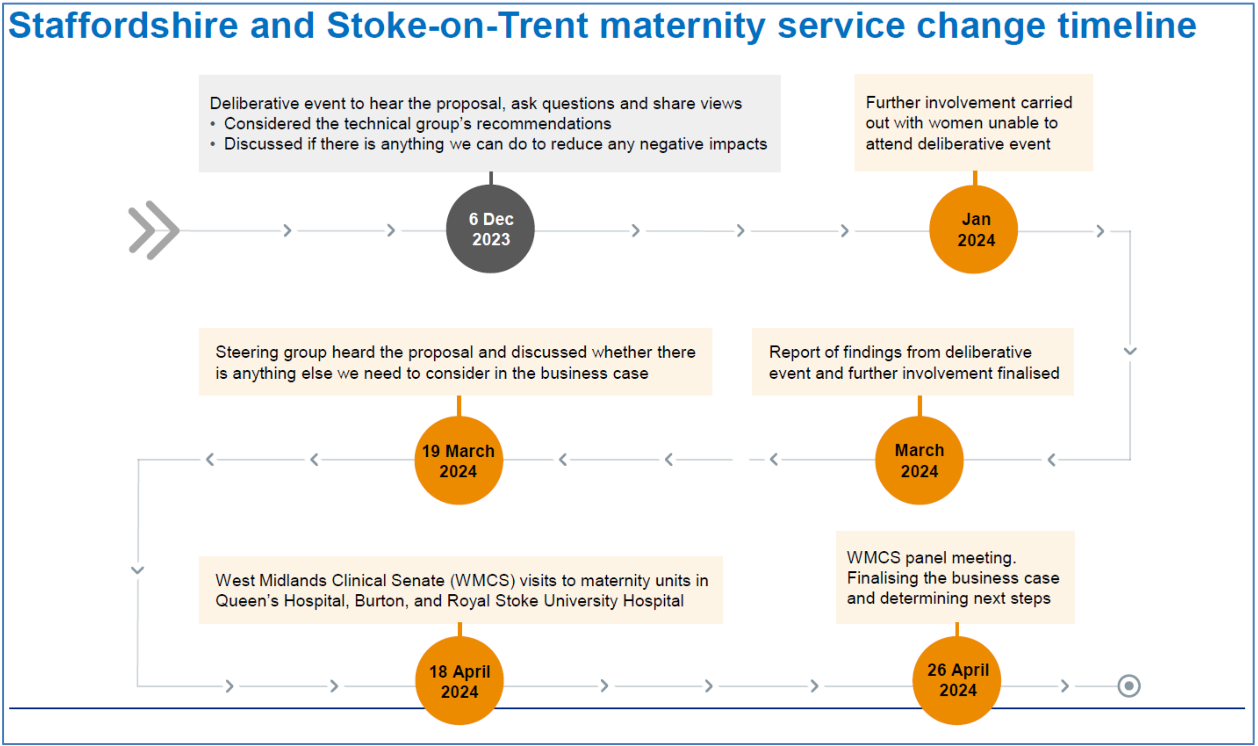
Following on, Heather described the governance structures for SSOT ICB, UHDB and for UHNM and how these provide the assurance needed from 'ward to board'. There is also a feed from the Local Maternity and Neonatal System (LMNS) which reports into the quality and safety meetings.

Then the panel heard from Helen Slater in the ICB, who explained the journey the system had been on to reach this point, stretching back to 2018 and a proposal was presented to the West Midlands Clinical Senate and a clinical review was undertaken to close the midwife led unit at County Hospital Stafford, and this was supported.[2] The panel received information which is best illustrated by the images below regarding the timing and stages of the process, as this spans several years and was the start of the system's transformation programme, including a wider presentation back to the Clinical Senate on these plans following a series of technical events which included clinicians and specialist colleagues from within maternity services.

[2] West Midlands Clinical Senate 2018 review can be found here


Staffordshire and Stoke-on-Trent maternity service change timeline
Start
Together We're Better (TWB) outlined clinical models (including maternity) and ran a listening exercise with survey and events
The former clinical commissioning groups (CCGs) and system partners looked at the survey findings
Summer 2019
We worked to develop proposals
Autumn 2019
Technical group considered findings of TWB listening exercise and defined essential criteria that proposals must meet
• Clinical sustainability
• Strategic fit
• Meeting the needs of the population
15 Oct 2019
Deliberative events in Lichfield, Stafford and Stoke-on-Trent
Oct-Nov 2019
Technical session considered findings from involvement exercise and reviewed proposals against further essential criteria
• Demand and capacity
• Workforce sustainability
• Estates
14 Nov 2019
Focus groups with expectant mothers and staff
Jan-Feb 2020


Staffordshire and Stoke-on-Trent maternity service change timeline
Freestanding midwife-led birthing units (FMBUs) temporarily closed for birthing services because of COVID-19
March 2020
Involvement restarted with questions on experiences of maternity services, homebirths and potential new models of care
• Survey (240 people responded)
• Events (28 people took part)
Summer 2021
2022
Homebirth services intermittently restarted and suspended
FMBUs not able to re-open because of staffing pressures
Case for change on future of FMBUs presented to NHS England
Both providers advised that new models of care considered in 2021 were no longer viable
17 July 2023
April 2023
Technical event to develop a shortlist of viable proposals on FMBUs. Two additional proposals identified. All seven proposals re-evaluated against essential criteria. Recommended that only one proposal was viable:
• Permanent closure of the birthing services at County and Samuel Johnson hospitals
26 Sept 2023



The panel heard how engagement started in 2019 as maternity services were part of a Trust-wide 12-week listening exercise that reached over 2000 people and then in 2020, focus groups were held with 25 new or expectant mothers and staff, with 40 surveys completed. (Some of the people who attended the focus groups may have also completed the survey, both the invite to the focus groups and online survey were open for the general public to sign up for or complete). The view was that this feedback would help shape plans for the future. The outcomes of these events were fed back to the panel:

What was working well:

- In 2019, people said waiting times were generally good, and we had fantastic staff
- 76% rated maternity services as 'excellent' or 'good'
- At the 2020 focus groups, they said maternity staff were supportive and compassionate
- The facilities and care received at County Hospital and Royal Stoke University Hospital were particularly praised.

What could be improved:

- In 2019, people said that health visitor clinics, after-care and shared records needed improvement. The distance / access to hospital was also an issue
- New mothers at a breastfeeding support group told us that there was a lack of continuity of care and a need for better access to support services after birth
- At the 2020 focus groups, continuity of care and access to support services were again raised as issues, along with communication, medical records and access to services close to home.

However, shortly after this, the Covid-19 pandemic caused the temporary service changes to be implemented and this transformation work was paused.

Helen continued to explain to the panel how they began re-engaging and involving staff and service users again in 2021, when the ICB held further listening exercises to check if any new feedback needed to be considered since the pandemic. An online survey had 240 responses and 28 people took part in two online workshops. The key points of which are:

- **Experiences before and during Covid-19:** the survey suggested experiences during Covid-19 were poorer. For example, in responses about experiences before Covid-19, 58% said that staff were professional and supportive, while in responses relating to experiences during Covid-19, the figure was 50%.
- **What could be improved:** common themes (both before and during Covid-19) were requests for consistent advice and seeing the same midwife, being treated with respect and empathy by staff, and more support with breastfeeding.
- **Homebirth:** 39% said they would consider a homebirth, 49% said they would not.
- **On-demand model:** 61% agreed with the model of an on-demand service, although there were concerns about whether staffing levels would be right.
- **Continuity of carer:** 67% agreed it was a good model.

The panel received further information that in 2023 there was a technical event held which included two new proposals, using hurdle[3] criteria to assess the proposals. A further deliberative event in December 2023 followed for the public and stakeholders to hear about the FMBUs and the proposal. 16 people took part, before later carrying out one-to-one interviews with women who had registered for the event but could not attend (three women were interviewed as they were unable to attend the deliberative event in December). Below is a summary of the feedback from the event and the interviews:

[3] Hurdle criteria are used to filter the number of existing criteria – reducing the long list to a shortlist.

Feedback on the proposal	Who would be disadvantaged?
• Maintaining the competency and skills of midwives is important • Workforce challenges are a concern • Increased staffing should be a priority • Assurance that units are safe is the top priority • Homebirth option should be available for people who want that choice • Good proposal on basis that there's a community option to receive pre- and post-birth care – would not support closure of units if that option wasn't there • It's not ideal for everyone because of travel.	• Disadvantaged groups, for example low-income families, migrants and new arrivals to the UK • People who have a long distance to travel, who live in rural areas or don't have access to a car • Those who need emergency services (for example: 999) need reliable services • Midwives currently working in Burton. **Alternative proposals** There were no alternative proposals to the service model identified, but participants wanted to ensure continuity of care and that homebirth is available as an option.

It was noted by the panel that the proposals to not reopen the two birthing units would have some disadvantages to some service users, who may have challenges with transport particularly, but in the past four years there had been no significant events, serious incidents, quality issues, or feedback on this issue. The panel noted one formal complaint related to the change to these services.

The presentation continued and the panel heard from Ali Budd, Lead Midwife for the LMNS, Sarah Noble, Director of Midwifery at University Hospitals of Derby and Burton and Sarah Jamieson, Director of Midwifery at University Hospitals of North Midlands - on the challenges and the clinical case for change.

The panel heard how the NHS three-year delivery plan for maternity and neonatal services, published in March 2023, drew on previous NHS reports and the learning from recent investigations including the Ockenden review. There are four main themes, and the conversations have been based around these:

1. Listening to women and families with compassion, which promotes safer care
2. Supporting our workforce to develop their skills and capacity to deliver high-quality care
3. Developing and sustaining a culture of safety to benefit everyone
4. Meeting and improving standards and structures that underpin our national ambition.

The presentation continued with information provided on birthing numbers across the area, and it was noted that on average eight women per month were giving birth at

the FMBU at County Hospital and when the staffing required is for two midwives 24 hours per day, this was considered an inefficient use of resource.

Births* at FMBUs compared with acute hospitals, 2019/20

We use the numbers from the year 2019/20, as this was the last year the FMBUs were open.

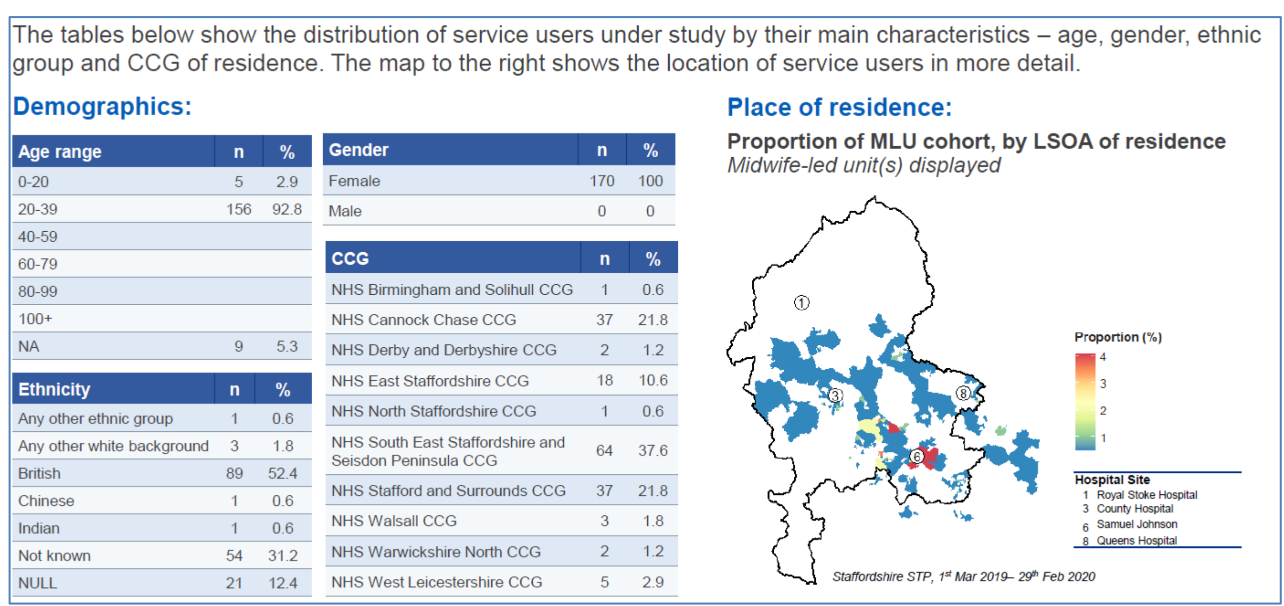
Type of unit	Location	Births
Consultant-led unit	Royal Stoke Hospital	5,264
	Royal Derby Hospital	4,770
	Queen's Hospital, Burton	2,329
Midwife-led unit (within same hospital as consultant-led unit)	Royal Stoke Hospital	970
	Royal Derby Hospital	802
	Queen's Hospital, Burton	584
FMBU	County Hospital, Stafford	94
	Samuel Johnson Community Hospital	220

*Total number of births (inclusive of SSOT births)

On average, in **2019/20** **8** women each month gave birth at County Hospital **18** women each month gave birth at Samuel Johnson Community Hospital in Lichfield

It is recommended that the units manage a minimum of **350 births per year** to be clinically and financially viable.

