Department of Health

Safer Maternity Care

Next steps towards the national maternity ambition

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1. Foreword from the Secretary of State for Health

England is a safe place to have a baby. Dedicated and hard-working NHS staff do an incredible job – 24 hours a day, every day of the year – of bringing new babies into the world and achieving great outcomes for women, newborns and their families.

Since 2010 we have made a sustained investment in maternity services, through capital funds run in 2012-13, 2013-14 and 2015-16. This total investment of almost £40m has been used by trusts to make tangible physical improvements to their maternity care settings, which have directly contributed to improved care for women, their partners and newborns, while also benefiting the staff that care for them. This Government has also made maternal mental health a real priority for the first time, and committed a total of £365 million from 2015/16 to 2020/21 to perinatal mental health services, building on the manifesto commitment to ensure women have access to mental health support during and after pregnancy.

But there is still more that we can do. As the stories from the families at Morecambe Bay University Hospitals Foundation Trust have starkly illustrated, the death or injury of even one new baby or mother is a devastating tragedy which we must all do everything we can to prevent. They show us all, whatever our role in delivering care or supporting those who do so, the importance of promoting a culture which is driven by a shared desire to continuously improve, and learn from its mistakes.

This government has championed patient safety across the NHS, and we want NHS maternity services to become an exemplar of continuous improvement in outcomes through openness, learning, innovation and collaboration - and to demonstrate how the NHS can become the world's largest learning organisation. Working together, we can make England one of the safest places in the world to have a baby.

Safety is the golden thread running through the Maternity Transformation Programme, which aims to drive improvement in our maternity services. Making better use of data, improving women's experiences of care, and ensuring the maternity workforce has regular training will all make a significant contribution to safer maternity services. My Department will work in close partnership with NHS England and our other key national partners to make real strides forward and improve outcomes for mothers and their newborns.

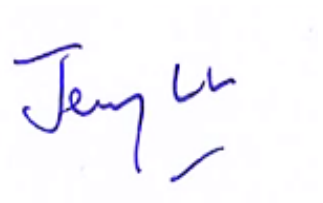
A focus on improving safety is vital but the evidence shows that this stretching ambition cannot be achieved through improvements to NHS maternity services alone. The public health contribution will be crucial. We know that not all women go in to pregnancy with the same risk of something going wrong - a BMI of over 40 doubles the risk of stillbirth and a quarter of stillbirths

are associated with smoking[i]. We also know that perinatal mental illness is one of the leading causes of maternal death[ii].

It is clear that our ambition cannot be achieved through national initiatives alone – we need a strong and energised programme of work on maternity, with partners at local and regional levels coming together to drive improvements and to build a culture of openness where teams can work together to share learning when things go wrong.

This plan asks for your support as NHS staff and as leaders at every level. I encourage you to focus on the improvements that will make a difference in your local area, and to ensure that the teams and cultures you work in are supportive and open to learning and positive change.

Together we can make our maternity services world-leading.



Jeremy Hunt

Secretary of State for Health

It is vital that all of us working in maternity services constantly strive to ensure women and their babies can access the very best maternity care. 'Safer Maternity Care' reflects this ambition. Much of it reflects work that is happily already underway but there is more to be done and in challenging times to achieve that all parts of the system must work together. The Royal College of Midwives is delighted therefore to endorse and support the action plan and looks forward to working closely with everyone involved, particularly our colleagues at the Royal College of Obstetricians and Gynaecologists, to ensure its implementation.

Cathy Warwick CBE, Chief Executive, Royal College of Midwives

THE ROYAL COLLEGE OF MIDWIVES

Everyone involved in providing maternity care in the UK wants the same outcome; the safe delivery of a healthy baby and a healthy mother. The Royal College of Obstetricians and Gynaecologists (RCOG) is therefore delighted to support and endorse the Department of Health's 'Safer maternity care – the next steps towards the national maternity ambition' programme of work. The targets are achievable and they complement the RCOG's current initiatives to improve incident reporting, data collection and above all appropriate analysis to ensure problems are identified early in pregnancy and that we constantly endeavour to share lessons so that better care is provided. The RCOG will play its part in promoting the aims of the ambition and work with the Royal College of Midwives, our midwifery and neonatal colleagues as well as other professionals to implement these actions.

