Department of Health & Social Care

NHS

Safer Maternity Care

Progress Report 2021

Contents

Acronyms

Atain - Avoiding term admissions into neonatal units

BAME - Black, Asian and Minority Ethnic

CCG – Clinical Commissioning Group

CN - Clinical Networks

CNST - Clinical Negligence Scheme for Trusts

CQC - Care Quality Commission

DHSC - Department of Health and Social Care

EBC - Each Baby Counts

EBC + L&S - Each Baby Counts and Learn and Support

e-LfH - e-Learning for Healthcare

EN - NHS Resolution’s Early Notification Scheme

HEE - Health Education England

HIE - Hypoxic Ischaemic Encephalopathy

HQIB - Healthcare Quality Improvement Partnership

HSIB - Healthcare Safety Investigation Branch

L&S - Learn and Support

LMNS Local Maternity and Neonatal Systems

LMS - Local Maternity Systems

MatNeoSIP - Maternity and Neonatal Safety Improvement Programme

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

MEWS - National Maternal Early Warning Score

MIS - Maternity Incentive Scheme

MMN - Maternal Medicine Networks

MMR - Maternity Mortality Rates

MSDS - Maternity Services Data Set

MSWs - Maternity support workers

MTP - Maternity Transformation Programme

MVP - Maternity Voices Partnership

NCCR - Neonatal Critical Care Transformation Review

NCT- The National Childbirth Trust

NHSE - NHS England

NHSI - NHS Improvement

NHSR - NHS Resolution

NIB - Neonatal Implementation Board

NICU - Neonatal Intensive Care Unit

NMPA - National Maternity and Perinatal Audit

NNU - Neonatal Unit

ODN - Operational Delivery Network

ONS - Office for National Statistics

PIER - Prevention, Identification Escalation and Response

PMCB - Personal Maternity Care Budgets

PMRT - Perinatal Mortality Review Tool

PReCePT – Prevention of Cerebral Palsy in Pre-Term Labour)

QI - Quality Improvement

QIS - Neonatal Qualified in Speciality

RCM - Royal College of Midwives

RCOG - Royal College of Obstetricians and Gynaecologists

RDU - Cabinet Office Race Disparity Unit

SANDs - The Stillbirth and Neonatal Death charity

SBLCB - Saving Babies' Lives Care Bundle

SC - Special Care

SIDS - Sudden Infant Death Syndrome

SMI - Severe Mental Illness

TC - Transitional Care

UKOSS - UK Obstetric Surveillance System

VBA - Very Brief Advice

Foreword from the National Maternity Safety Champions, Dr Matthew Jolly and Professor Jacqueline Dunkley Bent

The safety of pregnant women and their babies is and will always be an absolute priority for the National Health Service. Since the announcement of the National Maternity Safety Ambition in 2015 and our appointment as National Maternity Safety Champions, we have been heartened by the determination and commitment that exists across the whole system to deliver on this ambitious yet important goal.

This Safer Maternity Care Report offers an opportunity to reflect on what has been achieved in working towards our ambition by everyone involved in caring for and supporting women and babies. We would like to thank all those clinicians, commissioners, campaigners, charities, managers, mothers, Maternity Voices Partnerships, and many more who have made essential contributions to the progress we have seen since the landmark Better Births report was published in 2015.

Despite our achievements there is still much work to be done in order to meet the National Ambition and we need to use all the learning from the past few years to refine our maternity safety strategy. As National Maternity Safety Champions we believe that our maternity services have people with the talent and determination to continue to improve maternity care for all who use our services in England.

This report describes many initiatives spanning all aspects of maternity care. It is the collective impact from implementing each of these elements of best practice that has led to significant improvements in some important outcomes such as the reduction in the stillbirth rate. The data, however, highlight some areas where outcomes are disproportionately poor, particularly in the case of women from deprived or Black Asian and Minority Ethnic backgrounds. It is increasingly clear that to simply achieve equality of service to all is not enough. To achieve true equity, we need to embrace the principles of proportionate universalism so that the needs, experiences and outcomes of the most vulnerable women using maternity services are recognised and acted upon. The Continuity of Carer model provides a mechanism whereby midwives can gain a holistic understanding of women’s needs and triage women to the new forms of best practice care such as elements of the Saving Babies Lives Care Bundle or access to our evolving Maternal Medicine Networks (MMN).

It is only possible to deliver outstanding care where there is a departmental culture that values the diversity of its people and recognises the benefits of harmonious, respectful multidisciplinary teamwork. A safe and fair culture allows staff to reflect on where care could have been better and share the learning. One of our challenges is to understand how we build departments where these behaviours and values are embedded. We need to identify and minimise the stresses that cause teams to function poorly and develop a culture which nurtures cohesive very high performing teams. We recognise that there is an important link between departmental culture and clinical quality. We are developing a more sophisticated safety governance infrastructure based on combining data with intelligence from service users, deaneries, Healthcare Safety Investigation Branch (HSIB), the Care Quality Commission (CQC) and staff surveys which will identify earlier Trusts that are struggling to consistently provide high-quality care

We are committed to putting women at the centre of decision making and believe it is essential that women are included, listened to and given all the necessary information to be fully empowered and supported to make informed decisions about their pregnancy and birth. An approach made clear by the Montgomery ruling in 2015. By supporting and ensuring women's autonomy in maternity services, we can support the provision of world-class safe and personalised maternity care. That is why the Maternity Transformation Programme is developing a consent tool to enable women to exercise their autonomy and make informed choices about their care during childbirth.

We believe that the combination of these initiatives, while not exhaustive, will help to further drive improvements in maternity services so that we continue to ensure that England remains one of the safest places in the world to be pregnant, give birth and transition into parenthood.

Foreword from Nicky Lyon, User co-chair Maternity Transformation Programme Safety Workstream and Mum of Harry

The announcement of the National ‘Halve It’ Ambition in 2015 was a huge day for me as a bereaved parent. The fact that the Government committed to improving maternity safety, reducing deaths and brain injuries was amazing.

In 2008, when my son Harry was left profoundly brain-damaged following full-term labour, we knew instinctively our care had not been good, but we were not even invited to have any input into the internal investigation that was carried out. This situation is now changing, with the introduction of the Perinatal Mortality Review Tool and independent Healthcare Safety Investigation Branch investigations. Families are increasingly being invited to be part of the reviews and this is how it should be.

Harry died of his injuries aged 18 months. As a family we were left devastated. I knew I had to act and I’m now having my voice heard, having been asked in late 2018 to co-chair the Maternity Transformation Programme Safety Workstream. These meetings bring together the national organisations involved in maternity safety. I speak on behalf of users to try to ensure the NHS provides the best care for mothers and babies. All across the country users are also working with their local maternity systems to improve care, experience and outcomes for mothers and babies.

This report outlines the significant progress that has been made and the extensive work programme that is still to come, such as MMN centres and investment in neonatal care. Media reports of avoidable harm and the numbers of families coming forward to the current independent investigations, however, have been distressing and this must never happen again. There needs to be sufficient oversight and all clinicians must feel able to raise concerns and be confident that these will be acted upon. When findings, themes and recommendations come from investigations they must be actioned and solutions implemented to ensure errors are not repeated.

Women and families deserve consistently good care, day or night, weekday or weekend throughout the country. For this to happen, I believe we must ensure that all maternity professionals get world class training, work together with a common goal, that all units have the right staffing and all the resources needed. In short, clinicians should be supported to do the best job they can; this is good for staff and good for users.
Already the result of the huge team effort to improve safety in maternity is being seen, with a 25% reduction in stillbirths. This means that already hundreds of babies lives are being saved each year.

It would be truly amazing if by 2025 maternity and neonatal teams across the country had halved the deaths of mothers and babies and cases of brain injury – lives saved, lives

transformed.

Foreword from Eddie Morris President of Royal College of Obstetricians and Gynaecologists (RCOG) and Gill Walton, CEO Royal College of Midwives (RCM)

Making maternity services safe is all about relationships – how we cooperate, collaborate and who we form partnerships with. Working multi-professionally, breaking down barriers between midwives, obstetricians and other professionals, and in partnership with women and their families is critical for the delivery of safe and personalised care.

The RCM and RCOG are committed to working together, as two national organisations speaking with one voice, to bring about positive improvements in maternity care, both for women and families and for the staff who work in maternity services. We know how important lasting cultural change in multi-professional working, learning and leadership are for the development of safe and improving maternity services and for achieving the National Maternity Safety Ambition.

We also know that problems of culture are implicated in many instances of poor outcomes. Evidence from the Healthcare Safety Investigation Branch and NHS Resolution's Early Notification Scheme has highlighted how deficits in culture can be associated with staff who are afraid of asking for help or advice, are afraid of communicating their concerns to a more senior person or who blame or bully individuals. Unfortunately, disagreements and divergences between midwives and obstetricians and conflicts over professional boundaries are still present in some maternity units and poor culture is also often associated with poor implementation of training and improvement initiatives.

It does not have to be this way. Multi-professional teams can positively contribute to supportive workplace cultures, through mutually respectful team relationships, articulating a shared vision and common purpose and through a commitment to shared decision making. The delivery of multi-professional learning, as well as understanding the scale of multi-professional training and learning can also exert positive changes in culture. Like multi-professional working, strong and effective leadership is an essential pre-requisite for safe, high quality maternity care and is a key determinant of the organisational culture in which front line teams operate.

When all of these individual elements come together you will find excellent and safe services, where staff are empowered to work to the best of their abilities in a system that values and supports them, in order to provide the best possible care for women and their families.

This is particularly true in the context of the response to COVID-19, where rapidly adopted changes to ways of working and service delivery undoubtedly placed stress on frontline maternity staff. Nevertheless, in many areas strong leadership and positive relations between midwives and obstetricians have allowed teams to respond quickly, to introduce and measure change safely and at pace.

We welcome this Progress Report, which provides a timely update on the many initiatives undertaken to improve the safety of maternity care, as well as focussing on key areas where more still needs to be done.

Executive summary

This report provides an update on overall progress in meeting the National Maternity Safety Ambition and implementing the range of initiatives designed to improve outcomes for mothers and babies since 2015.

This report also celebrates the widespread collaboration by multi-professional and multi-disciplinary teams across the entire health system in reducing harm and saving the lives of hundreds of babies and women and continuing to do so during the COVID-19 pandemic.

In 2015, the Secretary of State for Health set a challenging ambition to halve the 2010 rates of stillbirths, neonatal deaths, maternal deaths and brain injuries in babies that occur during or soon after birth by 2030, with an expectation of a 20% reduction by 2020. In 2017, the government brought forward this ambition to 2025 and extended it to include a reduction in the national rate of pre-term births from 8% to 6% by the same year.

To achieve the 'Halve It' ambition, we need to improve care for populations most at risk of poor outcomes and we all play a critical role in driving this priority. Whilst mortality rates are reducing for the population overall, stark health inequalities persist. We know that maternal mortality is more than four times higher for Black women and almost twice as high for Asian women (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) 2021). Stillbirth rates and neonatal death rates are also higher in these groups of women. The 2020 UK Obstetric Surveillance System (UKOSS) report showed that 56% of pregnant women admitted to hospital with COVID-19 were from a Black, Asian and Minority Ethnic (BAME) background; improving care for these women has become a priority for maternity services across England.

The Department of Health and Social Care (DHSC) has been working closely with NHS England and NHS Improvement (NHSEI), the Royal Colleges, NHS Resolution (NHSR), the HSIB and other health system partners to support the implementation of policy initiatives aimed at making maternity and neonatal services in England the safest in the world.

As a result of the enormous efforts made by clinical professionals and support staff working in acute and community maternity and neonatal services, many more women and babies are being supported to have a healthy pregnancy, labour and birth and a healthy postnatal period, in which physical and mental wellbeing is promoted. This is an even more exacting challenge in the light of COVID-19.

COVID-19 has had an impact on maternity services, and NHS staff have been working tirelessly to care for both infected and uninfected women in acute settings and in the community, doing all they can to keep mothers and babies safe.