Furthering this, the panel heard a summary of the population characteristics and the distribution of the service users, it was noted that most of the service users using the units that are temporarily closed were local to those units, and that population ethnicity data during the 2019 period was not as good as it could have been and is an area of work that continues to be improved to ensure the ICB have a full understanding of their population's demographics. This lack of accurate or robust ethnicity data was highlighted as a particular area of concern when considering the CORE20PLUS5 objectives around maternal outcomes. The panel was assured that the proposal affected geographic areas where the demographic was skewed to White British and there was no concern about unmet needs from ethnically diverse patient populations who were also socio-economically deprived. However, the panel was assured that this was an area that was being looked at closely to ensure that the data was being captured moving forward.



The tables below show the distribution of service users under study by their main characteristics – age, gender, ethnic group and CCG of residence. The map to the right shows the location of service users in more detail.

Demographics:

Age range	n	%
0-20	5	2.9
20-39	156	92.8
40-59		
60-79		
80-99		
100+		
NA	9	5.3

Ethnicity	n	%
Any other ethnic group	1	0.6
Any other white background	3	1.8
British	89	52.4
Chinese	1	0.6
Indian	1	0.6
Not known	54	31.2
NULL	21	12.4

Gender	n	%
Female	170	100
Male	0	0

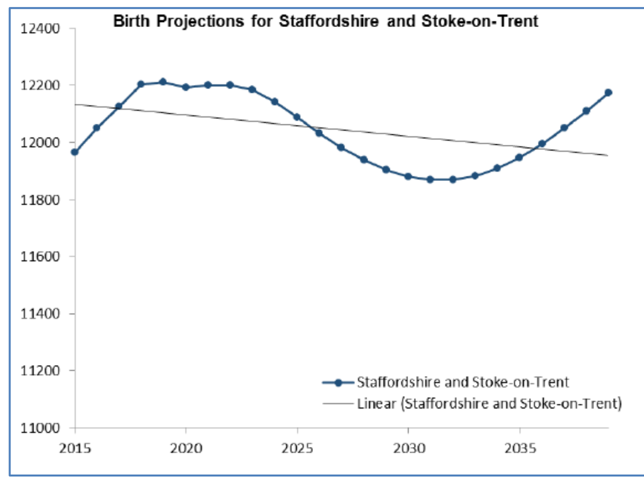
CCG	n	%
NHS Birmingham and Solihull CCG	1	0.6
NHS Cannock Chase CCG	37	21.8
NHS Derby and Derbyshire CCG	2	1.2
NHS East Staffordshire CCG	18	10.6
NHS North Staffordshire CCG	1	0.6
NHS South East Staffordshire and Seisdon Peninsula CCG	64	37.6
NHS Stafford and Surrounds CCG	37	21.8
NHS Walsall CCG	3	1.8
NHS Warwickshire North CCG	2	1.2
NHS West Leicestershire CCG	5	2.9

Place of residence:

Proportion of MLU cohort, by LSOA of residence
Midwife-led unit(s) displayed

The panel heard how there are circa 11,000 births a year within the Staffordshire and Stoke-on-Trent population, and this is forecasted to fall over the next 10 years, before rising again after 2030. Some key assumptions are:

- Local demographic growth is assumed to be as per ONS demographic growth, of 0.39% for 2023/24.
- Maternity projections:
  - based solely on gender and age band (see figures bottom right)
  - show that:
    - the 20-40-year-old female population is forecasted to have decreased by 0.12% during 2023/24.
    - each of the 5-year age bands demonstrate variability.
- Non-demographic growth of 1.1% per annum, as per previous finance Long Term Plan assumptions.



Age vs growth projections

20-24	-1.43%
25-39	-1.10%
30-34	+0.25%
35-39	+1.53%

Following on, the panel heard how this expected fall in births over the coming years will also be accompanied by births that are taking place which are more complex, previously (2017/18) around 29% of births were considered low risk, this number is now closer to 17% and will likely decrease further. This was evidenced in 2022 when UHNM had a Birthrate Plus™ assessment, and despite campaigns to the public to use the County Hospital FMBU, the number of births continued to fall until its temporary closure. Since the County Hospital unit closed there have been no formal complaints, and only one for Samuel Johnson. UHDB is in a similar position with the majority of pregnancies classed as high-risk. UHDB have also had a Birthrate Plus™ assessment.

Developing and sustaining a culture of safety is one of the key themes of the NHS three-year plan, and unquestionably an aspiration the ICB will want to achieve.

The panel heard how workforce sustainability had been a significant issue for the service, with a considerable shortage of midwives, (this is a national issue with 2500 midwives needed across England) with decisions having to be made about maintaining safe staffing at the consultant-led birthing units, whilst workforce plans came into place. To run an FMBU requires 11 midwives for each unit, and these staff cannot support other maternity services. Therefore, these midwives do not acquire the same exposure or experiences to the more complex births, meaning their skills are under-utilised and they may struggle to maintain their clinical competencies.

Staff shortages mean that, at present, the Trusts cannot staff the FMBUs for births as well as safely staff the services at Royal Stoke Hospital and Queen’s Hospital in Burton.

The presentation continued with the panel again hearing from Ali Budd on the proposal considered for maternity service change, and the ICB's vision was shared:

Empower women, and their partners, by putting them at the centre of their care so they have the best support	Aim to develop a continuity of carer model during pregnancy, birth and beyond for those most vulnerable in our community
Design a service that supports women to access a team of midwives, who have worked with them to develop their own personal birth plan	Make the best use of our staff, allowing them to maintain their skills and competency, work more flexibly and really get to know the women and families in their local communities
Provide a network of places where women can choose to have their care, that are high-quality and safe, have the right staff skill mix and also represent value for money	To develop and sustain a culture of safety which reduces inequalities in outcomes.

In order to develop these proposals, the ICS has taken a number of steps, including:

1. Reviewing the earlier options appraisal process and findings from public involvement.
2. Analysing the relevant data, including demographics, numbers of births at the different units, clinical complexity and equalities.
3. Making sure their strategy for maternity is aligned with the national plans.
4. Making sure they are considering the need for patient choice.
5. Ensuring that any plans will promote equity for mothers and babies from Black, Asian, and mixed ethnic groups and those living in the most deprived areas.
6. Developing a case for change (submitted to NHS England in July 2023).
7. Confirming a new clinical model.

The technical event held in September 2023 reviewed evidence and developed a shortlist of viable proposals. The clinicians reviewed five potential proposals already identified against six essential criteria. During the event, the group identified and considered two further proposals (final two in the list below).

The technical group found that only one proposal was viable (shown in bold):

- Reinstatement of birthing service at County Hospital and Samuel Johnson Community Hospital.

- Reinstatement of a single birthing service at one or other of the FMBUs.
- Implementation of an on-demand model at both FMBUs.
- Implementation of an on-demand model at one or other of the FMBUs.
- **Permanent closure of birthing service at County Hospital and Samuel Johnson Community Hospital.**
- Implementation of a single birthing unit at an alternative site (that would need to be identified).
- Implementation of an on-demand model at an alternative site (that would need to be identified).

A further deliberative event was held in December 2023 for the public and staff to hear the proposal, share views and ask questions about the proposal and the process taken to reach it.

The advantages and disadvantages of these options were drawn up, and shown to the panel:

Advantages and disadvantages of service models

Service model	Advantages	Disadvantages
24/7 FMBU	• **Choice** of non-clinical setting to give birth is offered • **Less travel** for those living close to the units who are eligible to use the units and who choose to give birth there.	• **Low number** of patients eligible and choosing to give birth at units in the past • 24/7 staffing of units means **midwives can't support homebirths or other midwife-led units** • Due to low numbers of deliveries, there is a possible **under-utilisation of skilled, experienced midwives** who cannot support in other areas of maternity care while working in the FMBU • **Patients who develop complications would need to be transferred** to a hospital unit either at Royal Stoke or Burton during labour
On-demand FMBU	• **Less impact** on staffing when compared to running a 24/7 birthing unit but would likely need further recruitment beyond the current plans • **Midwives maintain their skills** – delivering more births at home and midwife-led units • They can also **fully utilise their skills and experience** to support other areas of maternity care.	• As above, and: • The units are not staffed 24/7 so **patients may arrive before the community midwife on-call** or they may be under the impression there will always be midwives and other healthcare professionals available to support as it is located within a hospital • This poses a **governance risk** to Trusts, who would be held accountable for incidents on the hospital premises
Permanent closure of FMBU for births	• Women would **continue to receive** the majority of **antenatal and postnatal care** within the units • Staff-to-patient **ratios would be the same** across all units • **Midwives can support** the homebirth services and midwife-led units • They can also **fully utilise their skills and experience** to support other areas of maternity care. • Patients who develop complications would **no longer need to be transferred** to a hospital unit during labour	• There may be **travel implications** for women who are eligible to give birth at County Hospital or Samuel Johnson Community Hospital, who live close to the units and who would have chosen to give birth there • Requires the **reinstatement of homebirth services** to ensure **full patient choice** is offered.

The hurdle criteria also being used to support the decision making are shown below:

	Clinical sustainability	Strategic fit	Meeting the needs of population	Demand and capacity	Workforce sustainability	Estates
Reinstatement of birthing service at County Hospital and Samuel Johnson Hospital	No	No (but offers additional choice for women)	No	No	No	Yes
Reinstatement of birthing service at one or other FMBU	No	No	No	No	No	Yes
Reinstate FMBU at alternative site	No	No	No	No	No	No
Implement on-demand at both FMBUs	No	No	Yes	No	No	Yes
Implement on-demand at one or other FMBUs	No	No	No	No	No	Yes
Implement on-demand at alternative site	No	No	No	No	No	No
Permanent closure of birthing service at both sites	Yes	Yes	Yes	Yes	Yes	Yes

Following these assessments the technical group recommended that only one proposal was viable, which is to **make permanent the temporary closure of the birthing service at County Hospital and Samuel Johnson Hospital**. The closure relates to 5 low risk birthing rooms (LDRP - Labour, Delivery, Recovery, Post-Partum) across the two sites (2 at County Hospital and 3 at Samuel Johnson Hospital).

However, it was explained to the panel the proposal needs to be considered alongside the maternity clinical model, which is:

- No change to the provision of consultant-led services.
- No change to the midwifery-led care offered at Royal Stoke Hospital and Queen's Hospital in Burton.
- Reintroduce and grow the homebirth services.
- Develop and grow a continuity of carer model for the most vulnerable in the county.
- No change to the antenatal and postnatal care at County Hospital and Samuel Johnson.

The ICB had utilised the demographic data of people who have historically used the units alongside the pregnancy and birth data for each of the localities from the Public Health England fingertips toolkit to complete the equality impact assessment (EIA).

The impact of this proposal was explained to the panel as being positive for equity of provision, proximity to other clinical teams where required (e.g. neonatal), reduced

need for blue light ambulance transfers, and clinical and workforce sustainability. From a negative point of view, only one area was identified of potential travel implications for a small number of people. From a neutral perspective, the ICB recognised that there are variances in outcomes for particular groups, for example those from Black, Asian and mixed ethnic groups and those living in deprived areas (MBRACE-UK report). The service did not target these demographics specifically or address inequalities and the EIA did not identify any groups that would be disproportionately impacted by this proposal. Given the demographics of those that attended the FMBUs the ICB stated that it is likely that the reinstatement of services would create an inequality due to diverting resource from the acute sites and those that are identified as needing high-risk care.

To conclude the presentation, the panel heard again from Helen Slater who explained the next steps in the business case sign-off process, which is planned for December 2024.

The Chair of the panel thanked the sponsoring organisation for their thorough and clear presentation of the situation and plans, before opening to a series of questions from the panel and splitting into three groups for afternoon discussions. The three groups were:

1. UHNM MDT at County Hospital FMBU, including community midwifery lead, and additional midwife, MLU lead midwife and additional midwife.
2. UHDB MDT (as above via Microsoft Teams).
3. Strategic Group including communications leads.

Themes arising from these questions and from the evidence previously provided were drawn up; the remaining feedback and subsequent conclusions are structured around these themes.

Staffing / workforce and operations

The panel understood that the Trusts are now taking bookings for the home birth services, and staff are confident these will be able to go ahead, with the increased staffing. The panel did, however, note that the number of home births that actually take place is still extremely low at circa 2% nationally, despite circa 39% indicating

they would consider it as a birthing option when discussed at the local listening events. National data would suggest that only 10% do choose the option to home birth (although they may not actually end up being a home birth). The panel also heard how UHDB will staff the homebirth service from a mix of MLU midwives and community resource and would respond to a birthing mother when needed, meaning they can utilise their time and skills within that unit whilst waiting for a possible homebirth. This was seen as a positive and a good use of resources.

The panel queried whether the absence of the FMBUs and the homebirth services had increased the number of women making birth choices outside of guidelines and the panel received information that no increase in the number of women seeking to birth outside of guidance has been seen since the temporary closures.

During the discussion, the panel heard of the robust plans to have a fully established workforce by the end of this year (2024), with considerable workforce recruitment and retention work having been undertaken, including working with two local universities, attracting the local workforce and international recruits, and providing strong preceptorships once recruited. Retention rates at UHNM for 2022-2023 were 100% with only 2% attrition overall, one of the lowest of the peer groups.

