REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

Maternity Services in Oxfordshire:

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INTRODUCTION AND OVERVIEW

1. At its meeting on 22 November 2024, the Oxfordshire Joint Health and Overview Scrutiny Committee (HOSC) received a report providing an update on maternity services in Oxfordshire.

2. The Committee felt it crucial to receive an update on the current state of maternity services in light of the maternity dossier released by Keep the Horton General (KTHG) as well as a recent Care Quality Commission (CQC) inspection of maternity services. The Committee was keen to understand the measures being taken by system partners to seek to address the challenges with maternity services in Oxfordshire, and to explore how the experience of mothers and babies could be improved in light of some of the challenging experiences of service users.

3. This item was scrutinised by HOSC given that it has a constitutional remit over all aspects of health as a whole; and this includes the efficacy of maternity services during pregnancy, childbirth, and postnatal care. Upon commissioning this item, some of the points the Committee sought to investigate involved the following:

   - Information around the data on local trends with regard to injuries, deaths, and birth trauma.
   - What steps have been taken to improve maternity services in light of concerns raised by the CQC and the birth dossier produced by KTHG?
   - Details of any partners, stakeholders or patients that have been engaged with for the purposes of coproducing and improving maternity services?
   - Details on any improvements in processes around safety checks as well as the safe storage of medications in correct temperature ranges?
   - Whether there are any plans to improve the processes of assessment of risks to women and babies?
   - Details on improvements that have been made with regard to tackling inequalities in maternity care amongst ethnic minority groups most at risk and women with particular health conditions.

- How staff are being supported to improve maternity services and create a positive workforce culture; and how Oxfordshire maternity services compare with other areas on addressing undermining workforce behaviours?

- Whether there is a sufficiency of resources and maternity workforce to support improvements in maternity services (and how Oxfordshire maternity services compare with other similar services across England with respect to resources, workforce capacity and outcomes)?

- Details on any plans to improve digital integration to enhance communication across primary and secondary care pathways.

SUMMARY

4. The Committee would like to express thanks to Yvonne Christley (Oxford University Hospitals NHS Foundation Trust Chief Nurse); Rachel Corser (Chief Nursing Officer, Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board); and Dan Leveson (former Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board Place Director for Oxfordshire) for attending this item and for answering questions from the Committee on maternity services.

5. A key aspect of the discussion revolved around new training programmes and staff participation in these, as was highlighted in the report submitted to the Committee. It was explained that the Trust had implemented new training initiatives for obstetricians and midwives, including the Peaches programme and PROMPT training. The Peaches programme aimed to recognise and prevent third and fourth-degree tears, while PROMPT focused on enhancing teamwork and coordination between medical professionals and midwives. Staff participation in these training programmes was regularly monitored and reported to the Trust board, with approximately 90% of staff having completed the training at any given time.

6. The issue of birth injuries in Oxfordshire was also discussed, and the Committee were informed that these were generally below national rates, which was positive. Efforts continued to minimise these injuries further. Notably, therapeutic cooling rates for infants over 37 weeks had reduced to 0.07, beating the national target of 0.1 to 0.3, thanks to significant interventions. Oxford University Hospitals NHS Foundation Trust (OUH) maternity services handled complex cases, and maintaining low injury rates was an important indicator of the level of quality and safety of care.

7. The Committee questioned why the number of patients accessing the birth reflection service was projected to be significantly higher in 2025. It was confirmed that the higher projection was attributed to increased awareness of birth trauma among women and the service itself. The growth was seen as a positive indicator of timely interventions and greater awareness among women and families. Although there was not a direct link to COVID, the pandemic created an environment of isolation for women and families, possibly raising

awareness and intervention needs as restrictions eased. The pandemic was further noted to have had a wide-ranging impact on health services, including potential interruptions in training.

8. The issue of the mental health support provided for both pregnant mothers and fathers affected by mental health challenges was raised by the Committee. The Trust confirmed that they had bereavement suites and specially trained staff to assist families experiencing stillbirth or maternal and baby death. These suites provided a family environment where families could spend time with their baby and access counselling services. There was a dedicated trauma midwife and a service ensuring timely interventions for those who had experienced birth trauma. Mental health was assessed throughout the entire maternity care pathway, from antenatal to postnatal stages. The Trust had invested in mental health services, with Oxford Health NHS Foundation Trust developing clinical teams to support these pathways. The support also extended to fathers, acknowledging their need for mental health assistance during and after traumatic birth experiences.