Some initiatives have been suspended to take as much burden off NHS trusts as possible during the pandemic, so that local systems can focus their efforts on the safe delivery of frontline care. This has resulted in a temporary pause or delays in implementing some of the interventions set out in this report. However, we are now working towards resuming all interventions albeit with revised timescales. We also need to simultaneously respond to ongoing COVID-19 needs and maintain COVID-19 innovations that have been considered to be effective.

Providers and commissioners across NHS trusts, Local Maternity Systems (LMS) and Clinical Networks (CN) have collaborated by establishing new structures and processes to share information, best practice and innovative ways of delivering safe and responsive maternity services and addressing the unique challenges in their communities. They have worked closely with service users, including over 100 Maternity Voice Partnerships across England to ensure that maternity services are responding to what women and their families need and want.

The Maternity Transformation Programme (MTP) provides the infrastructure for delivering the recommendations from 'Better Births'; the Neonatal Critical Care Review (NCCR) and the Government's National Maternity Safety Ambition. This report focusses on the progress made across the MTP, where safety is the golden thread running through the programme.

We also review progress against the trajectories for each of the five elements of the National Maternity Safety Ambition as we have now surpassed the halfway point between the ambition's launch and the goal for 2025.

Overall, while the outcome data shows that maternity and neonatal services are making real progress, there is no room for complacency, and we know that unacceptable variations in the quality of care and outcomes remain. We are putting in place specific, focused support for challenged areas, and are working to further improve oversight and escalation processes to identify concerns about the quality of care.

Through your hard work, we have implemented a range of Maternity Safety Strategy interventions and developed an architecture across the entire system that we can use for further improvement, such as better data collection, quality improvement support and improved tools and processes for incident reviews and investigations. There are key areas that we need to continue to develop including organisational leadership and addressing poor culture, board capabilities, care pathways, and teamworking across different disciplines.

The Ockenden Review published on 10 December 2020, set out initial findings from the independent review of the maternity services at the Shrewsbury and Telford Hospital NHS Trust. The Report highlighted the importance of strengthening leadership and oversight for maternity, addressing toxic workplace culture and fostering more collaborative approaches in maternity and neonatal services.

Following publication of the report, NHSEI wrote to NHS Trust and Foundation Trust Chief Executives and Chairs, setting out the immediate response required of all Trusts providing maternity services and next steps to be taken nationally.

In addition, in January 2021, DHSC announced a new £500,000 fund for Maternity Leadership Training for NHS maternity and neonatal leaders. The training aims to equip leaders with a range of skills and knowledge to address poor workplace culture and facilitate collaborative working between nurses, doctors, midwives and obstetricians. The training will aim to apply lessons learned both from the pandemic and maternity safety inquiries, including a key issue identified in the Ockenden Review regarding disconnect between 'ward and board'.

The inspiring progress made in improving the safety of maternity and neonatal care in the last five years could not have been achieved without the support and commitment from teams in NHS trusts across the country. With your continued efforts and collaboration, we can continue to make the strides needed to achieve the National Ambition by 2025.

Key messages

- Since 2010, the stillbirth rate in England has decreased by 25% and is ahead of the target to meet the 2020 ambition. The number of stillbirths is more than 750 fewer than if the rate had stayed the same.

- The neonatal mortality rate in England across all gestational ages increased to a rate of 2.8 deaths per 1,000 live births in 2018, after falling to a low of 2.5 deaths per 1,000 live births in 2014. However, since 2014, this neonatal mortality rate increased to a rate of 2.8 deaths per 1,000 live births in 2017 but has reduced to 2.7 in 2019. The Office for National Statistics (ONS) reported that a small increase in the number of babies born alive at under 24 weeks gestation is contributing to this trend. Therefore, from now on we will measure progress against the neonatal ambition using deaths occurring in babies born from 24+0 weeks gestation onwards. The neonatal mortality rate for babies born from 24 weeks gestation onwards shows a 29% reduction in the rate between 2010 and 2019.

- The pre-term birth rate has remained at around 8% of all births since 2013. Reducing preterm births was added to the ambition in 2017 and the Saving Babies Lives Care Bundle (SBLCB) has been revised to include a new initiative to address this.

- The overall rate of brain injuries occurring during or soon after birth has fallen to 4.2 per 1,000 births in 2019, since rising from 4.2 to 4.7 per 1,000 births between 2012 and 2014. The rate of infants with hypoxic ischaemic encephalopathy has fallen by 15% between 2014 and 2019.

- We may be on course to meet the 2020 target to reduce maternal morbidity however efforts will need to increase to meet the ambition for 2025. Additional initiatives, with a focus on addressing inequalities, are underway including Continuity of Carer, MMN and support for better perinatal mental health.

- There remains a more than four-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds, a three-fold difference amongst women of mixed ethnicity and almost a two-fold difference amongst women from Asian ethnic backgrounds compared to white women (MBRRACE-UK 2021), emphasising the need for a continued focus on actions to address these disparities. Work to improve equity is being led by the Chief Midwifery Officer.

- There is an expectation for provider trusts to clearly and publicly articulate how they are 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 Black, Asian and minority ethnic backgrounds and the most deprived areas.

- Implementation of Maternity Safety Strategy initiatives has been staggered over the last three years. Some initiatives aimed at addressing mortality, such as MMN and the NCCR recommendations, are only now beginning to be implemented, meaning that the impact of many initiatives is still to be realised.

- Through commitments outlined in the NHS Long Term Plan (January 2019) and The NHS Patient Safety Strategy (July 2019), efforts to implement key safety initiatives will be maintained.

Chapters

1. Progress on the National Maternity Safety Ambition outcomes: this chapter reviews progress made in meeting the National Ambition, including elements of the ambition that are on track and those which may require more research or a greater focus on improvement activities.

2. Maternity Safety Strategy Initiatives - what has been achieved? this chapter focuses on achievements under three themes relating to culture change, specific safety initiatives and system enablers, focusing on their impact on the provision of high-quality clinical care.

3. Next steps: this chapter sets out what action is needed to meet the National Ambition, including continued and furthered commitment to deliver the initiatives that are moving from the planning stages to implementation, through the NHS Long Term Plan and Patient Safety Strategy, supported by new resources co-produced in light of COVID-19.

1. Progress on National Ambition outcomes

Overall, the outcomes data shows that real progress is being made in meeting the National Maternity Safety Ambition.

The changing maternity and neonatal landscape, scale of change, staggered approach to implementation of initiatives, wide range of initiatives and the complex interactions between these are important considerations in determining progress to date, an even more exacting challenge in the light of COVID-19.

Whilst mortality rates are reducing for the population overall, stark health inequalities persist (MBRRACE-UK 2021). We know that maternal mortality is more than four times higher for Black women, three times higher for mixed ethnicity and almost twice as high for Asian women. Stillbirth rates and neonatal death rates are also higher in these groups of women. The 2020 UKOSS report showed that 56% of pregnant women admitted to hospital with COVID-19 were from a BAME background; improving care for these women has become a priority for maternity services across England.

Two factors provide important context when interpreting progress with meeting the ambition:

- two to three-year time lags in publishing national maternal and perinatal mortality data where latest rates do not reflect efforts in the months/years since that period; and

- the time lag between implementation and the impact of interventions being realised. Crude estimates suggest it takes one and a half years to implement an initiative, one year to embed the intervention and two years across which the impact would be seen.

Drawing on these caveats, Table 1 below sets out the key safety initiatives and the expected timeframes to see an impact on the national ambition outcomes.

Table 1: Maternity Safety Programme Initiatives and their expected impact time frame on the government's ambition elements

Intervention	Announced	Implementation	Embed	Expected Impact	Stillbirth	Neonatal Mortality	Maternal Mortality	Brain Injuries	Pre-term birth
Maternity Safety Champions	2016	2017	2019	2020-22	✓	✓	✓	✓	✓
Saving Babies' Lives Care Bundle v1	2016	2016-17	2017-18	2018-19	✓	✓			
Maternity Safety Training Fund	2016	2017-18	2018-19	2019-21	✓	✓	✓	✓	✓
Maternal Mental Health Mother & Baby Units and Community Services	2016	2017-18	2018-19	2019-21			✓		
Perinatal Mortality Review Tool	2016	2018-19	2019	2020-22	✓	✓			✓
MATNEO SIP QI Programme	2016	2017-18	2018-19	2019-21	✓	✓	✓	✓	✓
NHSR Early Notification Scheme	2016	2017-18	2019	2020-21				✓	
Saving Babies' Lives Care Bundle v2	2017	2018-20	2020-21	2021-23	✓	✓			✓
Increasing Smoking Cessation Advisors	2017	2018-20	2021	2021-23	✓	✓	✓		✓
Maternal Medicine Networks	2017	2020-21	2021-22	2022-24			✓		✓
Neonatal Critical Care Review Implementation	2017	2020-21	2021-22	2022-24	✓	✓		✓	
NHSR CNST Maternity Incentive Scheme	2017	2018-19	2019-20	2020-22	✓	✓	✓	✓	✓
HSIB Maternity Investigations	2017	2018-19	2019-20	2020-22	✓	✓	✓	✓	
Each Baby Counts Learn & Support	2017	2018-19	2020-21	2022-24	✓	✓		✓	✓

Stillbirths

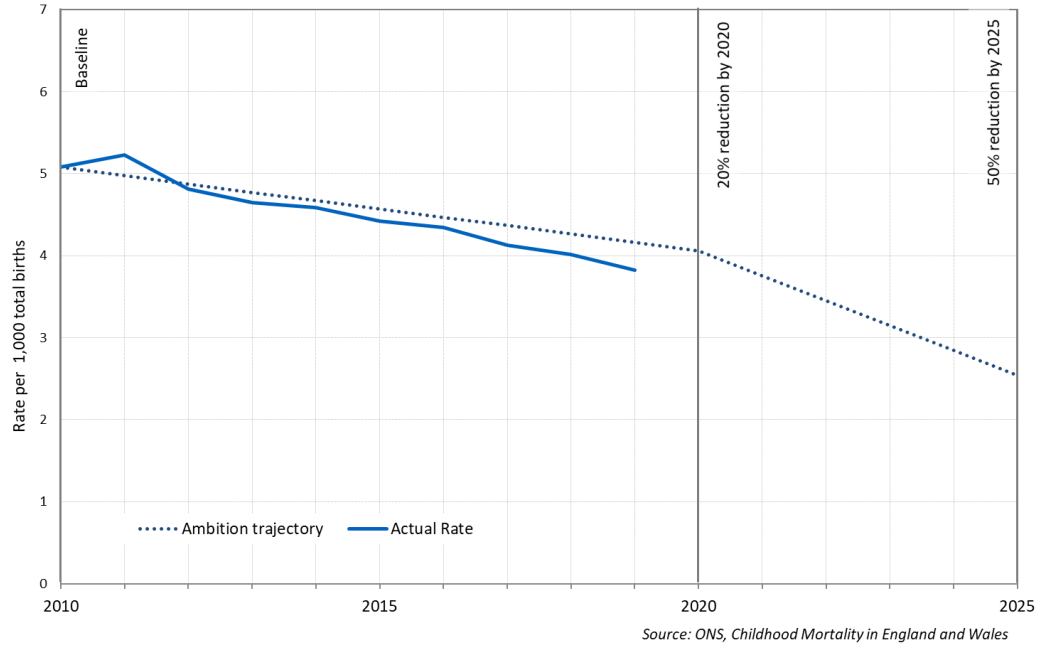
The government's National Ambition is to halve the rate of stillbirths from a 2010 baseline by 2025, with a 20% reduction by 2020, reducing the rate from 5.1 per 1,000 births in 2010 to 4.1 in 2020 and 2.5 in 2025.

Chart 1 shows that since 2010, the stillbirth rate has fallen from 5.1 stillbirths per 1,000 births to 3.8 stillbirths per 1,000 births in 2019, a 25% reduction in the stillbirth rate and is ahead of target to meet the 2020 ambition. The number of stillbirths is more than 750 fewer than if the rate had stayed the same, meaning that already hundreds of babies' lives are being saved each year.

In December 2020 MBRRACE-UK reported that the largest reduction in deaths is seen for stillbirths at 37+0 to 41+6 weeks, with a fall in mortality rates of almost one quarter (24.4%) over the five year period, and this is likely to reflect initiatives in place across the UK focusing on the reduction of term stillbirths.

