Classification: Official

Publications approval reference: 001559

Transforming perinatal safety

A resource pack to support improvement in maternity and neonatal services in England

Contents

Foreword 3
Introduction 5
The NHS Patient Safety Strategy 6
Our Vision for Maternity and Neonatal Safety 8
The Maternity and Neonatal Safety Improvement Programme 12
Core responsibilities 18
- Insight 18
- Involvement 19
- Improvement 20

Local Maternity Systems 21
Maternity Voices Partnerships 23
Frontline maternity and neonatal safety champions 25
Board safety champion and non-executive director 28
Heads of midwifery and clinical directors 32
Data sources and guidance 35
- Locally available data sources 35
- System level data sources 36
- National Reports 36
- Additional sources of guidance 36
- COVID-19 related resources 37

National ambition trajectories 38
Core safety improvements 39

Atain - Avoiding Term Admissions Into Neonatal units 39
Continuity of Carer 39
Each Baby Counts Learn and Support 39
HSIB led Maternity Investigations 40
Maternity and neonatal safety champions 40
The Maternity Incentive Scheme 40
MatNeoSIP 41
Tackling Inequalities 41
The National Maternity Safety Strategy 41
The Neonatal Critical Care Review 42
Networked Maternal Medicine 42
Perinatal Mental Health 43
The Perinatal Mortality Review Tool 43
The Saving Babies' Lives Care Bundle v2 43
Smoking cessation resources 44
Standardising Investigation 45
Safety as a Golden Thread 46
Workstream 1- Supporting local transformation 46
Workstream 3 - Choice and personalisation 46
Workstream 4 - Perinatal mental health 47
Workstream 5 - Workforce 47
Workstream 6 - Data 48
Workstream 7- Harnessing digital technology 48
Workstream 8 - Maternity payment system 48
Workstream 9 - Prevention 49
Workstream 10 - Neonatal 49
Glossary 51

Foreword

Improving the safety of maternity and neonatal services in England is one of the NHS's highest priorities. The National Maternity Review, led by Baroness Julia Cumberlege, published its report, *Better Births*, in 2016. It provided a holistic vision for the future of NHS maternity services, with twin aims of safer and more personalised care. In November 2015, the Secretary of State for Health announced a national ambition to halve the rate of stillbirths, maternal and neonatal deaths and brain injuries that occur during or soon after birth by 2030. The ambition was subsequently extended to include reducing preterm birth from 8% to 6% and the timeframe revised to 2025. The Maternity Transformation Programme (MTP) aims to implement this overall vision, with the *NHS Long Term Plan* (LTP) providing longevity for implementation and strengthening key areas of safety.

To achieve the 'halve it' ambition, we need to improve care for populations most at risk of poor outcomes. Safety champions, as ambassadors for maternity safety at every level of the system, play a critical role in driving this priority. Whilst mortality rates are reducing for the population overall, stark health inequalities persist: for example, we know that maternal mortality is five times higher for Black women, three times higher for mixed ethnicity and twice as high for Asian women (MBRRACE-UK, 2019). Stillbirth rates and neonatal death rates are also higher in these groups of women. The 2020 MBRRACE-UK and UKOSS reports showed that 55% of pregnant women admitted to hospital with COVID-19 were from a Black, Asian or Minority Ethnic (BAME) background. Improving care for these women must be an absolute priority for maternity services across England.

Furthermore, the Ockenden Review of maternity services at Shrewsbury and Telford NHS Trust, the Kirkup Review of maternity services in East Kent, and the earlier findings of the Morecambe Bay Review all have shown that there are some units where core safety standards have not been met, with tragic consequences.

A range of maternity safety initiatives have been therefore implemented since the national ambition was announced with notable success by frontline teams; however, the proliferation of safety activities means the full picture of maternity safety is complex. This guide has been created to make sure that everyone involved in leading or providing maternity and neonatal care fully understands their

role in delivering personal and safe care for women, babies and their families; an even more exacting challenge in the light of COVID-19.

We have modelled the guide on the three primary drivers of Insight, Involvement and Improvements for safety as set out in the *NHS Patient Safety Strategy*.

As National Maternity safety champions, we want to say thank you to all staff involved in delivering maternity and neonatal care in England – your hard work has seen huge improvements in safety over the past few years. We hope you find this a useful framework for describing your role in the maternity safety strategy. We now need your ongoing support to ensure we reach our common vision for England to be the safest place in the world to have a baby.

Professor Jacqueline Dunkley-Bent

Chief Midwifery Officer for England

Dr Matthew Jolly

National Clinical Director for Maternity and Women's Health

December 2020

Introduction

This guide will support everyone working as a local, regional or national partner to improve the safety of maternity services in England by improving the understanding of current maternity safety initiatives, how they align and the specific roles of supporting agencies to enable delivery of the Maternity Transformation Programme and the national ambition.

Specifically, it will help those working to improve maternity and neonatal services in line with the Better Births vision, to understand with greater clarity what their role is in supporting and implementing safety initiatives.

The term ‘the golden thread of safety’ has been widely adopted to explain safety as an integral part of all the activities of the Maternity Transformation Programme, rather than a set of stand-alone initiatives. It may be best considered in terms of individuals in an organisation or system working on a series of identified improvements in a cohesive and collaborative manner.

This approach requires everyone at every level of the maternity system to fully understand their role and their unique position in improving the safety of their services – a collective effort and commitment that offers potential for transformational changes to safety in maternity and neonatal services.

Useful publications supporting this work include *Better Births*, *Safer Maternity Care: Next steps towards the national maternity ambition* and *Safer Maternity Care: Progress and Next Steps.*

The NHS Patient Safety Strategy

The *NHS Patient Safety Strategy* published in 2019 has been developed to support the NHS in becoming the safest healthcare system in the world. It runs alongside the *NHS Long Term Plan* and is relevant across all parts of the NHS - including physical and mental health care, in and out of hospital and primary care.

The three primary drivers of patient safety in the new strategy are:

- **Insight:** to be world leading at drawing insight from multiple sources of patient safety information
- **Involvement:** to give staff the skills and support to help improve patient safety; to be the infrastructure for safety improvement, working with patients and partner organisations
- **Improvements**: to decrease harm in key areas by 50% as of 2023/24, through specific patient safety initiatives

When applied to the maternity safety programme, these aims can be described as:

- **Insight:** drawing on routinely collected data as well as insights from incidents of harm to drive improvements in care. We will support this by providing standards and developing skills for undertaking high quality reviews and investigations in support of the national ambition
- **Involvement**: to develop the safety culture within the workforce to ensure high quality, safe maternity and neonatal care, involving women and families in the development of initiatives
- **Improvements**: to deliver harm reduction programmes to improve the safety of maternity services, ensuring efficient and consistent measurement and improvement methods

The core principles that underpin the implementation of the NHS Patient Safety Strategy and the values and behaviours fundamental to delivering safe healthcare for patients include:

- a just culture
- openness and transparency
- continuous improvement

While they are not the only principles that should underpin a safety culture, they are especially pertinent to the challenges we face. Together they should form a golden thread that runs through all aspects of healthcare from frontline provision and the interaction between patients and clinicians, to national leadership for the healthcare system.

Our Vision for Maternity and Neonatal Safety

Our aims

We aim to make measurable improvements in safety outcomes for women, their newborn and families in maternity and neonatal services, as set out in *Better Births.* We also aim to reduce the rate of stillbirths, maternal and neonatal deaths and neonatal brain injuries occurring during or soon after birth by 20% by 2020 and 50% by 2025. 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.

Insight

Our goal is to provide standards and develop skills for undertaking high quality reviews and investigations. This will enable action to be taken following incidents of harm and drive improvements in care, in support of the national ambition. A key responsibility of the safety champion is to ensure effective service improvements, not only from incidents and near misses but from successes and good practice through authentic engagement with users of maternity service.

This goal will be supported by:

- publishing standards for maternity investigation as part of the Patient Safety Incident Response Framework
- publishing data to demonstrate progress with the national ambition
- promoting and incentivising the use of the Perinatal Mortality Review Tool (PMRT) to support standardised, systematic, multidisciplinary, high quality reviews
- exploring the use of a single reporting portal to reduce the burden of duplicate reporting to national bodies
- collating improvement priorities from the Healthcare Safety Investigation Branch maternity investigations, Each Baby Counts (EBC), NHS Resolutions Early Notification Scheme and MBRRACE-UK led

investigations and reviews through a new Insights group working with Maternity and Neonatal Safety Improvement Programme (MatNeoSIP), and the new EBC Learn and Support to identify areas amenable to quality improvement

- drawing on the MatNeoSIP to share good practice, local insights and intelligence from Patient Safety Networks, embedding quality improvement as a core principle in line with Safety 2 thinking

Involvement

We aim to develop the safety culture and skills of the workforce to ensure capability to provide high quality and safe maternity and neonatal care.

