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

Pre-consultation business case for submission to NHS England

NHS Staffordshire and Stoke-on-Trent Integrated Care Board
University Hospitals of North Midlands NHS Trust
University Hospitals of Derby and Burton NHS Foundation Trust

DOCUMENT CONTROL SHEET

VERSION	DATE	OWNER	ACTION
0.1	24/06/2024	ICB	Chapters circulated to responsible leads for comment
0.2	24/07/2024	ICB	Feedback incorporated
0.3	16/08/2024	ICB	Additional feedback incorporated and exec summary included. Circulated to NHS England as early draft and to key ICS system leads.
0.4	11/09/2024	ICB	Additional feedback from system leads and NHS England incorporated.
0.5	06/01/2025	ICB	PCBC revised following Stage 2 NHSE assurance meeting
1.0	22/01/2025	ICB	PCBC revised following further discussion with NHSE
1.1	19/02/2025	ICB	Additional feedback from NHS England incorporated.

Contents

Table of Contents

Contents 3
1 Executive summary 12
2 Introduction 21
3 The Strategic Context 26
3.1 Introduction 26
3.2 National strategy and policy 26
3.2.1 Better Births 26
3.2.2 The NHS Long Term plan 27
3.2.3 The Ockenden report 27
3.2.4 Birthrate plus® 28
3.2.5 The 'Reading the signals' report 29
3.2.6 Women's Health Strategy 2022 29
3.2.7 National standards and aims 30
3.2.8 Operational Planning Guidance 33
3.3 Local strategy and policy 35
3.3.1 ICP Strategy 35
3.3.2 Staffordshire and Stoke-on-Trent Joint Forward Plan 35
3.3.3 Alignment with ICS maternity plans 35
3.3.4 The local maternity and neonatal system (LMNS) 36
3.3.5 Maternity and Neonatal Equity and Equality Plan 37
3.3.6 Maternity and Neonatal Independent Sector Advisor (MNISA) 37
3.3.7 The maternity and neonatal voices partnership (MNVP) 38
4 Birthing services case for change 39
4.1 Introduction 39
4.2 Local context 39
4.2.1 Royal Stoke Hospital 41
4.2.2 County Hospital, Stafford 43
4.2.3 Queen's Hospital, Burton 44
4.2.4 Samuel Johnson Community Hospital, Lichfield 44
4.2.5 Low risk maternity pathway 45
4.3 Local challenges 47
4.4 Clinical sustainability case for change 48

4.5 Workforce sustainability case for change 55
5 Proposal development including patient, public and staff involvement 61
5.1 Introduction 61
5.2 Phase one - Together we're better 2019 63
5.2.1 Proposal development 2019 63
5.2.2 TWB engagement 2019 64
5.2.3 Findings - TWB engagement 2019 65
5.2.4 Technical event 1 66
5.2.5 Deliberative events Oct/Nov 2019 66
5.2.6 Technical event 2 68
5.3 Phase two – Maternity involvement 2020 69
5.3.1 Findings – Maternity involvement 2020 69
5.3.2 The continuing process 70
5.3.3 Pause in engagement and involvement 71
5.4 Phase three – involvement in 2021 71
5.4.1 Maternity involvement 2021 72
5.4.2 Summary of responses - 2021 involvement 72
5.4.3 Supporting seldom heard groups - 2021 involvement 73
5.4.4 Technical event to review proposals 74
5.5 Phase 4 - Options appraisal and public involvement 2023 74
5.5.1 Re-establishment of the options appraisal process 74
5.5.2 Technical event September 2023 75
5.5.3 Deliberative event 91
5.6 Staff and clinical involvement 93
5.7 Continuous involvement 94
5.8 Engagement with Health Overview and Scrutiny Committees 96
6 Workforce analysis 103
6.1 Introduction 103
6.2 Process used to develop workforce plans 103
6.2.1 System-wide governance 105
6.2.2 Safer staffing 106
6.3 Workforce impact for each scenario 109
6.3.1 Recruitment 109
6.3.2 Training and Retention 109
6.3.3 Workforce interdependencies 110

6.4 Measures for workforce sustainability 111
6.4.1 Training and competencies for sustainability 111
6.4.2 Recruitment and retention for sustainability 112
7 Financial analysis 115
7.1 Introduction 115
7.2 Staffordshire and Stoke-on-Trent ICB finances 116
7.3 UHNM and UHDB baseline financial situation 117
7.4 Impact of the proposals 119
7.4.1 Staffing costs 120
7.4.2 Capital costs 121
7.5 Staffordshire and Stoke-on-Trent ICS financial principles 122
7.6 Future prospects and funding 122
8 Evaluation of proposals 123
8.1 Introduction 123
8.2 The Government's four tests of service change and NHS England patient care test 123
8.2.1 Strong public and patient engagement 124
8.2.2 Consistency with current and prospective need for patient choice 124
8.2.3 Clear, clinical evidence base 125
8.2.4 Support for proposals from clinical commissioners 126
8.2.5 Bed test 126
8.3 Quality, safety and clinical sustainability 128
8.3.1 Care Quality Commission (CQC) Inspection 129
8.4 Impact analysis 130
8.4.1 Equality Impact Assessment including health inequalities 130
8.4.2 Travel Impact analysis 132
8.5 Deliverability 133
8.6 Independent review of clinical model and proposal 135
8.6.1 Introduction 135
8.6.2 Clinical senate recommendations 135
8.6.3 Programme response to recommendations 136
8.6.4 Conclusion/summary 138
9 Management and Governance 139
9.1 Introduction 139
9.2 Timeline and next steps 139

9.3 Next steps 139
9.4 Risk management 140
9.5 Plan for consultation 141
9.6 Implementation plan 142

List of appendices

Appendix 01 UHNM NHST Final Birthrate Plus® Workforce Report_7.7.2022
Appendix 02 UHDB Birthrate Plus® Workforce Final Report _incl_CoC_ AMENDED 17 05 2021
Appendix 03 Report of Findings_Deliberative events 2019
Appendix 04 Report of Findings_Maternity involvement 2020
Appendix 05 QIA SSOT maternity service change_03Sept2024 FINAL
Appendix 06 UHNM assurance and governance Jan 2024
Appendix 07 UHDB assurance and governance
Appendix 08 EIA_SSOT maternity service change_September 2024
Appendix 09 Maternity travel analysis_V2_14.02.2024
Appendix 10 SSOT ICB Strategic Service Change Programme on Maternity – Public Consultation Plan

Abbreviations and Definitions

AN	Antenatal – refers to the period during pregnancy and before the birth of a baby.
BSOTs	Birmingham Symptom Specific Obstetric Triage System.
CCG	Clinical Commissioning Group. These were clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
CNST	Compliance against the Clinical Negligence Scheme for Trusts.
CQC	Care Quality Commission.
DMBC	Decision-making business case.
DS	Delivery Suite.
ICB	Integrated Care Board. These replace CCGs in the NHS in England from 01 July 2022 and took on the NHS planning functions that were previously held by CCGs.
ICS	Integrated Care System. These are local partnerships that bring together NHS organisations local authorities and others to develop shared plans and joined-up services in their local area.
FMBU	Freestanding Midwifery Birth Unit. Throughout the document, birthing services at County Hospital and Samuel Johnson Community Hospital are referred to as FMBUs. This refers to the LDRP rooms (see below) that were available within these sites prior to March 2020.
Fetal	Both fetal and foetal are acceptable spellings. Throughout this document we have used the term fetal. The fetal stage of development begins around the ninth week and lasts until births.
GTT	Glucose Tolerance Testing.
HOSCs	Health Overview and Scrutiny Committees.
IoL	Induction of Labour.
Intrapartum	Intrapartum care is defined as the care of the women and their babies from the onset of labour and immediately after birth.
LDRP	Labour, Delivery, Recovery and Postpartum. These are the rooms that were available at County Hospital and Samuel Johnson Community Hospital where mothers give birth, bond with their baby and recover in one place until families are ready to go home.
LMNS	Local Maternity and Neonatal System. The LMNS is a partnership of maternity and neonatal service providers, commissioners, local authorities and maternity voices

	partnerships, who are work together to transform maternity services.
Low risk/high risk pregnancies	A low-risk pregnancy is where women have been healthy and well throughout the pregnancy with no known medical conditions. A high-risk pregnancy is any pregnancy that carries increased health risks for the woman or the unborn baby. This may include exiting medical conditions, the development of pregnancy-related health conditions during the pregnancy such as high blood pressure or diabetes, or may be due to complications with previous pregnancies.
MLCSU	Midlands and Lancashire Commissioning Support Unit.
MSW	Maternity Support Worker.
Neonatal	Newborn. Neonatal services are provided for newborn babies who need extra care.
NHS England	NHS England leads the National Health Service in England. It's an independent body whose main role is to set the priorities and direction of the NHS, whilst at the same time improving health and care across England.
NICE	National Institute for Health and Care Excellence. The organisation provides national guidance and advice to improve health and social care.
NIPE	Newborn and Infant Physical Examination.
Obstetric	In an obstetric unit, care is provided by a team of midwives and doctors. Midwives provide care to all women in an obstetric unit, whether or not they are considered at high or low risk and take primary responsibility for women with straightforward pregnancies during labour and birth. Obstetricians have primary professional responsibility for women at high risk of complications and for women who develop complications during labour and birth.
PCBC	Pre-consultation business case.
PN	Postnatal – refers to the period immediately after the birth of a baby.
Pregnant Women	Both pregnant women and pregnant people are acceptable phrases. Throughout this document we will refer to women or pregnant women.
RCM	Royal College of Midwives. Royal Colleges are professional bodies that are responsible for the development or and in training within their speciality.
RNs	Registered Nurses.

RCOG	Royal College of Obstetricians and Gynaecologists. Royal Colleges are professional bodies that are responsible for the development or and in training within their speciality.
SBLCB	Saving Babies Lives Care Bundle.
TSA	Trust Special Administrator.
TWB	Together We're Better.
UHDB	University Hospitals of Derby and Burton NHS Foundation Trust.
UHNM	University Hospitals of North Midlands NHS Trust.
WMCS	West Midlands Clinical Senate.
wte	Whole time equivalent.

Purpose of this Document

The purpose of this pre-consultation business case (PCBC) is to:

- Describe the health needs of our combined geographies and set out the case for change: The case for change describes the key challenges faced by the local health economy – and explains why change is necessary.
- Describe the process we have followed: This describes the governance of the programme, and the process we have followed to ensure any recommendations or decision-making is supported by underlying evidence and local stakeholders.
- Describe how key stakeholders and the public have been engaged and involved in our process: Our early engagement has been extensive and captured a wide range of views. We also set out how we will plan to consult if a decision is made to proceed.
- Describe the clinical model and potential benefits thereof: The clinical model has been developed to meet local needs for our combined geographies based on clinical standards and evidence based best practice.
- Set out our options consideration process: We have followed a standard approach to understand the possible options to address the challenges set out in our case for change and deliver our clinical model. This document describes a long list, initial tests to reach a short list, and the evaluation of the short list through defined criteria.
- Carry out an analysis of financial impact and affordability: We have used a range of financial metrics to assess the financial impact of the shortlisted options, and to test the affordability of each.
- Set out how we will assure and potentially implement our plans if a decision is made to move forward: This describes the role of assurance bodies and governance around decision-making.

While the below list is not exhaustive the PCBC seeks to:

- build alignment between NHS commissioners and local authorities and other stakeholders.
- build on the case for change.
- demonstrate that all options, benefits and impact on service users have been considered.
- demonstrate that the planned consultation will seek the views of service users and members of the public who may potentially be impacted by the proposals.

This document is not the final business case. Following consultation, a detailed decision-making business case (DMBC) will be produced which will be the basis for the final decision to proceed with any changes.

Scope

This document does not attempt to provide a full description of all maternity services, or service improvement plans across Staffordshire and Stoke-on-Trent. The scope of work described within this PCBC focuses on the birthing services that were offered at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield until March 2020 when they were temporarily suspended.

Other services offered across Staffordshire and Stoke-on-Trent are not within scope as there are no proposed changes to these services. These are:

- Antenatal and postnatal services offered at the County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield
- Community-based clinics across Staffordshire and Stoke-on-Trent
- Obstetric-led services at Royal Stoke Hospital and Queen's Hospital, Burton
- Midwife-led services at Royal Stoke Hospital and Queen's Hospital, Burton
- Neonatal services
- Homebirth services

1 Executive summary

Birthing services at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield

Background

The Staffordshire and Stoke-on-Trent Integrated Care Board (ICB), along with colleagues from the neighbouring Derby and Derbyshire ICB have been working with provider partners to outline the current position in relation to the birthing services that were previously provided at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield.

In 2018/19, system partners identified maternity services as one of five clinical areas for review and consideration of alternative future models of care. An options appraisal process commenced in 2019, which included patient and public involvement, however COVID-19 led to a pause in the transformation programme for Staffordshire and Stoke-on-Trent, and to a pause in specific plans for local birthing services.
In 2020, at the beginning of the Covid-19 pandemic and in line with national guidance, birthing services at both at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield were temporarily suspended to consolidate the midwifery workforce at the main acute sites.

Home birth services were also temporarily suspended at the start of the pandemic and neither Trust has been able to sustainably reinstate these services due to the ongoing midwifery staffing workforce shortage until recently. Both Trusts began booking women into the home birth service during their early pregnancy from 01 April 2024 which now means that women have the full range of low-risk birth settings to choose from.

During 2022 it was anticipated that both Trusts would be in position to reinstate services either as per the clinical model of 2020 (pre-COVID) or through the implementation of an ‘on-demand model’. However, workforce challenges in relation to recruitment and retention of staff meant that neither provider was able to implement a revised service offer. During this time, both organisations provided regular updates to the Local Maternity and Neonatal System (LMNS) Partnership Board and correspondence was maintained with NHSE via the service change assurance routes.

Due to continued staffing pressures throughout 2022/23, both organisations informed the ICB in April 2023 they were not in a position to reinstate services as per the model of care considered in 2021, therefore it was agreed that the service change and public involvement process would be re-established and further work would be undertaken to explore all possible proposals for future service provision.

County Hospital and Samuel Johnson Community Hospital have remained open for antenatal and postnatal care throughout this period and both Trusts continue to offer the choice of a consultant-led or midwife-led birth at Royal Stoke University Hospital and Queen's Hospital, Burton.

Why change is needed

Before the temporary closure, the number of babies born in a Freestanding Midwifery Birth Unit (FMBU) was very low. Based on the number of births in 2019/20, this amounted to an average of eight per month at County Hospital in Stafford and 18 per month at Samuel Johnson Community Hospital in Lichfield. This has implications for our staff:

- The units had to be staffed 24/7, with two midwives present for a birth. The low number of births meant we were not making the best use of our staff's time. This is a concern, especially given staffing pressures.
- It is recommended that the units manage a minimum of 350 births per year for them to be clinically and financially viable – in other words, for the workforce to be used in the best way possible, to ensure they maintain their skills and competency, and for the services to give value for money. There were not enough births in the FMBUs to ensure this.

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 women who give birth at UHNM fall into the moderate or high-risk category. This means that just under 17% (1,045) are suitable for low-risk care – compared to 29% in 2017/18 (West Midlands Clinical Senate review). A similar level of complexity is seen at UHDB where the 2021 Birthrate Plus® assessment showed that just over 82% of all births fall into the moderate or high-risk categories.

There are around 10,500 births per year for the Staffordshire and Stoke-on-Trent population when we include births at all hospitals (including those that are outside of our area). Birthrate Plus® assessment can only be completed for a particular Trusts footprint and therefore cannot be completed for an ICB population as a whole. However, applying the trends being seen at UHNM and UHDB gives an estimate of the levels of low, and moderate or high-risk pregnancies for the local population. Staffordshire and Stoke-on-Trent would therefore expect 8,715 pregnancies each year to be moderate or high-risk, and 1,785 pregnancies to be low-risk.

Although the Trusts promoted birthing services at the FMBUs, 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.

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

successful recruitment campaigns with the majority of posts filled however a proportion of these will still be working through their preceptorship programme. This requires a period of structured support from more experienced midwives for newly registered midwives whilst they integrate into their new team and place of work.

To run the birthing services at the FMBUs and safely staff them 24/7, a minimum of 12.15 experienced Band 7 midwives (whole-time equivalent) would be needed for each unit.

The skill mix ratio as a result of the proportion of newly qualified midwives 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.

As the number of women with low-risk pregnancies is getting lower, we needed to consider:

- 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.

Proposal development and patient and public involvement

Patient and public involvement is a priority for the Staffordshire and Stoke-on-Trent Integrated Care System (ICS). Women, their families and carers, staff and clinicians and local people have been informed and involved in developing these proposals for the future of maternity services in Staffordshire and Stoke-on-Trent from the outset. Figure 1 at the end of this section outlines the process we have undertaken over the past few years.

Women, their families and carers, staff and clinicians and local people have been informed and involved in developing these proposals for the future of birthing services in Staffordshire and Stoke-on-Trent from the outset. The ICB, along with UHNM and UHDB, used this collective feedback to inform the development of the proposals and this pre-consultation business case and its proposal for the future of birthing services formerly provided at County Hospital Stafford and Samuel Johnson Community Hospital, Lichfield.

The development of the proposals and patient and public involvement that ran alongside this fall into four phases:

- Phase one - the initial proposal development and the patient, public and stakeholder involvement that took place during 2019-20 as maternity services were considered as part of the wider Together We're Better transformation programme.
- Phase two – Targeted maternity involvement in 2020 as part of the Together We're Better transformation programme.

- Phase three – The process of developing proposals for the future of these services was paused in 2020 as a result of the COVID-19 pandemic. In late summer 2021 the process was started again with further engagement to understand whether there were any additional considerations about the future of maternity services
- Phase four – Re-established proposal development process undertaken in 2023 along with public involvement to explore all possible proposals for future service provision.

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.

In April 2023, the service change and public involvement process was re-established and SSOT 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. This service change programme has progressed in line with national and local strategy and policy and the key drivers for change within maternity and neonatal 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 birthing services at County Hospital and Samuel Johnson Community Hospital. The closure relates to five low-risk birthing rooms (LDRP - Labour, Delivery, Recovery, Post-Partum) across the two sites (two at County Hospital and three at Samuel Johnson Community Hospital).

If the proposal were implemented, this would not directly impact the end-to-end pathway for maternity services. Women would continue to be assessed throughout their pregnancy to check for any developing risk factors or complications, which may require a change of delivery options. The proposal needs to be considered alongside the maternity clinical model which is:

- no change to routine antenatal and postnatal services which would remain locality based as recommended by both the National Maternity Review (Better Births) and the Trust Special Administrator (for UHNM).

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

Following the technical event, a deliberative event with women and key stakeholders was held online in December 2023 to discuss the proposal for birthing services previously provided at County Hospital and Samuel Johnson Community Hospital. Further involvement was carried out with women who registered but were unable to attend the event.

A report of findings was developed by the Midlands and Lancashire Commissioning Support Unit (MLCSU) following the deliberative event and further involvement and was presented to the Maternity Service Change Steering Group.

The group formally received the report of findings and confirmed they were confident with the process that had been undertaken. The group was also asked to consider whether anything further needed to be considered within the business case in light of the feedback received.

Workforce and finance implications

The proposal makes permanent the temporary arrangements that have been in place since March 2020 when birthing services at County Hospital and Samuel Johnson Community Hospital were temporarily suspended.

Workforce plans have been developed in line with Birthrate Plus® to ensure the appropriate number of midwives according to the clinical needs of the local maternity population. These have not been developed in response to this proposal, instead they have been developed for overall maternity services to ensure the Trusts reach full workforce establishment with sustainable recruitments plans in place for the future workforce.

The single viable proposal described within this pre-consultation business case would not introduce any new models of care and end-to-end pathways would not be affected. The proposal has no direct implications on staffing levels however workforce plans are described within this document to demonstrate the longer-term workforce sustainability within overall maternity services.

Both Trusts have made significant investment to ensure they are at the full midwifery establishment in line with Birthrate Plus®. The additional investment within each of the Trusts mean they are able to safely staff maternity services under the current operating

model which mirrors the proposal within this pre-consultation business case. As a result, there are no additional staffing costs as a result of this proposal and no additional estates costs have been identified.

Impact analysis

Section 8 of this PCBC describes the quality, equality and travel impact assessments that have been completed for the single viable proposal. The assessments largely identify either a positive or neutral impact of the proposal. The key positive impacts include:

- Equity of provision across Staffordshire and Stoke-on-Trent
- Proximity to other clinical teams where required e.g. neonatal services
- Reduced need for emergency ambulance transfers
- Clinical sustainability and workforce sustainability

The equality impact assessment identifies the protected characteristics of pregnancy and maternity as the most likely to be impacted due to the travel implications. Whilst no negative or positive impacts were identified for other protected characteristics, this was identified following due consideration of the needs of the birthing population.

The negative impact identified relates to the potential travel implications/impact for those who are eligible to give birth at County Hospital or Samuel Johnson Community Hospital and who would have chosen to give birth there.

The travel analysis included within section 8.5.2 shows that the average travel time for women would increase by around 8 minutes compared to Baseline or by 6 minutes compared to the actual travel time.

Women within the Stafford area who utilised the FMBU (n=73) are most affected by the proposals with travel time increasing by around 14 minutes compared to actual travel time. While a number of patients are affected by the additional travel time of approximately 8 minutes on average, the travel analysis highlights choice of place of birth can be a factor over travel time as 25% of the cohort analysed chose to travel further to an FMBU rather than to their nearest maternity unit.

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, provision of other aspects of maternity care have continued through the FMBUs such as antenatal and postnatal clinics, therefore appointments and support for low-risk women during their pregnancy is provided closer to home.

Independent clinical review

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.

In April 2024, the Case for Change and associated clinical evidence was presented to the West Midlands Clinical Senate. The Clinical Senate 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. As such, the Senate supported the proposal to make permanent the temporary closure of the birthing service at the two Freestanding Midwifery Birth Units (FMBUs) at County Hospital in Stafford and Samuel Johnson in Lichfield.

The review panel has now published its report which includes five recommendations to support the transformation programme to move forward through the NHS England assurance process for major service changes.

The ICB have accepted the recommendations of the panel and have responded to these recommendations (see section 8.6), to inform this pre-consultation business case.

Key tests of change

The development of proposals and the associated assurance process has been undertaken in line with the process outlined within the Planning, Assuring and Delivering Service Change for Patients guidance[1].

Through the assurance process, NHS commissioners are required to apply the tests of service change. These include the Government's four tests of service change:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- Clear, clinical evidence base.
- Support for proposals from clinical commissioners.

And in addition:

- NHSEI's Patient Care (bed closure) Test.

The proposals for the services previously provided at County Hospital and Samuel Johnson Community have been developed in line with these tests.

The independent review panel (IRP) evidence submission to Lord Darzi's Independent Investigation of the National Health Service in England and the subsequent report from Lord Darzi's was published during the final stages of the PCBC development. The ICB

[1] p13, Planning, assuring and delivering service change for patients, NHS England 2018

has taken into account the recommendations regarding service change processes, and this is reflected throughout the PCBC.

Next Steps

This pre-consultation business case will be subject to NHS England assurance, before being reviewed by the NHS Integrated Care Board (ICB) as the statutory decision makers. The ICB will then determine the level of further involvement activity is required to inform a decision on long-term provision.

Throughout this process the ICB, UHNM and UHDB are committed to maintaining an honest and transparent dialogue about the challenges and opportunities faced locally. Importantly, partners remain open to new, viable considerations throughout this process. At the heart of this work, is delivering the best care possible for local patients.

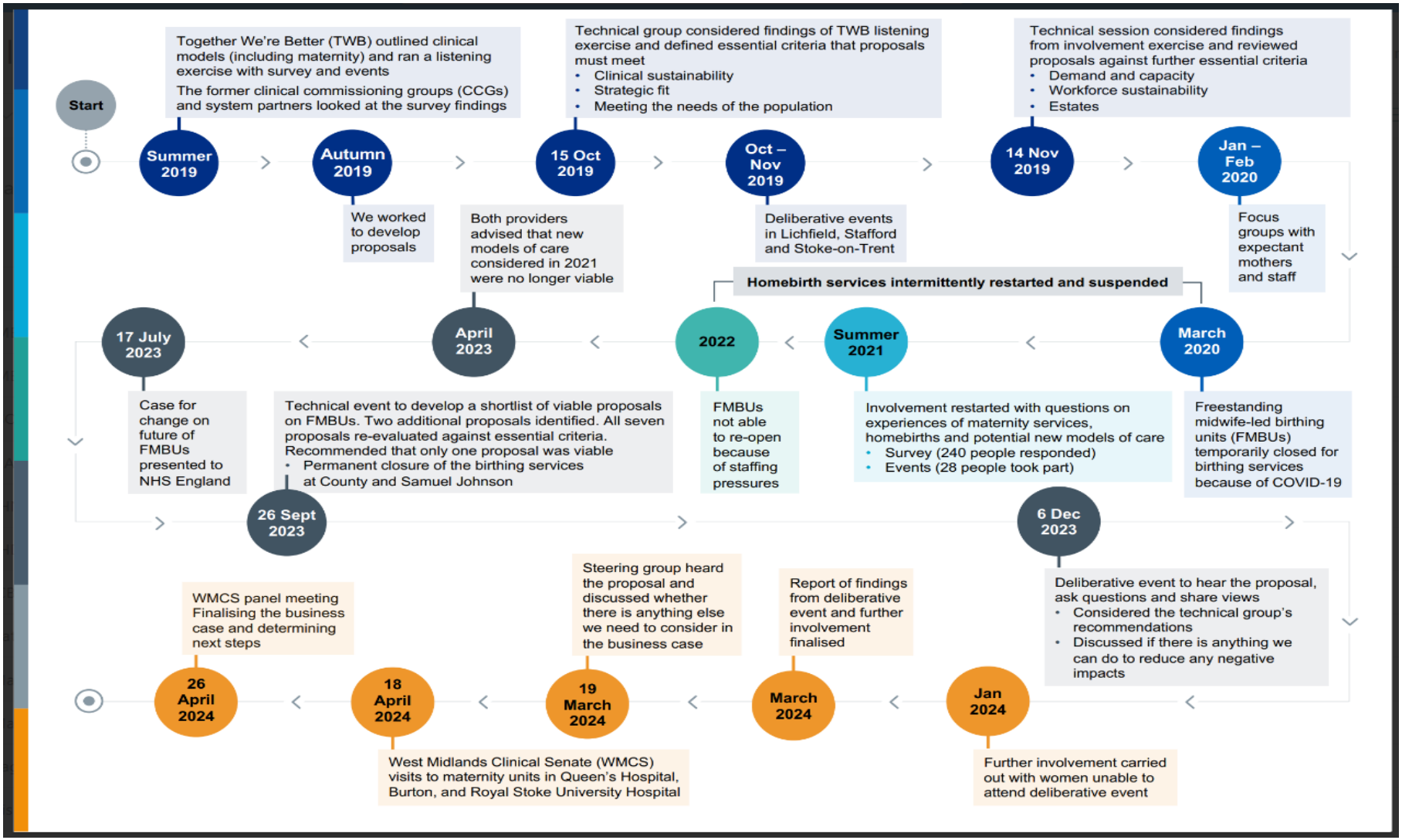


Figure 1: Process timeline leading to the development of proposals.

2 Introduction

Background

This pre-consultation business case (PCBC) is presented by Staffordshire & Stoke-on-Trent Integrated Care Board together with University Hospitals of North Midlands NHS Trust (UHNM) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) to align commissioning arrangements for the provision of birthing services in Staffordshire and Stoke-on-Trent with national policy, system-wide strategic vision and the established operational position.

The geographic area covered in this proposal includes Staffordshire and Stoke-on-Trent. The proposal takes account of national best practice, clinical quality and safer staffing. It is set against the background of a challenged maternity system and the national 3-year delivery plan for maternity and neonatal services which aims to make care safer, more personalised and more equitable for women, babies and families.

Our vision and commitment

The Staffordshire and Stoke-on-Trent Integrated Care System (ICS) brings together a range of partners who are responsible for planning and delivering health and care and for improving the lives of people who live and work in our area. The ICS is the geographical area in which health and care organisations work together. The purpose of ICSs is to bring partner organisations together to:

- improve outcomes in population health and healthcare.
- tackle inequalities in outcomes, experience, and access.
- enhance productivity and value for money.
- help the NHS support broader social and economic development.