In 2022 the identified gap was 70 whole time equivalent midwives at UHNM. During 2022, 22 new staff started, a further 26 in 2023 and 25 more will be recruited in October 2024, bringing the service to full establishment. This is to be commended by the panel given how challenging the national picture is. The panel queried whether there was any dilution of skills or experience, and received confirmation that as the new midwives were being recruited, they are spread across teams to ensure that dilution is not an issue with formal preceptorship programmes in place for them as well. The panel were pleased to hear that staffing shortages, once identified, had started to be recruited to whilst funding was being agreed, demonstrating the importance placed on having a safe staffing level for these services. The ways in which the services are retaining staff was also pleasing to hear; engaging staff members in lead roles, research, rotations and learning opportunities were all considered extremely positive by the panel; however, the clinical review team were unclear as to how these rotational opportunities would be planned and managed.

On reviewing the historic Workforce Racial Equality Standards (WRES) reports, the panel identified that in several areas, there appeared to be worsening in outcomes over the preceding years. Therefore, the clinical review team sought to understand whether this was an issue and whether there were any organisational cultural issues or worsening opportunities for those with protected characteristics, which was being reflected in the lack of improvement or, in some cases, worsening of indicators around racial inequities in the workforce. The panel heard that the ICB was aware of the data and UHNM are recruiting 8 midwives of Black, Asian or other ethnic minority groups within their workforce. They also assured the panel there was a positive culture towards equality, and they are currently advertising to recruit a lead midwife for equality and inclusion, who has been looking mostly at patient equality but will also be looking at staff in the future; this was viewed by the panel as a positive step.

The panel were pleased to hear the work that has been undertaken across the services with training opportunities for staff, with learning taking place with teams from neonatal services, and joint training with partners such as the ambulance services. Furthermore, staff were complimentary of the response received from the ambulance trusts when needed and with no reports of delays for transfer to an appropriate unit.

A culture of 'bottom-up' leadership was described to the panel, and this was experienced throughout the review, leading to the empowerment of staff to be able to act in the best interests of patients and service users. MDT working with the consultants was also described as effective, and the midwives are respected within the units. Staff were generally supportive of the proposal to make the temporary changes permanent, but the clinical review panel heard of a feeling of loss from some staff from the closure of the MLU at Samuel Johnson. It appears that it was considered a beautiful building with a strong bond between staff, which holds a special place for some staff. This emotional impact does not appear to have been fully addressed and could leave some staff feeling less engaged with the new ways of working, and the panel felt this is an area that would benefit from some internal focus.

Digital and Data

During the discussion the clinical review panel heard how some birthing mothers in the area will go across county borders to areas such as Sutton Coldfield or Walsall to give birth because these units are nearer or preferred, which, while the care of the patients was considered safe, the handover between antenatal, birthing and post-natal care rely on transfer of data, often between differing IT systems or in some areas paper records still and this appears to be lacking. The panel also heard that within the area, there are two main IT systems for maternity services in place: K2 in UHNM, which is an end-to-end maternity system, and soon to be BadgerNet in UHDB. This system is also used by Good Hope Hospital to the south of the county, which is relevant when patients cross the county line for birthing.

The panel did hear how user-friendly the K2 system is, and how a patient could log in and have access to their records and in any language needed, which is a very positive feature. In addition, UHDB staff were excited to be getting BadgerNet as this is a step forward for them. The digital strategies in place will need to support the development and integrations moving forward to best utilise these systems and allow for continuity of care with a constantly accessible clinical record.

6. Conclusions and advice

The panel felt that the written evidence provided, discussions held during the day and in the pre-visits to Royal Stoke and Queen's Hospital had conveyed a vast amount of quantitative and qualitative information, which had supported the panel in their deliberations. The Chair of the panel thanked the staff who had made themselves available in the afternoon sessions, and asked for the panel's thanks to be extended to those staff who supported the pre-visits to Royal Stoke and Queen's Hospital. These visits were an essential part of the review process, as they proved to be very valuable to the team in visualising the physical estates and working environments and in furthering understanding of the services.

The Chair noted that the journey from a workforce crisis to the current and projected position of a full midwifery establishment, with strong recruitment and retention and empowered midwives, was a great success story.

The panel was very grateful for the open and honest conversations throughout the day and the level of knowledge and passion witnessed for the service and its users. They were impressed with some of the initiatives that have been undertaken within the area, such as the work with the neonatal team from cross-working opportunities, support to military families and refugees, and bereavement care for families and staff.

The Chair concluded with verbal feedback to the sponsoring organisation and the written conclusions below build on this to provide further detail.

The panel were specifically asked to consider:

1. **If they support the proposal to make permanent the temporary closure of the birthing/intrapartum service at the Freestanding Midwifery birth units at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield.**

The panel unanimously concluded that they supported the permanent closure of these two freestanding midwifery birth units for intrapartum care. Given the intensity

of resources needed, coupled with the relatively low numbers of births taking place prior to Covid-19 (in some cases only 8 births per month), it was not considered to be a sustainable use of clinical staffing. In addition, with a projection of a reduction in births over the coming years, but an increase in complexity of births, these birthing units may be utilised even less than previously. The plans presented were predominantly clear and well thought through, the exceptions are noted at the end of the conclusions.

The panel did note during the review the feeling of bereavement from some staff, with the sense of emotional and community loss of the birthing unit at Samuel Johnson. It would be appropriate to recognise this and to ensure staff are supported and fully engaged in the new model.

2. **Does the clinical model consider the wider interdependencies of the maternity/birthing pathway, specifically around safe care during unexpected complications?**

The panel concluded that the clinical model predominantly considers these wider interdependencies. It uses a rotational staffing model, where staff can work in the busy midwifery-led units to ensure they keep their knowledge and skills refreshed. The plans for the home birthing midwives also co-locating at these units enable the workforce to flex and adapt.

Additionally, there is a very low transfer time for babies or mothers that need additional care being so close to the consultant led units. It was clear to the panel that the ICB, the providers, and the staff want to offer the best choice for patients and agree that it is a safe and robust offer. The panel did, however, feel more work is required around the home birthing offer, which is detailed below.

3. **Does the proposed model align with national and local strategies to make maternity care safer, more personalised and equitable for all?**

The panel concluded that the proposed model does align with both national and local strategies for safer care, but it also recognised there will always be pockets of

inequality within a population when making changes and that achieving 100% coverage will remain a challenge and an ambition for many services and organisations. The panel felt the work undertaken around engagement to date has been very good, but there is always the opportunity to go further into the communities that may be underserved by NHS services. Ensuring the workforce is representative of the communities served will also help with reaching these groups to understand their needs.

In addition, ensuring the birthing experience in terms of the delivery rooms is important to reduce any feeling of inequality from mothers, due to differences in the birthing environment, which the panel identified when they visited the different sites during the pre-visits.

4. **If there are factors that the panel thinks need further consideration, which have not been covered. This should include a review of any potential unintended risks/consequences, patient experience and patient outcomes and with consideration given to addressing health inequalities.**

The panel concluded that the plans, evidence and discussion had covered a lot of areas, and that there will always be areas of improvement to focus on, such as equality and access to services. The panel were reassured by the level of engagement that had taken place to date and hope the system continues with this to ensure they are receiving continuous feedback for improvement. The panel did identify a couple of areas of concern that fall within the scope of this question.

It was also noted in the production of this report, that the public will need to be clear as to what services will be available at these sites during any public consultation and going forwards, as they will no longer be FMBUs.

Home birthing service

The panel commended the work that has been undertaken to improve the workforce to enable them to provide patients with choice about their birth, which includes the home birthing element. However, through the evidence and the discussion at the

review, the panel did not feel fully reassured that the whole process and operational delivery of this service was fully developed or understood. It is positive to see that home births are now being booked in, but without those proper processes in place a level of risk may exist that is not currently identified. The panel would therefore encourage more robust planning for this service to ensure it is fully developed in time for their first home births.

The panel did note how positive and excited the midwives are about restarting the home birthing service and were real champions for this option.

Estates

During the pre-visit to Royal Stoke and Queen's Hospital in Burton some disparity in the physical birthing environment was noted. Whilst quite significant physical alteration work is being undertaken to make improvements at Queen's Hospital, it will be important to ensure patients have access to high quality, comfortable and comparable environments, regardless of the birthing location.

Cross Border Working

Throughout the review the panel heard how a number of expectant mothers, particularly in the south of the county will choose to birth in a hospital in a different ICS area, it was noted that this is a long-standing movement of patients. Birthing mothers will cross the border into the Birmingham and Solihull (BSol) ICS area, or the Black Country (BC) ICS area and whilst very little mention was made of Walsall and Wolverhampton, there was some discussion about Good Hope Hospital (GHH), within the BSol ICS area and in particular, the lack of consultant notes post-discharge.

This area of concern should be picked up as part of good data sharing systems and the panel would recommend the ICB review their processes to ensure this is addressed. Through the review the panel heard how considerable work has been undertaken with Derby and Derbyshire ICB, but this was not necessarily replicated for the other neighbouring ICSs. The panel felt there is further opportunity for closer working between SSOT ICB and BSol ICB in particular at an LMNS level to ensure that all mothers receive the same standard of care during pre-natal, intrapartum and post-natal stages of pregnancy and birthing. Moreover, if there are issues with

transfer of information or lack of information being passed across different providers, then this should be addressed.

An offer was made from a Senate panel member working within an LMNS capacity to support the linking of the teams together.

Data and IT

The panel heard how UHNM utilises the K2 software (since 2016) for their maternity service clinical records and that UHDB will shortly be utilising BadgerNet for theirs, however, there are also still paper records within other parts of the service and neighbouring trusts. This has the potential for leading to a loss of clinical information or detail during handovers of care. Furthermore, with a sizeable proportion of patients giving birth in neighbouring ICS areas, there is further scope for loss of data and continuity of care when transferring care back. The panel appreciate that this is a difficult and longstanding issue to solve across many areas of the NHS, however, it would be beneficial to continue with the digital strategy to support the integration of the systems to ensure the highest levels of patient safety are maintained and the risks are reduced or mitigated appropriately.

Public engagement

The panel were reassured by the level of engagement that had taken place and concluded this had been thorough and proportionate, spanning many years since the start of this programme in 2018. During the process staff have been kept updated, along with the Health Overview and Scrutiny Committee (HOSC) as well as ICB board updates.

The engagement had covered women and families, staff, public and key stakeholders and had taken a variety of forms, including online meetings, face to face meetings, briefings, listening events, online and paper survey and decision groups, and spanning a wide geography as well. The panel hope this engagement continues after the new proposals have been agreed and implemented to enable continuous learning and improvement, ensuring that the groups that may be undeserved by NHS services are also considered and engaged appropriately.

The Chair of the panel closed the review, thanking Staffordshire and Stoke-on-Trent ICB, University Hospitals of Derby and Burton NHS Foundation Trust and University Hospitals of North Midlands NHS Trust for their time and hospitality, as well as for their openness in providing information to the panel.

7. Recommendations

7.1.1 Recommendation 1

The panel supports the ICB's proposal to make permanent the temporary closure of the birthing/intrapartum service at the two FMBUs for intrapartum maternity care and reinstate the home birthing service.

7.1.2 Recommendation 2

The panel recommend that consideration is given to the different standards of birthing environment in place across the acute sites to ensure patients have a comparable high standard environment regardless of the birthing location.

7.1.3 Recommendation 3

The panel recommend that engagement with neighbouring ICBs at an LMNS level is widened to ensure that mothers receive equitable care during birthing and consider putting in place systems to ensure that all clinical notes are made accessible to those that need them in a timely manner.

7.1.4 Recommendation 4

The panel recommend that the ICB works with the provider Trusts to fully develop and implement the home birthing service to ensure it is fully planned and understood to ensure safe delivery of babies at home. The panel was supportive of the workforce and operational/clinical model being led and developed by the staff in the services with oversight from senior midwives.

7.1.5 Recommendation 5

The panel suggest the ICB and provider Trusts give due consideration to the naming of the FMBUs to ensure the public are clear on what services will be available going forwards.

Appendix A: Clinical Review Panel Terms of Reference

CLINICAL REVIEW TERMS OF REFERENCE

Title: Staffordshire and Stoke-on-Trent Intrapartum Maternity Services

Sponsoring Organisation(s): Staffordshire and Stoke-on-Trent Integrated Care Board (SSOT ICB) on behalf of the Integrated Care System (ICS) including University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and University Hospitals of North Midlands NHS Trust (UHNM)

Clinical Senate: West Midlands

NHS England region: Midlands

Terms of reference agreed by: Emma Orrock/Will Taylor **on behalf of clinical senate and**

Heather Johnstone (SRO), Chief Nursing & Therapies Officer, SSOT ICB

Helen Slater, Associate Director of Transformation, SSOT ICB

on behalf of sponsoring organisation(s)[*]

Date: 7th February 2024

<u>**Clinical review team members**</u>

Chair: Dr Will Taylor, GP Partner, Lordswood Medical Group (Our Health Partnership) and Chief Medical Officer, Herefordshire and Worcestershire ICB

Clinical Senate Vice Chair

Panel members:

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* Written email confirmation approving these TORs must be received by the Head of Clinical Senates from each sponsoring organisation by the named person in these TORs or their nominated deputy/deputies.