We will do this by:

- investing in safety champions: by continuing our themed online seminars publishing regular, relevant safety news items in our safety champion newsletter; signposting to new and existing guidance to support you in your role; updating our existing safety champions hub with useful resources, engaging with safety champions as part of local and regional events
- working with teams from 16 trusts as part of Each Baby Counts - Learn and Support: using quality improvement methodology to drive improvements in escalation, culture change, workforce wellbeing and human factors
- standardising core safety training to include clinical as well as non-technical skills training
- promoting a culture of civility, teamwork and a common vision for safety from frontline to board

Improvements

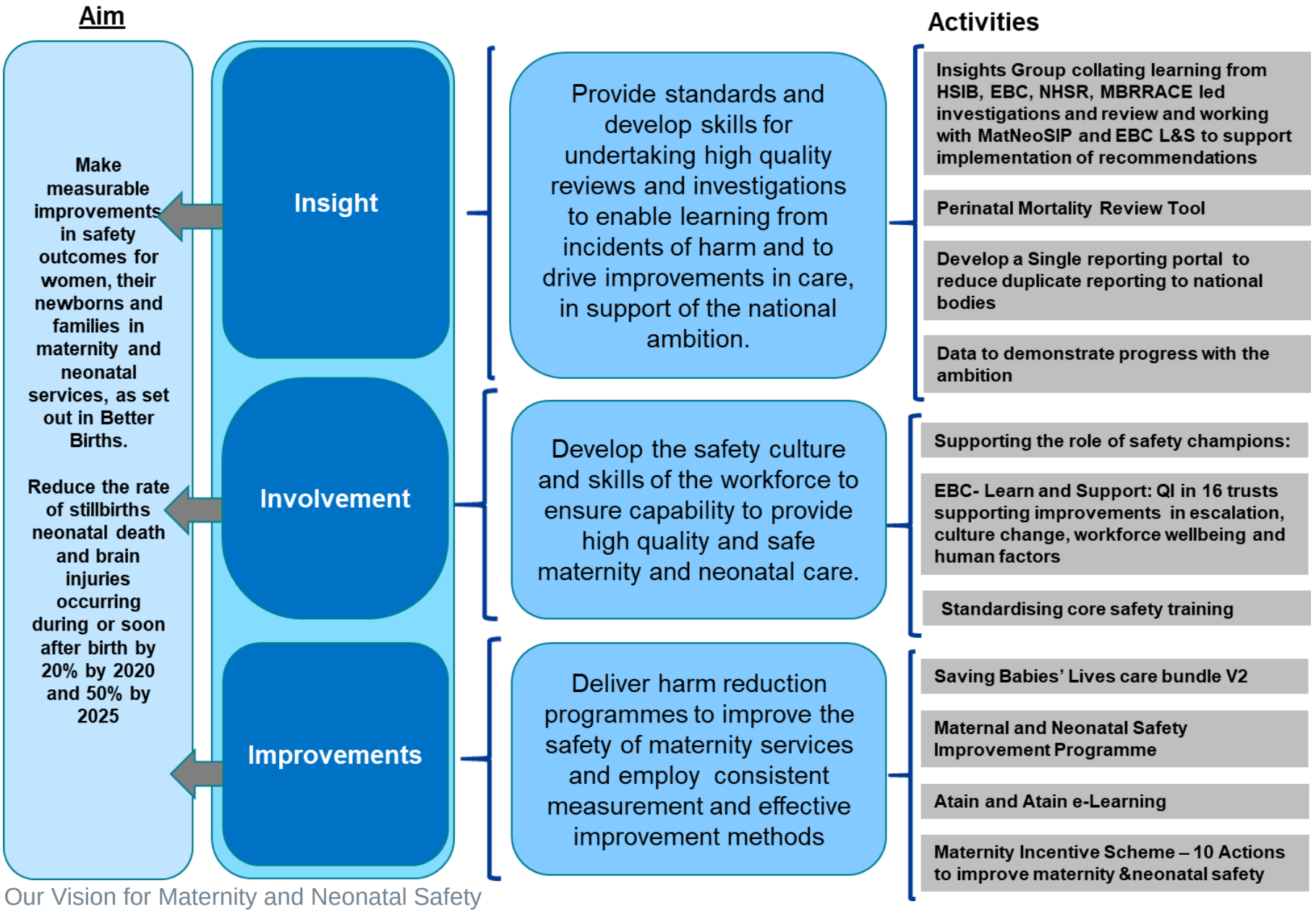
We will deliver harm reduction programmes to improve the safety of maternity services, ensuring efficient and consistent measurement and improvement methods

We will do this through:

- *the Saving Babies' Lives care bundle v2 (SBLCBv2)*

- the Maternity and Neonatal Patient Safety Networks by sharing safety intelligence and providing bespoke capacity (and capability) building for staff to actively participate and mobilise improvement work aligned to the MatNeoSIP national driver diagram
- the Maternity CNST Incentive scheme – incentivising safer practice focusing on ten criteria, including Maternity Transformation Programme initiatives.
- the Atain and Atain e-Learning programme
- the four actions set out in 'Perinatal support for BAME women during the COVID-19 Pandemic' letter
- developing solutions for best practice in organisations where improvement methodology is being implemented across the wider organisation to ensure the cross-cutting nature of maternity is considered along with improvements in other areas
- building on the safety culture surveys (SCORE) to maintain a focus on the importance of culture and ensuring insights are utilised to inform local quality improvement plans.
- continuing to support the implementation of Continuity of Carer and, through initiatives to address inequality, identify interventions which aim to achieve equity of outcomes for mothers and their babies.

The aims and activities of the safety workstream of the Maternity Transformation Programme



The Maternity and Neonatal Safety Improvement Programme

The NHS Patient Safety Strategy sets out the vision for the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP), previously known as the Maternal and Neonatal Health Safety Collaborative (MNHSC), which will support the continuation of the safety improvement work beyond the current three year programme and will build on its alignment to the wider maternity transformation agenda.

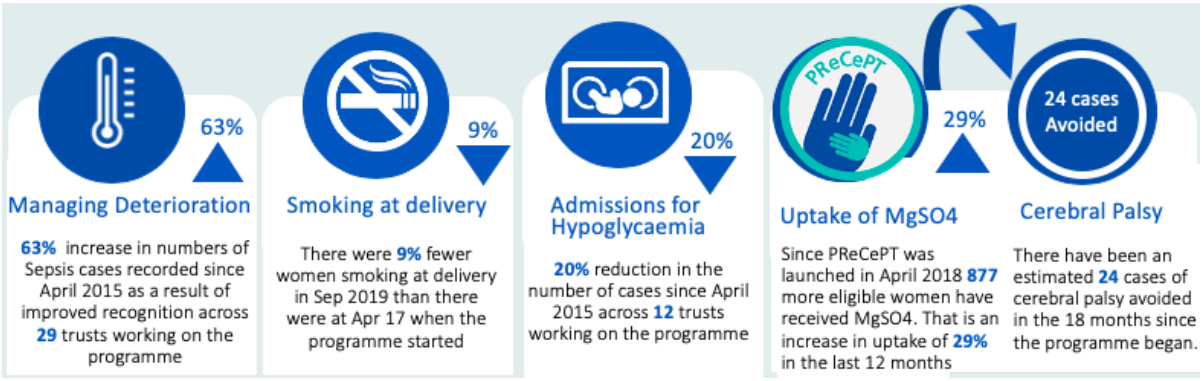
What has the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) achieved so far?

Since 2016 MatNeoSIP has contributed to the national improvement ambition through a range of key activities working with all 134 maternity and neonatal providers in England. We have supported each trust to focus on a range of key improvement projects aligned to the national ambition.

Through a series of national learning sets we have:

- Trained over 800 healthcare professionals in improvement science
- Developed a mature improvement architecture across the country involving all of the relevant network partners (including the 44 local maternity systems, 15 patient safety collaboratives, the 12 maternity clinical networks and the 10 neonatal networks). The support has built the ability and resource across the country for organisations and teams to both undertake and develop improvement projects in their own organisations.

As well as contributing to the improvements in the national data, the work has specifically resulted in improvement to the clinical outcomes outlined below:



Making change sustainable

We recognise as a national programme that the safety improvement work we have carried out so far covers the tip of the iceberg and there is much more to do. The system is awash with national advice and guidance outlining good clinical practice but appears to have a variable understanding of 'how' to make **sustainable change** happen. Similarly, improvements through clinical interventions across all 134 trusts make an important contribution to the national ambition but represent a proportion of the overall improvement required across the system, specifically in relation to improvements to teamwork and safety culture.