Professor Lesley Regan, President, Royal College of Obstetricians and Gynaecologists

Royal College of Obstetricians & Gynaecologists

2. Call to action

In my clinical work as an obstetrician I have seen inspiring progress on maternity safety over recent years. Across the country, teams are making great strides in addressing unwarranted variation through multi-disciplinary working, sharing clinical best practice, and focusing together on ways to drive improvements in safety and reduce avoidable harm.

The ambition to halve adverse outcomes in maternity care provides further momentum nationally to the system wide approach of the maternity review. We must seize this opportunity to improve outcomes by joint working, shared learning, and best practice quality improvement. By embedding these practices in routine care we will achieve better outcomes and improve the experience of those using our maternity services.

I know that there is real enthusiasm for change in NHS maternity services and I look forward to working with you over the coming years to deliver this action plan.

Matthew Jolly

National Champion for Maternity Safety

As a midwife I know that families need and deserve maternity care that supports safe outcomes for mother and baby. We already have some great practice across the country, where teams are working together to create a culture where safety is the cornerstone of maternity care.

But there is more to do. We need strong leadership at every level to scrutinise what we are doing and understand what we can do better, whether learning from investigations, making best use of training, or improving our understanding and use of data.

We need to ensure that action to improve quality becomes an essential part of each person's job, day after day, in all parts of the system. This action plan will help us focus on how to make the improvements that will really count.

I am excited to be working to support you as you engage with this important opportunity to drive real change in maternity safety.

Jacqueline Dunkley-Bent

National Champion for Maternity Safety

3. Executive summary

This document is an action plan setting out our vision for making NHS maternity services some of the safest in the world, by achieving our national ambition to halve the rates of stillbirths, neonatal deaths, brain injuries that occur during or soon after birth and maternal deaths, by 2030.

We have structured this plan around the five key drivers for delivering safer maternity care, which are based on the guidance set out in Spotlight on Maternity.

Focus on leadership: create strong leadership for maternity systems at every level.

Focus on learning and best practice: identify and share best practice, and learn from investigations.

Focus on teams: prioritise and invest in the capability and skills of the maternity workforce and promote effective multi-professional team working.

Focus on data: improve data collection and linkages between maternity and other clinical data sets, to enable benchmarking and drive a continuous focus on prevention and quality.

Focus on innovation: create space for accelerated improvement and innovation at local level.

What will look different in a maternity service by 2018?

The actions outlined in this plan are for trusts to use to continue to make improvements to the services they provide for women and their newborns. They are actions that will make a difference in each and every maternity and neonatal service across the country, and in a trust that has implemented the main elements of this plan, the following actions will have taken place by 2018:

Focus on leadership

- Board level Maternity Champion appointed. *Target date: January 2017.*
- Maternity Safety Champion appointed in Maternity Clinical Networks. *Target date: February 2017.*
- Trusts will have one obstetrician and one midwife jointly responsible for championing maternity safety in their organisation. *Target date: February 2017.*
- Bespoke Maternity Safety Improvement Plan agreed and made public. *Target date: January 2017.*

Focus on learning and best practice

- Informed by the independent evaluation, NHS England will publish the final version of the Saving Babies' Lives care bundle for use by maternity commissioners and providers by April 2018.
- A package of publications and resources will be available for maternity and neonatal teams to support them to provide safer care and avoid unnecessary separation of mother and baby. *Target date: January 2017.*

Focus on teams

- Learning and development plan in place for entire multi-disciplinary team. *Target date: January 2017.*
- The maternity team has attended maternity safety training, with funding from the Maternity Safety Training Fund. *Target date: March 2017.*

