To:	The Board
For meeting on:	26 July 2018
Agenda item:	7
Report by:	Ruth May, Execuitve Director of Nursing
Report on:	Update on NHS Improvement Maternity Programme

Introduction

1. This report provides an update on NHS Improvement's maternity programme. This comprises three main components:
   - Delivery of the 'promoting good practice for safer care' workstream within the national Maternity Transformation Programme (work stream 2, WS2)
   - Delivery of support to trusts on the Maternity Safety Support List (MSSL) established by the former Secretary of State.
   - Professional midwifery leadership

2. The Board should note that there are nine workstreams within the national Maternity Transformation Programme and NHS Improvement is responsible for leading WS2. Progress against WS2 deliverables is reported through to the national programme board, chaired by Sarah-Jane Marsh. The national programme was established to deliver the vision set out in *Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care*[1], the report of the National Maternity Review (2016) and the government's national maternity ambition - *Safer Maternity Care* (DHSC 2016)[2].

   The Board is being asked to review this update paper and provide comments.

Delivery of work stream 2 (WS2) of the Maternity Transformation Programme – promoting good practice for safer care

3. The objectives of this work stream are to:

[1] This report, published by NHS England, sets out the vision for the planning, design and safe delivery of maternity services; how women, babies and families will be able to get the type of care they want; and how staff will be supported to deliver such care.
[2] The Safer Maternity Care action plan is part of the national ambition to halve rates of stillbirths, neonatal deaths, maternal deaths and brain injuries that occur during or shortly after birth

- Make measurable improvements in safety outcomes for women, their newborns and families in maternity and neonatal services, as set out in *Better Births*.
- Deliver the government's national ambition to halve the 2010 rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries in babies by 2025, with a 20% reduction by 2020.

Leadership of the workstream was handed over from the Department of Health to NHS Improvement under the leadership of Ruth May, as Senior Responsible Officer (SRO) on 1 April 2017.

4. In leading this workstream, NHS Improvement is responsible for oversight of eighteen deliverables (see appendix 1); thirteen deliverables require significant ongoing activity and the following four currently constitute our key priorities:
   - The 'Saving Babies' Lives' care bundle (led by NHS England)
   - Supporting maternity safety champions at board, frontline and regional level
   - ATAIN (Avoiding Term Admission Into Neonatal units)
   - The Maternal and Neonatal Health Safety Collaborative programme.

5. A series of new announcements was made by the former Secretary of State in autumn 2017 (*Safer Maternity Care: next steps towards the national ambition*) which required a review and refresh of WS2. This resulted in:
   - Revised terms of reference, with an emphasis of greater cohesion at national level in terms of support for the system and channels of communication
   - Review of WS2 membership and an invitation of membership to the Health Safety Investigation Branch, (HSIB) given its role in investigations of maternal death, neonatal deaths and severe brain injury cases.
   - Development of a comprehensive work plan detailing activities, time frames, alignment and responsibilities for all WS2 deliverables.
   - Collation of all maternity and neonatal safety activity undertaken at national level across the system - this will be made available on the NHSI hub at: https://improvement.nhs.uk/improvement-hub/maternity-and-neonatal/
   - In response to feedback from frontline teams and system partners, the development of a graphic/visual with a supporting narrative expressing succinctly the range and alignment of maternity safety activity.
6. WS2 remains on track and an update on progress against the initiatives and deliverables can be found in Appendix 2.

7. NHS Improvement will be providing further guidance to trusts on understanding the safety landscape in maternity services; *Exploring the Golden Thread* is due to be published in late summer 2018.

Delivery of support to trusts on the Maternity Safety Support List (MSSL) established by the former Secretary of State

8. In autumn 2017, the former Secretary of State commissioned NHS Improvement to establish a maternity safety 'urgent support offer' for trusts with the greatest safety challenges, the 'Maternity Safety Support List' (MSSL).