Good progress is being made in reducing term stillbirths, with the revised version of the SBLCB including a specific focus on preterm stillbirth prevention by focussing more attention on pregnancies at highest risk of Fetal Growth Restriction. It is anticipated that the pace of reducing the rate of stillbirths will increase as interventions continue to embed.

Chart 1: Stillbirth rate trend for all births in England since 2010



Neonatal deaths

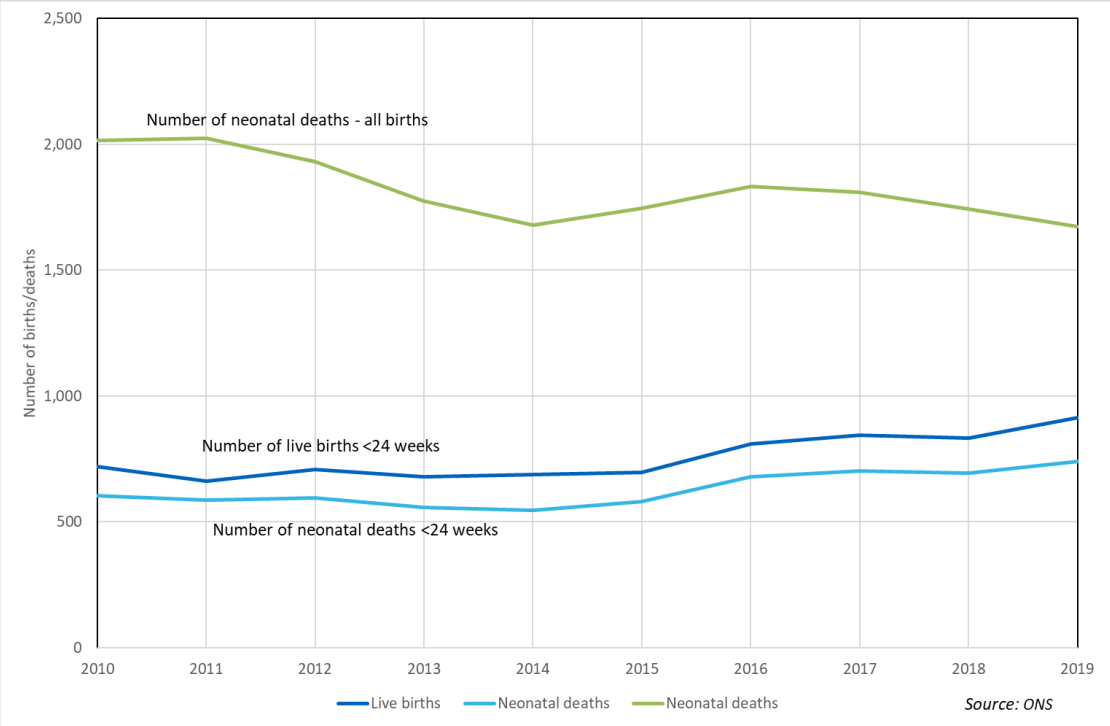
The neonatal mortality rate in England across all gestational ages increased to a rate of 2.8 deaths per 1,000 live births in 2018, after falling to a low of 2.5 deaths per 1,000 live

births in 2014. However, since 2014, this neonatal mortality rate increased to a rate of 2.8 deaths per 1,000 live births in 2017 but has reduced to 2.7 in 2019.

The ONS reported that one factor contributing to the trend in the neonatal mortality rate has been a small increase in the number of babies born alive at under 24 weeks gestation, despite a decrease in the overall number of births. In 2019, the proportion of live births where gestational age was under 24 weeks increased to 0.15% compared with 0.13% in 2018 and 0.10% in 2010. Sadly, these extremely premature babies are likely to only survive a short time with 84.0% of all the neonatal deaths of babies born below 24 weeks gestation occurring within a day of the birth.

Chart 2 shows that the increase in live births and neonatal deaths under 24 weeks gestation in England corresponds with the increase in the overall neonatal death rate since 2014.

Chart 2: Pre-24-week live births and neonatal deaths and all neonatal deaths in England since 2010



One potential explanation for these trends is that more very pre-term babies are being classified by health practitioners as live births, whereas in the past they may have been classified as a late fetal loss.

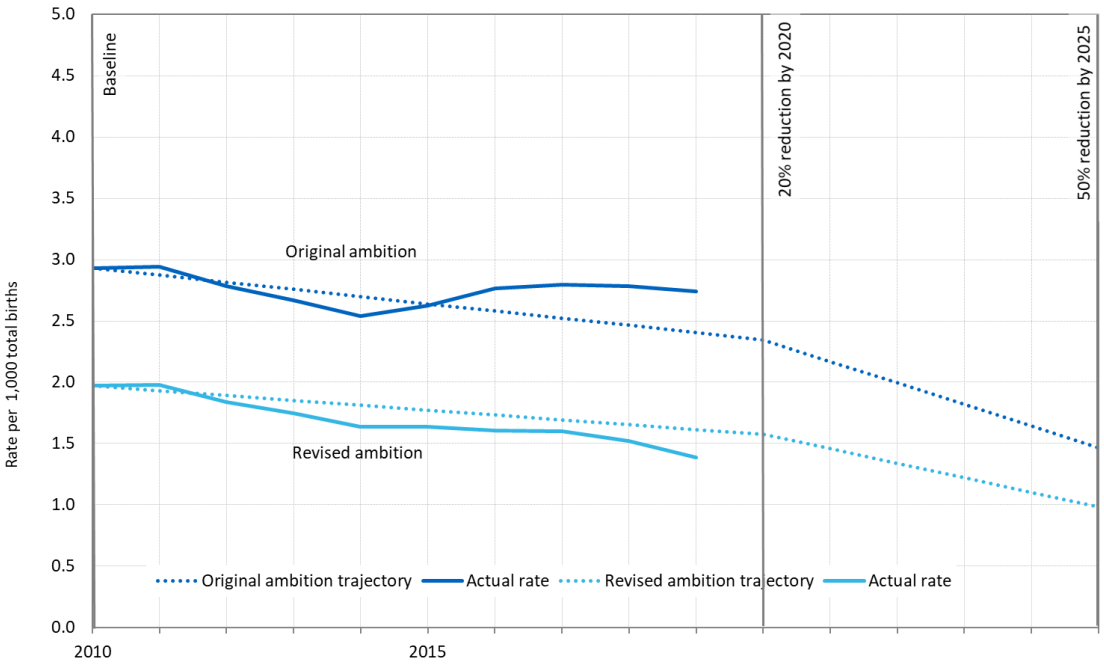
Work is well underway to address the need for clear guidelines for health practitioners on assessing signs of life to support consistent decision making about birth classification. MBRRACE-UK have developed guidance (November 2020) to support health care

professionals in the assessment and documentation of signs of life in extremely preterm births. The guidance aims to reduce the confusion and distress experienced by parents and increase the consistency of the registration of births and deaths.

Due to the impact of the changes and current variation in clinical practice, we consider it is no longer accurate to measure progress against the National Ambition using the current approach. Therefore, from now on we will measure progress against the neonatal ambition using deaths occurring in babies born from 24+0 weeks gestation onwards.

Chart 3 shows that from 24 weeks gestation the neonatal mortality rate has reduced by 29% from 2.0 deaths per 1,000 live births in 2010 to a rate of 1.4 deaths per 1,000 live births in 2019.

Chart 3: Neonatal mortality rate trend in England since 2010



Source: ONS, Childhood Mortality in England and Wales and bespoke analysis

We will still be able to monitor the trends for babies that are born under 24 weeks gestation. MBRRACE-UK will continue to conduct surveillance of all late fetal losses (22+0 to 23+6 weeks gestational age), and from February 2021 ONS has started publishing their neonatal data broken down by gestational age in their annual Child and infant mortality in England and Wales release.

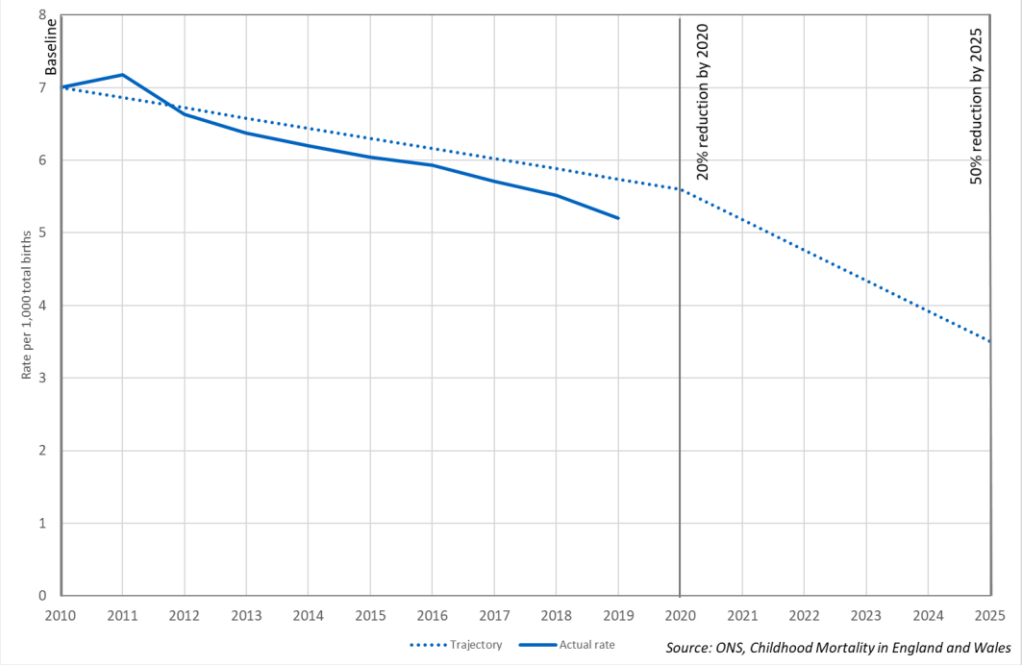
In addition, the independent Pregnancy Loss Review (commissioned by DHSC) is expected to be publish its findings later this year. The Review has successfully engaged with a range of stakeholders including baby loss charities, parents with lived experience of pregnancy loss, registrars and clinicians. The Review will make recommendations to

government aimed at improving the care and support women and families receive when experiencing a pre-24 week gestation baby loss.

Perinatal Mortality

Given the complex interplay of initiatives aimed at addressing the ambition, a more accurate understanding of this ambition metric may be obtained by combining the stillbirth and neonatal mortality rate into one indicator. Chart 4 shows that the reduction in the combined perinatal mortality rate is broadly on a trajectory to meet the ambition (a 25.7% reduction between 2010 and 2019 against the 2020 ambition trajectory of an 18% reduction)[1].

Chart 4: Composite stillbirth and neonatal death rate trend in England since 2010



[1] The chart shows the rate of neonatal deaths of infants of gestational age of at least 24 weeks and stillbirths combined per 1000 live births of any gestational age.

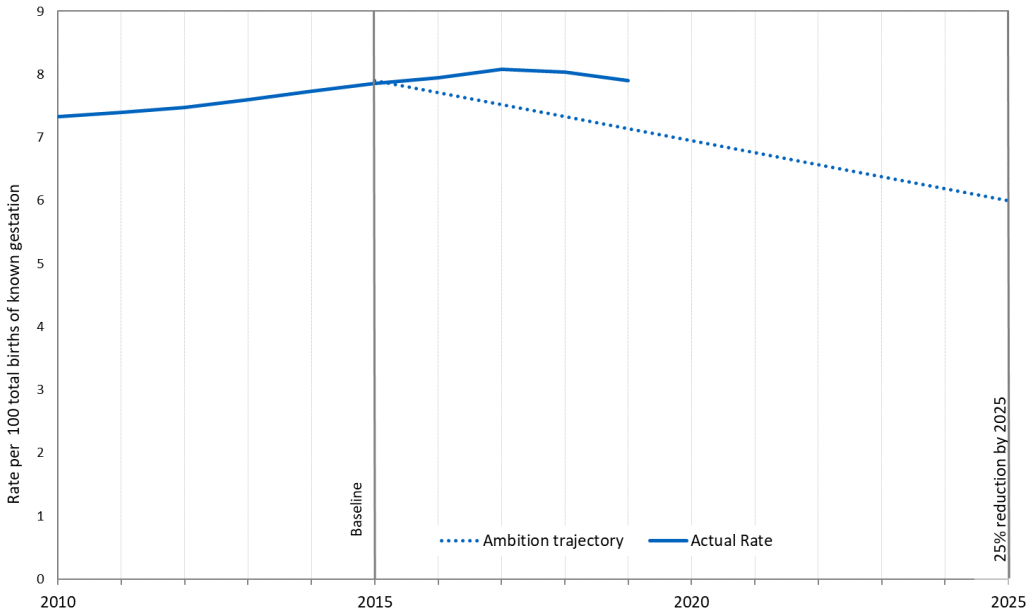
Pre-term births

The pre-term birth rate ambition, announced by the government in the 2017 Maternity Safety Strategy, is to achieve a 25% reduction from an 8% baseline in 2015 to 6% in 2025.