Name	Role	Organisation
Angela Holden	ST6 Respiratory & General Internal Medicine Previous Clinical Leadership Fellow	University Hospitals Birmingham NHS Foundation Trust Midlands Clinical Senates
Barbara Edwards	Senior Lecturer-Adult Nursing	School of Health Science and Wellbeing, Staffordshire University
Dawn Lewis	Lead for Governance and Quality	Black Country Local Maternity and Neonatal Services
Ellen Jones	Associate Postgraduate Dean Consultant in Emergency Medicine	Workforce Training and Education Directorate - NHS England University Hospitals Birmingham NHS Foundation Trust
Gillian Richards	Patient Representative	West Midlands Clinical Senate
Ian Mursell	Consultant Paramedic	East Midlands Ambulance Service NHS Trust
Jason Evans	Deputy Director Chair	West Midlands 999 and NHS 111 Commissioning Team National Ambulance Commissioners Network (NACN)
Joe Seager	Consultant Anaesthetist	The Dudley Group NHS Foundation Trust
Jyothi Nippani	Consultant Gynaecologist National Clinical Lead - Hospital Transformation	South Warwickshire Foundation Trust NHS England (ECIST)

	Clinical Director - Emergency and Elective Improvement Support Team	
Mandy Clarkson	Healthcare Public Health Consultant	NHS England – Midlands
Matthew Parsons	Consultant Obstetrician and Gynaecologist	Birmingham Women's and Children's NHS Foundation Trust
Natalie Whyte	Patient Representative	West Midlands Clinical Senate
Richard Mupanemunda	Consultant in Neonatal Medicine	University Hospitals Birmingham NHS Foundation Trust
Serena Cox	Matron Maternity Engagement and Experience	Nottingham University Hospitals NHS Trust
Shehla Imtiaz-Umer	GP Partner EDI Director Previous Clinical Leadership Fellow	Wilson Street Surgery The Hub Plus Midlands Clinical Senates
Simon Brake	Professor of Clinical Leadership & Management	University of Warwick
Tony Thomas	Consultant Obstetrics & Gynaecology	Walsall Healthcare NHS Trust
Vanessa Barrett	Patient Representative	West Midlands Clinical Senate

Background

The Integrated Care Board (ICB) in Staffordshire and Stoke-on-Trent is responsible for the health and care of 1.1 million people across a geographical area of 1,048 miles. The ICB is aligned with two upper-tier local authorities, Staffordshire County Council and Stoke-on-Trent City Council. The population is diverse with complex

health and care needs, comprising both rural and urban areas, extremes of affluence and deprivation, as well as significant health inequalities. For this programme of work, the ICB is working closely with its provider partners the University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and the University Hospitals of North Midlands NHS Trust (UHNM).

UHDB run the services that are offered in Samuel Johnson Community Hospital, Lichfield and UHNM run the services that are offered at County Hospital, Stafford.

Derby and Derbyshire ICB are the organisation who hold the contract for UHDB.

Intrapartum services in Staffordshire and Stoke-on-Trent in recent years have been provided from a number of locations as listed below and identified on the map.

- Consultant led units in Royal Stoke University Hospital (1) and Queen's Hospital Burton (2)
- Alongside midwife led units/services in Royal Stoke University Hospital (1) and Queen's Hospital Burton (2)
- Freestanding Midwifery birth units at County Hospital, Stafford (3)[*] and Samuel Johnson Community Hospital, Lichfield (4)
- Homebirth services

[*] The West Midlands Clinical Senate undertook a Stage 2 Clinical Assurance Review in 2018 related to the Freestanding Midwifery-led Birth Unit at County Hospital Stafford. This report is published and available on the Midlands Clinical Senates website.

Freestanding Midwifery Birth Units (FMBUs) are midwifery-led units, separate from a hospital site, where some pregnant people (considered low-risk) can choose to give birth. They do not have immediate obstetric, neonatal, or anaesthetic care, so people may need to be transferred to an acute hospital if there are complications during or after birth.

In 2020, at the beginning of the Covid-19 pandemic and in line with national guidance, birthing services at both FMBUs were temporarily suspended to consolidate the workforce at the main acute sites.

Home birth services have also been intermittently suspended following the pandemic and neither Trust have been able to sustainably reinstate these services due to the ongoing midwifery staffing workforce shortage. The Trusts are looking to reinstate the booking of women into the home birthing service from April 2024.

Whilst the initial FMBU closures were directly related to Covid-19, significant staffing challenges in the maternity workforce have prevented both Trusts from being able to safely reopen these units to intrapartum services.

Both Trusts continue to provide antenatal and post-natal care at their FMBUs and offer the choice of a consultant-led or midwifery-led birth at Royal Stoke University Hospital and Queen's Hospital Burton.

At the time of the temporary closure, the transformation of maternity services had already begun and the ICB has completed various involvement activities to understand people's experiences of using maternity services. During 2019 and 2020, a range of activities were undertaken to listen to people and understand what worked well and what could be improved in health and care services as well as seeking views on emerging models of care and criteria for evaluating proposals. In 2021, post pandemic feedback was sought, together with views on the Homebirth services and new models of care proposed at that time.

More recently, the ICB have been working with colleagues from UHNM, UHDB and Derby and Derbyshire ICB to outline the current position in relation to the FMBUs and consider proposals for the future, as each Trust is using their workforce in a different way to deliver safe services.

At a technical event held in September 2023, clinicians reviewed seven potential proposals to develop a shortlist of viable proposals. These were assessed against six essential criteria. During the event it was recommended that only one proposal is viable at this stage - which is to make permanent the temporary closure of intrapartum birthing services at County hospital and Samuel Johnson hospital.

Aims and objectives of the clinical review

The sponsoring organisation consider their preferred option to be a viable proposal as the current service provision, with women receiving antenatal and post-natal care

at their FMBUs if this is their preference - with the choice of a consultant-led or midwifery-led birth at Royal Stoke University Hospital or Queen's Hospital Burton. Women also have the choice of alternative providers outside of Staffordshire and Stoke-on-Trent. The Trusts are looking to reinstate the booking of women into the home birthing service from April 2024.This will ensure women are offered the choice of place of birth recommended by the National Perinatal Epidemiology Unit (NPEU) Birthplace Study, Better Births and the National Institute of Clinical Excellence (NICE).

The Clinical Senate team has been asked to review the information provided by Staffordshire and Stoke-on-Trent ICB, University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and University Hospitals of North Midlands NHS Trust (UHNM) and to consider the proposal presented.

The proposal needs to be considered alongside the maternity clinical model, which is:

- No change to the provision of consultant-led services
- Midwifery-led care would continue to be offered at Royal Stoke Hospital and Queen's Hospital Burton, alongside consultant-led units
- Reintroduction of and grow the homebirth services
- Develop and grow a continuity of carer model for the most vulnerable in the county
- Antenatal and postnatal care will continue at the FMBUs

The panel are specifically asked to consider:

1. If they support the proposal to make permanent the temporary closure of the birthing/intrapartum service at the Freestanding Midwifery birth units at County Hospital, Stafford (3) and Samuel Johnson Community Hospital, Lichfield (4).
2. Does the clinical model consider the wider interdependencies of the maternity/birthing pathway, specifically around safe care during unexpected complications?
3. Does the proposed model align with national and local strategies to make maternity care safer, more personalised and equitable for all?

4. If there are factors that the panel thinks need further consideration, which have not been covered. This should include a review of any potential unintended risks/consequences, patient experience and patient outcomes with consideration given to addressing health inequalities.

Scope of the review

This clinical review of maternity services will focus on the birthing services (intrapartum) aspect of the pathway that were offered at the FMBUs until 2020 and the proposal for these sites going forward. Within scope is also the reintroduction of the home birthing services as this supports the birthing options for women.

When reviewing the case for change and options appraisal the Clinical Review Panel should consider (but is not limited to) the following questions:

- Will these proposals deliver real benefits to patients (access/clinical outcomes/quality*)? For example, do the proposals reflect:
    - The rights and pledges in the NHS Constitution?
    - The goals of the NHS Outcomes Framework?
    - Up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Is there evidence that the proposals will improve the quality, safety and sustainability of care? For example:
    - Do the proposals align with local joint strategic needs assessments, commissioning/ICB plans and joint health and wellbeing strategies?
    - Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?
    - Is there a clinical risk analysis of the proposals, and is there a plan to mitigate identified risks?

* Quality (safety, clinical effectiveness and patient experience)

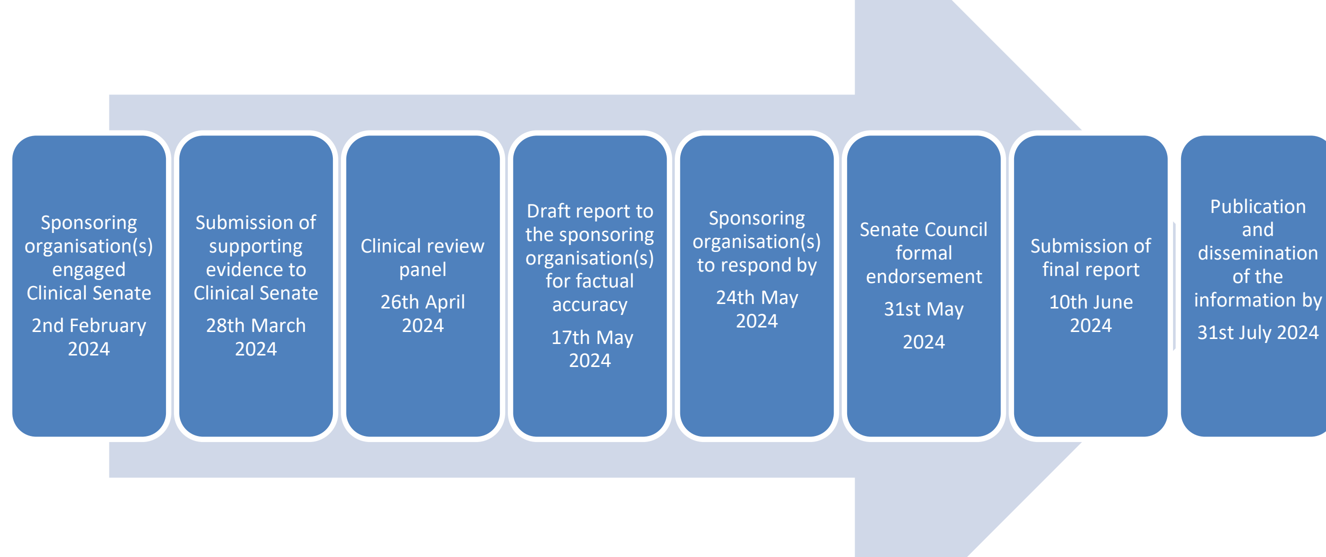
- Do the proposals meet the current and future healthcare needs of their patients?
- Do the proposals demonstrate good alignment with the development of other health and care services?
- Do the proposals support better integration of services?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Do the proposals consider the workforce requirements and transformation required to deliver this new model?

The Clinical Review Panel should assess the strength of the evidence base of the clinical case for change and proposed models. Where the evidence base is weak then clinical consensus, using a voting system if required, will be used to reach agreement. The Clinical Senate Review should indicate whether recommendations are based on high quality clinical evidence e.g. meta-analysis of randomised controlled clinical trials or clinical consensus e.g. Royal College guidance, expert opinion.

Timeline

The lead in time for clinical reviews is a minimum of 10-12 weeks' notice due to Senate members working in a voluntary capacity (which allows sufficient time for clinical commitments to be covered and the appropriate notice to be given if required) and also due to the preparation and planning requirements in the lead up to the review. It is highly unusual that a system/provider would make a unilateral decision to stand down a Senate review and this should be considered as exceptional circumstances only and certainly not within 6 weeks before the planned review day itself given the commitment that will already have been made by Senate panel members. It is essential that the sponsoring organisation(s) is committed to the review timeline and process before formally engaging the Clinical Senate and

agreeing a clinical review date. Any concerns should be discussed with the Head of Clinical Senates at the earliest opportunity.



A full Senate review and site visit will include time during the day spent with both senior and frontline staff working in the services and sometimes walking around a department/pathway(s). The clinical review team may wish to determine which professional staffing groups and roles it would like to have access to as part of the review process. On occasion, it may be helpful for a smaller number of panel members to visit a site/organisation before the review day itself if not all areas can be covered in a day and this is deemed essential by the clinical review team.

The above timeline includes a pre-visit on 18th April to UHNM (Royal Stoke) in the morning and UHDB (Queen's Hospital Burton) in the afternoon. This will likely be no more than 2-3 panel members with specific expertise supported by a member of the core Senates' team.

Reporting arrangements

The clinical review team will report to the Clinical Senate Council which will agree the report and be accountable for the advice contained in the final report.

Clinical Senate Council will report to the sponsoring organisation(s) and this clinical advice will be considered as part of the NHS England assurance process for service change proposals (if appropriate).