9. NHS Improvement worked with DHSC, CQC and the other NHS arm's length bodies (ALBs) to develop inclusion (and exit) criteria to identity the trusts with the greatest need for support. The criteria for inclusion are as follows:

    - The maternity services have an overall Care Quality Commission (CQC) rating of 'inadequate'.
    - The maternity services have an overall CQC rating of 'requires improvement' with an 'inadequate' rating for either the safe or well-led domains.
    - The maternity services have been issued with a CQC 'warning notice' (indicating that there is a need for significant improvements in the quality of care).
    - There has been a DHSC or NHS Improvement request for investigation and support.

10. The programme (funded until the end of March 19) incorporates and/or aligns with any existing quality improvement initiatives, as well as the work on special measures. An outline of the programme is attached as appendix 3. There is a focus on six key drivers for delivering safety maternity care, building on the guidance set out within the *Spotlight on Maternity* (DH and NHS England 2016) publication:

    - Leadership
    - Governance
    - Patient voice
    - Quality improvement
    - Staff engagement
    - Safety culture

11. A Maternity Improvement Advisory Team has been established and an advisor has been allocated to each of the trusts on the MSSL. The advisor works in partnership with the trust's improvement director (where appointed), the director / head of midwifery, the divisional clinical director and wider stakeholder partners.

12. The trusts on the MSSL have made good progress. The list originally comprised nine trusts. Two trusts have been removed from the list having achieved improved CQC ratings and a further two are expected to exit over the summer. However, two additional trusts have been added to the list, both following receipt of CQC 29a Warning Notices. A summary is provided in appendix 4.

13. An interim evaluation of the support programme will take place during September. The following have been identified through the visits of the Maternity Improvement Advisory Team as emerging themes:

    - The position within the organisational hierarchy of the director / head of midwifery and access to executive leadership and the trust board
    - Multi-disciplinary leadership and directorate team cohesion
    - Governance infrastructure, effectiveness and application
    - Whether shared directorate ambitions are known and supported from 'ward to board'.

14. The focus of work in the next quarter will focus on the roll-out of quality improvement toolkits; a key component of the support offer.

Professional midwifery leadership

Heads of midwifery leadership programme

15. Successful delivery of the national Maternity Transformation Programme relies in huge part upon the effective and visible leadership of midwifery professionals. Within trusts, board-level focus on improving safety and quality and maternity services is critical and heads of midwifery (HoMs) need to have the skills and experience to influence at board level.

16. NHS Improvement established the first national leadership programme developed exclusively for HoMs. This six-month masterclass programme, which launched in January 2018, has been designed to be interactive, using real life rather than 'textbook' examples, and to support the establishment of a national community of practice. The aims of the HoM programme are to:

    - Develop HoMs' personal resilience, strength and resolve
    - Enable HoMs to influence beyond their personal authority
    - Develop self-confidence and belief to role model effectively
    - Lead upwards with courage and ability to challenge effectively
    - Creatively lead and innovate as strong leaders working across systems
    - Promote professional cultures
    - Recognise, build and harness collective leadership impact
    - Create a strong peer network that offers support, advice and knowledge sharing

17. The programme comprised 4 regional cohorts, run in parallel between January and June this year. The programme was open to all HoMs to apply and there were 80 participants in total (England-wide coverage of c60%).

18. The programme is already having demonstrable impact:

    - HoMs are building extended networks and influencing strategic developments at both local and system levels.
    - A greater number of HoMs are influencing upwards effectively at a time when the maternity agenda is in competition with a number of priorities at board and system level.

Aspirant heads of midwifery leadership programme

19. There are 134 acute trusts providing maternity services across England, each led by a HoM. 25% of the existing HoMs are eligible to retire in the next 5 years and, additionally, there are vacancies or interim appointments in approximately 15% of trusts. Recently, the John Radcliffe Oxford, University Hospitals Southampton, North Bristol and Guys and St Thomas' all advertised three times before successfully appointing a HoM, with some taking more than a year to fill their vacant posts.

20. Ensuring a strong pipeline for future HoM roles will be crucial to sustainable delivery. HoM roles within the NHS are becoming harder to fill, with the role becoming increasingly challenging and complex and the gap between HoM and deputy HoM roles increasing. Where talented individuals have had the aspiration to progress,

there hasn't always been the support available to equip them with the skills required to take on a sub board-level role nor a clear route for progression.