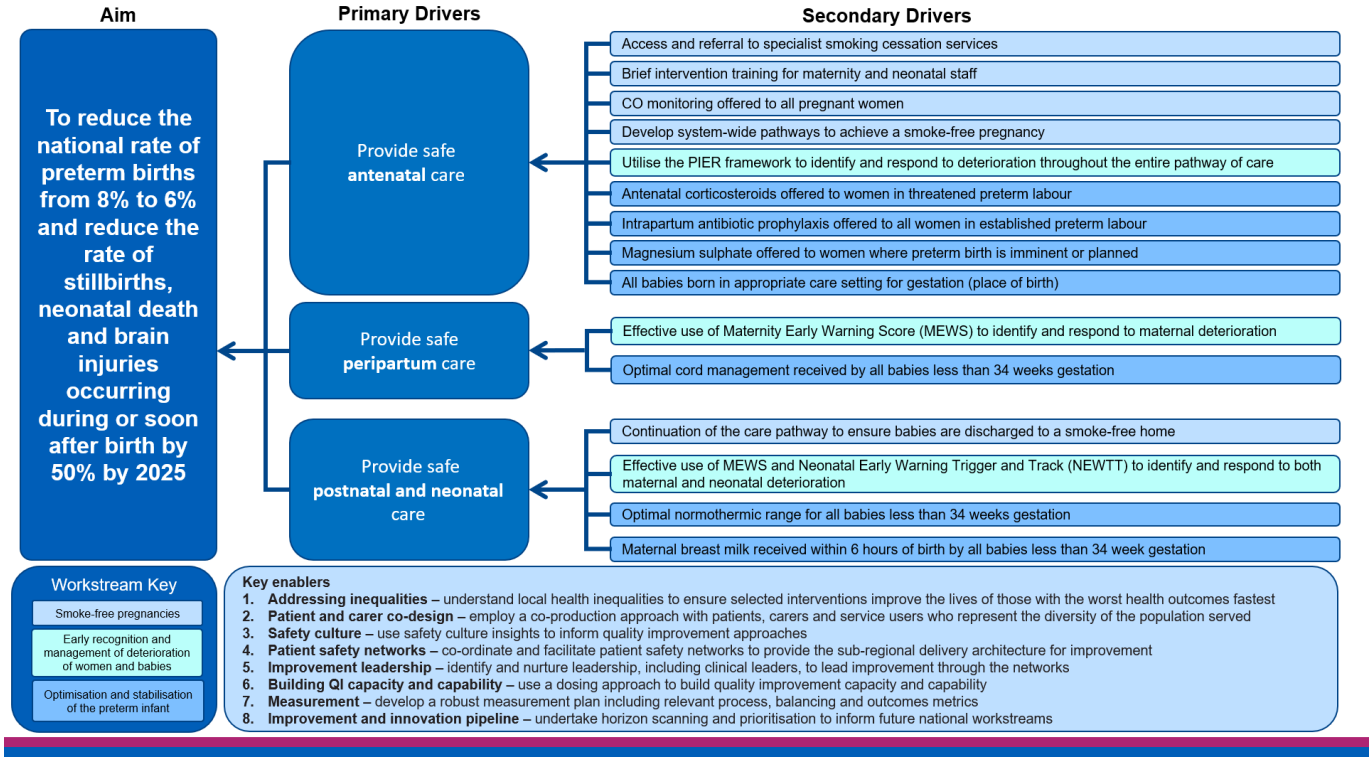
Through the programme's work in phase 1, as well as developing improvement capability we have also examined the impact and importance of a positive safety culture. We have undertaken a comprehensive safety culture assessment, gaining insights from 21,000 healthcare professionals in all 134 trusts, one of the largest culture surveys in the NHS.

How will we respond to new insights and emerging safety concerns?

Incidents of harm are currently investigated by multiple reporting organisations, all of which generate insights and recommendations as a primary source. MatNeoSIP will continue to work with these organisations to establish the scale of the issue and opportunities for improvement. The national reporting and learning system (NRLS) will provide additional national insights and local insights will be gained through direct work with multi-professionals within frontline teams. Part of the programme's capacity will enable a rapid response to new insights and safety concerns where amenable to quality improvement.

MatNeoSIP national driver diagram

The clinical themes for the next three years of the programme are shown in the driver diagram below.



The Maternity and Neonatal Patient Safety Networks will support the delivery of MatNeoSIP and will focus on all clinical priorities / primary drivers and key enablers. The networks will build on the successes of the improvement work previously undertaken by the Local Learning Systems. Each will each directly support a number of LMSs within their footprints in relation to the programme's priorities and will include all providers of maternity and neonatal services, multi-professionals, women, families and other key system stakeholders.

Improving support for mothers, families and healthcare staff

What are the issues?

- Women and families can feel powerless to influence how their care is delivered and planned and many do not feel listened to when raising concerns.

- There is an increasing body of evidence that highlights disproportionately poor maternity outcomes for mothers and their babies from BAME backgrounds.
- There is clear evidence that a poor safety culture, dysfunctional relationships within teams, between professional groups and across departments result in significantly worse health outcomes for patients and higher rates of personal burnout for staff.
- Senior leaders can lack understanding of improvement methods and of how to interpret, approach, test and ensure national recommendations from across the system are embedded, monitored and sustained over time.

What will we do?

- Employ a co-design approach with women and families, representative of the diversity of the population served, at both national and local programme level.
- Ensure those most likely to have poor outcomes are able to input from the very start in the design of local improvement plans and be part of the identification and evaluation of change ideas.
- Undertake a scoping exercise to better understand the ethnicity, demography and social deprivation factors that are present across the system; as well as the safety issues most affecting local communities. This data will be shared with local systems and used to inform and prioritise local improvement approaches.
- Undertake a deep dive with a number of Trusts seen to reflect high performing teams and safety culture surveys scores to elicit the key interventions for testing elsewhere. This will help build cross-system learning and teamwork and will quicken the pace of improvement adoption.
- Support maternity and neonatal providers to utilise their safety culture insights, enabling teams to actively create the conditions for a safety culture through quality improvement.
- Develop a small cohort of multi-disciplinary clinicians (doctors, midwives, obstetricians, neonatologists) to provide leadership for organisational and system level improvements ensuring they have the right skills and tools to do so.

- Develop 15 Maternity and Neonatal Patient Safety Networks, based on a population size of two to five million as the key vehicle to drive specific patient safety improvement and to directly support the 44 established local maternity systems.

Improving outcomes for women and babies

What are the issues?

- Preterm birth is the most important single determinant of adverse infant outcome with regards to survival and quality of life. Caring for a preterm baby also has significant short and longer-term financial impacts on health services, education services and the family involved.
- Smoking during pregnancy is the leading modifiable risk factor for poor birth outcomes, including stillbirth, miscarriage, preterm birth, low birthweight and Sudden Infant Death Syndrome (SIDS).
- Failure to identify, escalate and respond appropriately is one of the most commonly cited factors in cases of harm in both women and babies' and specifically, infant brain injury.
- Miscommunication and a lack of standardised processes for escalating critical information between multi-disciplinary teams means that safety-critical information may be lost, and patient safety compromised.
- Failures to recognise, manage and communicate risks early in the care pathway, i.e. during antenatal care means that opportunities are lost to optimise the health, outcomes and wellbeing of mother and baby.
- The challenging issues that face individual teams and organisations are not unique. However, the ability to learn and action change is hampered by silo approaches to working. This frequently occurs both within and between organisations in local maternity systems.

What will we do?

- Develop a focused set of key **clinical interventions** that reflect the current themes, insights and safety concerns identified from key reporting organisations.

- Ensure trusts work together so mothers (specifically prior to 34 weeks of pregnancy) are able to **deliver their babies in the most suitable hospital** for their stage of pregnancy. As well as undertaking a range of targeted therapies before, at the time of, and immediately after birth that will ensure each baby has the best possible outcomes.
- Develop a **whole pathway of care for the most vulnerable babies**, moving the focus away from individual interventions. This will improve working between clinical teams within organisations as well as supporting the care for women across local maternity systems.
- Continue to improve the **prediction, detection and management of the deterioration of mother and/or baby** during or immediately after birth. Specifically, this will focus on developing a new nationally agreed tool for detecting maternal deterioration and increasing the use of a validated tool for detecting the deterioration of the baby in the first few days after birth.
- Identify and support mothers (and partners) to successfully **stop smoking**.

Core responsibilities

This section summarises the core responsibilities for all staff and teams to promote safer outcomes for women, their babies and families, regardless of where in the system you work. The additional responsibilities outlined in forthcoming chapters are role specific and support the core responsibilities outlined below. Hyperlinks have been added where available, to provide immediate access to further information from external sites or to relevant information within this document.