Focus on data

- Trust is reporting to Maternity Services Dataset and other key data sets such as MBRRACE-UK, the Royal College of Obstetricians and Gynaecologists' Each Baby Counts programme, the National Neonatal Dataset and the new National Maternity and Perinatal Audit. *Target date: September 2018 although trusts should prioritise early implementation wherever possible.*
- Maternity and neonatal teams are using the Standardised Perinatal Mortality Review Tool to review and share learning from every stillbirth and neonatal death, when it is available.
- Maternity team is using national indicators dashboard to track their outcomes over time and benchmark against other organisations in their local maternity system and across the region. *Target date: March 2018.*

Focus on innovation

- The maternity team will be taking part in the new national Maternal and Neonatal Health Quality Improvement Programme in their region. *Target date: February 2017.*
- Individual or team may have applied for and used funding from the Maternity Safety Innovation Fund to develop an innovative idea. *Target date: March 2017.*

4. Introduction

What is this document?

Safer Maternity Care: next steps towards the national maternity ambition is an action plan setting out our vision for making NHS maternity services some of the safest in the world.

The plan details the actions needed at national and local level that will help us to build on the progress we have already made to improve the safety of maternity services. Earlier this year, the guidance document Spotlight on Maternity was published via Sign up to Safety. This document set out guidance under five themes, to support trusts to plan local actions that contribute towards achieving the national ambition. A national learning event, Maternity Care: Learning Together, was held in March 2016, during Patient Safety Week. This brought together around 200 clinicians from maternity teams across the country to learn from each other and share best practice.

This plan aims to bring together advice from experts and build on the themes set out in Spotlight on Maternity to provide more in-depth guidance and support to local maternity systems seeking to provide the safest possible services for women and newborns.

Whilst this plan is primarily about improving safety in maternity settings, everyone has a part to play across the health system if we are to achieve our national ambition. The plan is part of the 'Promoting good practice for safer care' workstream of the Maternity Transformation Programme, through which the health system is working together to respond to the vision set out in the National Maternity Review, Better Births. Safety for women and newborns is a key theme running through the entire programme and the different strands of the programme, set out in the next page, will all contribute to achieving the ambition.

The nine workstreams of the Maternity Transformation Programme

1. Supporting local transformation
2. Promoting good practice for safer care
3. Increasing choice and personalisation
4. Improving access to perinatal mental health services
5. Transforming the workforce
6. Sharing data and information sharing
7. Harnessing technology
8. Reforming the payment system
9. Improving prevention

Who is this plan for?

This plan is for all those working in local maternity systems – the clinical staff who directly deliver the services, as well as managers, leaders and commissioners. It aims to provide the systems, tools and guidance to enable everyone caring for new and expectant mothers, their newborns and families to improve in the care they provide.

How should I use this plan?

This action plan should be used alongside Spotlight on Maternity and other useful resources and tools collated by the Sign up to Safety team which are easily accessible at www.signuptosafety.nhs.uk/maternity. Sign up to Safety will continue to host regular, free webinars and provide ways for people to share and showcase their progress. Support will also be signposted via the weekly, free SignUPdate newsletter and campaign twitter account.

Will this plan be updated?

The ambition spans a fifteen year period. We will continue to revisit and update plans over that period to meet future needs and take into account future developments. This plan therefore focuses on immediate actions that need to be taken at all levels of the system over the next 12 to 18 months to improve maternity safety. Longer term actions are indicative and may need to be adapted in future years. We will refresh them alongside future annual reports of progress against the national ambition.

5. Our vision: an ambition for change

The NHS is a safe place to give birth. Maternity services in England are safe and high quality, and outcomes are improving. The stillbirth and neonatal mortality rates fell by 12% and 10% respectively between 2010 and 2015[iii]. The majority of women have a positive experience of childbirth and good outcomes.