Methodology

The sponsoring organisation(s) has agreed to collate and provide the following supporting evidence to the Clinical Review Panel, and to reference the evidence base wherever possible when drawing on clinical guidelines and national best practice. The evidence submitted will be meaningful and credible. To support the development of the evidence submission, the sponsoring organisation(s) will have consulted the Suggested Minimum Evidence Requirements document provided by the Senates team as part of the review process. *The duty is on the sponsoring organisation(s) to make sure the supplied material is only relevant to the review.*

- Clinical case for change and a summary of the current position and proposed alternative service/care model
- Copies of Quality Impact Assessments
- Information pertaining to/copies of any evaluation criteria used to shape the proposals/options appraisal required for the Pre-Consultation Business Case such as the hurdle criteria (please see document provided entitled “Suggested Minimum Evidence Requirements” where relevant)
- Impact of withdrawing/reconfiguring services, including risk register and mitigations
- How proposals reflect clinical guidelines and best practice, the goals of the NHS Outcomes Framework and Constitution
- Alignment with local authority joint strategic needs assessments and a narrative around health inequalities and demographics e.g. HEAT Tool (Health Equity Assessment Tool) and Equality Impact Assessment (EIA)
- Evidence of alignment with organisational/system plans
- Evidence of how any proposals meet future healthcare needs, including activity modelling, pathways, and patient flows
- Demonstrate how patient access and transport will be addressed
- Demonstrate how any implications on the Ambulance Service will be addressed

- Consideration to a networked approach
- Education and training requirements
- Implications on workforce (to be able to demonstrate alignment to new ways of working, and to describe how the future workforce will look to support any new models of care/reconfiguration proposed)
- Implications for the workforce (to describe how the workforce will be engaged, supported and motivated to work in new ways and in new places that support any new models of care/reconfiguration proposed)
- Implications for the clinical support services and those staff (e.g. clinical engineering, radiology, pharmacy)
- SHAPE (Strategic Health Asset Planning and Evaluation) Place Atlas, which helps organisations to consider the evaluation of the impact of service configuration on proposals and assess the optimum location of services
- Core service inspection reports (i.e. CQC)
- Public, patient and staff engagement plans and particularly, evidence of patients' experiences of services (including any engagement with or involvement by patients and public at the earliest developmental design stages of any proposed services changes)
- Evidence of consideration to the sustainability and environmental impact of these proposals
- Clinical framework for presenting evidence and considering multiple site single service models of care (recommended clinical framework can be found here: Midlands Clinical Senates - Proactive Projects (midlandssenates.nhs.uk))

All evidence should be submitted three weeks prior to the review date as specified in the TORs. Any allowances to this should be agreed with the Head of Clinical Senates (or one of their deputies) and only in exceptional circumstances can we consider a late submission. Any evidence received within 48 hours of the review will likely not be shared with panel members and may not be considered within the review process unless prior agreement with the Head of Clinical Senates (or one of their deputies).

Report

A draft clinical senate report will be circulated within 15 working days of the final meeting - to team members for comments, to the sponsoring organisation(s) for fact checking.

Comments/corrections must be received within a further 5 working days.

The final report will be submitted to the sponsoring organisation(s) by 10th June 2024.

Communication and media handling

The clinical senate will publish the final report on its website once it has been agreed with the sponsoring organisation(s). The sponsoring organisation(s) is responsible for responding to media interest once in the public domain.

Disclosure under the Freedom of Information Act 2000

The West Midlands Clinical Senate is hosted by NHS England and operates under its policies, procedures and legislative framework as a public authority. All the written material held by the clinical senate, including any correspondence you send to us, may be considered for release following a request to us under the Freedom of Information Act 2000 unless the information is exempt.

Resources

The senate(s) office will provide administrative support to the review team, including setting up the meetings, taking minutes and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation(s).

Accountability and Governance

The clinical review team is part of the West Midlands Clinical Senate's accountability and governance structure.

The West Midlands Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation(s).

The sponsoring organisation(s) remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation(s) may wish to fully consider and address before progressing with their proposals.

Functions, responsibilities and roles

The **sponsoring organisation(s)** will

- provide the clinical review panel with all relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and projections, evidence of alignment with national, regional and local strategies and guidance
- respond within the agreed timescale to the draft report on matters of factual inaccuracy
- undertake not to attempt to unduly influence any members of the clinical review team during the review. Additionally, all communication (verbal and written) throughout the whole process should be addressed to the Head of Clinical Senates or an appropriate identified deputy
- submit the final report to NHS England for inclusion in its formal service change assurance process (if appropriate)
- arrange and bear the cost of a suitable venue and light refreshments (as advised by the senate(s) office) for the panel

Clinical senate council and the sponsoring organisation(s) will

- agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements

Clinical senate council will

- appoint a clinical review team; this may be formed by members of the senate, external experts, or others with relevant expertise. It will appoint a chair or lead member
- endorse the terms of reference, timetable and methodology for the review

- endorse the review recommendations and final report
- provide suitable support to the clinical review team

Clinical review team will

- undertake its review in line with the methodology agreed in the terms of reference
- follow the report template and provide the sponsoring organisation(s) with a draft report to check for factual inaccuracies
- submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council
- keep accurate notes of meetings

Clinical review team members will undertake to

- Commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology)
- contribute fully to the process and review report
- ensure that the report accurately represents the consensus of opinion of the clinical review team
- comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally, they will declare, to the chair or lead member of the clinical review team and the Head of Clinical Senates, any conflict of interest prior to the start of the review and /or which may materialise during the review

Appendix B: Summary of documents provided by the sponsoring organisation as evidence to the panel

The following documents were provided as evidence to the Clinical Review Panel received on 27th March 2024 and were made available to the clinical review team though the Senate's Document Management System on the same day:

- Contents.docx
- Document 00_FMBU Evidence for WMCS – 26March2024(1).docx
- West Midlands Clinical Senate Meeting Submission.pdf

Further documents, as requested by the Clinical Senate, were received on 9th April and shared with the panel:

- Maternity and Neonatal risks 4th April 2024.pdf
- Maternity data – UHDB – 2019-23
- Maternity data – UHNM – 2019-23
- LMNS Maternity data – 2324 – M11

Final documents were received by the Clinical Senate further to its pre-meet on 16th April and shared with the clinical review panel upon receipt on 19th April:

- Maternity_Clinical Senate presentation FINAL.pdf
- West Midlands Clinical Senate Group Sessions Scheule FMBU v1.odt
- Staffordshire and Stoke-on-Trent LMNS Equity and Equality Action plan
- Staffordshire and Stoke-on-Trent Equity and Equality analysis with supporting documents
- Derby and Derbyshire LMNS Equity and Equality Action plan
- Job description for EDI midwife that will be based at UHNM. Please note this is in draft and subject to final approval

A link to a short video for the FMBU at Samuel Johnson Midwifery Led Maternity Unit at Samuel Johnson Community Hospital (youtube.com) was also provided ahead of the review as a site visit did not take place at Samuel Johnson Community Hospital.

Appendix C: Clinical review team members and their biographies, and any conflicts of interest

Name	Role	Organisation	Conflict of Interest
Angela Holden	ST6 Respiratory & General Internal Medicine Previous Clinical Leadership Fellow	University Hospitals Birmingham NHS Foundation Trust Midlands Clinical Senates	None
Barbara Edwards	Senior Lecturer- Adult Nursing	School of Health Science and Wellbeing, Staffordshire University	Barbara is a Staffordshire University Liaison/Link with UHDB Trust for Adult Nursing
Dawn Lewis	Lead for Governance and Quality	Black Country Local Maternity and Neonatal Services	Employee of Black Country ICB. This is declared in the spirit of transparency as Black Country LMNS have buddying arrangements with an MOU with Stafford and Staffordshire ICB
Ellen Jones	Associate Postgraduate Dean	Workforce Training and Education Directorate - NHS England	None

	Consultant in Emergency Medicine	University Hospitals Birmingham NHS Foundation Trust	
Gillian Richards	Patient Representative	West Midlands Clinical Senate	None
Jason Evans	Deputy Director Chair	West Midlands 999 and NHS 111 Commissioning Team National Ambulance Commissioners Network (NACN)	None
Joe Seager	Consultant Anaesthetist	The Dudley Group NHS Foundation Trust	None
Jyothi Nippani	Consultant Gynaecologist National Clinical Lead - Hospital Transformation Clinical Director - Emergency and Elective Improvement Support Team	South Warwickshire Foundation Trust NHS England (ECIST)	None
Mandy Clarkson	Healthcare Public Health Consultant	NHS England – Midlands	None
Matthew Parsons	Consultant Obstetrician and Gynaecologist	Birmingham Women's and Children's NHS Foundation Trust	None
Natalie Whyte	Patient Representative	West Midlands Clinical Senate	None

Richard Mupanemunda	Consultant in Neonatal Medicine	University Hospitals Birmingham NHS Foundation Trust	Chaired the clinical oversight group which was charged with steering the WMODN from July 2019 until June 2022. Panel member for the WMCS review in 2018 for UHNM regarding the MLU at County Hospital
Shehla Imtiaz-Umer	GP Partner EDI Director Previous Clinical Leadership Fellow	Wilson Street Surgery The Hub Plus Midlands Clinical Senates	None
Simon Brake	Professor of Clinical Leadership & Management	University of Warwick	Chaired the WMCS review in 2018 for UHNM regarding the MLU at County Hospital
Tony Thomas	Consultant Obstetrics & Gynaecology	Walsall Healthcare NHS Trust	None
Vanessa Barrett	Patient Representative	West Midlands Clinical Senate	None

Clinical Senate Support Team

Emma Orrock – Head of Clinical Senates, NHS England

Chris Harris – Senior Programme Manager, East Midlands and West Midlands Clinical Senates, NHS England

Biographies

Angela Holden

Specialist Registrar in Respiratory Medicine

University Hospitals Birmingham NHS Foundation Trust

Angela is a specialist registrar in Respiratory Medicine working in the West Midlands. She graduated from the University of Birmingham in 2015 and has remained in the West Midlands for her training so far.

She has interests in leadership and management and education, having completed a year as RCP Chief Registrar and also a Simulation Fellowship. Her clinical interests include bronchiectasis and cystic fibrosis.

Barbara Edwards

Adult Nurse and Senior Lecturer

Staffordshire University

Barbara is an adult nurse and senior lecturer at Staffordshire University.
She is involved with teaching for BSc Nursing Practice for Adult, Child and Mental Health students and Nursing Apprenticeship courses.
She has worked in higher education since 2020 moving from clinical practice during the Covid-19 pandemic.
Her clinical background has focussed on long term conditions and then cancer and palliative care.
Her last clinical post was a specialist role centred around primary and metastatic bone cancers and specifically Metastatic Spinal Cord Compression.

Dawn Lewis

Black Country LMNS Lead Midwife Risk and Quality Assurance

Dawn initially trained as a nurse in 1983 in Birmingham and then later as a midwife in 1995 in Wolverhampton. After working at New Cross for several years Dawn worked in a number of midwifery roles across the Black Country and Staffordshire, taking some time out of midwifery to work as a Health Development coordinator for Walsall PCT. Returning to midwifery in 2009 in a variety of leadership roles across the Black Country. After retiring as the Head of Midwifery at Dudley Group NHS Trust in 2021

Dawn has returned to work part time in the Black Country LMNS. Dawn is passionate about ensuring services are safe, equitable and personalised with women and their families at the centre of care.

Ellen Jones
Associate Postgraduate Dean, Workforce Training and Education Directorate - NHS England
Consultant in Emergency Medicine, University Hospitals Birmingham NHS Foundation Trust
Ellen is a consultant in Emergency Medicine at University Hospitals Birmingham and Associate Postgraduate Dean at NHS England.
She has previously been Head of School of Emergency Medicine training in the West Midlands and Head of Undergraduate Academy at Heart of England NHS Trust. She has been involved in the development of Advanced Clinical Practitioner credentialling at Royal College of Emergency Medicine and co-chaired a national project to develop and implement leadership training for Emergency Medicine trainees.

Gillian Richards
Patient Representative
Gill worked in the NHS for over 20 years in a variety of departments including outpatients and inpatient wards, before going onto A&E and children's mental health services.

Gill supported NHS England with its Passport to Health GP surgeries and sugary drinks in hospitals and offered personal insights into engaging marginalised groups. Gill was part of the interview panel for the appointment of the chief executive of NHS England.

Gill is a research Ambassador for the West Midlands National Institute for Health Research and on their Equality and Diversity Group. More recently she has focused her efforts in the voluntary and community sector, whilst also being a member of Birmingham and Solihull HealthWatch for 8 years. In 2023, Gill was appointed as a Patient and Public Involvement (PPI) representative onto the West Midlands Senate Council and is looking forward to bringing her valuable insights and patient voice into

the Clinical Senate's work, particularly from an Ethnic Minority perspective. Gill is the proud mother of two wonderful sons.

Jason Evans
Deputy Director, West Midlands 999 and NHS 111 Commissioning Team
Chair, National Ambulance Commissioners Network (NACN)
For over twenty-five years in a local and regional context Jason has held roles in public health and NHS senior commissioning. As a result, he has extensive experience of working with patients, the public, clinicians and wider stakeholders to design, commission and performance manage high quality, safe and efficient NHS services.

In 2014 Jason's career shifted into the challenging field of urgent and emergency care commissioning, going on to secure in 2020 appointment as Accountable Lead for West Midlands Integrated Urgent & Emergency Care Service (IUEC). Overseeing the performance, quality, and transformation of a £350+ million portfolio of 999 emergency ambulance and NHS 111 services, for the 6.2 million people of the West Midlands.

Jason is chair of the National Ambulance Commissioners Network (NACN) and a regular contributor to central policy development and transformational programmes for 999 and NHS 111 services across England. He is a qualified emergency planning officer and the executive commissioning lead for Emergency Preparedness Resilience and Response (EPRR) for West Midlands IUEC.

Complementing his commissioning experience, Jason is a graduate of the NHS Leadership Academy INTERSECT system leadership programme and long-standing member of West Midlands Clinical Senate Assembly.

Joe Seager
Consultant Anaesthetist
The Dudley Group NHS Foundation Trust
Joe graduated from Brimingham Medical School in 2010 and completed his post-graduate training at a variety of hospitals in the West Midlands. He works as a Consultant Anaesthetist at Russells Hall Hospital in Dudley and is currently the

clinical lead for Obstetric Anaesthesia and Emergency Theatres. Joe is passionate about improving anaesthetic care and pathways for both obstetric patients and patients requiring emergency surgery.