Insight

- Review progress in meeting the national ambition trajectories in relation to the area in which you work (unit, provider trust, clinical network, local maternity system (LMS)) using the Maternity Services Data Set, ensuring standards are met for effective data quality and coverage, as defined by NHS Digital in the new data quality standards
- Review progress towards implementing the range of safety initiatives aimed at achieving the national ambition
- Review the full range of maternity and neonatal data sources and reports relevant to the area in which you work to identify areas requiring action
- Review progress with meeting the requirements for each action of the Maternity Incentive Scheme
- Draw on insights from service users to inform and co-design service improvements
- Ensure that insights from episodes of harm are shared across the team and with safety champions so that themes can be identified and addressed, including through the LMS
- Draw on the insights and experience of those who have successfully implemented improvements e.g. peer trusts, through clinical networks, Maternity and Neonatal Patient Safety Networks
- Review local safety culture surveys (SCORE) and utilise insights to inform the design and planning of improvement activity

Involvement

- Promote the provision of seamless multidisciplinary perinatal services which are responsive to both the physical and mental health needs of women, babies and their families
- Promote understanding of the Saving Babies Lives care bundle v2, ensuring clarity on the role of your teams in supporting implementation in full
- Draw on evidence to promote comprehensive understanding of the importance of Continuity of Carer; its role in improving outcomes and the importance of prioritising vulnerable groups, thus making services safer and reducing the risk of error.
- Review and implement recommendations within the Neonatal Critical Care Review, relevant to where in the system you work
- Promote a comprehensive understanding of the need for informed choice to promote safe, personalised care
- Share insights from review of the data sources with your safety champions, supporting your board safety champion to represent the safety needs of your service(s) at board and LMS level
- Ensure that local learning from reviews and investigations is shared so that all staff learn from what has gone well as well as responding appropriately to things which have gone wrong
- Work collaboratively with service users, through Maternity Voice Partnerships, to understand the experiences of people using local services as to how safe they feel and coproduce improvements
- Encourage and embed positive working conditions which promote a culture of kindness and civility. The importance of individuals' day-to-day behaviour in relation to safety is increasingly recognised.
- Work with your team to agree a plan for addressing insights from your safety culture surveys (SCORE). Share progress updates with your safety champions.

Improvement

- Work across boundaries to support full implementation of the range of improvement initiatives aimed at achieving the national ambition
- Promote a culture of multidisciplinary team-working as part of a seamless perinatal service
- Raise any safety concerns as part of safety walkabouts with your board safety champion and non-executive director, including barriers to implementing the named safety initiatives
- Identify key trust-level safety improvement priorities, including areas identified as a safety concern during COVID-19 drawing on the safety culture surveys (SCORE) and Maternity Voices Partnership involvement to design improvements
- Through your Patient Safety Network. continue to engage with the MatNeoSIP to embed improvement initiatives, develop capability and formulate solutions from successfully implemented improvement work
- Target improvement work at minority groups and those most at risk of poor outcomes, involving service users in the design and implementation of improvements.
- Ensure mental health-related causes are addressed with equal priority to those relating to physical health.
- Support implementation of Maternity Digital Care Records (ePHR) for two-way information flow with women and families.
- Build re-design of services into LMS planning to ensure that safer care is delivered where access to specific services are limited.

The following sections outline the additional, key responsibilities for those in specific roles or levels of the system. Responsibilities have been set out using the three principles of Insight, Involvement and Improvement. These are colour coded to enable you to identify synergy between your and others' roles.

Local Maternity Systems

Local Maternity Systems (LMSs) are groups of local system leaders from provider, commissioner and other local organisations, with the active involvement of service users. They provide a forum for identifying safety issues, agreeing solutions and overseeing implementation of improvements. LMSs have been undertaking a range of safety interventions and will continue to throughout the *NHS Long Term Plan* (LTP) period, in order to meet the safety ambitions.

Insight

Draw on both quantitative and qualitative data to identify and implement priorities. Share findings with clinical network safety champions who in turn provide support and oversight for safety improvements.

- Draw on data in relation to standards and outcomes, including comparative analysis and trends across varying pathways of care/service providers within and between LMS, and between different population groups
- Review clinical quality outcomes with your trust board and Clinical Network safety champions regularly to identify and implement opportunities for improvement
- Assess how well trusts are meeting recommendations and learning arising from local serious incident (SI) and HSIB investigations
- Review providers' positions in relation to the Maternity Incentive Scheme
- Draw on resources by pioneers and information from NHS.uk to enable safe choices, promoting safety as integral to personalised care plans.

Involvement

Those who sit on LMS boards provide leadership on key aspects of local transformation, including safety, in line with the LMS plan.

- Provide opportunities for clinicians from different providers to come together to share insight and develop a cross-boundary shared safety culture

- Seek assurance that each provider in the LMS has strong clinical safety leadership through board, midwifery, obstetric and neonatal champions
- Establish strong partnerships with leaders responsible for implementing and overseeing safety initiatives, specifically Board and clinical network safety champions, Regional Chief Midwives, Patient Safety Network leads, perinatal mental health leads and personalisation and choice champions
- Make evidence-based information easily available to enable women to make informed decisions.
- Promote the use of personal health records providing contextual, personalised and clinical information from before conception to postnatally.

Improvement

Support delivery of harm reduction programmes to improve the safety of services.

- Support maternity services to achieve full scale Continuity of Carer as this will positively impact all the other work streams.
- Target LMS transformation funding towards areas requiring greater resource based on the needs of the local population, in particular those from a BAME background or from deprived areas.
- Design and implement pathways, supported by shared clinical governance, across LMS providers so that women and their babies receive a consistent, safe service and quick access to more specialist care when required, prioritising those families from vulnerable backgrounds.
- Draw on resources and adopt solutions from those who have successfully implemented Continuity of Carer to address barriers to implementation.
- Disseminate resources for staff to support women who smoke to receive Very Brief Advice and referral to specialist stop smoking advice
- Ensure access to smoking cessation support is routinely available
- Ensure high quality specialist support is provided and co-ordinated through implementation of maternal medicine clinics and preterm birth clinics
- Support the use of prevention and pre-conception pathways
- Support implementation of the *Neonatal Critical Care Review*

Maternity Voices Partnerships

Maternity Voices Partnerships (MVPs) are multi-disciplinary working groups made up of service users, maternity staff and commissioners, who work together to review and contribute to the coproduction of local maternity services. MVPs are involved in gathering feedback in their local communities, working on coproduction projects with their local providers and are represented at LMS board level.

Insight

Draw on both quantitative and qualitative data to identify and implement priorities.

- Develop links with local groups, women, partners, users of maternity and neonatal services to gather feedback, listen to reflections and learn about experiences of care
- Develop links with diverse groups to ensure their views are listened to
- Use this feedback to co-design services that meet local needs, involving your board level advocate
- Seek ongoing feedback from women on the quality of choice and personalised care plans

Involvement

Work with local teams to ensure women's needs are central to improvement.

- With support and advice from National Maternity Voices, facilitate well-established and appropriately resourced MVPs locally
- Work with LMSs and local teams to provide a user perspective on the redesign of services that reflect the needs of the local population
- Work with LMSs, board and frontline safety champions and the board level advocate to ensure that co-production is embedded in any safety improvement work

- Work with LMSs and local teams to ensure staff are aware of and working in partnership with specialist perinatal mental health services

Improvement

Service user participation and coproduction, via MVPs, should be at the centre of all planning.

- Use the Fifteen Steps for Maternity toolkit to assess quality from a user perspective and to identify potential safety improvements
- Support implementation of Maternity Digital Care Records to ensure two-way information flow with women and families
- Through the use of service user stories, support the development of a positive environment and unit culture which optimises patient experience and mental wellbeing.
- Help to test communication approaches, such as explanation of risk so that understanding is optimised through language or images which are easily understandable.

Frontline maternity and neonatal safety champions

Every Trust in England has named midwifery, obstetric, neonatal and board level maternity safety champions responsible for working closely with their clinical network and LMS leads to champion safety at frontline and system level. Each Trust should have developed a local pathway which describes how frontline midwifery, neonatal, obstetric and board safety champions share safety intelligence from floor to board and through the LMS and Maternity and Neonatal Patient Safety Networks.

Maternity and neonatal safety champions are responsible for:

- supporting the provision of a seamless multidisciplinary perinatal service responsive to the needs of women, babies and their families
- supporting implementation of the *Neonatal Critical Care Review* recommendations
- supporting board safety champions to represent the safety needs of their services at board level
- building the maternity and neonatal safety movement locally to prioritise improvement activities and adopt best practice within the organisation.
- ensuring safe delivery of care provision with appropriate protection for staff, women and their families in light of the COVID-19 pandemic

Insight

Maternity and neonatal safety champions need reliable, standardised sources of data to help understand what safe care, outcomes and quality look like across their maternity and neonatal service and where improvements can be made.

- Develop strong working relationships with and draw on insights from those leading all safety and improvement-related activity in the organisation (e.g. your risk manager, lead reporters, MatNeoSIP improvement leads).
- Support staff to draw on local data to inform future improvement activity.
- Ensure your trust meets the standards required for effective data quality and coverage, as defined by NHS Digital in the new data quality standard.

Involvement

Strong, cohesive relationships at the frontline between all those leading maternity and neonatal safety initiatives will enable safety improvements to be made locally.

- Act as a point of organisational contact for the central programme team if there are issues with team engagement or improvement progress
- Work with local specialist perinatal mental health teams for consultancy, supervision and joint-care planning for women experiencing mental health difficulties
- Access dashboard and analytical tools that provide data sharing across specialties to improve interoperability between provider systems
- Support implementation of Maternity Digital Care Records (ePHR) for two-way information flow with women
- Draw on the A-EQUIP (advocating for education and quality improvement) model to support staff professionally and personally, and leading on quality improvement.