Although progress has been made in recent decades, national and international evidence demonstrates that there is still more that we can do. Our outcomes do not reflect our potential. Our stillbirth rate in particular remains unacceptably high when compared to other similar countries – the Lancet Stillbirth Series, which was published in January 2016, ranked the UK 24th out of 49 high-income countries[iv]. This same publication showed that our annual rate of stillbirth reduction of 1.4% is much slower than many other countries –for example, the Netherlands achieve 6.8%[v].

In November 2015 the national maternity ambition was launched, setting out the aim to reduce the rates of stillbirths, neonatal and maternal deaths and brain injuries that occur during or soon after birth in England by 50%. To make sure progress is being made quickly, we have set out that we expect to see a reduction of 20% by 2020.

There is more we can do in maternity services to improve outcomes faster. We know that there are variations in outcomes linked to socio-economic and geographical differences. We also know that high quality maternity care can and does make a difference to outcomes for mothers and newborns. For example, the variation in stillbirth rates across England cannot be explained solely by differences in women's risk factors – the quality of care that women receive affects their outcomes. The evidence shows that more than half of all term antepartum stillbirths had at least one element of care that required improvement and may have made a difference to the outcome[vi]. Similarly for maternal deaths, the confidential enquiry led by MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) found that basic observations and rapid actions have the potential to save women's lives, for example in relation to sepsis[vii].

As the health system begins to implement the vision set out in Better Births, now is the time for all those caring for and supporting new and expectant mothers and their babies to come together to make NHS maternity services as safe and effective as they can be.

6. Taking action

Focus on leadership

Why focus on leadership?

We will not achieve our national ambition unless everyone caring for pregnant women and newborns is determined to succeed. Strong leaders work across system boundaries and promote professional cultures that support teamwork, continuous improvement and service user engagement. They can pave the way for the kind of culture change that we need in order to make sure women and newborns get the best and safest care - a culture where learning from investigations and other services is the norm. In local areas, improvements will only be successful if organisations providing maternity and newborn services have strong, supportive leaders that take responsibility for improving these services as well as providing them.

Leadership at every level

At national level, we have appointed two **national Maternity Safety Champions**, Matthew Jolly, Consultant Obstetrician and NHS England National Clinical Director for Maternity and Women's Health, and Professor Jacqueline Dunkley-Bent. Head of Maternity, NHS England. They will lead the way by working across professional groups and system boundaries to maintain a continuous emphasis on high quality, safe maternity care for women and newborns. They will promote learning and innovation, seeking out best practice and sharing it across the system.

At a regional level, the 12 Maternity Clinical Networks bring professionals, providers, commissioners and experts together to share information, best practice and learning to develop care pathways that are responsive to the needs of their local populations. The most effective networks are built on supportive multi-professional relationships and collaborative working with a focus on specific initiatives to improve care quality. Networks have a unique role to play in reducing the variation in adverse maternity outcomes that currently exists between providers and regions. We are therefore looking to the **Maternity Clinical Networks to designate a Maternity Safety Champion** to act as a local quality improvement adviser, coach and conduit for sharing learning arising from national and international research and from local investigations or initiatives. Relationships between Maternity Clinical networks and Neonatal Operational Delivery Networks should be fostered and developed and the Maternity Safety Champion role should extend to include strong collaboration with neonatal networks.

At local level, we need to ensure leadership at all levels of our organisations. We need to empower the whole workforce to take a lead in identifying opportunities to improve, to develop a culture where all staff feel a responsibility to contribute towards improving the care they provide.

Senior trust managers will want to ensure unfettered communication from 'floor-to-board' by appointing a **board level Maternity Champion**. As Spotlight on Maternity set out, all organisations should ensure a board-level focus on improving safety and outcomes in maternity services, as well as ensuring senior leaders are routinely visible to and learning directly from both those providing and receiving care. Maternity safety should be a priority item at Board

meetings, with the Board taking action where needed, as well as regularly monitoring quality and safety outcomes. To maintain momentum, we would expect all boards to have a Maternity Champion in place by January 2017. As outlined in Spotlight on Maternity, champions will want to ensure that a bespoke Maternity Safety Improvement Plan for their organisation is agreed and made public.