In 2019 there were 46,575 pre-term live births and 1,699 pre-term stillbirths (gestational age between 24+0 and 36+6 weeks) in England. Chart 5 shows that the rate of pre-term births rose from 7.3% in 2010 to 8.1% in 2017 and reduced to 7.9% in 2019.[2]

A range of inter-connected initiatives being implemented by maternity and neonatal professionals support efforts to reduce pre-term births and optimise outcomes when preterm birth is inevitable. These include the Saving Babies Lives Care Bundle Version 2 (SBLCBv2); recommendations outlined in the NCCR, specialist preterm birth clinics, implementation of Continuity of Carer and the National Maternity and Neonatal Safety Improvement Programme (MatNeoSIP). These initiatives have longevity for ongoing implementation through the NHS Long Term Plan.

Chart 5: Pre-term birth rate trends since 2010



Source: ONS

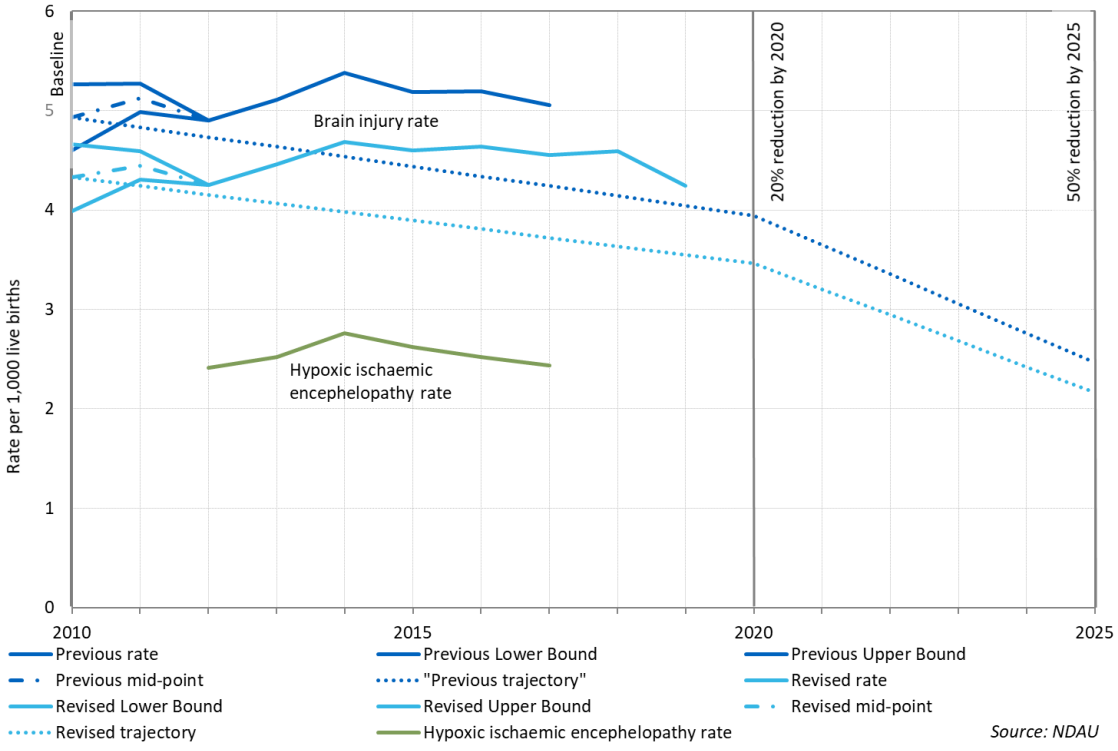
[2] Office for National Statistics:user requested analysis available at https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/12561livebirthsstillbirthsandneonataldeathsbygestationalageinengland2010to2018neonataldeathsand2010to2019livebirthsandstillbirths

Brain injuries occurring during or soon after birth

The government's National Ambition is to halve the rate of intrapartum brain injuries from a 2010 baseline by 2025. According to the earlier report by the Neonatal Data Analysis Unit[3], where a definition of brain injury was published, this meant reducing the rate from 4.93 per 1,000 births in 2010 to 3.95 in 2020 and 2.47 in 2025. As part of a recent publication applying this definition to later years[4], these figures have been corrected to reducing the rate from 4.3 per 1,000 live births in 2010 to 3.5 in 2020 and 2.2 in 2025.

Chart 6 shows the findings from the recent report, which states that the brain injury rate has fallen to 4.2 per 1,000 live births in 2019, since rising from 4.2 to 4.7 per 1,000 live births between 2012 and 2014. The rate of infants with hypoxic ischaemic encephalopathy (HIE) has fallen by 15% between 2014 and 2019.

Chart 6: Brain injury rate and HIE rate since 2010



The RCOG led Each Baby Counts (EBC) programme and NHS Resolution's Early Notification (EN) Scheme concluded that there was an average of seven critical

[3] Imperial College London. Brain injury occurring during or soon after birth: a report for the national maternity ambition commissioned by the Department of Health, 2017. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662974/Report_on_brain_injury_occurring_during_or_soon_after_birth.pdf

[4] Imperial College London. Brain injury occurring during or soon after birth: annual incidence and rates of brain injuries to monitor progress against the national maternity ambition 2018 and 2019 national data, 2021 https://www.imperial.ac.uk/neonatal-data-analysis-unit/our-research/reports/

contributory factors for each baby where different care might have had made a difference to the outcome. Understanding the links and interplay between multiple contributory factors in local investigations is key to addressing the factors leading to term brain injury.

The impact that brain injuries at birth have on families is severe and devastating and efforts to reduce avoidable brain injury must be prioritised. Brain injury as a result of clinical negligence leads to significant cost implications for the NHS.

The government's first response to this is rightly to improve safety to help reduce the potential for harm occurring in the first place. We committed in the Spending Review to consult during 2021 on reducing the rising costs of clinical negligence.

£9.4m was awarded in the 2020 Spending Review to improve maternity safety, including a national brain injury reduction programme that aims to reduce incidences of brain injury and improve the quality and safety of services across the country.

Maternal deaths

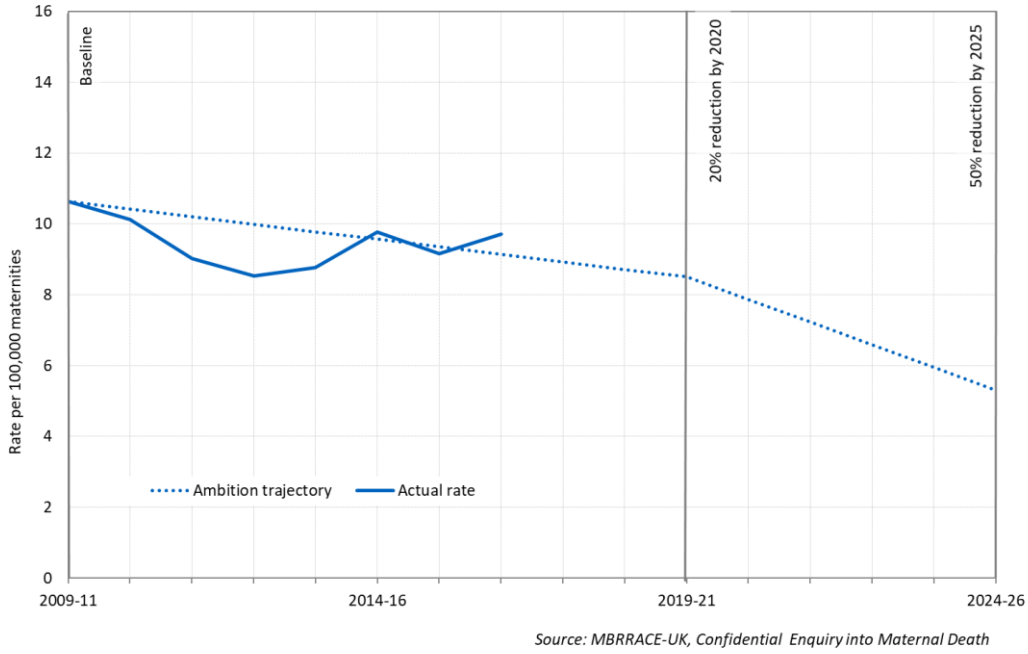
Maternal mortality is fortunately a rare occurrence in the UK. Because the numbers are small, maternal mortality rates (MMR) are presented triennially rather than annually. For the purposes of monitoring progress with achieving the National Ambition, data for the mid-point of the triennial is used, so the baseline for the MMR is 2009-11[5].

The government's National Ambition is to halve the rate of maternal deaths from a 2010 baseline by 2025, with a 20% reduction by 2020, reducing the rate from 10.6 per 100,000 maternities in 2010 to 8.5 in 2020 and 5.3 in 2025.

Chart 7 shows that the maternal mortality rate in 2016-18 is 9% lower than the 2009-2011 baseline, having increased between 2012-14 and 2014-16. The volatility of the series is likely due to the small numbers of incidents.

[5] MBRRACE-UK cautions that the decrease in the rates from 2009-11 to 2011-2014 is not statistically significant and, for this reason, achieving the aspiration to halve the maternal mortality rate will be a challenge for UK health services.

Chart 7: Maternal mortality rate trends since 2010



Maternal mortality rates are influenced by multiple morbidities such as diabetes or cardiac conditions.

In January 2021, MBRRACE-UK reported that thrombosis and thromboembolism remains the leading cause of direct maternal death during or up to six weeks after the end of pregnancy.

Cardiac disease remains the largest single cause of indirect maternal deaths. Maternal suicide remains the leading cause of direct deaths occurring within a year after the end of pregnancy.

Implementing MMN will ensure that women with complex needs and multiple morbidities receive specialist advice and care in the most appropriate setting, and at the right time. The increasing access to specialist perinatal mental health community and inpatient services introduced as part of the Five Year Forward View for Mental Health and the NHS Long Term Plan should provide timely, high quality care to women with moderate/complex-severe mental health needs.

The NHS Long Term Plan includes a commitment for a further 24,000 women to be able to access specialist perinatal mental health care by 2023/24, building on the additional 30,000 women who will access these services each year by 2020/21 under pre-existing plans. Specialist care will also be available from preconception to 24 months after birth, which will provide an extra year of support.

Maternity outreach clinics will integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience including those who have lost a child in pregnancy, during labour and childbirth or in the neonatal period.

Health inequalities

There remains a more than four-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds, and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to white women. Statistically significant differences remain in the maternal mortality rates between women living in the most deprived areas and those living in the least deprived areas.

Mortality rates remain high for Black and Asian babies and those born to mothers living in the most deprived areas. NHS England and NHS Improvement is taking action, based on the evidence about what works, to achieve equity in outcomes for these groups.

In September 2020, the Minister for Patient Safety, Suicide and Mental Health established the Maternity Inequalities Oversight Forum to bring together experts from key stakeholders to consider and address the inequalities for women and babies from different ethnic backgrounds and socio-economic groups. This Forum will provide rapid and contemporary information about reduction in disparities and will review whether policies and strategies are being implemented as intended and that expected results are being achieved. The next Forum meeting will be held in April 2021.