Improvement

Provide visible organisational leadership in support of improvement initiatives among health professionals and the wider team

- Ensure awareness of and support for safety improvement activity locally, regionally as well as nationally. This should include:
    - maternity and neonatal quality and safety improvement activity within the trust, including that determined in response to COVID-19 safety concerns

  - the Maternity and Neonatal Patient Safety Networks of which each trust will be a member
  - specific national improvement work and testing led by MatNeoSIP that the trust is directly involved with
  - the Patient Safety Network clinical leaders' group where trust staff are members
- Ensure awareness of and support for safety improvement activity locally
- Support clinical leaders to implement changes to service models and clinical practice to improve safety
- Identify staff who have received training in Very Brief Advice and specialist stop smoking advice, ensuring protected time to provide advice to women and their partners
- Support local initiatives to reduce preterm births and to optimise outcomes where preterm birth prevention is not possible.
- Develop and regularly update a safety dashboard or equivalent, visible to both maternity and neonatal staff which reflects action and progress made on identified concerns raised by staff and service users. This should include concerns relating to the COVID-19 pandemic.
- Share progress with agreed action plans on all improvement initiatives with the board, your Local Maternity System and operational delivery network leads and your Regional Chief Midwife.

Board safety champion and non-executive director

Board-level perinatal safety champions (ideally a non-executive director in addition to an executive director) act as a conduit between the Trust Board and the frontline obstetric, midwifery and neonatal safety champions. Working closely with their non-executive champion, board level service user advocate, clinical network and LMS leads, MatNeoSIP leads and the Regional Chief Midwife the Board perinatal champion supports safety at frontline and system level. Published guidance sets these responsibilities out in detail.

Critically, board-level safety champions and non-executive directors are responsible for:

- adopting a curious approach to understanding quality and safety of services
- working with local maternity and neonatal champions, their head / director of midwifery and clinical director for maternity and neonatal services and the executive sponsor for the MatNeoSIP to understand, communicate and champion successes and challenges at board level
- jointly, with frontline safety champions, drawing on a range of intelligence sources to review outcomes, including staff and user feedback to fully understand the services they champion
- updating the Trust Board on issues requiring board-level action.
- The Board should be updated using a board level dashboard which includes as a minimum:
    - All maternity and neonatal Serious Incidents
    - Incidents graded as moderate harm or higher
    - Trust position in meeting national ambition trajectories for stillbirth, brain injury, maternal mortality, neonatal mortality and preterm birth rates; implementation rates of SBLCBv2 and Continuity of Carer
    - safe staffing levels

  - correspondence or concerns raised by the Regional Chief Midwife and Lead Obstetrician, Coroners, Deaneries, national bodies including NHS Resolution, CQC, HSIB or the Invited Review process
- ensuring that Duty of Candour is upheld and that locally undertaken SI investigations meet national standards for review
- Ensuring that all maternity SI reports (and a summary of the key issues) are sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency.
- ensuring themes and learning from SI investigations, Never Events, Invited Reviews and concerns raised by external parties, including service users, are implemented, audited for efficacy and monitored at board level ensuring accountability for actions being undertaken
- providing oversight and appropriate challenge in relation to evidence for the CNST maternity incentive scheme safety actions
- ensuring that learning as well as improvement activity is shared with the LMS, Regional Chief Midwife and Lead Obstetrician and Patient Safety Networks as part of revised oversight and governance structures.
- supporting the Regional Chief Midwife and the regional and national maternity safety champions locally to deliver safer outcomes including:
  - perinatal quality and safety improvement activity within the trust, including that determined in response to COVID-19 safety concerns
  - quality improvement activity supported by the Maternity and Neonatal Patient Safety Networks of which each trust will be a member
  - specific national improvement work and testing led by MatNeoSIP
  - the Patient Safety Network clinical leaders' group where trust staff are members
- jointly, with the frontline safety champions, reviewing local outcomes as set out in the below reports, addressing relevant actions and recommendations:
  - the UKOSS report on characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2
  - the MBRRACE-UK SARS-COVID19 report
  - the 'Perinatal support for BAME women during the COVID-19 Pandemic' letter

Insight

Draw on local, regional and national level data to regularly monitor safety and outcomes in maternity and neonatal services.

- Engage with staff and service users to determine views on safety and staff satisfaction through walkabouts, audit, investigation and user feedback.
- Ensure high quality key learning points are reflected at the board ensuring accountability for actions being undertaken.
- Working with MatNeoSIP via the Maternity and Neonatal Patient Safety Networks to share safety intelligence and support capacity (and capability) for staff to actively participate and mobilise improvement work aligned to the MatNeoSIP national driver diagram and key enablers.
- Working with local Improvement Leads to gain a deeper understanding of QI methodology, build understanding of measurement for improvement to enable teams to use data to drive improvements effectively.
- Ensure staff are supported to respond to the findings of local SCORE surveys
- Ensure your trust meets standards required for effective data quality and coverage, as defined by NHS Digital in the new data quality standard.
- Review the quality of investigation reports; assess how well they meet national standards for review; address the recommendations; provide leadership and oversight for improvement by working closely with your improvement leads and frontline safety champions.

Involvement

To promote unfettered communication from 'floor-to-board', the board-level safety champion should ensure a board-level focus on improving safety and outcomes as part of improving maternity services.

- Ensure your board receives a minimum of monthly updates on national ambition trajectories and improvement priorities are identified from reviews and investigations.

- Ensure that actions to address findings or recommendations are monitored at board level through the board-level safety measures to ensure the required improvements are undertaken.
- Meet bi-monthly with your midwifery, obstetric and neonatal safety champions to enable taking action from insights, successes and barriers which need reflecting at board level
- Engage with leaders in other parts of the organisation responsible for safety and improvement to ensure alignment of all safety initiatives.
- Ensuring visibility to staff through bi-monthly walk-abouts as part of the requirements of Safety Action 9 of the CNST MIS, identifying safety concerns and ensuring action is undertaken in response to feedback from those providing and receiving care.

Improvement

Provide visible board-level leadership in support of safety and improvement initiatives to deliver safe, personalised maternity and neonatal care.

- Act as the first point of contact for the central programme team if there are issues with team engagement or improvement progress.
- Ensure staff in maternity and neonatal services get all the training, support and resources they need, drawing on safety champion walk-abouts to understand these needs.
- Support improvement initiatives that require both maternity and neonatal collaboration e.g. implementation of Neonatal Critical Care Review recommendations, PReCePT, preterm optimisation, postnatal care, Atain
- Set out clearly and publicly how the Trust is working to improve the safety of perinatal services – including those relating to COVID-19 service changes and service user feedback, taking into account the increased risk facing women from BAME backgrounds and the most deprived areas.
- Set out clearly and publicly how the Trust is working to deliver Continuity of Carer at scale for all women and families to benefit but specifically those from BAME backgrounds and most deprived areas.

Heads of midwifery and clinical directors

The head of midwifery and clinical director are leaders of midwifery, obstetric and neonatal services at Trust level, providing managerial and professional leadership of the maternity, obstetric and neonatal workforce. In partnership with the midwifery, obstetric and neonatal safety champions, they play an important role in supporting Board safety champions to represent the safety needs of their services at Trust board level.

They are responsible for:

- promoting high standards of care across maternity and neonatal services
- providing visible leadership through modelling professional behaviours in response to safety needs
- promoting a culture of multidisciplinary team-working, with joint training, briefings and handovers
- working closely with, and drawing on the insights from, those leading safety related activity within the organisation
- facilitating implementation of the *Neonatal Critical Care Review* recommendations
- supporting the provision of a seamless multidisciplinary perinatal service responsive to the needs of women, babies and their families.
- understanding the synergies between personalised care and safe care.
- acting as a conduit to share improvement priorities and best practice within the organisation.
- promoting the practical elements of transformation such as Continuity of Carer

Insight

Drawing insight and developed solutions from multiple sources of maternity safety data collected locally and system wide. Providing visible multi-professional leadership for a safety culture by bringing teams together to review and discuss

data, investigate mistakes and use them as improvement opportunities, embedding a culture of continuous learning and MDT training.

- Use regular reviews of a local dashboard to determine progress with safety initiatives and related relevant priorities.
- Support the use of a systematic, evidence-based process to calculate midwifery staffing establishment.
- Draw on findings from your midwifery and clinical workforce planning analysis to inform an action plan which meets the required standard
- Following a serious incident, support in-depth review; ensuring contributory factors are understood, action taken learning shared with all staff and impact monitored.
- As part of the review of relevant SI's, consider whether contributory factors include missed implementation of one or more of the *SBLCBv2* elements
- Support digital leadership development for the multidisciplinary team (MDT).

Involvement

Promote a positive culture by drawing on local culture surveys and gathering information from staff about how they work with each other and feel about their work.

