Oxford University Hospitals
NHS Foundation Trust

Maternity Summary Slides

Sam Foster
Chief Nursing Officer
09/03/2022

Responsibility for safety…

“The prime responsibility for ensuring the safety of clinical services rests with the clinicians who provide them...

The prime responsibility for ensuring that they provide safe services, and that the warning signs of departure from standards are picked up and acted upon, lies with the Trust, the body statutorily responsible for those services.”

Dr. Bill Kirkup

National maternity safety ambition

‘Halve it’ campaign

Our Collective aim is to make measurable improvements in safety outcomes for women, their babies and families in maternity in neonatal services, as set out in Better Births in 2016.

This includes halving the rate of stillbirths, neonatal deaths, intrapartum brain injuries and maternal deaths by 2025 (2010 baseline), with a 20% reduction by 2020. Also, reducing pre-term births by 25% (2015 baseline) by 2025 by reducing the pre-term birth rate from 8% to 6%.

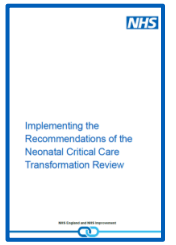
Local Maternity Systems and Provider organisations have been undertaking a range of safety interventions and should continue to throughout the Long Term Plan (LTP) period, in order to meet the safety ambitions.

The journey to a national maternity safety ambition

2014
Five Year Forward View

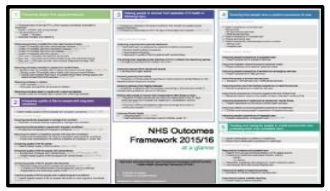
2015 – National Ambition

2016 – Safer Maternity Care Action Plan

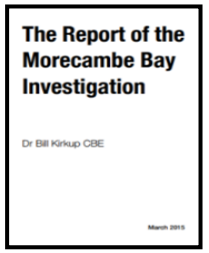


2019 - Implementing the Neonatal Critical care review Recommendations

2010 - NHS Mandate & Outcomes Framework



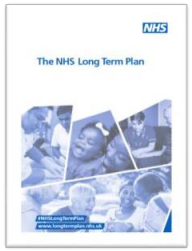
2015 – Kirkup Report



2016 – Better Births

2017 – Progress and next steps

2019 - Long term Plan



A key theme of the National reviews has been the voice of the parent, as a Board we must ask ourselves:

A parent's view: my challenge to board level safety champions

Nicky Lyon, Campaign for Safer Births and User Co-Chair of the National Maternity Safety Workstream, asks the following questions for Board level safety champions:

HOW DO YOU KNOW…

- If your unit is delivering the safest care possible?
- Do you read feedback and comments from parents? What changes have you made in response?
- Is your unit following all current guidelines? Are they documented, trained and audited?
- Have you checked that the staff in your unit have all the resources, training and support they need to do their job well?
- Is the MDT training developed in your trust with joint training briefings and handovers?
- Are you investigating all SI's and perinatal deaths robustly with external representation and invited parental input?
- Do you know how many stillbirths there have been in your unit? How many occurred in labour? How many SI's?
- Have you briefed the Board on maternity safety and the activity you would like to undertake to improve further?

Find out more: A parent's view: my challenge to board-level maternity safety champions

Oxford University Hospitals
NHS Foundation Trust

The National requirements that require board assurance in this timeframe include:

- **The Ockenden Report (2020) :** The report from the outset set out to give a **parent's a voice** so their concerns could be addressed- **Based on the serious failings** in maternity care initially raised by two bereaved families in 2016 at the Shrewsbury and Telford maternity hospital – subsequently over 250 case reviews have been undertaken and the themes of these led to National recommendations. The Board received initial an initial declaration endorsed by the Chief Executive Officer against 12 specific urgent clinical priorities which was submitted to NHSI in December 2021, following this, an assessment against seven immediate and essential actions (IEAs) were completed and reported to Trust Board in June 2020 - One year on Trust Boards are asked to review their position.

- **Maternity Incentive Scheme** (**MIS**) The scheme supports **the delivery of safer maternity care** through an incentive element to trust contributions to the CNST. Trusts are asked to continue to apply the principles of the 10 safety actions, given that the aim of the MIS is to support the delivery of safer maternity care.

- **Continuity of Carer -** Evidence shows that continuity models improve safety and outcomes – “Better Births First and foremost continuity of carer means that there is consistency in the midwife or clinical team that provides hands on care for a woman and her baby throughout the three phases of her maternity journey: • Pregnancy • Labour • The postnatal period

- **CQC Action plan** following the visit in 2021 and the Results of the **CQC Patient Maternity Survey** published in February 2022

- **Safe staffing –** One of the MIS requirements is bi-annual assurance to the Trust Board on Midwifery staffing

- **Perinatal Mortality Review-** To be taken in private session as risk of identification of patients.