In addition, DHSC launched a new £7.6m Health and Wellbeing Fund, based on the theme of ‘Starting Well’ that will support 19 projects to reduce health inequalities among new mothers and babies. The projects include a number of innovative schemes aimed at levelling up BAME groups and promoting healthy behaviours.

Officials in the Cabinet Office Race Disparity Unit (RDU) are supporting the Department of Health and Social Care in driving positive actions through a number of interventions on maternal mortality from an equalities perspective. The Minister for Equalities co-hosted a successful roundtable discussion on maternal mortality rates for ethnic minority women with the Minister for Patient Safety, Suicide Prevention and Mental Health in September 2020. Following the roundtable, the RDU has also met a number of stakeholders over the past four months, including academics, midwife practitioners from regional trusts and public health experts, to develop joint solutions to this issue.

Work to reduce health inequalities around maternal and extended perinatal mortality rates is led by Professor Jacqueline Dunkley-Bent OBE, Chief Midwifery Officer. The work aims to understand why mortality rates are higher, consider evidence about what will reduce mortality rates and take action to improve equity in outcomes for mothers and their babies.

The work is multi-disciplinary and involves a range of stakeholder groups, including parents.

NHSE&I are working with a range of national partners, led by the Chief Midwifery Officer for England and the National Specialty Advisor for Obstetrics, to develop an Equity strategy which will focus Black, Asian and mixed-race women and their babies and those living in the most deprived areas.

The NHS Long Term Plan committed to implementation of an enhanced and targeted Continuity of Carer model for Black and Asian women, as well as for women living in the most deprived areas. Continuity of Carer models help reduce baby loss, pre-term births, hospital admissions, the need for intervention during labour, and improve women's experience of care[6]. Across England, Continuity of Carer teams are serving communities with high Black and Asian populations and areas with high levels of deprivation. By March 2021, at least 35% of pregnant women will start to receive Continuity of Carer. In doing so, maternity services will make sure that the proportion of Black and Asian women and those from the most deprived neighbourhoods on Continuity of Carer pathways meets or exceeds that for pregnant women as a whole. By 2024, 75% of Black and Asian women, and a similar proportion of women who live in the most deprived areas, will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period.

Maternity Voices Partnerships (MVP) bring parents and staff together to design and review maternity services, and action is underway to ensure diverse voices are heard. National Maternity Voices, funded by NHSEI, are providing additional support for BAME parent representatives. This support includes developing a BAME MVP Network, ensuring that MVPs are inclusive of BAME parents and providing training about how Maternity Voices Partnerships can involve BAME parents and get feedback from BAME communities.

COVID-19 has further exposed some of the health and wider inequalities that persist in our society. Women from a BAME background make up more than half (56%) of pregnant women admitted to hospital with COVID-19, with Black pregnant women being eight times more likely to be admitted to hospital than White women[7]. Therefore, the Chief Midwifery Officer has written to Local Maternity Systems, asking them to take four specific actions:

- Increase support of at-risk pregnant women. Clinicians should have a lower threshold to review, admit and consider multidisciplinary escalation in women from a BAME background.

[6] Sandall et al (2016) Cochrane review of 17,674 women
[7] Knight, M et al 2020 Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK: national population based cohort study BMJ 2020;369:m2107 https://www.bmj.com/content/369/bmj.m2107

- Reach out and reassure pregnant BAME women with tailored communications.

- Ensure hospitals discuss vitamins, supplements and nutrition in pregnancy with all women.

- Ensure all providers record on maternity information systems the ethnicity of every woman, as well as other risk factors, to identify those most at risk of poor outcomes.

In addition, a range of communications materials about COVID-19 have been coproduced with parents to help engage, reassure and support women at heightened risk. We have developed resources and information for pregnant women, such as the NHS.UK Pregnancy and coronavirus page, Four coronavirus maternity information leaflets – which have been translated into 11 languages – and a film about the changes to maternity services and why it's important for women to keep in touch. In support of the four specific actions that Local Maternity Systems have been asked to take – and to support trusts to better communicate and engage with diverse audiences – we have produced a Communications Toolkit that provides advice, resources and messaging that are all targeted towards pregnant BAME women to provide direct reassurance for the concerns these communities may be experiencing.

As well as these materials, a major campaign targeted towards pregnant women was also launched as part of the NHS's Help Us Help You activities to remind pregnant women about the importance of attending check-ups, contacting their midwife or maternity team when something doesn't feel right, and reassure them that the NHS is here to see them safely. The Help Us Help You campaign has been carefully targeted to reach pregnant women from Black, Asian and minority ethnic backgrounds, including through the creative design of the campaign's materials, targeting promoted content to diverse communities and developing partnerships with popular and culturally relevant social parenting groups and media organisations.

2. What has been achieved?

This chapter looks at achievements under three themes: changing culture, specific maternity safety strategy initiatives and system enablers - all of which are key requirements if we are to achieve safer care.

Together as a system, from frontline services to LMS, CN and Operational Delivery Network (ODN) level, supported by the national MTP, most of the safety initiatives announced in both the 2016 and 2017 government strategies have now been implemented.

2.1 Changing Culture

The culture of an organisation is key to enabling improvement and underpins the quality of care, shaping the behaviour of everyone in it and its overall performance. However, poor culture is often one of the most difficult issues to address and positive culture change can take a long time to become properly embedded.

The Ockenden Report published on 10 December 2020, set out initial findings from the independent review of the maternity services at the Shrewsbury and Telford hospital NHS Trust. The Report highlighted the importance of strengthening leadership and oversight for maternity, addressing toxic workplace culture and fostering more collaborative approaches in maternity and neonatal services.

Establishing a patient safety culture is a key foundation to meet the NHS safety vision. The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented.

The NHS Patient Safety Strategy (July 2019) sets out specific actions to support a patient safety culture, which requires local systems to:

- use existing culture metrics such as those in the NHS Staff Survey to understand their safety culture and focus on staff perceptions of the fairness and effectiveness of incident management;
- focus on the development and maintenance of a just culture by adopting the NHS Just Culture Guide or equivalent; and
- embed the principles of a safety culture within and across local system organisations and align those efforts with work to ensure organisations adhere to the well-led framework and its eight key lines of enquiry.

Ongoing work to build a safety culture across the maternity system includes:

- In January 2021, DHSC announced a new £500,000 fund for Maternity Leadership Training for NHS maternity and neonatal leaders, including NHS Trust Board safety champions, heads of midwifery, clinical directors of neonatal and clinical directors of midwifery, leaders of local maternity systems and regional chief midwives. This addresses issues raised in the Ockenden review recommendations of disconnect between “ward and Board” in maternity services and the importance of multi-disciplinary training, escalating concerns to senior leaders, and applying lessons learned from serious incidents. It will equip maternity leaders with the skills and knowledge to improve workplace culture and facilitate greater collaborative working between nurses, doctors, midwives and obstetricians.

- Through the MatNeoSIP (previously known as the Maternal and Neonatal Health Safety Improvement Collaborative) every maternity and neonatal service has undertaken a safety culture survey to develop a better awareness and understanding of the culture and learning system within the department, and how to develop the conditions where teams and individuals can flourish in the delivery of high-quality healthcare to patients and their families. By March 2023, MatNeoSIP will have offered a further safety culture survey to all maternity and neonatal care providers and through Patient Safety Networks and will continue to provide support for debriefing and result interpretation to help utilise insights to inform local quality improvement plans. In addition, MatNeoSIP will undertake a deep dive with a number of Trusts seen to reflect high performing teams and culture survey scores to elicit the key interventions for testing elsewhere.

- The EBC + Learn and Support (EBC+L&S) programme aims to address communication and cultural problems and to achieve sustainable quality improvement, focusing on the two areas of escalation and debrief.

- Progress on developing a safety culture will be supported by the introduction of the national patient safety syllabus and the designation of patient safety specialists, as well as wider mechanisms. Progress will be monitored through NHS Staff Survey metrics about fairness and effectiveness of reporting, and staff confidence and security in reporting. The introduction of proxy indicators for problematic cultures, such as levels of staff suspension and of anonymous incident reporting, will also be explored.

- NHS Resolution produced their guidance on Being Fair (July 2019) which sets out the rationale for NHS organisations adopting a more reflective approach to learning from incidents and supporting staff.

- One Voice brings together the RCM, RCOG, the Stillbirth and Neonatal Death charity (SANDs), National Childbirth Trust (NCT), Institute of Health Visitors and Association of Anaesthetists in a collaboration with the aim of ensuring the best outcomes for

mother and baby and the best possible experience for mothers, fathers and families through pregnancy, birth and postnatal care.

Maternity Safety Champions

Improving culture requires strong leadership at every level of the system. Maternity and neonatal safety champions should develop strong partnerships and promote the professional cultures needed to deliver better care.

Strong leadership has been established across the system with the appointment of named regional and local Maternity Safety Champions led by two national Maternity Safety Champions (Matthew Jolly and Jacqueline Dunkley-Bent).

Safety champions at the frontline, trust board, regional and national level play an important role in enabling and leading teams to deliver the improvement activity involved in meeting the ambition.

To promote safe working, every national, regional and local NHS organisation involved in providing maternity and neonatal care has both named maternity and neonatal safety champions.

NHSEI support Safety Champions in their nominated role through guidance (published in February 2018), regular themed webinars and newsletters providing information on relevant safety activity and messages. A number of events aimed at role clarification and relationship building between safety champions and a safety champion hub have been held.

A number of additional resources, including a Toolkit and refreshed guidance are being produced to strengthen the role of the safety champion in three key areas relating to leadership, oversight for quality through strong governance processes and relationships with key partners.

In support of enhancing the safety of both maternity and neonatal services, NHSEI has drawn on insights from NHS trusts who have been supported through the Maternity Safety Support Programme (April 2018) which helps maternity services achieve sustained improvement across the five CQC domains (are services safe, effective, caring, responsive to people's needs, and well-led). Based on these insights, a self-assessment tool launched in February 2020 aims to enable maternity services to benchmark themselves against what 'Good' and 'Outstanding' services looks like.

Case study: innovative collaborative working within/across trusts

The senior maternity leadership team at University Hospitals Coventry & Warwickshire NHS Trust have taken steps to increase staff awareness of actions the maternity unit have been taking in response to meet the National Ambition. This includes:

1) The development of a bespoke maternity safety improvement plan to capture all recommendations from the national documents.

2) Moving the bi-weekly Maternity Safety Champion meetings to the labour ward, to be conducted with all staff on duty in the maternity and neonatal unit. This provided the opportunity for staff to raise any concerns about maternity safety directly with the Head of Midwifery, Clinical Director and Board Level safety champions.

3) Using a range of metrics to track the trust's progress including rolling year to date statistics for the stillbirth, neonatal death and HIE rate and a comparison to the national average.

4) Regularly inviting patients to come along to each meeting to ensure that service users are consistently being considered in maternity safety.

As a result of moving the bi-weekly champion meetings to the labour ward, over 40 staff from the whole multidisciplinary team were able to attend the meeting. Since these steps were introduced, there has been overwhelmingly positive feedback from all levels of staff and awareness of the national ambition has been raised significantly.

The team have now launched a daily multidisciplinary team LMS safety huddle across Coventry and Warwickshire to ensure discussions are joined up on capacity issues, cot capacity etc, to ensure mother and baby are in the right place at the right time.

Coproduction with women and families

Coproducing safe and personal maternity care is fundamental, with service user representatives at national, regional and local level. The MTP Safer Care programme of work continues to prioritise hearing the voices of women and their families and ensuring coproduction of safety initiatives at national, regional and local level. A key aspect of this is having an active and committed Service User Voice Representative as reflected through co-chairing arrangements for the MTP Workstream 2: 'Promoting Good Practice through Safer Care'. The remaining nine Workstreams also have dedicated Service User Voice representatives to ensure women are central to strategic decision-making, planning and implementation.

At a local level, 123 user-led MVPs have been established across England. MVPs include those using services, those providing services (maternity and neonatal staff) and those who commission services.

MVPs review maternity care and coproduce improvements, so women and families are at the heart. Examples include MVPs using the 15 Steps for Maternity toolkit to assess quality from the perspective of maternity service users and coproducing information for people about local maternity services, shown in the case study below.