- Support your board safety champion and non-executive director to represent key improvement priorities at the board.
- Develop and implement a unit-wide strategy to promote multidisciplinary team-working with joint training, briefings and handovers.
- Ensure staff in get the training, support and resources they need drawing on feedback from safety champion walk-abouts
- Ensure that staff trained in specialist skills (e.g. stop smoking advice and breastfeeding support) are used effectively to increase access to monitoring, intervention and interpretation to determine future needs.
- Encourage a culture of openness by ensuring that duty of candour is appropriately discharged according to national regulations.
- Ensure staff have access to mental health training, appropriate supervision and support to work with women with mental health difficulties

Improvement

Actively engaging with the MDT to support implementation of best practice and local improvement activities.

- Lead the implementation of changes to service models and clinical practice agreed by the LMS to improve safety
- Work closely with midwifery, obstetric and neonatal safety champions to develop and implement a best practice learning and development plan for the entire MDT
- Engage with maternity and neonatal safety champions and others responsible for improvement to ensure work is aligned
- Contribute to developing a ‘learning system’ and ensure that improvement actions are disseminated and shared across the organisation and, where relevant, the wider system, including on a national platform.

Data sources and guidance

The below data sources and guidance will be helpful for everyone involved in improving safety at any level.

Locally available data sources

A range of insights and data are available which should be drawn upon to inform completion of the Board level dashboard measures, of which a minimum data set can be accessed here:

- MVP and service user feedback
- Lead reporters for reviews and investigations
- Clinical risk manager and incident reporting system
- Safety champions
- The NHS Digital dashboard
- HSIB led investigations
- Reviews using the PMRT
- MBRRACE reviews
- Each Baby Counts reviews
- SI investigations
- GIRFT data
- Atain reviews
- Staff feedback from safety champion walkabouts
- Safety culture surveys (SCORE)
- Workforce needs
- Education needs
- Progress in meeting actions with each aspect of the 10 Maternity Incentive Scheme Actions

System level data sources

The data sources below provide a breakdown of data at LMS, Trust, CCG and Local Authority level:

- National Maternity Indicators
- Clinical Quality Improvement Metrics
- Regional reporting tool
- PHE Fingertips profiles
- MBRRACE-UK Perinatal Mortality Surveillance reports

National Reports

- NMPA and NNAP audit reports
- MBRRACE-UK and PMRT
- SARS-Covid UKOSS report and the MBRRACE-UK report.
- HSIB reports
- Neonatal Critical Care Review
- Each Baby Counts
- CQC reports and surveys
- National Maternity Digital Maturity report
- DHSC Annual report 2020

Additional sources of guidance

LMS Resource pack

This resource pack is designed to help Local Maternity Systems lead and manage that local transformation. It provides guidance on implementing the recommendations of Better Births that require local action, and describes national policy that will support implementation.

LMS LTP guidance

This document is to guide Local Maternity Systems (LMSs) as they work with the local system (ICS/STP) to plan for and implement the maternity and neonatal commitments within the NHS Long Term Plan. It includes details of the key

maternity and neonatal commitments; a summary of the overall funding and implementation timeline and the key enablers.

National Patient Safety Alerts

National Patient Safety Alerts are sent out by the NHS England and NHS Improvement Patient Safety Team when a new or under-recognised risk has been identified to rapidly alert frontline services on what action needs to be taken.

Generic Maternity safety Resources for champions

COVID-19 related resources

- Specialty Guide on Intrapartum Maternity Care
- RCOG Coronavirus in Pregnancy Guidance
- Saving Babies' Lives Care Bundle v2 Guidance
- NHS England and NHS Improvement Specialty Guides
- RCM Coronavirus Guidance
- RCPCH Coronavirus Guidance
- Coronavirus Infection Prevention and Control

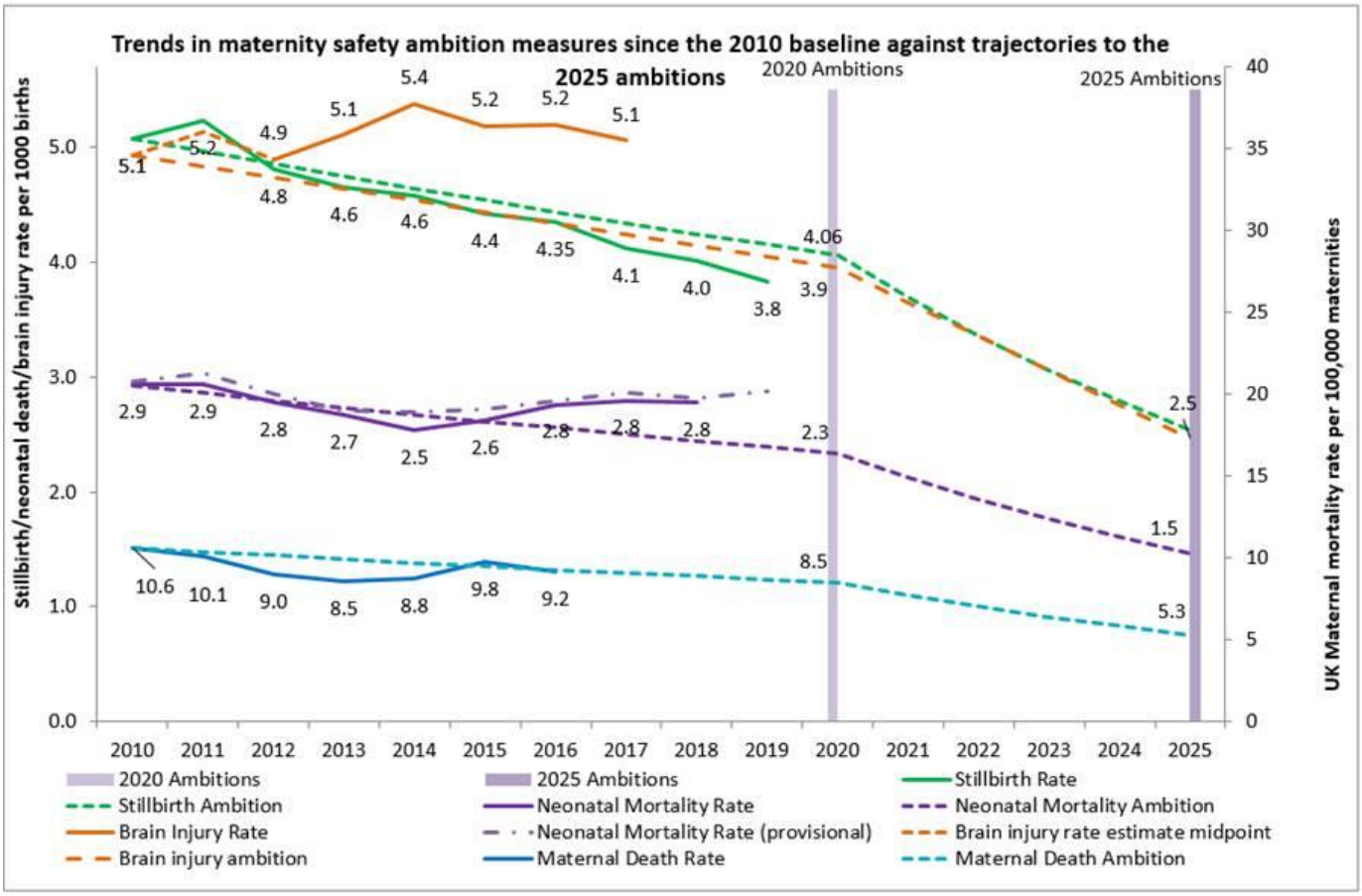
National ambition trajectories

Anyone working to promote safety should make sure they're aware of these key ambitions and the trends, so they know why and how much more needs to be done.

Our national ambition is to halve the rates of:

- stillbirth from 5.1 per 1,000 births in 2010 to 4.1 in 2020 and 2.5 in 2025
- neonatal death from 2.9 per 1,000 births in 2010 to 2.3 in 2020 and 1.5 in 2025
- intrapartum brain injuries rate from 4.9 per 1,000 births in 2012 to 4.1 in 2020 and 2.5 in 2025
- maternal deaths from a 10.6 per 100,000 maternities in 2010 to 5.3 in 2025

The pre-term birth rate ambition is to achieve a 25% reduction from an 8% ONS baseline in 2015 to 6% in 2025.



Core safety improvements

It is important that you are aware of some key activities that comprise our core safety improvements. We have summarised a number of these below.

Atain - Avoiding Term Admissions Into Neonatal units

A programme of work to reduce harm leading to avoidable admissions to neonatal units for babies born at or after 37 weeks.

Continuity of Carer

Continuity of Carer, put simply, is where maternity care is provided by midwives organised into teams of eight or less headcount, each midwife aiming to give all elements of care to approximately 36 women per year, supported by the team for out of hours care. Continuity of Carer is the best way to provide care that is safe and personalised.