We also expect that trusts will wish to designate **one obstetrician and one midwife** to be jointly responsible for championing maternity safety in their trust, making appropriate links to the Board, the local Maternity Clinical Network and to the Maternal and Neonatal Health Quality Improvement Programme in their region.

To ensure that maternity units have the right leadership on their labour wards, Health Education England has worked with NHS Improvement, the 'atain' programme[1], the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives to develop a leadership training programme for labour ward coordinators and obstetricians. This will be launched in 32 trusts by the winter. It will focus on safety leadership, culture change, risk identification and handover. These pilot sites will be followed by further roll-out subject to evaluation.

We also need the right leadership in the commissioning of maternity and neonatal services. In local maternity systems, we expect that a **lead commissioner for maternity safety** will champion the most effective commissioning of maternity services and hold providers to account for improving outcomes.

[1] 'atain' is an acronym for 'avoiding term admissions into neonatal units' and is a programme of work to reduce harm leading to avoidable admission to a neonatal unit for infants born at term i.e. at or beyond 37 weeks gestation. https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/

Focus on learning and best practice

Why focus on learning and best practice?

It is essential that leaders promote a learning culture across their organisations and networks – a culture that will make it easier for learning from investigations to be implemented, and best practice to be shared and adapted by other services. There are many examples of innovative practice in NHS maternity and neonatal services and it is important that we build on these local successes and share the learning across the country. The new national Maternal and Neonatal Health Quality Improvement Programme, outlined on page 22, will also provide opportunities for teams to come together and learn from each other in a structured way.

Learning from best practice

Improving the quality of care across the maternity pathway, from the first booking appointment to delivery and postnatal care, is fundamental to improving outcomes for women and newborns. Effective, collaborative commissioning of services across organisational boundaries will enable the delivery of the right care in the right place at the right time. Getting personalised care in place early is crucial, as a preventative approach to reducing the rates of stillbirths, neonatal deaths, maternal deaths and brain injuries that occur during or soon after birth. Two examples of best practice are the Saving Babies' Lives care bundle and the 'atain' programme. Both should be used at a local level to implement change, as they are of particular relevance to our national maternity safety ambition.

In March 2016 NHS England published the **Saving Babies' Lives care bundle**, which is designed to support providers and commissioners to tackle stillbirth and early neonatal death in a focused way. It brings together four key elements of care and related recommendations in order to improve practice in the areas of: smoking in pregnancy; fetal growth restriction; reduced fetal movement; and fetal monitoring during labour. NHS England is working closely with Maternity Clinical Networks to track implementation and support commissioners and maternity care providers to deliver the bundle's requirements locally. Furthermore, work to understand the impact of the care bundle is ongoing with the University of Manchester.

By providing services and staffing models which keep mother and baby together we can reduce the harm caused by separation The **'atain' programme**, led by NHS Improvement in collaboration with clinical experts, identified that over 20% of admissions of full term babies to neonatal units could be avoided. Separation of mother and baby after birth contributes significantly to postnatal mental health morbidity and should be avoided where possible. Early opportunities for bonding optimise long term outcomes for babies, mothers and families. We want all maternity and neonatal services to work together to identify babies whose admission to a neonatal unit could be avoided and to promote understanding of the importance of providing models of care which keep mother and baby together when safe to do so.

We know that variation in practices to screen babies for conditions such as jaundice and low blood sugar levels have led to avoidable brain injury[viii]. We want maternity and neonatal teams to standardise local practices, drawing on national guidance and best practice models to reduce harm in these areas.

It is essential that we learn from best practice not only in our maternity services but also our public health and perinatal mental health services. The evidence shows that the national ambition cannot be achieved through improvements to NHS maternity and neonatal services alone. The public health and prevention contribution will be crucial. Not all women will have the same risk of something going wrong in pregnancy or during labour. Women's health before and during pregnancy – including weight, perinatal mental health, smoking and alcohol use – are some of the factors that most influence rates of stillbirths, neonatal deaths and maternal deaths.