Meeting the needs of our population

It is well documented that health and wellbeing outcomes are impacted by a whole range of factors related to the circumstances in which we are born, grow, live, work and age. These are known as the ‘wider determinants’ of health. We recognise that there are many factors that impact on the wider determinants of health including socioeconomic factors, physical environment, health behaviours and health care. The biggest factor is socioeconomic where we need to collectively develop the building blocks to have the biggest impact. These building blocks are education, employment, family/social support, income and community safety.

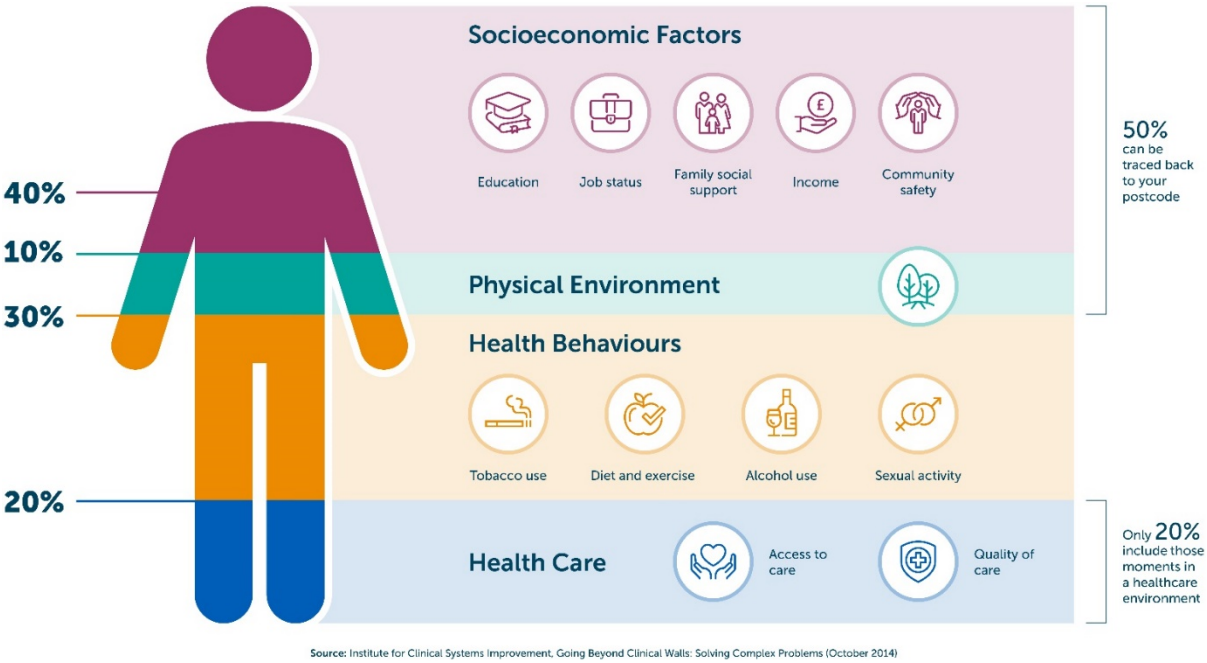


Figure 2: Social Determinants of Health Infographic
Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

We know that inequalities can start before birth and can affect all stages in life ('across the life course'). They can impact on outcomes across housing, education, employment, healthy lifestyles, dental, mental health, physical health and loneliness.

Health inequalities in Staffordshire

Staffordshire County Council has recently undertaken a piece of work to analyse data to compare the outcomes of people living in the most deprived areas with the most affluent against the Staffordshire average.

It showed that someone living the most deprived area is:

- 90% more likely to have parents who smoke
- 12% more likely to have a low birth weight
- 2.5 times more likely to be in poverty
- 2.5 times more likely to claim unemployment benefits
- 49% more likely to experience fuel poverty
- 49% more likely to be living alone as an older adult.

Someone living in the most affluent area is:

- likely to live 3.7 years longer
- 47% less likely to have a hospital admission for dental decay
- 21% less likely to be overweight or obese (in year six)
- 41% more likely to achieve English and Maths grades

- 10% less likely to be admitted to hospital because of alcohol harm
- 46% less likely to die from coronary heart disease before the age of 75.

Figure 3: Health inequalities in Staffordshire

Health inequalities in Stoke-on-Trent

Figures for Stoke-on-Trent show:

- Ranked 13th out of 317 across the country for deprivation
- More than half of Stoke-on-Trent areas are in the two most deprived deciles
- The number of people in fuel poverty is higher than the England and West Midlands average
- 29% of children live in absolute low-income families
- The highest rate of infant deaths when compared to England and the West Midlands. This includes neonatal (in the first 28 days after birth) and post-neonatal (28-365 days after birth) deaths, premature births (born before 37 weeks), and low birth weight
- 1 in 6 women smoke through pregnancy (ranked 5th highest in England)
- The number of premature deaths is higher than the England and West Midlands average, with the main reasons being lung cancer, cardiovascular disease and respiratory.

Figure 4: Health inequalities in Stoke-on-Trent

In addition to the information outlined above, each year, there are around 10,500 births from within the Staffordshire and Stoke-on-Trent population with a higher level of multiple births in Stoke-on-Trent compared to Staffordshire, regional and national figures (2021).

Staffordshire low birth weight rates are largely in line with national rates, however there is increased incidence of low birth weight in Stoke-on-Trent. Very low birth weight rates vary between Staffordshire and Stoke-on-Trent, though are generally in line with the national rate.

There is variance across the Staffordshire and Stoke-on-Trent geography in the proportion of births to mothers from ethnic communities; in the Stoke-on-Trent area, the data is in line with national rates, however across the Staffordshire area in general there largely a much lower percentage of births to mothers from ethnic communities (except for East Staffordshire).

The general fertility rates are higher in Stoke-on-Trent when compared against Staffordshire, Regional and National figures, and the proportion of caesarean section

births across the Staffordshire and Stoke-on-Trent are virtually the same, but higher than regional and national rates.

The incidence of hospital admissions for babies under 14 days old is generally higher across the ICB compared to both regional and national figures.

There is variance in the rates of teenage mothers across the Staffordshire and Stoke-on-Trent. Staffordshire is generally in line with regional figures and slightly higher that national figures with Stoke-on-Trent seeing the highest rates in the locality and significantly higher than regional and national figures.

The table below shows pregnancy and birth data captured from the PHE Fingertips website: Source: Public Health England. Public Health Profiles. [09/05/2024] https://fingertips.phe.org.uk

Indicator	Year	Staffordshire	Stoke-on-Trent	Region	England
Percentage of deliveries to mothers from BAME groups	2022/23	9.5%	26.6%	31.1%	25.3%
General fertility rate	2022	53.1 per 1000	60.4 per 1000	55.4 per 1000	51.9 per 1000
Caesarean section	20222/23	38.1%	36.2%	37.6%	37.8%
Multiple births	2021	13.2 per 1000	16.4 per 1000	12.8 per 1000	13.7 per 1000
Low birth weight of all babies	2021	7.1%	8.1%	7.9%	6.8%
Very low weight of all babies	2021	1.2%	0.8%	1.4%	1.0%
Premature births (under 37 weeks gestation)	2019/20		94.2 per 1000	85.9 per 1000	77.9 per 1000
Stillbirth rate	2020-22	3.2 per 1000	3.8 per 1000	4.4 per 1000	3.9 per 1000
Admissions of babies under 14 days	2022/23	127.8 per 1000	203.1 per 1000	92.9 per 1000	84.8 per 1000
Teenage mothers	2022/23	0.9%	1.4%	0.8%	0.6%
Baby's first feed breastmilk	2020/21	63.3%	62.2%	68.3%	71.7%

Table 1: Public Health England pregnancy and birth data

The Staffordshire and Stoke-on-Trent Integrated Care Partnership Strategy provides the health and care strategy for the ICS. This strategy outlines how ICS partners will work in partnership to improve the health of our population, including pregnant women

and new families to improve health outcomes across the life course and prevent infant mortality.

In response to the Strategy an ICS Infant Mortality Steering Group and pre-conceptive health working group have formed with leads from stakeholder organisations in the Local Maternity and Neonatal System, Children and Young People and Family Services working in partnership.

These programmes of work have a specific focus on improving the health in women of conceptive age to reduce prevalence of women booking with poor health status or experiencing difficulty managing long term conditions that increase risk of adverse pregnancy and neonatal outcomes.

The developing system pre-conceptive care action plan will address how we improve health and wellbeing in women of conceptive age. Priorities for the action plan from stakeholder engagement, local data and evidence on best practice include:

- Improving community-based women's health service provision
- Access to contraception
- Delivering information and education on pre-conceptive health and healthy behaviours during pregnancy
- Partnership approach to addressing risk factors for poor health in pregnancy and poor neonatal pregnancy outcomes in pregnancy. This includes obesity and excess weight, alcohol, smoking and unmanaged long term health conditions.

3 The Strategic Context

3.1 Introduction

This service change programme is in line with national and local strategy and policy. This section sets out the key drivers for change within maternity and neonatal services and how this programme of work aligns to those strategies and policies.
It includes:

- National strategies and plans
- Local strategies and plans

3.2 National strategy and policy

3.2.1 Better Births

In 2016 the National Maternity Review report; Better Births[2] was published following a major review of maternity services that was initiated in 2015 as part of the NHS Five Year Forward view. The report sets out a clear vision for maternity services;

- **Personalised Care**, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.
- **Continuity of carer**, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.
- **Safer care**, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.
- **Better postnatal and perinatal mental health care**, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby, and family.
- **Multi-professional working**, breaking down barriers between midwives, obstetricians, and other professionals to deliver safe and personalised care for women and their babies.
- **Working across boundaries** to provide and commission maternity services to support personalisation, safety, and choice, with access to specialist care whenever needed.
- **A payment system** that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice.

[2] NHS England » Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care

To deliver the vision for the future of maternity services, the report outlines a number of recommendations for action, who should take responsibility within local systems and the timescales they should work toward.

3.2.2 The NHS Long Term plan

The NHS Long Term Plan[3] (LTP), formerly known as the 10-year plan, was published in 2019 setting out key ambitions for the NHS over the following 10 years until 2029. It reaffirms key national aims for maternity:

- achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality, and serious brain injury by 2025.
- expand the choices and control people have over their own care – from maternity to end of life.
- implement an enhanced and targeted continuity of carer model to help improve outcomes for the most vulnerable mothers and babies.

A number of key drivers and enablers were identified plan to ensure delivery of the aims within the long-term plan. These include;

- Roll out of the Saving Babies Lives Care Bundle[4] (version 2) across every maternity unit in England. The care bundle includes evidence based and best practice care in 5 elements in order to reduce perinatal mortality.
- Establish Maternal Medicine Networks to ensure women with acute and chronic medical problems have timely access to specialist advice and care at all stages of pregnancy.
- The Maternity Incentive scheme that rewards delivery of 10 key maternity safety actions through a Clinical Negligence Scheme for Trusts rebate.

3.2.3 The Ockenden report

The Ockenden report, published in December 2020[5], was written following a review of safety concerns at Shrewsbury and Telford Hospital NHS Trust. The report outlines 12 specific urgent clinical priorities within seven immediate and essential actions (IEAs) that were shared with Trusts/local maternity systems to improve the quality and safety of maternity services;

- **Enhanced Safety.** Trusts must work collaboratively to ensure serious incidents are investigated thoroughly and Trust Boards must have oversight of these.
- **Listening to women and their families.** Maternity Services must ensure women and their families have their voices heard.
- **Staff training and working together.** Staff who work together must train together and MDT Ward Round Twice Daily.

[3] NHS Long Term Plan, 2019
[4] NHS England » Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality
[5] OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (donnaockenden.com)

- **Managing complex pregnancy.** There must be robust pathways in place for managing women with complex pregnancies.
- **Risk assessment throughout pregnancy.** Staff must ensure that women undergo risk assessments in pregnancy at each contact.
- **Monitoring fetal wellbeing**. Dedicated leads for fetal monitoring who champion best practice in fetal surveillance.
- **Informed Consent.** Women must have access to accurate information to enable informed choice.

Local systems were required to complete a maternity services assessment and assurance tool which included;

- All 7 IEAs of the Ockenden Report
- NICE guidance relating to Maternity
- Compliance against the Clinical Negligence Scheme for Trusts (CNST) safety actions A current workforce analysis.

Systems were required to assess their current position against the above and provide assurance of effective implementation to their public Boards, Local Maternity System and NHSE/I regional teams.

A final report of the Ockenden review was published in March 2022[6]. The report builds on the initial immediate and essential actions and includes 15 recommendations for changes to all maternity services in England. The recommendations within the report fall into four key pillars;

- Safe Staffing levels
- A well-trained workforce
- Learning from incidents
- Listening to families;

Systems were required to implement the initial IEAs and report their compliance against the framework. Both Trusts completed the initial reporting requirements and continue to work within the framework as part of their Maternity Improvement Plans.

3.2.4 Birthrate plus®

In addition to implementing the key actions outlined within the Ockenden report, Trust Boards were required to confirm plans and timescales for implementing the Birthrate® Plus standard[7].

Birthrate® Plus is the only national tool available for calculating midwifery staffing levels. It is based on data that has been collected over many years and its use is

[6] OCKENDEN REPORT - FINAL (ockendenmaternityreview.org.uk)
[7] Home - Birthrate Plus®

strongly recommended by the RCM to undertake a systematic assessment of workforce requirements.

The tool is designed to help maternity units calculate how many midwives they need to deliver one-to-one care in labour, taking account of both the local birth rate and the complexity of the caseload.

In recognition of the continued workforce challenges that maternity services face, the target date for implementing the maternity continuity of carer model[8] (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.

3.2.5 The 'Reading the signals' report

The Kirkup report, published in October 2022[9], was written following an investigation of maternity services at East Kent Hospitals University NHS Foundation Trust. The report outlines four areas for action:

- To get better at identifying poorly performing units
- Giving care with compassion and kindness
- Teamworking with a common purpose
- Responding to challenge with honesty

Shortly after the publication of the report, NHS England wrote to all systems and outlined the expectation for all Trusts and ICBs to review the findings of the report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

Staffordshire and Stoke-on-Trent ICB reviewed the report at the LMNS Partnership Board and ICB Quality and Safety Committee which in turn reported to the ICB Board. Agreement was received at each that the mechanisms for assurance were adequate and relied on the providers providing assurance through these mechanisms.

Within the letter, NHS England confirmed the upcoming publication of a single delivery plan for maternity and neonatal care but requested that systems do not delay implementing appropriate actions in response to the 'reading the signals' report.

3.2.6 Women's Health Strategy 2022

The Women's Health Strategy for England[10] (published in July 2022 and revised in August 2022) is a 10-year strategy that sets out a range of commitments to improve women's health across their life course. The strategy is underpinned by the findings

[8] B2011-Midwifery-Continuity-of-Carer-letter-210922.pdf (england.nhs.uk)
[9] Maternity and neonatal services in East Kent: 'Reading the signals' report - GOV.UK (www.gov.uk)
[10] Women's Health Strategy for England - GOV.UK (www.gov.uk)

of a listening exercise that generated nearly 100,000 responses from women across England. Views were sought on the following priority areas:

- menstrual health and gynaecological conditions
- fertility, pregnancy, pregnancy loss and postnatal support
- menopause
- mental health and wellbeing
- cancers
- the health impacts of violence against women and girls
- healthy ageing and long-term conditions

The findings of the survey were collated and resulted in a number of key ambitions within the strategy for each of the priority areas.

The key ambitions for pregnancy and maternity care are:

- the NHS is the best place in the world to give birth through personalised, individualised, and high-quality care. Women are treated as equal partners in the planning of their care throughout pregnancy, labour and the postnatal period. Their personalised care and support plans are dynamic and responsive to changes in their clinical needs and choices, and women are supported to make informed decisions during labour.
- disparities in outcomes and experiences of care for mothers and babies are reduced, and all women receive equitable maternity care that is responsive to their individual needs and choices.
- all women with significant medical conditions that pre-date or arise in pregnancy will receive timely specialist care and advice before, during and after pregnancy.
- NHS maternity services will be aspirational workplaces in which multidisciplinary teams work in safe environments and cultures of mutual respect where continuous learning for improvement is the norm.

The strategy outlines a number of key actions for maternity that are being addressed through the NHS England Maternity Transformation Programme such as delivering the Better Births vision to make care safer, more personalised, and more equitable. The strategy also refers to the publication of the refreshed delivery plan for maternity and neonatal services that will set out clear priorities for delivering the maternity and neonatal safety ambitions and providing more personalised care.

The strategy also encourages the expansion of women's health hubs to bring together essential women's services and is expected to include pre-conception advice.

3.2.7 National standards and aims

The three-year delivery plan for maternity and neonatal services was published in March 2023 and consolidates the improvement actions committed to in Better Births,

the Long-Term Plan, the Neonatal Critical Care review[11] and the independent investigation reports at both Shrewsbury and Telford Hospital NHS Trust and maternity and neonatal services in East Kent.

The delivery plan for maternity and neonatal services asks services to focus on four high level themes over the next three years to improve services. These are;

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

The plan outlines a framework for delivery with key actions and metrics identified within each theme. The plan does not introduce new standards for maternity and neonatal teams and instead aims to ensure existing best clinical practice, high quality data and digital tools are consistently implemented in order to address many of the concerns raised in NHS maternity and neonatal services that have been highlighted in recent years.

Theme 1: Listening to women and families with compassion which promotes safer care.

Listening and responding to all women and families is an essential part of safe and high-quality care. It improves the safety and experience of those using maternity and neonatal services and helps address health inequalities. Both the National Maternity Review report; Better Births (2016) and the Ockenden Reports (2020, 2022) highlighted the need to ensure care is personalised, equitable and that families have their voices listened to. Several objectives are identified within the delivery plan to ensure these ambitions are met.

Theme 2: Supporting our workforce to develop their skills and capacity to provide high-quality care.

The ambition of safer, more personalised, and more equitable maternity and neonatal services in this plan can only be delivered by skilled teams with sufficient capacity and capability. However, despite significant investment leading to increases in the midwifery, obstetric, and neonatal establishment, NHS maternity and neonatal services do not currently have the number of midwives, neonatal nurses, doctors, and other healthcare professionals they need. This means existing staff are often under significant pressure to provide the standard of care that they want to. This theme has been highlighted across a number of reports (Better Births 2016, Ockenden 2020 and 2022) over the years, with Trust Boards required to confirm plans and timescales for

[11] NHS England » Implementing the Recommendations of the Neonatal Critical Care Transformation Review

implementing the Birthrate Plus® standard. This standard is designed to help maternity units calculate how many midwives they need to deliver one-to-one care in labour, taking account both of the local birth rate and the complexity of the caseload.

Furthermore, 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.

This theme further highlights the need to support and develop the workforce and sets out three areas of action for maternity and neonatal staffing: continuing to grow our workforce; valuing and retaining our workforce; and investing in skills. This plan is informed by the best available evidence such as the Quality Maternal and Newborn Care (QMNC) framework which underpins the NMC midwifery standards and follows the principles of NHS England's workforce planning guidance and builds on the NHS Long Term Plan and NHS People Plan which sets out how improving the experience of people working in the NHS will encourage them to stay in the NHS longer.

Theme 3: Developing and sustaining a culture of safety to benefit everyone.

An organisation's culture is shaped by the behaviour of everyone in it. In maternity and neonatal services, a safety culture improves the experience of care and outcomes for women and babies and supports staff to thrive. We want everyone to experience the positive culture that exists in many services – poor cultures need to be challenged and addressed. The failures in care identified in the Kirkup report (2022) stemmed from weaknesses in culture throughout the organisation, including a lack of teamworking, professionalism, compassion, listening, and learning.

Both the Better Births and the Ockenden reports clearly highlighted the need to improve the safety of maternity services and ensure professionals are working together across boundaries and ensure serious incidents are investigated thoroughly with Trust Board oversight of these. This theme identifies a number of key actions across three areas: developing and sustaining a positive safety culture for everyone; learning and improving; and support and oversight.

Theme 4: Meeting and improving standards and structures that underpin our national ambition.

To deliver the ambition set out in the plan, maternity and neonatal teams need to be supported by clear standards and structures. The plan does not introduce new standards for maternity and neonatal teams and instead aims to ensure existing best clinical practice, high quality data and digital tools are consistently implemented in

order to address many of the concerns raised in NHS maternity and neonatal services that have been highlighted in recent years.

Overall, the plan aims to deliver change rather than set out new policy. It seeks to help each part of the NHS to plan and prioritise their actions by bringing together learning and action from a range of national reports and plans into one cohesive document.

3.2.8 Operational Planning Guidance

The 2024/25 priorities and operational planning guidance[12] (March 2024) makes clear the commitment to transform maternity services to make care safer, more personalised and more equitable.

To achieve this, the guidance asks systems and services to implement the key actions related to the Three-year delivery plan's 4 high-level themes and use the success measures to monitor outcomes and progress.

The guidance further outlines a number of key actions for maternity and neonatal services:

- make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury.
- reduce inequalities in experience and outcomes for the groups who experience the greatest inequalities (Black, Asian, and mixed ethnic groups and those living in the most deprived areas).
- increase fill rates against funded establishment by growing and retaining the maternity and neonatal workforce and continue to invest in the skills and capacity to provide high-quality care.
- agree safe staffing levels for the obstetric workforce in Trusts, and support Trusts to achieve them through action on recruitment and retention.
- ensure all women and families have personalised and safe care, with every woman offered a personalised care plan and being supported to make informed choices.
- consistently implement best practice, including the revised National Maternity Early Warning Score (MEWS)[13] and Newborn Early Warning Trigger and Track (NEWTT-2) tools[14].
- continue to develop a positive safety culture, including regular board-level review of the progress of a focused plan to improve and sustain culture.

For 2024/25 and the following two years, systems and services are also asked to support implementation of the Maternity Safety Package, which includes rollout of the reducing brain injury programme, training an additional 6,000 midwives in neonatal

[12] PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf (england.nhs.uk)
[13] New Maternity Early Warning Score to be implemented in the NHS | NIHR
[14] NEWTT2 | British Association of Perinatal Medicine (bapm.org)

resuscitation, nearly doubling the number of clinical staff receiving specialist training in obstetric medicine, funding 160 new midwife posts over three years, and funding to support the rollout of maternity and neonatal voice partnerships.

ICBs are also asked to work in partnership with local authorities to:

- establish and develop at least one women's health hub in every ICB by the end of December 2024 in the line with the core specification, improving access, experience, and quality of care. NHS England will work with ICBs to ensure that at least 75% have a hub in place by July 2024 that meets minimum requirements, including a virtual option.
- support and develop universal services for pregnancy and beyond in family hubs.

3.3 Local strategy and policy

3.3.1 ICP Strategy

Our strategic approach to understand the needs of the population and improving services for local people and communities is outlined in our Integrated Care Partnership Strategy[15] .

We will do this by;

- Improving health and wellbeing of our people and communities.
- Ensuring personalised care.
- Empowering individuals to take personal responsibility for their health and wellbeing.
- Focussing on prevention and health inequalities.
- Productivity – making best use of our resources.

3.3.2 Staffordshire and Stoke-on-Trent Joint Forward Plan

The Joint Forward Plan[16] (JFP) outlines how the Integrated Care System (ICS) will support the delivery of the ambitions articulated in the ICP Strategy describing our collective priorities over the period 2023 to 2028. The JFP describes how the ICB and its partner Trusts intend to arrange and/or provide NHS services to meet the physical and mental health needs of the population. These ambitions are aligned to the core national, regional and local strategic drivers of the NHS, including the NHS Long Term Plan (LTP), the Health and Care Act and the Core20PLUS5[17] approach. This document is the first JFP for NHS partners since the inception of the statutory ICS in Staffordshire and Stoke-on-Trent.

3.3.3 Alignment with ICS maternity plans

The local maternity and neonatal system team have led conversations with system partners to ensure our strategic direction is one that meets the requirements of the national directives but also meets the need of our population. The strategic vision is to:

- Empower women, and their partners, by putting them at the centre of their care so they have the best support.
- Design a service that supports women to access a team of midwives, who have worked with them to develop their own personal birth plan.
- 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.

[15] Staffordshire and Stoke-on-Trent Integrated Care Partnership ICP Strategy (icb.nhs.uk)
[16] Staffordshire and Stoke-on-Trent Joint Forward Plan 2023-2028 - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk)
[17] NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

- To provide continuity of carer during pregnancy, birth and beyond to those most vulnerable in our community
- Make the best use of our staff, allowing them to work more flexibly and really get to know the women and families in their local communities.
- To develop and sustain a culture of safety which reduces inequalities in outcomes.

This vision coupled with the ICS' commitment in the Joint Forward Plan[18] to ensuring that all activities in the maternity and neonatal programme will support achievement of the four themes of the National Delivery Plan[19] is the strategic backdrop to the proposals for the future of the FMBUs.

3.3.4 The local maternity and neonatal system (LMNS)

The local maternity and neonatal system (LMNS) is a partnership of maternity and neonatal service providers, commissioners, local authorities and maternity voices partnerships, who are working together to transform maternity services in Staffordshire and Stoke-on-Trent.

Our LMNS, despite the challenges created by the pandemic, has continued to develop a system approach to maternity and neonatal care, identifying where we can make a positive change to our services and improve care for women, babies and their families.

Pre-Covid, the focus of the LMNS has been transformation. However, in line with national policy, the responsibility and make-up of the team has changed to ensure that as well as transformation, quality surveillance, governance and reporting of the systems services is robust.

The LMNS Partnership Board provides the strategic direction for development of maternity services and ensures that the deliverables as outlined in the 3-year delivery plan for maternity and neonatal care are achieved across the whole ICS on time and in a cost-effective manner. This together with the local Equity and Equality Action Plan[20] sets out how the system will work together to address the challenges identified and improve outcomes for those accessing our local services.

Strategic leadership, partnership engagement and assurance are delivered through the Board and wider project structures, ensuring the priorities set out in the delivery plan are realised. Assurance is provided to regulators and external partners, as and when required that the Staffordshire and Stoke-on-Trent system is delivering the requirements laid out in the national plan.

[18] Joint Forward Plan 2023-2028 - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk)
[19] B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk)
[20] View our equity and equality plan here.

The Staffordshire and Stoke-on-Trent LMNS partnership board has Memorandums of understanding in place with its neighbouring ICB's to support shared learning and working together, in particular with Derby and Derbyshire ICB as the lead commissioner of services at UHDB. We also work closely with Birmingham and Solihull ICB and Black Country ICB.

3.3.5 Maternity and Neonatal Equity and Equality Plan

The MBRACE-UK report[21] about maternal and perinatal mortality shows worse outcomes for those from black, Asian and mixed ethnic groups and those living in deprived areas. All Local Maternity and Neonatal system must implement a Maternity and Neonatal Equity and Equality Plan to set out how the system will work together to address the challenges identified and improve outcomes for those accessing local services by:

- improving equity for mothers and babies from black, Asian, and mixed ethnic groups and those living in the most deprived areas, and
- promoting race equality within staff groups.

All systems must work to address five key priorities:

- Priority 1: Restore NHS services inclusively.
- Priority 2: Mitigate against digital exclusion.
- Priority 3: Ensure datasets are complete and timely.
- Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor health outcomes.
- Priority 5: Strengthen leadership and accountability.

Each priority includes key process and outcome indicators that each LMNS must monitor and report on their compliance.

Staffordshire and Stoke-on-Trent at their LMNS Partnership Board meeting in March 2024 agreed to fund a 12-month pilot Equality, Diversity and Inclusion (EDI) midwife to support the progression of the Equity and Equality Action plan. This will ultimately improve outcomes for those within the at-risk groups.

3.3.6 Maternity and Neonatal Independent Sector Advisor (MNISA)

The MNISA is a new senior role being piloted to support women and their families in England when they are involved in an investigation or complaint relating to their maternity or their baby's neonatal care.

The MNISA role aims to provide independent guidance and support to women and families affected by an adverse outcome following an episode of maternity or neonatal care, and to use this feedback to bring about system change and improvement.

[21] MBRRACE-UK_Maternal_Compiled_Report_2023.pdf (ox.ac.uk)

MNISA's receive specialist training to support families navigating some of the complex investigation processes which follow an adverse outcome such as a significant health complication or bereavement. Advocates are also able to share families feedback, compliments and concerns (with their permission) to ensure that they are listened to, heard and used to shape and improve care for women, babies and families.