The 2016 Cochrane review concluded that using a Continuity of Carer model saves babies lives, reduces interventions and improves clinical outcomes. Women receiving this care say it makes a big difference to them, and midwives enjoy providing care in this way, saying it improves their work life balance.

By undertaking this change in practice proving a programme of care that is better for midwives and women will inevitably reduce clinical error and poor outcomes. It significantly contributes to reducing health inequalities, promotes good physical and mental health, and will help achieve NHS aspiration by supporting delivery of key safety initiatives.

Each Baby Counts Learn and Support

Each Baby Counts + Learn and Support is a joint initiative between the RCOG and RCM to help improve maternity care in England. Funded by the Department of Health and Social Care until December 2021, EBC+L&S evolved from

recommendations made by the original Each Baby Counts programme and has close links with the Maternity and Neonatal Safety Improvement programme. The project is looking at issues around workplace culture and staff wellbeing, working with a number of NHS Trusts in England to develop, test and evaluate new approaches to promote a more positive and supportive workplace environment.

HSIB led Maternity Investigations

HSIB are undertaking approximately 1,000 independent maternity safety investigations to identify common themes and influence systemic change. Criteria for referral are the same as the Each Baby Counts referral criteria. All 130 NHS trusts with maternity services in England refer incidents to HSIB.

Maternity and neonatal safety champions

Safety champions work across regional, organisational and service boundaries to develop strong partnerships, promoting the professional cultures needed to deliver better care. They play a central role in ensuring that mothers and babies continue to receive the safest care possible by adopting and developing solutions for best practice. Named Board level as well as frontline maternity and neonatal safety champions have been appointed in every trust with maternity and neonatal services in England.

The Maternity Incentive Scheme

The NHS Resolution CNST Maternity Incentive Scheme applies to all acute trusts that deliver maternity services and are members of the CNST. Members contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold do not recover their contribution to the CNST maternity incentive fund, but may be

eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund

MatNeoSIP

The MatNeoSIP supports improvement in the quality and safety of maternity and neonatal units across England. MatNeoSIP was formerly known as the Maternal and Neonatal Health Safety Collaborative.

Tackling Inequalities

Mortality rates are higher Black and Asian women and their babies and for women from the most deprived areas and their babies; these health inequalities are likely to have a disproportionate impact on overall maternity outcomes. COVID-19 has further exposed some of the health and wider inequalities that persist in our society. Drawing on Marmot's principle of proportionate universalism, the NHS Long Term Plan committed to implement Continuity of Carer for most women with an enhanced and targeted Continuity of Carer model for 75% of Black and Asian women, as well as for a similar proportion of women living in the most deprived areas. Continuity of Carer models help reduce baby loss, pre-term births and improve women's experience of care. Local Maternity Systems are ideally placed to identify variation in outcomes and take action to address local population needs, including through interventions such as Continuity of Carer. A national Equity Strategy will set out a clear roadmap to improve equity in outcomes for maternity and neonatal care when it is published. Given the legal duty under the NHS Constitution for staff to 'contribute towards providing fair and equitable services', work to achieve equity in outcomes should not wait until the strategy is published.

The National Maternity Safety Strategy

Following the announcement of the national ambition to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur during or soon after birth, the government published an action plan in October 2016 outlining a number of initiatives at national level as well as practical action to build leadership at local

level to champion maternity services and support local teams. The following year the government published an updated report on progress against that initial action plan. Several steps are proposed to prevent serious incidents in maternity services.

All the initiatives outlined in these documents make up the work of the safety workstream of the MTP and are reflected in the National Maternity Safety Strategy.

The Neonatal Critical Care Review

This report sets out the actions that should be taken, who should complete them; the timetable and support available to deliver the recommendations of the Neonatal Critical Care Review. The NHS Long Term Plan has committed to new investment in neonatal services over the next 5 years to meet the action plan. It's three key commitments are focused on: developing neonatal capacity; developing the expert neonatal workforce required and enhancing the experience of families through care coordinators and investment in improved parental accommodation.

The action plan is aligned with these commitments and the "Making it happen" section sets out how to ensure delivery of the actions contained in the plan, and how to track outcomes. To support this, links are provided throughout to sources of further information.

Networked Maternal Medicine

Maternal Medicine Networks (MMN) will enable the vision for every woman in England with acute and chronic medical problems to have timely access to specialist preconceptual advice and care during and after pregnancy. The Networks will ensure that women receive specialist advice and care in the most appropriate setting, and at the right time. MMN should play a significant role in addressing maternal mortality and morbidity and in responding to findings from MBRRACE-UK and HSIB reports.

Perinatal Mental Health

A number of resources have been developed to support Improving Access to Perinatal Mental Health including a Good Practice Guide for Implementing Trauma-Informed Care in Maternity and Perinatal Mental Health Services; a coproduced Trauma-Informed Care in Maternity and Perinatal Mental Health Services webinar and a number of Health Education England resources.

The Perinatal Mortality Review Tool

The Perinatal Mortality Review Tool has been designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'. The PMRT is intended to support standardised, systematic, multidisciplinary, high quality perinatal mortality reviews across NHS maternity and neonatal units in England.

The Saving Babies' Lives Care Bundle v2

Version two of the Saving Babies' Lives Care Bundle (SBLCBv2), builds on the achievements of version one and address the issues identified in the SPiRE evaluation. It provides detailed information on how to reduce perinatal mortality across England. This second version brings together five elements of care widely recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy: CO testing for all women at booking; test through pregnancy as appropriate; identification of smokers and referral for support; all staff to be trained in VBA.

2. Risk assessment and surveillance for fetal growth restriction – focus on high risk identified at booking; focus on training staff in symphysis-fundal measurement, publication of detection rates and reviews of missed cases.

3. Raising awareness of reduced fetal movement – Raise awareness amongst pregnant women; best evidence protocols in place; evaluate compliance with national best practice.

4. Effective fetal monitoring during labour – CTG competency and Buddy system, principles for training packages, standardised risk assessment tool, regular CTG reviews and fetal monitoring lead.

5. Reducing Pre Term Birth - new element – Focus on prediction, prevention and preparation. Where women are cared for in a Continuity of Carer model preterm birth is reduced by 24%.

The second version of the care bundle includes a greater emphasis on continuous improvement with a reduced number of process and outcome measures. SBLCBv2 includes sections which reference the importance of other interventions outside of the remit of the care bundle, such as Continuity of Carer models, following NICE guidance, delivering 'healthy pregnancy messages' before and during pregnancy and offering choice and personalised care to all women. These are not mandated by the care bundle but reflect best practice care and are recommended to be followed in conjunction with the care bundle.

The British Association have developed an Antenatal Optimisation Toolkit which aligns to the 'preparation' aspect of Element 5.

Smoking cessation resources

Smoking in pregnancy is the main modifiable risk factor for a range of adverse outcomes for both mother and baby. Women who smoke during pregnancy are twice as likely to experience a stillbirth, up to 32% more likely to miscarry, and babies born to smokers are three times more likely to suffer from Sudden Infant Death Syndrome.

A number of initiatives already exist to support action in this area, including:

- The commitments in the LTP to making England a smokefree society
- Element 1 of the SBLCBv2 which is one of the five primary clinical drivers of the MatNeoSIP
- A one-off fund of £150K saw an increase of 598 more midwifery staff across a range of providers trained to support women to have a smoke free pregnancy.

Standardising Investigation

The development of an introductory Patient Safety Incident Response Framework responds to calls for a new approach to Serious Incident management which facilitates inquisitive examination of a wider range of patient safety incidents “in the spirit of reflection and learning” rather than as part of a “framework of accountability”. The framework supports a systematic, compassionate and proficient response to patient safety incidents; anchored in the principles of openness, fair accountability, developing solutions and continuous improvement.

At the heart of this work is the ambition to refocus systems, processes and behaviours to ensure responses deliver effective and sustainable reduction in risk, rather than simply applying a reactive, bureaucratic process that too often does not lead to change.

Safety as a Golden Thread

As mentioned above, safety is the golden thread that runs through our approach to maternity care. This section looks at key safety improvement activities underway under each of the workstreams that comprise our national Maternity Transformation Programme.

Workstream 1- Supporting local transformation

Continuity of Carer

Women who receive Continuity of Carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth[1]. Fewer women require episiotomies or instrumental births. In addition, maternal experience is enhanced where women are more likely to be cared for in labour by midwives they already know.

A planned phased rollout of Continuity of Carer of to update with new trajectories post-COVID 35% by 2020 and most by 2021 is underway. 75% of Black/Black British and Asian/Asian British women and those from the 10% most deprived neighbourhoods will receive Continuity of Carer by 2024. It is anticipated that this will expedite the impact on reducing maternal and neonatal mortality and morbidity.

Networked Maternal Medicine

Maternal Medicine Networks (MMN) will ensure that women receive specialist advice and care in the most appropriate setting, and at the right time. MMN should play a significant role in addressing maternal mortality and morbidity and in responding to findings from MBRRACE-UK and HSIB reports.