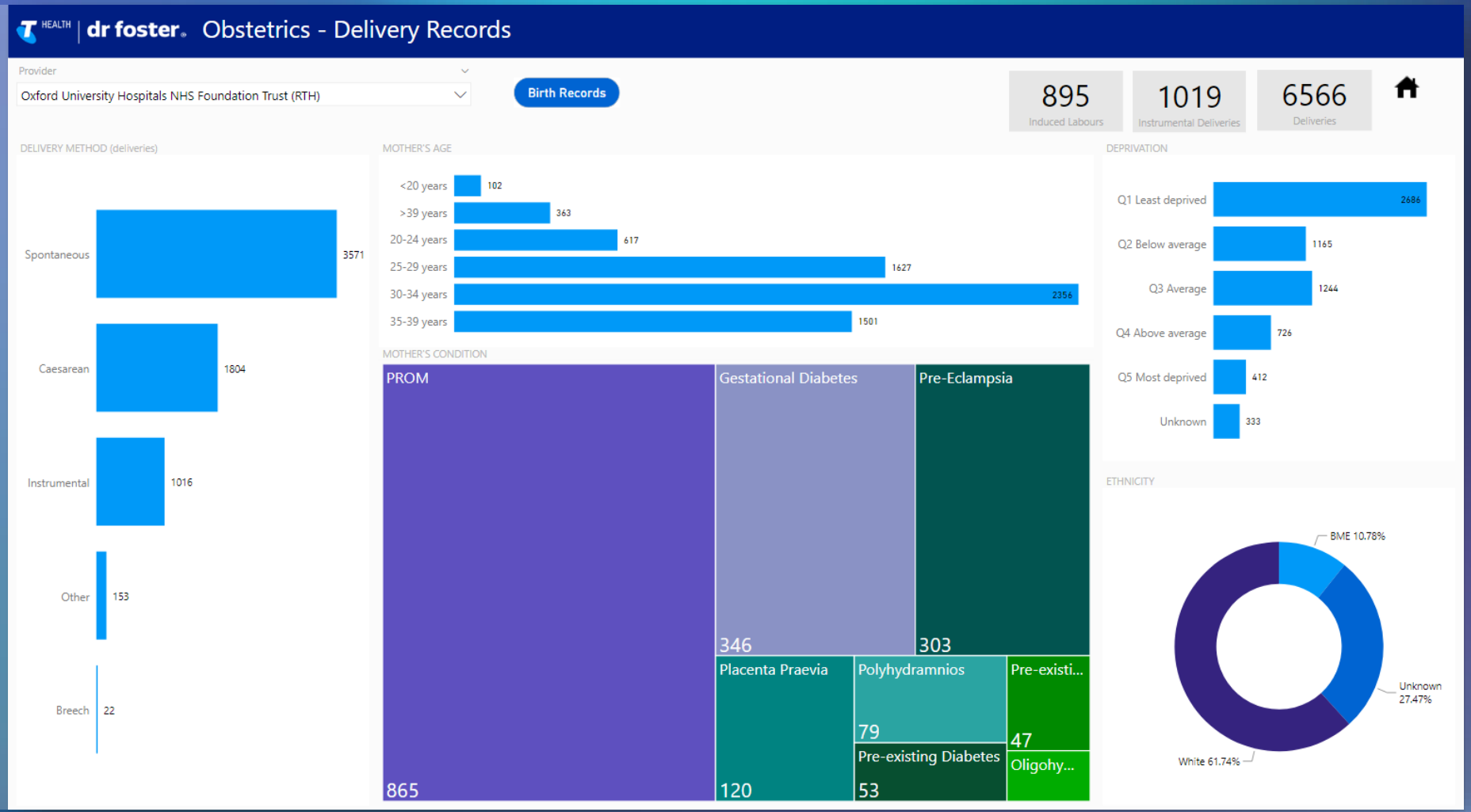
Activity Summary – delivery records

The Trust reports 6,566 deliveries in the 12 month period

3,571 = spontaneous vaginal
1,804 = caesarean section
1,016 = instrumental

- **36% (2,356) of mothers are aged 30-34yrs**
- **41% of mothers fall into 'least deprived' (i.e. most affluent) deprivation quintile**
- **61.7% of mothers identify as 'white' ethnicity**