9. Another aspect of the discussion was around the Committee's concerns regarding the higher likelihood of women of ethnic minorities dying in pregnancy and childbirth, when compared with other demographics. Members wanted to know what was being done to address this discrepancy in differing ethnic groups. It was highlighted that the Trust monitored birth injuries and patient experiences by ethnicity monthly to identify disproportionate impacts. Equality, diversity, and inclusion midwives worked with specific groups to ensure effective access to services and address health concerns. Community outreach was conducted to address health issues and improve service access for ethnic minorities. These measures aimed to provide equitable care and address disparities in maternal mortality rates.

10. The potential to work with partners on maximising what could be achieved with health checks for both physical and mental health purposes was also raised during the session. The significance of collaborating with public health was noted to monitor weight management and address equity and prevention of ill health within the community, especially focusing on areas with greater deprivation and higher numbers of ethnic minorities and other identified populations at high risk. Oxford Health NHS Foundation Trust provided health visiting and school nursing services, working with midwives to support those most at risk and ensure a smooth transition of care. The importance of postnatal care was highlighted for the well-being of both the infant and the mother, emphasising ongoing efforts to improve and strengthen postnatal care services.

11. The Committee requested further details on the overall evaluation process of the CQC concerns, including the parties involved in assessing the improvements related to maternity services. The Trust formed an evidence group to monitor and evaluate the CQC actions' progress and effectiveness. This group assessed the assurance level for each action, categorising them as limited, medium, or fully assured, and met monthly to review data and address challenges. Chaired by the Chief Nurse, it included the assurance and maternity teams. Reports were given to the delivery Committee, chaired by the Chief

Executive, ensuring sustained improvements. External review support came from the Maternity and Newborn Safety Investigations department for specific cases, adding further scrutiny.

12. The Committee asked whether within this there was a clear process of learning from errors which were made in the quality of maternity care, and what the learning journey was from mistakes made. It was explained that the Trust had a strong reporting culture, classifying incidents like third or fourth-degree tears as moderate harm from the start. This proactive approach helped identify safety risks early. Each incident was thoroughly analysed to understand the context and find learning opportunities. Clinicians had open conversations with patients and families, following duty of candour by informing them of any issues and investigation processes. Complaints were taken seriously, broken down for detailed analysis, and responded to comprehensively, highlighting learning points and planned improvements. These responses, approved by the Chief Nurse, could involve follow-up meetings with patients and their families.

13. The Committee inquired about local improvements for maternity services in Oxfordshire. The ICB decided to invest transformation funds directly into supporting the Trust rather than simply adding more resources at the BOB system level. They were collaborating with NHS England on the Trust's improvement and aiming to increase capacity within each trust. Additionally, the ICB was focusing on system-wide shared learning, like enhancing translation services.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS

14. Below are some key points/themes of observation that the Committee has in relation to the current state of maternity services in Oxfordshire, as well as around the efforts to improve these services. These observations have also informed the specific recommendations being made by the Committee for the improvement of maternity services for Oxfordshire residents.

Training for maternity staff: The provision of high-quality maternity services is crucial to ensure the health and well-being of both mothers and their newborn babies. Continuous professional development and training for maternity staff plays a key role in maintaining and improving the standards of care provided. The field of obstetrics and gynaecology is constantly evolving with new medical research, technologies, and procedures emerging regularly. Regular training will help to ensure that maternity staff can remain up to date with the latest advancements and principles around best practices. This knowledge is crucial for the provision of safe and effective care, addressing complications promptly, and improving overall patient outcomes. In one 2009 study published in the *Midwifery Journal*, it was found and highlighted that maternity staff not only had more knowledge of best practice if they were receiving

regular training, but that such exposure to regular training provided them with the confidence in being able to provide professional maternity care[1]. Healthcare policies and guidelines are constantly evolving in line with new evidence as well as public health priorities. Engaging in regular training programs can help maternity staff to remain compliant with current regulations and standards. This could in effect minimise risks and enhance the overall quality of care being provided to patients. Regular updates on policies can help to ensure that staff are thoroughly informed regarding any legal or ethical considerations, which could help to safeguard both patients as well as healthcare staff and providers. An exemplar of this would be epilepsy which the Committee had found as a particular patient group that was both high risk (with a near doubling of maternal and baby deaths nationally) and facing serious ethical considerations concerning how local providers would maintain assurance of shared decision-making and access to treatment.