The MNISA for Staffordshire and Stoke-on-Trent can provide support to any family who has received maternity or neonatal care at:

- The Royal Stoke University Hospital/County Hospital, Stafford (University Hospitals of North Midlands)
- Queen's Hospital, Burton/Samuel Johnson Community Hospital, Lichfield (University Hospitals of Derby & Burton)
- New Cross Hospital/Cannock Chase Hospital (Royal Wolverhampton Trust)

Recent reports and inquiries into maternity and neonatal care identify a range of adverse outcomes that can occur during care. During the initial pilot phase, the MNISA can support families if they have experienced any of the following adverse outcomes:

- Where a baby has been stillborn (after 24 weeks of your pregnancy).
- Where a baby has died at or in the first 28days after their birth.
- The baby's mother has died within one year of pregnancy/childbirth (and of a related cause).
- Unexpected or unplanned hysterectomy at/or within 6 weeks of pregnancy or childbirth.
- Unexpected admission to the critical or intensive care unit as a result of a complication associated with pregnancy/childbirth.
- Where a baby had, has or may have a brain injury.

The role of the MNISA is to guide families through any investigation and complaint processes and attend inquests/meetings with professionals with the families. The MNISA also supports families through the maternity and neonatal healthcare system to help them understand what happened to them or their baby and offer signposting to support organisations.

In addition to supporting families, the MNISA will regularly report to LMNS and Trust level boards, providing robust feedback and recommendations to improve service user experience and patient safety.

The role and learning themes identified across all MNISA pilots will be evaluated nationally to highlight key improvement areas. This is expected in the Autumn of 2025.

3.3.7 The maternity and neonatal voices partnership (MNVP)

The MNVP listens to the experiences of women and families and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care.

The Staffordshire and Stoke-on-Trent MNVP has an independent chair and includes a team of champions (volunteers who are local service users), a project support officer, the Local Maternity and Neonatal System, commissioners and providers (midwives, neonatal nurses and doctors) working together to review and contribute to the development and co-production of local maternity care.

Listening and responding to all women and their families is an essential part of safe and high-quality care. It improves the safety and experience of those using maternity and neonatal services within our system and helps address health inequalities. The MNVP's focus is to gather feedback from women/birthing people and their families around their experiences, to help shape the future of local maternity services and drive forward improvement.

Our Equity and Equality Action Plan aims are to improve equity for mothers and babies from black, Asian, and mixed ethnic groups and those living in the most deprived areas, and to promote race equality within staff groups. The MNVP will seek out and listen to these voices to ensure services are representative of the whole local population.

4 Birthing services case for change

4.1 Introduction

This section sets out the case for change for proposals for birthing services previously provided at County Hospital in Stafford and Samuel Johnson Community Hospital in Lichfield.
It includes:

- Local context
- The clinical sustainability case for change
- The workforce sustainability case for change

4.2 Local context

Maternity services in Staffordshire and Stoke-on-Trent in recent years have been provided from a number of locations;

- Consultant-led births in Royal Stoke University Hospital and Queen's Hospital, Burton
- Midwife-led births in Royal Stoke University Hospital and Queen's Hospital, Burton
- Freestanding Midwifery birth units at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield
- Home birth services

All women are asked about their preferred choice of place of birth during an assessment with the midwife. The midwife will take a number of factors into consideration including a woman's weight, age, overall health and any history of previous deliveries. The table below illustrates the differences between the maternity services available in our area and the key benefits of each of these.

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	• 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

Table 2: maternity services by type and location

Freestanding Midwifery Birth Units are midwife-led units, separate from an acute hospital, where some pregnant women (considered low-risk) can choose to give birth. They do not provide 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.

Women also have the choice of alternative providers outside of Staffordshire and Stoke-on-Trent. Data from 2019/20 indicates that around 24% (26,732/11,468) of births for the Staffordshire and Stoke-on-Trent population occur in hospitals that are outside of our local area. Both local and out of area maternity services are illustrated in the below map.

Figure 5: Local and out of area maternity services

The table below provides further detail on the utilisation of services within the Staffordshire and Stoke-on-Trent area compared to services that border our local area and those that are out of area. These figures cover all birthing services. Since 2019/20 an additional 121 women have delivered in neighbouring area units however the data does not identify whether these were within consultant-led units or within midwife-led units.

	2019/20	2020/21	2021/22	2022/23	2023/24
In area services	8736 (76.18%)	8275 (75.60%)	8293 (74.82%)	8154 (73.31%)	7783 (72.94%)
Neighbouring area services	2582 (22.51%)	2527 (23.09%)	2642 (23.84%)	2770 (24.90%)	2703 (25.33%)
Out of area services	150 (1.31%)	144 (1.32%)	149 (1.34%)	199 (1.79%)	184 (1.72%)
Total	**11468**	**10946**	**11084**	**11123**	**10670**

Table 3: Maternity service utilisation

4.2.1 Royal Stoke Hospital

The University Hospitals of North Midlands NHS Trust provides general acute hospital services for approximately 900,000 people in Staffordshire, South Cheshire and Shropshire. The Trust also provides specialised services for three million people

across a wider area, including neighbouring counties and north Wales. These specialised services include cancer diagnosis and treatment, cardiothoracic surgery, complex orthopaedic surgery, laparoscopic surgery, the management of liver conditions, neurosurgery, neonatal intensive care, paediatric intensive care, renal and dialysis services, respiratory conditions, spinal surgery, trauma and upper gastrointestinal surgery. The Trust employs over 10,000 staff and has more than 1,250 inpatient beds. Services are provided at Royal Stoke University Hospital, County Hospital and a small number of community settings.

Royal Stoke University Hospital is the main site for all maternity services for the Trust, with County Hospital providing a range of antenatal and postnatal services. There were just under 6,000 deliveries in total during 2023/24. The Royal Stoke unit comprises of a delivery suite with maternity theatres, induction of labour beds and enhanced recovery area. There are antenatal and postnatal wards, a midwifery birth centre, a day care assessment area and maternity assessment unit (triage). The service also provides specialist substance misuse clinics, perinatal mental health and lifestyle clinics, fetal medicine and maternal medicine services. These services are available to pregnant women from across Stoke-on-Trent and Staffordshire.

In October 2014, the Mid Staffordshire NHS Foundation Trust (Stafford) was formally dissolved and services were transferred to University Hospitals of North Midlands NHS Trust and The Royal Wolverhampton Hospitals NHS Trust.

As part of this dissolution, the Trust Special Administrators (TSA) detailed a number of service moves that needed to take place in order to ensure clinical and financial sustainability. All of the proposed changes were validated by local clinical groups (commissioners and providers) and national clinical bodies including the relevant Royal Colleges.

As these were major changes to service provision, the proposals were subject to extensive consultation with the public, GPs and other stakeholders during summer/autumn 2013. A report and recommendations were delivered to the Secretary of State in December 2013. The proposals were signed off by the Secretary of State in February 2014. Implementation of those recommendations followed from November 2014.

One of the services that the TSA recommended to be moved during the consultation was consultant-led obstetrics. The two main factors behind the recommendation to move obstetrics were:

- a consultant-led obstetric unit needs other support services such as neonatology, paediatrics, intensive or critical care services, general surgery and anaesthetics. Many of these services had already been moved to the RSUH site as part of the TSA recommendations and therefore the consultant-

led obstetrics unit needed to move due to the interdependency of these services.

- the consultant-led obstetric unit in Stafford was one of the smallest maternity units in the country. In 2012/13 it ranked 127 out of 139 maternity services in England based on its number of births.

The TSA stated that a midwife-led unit would need to manage a minimum of around 350 births a year to cover the cost of the service and the evidence used in the draft report showed this number would not be achieved. This also aligned with the Royal College of Midwives' guidance for setting up and sustaining freestanding midwifery birth units.

4.2.2 County Hospital, Stafford

NHS England's publication *Better Births: Improving outcomes of maternity services in England* recommends the development of community hubs to: "help every woman access the services she needs, with obstetric units providing care if she needs more specialised services."

The Women's Unit, which was developed at County Hospital, has historically provided a range of services that the national review recommends in a community hub, including:

- consultant-led antenatal clinics
- community midwives base
- a homebirth team
- diagnostics including ultrasounds and glucose tolerance testing.

The Community Midwifery Team provide antenatal care, booking clinics, postnatal care and an on-call rota to support the homebirth service and the FMBU birth activity. It also means that all maternity-related outpatients and gynaecology procedures such as colposcopy, hysterectomy and urogynaecology clinics are physically co-located.
Antenatal services continue to be offered at County Hospital and include:

- Antenatal clinics throughout pregnancy
- Routine ultrasound scanning
- Glucose Tolerance Testing (GTT) clinics
- Vaginal birth after caesarean section clinics
- Lifestyle clinics
- Vaccination services

The Trust has continued to offer postnatal care at the unit in addition to the range of antenatal services that are offered. This also includes support services such as the bereavement service and the Birth Afterthought clinic.

Prior to the temporary closure of birthing services, the unit at County hospital provided a low-risk birthing option. This consisted of **two rooms** (Labour, Delivery, Recovery

and Post-Partum rooms, also known as LDRP rooms). These allow mothers to give birth, bond with their baby and recover in one place until families are ready to go home.

The temporary closure of birthing services at County Hospital means it is these two rooms that have not been utilised for births since March 2020. All other services as described above continue to be offered at the site with LDRP rooms available at Royal Stoke Hospital.

4.2.3 Queen's Hospital, Burton

The University Hospitals of Derby and Burton NHS Foundation Trust provides acute and community services to people in Derbyshire and Staffordshire. In total the Trust has around 1,700 beds and employs around 13,000 staff. The Trust is comprised of two hospitals; Royal Derby Hospital and Queens Hospital, Burton. University Hospitals of Derby and Burton NHS Foundation Trust also provides community inpatient services in Derbyshire and Staffordshire.

Queens Hospital Burton is the principal provider of acute hospital services for the residents of Burton upon Trent and surrounding areas including South Staffordshire, South Derbyshire and Northwest Leicestershire. It provides a range of maternity services including both antenatal and postnatal ward as well as an antenatal clinic. There are approximately 2700 deliveries each year, with caesarean sections and options for pool-based birth.

Community services include community health inpatient services, community end of life services, community urgent care services and community services for adults. These are provided across three locations; Sir Robert Peel Hospital, London Road Community Hospital and Samuel Johnson Community Hospital. Across the Trust locations, University Hospitals of Derby and Burton NHS Foundation Trust has 75 wards and 50 operating theatres.

4.2.4 Samuel Johnson Community Hospital, Lichfield

The Samuel Johnson Community Hospital is part of University Hospitals Derby and Burton NHS Foundation Trust. The hospital provides a minor injuries unit, medical care and rehabilitation on two wards, maternity services and outpatients. The hospital is based in Lichfield, 13 miles from the main Trust site in Burton Upon Trent.

The community midwifery team based at Samuel Johnson Community Hospital provide antenatal care, booking clinics, postnatal care and have historically, run an on-call service to support the homebirth service and the FMBU birth activity.

Antenatal and postnatal clinics continue to be offered at the site and the newborn hearing screening team attend and host clinics.

Prior to the temporary closure of birthing services, the unit at Samuel Johnson Community Hospital provided a low-risk birthing option. This consisted of three rooms (Labour, Delivery, Recovery and Post-Partum rooms, also known as LDRP rooms). These allow mothers to give birth, bond with their baby and recover in one place until families are ready to go home.

The temporary closure of birthing services at Samuel Johnson Community Hospital means it is these **three rooms** that have not been utilised for births since March 2020. All other services as described above continue to be offered at the site with LDRP rooms available at Queen's Hospital, Burton.

4.2.5 Low risk maternity pathway

The figure below illustrates the routine care pathway for low-risk pregnancies.

Low-risk women are supported within their local community, rather than within an inpatient setting, for both antenatal and postnatal care. In addition to offering this support at County Hospital and Samuel Johnson Community Hospital, women can also access these services within alternative community sites or clinics held within GP practices across Staffordshire and Stoke-on-Trent.

Planning where to give birth begins early in pregnancy. Maternity staff in Staffordshire and Stoke-on-Trent are trained to provide up to date information to help support this individual care planning. Women who are at low risk of having complications are currently offered a choice of place of birth either at home, in an alongside midwifery birth centre or a consultant unit. Individual circumstances and choices, including what would happen if an obstetrician needs to be involved, are discussed and a personalised plan put in place.

Throughout the pregnancy the named community midwife undertakes a risk assessment at each contact and within the last trimester will support the woman to develop their birth plan. Discussions about the safest place to give birth are evidence based and those at low risk of complications are encouraged to choose a midwifery led care pathway in line with the Birthplace study[22].

- For women having a second or subsequent baby, home births and midwifery unit births appear to be safe for the baby and offer benefits for the mother and those women who had births in a midwifery led setting were far less likely to have a caesarean section, instrumental delivery or episiotomy.
- For women having a first baby, a planned home birth increases the risk for the baby.
- For women having a first baby, there is a fairly high probability of transferring to an obstetric unit during labour or immediately after the birth.

[22] Microsoft Word - Report 1_Safety of birthplace and implications overview Feb 2016

- For women having a second or subsequent baby, the transfer rate is around 10%.

The birth plan includes the planned choice of place of birth, any special wishes for during labour such as who will support as birth partner and pain relief.

Both providers offer a home birth service where community midwives provide the care. Each Trust also offers a midwifery led care setting within the main maternity units.

Royal Stoke Hospital has 4 Midwifery led care (MLC) rooms which are close to the consultant unit with a very short transfer time if medical support is needed. This area is staffed by Midwives and support workers and is protected capacity for low-risk births. There is also a birthing pool here. Whilst there are designated rooms for low-risk births within the midwife-led unit at Royal Stoke, additional capacity is available within the consultant-led unit. If additional capacity were required, women would be supported to have a midwife-led birth within the consultant-led unit.

Queens Hospital, Burton have 2 rooms identified on the consultant birth centre for use by women on an MLC pathway. This is protected capacity for low-risk births but further rooms can be flexed to support low risk care if required. A birthing pool is available and Midwives are allocated from core maternity unit staff.

Both Trusts are committed to retaining midwifery led birthing options for women on a low-risk pathway as seeking the safest outcomes for mother and baby are paramount. Birthrate plus assessments (described in more detail in section 4.4) ensure there are the right number of midwives are in place to support both low and high-risk pathways. This assessment is completed every three years to take into account any changes in the local birthrate and the complexity of those births.

The birthing element (labour and birth) account for one day within a low-risk pathway and is the area within scope of this PCBC. The proposal would not directly impact the end-to-end pathway for maternity services. Women continue to be assessed throughout their pregnancy, as described above, to check for any developing risk factors or complications, which may require a change of delivery options. There would be no change to routine antenatal and postnatal services which would remain locality based as recommended by both the National Maternity Review (Better Births) and the TSA (for UHNM).

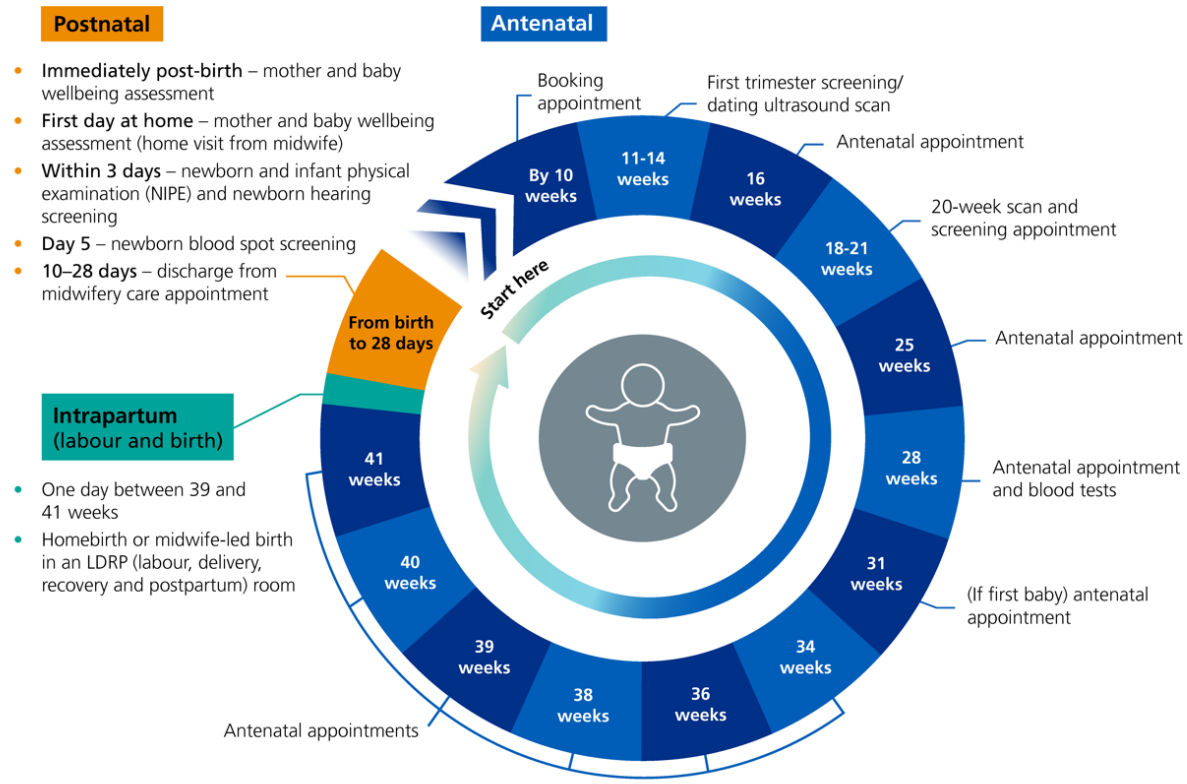


Figure 6: routine care pathway for low-risk pregnancies

4.3 Local challenges

Birthing services (labour and birth) at the Freestanding Midwifery Birth Unit (FMBU) at County Hospital, Stafford provided by University Hospitals of North Midlands and Samuel Johnson Community Hospital (SJH), Lichfield, provided by University Hospitals of Derby and Burton NHS Foundation Trust (UHDB), were temporarily suspended in March 2020 at the beginning of the COVID-19 pandemic. This enabled maternity staff to be redeployed to the Trusts maternity units in accordance with guidance published by Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) in April 2020 *(Guidance for the provision of midwife led settings and homebirth in the evolving coronavirus pandemic, April 2020).*

Home birth services have also been intermittently suspended following the pandemic and neither Trust has been able to sustainably reinstate these services due to the ongoing midwifery staffing workforce shortage until recently. Both Trusts began booking women into the home birth service during their early pregnancy from 01 April 2024 which now means that women have the full range of low-risk birth settings to choose from.

Whilst the initial closures were directly related to COVID-19, staffing challenges in the maternity workforce historically prevented both Trusts from being able to safely reopen these units to birthing services.

Given the learning from high profile investigations into maternity services e.g. Shrewsbury and Telford / East Kent / Nottingham there is greater focus on the delivery of safe staffing levels across the breadth of maternity services.

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

The current position continues with the arrangements described above. Women who may have previously chosen to give birth in one of the FMBUs are offered a midwife-led birth at the acute Trusts. Women also have the option to give birth at home. Both Trusts began booking women into the home birth service during their early pregnancy from 01 April 2024 which now means that women have the full range of low-risk birth settings to choose from.

4.4 Clinical sustainability case for change

A major influence for the proposal is the rising complexity of women being seen. 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 antenatal, intrapartum and postpartum care. Birthrate Plus® assessments are completed for a particular Trust's footprint based on clinical indicators of the wellbeing of the mother and infant(s) throughout labour and delivery within a given unit. The tool is designed to help maternity units calculate how many midwives they need to deliver one-to-one care in labour, taking account of both the local birth rate and the complexity of the caseload.

The Birthrate Plus® assessment completed in 2022 for UHNM also shows that the complexity of women at the birthing units has increased significantly over the years. 69.9% of women in the UHNM delivery suite are in the highest levels of complexity categories IV & V. These women would only be cared for at Royal Stoke University Hospital. 96.5 % of women on the delivery suite are moderate or high risk, which means that 83.2% of all women at UHNM are moderate or high risk overall.

The continued increase in case mix complexity means that potentially less than 17% of women may be suitable for low-risk care across the UHNM footprint (this was 29% in 2017/18 at the point the West Midlands Clinical Senate originally reviewed the service at UHNM).

UHNM Royal Stoke maintains a full service for the alongside Birthing Centre, offering low risk midwife-led care to all women who are suitable.

Despite repeated campaigns to promote the FMBU, women choosing to give birth there continued to fall. By 2019/20 this had dropped to less than 1.6% of all UHNM births.

It is also of note that the Birthrate Plus® assessment at UHNM did not take into consideration the provision of birthing services at Stafford as it was closed at the time. For UHNM to re-open birthing services at the FMBU with the same staffing model as before a further investment of 12.15wte band 7 midwives would be required.

The Birth-rate Plus® assessment completed in 2021 for UHDB identified that between 63.9% (QHB) and 68.9% (RDH) of women were in the two highest levels of complexity categories of care, IV and V, a percentage that is higher than the average for England of 58% (based on 55 maternity units from a wide range of size and location), and a figure that had risen by 6% since the previous Birth-rate Plus® assessment in 2017. These women would only be cared for at either QHB or RDH where there is obstetrician-led care. Overall, the 2021 Birthrate Plus® assessment showed that just over 82% of all births at UHDB fall into the moderate or high-risk categories.

Complexity of workload has continued to rise since 2021 with more women presenting with comorbidities and requiring consultant-led care. These factors substantially reduce the number of women suitable for low-risk care than prior to the temporary suspension of births at Samuel Johnson Community Hospital.

Similar to UHNM, UHDB saw low numbers of women choosing to give birth at the FMBU at SJH despite promoting the FMBU. In 2019/20, 2.5% of all UHDB births were at the FMBU.

Complexity of workload has continued to rise since the Trusts Birthrate Plus® reports were finalised with more women presenting with comorbidities and requiring consultant-led care. These factors substantially reduce the number of women suitable for low-risk care than prior to the temporary closures of birthing services at the FMBUs.

It is recognised that a whole system approach is required to improve the overall health of the population and in turn increase the number of low-risk pregnancies and births. The Staffordshire and Stoke-on-Trent Integrated Care Partnership Strategy outlines how ICS partners will work to improve the health of our population, including pregnant women and new families to improve health outcomes across the life course and prevent infant mortality (described in further detail in Section 2).

Better Births (2016) recommended that maternity services should develop a continuity of carer model to ensure safer care based on a relationship of mutual trust and respect

between women and their midwives. The continuity of carer model is a way of delivering maternity care so that women receive dedicated support from the same midwifery team throughout their pregnancy.

This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience; and was the single biggest request of women of their services that was heard during the National Maternity Review.

During the pandemic in 2020, the full scale roll out of the model was paused, recognising the workforce challenges services were experiencing at the time.

Understanding the change in demographics of women in Staffordshire and Stoke-on-Trent has enabled both Trusts to develop equity and equality plans to support those most vulnerable and at risk of poorer outcomes including a targeted approach to continuity of carer. This enhanced model of care will ensure, that in line with the NHS Long Term Plan, communities in need can be targeted to ensure equity of outcomes is improved.

Both Trusts plan to introduce geographically based teams who will work with pregnant women from the most deprived areas and provide continuity of carer across the whole maternity pathway. Utilising the midwifery workforce in a more targeted way rather than through the FMBU will ensure those most in need are supported.

In 2019/20, 94 women (an average of 8 per month) gave birth at County Hospital and 220 women (an average of 18 per month) gave birth at Samuel Johnson Community Hospital. 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 FMBU to ensure this. The number of births per year at the Samuel Johnson Community Hospital also fell short of this number.

The number of births within the FMBUs in the years prior to the temporary closure is included in the table below. There is no available data beyond March 2020 as the units have remained temporarily closed to births and therefore no women have given birth within these units.

Freestanding Midwifery Birth units	Number of Births				
	2015/16	2016/17	2017/18	2018/19	2019/20
Samuel Johnson Hospital	not available*	187	260	216	220
County Hospital	121	137	116	90	94

Table 4: Number of births at the freestanding midwifery birth units

*Due to the merger of Burton Hospitals NHS Foundation Trust and Derby Teaching Hospitals Foundation Trust and the subsequent merger of clinical system, data from 2015/16 is unavailable

The graphs below, show the demographics of women using the FMBUs. The graphs highlight where women gave birth within the FMBU or were transferred to an acute hospital after initially arriving at the FMBU. As the units have remained temporarily closed to births since March 2020, the most recent data from 2019/20 has been illustrated.

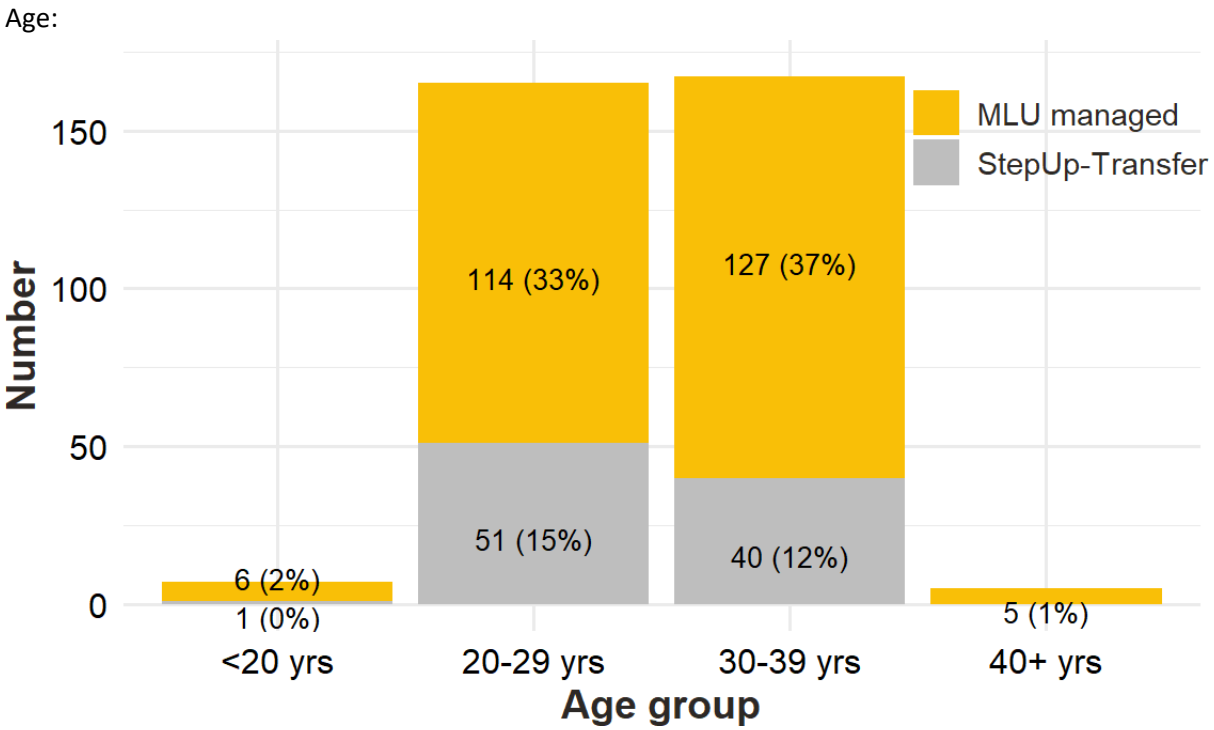


Figure 7: age group of people who used intrapartum services at the FMBUs during 2019/20

Deprivation:

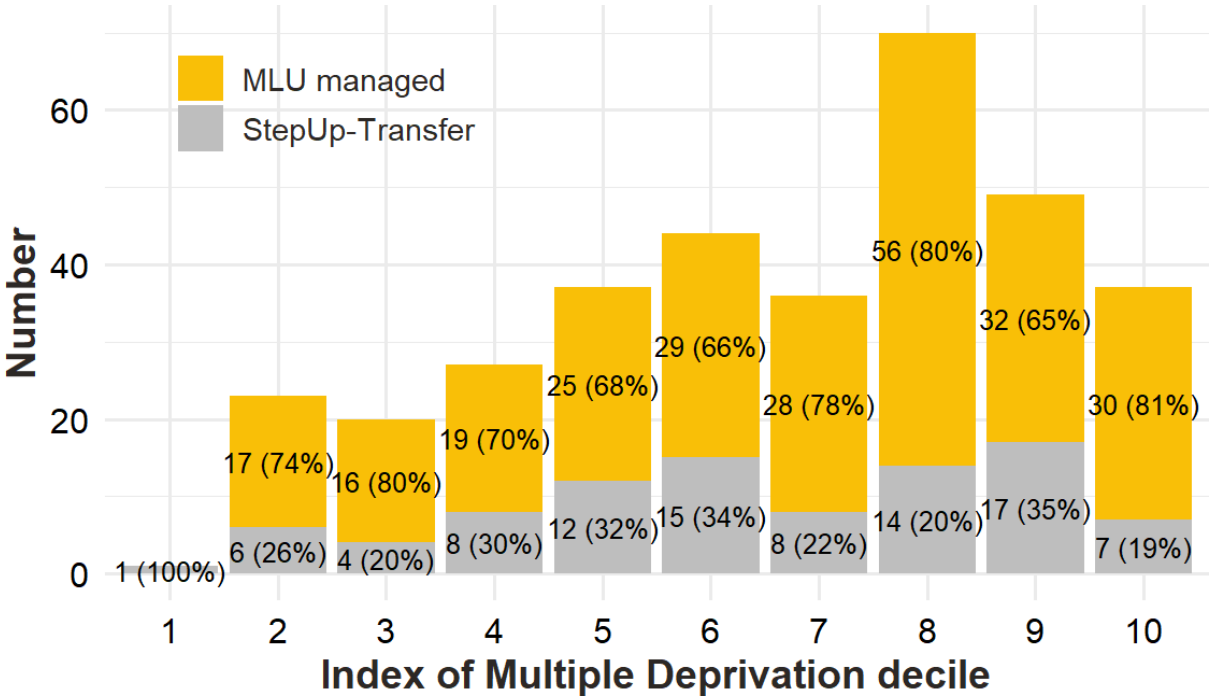


Figure 8: IMD deciles of people who used intrapartum services at the FMBUs during 2019/20