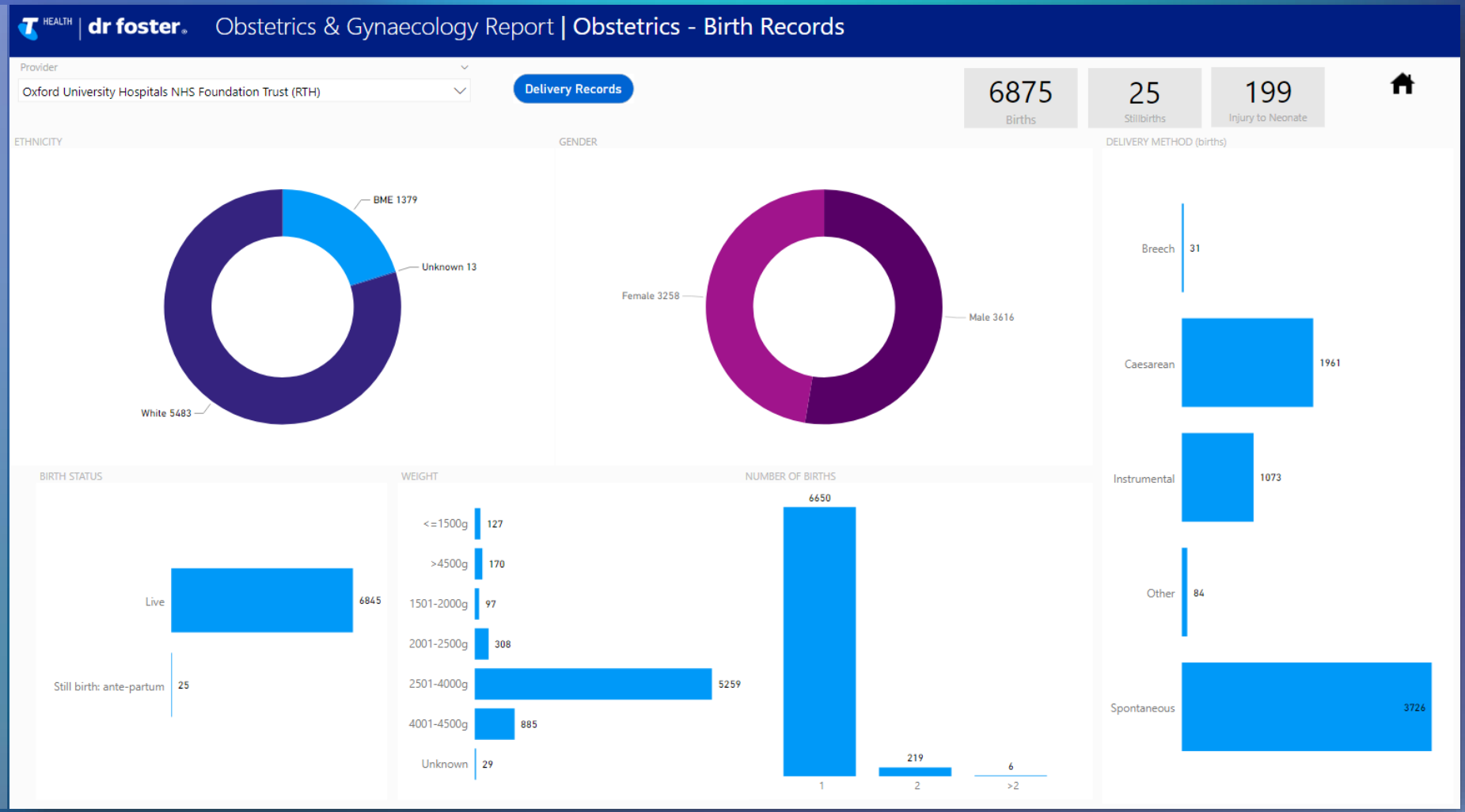
- **13.2% (865) mothers were diagnosed with PROM**
- **5.3% with gestational diabetes**
- **4.1% with pre-eclampsia**



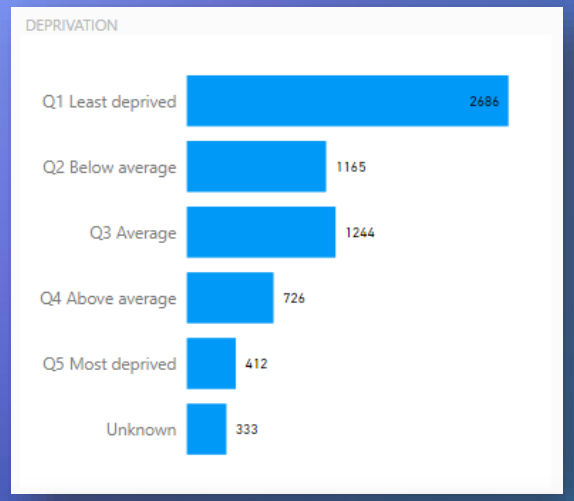
Activity Summary – births

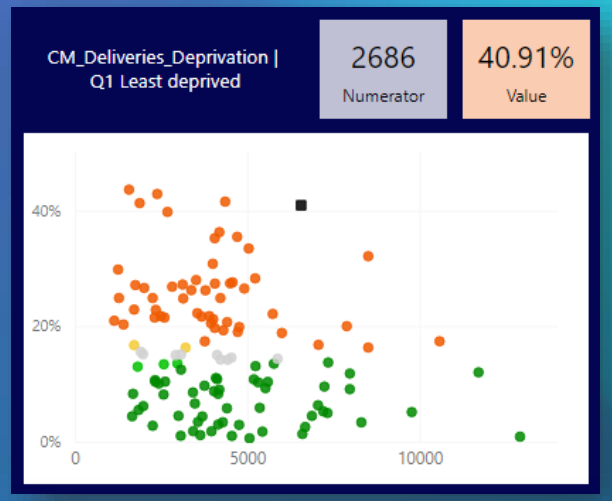
Of the 6,875 births in the year:

- 5,259 (76.5%) babies have a birthweight of 2501-4000g
- 127 (1.9%) babies have a birthweight of <1500g
- 225 (3.3%) babies are multiple births
- 25 stillbirths have been recorded in the data in the last 12 months

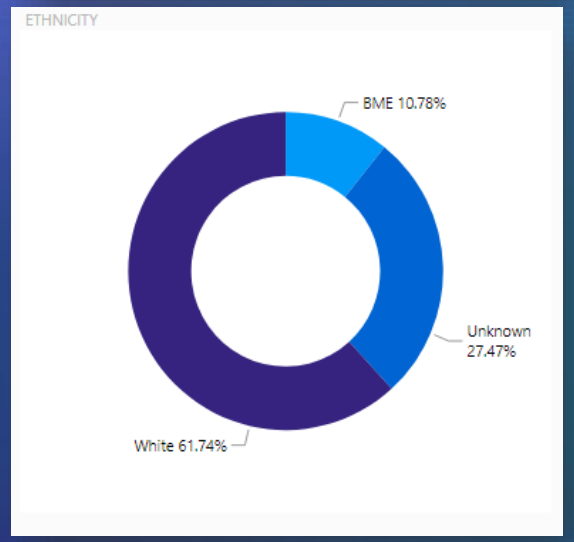


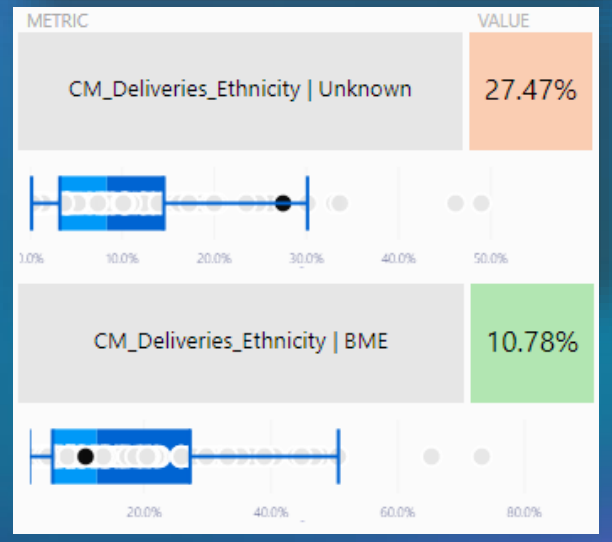
Case Mix – ethnicity & deprivation





- 41% of deliveries were by mothers in the lowest quintile of deprivation
- This is significantly higher than the national position
- The greater the quintile of deprivation the lower down the scatter plot OUH appears, suggesting that the mothers choosing to deliver at OUH are less deprived than in the peer





- The mother's ethnicity was unknown, or unrecorded in 27.5% of cases
- This compares poorly with the peer being well into the upper quartile
- If ethnicity is under-recorded comparison becomes less informative when reviewing health inequalities
- Black and minority ethnic (BME) mothers are slightly lower than the mean, but well inside the interquartile range

NATIONAL MATERNITY REVIEW

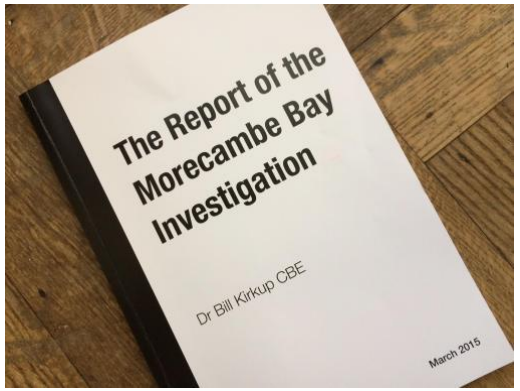
BETTER BIRTHS

Improving outcomes of maternity services in England

A Five Year Forward View for maternity care

CareQuality Commission

NHS
Oxford University Hospitals
NHS Foundation Trust



NHS
Resolution

- Key focuses:
  Digital Roadmap agreement
  Estates options
  Bids for workforce development
  Develop training compliance assurance

Ockendon Assurance Tool 1 year on

Oxford University Hospitals NHS Foundation Trust

	Criteria	RAG	Review Comments
IEA 1	Enhanced Safety		There were two areas that evidence had not been provided for in June 2021. Evidence supplied since that date (please see Ockenden paper: One Year on)
IEA 2	Listening to Women and Families		Criteria compliant & evidence linked to assurance tracker.
IEA 3	Staff Training and Working Together		Action plans are in place to demonstrate how we will meet this IEA.
IEA 4	Managing Complex Pregnancy		Criteria compliant & evidence linked to assurance tracker.
IEA 5	Risk Assessment Throughout Pregnancy		Action plans are in place to demonstrate how we will meet this IEA.
IEA 6	Monitoring Fetal Wellbeing		Action plans are in place to demonstrate how we will meet this IEA.
IEA 7	Informed Consent		Action plans are in place to demonstrate how we will meet this IEA.
Section 2	Workforce Planning		Action plans are in place to demonstrate how we will meet this IEA.
	NICE Guidance related to maternity		Action plans are in place to demonstrate how we will meet this IEA.