Good and coordinated maternity care can often relies on multidisciplinary teams involving obstetricians, midwives, nurses, anesthetists, and pediatricians. In one 2024 study published in the *Journal of Multidisciplinary Healthcare*, it was emphasised that training for maternity staff should emphasise teamwork and communication in order to create better collaboration among the various professionals providing maternity care[2]. Interdisciplinary training enhances understanding of each team member's role, leading to coordinated and smooth care for patients.

Furthermore, the Committee is also recommending that staff are also trained in patient-centred care. In the context of maternity services, this would involve respect for the choices of expectant mothers, the provision of individualised care plans, and ensuring that they are actively participating in any decisions being made as part of their care and treatment. This would help to create trust and empathetic relationships between healthcare providers and patients. Involving experts by lived experience including birth trauma, birth injury, still birth and bereavement could support this.

Recommendation 1: *To ensure that maternity staff receive ongoing training around improving maternity services. It is recommended that staff are also trained in patient-centred care.*

Support for maternity staff: In order to provide the best possible care for mothers and their newborns, and as part of the efforts to improve maternity services overall, the welfare and wellbeing of maternity staff should be given the utmost consideration. The Committee places significant emphasis on the overall wellbeing of all maternity staff, and urges the Trust to continue to seek improvement in pursuing this both in principle and in practice. It is also crucial that staff are protected from and

[1] Health-care professionals' views about safety in maternity services: a qualitative study - ScienceDirect
[2] Full article: The Impact of a Multidisciplinary Experiential Training Model on Knowledge, Attitude and Practice of Healthcare Workers in Maternity Health Management: A Preliminary Study

fully supported in respect of what might properly be considered any undue negative pressures (e.g. abuse or threats), as their health and job satisfaction are crucial elements in delivering high-quality care. In the context of a national workforce shortage in healthcare, it is imperative that maternity staff are sufficiently looked after by the Trust so as to reduce the likelihood of staff feeling put off from continuing to work for the Trust.

Maternity staff, including midwives, nurses, obstetricians, and support workers, play a pivotal role in the delivery of maternity services. Their physical and mental wellbeing would directly affect their capacity to perform their duties effectively. When staff are well-supported, they are more likely to provide compassionate and competent care, fostering a positive birth experience for mothers and families. The workforce environment in which maternity staff operate is crucial. It was found in one 2021 study in the *British Journal of Midwifery* that a supportive work environment is fundamental to the welfare of maternity staff[3]. This includes manageable workloads, adequate staffing levels, safe working conditions, and access to necessary resources. Indeed, the Committee feels that in the absence of any of these, it would be difficult to create a positive workforce environment in which maternity staff feel supported enough to be able to execute their roles passionately and empathetically.

In addition, particular attention needs to be placed on the emotional and mental health of maternity staff. Regular access to counselling services, peer support groups, or mental health resources can help staff cope with the emotional demands of their work. Creating a culture that encourages openness about mental health and provides support for those in need is essential. The imperative for adequate mental health support for maternity staff was also reflected in a 2021 review published in the *Health Services Research Journal,* where it was emphasised that maternity staff are often having to deal with stressful medical scenarios as well as emotional circumstances involving pregnancy and childbirth[4].

Furthermore, the Committee understands the importance of the Trust and its relevant partners in being able to improve maternity services in light of the findings of the CQC inspection as well as the KTHG dossier. However, if any such improvements are to be sustainable, it is crucial that a balance is sought between training, supporting, and encouraging staff to drive improvements on the one hand, without subjecting staff to any undue negative pressure as part of these efforts. This point was also emphasised in a summer 2024 briefing that the Committee held with the Trust in relation to the CQC improvement journey around maternity services.

[3] How do power and hierarchy influence staff safety in maternity services? | British Journal of Midwifery

[4] Effects of the Covid-19 pandemic on maternity staff in 2020 – a scoping review | BMC Health Services Research

Recommendation 2: *To continue to improve the support for the welfare and wellbeing of maternity staff in the context of improving maternity services. It is especially crucial that staff are not subjected to undue negative pressure due to their working in maternal services or as part of efforts to improve maternity services.*

Mental health support for mothers and partners: The birth of a child is often anticipated to be a joyful and exciting moment for mothers as well as their partners and loved ones. However, for some families, there can be unforeseen complications, difficult births, stillbirths, or even the birth of a premature baby. These situations can have profound emotional and psychological impacts on mothers as well as their partners. It is crucial that the Trust and its relevant partners provide comprehensive mental health support to help these families to cope with any challenges they might be facing.