Ethnicity:

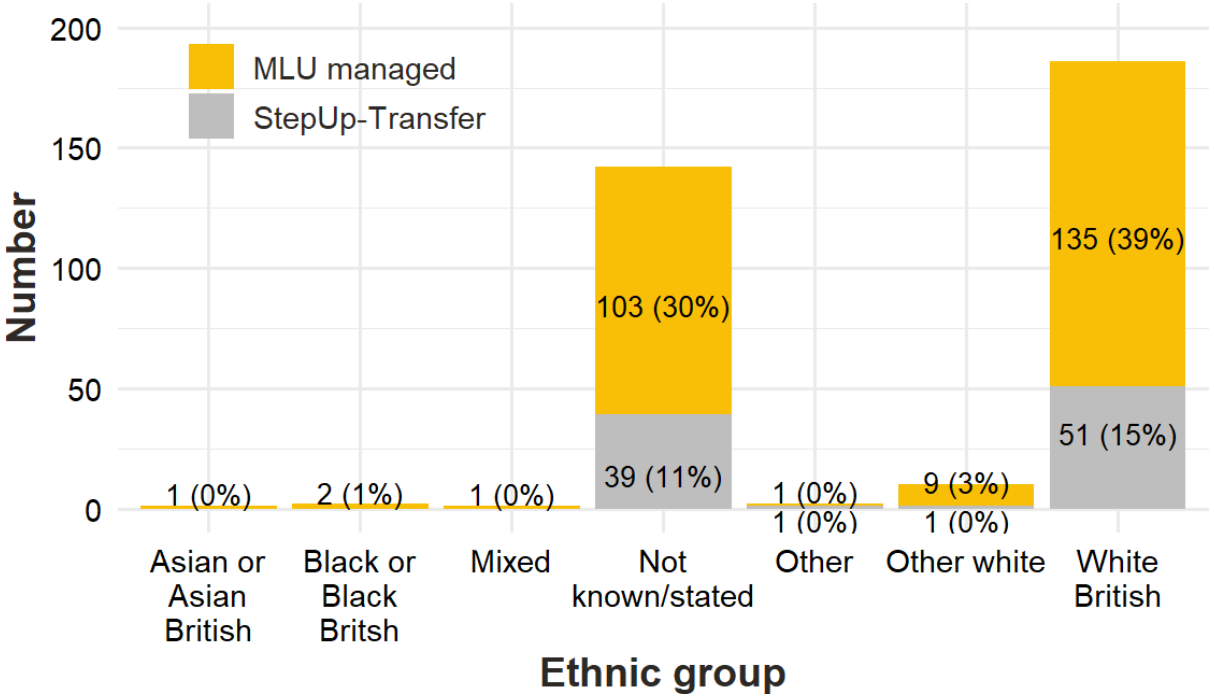


Figure 9: Ethnic group of people who used intrapartum services at the FMBUs during 2019/20

The map below highlights the place of residence of those that gave birth within the FMBUs during 2019/20:

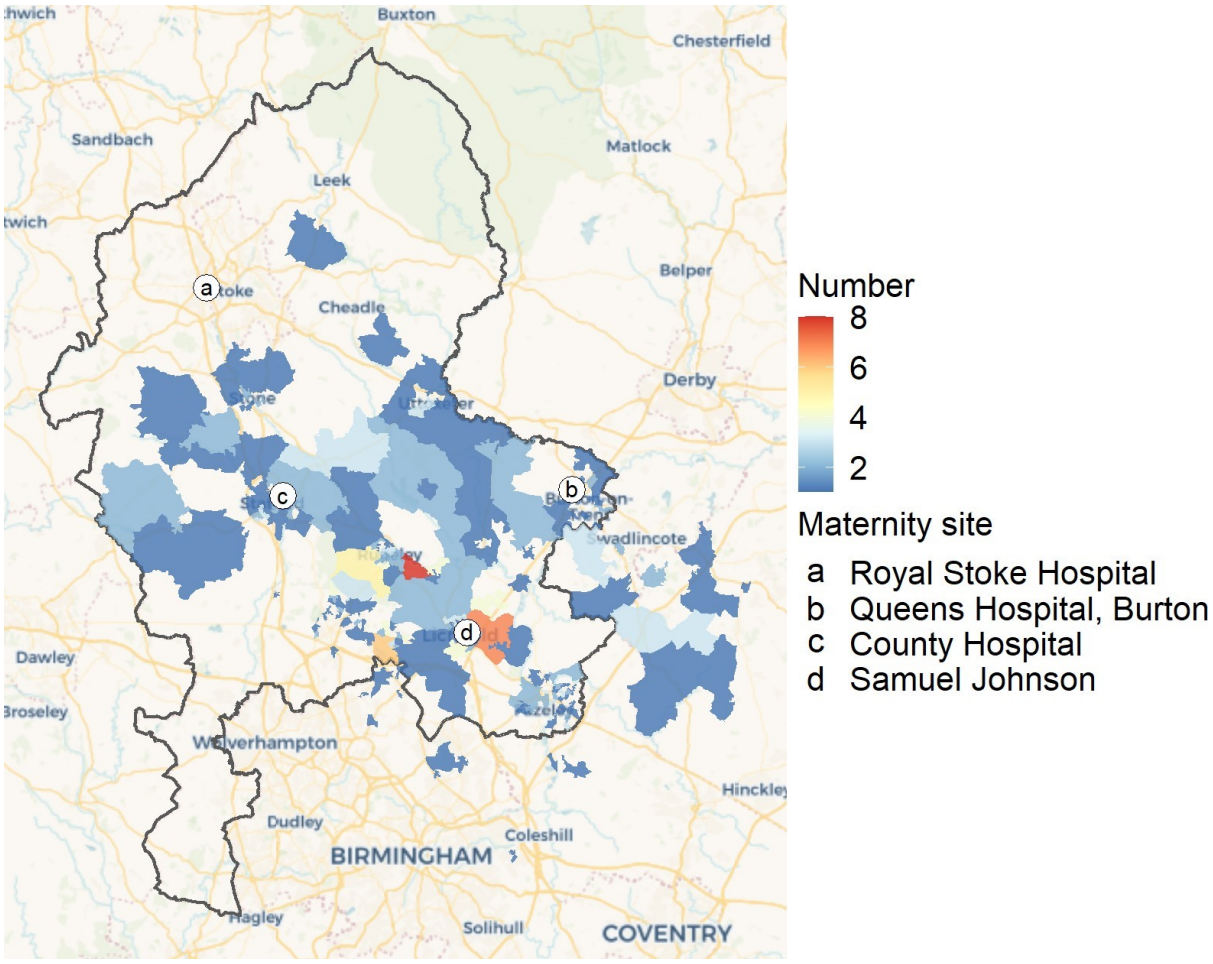


Figure 10: place of residence of people who used intrapartum services at the FMBUs during 2019/20

In contrast, the number of births within the consultant-led units and alongside midwife-led units/services for the year prior to the closure and in more recent years are included the table below.

Hospital	Birth Type	2019/20	2020/21	2021/22	2022/23	2023/24
Royal Stoke Hospital	Consultant-led	5,264	5,283	5,428	5,549	5,299
	Midwife-led	970	880	666	543	595
Royal Derby Hospital	Consultant-led	4,770	4,892	5,021	5010	4938
	Midwife-led	802	641	853	819	737

Queen's Hospital, Burton	Consultant-led	2,329	2,231	2,581	2,715	2,528
	Midwife-led	584	727	380	0*	0*

Table 5: Number of births within the acute units

*During 2022, midwife-led births were included within the consultant-led data at Queen's Hospital Burton due to a change in the way the overall data was electronically collated. This meant midwife-led and consultant-led births could only be disaggregated manually. The introduction of Badgernet, a new electronic maternity record, in June this year is expected to support the service to electronically capture the different pathways of births going forward.

Although the Trusts promoted the FMBUs, the number of births there continued to fall, and had dropped to less than 3% off all births across both sites at the time of the temporary closures as most low-risk women were choosing midwife-led births at the main hospitals instead.

It is unlikely that the number of births within the FMBUs would rise if they were to re-open due to the trajectory for the high-risk births as outlined within the Birthrate Plus® Reports.

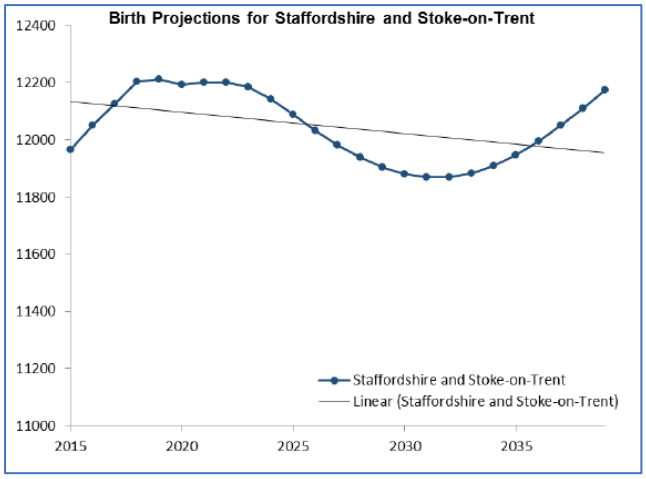
Consideration has been given the women choosing to give birth outside of the Staffordshire and Stoke-on-Trent area and whether the number of births at the FMBU would increase if these women chose to give birth within the two FMBUs. During 2023/24, an additional 121 women gave birth within neighbouring hospitals when compared to the number of women who gave birth in neighbouring hospitals during 2019/20 (Table 3 within 4.2). The data does not identify whether these are high-risk or low-risk women who may or may not choose to give birth within the two FMBU within Staffordshire and Stoke-on-Trent. Taking these numbers into account this would still not meet the minimum of 350 births per year that were recommended for an FMBU to be clinically and financially viable.

There were just over 10,500 births during 2023/24 within the Staffordshire and Stoke-on-Trent population. 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. ONS population projections are utilised to ensure uniformity of approach across all platforms and programmes of work within the NHS. ONS calculations are complex and allow for a degree of housing growth and population in-flow/out-flow which aligns to the data included within district and borough locality plans, for example the growth within the Lichfield population due to local housing development. ONS population projections are

therefore the standard used in NHS statistical modelling and planning assumptions.

- 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.



Age vs growth projections

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

Figure 11: birth projections for Staffordshire and Stoke-on-Trent

This expected fall in births over the coming years will also be accompanied by births that are taking place which are increasingly more complex. Developing and sustaining a culture of safety is one of the key themes within the three-year delivery plan and therefore it is key the ICS ensure appropriate services are in place to meet the changing needs of the population.

The Birthplace in England Research Programme (2022), coordinated from the National Perinatal Epidemiology unit, University of Oxford, identified that whilst midwife-led birth units appear to be safe and offer benefits to the mother, especially for low-risk mothers having a second or subsequent baby, for women having a first baby there is a high probability (36% chance) of needing to be transferred to an obstetric unit during labour or immediately after birth.

Skill mix and sustained competency of midwives is also a key safety factor to consider when birthing numbers are so low.

4.5 Workforce sustainability case for change

Staffing shortages in midwifery remain a challenge across the NHS with a shortage of just under 2,500 midwives across England (Royal College of Midwives, 5 April 2023). Recent investigations into maternity services have emphasised how important it is to maintain safe staffing levels in line with Birthrate Plus®.

One of the key themes within the three-year delivery plan for maternity and neonatal services focuses on workforce. NHS England's report acknowledges that the ambitions of the plan "can only be delivered by skilled teams with sufficient capacity and capability" and that currently services do not have the staff they need. As a result, Objective 5 within the delivery plan is to grow the workforce.

Birthrate Plus® workforce assessments have been completed for UHNM and UHDB with both Trusts Boards approving an increase in midwives to achieve the required midwifery staffing levels. This has been enabled through a combination of Ockenden funding and Trust investment. Recruitment campaigns have been undertaken at both Trusts and progress with recruitment has been made. Both Trusts have a recruitment trajectory to meet safe staffing requirements in line with Birthrate Plus®, by October 2024 and includes newly qualified international midwives and midwives acquired through the recruitment campaign and events.

The Birthrate plus® assessment completed for UHNM in July 2022 outlines the following baseline staffing requirements based on 25.99% uplift. The full Birthrate plus® assessment for UHNM is included in Appendix 01.

Clinical WTE required	
Delivery Suite: • Births • A/N cases • Non-viable pregnancies • Escorted transfers out • Inductions of labour	83.57wte
Triage - BSOTS Model & additional hrs	13.17wte
Midwife Birth Centre • Births & postnatal care • Births only • Transfers to Delivery Suite • Triage cases	12.15wte
Antenatal Ward - 305 • A/N Admissions • Inductions of Labour Postnatal Ward - 306 • Postnatal women • NIPE • Extra Care Babies • Postnatal readmissions	78.23wte *(may Include MSWs postnatal care)*

• Postnatal Day Attenders	
Outpatients Services • Midwives/Specialist clinics • Midwife scan review clinics • Obstetric/Specialist clinics • Fetal medicine • Day Assessment Unit	8.75wte MWs 3.46wte
Community Services: • Home births • Community AN & PN care • Attrition • Additional safeguarding FMBC – Stafford County • Obstetric clinics • Day Unit • Transfers out	 69.38wte *(may Include MSWs - postnatal care* 3.17wte*
Total Clinical WTE	**271.88wte RMs & PN MSW**

Table 6: UHNM midwifery staffing requirements identified within the Birthrate Plus® assessment

*As the FMBU was closed to births at the time of the assessment, the staffing calculation is based on antenatal and postnatal care only.

The Birthrate plus® assessment completed for Royal Derby Hospital in May 2021 outlines the following baseline staffing requirements based on 24% uplift. The full Birthrate plus® assessment for UHDB is included in Appendix 02.

Royal Derby Hospital **Annual Data 2020/21** • Total Deliveries = 5604 • Total Community Cases = 8062	
Clinical required	**WTE**
Delivery Suite • Births • A/N cases • Escorted transfers out • Non-viable pregnancies	 68.05wte (without IoLs) (71.82wte inc IoL)
Triage / PAU	18.05wte
Induction of labour activity	3.77wte

Midwifery Led Unit: • Births only • PN care & NIPE • Transfers to DS **small % women transferred to PN ward often for baby monitoring so included in ward staffing*	14.72wte
Ante Natal Ward: • A/N Admissions • Postnatal women • NIPE • Extra Care Babies • Postnatal readmissions	7.37 57.35wte (*includes band 3 support staff)*
Outpatients Services • All Midwife Led Clinics • All Obstetric Led Clinics • Specialist Obstetric Clinics	9.75wte
Community Services: • Home births • Community AN & PN care • Attrition • Additional hours for Safeguarding	77.01 (*includes band 3 support staff)*
Total Clinical WTE	**256.07wte**

Table 7: Royal Derby Hospital midwifery staffing requirements identified within the Birthrate Plus® assessment

The Birthrate plus® assessment completed for Queen's Hospital, Burton in May 2021 outlines the following baseline staffing requirements based on 24% uplift. The full Birthrate plus® assessment for UHDB is included in Appendix 02.

Queens Hospital Burton Annual Data 2020/21 • Total Deliveries = 2995 • Total Community Cases = 3792	
Clinical required	**WTE**

Delivery Suite • Births • A/N cases • Escorted transfers out • Non-viable pregnancies	36.08wte
Triage / MAU	13.89 wte
Induction of labour activity	2.04wte
Ante Natal Ward: • A/N Admissions • Postnatal women • NIPE • Extra Care Babies • Postnatal readmissions	4.04 28.25wte (*includes band 3 support staff)*
Outpatients Services • All Midwife Led Clinics • All Obstetric Led Clinics • Specialist Obstetric Clinics	3.24wte
Community Services: • Home births • Community AN & PN care • Attrition • Additional hours for Safeguarding	34.13 (*includes band 3 support staff)*
Samuel Johnson FMU • Births (total Care) • Transfers to Obstetric Unit • Triage cases • GTT Clinic & Anti D	**8.48***
Total Clinical WTE	**130.15wte**

Table 8: Queen's Hospital Burton midwifery staffing requirements identified within the Birthrate Plus® assessment

*Calculated based on antenatal and postnatal activity through the FMBU and birth activity from when the unit was open. To run the birthing services at the FMBUs and safely staff them with two midwives per shift 24/7, a minimum of 12.15 experienced midwives (whole-time equivalent) would be needed.

As of October 2023, both Trusts remained short of the budgeted establishment. UHNM had midwifery vacancies at 57.53 whole time equivalents (wte) and UHDB had vacancies at 41wte.

By March 2024, the vacancy position had significantly improved as a result of recruitments drives at both Trusts. At that time UHNM had a vacancy position of 25.03wte and UHDB has a vacancy position of 3wte. There are an additional 17 WTE funded as part of the maternity safety case and UHDB is utilising bank staff to fill these posts. The Trust has recently made the decision to appoint to these posts. Both Trusts continue to actively recruit to achieve the full midwifery establishment.

Both providers have developed a Continuity of carer plan which aligns to the personalised care and choice agenda and the National strategy. They involve ensuring the building blocks are in place for an effective sustainable approach to care for those known to be most at risk of poorer outcomes. The plans include:

- Ensuring workforce establishments align to Birthrate plus assessments and include provision for home births and enhanced continuity of carer models.
- Empowering staff to deliver personalised care by providing time, training, tools and information.
- Re-establishing the home birth service and strengthening this as a choice of place of birth.
- Developing and embedding the personalisation and choice agenda for all pregnant people regardless of risk to ensure they have care that takes into account their physical health, mental health, social complexities and choices.

Whilst safe midwifery staffing continues to be one of the ten safety actions within NHS Resolution CNST maternity incentive scheme a key action of Ockenden the Final Report (2022), the three-year delivery plan also places emphasis on the need to retain the workforce and invest in skills (objectives four and five).

Identifying and implementing ways to improve people's professional experience, and ensuring they have the skills and support they need, are key to staff retention and recruitment.

We must therefore ensure we are implementing staffing models that focus on the longer-term sustainability of the workforce by ensuring staff are working in environments that give them the required experience to not only safely maintain their skills but provides opportunities to grow and develop their skills.

Due to the low number of deliveries at the FMBUs, we must consider how we make the best use of such a scarce clinical resource at a time when the recruitment and retention of midwives is a challenge nationally. With such a low level of demand at these units, we must also consider how we support staff to develop their skills and have a fulfilling and sustainable career within the NHS.

5 Proposal development including patient, public and staff involvement

5.1 Introduction

Patient and public involvement is a priority for the Staffordshire and Stoke-on-Trent ICS. Patients, their families and carers, staff and clinicians and local people have been informed and involved in developing these proposals for the future of maternity services in Staffordshire and Stoke-on-Trent from the outset.

This section of the pre-consultation business case describes briefly:

- Phase one - the initial proposal development and the patient, public and stakeholder involvement that took place during 2019-20 as maternity services were considered as part of the wider Together We're Better transformation programme.
- Phase two – targeted maternity involvement during 2020 as part of the Together We're Better transformation programme.
- Phase three – The process of developing proposals for the future of these services was paused in 2020 as a result of the COVID-19 pandemic. In late summer 2021 the process was started again with further engagement to understand whether there were any additional considerations about the future of maternity services.
- Phase four – Re-established proposal development process undertaken in 2023 along with public involvement to explore all possible proposals for future service provision.
- The ongoing engagement with local authority Health Overview and Scrutiny Committees.
-

Women, their families and carers, staff and clinicians and local people have been informed and involved in developing these proposals for the future of birthing services in Staffordshire and Stoke-on-Trent from the outset. The ICB, along with UHNM and UHDB, used this collective feedback to inform the development of the proposals and this pre-consultation business case and its proposal for the future of birthing services formerly provided at County Hospital Stafford and Samuel Johnson Community Hospital, Lichfield.

This process has been applied in line with the guidance *Planning, Delivering and Assuring service change for patients*[23], published by NHS England in 2018 and updated in May 2022.

[23] NHS Planning, assuring and delivering service change for patients, April 2018

The way in which the proposal for change has been arrived at will, if progressed, be exposed to scrutiny by local authority health overview and scrutiny committees (HOSCs), by patients, the public and other stakeholders, possibly by the courts and possibly by the Independent Reconfiguration Panel (IRP) if a referral is made to the Secretary of State.

It is important that when proposals are developed, a comprehensive range of perspectives is sought to identify the full range of service change solutions that could meet the stated objectives of the programme within available resources.[24]

There is no duty to carry forward to public consultation proposals that in the view of the commissioners are unrealistic, unviable or unsustainable.[25]

The objective of the options appraisal process was to develop proposals for the future of birthing services for women from Staffordshire and Stoke-on-Trent that, until March 2020, included low-risk birthing services at County Hospital and Samuel Johnson Community Hospital. The aim being that proposals that emerge from the process should:

- Fit with the national and local strategy for maternity services.
- Provide the highest quality service across all options for women.
- Make best use of workforce and financial resources and are fit with the overall estates strategy for the system.

Healthcare organisations have a statutory duty to ensure that individuals to whom current or potential future services are being or may be provided are *"involved in the development and consideration of proposals [for changes] where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them [at the point where the services are received by users]"*[26] and this has been taken into account throughout the development of proposals for birthing services previously provided at County Hospital and Samuel Johnson Community Hospital.

Figure 1 in section one illustrates the process that the programme team have undertaken to support the development of proposals. The timeline was impacted by the pause for our systems response to COVID-19. The outputs from the involvement activity have provided valuable information and the options appraisal process included key stages where further patient, public and stakeholder feedback was used to shape and review proposals.

[24] p25, NHS Planning, assuring and delivering service change for patients, NHS England 2018

[25] R(Nettleship) v NHS South Tyneside CCG and Sunderland CCG [2020] EWCA Civ 46

[26] S13Q & 14Z2 National Health Service Act 2006 as amended Health and Social Care Act 2012

5.2 Phase one - Together we're better 2019

5.2.1 Proposal development 2019

The Staffordshire and Stoke-on-Trent system-wide Case for Change[27] set out the needs of the population, provision of health and care at that time and outlined the vision and aims for local health and care in the future.

Whilst developing the case for change a series of interdependency workshops took place to identify challenges and opportunities within and across each clinical programme. A standard approach was undertaken to identify a range of potential scenarios. These in turn were refined in a structured way through the options appraisal process.

To generate a theoretical longlist, the maternity programme considered the fixed points for their service, which included minimal staffing levels, interdependencies with other services such as primary/community care, benefits of co-location as well as the benefits and outcomes for patients. Therefore, it was agreed there would be no case for change in relation to other maternity services, other than the birthing services at the two existing FMBU's. The Case for Change also specifies the need to continue to provide a real choice of maternity care settings for women that meet their needs now and in the future. Such options must be safe, appropriate and high-quality and therefore consideration was given to the best and most viable ways to provide these options.

Key considerations also included volume (number of births at each site) and the number of transfers between site during or after labour.

This strategic view is the background to the development of proposals for the future of birthing services previously provided by at County Hospital and Samuel Johnson Community Hospital. The maternity specific elements outlined within the case for change were developed through the Sustainability and Transformation Partnership (STP) Maternity Programme Board, building on the NHS Long Term Plan.

A Clinical Advisory Group (CAG) for the transformation programme met four times in 2019/20. The CAG is an expert group of clinical leads from across the clinical programmes and organisations, GPs and Public Health clinicians, with the purpose of reviewing the clinical models in the transformation programme throughout the options appraisal process. Maternity services, as one of the elements in TWB, was included in their discussions.

In May 2019, the Case for Change was presented to the West Midlands Clinical Senate (WMCS). The Clinical Senate was of the view that the STP articulated a

[27] Case for Change, Together We're Better, 2019

credible case for change and the aspirational principles of the programme of work were in keeping with the needs of the population, and general NHS national policies and guidance.

In June 2019, the maternity case for change was presented to NHS England and NHS Improvement (NHSEI) alongside the clinical models for four other programmes that were part of the service change process at that point in time. They gave permission to hold engagement events in the summer of 2019.

In June 2019 Staffordshire and Stoke-on-Trent health and care system published its Case for Change document as part of its service transformation plan for services across the area. This set out the needs of the population, the current provision of health and care and outlined the vision and aims for local health and care in the future.

The case for change was articulated to the public during a 12-week listening exercise in summer 2019. 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.

5.2.2 TWB engagement 2019

In order to articulate the maternity case for change a range of materials were produced to inform stakeholders about the listening exercise in summer 2019 and to gather feedback. A mix of communication channels were used to raise awareness about the listening exercise and encourage participation. Information was also shared with stakeholders via the TWB monthly newsletter which was sent to MPs along with members of the public, the voluntary sector, Health Overview and Scrutiny Committee (HOSC) members and chairs, Chief Executives, providers and staff.

There was involvement with a number of organisations who could provide links to seldom heard groups and areas of health inequality including Local Equality Advisory Forum (LEAF), Healthwatch, Support Staffordshire (which provides county-wide support for the Voluntary, Community and Social Enterprise Sector) Burton YMCA, Burntwood Town Council and Staffordshire Sight Loss Association. The communications and engagement team worked with Assist in the North, and with Mind in East Staffordshire, asking for their support to promote the listening exercise across their members. A comprehensive stakeholder mapping exercise was undertaken and was reviewed throughout the engagement phase.

You can read more about our approach in our report of findings[28].

[28] Together We're Better Listening Exercise Report of Findings, 25 October 2019

5.2.3 Findings - TWB engagement 2019

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.

Findings from this engagement exercise were shared with participants at options appraisal events for the public and one for staff on 5 November 2019, and technical

events on 15 October and 14 November 2019 for evaluators, including clinicians, observers, including a patient and public engagement (PPI) representative, and advisers including senior staff.

In addition, the report of findings from the engagement work was presented in a workshop for programme leads/clinical leads and shared by email offering them the chance to ask for any further information /clarity to inform the development of proposals. The Governing Body of Staffordshire CCGs formally received the report on 7 November 2019. A summary, public facing report of findings was published in February 2020[29]. Together We're Better also held workshops in Autumn 2019 to share the feedback from the listening exercise, to discuss the emerging models of care and to seek views on the desirable criteria.

5.2.4 Technical event 1

On 15 October 2019 a technical group consisting of clinicians, operational leads, strategic leads and communications colleagues considered the findings of the TWB listening exercise and defined essential criteria that proposals would have to meet (these criteria would be applied to any proposals within the transformation programme). These were:

- Clinical sustainability.
- Strategic fit.
- Meeting the needs of the population.

The group reviewed the proposals against these criteria. It was agreed at this event that the proposals should remain on the medium list. The previous sections of the pre-consultation business case give detail of the strategic fit, clinical sustainability and needs of the population that were taken into account during the technical event.

5.2.5 Deliberative events Oct/Nov 2019

Following the first technical event (15 October) and as part of the appraisal process for the whole transformation process, four deliberative events were held, one for patients and the public in each of the geographies of Staffordshire and Stoke-on-Trent; North, and South East and South West plus one event for staff:

- 24 October Port Vale football Club
- 28 October Lichfield, George hotel
- 30 October Stafford, Entrust
- 05 November Yarnfield, Stone (Staff only event)

The events covered the five service areas of urgent and emergency care, integrated community services, maternity care services, planned care services and mental health

[29] Together We're Better Listening Exercise, Report of Findings, October 2019

services. The vision, aims and partners involved in the Transformation Programme were outlined and the clinical case for change was presented. In addition, participants heard a summary of the feedback about maternity from the listening events held in Summer 2019. They were shown the clinical model for maternity services.