Morecombe Bay Review

	Criteria	RAG	Review Comments
1	Is an apology given to those affected, for the avoidable damage caused and any previous failures to act.		Criteria compliant & evidence linked to assurance tracker.
2	Review the skills, knowledge, competencies, and professional duties of care of all obstetric, paediatric, midwifery and neonatal staff, and agency, locums caring for the critically ill in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies.		Action plans are in place to demonstrate how we will meet this requirement.
3	Identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice.		Criteria compliant & evidence linked to assurance tracker.
4	Continuing professional development of staff and link this explicitly with professional requirements including revalidation.		Action plans are in place to demonstrate how we will meet this requirement.
5	Promote effective MDT working, joint training sessions.		Criteria compliant & evidence linked to assurance tracker.
6	Protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of high or low risk care.		Action plans are in place to demonstrate how we will meet this requirement.
7	Audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols.		Action plans are in place to demonstrate how we will meet this requirement.
8	Identify a recruitment and retention strategy achieving a balanced and sustainable workforce with the requisite skills and experience.		Criteria compliant & evidence linked to assurance tracker.
9	Joint working between its main hospital sites, including the development and operation of common policies, systems and standards.		Criteria compliant & evidence linked to assurance tracker.
10	Forge links with a partner Trust, to benefit from opportunities for learning, mentoring, secondment, staff development and sharing.		Criteria compliant & evidence linked to assurance tracker.
11	Staff awareness of incident reporting, review its policy of openness and honesty. Duty of Candour compliance.		Criteria compliant & evidence linked to assurance tracker.
12	Review the structures, processes and staff involved in investigating incidents, RCA, learning, training. Include arrangements for staff debriefing and support following a serious incident.		Action plans are in place to demonstrate how we will meet this requirement.
13	Review the structures, processes and staff involved in responding to complaints, and learning are the public involved.		Criteria compliant & evidence linked to assurance tracker.
14	Review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support.		Action plans are in place to demonstrate how we will meet this requirement.
15	Review of governance systems clinical governance, so that the Board has adequate assurance of the quality of safe care.		Action plans are in place to demonstrate how we will meet this requirement.
16	Ensure middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality and provide appropriate guidance and training.		Action plans are in place to demonstrate how we will meet this requirement.
17	Review access to theatres, and ability to observe and respond to all women in labour and ensuite facilities; arrangements for post-operative care of women		Action plans are in place to demonstrate how we will meet this requirement.
18	All of above should involve CCG, and where necessary, the CQC and Monitor.		Criteria compliant & evidence linked to assurance tracker.

Maternity Incentive Scheme

Oxford University Hospitals NHS Foundation Trust

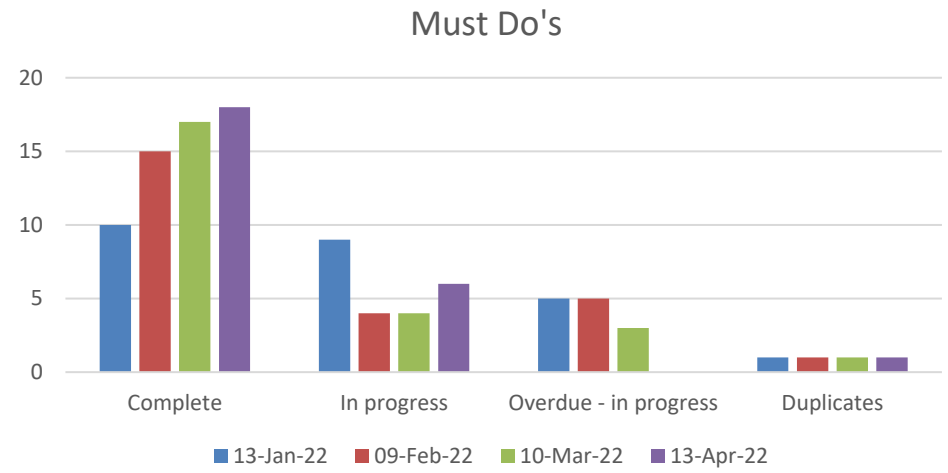
	Criteria	RAG	Review Comments
1	Are you using the PMRT to review perinatal deaths to the required standard?		Expecting to be compliant, evidence linked to assurance tracker
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		Action plans are in place to demonstrate how we will meet this safety action (SA).
3	Can you demonstrate that you have transitional care services in place to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?		Action plan developed to fully implement the pathway into transitional care.
4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?		Action plans are in place to demonstrate how we will meet this safety action (SA).
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		Expecting to be compliant, evidence linked to the tracker.
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle (Version 2)?		Action plans are in place to demonstrate how we will meet this safety action (SA).
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?		Expecting to be compliant, evidence linked to assurance tracker.
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?		Action plans are in place to demonstrate how we will meet this safety action (SA).
9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bimonthly with Board level champions to escalate locally identified issues?		Action plans are in place to demonstrate how we will meet this safety action (SA).
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?		Expecting to be compliant. All qualifying cases have been reported to HSIB for 2021/22 to date.