The process of giving birth can prove to be unpredictable, and complications could emerge which lead to difficult births. These complications can include prolonged labor, emergency cesarean sections, or other medical interventions. Such experiences can be traumatic for mothers, resulting in feeling fear, anxiety and helplessness. A 2021 study published in the *Journal of Women and Birth* found that complications arising during childbirth can have a long-term psychological impact for some families which leads to anxiety as well as a sense of powerlessness for women who have faced such challenges, sometimes necessitating long-term mental health support post-birth[5]. Those who often witness these events, may also experience significant distress and feel powerless to seek help.

It is crucial to identify the signs of mental trauma in both mothers and their partners post-birth. Some of the symptoms could involve flashbacks of the birthing experience, panic attacks or severe anxiety, disturbed sleep, moody and irritable behaviour, avoiding being reminded of the birthing experience, and even feeling a sense of sadness or guilt. The Committee strongly urges that it is vital that these symptoms are identified early so parents can experience self-validation births and to provide timely support.

One way in which mothers and their partners could be supported is via counselling and support groups. Access to therapy can help such residents to process their emotions and to form coping strategies, and work through any feelings of trauma. Support groups provide a sense of community and understanding, allowing parents to share their experiences and gain support from others who have been through similar situations.

Furthermore, the birth of a premature baby can be a highly stressful and anxiety-inducing experience. Parents could experience a range of challenges including prolonged hospital stays, medical complications,

[5] Women's experiences of birth trauma: A scoping review - ScienceDirect

and uncertainty about their baby's health and future. Providing mental health support is vital to help parents cope with the demands of caring for a premature baby.

Recommendation 3: *To develop a maternity trauma care pathway for ongoing support for mothers (and their partners) to include those who have experienced difficult births, complications, premature babies, and still births and bereavement. It is recommended that this is undertaken in co-production with voluntary organisations that work with families experiencing trauma and who include experts with lived experience. It is crucial to be proactive in reaching out to such patients and their partners in this regard.*

Evaluating efficacy of improvements: The Committee recognises the steps that have been taken by the Trust as well as the ICB to work toward improving maternity services, and is pleased to see the commitment toward resolving some of the challenges in maternity provision. To achieve improvements in maternity services, it is crucial to establish robust processes to monitor and evaluate the effectiveness of various measures implemented. Monitoring and evaluation are a key part of any healthcare improvement initiative. They provide data and insights into the performance of implemented measures. This then allows for more informed decision-making and continuous improvement. In the context of maternity services, effective monitoring and evaluation processes help to ensure that any measures being taken by the Trust or the ICB are resulting in better health outcomes for mothers and infants, and that resources are being utilised as effectively and efficiently as possible.

In one study conducted by the *University of Southampton*, it was concluded that being able to define clear and specified objectives is a crucial stepping stone toward improving and evaluating the quality of maternity care[6]. The Committee is of the view that some key potential objectives that could be monitored include:

- Assessing the effectiveness of interventions aimed at reducing maternal and neonatal mortality and morbidity.
- Evaluating the quality of care provided during antenatal, intrapartum, and postnatal periods.
- Identifying gaps and areas for improvement in maternity services.
- Ensuring adherence to clinical guidelines and best practices.
- Measuring patient satisfaction and experiences.

The Committee is pleased to see that the Trust had formed an evidence group to monitor and evaluate the progress of effectively implementing CQC actions in maternity care. However, it is also crucial, as the following

[6] 12757_Matthews.qxd

section outlines, for there to be adequate coproduction and transparency around the improvement journey.

Recommendation 4: *To establish robust processes through which to monitor and evaluate the effectiveness of measures aimed at improving maternity services.*

Importance of coproduction and transparency: The Committee firmly believes in the importance of engaging all stakeholders, including patients, throughout the process of monitoring and evaluating the improvement journey for maternity services in Oxfordshire. There is also a point about transparency which links into the point about engaging all stakeholders and patients. In one 2017 study published in the *Health Research Policy and Systems Journal*, it was emphasised that maternity is an often sensitive area of healthcare, and that any objectives to improve maternity should be sought through a process of coproduction as giving birth can be a highly personal experience[7]. Coproduction should involve placing the experiences and insights of mothers at the heart of the design and delivery of maternity care. It should ensure that their voices are heard and their needs are met. This approach will not only enhance the quality of maternity care, but would also foster trust and empowerment among service users. By involving women in the decision-making process, maternity services can become more person-centred, equitable, and effective. In essence, there are three key overarching benefits that could be achieved through coproducing maternity services:

- Improving service quality: Engaging mothers and families in the coproduction process helps to identify gaps and areas for improvement, leading to more tailored and effective services.