MVPs ensure service users, which make up a third of every Maternity Voices Partnership, are involved in reviewing anonymised complaints, and contributing to the ongoing review and clinical governance of local maternity services. Involvement of families is now integral to investigations and reviews into their care. This ensures their voices are listened to and that their contribution forms a key part of serious incident reviews.

MVPs are supported by National Maternity Voices, via networks, a range of resources and series of webinars - recent topics have included how to ensure MVPs represent the ethnic diversity of their local areas. Through the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), providers are required to confirm their MVP is hearing the voices of women from BAME backgrounds and women living in areas of high deprivation as a priority.

Guidance related to adequately funding an MVP can be found at in Chapter 4 of NHSEI's Implementing Better Births and at National Maternity Voices.

Case study: coproduction with service users

The West North East Cumbria MVP have been working to ensure women have access to information to be able to make informed choices and access personalised care. Their website provides information which has been coproduced with a dedicated group of parents, input from midwives at West Cumberland and technical support from North Cumbria Clinical Commissioning Group (CCG). Together they have produced a labour support resource for parents to use in Antenatal Classes and to be available in all birth rooms at maternity units. This will ensure women and partners are informed during labour and birth about some of the things that can help labour progress smoothly.

2.2 Specific safety initiatives

Maternity and Neonatal Safety Improvement Programme

Since 2016 MatNeoSIP has contributed to the national improvement ambition through a range of key activities, working with all maternity and neonatal providers in England. The MatNeoSIP 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. Participation in the MatNeoSIP is a key commitment outlined in the NHS Patient Safety Strategy.

MatNeoSIP has focussed on a number of clinical priorities that reflect the current themes, insights and safety concerns identified from key reporting organisations. It has specifically worked to test interventions where there is a strong evidence base, develop reliable pathways, systems and processes to reduce unwarranted variation in outcomes and care experiences.

Through a series of national learning sets MatNeoSIP has:

- 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 CNs and the 10 neonatal networks). The support 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 some early successes with system level improvement. An example includes the support of Prevention of Cerebral Palsy in Pre-Term Labour (PReCePT), which since its launch in April 2018 has led to 877 more eligible women receiving magnesium sulphate and an estimated 24 cases of cerebral palsy avoided.

Through the programme's work in phase one, MatNeoSIP examined the impact and importance of a positive safety culture and supported maternity and neonatal teams to utilise insights to inform local quality improvement plans. A comprehensive safety culture assessment was undertaken, gaining insights from 21,000 healthcare professionals in all 134 trusts, one of the largest culture surveys in the NHS. A national publication to support the use of safety culture insights was launched in March 2019.

In phase two, MatNeoSIP will continue to work alongside the many key stakeholders across the system to ensure there is an aligned and coordinated response. It will support interventions highlighted in SBLCB v2 (2019) and the NCCR (2019) and via the Patient Safety Networks. This will help providers and local maternity systems to mobilise how these are reliably and sustainably embedded into practice. It will continue to develop change theory, establish what works well, test implementation and pathway redesign, and support national scale up of evidence-based interventions.

MatNeoSIP Key Programme Outcomes

-To increase the proportion of smoke-free pregnancies to 94% or greater by March 2023.

-To improve the optimisation and stabilisation of the preterm infant:

-To increase the proportion of babies (less than 34 weeks gestation) born in appropriate care setting for gestation to 90% by March 2023*.

-To increase the proportion of eligible women (less than 30 weeks gestation) receiving antenatal administration of magnesium sulphate (MgSO4) in the 24 hours prior to delivery to 90% by March 2022*.

-To increase the proportion of women less than 34 weeks with threatened preterm labour receiving a full course of antenatal corticosteroids within one week prior to delivery to 90% by March 2023*.

-Improve the early recognition and management of deterioration of women and babies:

-To develop a national pathway approach for the effective management of maternal and neonatal deterioration using the Prevention, Identification Escalation and Response (PIER) framework across all settings by March 2024.

-To work with key stakeholders to develop a national maternal early warning score (MEWS) by March 2021 and spread to all providers by March 2024.

In addition to the clinical priorities, key enablers will be embedded within the programme of work and will form part of the overall improvement approach:

- Addressing Inequalities
- Women and family co-design
- Safety Culture
- Patient safety networks
- Improvement leadership
- Building Quality Improvement (QI) capacity and capability
- Measurement for improvement
- Improvement and innovation pipeline

Saving Babies Lives Care Bundle

The SBLCBv1 was launched in March 2016 and an independent evaluation showed a 20% decrease in stillbirths in participating Trusts concluding that despite many concurrent interventions it was highly plausible that SBLCBv1 had contributed to the fall. The percentage of NHS trusts that had fully implemented SBLCB v1 reached 90% in 2019.

The SBLCBv2 was launched in March 2019 and aims to be even more effective at reducing stillbirth and to minimise unnecessary intervention. It includes a new fifth element to reduce pre-term birth.

In 2019-20 Health Education England (HEE) provided funding for LMS's via a bidding process to support implementation of SBLCBv2. This included targeted training resources and the development of specialised e-learning modules for each element of SBLCBv2 which is now available on e-Learning for Healthcare (e-LfH).

Compliance with SBLCBv2 was included in the 2019/20 Planning Guidance and Standard Contract, with full implementation required by March 2020.

As a result of the pandemic, there was a temporary pause to Carbon Monoxide testing, which is a requirement of Element One of the care bundle. However, NHSEI are asking NHS trusts to continue to support full implementation and this is still a focus for the Maternity Incentive Scheme. The MTP has recommenced monitoring trust implementation of the Care Bundle via quarterly tracker surveys and is providing support where required.

Systems will receive additional funding to support delivery of SBLCB from 2021 onwards and will continue to be encouraged to work towards full delivery of the SBLCB, including the new element aimed at reducing pre-term births.

Reducing smoking in pregnancy

The percentage of women recorded as smokers at the time of delivery for the year 2019-20 was 10.4%, compared to 10.6% in 2018-19.

Element 1 of the SBLCB includes action to monitor exposure to Carbon Monoxide (a key toxin in tobacco smoke) in all pregnant women and refer people who smoke for specialist support. Routine CO monitoring at antenatal appointments was paused in March 2020 due to COVID-19 restrictions, although it is planned to resume from October 2020.

Prior to disruption caused by COVID-19, the SBLCB survey data had shown an improving trend in adoption of the Element 1 requirements for addressing smoking. The March 2020 survey results showed that 72% of providers were implementing all activities in Element 1 (up from 70% in November 2019); and 99% of providers were implementing at least one aspect of Element 1 (up from 98% in November).

Work is also ongoing across the NHS to consolidate existing resources, and signpost these to frontline staff. A toolkit has been developed for maternity safety champions, which pulls all available resources into one place.

The Government provided £150,000 for additional training for midwives to have the knowledge, skills and confidence to give very brief advice (VBA) to women during antenatal appointments and to upskill practitioners to deliver evidence-based stop smoking

interventions. Sixty-eight trusts took up the offer of training, with 598 maternity staff undertaking training. This was supported by a series of short film clips demonstrating the key elements of delivering VBA and supporting learning resources, which are hosted on the e-Learning for Healthcare platform.

A whole new range of training resources on smoking in pregnancy, aimed at health visitors, went live in 2020. This includes training slides, as well as video clips of effective interventions in various scenarios.

Reducing smoking during pregnancy is also an area of focus within the MatNeoSIP. Within the programme, 37 organisations have undertaken initiatives to increase smoke free pregnancies and six Safety Improvement Networks are focusing on this clinical area as part of their system wide improvement project.

Avoiding term admissions into neonatal units (Atain)

The 'Atain programme' commenced in 2015 and is one of a number of programmes contributing to reducing neonatal morbidity including a focus on understanding local contributory factors for admissions for hypoglycaemia, jaundice and respiratory symptoms. Atain focuses on reducing avoidable causes of harm that can lead to infants born at term (i.e. ≥ 37+0 weeks gestation) being admitted to a neonatal unit (NNU).

A resource pack to support trusts to tackle avoidable term admissions is available on a bespoke 'Atain platform', as part of the NHS Improvement hub, along with a range of additional resources from the Atain programme. The Atain e-learning programme for healthcare professionals was launched in November 2017 and currently has over 24000 professionals subscribed and accessing the programme.

Overall, there has been a reduction in admissions to NNU and an increase in Transitional Care capacity. Since 2016, there have been reductions in special care (SC) days, which 2018 data shows are now at the same level as in 2013.

Case study: collaboration at CN/ODN level around CNST maternity incentive scheme and Atain

As part of the Maternity and Neonatal Group, a sub-group of the London Maternity Transformation Board, the Neonatal ODN and Maternity Leads for NHSE came together to formulate a resource that both maternity and neonatal teams could utilise in developing their transitional care (TC) services.

The resource sets out the staff competency recommendations and includes the suggested staffing configuration for both nursing and medical staff. To help providers submit their Atain action plans for approval at Board level, a template was created to assist with formatting individual plans and documenting plan approvals at each necessary level. It

included a table of the themes and associated changes in practice/initiatives that were extrapolated from the action plans to help share areas of good practice and improvement.

The document was well received by London providers, pulling all the relevant TC information together in one document. Around 80% of providers used the action plan template when submitting their plans to the Boards for approval – this made reviewing the plans easier and quicker to interpret and provided an audit trail for sign off from the trust, LMS and ODN Boards. The resource has been used to help providers formulate their Standard Operating Policy and facilitated the review of staffing structures for TC services.

It ensured providers were compliant with the CNST maternity incentive scheme requirements in respect to submission of action plans and approval, and focused teams in developing TC services.

LMS and ODN teams have been working collaboratively to share their learning from Atain action plans and there is improved cross attendance at regional LMS and ODN board meetings.

Early Notification scheme

NHS Resolution launched their flagship EN scheme for maternity incidents which have the potential to result in very high value claims in April 2017.

Being involved early allows NHS Resolution to:

1. Carry out early liability investigations where indicated to improve the experience for both families and staff affected and provide early support.

2. Reduce formal litigation in the courts and the associated legal costs.

3. Identify learning and share at national, regional and local levels.

Year one of the EN scheme report (September 2019) highlighted six key recommendations relating to: candour, staff support, fetal monitoring, impacted fetal head, detection of maternal deterioration in labour and neonatal resuscitation. There will be ongoing work to build on the recommendations identified in the report and to work collaboratively with system partners and key stakeholders such as the Royal Colleges on key work streams for themes arising from the report. The EN team also work with the Healthcare Safety Investigation Branch.

EN provides the potential to build a robust database to provide valuable insight on what drives these incidents. To date the EN team have provided learning feedback to trusts on themes/individual cases and produce quarterly case stories, which have been developed based on themes from EN cases.

Each Baby Counts + Learn and Support

EBC + L & S 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 March 2022, EBC+L&S evolved from recommendations made by the original EBC programme and has close links with the MatNeoSIP.

Building the clinical leadership, safety thinking and quality improvement of 16 NHS maternity professionals, EBC L&S will facilitate and evaluate a structured quality improvement process using behavioural science to improve clinical escalation in intrapartum settings.

Continuity of Carer

Continuity of Carer means that a woman's maternity care is provided by midwives organised into teams of eight or fewer (headcount). Each midwife will aim to provide all antenatal, intrapartum and postnatal care for up to 36 women per year but is supported by the team for unsocial hours or out of hours care. Based on best evidence, including 2016 Cochrane Review,[8] Continuity of Carer is associated with significant improvements in the safety, personalisation and experience of maternity care.

Access to Continuity of Carer pathways has widened in England. In October 2020 15.9% of pregnant women were placed on a Continuity of Carer pathway.

Due to the pandemic, targets for Continuity of Carer have been revised. Therefore, by March 2021, the following women should be placed on Continuity of Carer pathways:

- At least 35% of all women booked;
- At least 35% of all Black and Asian women booked; and
- At least 35% of all women booked from the most deprived 10% of areas.