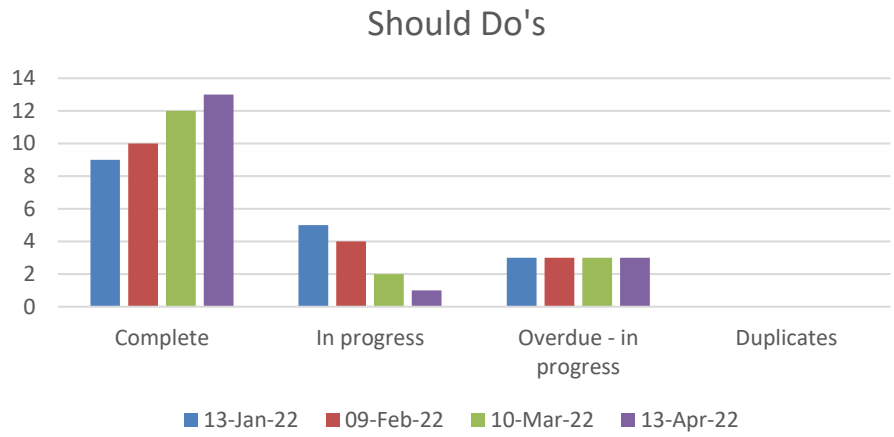
Continuity of Carer (CoC) as default model (Better Births requirement)

Oxford University Hospitals NHS Foundation Trust

Criteria	Review
National reports and assurance requires a plan to implement continuity of carer (CoC) as the "default model of care" by 21 March 2023 where staffing allows and building blocks are in place.	Guidance published 2021, now requires specific team structure and a midwifery working pattern that ensures the midwife follows the woman through every aspect of her care.
OUH current position	Lotus team is the only model of care that meets the criteria equates to 1% Mapping demonstrates the localities of greatest need to improve maternal and fetal outcome. Limited staff engagement as current establishment does not support expansion of the required model.
Proposal for implementation	Phased approach dependent on funding and resource available through the LMNS. Geographical based teams will be deployed dependent on monies and staff available to the areas that deliver best outcomes to the most vulnerable and deprived families.
Full business planning required	Paper to be submitted to TME on the confirmation of nationally available monies to support a significant increase in funded establishment to safeguard current provision of local and tertiary services and the implementation of full CoC.
Risks associated with achievement of CoC as a default model	Finance, staff engagement, recruitment to case loading teams

CQC Action Plan Update





- An unannounced inspection of maternity services across including onsite visits to the Women's Centre at the John Radcliffe Hospital, The Cotswold Birth Centre and the Horton Midwife Led Unit commenced 27 May 2021. The report was published on 02 September 2021. The outcome of this inspection resulted in a change of rating from good to requires improvement. A range of good practice was noted in the report alongside opportunities for improvement, with recommendations for nine 'must do' actions and eight 'should do' actions.
- An associated action plan was developed by the service and shared with CQC. The 17 overarching actions in the plan comprise 49 discrete actions (including one duplicate).
- Progress is reported through established governance processes. The action plan remains a standing agenda item on the Maternity Safety Champions meetings and has informed conversation with the executive team and our inspectors at the quarterly engagement meetings with the Chief Officers.
- The outcome of the inspection and action plan progress were, and continue to be the focus of targeted communications to a range of key stakeholders including service users, the Nursing and Midwifery Council, Partner Higher Education institutions, Maternity Voices Partnerships representatives and the Berkshire, Oxford and Buckinghamshire Local Maternity System.

2021 CQC Maternity Survey Results

Oxford University Hospitals NHS Foundation Trust

The results for the Maternity 2021 survey were published by the Care Quality Commission (CQC) on 10th February 2022.

- 533 patients were invited to take part, 264 completed the survey giving OUH Trust a 50% response rate, this was a 2% increase compared to the Trust's rate for the last survey in 2019. However, is 3% lower than the national average response rate of 53% for this year.
- CQC results show that: OUH Trust results were **better** than other trusts for 2 questions- (choice where to have their baby and feeding advice during evenings, weekends and nights)
- OUH Trust results were **worse** than other trusts for 1 question- (information and explanations given after the birth of their baby)
- OUH Trust results were **about the same** as other trusts for 47 questions.
- The Trust scored **better** than other Trusts for the first section of the survey "The start of care in your pregnancy".
- There were 15 questions in which the Trust shows a statistically significant decrease compared to the comparable results from the 2019 survey.