Benefit	Input	Output	Outcome
Improved experiences for women and their families	• System wide review of care delivery	• Increased access to maternity care	• Reduced stillbirths and neonatal deaths.
Improving patient access	• Development of maternity hubs	• Access to specialists roles throughout maternity.	• Improved continuity of care and carer, delivered closer to home.
Decreasing unwarranted variation in quality, safety and outcomes	• Meeting clinical standards in line with national standards set out in BB and SBLCB	• Provision of equitable choice	• Reduced stillbirths and neonatal deaths.
Solving workforce challenges	• Implementation of Birth Rate plus recommendations	• Appropriate workforce for current and future models of care	• Model of care will be in line with the national standards.
Improving efficiency	• Partnership working between CYP, public health and the NHS	• Integrated care	• Improved experience for women and their families.

Table 9: The expected benefits and outcomes for the maternity model of care

Participants were provided with data packs which provided demographic information, geographical information on service provision and activity level data.

They heard that, given the low number of births at each FMBU and the staffing challenges, there was a need to consider how best to re-provide services.

They heard that the proposals for provision of services, at that stage of the process, included:

- There is no case for change to consider changes to the provision of obstetrician-led services – therefore these would remain in place as they are within the geography.
- Alongside midwife-led units would be offered with obstetric-led units.
- We would look to enhance the home birth model – potentially with scope to consider a joint Staffordshire and Derby home births team.

- We would provide diagnostics and antenatal care at the hub level (community based)
- We would look to provide 'on demand midwife-led units' at hubs or freestanding midwifery birth units to allow women a choice of the equivalent of a home birth in a different setting – therefore a 24/7 midwife-led birthing model would not be offered at the existing FMBU sites.

Participants were asked three questions:

1. Is there anything we need to consider with the potential scenarios outlined for on demand maternity services?
2. Are there any locations missing that could be considered for an on-demand community midwife-led service?
3. What services could be integrated within community hubs?

.

We heard feedback on the following themes: access, staff, integration, patient care, services, demand, positivity around the model and support for particular groups. Only 6 % of respondents at this stage were maternity service users.

The feedback was presented and considered at the second technical event (14 November).

Following the deliberative event, it was agreed to undertake focused engagement with maternity service users, and this is described in section 5.3.

5.2.6 Technical event 2

On 14 November 2019 a further technical session was convened for evaluators and attended by advisors and observers. The evaluators were nominated clinicians and senior managers from across the system, in addition to workforce, estates, and quality representatives.

The evaluators received a report[30] on the outputs of deliberative events held in October and November and reviewed proposals against further essential criteria:

- Demand and capacity,
- Workforce sustainability, and
- Estates

Wide ranging discussions on these points included patient safety, management of risk, transfers of women during labour, home birthing service and staffing numbers.,

After these discussions, it was agreed that the proposals as they stood should remain on the medium list.

[30] Included in Appendix 03

5.3 Phase two – Maternity involvement 2020

Whilst the TWB listening exercise included the system case for change and the clinical model for maternity services across Staffordshire and Stoke-on-Trent, it was also important that more focused involvement activity was undertaken. In 2020, further involvement activities were undertaken and focus groups were held to talk in more detail about maternity services.

Six focus groups were held where maternity leads spoke to 25 new mothers, expectant mothers, people thinking about having a baby and staff who work in maternity services. 40 surveys were also completed. During these groups, leads shared the emerging models of care and sought attendees' views on the desirable criteria for evaluating proposals.

5.3.1 Findings – Maternity involvement 2020

During the 2020 involvement exercises, when asked about their experiences of maternity services, participants largely had positive experiences with healthcare staff – highlighting the good quality of care from community midwives, healthcare assistants, health visitors and paramedics.

Participants also highlighted areas for improvement, specifically:

- **Continuity of carer:** The need for improved continuity of carer to enable them to develop rapport with staff and avoid obtaining 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.

Participants were also asked to share their views on the clinical model and their considerations over where to give birth.

Most participants highlighted that the **safety** of both mother and baby was the main factor in deciding where to give birth. Some participants preferred to give birth at hospital to be reassured in case something went wrong. **Being close to home** and the available options and facilities (e.g. water birth, aromatherapy) were also taken into consideration.
The following factors were also highlighted:

- **Recommendations** from friends and medical professionals.
- **Health needs and requirements.**
- **Partners** being present throughout the birth.

- **Caring environment:** Participants wanted to give birth in a calm, less clinical environment and not feel medicalised.
- **Space, privacy and dignity:** One participant commented they didn't want to hear noise from other patients.

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.

Some participants said they weren't told about other available options such as community or homebirths, therefore they weren't offered a choice in where to give birth.

Participants were asked to share their views on the proposed desirable criteria that would be used to evaluate and score proposals for the future delivery of services across Staffordshire and Stoke-on-Trent.

Most participants agreed with the criteria and its domains and commented that this was a good idea.

However, the importance of **continuity of carer** before and after birth was raised again. Participants suggested this would help to improve communication between patients and medical professionals – avoiding any further issues. Participants also highlighted the need for greater access to breastfeeding and mental health support and for the clinical model to be implemented effectively.

The report of findings was shared with the TWB programme team and was incorporated into the evidence base for the options appraisal process. As the report was finalised during the Covid pandemic it was not published, as with other reports on the website. A full copy is included within Appendix 04.

5.3.2 The continuing process

In January 2020, technical events were held in relation to the other clinical areas subject to the TWB proposal appraisal process, the group were appraised of the process pertaining to maternity services in light of the interdependencies across programme areas.

The short list of proposals was shared with the Programme Board on 10 February 2020, and the Programme Board which included CEOs on 9 March 2020. A briefing paper was developed and circulated to all provider organisations to provide details of the proposals as they stood at that point in time ahead of progressing to the next stage of the business case development.

It should also be noted that a further workshop was held on 3 March 2020. The aim of this workshop was to develop the desirable criteria for all clinical programmes in the TWB transformation programme. This included examination of the proposals for the future of birthing services with discussion of what needed to be considered when deciding options.

The programme was then paused in March 2020 due to the response to the COVID-19 pandemic and re-deployment of staff to manage the response required across system partners to implement COVID-19 safe services and the vaccination programme.

5.3.3 Pause in engagement and involvement

COVID-19 led to a pause in the transformation programme for Staffordshire and Stoke-on-Trent, and to a pause in specific plans for local birthing services.

During the pandemic we continued to have conversations with service users regarding the temporary service changes and that women would continue to be able to choose between a midwife-led birth or a consultant-led birth at both UHNM and UHDB.

5.4 Phase three – involvement in 2021

In Summer 2021 the involvement conversation was restarted by system partners, supported by TWB. It was recognised that services and people's experiences have had to adapt during the pandemic, and so further sense-check involvement activity took place during summer 2021 to understand any new context and to inform this pre-consultation business case.

The engagement sought to gather feedback on

- Experiences of maternity services in Staffordshire and Stoke-on-Trent, before and during COVID-19
- Whether respondents would choose a homebirth and why
- The proposed new continuity of carer and on-demand models of care.

The objectives of this work were to:

- Gather any further information needed to inform proposals for future service change.
- Sense-check the model of care and emerging proposals to inform the business case.

5.4.1 Maternity involvement 2021

The relevant stakeholders received briefings, bulletins and updates, including information sent to organisations' communications teams so that they could pass on the link to the survey and information about the events. Local MPs were kept up to date with regular briefings with the CCG accountable officer and the interim Integrated Care System (ICS) chief executive.

Engagement activity included a short survey available between 16 July and 15 August 2021 and two maternity workshops held on 16 July 2021 and 12 August 2021.

A midpoint review of the involvement took place in August 2021 to identify any gaps in the groups responding. The mid-point review identified that most respondents were white, with underrepresentation from the other groups, a higher proportion of responses were from those without a religion and those stating Christianity as their religion and very little representation from other religious groups. Most respondents were aged 30-39 with a low response from under 25s. There was a lack of representation of those with a disability or long-term condition and most responses have been received from the Stafford area and the North of the county. The Tamworth, Lichfield and areas around Stafford were underrepresented. Responses had been received from across all the IMD deciles. However, the areas of most deprivation could be targeted to gather more responses. Almost three in ten of those participating in the engagement were currently pregnant while over a quarter have recently given birth.

As a result of the mid-point review, it was agreed to continue the engagement activity as planned to ensure that those areas which were underrepresented to date were targeted.

Altogether, at the end of the engagement process, 240 responses were received to the survey and 28 people attended the engagement events.

5.4.2 Summary of responses - 2021 involvement

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 during 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 homebirth, it was still important to weigh up the distance to travel if additional or emergency care was needed. Some respondents wanted a homebirth 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.

Further detail is available in the full report of findings[31] on the ICB's maternity transformation webpage.

5.4.3 Supporting seldom heard groups - 2021 involvement

The communications and engagement team worked closely with the CCGs' Local Equality Advisory Forum (LEAF) and the voluntary sector to identify opportunities to involve and empower these groups to get involved.

They ensured communications were accessible. The presentation slides at the engagement events and the questionnaire both included information about accessibility including a variety of opportunities to provide feedback, including attending the events, a survey, by phone or in writing.

The communications and engagement team built on relationships with the voluntary and community sector to utilise existing networks and their knowledge of working with seldom heard groups. Using these networks, they worked with trusted advocates, for

[31] PowerPoint Presentation (icb.nhs.uk)

example liaison officers for the homeless or the Gypsy, Roma and travelling communities to support conversations in a way that was approachable and understandable.

5.4.4 Technical event to review proposals

At a technical event held on 06 September 2021, a group comprising representatives of commissioners and providers from across the system including directors and/or leads for strategy and transformation, midwifery, communications and engagement and Healthwatch, reviewed comments from the Summer 2021 involvement and used this alongside their data to assess whether the proposals were viable.

The group received the report of findings and were asked to consider the new continuity of carer and on-demand models of care that were proposed prior to the pandemic.

Despite the easing of the lockdown restrictions, both UHNM and UHDB continued to report significant staffing pressures as a result of COVID and non-COVID related absences. Staff who were redeployed from the FMBUs during the first phase of the pandemic continue to be essential within the acute units, enhancing the senior midwifery presence and supporting Ockenden safety recommendations. As a result, it was made clear that the implementing the new models was dependent on achieving the full workforce establishment in line with Birthrate Plus®.

At this time the group agreed that implementation plans for the models would be developed that took into account the anticipated timelines for achieving the midwifery workforce establishment. To support the necessary development and workforce training, it was anticipated that the earliest the on-demand model of care could go live was during Winter 2021/Spring 2022.

5.5 Phase 4 - Options appraisal and public involvement 2023

5.5.1 Re-establishment of the options appraisal process

During 2022 it was anticipated that both Trusts would be in position to reinstate services either as per the clinical model of 2020 (pre-COVID) or through the implementation of an ‘on-demand model’. However, workforce challenges in relation to recruitment and retention of staff meant that neither provider was able to implement the pre-COVID 24/7 staffed model or a revised service offer. During this time, both organisations provided regular updates to the LMNS Board and correspondence was maintained with NHSE via the service change assurance routes.

Due to continued staffing pressures throughout 2022/23, both organisations informed the ICB in April 2023 they were not able to reinstate services as per the model of care considered in 2021.

In July 2023, the case for change on the future of birthing services at the FMBUs was presented to NHS England during a Stage 1 assurance meeting. No issues were raised by NHSE during the meeting and the feedback from NHSE was that the case was well presented with partners demonstrating a clear and robust understanding of the clinical model and the challenges the ICS is facing.

As a result, the ICB alongside system partners reinstated the service change process that was paused due to the pandemic and began to reassess proposals for the future of birthing services at County Hospital, Stafford and Samuel Johnson Hospital, Lichfield. Further work was undertaken to explore all possible proposals for future service provision. To develop the proposals, the ICS has taken steps including:

- Reviewing the earlier options appraisal process and findings from public involvement.
- Analysing the relevant data – including demographics, numbers of births at the different units, clinical complexity and equalities.
- Making sure our strategy for maternity is aligned with the national plans.
- Making sure we are considering the need for patient choice.
- 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.
- Developing a case for change (submitted to NHS England in July 2023).
- Confirming a new clinical model.

5.5.2 Technical event September 2023

During a technical event in September 2023, clinicians identified and reviewed seven potential proposals for the future of birthing services at County Hospital and Samuel Johnson Community Hospital. Each proposal was re-assessed against the six criteria that were used in the previous options appraisal process. For the proposals to be viable, they needed to meet all the criteria. These were:

- **Clinical sustainability:** Does the scenario allow for clinical services and their interdependencies to be maintained in the geography?
- **Strategic fit:** Does the scenario align with national and local strategies, including making best use of current estate?
- **Meeting the needs of the population:** Does the scenario allow for appropriate services to meet population need, based on activity and geographical spread of these services?

- **Demand and capacity:** Is this a viable scenario given the level of activity, from a deliverability, capacity and safety perspective?
- **Workforce sustainability:** Is there a sufficient level of workforce to deliver the scenario?
- **Estates:** Is there sufficient time to implement the scenario? Is there sufficient space to deliver the scenario?

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 reinstated on a permanent basis.

The tables below illustrate the pros and cons of each of the proposals for the future of birthing services that were considered during the technical event when assessing each of the proposals and presented to participants at the public facing deliberative event.

Advantages and disadvantages of the proposals

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

Advantages	Disadvantages
• 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 women eligible and choosing to give birth at the 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. For example, recent guidance recommends an induction of labour (IOL) is offered at 7 days past a due date (40 weeks plus 7 days). Women may be booked for an IOL, but if another woman presents in labour, they will take priority. Because of the unpredictable nature of labour and the workforce challenges, there will be times when IOLs are delayed, resulting in the recommendation not being met. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBUs were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Table 10: Advantages and disadvantages of reinstating birthing service at County Hospital and Samuel Johnson Community Hospital on a 24/7 basis

Reinstatement of a single birthing service at one or other of the FMBUs

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered • Less impact on staffing when compared to running two separate units.	• Low number of women eligible and choosing to give birth at the 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 For example, recent guidance recommends an induction of labour (IOL) is offered at 7 days past a due date (40 weeks plus 7 days). Women may be booked for an IOL, but if another woman presents in labour they will take priority. Because of the unpredictable nature of labour and the workforce challenges, there will be times when IOLs are delayed, resulting in the recommendation not being met. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBU were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Table 11: Advantages and disadvantages of reinstating birthing service at either County Hospital and Samuel Johnson Community Hospital on a 24/7 basis

Implementation of a single birthing unit at an alternative site (that would need to be identified)

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered • Less impact on staffing when compared to running two separate units.	• Low number of women eligible and choosing to give birth at the 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. For example, recent guidance recommends an induction of labour (IOL) is offered at 7 days past a due date (40 weeks plus 7 days). Women may be booked for an IOL, but if another woman presents in labour they will take priority. Because of the unpredictable nature of labour and the workforce challenges, there will be times when IOLs are delayed, resulting in the recommendation not being met. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBU were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Table 12: Advantages and disadvantages of reinstating birthing service at an alternative site on a 24/7 basis

Implementation of an on-demand model at both FMBUs

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered • Less impact on staffing when compared to running a 24/7 birthing unit. However, 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 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.	• Low number of women eligible and choosing to give birth at the units in the past. • The units are not staffed 24/7 so women 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. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBUs were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Table 13: Advantages and disadvantages of implementing birthing service at County Hospital and Samuel Johnson Community Hospital on an on-demand basis

Implementation of an on-demand model at one or other of the FMBUs

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered • Less impact on staffing when compared to running two separate birthing units. However, 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 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.	• Low number of women eligible and choosing to give birth at the units in the past. • The units are not staffed 24/7 so women 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. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBU were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Table 14: Advantages and disadvantages of implementing birthing service at County Hospital or Samuel Johnson Community Hospital on an on-demand basis

Implementation of an on-demand model at an alternative site (that would need to be identified)

Advantages	Disadvantages
• Choice of non-clinical setting to give birth is offered • Less impact on staffing when compared to running two separate birthing units. However, 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 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.	• Low number of women eligible and choosing to give birth at the units in the past. • The units are not staffed 24/7 so women 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. • Women who develop complications would need to be transferred to a hospital unit either at Royal Stoke or Burton during labour. Under previous arrangements, County Hospital had two non-emergency, high dependency vehicles on site 24/7 to transfer women from the FMBU to Royal Stoke if they developed complications during labour. This service was removed some years before the temporary closure of the FMBU due to the very low use of these vehicles. If the FMBU were to re-open, any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time.

Table 15: Advantages and disadvantages of implementing birthing service at an alternative site on an on-demand basis

Permanent closure of birthing service at County Hospital and Samuel Johnson Community Hospital

Advantages	Disadvantages
• Women would continue to receive most of their 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 • Women 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, 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.

Table 16: Advantages and disadvantages of permanently closing birthing services at County Hospital and Samuel Johnson Community Hospital

As described earlier in this section, for the proposals to be viable, they needed to meet all essential criteria. Further detail on each of the criteria and the considerations when assessing each of the proposals against these criteria is outlined below.

- **Clinical sustainability:** Does the scenario allow for clinical services and their interdependencies to be maintained in the geography?
- **Strategic fit:** Does the scenario align with national and local strategies, including making best use of current estate?
- **Meeting the needs of the population:** Does the scenario allow for appropriate services to meet population need, based on activity and geographical spread of these services?
- **Demand and capacity:** Is this a viable scenario given the level of activity, from a deliverability, capacity and safety perspective?
- **Workforce sustainability:** Is there a sufficient level of workforce to deliver the scenario?
- **Estates:** Is there sufficient time to implement the scenario? Is there sufficient space to deliver the scenario?

Financial impact was not included within the essential criteria and instead is considered once viable options have been identified. Section 7.4 of this PCBC outlines the potential financial impact of reinstating services at the FMBUs on a 24/7 basis or through an on-demand model of care.

The technical group assessed each of the proposals against the essential criteria. A summary of the discussion is outlined below.

Proposal 1: Reinstatement of birthing service at County Hospital and Samuel Johnson Hospital

Clinical Sustainability
All present agreed the proposal does not meet the criteria as clinical services and their interdependencies cannot be maintained in the geography.

Strategic fit
It was noted that birthing services at the FMBUs would provide additional choice for women, however FMBUs do not provide continuity of carer in line with national and local strategies.

The group stated that birthing services at the FMBUs would be difficult to operationalise, manage and maintain, and they would divert resource from wider maternity services.

The Better Births Five Year Forward View for Maternity Care states that women must be offered the choice of home birth, midwife-led births and obstetric-led births, however it does not state whether midwife-led births should be within a freestanding unit. An alongside midwife-led unit provides the same service as a freestanding unit and therefore satisfies the choice requirements outlined within national strategies.
The group therefore agreed the proposal does not meet this criterion but noted that this proposal does provide an additional element of choice for the women in the relevant geographical areas.

Meeting the needs of the population
The group agreed that birthing services at the FMBUs may meet the needs of those women who wish to choose to birth within an FMBU and live local to the units. However, evidence suggests the majority of the population would not choose to give birth in an FMBU – only 0.72% (46) of the birthing population used the County FMBU in 2018.

The group discussed whether this proposal meets the needs of ethnic communities or those from deprived areas and whether more people would choose to birth in an FMBU if it was in a different location to support these populations. The group concluded that there is no intelligence to suggest that women outside of the current catchment area of the FMBUs would choose to give birth within either unit.

The group also noted that the reinstatement of these services does not meet the needs of the overall population due to the increasing clinical complexity/acuity and the low numbers of women eligible to give birth within an FMBU.

At UHNM 83.2% of women are moderate to high risk and 96.5% of women on the delivery suite are moderate or high-risk. Women from a more deprived area tend to have more comorbidities which will place them in a higher risk category.

Based on the above, the group agreed the proposal does not meet this criterion.

Demand and Capacity
Data shows that birthing services at the FMBUs are not utilised as demonstrated by the low activity which raises concerns about the long-term deliverability and sustainability of the service. The group agreed the proposal does not meet this criterion.

Workforce sustainability
The group highlighted that workforce challenges have meant that it is not currently possible to staff the units, and this position is unlikely to change.

Feedback gathered from staff who have worked at County FMBU was that they did not find the job satisfying due to the low level of activity within the unit. There are also concerns about de-skilling of staff. This in turn impacts on the recruitment and retention of staff to run the unit.

This proposal also results in inequality in provision due to the disparity in staffing ratios at the FMBUs compared to the hospital units.24/7 staffing at the units also means midwives can't support home births or other midwife-led units.

The group agreed the proposal does not meet this criterion.

Estates
The group agreed this criterion was met as there is sufficient and available space to deliver birthing services in an FMBU. However, it was noted that Trusts are having to subsidise the space as it is underutilised.

Proposal 2: Reinstatement of a single birthing service at one or other of the FMBUs
This proposal relates to the reinstatement of birthing services at one of the existing sites at either County Hospital or Samuel Johnson Hospital.

It was noted that maternity services are provided by two different providers and offering services from a single unit would mean the two services are amalgamated.

The group assessed the proposal against each of the hurdle criteria and agreed that the assessment does not differ from Proposal 1 as the issues highlighted for all criteria would be the same.

At this point it was noted that whilst assessing Proposal 1, the group did discuss whether offering birthing services within an FMBU at an alternative site would meet the need of the population. It was agreed the additional proposal to open birthing services at a single FMBU at an alternative site would be assessed against the hurdle criteria.

Proposal 3: Reinstatement of a single birthing service at an alternative site.
It was noted this is an opportunity to provide the FMBU service in an area with a different demographic, for example a higher proportion of diverse or deprived communities that may not access birthing services at the FMBUs in their current location.

The group noted that this would not be co-located with an acute site. It was also noted that Governance arrangements between the two providers offering the services within a single unit would be a significant risk.

The group stated that the workforce constraints identified within proposal 1 would remain irrespective of where a 24/7 FMBU is located, and these cannot be mitigated.

Whilst this may be offered in an alternative location and potentially increase access for a different patient demographic, the complexity and levels of acuity do not change and therefore there are a limited number of patients that would be eligible to give birth within these units. As highlighted within proposal 1, there is limited evidence to suggest that people who are eligible to birth in these units would choose to do so based on historic activity data.

The group noted the cost implications of identifying and setting up a new site.
Anecdotal evidence suggests that people typically want to birth where they have a connection to and feedback from patients is that they are reluctant to travel elsewhere.

All present agreed that due to the issues raised above, no hurdle criteria were met for this proposal including the estates criteria as this proposal relates to the identification of a new site.

Proposal 4: Implementation of on-demand at both FMBUs
This proposal would be subject to similar challenges as a 24/7 staffing model within birthing services at an FMBU.

Workforce constraints would not be mitigated with this proposal in line with the Birthrate plus reports.

As this is an on-demand service the group discussed whether the clinical complexity and low number of patients eligible for this service is less of a factor when looking whether the service meets the needs of the population as the service would be offered on an on-demand basis.

It was noted that offering an on-demand service is similar to having an effective well-staffed home birth service when managing the low-risk population.

Powys was identified as an example of where an on-demand model works well. However, this targets a low-risk population and there isn't a consultant led unit within the area.

It was noted that if there was a continuity of carer model in place with the correct workforce to carry out this model with a robust home birthing service, an on-demand service would work well for the low-risk population.

The group therefore agreed this proposal met the criterion of meeting the needs of the population.

It was noted that as the unit is not staffed 24/7 and the midwives need to travel to this unit, the risk of patients arriving at an on-demand unit before the midwife arrives and the potential to experience clinical complications cannot be discounted.

The group agreed the estates criterion was met as the sites are available however no further criteria were met for this proposal.

Proposal 5: Implementation of on-demand at one or other of the FMBUs
It was noted that clarification would be needed as to which provider would provide the staffing, or whether it would be a joint responsibility of both providers if this proposal were to be taken forward.

It was agreed the assessment against the hurdle criteria is the same as the proposal to implement on-demand at both sites with the exception of meeting the needs of the population due to the travel implications of having a single site across the entire Staffordshire and Stoke-on-Trent geography.

The group agreed to add implementation of on-demand at an alternative site as an additional proposal for consideration.

Proposal 6: Implementation of on-demand FMBU at an alternative site
The group stated that there would need to be an assessment of where to locate the alternative site to best meet the need of the population but as it currently stands, there is no evidence this service would be utilised.

The group agreed, all workforce constraints would remain with the added complication of staff working with a potentially isolated site. This proposal would also raise challenges with regards to the clinical governance if two providers are to jointly offer birthing services at a single FMBU.

The group agreed this proposal does not meet any hurdle criteria including the estates criteria as this proposal requires the identification of new site.

Proposal 7: Permanent closure of birthing service at County Hospital and Samuel Johnson Hospital
Clinical Sustainability
All present agreed the proposal meets the criteria as clinical services and their interdependencies can be maintained within the current acute sites.

Strategic fit

The group agreed this criterion is met as this proposal offers choice in line with national guidance although this is dependent on having a home birthing service in place.

Meeting the needs of the population
The group agreed this criterion is met and the proposal meets the needs of the overall birthing population due to the increasing clinical complexity/acuity and the low numbers of women eligible to give birth within an FMBU.

Demand and Capacity
The group agreed this criterion is met as this proposal is the most effective way of managing activity.

It was noted there had been comments previously regarding whether UHNMs activity modelling account for activity outside of North Staffordshire and Stoke-on-Trent.
UHNM confirmed that modelling was completed as part of the implementation of the TSA model and the shift of obstetric-led activity from County Hospital to Royal Stoke. As a result, the small shift in activity from the FMBUs into the midwife led units will not impact on the longer-term sustainability of the service with regard to demand and capacity.

Workforce sustainability
The group agreed this criterion is met in line with earlier discussions regarding recruitment and retention.

Estates
The group agreed this criterion was met as there is sufficient and available space to deliver the proposal and utilises estates in the most effective way.

The table below summarises the results of the assessment. All present were in agreement with the assessment against the essential criteria.

	Clinical sustainability	Strategic Fit	Meeting the needs of the 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 a single birthing service at one or other of the FMBUs	No	No	No	No	No	Yes
Re-instate FMBU at alternative site	No	No	No	No	No	No
Implementation of on-demand at both FMBUs	No	No	Yes	No	No	Yes
Implementation of on-demand at one or other of the FMBUs	No	No	No	No	No	Yes
Implementation of on-demand at alternative site	No	No	No	No	No	No
Permanent closure of birthing service at County Hospital and Samuel Johnson Hospital	Yes	Yes	Yes	Yes	Yes	Yes

Table 17: Essential criteria assessment

The group were asked whether there were any other potential proposals for consideration and all agreed there were no other proposals to assess.

On assessing all proposals against the essential criteria, The Technical group recommended that only one proposal is viable, which is to make permanent the temporary closure of the birthing service at County Hospital and Samuel Johnson Community Hospital. The closure relates to five low risk birthing rooms (LDRP - Labour, Delivery, Recovery, Post-Partum) across the two sites (two at County Hospital and three at Samuel Johnson Community Hospital).

If the viable proposal were to be implemented, this would not directly impact the end-to-end pathway for maternity services. Women continue to be assessed throughout their pregnancy to check for any developing risk factors or complications, which may require a change of delivery options. Under this proposal, there would be no change to routine antenatal and postnatal services which would remain locality based as recommended by both the National Maternity Review (Better Births) and the TSA (for UHNM).

5.5.3 Deliberative event

In December 2023, the ICB held an online event with women and stakeholders to discuss the proposal for birthing services previously provided at County Hospital and Samuel Johnson Community Hospital.

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.

We worked with the Consultation Institute to design the methodology for this event. This recognised that the technical group had recommended only one viable proposal and as a result a scoring approach would not be appropriate. This event aimed to be open and transparent, sense-check the process so far and understand if there were any new considerations that would impact the viability of these, and any new proposals.

The group was recruited to form a balanced room of service users and carers, staff and seldom heard groups to discuss the process to date, the feedback received through previous engagement and assessment of each of the proposals.

16 people participated in the event. This included patients or members of the public, representatives from NHS Trusts and representatives from voluntary organisations and charities.

Those who attended received an information pack in advance on the event, explaining the background and challenges and the process so far. It included information on the findings from the 2019/20 and 2021 involvement events and information on the development of proposals.

At the deliberative event, those attending heard a recap of the process so far. They heard that new information or suggestions from the group would be included when the business case was finalised. All proposals that were considered were explained again, together with the view of the technical group that there is only one viable proposal.

Attendees at the deliberative event were asked a number of questions.
In answer to a question about whether they thought the proposal was a good solution; participants made the following points:

- 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.