In effect, the ambition for Continuity of Carer has been delayed by one year. In 2018, HEE distributed £745,000 as part of workforce development transformation funding to deliver training and education to support the implementation of Continuity of Carer. This was offered to all maternity service providers across England within LMS. Over 1,500 staff were trained across the country, with an average of 54 staff members per LMS. This training was completed in 2019.

[8] Sandall J, Soltani H, Gates S, Shennan A, Devane D. 2016. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5

A training offer had been planned similar to the previous, however due to the pandemic all face to face training had to be cancelled. HEE is now with three training providers to deliver more focused training, including digital resources and masterclasses, across HEE's seven regions. The training is underway and expected to be completed by Spring 2021.

From 2022, LMS will be required to begin working towards achieving an ambition for 75% of Black/Black British and Asian/Asian British women to receive Continuity of Carer by 2024, along with women living in deprived areas. A funded and comprehensive national support offer will begin for LMS to achieve this, in 2021.

Personalisation and Choice

From June 2016 until March 2019, seven Maternity Pioneer sites in England were selected to develop and test ways of improving Choice and Personalisation for women accessing maternity services, as recommended in Better Births. The Maternity Pioneers sought to deepen and widen the choices available to women by:

- seeking to widen the choice of provider organisations;
- working across CCG boundaries;
- empowering women to take control of decisions about their care through providing evidence-based information about their options; and
- testing Personal Maternity Care Budgets (PMCB).

The evaluation of the Choice and Personalisation Pioneers programme outlined the importance of providing detailed and accessible information to women about the choices available and having choice conversations with women. All Pioneers reported having better choice conversations based on improved information for women and women reported feeling more in control of their pregnancy journey.

Going forward, we will work closely with the CNs, Regional Maternity Boards and Local Maternity and Neonatal Systems (LMNS) to support implementation of personalised care with the support of two national clinical champions and two national maternity service user representatives. A detailed action plan has been developed to take this work forward along with plans to embed personalisation across all 10 MTP workstreams in 2020/21.

Maternal Medicine Networks

The NHS Long Term Plan committed to the establishment of MMNs by March 2024, to ensure that women with acute and chronic medical problems have timely access to specialist advice and care at all stages of pregnancy. Following regional and clinical engagement and a market testing exercise in 2019, we have identified a requirement for 18 funded networks across England and a minimum staffing level for these networks, at a cost of £3.6m p/a.

NHS England and Improvement has committed to implementing Maternal Medicine Networks across England, to ensure that all woman with acute and chronic medical problems have timely access to specialist advice and care at all stages of pregnancy. Implementation is ongoing regionally so that from 2021/22, all NHS maternity providers in England are operating within a Network on the basis of locally agreed footprints.

Neonatal Critical Care Transformation Review

Better Births recommended a dedicated review of neonatal services, which was undertaken in three phases.

Phase one comprised of an evidence review and resulted in the release of 'Data and Information Packs' in August 2018 to support local maternity transformation planning. An interim 'Neonatal Themes Report' accompanied the data packs and set out the actions required by LMS and ODN to begin to address the findings of the evidence review. This included the following two interim measures that local areas were asked to work towards:

- All births <27weeks should take place in maternity hospitals with a designated Neonatal Intensive Care Unit (NICU)

- All neonatal deaths are reviewed using the Perinatal Mortality Review Tool (PMRT)

Phase 2 comprised of a publication of an Action plan in December 2019, setting out the actions required to inform commissioner planning, which are directly linked to the case for change. The NHS Long Term Plan has committed investment to meet three aspects of this action plan. They are focused on:

- Addressing neonatal capacity;

- Developing the expert neonatal workforce required; and

- Enhancing the experience of families.

For phase three (implementation) a Neonatal Implementation Board (NIB) has been established, reporting to the MTP Board, Specialised Commissioning Group.

ODNs are developing local implementation plans setting out how they will deliver the expectations of the NHS Long Term Plan and the recommendations of the review. The NIB is developing a framework to support and assure delivery of these plans.

NHS Long Term Plan funding is to be also allocated for the development of expert allied health professional and pharmacist roles to address gaps in services identified by the NCCR

In 2019-20, HEE distributed £400,000 to ODNs support development and access to Neonatal Qualified in Speciality (QIS) training. HEE is now currently undertaking a deep-dive review of neonatal QIS education and training.

National Bereavement Care Pathway

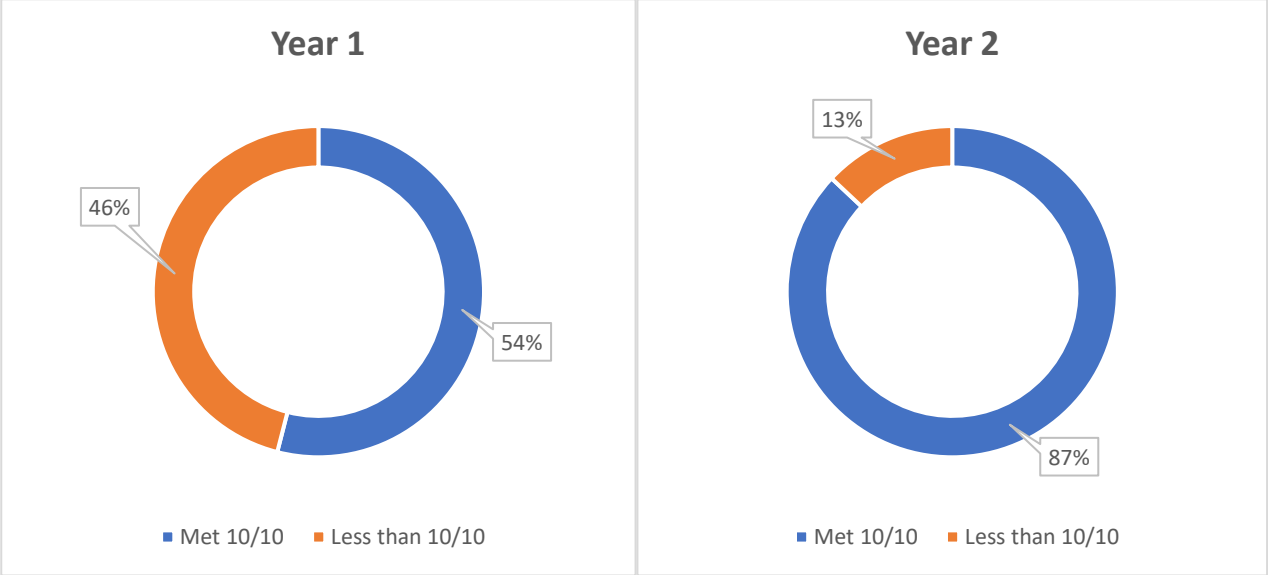
The Government has funded Sands, the Stillbirth and Neonatal Death charity, to work with other baby loss charities and Royal Colleges to produce and support the roll-out of a National Bereavement Care Pathway to reduce the variation in the quality of bereavement care provided by the NHS. The pathway covers a range of circumstances of a baby loss including miscarriage, stillbirth, termination of pregnancy for medical reasons, neonatal death and Sudden Infant Death Syndrome (SIDS).

The National Bereavement Care Pathway was rolled-out nationally in October 2018 and an evaluation (final report wave 2) was published May 2019. In June 2020 progress was shared in an Impact Report which showed over 50% of Trusts in England had signed up to the NBCP with almost all other Trusts having expressed interest. National rollout is encouraged and supported in the SBLCBv2. HEE e-learning for health (e-Lfh) in partnership with Sands and a collaboration of other charities have created an e-learning programme to support and share good practice in bereavement care.

Clinical Negligence Scheme for Trusts Maternity Incentive Scheme

In 2017 NHS Resolution launched a new scheme to incentivise and improve the delivery of best practice in maternity and neonatal services. The scheme aims to directly incentivise many of the actions arising from the work stream 2 safety programmes. By meeting the 10 safety actions, trusts are incentivised to deliver safer maternity services and may be expected to have fewer cases of harm.

Results overview as of 16 September 2020 Results include any changes to Trust certifications	
Year 1 Headlines	**Year 2 Headlines***
■ 132 trusts participated in the scheme ■ 71 trusts (54%) achieved 10/10 safety actions ■ 61 trusts (46%) achieved less than 10/10 safety actions	■ 130 trusts participated in the scheme (reduced number due to mergers). ■ 113 trusts (87%) achieved 10/10 safety actions. ■ 17 trusts (13%) achieved less than 10/10 safety actions



*Elements of most of the safety actions have changed between years one and two; with some including additional requirements in year 2. Therefore, the progress between years one and two of the maternity incentive scheme should be interpreted with caution as they are not directly comparable.

Both year one (2017-18) and year two (2018-19) of the maternity incentive scheme saw demonstrable impact in terms of delivering safety improvements, including:

- the improved use of the National Perinatal Mortality Review Tool (PMRT) and parental involvement in reviews;
- significant improvement in quality of reporting Maternity Services Data Set (MSDS) data to NHS Digital;
- 100% of Trusts were able to demonstrate the implementation of a comprehensive patient feedback mechanism within maternity services, which included acting on feedback received; and
- improved compliance with all four elements of Saving Babies Lives care bundle.

2.3 System enablers

This section assesses the changes that have been made to the maternity system to support the implementation of the specific-safety initiatives and enable the realisation of the national ambition.

Local Maternity Systems

Better Births set out a compelling vison of what maternity services should look like: working together across organisational boundaries to provide a service that is kind, personal and safe. Forty-four LMS were established in 2017 to bring together providers,

commissioners, local authorities and women who use services to provide best quality care, share working practices, and specifically look at the needs of their population.

Women's Digital Care Records

The MTP is supporting the delivery of trusted, digital, pregnancy information to women through NHS.UK and the NHS apps library.

Women's maternity digital care records are being offered to women in 20 accelerator sites across England. The NHS Long Term Plan set out a commitment to have offered 100,000 women with access to their record by the end of March 2020. In August 2019, this target was achieved.

Maternity Pioneers and Early Adopters commissioned and rolled out apps to help women to make choices about their care and access services and information in a more convenient and efficient way. The NHS apps library's Pregnancy and Baby section is one of the most popular sections hosting eight apps.

We will continue to expand the roll-out of interoperable maternity digital care records. All Maternity providers were requested to adopt the Digital Maternity Record Standard by November 2020, which will enable the flow of data across the woman's pathway of care regardless of system. By 2023-24, all women will be able to access their maternity notes and information through their smart phones or other devices.

Training and skills

A major element of the Safer Maternity Care Action Plan was the distribution of the £8.1m Maternity Safety Training Fund by HEE to 136 trusts throughout England, including all 134 NHS trusts with maternity units. The funding supported multi-disciplinary teams to train together and further develop skills and experience in leadership, multi-professional team communication, human factors and situational awareness, cardiotocography (CTG), as well as midwifery and obstetric emergency skills and drills.

Every trust in England received funding; 30,945 training places were delivered across multi-professional teams. Most frequently accessed training included: Multi-professional Skills and Drills Training, Child Birth Emergencies in the Community, Human Factors in Healthcare Trainers Course, CTG Masterclass, Labour Ward Leaders Workshop, Resilience Training for Maternity Healthcare Professionals, New-born Life Support, Maternal Critical Care.

An independent evaluation commissioned by HEE and carried out by the University of Cumbria found that maternity safety training has impacted on everyday practice through increasing confidence and empowering the maternity staff; enhancing skills, knowledge and awareness; improving multi-professional working and communication; improving patient safety; and encouraging cultural change.

Maternity support workers (MSWs) are an integral part of the maternity workforce and play an important role in supporting midwives and the wider maternity teams. HEE has worked closely with a wide range of partners and stakeholders to develop a comprehensive competency, education and career framework for MSWs (February 2019).

HEE has now made available £1,000,000 of funding to support the implementation of the MSW framework. This provides an opportunity for Trusts to widen participation by considering and developing a 'grow your own' pathway equitably across all groups of individuals supporting the maternity service.

Perinatal Mortality Review Tool

Since its launch in early 2018, the PMRT has now been implemented in every maternity service in England.

The PMRT is the first national tool developed to reduce variation in and improve the quality of reviews conducted when babies die. The reports enable comparison of issues with care across individual deaths and provide a basis for prioritisation of resources to support improvements in care. It also provides a means of engaging parents in the reviews and ensuring their perspectives, questions and concerns are considered as part of the review.