Prevention

Prevention in individual care pathways and at community and population level is particularly important in the drive to achieve the national ambition. Improving both public health and preventative clinical practice is required to engage with communities and high risk populations where outcomes are poorer and to support maternity services as they are providing care for women with increasingly complex pregnancies. For example, the average maternal age is increasing, obesity is rising in women of childbearing age, and more women with pre-existing medical conditions such as diabetes or epilepsy are becoming pregnant.

Public Health England (PHE) is leading the 'improving prevention' workstream of the Maternity Transformation Programme. This involves a range of work to prevent poor outcomes through action to improve women's underlying health, both in the preconception period and during and after pregnancy, since pregnancy is a window of opportunity to encourage women to live healthier lifestyles. The work focuses on reducing levels of the risk factors known to influence poor outcomes, including rates of stillbirths, neonatal deaths and maternal deaths. These include smoking during pregnancy, obesity and substance misuse.

PHE's work includes promoting best practice in whooping cough and flu immunisation in all pregnant women, improving awareness of the Chief Medical Officer's advice on drinking alcohol in pregnancy and promoting healthy weight for all women before and during pregnancy, as well as prevention and early help in perinatal mental health.

We know that smoking is the single most important modifiable risk factor in pregnancy and that reducing smoking in pregnancy reduces the likelihood of stillbirth. PHE is working to support a reduction in the rate of maternal smoking by increasing routine carbon monoxide monitoring of pregnant women at booking and other antenatal appointments. Working in collaboration with NHS England, PHE is developing a plan highlighting where action is required across the system. This will be linked to the government's ambition to reduce the prevalence of smoking during pregnancy.

In partnership with Sands and Best Beginnings, we have launched the Our Chance campaign to support women to understand advice about healthy pregnancies and how to act on it. The Our Chance campaign centres on 24 films which highlight the crucial risk factors during pregnancy and the postnatal period which may lead to adverse outcomes for the woman or her baby. It is vital that mothers and mothers-to-be understand these risk factors, the impact that they can

have on outcomes for them and their babies, and the lifestyle changes they can make to increase their likelihood of positive outcomes.

To ensure that midwives are well equipped to support women to do this, the Royal College of Midwives' 'Stepping Up for Public Health' project has developed a model for the role of midwives and maternity support workers in public health. The project provides access to evaluated online public health information sources, so that midwives can personalise care by supporting women to choose additional public health information relevant to them. It also identifies the need for specialist public health services for midwives to refer women to.

Perinatal mental health

Perinatal mental illness is one of the leading causes of death for mothers during pregnancy and the year after birth. We know that between 10 and 20 per cent of women develop a mental illness during pregnancy or within the first year after giving birth, and four in every 1000 women will experience complex or severe perinatal mental illness requiring psychiatric in-patient care in a specialist mother and baby unit[ix].

We are fortunate that there is widespread agreement about 'what good looks like' in perinatal mental health. We know what services are needed and how they should be organised. To ensure that these services are developed and women have access to the right care at the right time and close to home, the Government has committed to invest a total of £365 million from 2015/16 to 2020/21. NHS England has started work to expand perinatal mental health networks across the country. These networks, recommended by the National Institute for Health and Care Excellence (NICE), play a key role in sharing good practice and identifying care pathways for women in a local area, supporting all health professionals involved in caring for women during pregnancy and after birth.

Midwives and health visitors play a key role in early identification of risk, detection of perinatal mental health issues and appropriate referral to perinatal mental health services. They also help with the management of anxiety and mild to moderate depression and other perinatal mental illnesses.

Learning from investigations

As well as learning from best practice, is important that maternity teams learn from local investigations of deaths and injuries and also from 'near misses' when potential harm was averted. Staff, as well as women and their families, must be able to discuss problems with care in an open and honest way, and consistent investigations must be carried out with a focus on driving learning and improvement.