Jyothi Nippani
Consultant Gynaecologist, South Warwickshire Foundation Trust
Jyothi is a Consultant Obstetrician and Gynaecologist at the South Warwickshire University NHS Foundation Trust Group and AMD for Service improvement. She has been the AMD for the Emergency Division. She is currently the National Clinical Lead for Hospital Transformation in the admitted pathways. She is also the Clinical Director in NHS England - Emergency and Elective Improvement.

She has completed her Masters in Medical Leadership and has been formally trained as a flow coach with the Sheffield Microsystem Academy. She is keen in LEAN methodology as an improvement science in health care settings.

She has led on Acute Flow Programmes in the Trust, including implementation of extended day and 7 days working, speciality in reach, speciality rightsizing, annualisation of consultant job planning to allow for emergency flow, Hospital @night and frailty.

Mandy Clarkson
Deputy Director of Public Health
NHS England – Midlands
Mandy is a consultant in health care public health, providing advice and support to the NHS at regional and local system levels. She is a registered adult nurse, with a background mostly in community nursing. Mandy began her public health career in health protection before training in the East Midlands and subsequently working in various local authority and NHS roles.

Matthew Parsons
Consultant Obstetrician and Gynaecologist
Birmingham Women's and Children's NHS Foundation Trust

Matthew qualified from the University of Bristol in 1993 and undertook post-graduate training in SE Thames (SHO) and NE Thames (Registrar) Deaneries. He undertook a Clinical and Research Fellowship in Urogynaecology at King's College Hospital with Professor Linda Cardozo, leading to the award of Doctor of Medicine (King's College, London). He is now a Consultant Obstetrician and Gynaecologist, with interest in Pelvic Floor Medicine, and Urogynaecology, at Birmingham Women's Hospital, since 2005.

Until earlier this year, Matthew was Clinical Service Lead for the Maternity Division; he is now Clinical Service Lead for Pelvic Floor Medicine and Surgery (within Gynaecology) and OASI/Perineal Trauma (within Maternity). He is also Honorary Secretary and a Council Member for the UK Continence Society.

Natalie Whyte
Patient Representative
Natalie is a dedicated service user voice representative in maternity and neonatal services. Natalie brings a wealth of passion and expertise to the NHS. With a background in education, Natalie has seamlessly transitioned into advocating for improved services within the NHS, particularly in the East and West Midlands regions.

Driven by a deep-seated passion for enhancing the quality of care provided to parents and newborns, Natalie actively engages with various stakeholders to champion initiatives that prioritise patient well-being. Her commitment to ensuring that every individual receives the highest standard of care is evident in her unwavering dedication to this cause.

Natalie leverages her skills to educate upcoming midwifery students regarding best practices in the holistic needs of service users and their voice. By sharing her lived experience, knowledge and insights, she empowers students to make informed decisions regarding their practice.

Natalie's involvement with the East Midlands and West Midlands Clinical Senates underscores her proactive approach to driving positive change. This is demonstrated

by her involvement, collaborating and co-production with the Senates and key stakeholders.

Recognising the importance of diversity and equality, Natalie advocates for services that promote inclusivity and fairness. By amplifying voices from underrepresented communities, she strives to create a more inclusive environment that caters to the diverse needs of all individuals.

Natalie aims to bring her expertise and lived experience to the forum of the Clinical Senates to be instrumental now and in future projects to bring about meaningful change.

Richard Mupanemunda
Consultant in Neonatal Medicine
University Hospitals Birmingham NHS Foundation Trust

Richard has been a Consultant in Neonatal Medicine at the University Hospitals Birmingham NHS Foundation Trust for over 26 years and has been service lead for the neonatal service with over 11,000 annual births.

Richard has actively supported Neonatal Networks from their inception and was the inaugural chair of the West Midlands Neonatal Operational Delivery Network formed following the merger of the Southern West Midlands Maternity and Newborn Network and the Staffordshire, Shropshire, and Black Country Neonatal Operational Delivery Network.

Richard has interests in Medical Law, Ethics and Healthcare Education and has authored medical texts on Neonatology. Richard is the vice chair of the West Midlands - Solihull, Research Ethics Committee. Richard is also an Honorary Senior Clinical Lecturer at the University of Birmingham.

Shehla Imtiaz-Umer
GP Partner & EDI Director
Wilson Street Surgery Derby and The Hub Plus

Shehla is a GP Partner at Wilson Street Surgery in Derby. She graduated from the University of Leicester with a BSc in Medical Biochemistry before completing an MSc in Molecular Pathology and Toxicology.

Shehla then worked in pharmaceutical and academic research before commencing her medical degree and graduated from the University of Nottingham (Graduate-Entry Medicine) programme in 2012. Shehla undertook her postgraduate training across the East Midlands and completed GP training in 2019.

Alongside her current GP role, she is also the Equality, Diversity and Inclusion (EDI) Director for The Hub Plus, working to identify and address workforce-related inequities which impact patient care. Shehla also works as a GMC Associate with a particular focus on the PLAB2 exams. Her additional areas of interest are medical education and health inequalities.

Simon Brake
Professor of Clinical Leadership and Management
University of Warwick

Simon is a senior leader and chief officer working across academic, health service and government fields, having worked in a variety of roles at local, sub-regional, regional and national levels for over twenty-five years. Simon has been qualified since July 1995, having graduated from the University of Warwick, and gained his professional membership of the IHM (the Institute of Healthcare Management) in 1996, appointed a fellow of the IHM (by Assessment) in 2004, and a Masters of Public Administration (MPA) from the Warwick Business School (2007). In 2008 he gained a Post Graduate Certificate in Conflict Resolution Studies from Coventry University, his NHS England Clinical Commissioning Leadership National Accreditation in 2017 and holds academic and visiting professorships at the University of Warwick & Coventry University.

Simon has worked in a variety of general and senior management roles across health and social care, within the National Health Service in hospitals, commissioning, and central government policy until 2006, then as a senior officer for Coventry City Council. From 2015, Simon worked as a chief officer working in primary and community care across the NHS and local system, and then as the CCG

Chief Officer until 2019. In his current post, since 2019, Simon works as Chief Engagement & Innovation Officer and Professor at the University of Warwick Medical School, and as Group Director for Research & Development for the SWUFT Foundation Group of 4 NHS Trusts.

Simon undertakes several national and regional ministerially appointed and public NED roles, as well as expert committee membership for government, and during the pandemic, was seconded into the national emergency response as a senior civil servant & returning to NHS service in the local community, alongside his university duties.

Tony Thomas
Consultant Obstetrics & Gynaecology
Walsall Healthcare NHS Trust
Tony is Consultant Obstetrician and Gynaecologist at the Manor Hospital, Walsall Healthcare NHS Trust and has been in this role for 12 years. Walsall is a District General Hospital affiliated to the University of Birmingham Medical School and Aston University Medical School.
Tony is also the unit Lead Gynae-Oncology and is the training Programme Director for HEE Obstetrics and Gynaecology Specialty Training Programme.

Vanessa Barrett
Patient Representative
Since 2013 Vanessa has been a Trustee (and is currently Chair) of Healthwatch Shropshire. This is an independent organisation accredited by the Charities Commission, which seeks to act as a ‘critical friend’ to the health and social care services provided in the County, using the information it receives from the public on their experiences of using these services.

She applied to become a representative of patients and the public on the Clinical Senate because of her conviction of the importance of engaging effectively with the public at all stages of service change.

Vanessa qualified as a nurse in the 1960s and worked for 40 years in the NHS in a wide variety of roles. These included Director of Nursing in an acute London hospital,

Director of Commissioning in a District Health Authority and 10 years within West Midlands Regional Office (DoH) and successor strategic health authorities. She retired in 2007.

Will Taylor
GP Partner, Lordswood Medical Group (Our Health Partnership)
Chief Medical Officer, Herefordshire and Worcestershire ICB

Will has been a GP partner in South Birmingham since 2007. He is passionate about the integration of care and the role of General Practice within this. When CCGs came to being, he became interested in commissioning and what General Practice could bring to this new system.

He was appointed as contracting lead for University Hospitals Birmingham NHS Foundation Trust for Birmingham Cross City CCG. When the CCGs merged, he worked as the Clinical Director for Integration covering primary care, community care, urgent care and long-term conditions, then as the Deputy Chief Medical Officer for Birmingham and Solihull CCG, and finally as Chair of the CCG. He is now the Chief Medical Officer on the Herefordshire and Worcestershire ICB.

During his time working within Birmingham Cross City CCG, he worked with a small group setting up a large Super-partnership "at scale" General Practice organisation and sat on its board, from which he stood down when he took up the Clinical Director role within Birmingham and Solihull CCG.

Will is currently the Vice Chair of the West Midlands Clinical Senate, which gives a fascinating view of what's happening more regionally.

(DRAFT) Equality and Health Inequalities Impact and Risk Assessment (EHIIRA)

Stage 2 Template for Services, Policies & Functions

Birthing Services at County Hospital, Stafford and Samuel Johnson, Lichfield

Please complete all sections of this EHIIRA template and refer to the EHIIRA Guidance document for more information.

For further support or to submit your completed Stage 2 EHIIRA document for approval, contact your Inclusion Business Partner directly or e-mail inclusion.unit@nhs.net

1. Assessment Overview

Name of organisation: Staffordshire and Stoke-on-on-Trent ICB

Assessment Lead Contact: Helen Slater, Associate Director of Transformation (SSOT ICB)

Responsible Director/Board Member for this assessment:

Heather Johnstone, Chief Nursing and therapies Officer (SSOT ICB)

Other contacts involved in undertaking this assessment:

Gina Gill, Transformation Programme Lead (SSOT ICB)
Rachel Clorley, Local Maternity and Neonatal Quality and Safety Midwife (SSOT ICB)
Sarah Jamieson, Director of Midwifery (UHNM)
Sarah Noble, Director of Midwifery (UHDB)

Start Date: **15/01/2024** **Completed Date:** **19/08/2024**

Who is impacted by this service / policy / decision?	Yes	No	Indirectly / Possibly
Patients / Service Users	☑	☐	☐
Carers or Family	☐	☐	☑
General Public	☐	☑	☐
Staff	☑	☐	☐
Partner Organisations	☐	☐	☑

Summary information of the service / policy / decision being assessed:

As part of the ongoing involvement, the ICB and system partners are continuing to review maternity services in Staffordshire and Stoke-on-Trent. As part of this, we are exploring the future of the birthing services at the freestanding midwifery birth units (FMBUs).

These are units at County Hospital in Stafford and Samuel Johnson Community Hospital in Lichfield, where women with low-risk pregnancies could choose to give birth. The two FBMUs were closed for births during the COVID-19 pandemic, to ensure safe staffing at the acute units at Royal Stoke University Hospital and Queen's Hospital, Burton. Whilst the initial closures were directly related to COVID-19, significant staffing challenges in the maternity workforce have prevented both Trusts from being able to safely reopen these units.

Staffordshire & Stoke-on-Trent ICB is currently undertaking a service change programme in relation

to the birthing services that are temporarily closed. The service change programme will be conducting in accordance with the NHSE guidance - Planning, assuring and delivering service change for patients (https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf)

Antenatal and postnatal services continue to run from these sites.

No decisions have yet been made.

What are the aims and objectives of the service / policy / decision being assessed?

To provide a long-term solution for birthing services previously provided at Samuel Johnson Hospital, Lichfield and County Hospital, Stafford.

If this assessment relates to a review of a currently commissioned service or an existing policy, what are the main changes proposed and what are the reasons for the review?

In 2020, in line with national guidance, the birthing units were temporarily closed to consolidate the workforce at the main acute sites.

Due to workforce home births have also been intermittently suspended since the pandemic.

Although feedback on the birthing units was positive prior to the closure, there were signs that partners needed to consider a new approach:

- Birthrate Plus® is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the number of midwives required to provide intrapartum and postpartum care. Birthrate Plus® assessments have been completed at both Trusts. These show that the levels of complexity have continued to rise and even fewer women may be suitable for low-risk care across Staffordshire and Stoke-on-Trent.
- Despite repeated campaigns (prior to the temporary change) to promote the birthing service at the FMBUs, women choosing to give birth there continued to fall.
- Staffing shortages in midwifery are a challenge across the NHS with a shortage of just under 2500 midwives across England (Royal College of Midwives, 5 April 2023).
- Skill mix and sustained competency of midwives is also a key safety factor to consider when birthing numbers are so low.
- The temporary closure alongside revised national guidance has led to new ways of working and the system must now consider the long-term sustainability of services to ensure patients are offered a full choice of where to give birth.

The proposal would make permanent the temporary closure of the birthing service at County Hospital and Samuel Johnson Hospital. Under the proposal:

- There will be no change to the provision of consultant-led services (provided at Royal Stoke University Hospital and Queen’s Hospital Burton)
- Midwife-led care would continue to be offered at Stoke and Burton, alongside consultant-led units
- Home birth services will be reintroduced
- Aim to develop and grow a continuity of carer model for the most vulnerable in the county.
- Antenatal and postnatal care will continue at the FMBUs.