In answer to a question about any groups who they thought might be disadvantaged by the proposals, attendees highlighted the following groups:

- 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.

When asked whether there were any alternative proposals that should be considered, there were no alternative proposals to the service model identified, but participants wanted to ensure continuity of care and that that the homebirth service is available as an option.

During January – March 2024, we also conducted interviews with women who registered but were not able to attend the event to gather their feedback. We sent them the information pack to read in advance.

We interviewed three women, all of whom 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 and the feedback was largely in line with what we were told during the deliberative event. Respondents also told us the importance of being able to choose where to give birth, including a home birth option.

Further detail is available in the full report of findings on the ICB's maternity transformation webpage[32].

[32] Maternity transformation - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk)

5.6 Staff and clinical involvement

The development of proposals is in line with the process outlines within the Planning, Assuring and Delivering Service Change for Patients guidance.

A range of clinical colleagues and partners have been involved throughout the process including Trust and ICB clinicians (including Directors of Midwifery, Chief Nursing Officers, Chief Medical Officer, Heads of Midwifery and Community Midwives) maternity leads (including local maternity and neonatal system midwifes, maternity and neonatal independent sector advisor) quality leads and patient involvement leads across Staffordshire and Stoke-on-Trent and Derby and Derbyshire ICS.

Clinical colleagues have contributed to each of the Deliberative events described within Section 5 and supported with the development of proposals at each stage of the process. In addition, clinical teams were included within the stakeholder mapping and were invited to respond to the surveys and attend the public facing involvements that have been described within this PCBC.

Each of the report of findings includes a profile of participants and identifies whether participants work within the NHS or were representatives from voluntary organisations and charities.

When the services were temporarily closed in March 2020, staff who transferred from the FMBU's into the acute units were supported and upskilled as required. In some instances, upskilling was not required due to the rotational basis of the teams and the skills already acquired through working across different settings.

At UHNM, on transferring to Royal Stoke University Hospital, following the suspension of the FMBU services, there were three substantive Band 7 midwives that initially had a supernumerary period on delivery suite of two weeks followed by allocation to shifts where there was an addition band 7 to offer support and guidance.

At UHDB, affected staff had a 1:1 with their clinical lead and were able to choose their preferred place of work (i.e. the Royal Derby Hospital birth centre, the Queen's Hospital Burton labour ward, antenatal care or on an inpatient ward) All staff were supernumerary initially following the transfer and received in house training in their area of preference where this was required.
As the units remain closed, regular updates are shared with clinical teams through staff newsletters and briefings.

Throughout the assurance and governance stages we will continue to involve staff throughout the process. We will ensure that staff are involved in the consultation and a robust

communications plan will be developed to support any implementation plans once a final decision has been agreed.

5.7 Continuous involvement

A review of wider involvement activity, such as the ICB's surveys on their Joint forward Plan and the Integrated Care Partnership Clinical Strategy, was undertaken and feedback specific to maternity and neonatal care was collated to inform service transformation.

Joint Forward Plan engagement - The purpose of this engagement was to gather the views of the public on healthcare services across Staffordshire and Stoke-on-Trent. The feedback supported 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. Respondents were asked how the ICS could improve people's use and experience of maternity or neonatal care. 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 also asked to rate a series of statements relating to maternity and neonatal care.

ICP Clinical Strategy engagement survey – One respondent (out of 39) provided feedback in relation to maternity services during the engagement activity relating to the ICP clinical strategy. The respondent highlighted that due to recent changes to digital technology, maternity services having online referrals and digital notes. It was not clear if this was viewed as a positive or negative experience for the responder.

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 birthing 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.

The Maternity and Neonatal Independent Senior Advocate role also helps ensure the voices of women, birthing people and families are listened to, heard and acted upon by their maternity

and neonatal care providers when they have experienced an adverse outcome during their maternity and/or neonatal care.

5.8 Engagement with Health Overview and Scrutiny Committees

Overview and Scrutiny Committee responsibilities are outlined at the beginning of the pre-consultation business case. NHS commissioners kept the Staffordshire County Council Health and Care Overview and Scrutiny Committee up-to-date with information about the Together We're Better transformation programme as it progressed through 2019 and 2020. Information shared and discussed from 2021 onwards includes updates on wider maternity services across Staffordshire and Stoke-on-Trent, the situation regarding birthing services at County Hospital and Samuel Johnson Community Hospital and details of any patient and public involvement on these issues.

Key feedback to note is outlined in the table below:

Date	Committee	Outcome
09 Aug 2021	Staffordshire Health and Care Overview Scrutiny Committee	The Committee received an update report and presentation relating to the Temporary Closure of Free-Standing Midwife-led birthing Services. At the request of the Chair, the Lead Midwife Maternity Transformation Programme gave a brief overview of the Ockenden Review of maternity services at Shrewsbury and Telford Hospitals and of the Better Births Report published in 2016. The Lead Midwife provided an overview of the presentation and report relating to the temporary closure of freestanding midwife-led birthing units (FMBUs) at Samuel Johnson Community Hospital in Lichfield and County Hospital in Stafford which provided low risk care maternity services. Resolved: 1. That the report and presentation were noted. 2. That Committee requested further data about the trend for home births to be circulated. 3. That the final proposals would be considered by the Committee at a future meeting.

23 Sept 2021	Stoke-on-Trent Adult Social Care Health Integration and Wellbeing Overview and Scrutiny Committee	The Committee received an update report and presentation on the temporary closure of free-standing midwife-led birthing services. The presentation was delivered by Alison Budd – Lead Midwife, Staffordshire and Stoke-on-Trent CCG and Jenny Fullard – Communications and Engagement Service Partner, NHS Midlands and Lancashire Commissioning Support Unit. Agreed – That the report and update be noted and any future updates to include details of the work being done to develop support for dads.
11 July 2022	Staffordshire Health and Care Overview Scrutiny Committee	The Chief Nursing and Therapies Officer and Lead Midwife for Maternity Transformation, at Staffordshire and Stoke-on-Trent, ICB provided an update on maternity services transformation, the temporary closure of free-standing midwife-led birthing services and an update on progress against recommendations of the Donna Ockenden report about failings at Shropshire and Telford Hospital. Resolved: 1. That Health and Care Overview and Scrutiny Committee receive the update report and request that ICS midwife staffing data be circulated to Health and Care O&S Committee Members for information.
17 October 2022	Staffordshire Health and Care Overview Scrutiny Committee	The Chief Nursing and Therapies Officer, ICS provided an update on the Ockenden Report and Maternity Services. She advised that a further report relating to maternity services was due to be published and actions from all reports would be taken into account when developing maternity services. The Lead Midwife for Stoke on Trent and Staffordshire ICS outlined the detail in the report. The first publication of the Ockenden Report had fifteen immediate and essential actions, the second publication outlined a further seven immediate and essential actions with further work lying beneath them. The report to Committee provided an update on the initial fifteen actions and outlined areas where there was still work to do.

		Resolved: 1. That Health and Care Overview and Scrutiny Committee receive the update report.
27 November 2023	Staffordshire Health and Care Overview Scrutiny Committee	Helen Slater, Associate Director for Transformation at Staffordshire and Stoke-on-Trent ICB and Karen McGowan, Associate Director Nursing, Quality & Maternity at Staffordshire and Stoke-on-Trent ICB presented the Maternity and Neonatal Services Update to the Committee. Resolved – That (a) the report be received, and the Committee comments be noted. (b) Staffordshire and Stoke-on-Trent ICB investigate the feasibility of an external audit of maternity services in Staffordshire. (c) the Committee receive an update on maternity services and on the Freestanding Midwife-led birthing Units
15 February 2024	Stoke-on-Trent Adult Social Care Health Integration and Wellbeing Overview and Scrutiny Committee	The Associate Director Nursing, Quality and Maternity, Staffordshire and Stoke-on-Trent ICB, Karen McGowan and Director of Nursing – Maternity & Safeguarding, Lynn Tolley, attended the meeting to respond to questions from Committee members in respect of the report, which provided an update on Maternity and Neonatal Services within Staffordshire and Stoke-on-Trent. The report included areas of focus, responses to regulatory reports, areas to be commended as well as areas that need further support; the report also referenced the Ockenden Insight visit and NHS England's Three-Year Delivery Plan for Maternity and Neonatal Services, which was published in 2023. Agreed - That the Update on Maternity and Neonatal Services within Staffordshire and Stoke-on-Trent be noted and a further update would be shared with the Committee in June 2024.
13 May 2024	Derbyshire County Council Improvement	Tracy Burton, Deputy Chief Nurse and Claire Johnson, Lead Midwife introduced the report, which had been circulated in advance of the meeting, which provided an overview of the maternity services in Derbyshire for

	and Scrutiny Committee - Health	2023/24 and information on governance, assurance and safety of maternity services locally; this was accompanied by a presentation that highlighted the salient facts of the report regarding the maternity units at Chesterfield Royal Hospital (CRH) and University Hospitals of Derby and Burton (UHDB). **RESOLVED to** – 1) Review the contents of the report and note the actions taken to provide governance and assurance against the national maternity service recommendations and reports; and 2) Provide an update to Committee in 6-12 months time.
29 July 2024	Staffordshire Health and Care Overview Scrutiny Committee	Helen Slater, Associate Director of Transformation, Gina Gill, Transformation Programme Lead, Lynn Tolley, Assistant Chief Nursing & Therapies Officer and Jenny Brown, Lead Midwife for Maternity Transformation from the Staffordshire and Stoke-on-Trent ICB presented the Intrapartum services previously provided at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield to the Committee. The Committee were reminded that the Freestanding Midwifery Birthing Units (FMBU) at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield, were suspended at the beginning of the pandemic to ensure safe staffing of the consultant units at Royal Stoke Hospital and Queen's Hospital, Burton. It was reported that prior to the units closing on a temporary basis, 94 women gave birth at County Hospital in Stafford and 220 women gave birth at Samuel Johnson Community Hospital in Lichfield (2019/20 data).

		At a technical event held in September 2023, clinicians reviewed seven potential proposals to develop a shortlist of viable proposals, it was recommended at the event that there was only one viable proposal, which was to make permanent the temporary closure of the intrapartum birthing services at County Hospital and Samuel Johnson hospital. The Committee noted the following comments and responses to questions: • The Committee considered the proposal to undertake a 6-week public consultation and discussed that the consultation should be 12 weeks to allow the affected District and Borough Councils the opportunity to be a part of the consultation process. • The Committee requested to receive details of the reported 23% of Staffordshire residents giving birth outside of the area, and where they were giving birth. • 83% of birthing women were deemed to be a moderate of high risk in Staffordshire and Stoke-on-Trent. The Committee discussed that the 83% was County-wide and included Stoke-on-Trent which may not accurately reflect the individual Districts/ Boroughs within the County and there may be more eligible, lower risk pregnancies within the geographical remit of the FMBUs. • The West-Midlands Clinical Senate highlighted electronic notes and data sharing. The University hospitals at Derby and Burton had recently changed system to BadgerNet which was consistent with the notes from the Black Country Trusts for data sharing. It was reported that not all Maternity Trusts used BadgerNet so there were challenges in sharing data. • The Committee discussed the demographics and data used in the report was dated and would need to be updated due to ongoing and continued housing developments in the County.

		• Prior to the temporary closure of the FMBUs there were campaigns to increase the use of the service but there was little uptake. • There was an independent Maternity and Neonatal voices partnership across Staffordshire and Stoke-on-Trent which worked alongside the ICB. It was reported that Healthwatch worked alongside the partnership and Healthwatch would be involved in the consultation. **Resolved** – That (a) the report be received, and the Committee comments be noted. (b) the Committee recommend to the Staffordshire and Stoke-on-Trent ICB that: the period of consultation should be 12 weeks to allow more time for District and Borough Councils and other residents to be a part of the consultation process. the demographic data relied on in the report be updated due to ongoing and continued housing developments in the County. (c) the Committee requested to receive details on the reported 23% of Staffordshire residents giving birth outside of the area, and where they were giving birth. (d) the Committee consider further scrutiny of Intrapartum services previously provided at County Hospital and Samuel Johnson Community Hospital.
08 Aug 2024	Stoke-on-Trent Adult Social Care Health Integration and	Helen Slater, Associate Director of Transformation at Staffordshire and Stoke-on-Trent introduced the report which provides an update on the service change programme being undertaken on the future of intrapartum

	Wellbeing Overview and Scrutiny Committee	services at the Freestanding Maternity Birthing Units (FMBU) in the south of the county. These services were not utilised by Stoke-on-Trent residents historically however an update was provided as the service was available to all Staffordshire and Stoke-on-Trent residents prior to the temporary closure in March 2020. The FMBU services (births only) at County Hospital, Stafford, and Samuel Johnson Community Hospital, Lichfield, were suspended at the beginning of the pandemic to ensure safe staffing of the consultant units at Royal Stoke Hospital and Queen's Hospital, Burton. However since the pandemic, significant staffing challenges in the maternity workforce had prevented both Trusts from being able to safely reopen these units. The Committee asked ICB colleagues to ensure that it was clear that services at the local hospitals would be unaffected by the proposal, and that an update was provided for the committee following consultation.
August 2024	Derbyshire County Council Improvement and Scrutiny Committee - Health	An update on service change process sent to Derbyshire County Overview and Scrutiny Committee for circulation to committee members.

Table 18: Health Overview and Scrutiny committee feedback throughout the process

6 Workforce analysis

6.1 Introduction

This section of the pre-consultation business case considers the potential workforce implications of the proposal. It looks at:

- The process used to develop the workforce plans.
- The impact on the workforce of the scenarios that have been considered. It analyses future workforce capacity and competency requirements and demonstrates sufficient staff supply and safe staffing levels.
- Examining measures taken to ensure future sustainability.

The workforce plans have been developed in line with Birthrate Plus® to ensure the appropriate number of midwives according to the clinical needs of the local maternity population. These have not been developed in response to this proposal, instead they have been developed for overall maternity services to ensure the Trusts have a fully established workforce by the end of 2024, with sustainable recruitments plans in place for the future workforce.

6.2 Process used to develop workforce plans

As described within this pre-consultation business case, the proposal would not introduce any new models of care and end-to-end pathways would not be affected if the proposal was to be implemented. The proposal would have no direct implications on staffing levels however workforce plans are described within the following section to demonstrate the longer-term workforce sustainability within overall maternity services and the actions that are taken to ensure safe staffing levels are met at all times. Staffing levels and workforce profiles will also be reviewed in accordance with Birthrate Plus® and MCoC requirements on an as required basis.

The workforce plans for maternity services consider several national drivers and are overseen by a robust governance structure within the Trusts and ICB.

Safe midwifery staffing features in many national documents relating to safe maternity care including:

- Birthrate Plus® (the only calculating tool endorsed by NICE)
- NICE Safe midwifery staffing for maternity settings (NICE guidance 2015; NICE pathway 2021)
- NHS England National Quality Board Safe Staffing documents (2018)
- Delivering Midwifery Continuity of Carer (MCoC) at full scale (2021) which acknowledges the need to undertake a Birthrate Plus® assessment to understand the current standard-model midwifery workforce required and following this through with recruitment.
- Strengthening midwifery leadership: a manifesto for better maternity care (RCM, 2019)
- NHS England Maternity Business assurance Framework (revised July 2021)

- Safe midwifery staffing was also at the forefront of 'the safety of maternity services in England Parliamentary Business July 2021.
- HSIB (2020) published a National Patient Safety, 'Delays to intrapartum intervention once fetal compromise is suspected' and recommended the introduction of a flow coordinator. UHNM also contributed towards the report.

Midwifery staffing was at the forefront of 'the safety of maternity services in England Parliamentary Business, July 2021. Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping women safe from avoidable harm.

Safe midwifery staffing continues to be one of the safety actions within the NHS resolution CNST maternity incentive scheme year 6, it features within the three-year delivery plan far maternity and neonatal services and is recognised by NICE as being vital to safety in maternity units (NICE guidance 2015; NICE pathway 2021).

Full Birthrate Plus® reviews were completed for each of the Trusts. Birthrate Plus®, is a national tool that gives the intelligence and insights and informs decision-making about safe and sustainable services needed to be able to model midwifery numbers, skill mix and deployment across all maternity services based on the complexity risk rating of women within each Trust.

Following a full review of their Birthrate plus® assessments, both Trusts approved business cases to increase the workforce establishment.

The planned growth within maternity services submitted as part of the business case at UHNM is shown below:

Phase	Job Title	Recurrent Funding source	Non recurrent funding	Start Date for UHNM Funding	Pay Band	WTE
Ockenden Funding Received in 21/22	Ockenden - Operational midwives	Ockenden funding in place from 21/22 RECURRENT		01/04/2022	6	3.26
	Ockenden - Training midwives			01/04/2022	6	3.26
	Ockenden - Consultant Obstetrician DCC PA's			01/04/2022	-	0.60
	Midwives - Newly qualified			01/10/2022	6	20.00
	Midwives - MAU triage			01/10/2022	6	2.14
	Maternity Support Workers			01/10/2022	4	5.60
STAGE 1 TOTAL						**34.86**
- Birthrate Plus® Compliance	Band 6 - Operational midwives	Recurrent funding requested through Business Case		01/01/2023	6	18.81
	Maternity Support Workers			01/01/2023	3	0.68
Specialist role	Maternal & New-born Screening Lead Midwife			01/01/2023	7	1.00
Pharmacy	Band 8a - Specialist Pharmacist Support			01/01/2023	8a	0.50
STAGE 2 TOTAL						**20.99**

Table 19: Approved establishment increase at UHNM

The planned growth within maternity services approved within business cases from 2021 onwards at UHDB is shown below:

Row Labels	Sum of £000's	Sum of WTE
Anaesthetics and Theatres - Additional sections	1,893	24.93
Medics - additional obstetric support	1,120	11.79
Midwifery - Birth rate plus staffing	957	17.38
Midwifery - Continuity of Carer	124	2.21
Midwifery - Governance	52	1
Midwifery - management	544	11.36
Midwifery - on-call	216	3.04
Midwifery - Sonography	134	3
Midwifery - specialist posts	177	3.8
Midwifery - training	297	0
Neonates	1,659	27.52
Theatres - Additional theatre support	300	7.76
Transitional Care	660	12.73
Grand Total	**8,132**	**126.53**

Table 20: Approved investments into maternity services at UHDB

Overall, the maternity workforce at both of these Trusts is showing a planned increase of 182.38 whole time equivalents.

6.2.1 System-wide governance

Maternity services are under intense scrutiny to provide significant assurance relating to how they are improving the safety of the care provided to mothers, babies and families following the publication of the reports of the University Hospitals of Morecambe Bay (2015), the East Kent Hospitals University NHS Foundation Trust enquiry (2021) and the Shrewsbury and Telford Hospital NHS Trust Ockenden Report (2022).

Following the publication of Ockenden the Final Report (March 2022) Trusts have been asked to take action to mitigate any risks identified and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars, one of which being safe staffing levels.

The Royal College of Midwives (RCM) in March 2022 have additionally released their position statement on safer staffing;

- "Every woman in established labour should be cared for by at least one midwife.
- The Boards of NHS maternity providers are ultimately responsible for ensuring that there are, at all times, sufficient suitably qualified and competent midwives to provide women and babies with safe, compassionate, and high-quality care.
- Each Board should regularly review midwifery staffing levels and ensure that the maternity services budget covers the total cost of the midwifery staffing establishment.

> Midwifery staffing establishments should be regularly reviewed and monitored to ensure adherence to relevant guidelines and compliance with the recommendations of evidence-based workforce planning tools."

A robust governance structure is in place across the ICS to monitor and provide assurance on safe maternity staffing levels.

The midwifery staffing vacancy position is reported at a national level for each Trust through the PWR (provider workforce return) each month. The data for this is pulled from ESR based on the budgeted establishment. However, it includes data for all budgeted midwives throughout the organisation, not just those working clinically. Therefore, the figure quoted will not be representative of the actual clinical midwifery vacancy.

It does accurately represent the vacancies within the band 2, 3 and 4 roles. To have an accurate vacancy position, the senior team, ward managers and retention leads meet regularly with the Divisional finance lead to look at midwifery establishments numbers in every area to produce an accurate up to date position on a regular basis.

Workforce reports are compiled on a regular basis (at least quarterly) developed initially at ward/directorate level and reported through divisional governance, onto executive quality and safety oversight forums and then taken through Board level assurance and LMNS system wide assurance.

6.2.2 Safer staffing

The Birthrate Plus® tool has been utilised in both Trusts to identify the overall midwifery staffing requirements. The framework is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the Birthrate Plus® methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant(s) throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to deviations from obstetric normality. There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V) the lower the score the more normal are the processes of labour and delivery. The categories are described in the table below.

CATEGORY I Score = 6 This is the most normal and healthy outcome possible. A woman is defined as Category I [lowest level of dependency] if: The woman's pregnancy is of 37 weeks' gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring
CATEGORY II Score = 7 – 9

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.
CATEGORY III Score = 10 – 13 Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.
CATEGORY IV Score = 14 –18 More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.
CATEGORY V Score = 19 or more This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post- delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

Table 21: Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

Together with the casemix, the number of midwife hours per patient/client category is included. This is based upon the well-established standard of one midwife to one woman throughout labour. In addition, extra midwife time needed for complicated Categories III, IV & V, is included to calculate the clinical staffing for the annual number of women delivered.

Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, antenatal and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. Adjustment of clinical staffing between midwives and competent & qualified support staff is included.

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the locally agreed uplift (%) for absence allowances and for travel in community**.**

Based on 25.99% uplift, the overall maternity workforce requirements for UHNM are as shown in the table below:

Total Clinical WTE (including band B4 MSW's)	271.88
Non-Clinical	29.91
Clinical, Specialist, Management Total	301.79

Table 22: UHNM midwifery staffing requirements identified within the Birthrate Plus® assessment.

Based on 24% uplift, the overall maternity workforce requirements for UHDB are as shown in the table below:

Total Clinical WTE (including band B4 MSW's)	386.22
Non-Clinical	34.76
Clinical, Specialist, Management Total	420.98

Table 23: UHDB midwifery staffing requirements identified within the Birthrate Plus® assessment

The results are calculated based on three months case mix data and compared to previous reports to identify any changes in case mix and acuity and the resultant staffing requirements. Day-to-Day acuity in maternity is measured using the Birthrate Plus® intrapartum acuity app. This is reliant on 4 hourly data entries which identify any midwifery staffing needs and ensure safety for women and babies during this period.

The use of the acuity app is supplemented with daily safety huddles within each of the Trusts. During the safety huddle, representatives for the various areas within the maternity unit come together to give an accurate and readily available helicopter-level view of the whole unit. The huddles give all staff the opportunity to understand the workload within the unit, staffing and acuity and any potential or arising safety issues. The safety huddle board is updated throughout the day and supports the manager in planning the roster and allocation of staff.

Both Trusts anticipate reaching full midwifery workforce establishment by the end of 2024. While the mandate for implementing CoC by 2022 was removed by NHS England due to workforce challenges during the pandemic (see section 3), this was on the basis that Trusts review its implementation when it was safe to do so. 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. Both Trusts are developing plans for implementing CoC for the most vulnerable groups of women now that there is a clear trajectory for reaching full staffing establishment (see sections 4.4 and 4.5).

Consideration of workforce sustainability has been central to the programme: longer term clinical and workforce sustainability enables the system to develop and grow a continuity of carer model during pregnancy, birth and beyond for those most vulnerable in the local community. Any current plans to implement CoC or expand this to further cohorts of women would be placed on hold if birthing services at the FMBUs were to be reintroduced due to the work that would be required to either recruit additional midwives or reconfigure the workforce.

6.3 Workforce impact for each scenario

As highlighted above, the proposal within this pre-consultation business case makes permanent the arrangements that have been in place since March 2020 when the units temporarily closed to births. As a result, there are no additional staffing requirements as a result of the proposal. However, a number of workforce challenges would be more challenging if birthing services were to be reintroduced at County Hospital and Samuel Johnson Community Hospital and these are described within this section.

6.3.1 Recruitment

A major challenge is the difficulty of recruiting and retaining staff. As described earlier in this pre-consultation business case, there is a national shortage of midwives and the Trusts have run large recruitment campaigns to recruit to vacant posts. These campaigns are ongoing with both Trusts aiming to reach full establishment by the end of 2024. A further increase or reconfiguration of the workforce would be required to reinstate birthing services at the FMBUs and historically, it has been difficult to these roles due to the factors described in the following two sections. In addition, at a national level we have been struggling with retention rates, where more midwives are leaving the profession than are joining; as a result, the Trusts have worked on their preceptorship programmes, as part of their retention strategy, in order to ensure that staff feel valued and remain working within the profession.

While the reinstatement of an on-demand model would not have the same recruitment pressures as the reinstatement of a 24/7 model, this would increase the workload within the community midwifery teams and likely require an increase in the community staffing establishment. The model would require an increase in the number of community midwives who are on-call at any given time which reduces their capacity to deliver antenatal and postnatal care. Teams would also need to consider how this may impact on home birth services that became operational in October 2024.

6.3.2 Training and Retention

Recruitment of midwives at both Trusts has been increased through the appointment of internationally educated midwives. However, support to complete OSCEs, gain PINS and then a minimum period of 12 weeks' supernumerary has meant this has not provided an immediate impact on safe staffing. In addition, a large proportion of the new recruits are newly qualified midwives or international midwives who enter 12-18 month preceptorship programmes on qualifying. The preceptorship programme is a period of structured support for newly registered midwives whilst they integrate into their new team and place of work. The programmes include rotation through antenatal, intrapartum and postnatal care to enable preceptees to gain extensive knowledge within the area they want to work. Positive preceptorship experience is reported to result in newly registered nurses, midwives and nursing associates having increased confidence and sense of belonging, feeling valued by their employer, and having greater professional and team identity. Effective preceptorship outcomes are also linked to improved recruitment and retention. The standalone nature of the FMBUs mean midwives are largely isolated whilst working within the unit with very limited clinical wrap around support. As such these units can only be staffed by experienced midwives to ensure preceptees are able to fully integrate into wider maternity services.

Retention midwives are in place within both Trusts (Two at UHDB - one at Royal Derby Hospital and one at Queen's Hospital, Burton and one at UHNM based at Royal Stoke Hospital) who are actively engaged with the workforce to support with recruitment and retention. Exit interviews conducted by retention midwives identify that key reasons for leaving are recruitment to roles in midwifery education and lack of core positions for midwifery staff. This is being reviewed as part of the workforce review.

There are regular reviews of the workforce skill mix to identify any gaps and provide training as appropriate, supported by clinical education midwives. All staff, including support staff have a training matrix including mandatory training (for example Practical Obstetric Multi-Professional Training - PROMPT) and where there are any gaps in available training the Trust source that training.

In May 2023, the Core Competency Framework Version 2 was released, and NHS England stated all Trusts must have a local training plan using a Training Needs Analysis (TNA) to include the six core modules of the CCFV2 and this training programme should run over a three-year period. The CCFv2 sets out clear expectations for all Trusts, aiming to address known variation in training and competency assessment across England. It ensures that training to address significant areas of harm are included as minimum core requirements and standardised for every maternity and neonatal service. The Trusts training programmes have been developed to meet the requirements within the framework.

The Trusts monitor training guidance and best practice on an ongoing basis, including NHSEI and National Institute for Health and Care Excellence (NICE) guidance and provide appropriate training as required.

The Trusts also offer regular training workshops focussing on specialist clinical areas in addition to 'live' skills drills to test systems within clinical areas to improve safety and practice.
Staffing uplifts within the Birthrate Plus® assessments ensure teams can be offered dedicated time to complete their training and while Trusts maintain safe staffing within their units.

As the FMBUs managed a small number of low-risk births with very limited exposure to clinical complexities, there is also the risk that experienced midwives would be under-utilised and may struggle to maintain their competencies. They also are not exposed to the enhanced learning and training support that comes from working within an alongside unit.

6.3.3 Workforce interdependencies

During the options appraisal process, the clinical team outlined the following interdependencies for maternity services;

- Critical Care
- Anaesthesia
- Interventional radiology
- Emergency surgery for women
- Neonatal services

- Paediatric services
- Imaging
- Mental Health
- Pathology
- Gynaecology

These interdependent services have not been affected by the temporary closure of birthing services at the FMBU as both Trusts have continued to offer low-risk birth options within their maternity services and receive transfers/escalations into further care as required.

However, these services were not available within the FMBUs and the women or babies who required extra support were transferred via an ambulance to the acute hospitals. By centralising services on a single site it ensures women have access to timely emergency support. This also reduces the risk of a women having to be transferred in the later stages of childbirth, therefore reducing the potential for poorer experience of childbirth. As birth partners are not permitted in the ambulance, this may result in the mother feeling less supported and may also have a negative impact upon their birthing experience.