The report from the CQC summarises 5 areas where mothers' experience is **best** in OUH Trust and 5 areas where mothers' experience could **improve**:

The 5 areas identified as best were:

1. Mothers being offered a choice about where to have their baby during their antenatal care.
2. Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital.
3. Mothers being able to get support or advice about feeding their baby during evenings, nights, or weekends, if they needed this.
4. During antenatal check-ups, mothers being given enough information from either a midwife or doctor to help decide where to have their baby.
5. During antenatal check-ups, mothers being asked about their mental health by midwives.

The 5 areas where the Trust could improve were identified as:

1. Mothers being involved in the decision to be induced.
2. Mothers being given enough information on induction before being induced.
3. Mothers being given the information or explanations they needed while in hospital after the birth.
4. Mothers having the opportunity to ask questions about their labour and the birth after the baby was born.
5. The midwife or midwifery team appearing to be aware of the medical history of the mother and baby during care after birth.

Safe Staffing Q1 and Q2

Oxford University Hospitals NHS Foundation Trust

Criteria	Review Comments
A clear breakdown of BirthRate Plus® or equivalent calculations to demonstrate how the required establishment has been calculated.	Data collection and submission for full BR+ reporting has been undertaken. Full report available by April.
Planned versus actual midwifery staffing levels – to include evidence of mitigation/escalation for managing a shortfall in staffing.	Mitigation contained within escalation policy followed to ensure safe care. Details within the maternity safe staffing paper.
Action plan to address the findings from the full audit or table-top exercise of BirthRate Plus® or equivalent undertaken.	Q1 and Q2 recruitment has netted 24.65 wte. In the same period there were 24.83wte leavers. Data collection and submission for full BR+ reporting has been undertaken. Full report available by April.
Midwife: birth ratio	The midwife to birth staffing ratio for Q1 averaged 1:25.80 and Quarter 2 averaged 1:29.59.
Percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate Plus®	In Q1 and Q2 the number of management and specialist midwife roles in post accounted for 7.94% of the workforce in line with
100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour	In this data period there has been 100% compliance with the provision of 1:1 care in labour and supernumerary Delivery Suite Co-ordinator status.
Number of red flag incidents (associated with midwifery staffing)	The top three “Red Flag” incidents for the Q1 and Q2 are staff moving between areas, beds not opened to fully funded number (Wantage and Chipping Norton MLU’s closed) and staff working over their scheduled finish times.

- Summary and Next steps:

The Board are asked to receive and note the papers.
To discuss the progress one year post Ockendon review – also considering Morcombe Bay recommendations
To discuss the support required to deliver the national frameworks and recommendations
To support a future board seminar to review clinical outcomes

Dashboard

Champions' development and actions

Oxford University Hospitals
NHS Foundation Trust

Thank you

Any questions…?

- Supplemental information

Oxford University Hospitals
NHS Foundation Trust

Key roles and responsibilities of the Board level Safety Champion

Your role is to provide proactive board level leadership to ensure that:

- ✔ High quality clinical care
- ✔ Maternity and neonatal service and facilities
- ✔ Workforce numbers
- ✔ Learning and training systems and
- ✔ Effective team working

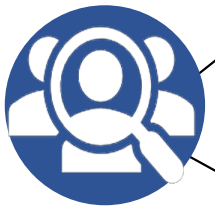
are all in place

- ✓ **Oversee effective learning from incidents**
- ✓ Share learning as well as successes within and beyond your own trust
- ✓ Promote authentic engagement with service users who access maternity services
- ✓ **Act upon their feedback to help deliver services which are some of the best in the world**

The Board Safety Champion is ideally a non-executive director and the same individual providing executive sponsorship for the MatNeoSIP, acting as a conduit between the Trust board and frontline safety champions.

Oxford University Hospitals NHS Foundation Trust

Key roles and responsibilities of the Board safety champion



- ➔Engage with staff and service users to determine views on safety and staff satisfaction through walkabouts, audit, investigation and user feedback
- ➔Review the quality of investigation reports and ensure they meet national standards;
- ➔Ensure Duty of Candour is upheld
- ➔Address recommendations from investigation findings; provide leadership and oversight for improvement
- ➔Ensure services are following national guidelines
- ➔ Oversee reviews and audit if the Trust is identified as an outlier
- ➔Ensure standards for effective data quality and coverage, as defined by NHS Digital in the new data quality standards are being met

Key contacts

- ➔ Maternity Voices Partnership User Chair
- ➔ Board level maternity safety champion
- ➔ Regional Chief Midwife
- ➔ Regional Lead obstetrician
- ➔ Local Improvement lead for MatNeo SIP
- ➔ Operational Delivery Network leads
- ➔ Lead commissioner for safety in LMS
- ➔ Maternity Transformation programme leads
- ➔ National Maternity Safety Champions