Workstream 3 - Choice and personalisation

The Better Births vision is personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine

[1] https://www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early

choice informed by unbiased, evidence-based information and supported by digital tools.

Personalisation, based on a robust and continued assessment of a woman's circumstances and choices based on a relationship of trust between the woman and her clinicians, is a vital prerequisite for safe care. A Personalised Care and Support Plan can be used to record the conversations which have led to an informed decision.

Following the landmark *Montgomery vs Lanarkshire* Judgement the definition for informed consent has changed so that doctors must provide information about all material risks; they must disclose any risk to which a reasonable person in the patient's position would attach significance.

Workstream 4 - Perinatal mental health

Around one in five women experience mental health problems in pregnancy and during the 24 months after giving birth. Access to specialist perinatal mental health community services have been expanded and play an important role in reducing maternal mortality where MBBRACE-UK reports have identified that more than two thirds of women who died had pre-existing physical or mental health problems.

New Maternity Outreach Clinics will provide integrated models of care between maternity, reproductive health and psychological therapy for women who experience mental health difficulties that arise within the maternity context eg PTSD following birth and perinatal loss.

Workstream 5 - Workforce

Ensuring we have the right numbers of doctors, midwives, nurses and other professions and support workers is essential to delivering safer care.

The Maternity Workforce Strategy[2] supports the MTP to deliver the vision set out in Better Births and the national ambition. The purpose of the strategy is to support services in making the required changes, whilst ensuring that there is sufficient

[2] https://www.hee.nhs.uk/our-work/maternity/maternity-workforce-transformation-strategy

capacity in the workforce nationally. It includes a number of initiatives to address maternity and neonatal workforce needs, including an additional 3,650 midwifery training placements, increasing neonatal nurse capacity and the development of workforce planning tools to support LMS. The Interim People Plan[3] and final People Plan is currently considering the national maternity and neonatal workforce requirements for the Long-Term Plan period.

Workstream 6 - Data

The aim of this workstream is to improve data and information collection, quality and developing solutions to drive maternity service improvement at local, regional and national levels. The objectives for achieving this aim include ensuring the Maternity Services Data Set is fit for purpose; informing the Quality Improvement Metrics and National Maternity Indicators; ensuring data is presented in a way that promotes understanding and helps identify unwarranted variation and enhancing clinical outcomes and promote safety through using data systems intelligently and ensuring information is shareable.

Workstream 7- Harnessing digital technology

The aim of the digital work stream is to ensure that all maternity records in England can be accessed digitally by both professionals and women, and that women have access to the right, unbiased information that enables them to receive a service in which there is choice, personalisation and safety. The objectives for achieving this aim are twofold: that national bodies, providers and commissioners are supported to roll out access to digital maternity records for professionals and women across England and secondly that all women in England have access to a digital maternity tool which can be used to support them during and after pregnancy.

Workstream 8 - Maternity payment system

The aim of the workstream is to deliver a maternity payment system that appropriately reimburses providers for delivering efficient, safe and high-quality maternity care whilst supporting integrated personalised care and facilitating patient choice.

[3] https://improvement.nhs.uk/resources/interim-nhs-people-plan/

Workstream 9 - Prevention

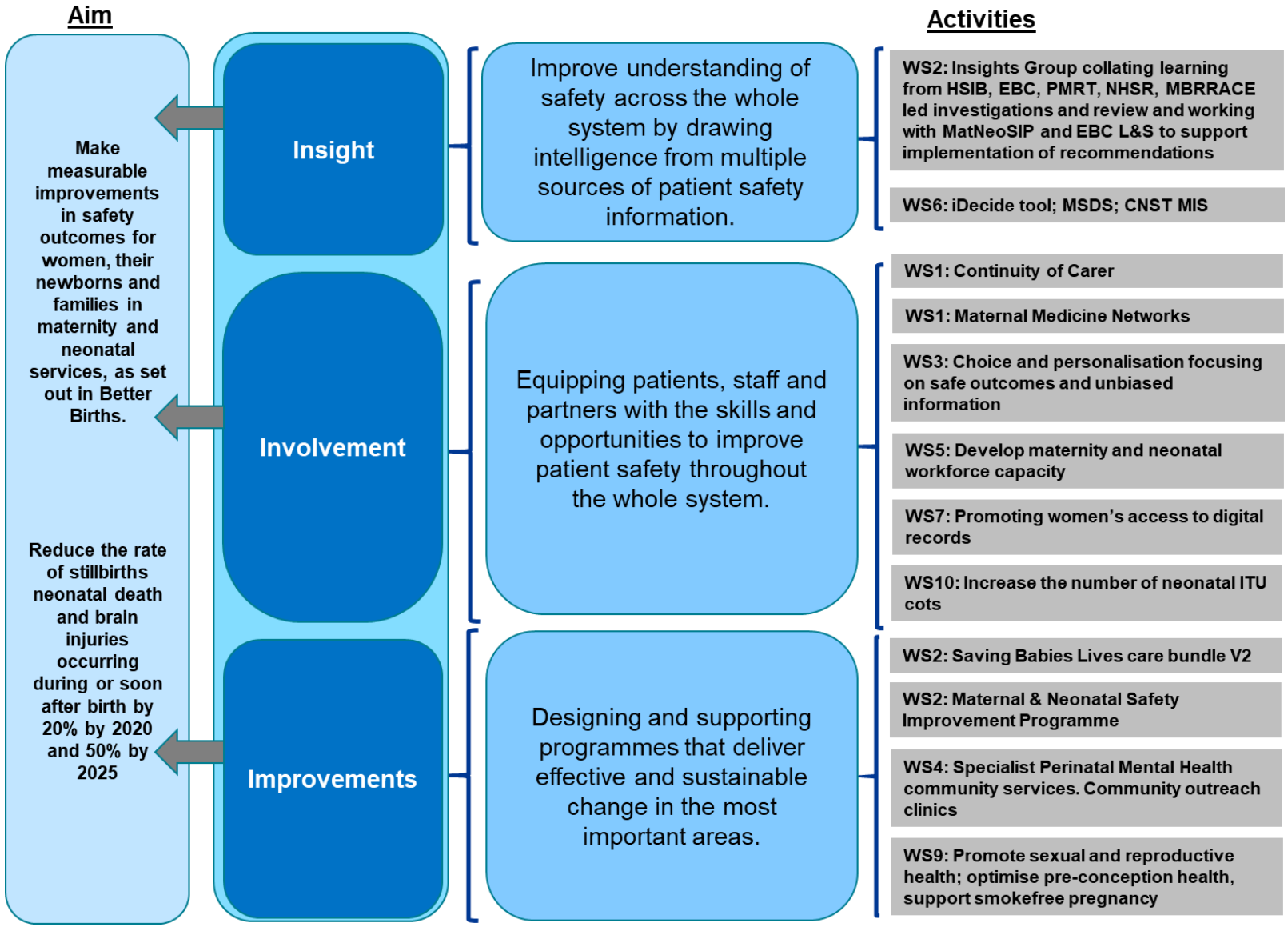
Focusing on improving long term outcomes by adopting a life-course approach; promoting sexual and reproductive health particularly in relation to family planning; optimising pre-conception health, supporting smoke free pregnancy and addressing perinatal mental health needs are major areas for focus within a large prevention agenda.

Workstream 10 - Neonatal

The NHS Long Term Plan committed to new investment over the next 5 years to meet the action plan for delivering the recommendations of the *Neonatal Critical Care Review*. Its three key commitments are focused on:

1. Developing neonatal capacity: redesigning and expanding neonatal critical care services to further enhance safety, effectiveness and the experience of families, to improve neonatal capacity and triage within expert maternity and neonatal centres.
2. Further developing the expert neonatal workforce required: extra neonatal nurses and expanded roles for some allied health professionals to support clinical care.
3. Enhancing the experience of families through care coordinators and investment in improved parental accommodation.

Safety as the golden thread across the Maternity Transformation Programme



Glossary

A-EQUIP (advocating for education and quality improvement)

Atain: an acronym for ‘avoiding term admissions into neonatal units’

CNST: Clinical Negligence Scheme for Trusts

CPD: continuing professional development

CQIM: clinical quality improvement metrics

EBC: Each Baby Counts

EBC L&S: Each Baby Counts Learn and Support

ePHR: electronic personal health record

HSIB: Healthcare Safety Investigation Branch

LMS: local maternity systems

LTP: NHS Long Term Plan

MatNeoSIP: Maternal and Neonatal Safety Improvement Programme

MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

MDT: multidisciplinary team

MIS: Maternity Incentive Scheme

MVP: maternity voices partnerships

NHSR: NHS Resolution

NHSR ENS: NHS Resolution’s Early Notification Scheme

NMI: national maternity indicators

NMM: Networked Maternal medicine

NPSCP: National Patient Safety Communities of Practice

PHE: Public Health England

PMRT: Perinatal Mortality Review Tool

PReCePT: Preventing cerebral palsy in preterm babies

SBLCBv2: Saving Babies Lives Care Bundle version 2

SI: Serious Incident