In Learning not Blaming, the Government response to the Public Administration Select Committee report, the Freedom to Speak Up report and the Morecambe Bay Investigation published in July 2015, the Government announced it would establish a **new independent patient safety investigation** branch (HSIB) to conduct investigations in the NHS. HSIB will

carry out investigations and share its findings, helping improve investigation practice and capability in the NHS by acting as an exemplar to the rest of the healthcare system. HSIB will operate with a particular focus on maternity cases for its first year.

A new **Standardised Perinatal Mortality Review Tool** will be developed to enable maternity and neonatal services to systematically review and learn from every stillbirth and neonatal death in a standardised way. These reviews will then be submitted and used centrally to understand national trends and extract concrete learning. The tool will enable teams to provide clear and accurate information to parents about why their baby died, and will also help staff understand where lessons can be learned and future care can be improved.

The Department of Health (DH) is considering ways to reduce future incidents of harm through **improving learning in cases of severe neurological birth injury**. Better Births recommends that the DH consider a Rapid Resolution and Redress (RRR) compensation scheme for cases where ‘avoidable harm’ has occurred during the labour or delivery process, citing evidence of the effectiveness of a similar scheme operating in Sweden. DH plans to launch a public consultation on the policy and elements of scheme design, such as eligibility, in the coming months. Alongside this, DH is working with the NHS Litigation Authority to change the way in which premia for the Clinical Negligence Scheme for Trusts (CNST) are calculated to reward trusts that are able to demonstrate improved outcomes in maternity care.

Focus on teams

Why focus on teams?

Every pregnant woman, regardless of her circumstances, will receive care from a multidisciplinary team, whose expertise may include sonographers, obstetricians, neonatologists, maternity support workers, GPs, anaesthetists and fetal medicine consultants, co-ordinated by her midwife. The most effective teams are those in which every highly-trained individual understands the roles of their colleagues and the value they bring to the women and newborn they care for. They train together, communicate easily and are prepared to raise concerns.

Embedding continuous learning and multi-disciplinary training will help to support a positive culture in maternity and neonatal services, increase motivation, share the responsibility for improving services and reducing harm, and ensure a greater capacity for change and innovation. It will improve communication and information dissemination within and across teams. Healthcare professionals in maternity services particularly identified the importance of multi-professional education and training in Better Births[x]. Training together is critical to effective multidisciplinary team working, but human factors also influence how functional a team is, and maternity and neonatal teams may wish to consider training that covers human factors such as personality types or promoting team morale.

We also recognise the importance of appropriate staffing levels. Health Education England's forecasts of future supply indicate that we are training more people to enter the workforce as qualified midwives and obstetric and gynaecology CCT-holders than we forecast will leave the system.

Multi-disciplinary training

In recent years various multi-professional training programmes have been identified and championed in some parts of the country; however, there has not been a consistent approach to the type or standard of training. Health Education England have been working with partners, led by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, to better understand the training needs for the multi-disciplinary teams working within maternity services. Health Education England have developed a **national catalogue of maternity safety training programmes**. The catalogue includes modules on leadership and multi-professional team working as well as midwifery and obstetric skills.

There is no 'one size fits all' solution – the training needs of different maternity units will vary. For that reason, as set out in Spotlight on Maternity, every organisation should work with staff to carry out a training and development self-assessment for their maternity team, to ensure an accurate and agreed understanding of the gaps. They should develop and implement a **learning and development plan** for the entire multi-disciplinary team, determining the appropriate training programme from the Maternity Safety training catalogue.

Maternity Safety Training Fund

From October 2016 trusts will be able to apply for a share of the **£8m Maternity Safety Training Fund**, to support them in providing training for their staff. Trusts will apply for funding from Health Education England, using their self-assessment to ensure the training is targeted to the needs of individual teams. Going forward, we will be looking at how to more effectively embed safety into existing training and continued professional development for doctors and midwives.

Focus on data

Why focus on data?