In addition, any babies born who need additional support would have closer access to a Neonatal Team at the main hospital sites, rather than a 'blue light' transfer to the hospital's neonatal unit.

Any transfer to an acute site would be through calling 999 and the waiting time for that ambulance would depend on the other calls they are responding to at that time. Centralising services reduces the risk of placing additional pressure on an already strained ambulance service.

6.4 Measures for workforce sustainability

Each Trust is carrying out a number of initiatives to ensure they have the workforce capacity for maternity services. This includes ensuring staff have the right competencies and skill mix.

6.4.1 Training and competencies for sustainability

The proposal under consideration assumes the reintroduction of the home birth services to ensure women have an alternative low-risk birth option. Both Trusts began booking women into the home birth service during their early pregnancy from April 2024 and as a result, refresher training for midwives was completed within both Trusts to prepare and upskill staff for the commencement of home birth services.

UHNM is currently in the process of providing in house training to all outpatient midwives. This comprises of a full day of training, focused on managing childbirth emergencies in a community setting. This is in addition to the Practical Obstetric Multi-Professional Training (PROMPT).

Following on from this, all community staff will work a supernumerary shift within an intrapartum area; preferably the birth centre with the purpose of consolidating learning and further

increasing confidence in preparation for offering and facilitating choices around home birth provision.

In addition, the Community staff are currently involved in multidisciplinary training with ambulance crew from West Midlands Ambulance Service (WMAS) on childbirth emergencies in the community to prepare for the reintroduction of the home birth service.

UHDB is currently in the process of providing in house training to midwives as required, including PROMPT mandatory training. The Trust is liaising with East Midlands Ambulance Service (EMAS) and WMAS to arrange joint in-house training. In addition, a one-day Babylife line Homebirth Emergency training is planned and will be taught jointly with the ambulance service. UHDB will undertake a skill gap analysis to identify staff that will need supported clinical supernumerary shifts in the midwife-led setting.

The home birth service will be configured in a more sustainable way going forward. It will form part of a mixed staffing model, midwifery resource to support complex birth and midwives to support universal care. In terms of universal care, midwife-led services and the home birth service will be staffed primarily by core birth centre midwives on shift, supported by community midwives who will be on call. Equally if activity is high in the birth centre community midwives on call would be expected to come in to support that activity. There will be a separate on call staff escalation by acute midwives to respond to peaks in activity for complex care. The proposed model ensures that staff are confident and competent to work in focused areas, as opposed to being expected to cover all, where historically it has been difficult to maintain skills due to the infrequency of exposure.

6.4.2 Recruitment and retention for sustainability

In terms of Trust level recruitment to support sustainability, proactive and successful recruitment campaigns have been completed and each Trust has lead midwifes for recruitment and retention in place to support the process. Midwifery recruitment and retention improvement plans have been developed which outline key actions that focus not only on reaching the required staffing establishment but reduce attrition with preceptees, offer support for staff to improve retention and ensure people feel valued within their roles.

The preceptorship programme at UHNM has seen great success with a 100% retention of the 2022 cohort. Some of the initiatives built into the preceptorship programme include*:*

- Strong onboarding process including afternoon tea, nights out and what's app group.
- Two-week induction including team building and orientation to the service.
- 6 weeks supernumerary time on top of induction.
- 4 protected nonclinical days for training and pastoral support.
- Allocated preceptor.
- Orange lanyard to identify preceptees. A successful way of ensuring good support.
- Opportunity to participate in Director of Midwifery fellowship.
- Enhanced financial package.

- Supportive package for preceptorship graduates with the Acorn scheme; new band 6's have an Acorn pin to identify them as junior staff members.

Initiatives have also been built into the Preceptorship programme at UHDB:

- Bespoke training packages for all newly qualifies midwives
- Students waiting for their PINS receive maternity specific mandatory training to support their transition to registrant
- Seven additional multidisciplinary / professional preceptorship days introduced, enhancing cross speciality learning and supporting the foundations of the preceptorship period.
- Maternity specific training days to support with skill development and wellbeing.
- All band 5 midwives now line managed by the retention leads to ensure a consistent approach, continuity whilst on rotation across the service and improving sickness, annual leave and wellbeing for each individual
- considering different ways of rotating across the service during the preceptorship period
- Supporting band 6 development packages
- Protected clinical supernumerary period for each rotation.
- Additional clinical support available if required via a bleep system

The development of the maternity support worker (MSW) workforce is key to the retention of MSW's and the improvement of maternity services. There are several opportunities available for support workers at UHNM to progress their career from entry level positions to entry on the NMC midwifery register. These include:

- Opportunities to take functional skills (Maths and English), NVQ level 2, & NVQ level 3
- Support of foundation degrees with a midwifery pathway to develop MSW's into B4 positions in the community, infant feeding, and education.
- Midwifery apprenticeships developing MSWs into midwives.
- Implementation of specialist MSW roles including:
    - Infant feeding
    - Substance abuse
    - Safeguarding
    - Bereavement
    - B4 community
    - Lead MSW for recruitment and retention.

- Celebration of MSW successes. One MSW has been nominated for and received a Chief Midwifery Officer award.
- Planned bespoke MSW training day to upskill the MSW workforce.

Developments for the maternity support worker workforce in UHDB includes;

- current workforce benchmarked against the national maternity support worker (MSW) framework, including 121 meetings with individuals to support career progression.

- Band 6 registered midwife and band 3 Maternity support worker appointed to support the benchmarking work.
- Applied for LMNS funding for a permanent band 6 RM and x2 Band 4 MSWs to support with bespoke training packages.
- Supporting Level 3 and Level 5 apprenticeship development for MSWs.
- Also supporting apprenticeship for MSWs to undertake midwifery training in Sept 24.
- Skills passports going through governance approval and should be ready for launch.
- Links with multiple academic providers to support with functional skills, and level 3 apprenticeship training to support different learning styles.
- Support from PLSU in the clinical area to help with assessments.
- Developing in house training for assessors to ensure a consistent approach.

At a system level, the ICS has been working collaboratively from a workforce perspective since 2017. Relationships have formed between NHS, local authority, ICB, primary care, social care and VCSE partners to tackle the workforce pressures at a system level.

Utilising the National People Plan, the Staffordshire and Stoke-on-Trent Interim People Plan 2022-23 and Beyond, prioritises workforce activities required to progress the ICS towards being a more integrated, inclusive, supportive system for our people. The People Plan prioritises working together to build compassionate and inclusive cultures, striving to affect positive change across the whole workforce, collaborating, widening participation, developing a broader talent pipeline and ensuring our workforce reflects our population.

The ICS is in the process of finalising our ICS Organisational Development (OD) Plan which intends to build on existing individual Organisation approaches to prioritising employee happiness and well-being in order to support improvements in engagement and experience efforts. Set within the strategic context of the NHS Long Term Workforce Plan, the Hewitt Review, the Fuller Stocktake, the NHS People Promise and The Future of HR and OD, it aims to cultivate a system wide culture of connection, collaboration and consistency with compassion, inclusion and belonging central to everything we do. The Plan will strategically shape our ICS Organisational Development approach and activities, guiding the focus for ICB Board Development and associated leadership and modelling of system culture and collaboration, as well as setting the scope and direction of agreed ICS strategic OD priorities. The Plan aims to identify and build on existing good practice, sharing learning, sourcing opportunities to scale, spread and innovate, in order to reduce duplication, whilst maximising efficiency.

Across the system, we have made significant progress to date in the areas of organisational development, equality, diversity and inclusion, staff engagement and talent and leadership. and staff engagement across their individual organisations. Health and Wellbeing and Positive Inclusive cultures are identified as collective priority areas of focus across providers. The OD action plan will identify areas of good practice that can be built upon, scaled and spread.
The infographic below sets out our ‘Journey to Work’ model which captures our long-term approach to engaging our communities; attracting and supporting local people into health and care volunteering, jobs and careers; and looking after people through the employment lifecycle.

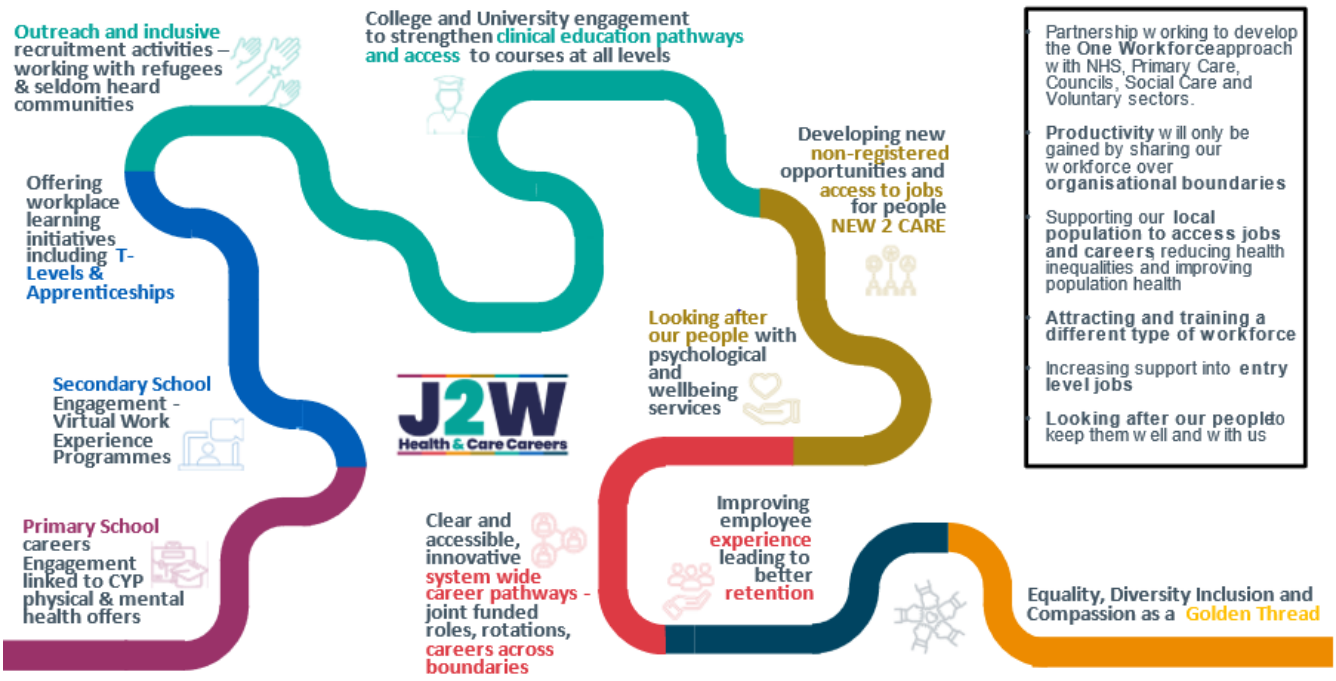


Figure 12: SSOT ICS 'Journey to work' model

7 Financial analysis

7.1 Introduction

This section describes the assessment of any financial impact of the proposal – making permanent the temporary closure of birthing services at County Hospital and Samuel Johnson Community Hospital.

The section includes:

- Staffordshire and Stoke-on-Trent ICB finances
- Trusts' baseline financial situation.
- Staffordshire and Stoke-on-Trent finance principles
- The impact of the proposals.
- Future prospects and funding.

The operating expenditure reflects the scale, nature and acuity of the women supported in the temporary model, by UHNM and UHDB within the acute sites and within the community. Inevitably of course, the current picture is different to that which existed prior to the temporary closure, and this section will demonstrate that.

True like-for-like comparisons are impractical as wherever based, maternity services required significant recruitment in order to reach the staffing establishment as identified within the Trusts Birthrate plus® reports. Nevertheless, this section will provide assurance that the proposal is sustainable within the overall financial plan for the Trusts and its commissioners and continues

to offer better value in financial terms than reverting to the pre-Covid model of a 24/7 staffed midwife-led birthing service at each unit.

7.2 Staffordshire and Stoke-on-Trent ICB finances

The Staffordshire and Stoke-on-Trent ICB estimated an underlying deficit of circa £200m before the pandemic and going into 2024/25 is circa £250m. Over the past year the system has implemented a financial strategy which has started the process of financial improvement. The system financial strategy alongside the system recovery plan has helped contain activity growth, also implemented double lock process for organisations to gain system approval for any business cases that deteriorate the underlying position.

Achieving financial sustainability is increasingly challenging and there will be significant control issues facing the system in the short and medium term, as partners work collaboratively to manage activity growth and reduce the underlying deficit. The system is working to maximise the significant opportunities for productivity improvements across all areas, which will be used to drive out the remaining deficit.

Maternity funding streams are within an overall block contract with providers. The contracts are not itemised on a line-by-line basis for each service therefore the allocation of resource to maternity activity is at the discretion of providers.

For intra-system providers (in area providers e.g. UHNM), the apportionment of resource allocations is split on a fair shares basis and growth applied accordingly within NHS guidelines. Any Ockenden funding is included within the ICB baseline funding, to which it is included in the block contract and ring-fenced for maternity services within UHNM.

For inter-system providers (out of area providers e.g. UHDB) For 2024/25, contract values for 2024/25 have been built up using the opening contract baseline (Exit 2023-24 recurrent contract value), any other known adjustments and then growth applied accordingly within NHS guidelines.

Each year transformation funding is allocated to Integrated Care Board LMNS partnerships with the purpose of supporting improvements in safe, personalised maternity and neonatal care.

High level objectives have been set out in NHS England » Priorities and operational planning guidance 2024/25 and all systems must continue to implement the NHS England » Three year delivery plan for maternity and neonatal services including meeting the key actions for systems identified in the planning guidance

Funding for maternity improvement comes in 3 main forms:

- Fair share allocation to support Three Year Delivery Plan Implementation including LMNS system leadership, safety and transformation.
- Funding for specific pilot projects which the system has agreed to take part in (Maternity bundle 2,3 & 4 where applicable)

- Funding relating to the Ockenden report which is for frontline maternity staff and is issued as a pass-through for provider Trusts :
    - Ockenden I: funding included in ICB core allocations from 2022/23 on a fair shares basis
    - Ockenden II: Maternity bundle 5 (Trust based allocations)
    - Ockenden III (as announced in Aug 2023) allocated within maternity bundle 1 (fair shares)

The LMNS was allocated a total of £3,371,000, the table below outlines the split of the allocation.

Summary	Allocation	Value
Maternity 1 **3 Year Delivery Plan Implementation** - Implementation funding including LMNS Capacity - Pre-term birth clinics and Maternal Medicine Networks - Perinatal Pelvic Health Services - Ockenden III workforce funding	SDF (recurrent)	£1,187,000
Maternity 2 Enhanced Continuity of Carer	Targeted	£196,000
Maternity 4 Independent Senior Advocate	Targeted	£90,000
Maternity 5 **Ockenden II Workforce** Bereavement Retention MSSW Improving Student Clinical Placement Experience Obstetric Leadership Capacity	SDF (recurrent)	£146,000
Initial funding for response to Ockenden included with ICB Baseline funding	Core ICB Allocations (recurrent)	£1,687,000
Maternal Mental Health LTP Maternity	SDF	£ 65,000

Table 24: SSOT ICB LMNS funding allocations 2023/2024

There are no associated costs with the proposal as described in the sections below and therefore it poses no risk to system finances.

7.3 UHNM and UHDB baseline financial situation

The table below provides the total operating expenditure (pay and non-pay) attributed to maternity provision at UHNM and UHDB, dating back prior to the temporary closure of birthing services in March 2020.

	2018/19 £,000	2019/20 £,000	2020/21 £,000	2021/22 £,000	2022/23 £,000	2023/24 £,000
County Hospital	1227	792	490	570	645	300
Royal Stoke Hospital	25,786	27,345	29,581	33,043	35,049	38,894

Table 25: Total maternity operating expenditure at UHNM April 2018 – March 2024

- This excludes fixed corporate overheads which may be attributable to the estate for a 'full absorption' expenditure view, but this is notional and variable based upon changing methodology over time and would be fixed in the medium term regardless of changes in operating models.
- The reduction in costing aligned to County Hospital in 2023/24 was due to the merging of the County Community Midwifery budget into a combined Midwifery team budget that is coded within the Royal Stoke Hospital Budget line.
- Expenditure includes any staff pay uplifts awarded.
- Medic cover is included within the expenditure for all years. These roles include support for Gynaecology however these costs cannot be disaggregated due to the dual nature of the Obstetrics and Gynaecology medical roles.

	2018/19 £,000	2019/20 £,000	2020/21 £,000	2021/22 £,000	2022/23 £,000	2023/24 £,000
Samuel Johnson Hospital	579	562	421	239	22	6
Sir Robert Peel Hospital	49	-1	0	0	0	0
Queens Hospital, Burton	10,278	10,161	9,812	10,462	11,261	12,085
Royal Derby Hospital	20,782	21,850	21,891	24,284	27,119	30,731
Cross site expenditure	799	1,040	1,139	1,432	1,440	2,316

Table 26: Total maternity operating expenditure at UHDB April 2018 – March 2024

- This excludes fixed corporate overheads which may be attributable to the estate for a 'full absorption' expenditure view, but this is notional and variable based upon changing

methodology over time and would be fixed in the medium term regardless of changes in operating models.
- Expenditure includes any staff pay uplifts awarded.
- Medic cover is included within the expenditure for all years. These roles include support for Gynaecology however these costs cannot be disaggregated due to the dual nature of the Obstetrics and Gynaecology medical roles.
- The decrease in budget at Samuel Johnson Hospital during 2022/23 and 2023/24 reflects a change in budget line where redeployed staff took up permanent posts within another role in the years following the temporary closure.

7.4 Impact of the proposals

The proposal makes permanent the temporary arrangements that have been in place since March 2020 when birthing services at County Hospital and Samuel Johnson Community Hospital were temporarily suspended. There are no additional staffing or estates costs as a result of the proposal however this section outlines the estimated costs associated with reestablishment of the clinical model as per March 2020 or as an on-demand service.

The required investment into maternity services overall, regardless of the service change process, means a direct comparison of the overarching cost of past and present models is not possible as this investment was required prior to the temporary closure of services to increase staffing levels to the required baseline.

The table below (also included within section 6.2) outlines the additional investment into maternity services at UHNM since 2021 to increase the midwifery workforce establishment to meet the workforce requirements as outlined within the Birthrate Plus® report.

Phase	Job Title	Recurrent Funding source	Non recurrent funding	Start Date for UHNM Funding	Pay Band	WTE	FYE
2021/2023							
Ockenden Funding Received in 21/22	Ockenden - Operational midwives	Ockenden funding in place from 21/22 RECURRENT		01/04/2022	6	3.26	(182,635)
	Ockenden - Training midwives			01/04/2022	6	3.26	(182,097)
	Ockenden - Consultant Obstetrician DCC PA's			01/04/2022	-	0.60	(92,372)
	Midwives - Newly qualified			01/10/2022	6	20.00	(946,362)
	Midwives - MAU triage			01/10/2022	6	2.14	(101,261)
	Maternity Support Workers			01/10/2022	4	5.60	(182,274)
TOTAL						**34.86**	**(1,687,000)**
2022/2023							
Birthrate Plus® Compliance	Band 6 - Operational midwives	Recurrent funding requested through Trust Business Case		01/01/2023	6	18.81	(890,054)
	Maternity Support Workers			01/01/2023	3	0.68	(21,055)
Specialist role	Maternal & New-born Screening Lead Midwife			01/01/2023	7	1.00	(52,881)

Pharmacy	Band 8a - Specialist Pharmacist Support		01/01/2023	8a	0.50	(31,494)
TOTAL					**20.99**	**(995,484)**

Table 27: UHNM midwifery staffing investment

The table below (also included within section 6.2) outlines the additional investment into maternity services at UHDB since 2021 to increase the midwifery workforce establishment to meet the workforce requirements as outlined within the Birthrate Plus® report.

Row Labels	Sum of £000's	Sum of WTE
Anaesthetics and Theatres - Additional sections	1,893	24.93
Medics - additional obstetric support	1,120	11.79
Midwifery - Birthrate plus® staffing	957	17.38
Midwifery - Continuity of Carer	124	2.21
Midwifery - Governance	52	1
Midwifery - management	544	11.36
Midwifery - on-call	216	3.04
Midwifery - Sonography	134	3
Midwifery - specialist posts	177	3.8
Midwifery - training	297	0
Neonates	1,659	27.52
Theatres - Additional theatre support	300	7.76
Transitional Care	660	12.73
Grand Total	**8,132**	**126.53**

Table 28: UHDB maternity services investment

This additional investment within each of the Trusts mean they are able to safely staff maternity services under the current operating model which mirrors the proposal within this pre-consultation business case.

The ICS has developed cost estimates for the reinstatement of birthing services at County Hospital and Samuel Johnson Community Hospital that would be required in addition to the above investment.

7.4.1 Staffing costs

The Birthrate plus® assessment completed for UHNM did not include the required staffing for birthing services at County Hospital as the service was temporarily closed at the time. These were not therefore, included within the business case to increase the staffing establishment. As a result, further investment would be required to reinstate these services in order to fund the additional midwives what would be needed to run birthing services at County Hospital.

The cost estimate for reinstating birthing services on a 24/7 basis at County Hospital is £1,091,704. This includes an increase of 12.15 wte Band 7 midwives to ensure there are 2 midwives present at a birth and 5.6 wte Band 2 admin support for the service within the hospital. This also includes any initial equipment costings.

Whilst the Birthrate plus® reports for UHDB included the births within the FMBU, the assessment was based on historic activity and did not reflect the required rota to staff the unit on a 24/7 basis. The Birthrate Plus® assessment included a requirement for 8.48 whole time equivalents to cover births within the unit and any transfers to obstetric care in addition to covering antenatal clinics. An increase of 3.67 wte band 7 midwives would be required to reach the minimum of 12.15 midwives to cover the births within an FMBU and to cover the rota for the unit to be staffed on a 24/7 basis. This would require an investment of £261,960 to fund the additional midwives that would be required. It is likely that an increase beyond 12.15 midwives would be required to cover the antenatal activity however this cannot be quantified as the Birthrate plus® assessment does not provide a breakdown of the staff required for each element of care within the unit.

Reinstatement of services on an on-demand basis would require the utilisation of the community midwifery team. A 24 hour on-call rota is currently in place with midwives supporting the alongside midwife-led and consultant-led units as required. Given the historic low demand and rising complexity within pregnancies, it is not clear that reinstating services on an on-demand basis would incur additional costs for the Trust. This would however require a reconfiguration of the teams to ensure there is adequate cover across all maternity services. If this proposal were to be implemented, additional costings associated to the reconfiguration would likely become apparent. Whilst it is not possible to quantify the impact, there would be cost implications if demand for birthing services at the FMBU were to increase as additional workforce would be required to maintain the long-term sustainability of home birth services and birthing services at the FMBU simultaneously.

7.4.2 Capital costs

Potential capital costs associated within the reinstatement of birthing services within the FMBUs have been identified by utilising the backlog maintenance figures for each of the sites.

The summary backlog figure for the FMBU at County Hospital, Stafford is included in Table 29 below which shows total of £1.3m less VAT, fees and risk (c40% in addition to the £1.3m).

	Physical Condition	Statutory Standards	Total
High	£0	£0	£0
Significate	£218,594	£26,488	£245,083
Moderate	£979,824	£1,577	£981,401
Low	£3,276	£0	£3,276
Total	£1,201,694	£28,066	**£1,229,759**

Table 29: County Hospital FMBU summary backlog position

The backlog figures outlined above are to bring the area to Condition B and does not take into account re-modelling or to create an area that is compliant with new non-retrospective legislation or recommendations from the Department of Heath technical standards and guidance for estates; the Health Technical Memoranda documents (HTM) and the Health Building Notes (HBN). This could be around £7m based on the costs for recent projects at County Hospital, to ratify these figures a feasibility study would need to be undertaken.

No additional capital costs or backlog maintenance has been identified for birthing services at Samuel Johnson Community Hospital with the exception of £16,200 for replacement equipment.

7.5 Staffordshire and Stoke-on-Trent ICS financial principles

In agreeing to the deficit position, the system has agreed to the following principles in taking the swift action required to bring the financial position to plan.

These key principles are:

1. We will not take measures which adversely impact upon the safety of services provided and we will ensure that the decisions we make do not adversely impact the access, experience or outcomes of any disadvantaged individuals, inclusion groups or communities.
2. We will work collectively to make the best use of the local pound and demonstrate value for money in the use of our collective resource.
3. We will maintain and strengthen our controls over pay and non-pay, and evidence the impact of those controls through improved metrics such as lower bank and agency spend.
4. We will strengthen controls over corporate spend by freezing vacancies, where safe to do so, and using opportunities to share resource across partners.
5. Recognising the difficulty in taking existing capacity out, we will hold new allocations and new commitments until we have delivered sufficient efficiencies to deliver our agreed financial plan.
6. Any business case that would worsen the financial position will be taken through the system double lock process.

7.6 Future prospects and funding

The Staffordshire and Stoke-on-Trent (SSOT) Integrated Care System has agreed to meet a financial target to achieve a deficit of no more than £90m in 2024/25. Addressing the financial challenges and deficit within the system requires a multifaceted approach, combining immediate financial management strategies with long-term planning and investment in innovation and efficiency improvements. The system has recognised that it must develop a plan that returns the system to a sustainable financial position. Work on this medium-term plan is already underway and the milestone events have been agreed.

Looking further forwards, the financial model of all services will be kept under review to ensure the services not only remain safe and contemporary in terms of quality standards, and follow the national direction, but also that they offer value for money, compared against benchmarks, reference costs and other comparators. Workforce planning and building community capacity is essential.

8 Evaluation of proposals

8.1 Introduction

This section describes the evaluation of the proposals for the future of birthing services previously provided at County Hospital and Samuel Johnson Community Hospital. It includes:

- The Government's 'four tests' and bed test applied to service change.
- Quality, safety and clinical sustainability.
- Deliverability.
- Equality and health inequalities.
- Independent review of clinical model and proposal

The proposal for these services is:

- To make permanent the temporary closure of birthing services only at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield.

Antenatal and postnatal care would continue to be offered at the above locations.

8.2 The Government's four tests of service change and NHS England patient care test

NHS commissioners are required[33] to apply the tests of service change.[34] These include the Government's four tests of service change:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- Clear, clinical evidence base.
- Support for proposals from clinical commissioners.

And in addition:

- NHSEI's Patient Care (bed closure) Test.

This final test requires that local NHS organisations show that significant hospital bed closures subject to the current formal public consultation tests can meet one of three new conditions before NHS England will approve them to go ahead:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or

[33] R (London Borough of Lewisham & Anor) v Secretary of State for Health & Ors [2013] EWHC 2381 & R (Cherwell District Council & Ors) v Oxfordshire CCG [2017] EWHC 3349 (Admin)
[34] p13, Planning, assuring and delivering service change for patients, NHS England 2018

- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme)

The proposals for the services previously provided at County Hospital and Samuel Johnson Community have been developed in line with these tests.

8.2.1 Strong public and patient engagement

The IRP recommendation to the Lord Darzi report states that '*The IRP is also concerned about the number of overnight or full closures of services that were originally implemented as a short term solution due to staffing issues during the Covid-19 pandemic but still remain ongoing years later. These type of 'temporary reconfigurations' are prevalent among urgent treatment centres and freestanding midwifery-led birth units, restricting access to care and calling into question their long-term sustainability. The continuing uncertainty around the future of these services is unfair to patients and the NHS staff who work in them. It is important that NHS integrated care boards regularly review these ongoing temporary changes to address any concerns raised and to develop effective long-term plans in collaboration with their local system partners and the public*'.

Section five explains in detail the extensive public and patient engagement carried out whilst developing the options for the services previously provided at County Hospital and Samuel Johnson Community hospital. The section outlines engagement activity and plans, together with records of relevant meetings with stakeholders such as the Overview and Scrutiny Committee, and information about engagement with people from the nine protected characteristics and in areas of health inequality.

This section clearly outlines the review process undertaken prior to and throughout the period of the temporary closure to identify effective long-term plans for birthing services and the engagement with system partners and the public throughout the process.

8.2.2 Consistency with current and prospective need for patient choice

The NHS Choice Framework sets out patients' rights to choice in healthcare, where to find information to help choose and how to complain if choice isn't offered.

For maternity services this means women can choose to receive antenatal care from a midwife or from a team of maternity healthcare professionals, including midwives and obstetricians.

Women should also be able to choose whether to give birth at home with the support of a midwife, within a midwife-led facility with the support of a midwife or in a hospital with the support of a maternity team.