21. In response to this gap, NHS Improvement will be launching the aspirant HoM leadership development programme with the first cohort of 40 participants in September 2018 and 2 further cohorts planned for during 2019 (dependant on funding). The programme will support aspiring HoMs to develop the senior leadership skills required and provide robust mechanisms for connection and networking between aspiring HoMs nationally.

Request to the Board

22. The Board is asked to note:

(1) In relation to WS2 of the Maternity Transformation Programme, "promoting good practice for safer care":

- The substantial progress made following the transfer of leadership of WS2 of the Maternity Transformation Programme from the DH to NHS Improvement in April 2017, including against the new initiatives announced last autumn by the former Secretary of State.

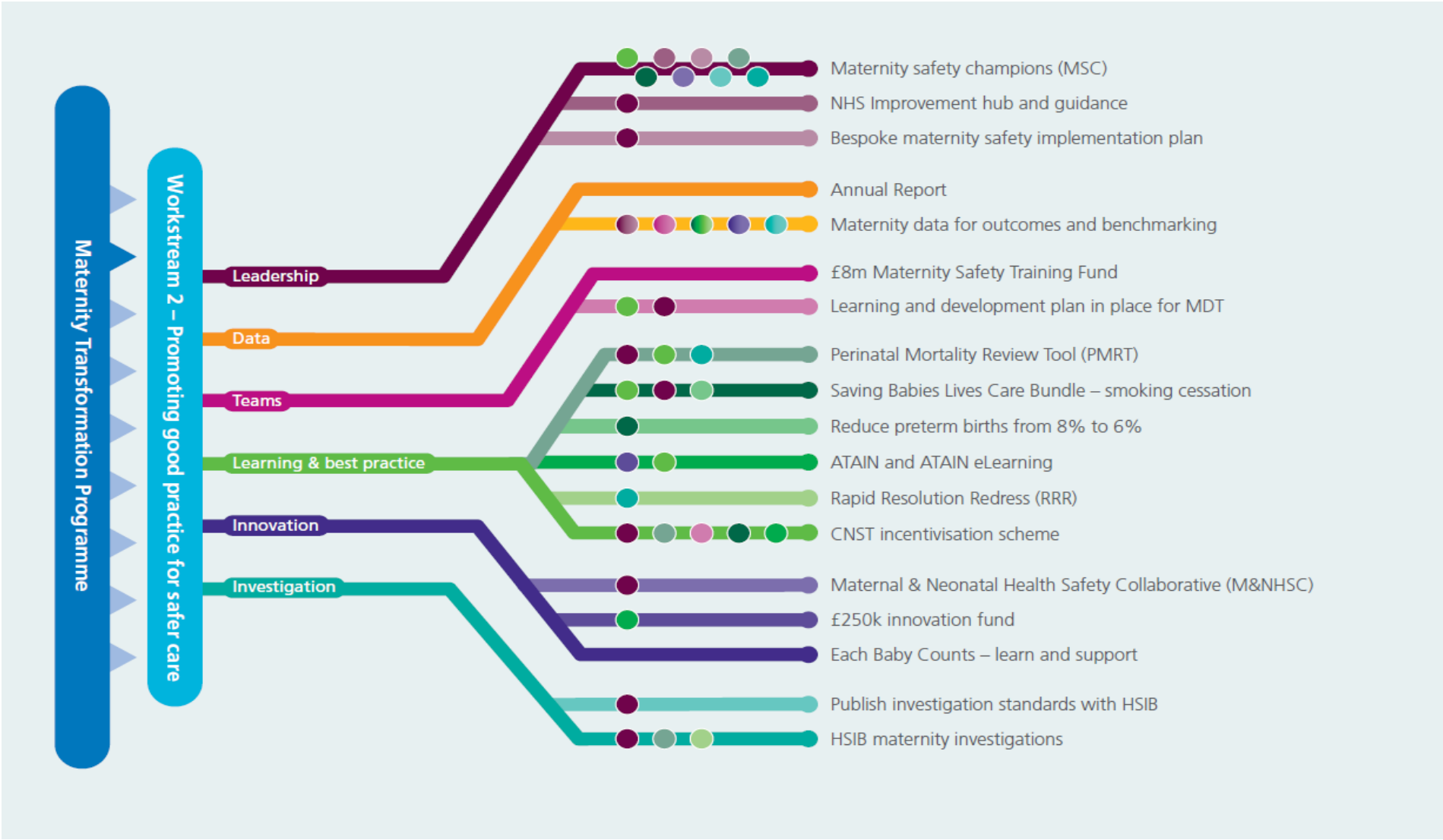
(2) In relation to the delivery of support to trusts on the Maternity Safety Support List established by the former Secretary of State:

- The progress made to deliver safety and quality improvements at pace to the most challenged maternity services.
- That the MSSL urgent support offer (annual cost of £500k) is funded until the end of March 2019. This work will require additional funding to continue beyond April.

(3) In relation to professional midwifery leadership

- The progress made to develop the current senior midwifery leadership.
- The progress made to ensure a pipeline of skilled and able future midwifery leaders.
- That these leadership programmes (annual cost of £160k) are funded until end March 2019. To achieve full coverage (as near as possible) it is likely that funding would need to continue into 2019/20 and 2020/21.

Appendix 1: WS2 list of maternity and neonatal safety deliverables



Appendix 2: Update on progress on WS2 initiatives and deliverables

During 2018 the workstream has:

- Identified and secured contact details for the board, midwifery and obstetric champion in every trust in England.
- Developed a ‘maternity safety champion’ hub within the NHSI hub to serve as a single ‘go to’ place for information and support.
- Published guidance for maternity safety champions at every level of the system.
- Introduced bi-monthly newsletters and webinars to support champions.
- Developed a single communications route to champions which coordinates system messages targeted at champions to ensure a coordinated approach.
- Launched the national perinatal mortality review tool, with 100% of units now having successfully implemented use of the tool.
- Undertaken an evaluation of the Saving Babies Lives care bundle.
- Planned a refresh of the Saving Babies Lives care bundle to include a reduction in preterm births from 8% to 6%.
- Continued to develop proposals for the Rapid Resolution and Redress scheme.
- Undertaken a survey of trusts relating to the £8.1m multidisciplinary team training fund.
- Supported 44 trusts through Wave 1 of the Maternal and Neonatal Health Safety Collaborative and initiated support for 43 trusts in Wave 2.
- Undertaken culture surveys in maternity and neonatal units in 44 Wave 1 trusts
- Undertaken a series of roadshows to support the implementation of the NHS England led Improving Value Atain scheme.
- Worked with NHS England, HEE and PHE to design a programme to increase the number of smoking cessation advisors, complementing the Saving Babies Lives care bundle and contributing to the national ambition.
- Worked with NHS England, the Department of Health and Social Care and HSIB to develop information and guidance on standards for maternity investigations.
- Worked closely with NHS Resolution to develop the Maternity Clinical Negligence Scheme for Trusts (CNST) incentivisation scheme.
- Collaborated with the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives (RCM), the WS2 lead and the Maternal and Neonatal Health Safety Collaborative regarding provision of additional quality improvement support for trusts
- Mapped existing safety activity against report recommendations from MBRRACE-UK, Each Baby Counts, CQC standards and other publications to determine gaps which the workstream will then consider addressing or using to inform future policy.
- Developed a safety graphic and supporting narrative to explain the breadth of safety activity as a ‘golden thread’ throughout the Maternity Transformation Programme.

NHS Improvement

Maternity Safety Support Programme

June 2018

Overview

- The national Maternity Safety Ambition, launched in November 2015, aims to reduce the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries in babies that occur during or soon after birth by 20% by 2020 and 50% by 2025; and to reduce the national rate of pre-term births from 8% to 6% by 2025.

- Maternity safety is a priority for Secretary of State. NHS Improvement, together with the Care Quality Commission, has been tasked with developing a maternity safety support programme for implementation from April 2018 to March 2019.