Accurate, consistent data collection is vital to enable us to measure outcomes across the NHS, so that we can understand where progress is being made and where more needs to be done. Good data drives quality, enabling trusts to compare and benchmark their performance, highlighting opportunities for improvement. Good data also drives prevention at individual community and population levels. Sharing data across local maternity and neonatal networks will help teams to develop innovative solutions to challenges within their services.

A **new National Maternity and Perinatal Audit** led by the Royal College of Obstetricians and Gynaecologists will evaluate the quality of care received by women and newborns cared for by NHS maternity services. By collecting robust information on outcomes, this audit will allow healthcare professionals, NHS managers, commissioners and others to examine the extent to which current practice meets clinical guidelines and standards and to compare services and maternal and neonatal outcomes among maternity units.

A **national indicators dashboard**, offering a range of metrics that trusts will be able to select to focus attention on, will be established by 2018. The dashboard will enable multi-professional teams in local maternity and neonatal services to make better use of routinely collected data in order to track their outcomes, benchmark their performance and improve the quality of their services. Multi-professional teams should meet regularly to review performance against the indicators, alongside other clinical and patient experience data, to understand where there is scope to improve their services.

As the Maternity Services Data Set becomes established, there will be a real opportunity for local services to understand where they are doing well, and where they need to drive improvement. Currently, not all trusts are submitting the data that enables this type of comparison. However, **all trusts will be mandated to submit data to the Maternity Services Dataset by 2018**. We welcome those who are already fast tracking this to achieve it earlier. We expect trust chief executives to ensure that maternity information systems will be in place and compliant with reporting data to the Maternity Services Data Set and other key data sets.

Focus on innovation

Why focus on innovation?

We know it is vital for organisations to learn from examples of best practice and from investigations into problems with care, in order to improve care and reduce regional variations. We need to accelerate the pace at which this learning is translated into practice, by encouraging a culture of innovation and drive for continuous improvement.

Maternal and Neonatal Health Quality Improvement Programme

To support organisations across local maternity systems to do this **we will launch a new national Maternal and Neonatal Health Quality Improvement Programme** to provide structured support for maternity and neonatal teams to develop innovative ideas and turn them into plans for measurable improvements to their service.

National and international maternity, neonatal, patient safety and quality improvement experts will provide the vision for improvement, leadership, and coaching for participating maternity and neonatal teams. Funding will support teams to attend regular quality improvement learning events, which will be followed by 'action periods' for services to test new care practices within their maternity services. Frontline staff and commissioners will be supported through regular networking events and access to a range of tools and resources.

This approach has been linked to improvements in maternity quality and safety outcomes in other places including Scotland, where there has been substantial progress in reducing the stillbirth rate in recent years.

Maternity Safety Innovation Fund

Through the **new £250,000 Maternity Safety Innovation Fund** we will invite open applications for pioneering proposals for new ways to drive improvements in maternity safety, and provide funding for the best ideas to be developed and rolled out. Individuals and organisations will be able to bid for the funding from the Department of Health.

7. Measuring progress

Understanding local progress

We will use a range of measures to understand how local areas are performing on maternity and neonatal safety, and offer expert advice and support to areas with the most scope for improvement, including support to participate in the national Maternal and Neonatal Health Quality Improvement Programme. These measures will include the CCG Improvement and Assessment Framework (IAF), which will assess CCGs against a number of key maternity indicators. They will also include measures of provider performance such as the new National Maternity and Perinatal Audit, which will evaluate the quality of care received by women and newborns cared for by hospital services, and the annual surveillance conducted by MBRRACE-UK to monitor and report on rates of stillbirth and neonatal deaths.

Reporting on progress

We will measure our progress against the national ambition, and the Government will publish an annual report each year. The annual report will assess progress at both national and local levels. As outlined in Spotlight on Maternity, trusts should ensure that a bespoke Maternity Safety Improvement Plan is agreed and made public, and this will input to the annual report.

We will use 2010 as the baseline year for the annual report and our progress against this baseline will inform updates to the maternity safety action plan.

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