The choices available to women will be dependent on their clinical need. The table in Section 4.2 below provides a summary of the places in Staffordshire and Stoke-on-Trent that can be considered as part of a birth plan. Women will continue to be offered a choice of place birth, including the choice of a midwife-led birth, as recommended by the Birthplace Study (National

Perinatal Epidemiology Unit, 2011), Better Births and the National Institute of Clinical Excellence (NICE). Section four describes in detail the case for change for the future of birthing services that were previously delivered at County Hospital and Samuel Johnson Community Hospital in particular the consideration of both the workforce sustainability and the clinical sustainability of services.

Section five provides further detail on the feasibility of continuing to provide birthing services within an FMBU and the process followed to arrive at the single viable proposal for the future of services, including the criteria applied. The section explains the limitations of providing services within an FMBU and discusses the wider birthing choices available to women across Staffordshire and Stoke-on-Trent and the advantages of offering midwife-led births as an alongside model.

8.2.3 Clear, clinical evidence base

Section three explains the national commitment to ensuring maternity services are safer, more personalised and more equitable. As outlined within the three-year delivery plan, this ambition can only be achieved when services are delivered by skilled teams with sufficient capacity and capability. Section four outlines the rising complexity of pregnancies over recent years with more women presenting with comorbidities and requiring consultant-led care. This substantially reduces the number of women suitable for low-risk birthing services that were offered at County Hospital and Samuel Johnson Community Hospital. It is therefore essential that midwives are supported to develop and maintain their competencies to manage a more clinically complex workload and deliver high quality, safe care. This is particularly important given the national shortage of midwives.

Table 17 in 5.5.2 outlines the assessment of all proposals considered by the technical group. This highlighted a single viable proposal when considered against each of the six essential criteria which includes clinical sustainability and workforce sustainability.

The IRP recommendations to the Lord Darzi reports states that '*The IRP has also seen a shift to centralisation within the NHS justified as a clinical necessity and a means of resolving staffing issues, even when it presents a risk to access for patients and may negatively impact the patient experience, often with regards to travel, transport and ambulance conveyance times*.'

The information in Sections three and four and five references the strong evidence for centralising birthing services within the acute Trusts to meet the changing clinical needs of the population and ensure safe, high quality, and equitable services are offered to women. As highlighted within the quality impact assessment, making permanent the temporary closure of birthing services at the FMBUs also ensures midwives skills, experience and capacity are fully utilised in all areas of maternity care in order to support the delivery of key national requirements. Midwives rotate across both the low-risk and high-risk maternity units in line with demand rather than diverting resource to an underutilised unit.

Section 8.3 and 8.4 of this PCBC outline the assessment of any potential impact on access for women as a result of this proposal. As identified throughout this PCBC, the proposal reduces

the requirement for ambulance conveyances as centralising services means women and their babies have immediate access to additional support if required rather than needing to be transferred from an FMBU to an acute site in an ambulance.

8.2.4 Support for proposals from clinical commissioners

The maternity case for change was developed originally through the Sustainability and Transformation Partnership (STP) Maternity Programme Board, building on the NHS Long Term Plan. The Case for Change[35] sets out the needs of the population, the current provision of health and care and outlines our vision and aims for local health and care in the future.

In July 2023, a stage 1 assurance meeting took place. During the meeting, the ICS shared the current position of maternity services, the current case for change and clinical model ahead of undertaking the appropriate stages required within the NHSE service change process.

In April 2024, the Case for Change was presented to the West Midlands Clinical Senate. The Clinical Senate 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. Further detail on the recommendations from the Clinical Senate and the ICSs response is included later in Section 8.6.

Detail of clinical involvement in the development of the proposals is detailed in Section five, including clinical involvement in technical events evaluating the proposals.

The ICB has ensured that neighbouring ICBs are aware of the process undertaken and have confirmation of support for the proposal outlined within the business case from Derby and Derbyshire ICB.

The business case will be subject to both NHSE and the Staffordshire and Stoke-on-Trent Integrated Care Board assurance and governance processes prior to a final decision being made.

8.2.5 Bed test

When looking at the bed test, bullet point one is the most relevant to this business case:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it.

There were no inpatient beds within the FMBUs at the time of the temporary closure. There were two labour, delivery, recovery and postpartum (LDRP) rooms at County Hospital and three at Samuel Johnson Community Hospital at the time of the temporary closure.

Activity modelling for low-risk eligible women within both acute Trusts has been completed using the Birthrate Plus® assessment. The activity modelling has been used to ensure the correct number of low-risk LDRP beds are available at each unit. UHNM have four designated

[35] Case for Change, Together We're Better, 2019

LDRP rooms at Royal Stoke University Hospital and Queens Hospital Burton have two designated rooms. This is ring-fenced capacity for low-risk births meaning that any increase in demand within other areas of maternity, for example an increase in inductions of labour, will not impact on the Trusts ability to offer low-risk, maternity-led care.

Whilst there are designated rooms for low-risk births within each hospital both sites have the ability to flex other delivery rooms to provide low-risk care as required. If additional capacity were required, women would be supported to have a midwife-led birth within available rooms on the consultant-led units.

The Birthrate Plus® reports for both Trusts demonstrate a continuing rise in maternal complexity, which means even fewer women are suitable for low-risk care currently than prior to the temporary closure of birthing services at the FMBUs. In addition, very few women chose to give birth at the FMBUs despite campaigns to promote the units. As described above, there is protected low-risk capacity within each of the Trusts. This protected capacity and the nature of low-risks births, i.e. that women and their babies do not require care on a ward or within the neonatal unit, means that low-risk births do not impact on the Trusts ability to provide care within other areas of overall maternity services.

Both Trusts are committed to retaining midwifery led birthing options for women on a low-risk pathway to ensure women have personalisation and choice.

Royal Stoke Hospital has 4 Midwifery led care (MLC) rooms which are close to the consultant unit with a very short transfer time if medical support is needed. This area is staffed by midwives and support workers and is protected capacity for low-risk births. There is also a birthing pool here. Whilst there are designated rooms for low-risk births within the midwife-led unit at Royal Stoke, additional capacity is available within the consultant-led unit. If additional capacity was required, women are supported to have a midwife-led birth within the consultant-led unit. Access to the Royal Stoke Midwifery Birthing Unit is monitored monthly through the Quality and Safety Oversight Forum through several balance measures.

Queens Hospital Burton has 2 birthing rooms identified for midwifery led care on the consultant birth centre and a birthing pool is available for use by women on an MLC pathway. This is protected capacity for low-risk births, but further rooms can be flexed to support low risk care as and when required. Women can also access the Royal Derby Birth Centre which is an alongside Midwifery Birthing unit which consists of 4 ensuite rooms and a birthing pool room. In Q3 24/25 22% of births at QHB were assessed as low risk in labour.

Both Trusts began booking women into the home birth service during their early pregnancy from 01 April 2024 which now means that women have the full range of low-risk birth settings to choose from.

QHB & UHNM have had no service suspensions or external diversions due to capacity over 2024/25.

The MNVP plan to work with UHNM and QHB to promote the midwifery led care birth options and plan to develop resources for birthing people.

As a result, there has been no operational impact as a result of the transfer of this activity to the main acute sites during the past four years and the proposal has no anticipated impact on the longer-term sustainability of the service.

8.3 Quality, safety and clinical sustainability

The case for change outlined earlier within this document articulated the system ambition to deliver high quality maternity services. A Quality Impact Assessment (QIA) has been completed for this service change (see Appendix 05).

The key quality impacts are outlined below:

- Consistent staff to patient ratios across sites removing the inequity in provision seen when the FMBUs were open.
- Women who develop complications would no longer need to be transferred to a hospital unit during advanced labour after already having travelled to an FMBU.
- 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.
- FMBUs are for low-risk pregnancies only and the vast majority of the Staffordshire and Stoke-on-Trent maternity 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.

Service specific quality reports are taken through both Trusts governance process. These reports begin at ward/directorate level, through divisional governance, onto executive quality and safety oversight forums and then taken through Board level assurance and LMNS system wide assurance. Key reports include progress reporting against national recommendations such as Saving Babies Lives and Ockenden, workforce and training position, any serious incidence and family experience.

Further detail on the quality reporting undertaken and the associated assurance and governance process within each of the Trusts is included within Appendices 06 and 07.
The Trust assurance processes include reporting through the Local Maternity and Neonatal System (LMNS) Partnership Boards. The Staffordshire and Stoke-on-Trent LMNS governance framework is illustrated below:

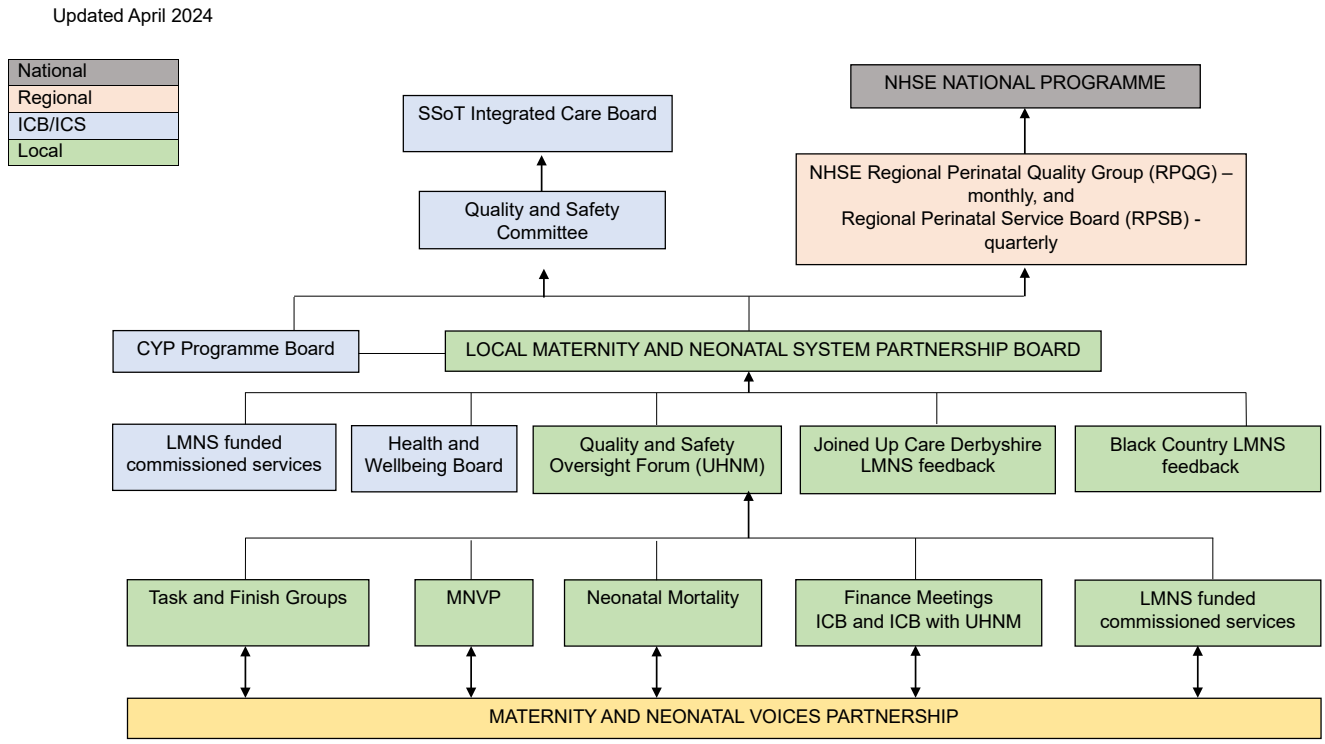


Figure 13: SSOT LMNS governance framework

8.3.1 Care Quality Commission (CQC) Inspection

The latest Care Quality Commission (CQC) inspection of maternity services at UHNM was in March 2023 and at UHDB in August 2023. As these were service specific inspections, services were inspected against two of the five domains – safe and well-led.

At UHNM, the service rating for safe moved from requires improvement to inadequate and moved from good in well-led to requires improvement. The overall rating for maternity services moved from good to requires improvement. The overall Trust rating is not affected and remains as requires improvement. The full report, published in June 2023 can be found within the maternity section here Royal Stoke University Hospital - Care Quality Commission (cqc.org.uk).

Following the inspection, a System Maternity Oversight and Assurance Group (SMOAG) was established in August 2023. The group was led by the SSoT ICB Chief Nurse and the Regional Chief Nurse. The group were accountable for gaining assurance for the delivery of the overall integrated quality improvement plan, and particularly progress against the actions being taken to address the CQC Section 29a conditions and the CQC actions which the Trust have been advised they must or should take to improve their maternity services. The group met monthly and reported to the LMNS Partnership Board and the ICB's quality and safety committee. Updates were included in the ICB report into the quarterly Regional Quality Group as a specific item.

The SMOAG was stepped down following the UHNM Rapid Quality Review meeting that was held with the national team, regional team, ICB, CQC, GMC, NMC, Maternity Safety Support Programme and UHNM on the 5th of April 2024. The Trust presented their progress against the CQC Action Plan, Maternity Incentive Scheme actions and any ongoing concerns or issues.

The Trust was commended for all the work they have achieved over the last year and the focus now should be on sustainability. The ICB was also praised for the pragmatic way in which it worked and supported UHNM. The ICB will continue with oversight locally through the LMNS QSOF and the data will be reviewed monthly through a Perinatal Quality Oversight pack that has been developed.

At UHDB, specifically Queen's hospital Burton the service rating for both safe and well led moved from requires improvement to inadequate. The overall rating for Queen's Hospital was not affected and remains as requires improvement. The full report, published in November 2023 can be found in the maternity section here Queens Hospital - Care Quality Commission (cqc.org.uk)

UHDB had recognised and acknowledged their challenges prior to the CQC inspection and sought additional support by requesting to join the Maternity Safety Support Programme earlier in the year. Immediate plans were put into place to address the issues raised by the CQC and the Trust track and report on their progress through their governance and assurance process.

On the 24 August 2023 the Care Quality Commission (CQC) inspected maternity services at UHDB

UHDB was issued with a notice of decision to impose additional conditions on the Trust's registration as a service provider in respect of regulatory activity at the Royal Derby Hospital site for maternity services under Section 31 of the Health and Social Care Act 2028.

On 7 September 2023 the Trust was issued with a notice of decision to impose a Section 29A warning notice for maternity services at Royal Derby Hospital (RDH) and Queen's Hospital Burton (QHB) sites.

On the 29 November 2023 the CQC reports for QHB and RDH were published detailing must and should do actions and an outcome of inadequate for safe and well led domains in maternity services for both sites were declared.

Neither Trust received recommendations to reinstate services at the FMBUs and no concerns were raised specifically regarding midwife-led services at Queen's Hospital Burton or Royal Stoke University Hospital.

8.4 Impact analysis

8.4.1 Equality Impact Assessment including health inequalities

An Equality Impact Assessment (EIA) was completed in August 2024 (see Appendix 08) which supports the proposal to make permanent the temporary closure of birthing services at the FMBUs.

The EIA identifies the protected characteristics of pregnancy and maternity as the most likely to be impacted. Whilst no negative or positive impacts were identified for other protected characteristics, this was identified following due consideration of the needs of the birthing population.

The impacts are as follows:

Age – 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 women. 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 women 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 women.

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 women who accessed the FMBUs were from the Derby area suggesting minimal impact on this cohort of women. Furthermore, women from Derby travel further to reach the FMBU at either Samuel Johnson Community 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 women.

Disability – 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 women would not be affected by the proposal as FMBUs manage low-risk pregnancies only.

Race – 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.

Pregnancy and Maternity – Negative Impact
The women affected by this change will be pregnant and may need to travel further to an alternative low-risk unit. Further detail on the travel analysis is included in the section below.

8.4.2 Travel Impact analysis

Travel 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 of blue light transfers on total travel time for women who developed complications and were transferred to the main acute sites.

Within the travel analysis, scenario 4 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. The full analysis is available at Appendix 09, including information about how the assumptions were made in deciding how potential women might travel and where they would be travelling from.

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.

Women 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 women are using alternative units that are closer to their home address.

Mitigating factors

While a number of women 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 25% 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 have continued to operate during this time at the FMBU. This reduces the travel impact to intrapartum care only.

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. Trusts began booking women into the home birth service during their early pregnancy from April 2024 which now means that women have the full range of low-risk birth settings to choose from.

Women and families have been kept regularly updated via the Maternity and neonatal voices partnership (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.

As described within the QIA, where clinical complications arose during labour at an FMBU, women were transferred to acute sites during the advanced stages of labour. This would be in addition to the time already taken to travel to the FMBU from home. The proposal mitigates this risk of additional travel time, as births within low-risk settings at the acute hospitals would be transferred immediately without the need to transfer to a different hospital.

8.5 Deliverability

The initial temporary closure of birthing services at the FMBUs was unusual in that it was in response to the COVID-19 pandemic and services were temporarily suspended in March 2020.

As a result, the proposal described within this pre-consultation business case has been implemented and delivered in this way for over four years. During this four-year period, maternity services have developed in line with national reports and delivery plans, including those relating to the ICS digital strategy.

The proposal would not impact on the local health economy to plan for, and to respond to, a major incident - on call managers have access to SHREWD (Single Health Resilience Early Warning Data Base), a digital platform which provides a visual real time display of activity across our providers. Discussions have commenced between the Digital Midwives in UHNM and those responsible for SHREWD in the ICB, with a view to including induction of labour figures provided on the daily sitrep, but with more regular updates. The benefits of utilising SHREWD have been recognised by NHS England and other providers with an expectation that this will be extended across the region.

Capacity and demand modelling for maternity, including inductions of labour, is based on staffing capacity rather than physical bed capacity. Modelling has been completed using the nationally recognised Birthrate Plus assessment tool as described in Section 4. This is completed every three years to ensure there is sufficient staffing and takes into account both the local birth rate and the complexity of the caseload. Both Trusts have confirmed there is sufficient low risk capacity to meet current demand with ongoing recruitment programmes to maintain staffing levels in line with Birth Rate Plus. Both Trusts are in the process of re-running their Birthrate Plus assessments to support future workforce planning.

With regard to physical capacity, there are designated rooms for low-risk births within each hospital. This is ring-fenced capacity for low-risk births meaning that an increase in demand within other areas of maternity will not impact on the Trusts ability to offer low-risk, maternity-led care. Both sites have the ability to flex other delivery rooms to provide low-risk care as required. If additional capacity were required, women would be supported to have a midwife-led birth within the consultant-led units.

The information included within section four highlights the limited and reducing preference for birthing within the FMBUs in addition to the changing needs of the population (increasing complexity) who would not be suitable for low-risk care. The proposed model therefore is not only deliverable but supports the longer-term sustainability of services and ensures the ICS meets the needs of the population.

Information in Section five shows the advantages of the proposal and the report of engagement in this section illustrates the views of patients, the public and stakeholders.

The figures in the finance section (Section seven) show that the new arrangement for delivering these services for people as proposed within the business case is less costly than reinstating birthing services at the freestanding units. There are no capital requirements related to the proposal.

It is therefore clear that the proposal is deliverable.

8.6 Independent review of clinical model and proposal

8.6.1 Introduction

The West Midlands Clinical Senate review of proposals for birthing services previously provided at County Hospital Stafford and Samuel Johnson Community Hospital in Lichfield was commissioned by Staffordshire and Stoke-on-Trent Integrated Care Board (SSOT ICB) on behalf of the Integrated Care System (ICS) including University Hospitals of North Midlands NHS Trust (UHNM) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) 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 review took place on 26 April 2024.

The purpose of the review is to offer external clinical assurance and focused on the birthing element of the maternity pathway and specifically, the proposal to make permanent the temporary closure of the birthing service at the two Freestanding Midwifery Birth Units (FMBUs) at County Hospital in Stafford and Samuel Johnson Community in Lichfield. 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'*.

The report[36] contains five recommendations for the programme to consider. These are outlined below.

8.6.2 Clinical senate recommendations

Recommendation 1

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.

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.

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.

Recommendation 4

[36] Midlands Clinical Senates - Our Published Work (midlandssenates.nhs.uk), June 2024

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.

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.

8.6.3 Programme response to recommendations

Recommendation	Programme response
Recommendation 1 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.	Staffordshire and Stoke-on-Trent ICB along with UHNM, UHDB and Derby and Derbyshire ICB acknowledge the time and due diligence that the WMCS panel members took in reviewing the evidence submitted and the rounded discussion that took place in order for the panel to support the proposal.
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.	UHDB will give continued consideration to ensuring a high-quality birthing environment is maintained and provides equity of access across acute sites. Standards will be monitored and maintained and capital funding will be sought when upgrades are required.
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	This is a national issue which is specific currently for birthing people receiving post-natal care in Staffordshire but who have given Birth at University Hospitals Birmingham NHS Foundation Trust (UHB). University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) have introduced a new electronic maternity record, which will be the same one as that used at UHB and therefore all clinical notes will be electronically accessible. Staffordshire and Stoke-on-Trent ICB (SSOT) LMNS has arranged to meet with UHDB once implemented to review success. Whilst this hasn't been raised by University Hospitals of North Midlands

need them in a timely manner	NHS Trust as an issue within maternity services, the LMNS will scope this and ensure actions taken as required. Digital Maturity assessments and "What good looks like" benchmarking exercise has taken place with our providers. This formed the basis of their maternity digital strategy, which includes standardisation and interoperability. The SSOT LMNS works closely with Derby and Derbyshire ICB/ LMNS and Black Country ICB / LMNS as part of the wider maternity programme and will work with other ICBs at an LMNS level to understand any barriers to the sharing of clinical records in any cross-border patient flows. As an LMNS, we continue to be an active member of the regional digital maternity leadership network, and learning is shared widely across the system to help drive forward equitable care. As a system, we have continued to progress steps to Digitise, Connect and Transform. This aims to increase digital maturity and ensure a core level of infrastructure, digitisation and skills. Our actions contribute to meeting the ambition of a digitised, interoperable and connected health and care system as a key enabler to deliver more effective, integrated care and reducing digital inequity. The ICS digital teams are progressing our Electronic Patient Record programme focusing on interoperability and system-wide working. Our priority is now on the procurement process and embedding the identified solution.
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.	Both providers have reinstated the offer of home birth commencing on the 1st April 2024 with home birth being offered to those who book from that date forward and those who fit the criteria. UHDB have undertaken multidisciplinary skills training, which is included within their PROMPT training days, which are also attended by paramedics at EMAS and WMAS. This facilitates working together around transfer women in practical scenarios. Additional bespoke home birth education is planned for August. Community midwives are also going through a process of reorientation with intrapartum birth settings to refresh their skills. Similarly, UHNM have held multidisciplinary skills training in home birth, including WMAS colleagues who have been attending training and updating in home birth, emergencies,

	and transfers. Community midwives are also going through a process of reorientation with intrapartum birth settings to refresh their skills. UHNM have commenced a staff Home Birth Working Group to support the service. Within the considerations of the working group we are including future plans for continuity of carer wherever possible. Home birth is included as an update at both LMNS Quality & Safety Oversight Forum and the LMNS Partnership Board and the ICB will oversee implementation through these forums.
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.	The Trusts and ICBs will work collaboratively with their MNVPs to develop the appropriate signage for maternity services within County Hospital and Samuel Johnson Community Hospital.

Table 30: WMCS recommendations and system response

8.6.4 Conclusion/summary

This section outlines our responses in relation to the Government's four tests of service change and NHS England patient care test, outlines the impact assessment that have been undertaken as well as the recommendations produced by the West Midlands Clinical Senate in relation to proposals for birthing services previously provided at County Hospital Stafford and Samuel Johnson Community Hospital in Lichfield following their visit on 26 April 2024. These recommendations have been accepted and considered by the programme team who continue to work to address them. Information on the work undertaken and work being pursued is included in this pre-consultation business case.

9 Management and Governance

9.1 Introduction

This section of the pre-consultation business case:

- Explains the management and governance of the programme deciding the future of birthing services provided at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield until March 2020.
- Outlines the timeline and governance for sign off of the business case and the evaluation plan, together with the appropriate and agreed Health Overview and Scrutiny Committee arrangements.
- The programme risk register is explained together with any mitigations.
- Includes plans for appropriate engagement in the next stage, and this may include a public consultation. Throughout the process of developing the final proposal for the future of the services, there has been extensive public and patient, clinical, staff and stakeholder engagement.

9.2 Timeline and next steps

Legislation relating to NHS bodies changed on 01 July 2022, when the Staffordshire and Stoke-on-Trent Integrated Care Board took over health service commissioning responsibilities from the Staffordshire and Stoke-on-Trent Clinical Commissioning Groups. Governance for this programme transitioned seamlessly from the CCGs to the ICB.

This pre-consultation business case has been reviewed and approved for submission to the Staffordshire Integrated Care Board for consideration.

There will be continued liaison with the Staffordshire Health and Care Overview and Scrutiny Committee, which will have a key role in ensuring that the proposals deliver effective care for the population.

If the Scrutiny Committee recommends further involvement, the ICB will decide what further appropriate public involvement is needed. A decision-making business case will be developed to reflect the outputs of that involvement activity and be presented to the Board of the Integrated Care Board for consideration and decision.

9.3 Next steps

The upcoming milestones and indicative dates for the process as it proceeds have been set out as:

Date	Milestone
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)
February 2025	ICB decision on whether to proceed with involvement
May - August 2025	Potential involvement activity
August - October 2025	Analysis of outputs from involvement activity
Autumn/Winter 2025	Develop decision-making business case

Table 31: Indicative programme timeline

9.4 Risk management

The programme has created a risk register, with appropriate mitigations. These have been reviewed and managed throughout the process.

9.5 Plan for consultation

The ICB is keen to ensure that we build on previous involvement activity and understand if there is any new or additional information that should be taken into consideration ahead of decision-making. Therefore, a draft consultation plan, draft consultation document and questionnaire is being developed which will be updated pending the outcome of NHSE assurance process and subsequent governance.

Scope of the work

This consultation activity will inform the decision-making about the proposal to make permanent the temporary closure of the birthing service at the two Freestanding Midwifery Birth Units (FMBUs) at County Hospital in Stafford and Samuel Johnson Community in Lichfield.

Aims and objectives

If further involvement activity to gather views is required, the aims of this would be to take forward a twelve-week public consultation in order to:

- articulate the case for change and the single viable proposal to make permanent the temporary closure of the birthing service at the two Freestanding Midwifery Birth Units (FMBUs).

- inform and involve staff, service users, carers, carer representatives and other stakeholders about the work to date and the proposal identified through the options appraisal process and wider involvement activity.
- reassure staff, service users, carers, carer representatives and other stakeholders about the scope of the proposal and the wider maternity clinical model.

- understand views about the process we have undertaken and the technical group's recommendation about the single viable proposal.

We will seek to understand people's views on the proposal, and in particular:

- if there are any proposals we have not considered to date.
- if there is any positive or negative impact that we have not already considered, if we decide to go ahead with this proposal.
- how we can support people if these changes are agreed.

The objectives of this work will be to gather any further information needed to inform the decision by decision-makers to meet our statutory duties. The full consultation plan is included in Appendix 10.

Key documentation

There will be three main documents which will act as the platform for the consultation activity:

- Consultation Plan. The plan includes surveys, online events, roadshow drop-in events and targeted engagement with specific demographics to ensure we hear from as many people as possible.
- Consultation document. Includes details of the case for change, the proposals, impact analysis, low risk maternity pathway, and details of the consultation process as supporting information.
- Survey. This will be developed in digital and print version, with support to complete these if required. Surveys and information will be made available in alternative formats as required.

In addition, this PCBC will be available on the ICBs webpage and all public facing documentation will be made available through various media outlets.

9.6 Implementation plan

Normally with a business case involving a move of services or a rebuild there would be an implementation timeframe, with metrics and an evaluation plan. However, this business case is recommending a single viable proposal for the future of birthing services. As outlined within the workforce section, both Trusts continue to recruit and retain their midwifery workforce through a range of training development opportunities to ensure that the current temporary arrangements are robust and resilient should the proposal be implemented on a permanent basis. As both Trusts are currently re-running their Birthrate Plus assessments with reports due during Q1 2025/26, this will be assessed to inform their ongoing workforce plans.

The current service provision through UHNM and UHDB would continue in place alongside the contracting, quality and, assurance measures that are already established via our LMNS partnership delivery and assurance arrangements see 8.3.

If during the formal public consultation, any additional proposals are identified, these would be reviewed against the essential criteria during a technical event and if these are deemed viable, implementation plans would be developed and taken into consideration through the process.

Following any formal implementation stage, the ICB will utilise both real time and process and outcome data to both monitor and drive improvements.