- The programme focuses on the most challenged maternity units. NHS Improvement has worked with CQC to develop inclusion and exit criteria in order to identity trusts that have the greatest need for support. Given the clear inclusion and exit criteria, the intention is that the trusts on the maternity safety support list will change on a rolling basis. Currently there are 7 trusts on the list.

Inclusion criteria	Exit criteria
○ Maternity services which have an overall rating of Inadequate ○ Maternity services which have an overall rating of Requires Improvement with an Inadequate rating for either the Safety or Well-Led Domains ○ Maternity service issued with a CQC warning notice. ○ DH or NHSI request for investigation	○ CQC rates the service to be Requires Improvement or better ○ CQC removes the warning notice

- The programme will incorporate and/or align with existing national quality improvement work, as well as the work on special measures, and will encourage shared learning and the embedding of sustainable quality improvement approaches to support sustained development of maternity services at pace.

- The programme will focus on six key drivers for delivering safer maternity care, which build on the guidance set out under the Secretary of State commissioned *Spotlight on Maternity.* These are: 1. Leadership; 2. Patient voice; 3. Staff engagement; 4. Governance; 5. Active quality improvement approach; and 6. Safety culture.

- The support offer will be led locally by a Maternity Improvement Advisor who will work to deliver guidance and practical advice directly to trusts.

The objectives and aims for the programme

Programme objective

The overall objective is to deliver a maternity safety support initiative which will support challenged maternity units improve across key areas in order to deliver safer maternity care. The programme will be led by NHS Improvement and supported by Care Quality Commission (CQC); CQC's primary role will be the provision of intelligence to identify priorities for improvement and assurance that required changes have been made.

Programme aims

With an increased national focus on improving outcomes for women and babies in maternity units, the Secretary of State has asked for targeted support for maternity units that have been rated inadequate by the CQC. The key aim of the programme is, from a maternity perspective, to affect sustainable change in the five CQC domains of safety, effectiveness, responsiveness, caring and well led.

A Maternity Improvement Advisory Team (and allocated Advisor) will work in partnership with the trust's Improvement Director (where one in situ), the Director/Head of Midwifery and Divisional Clinical Director and wider stakeholder partners to support any developments needed to improve the aspects of:

Leadership	Patient voice	Staff engagement
Governance	Quality improvement	Safety culture

A Maternity Improvement Advisor will be allocated to a series of Trusts under Special Measures and will work primarily with the executive clinical directors and divisional leaders to deliver outcomes required identified by the CQC Report and detailed in the Trusts Improvement Plan. They will work in an advisory capacity but not cut across the jurisdiction of the responsibilities of the Trust Board. The Maternity Advisors will in turn be supported by the NHSI Maternity Clinical Fellow and Clinical Director for Maternity and Children.

Methodology

The programme will employ a two phased approach in order to develop maternity units that require additional support to improve outcomes. This approach is built on the successful work carried out in maternity services across England

PHASE ONE

Discovery & gap analysis

- Introduction to key personnel and stakeholders
- Review trust action plans in collaboration with the trust and NHS Improvement regional teams
- Enable trusts to spend active time to reflect on their existing action plan and assess the impact of their existing initiatives / actions
- Undertake a site visit and hold conversations with key personnel within the maternity unit (e.g. Head of Maternity, senior leadership) to gather practical information and ascertain progress against trust action plan
- Support trusts to undertake an in-depth gap analysis against their action plan and offers outlined by NHS Improvement in order to help:

  - identify what is in place but not happening at pace
  - what could be added to the current work programme to enable sustained change
  - Identify what is in place that the trusts could afford to deprioritise or stop altogether

PHASE TWO

Bespoke support offer

- Following review of the trust action plan and subsequent gap analysis, a dedicated Maternity Improvement Advisor will facilitate and drive a bespoke support offer to improve maternity outcomes. This will include:

  - running a development session on current maternity challenges, data appreciation and implications for care in order to enable whole board challenge of the maternity agenda and outcomes
  - designing an appropriate support programme which will focus on six key elements:

1. Leadership
2. Patient voice
3. Staff engagement
4. Governance
5. Active quality improvement approach
6. Safety culture

Spotlight on maternity

Leadership

Key objective: Evidence of a highly committed multi-disciplinary and enthusiastic team with a shared joint vision and passion to achieve optimum care for women and their families.