Quality Impacts

- Consistent staff to patient ratios across sites removing the inequity in provision seen when the FMBUs were open
- Midwives' skills and experience are fully utilised in other areas of maternity care such as the alongside midwife-led units and within the home birth service. This also means they can support the delivery of key national requirements e.g. inductions of labour.
- Patients who develop complications would no longer need to be transferred from the FMBU to a hospital unit during advanced labour after already having travelled to an FMBU.
- FMBUs are for low-risk pregnancies only and the vast majority of the population (83%) fall into the moderate to high -risk category. Over time, even fewer women will fall into the low-risk category as data shows pregnancies are becoming more complex. As a result, the FMBUs do not meet the needs of the majority of the population.

What engagement work is planned (or has already been carried out)? How will you involve people from protected characteristics, vulnerable groups, and groups that experience health inequalities to ensure that their views inform this decision-making process?

In recent years, the ICB has completed various involvement activities to understand people's experiences of using maternity services and listen to their ideas on how services could be improved.

Summer 2019: a 12-week listening exercise to understand what is working well and what could be improved in health and care services.

During this exercise the ICB spoke to over 2,000 service users, staff and local communities about different health and care services, including maternity services. The ICB also held focus groups to gain in depth feedback on particular services.

- 76% of all respondents rated maternity services as 'excellent' or 'good' and people said that waiting times were generally good and we had fantastic staff.
- People did however tell us that health visitor clinics, after care and shared records needed improvement. Respondents also stated that distance/access to hospital was an issue.
- New mothers at a breastfeeding support group told us that there was a lack of continuity of care and a need for better access to support services after birth.

January/February 2020: deliberative groups to talk in more detail about maternity services.

Six focus groups were held where the ICB spoke to 25 new expectant mothers and staff who work in maternity services. 40 surveys were also completed. During these groups, the ICB shared the emerging models of care and sought attendees' views on the desirable criteria for evaluating proposals. At the focus groups, people said maternity staff were supportive and compassionate. The facilities and care received at County Hospital and Royal Stoke University Hospital were particularly praised. Continuity of care and access to support services were again raised as issues, along with communication, medical records and access to services close to home.

Summer 2021: As the involvement work was paused in March 2020 to allow partners to respond to COVID-19, the ICB held further listening exercises to understand if any new feedback needed to be considered since the pandemic. Views were also sought on home birth services and the proposed new continuity of carer and on demand models of care.

Prior to COVID-19, respondents told us they were well cared for in labour by supportive and "amazing" staff. Respondents also told us they were well cared for during pregnancy and after birth. Samuel Johnson Community Hospital was praised for its calming environment with respondents telling us staff were responsive and happy to talk through any concerns.

Respondents did however highlight a number of areas they felt required improvement;

- Better support for birth planning
- Getting the right information to promote good choices at each stage of the journey
- Being listened to and treated with respect
- Receiving more help with breastfeeding
- Consistent advice and seeing the same midwife

We heard that things went well for many women - even in the especially challenging circumstances of COVID-19. Respondents shared stories about good, supportive care and positive experiences during pregnancy and labour.

COVID-19 restrictions meant that partners were often not able to be there during appointments, scans, or labour, and this made things much more difficult and sometimes distressing. Many women said they felt very lonely without their partner to support them.

Respondents told us that when planning where to give birth, they considered issues like the location of hospitals. For women who were keen to have a home birth, it was still important to weigh up the distance to travel if emergency care was needed. Some respondents wanted a home birth because they felt they would be more relaxed at home and there would be no limitation on the time their partner could be there.

Respondents told us how important continuity of carer is and that being able to see the same midwife throughout their journey makes them feel more supported and less anxious.
Many liked the idea of the on-demand midwife-led units, although there were concerns about whether the staffing levels would be right, and whether a woman might arrive at the unit before the midwife.

Winter 2023/24: A deliberative event was held with women and stakeholders. The purpose of the event was to:

- Give an overview of the birthing services at the freestanding midwifery birth units (FMBUs) and the proposal for the case for change
- Talk about how the proposal was developed and any challenges faced
- Gather feedback from participants about their own experiences, and about the recommended proposal.

The most recent report of findings following our involvement during winter 2023/24 is appended to this assessment.

Staffordshire and Stoke-on-Trent Maternity and Neonatal Voices Partnership (MNVP) has continued to actively seek feedback from service users through a number of sources whilst the FMBU birthing service and the home birth service have been temporarily suspended.

The MNVP is currently reviewing how to engage and recruit maternity champions from seldom heard groups. This will further support a mechanism for reaching out to engage with women and families that we have not previously heard from.

Is this proposal likely to affect health inequalities – either positively or negatively? YES ☑ / NO ☐

Please provide rationale for your answer below:

A positive impact is expected with regard to equity of provision.

There are national recommendations regarding the ratio of clinical midwives to the annual number of births to assure safe staffing levels. Trusts must use a NICE-endorsed toolkit to calculate the required midwifery staffing establishment. The Birthrate Plus® tool is utilised within UHNM and UHDB and calculates staffing requirements based on their specific activity, case mix, demographics and skill mix within their areas.

The low number of births at the FMBUs meant there was an inequity for women depending on which site they attended. Were the FMBUs to re-open this inequity would remain as the limited number of midwives means that a disproportionate level of resources would be needed to support the FMBU and results in the higher-risk pregnancies receiving less support.

Making permanent the temporary closure of the FMBUs removes this inequity.

What evidence have you considered to inform your decision-making within this assessment?

The more evidence you are able to provide in this section, the better informed your decision-making will be. Such evidence may include NICE guidance, clinical research, literature reviews, quality and performance data, workforce metrics, engagement findings, demographic data, community intelligence, health inequalities data (RightCare profiles, JSNA), etc.

National Guidance

- National Maternity Review: Better Births (2016)
- NHSE Saving Babies' Lives Care Bundle V2 (2019)
- NHS Long Term Plan (2019)
- Ockenden review (2021)
- Birthplace in England Research Programme (2011)
- Operational planning guidance for (2023/24)
- Three year delivery plan for maternity and neonatal services (2023)
- NHS Choice Framework (2024)
- The Equality Act 2010 and the public sector Equality Duty
- Human Rights Act 1998

Local Strategy

- Staffordshire and Stoke-on-Trent Joint Forward Plan (2023-2028)
- Staffordshire and Stoke-on-Trent Integrated Care Partnership Strategy (2023)
- Staffordshire and Stoke-on-Trent Operational Plan (2023/24)
- Staffordshire and Stoke-on-Trent Maternity and Neonatal Equity and Equality Action Plan
- Birthrate Plus® workforce planning tool
- Derby and Derbyshire Joint Forward Plan 2023/24 – 2027/28
- Derby and Derbyshire Integrated Care Strategy 2023
- NHS Derby and Derbyshire Operational Plan 2023-2024

- Derby and Derbyshire Maternity and Neonatal Equity and Equality Action Plan 2022 – 2027 Maternity services » Joined Up Care Derbyshire

Local Evidence

Involvement feedback

A summary of the feedback from various involvement activity is included in Section 1.
The outcomes from the involvement activity is included on the ICB maternity transformation webpage Maternity transformation - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk) The most recent report of findings following our involvement during winter 2023/24 is appended to this assessment.

A review of wider involvement activity was undertaken and feedback specific to maternity and neonatal care was collated to inform service transformation. This also has been appended to this assessment.

Clinical Sustainability

FMBUs are for low-risk pregnancies only. A Birthrate Plus® assessment completed for UHNM in 2022 showed that pregnancies are becoming more complex. Just over 83% (5,102) of all pregnant women in UHNM's delivery suite are either moderate or high-risk pregnancies. This means that just under 17% (1,045) of all pregnancies are suitable for low-risk care – compared to 29% in 2017/18 (West Midlands Clinical Senate review).

There are around 11,000 births for the Staffordshire and Stoke-on-Trent population when we include births at all hospitals. If we apply the trends being seen at UHNM to give an estimate of the levels of low and moderate or high-risk pregnancies, this means we would expect 9,130 pregnancies each year to be moderate or high-risk, and 1,870 pregnancies to be low-risk.

Although UHNM ran campaigns to promote the FMBU at County Hospital, the number of births there continued to fall, as most low-risk women were choosing to give birth in the midwife-led units at the main hospitals instead.

UHDB is in a similar position and the majority of pregnancies are high-risk. Over time more pregnancies are likely to be classed as moderate or high-risk.

Workforce Sustainability

Providing safe services is vital. Recent investigations into maternity services have emphasised how important it is to maintain safe staffing levels in line with Birthrate Plus®. Both trusts have had Birthrate Plus® assessments, and both have run recruitment campaigns but remain short of the full staffing complement identified within the Birthrate Plus® assessments.

To run the birthing services at the FMBUs and safely staff them 24/7, a minimum of just over 11 staff (whole-time equivalent) would be needed for each unit.

Staff shortages mean that, at present, the trusts cannot staff the FMBUs for births as well as safely staffing the services at Royal Stoke University Hospital and Queen's Hospital, Burton.

There are national recommendations regarding the ratio of clinical midwives to the annual number of births to assure safe staffing levels. The recommended ratio is one full-time midwife for every 28 births at a hospital and in the community. Due to the low numbers of births at the FMBU at County Hospital, the ratio of midwives to women with low-risk births was 1:7 when it was open. In comparison, there was one midwife to every 30 women with more complex, high-risk births.

UHDB are in a similar position as they also saw low numbers at the FMBU at Samuel Johnson Community Hospital – there were fewer clinical midwives to the number of complex high-risk births compared to the ratio for low-risk births. For both trusts, this means there would be an inequality in provision for those giving birth in the hospitals if the FMBUs were reopened – because, with a limited

number of midwives, a disproportionate level of resources would be needed to support the FMBU. This would result in the higher-risk women getting less support.

As the number of women with low-risk pregnancies is getting lower, consideration has been given to:

- whether it is viable to re-open the units
- whether it would make the best use of our workforce if we did, because the low number of births mean midwives will struggle to maintain their skills and competencies if they are based at an FMBU.

This was considered alongside how and when the home birth services – also for low-risk pregnancies only – can be made available again.

We also needed to take into consideration what this means for health services overall – not having enough staff and not maximising use of our estate contributes to a worsening financial position for the local NHS.

Travel impacts
Travel time analysis was commissioned to understand the impact of the proposal on travel time.

The analysis covered a range of scenarios:

Actual time: Time that women actually travelled from their home address to either County or Samuel Johnson.
Baseline: With County and Samuel Johnson still open and this situation is based on travel time to the nearest maternity site within Staffordshire (i.e. County, Samuel Johnson, Royal Stoke or Burton). This is assuming women travel to their nearest site, which is not actually the case as women have opted to travel further to use County and Samuel Johnson.
Scenario 1: All activity that would have happened at County or Samuel Johnson moves to the nearest site within Staffordshire, i.e. Royal Stoke or Burton.
Scenario 2: All activity that would have happened at County or Samuel Johnson moves to the nearest site, either within Staffordshire or to an external provider site if nearer.
Scenario 3: All activity that would have happened at County or Samuel Johnson moves to the nearest site within Staffordshire (i.e. Royal Stoke or Burton) or to a nearer external provider if the site has a midwife-led unit. In this scenario activity it is assumed that women will only travel outside of Staffordshire to attend an MLU if it is the nearest site, otherwise it is assumed they will travel to Royal Stoke or Burton.
Scenario 4: Deliberate reallocation of activity based on historic patient flows, including home births and taking into account travel times

Additional analysis was completed to consider the impact blue light transfers on total travel time.

<u>Independent review of clinical model and proposal</u>
For complex service change commissioners should consider clinical senate advice. Clinical senates have been established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them to make the best decisions about healthcare for the populations they represent.

The clinical senate review and responses to the points raised in its recommendations form an essential part of the preparation for the stage two assurance checkpoint process as set out in NHS England's service change guidance: 'Planning, assuring and delivering service change for patients'.

In April 2024, the Case for Change and associated clinical evidence was presented to the West Midlands Clinical Senate. Chaired by Dr Will Taylor, the review was carried out by a panel of 16 experts from the West Midlands Clinical Senate, most of whom are practicing clinicians.

The purpose of the review was to offer external clinical assurance and focused on the intrapartum element of the maternity pathway and specifically, the proposal to make permanent the temporary closure of the birthing/intrapartum service at the two FMBUs at Samuel Johnson in Lichfield and County Hospital in Stafford.

The Clinical Senate supported the proposal that was presented and was of the view that the ICS articulated a credible case for change and the principles of the programme of work were in keeping with the needs of the population, and general NHS national policies and guidance.

A report of the Independent Clinical Senate Review Panel was shared with the ICS and a copy of the report is appended to this assessment.

If this assessment relates to a policy / strategy, has an equality statement been added (or is it planned to be added) to the document? YES ☐ / NO ☐ / N/A ☑

If you have answered 'No', please explain why not:

2. Impact Assessment

This section should record any identified and/or potential impacts on protected characteristic groups, groups experiencing health inequalities, and other groups at risk of experiencing poorer health outcomes. Both positive and negative impacts should be recorded for each of the groups defined below where applicable.

Think about any barriers to access, areas of inequity, and how different groups may be disproportionately impacted by this proposal. Conversely, think about how certain groups may benefit or see better health outcomes as a result of this proposal.

Protected Characteristics

Age Groups impacted may include young people, older people or working-age population.		**Positive impact**	**Negative impact**	**Neutral impact**
		☐	☐	☑

Consideration has been given to teenage pregnancy rates as this population may have less access to private transport and there may be a travel impact if required to travel further to a

birthing unit. The demographic data of those who accessed services in 2019/20 shows a very small proportion of those who accessed the FMBUs were aged under 20 years of age (2%) suggesting minimal impact on this cohort of patients. Pregnancy rates broken down by area was subsequently reviewed to understand the impact for a particular locality.