- Increased patient satisfaction: When women feel that their opinions and experiences are valued, their satisfaction with maternity services can increase.

- Enhanced trust: Collaborative efforts build trust between service providers and users, fostering a supportive and respectful care environment.

The issue of trust is a crucial one, as there have been indications of increased dissatisfaction and an increased lack of faith in maternity care amongst some patients and their families locally as well as nationally. Coproduction will constitute a key avenue through which to restore the trust and confidence in maternity services in Oxfordshire. There are various ways in which to involve service users in coproducing maternity services including through conducting regular stakeholder meetings and consultations, ensuring transparency and open communication about findings and actions in the realm of maternity care, and generally eliciting a culture of patient and community involvement.

[7] Engaging stakeholders: lessons from the use of participatory tools for improving maternal and child care health services | Health Research Policy and Systems

The Committee also recommends that the Trust reaches out to patients who have had poor experiences in maternity care and childbirth, and to then utilise these insights as a means to prevent such poor experiences from occurring again. Therefore, coproduction should strongly inform the process of learning and evaluation that the Trust would employ as part of the efforts to improve maternity care.

The Committee was mindful of the MBRRACE report 2024 that national maternal death rates have increased to levels not seen since 2003-05. Suicide is a leading cause of maternal death in the first postnatal year, with a concerning increasing trend and significant numbers with a history of trauma.

Recommendation 5: *To ensure that coproduction remains at the heart of the design as well as the improvements of maternity services. It is also recommended for collaboration amongst relevant system partners, to explore the opportunity for coproduction work to maximise the potential of health checks for supporting women who have given birth, with a view to improve their physical and mental wellbeing and that of their families in the long run.*

Clear communication with patients: The Committee firmly believes that in the realm of healthcare, clear communication between medical professionals and patients is paramount. It is not only a case of providing accurate information but is also a cornerstone of building trust, ensuring compliance with treatment regimens, and ultimately improving health outcomes. This becomes even more critical when dealing with patients who may not be fluent in the English language.

It is vital that maternity patients are thoroughly communicated with through every stage of their care. In a 2019 study published in the *British Journal of Midwifery*, it was found that thorough and regular communication with maternity outpatients and inpatients was crucial to help reduce the stresses and anxieties that mothers and their partners can face when going through pregnancy and childbirth[8]. Being a subject of regular communication can help a maternity patient feel empowered and listened to at a time when they might feel a heightened sense of vulnerability.

The issue of managing and dealing with language barriers is especially crucial. Language barriers in maternity care can lead to misunderstandings, and potentially misdiagnoses and inadequate treatment. Patients who cannot fully comprehend medical instructions are at a higher risk of non-compliance with prescribed treatments or options, which can result in further deteriorating their condition. Additionally, and as highlighted by the aforementioned study in the *British Journal of Midwifery*, language barriers can cause significant emotional stress for patients, who may already be in a vulnerable state due to their health issues.

[8] The importance of language in maternity services | British Journal of Midwifery

One of the most effective and basic ways to overcome language barriers is to hire healthcare professionals who are fluent in the languages spoken by the patient population. This includes doctors, nurses, administrative staff, and interpreters who can provide accurate as well as culturally sensitive communication. However, the Committee understands that it may not always be feasible to hire (or to have readily available) multilingual staff. It is in this context that professional interpreters can play a crucial role. Trained interpreters, either in-person or via digital platforms, can help to ensure that patients receive accurate information and feel understood. In some cases, it may even be more ideal to utilise professional interpreters as opposed to relying on family members. In one particular 2008 study published in the *Patient Education & Counselling Journal,* it was found that professional interpreters can be more ideal to utilise in the context of healthcare services and decisions when compared to family interpreters given that the latter may lack the necessary medical vocabulary and objectivity[9].

Additionally, it is also crucial that translated written materials such as consent forms, educational brochures, and medication instructions are provided to patients from minority backgrounds who may not be fluent in English. Materials should therefore be available in the languages prevalent among the patient population. This will not only help patients to better understand their journey through maternity care, but can also empower patients to take an active role in their healthcare decisions.

Recommendation 5: *For there to be clear communication with patients, including in indigenous languages for those who may not be fluent in English.*

Legal Implications

15. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
 Power to scrutinise health bodies and authorities in the local area
 Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
 Duty of NHS to consult scrutiny on major service changes and provide feedback on consultations.

16. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

17. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide

[9] Through interpreters' eyes: Comparing roles of professional and family interpreters - ScienceDirect

that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Annex 1 – Scrutiny Response Pro Forma

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January 2025