Example support offer: Provide coaching individually and learning events for the divisional triumvirate.

Patient voice

Key objective: Evidence of user partnership (through MVP) and participation in service planning and evaluation from patient contacts through to directorate and board

Example support offer: Inclusion of patient or service user voice in shaping the direction of care and new pathways

Staff engagement

Key objective: Evidence of moving towards 95% staff engagement in the Staff Surveys, timely response to complaints and learning from such complaints and incidents.

Example support offer: Ensure a clear plan to address areas of development following the staff survey is in progress.

Governance

Key objective: Evidence of individual / directorate accountability to patient safety and application of research based clinical policies along with a concurrent risk register with clear timelines to reduce risks.

Example support offer: Review of governance, line of sight and all procedures in maternity specifically SI investigation capacity and capability (links to HSIB).

Quality improvement

Key objective: Evidence of Trust and Directorate engagement with the ambitions of the National Maternity Transformation Programme and recommendations from key National Reports.

Example support offer: Offer of exchange visits with Trust achieving Outstanding in maternity provision (consider formal buddying arrangement).

Safety culture

Key objective: Evidence of staff being protected by a strong safety culture focussing on openness, transparency, learning and recovery with 95% application to the Directorate Mandatory Training Programme.

Example support offer: Review Trust monitoring of directorate application to the National Maternity Safety Ambitions.