A review of Staffordshire and Stoke-on-Trent demographic information highlights a higher rate of teenage pregnancies in Stoke-on-Trent when compared to the other localities and when compared to regional and national rates. The demographic data of those who accessed services in 2019/20 shows that there were no patients who gave birth at either of the FMBUs. This may be due to the proximity of the alongside midwife-led units at Royal Stoke University Hospital. As a result, there is no impact expected for this cohort of patients.

Within Derby (City), there is also a higher rate of teenage pregnancies when compared to other localities within Derbyshire and when compared to national rates. Less than 2% of patients who accessed the FMBUs were from the Derby area suggesting minimal impact on this cohort of patients. Furthermore, patients from Derby travel further to reach the FMBU at either Samuel Johnson Hospital in Lichfield or County Hospital in Staffordshire than they would if accessing midwife-led services at Queen's Hospital in Burton suggesting travel time is not a factor for this cohort of patients.

In addition, all women receive an individualised risk assessment and personalised care plan, which includes options around place of birth, as part of their holistic needs. This is regularly reviewed at every contact.

Disability Groups impacted may include people with physical / learning disabilities, long term conditions, or poor mental health	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

All women receive an individualised risk assessment and personalised care plan, which includes options around place of birth, as part of their holistic needs. This also includes assessing any access requirements and communication needs. This is regularly reviewed at every contact during the pregnancy. Part of this assessment includes identifying where any protected characteristic, such as a long-term condition, means a pregnancy may fall into the high risk-category and women are counselled on a referral to consultant-led care. As such, this cohort of patients would not be affected by the proposal as FMBUs manage low-risk pregnancies only.

Sexual Orientation Groups impacted may include gay / bisexual men, lesbian / bisexual women, or heterosexual people	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

All women receive an individualised risk assessment and personalised care plan, which includes options around place of birth, as part of their holistic needs. This is regularly reviewed at every contact during the pregnancy.

Gender Reassignment This includes people proposing to undergo, who are undergoing or have undergone gender reassignment.	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

All women receive an individualised risk assessment and personalised care plan, which includes options around place of birth, as part of their holistic needs. This is regularly reviewed at every contact during the pregnancy.

Sex (Gender) Groups impacted may include males or females – or specific gendered groups such as boys and girls.	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

All women receive an individualised risk assessment and personalised care plan, which includes options around place of birth, as part of their holistic needs. This is regularly reviewed at every contact during the pregnancy.

Race Groups impacted may include different ethnicities, nationalities, national identities, and skin colours.	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

The MBRACE-UK report about maternal and perinatal mortality shows worse outcomes for those from black, Asian and mixed ethnic groups and those living in deprived areas. The ICB utilised the demographic data of people who has historically used the units alongside the pregnancy and birth data for each of the localities from the Public Health England fingertips toolkit to complete this assessment. It is recognised that there are variances in outcomes for particular groups, for example those from black Asian and mixed ethnic groups and those living in deprived areas (MBRACE-UK report). The service did not target these demographics specifically or address inequalities and the EIA did not identify any groups that would be disproportionately impacted by this proposal.

The demographic profiling within the travel analysis shows that the units were predominantly used by white British or white other ethnic groups who were not within the most deprived areas of Staffordshire and Stoke-on-Trent. Given the demographics of those that attended the FMBUs, it is likely that the reinstatement of services would create an inequality due to diverting resource from the acute sites and those that are identified as needing high-risk care

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Religion & Belief Groups impacted can include all recognised faith groups and those who do not follow any religion or belief system	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

All women receive an individualised risk assessment and personalised care plan, which includes options around place of birth, as part of their holistic needs. This is regularly reviewed at every contact during the pregnancy.

Pregnancy & Maternity Groups impacted may include pregnant women, people on maternity leave and those caring for a new-born / young child	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☑	☐

The women affected by this change will be pregnant. We will be looking to minimise any negative effects arising from the feedback received.

Within the travel analysis, scenario 4 (detailed above) takes into account the re-introduction of the home birth service and the patient flows during the temporary closure of birthing service at the FMBUs. It is likely this scenario represents the impact of the proposal more accurately than other scenarios and further detail is provided below. Further detail on the other scenarios can be found in the full report.

Within scenario 4, the average travel time would increase by around 8 minutes compared to Baseline or by 6 minutes compared to the actual travel time.

Patients within Stafford are most affected by the proposals with travel time increasing by around 14 minutes compared to actual travel time. Within this scenario, the average travel time decreases in a number of areas as patients are using alternative units that are closer to their home address.

While a number of patients are affected by the additional travel time of approximately 6 minutes on average, the comparison of scenarios highlights choice of place of birth can be a factor over travel time as 26% of the cohort analysed chose to travel further to an FMBU rather than to their nearest maternity unit.

It is recognised that there may be an impact on those who were eligible to give birth at County Hospital or Samuel Johnson and who would have chosen to give birth there and therefore alternative options for low-risks births are offered to women (as outlined below). It is however noted that the proposal affects a relatively small number of births (around 344 per year) when compared to the overall number of births at UHNM and UHDB (around 15,033 per year)

Although the FMBU is temporarily closed to births only, all other maternity services (antenatal and postnatal clinics) have continued to operate during this time at the FMBU, therefore, the majority of appointments and support during the pregnancy continue to be provided closer to home.

All women receive an individualised risk assessment and personalised care plan, which includes options around place of birth, as part of their holistic needs. This is regularly reviewed at every contact during the pregnancy.

There are plans in place to begin booking women into the home birth service from April 2024 which will provide an alternative option for low-risk births.

Women and families have been kept regularly updated via the MNVP and both the Trust and ICBs Communications and Engagement Team regarding changes to the FMBU, home birth service and any other service changes to maternity.

Marriage & Civil Partnership This includes people within a formal legal partnership – same sex and opposite sex	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

All women receive an individualised risk assessment and personalised care plan, which includes options around place of birth, as part of their holistic needs. This is regularly reviewed at every contact during the pregnancy.

Inclusion Health Groups

The services we commission should be available to all and as inclusive as possible. Your proposal should also consider any other population groups that are (or are at risk of being) socially excluded. This can include carers, people who experience homelessness, drug and alcohol dependence, Gypsy, Roma and Traveller communities, sex workers and many other socially excluded groups.

Think about which other inclusion health groups may be impacted by your proposal. Select from the drop-down list in each section below or manually state which other socially excluded groups you are considering. Select the table and click the blue '+' symbol in the bottom right of the table to add more sections if required.

For more information about inclusion health groups, please refer to our EHIIRA Guidance document.

Choose a group Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☐

Add narrative here

Choose a group Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☐

Add narrative here

Choose a group Select from the drop-down list above and add a new section using the '+' symbol in	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☐

the bottom right of this table for each additional group you need to consider			

Add narrative here

Core20PLUS5

Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the '**Core20PLUS**' – and identifies '**5**' areas of clinical focus requiring accelerated improvement.

Core20 refers to the most deprived 20% of the national population as identified by the Index of Multiple Deprivation (IMD)

PLUS refers to ICS-chosen population groups experiencing poorer than average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach.

The **5** areas of clinical focus are as follows:

1. **Maternity** - Ensuring continuity of care for 75% of women from ethnically diverse backgrounds and from the most deprived groups.
2. **Severe Mental Illness** - Ensuring annual health checks for 60% of those living with SMI (bringing this in line with success seen in learning disabilities)
3. **Chronic Respiratory Disease** - A clear focus on COPD driving up uptake of COVID, flu and pneumonia vaccines
4. **Early Cancer Diagnosis** - Ensuring that 75% of cases are diagnosed at Stage 1 or Stage 2 by 2028.
5. **Hypertension Case-finding** - Allow for interventions to optimise blood pressure and minimise risk of myocardial infarction and stroke.

More information about Core20PLUS5 can be found using the following link - https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/

Please record any identified or potential areas of impact – both positive and negative – for the target cohorts and any relevant clinical areas defined below and consider how your proposal may be able to contribute to making improvements in these priority areas.

Core20 - Deprivation The most deprived 20% of the population as identified by the national Index of Multiple Deprivation (IMD).	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☑

The geographical location of the FMBUs has meant that those accessing services are predominantly from within the least deprived IMD deciles therefore minimal impact is expected for the most deprived 20% of the population.

During the options appraisal process, consideration was given to whether the relocation of the birthing units to an alternative location would increase access for a different patient demographic, such as the most deprived of the population. However, there is no intelligence to suggest that women outside of the current catchment area of the FMBUs would choose to give birth within such a unit.

In addition, reinstatement of the FMBUs do not meet the needs of the population due to the increasing clinical complexity/acuity and the low numbers of women eligible to give birth within an FMBU.

PLUS Any other locally determined population groups experiencing poor health outcomes – examples are listed above. **Please state which groups you are considering in your response.**	**Positive impact**	**Negative impact**	**Neutral impact**
	☐	☐	☐

1. Maternity Select from the drop-down list above and add a new section using the '+' symbol in the bottom right of this table for each additional group you need to consider	**Positive impact**	**Negative impact**	**Neutral impact**
	☑	☐	☐

In recognition of the continued workforce challenges that maternity services face, the target date for implementing the maternity continuity of carer model (MCoC) was removed in September 2022. At the heart of the model is the vision that women have consistent, safe and personalised maternity care and requires appropriate staffing levels to be implemented safely. Focus is instead placed on the retention and growth of the workforce and developing plans that take into account local requirements.

Consideration of workforce sustainability has been central to the programme: longer term clinical and workforce sustainability as described in Section 2 will enable the system to develop and grow a continuity of carer model during pregnancy, birth and beyond for those most vulnerable in the local community.

3. Compliance with Legal Duties

Has the organisation given due regard and consideration to the following areas?

Eliminating unlawful discrimination, harassment and victimisation **YES ☑ / NO ☐**

Unlawful discrimination takes place when people are treated 'less favourably' due to having a protected characteristic.

Advancing equality of opportunity between people who share a protected characteristic and those who do not. **YES ☑ / NO ☐**

This means making sure that people are treated fairly and given equal access to opportunities and resources.

Fostering good relations between people who share a protected characteristic and those who do not. **YES ☑ / NO ☐**

This mean creating a cohesive and inclusive environment for all by tackling prejudice and promoting understanding of difference.

Are there any Human Rights concerns? **YES ☐ / NO ☑**

If you have answered '**Yes**', please seek advice from the Inclusion Unit to discuss carrying out a specific Human Rights Assessment

Compliance with the NHS Standard Contract? **YES ☑ / NO ☐**

In relation to Service Condition SC13 which includes the NHS Accessible Information Standard

Please provide a supporting narrative to support your responses to the above questions: **This section must be completed**

Careful consideration has been given to discrimination, harassment and victimisation, particularly in light of the proposed service change. Consideration has also been given to advancing equality of opportunity and fostering good relations between people who share a protected characteristic and those who do not. The involvement process was undertaken to understand if there are any impacts that have not been taken into account including any specific groups that may be negatively impacted by any proposed service change. Extensive communication will be shared with colleagues across the system following decision-making with support offered where required. ICB support is continually available via the patient advice and liaison service (PALs).

4. Equality Related Risk

If you have identified an area of actual or potential equality-related risk due to your proposal, please use the matrix below to work out the risk score and tick the corresponding box. If the area of risk gives a score of 9 or above, this should be escalated using the organisation's risk management procedures.

Risk score is calculated as the likelihood of risk multiplied by the level of consequence.

For more information about how to calculate a risk score, please refer to the EHIIRA Guidance document.

Likelihood of risk → Level of consequence ↓	RARE = 1	UNLIKELY = 2	POSSIBLE = 3	LIKELY = 4	HIGH = 5
NEGLIGIBLE = 1	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
MINOR = 2	2 ☐	4 ☑	6 ☐	8 ☐	10 ☐
MODERATE = 3	3 ☐	6 ☐	9 ☐	12 ☐	15 ☐
MAJOR = 4	4 ☐	8 ☐	12 ☐	16 ☐	20 ☐
CATASTROPHIC = 5	5 ☐	10 ☐	15 ☐	20 ☐	25 ☐

Please provide a narrative to explain the risk score relating to your proposal:

The risk score relates to the potential travel impact on those who were eligible and chose to use the FMBUs. This assessment does not identify a disproportionate impact on any of the groups with a protected characteristic as a result of this risk.

5. Equality Action Plan

Please outline any actions or recommendations arising from this assessment of the proposal.

A target completion date is required for all actions and recommendations

Action Required	Lead Person	Target Date	Further Comments
N/A		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	

6. Approval

All EHIIRAs should have governance oversight via formal committee. Please provide details of the arrangements for formal approval below.

Name of formal committee approving this assessment: Staffordshire and Stoke-on-Trent ICB Board meeting

Date of committee meeting: **TBC – likely Winter 2024**

Name of person completing this assessment: Gina Gill

Below fields to be completed by the EDI Lead receiving assessment:

Date received by Inclusion Unit for assurance check: **05/07/2024**

Name of EDI lead completing assurance check: Granville Thelwell

Date of completed assurance check: **19/08/2024**

7. What Next?

1. **Regularly review the action plan and update the EHIIRA accordingly.**
2. **Save a finalised copy for your records and share via your governance pathways and with the Inclusion Unit.**
3. **Follow any specialist advice or guidance from the Inclusion Unit (if provided).**