Further information and detail is set out in ‘Transforming Perinatal Safety’ resource pack

Safety champions – ask each other:

- How do you maintain oversight of safety incidents and monitor outcomes in relation to stillbirth, neonatal death, neonatal brain injury and maternal mortality?
- How are you balancing the response to COVID-19 with the continuing need to manage obstetric risk?
- How do you coordinate service changes via your Local Maternity System, Clinical Network and your Regional Chief Midwife?
- What are you doing to achieve a thorough understanding of the safety of your local maternity and neonatal services?
- How does your role integrate with internal governance and learning processes?
- How do you ensure your board is appraised of maternity safety?
- What are you doing to maximise your impact in your unit?
- Have you evaluated your role and its impact?
- What role are you playing as a catalyst for rapid learning?
- Do your maternity and neonatal teams have a good understanding of your role?

Oxford University Hospitals
NHS Foundation Trust

Maternity and Neonatal Safety Champions supporting co-production with Maternity Voices Partnerships

Board and frontline safety champions should work together with their Maternity Voices Partnership service user chair to co-develop plans, ensuring that options continue to be on the basis of a personalised risk assessment and package of care agreed with each woman based on options available at the time.

Together MVP's should aim to understand their population profile and offer services which truly reflect their needs with a focus on improving outcomes women with health inequalities and those from disadvantaged backgrounds.

Your MVP should be funded, the user chair should be represented on the LMSs and both board and frontline safety champions should work with the MVP user chair to ensure co-production is embedded in all safety improvement work.

More information on this can be found in 'Transforming Perinatal Safety' resource pack.

NATIONAL Maternity Voices
Networking Maternity Voices Partnerships in England

Achieving equity

To achieve the 'halve it' ambition, we need to improve care for populations most at risk of poor outcomes and Safety Champions can help to drive this. The NHS also has a legal duty to reduce inequalities through the NHS Constitution and Health & Social Care Act 2012.

Whilst **mortality rates are reducing for the population overall**, stark health inequalities persist (MBRRACE-UK 2019):

- **Maternal mortality** is 5 times higher for Black women, 3 times higher for mixed ethnicity & twice as high for Asian women than white women;
- **Stillbirth rates** are twice as high for Black & Asian babies and 1.5 times higher for babies born to mothers living in the most deprived areas
- **Neonatal death rates** are increasing for Black and Asian babies (x1.7) . The rate for babies born to mothers in the most deprived areas is x1.2.

References

- Care Quality Commission (2021) Maternity Inspection Report for John Radcliffe Hospital accessed via RTH08 John Radcliffe Hospital (cqc.org.uk) date of accession 08/03/22
- Cumberlege, J. (2016) Better Births: Improving Outcomes of Maternity Services in England A Five Year Forward View for maternity car accessed via national-maternity-review-report.pdf (england.nhs.uk) date of accession 08/03/22.
- Department of Health (2016) Safer Maternity Care Next steps towards the national maternity ambition accessed via Safer Maternity Care: Next steps towards the national maternity ambition (publishing.service.gov.uk) date of accession 08/03/22.
- Department of Health (2019) The NHS long Term Plan as accessed via NHS Long Term Plan v1.2 August 2019 date of accession 08/03/22.
- Kirkup, B. (2015) The Report of the Morecombe Bay Investigation accessed via The Report of the Morecambe Bay Investigation (publishing.service.gov.uk) date of accession 08/03/22.
- NHSE/I (2019) Implementing the Recommendations of the Neonatal Critical Care Review as accessed via Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk) date of accession 08/03/22.
- NHSR (2021) Maternity Incentive Scheme Year 4 October 2021 update accessed via https://www.all4maternity.com/wp-content/uploads/2017/10/National-Maternity-Review-Better-Births.png date of accession 08/03/22
- Ockenden, D. (2020) The Ockenden Report as accessed via OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (ockendenmaternityreview.org.uk) date of accession 08/03/22.

Temporary Suspension of Services in Maternity

NHS
Oxford University Hospitals
Trust

Closures

Chipping Norton and Wantage Midwifery led Units closed to intrapartum care since 26/08/2021

Services reviewed daily

The following closures happened in March:

Horton MLU was closed to intrapartum care twice

Wallingford MLU was closed to intrapartum care 16 times

Our Homebirth service was closed 24 times

Since August 2021, six women have been directly affected by these closures, with three of these in March 2022.

Recruitment Plan

Oxford University Hospitals

- April 2022 – 11wte midwifery vacancies plus 2 predicted vacancies in June and July
- 35 midwifery students interviewed from May 2022
- 16 external applicants' interviews arranged for May 2022
- April 2022 – 12 wte Midwifery Support Workers (MSW) vacancies
- MSW interviews have taken place with a programme of ongoing recruitment
- 5 midwifery training places for conversion from RN to RM to commence September 2022
- Overseas recruitment of midwives to become UK registrants
- Nurse recruitment in place as part of midwifery workforce ongoing