The PMRT second annual report was published in December 2020 which presents an analysis of data from the 3,693 reviews conducted between March 2019 and February 2020. Between the launch of the PMRT in January 2018 and 19th October 2020 over 10,500 reviews have been started and/or completed using the tool.

Healthcare Safety Investigation Branch

In an update to the National Maternity Safety Strategy in November 2017, the Secretary of State announced in Parliament that from April 2018 onwards, all investigations of intrapartum stillbirths, neonatal deaths or suspected brain injuries notified to the Royal College of Obstetricians and Gynaecologists' Each Baby Counts Programme - about 1,000 incidents annually - would become the responsibility of HSIB instead of the local NHS trust. In addition, HSIB would investigate the death of any woman while pregnant or within 42 days of the end of her pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes and excluding suicides.[9] The programme was formally established with the HSIB Maternity Directions 2018[10].

[9] A full description of the criteria is included in the HSIB Maternity Directions.
[10] The National Health Service Trust Development Authority (Healthcare Safety Investigation Branch) (Additional Investigatory Functions in respect of Maternity Cases) Directions 2018.

The HSIB maternity programme was fully operational in all 130 trusts in England providing maternity services by the end of March 2019. To date, HSIB have completed 1,376 maternity reports.

HSIB investigations have identified recurring themes in maternity safety incidents; among the most frequent are issues relating to effective escalation, clinical oversight, clinical assessment and monitoring, and the use of local and national guidance. HSIB works closely with trusts to ensure safety risks are rapidly shared and escalated, and to ensure trusts are responding effectively to address the identified risks. HSIB's unique insight into local maternity services contributes to learning through NHS national maternity safety improvement programmes. HSIB has also published national learning reports on topics including key safety themes from the investigations in maternity services; severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection, and neonatal collapse alongside skin to skin contact. There are further national learning reports and HSIB national investigations focusing on maternity services to be published during 2021.

HSIB's positive impact on safety culture is demonstrated through family and staff feedback showing that they value professional, independent maternity investigations, and the importance of HSIB's commitment to a just culture approach based on safety science.

Though it is new to the NHS, the HSIB maternity investigations programme is beginning to produce valuable system level learning and a positive safety impact, with the scope for further development opportunities through HSIB's plans to professionalise safety investigation training and education.

Maternity Services Data Set

NHS Digital released a major update to the MSDS in April 2019, which enables richer clinical data to be collected for greater insight into outcomes to inform better care. Incentives and levers are being put in place to drive improved data quality, including year three of the CNST Maternity Incentive Scheme, which encourages providers to submit better quality data to MSDS.

National Maternity and Perinatal Audit

Commissioned by the Healthcare Quality Improvement Partnership (HQIP) in 2016, the NMPA is a quality improvement programme aimed at identifying variation in clinical measures by trust and publishes annual clinical reports and topic specific sprint audits.

The second organisational survey[11] of the NMPA maps current service provision as of January 2019 across England, Scotland and Wales. Responses to the survey suggest that

[11] A Blotkamp, 2019. NMPA Project Team. National Maternity and Perinatal Audit: Organisational Report 2019. London: RCOG.

maternity and neonatal services are making considerable efforts to implement the recommendations of recent reviews and other national initiatives. They also highlight some of the challenges to reconcile the range of ambitions. While acknowledging an inherent degree of uncertainty in surveys as a data collection method, the results suggest that maternity and neonatal service provision is improving in a number of important areas whilst facing new and ongoing challenges.

3. Next steps

This report shows the progress that has been made in meeting the National Maternity Safety Ambition, including progress in implementing policy initiatives announced since 2015. While a significant amount has been achieved already, we will need to maintain the commitment shown to date in order to meet our 2025 ambition.

In particular, the report demonstrates the enormous efforts that have been made by multidisciplinary teams in NHS trusts across England and the widespread collaboration across NHS trusts, LMS and CNs, with involvement from women and families and user representatives, to share information, best practice and new innovative ways of implementing maternity services in their communities, which contributes to the progress against meeting the National Ambition.

This is an even more exacting challenge in the light of COVID-19 and we appreciate that NHS staff have been working tirelessly throughout the pandemic to keep women and babies safe.

The pandemic has impacted on our progress, with a need for a temporary pause or delays in implementing some of the interventions set out in this report, however we are now working towards resuming all interventions albeit with revised timescales.

A significant amount of activity is already underway, while some initiatives aimed at addressing mortality and improving safety are still to be implemented.

The MTP work will continue to implement the maternity safety initiatives, including those published in the NHS Long Term Plan and The NHS Patient Safety Strategy. A comprehensive review of programme activities has been undertaken to inform priorities and governance arrangements as the MTP maintains oversight of the safety ambition into the next five years.

The NHS Long Term Plan, published in January 2019, aims to make the NHS the best place in the world to give birth by offering mothers and babies high quality support and safe care. The plan includes a range of initiatives with a focus on personalisation, Continuity of Carer, reducing pre-term births, more postnatal physiotherapy for women who experience incontinence after childbirth, increasing access to specialist, evidence-based care for women who experience moderate/severe/complex mental illness in the perinatal period, and a major redesign of neonatal services, supported by an expansion in staff numbers. Annex A provides a breakdown of the maternity-focused commitments in the NHS Long Term Plan.

Public Health England will also continue to improve safety through various initiatives including the design of an interactive Healthy Pregnancy Pathway in 2020, extending the

beginning of the healthy child programme to include pre-conception care and developing a suite of evidence-based resources, aimed at health and social care providers as well as service users to help women with severe mental illness (SMI) access preconception care/advice. PHE are also in the process of building up the evidence base for universal preconception care services as part of the reproductive health service package in the UK.

Through your hard work a significant amount of activity is already underway. The inspiring progress made in improving the safety of maternity and neonatal care in the last four years could not have been achieved without the support and commitment from teams in NHS trusts across the country. With your continued efforts and collaboration, we can continue to make the strides needed to achieve the National Ambition by 2025.

Annex A: The NHS Long Term Plan maternity-focused commitments

Specific Safety initiatives

- **SBLCBv2:** An expansion to the SBLCB was published in 2019. We will support maternity services to fully implement the expanded SBLCB in 2020.

- **Continuity of Carer:** We will continue to work with midwives, mothers and their families to implement Continuity of Carer so that, by March 2021(date revised due to Covid-19), most women receive continuity of the person caring for them during pregnancy, during birth and postnatally. This will be targeted towards women from BAME groups and those living in deprived areas, for whom midwifery-led continuity of carer is linked to significant improvements in clinical outcomes.

- **Improving Choice and Personalisation:** All pregnant women have a personalised care and support plan by March 2021. All women can make choices about their maternity care during pregnancy, birth and postnatally. More women can give birth in midwifery settings (at home and in midwifery units).

- **Perinatal mental health:** By 2023/24, at least 66,000 women with moderate severe/complex perinatal mental health difficulties will have access to specialist community care from pre conception to 24 months, and there will be expanded access to evidence-based psychological therapies within specialist perinatal mental health services, considering areas such as parent-infant, couple, co-parenting and family interventions.

- By 2023/24 **Maternity Outreach Clinics** will be available across the country, combining maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience.

- **Postnatal physiotherapy:** We will improve access to postnatal physiotherapy to support women who need it to recover from birth.

- **Infant feeding programme:** All maternity services that do not deliver an accredited, evidence-based infant feeding programme, such as the UNICEF Baby Friendly Initiative, will begin the accreditation process in 2019-20.

System enablers

- **Digital care records:** Maternity digital care records are being offered to 20,000 eligible women in 20 accelerator sites across England, rising to 100,000 by the end of 2019-20. We will continue to expand the roll-out of maternity digital care records. By

2023-24, all women will be able to access their maternity notes and information through their smart phones or other devices.

- **Neonatal critical care services:** We will redesign and expand neonatal critical care services to improve the safety and effectiveness of services and experience of families. In particular, we will address the shortage of neonatal capacity through the introduction of more Neonatal Intensive Care Cots where the Neonatal Critical Care Review has identified under capacity. We will improve triage within expert maternity and neonatal centres so that the right level of care is available to babies as close to the family home as possible.

- We will enhance the experience of families during the worrying period of neonatal critical care. From 2021-22, care coordinators will work with families within each of the clinical neonatal networks across England to support families to become more involved in the care of their baby and invest in improved parental accommodation.

- **Neonatal nursing workforce:** We will develop our expert neonatal nursing workforce. This will mean extra neonatal nurses and expanded roles for some allied health professionals to support neonatal nurses.

Annex B: Maternity Safety Programme Context

Over 2016 and 2017 DHSC worked collaboratively with clinical and academic experts to publish two documents, an action plan, Safer Maternity - Next steps towards the national maternity ambition and a refreshed maternity strategy, Safer Maternity Care - Progress and Next Steps, outlining around 21 safety related initiatives. At the same time, the National Maternity Safety Ambition to halve the rates of stillbirths, neonatal deaths, maternal deaths and neonatal brain injuries that occur during or soon after birth was brought forward to 2025 with the additional requirement to reduce the national rate of pre-term births from 8% to 6% by 2025.

These recommendations, together with advice from clinical professionals and patient safety experts highlighted a need to focus on:

- Leadership: creating strong leadership for maternity systems at every level;
- Learning and best practice: identifying and sharing best practice and learning from investigations;
- Teams: prioritising and investing in the capability and skills of the maternity workforce and promoting effective multi-professional team working;
- Data: improving data collection and linkages between maternity and other clinical data sets to enable benchmarking and to drive a continuous focus on prevention and quality; and
- Innovation: creating space for accelerating improvement and innovation at local level.

The National Maternity Review published its report, Better Births, on 23 February 2016, setting out recommendations for the future shape of modern, high quality and sustainable maternity services across the NHS in England. *Better Births* set out a clear vision for: maternity services across England to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to make decisions about her care; and where she and her baby can access support that is centred on their individual needs and circumstances.

The MTP was established to take forward implementation of the vision set out in *Better Births*, bringing together a wide range of organisations to lead and deliver across ten work streams. Oversight and governance for delivery of the Maternity Safety Strategy was transferred to NHS Improvement under the auspices of MTP Workstream 2, 'Promoting Good Practice for Safer Care' with the Chief Nursing Officer as the Senior Responsible Officer. The MTP Stakeholder Council provides advice and constructive challenge to the MTP Board and all of the workstreams.

Since the National Ambition to halve the number of still births was launched in 2015, the landscape for maternity and neonatal services has changed. We now have significantly more detailed information on service delivery and outcomes for individual trusts. We have a good understanding of clinical best practice and we have been working with frontline teams through the Maternity and Neonatal Safety Improvement Programme to support staff to ensure that best practice is implemented across the country, taking into account the challenges specific to geographic areas and populations. We have witnessed collaboration at its best with teams working across maternity and neonatal services to understand each other's challenges and surmount barriers to safety. Women, their babies and families are at the heart of these improvements and now play a prominent role in helping to develop policies; service user representatives are part of the MTP stakeholder council, with user roles on all the MTP workstream boards and working groups.

The NHS Long Term Plan was published in January 2019, setting out the 10-year plan for the NHS to improve the quality of patient care and health outcomes. The NHS Long Term Plan reiterated the NHS's commitment to achieve the Government's national maternity ambition and includes new initiatives to improve safety, quality and continuity of care that will help accelerate action to meet the ambition.

In July 2019, The NHS Patient Safety Strategy - Safer culture, safer systems, safer patients was published to support NHS staff and organisations to ensure that wherever NHS care is delivered it is provided in the safest possible way. The strategy sets a vision of continuous safety improvement, underpinned by a safety culture and effective safety systems. It sets out the NHS safety vision to continuously improve patient safety by building on two foundations: a patient safety culture and a patient safety system across all settings of care, and sets out three principles to support the development of both: Insight; involvement and Improvements. The NHS Patient Safety Strategy includes a commitment to deliver the Maternity and Neonatal Safety Improvement Programme to support reduction in stillbirth, neonatal and maternal death and neonatal asphyxial brain injury by 50% by 2025.

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