Appendix 4: Synopsis of the Maternity Safety Support List as at June 2018

Trust	MSSL entry (month)	Issues and update: NHSi Action	Special Measures Finance / Quality / Anticipated exit (last review)			Engagement with MSSL Programme	Trajectory (change)	
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	Sep 2017	The Trust have the support of two new improvement directors Sally Herne and Seamus Watson, and also continues to be supported by the London Regional Team. Provisional date for CQC inspection in June 2018. The Trust remain on the MSSL programme and is supported by Neil Tomlin, local support as well as joint meeting with CSU and regional team. The new HoM started May 2018 and the Director of Midwifery from the Royal Free Group continues to support NMUH 1 – 2 days per week.	Y	Y	N	Maternity Improvement Advisor Neil Tomlin	→	
ROYAL CORNWALL HOSPITALS NHS TRUST	Dec 2017	Maternity and gynaecology services are rated inadequate in the latest CQC report (inspected July 2017). The Trust is now formally in special measures for quality, and is expected to exit within 12 months (October 2018). Section 29A Warning Notice issued in Dec 2017 and trust continues to require intensive improvement support in maternity. Trust is engaged with the improvement work. Meeting scheduled with region, the Maternity Improvement Advisory Team and Kate Langford (clinical medical lead in NHSI) planned for June 2018.	Y	Y	N	Maternity Improvement Advisor Neil Tomlin	→	
NORTH DEVON HEALTHCARE NHS TRUST	March 2018	Following the most recent issue of the Section 29A Warning Notice issued on 18th December 2017 Ruth May has written to the Trust in April 2018 informing them of the Maternity Support Offer. The Trust therefore joins the Support List and early contact with the NHSI South Regional Office has been made. Neil Tomlin the allocated Maternity Improvement Advisor.	Y	Y	N	Maternity Improvement Advisor Neil Tomlin	new →	
WALSALL HEALTHCARE NHS TRUST	Sep 2017	Final CQC report was published December 2017 which still shows the unit I remains inadequate for safe, well led and therefore, inadequate overall. The unit needs to improve on learning from incidents and complaints, acuity tool usage and involving women when managing risk. NHSIs Executive Director of Nursing visited during Q4. CQC has no date for re-inspecting maternity, recognising that time is needed to evidence embedded changes. Joint support is being provided by Sascha Wells-Munro, Maternity Improvement Advisor and Kate Langford, clinical medical lead .	Y	Y	N	Maternity Improvement Advisor Sascha Wells-Munro	→	
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	Sep 2017	The independent review into the investigations of specific maternal and neonatal deaths and cases of harm that was commissioned by NHSI (on behalf of SoS) is ongoing (Independent Panel Chair, Donna Ockenden). An additional three cases have been identified (February 2018) and will be contacted for consent for inclusion, on completion of the case record identification process. Future strategic model for maternity services is under consideration by the CCG and encompasses relocation of MLU midwifery staff from the 3 smaller MLU's to the consultant unit. Trust awaiting the results of the Perinatal Lookback Review and Investigation regarding recent mortalities. Light touch support from Maternity Improvement Advisory Team until outcome of review is known.	N	N	N/A	Maternity Improvement Advisor Sascha Wells-Munro	→	
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	Sept 2017	Progress has occurred against all of the CQC Must Do and Should Do actions, under the leadership of the interim Head of Midwifery. Further work is needed to ensure all of the actions are embedded. The CQC is in the process of undertaking a core comprehensive inspection, which included Maternity Services. They were on site between the 8th and 11th May. A review of Maternity services and development of a future maternity model is being undertaken across the commissioning footprint, including LSMS input. The Trust have commissioned a joint review from the RCOG and the RCM; terms of reference have been agreed by the trust, CCGs, NHSI and NHSE. This will commence May 2018. Joint support is being provided by Sascha Wells-Munro, Maternity Improvement Advisor and Jo Mountfield, External Obstetrician commissioned by NHSI.	Y	Y	N	Maternity Improvement Advisor Sascha Wells-Munro	→	
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	May 2018	Following the recent issue of the Section 29A Warning Notice issued on 17th May 2018 Ruth May has written to the Trust explaining the Maternity Support Offer. The Trust therefore joins the Support List and early contact with the NHSI Midlands and East Regional Office has been made. Sascha Wells-Munro is the allocated Maternity Improvement Advisor. Meeting scheduled with region, the Maternity Improvement Advisory Team and Kate Langford (clinical medical lead in NHSI) planned for June 2018	N	N	N	Maternity Improvement Advisor Sascha Wells-Munro	new →	
BARTS HEALTHCARE NHS TRUST	Sept 2017	Good progress made and from CQCs recent inspection, Newham and Royal London Hospital sites are now Requires Improvement overall with no inadequate domains and so the Trust has progressed and is no longer on the MSSL. The Trust continues to be supported by the regional NHSI team and NHSE Maternity Lead for London, a visit to Newham maternity unit was undertaken in March supported by Julia Holding National Patient Experience Lead NHSI, following a poor score in the recent CQC patient experience survey. the visiting team were assured by the revised maternity QIP plan that the Trust intent to continue on their improvement journey. The Trust have been offered support from the MSSL Maternity Improvement Advisor but this is not mandated due to the improved ratings.	Y	Y	Yes	Maternity Improvement Advisor Neil Tomlin	→	
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	Sep 2017	Good progress made and the Trust has had a subsequent CQC inspection which completed on 26 January 2018, the early outcome for maternity is not yet published. but the draft report seen by NHSI indicates that the Maternity Services will be rated as Requires Improvement and so formally do not require to stay on the MSSL List however the Trust has asked for continued support from NHSI to recruit the next Head of Midwifery Post	Y	Y	Yes	Maternity Improvement Advisor Sascha Wells-Munro	→	
PENNINE ACUTE HOSPITALS NHS TRUST	Sept 2017	Good progress made and the most recent CQC Inspection for this Trust has formally demonstrated improvement in key areas of leadership and care and therefore have excited the need for the NHSI Maternity Support Offer. The Trust has been asked to share good practice and achievements (with NHSI) in relation to their improvement journey.	N	N	N/A	Exited April 2018	→	
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	Sept 2017	Good progress made and the recent CQC Inspection indicated that the Trust Maternity Services has changed from Inadequate to Requires Improvement and therefore should exit the MSSL. In the draft CQC Report the Trust as achieved good for Maternity in the domains of effectiveness, caring, responsiveness and safety with further work needed in the domain of well led which achieved Requires Improvement. RM visited the Trust on 7th December 2017 and has since written to the Trust acknowledging the revised CQC position.	N	N	NA	Exited April 2018	→	